Healthy Attitudes:
Quality of Working Life in the London NHS 2000-2002

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Healthy Attitudes: Quality of Working Life in the London NHS, 2000-2002

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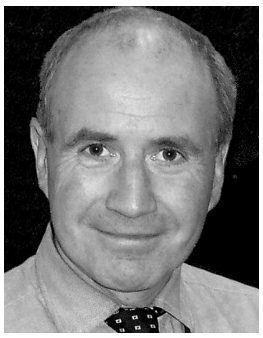


David High

London SHRINE
Delivering Modernisation

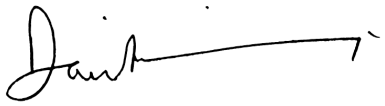
The London NHS *Quality of Working Life* Staff Attitude Survey had modest and some might say inauspicious beginnings. *Working Together*, the first Human Resource Strategy for the NHS, was published in September 1998; this required all NHS employers to carry out annual surveys of the attitudes of their staff – something very few had ever done before. On a gloomy and overcast day in the autumn of that year, the then Inner London HR Directors Group, meeting at St Thomas' Hospital, decided that a common London-wide survey instrument should be developed. I foolhardily agreed to lead a steering group to implement the project. After a competitive process the steering group, in the summer of 1999, awarded the contract to develop, administer and report on the survey to the Institute for Employment Studies (IES), a not-for-profit institute with a long history of employee surveys in both the public and private sectors.

Since then there have been three annual surveys. A total of 99 London employers have participated (Trusts, PCTs, Health Authorities and others) and a total of 97,000 employees have completed questionnaires (33,500 Nurses and Midwives, 5,500 HCAs/Nursing Auxiliaries, 5,500 Doctors and Dentists, 20,000 Therapists, Scientists and Technicians, and 30,000 Administrative & Clerical, Support and Senior Managerial staff). In the 2002 survey, 23 per cent of London's entire NHS workforce (around 124,000) participated by completing a questionnaire. This report encapsulates their views.

The very good news is that, at a time of unprecedented change and pressure, staff consistently report that the NHS in London has become, in almost every respect, a better place to work. This result is a tribute to a large number of managers and staff working in London's Health Services — Boards, Chief Executives, Directors of Human Resources, as well as line managers, trade union representatives and staff too numerous to mention.

On behalf of the steering group, I would like to thank all those involved, and of course IES, without whose professionalism and efforts this project would not have been such a success. The new National Survey, organised by the Commission of Health and Improvement (soon to be CHAI), has now taken over from the London survey. Agreement has been reached that a London report will be produced, which will allow the benchmarking

between employers in London, and the tracking of changes within individual London organisations, to continue.



David High

Director of Human Resources and Corporate Development at The Lewisham Hospital NHS Trust

Chair of the London NHS *Quality of Working Life* Staff Attitude Survey Steering Group

Issues overview

London NHS staff are, in their responses to the (QWL) survey between 2000 and 2002, giving a clear message that things are improving

- Attitudes towards the different aspects of working life have improved, accidents and injuries have decreased, harassment has declined, and respondents are more likely to say that they intend to stay in their jobs.
- London NHS employers have put considerable energy into extending the coverage of appraisals and PDPs.
- On all key attitude dimensions, views have improved. Only one dimension — pay — still has a negative average score. Respondents, overall, are very positive about colleagues, jobs satisfaction and immediate management.
- Although views about health and safety have improved, workplace cleanliness and security remain issues to be tackled further.
- The picture on equal opportunities is positive overall, although minority ethnic respondents, and those with a disability/ medical condition, are less sure that they get a fair deal.
- Working patterns are changing, with more staff working days rather than shifts or on a rota.
- The workforce is ageing, which raises issues about the attractiveness of the public sector as a place to work for younger people. Although pay is not a powerful factor in retention, it appears to be far more important in recruitment.
- Support, Administrative & Clerical and Technical staff are less satisfied than those in managerial, clinical professional and patient-facing roles.
- Access to training and development processes and opportunities, though improving, is not equal across staff groups.
- Senior Managers — the people charged with the responsibility of improving working life for staff working in the London NHS — are displaying increasingly high stress levels.
- Encouragingly, staff are showing increasing confidence that their views will be heard and acted upon.

1. Issues Overview

Sarah Perryman and Dilys Robinson

1.1 Background

In 1999, the Institute for Employment Studies (IES) was commissioned to carry out employee attitude surveys on behalf of a consortium of NHS Trusts/PCTs and Health Authorities in London. The resulting series of surveys — in 2000, 2001 and 2002 — has created a huge, rich data set, comprising both descriptive data (biographical and job details) and information about the experiences and attitudes of staff working for the London NHS.

The original impetus for the surveys was the HR strategy document *'Working Together: Securing a quality workforce for the NHS'*, published in the autumn of 1998. This signalled the Government's intention to identify and promote, within the NHS, some core principles of best human resource management practice. An important plank of the strategy was the belief that the views of NHS staff should be sought, regularly, via attitude surveys — at the time, a relatively under-used tool within the healthcare sector. Now, several years on, NHS staff have become familiar with surveys and, as a result, have an expectation that their views will be sought, listened to, and acted upon. At a time when the NHS is looking forward to the results of its first ever national staff survey, it is appropriate to look back over the three year period and attempt to draw some conclusions, and highlight some issues, of particular relevance to the London NHS.

The 2001 issues paper drew attention to the particular challenges faced by the NHS in London, and these have not changed. The concentration of large teaching hospitals in the capital means that specialist skills are in constant demand, while the very high cost of living brings serious recruitment and retention difficulties. Housing prices mean that many employees have to travel considerable distances to work, which in turn lessens opportunities for part-time employment (used extensively by the NHS outside London). In addition, London has areas of inner city deprivation, with associated health problems, and also has to cope with huge numbers of visitors to the capital every year. In common with the rest of the NHS, London has seen structural changes over the three-year period, with many Trust mergers and de-mergers, and the creation of new Primary Care Trusts (PCTs) and Strategic Health Authorities.

This overview chapter will draw out the main themes and issues of the *Quality of Working Life (*QWL*)* surveys in London over the three-year period. It is accompanied by a series of chapters that delve more deeply into some of the varied aspects of working life that make the London NHS such an interesting and vibrant place to work.

1.2 It has all been worthwhile

Perhaps the main message to emerge from the three years of attitude surveys is that things are improving for London NHS employees. Attitudes overall have become more positive, people are experiencing fewer accidents and injuries and are happier with health & safety, views about equal opportunities have improved and harassment has decreased, and respondents are more likely to say they intend to stay with their employing Trust/PCT. There are clear links between these improvements and the action that London NHS employers have taken in response to survey findings. For example, the first survey uncovered a strong link between the coverage of appraisals and performance development plans (PDPs) and overall attitude scores. As a result, Trusts, PCTs and HAs have worked hard to increase coverage, and this has paid dividends. Similarly, NHS employers in London have put energy into tackling many health and safety and harassment issues over the past three years, at least partly in response to the messages given to them by respondents to the first survey.

1.3 Notable improvements in key QWL dimensions

The surveys asked London NHS staff to give their views about many aspects of working life by responding to a variety of statements using a five point scale ranging from 1 (strongly disagree/very dissatisfied) to 5 (strongly agree/very satisfied). The midpoint of the scale, indicating a neutral view, is 3, so any scores above 3 can be interpreted as positive, and scores under 3 as negative. To assist analysis and make the results easier to interpret and understand, these statements have been grouped together statistically into overall themes. Table 1.1 shows clear improvements in almost all aspects of working life, with only the 'pay and benefits' cluster remaining level, and no downward trends.

Table 1.1: Mean scores for clusters, 2000 to 2002

	Trend	2002	2001	2000
Communication	Up	3.2	3.1	3.1
Pay and benefits	Level	2.5	2.5	2.5
Performance and appraisal	Up	3.1	3.0	2.9
Feeling valued and involved	Up	3.1	3.0	3.0
Training, development and career	Up	3.4	3.3	3.1
Job satisfaction	Up	3.8	3.8	3.5
Commitment to the Trust/PCT	Up	3.2	3.1	3.0
Immediate management	Up	3.6	3.5	3.3
Co-operation	Up	3.0	2.9	2.9
Colleagues	Up	3.9	3.8	—
Stress and work pressure	Up	3.1	3.0	3.0

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

1.4 Positive trends in training and development

1.4.1 Formal, off-the-job training days

Respondents give mixed messages about this aspect of working life. Table 1.2 shows that the percentage of those experiencing no formal training during the year has decreased since 2000, but this still means

Table 1.2: Training days — overall (per cent)

	Trend	2002	2001	2000
No training	Down in last year	23.7	25.0	24.5
1-5 days training	Down	48.6	47.3	47.8
6-10 days training	Up	17.5	16.4	16.0
Over 10 days training	Down	10.2	11.2	11.7

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

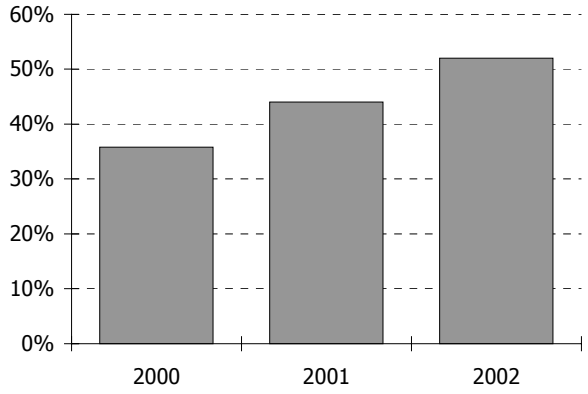
that almost a quarter of London NHS staff are receiving no formal training from one year to the next. Table 1.3 indicates that the mean average number of training days is on the decrease, although the median (middle value) has remained the same over the three-year survey period. Further investigation reveals differences by staff type and Trust type, described further in Chapter 7 ('The Incidence and Impact of Training').

Table 1.3: Average training days

	Trend	2002	2001	2000
Mean	Down	5.2	5.3	5.5
Median	Level	3.0	3.0	3.0

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Figure 1.1: Prevalence of personal development plans — overall



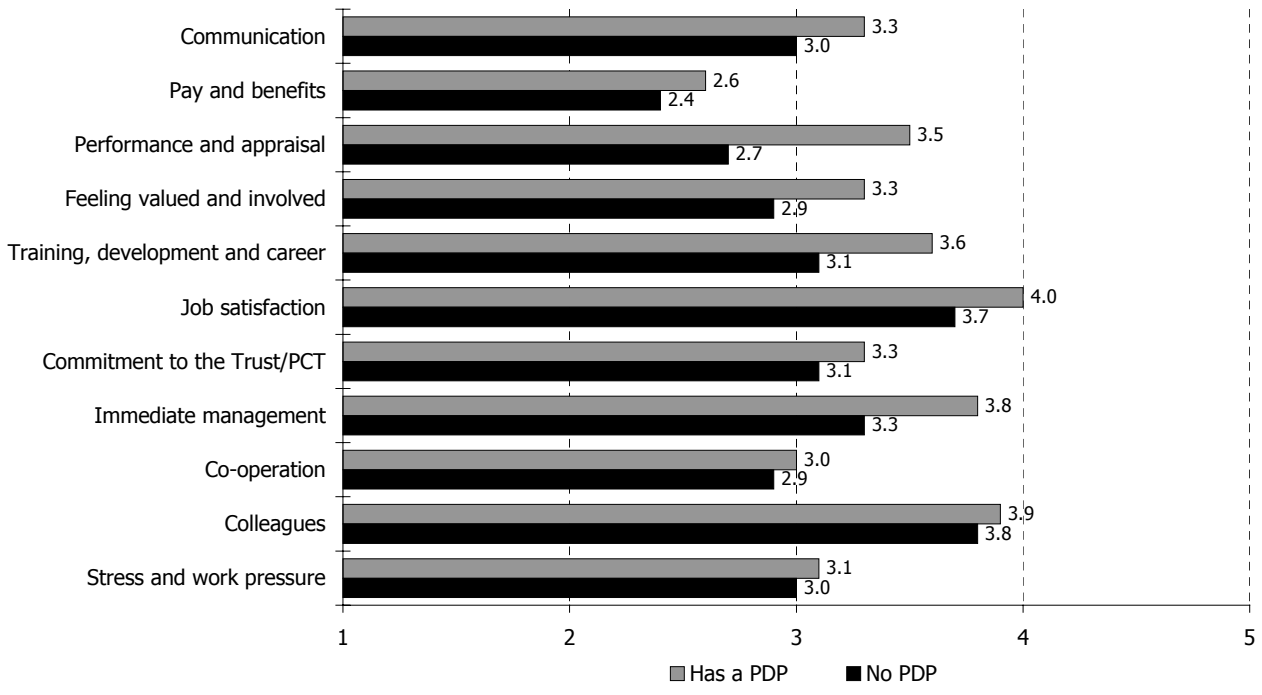
Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

1.4.2 Personal development plans

Moving away from formal to less formal training and development, it is very encouraging to see a notable growth in the prevalence of PDPs — an increase in coverage from around one-third of staff in 2000, to over half in 2002 (see Figure 1.1). Further analysis by Trust type (see Appendix Table 1.1) indicates that this increased coverage is general, rather than concentrated in any one type of Trust, although it is apparent that staff in PCTs are more likely to have a PDP than those in other types of Trust.

The increase in coverage of PDPs is important, because having a PDP is linked with having more positive attitudes about the whole of working life — not just those aspects concerned with training,

Figure 1.2: Mean scores for clusters and presence of a PDP, 2002



Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Table 1.4: Assessment of development opportunities and cluster mean values, 2002

	Excellent/ Good	Adequate	Poor/ Non-existent
Communication	3.5	3.2	2.9
Pay and benefits	2.9	2.6	2.2
Performance and appraisal	3.7	3.3	2.6
Feeling valued and involved	3.6	3.2	2.7
Training, development and career	3.9	3.5	2.9
Job satisfaction	4.2	3.9	3.6
Commitment to the Trust/PCT	3.6	3.3	2.9
Immediate management	4.0	3.7	3.2
Co-operation	3.2	3.0	2.8
Colleagues	4.1	3.9	3.7
Stress and work pressure	3.2	3.1	2.9

Source: IES NHS Staff Attitude Surveys, 2002

development and appraisal (see Figure 1.2). Note that all these differences in scores are significant statistically — that is, the probability that they could have happened by chance, rather than representing real differences in attitudes, is practically non-existent.

It is also noteworthy that respondents with a PDP get more formal training than their colleagues without a PDP (see Appendix Table 1.2), though this link is less clear now than it was in 2000. The difference in days between those with, and those without, a PDP is significant statistically.

1.4.3 Formal performance appraisal reviews

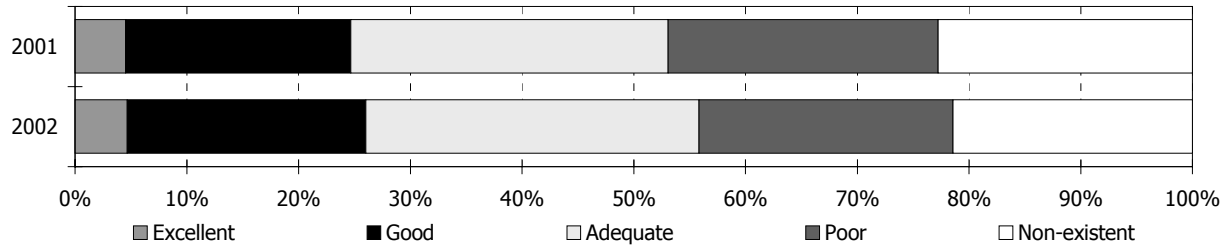
In 2001, the QWL survey asked respondents whether or not they had experienced a formal performance appraisal during the past year. This is another area that has seen a notable increase in coverage — from 48 per cent of respondents in 2001, to 54 per cent in 2002 (a statistically significant increase).

The coverage of performance appraisals is important because, as with PDPs, mean scores on the main clusters are higher among people with performance appraisals, and these differences are all significant statistically. Those who have received an appraisal also get more formal training days (a mean of 6.2 days, compared with 4.2 days for those who have not been appraised).

1.4.4 Less-formal development opportunities

Figure 1.3 shows the ratings given to respondents when asked about their access to less-formal development opportunities such as secondments, coaching, multi-disciplinary group working and special projects. The improvement in attitudes is clear, with a higher percentage of staff in 2002 rating their access as 'adequate' or better.

Figure 1.3: Assessment of development opportunities 2001 and 2002 — overall



Source: IES surveys, 2001, 2002

However, over one-fifth of respondents still rate their access to such opportunities as 'non-existent', and this view is particularly prevalent among staff who are in support roles, rather than clinical professionals and managers. Appendix Table 1.5 shows that views vary by Trust type, with staff in Acute Trusts having the lowest opinion of their access to development opportunities.

Access to development opportunities appears not only to broaden the horizon for respondents, but also to make them feel more positive about working life in general. The average scores for those who rate their access as 'good' or 'excellent' are significantly higher than those who opted for 'adequate', 'poor' or 'non-existent' (see Table 1.4).

Access to development opportunities is also linked to the number of training days experienced by respondents (see Appendix Table 1.6).

1.5 Better health and safety at work

1.5.1 Fewer staff experiencing accidents and injuries

Table 1.5 shows that fewer respondents are experiencing accidents or injuries at work, and that those who are unfortunate enough to have such an experience, are having fewer accidents. An analysis by Trust type, however (see Appendix Table 1.7), highlights two areas of concern. Firstly, the downward trend is not universal when comparisons are made between 2001 and 2002, in that respondents in Teaching Trusts appear to be experiencing more accidents and injuries, rather then fewer. Secondly, the percentage of respondents who said they had reported their accident or injury is fairly low and, in most Trust types, is decreasing.

Table 1.5: Accidents and injuries — overall (per cent)

	Trend	2002	2001	2000
No accidents	Up	84.1	83.0	81.6
1	Down	9.7	10.1	11.1
2	Down	3.6	3.9	4.2
3-5	Down	2.1	2.3	2.3
6 or more	Down	0.6	0.7	0.7

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Table 1.6: Health and safety (mean values)

	Trend	2002	2001	2000
Physical work environment	Up	3.1	3.0	3.0
Health and safety training in this Trust/PCT	Up	3.3	3.2	3.2
The cleanliness of the working environment	Up	2.9	2.8	—
Access to staff counselling	Up	3.2	3.1	3.1
Managers' attitudes to health and safety issues	Up	3.5	3.5	3.4
The quality of the equipment used in job	Level	3.2	3.2	—
Access to Occupational Health Services (excluding counselling)	Down	3.5	3.5	3.6
Security in the workplace	Level	3.0	3.0	—

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

1.5.2 Staff generally happier with health and safety

Table 1.6 shows that, in general, attitudes towards the different aspects of health and safety have improved between 2000 and 2002. However, there is a lot of scope for more improvement; the score for workplace cleanliness, for example, is still below the midpoint, while views about workplace security are neutral. It is encouraging to see that respondents are clearly positive about their access to Occupational Health Services and about their managers' attitudes towards health and safety, although the former score has decreased slightly from its highest point in 2000.

1.6 Greater equality of opportunity; harassment declining

1.6.1 Views about equal opportunities

In general, the picture is a positive one, with scores for all the main aspects of equal opportunities increasing between 2000 and 2002 (see Table 1.7). The low score for disability policies may indicate a lack of knowledge about this aspect rather than dissatisfaction, given the relatively low number of people with a disability who work for the NHS. Table 1.8 indicates that satisfaction with most aspects of equal opportunities is widespread among respondents in different Trust types.

Table 1.7: Equal opportunities — overall (mean values)

	Trend	2002	2001	2000
Equal opportunities and fair treatment	Up	3.5	3.4	3.4
Family-friendly policies	Up	3.2	3.2	3.1
Racial discrimination policy	Up	3.5	3.4	3.4
Sex discrimination policy	Up	3.5	3.4	3.4
Disability policy	Up	3.0	2.9	2.9

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Table 1.8: Equal opportunities by Trust type, 2002 (mean values)

	Acute	Teaching	Mental Health	PCT
Equal opportunities and fair treatment	3.4	3.5	3.5	3.6
Family-friendly policies	3.2	3.2	3.2	3.3
Racial discrimination policy	3.5	3.5	3.4	3.5
Sex discrimination policy	3.5	3.5	3.5	3.5
Disability policy	3.0	3.0	2.9	3.0

Source: IES NHS Staff Attitude Surveys, 2002

Table 1.9 presents what is, on the whole, a very encouraging picture. A notably lower percentage of respondents say that they have experienced harassment or violence while at work in 2002, compared with 2001. All types of harassment from two sources — patients and their relatives, and colleagues — have decreased. Harassment and violence from managers, however, although not widespread, is not showing the same downward trend. The explanation for this is not clear, although one observation is that the group of staff classified as 'Senior Managers' appear to suffer the most from workplace stress and pressure. This is not unique to the NHS, but is a feature of all employment sectors, public and private. Respondents' experiences of harassment and violence are described in more detail in Chapter 6, 'Well-being at Work'.

Table 1.9: Experience of incidents of harassment or violence (per cent)

	Trend	2002	2001
Racial harassment from colleagues	Down	2.2	2.4
Racial harassment from managers	Down	1.2	1.3
Racial harassment from patients/relatives	Down	4.1	4.2
Sexual harassment from colleagues	Down	1.1	1.2
Sexual harassment from managers	Level	0.3	0.3
Sexual harassment from patients/relatives	Down	1.7	2.0
Verbal harassment from colleagues	Down	8.4	8.9
Verbal harassment from managers	Up	5.4	5.3
Verbal abuse from patients/relatives	Down	15.9	17.7
Violence from colleagues	Down	0.4	0.5
Violence from managers	Level	0.1	0.1
Violence from patients/relatives	Down	6.9	7.4

Source: IES NHS Staff Attitude Surveys, 2001, 2002

1.7 Staff are noticing the difference

1.7.1 Trust/PCT ratings by staff

There is some evidence that staff are noticing the changes at their workplace, and are reacting to them positively. Every year, respondents have been asked to rate their Trust/PCT as better, the same, or worse than two years ago. Respondents with less than two

Table 1.10: How the Trust/PCT compares with two years ago (per cent)

	Trend	2002	2001	2000
Better	Up in last year	22.2	17.0	18.1
The same	Down in last year	51.4	52.3	43.9
Worse	Down	26.3	30.7	37.9

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

years service have been filtered out of the analysis of this question. Table 1.10 shows that the percentage rating their Trust/PCT as 'better' has increased significantly from 2000 to 2002 — an encouraging sign, albeit tempered by the caveat that the percentage rating their Trust/PCT as 'better' is still lower than the percentage awarding a 'worse' rating. Appendix Table 1.8 shows that Acute and Teaching Trusts/PCTs — which have perhaps seen the least structural disruption over the past few years — show the greatest improvements in rating.

1.7.2 More staff intend to stay

Table 1.11 shows that, compared to 2000, a higher percentage of respondents say that they intend to stay with their Trust/PCT for another year or more (70.2 per cent, compared to 67.8 per cent). Appendix Table 1.9 shows that staff in Teaching Trusts/PCTs — who may, perhaps, want to work in a large teaching hospital for a limited time, to get experience in a specialist area — are least likely to plan to stay longer term. PCTs and Mental Health Trusts/PCTs appear to be more 'stable' in terms of intentions to stay.

Table 1.11: Career intention (per cent)

	Trend	2002	2001	2000
Leave as soon as opportunity arises	Down	15.0	16.7	15.9
Leave within the next year	Down	14.8	15.8	16.3
Likely to stay for at least another year	Up in last year	24.4	23.7	24.5
Stay for the foreseeable future	Up	45.8	43.8	43.3

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

1.7.3 Staff confidence

Another piece of evidence that can be used to assess respondents' belief that things are improving is responses to the statement, *'I am confident that the results of this survey will be acted upon'*. Table 1.12 shows that there has been a significant increase in the percentage agreeing or strongly agreeing with this statement — from 19.5 per cent in 2001, to 24.1 per cent in 2002. This result indicates that staff feel more positive that their views are being heeded. A caveat is needed, however; the percentage disagreeing remains notably higher than the percentage agreeing. Encouragingly, Appendix Table 1.10 and

Table 1.12: 'I am confident that the results of this survey will be acted upon' — overall (per cent)

	2002	2001
Strongly disagree	13.3	14.6
Disagree	22.2	25.4
Neither	40.4	40.5
Agree	20.3	16.6
Strongly agree	3.8	2.9

Source: IES NHS Staff Attitude Surveys, 2001, 2002

Appendix Table 1.11 indicate that the greater confidence is general, across all types of Trust.

1.8 Workforce trends

As well as measuring attitudinal changes over time, the QWL surveys have enabled a variety of workforce trends to be identified and monitored. Some of these changes in the NHS workforce in London are of interest to planners, as they have long-term implications.

1.8.1 Working patterns are changing

Table 1.13 shows that the percentages of those working full- and part-time in the London NHS have remained fairly steady. The same is not true, however, of working pattern. Table 1.14 indicates that there has been a steady and noticeable increase in staff with daytime working patterns, and a corresponding decrease in shift and rota working.

Table 1.13: Contract type (per cent)

	Trend	2002	2001	2000
Full-time	Down in last year	76.2	76.5	75.8
Part-time	Up in last year	21.3	20.8	21.5
Job share	Down in last year	0.9	1.0	0.9
Bank	Up in last year	1.7	1.6	1.8

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Table 1.14: Working pattern (per cent)

	Trend	2002	2001	2000
Days	Up	72.6	69.8	65.7
Shifts	Down	17.2	19.1	21.8
On a rota	Down	10.2	11.0	12.5

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Table 1.15: Age profile of respondents (per cent)

	Trend	2002	2001	2000
Under 29	Down	18.7	20.5	21.5
30-39	Down	31.2	32.5	33.5
40-49	Up	27.3	25.9	25.0
50-59 years	Up	19.8	18.4	17.4
Over 60	Up	3.0	2.7	2.7
Mean age	*Up*	*40.2*	*39.5*	*39.1*

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

1.9 An ageing workforce

There is evidence (for example, the recent Audit Commission report) that the workforce is ageing noticeably, not just in the NHS, but in other parts of the public sector. This, in turn, raises questions about the attractiveness of public sector work to younger people. And yet, when QWL views are analysed by age group, the youngest group is often the most positive. This apparent contradiction indicates that Trusts/PCTs experiencing a measure of success in recruiting younger people might benefit from doing so, by having a more positive workforce. However, recruitment strategies are often focussed on older, more stable workers, who are less likely to want to move on. Table 1.15 shows a worrying picture of an increasingly 'greying' workforce, and a fairly large bulge of 'baby boomers' who will approach retirement within the foreseeable future. Traditionally, the London NHS has attracted younger people, particularly into training roles, but this appears to be far less common now than in the past. Appendix Table 1.12 shows that average (mean) ages are getting higher in all Trust types except for Acute; even Teaching Trusts are seeing an ageing workforce.

1.10 Minority ethnic workers

Table 1.16 indicates that the percentage of respondents from a minority ethnic background is increasing year on year. The reasons for this are unclear. It could be because the London NHS is employing more minority ethnic staff, or — perhaps more likely — that the minority ethnic workforce is increasingly prepared to respond to staff surveys. The latter possibility would be very encouraging, given that this group of workers always tends to be under-represented in attitude surveys, with the QWL surveys being no exception. Ethnicity clearly makes a difference to QWL attitudes and experiences (see Chapter 10, 'Minority Ethnic Staff in the London NHS'). The QWL data set has enabled fairly extensive analysis of these differences, by ethnic group as well as by the simpler (but sometimes misleading) White/non-White classification.

Table 1.16: Percentage of respondents from a minority ethnic group, by Trust type

	Trend	2002	2001	2000
Acute	Up	24.6	20.8	18.8
Teaching	Up	23.7	20.5	17.8
Community	—	—	21.5	21.6
Mental Health	Up	29.0	25.8	22.9
PCT	Up	20.1	19.5	—
Total	*Up*	*24.1*	*21.3*	*19.3*

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

1.11 But not everything is rosy

The overall improvements reported in this overview could leave the impression that little remains to be done. That this is not the case will probably be evident from some of the caveats expressed in this chapter, and it is certainly apparent when reading some of the associated chapters. The following issues appear, from the messages contained in the data, to be calling for further attention:

- Support, Administrative & Clerical and Technical staff are notably less satisfied than their Senior Managerial and clinical professional colleagues, about almost every aspect of working life. It appears that this observation is not related solely to being in a support role, because Auxiliary/HCAs and Therapy support workers are, on the whole, fairly positive about working life. It is possible that staff not in direct contact with patients/clients have fewer opportunities to feel valued and involved than their more 'hands-on' colleagues.
- Senior Managers appear to be experiencing a lot of stress and workload pressure. In some ways, this could be seen as unimportant, particularly given that they are a notably positive group about most aspects of working life. However, it is also noticeable that the percentage of respondents reporting some form of harassment from managers has increased, which could indicate that some Senior Managers are beginning to find the pressure intolerable.
- The experiences of some minority groups — particularly respondents reporting some form of disability or medical condition, and the Black and Mixed minority ethnic groups — are less positive than average. These are the subject of separate chapters.
- Access to training and development processes and opportunities is not equal across various staff groups. There is clear evidence that people who receive training, are given access to development opportunities, receive an appraisal and have a PDP, are notably more positive about working life, and feel a greater sense of belonging and involvement.

- Pay is still an issue – in fact, it is the only aspect of working life to receive a consistently negative score. Although this is not an unusual finding of attitude surveys, it is noticeable that attitudes towards pay and benefits vary a lot by staff group. It is a particular issue for staff in support roles.

List of appendix tables

Appendix Table 1.1: Percentage of staff with a PDP, by Trust type

	Trend	2002	2001	2000
Acute	Up	48.7	43.1	33.2
Teaching	Up	52.3	41.9	32.7
Community	Up	—	55.0	46.4
Mental Health	Up	50.0	36.5	27.5
PCT	Up	58.1	50.3	—

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.2: Average number of training days and presence of a PDP

	Trend	2002	2001	2000
Has PDP				
Mean	Down	6.3	6.6	7.3
Median	Level	4.0	4.0	4.0
No PDP				
Mean	Down	4.1	4.4	4.6
Median	Level	2.0	2.0	2.0

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.3: Percentage of staff experiencing a performance appraisal, by Trust type

	Trend	2002	2001
Acute	Up	50.8	45.0
Teaching	Up	57.0	49.4
Community	—	—	49.7
Mental Health	Up	54.0	44.4
PCT	Up	55.4	50.6

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.4: Assessment of development opportunities — overall (per cent)

	Trend	2002	2001
Excellent	Up	4.7	4.5
Good	Up	21.3	20.2
Adequate	Up	29.8	28.4
Poor	Down	22.7	24.2
Non-existent	Down	21.4	22.8

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.5: Assessment of development opportunities, by Trust type, 2002 (per cent)

	Acute	Teaching	Mental Health	PCT
Excellent	3.8	5.2	4.9	5.1
Good	18.8	22.7	22.3	22.8
Adequate	28.9	29.7	30.0	31.3
Poor	23.8	22.1	23.2	21.6
Non-existent	24.6	20.4	19.6	19.2

Source: IES NHS Staff Attitude Surveys, 2002

Appendix Table 1.6: Average number of training days by assessment of access to development opportunities, 2002

	Mean	Median
Excellent/Good	7.9	5.0
Adequate	5.6	3.0
Poor/Non-existent	3.6	2.0

Source: IES NHS Staff Attitude Surveys, 2002

Appendix Table 1.7: Respondents' experience of accidents and injuries, by Trust type

			All respondents			
	Respondents reporting incidents2002	Total incidents experienced 2002	Average per person 2002	Average per person 2001	% reported 2002	% reported 2001
Acute	1,554	3,169	0.34	0.35	54.0	50.1
Teaching	1,416	2,808	0.33	0.29	50.0	52.9
Community	—	—	—	0.25	—	57.6
Mental Health	679	1,485	0.34	0.40	66.3	71.6
PCT	717	1,232	0.21	0.30	58.5	60.8

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.8: How the Trust/PCT compares with two years ago, by Trust type (per cent)

	Trend	2002	2001	2000
Acute				
Better	Up in last year	23.8	16.6	17.7
The same	Up	50.0	48.8	41.1
Worse	Down	26.2	34.6	41.2
Teaching				
Better	Up	22.1	16.6	16.6
The same	Down in last year	54.2	54.9	45.6
Worse	Down	23.7	28.5	37.8
Community				
Better	—	—	16.1	16.5
The same	—	—	55.6	44.9
Worse	—	—	28.3	38.6
Mental Health				
Better	Up in last year	23.8	20.2	25.7
The same	Down in last year	47.7	47.8	42.2
Worse	Down	28.5	32.0	32.1
PCT				
Better	Up	18.7	17.4	—
The same	Down	52.8	53.3	—
Worse	Down	28.5	29.3	—

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.9: Staying/leaving intentions, by Trust type (per cent)

	Trend	2002	2001	2000
Acute				
Leave as soon as opportunity arises	Down in last year	15.2	16.6	16.0
Leave within the next year	Up in last year	14.2	13.9	14.5
Likely to stay for at least another year	Up in last year	23.3	21.5	23.2
Stay for the foreseeable future	Down in last year	47.3	48.0	46.3
Teaching				
Leave as soon as opportunity arises	Down in last year	15.9	17.9	17.7
Leave within the next year	Down	17.5	18.5	19.7
Likely to stay for at least another year	Up in last year	25.9	24.7	25.3
Stay for the foreseeable future	Up	40.7	38.9	37.3
Community				
Leave as soon as opportunity arises	–	–	13.2	13.3
Leave within the next year	–	–	14.2	13.9
Likely to stay for at least another year	–	–	24.9	24.7
Stay for the foreseeable future	–	–	47.6	48.2
Mental Health				
Leave as soon as opportunity arises	Down in last year	13.3	17.4	14.7
Leave within the next year	Down	11.9	14.8	15.5
Likely to stay for at least another year	Up in last year	24.8	24.4	26.2
Stay for the foreseeable future	Up in last year	50.0	43.5	43.7
PCT				
Leave as soon as opportunity arises	Down	13.3	15.5	–
Leave within the next year	Down	11.9	12.5	–
Likely to stay for at least another year	Up	24.8	24.1	–
Stay for the foreseeable future	Up	50.0	47.8	–

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Appendix Table 1.10: 'I am confident that the results of this survey will be acted upon', by Trust type (per cent)

	Trend	2002	2001
Acute			
Strongly disagree	Down	13.9	16.0
Disagree	Down	21.8	26.0
Neither	Down	38.7	38.8
Agree	Up	21.6	16.2
Strongly agree	Up	4.0	3.0
Teaching			
Strongly disagree	Down	13.8	15.4
Disagree	Down	23.1	25.5
Neither	Down	38.7	40.0
Agree	Up	20.4	16.2
Strongly agree	Up	3.9	2.9
Mental Health			
Strongly disagree	Down	13.4	14.6
Disagree	Down	21.5	26.3
Neither	Up	43.4	42.2
Agree	Up	17.7	14.1
Strongly agree	Up	4.0	2.8
PCT			
Strongly disagree	Down	11.6	12.9
Disagree	Down	21.9	25.7
Neither	Up	43.4	42.3
Agree	Up	20.0	16.8
Strongly agree	Up	3.1	2.3

Source: IES NHS Staff Attitude Surveys, 2001, 2002

Appendix Table 1.11: Mean score for 'I am confident that the results of this survey will be acted upon', by Trust type

	Trend	2002	2001
Acute	Up	2.8	2.6
Teaching	Up	2.8	2.7
Mental Health	Up	2.8	2.6
PCT	Up	2.8	2.7

Source: IES NHS Staff Attitude Surveys, 2001, 2002

Appendix Table 1.12: Average age, by Trust type

	Trend	2002	2001	2000
Acute	Down in last year	40.3	40.7	40.1
Teaching	Up	37.4	37.2	36.6
Community	–	–	42.0	41.4
Mental Health	Up	41.7	40.3	39.4
PCT	Up	42.9	41.5	–

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Profiles of Staff Groups in the London NHS

The 14 different staff groups in the London NHS:

- are consistent in their appreciation of their colleagues, the job they do, and their immediate managers
- would like to be much better paid, and would appreciate improvements in their working environment, and a wider range of workplace facilities
- depending on their role, people have very different perceptions of working life, with those in support roles (especially Technicians, Administrative & Clerical staff, and Support workers) being notably less positive than those in clinical, professional or managerial roles
- vary enormously in their experiences at work, particularly whether or not they experience accidents/injuries (Support staff are most likely to, Senior Managers least likely), and the extent to which they are at the receiving end of harassment or violence (Midwives experience the most, Scientists and Senior Managers the least)
- have very different amounts of formal training (Nurses have the most, Administrative & Clerical staff the least), and different views of their access to development opportunities (Senior Managers are the most positive, Support staff the least)
- vary a lot in their experiences of appraisal, and whether or not they have a PDP (for both aspects, Therapy staff most likely, Support staff least).

2. Profiles of Staff Groups in the London NHS

Sue Hayday

The data from the 50 Trusts/PCTs involved in the 2002 QWL survey provides a rich source of data which will be used in this chapter to provide pen pictures of the fourteen staff groups which make up the London NHS workforce. The personal and employment details of the groups will be discussed and the different views and experiences of these groups will also be described. Nearly 28,000 respondents are covered by the survey for 2002 and the size of this database enables extensive analysis at staff group level. Details will be given of the following groups.

- Qualified Nursing staff:
  - Nurses
  - Midwives
  - Health Visitors and School Nurses
  - District Nurses
- Medical staff:
  - Doctors
  - Dentists
- Allied Health Professional and Scientists:
  - Therapists
  - Pharmacists
  - Scientists
- Supporting or managerial roles:
  - Nursing Auxiliaries and Healthcare Assistants (HCAs)
  - Technicians
  - Administrative & Clerical staff
  - Support staff
  - Senior Managers.

Charts and tables are presented in the appendix at the end of this chapter. These enable comparisons to be made across all the staff groups, in contrast to the descriptions below which focus on each group separately. In addition, Table 2.1 (within the body of this chapter) gives some key comparative characteristics for all 14 staff groups.

Table 2.1: Key statistics, by staff group

		Nurse	Midwife	Health Visitor/School Nurse	District Nurse	HCA/Nursing Auxiliary	Doctor	Dentist	Therapy	Pharmacist	Scientist	Technician	Administrative & Clerical	Senior Manager	Support	Total
Percentage statistics																
Gender	Male	17	3	1	6	16	48	31	13	17	32	33	13	33	63	20
	Female	83	97	99	94	84	52	69	87	83	68	67	87	67	37	80
Ethnicity	White	67	65	77	76	61	74	71	88	73	84	77	82	87	79	76
	Minority Ethnic	33	35	23	24	39	26	29	12	27	16	23	18	13	21	24
Have children 16 or under at home	Yes	33	41	48	42	37	41	29	26	27	28	33	30	36	28	33
	No	67	59	52	58	63	59	71	74	73	72	67	70	64	72	67
Have adult/eldercare responsibilities	Yes	10	12	15	15	17	8	9	9	11	9	13	14	11	20	12
	No	90	88	85	85	83	92	91	91	89	91	87	86	89	80	88
Have disability/medical condition requiring support in the workplace	Yes	5	7	5	4	7	3	2	4	3	3	6	5	4	11	5
	No	95	93	95	96	93	97	98	96	97	97	94	95	96	89	95
Contract type	Full-time	83	70	51	71	78	80	57	72	81	83	81	71	90	85	78
	Part-time*	17	30	49	29	22	20	43	28	19	17	19	29	10	15	22
Hours worked	Days	46	37	99	88	36	61	96	94	93	92	85	94	96	73	72
	Shifts	39	46	0	5	43	8	2	3	3	3	7	4	2	17	17
	On a rota	15	18	0	8	21	32	3	4	4	5	8	2	2	9	10
Performance appraisal in last 12 months	Yes	55	53	59	51	44	67	52	70	53	53	41	45	61	34	54
	No	45	47	41	49	56	33	48	30	47	47	59	55	39	66	46
Has a PDP	Yes	59	53	66	59	43	54	52	69	57	48	40	37	56	25	52
	No	41	47	34	41	57	46	48	31	43	52	60	63	44	75	48

		Nurse	Midwife	Health Visitor/School Nurse	District Nurse	HCA/Nursing Auxiliary	Doctor	Dentist	Therapy	Pharmacist	Scientist	Technician	Administrative & Clerical	Senior Manager	Support	Total
Percentage statistics																
Accident or injury at work in the last 12 months	No	79	83	90	81	75	84	82	85	90	89	80	89	93	75	84
	Yes	21	17	10	19	25	16	18	15	11	11	20	11	7	25	16
Incident of harassment/violence at work in last 12 months	Yes	36	38	19	25	33	25	16	21	18	15	24	20	15	23	26
	No	64	62	81	75	67	75	84	79	82	85	76	80	85	77	74
Average (mean) statistics																
Age		38.3	41.4	46.4	44.7	40.4	39.8	40.6	37.2	36.6	39.2	38.5	42.4	41.8	46.2	40.1
Length of service (years)		6.8	9.3	9.6	9.9	7.0	5.9	8.2	5.8	5.7	7.6	7.2	6.8	6.9	9.6	6.9
Number of days spent on formal training and development in last 12 months		7.5	5.1	5.8	6.2	4.8	6.3	4.6	5.1	5.2	5.0	4.6	2.6	4.7	3.3	5.2

* Including job share and bank

Source: IES NHS Staff Attitude Surveys, 2002

2.1 Qualified nursing staff

2.1.1 Nurses

Nurses form 29 per cent of respondents to the survey and are the largest single group. The majority are female (83 per cent), and they have an average age of 38.3 years. One-third have children, and one in ten has caring responsibilities for an adult who is sick, disabled or elderly. Five per cent of Nurses report that they have a disability or medical condition requiring support in the workplace. Two-thirds of Nurses are White, 15 per cent Black, nine per cent Asian, and two per cent Chinese. The remainder are from mixed or other ethnic groups.

The employment details of Nurses show that 30 per cent have under two years service with their current employer, and 26 per cent have over ten years. Most are full time (83 per cent) and just under half work days only, with 39 per cent working shifts and 15 per cent being on a rota.

When the attitude clusters representing groups of statements about working life are considered, Nurses do not hold any extreme views when compared to other staff groups. The aspects of their job about which they are most enthusiastic are job satisfaction, and their relationship with colleagues. Their immediate managers and training and development opportunities, are very positive aspects of their work. Pay is the only area about which that they feel negatively, although their views on co-operation within their organisation, coping with work pressure and feeling valued and involved, are largely neutral.

Nurses' positive views of training are related to the fact that they receive the highest amount of all staff groups — 7.5 days on average in the past year. Fifty-five per cent of Nurses have had a performance appraisal in the last twelve months, and 59 per cent have a PDP. However, despite the presence of these formal processes, a surprising 38 per cent feel that their access to development opportunities is poor or non-existent.

Just over one in five Nurses (21 per cent) has experienced an accident or injury at work during the past year. They are the third most likely staff group to have this problem. Just under a quarter (24 per cent) of Nurses who have had an accident or injury have reported none of the incidents. Nurses are also the second most at risk group for incidents of harassment or violence, most usually from patients or their relatives. They hold the least positive views on security in the workplace, and are also concerned about the cleanliness of the environment. They do, however, express satisfaction with their managers' attitudes towards health and safety issues, and their access to Occupational Health Services.

When invited to comment on the best things about working for their Trusts/PCTs, Nurses give their colleagues, training, job content, and convenient location as the top four items. In contrast, the areas that they see as needing improvement are staffing levels, working conditions, pay and workplace facilities.

Thirty-two per cent of Nurses say that they are likely to leave their current employer within the next year, which is a relatively high figure. An encouraging 26 per cent of nurse respondents believe that the results of the QWL Survey will be acted upon, an increase of five percentage points from 2001.

2.1.2 Midwives

For the majority of Trusts/PCTs, there was insufficient data to analyse Midwives as a separate group, but within the combined database they account for two per cent of the sample and can be treated on their own. Only three per cent of Midwives are male, and 54 per cent are over 40. They have a higher proportion of respondents with caring responsibilities when compared with hospital Nurses; 41 per cent have children, and 12 per cent have adult caring responsibilities. Seven per cent have a disability or medical condition that needs support. Of all the qualified nursing groups, Midwives have the highest proportion of minority ethnic staff at 35 per cent, and the majority of these are Black.

Reflecting their older ages, 42 per cent of Midwives have over ten years service. Seventy per cent work full time, and they are also more likely than other nursing groups to be working shifts, with 46 per cent reporting working this way.

The overall attitudes of Midwives follow a similar pattern to those of hospital Nurses, but they tend to be less satisfied, particularly when training and immediate management are considered; the exception to this general rule is job satisfaction, where they are more positive. Colleagues are also rated highly, but pay, and feeling valued, are sources of dissatisfaction.

Midwives report an average of 5.1 days training in the past year, less than other nursing groups. Just over half (53 per cent) have had an appraisal, and a similar percentage have a PDP. A relatively high 43 per cent view their access to development opportunities as poor or non-existent.

Seventeen per cent of Midwives have had an accident or injury at work in the last year; however, 55 per cent of these have not reported their accidents. They are among the most dissatisfied staff when quality of equipment and cleanliness of the environment are being rated. They do, however, feel very positive about their access to Occupational Health Services.

Midwives are the staff group most likely to be subjected to harassment and violence; 38 per cent have been involved in incidents during the past twelve months. They are most affected by harassment from patients and relatives. Their views on equal opportunities show low satisfaction, and they give the least positive scores to equal opportunities and fairness, racial discrimination and family-friendly policies.

One-third of Midwives plan to leave their current Trusts/PCTs within the next year, which makes them the third most likely group to leave after Doctors (many of whom are on fixed-length rotations) and Pharmacists.

The aspects of their working lives that Midwives cite as being the best are colleagues and location. The actual job content, although third, comes some way behind these. Areas for improvement are given as better staffing, hours, equipment, workplace facilities and car parking. Just over one in five Midwives (21 per cent) are confident that the results of the survey will be acted upon — an increase over the 16 per cent who thought this in the previous year's survey.

2.1.3 Health Visitors and School Nurses

These two groups have been combined to represent two per cent of the respondents to the survey. Their roles involve working in the community and, as a result, they may have comparatively little direct contact with their employing Trust/PCT.

This group is almost exclusively female, with only one per cent being male. They are generally older, with 38 per cent being aged 30 to 39, and 40 per cent being over 40. This age profile will have implications for workforce planning and recruitment as these staff approach retirement. They are the nursing group with the greatest level of caring responsibility, with 48 per cent having children at home and 15 per cent having adult caring responsibilities. Just over three-quarters are White, the highest proportion for all nursing groups.

The mean length of service for Health Visitors and District Nurses is 9.6 years, the third longest of all staff groups. They are almost equally divided between full- and part-time working (51 per cent and 49 per cent respectively), and virtually all of them work days.

The overall aspects of their work that Health Visitors and School Nurses rate most highly are colleagues and job content, followed by immediate management and training. Their commitment to their Trust/PCT is slightly less than that for hospital Nurses and Midwives, and they are equally dissatisfied with pay.

On average, Health Visitors and School Nurses receive 5.8 days training a year and, of the nursing groups, are the most likely to

have had an appraisal and a PDP (59 per cent and 66 per cent respectively). They are also the most positive nursing group about development opportunities, with one-third thinking that they are excellent or good.

They are the second least likely staff group to have experienced an accident or an injury in the past year. Where this has occurred, 61 per cent of the staff group have reported their accidents or injuries. Their views on health and safety show that they are one of the most positive groups about the cleanliness of the work environment, and they also view security in the workplace more favourably than other Nurses.

Health Visitors and School Nurses are among the staff least likely to experience harassment or violence at work, although almost one in five (19 per cent) have been affected. Their work colleagues, and patients and their relatives, are the most likely sources of harassment.

Twenty-four per cent report that they are likely to leave their current employer within the next year, making them one of the more stable staff groups in the London NHS. When asked about the best aspects of their jobs, their colleagues are clearly at the top of their list. Some way behind colleagues are the work location, and content of the job. Areas for improvement are seen as working conditions, staffing levels, administrative/secretarial/ ICT Support, and Senior Management. Health Visitors and School Nurses express the second lowest degree of confidence that the survey will be acted upon; only Doctors are more sceptical. Seventeen per cent of Health Visitors and School Nurses are positive about this, which shows a small improvement over the 15 per cent recorded last year.

2.1.4 District Nurses

The final nursing group is District Nurses, who make up two per cent of all respondents to the 2002 survey. Only a small minority, six per cent, are male. Along with Health Visitors and School Nurses, they have an older age distribution, with 39 per cent being aged 40 to 49 and one-third being aged 50 or over. Again, as these approach retirement, the numbers of experienced Nurses in this profession will seriously decline. This has implications for workforce planning, recruitment and service delivery.

Forty-two per cent of District Nurses have children at home, and 15 per cent have caring responsibilities for an adult; both among the higher rates of caring responsibilities.

District Nurses are similar to Health Visitors and School Nurses in that, compared to the other nursing groups, they have lower levels of minority ethnic staff (one in four, compared to one in three for hospital Nurses and Midwives). When length of service

is considered, again they resemble Health Visitors and School Nurses, with 45 per cent having over ten years service. Their average length of service is 9.9 years, which is the longest for any staff group. Seventy-one per cent work full time and 12 per cent are on shifts or rotas.

In terms of how they feel about their working lives, District Nurses are most enthusiastic about the satisfaction they get from their work and their colleagues. They are also positive about their training and development. They are one of the groups that is most dissatisfied with pay. District Nurses, along with Health Visitors and School Nurses, have low scores for commitment to their Trusts/PCTs.

District Nurses receive the third highest number of days' training, at 6.2 days, a figure only exceeded by hospital Nurses and Doctors. Interestingly, this high level of training is not associated with performance appraisal; a relatively low proportion (51 per cent) have had appraisals in the past year. PDPs, however, are relatively more common among District Nurses, with 59 per cent having one. A possible result of this is that 27 per cent view their access to development opportunities as excellent or good, with a relatively low 31 per cent saying that their opportunities are poor or non-existent.

District Nurses are the fifth most probable staff group to be affected by an accident or injury at work, with 19 per cent experiencing one or more. Twenty-eight per cent of those involved did not report any of the accidents. District Nurses are one of the most positive groups about the cleanliness of the working environment, but are also one of the most critical when access to staff counselling and Occupational Health Services are assessed.

When equal opportunity policies are rated, District Nurses are one of the groups that feels least positively about family-friendly policies. Four out of five of them have experienced harassment or violence at work, predominantly from patients and their relatives.

A relatively low 24 per cent of District Nurses plan to leave their current Trusts/PCTs in the next year, which makes them (along with Health Visitors and School Nurses) among the least likely to leave; only Dentists show less inclination to resign. The things that keep District Nurses in their jobs are — as for all staff groups — overwhelmingly their colleagues, and to a much lesser extent, the work location, nature of the job and training and development. Areas for improvement are seen as staffing, working conditions, pay, and a need for greater recognition and appreciation. District Nurses are the only nursing group to feel less confident this year than last year that the survey results will be acted upon; 18 per cent, compared to 21 per cent.

2.2 Medical staff

2.2.1 Doctors directly employed by Trusts/PCTs

Doctors form one of the larger groups in the survey, and represent eight per cent of respondents. They are almost equally divided by gender, 48 per male and 52 per cent female. Their average age is 39.8 years, with the largest proportion (37 per cent), falling into the 30 to 39 age range. This results in them being one of the groups to be more likely to have children under sixteen (41 per cent) but less likely to have caring responsibilities for adult dependants (eight per cent). Seventy-four per cent of doctors are White, and 16 per cent are Asian.

The average length of service for Doctors is 5.9 years, but within this, 60 per cent of Doctors have under five years service and 22 per cent have over ten. Many junior Doctors are working on fixed-term rotations, which means that they have relatively low lengths of service in any particular Trust/PCT. One in four Doctors works on a part-time basis, and 40 per cent are on a shift system or rota.

Doctors, in common with Senior Managers, express the highest levels of satisfaction with their jobs. However, they are the group that feels least able to cope with work pressure, and they also record a relatively low level of commitment to their Trusts/PCTs. They are one of the groups that is least dissatisfied with pay, and they are satisfied with their colleagues, training and immediate managers.

Receiving 6.3 training days a year means that Doctors are second, after Nurses, in terms of the amount of formal training given. They are also the second most likely group to have had an appraisal, with two-thirds reporting one in the past year. Fifty-four per cent have a PDP, and one in four feels that their access to development opportunities is excellent or good. However, 34 per cent of Doctors think that their access to development is only adequate.

Sixteen per cent of Doctors have had an accident or injury in the past twelve months, and almost half of these have not reported any of the incidents. Their views on health and safety are somewhat negative. They are among the most dissatisfied staff for six of the eight health and safety attitude clusters. These are: cleanliness, security, equipment, health and safety training, their managers' attitudes, and access to Occupational Health Services.

One in four of the Doctors has been involved in an incident of harassment in the past year. These come predominantly from patients and their relatives, and some have involved violence.

Thirty-six per cent of Doctors claim that they are likely to leave within the next year. This is influenced by the training structure

for junior Doctors; 60 per cent of those with under one year service say they will leave, but this reduces steadily to only 17 per cent among those with over ten years service.

The aspects that Doctors enjoy about their jobs are clearly their colleagues, which they mention most frequently; a long way behind comes the work itself and involvement with patients. The things they would wish to see changed are working conditions, staffing levels, workplace facilities and generally improved hygiene. They have the least faith that actions will result from the current survey, with only 15 per cent feeling confident that this will happen — but even this is a considerable improvement on last year's figure of ten per cent.

2.2.2 Dentists directly employed by Trusts/PCTs

Dentists as an identifiable group have appeared in very few individual Trust/PCT reports, but the combined database now enables this to be done. The numbers are still small (less than one per cent of the sample) but sufficient to provide a useful profile of directly employed Dentists in the London NHS.

Most Dentists are female (69 per cent) and they have an average age of 40.6 years. Only 29 per cent of them have children under sixteen, and nine per cent have adult caring responsibilities, both relatively low figures. Seventy-one per cent are White and 19 per cent are Asian, a similar pattern to Doctors.

One-third of Dentists have service of over ten years, with a mean length of 8.2 years. This puts them among the longer-serving staff groups. They are the second most likely group to be working part time, with 43 per cent of them reporting working this way.

Their attitudes closely follow those of Doctors, with the exception of stress and work pressure, where they are more confident in their ability to cope. They are enthusiastic about their job satisfaction and colleagues and, relatively, are one of the more positive groups about pay. However, their views of their line managers are the least positive of all staff.

Dentists receive one of the lowest levels of training a year, at 4.6 days. Fifty-two per cent of them have had appraisals in the past year, and the same percentage have a PDP, a figure which is about average for all staff. Half feel that their access to development opportunities is poor or non-existent, and a low 23 per cent perceive it to be excellent or good.

Nineteen per cent of Dentists have had an accident or injury at work, and just under half have not reported any of these. Their views on health and safety show some difference to those of Doctors, in that they are more positive overall. They are one of the most satisfied groups with the cleanliness of the environment, in

contrast to Doctors who are one of the least. Dentists rate their managers' attitudes to health and safety most highly, followed by health and safety training. When access to Occupational Health Services is analysed, however, they are among the least satisfied.

Dentists, with Therapy workers, are the most positive about racial discrimination policies, and rate highly equal opportunities and fair treatment. They are one of the groups least affected by harassment and violence, but 16 per cent still report being involved in such incidents. These are, as for most respondents, typically from patients and their relatives.

Their career intentions show that Dentists are among those least likely to leave, with 23 per cent saying that this is possible within the year. The aspects of their work that they enjoy most are their colleagues, the work itself, and their patients. Their most popular recommendations for improvements are better equipment, more staff, better workplace facilities and more teamwork. Eighteen per cent are confident that the findings from the survey will be acted upon — an increase of one percentage point over 2001.

2.3 Allied Health Professionals and Scientists

2.3.1 Therapy staff

Therapy staff (including therapy support staff) are the third largest group of respondents in the QWL survey, contributing 11 per cent of the sample.

They are mainly female (87 per cent) and, at 30 per cent, have the highest proportion of members aged under 30. Resulting from this, they have the lowest average age of 37.2 years. Just over a quarter have children under 16, and nine per cent have adult caring responsibilities. They also have more White staff than any other group, at 88 per cent. Reflecting their younger ages, Therapy staff have one of the shortest average lengths of service (5.8 years). Their pattern of working is usually days (94 per cent) and is typically full time (72 per cent).

Therapy staff are overall more enthusiastic than average about their working lives. They are, of all staff groups, most positive about the aspects of colleagues, training and communication. They also rate job satisfaction, immediate management and performance appraisal notably highly. They express least satisfaction with pay and workplace stress.

They have had, typically, 5.1 training days in the past year; near the average for all respondents. When performance appraisal is considered, they hold the leading position, with 70 per cent of them having had an appraisal in the past year. Again, they are the most likely group to have a PDP, with 69 per cent reporting having one. Despite this, they do not hold the most positive views

about development opportunities (these are held by Senior Managers); Therapy staff come second, with 34 per cent seeing their opportunities as excellent or good.

Fifteen per cent of Therapy staff have had an accident or injury in the past year, making them one of the less likely groups to have such an experience. A quarter of those having accidents or injuries failed to report any of them. Their attitudes towards health and safety in their Trusts/PCTs shows that they are the among the most positive groups when their managers' attitudes towards health and safety is considered, and they are also notably positive about access to staff counselling. In addition, they are satisfied with access to Occupational Health Services, and with health and safety training. The areas that they are least positive about are the physical environment, and security in the workplace.

When attitudes towards equal opportunities are examined, Therapy staff hold the most positive views of all groups about fair treatment and about the racial discrimination policy. One in five of them has been subjected to harassment or violence in the past twelve months and, as for other groups, this was most often from patients or their relatives.

Twenty-eight per cent of Therapy staff are thinking of leaving their Trusts/PCTs within the next year, a figure which declines from 36 per cent at one year service to 18 per cent at ten years service and over. The good things about their work are identified as their colleagues, the job content, the patients they encounter and the training received. Suggestions for improvement centre on better working conditions, more staff, workplace facilities and better pay. They are fairly optimistic that the finding of the survey will be acted upon, with 22 per cent agreeing that they are confident about this. This shows a good improvement over last year, when only 16 per cent expressed such confidence.

2.3.2 Pharmacists

Pharmacists are one of the smaller staff groups in the London NHS QWL survey, accounting for one per cent of the total.

Pharmacists are mainly female (83 per cent) and are the youngest group, with an average age of 36.6 years. Twenty-seven per cent have children under 16, and 11 per cent care for dependent adults. Just under three-quarters are White (73 per cent) and 11 per cent are Asian. Owing partly to their relative youth, they have the shortest service length of 5.7 years. Their employment contracts are mainly full time (81 per cent) and they typically work days (93 per cent).

Their attitudes towards the different aspects of their working lives tend to hover around the average for all the staff groups, so that they show no extreme views. They get most satisfaction from their

jobs, their colleagues, immediate management, and their training and development. They show least satisfaction with pay, co-operation within the Trust/PCT, and handling stress and work pressure.

Pharmacists spent, on average, 5.2 days being formally trained in the last twelve months — a figure comparable to Therapy staff, Midwives and Scientists. Just over half have been appraised in the past year (53 per cent), and 57 per cent have a PDP. They view their development opportunities positively, with 27 per cent feeling that they are excellent or good.

As a group, they are less likely than average to experience accidents or injuries, with a relatively low 11 per cent being affected. Thirty-six per cent of those involved in accidents did not report them. Interestingly, they hold some of the most negative views on health and safety within their Trusts/PCTs. They are the most negative group about the physical working environment, and are as negative as Doctors about the quality of equipment they have to use. They do, however, express satisfaction with their managers' attitudes towards health and safety, and with their access to Occupational Health Services.

With respect to equal opportunities, they are one of the most satisfied groups about racial discrimination policies, and are also positive about fair treatment and sex discrimination policies. Eighteen per cent have experienced harassment or violence, mainly coming from patients and their relatives.

Pharmacists are the second most likely staff group to intend to leave their posts within the next year, with 35 per cent being likely to move. The features they enjoy in their work are their colleagues, the location, the work itself, their working conditions and training. Although some Pharmacists are pleased with their working conditions, others express concern, and this is the leading suggestion for improvement, followed by workplace facilities, more staff, better administrative/secretarial/ICT support, and cleaner working conditions. Those agreeing that the survey will result in action being taken shows an increase compared to last year, from 22 per cent to 26 per cent.

2.3.3 Scientists

Scientists account for four per cent of the respondents to the QWL survey, and are composed of a variety of professional groups such as Biochemists, Medical Laboratory Scientific Officers and Psychologists.

Just over two-thirds are female (68 per cent), and they are one of the younger staff groups, with an average age of 39.2 years. Twenty-eight per cent have caring responsibilities for children under sixteen, and nine per cent are carers for adults in need of

support. A relatively high proportion of Scientists (84 per cent) are White. Their average length of service is 7.6 years, with one-third having under two years service and 22 per cent serving over ten years. Seventeen per cent have part-time contracts and eight per cent work shifts or rotas.

Their attitudes to working show that they are the most dissatisfied group with co-operation within their Trusts/PCTs, and are among those showing least commitment. As with other staff groups, they are most satisfied with their colleagues, the job they are doing, their immediate manager, and their training.

Scientists have received, on average, 5.0 days formal training in the past year. Fifty-three per cent have had an appraisal in the past twelve months, and approaching half (48 per cent) have a PDP. Their views on access to development opportunities are not enthusiastic, as 49 per cent believe that they are poor or non-existent, and a further 27 per cent rate them as adequate.

At 11 per cent, they have a similar rate of accidents to Pharmacists. Twenty-seven per cent of Scientists experiencing accidents did not report them. They are most impressed with their managers' attitudes towards health and safety, and with their access to Occupational Health Services. They show some degree of dissatisfaction with the cleanliness of the workplace and the physical work environment.

The views of Scientists about equal opportunities mirror those of respondents as a whole. They are most positive about fairness and about racial and sex discrimination policies. They are, with a rate of 15 per cent, one of the two groups least likely to suffer from harassment or violence (the other being Senior Managers). Unusually, the harassment is more likely to come from colleagues and managers, rather than patients. This is probably due to the less public-facing nature of their work.

Twenty-nine per cent of Scientists are planning to leave in the coming year, a figure which shows a jump to 40 per cent at four years service. The things that attract Scientists to their work are the familiar themes — colleagues, their work, the location, training received, and their managers. The aspects they dislike are their working conditions, pay, staffing levels and workplace facilities. Eighteen per cent of Scientists feel confident that the survey will be acted upon; an increase from the 14 per cent recorded in 2001.

2.4 Supporting and managerial roles

2.4.1 Healthcare Assistants and Nursing Auxiliaries

HCAs and Nursing Auxiliaries represent six per cent of the London NHS QWL survey database, and are the fifth largest staff group.

They are mainly female (84 per cent), and have an average age of 40.4 years. They are evenly spread across all age groups, with 19 per cent being under 30 and 24 per cent being over 50. Almost two in five have children under sixteen (37 per cent), and 17 per cent have a caring role for an adult who is elderly, disabled or sick. They are the group with the highest level of responsibility for dependent adults. Seven per cent of HCAs/Nursing Auxiliaries report having a medical condition or disability themselves that needs support in the workplace. At 39 per cent, they have the most minority ethnic staff of all staff groups, with two-thirds of these being Black.

Their average length of service is 7.0 years, with 31 per cent of staff having under two years service and 26 per cent having over ten. Approaching one-quarter of HCAs/Auxiliaries work part time. Many are on shifts (43 per cent), followed by those working days (36 per cent) and the remaining 21 per cent on rotas.

In terms of attitudes towards the different aspects of their working lives, they are the group that feel best able to cope with stress. However, they are, in common with Technicians and Support staff, the least positive about their colleagues (although they are still clearly positive about this aspect). They are also positive about job satisfaction and immediate management. They express clear dissatisfaction with pay, and are neutral about co-operation within the Trust/PCT.

HCAs/Nursing Auxiliaries have one of the lower rates of training, with 4.8 days in the past year. Forty-four per cent have had an appraisal during the past twelve months, and the same percentage report having a PDP. Their views about their access to development opportunities are reasonably positive, with 22 per cent feeling that they are excellent or good, and 48 per cent seeing them as poor or non-existent.

Along with Support workers, HCAs/Nursing Auxiliaries are the groups most likely to sustain an accident or injury, with one in four being affected in the last twelve months. Twenty-one per cent of these reported none of the incidences. Their attitudes to health and safety are remarkably positive in the light of the frequency with which they are involved in accidents. They are the most positive group about health and safety training, and are one of the most satisfied groups when their managers' attitudes towards health and safety, access to Occupational Health Services, and the quality of equipment used in their jobs are considered.

Their assessments of equal opportunities in their Trusts/PCTs show that they are most satisfied with the racial discrimination policy, which is particularly relevant for them due to the high percentage of minority ethnic staff, and the sex discrimination policy. They are the third most likely staff group to be involved in incidents of harassment or violence. The majority of their

problems come from patients and their relatives, and they are the most likely group to be subjected to actual violence.

In terms of their intentions to stay or leave their Trusts/PCTs, HCAs/Nursing Auxiliaries are about average, with 72 per cent planning to stay for at least another year. The features that they like about their jobs are colleagues (by a large margin) followed by patient contact, the job they do, the location, hours and working conditions. Their ideas for improvements in their working lives are spread over better pay, more staff, more communication/ meetings, and better workplace facilities. Thirty-five per cent of HCAs/Nursing Auxiliaries feel that the results of the survey will be acted upon; a level of confidence only exceeded by that of Senior Managers, and showing an encouraging increase over the 31 per cent recorded last year.

2.4.2 Technicians

Technicians (who work in a variety of areas such as operating theatres, medical physics, physiological measurement and dentistry) make up three per cent of the sample for the QWL survey in 2002.

Technicians have a similar gender profile to Scientists, with two-thirds being female. Technicians are on average 38.5 years old, and they are also one of the groups most evenly spread across the age groups. One-third have children under 16, and eight per cent are carers for adults. At 23 per cent, they have relatively low minority ethnic membership. The average length of service of Technicians is 7.2 years, with 29 per cent being with the same Trust/PCT for ten years or more. Eighty-one per cent work full time, and 15 per cent are on shifts or rotas.

They have some of the lowest scores for three of the eleven clusters about attitudes towards working life. They are among the least positive about performance and appraisal, feeling valued and involved, and about their work colleagues. They do still rate their jobs and their colleagues highly, but not as enthusiastically as other staff groups. They are as positive about their immediate managers as other staff groups, but hold below-average views about training and development.

Technicians have one of the lowest levels of training (4.6 days, on average in the past twelve months), which probably contributes to their less positive feelings about this aspect. They are less likely than average to have an appraisal (41 per cent report one in the past year) and, at 40 per cent, only Administrative & Clerical and Support staff have lower levels of PDPs. Unsurprisingly, 58 per cent see their access to development opportunities as poor or non-existent.

Twenty per cent of Technicians have experienced an accident or injury in the past year, making them the fourth most likely group to be involved. Thirty-five per cent of the Technicians affected did not report the fact. Their opinions of health and safety show no great deviation from the average for all staff, and they, like other groups, are positive about access to Occupational Health Services and their managers' attitudes towards health and safety.

Twenty-four per cent of Technicians experienced incidents of harassment or violence in the past year. Colleagues, and patients and their relatives, were most likely to be the source, although there were also significant reports of harassment by managers. Technicians' views on equal opportunities in their Trusts/PCTs show that they have most confidence in the racial discrimination policy, followed by the sex discrimination policy and fairness overall.

One-third of Technicians are intending to resign in the next year, and this peaks at four years service, when 46 per cent are thinking of leaving. The factors that Technicians see as positive and enjoyable about their jobs are their colleagues, the location, and the work they are involved in. The improvements they would like to see centre on pay, staffing levels, working conditions and workplace facilities. One in five Technicians believe that the survey will result in actions being taken, an improvement on the figure for 2001 of 16 per cent.

2.5 Administrative & Clerical staff

Administrative & Clerical staff are the second largest staff group discussed in this chapter, accounting for just over one in five (22 per cent) of the sample.

Administrative & Clerical staff are predominantly female (87 per cent), with an average age of 42.4 years. They are fairly well spread throughout the age groups, with 16 per cent under 30, and five per cent over 60. Twenty-seven per cent have children under 16, and 11 per cent care for elderly, sick or disabled adults. Approximately four out of five (82 per cent) are White and nine per cent are Black. Their average length of service is 6.8 years with 48 per cent having over five years service. Twenty-nine per cent work part time, and only six per cent are on a shift or a rota.

The attitudes of Administrative & Clerical respondents to their working lives place them with some of the least satisfied staff for pay and performance appraisal. They also have clearly below average ratings for both job satisfaction and training. They are, however, very positive about their colleagues, and feel better able to cope with stress than respondents overall.

They receive less formal training than all the other staff groups, with 2.6 days in the last twelve months. Forty-five per cent of

Administrative & Clerical staff have had an appraisal in the past year, which is better than or equal to four of the other staff groups. They are almost the least likely group to have a PDP, with 37 per cent reporting having one; a figure which only exceeds that for Support staff. Needless to say, their views of their access to development opportunities are not good, with 61 per cent seeing them as poor or non-existent.

Administrative & Clerical staff are one of the groups least affected by accidents and injuries; they report a rate of 11 per cent. One-third of these incidents go unreported. Their views on health and safety aspects in their Trusts/PCTs are almost identical to the averages for all staff groups. They are most positive about access to Occupational Health Services, and express some dissatisfaction with the cleanliness of the working environment.

Their opinions of equal opportunities are the same as staff overall, with the exception of family-friendly policies, about which they are slightly more positive. One in five Administrative & Clerical staff have experienced harassment or violence, with this coming from patients and their relatives and, to a lesser extent, from colleagues.

Twenty-eight per cent of Administrative & Clerical staff plan to leave in the coming year. This intention declines with length of service, from 35 per cent at one year to 21 per cent at over ten years. The best features of working life for these staff are, in descending order: colleagues, the location, the work, and the hours they work. Suggestions for areas of improvement are working conditions, pay, workplace facilities, and communication. They are the only group to put, in their top four choices, hours as a positive feature, and better communication as a suggested improvement. Twenty-two per cent of Administrative & Clerical staff are confident that the survey will be acted upon; an encouraging increase over the 18 per cent from last year.

2.6 Support staff

Support staff include those involved in such activities as housekeeping, portering, maintenance and security. They represent two per cent of the response to the QWL survey; a percentage that is lower than their true representation in the London NHS workforce, as this group is generally less inclined to take part in surveys. Even with full representation, Support is a small group. In most Trusts/PCTs, many support services have been contracted out. This may have caused staff in this group to feel less valued and involved than colleagues in other groups.

The majority of Support staff (63 per cent) are male, the only staff group in which this is the case. They have an average age of 46.2 years, and are the second oldest group after Health Visitors and School Nurses. Forty-three per cent are over 50. Twenty-three per

cent have children under 16 at home, and 15 per cent, the highest of any group, have caring responsibilities for an adult. They are also the staff group with the most members having a medical condition or disability that needs support in the workplace (11 per cent). Seventy-nine per cent are White, ten per cent Black, and five per cent Asian. Support workers have one of the longest lengths of service, at 9.6 years. Eighty-five per cent have full-time contracts, and 26 per cent work shifts or rotas.

The attitudes of Support workers to their working lives are among the least positive for nine of the eleven clusters. The exceptions are coping with stress, where they are just above the average, and pay, where they are just below the average. They are the most disenchanted group with training and development, and express the least job satisfaction of all the groups.

They have, on average, experienced 3.3 days training in the past year, which only exceeds that received by Administrative & Clerical staff. As a group, they are the least likely to have had an appraisal (34 per cent), and only 25 per cent have a PDP. Their views on their access to development opportunities reflect this, with 63 per cent saying that they are poor or non-existent.

Support workers are the group most likely to have had an accident or injury at work during the past year, with one in four experiencing at least one incident. Twenty-seven per cent of these did not report any of the incidents. Their views on health and safety show that they are more positive than average in their assessment of security in the workplace, the physical work environment, and cleanliness. This may reflect their involvement in the delivery of these services. They are also more positive than average about access to Occupational Health Services, which is encouraging, given that they are the group most likely to have a disability/medical condition, and to have experienced accidents and injuries.

Twenty-three per cent of Support staff have experienced harassment or violence, coming almost equally from patients and their relatives, managers and colleagues. Support staff views on equal opportunities show that they are among the most positive groups about the disability policy but, with Midwives, are the least confident about equal opportunities and fairness generally.

Just under three-quarters of Support staff plan to stay with their Trusts/PCTs for at least another year. The features of their jobs that are regarded as the best are, in order of preference: colleagues, work location, the jobs they do, and the hours worked. Their main recommendation for improvement is clearly better pay. Following this, with half as many mentions, are requests for a range of improvements including better senior management, working conditions, staffing, hours and teamwork. Their confidence that their views will be acted upon as a result of the

survey has increased since last year, with 27 per cent now feeling this, compared to 24 per cent in 2001.

2.7 Senior Managers

Senior Managers form seven per cent of the London NHS sample, and are typically the group most likely to respond to the QWL surveys. They show considerable differences in their attitudes when compared to many of the groups previously discussed in this chapter. This is probably linked to their position in the organisation, which gives them the ability to determine overall direction, including policies and their implementation.

Two-thirds of Senior Managers are female, and they have an average age of 41.8 years. Thirty-six per cent have children under 16, and 11 per cent are carers for dependent adults. Only 13 per cent are from a minority ethnic group. Their average length of service is the same as the sample overall, at 6.9 years. The majority (90 per cent) work full time, and only four per cent report shift or rota working.

In terms of their attitudes, Senior Managers are the most positive group for six of the eleven clusters about working life. They are particularly positive about job satisfaction, immediate management, feeling valued and involved, commitment to the Trust/PCT, communication, and even rate pay neutrally rather than negatively. The only aspect about which they are slightly negative is coping with stress and work pressure.

Senior Managers have had an average of 4.7 formal training days each in the past twelve months, which is low when compared to other staff groups. They are likely to have had an appraisal in the past year (66 per cent report this), and 56 per cent have a PDP. At 41 per cent, Senior Managers have the highest level of all groups feeling that their access to development opportunities is excellent or good.

As might be expected, due to the nature of their work, Senior Managers are the least likely to sustain an accident or injury at work. Their attitudes towards health and safety are more positive than their colleagues. They give the highest scores of all groups to their managers' attitudes towards health and safety, the quality of equipment used, security in the workplace, and cleanliness of the workplace.

Although one of the two groups least involved in incidents of harassment or violence, 15 per cent have still experienced this. They are, unusually, most at risk from other managers and their colleagues. Their views on all aspects of equal opportunities are the most positive of all staff groups. They are particularly satisfied with fair treatment and with family-friendly and sex discrimination policies.

Senior Managers are among those most likely to stay with their Trusts/PCTs; 73 per cent plan to stay for at least a year. Along with most other staff groups, Senior Managers see the best things about working for their Trusts/PCTs as their colleagues, the job content, convenient location, and their managers. They are also the most appreciative group of the good reputation and forward thinking of their Trusts/PCTs. Aspects that they would like to see improved are working conditions, workplace facilities, communication, and administrative/secretarial/ICT support. They also express the greatest confidence that the findings from the survey will be acted upon, with 36 per cent agreeing with this and 38 per cent being neutral. Last year, these figures were 32 per cent and 36 per cent respectively.

2.8 Conclusion

This chapter has given the profiles of the main staff groups found in the London NHS and shows that, despite some common ground, the experience of working life varies markedly from staff group to staff group.

- The biographical areas of difference — the composition of the groups by age, gender, ethnicity and family responsibilities — have implications for recruitment, workforce planning, training, and equal opportunities & fairness policies.
- Employment profiles also show distinct differences between the groups when length of service and patterns of working are considered. These aspects have a major impact on the attitudes and concerns of the different groups.
- Intention to leave the Trust/PCT varies by job type, with some groups being clearly more at risk, and some showing an interesting 'moving on' peak at four years service (see Chapter 5, 'Factors Influencing Retention'.
- The likelihood of being involved in an accident or sustaining an injury is clearly related very closely to the role performed, although in all staff groups, many of the incidents still remain unreported. The views of staff on health and safety also show varying degrees of access to Occupational Health and staff counselling, and different views about some aspects (such as workplace security and cleanliness) depending on the perspective of the staff groups and their involvement with patients.
- The incidence of harassment and violence shows great variation between the staff groups, again, largely related to the type of work they do. Those with more public-facing roles are clearly at much greater risk. The fact that many staff are also harassed by colleagues and managers should not be overlooked.
- However, staff do show remarkable agreement about appreciating their colleagues, the actual work they do, and

being satisfied with their immediate manager. They are almost unanimous in expressing dissatisfaction with pay and benefits. There is also considerable agreement that better workplace conditions and more staff would improve their working lives.

To summarise, staff in the London NHS are not homogeneous. The groups place different emphases on the aspects of their working lives, have different experiences, and express different levels of satisfaction with the features of their jobs. 'One size fits all' is not a prescription that will succeed in the London NHS. Instead, HR practitioners and Senior Managers need to try to get under the skin of people in the different staff groups, and see working life through their eyes. The QWL surveys are only the starting point in this process.

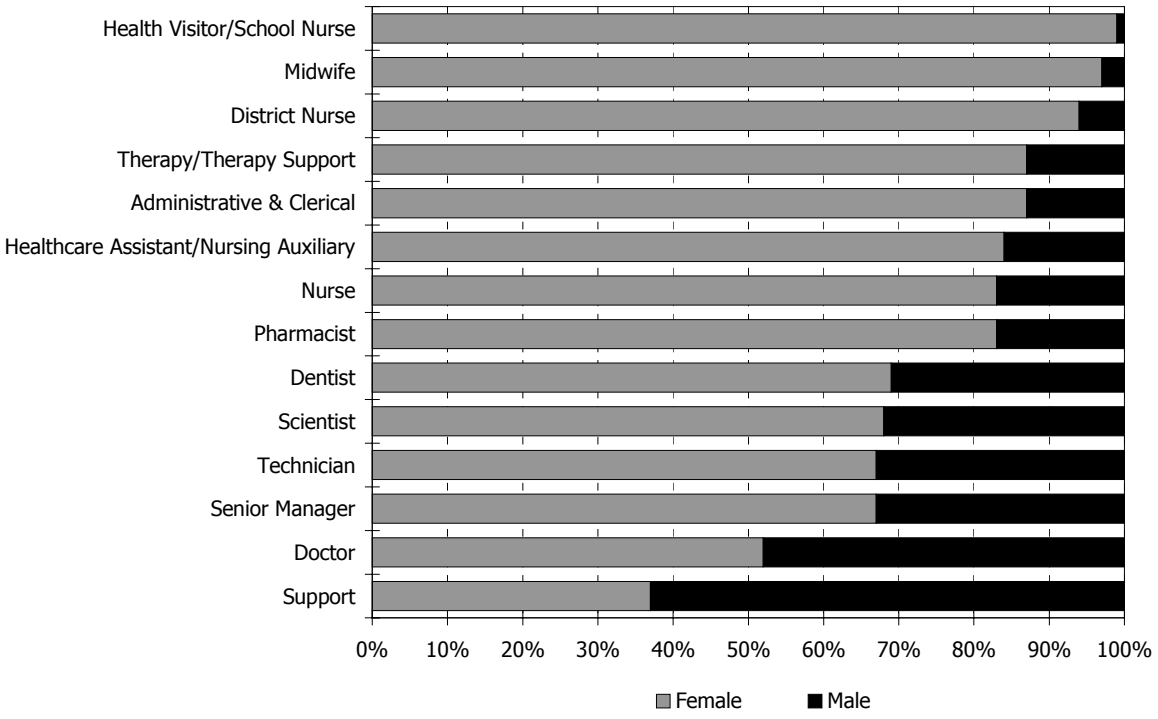
List of appendix tables and figures

Appendix Table 2.1: Job groups in the London NHS surveys, 2002

	No.	%
Nurse	7,804	29
Midwife	655	2
Health Visitor/School Nurse	661	2
District Nurse	471	2
Doctor	2,237	8
Dentist	118	0
Therapy/Therapy Support	2,896	11
Pharmacist	401	1
Scientist	1,144	4
Healthcare Assistant/Nursing Auxiliary	1,570	6
Technician	717	3
Administrative & Clerical	6,094	22
Support	493	2
Senior Manager	2,048	7

Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.1: Job group and gender (per cent)



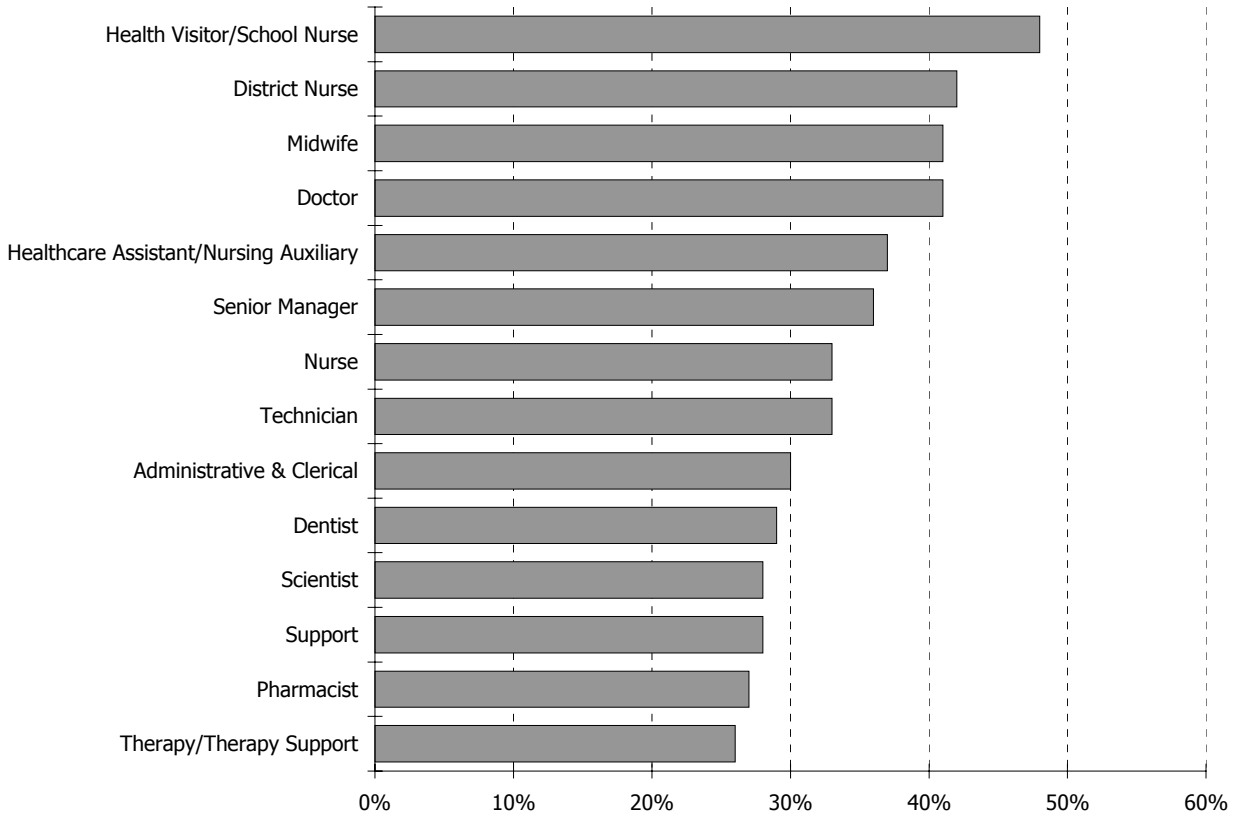
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Table 2.2: Mean length of service by job group (years)

	Length of service
District Nurse	9.9
Health Visitor/School Nurse	9.6
Support	9.6
Midwife	9.3
Dentist	8.2
Scientist	7.6
Technician	7.2
Healthcare Assistant/Nursing Auxiliary	7.0
Senior Manager	6.9
Nurse	6.8
Administrative & Clerical	6.8
Doctor	5.9
Therapy/Therapy Support	5.8
Pharmacist	5.7
Total	*6.9*

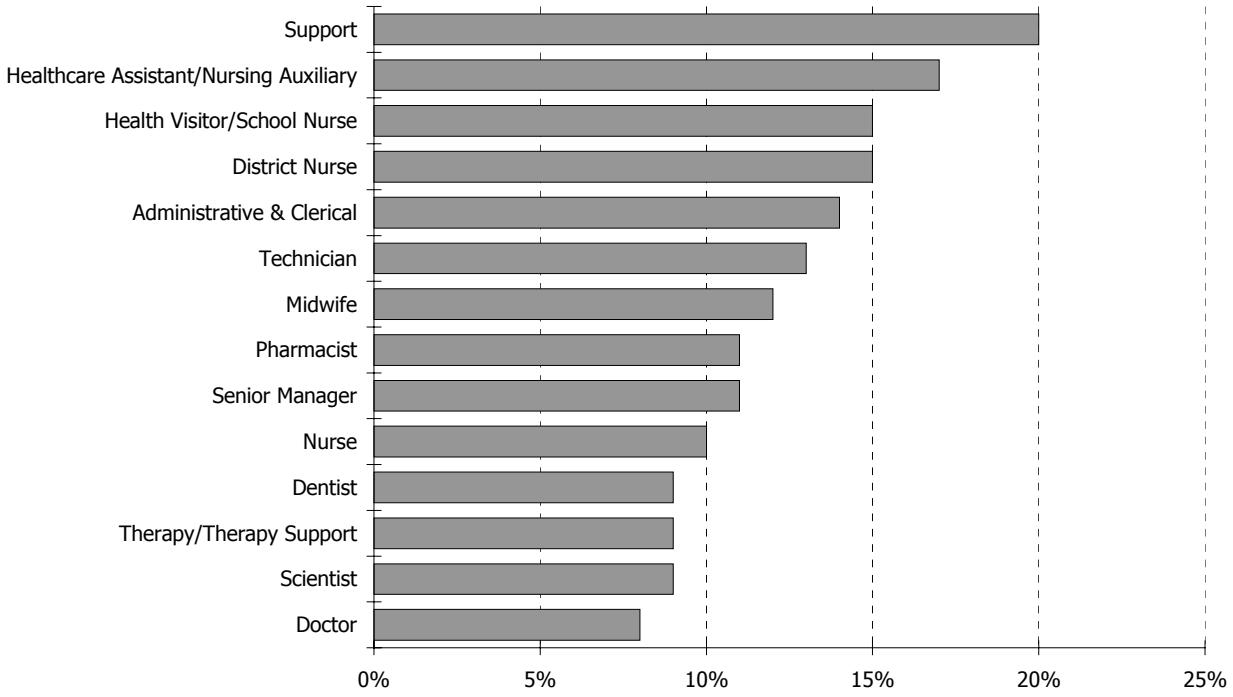
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.2: Job group and have children under 16 at home



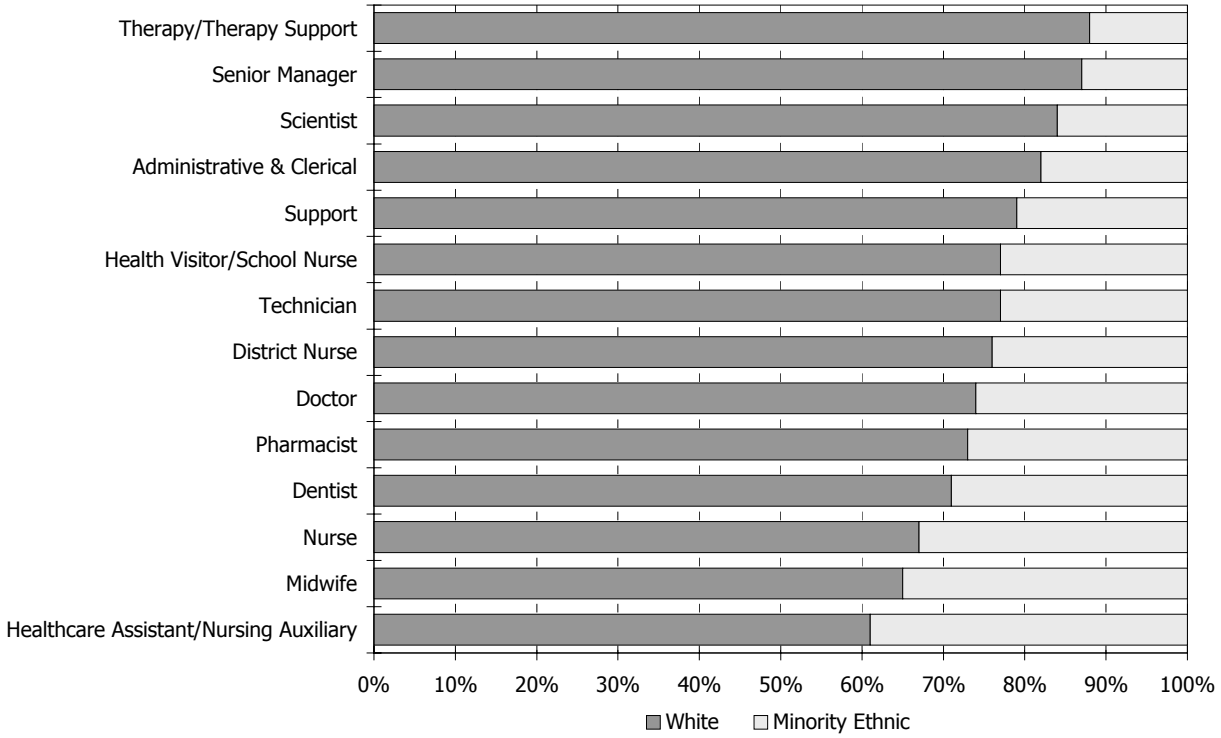
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.3: Job group and have eldercare/adult caring responsibilities



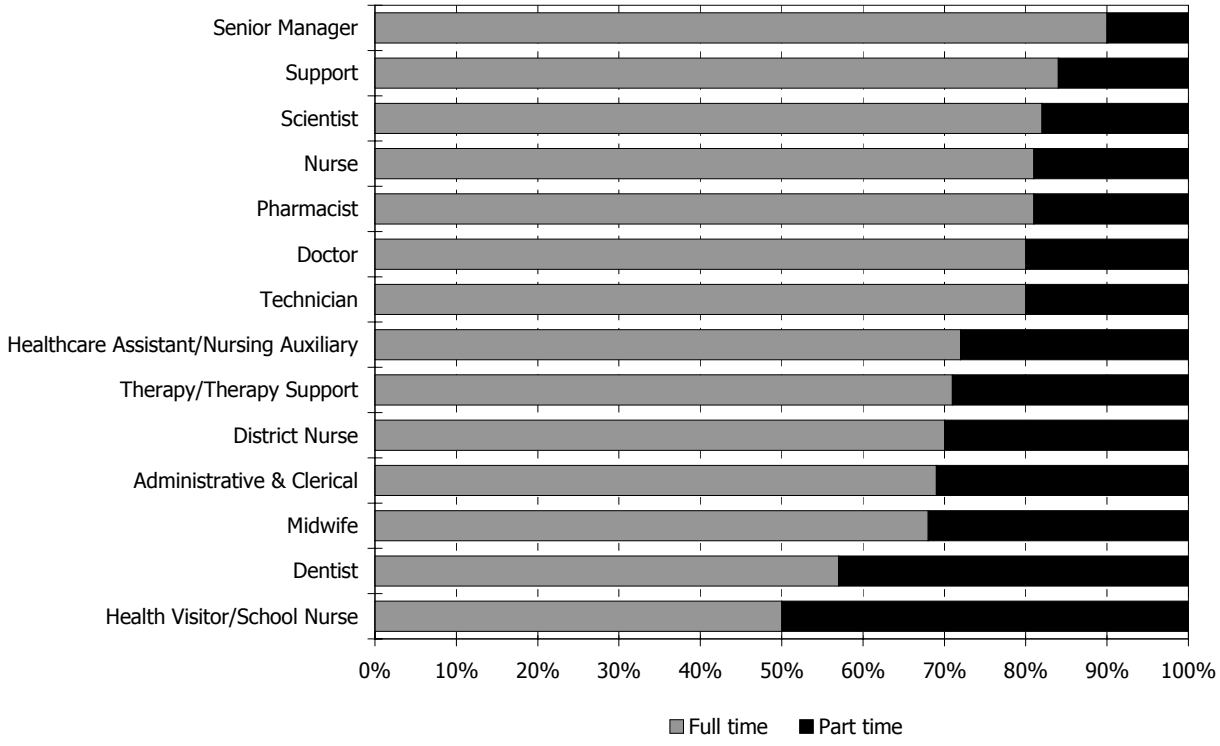
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.4: Job group and ethnicity



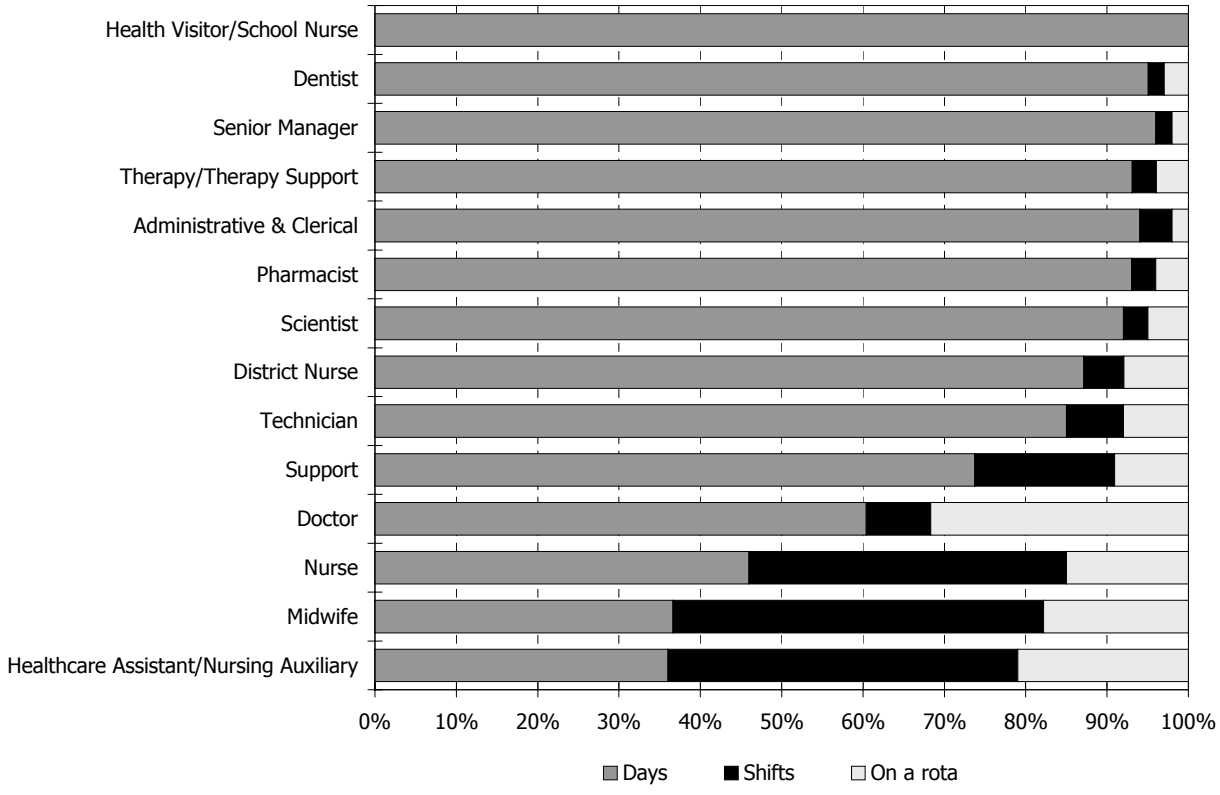
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.5: Job group and full- or part-time



Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.6: Job group and pattern of work



Source: IES NHS Staff Attitude Surveys, 2002

Appendix Table 2.3: Attitudes and job group — distance from the overall mean

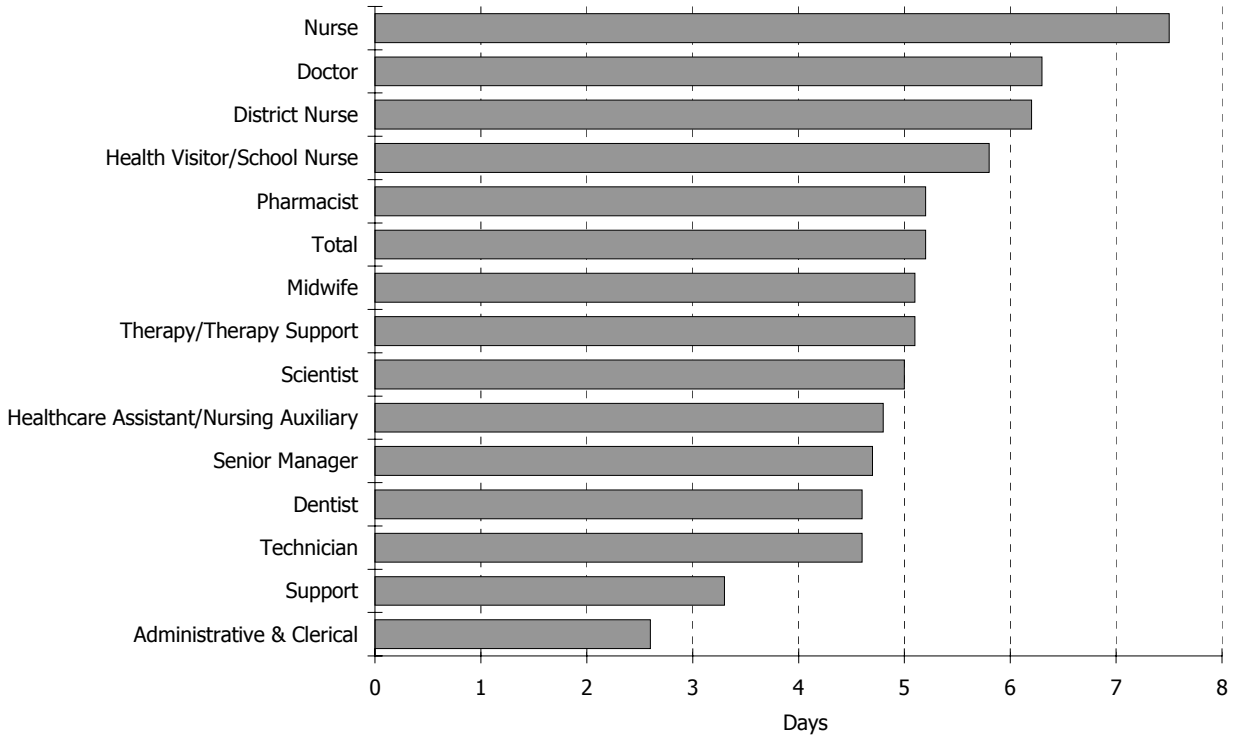
	Nurses	Midwives	HVs/School Nurses	District Nurses	HCAs/NAs	Doctors	Dentists	Therapy	Pharmacists	Scientists	Technicians	A & C	Support	Senior Managers
Communication	+		+		+	−		++	+	+		−	−−	++
Pay and benefits		−		−−	−	++	++	+	++	−	−	−−	−	+++++
Performance and appraisal	+	−				−	−	++++		−	−−	−−	−−	+++
Feeling valued and involved		−−	−	−		−	−	++	+		−−	−	−−	++++
Training, development and career	−	−−	++	+	−			++		−	−−	−−−	−−−−	+
Job satisfaction		+		+	−−−	++	+	+		−	−−	−−−	−−−−	++
Commitment to the Trust/PCT			−	−	+	−				−			−	++
Immediate management	+	−−	+			−	−−	++	+	+			−−	+++
Co-operation	+	+	+		+		+	+		−				+
Colleagues			+	++	−	+		++		+	−		−	+
Stress and work pressure		−		−	+++	−−	+	+	−		+	++	+	−

Notes: 1. The overall mean averages have been weighted so that every staff group, regardless of size, makes an equal contribution to the calculation of the mean.

2. Every + represents a distance of 0.1 above the mean, and every − a distance of 0.1 below the mean. '++', for example, indicates that respondents in the staff group have an average score that is 0.2 above the weighted mean.

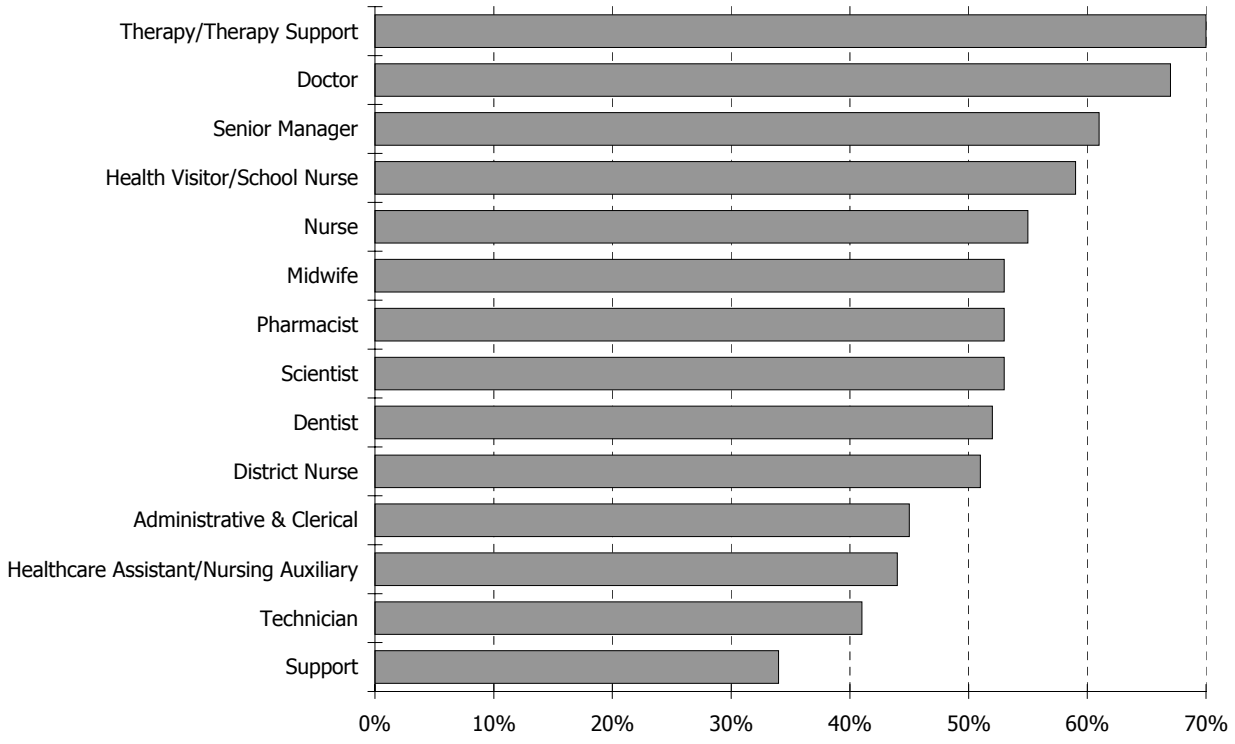
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.7: Mean number of training days in past 12 months, by job group



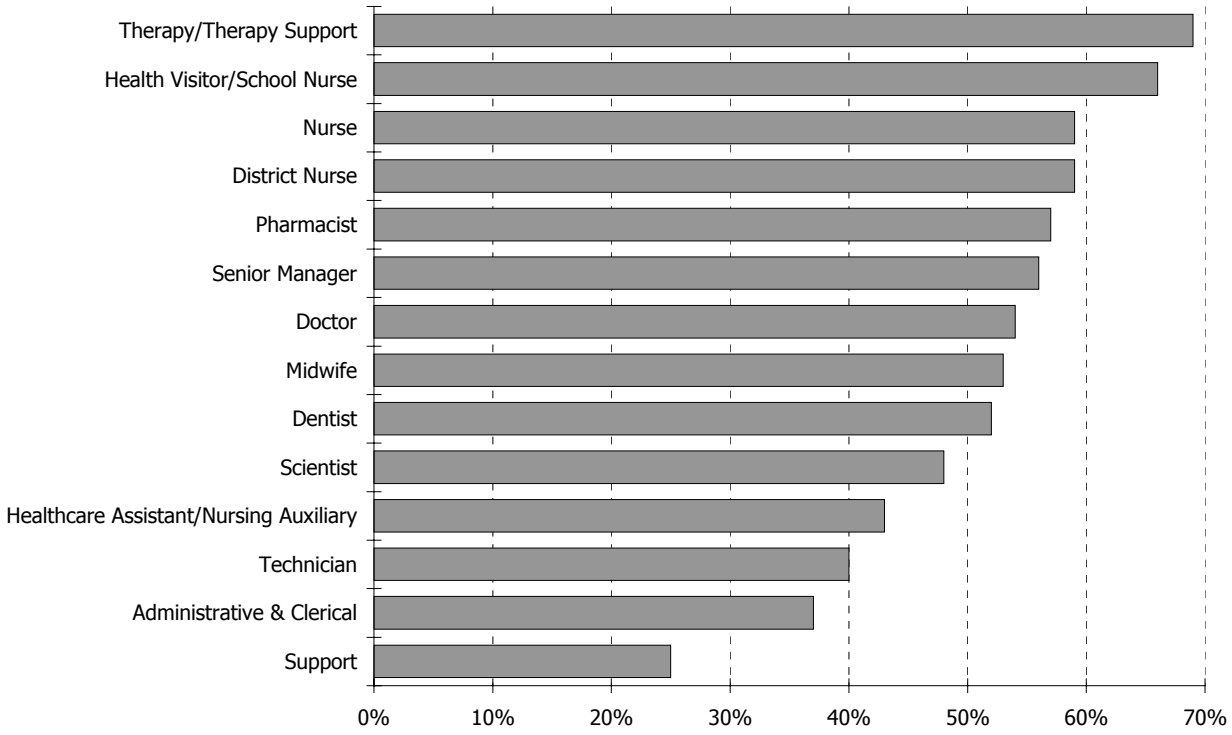
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.8: Job group and performance appraisal in past 12 months



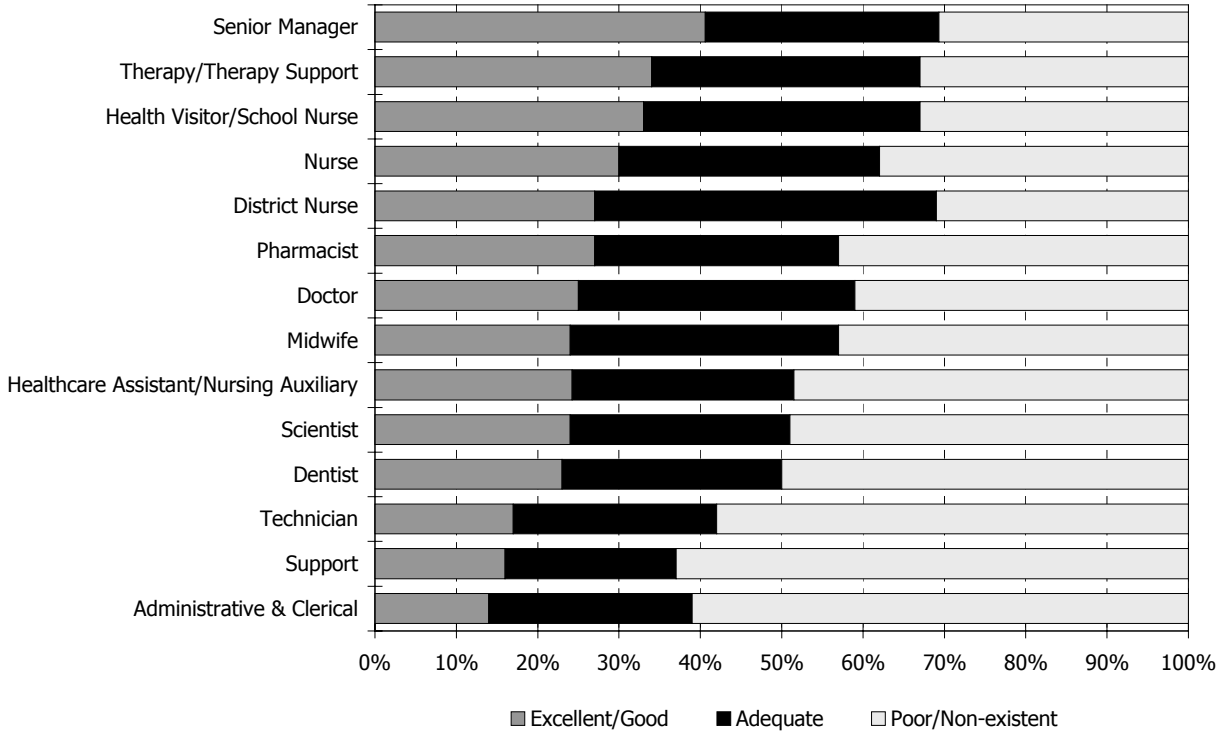
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.9: Those with a Personal Development Plan, by job group



Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.10: Job group and access to development opportunities



Source: IES NHS Staff Attitude Surveys, 2002

Appendix Table 2.4: Attitudes towards health and safety and job group – distance from the overall mean

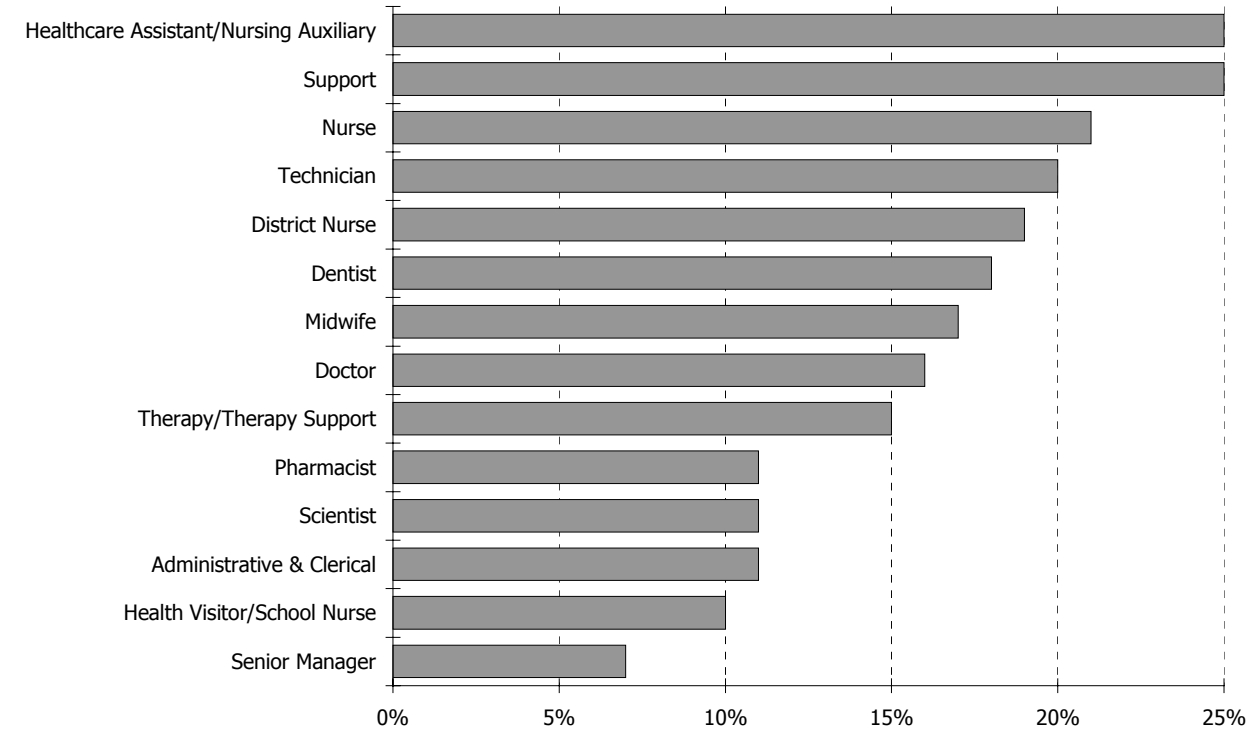
	Nurses	Midwives	HVs/School Nurses	District Nurses	HCAs/NAs	Doctors	Dentists	Therapy	Pharmacists	Scientists	Technicians	A & C	Support	Senior Managers
Physical work environment		–			++	– –	+	–	– – – –	– –		–	++	+++
Health and safety training				–	++	– – –			–		– –	–	–	
Cleanliness of the working environment		– –	+++	+++	+	– –	+++	+	– –	–	–	–	++	+++
Access to staff counselling		–	–	– –	–	–	–	++			–		–	+++
Managers' attitudes to health and safety issues	+	–			++	– –	+			+		–	–	++
Quality of equipment used in job		– –	–	+	++	– –			– –	+				++
Access to Occupational Health Services (excluding counselling)	+	+		–	++	–	–				+		+	+
Security in the workplace	– –	–	+			– –		–		–	–	–	+	++

Notes: 1. *The overall mean averages have been weighted so that every staff group, regardless of size, makes an equal contribution to the calculation of the mean.*

2. *Every + represents a distance of 0.1 above the mean, and every – a distance of 0.1 below the mean. '++', for example, indicates that respondents in the staff group have an average score that is 0.2 above the weighted mean.*

Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.11: Job group and incidence of accidents and injuries in the last 12 months



Source: IES NHS Staff Attitude Surveys, 2002

Appendix Table 2.5: Attitudes towards equal opportunities and job group — distance from the overall mean

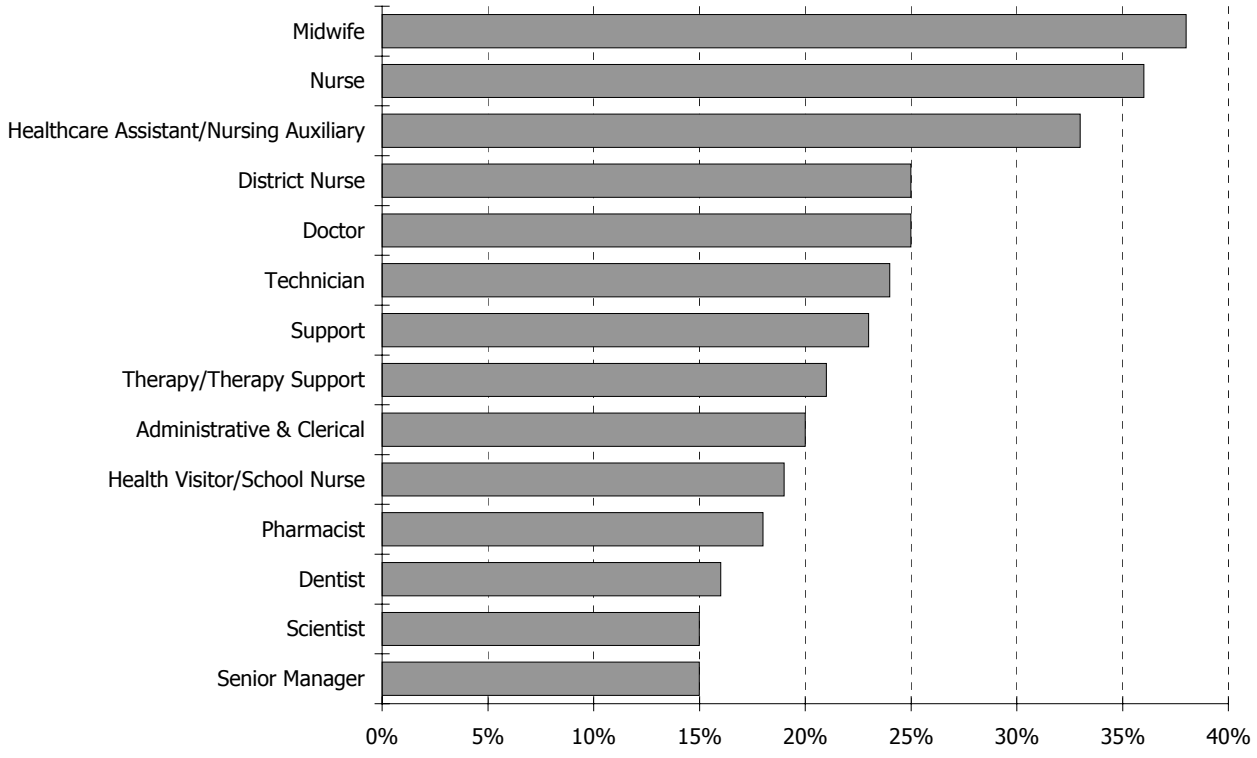
	Nurses	Midwives	HVs/School Nurses	District Nurses	HCAs/NAs	Doctors	Dentists	Therapy	Pharmacists	Scientists	Technicians	A & C	Support	Senior Managers
Equal opportunities and fair treatment	–	– – –			–			+			–		– –	+
Family friendly policies		–	+	–	+	–		+				+		+++
Racial discrimination policy	–	– – –	–			–	+	+	+					+
Sex discrimination policy	–	– –									–		–	+
Disability policy		–		–						–			+	–

Notes: 1. *The overall mean averages have been weighted so that every staff group, regardless of size, makes an equal contribution to the calculation of the mean.*

2. *Every + represents a distance of 0.1 above the mean, and every – a distance of 0.1 below the mean. '++', for example, indicates that respondents in the staff group have an average score that is 0.2 above the weighted mean.*

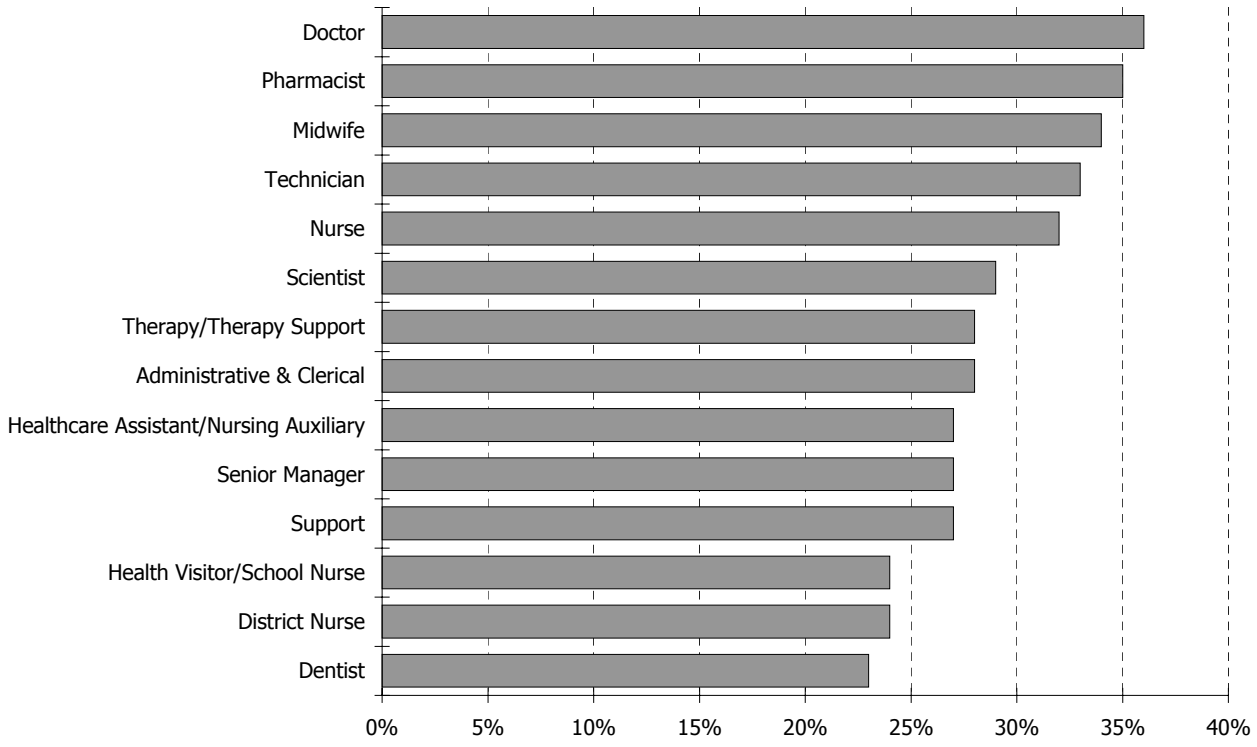
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.12: Job group and incidence of harassment and violence in the last 12 months



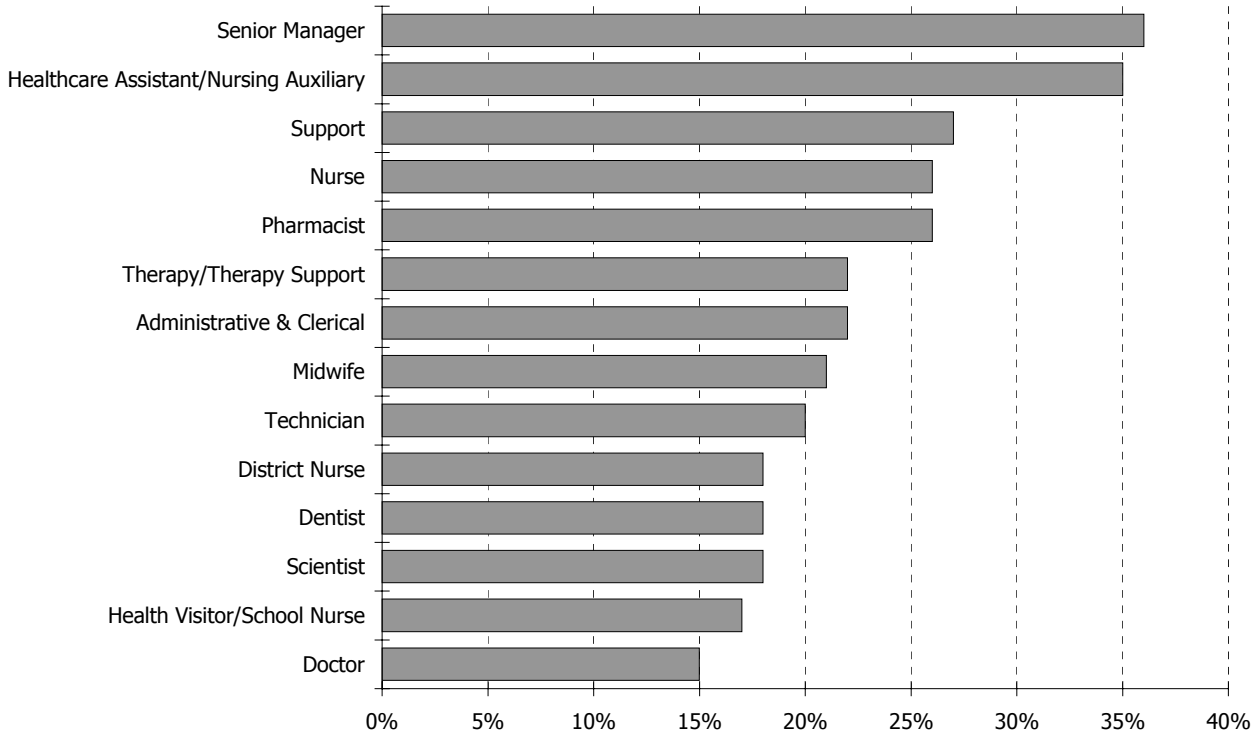
Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.13: Job group and intention to leave within the next year



Source: IES NHS Staff Attitude Surveys, 2002

Appendix Figure 2.14: Job group and agreement that results of survey will be acted upon



Source: IES NHS Staff Attitude Surveys, 2002

The Influence of the Line Manager

There are a number of good reasons why Trusts/PCTs should support and develop their line manager capacity. Good line managers are recognised and valued by staff, and when staff have supportive relationships with their line manager, they express greater happiness with a wide range of other features of their working life. Satisfaction with line management and these other features of working life is associated with a greater intention to stay with the Trust/PCT.

Evidence from our survey suggests that a good manager:

- engages with their staff's performance, giving encouraging feedback and regular appraisals
- makes real the Trust's/PCT's commitment to staff development, championing PDPs, facilitating access to formal training, and promoting the value of, and access to, less-formal development opportunities
- handles any 'shocks' well**.** Although prevention is always better than a cure, there is still a place for effective policies and procedures for dealing with incidents of harassment, violence and accidents at work. Effective line managers deal with these experiences and their aftermath sympathetically and supportively.
- embodies Trusts'/PCTs' ambitions to build a culture that values equality of opportunity and fair treatment
- facilitates their staff's efforts to balance work and home lives.

3. The Influence of the Line Manager

Sarah Perryman

3.1 Key messages and suggestions

In this chapter, we explore how staff satisfaction with the line manager is crucial to London NHS employees' sense of well-being and the quality of their working lives.

The questionnaire asked staff their opinion about a number of different aspects of their line manager's performance. These include:

'My immediate manager is sensitive to work/life issues'

'My immediate manager lets me know how I am doing'

'I have a good working relationship with my immediate manager'

'My immediate manager supports me when things go wrong'.

These four attitude statements sit together statistically, which allowed us to combine them into one line management 'cluster' or scale. This offers an advantage, as scales made up from items that are related statistically are more reliable than scores derived from replies to individual attitude statements. An identical approach was adopted with the attitude statements that look at other aspects of the quality of working life, *eg* communications.

3.2 Line managers getting better and better

If we look at the scores given to line managers' performance over the three years (Table 3.1), we can see that:

- in general, immediate managers are held in high regard and have good working relationships with their subordinates. The scores are above the neutral point (3), and well into the 'satisfied' range.
- scores have increased over the three years, showing staff satisfaction with their line mangers rising steadily. What is more, this trend is statistically significant, year-on-year.

The importance of line managers in the QWL can also be seen when staff look back over their employment. Staff who think their Trust/PCT is now a better place to work than it was in 2000, rate their

Table 3.1: Satisfaction with immediate management, 2000 to 2002

Year	Mean	No.
2000	3.46	31,729
2001	3.52	34,298
2002	3.57	27,766

Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

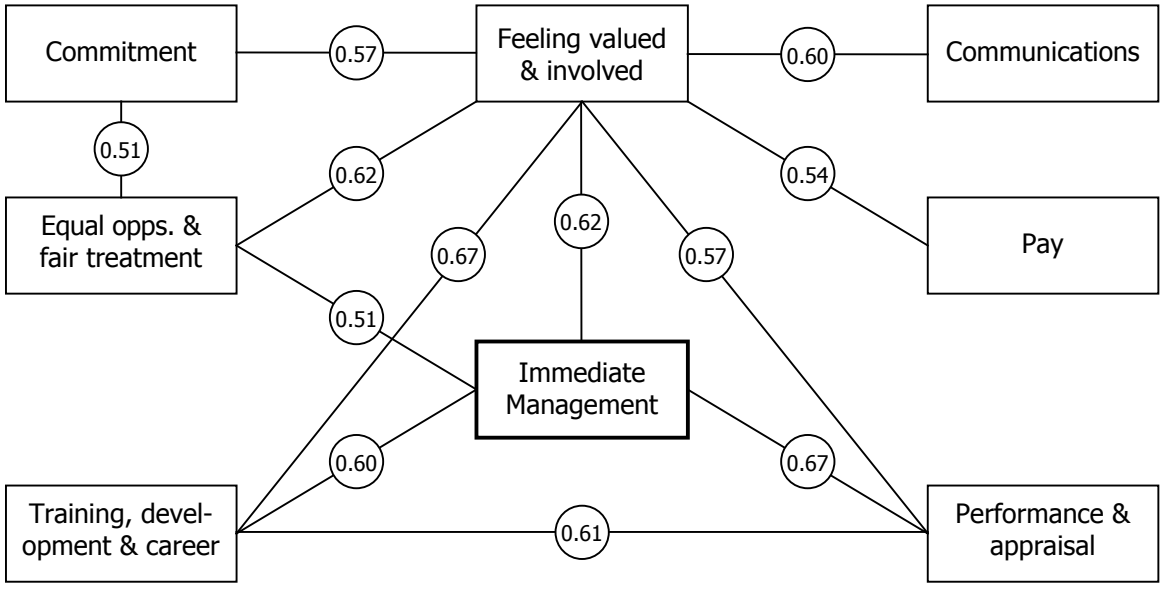
Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

line managers extremely highly — a mean of 3.9. Those who think it is the same are also very satisfied with their relationship with their line manger (3.6). However, staff who think their Trust/PCT is a worse place to work are non-committal about their line managers, giving them a neutral score (3.0).

3.3 Line managers are the key

Our analysis shows that the various indicators of staff satisfaction (*eg* job satisfaction, equal opportunities and fair treatment) are inter-related. Each of the factors correlates with the others, in that greater satisfaction with one aspect of working life is usually mirrored by greater satisfaction with another. For example, staff who are satisfied with communications in their Trust are also more likely to feel valued and involved. However, if we focus our attention on the strongest links between the various indicators of staff satisfaction, we have a powerful tool for understanding and influencing the quality of working life for London NHS employees. Our model is presented in Figure 3.1 below.

Figure 3.1: Significant links between key aspects of working life



Figures shown are correlation co-efficients. Only correlations in excess of 0.5 have been shown.
All relationships statistically significant: $p < 0.01$

Source: IES NHS Staff Attitude Surveys, 2002

What the model clearly shows is how the line manager is central to staff satisfaction with many different aspects of working life. It also shows the way in which the scales for each of these different aspects interrelate with each other. The strongest links between different sources of satisfaction with the QWL are shown.

This diagram shows that line managers have a pivotal role in staff satisfaction with:

- their experience of performance and appraisal
- their training, development and careers
- equal opportunities and fair treatment
- perhaps most importantly, the extent to which staff feel valued and involved.

Each of these, in turn, influence staff satisfaction in a range of indicators of quality of working life. For example, where satisfaction with line managers is highest, staff also report feeling valued and involved. This then in turn positively influences satisfaction with pay, commitment and communications, as well as reinforcing the line manager's role in supporting equal opportunities and fair treatment.

3.4 Who appreciates their manager the most?

High esteem for immediate managers is universal among the Trusts/ PCTs we surveyed. In 2002, the score for the immediate management scale among Trusts/PCTs ranged from 3.3 to 3.8. Among Acute and Teaching Trusts, the average Trust score was 3.5. In Mental Health Trusts and PCTs, the average score was 3.7.

The immediate management score does vary among different groups of staff, although relationships with line managers are generally rated highly.

- White staff score their line managers higher than do their minority ethnic colleagues (3.6 compared to 3.4). Among the different ethnicities, scores are lowest amongst Chinese staff.
- The under-30s are the most positive age group (3.7), closely followed by the 30 to 39 year olds (3.6). Staff aged 40 and over score their line managers at 3.5.
- Staff with a medical condition or disability that requires support in the workplace are less satisfied than their colleagues with their immediate managers, with mean scores of 3.3, compared to 3.6.
- Senior Managers score their immediate managers the highest (3.8), followed by Therapy staff (3.7). The lowest levels of satisfaction are expressed by Support staff (3.3), Doctors & Dentists (3.4), Technicians (3.5), Administrative & Clerical staff (3.5), and HCAs/ Nursing Auxiliaries (3.5).

- Staff working days (3.6) are more satisfied with their line manager than are those working shifts (3.5) or rotas (3.4).
- Satisfaction with line managers appears to decrease with length of service. Staff who have just joined their Trusts/PCTs rate their managers very highly (3.7), but this falls steadily away to 3.5 among staff with ten or more years service.

3.5 What do line managers do that makes a difference?

Line managers have a pivotal role in staff perceptions of how valued they are and how involved they can be. But how does this work in practice? We have information from the staff surveys on a number of line management activities:

- appraising performance
- supporting personal development plans
- smoothing access to formal, off-the-job training
- easing the way to less-formal development opportunities
- preventing, and dealing with, the aftermath of harassment and abuse
- co-ordinating the response to accidents and injuries
- supporting a culture of equality of opportunity
- helping their staff achieve an acceptable work/life balance.

3.5.1 Appraising performance and supporting PDPs

Performance and appraisal systems are heavily influenced by line managers. We found that the more immediate managers gave regular feedback on performance and took the performance appraisal system seriously, the more highly employees rated their line manager.

However, performance appraisals, whilst growing in coverage, are not given to everyone; just over half (54 per cent) of staff received an appraisal in the last year. It is therefore not surprising that, overall, staff are only slightly satisfied with their manager's approach to managing individuals' performance and appraisal, giving this scale a mean of 3.1.

Where they do take place, however, line managers' commitment of time and effort to the performance and appraisal of individual staff appears to build supportive working relationships. Staff who had an appraisal in the last year were very much more satisfied with the relationship with their line manger (mean score 3.8) than those who had not been appraised (3.3).

Personal development plans (PDPs), which reflect a mutual commitment by employer and employee to development, also appear to build successful working relationships between line managers and

their staff. Employees with a PDP rate their line manager more highly than those who do not have a PDP (3.8 compared to 3.3).

3.5.2 Smoothing access to formal, off-the-job training

Similarly, staff who did not receive any training in the previous 12 months were less satisfied with their line manager than those who had been trained, and satisfaction grows with the number of training days received. Staff who did not receive training scored their manager at 3.3, whereas those with one to five days rated their managers at 3.6, and those experiencing six days or more, at 3.7.

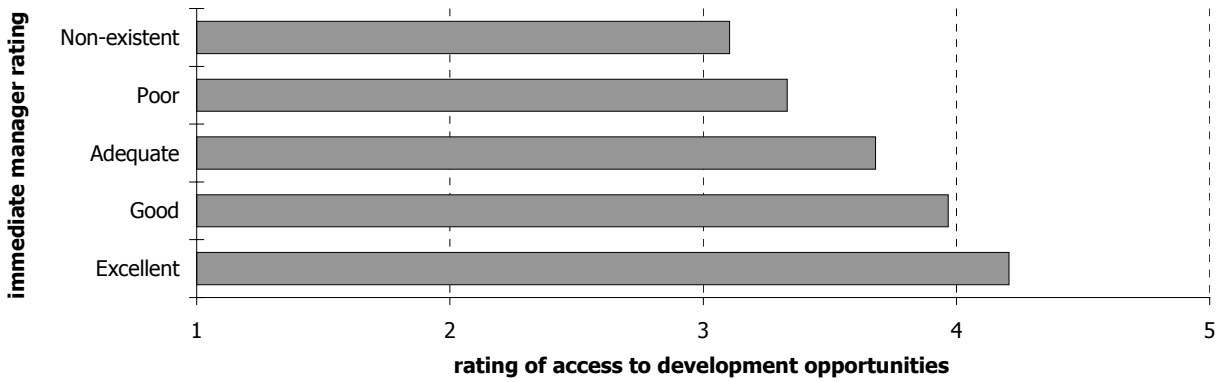
Where the Trust's/PCT's commitment to an individual's training, development, and career progression is perceived as strongest, staff are more satisfied with their line manager and the extent to which they feel valued and involved. Staff value active support for continuing professional development, equal access to training and development opportunities, and adequate training.

Line managers also have an active role in communicating that they take staff development seriously, discussing training needs on a regular basis, engineering time off for staff to train, and encouraging their personnel to develop new skills.

3.5.3 Easing the way to less-formal development opportunities

Official routes to career development are not the whole story. Line managers are more well-regarded when they assist staff to access the less-formal development opportunities that further enrich their career aspirations, as Figure 3.2 illustrates.

Figure 3.2: Satisfaction with immediate management, by rating of access to less-formal development opportunities



Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Surveys, 2002

Table 3.2: Incidence of unpleasant experiences and satisfaction with line manger

Experienced ...	Yes	No
... incident of harassment or violence	3.3	3.7
... accident or injury	3.4	3.6

Source: IES NHS Staff Attitude Surveys, 2002

3.5.4 Dealing with the aftermath

We have identified at least two experiences that diminish the extent to which staff feel valued and involved. Staff who experienced either an incident of harassment or violence, or an accident or injury, in the previous year, rate their line mangers less highly (see Table 3.2).

It seems unlikely that staff who are less satisfied with their line managers attract more harassment or accidents than others. Therefore, we suggest that these experiences, and, in particular the way in which they are handled, may dent employees' confidence in the organisation and their supervisor. However, it may also be true that a supportive relationship with a line manager may effectively 'shock proof' employees.

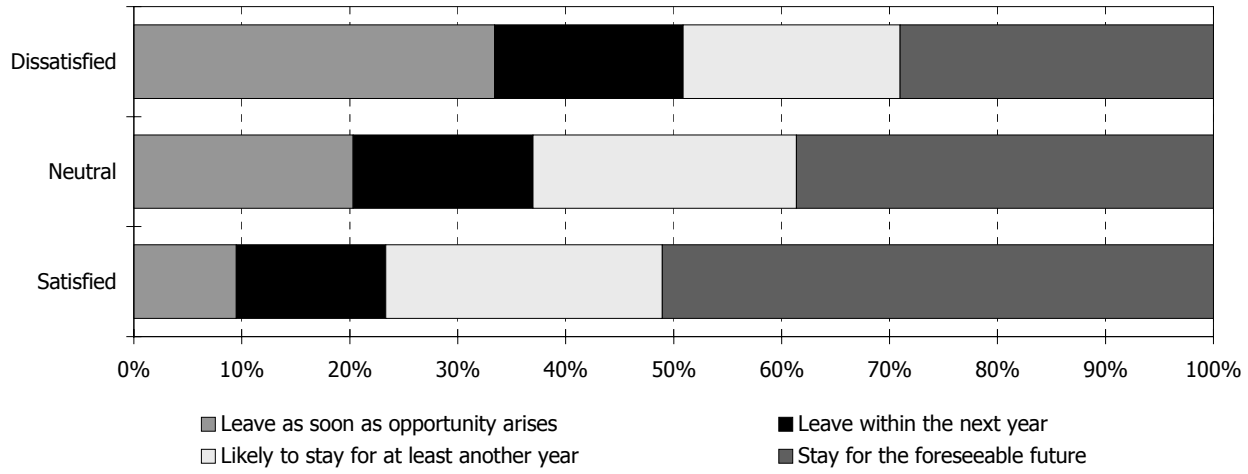
Unsurprisingly, when incidents of racial, sexual or verbal harassment, or acts of violence are committed by managers, this has a devastating effect on staff opinion of supervisors. Staff harassed by their manager are dissatisfied with their line manager (2.6), whereas other staff are very satisfied (3.6).

3.5.5 Supporting a culture of equality of opportunity

Line managers have a central role in Trusts'/PCTs' efforts to build an NHS culture that values equality of opportunity and fair treatment. There is a strong correlation between employees' satisfaction with their line manager and their faith in equality of opportunity and fair treatment for themselves, colleagues, and patients at work (Figure 3.3). This suggests that staff value their line manager's efforts in ensuring that their Trust/PCT makes its positive commitment to equal opportunities clear, and in delivering services to patients that are free from discrimination.

Policies need to be backed up with practice. It is important to staff that they feel they are treated fairly as individuals, that they have work environments free from harassment and bullying, that their face need not fit to be accepted, and that they feel they have a fair chance to apply for internal vacancies. Again, the line manager plays a central role in delivering the Trust's/PCT's values.

Figure 3.3: Staff satisfaction with line management and career intentions



Source: IES NHS Staff Attitude Surveys, 2002

3.5.6 Achieving work/life balance

Staff are highly appreciative of managers who are sensitive to work/life issues, and give their managers an overall score of 3.7 (highly satisfied) for this aspect of their behaviour.

In particular, staff who are happy with their manager are more likely to report satisfaction with the extent to which people in the organisation with family commitments have equal career opportunities. They are also more likely to call the Trust/PCT 'a family-friendly employer'. In practice, staff commend line managers who receive requests for changes in work patterns positively, and who ensure that staff with family responsibilities are able to access the tailored support for them that the Trust/PCT provides.

3.6 Other positive outcomes

A successful working relationship between employees and their supervisors delivers a number of benefits to Trusts/PCTs.

- As Figure 3.3 shows, staff who rate their line managers most highly are the least likely to plan to leave.
- IES research shows that staff with a supportive relationship with their line manager are also likely to be 'engaged employees', which brings benefits to employers such as staff who 'will go the extra mile'.
- Satisfaction with immediate managers is also associated with higher job satisfaction, better working relationships with colleagues, more co-operation within the workplace, greater commitment and less dissatisfaction with pay and communications.

Factors Affecting Job Satisfaction

Statistical modelling of job satisfaction shows that personal job and organisational characteristics, together with experiences at work, can all impact on job satisfaction.

- Staff who feel valued and involved; who like their colleagues; who are committed to their Trust/PCT; and who have a good relationship with their immediate manager, are particularly likely to feel satisfied in their jobs.
- Pay is also important, but less so than the above aspects.
- High levels of job satisfaction are associated with an intention to stay in the Trust/PCT.
- Receiving training, and having an appraisal and a PDP, are related to higher levels of job satisfaction.
- Perceptions of family friendliness are associated with greater job satisfaction.
- Doctors have higher job satisfaction levels than Nurses, but Support, Administrative & Clerical and Technical staff are less happy in their jobs than Nurses.
- Women have higher levels of job satisfaction than men.
- Minority ethnic staff are not as happy with their jobs as their White colleagues.
- Older employees (50+) are happier in their jobs.
- Having a disability/medical condition is related to lower job satisfaction.
- Being at the receiving end of harassment or violence is associated with lower job satisfaction.

4. Factors Affecting Job Satisfaction

Vania Gerova

This chapter will focus on the determinants of job satisfaction among the staff employed by the London NHS. It examines the results from the *'Quality of Working Life Survey 2002'*, conducted by the Institute for Employment Studies, on behalf of London NHS employers.

4.1 Defining and constructing a job satisfaction variable

A discussion about job satisfaction measures can be found in Appendix 4.1. The overall job satisfaction variable used by IES for this study is a mean composite scale measure, based on responses to the following three statements:

'There is a lot of variety in my job.'

'I do interesting and challenging work.'

'I get a feeling of accomplishment from my job.'

The individual responses to each of the three statements are based on a five-point scale: from strongly disagree (1) to strongly agree (5). A new composite scale variable called 'job satisfaction' was created by values combining the mean of the responses to each statement. For the purposes of the model adopted in this study, the scales of the job satisfaction variable were collapsed again into three hierarchical categories: disagree (1), neither (2), and agree (3). Table 4.1 presents the basic summary statistics of the variable 'job satisfaction'. Nearly two-thirds (63.73 per cent) of all respondents seem to agree or strongly agree with the three statements above.

The model used for this study is called the 'ordered logit' model. It is described in more detail in Appendix 4.2.

Table 4.1: Summary of variable 'job satisfaction'

Job satisfaction	Frequency	%
Disagree	2,383	10.72
Neither	5,680	25.55
Agree	14,167	63.73
Total	*22,230*	*100.00*

Source: IES NHS Staff Attitude Surveys, 2002

4.2 Results of running the model

The estimates from the ordered logit model on job satisfaction are presented in Table 4.2, at the end of this chapter.

4.2.1 Individual characteristics

Age

Employees aged less than 30, and those aged 40 to 49, are significantly more likely to indicate job dissatisfaction than employees over 50. This suggests that newly recruited, and also more experienced middle-aged staff, are less likely to be 'job satisfied' than those approaching retirement. Staff aged less than 30 and in the age group of 40 to 49, have odds of being 'job satisfied' that are respectively 16.2 per cent and 11.1 per cent lower than those of over 50, holding all other variables constant. One can speculate on a range of issues, such as better adjustment of the individuals to the job as they get older; the differences in jobs between younger and older workers; more opportunities outside for younger staff; and frustrated career ambitions in staff who are in their 40s, but do not yet have retirement to look forward to.

Being in the 30 to 39 age group is not statistically associated with a reduction or increase in job satisfaction.

Gender, ethnicity, disability and caring responsibilities

Being female is associated with a significantly increased probability of being 'job satisfied' (by 21.2 per cent) compared to males.

Being White is also significant, and is positively related to job satisfaction, compared to being from a minority ethnic group. White staff have odds of being 'job satisfied' that are 56 per cent higher than minority ethnic staff. This may be explained by the different job experiences among the different ethnic groups, as well as differences in cultural perspectives and views of work.

Having a disability or medical condition significantly reduces (by 13.9 per cent) the odds of being 'job satisfied', holding all other variables constant.

Having caring responsibilities was found not to be statistically associated with a reduction or increase in job satisfaction.

In interpreting the individual coefficients (or odds ratios) the importance of the 'other things being equal' statement must be emphasised. The estimate on the variable 'gender' for example, is positive and significant, indicating that other things being equal, women have a higher probability of being job satisfied and a lower probability of being job dissatisfied, than men. The correct interpretation is that, given two people who are similar in every

respect (individual, job and employer characteristics and attitudes) except gender, the person who is female is more likely to be satisfied with her job and less likely to be dissatisfied with her job, than the person who is male.

4.2.2 Job-related characteristics

Job-related characteristics such as length of service and work pattern (days, shifts, on a rota), are not statistically associated with a reduction or increase in job satisfaction.

Occupation

The model estimates indicate that Support staff[1], Administrative & Clerical staff[2], HCAs/Nursing Auxiliaries[3], Pharmacists, Scientists & Technicians[4], are all statistically more likely to be 'job dissatisfied', compared to Qualified Nursing & Midwifery staff, holding all other variables constant. The staff categories above are in descending order, starting with the least satisfied, but always compared to the qualified Nursing & Midwifery group. Doctors & Dentists are the only occupation group for which the odds of being 'job satisfied' are greater than those of Qualified Nursing & Midwifery staff (by 81.4 per cent). One assumes that their job offers more challenges, variety, autonomy and a feeling of accomplishment. Therapy staff, Senior Managers and other occupation groups, are not statistically associated with a reduction or increase in being 'job satisfied', when compared to Qualified Nurses & Midwives.

Training, personal development plans and appraisals

Issues such as receiving training, having a personal development plan and having a performance appraisal review, seem all to be positively related to job satisfaction. Employees who have received training have odds of being 'job satisfied' that are 34 per cent greater than the employees who have not. Training and development are important human capital investments, and one would expect that more highly-trained staff would feel more positive about their job.

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1 Support staff have odds of being job satisfied that are 55.4 per cent lower than Qualified Nursing & Midwifery staff.

2 Administrative & Clerical staff have odds of being job satisfied that are 53.3 per cent lower than Qualified Nursing & Midwifery staff.

3 HCAs/Nursing Auxiliaries have odds of being job satisfied that are 50.2 per cent lower than Qualified Nursing & Midwifery staff.

4 Pharmacists, Scientists & Technicians have odds of being job satisfied that are 21.9 per cent lower than Qualified Nursing & Midwifery staff.

Incidents of harassment

Not surprisingly, staff who have experienced incidents of harassment or violence at work are significantly less likely to be satisfied with their job than those who have not (the odds ratio in terms of percentage decrease is 8.2 per cent).

This finding confirms existing research. Shields and Price (2000) have found, for example, that one of the most important determinants of job satisfaction for minority ethnic Nurses is the experience of racial harassment in the workplace, with racial harassment from colleagues having a more detrimental effect on job satisfaction than racial harassment from patients. Our results suggest that in general, all employees who have experienced forms of 'employee discrimination' or 'consumer discrimination' have a significantly lower likelihood of being 'job satisfied'.

4.2.3 Employer-related characteristics

Policy variables

Following the discussion in the previous paragraph, it is interesting to observe that ethnic and sex discrimination policies, and disability policy variables, are statistically not associated with an increase or reduction in job satisfaction. These are not variables that indicate whether such policies are in place or not, but are attitudinal composite measures similar to the job satisfaction variable itself. The results seem to suggest that whether employees agree or disagree with certain statements concerning ethnic and sex discrimination, or disability policies at their workplace, is not a statistically significant determinant of their job satisfaction.

The only policy attitude variable that is significant and positively related to job satisfaction, is the perception of the workplace as a family-friendly employer, that is, one which does not discriminate against people with family responsibilities, in terms of career progression and opportunities. The importance of the family-friendly workplace may be explained to a certain extent by the female domination not only in the sample (79 per cent are women), but in the healthcare sector generally. In addition, about 41 per cent of all females in our sample report caring responsibilities, either for children under 16 years of age or for sick, disabled or elderly people.

Trust type

Our reference variable in this case is 'Acute Trusts'. Staff employed by the 'Teaching Trusts' have odds of being 'job satisfied' that are 8.3 per cent lower than staff employed by the 'Acute Trusts'. The results for the other two Trust types — 'Mental Health Trusts' and 'PCTs' — are statistically not significant.

4.2.4 Employees' attitudes

The most interesting result from this research is that all attitude variables are significant for job satisfaction. All of them are positively related to job satisfaction, with exception of the stress variable, which is negatively related. The first five, in order of importance to employees' feelings of satisfaction with their jobs, are:

- feeling valued and involved (the odds of being 'job satisfied' are 104 per cent greater for employees who are happy with this aspect, than those who are not)
- colleagues (employees who are happy with their colleagues have odds of being job satisfied that are 99.3 per cent greater than those who are not happy with their colleagues)
- commitment to the Trust/PCT (employees who feel committed have odds of being 'job satisfied' that are 68.4 per cent greater than those who do not)
- immediate management (employees who are happy with their immediate manager have odds of being 'job satisfied' that are 57 per cent greater than those who are not)
- pay and benefits (employees who agree they are being fairly rewarded have odds of being 'job satisfied' that are 54.1 per cent greater than those who disagree).

The relative significance of the first four variables above seems to suggest the importance of non-pecuniary rewards for healthcare workers. Issues like communication, co-operation, health and safety, and equal opportunities and fair treatment, are also positively related to job satisfaction, although to a lesser extent than those listed above.

Intentions to stay or leave

Finally, the highly positive and significant result for the 'intentions to stay' variable, indicates its importance for the job satisfaction variable. Employees who are likely to stay for at least a year have odds of being 'job satisfied' that are 87 per cent greater than employees who are likely to leave within the next year.

Table 4.2: Ordered logit estimates of the determinants of job satisfaction

Explanatory variables	Coeff.	z-stat	Odds ratio	Odds ratios in terms of % change	
				(odds-1)*100	
Individual characteristics					
Age group < 30 years	–0.177	–3.10	0.838	–16.2	*
Age group 30-39	–0.037	–0.76	0.964	–3.6	
Age group 40-49	–0.118	–2.55	0.889	–11.1	*
Females	0.192	4.89	1.212	21.2	*
White ethnic group	0.445	12.00	1.560	56.0	*
Has caring responsibilities	–0.027	–0.80	0.974	–2.6	
Has medical condition/disability	–0.149	–2.03	0.861	–13.9	*
Job-related characteristics					
Full-time	0.098	2.45	1.103	10.3	*
Length of service in years	0.004	0.63	1.004	0.4	
Length of service squared	0.000	0.51	1.000	0.0	
Hours worked — days	–0.003	–0.05	0.997	–0.3	
Hours worked — shifts	–0.081	–1.38	0.922	–7.8	
Nursing Auxiliaries & HCAs	–0.697	–10.15	0.498	–50.2	*
Doctors & Dentists	0.596	9.16	1.814	81.4	*
Therapists & Therapy Support	0.073	1.25	1.075	7.5	
Pharmacists, Scientists and Technicians	–0.248	–4.18	0.781	–21.9	*
Administrative & Clerical	–0.761	–16.54	0.467	–53.3	*
Senior Managers	0.076	1.13	1.079	7.9	
Support	–0.808	–7.08	0.446	–55.4	*
Other	–0.156	–1.21	0.856	–14.4	
Experienced incidents of harassment or violence at work	–0.086	–2.44	0.918	–8.2	*
Had performance and appraisal in the last 12 months	0.078	2.19	1.081	8.1	*
Has a personal development plan	0.152	4.24	1.164	16.4	*
One or more days training	0.293	8.05	1.340	34.0	*
Employer-related characteristics					
Teaching Trusts	–0.087	–2.31	0.917	–8.3	*
Mental Health Trusts	–0.011	–0.24	0.989	–1.1	
PCTs	–0.081	–1.82	0.922	–7.8	
Family-friendly policies	0.145	3.06	1.156	15.6	*
Racial discrimination policies	0.047	1.26	1.048	4.8	
Sex discrimination policies	0.018	0.37	1.018	1.8	
Disability policy	–0.029	–0.49	0.972	–2.8	

Explanatory variables	Coeff.	z-stat	Odds ratio	Odds ratios in terms of % change	
Employees' attitudes					
Communication	0.160	3.32	1.173	17.3	*
Pay and benefits	0.432	7.31	1.541	54.1	*
Feeling valued and involved	0.713	10.51	2.040	104.0	*
Commitment to the Trust/PCT	0.521	11.07	1.684	68.4	*
Immediate management	0.451	13.23	1.570	57.0	*
Co-operation	0.262	3.19	1.300	30.0	*
Colleagues	0.690	22.01	1.993	99.3	*
Stress and work pressure	–0.146	–3.55	0.865	–13.5	*
Health and safety	0.266	4.40	1.305	30.5	*
Equal opportunities and fair treatment	0.213	4.41	1.237	23.7	*
Likely to stay for at least a year	0.626	18.89	1.870	87.0	*
Sample	*22,230*				
Log likelihood	–16,830.678				
Model Wald chi2(42)	4,001.43				
Pseudo R2	0.1349				

Notes: *Statistically significant

Our base categories are: age 50+, males, non-White ethnic minorities, has no caring responsibilities, has no disability/ medical condition, part-time, no training, on a rota, no experience of incidents of harassment or violence at work, Acute Trusts, Qualified Nursing and Midwifery, did not have a performance appraisal in the last 12 months, does not have a personal development plan, **does not agree on the following**: communication, pay, being valued, commitment to the Trust, immediate management, co-operation, colleagues, stress, health and safety, equal opportunities, family friendly policies, racial discrimination policies, sex discrimination policies, disability policies, likely to leave within next year.

Source: IES NHS Staff Attitude Surveys, 2002

Table 4.3: Sample characteristics

Variables	Mean	Std Dev.	Min	Max
Job satisfaction	2.530	0.681	1	3
Individual characteristics				
Age group < 30	0.192	0.394	0	1
Age group 30-39	0.323	0.468	0	1
Age group 40-49	0.272	0.445	0	1
Age group > 50	0.213	0.410	0	1
Female	0.791	0.407	0	1
White ethnic group	0.788	0.409	0	1
Has caring responsibilities	0.399	0.490	0	1
Has medical condition/disability	0.045	0.207	0	1
Job related characteristics				
Full-time	0.777	0.416	0	1
Length of service in years	6.751	7.170	0.083	48
Length of service squared	96.995	187.278	0.007	2,304
Hours worked — days	0.742	0.438	0	1
Hours worked — shifts	0.160	0.366	0	1
Hours worked — on a rota	0.098	0.298	0	1
Qualified Nursing and Midwifery	0.337	0.473	0	1
Nursing Auxiliary & HCAs	0.043	0.204	0	1
Doctors & Dentists	0.087	0.282	0	1
Therapists & Therapy Support	0.113	0.317	0	1
Pharmacists, Scientists and Technicians	0.087	0.281	0	1
Administrative & Clerical	0.220	0.414	0	1
Senior Managers	0.082	0.274	0	1
Support	0.016	0.126	0	1
Other	0.015	0.121	0	1
Experienced incidents of harassment or violence at work	0.250	0.433	0	1
Had performance and appraisal in the last 12 months	0.549	0.498	0	1
Has a personal development plan	0.525	0.499	0	1
1 to more than 10 days training	0.775	0.418	0	1
Employer related characteristics				
Acute Trusts	0.329	0.470	0	1
Teaching Trusts	0.317	0.465	0	1
Mental Health Trusts	0.150	0.357	0	1
PCT	0.204	0.403	0	1
Family friendly policies	0.188	0.391	0	1
Racial discrimination policies	0.358	0.480	0	1
Sex discrimination policies	0.203	0.402	0	1
Disability policy	0.095	0.293	0	1

Variables	Mean	Std Dev.	Min	Max
Employees' attitudes				
Communication	0.177	0.382	0	1
Pay and benefits	0.128	0.334	0	1
Feeling valued and involved	0.141	0.348	0	1
Commitment to the Trust	0.219	0.414	0	1
Immediate management	0.448	0.497	0	1
Co-operation	0.061	0.239	0	1
Colleagues	0.623	0.485	0	1
Stress and work pressure	0.205	0.404	0	1
Health and safety	0.120	0.325	0	1
Equal opportunities and fair treatment	0.244	0.429	0	1
Likely to stay for at least a year	0.701	0.458	0	1
observations: 22,230				

Source: IES NHS Staff Attitude Surveys, 2002

Appendix 4.1: Background to Job Satisfaction Measures

> '*Job satisfaction is defined as a job attitude and studied along with other attitudinal concepts, such as morale, job involvement, and organisational commitment'* (Berry & Houston, 1993).

The basic concept of attitude is studied by the social psychologists, and is defined as '*an emotionally charged idea that predisposes action toward the stimulus*' (Berry & Houston, 1993). The attitude can be described in terms of any of its cognitive, emotional or behavioural components. The cognitive element highlights how people think about the meaning of their work experience. The emotional component determines whether an attitude is positive or negative, and thus we can derive job satisfaction or job dissatisfaction respectively. The behavioural component will indicate what people are likely to do, and one action might be to leave a dissatisfying job.

Measuring job satisfaction is difficult. Issues like reliability and validity of the measurement, creating job satisfaction scales (different scales may not be comparable), different interpretation of the same questions by the interviewees, and the instability of job satisfaction attitude (may change over time) arise.

The growing literature on job satisfaction has focused on estimating the determinants of job satisfaction. Most of the research in this area has been conducted by social psychologists, resulting in considerable agreement over the most important explanatory variables for job satisfaction. Until the seminal work of Hammermesh (1977) and Freeman (1978), economists have been reluctant to study job satisfaction, due to the subjective nature of individual responses. In recent years, a growing literature on job satisfaction has predicted quits (*eg* Hammermesh, 1977; Freeman, 1978; Akerlof *et al*., 1988; Clark *et al*., 1999), absenteeism (*eg* Clegg, 1983) and worker productivity (*eg* Mangione and Quinn, 1975; Tsang *et al*., 1991). One of the most recent studies on racial harassment, job satisfaction and intentions to quit in the nursing profession, was conducted by Shields and Price (2000), and the cohort effects and job satisfaction of academics was investigated by Sloane and Ward (2001).

Researchers have been broadly interested in individual 'happiness' at work issues, in the relationship between job satisfaction, productivity, and pecuniary and non-pecuniary rewards and intentions to quit. They are also interested in the impact of personal characteristics such as race, gender and education, and the effects of work-related characteristics such as establishment size, trade union membership and self employment on job satisfaction.

4.3 Appendix 4.2: The 'Ordered Logit' Model

One of the most commonly used and appropriate methods for estimating models with more than two outcomes, when the dependent variable associated with the outcomes is both discrete and ordinal, is ordered logit. The dependent variable is discrete (disagree [1], neither [2] and agree [3]), with respondents falling into one of the three categories. Furthermore the variable is ordered from 'disagree [1]' to 'agree [3]', *ie* 'stronger' outcomes are associated with higher values of the variable. This does not mean, however, that the outcome associated with 2 ['neither'], for example, is twice as strong as that associated with 1 ['disagree']. With such an ordinal variable, we might say that someone who scored 'agree' is more likely to be 'job satisfied' than someone who scored 'disagree', but we cannot say precisely how much more.

When using the ordered logit model, we assume that the error term (capturing the factors that may have been left out or measured inaccurately) is logistically distributed. The logistic distribution is similar to the normal, except in the tails, which are considerably heavier (Borooah, 2002). As Greene (2000) points out, 'it is difficult to justify the choice of one distribution over the other on theoretical grounds … in most applications, it seems not to make much difference' (p. 815).

Another advantage of the ordered logit model is that it allows us to interpret the results in terms of odds ratios.

References

Akerlof G A, Rose A K, Yellen J Y (1988), 'Job switching and job satisfaction in the US', *Labour Market Brookings Papers of Economic Activity*, Vol. 2, pp. 495-582

Berry L M, Houston J P (1993), *Psychology at Work,* Brown and Benchmark Publishers

Borooah V K (2002*), Logit and Probit, Ordered and Multinomial Models,* SAGE University Paper, 138, Series: Quantitative Applications in the Social Sciences

Clark A, Georgellis Y, Sanfey P (1999), 'Job satisfaction, wage changes and quits: evidence from Germany', *Research in Labour Economics*, forthcoming

Clegg C W (1983), 'Psychology of employee lateness, absence and turnover: a methodological critique and an empirical study', *Journal of Applied Psychology*, Vol. 68, p. 88-101

Freeman R B (1978), 'Job satisfaction as an economic variable', *American Economic Review*, Vol. 68, pp. 135-41

Greene W (1997), *Econometric Analysis*, 3rd edition, London: Macmillan

Hamermesh D S (1977), 'Economic aspects of job satisfaction', *Essays in Labour Market Analysis,* Ashenfelter O E, Oates W E (eds), John Wiley, New York

Mangione T W, Quinn R P (1975), 'Job satisfaction, counterproductive behaviour and drug use at work', *Journal of Applied Psychology*, Vol. 60, pp. 114-16

Shields M A, Price S W (2002), 'Racial harassment, job satisfaction and intentions to quit: evidence from the British nursing profession', *Economica*, Vol. 69, pp. 295-326

Sloane P J, Ward, M E (2001), 'Cohort effects and job satisfaction of academics', *Applied Economics Letters*, Vol. 8, pp. 787-791

Tsang M, Rumberger R, Levin H (1991), 'The impact of surplus schooling on work productivity', *Industrial Relations*, Vol. 30, pp. 209-28

Factors Influencing Retention

Different groups of employees are more likely to plan to leave than others. Those most at risk are:

- men
- younger employees
- minority ethnic staff
- employees with a disability/medical condition
- staff without caring responsibilities
- Doctors, Pharmacists/Scientists/Technicians and Nurses
- full-time staff
- those with one, two, or four years service
- staff who have not had an appraisal, or do not have a PDP
- those who have had bad experiences, *ie* accidents or harassment.

Those who plan to leave are notably dissatisfied with many aspects of working life, while those who plan to stay are satisfied with almost every aspect.

The most important factors that predict intention to stay or leave are:

- feeling valued and involved
- equal opportunities and fair treatment
- length of service
- stress and work pressure
- job satisfaction
- caring responsibilities
- contract type (full or part time)

This varies somewhat by job group, although feeling valued and involved is the most important factor for most groups.

5. Factors Influencing Retention

Michael Silverman

This chapter explores the various factors that influence employee retention within the London NHS, using the data collected by the QWL staff surveys. Identifying those factors that are most important, and investigating how they contribute to employees' intentions to leave, should help to inform retention strategies for specific groups of staff.

The QWL questionnaire asked employees about their current career intentions, in order to obtain a measure of intention to leave. This item was worded as follows:

> 'Which of the following statements most reflects your current career intentions:
>
> *Plan to leave as soon as the opportunity arises*
>
> *Likely to leave within the next year*
>
> *Likely to stay for at least another year*
>
> *Plan to stay for the foreseeable future.'*

Part of the analysis conducted for this chapter involved using the above four responses as given. However, for some analyses it was more useful to combine responses, to give a simpler categorisation: either 'likely to leave within the next year' or 'likely to stay for at least one year'.

This chapter has five main aims:

1. to provides a summary of the data outlining those employees who are more likely to leave, in terms of demographics, job details, and their experiences of working in the NHS
2. to explore the most important factors that influence retention rates
3. to investigate these factors within different job categories, to identify whether employees working in different jobs have different reasons for wanting to leave
4. to explore data from the last three years, to identify whether the reasons employees want to leave have changed over time
5. to make recommendations based on the findings of this chapter, regarding those issues worthy of the greatest focus in order to improve retention rates.

5.1 Who wants to leave?

5.1.1 Biographical characteristics

Gender

Men have significantly stronger intentions to leave within the next year than women (33 per cent of men, compared to 29 per cent of women). Although this difference is small, it is highly significant.

Age

As one would expect, there is a significant correlation between age and intentions to leave. A linear relationship exists between the two variables which indicates that intentions to leave decrease as age increases. For example, 41 per cent of employees aged under 30 years intend to leave within a year, compared to just 21 per cent of employees aged 50 and above.

Ethnicity

Compared to White employees, minority ethnic employees taken together have significantly stronger intentions to leave (28 percent of White staff, compared to 37 per cent of minority ethnic staff). Further analysis involving the individual ethnic groups indicates that employees of Chinese origin have significantly stronger intentions to leave, in comparison to any other ethnic group. In addition, Black employees, or employees of mixed race, have significantly stronger intentions to leave than White employees. However, there are no significant differences in leaving intentions between White and Asian employees.

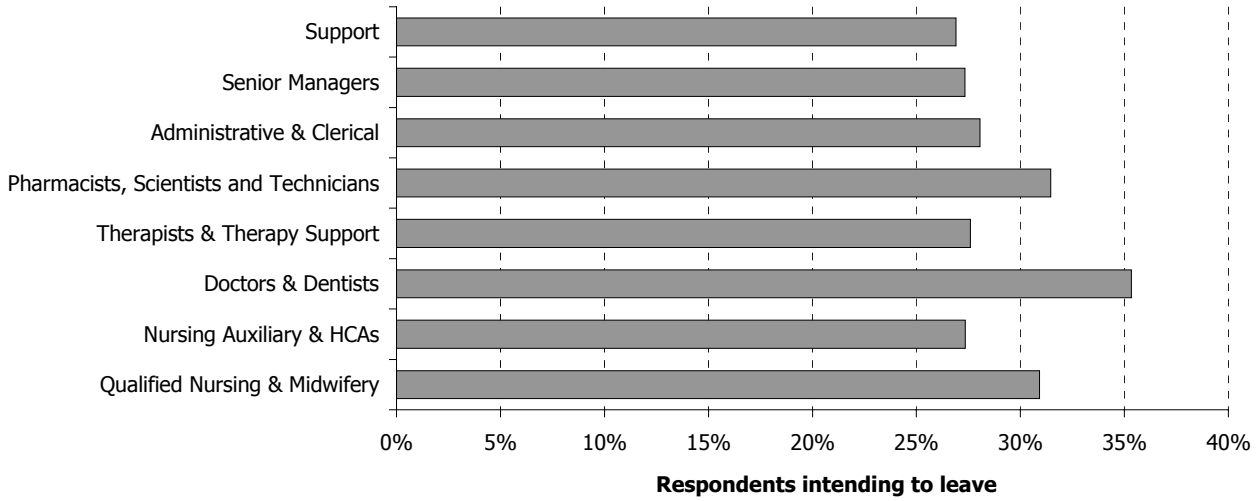
Disability/medical condition

There is a significant difference between the leaving intentions of employees with a disability/medical condition, and those without. Thirty-six per cent of employees with a disability/medical condition intend to leave within a year, compared to 30 per cent of those without.

Caring responsibilities

Employees who have caring responsibilities of one kind or another show significantly less intention to leave than employees who have no caring responsibilities. That is, 26 per cent of carers intend to leave, compared to 33 per cent of non-carers. Further analysis reveals that the type of caring responsibility (whether caring for children, adult/ elderly dependants, or both) has no impact on the level of intention to leave. What is important is whether caring responsibilities are present or not; it seems that the type of caring responsibility makes no difference with regard to retention.

Figure 5.1: Leaving intentions by job category



Source: IES NHS Staff Attitude Surveys, 2002

5.1.2 Job characteristic variables

Staff group

Figure 5.1 shows the percentage of employees who intend to leave within the next year, within different job categories. As the figure illustrates, Doctors and Dentists have the highest intentions to leave (over 35 per cent intend to leave). This must be interpreted with caution, however, considering that junior doctors on rotations often only stay at any particular Trust/PCT for a short period of time, which distorts the leaving intentions of this group. In contrast, Support staff have the lowest leaving intentions (27 per cent intend to leave).

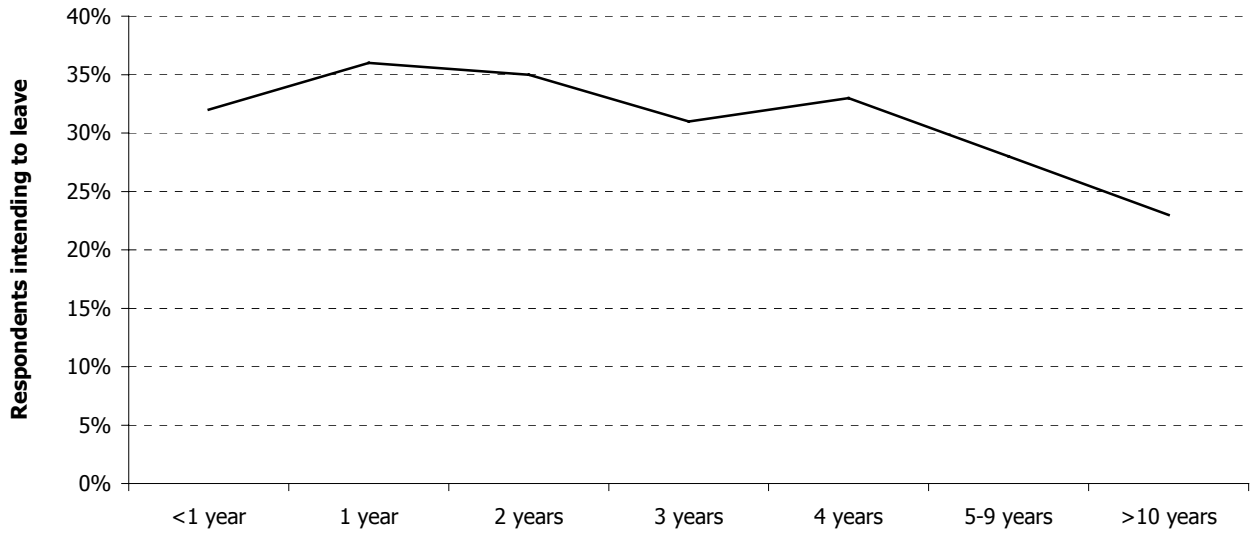
Contractual arrangements and working patterns

There is a highly significant difference in the leaving intentions of those employees who work part time and full time. For employees who work part time or job share, 22 per cent intend to leave, compared to 32 per cent of those who work full time. With regard to working patterns, employees who work on a rota basis are most likely to leave (38 per cent), compared to employees who work shifts (34 per cent) and those who work days (28 per cent). By comparing job categories to work patterns, this finding can be partly explained by the fact that Doctors and Dentists have the highest percentage of staff working on a rota basis (30 per cent, compared to a mean of just ten per cent).

Tenure

A illustrated in Figure 5.2, intention to leave decreases as length of service increases. Employees who have been with the NHS for between one and two years show the highest leaving intentions (36 per cent intend to leave). Employees with more than ten years service show significantly less intention to leave than any other group (23 per cent intend to leave). There is an interesting small peak at four years

Figure 5.2: Intention to leave, by tenure



Source: IES NHS Staff Attitude Surveys, 2002

service, indicating perhaps that career moves are often made at around this time, or that employees start to feel in need of a new challenge. Although there is a link between age and length of service (very young employees could not possibly have over ten years service, for example), the link between age and leaving intention is not as clear cut as that between tenure and leaving intention.

5.1.3 Experience of working in the NHS

Development and appraisal

A significant association exists between whether staff have experienced a performance appraisal in the previous year, and intention to leave. For those who have had a performance appraisal, 27 per cent intend to leave, compared to 33 per cent of those who have had no performance appraisal. The same is true for personal development plans (PDPs), which are likely to be related to performance appraisals. Only 26 per cent who have a PDP intend to leave, compared to 34 per cent who do not have a PDP.

Accidents and harassment

The data indicate that experiencing an accident at work increases employees' intentions to leave. A significant difference was found between the leaving intentions of those who had experienced an accident at work over the previous year (38 per cent intend to leave), compared to those who had not (28 per cent intend to leave). There is also a strong correlation between the number of accidents experienced and leaving intentions. That is, the more accidents an employee has experienced, the stronger their intention to leave. For example, of those employees who have experienced just one accident, 34 per cent

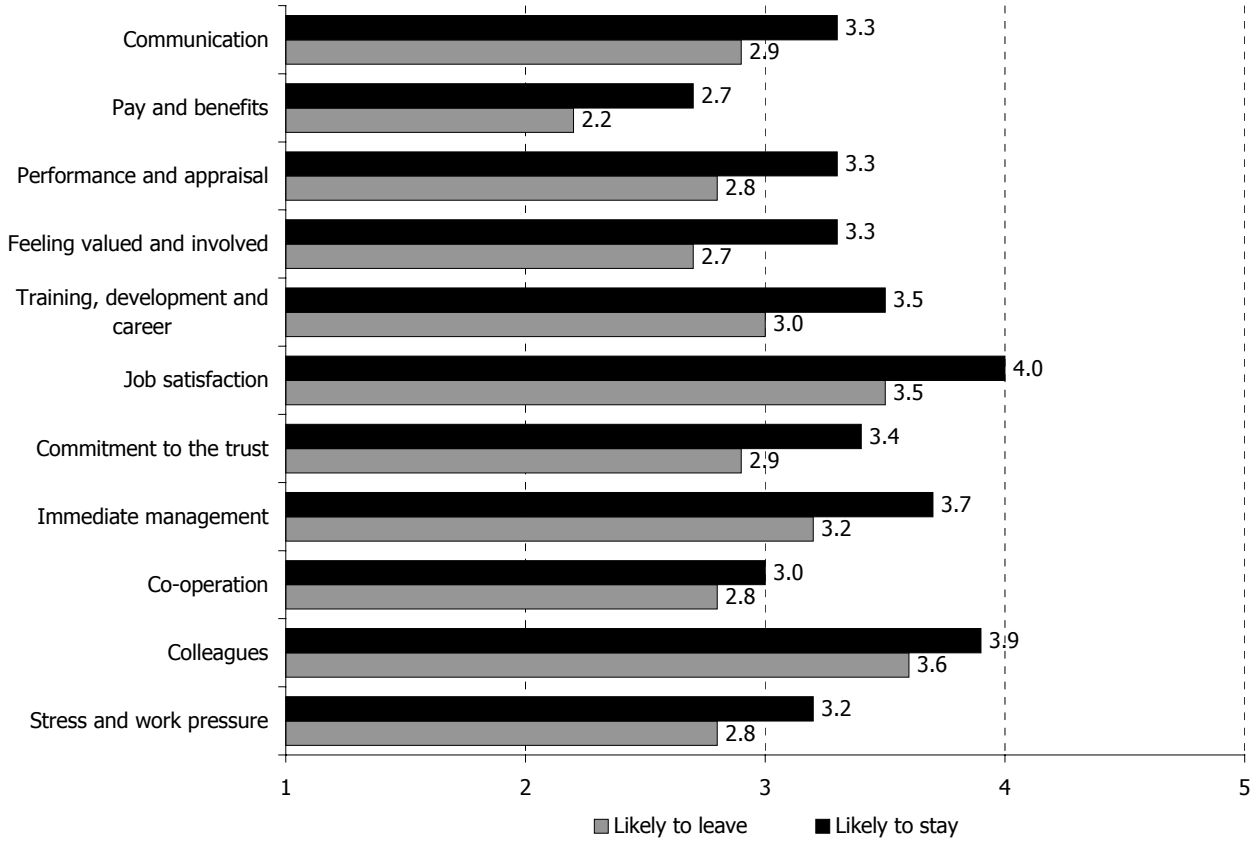
intend to leave. This figure rises to a massive 51 per cent for those who have experienced six or more accidents.

Also highly significant is whether or not employees had experienced an incident of harassment or violence over the previous year. Forty-one per cent who had experienced such an incident were likely to leave, compared to just 26 per cent of employees who had experienced no such incident.

Overall attitudes towards work

Figure 5.3 shows the mean cluster scores (an average of scores out of five) for the various attitudinal variables assessed in the survey questionnaire. The scales are aligned so that the higher the score, the more positive the attitude. A score of three represents the midpoint, so scores greater than three indicate satisfaction with that particular issue, whereas scores less than three indicate dissatisfaction with that particular issue. As the chart demonstrates, employees who have stronger intentions to leave have consistently much less positive views about the various aspects of their work, compared to employees who are likely to stay. On average, they have negative views about seven aspects, while those planning to stay are negative about just one aspect.

Figure 5.3: Mean work attitudes cluster scores, by intention to leave



Source: IES NHS Staff Attitude Surveys, 2002

5.2 What makes people most want to leave?

So far, a variety of significant differences have been demonstrated between various demographic and work-related variables, and intentions to leave. However, whilst many significant relationships may exist, it is crucial to ascertain which variables are most important in contributing to employees' intentions to leave. The question we are considering here is: 'Considering all the variables together and the interactions between them, which ones have the most impact on retention?' For this purpose, it is possible to use the technique of multiple regression to explore the relationships between the various work-related variables, and intentions to leave. More specifically, we can specify which combination of factors will do the best job of predicting why people intend to leave.

Taking all the variables together, they are able to explain 24 per cent of the variance in intentions to leave; this is a good result for a multiple regression analysis. Another way of saying this is that 76 per cent of the reasons why people leave cannot be explained by the items covered in the survey questionnaire. This makes intuitive sense, in that many employees intend to leave work for reasons that are entirely external from the work itself. Nonetheless, of the work-related variables that do contribute to employees leaving, there are a handful that stand out as being particularly important, and account for almost all of the 24 per cent. These are listed below in order of importance:

1. **Feeling valued and involved**. The results of the analysis suggest that this is by far the single most important factor that predicts employees' intentions to leave. It accounts for 13 per cent of the variance in intentions to leave.
2. **Equal opportunities and fair treatment**: This accounts for an additional three per cent of the variance in intentions to leave. This underlines the important role of the line manager, discussed in detail in Chapter 3.
3. **Length of service**. Accounts for two per cent of the variance in intentions to leave.
4. **Stress and work pressure**. Accounts for one per cent.
5. **Job satisfaction**. Accounts for one per cent.
6. **Caring responsibilities**. Accounts for one per cent.
7. **Contract type**. Accounts for one per cent.

In order to develop a more refined predictive model to investigate the specific impact of these variables in more detail, we can use the technique of logistic regression. The logistic regression analysis allows an assessment of the percentage change in the odds (the likelihood) of employees intending to leave. The analysis reveals the following:

- The more employees feel valued and involved, the less their intention to leave. A one point increase in the score for this

variable (on a 1 to 5 point scale) reduces the odds of intending to leave by 24 per cent.

- The more employees feel that they are treated fairly and have equal opportunities, the less their intention to leave. A one point increase in the score for this variable (on a 1 to 5 point scale) reduces the odds of intending to leave by 31 per cent.
- Compared to employees who have been in their job for less than one year, a tenure of:
  - between three and four years reduces the odds of intending to leave by 32 per cent
  - between four and five years reduces the odds of intending to leave by 26 per cent
  - between five and ten years reduces the odds of intending to leave by 43 per cent
  - over ten years reduces the odds of intending to leave by 62 per cent.
- The less employees experience stress and work pressure, the less their intention to leave. A one point increase in the score for this variable (on a 1 to 5 point scale, where a high score indicates a positive attitude) reduces the odds of intending to leave by 26 per cent.
- The more employees feel that they are satisfied with their job, the less their intention to leave. A one point increase in the score for this variable (on a 1 to 5 point scale) reduces the odds of intending to leave by 25 per cent.
- Compared to employees with no caring responsibilities:
  - caring for children or adult/elderly dependants reduces the odds of intending to leave by 27 per cent
  - caring for both children and adult/elderly dependants reduces the odds of intending to leave by 27 per cent.
- Compared to employees who work full time, working part time or job sharing reduces the odds of intending to leave by 26 per cent.

5.3 Do people working in different jobs want to leave for different reasons?

In order to answer this question, separate regression analyses were conducted for each job category. Overall, the results are similar for each job category, with the same variables coming up again and again. However, there are slight differences among the groups. An effective way to illustrate these differences is to highlight the top three factors for each job category. This is shown in Table 5.1.

Table 5.1: Most important factors influencing leaving intentions by job category

Job group	Top three factors
Qualified Nursing & Midwifery	1. Feeling valued and involved
	2. Equal opportunities and fair treatment
	3. Length of service
HCAs/Nursing Auxiliaries	1. Feeling valued and involved
	2. Stress and work pressure
	3. Commitment to the Trust/PCT
Doctors & Dentists	1. Feeling valued and involved
	2. Length of service
	3. Caring responsibilities
Therapists & Therapy Support	1. Feeling valued and involved
	2. Contract type
	3. Commitment to the Trust/PCT
Pharmacists, Scientists and Technicians	1. Feeling valued and involved
	2. Equal opportunities and fair treatment
	3. Job satisfaction
Administrative & Clerical	1. Equal opportunities and fair treatment
	2. Job satisfaction
	3. Stress and work pressure
Senior Managers	1. Feeling valued and involved
	2. Equal opportunities and fair treatment
	3. Length of service
Support	1. Equal opportunities and fair treatment
	2. Stress and work pressure
	3. Length of service

Source: IES NHS Staff Attitude Surveys, 2002

As Table 5.1 illustrates, feeling valued and involved is the most important factor contributing to intentions to leave for all job groups except Administrative & Clerical staff and Support staff, where this variable does not even appear in the top three. It is difficult to speculate on the reasons for this. Perhaps these staff groups feel so unappreciated that feeling undervalued and uninvolved has become the norm for them? Other features worthy of noting are listed below.

- The issue of equal opportunities and fair treatment is most important in contributing to intentions to leave for Administrative & Clerical and Support staff. This is also important, albeit to a lesser extent, for Qualified Nursing & Midwifery staff, Pharmacists, Scientists & Technicians, and Senior Managers.
- Length of service is a highly significant predictor of intentions to leave for Qualified Nurses & Midwifes, Doctors & Dentists, Senior Managers, and Support staff. That is, for these staff groups it is particularly the case that shorter tenure is associated with

increased intentions to leave (with the caveat, for junior medical staff, that short service is related to rotations).

- A feeling of commitment to the Trust/PCT is important for HCAs/ Nursing Auxiliaries, and for Therapists and Therapy Support staff. Lack of commitment among these groups is related to increased intentions to leave.
- Issues surrounding stress and work pressure are most likely to increase intentions to leave for HCAs/Nursing Auxiliaries, Administrative & Clerical staff, and Support staff.
- Job satisfaction is an important factor for Pharmacists, Scientists and Technicians, and Administrative & Clerical staff.

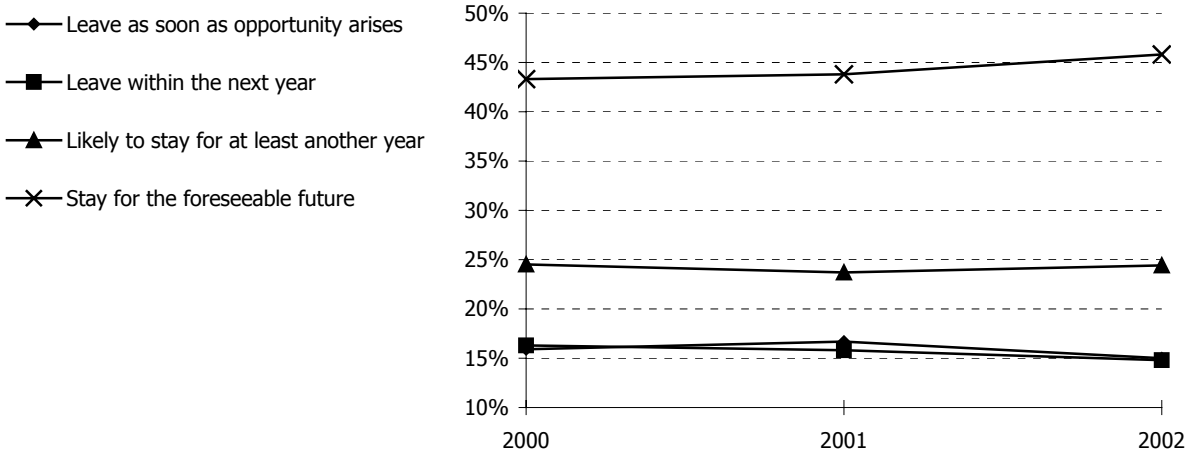
5.4 Have the reasons people want to leave changed over time?

Over the last three years, as illustrated in Figure 5.4, there has been a general decrease in employees' intentions to leave, coupled with an associated increase in intentions to stay. This is particularly true for those who intend to stay for the foreseeable future.

In order to identify the most important factors that have influenced retention over the previous three years, three separate regression analyses were conducted on each of the three datasets. Table 5.2 shows the five most important factors in each year.

The main points to note are that feeling valued and involved is consistently the most important factor regarding employees' intentions to leave. Another important aspect of the table concerns the issue of equal opportunities and fair treatment. In 2002 and 2001, this factor was found to be second only to feeling valued in its impact on leaving intentions. However, in 2000, the issue of equal opportunities and fair treatment does not even make the top five. This suggests that receiving equal opportunities and being treated fairly is now more

Figure 5.4: Leaving intentions over time



Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

Table 5.2: Most important factors influencing leaving intentions over time

2000	2001	2002
1. Feeling valued and involved	1. Feeling valued and involved	1. Feeling valued and involved
2. Length of service	2. Equal opportunities and fair treatment	2. Equal opportunities and fair treatment
3. Commitment to the Trust/PCT	3. Length of service	3. Length of service
4. Job satisfaction	4. Job satisfaction	4. Stress and work pressure
5. Stress and work pressure	5. Stress and work pressure	5. Job satisfaction

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

important to employees in its contribution to leaving intentions than in previous years. In addition, the notion of organisational commitment also appears to have been of major importance in 2000, but this is not the case in 2001 and 2002. This may be partly explained by the fact that 2001 and 2002 were fairly disruptive years for many employees, with a considerable amount of Trust restructuring, PCT creation, *etc.*

5.5 Key messages and suggestions

- The key messages coming out of the present analysis suggest that employees are more likely to stay if they:
  - are made to feel valued and involved
  - perceive equal opportunities and fair treatment
  - do not experience excessive work-related stress
  - are able to derive satisfaction from their work
  - have an appraisal review with their manager, and a PDP
  - do not experience 'shocks to the system', such as accidents and harassment — or if they do, these incidents are dealt with effectively.
- It is interesting that pay and benefits did not emerge as a significant predictor of intentions to leave, which confirms that employees within the NHS work for much more than just money — a strong basis for a committed workforce.
- The longer an employee stays in with the NHS, the less likely they are to leave. Therefore, retention strategies should focus most strongly on employees in their early years of service, as they have the strongest intentions to leave. It is also important to pay attention to the four year 'blip', and to consider whether offering career or development opportunities at that time may encourage employees to stay.

Well-being at Work

- Although the trend appears to be moving in the 'right' direction, a large proportion of London NHS staff are still affected by harassment or violence, or accidents and injuries each year. What is more, many staff are subjected to multiple incidents of harassment.
- Verbal harassment and violence are the most common forms of incident.
- Our survey confirms that much of this comes from patients and their relatives. However, harassment of any form from co-workers has a bigger impact on staff perceptions of their well-being.
- Staff in some occupations (*eg* Nursing) are more prone to harassment than others (*eg* Scientists). Similarly, staff with certain personal characteristics are also more likely to be harassed — younger staff, and those with a disability/medical condition, for example.
- The outcomes of harassment and violence, and accidents/injuries, are not just working days lost to sickness absence, or higher job turnover. Staff who have been harassed or injured can also lose their trust and goodwill towards their work, line manager and employer. They also feel less able to cope with the pressures of work, and become disillusioned.
- Trust/PCT responses to incidents of harassment/violence and accidents/injuries are generally well received by employees. However, they could be improved, especially in respect of racial and sexual harassment.
- This chapter concludes with suggestions for how Trusts/PCTs could move forward and address staff well-being at work.

6. Well-Being at Work

Sarah Perryman

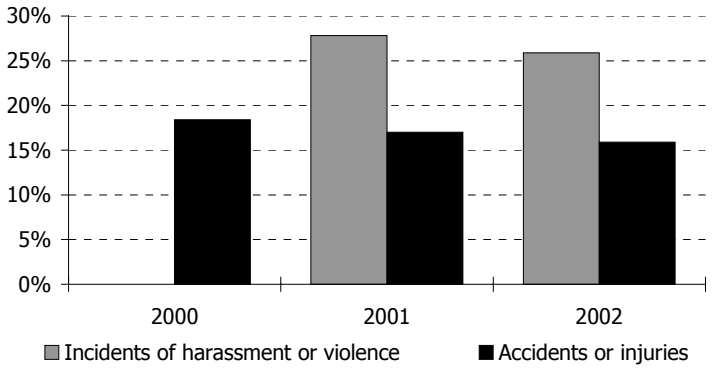
A number of NHS employees in London are subjected to unwanted physical and verbal harassment from patients and their relatives, and on occasions, colleagues and managers. Other employees have accidents and injuries at work. This chapter highlights patterns of harassment and accidents. We also explore the outcomes of these events, including the emerging link between experiencing harassment or accidents and having negative attitudes towards many different aspects of working life. Finally, we look at Trusts'/PCTs' responses to harassment and accidents through the eyes of the employees involved.

6.1 How many staff are involved?

In 2002, 26 per cent of staff in London NHS Trusts/PCTs experienced harassment or violence, and 16 per cent had an accident or injury at work. To establish the scale of this issue, over 7,000 employees reported 47,000 instances of harassment or abuse, and nearly 4,400 staff were involved in 8,700 accidents or injuries across the previous year.

Although these figures are high, the trend is encouraging. As Figure 6.1 illustrates, the proportion of employees experiencing accidents or injuries has fallen by two percentage points since 2000. Likewise, experience of incidents of harassment or violence fell between 2001 and 2002, again by two percentage points.

Figure 6.1: Experience of incidents of harassment or violence, and accidents and injuries



Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

6.2 What do we know about different forms of harassment?

The questionnaire collected information about the type of harassment experienced by staff. Their answers for both 2001 and 2002 are presented in Table 6.1.

- Verbal harassment is the most common form of abuse experienced by London NHS staff — overall, 23.5 per cent of staff had been verbally harassed at work in the previous year, a lower proportion than in 2001 (25.4 per cent).
- Violence is the next most common form of harassment, and around 7.3 per cent of staff had been attacked (10.7 per cent in 2001). This substantial drop may reflect the impact of the 'zero tolerance' campaigns being waged in many Trusts/PCTs.
- Racial harassment was experienced by 5.9 per cent of staff (down from 6.3 per cent in 2001).
- Overall, 2.8 per cent of employees experienced sexual harassment, again, a lower proportion than in 2001 (3.1 per cent).
- Patients and their relatives/friends are by far the most common source of harassment and violence in these workplaces. In total, 16.9 per cent of London NHS staff were abused by a patient or patient's relative.
- Nearly one in ten (9.7 per cent) staff had been abused by a colleague.
- Managers were the source of harassment or violence for 5.9 per cent of employees.

Table 6.1: Experience of incidents of harassment and violence (per cent)

	2001	2002
Racial harassment from colleagues	2.4	2.2
Racial harassment from managers	1.3	1.2
Racial harassment from patients/relatives	4.3	4.1
Sexual harassment from colleagues	1.2	1.1
Sexual harassment from managers	0.3	0.3
Sexual harassment from patients/relatives	2.0	1.7
Verbal harassment from colleagues	8.9	8.4
Verbal harassment from managers	5.3	5.4
Verbal harassment from patients/relatives	17.8	15.8
Violence from colleagues	0.5	0.4
Violence from managers	0.1	0.1
Violence from patients/relatives	7.4	6.9

Source: IES NHS Staff Attitude Surveys, 2001, 2002

6.2.1 Lightning does strike twice

Some staff are the victims of multiple abuse. Of the 7,000 staff who experienced an incident of harassment or violence:

- around half (49 per cent) report only one type of abuse out of the 12 kinds we sought information on (see Table 6.1 for the list). Even among staff experiencing only one type of harassment/abuse, around two-thirds report more than one incident.
- thirty per cent experienced two different kinds, 12 per cent three kinds
- five per cent four or more different forms of abuse
- the remaining three per cent experienced five, or in some cases more, different types of abuse.

6.3 Fewer staff with accidents and injuries

Returning to accidents and injuries, not only has the proportion of staff experiencing an accident or injury fallen over the three years of the survey, but the number of accidents experienced has also fallen (see Table 6.2).

6.4 Who is maltreated?

On average, each employee experienced 1.8 incidents of harassment or violence across 2002. However, some staff members appear more likely to experience incidents. When incidents of harassment of all four types are considered, the following findings come to light.

- Younger staff are more likely to be harassed than older staff. Among the under 30s, 28 per cent report incidents, compared with 27 per cent of people in their 30s, 26 per cent of those in their 40s, 23 per cent of staff in their 50s, and 17 per cent of those over 60.
    - Around three per cent of the under 30s have experienced sexual harassment from patients/relatives, compared with one per cent of the over 50s.

Table 6.2: Accidents and injuries — overall (per cent)

	Trend	2000	2001	2002
No accidents	Up	81.6	83.0	84.1
1	Down	11.1	10.1	9.7
2	Down	4.2	3.9	3.6
3-5	Down	2.3	2.3	2.1
6 or more	Down	0.7	0.7	0.6
Mean	Down	0.36	0.33	0.32

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

- Staff in their 40s and 50s experience higher rates of verbal harassment from managers (six per cent, compared with just three per cent of the under 30s).
- One in five under 30s (20 per cent) report verbal abuse from patients and relatives, a proportion which falls with each successive age cohort to nine per cent among the 60 and over age group.
- A similar pattern is seen in respect of violence from patients and relatives. Nine per cent of the under 30s had received this kind of abuse, falling away to two per cent among staff aged 60 plus.
- Younger staff are also more likely to record more than one type of incident.

- A higher proportion of minority ethnic staff have been harassed – 31 per cent, compared with 24 per cent of their White colleagues.
  - Six per cent of minority ethnic staff had been racially harassed by their colleagues, compared with one per cent of White staff.
  - Four per cent of minority ethnic staff had been racially harassed by managers, compared with less than one per cent of White staff.
  - Ten per cent of minority ethnic staff had been racially harassed by patients or their relatives, compared with two per cent of White staff.
  - Minority ethnic staff are also more likely to receive verbal harassment from colleagues than are their White colleagues (12 per cent, compared with seven per cent).
  - Among the ethnic groups, respondents describing themselves as Black, of Mixed or 'Other' ethnicity, tend to attract higher levels of harassment than those who are Asian or Chinese.
  - All minority ethnic groups are more likely to experience a number of types of incident than are White staff.
- 41 per cent of staff with a medical condition or disability that requires support in the workplace received harassment, compared with 26 per cent of other staff.
  - Staff with a medical condition/disability are more likely to attract racial harassment than their colleagues (11 per cent, compared to five per cent). However, as Chapter 11 illustrates, a high proportion of staff with medical conditions/disabilities are from minority ethnic groups.
  - Verbal harassment from colleagues is also more common. Seventeen per cent of employees with a medical condition/ disability report this kind of harassment, compared with eight per cent among the rest of the workforce. The same is true of both verbal harassment from managers (15 and five per cent)

and verbal abuse from patients/relatives (21 per cent and 16 per cent).

- Staff with a disability/medical condition are also more likely to experience a number of different types of incident.

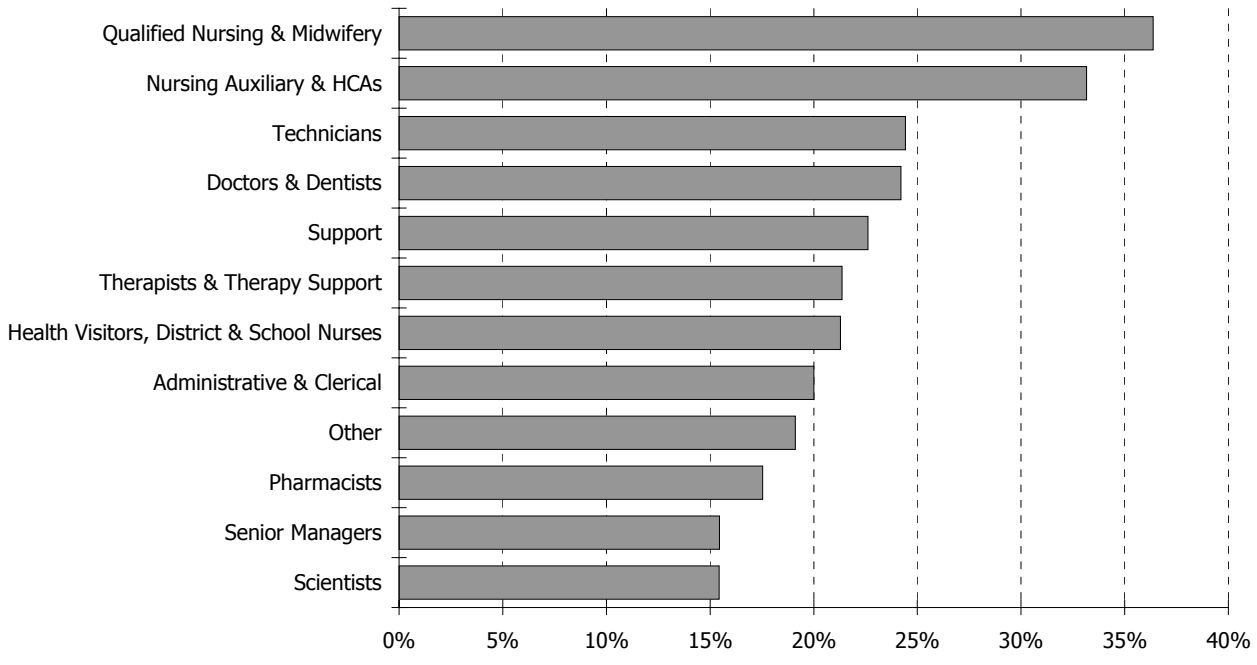
- Overall, there is no difference between the proportion of male and female employees reporting harassment or violence. However, men are a little more likely to receive racial harassment from patients and their relatives than are women (5.4 per cent, compared to 3.7 per cent). Men also experience more violence from patients and their relatives (9.4 per cent) than do women (6.3 per cent). Men also experience a wider range of types of incident.

6.5 Where are employees most at most risk?

6.5.1 Harassment and violence

The types of incident experienced by different staff groups is, in part, a reflection of the gender and ethnic profile of each group (see Chapter 2). However, this means that harassment and violence at work affect some staff groups more heavily than others, as shown in Figure 6.2. Nursing staff experience the highest levels of harassment ; more than one-third were harassed at work across the course of the previous year, twice the proportion of Senior Managers and Scientists. Qualified Nursing & Midwifery staff, and HCAs/Auxiliary Nursing staff are also more likely to experience more than one kind of harassment or abuse.

Figure 6.2: Experience of incidents or harassment or violence, by staff group



Source: IES NHS Staff Attitude Surveys, 2002

Table 6.3: Respondents' experience of accidents and injuries

	Average per person 2001	Average per person 2002	% reported 2001	% reported 2002	Total no. of accidents/injuries experienced 2002
Acute	0.35	0.34	50.1	54.0	3,169
Teaching	0.29	0.33	52.9	50.0	2,808
Mental Health	0.40	0.34	71.6	66.3	1,485
PCT	0.30	0.21	60.8	58.5	1,232

Source: IES NHS Staff Attitude Surveys, 2001, 2002

Other 'risk factors' can be identified:

- Full-time staff experience more harassment and violence than part timers (28 per cent, compared to 20 per cent). Full timers and bank staff are more likely to attract a range of types of harassment.
- Staff working shifts (42 per cent) are more likely to have been affected than their colleagues working on rotas (36 per cent) and staff working days (20 per cent). Staff on shifts or rotas also experience a wider range of types of harassment than do their colleagues.
- Workers in Mental Health Trusts experience more harassment and violence (31 per cent) than their peers in Acute and Teaching Trusts (27 per cent in both cases) and PCTs (20 per cent). Again, staff in Mental Health Trusts experience a greater variety of types of harassment than their colleagues in other types of organisation.

6.5.2 Accidents and injuries

Type of Trust also appears to influence not only the chance of experiencing an accident or injury — staff in PCTs have much lower rates in 2002 — but also the likelihood of reporting the event (Table 6.3). It is unclear why in all but Acute Trusts, the proportion of accidents reported has fallen over the last year. A possible partial explanation is that reporting systems may not have been fully embedded in newly formed Trusts (Mental Health and PCTs).

6.6 Staff opinions about health and safety at work

Above are the hard facts and figures about the prevalence of harassment, violence, accidents and injuries. But how do these events colour the experience of staff?

For a start, staff in London NHS Trusts/PCTs are unconvinced that their employers are concerned about their health and well-being, collectively giving their Trusts/PCTs a neutral score of 3.0 for their performance. Staff who have experienced an incident of violence or harassment, or an accident/injury, tend not to believe that their Trust/PCT is concerned for their welfare. (see Table 6.4).

Table 6.4: Incidence of unpleasant experiences and staff responses to 'This Trust is concerned about my health and well-being'

Experienced ...	Yes	No
... incident of harassment or violence	2.7	3.1
... accident or injury	2.8	3.0

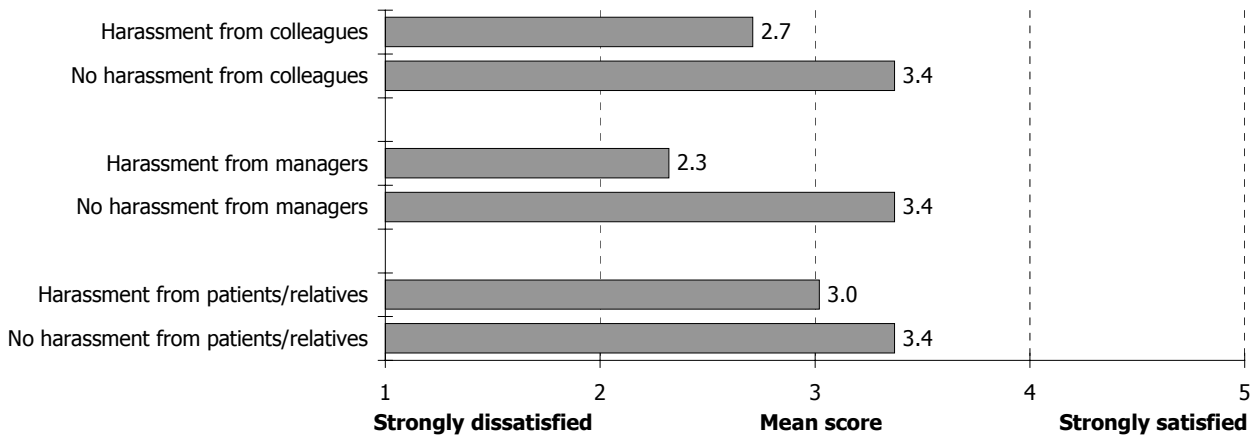
Source: IES NHS Staff Attitude Surveys, 2002

The working environment may contribute to the staff feeling of safety and security, and may also be implicated in patients' and co-workers' reactions to stressors such as delays. Staff are again cool about their working environments, giving scores of 2.9 (slightly dissatisfied) to cleanliness, 3.0 (neutral) to security, and 3.1 (slightly positive) to the physical working environment. They show slightly more enthusiasm about the quality of equipment, giving a score of 3.2 on average.

On the whole, staff strongly agree that they are treated with respect by the people they work with (3.9), and agree that they are treated with dignity at work (3.3). However, an incident of harassment or violence severely dents staff satisfaction with the level of dignity which they are afforded at work (reducing the mean score to 2.9, 'slightly dissatisfied'). An incident also shakes staff confidence in the respect that they receive from their colleagues, although they remain highly satisfied with this aspect of their co-workers' behaviour (3.6). Experiencing an accident or injury also has an impact on these two dimensions of employee relations, but to a lesser extent.

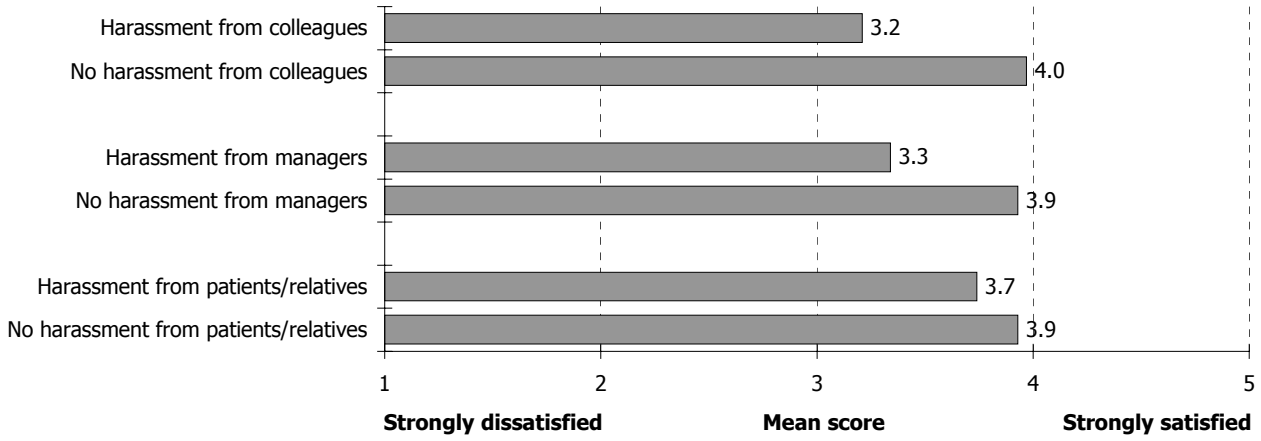
The knock in confidence staff receive to their perception of the respect they are given by their co-workers is amplified when the source of the abuse is a colleague, or even worse, a manager. However, it is fascinating to see that when these acts are committed by patients or their relatives, the impact on staff satisfaction with the dignity they are afforded at work appears to be smaller than when the aggressor is a co-worker (see Figure 6.3). A similar pattern is seen with perceptions of the respect staff feel they receive from their co-workers, although

Figure 6.3: 'I am treated with dignity here' and experience of harassment



Source: IES NHS Staff Attitude Surveys, 2002

Figure 6.4: 'I am treated with respect by staff I work with' and experience of harassment



Source: IES NHS Staff Attitude Surveys, 2002

abuse from colleagues is more damaging than that from managers in this instance (Figure 6.4).

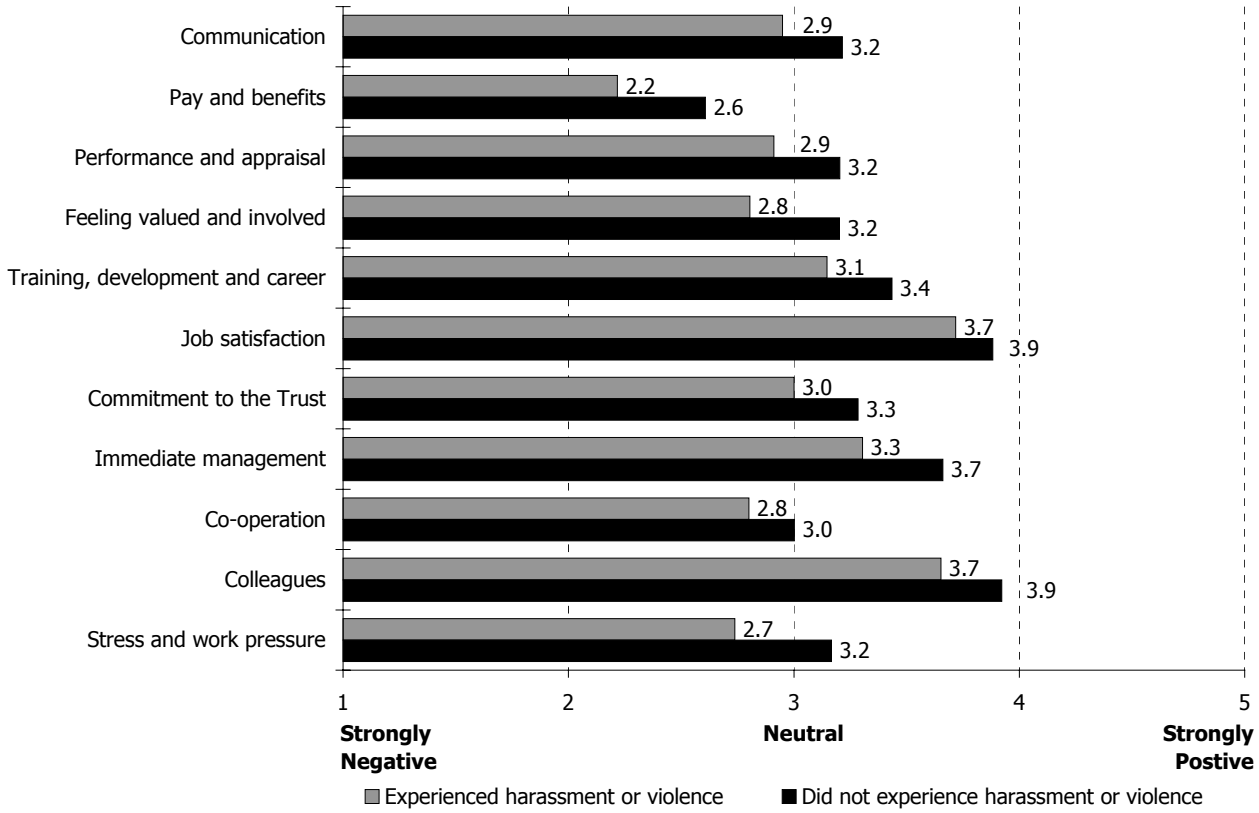
Perhaps staff in patient-facing roles expect a certain degree of harassment from patients, but have higher expectations of their co-workers' behaviour. Alternatively, the way in which the Trust/PCT, the line manager and/or colleagues act after an incident from a patient, may be perceived as more satisfactory than reactions to other forms of abuse. It may also be that patient- or relative-led abuse is more likely to be reported, thus instigating a formal response, including offers of support. We see that staff who reported an accident or injury are not as dissatisfied with the Trust's/PCT's concern about their health and well-being (2.8) than staff who did not report their experience (2.6).

The majority of staff (60 per cent) find that their work environment is free from bullying and harassment, although one in five (21 per cent) do not think that this is the case. Verbal harassment is closely linked with bullying in the minds of employees — staff who have been verbally abused do not believe that the work environment is free of bullying and harassment, whereas other staff strongly believe that it is.

However, the picture of staff perceptions of racial harassment is less cheerful still. Only 27 per cent agree that racial harassment in their workplace is decreasing, whereas two-thirds have not seen a noticeable improvement.

Unsurprisingly, staff who have been racially harassed at work disagree that racial harassment is decreasing in their workplace, and that their work environment is free from bullying and harassment, though other staff have much more positive views of these aspects of work. As before, harassment or violence from colleagues or managers is much more 'toxic' than abuse received from patients and their relatives. This is reflected in the very much lower average scores for these two issues among those harassed by co-workers.

Figure 6.5: Scales and incidents of harassment or violence



Source: IES NHS Staff Attitude Surveys, 2002

6.7 Outcomes

6.7.1 Diminished quality of working life

Harassment, violence, accidents and injuries also have an impact on how staff feel about other aspects of the quality of their working lives. As Figure 6.5 shows, harassed staff feel less positively about all the main dimensions of work satisfaction than do their colleagues. Experiencing an accident or injury has a similar, though slightly less marked, effect.

6.7.2 'Stress'

Experiencing harassment, violence, accident or injury at work, has a particularly strong impact on staff satisfaction with stress and work pressure (see Table 6.5). Affected staff are much more likely to say that they feel under too much work pressure, and feel under constant strain. They also struggle more with getting everything done in the time available, than do their colleagues. The impact of these kinds of events also extends beyond the workplace. Staff who have been harassed are more likely to report losing sleep over work problems, and find that the demands of the job seriously interfere with their private lives.

However, these incidents do not appear to depress confidence greatly in their own ability to cope with work pressure. In conjunction with

Table 6.5: 'Stress' and work pressure

	Experienced harassment or violence		Experienced accident or injury	
	Yes	No	Yes	No
I do not feel I am under too much work pressure	2.3	2.6	2.4	2.6
I have not felt under constant strain recently	2.6	3.1	2.7	3.0
I have enough time to get everything done in my job	2.4	2.7	2.5	2.6
I have not been losing sleep over work problems	3.2	3.6	3.3	3.6
The demands of the job do not seriously interfere with my private life	2.9	3.3	3.0	3.2
I am very confident in my own ability to cope with work pressure	3.7	3.8	3.7	3.8

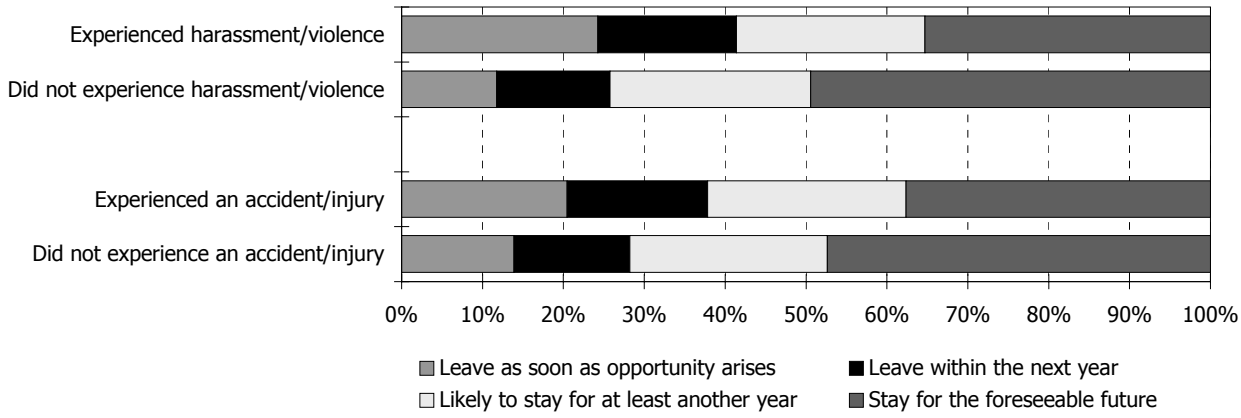
Source: IES NHS Staff Attitude Surveys, 2002

the less positive answers given to the other questions about stress and work pressure, this suggests that harassed or injured staff could be 'putting a brave face on it', which may have long-term implications for their well-being.

6.7.3 Turnover

Staff who experience harassment or violence, or an accident or injury, are more likely to want to leave their Trust/PCT than staff who have not (Figure 6.6). 'Intention to quit' is a good predictor of turnover, as recently verified for Nursing staff in London NHS Trusts/PCTs by the research team at Kings College[1].

Figure 6.6: Experience of harassment/violence and accident/injury, and career intentions



Source: IES NHS Staff Attitude Surveys, 2002

6.7.4 Disillusionment

Harassment/violence and accidents/injuries also squash staff perceptions of their whole recent employment experience. Thirty-seven

[1] Deery S, Guest D and Oakley P (2002), Retention of Nurses and Other Staff in the National Health Service, Kings College/SHRINE.

per cent of employees who have been harassed or abused think that their Trust/PCT is a worse place to work than it was two years ago, compared to 22 per cent of their colleagues. Among staff suffering accident or injury, one-third (34 per cent) think things have worsened, compared to a quarter (25 per cent) of other staff.

In addition, staff who have been abused or suffered accident/injury could be described as more fearful than their colleagues — they are certainly dissatisfied with security in the workplace. They may withdraw from Trust life, as is shown in greater dissatisfaction with the social facilities that their organisation offers. Also, their commitment to their Trust/PCT diminishes, and the Trust/PCT concerned can lose a useful ambassador who speaks highly of the organisation to their friends.

6.8 Support from Trusts/PCTs through the eyes of employees

At this point, we can begin to paint a more positive picture. Although the number of incidents are high, and this appears to have a range of negative outcomes for staff and Trusts/PCTs, the responses of organisations and line managers are generally well received by employees.

6.8.1 Line managers perform well

Line managers have a crucial role in organising the response to incidents and accidents. Overall, staff rate their managers' attitudes to health and safety highly (3.5, very satisfied). To the credit of the line managers of the London NHS, although staff who have experienced abuse or accident/injury rate their managers' attitudes a little lower, they remain satisfied with this part of their work experience.

6.8.2 Formal assistance is well respected

Taken as a whole, employees are satisfied with access to staff counselling (mean score 3.2), and very satisfied with their access to Occupational Health Services (OHS) (mean score 3.6). Staff who have had a negative experience are a little less satisfied with access to OHS, but not greatly so. However, Trusts/ PCTs have an opportunity to do more in respect of counselling — staff who have been involved in an incident of harassment or violence, or experienced an accident or injury, are neither satisfied or dissatisfied with their access to counselling.

6.8.3 Positive views on health and safety training

Training has a role in enabling staff to avoid, and where necessary manage, abuse and accidents. Regardless of experiences over the last year, staff are satisfied on average (mean 3.3) with the health and

safety training in their Trust/PCT, although those who have had a negative experience score their organisations 0.2 lower than do their colleagues.

6.8.4 Racial and sexual harassment — mixed messages

Although many staff report that in their experience racial abuse is not decreasing in the workplace, staff are generally confident in their Trust's/PCT's commitment to tackling and eradicating racially-motivated harassment. They believe that their Trust/PCT has taken effective actions to prevent all forms of racial harassment, and are confident that effective action will be taken to tackle racial harassment when it occurs. Overall, staff are also confident that the work environment is free from ethnic discrimination. Staff who have been a victim of abuse, or involved in an accident or injury, are less confident about their Trust's/PCT's approach, but are still satisfied. However, Trusts/PCTs need to do more for those who have been racially harassed at work. These employees are very dissatisfied with their organisation's performance in managing this form of hazard.

Similarly, the majority of staff are very satisfied that their work environment is free from sexual harassment (mean 3.9), and they are confident that their Trust/PCT will act upon any reported incident of staff harassment (mean 3.6). Sadly, those who have been sexually harassed do not share their colleagues' positive views, and are dissatisfied with the extent of sexual harassment in the workplace (mean 2.8), and much less confident of their employer's response (3.1).

In the case of racial and sexual harassment, staff appear to believe that their employers are committed to dealing with these hazards, but appear to be disappointed when the Trust/PCT is called upon to deliver on that commitment.

6.9 Moving forward

Trusts/PCTs face great challenges in managing the well-being of their staff. In response to harassment and violence, accidents and injuries, Trusts/PCTs could:

- reinforce the message that they have a commitment to staff health and well-being — maintain the push towards 'zero tolerance'
- identify which staff members are most likely to receive harassment, and take action to minimise the risks. There is also a place for coaching both employees and their managers in how to deal with any incidents, and their aftermath.
- encourage staff to report harassment and abuse. Not only would this help them assess the true nature and scale of the issue, but it seems that Trusts'/PCTs' formal responses take the edge off staff dissatisfaction.

- encourage the less-formal responses of colleagues and managers, which support their co-workers dealing with harassment from patients/relatives, to be demonstrated for other incidents
- review their response to incidents of harassment or violence – what works best for the employees affected?

The Incidence and Impact of Training

- On average, staff received 5.2 days training in the previous year.
- This masks a wide variation, with almost a quarter getting no training at all.
- Nurses, Doctors and Therapists receive the most training; Support and Administrative & Clerical staff the least.
- People who get a performance appraisal review, and who have a PDP, are more likely to receive training.
- Not surprisingly, receiving training is linked to positive views about training, performance & appraisal, and development issues.
- However, it is also linked to positive views about working life generally, especially about staff involvement, and increased confidence in coping with stress and workload pressure.
- People at the receiving end of harassment or violence are *less* likely to report training, possibly indicating a degree of withdrawal and a loss in confidence.

7. The Incidence and Impact of Training

Nick Jagger

The London NHS QWL surveys asked respondents a variety of questions about training and development. This chapter examines the extent, pattern and impact of training received by respondents, based on the following question:

> *How many days have you spent on formal, off-the-job training and development in the last 12 months?*

Table 7.1 shows the average number of training days received by staff in different types of Trusts. This shows what, on the surface, appears to be a surprising pattern, with Mental Health Trusts providing on average 6.1 days of training to their staff, compared to an average of 4.7 days per staff member in Acute Trusts. Primary Care Trusts had the lowest standard deviation in the amount of training offered to staff, suggesting that the available training was more evenly spread. This compares with the Mental Health Trusts, which as well as having the highest average levels, also had the highest standard deviation. This suggests that high levels of training in the Mental Health Trusts can be explained by a relatively small number of staff receiving a lot of training.

If we examine the average number of days training by staff group, as in Table 7.2, the beginning of an explanation of the pattern of training in Table 7.1 emerges. This shows a significant difference in the number of days training offered to different staff groups. On average, Qualified Nursing & Midwifery staff receive the most training (7.1 days) compared with an average of 2.6 days for Administrative & Clerical staff.

Table 7.1: Days spent on formal training, by type of Trust

	Average no. of days	No. of staff
Acute	4.7	8,945
Teaching	5.6	8,119
Mental Health	6.1	4,118
PCT	4.9	5,489
Total	*5.2*	*26,671*

Source: IES NHS Staff Attitude Surveys, 2002

Table 7.2: Mean number of days spent on formal training and development in the last 12 months

	Average no. of days training	No. of staff
Qualified Nursing & Midwifery	7.1	9,094
Doctors & Dentists	6.2	2,262
Therapists & Therapy Support	5.1	2,803
Pharmacists, Scientists and Technicians	4.9	2,184
Nursing Auxiliary & HCAs	4.8	1,414
Senior Managers	4.7	2,012
Support	3.3	460
Administrative & Clerical	2.6	5,890
Total	*5.2*	*26,521*

Source: IES NHS Staff Attitude Surveys, 2002

Apart from Nursing and Midwifery staff, Doctors and Dentists also received a high number of training days on average (6.2 days).

If the pattern of staff mix in the different types of Trust is taken into account, as in Table 7.3, then it can be seen that the variation in training is greatly reduced. This indicates that the majority of the variation in the amount of training offered is due to staff mix.

7.1 Extent of training

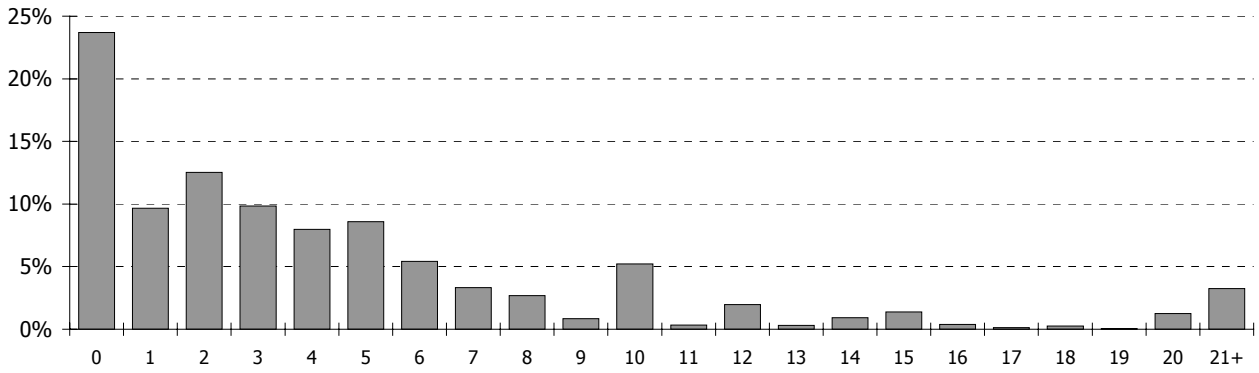
The average number of training days examined so far in this chapter disguises a distinct variation in the training received between and within groups. Some staff report no training, while others report more than four weeks formal training in the last 12 months. Figure 7.1 shows the percentage distribution of the number of days training received by staff. Perhaps most importantly, this shows that 23.7 per cent, or nearly a quarter of staff, reported receiving no training. At the same time, almost the same proportion (22.2 per cent) reported one or two days training. At the other extreme, 3.3 per cent reported more than 20 days training. As can be seen, the distribution is very skewed, with the majority of staff reporting no training, or only a very small

Table 7.3: Comparison of actual average number of days training and that explained by staff mix, by type of Trust

	Actual average no. of days training	Average no. of days training, taking account of staff mix
Acute	4.66	5.19
Teaching	5.66	5.39
Mental Health	6.09	5.25
PCT	4.91	5.15
Total	*5.24*	*5.25*

Source: IES NHS Staff Attitude Surveys, 2002

Figure 7.1: Percentage distribution of number of days of training received by staff



Source: IES NHS Staff Attitude Surveys, 2002

amount of training. As can be seen from Table 7.4, there is no clear trend in the percentage of staff reporting no training, with a rise in 2001 followed by a fall in 2002.

The rest of this chapter focuses on the attitudes and situations that are associated with those who report, or do not report training. People who report training — especially those who report a higher number of training days — as one might expect, have positive views on training-related issues. These include responses to the following statements:

I have many opportunities for training

I am given adequate training to do my current job

I am able to get time off work for training

I am encouraged to develop new skills

The training and development activities I have undertaken have helped to improve my performance

My training needs are regularly discussed

I feel I have equal access to training and development opportunities

My line manager takes staff development seriously.

At the same time, it is known that positive attitudes towards activities involving immediate line managers (see Chapter 3) are associated

Table 7.4: Change in numbers reporting no training & more than three days training, 2000 to 2002

	2002	2001	2000
No training	23.7	25.1	24.5
At least three days training	32.0	31.7	32.2
More than three days training	44.3	43.3	43.3
	100.0	*100.0*	*100.0*

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

with a generally positive outlook, and an intention to remain at the Trust/PCT. It is therefore important to examine what can be done to increase training uptake and, it is to be hoped as a result, foster a positive outlook and improve staff retention.

7.2 Modelling reported training

In an attempt to understand further the patterns underlying these relationships between attitudes and training, a logistic regression model was developed. The model examined 'no days training' versus 'some training'. A logistic regression allows the impact of a range of factors to be examined with all the other factors being held constant and, as such, is very useful in this situation.

Since staff group is known to be significantly linked to the incidence of training, these were initially entered into the model. Table 7.5 shows that Qualified Nursing & Midwifery staff are very significantly more likely to receive training. It is possible to calculate that Qualified Nursing & Midwifery staff are 108.2 per cent more likely to receive training, all other things being equal, than the other staff groups. Therapists & Therapy Support staff have a 63 per cent greater likelihood than other staff groups of reporting training. On the other hand, Support staff have a 41.8 per cent, and Administrative & Clerical staff a 34.6 per cent, lower likelihood of receiving training. Respondents to the statement 'I am able to get time off work for training', were analysed to see if any staff groups had particular difficulty in accessing training opportunities due to work constraints. However, there were no significant differences between the staff groups.

Further tests were then carried out using a variety of variables.

- When gender, ethnicity, age and length of service were tested by the model, it was found that there was no significant relationship between these variables and whether or not training was reported.
- All attitude statements were tested for entry into the model, and only those generating a significant association were retained (see Table 7.5).
- Once the staff group is taken into account, the next most important factor in determining whether or not training was reported is having a Personal Development Plan (PDP), and having had a performance appraisal in the last 12 months. Having a PDP is associated with a 33.6 per cent greater probability of reporting training, and having a performance appraisal is associated with a 32.5 per cent greater probability.
- Respondents with a more positive view of their access to less-formal development opportunities were 25.4 per cent more likely to report training.

Table 7.5: The model

	B Value	Signif-icance.		% impact
Staff group				
Qualified Nursing & Midwifery	0.733	0.000	**	108.2
HCAs/Nursing Auxiliary	0.158	0.303		17.2
Doctors & Dentists	0.326	0.026		38.6
Therapists & Therapy Support	0.489	0.001	*	63.0
Pharmacists, Scientists & Technicians	–0.061	0.668		–5.9
Administrative & Clerical	–0.424	0.002	*	–34.6
Senior Managers	–0.157	0.278		–14.6
Support Staff	–0.542	0.002	*	–41.8
Performance and Development variables				
Has a PDP	–0.409	0.000	**	–33.6
Had a performance appraisal in the last 12 months	–0.392	0.000	**	–32.5
View on access to less formal development opportunities	–0.293	0.000	**	–25.4
Significant attitude statements				
Staff are involved in decisions made about patient issues	0.137	0.000	**	14.7
My job improves patients' lives	0.115	0.000	**	12.2
I am very confident in my own ability to cope with work pressure	–0.125	0.000	**	–11.8
I feel able to voice my ideas and opinions	0.099	0.000	**	10.4
I do not know where my career is going	0.083	0.000	**	8.7
The 'grapevine' is the most effective communication channel round here	0.076	0.000	**	7.9
I have a clear understanding of my job responsibilities and what is expected of me	–0.063	0.003	*	–6.1
My immediate manager lets me know how I am doing	0.058	0.002	*	6.0
Other significant variables				
Contract type	–0.217	0.000	**	–19.5
Experienced a incident of harassment or violence in last 12 months	–0.183	0.000	**	–16.8
Constant	2.788	0.000	**	1525.3

Notes: ** significant at one in a thousand * significant at one in a hundred

Source: IES NHS Staff Attitude Surveys, 2002

- Those on full-time contracts, compared with part-time, job-share or bank type contracts, were also more likely to report training.
- People who have not experienced an incidence of harassment or violence are more likely to report receiving training. At first sight, it is puzzling that this should be linked to reported training. A variety of possible explanations can be made:

- the training directly improved respondents' skills, and this allowed them to deflect situations leading to harassment and violence
- the link is a consequence of training leading to feeling more valued, which in turn leads to more positive feelings about the Trust/PCT, which in turn means that negative experiences are minimised or not reported
- those who had been on the receiving end of harassment or violence have become disaffected, which means that negative views about the Trust/PCT grow, and training is not sought or taken up.

- Those who believe they are involved in decisions about patient issues and those who feel that their job improves patients' lives, are more likely to report training.

- There are two more statements associated with a increased likelihood of reporting training, linked with a feeling of personal confidence and involvement:

  I feel confident in my own ability to cope with work pressure

  I feel able to voice my ideas.

- One statement linked to an increased likelihood of reporting training is a touch perplexing:

  I do not know where my career is going

  This may indicate that people in the grip of career confusion seek out training opportunities in different areas to help clarify their thoughts about where they would like to go.

- Another statement linked to increased likelihood of reporting training suggests that people often find out about training opportunities via informal communication networks:

  The 'grapevine' is the most effective communication channel round here

- Finally, there is a negative linkage to:

  I have a clear understanding of my job responsibilities and what is expected of me.

  This last association may indicate that people who have a good understanding of their job feel that they do not need training.

7.3 Summary and implications of the model

The main, and obvious, finding is that training is more likely to be provided to front-line clinical staff than to support staff. Another clear message is that training is associated with a range of linked benefits. However, there is also a range of interesting associations linked to attitudes towards the Trust/PCT and resilience in the face of stress. These other benefits may be as important as the more obvious and expected associations.

There remains almost a quarter of staff who report no off-the-job training. As take-up of training appears to be strongly linked with PDP and performance appraisals, the roll-out of these, often HR led, should lead to a more widespread take-up of training. As well as reaping the direct benefits of training, the wider attitudinal changes may lead to related benefits — for example, more positive attitudes overall.

Work/Life Balance

- Overall, NHS staff in London are satisfied that their employer is 'family friendly', and scores have improved slowly over the three-year period, but from a starting point only a little above neutral.
- Staff are also satisfied (but only just) that they would be able to work flexible hours if needed at home, and that their employer receives positively any requests for a change in work patterns.
- There is much more enthusiasm when staff are asked about their immediate manager's sensitivity to work/life issues. Overall, the response is very positive, and improving.
- Ironically, however, it is staff *without* caring responsibilities who are most enthusiastic about family-friendliness. Those with children are not quite so positive, while those with eldercare/adult responsibilities are even less so. Staff with the heaviest caring load — for both children and an adult — are least positive of all.
- Caring responsibilities are not spread evenly over the workforce:
  - The peak child care age is between 30 and 49, while those aged 50 and over are most likely to have eldercare/adult caring responsibilities.
  - Minority ethnic staff are significantly more likely than White staff to be carers.
  - Respondents who themselves have a disability/medical condition that requires workplace support, are significantly more likely to also have eldercare/adult caring responsibilities.
  - PCTs have the highest percentage of staff who are carers; teaching Trusts/PCTs the lowest.

8. Work/Life Balance

Hülya Hooker

8.1 Family-friendliness

In this chapter, we examine some of the issues around work/life balance. With a predominantly female workforce, it is perhaps particularly important for the NHS to be a family-friendly employer.

The questionnaire asked respondents their opinion about a number of different aspects of work/life balance. These include:

People in this organisation with family commitments have equal career opportunities

Part-timers have equal access to career progression

This Trust provides good support for staff with family responsibilities

This Trust is a family-friendly employer.

These four attitude statements fit together statistically, which enabled us to construct a reliable 'cluster' or scale measuring family-friendliness. We also examined some of the individual statements in the questionnaire that dealt with work/life balance issues. These three individual items are:

I feel able to work flexible hours if I am needed at home

Requests for change work patterns are received positively here

My immediate manager is sensitive to work/life issues.

We examined satisfaction scores on the family-friendliness scale, and on these three individual statements, to find out what kind of trends they were showing. The trend is encouraging overall.

In particular:

- respondents show very high scores (3.6 in the 2002 survey) for their manager's sensitivity to work/life issues
- satisfaction scores for the family-friendliness scale show a significant increase

Table 8.1: Satisfaction scores (mean) on different aspects of work/life balance, 2000 to 2002

	2002	2001	2000
Family-friendliness scale	3.2	3.2	3.1
I feel able to work flexible hours if I am needed at home	3.1	3.0	3.0
Requests for changed work patterns are received positively here	3.1	3.1	—
My immediate manager is sensitive to work/life issues	3.6	3.5	3.5

Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

- although still low, the score for the item about feeling able to work flexible hours if needed at home, is now more on the satisfied side (from a previously neutral position)
- the score for the item about requests for changing work patterns being received positively, has not changed between 2001 and 2002.

8.2 Those with caring responsibilities

Respondents were asked if they had any of the following caring responsibilities:

- having children aged 16 or under living with them
- looking after or giving special help to sick, disabled or elderly family members
- having both types of caring responsibilities.

We looked to see if the number of staff with caring responsibilities has changed in any way. Over the three years, there has hardly been any change in the percentage of staff with childcare responsibilities. However, there has been a steady increase in the percentage of those with eldercare/adult caring responsibilities, or with both forms of caring responsibility. The percentage of respondents without caring responsibilities has decreased accordingly, although it is still the case that the majority of respondents do not have such responsibilities (Table 8.2). The increase in eldercare/adult caring responsibilities is related to a small increase in the average (mean) age of employees; the majority of employees with such responsibilities are in the older age groups.

Table 8.2: Change over time in caring responsibilities (per cent)

	2002	2001	2000
Child care	29.0	28.5	28.9
Eldercare/adult caring responsibilities	7.7	7.0	6.3
Both	4.0	3.8	3.5
Neither	59.3	60.7	61.2

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

8.2.1 Who has caring responsibilities?

- A higher proportion of women have caring responsibilities for an adult — 8.3 per cent, compared with 5.6 per cent of men.
- A significantly higher proportion of minority ethnic staff have child care responsibilities — 36 per cent, compared to 26 per cent of White staff. They also have a significantly higher percentage with both forms of caring responsibility — six per cent, compared to three per cent of White staff.
- Not surprisingly, the age brackets of 30 to 39 and 40 to 49 have a significantly higher percentage of staff with child care responsibilities (39 and 46 per cent respectively). Those in the 50 to 59 and 60 and over age groups are more likely to have caring responsibilities for an adult than are their younger colleagues (18 and 17 per cent respectively).
- Those with a disability/medical condition requiring support in the workplace are significantly more likely to have adult caring responsibilities — 18 per cent, compared to seven per cent of those without a disability/medical condition.
- Doctors and Dentists (36 per cent), and Senior Managers (32 per cent) are the group most likely to have childcare responsibilities, whilst Support (15 per cent), Administrative and Clerical (11 per cent) and HCAs/Auxiliaries (ten per cent) are the groups most likely to have caring responsibilities for an adult.
- PCTs have the highest proportion of staff with childcare responsibilities (33 per cent), whilst Teaching Trusts have the lowest (23 per cent). PCTs also have the highest number of staff with caring responsibilities for an adult (ten per cent), and Teaching Trusts have the lowest (three per cent).

8.2.2 Do carers feel differently about work/life balance issues?

Bearing in mind that staff with caring responsibilities may have stronger views about the issues concerning work/life balance, we also examined their satisfaction scores on the family-friendliness scale and the individual statements.

As can be seen in Table 3, respondents with caring responsibilities are less satisfied with family-friendliness than those without. In particular, staff with both childcare and adult caring responsibilities have significantly lower satisfaction scores (3.0) than those who have neither (3.3). Staff without any caring responsibilities clearly feel more satisfied about their Trust/PCT providing good support for those with family responsibilities, and that their Trust/PCT is a family-friendly employer. Ironically, those with both types of caring responsibilities have rather neutral views on their Trust's/PCT's family-friendliness. The good news is that there has been a significant improvement in the scores since the 2000 survey.

Table 8.3: Satisfaction scores (mean) on different aspects of work/life balance, 2000 to 2002

		2002	2001	2000
Family-friendliness cluster	Childcare responsibility	3.1	3.1	3.0
	Other caring responsibilities	3.1	3.1	3.0
	Both	3.0	3.0	2.8
	Neither	3.3	3.2	3.2
I feel able to work flexible hours if I am needed at home	Childcare responsibility	3.2	3.1	3.0
	Other caring responsibilities	3.1	3.0	2.9
	Both	3.1	3.1	3.0
	Neither	3.1	3.0	2.9
Requests for change work patterns are received positively here	Childcare responsibility	3.2	3.1	—
	Other caring responsibilities	3.1	3.0	—
	Both	3.1	3.0	—
	Neither	3.1	3.1	—
My immediate manager is sensitive to work/life issues	Child care responsibility	3.6	3.5	3.5
	Other caring responsibilities	3.5	3.4	3.4
	Both	3.5	3.5	3.4
	Neither	3.6	3.5	3.5

Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Survey, 2002

Staff with childcare responsibilities only, have significantly higher satisfaction scores on the three individual items than those who have adult or both types of caring responsibilities. They are particularly satisfied (mean score of 3.6) with their manager's sensitivity to work/life issues. The trend with these statements is also encouraging as it shows significant improvement over time.

We also examined the scores of those who are the 'likely carers' on the family-friendliness and the other relevant work/life balance items. Table 4 shows the following differences.

- Women are happier with their Trust's/PCT's family-friendliness, in that they score significantly higher for the family-friendliness cluster, and on other statements, than do men.
- In comparison to their minority ethnic colleagues, White staff are significantly more satisfied with family-friendliness, and with other aspects of work/life balance.
- Staff aged 30 and under, and those aged 60 and over, are happier with all aspects of work/life balance than those in their 30s and 40s.
- Part-time staff have a significantly lower satisfaction score for the family-friendliness scale, but they have significantly higher scores for the other three items.

Table 8.4: Satisfaction scores (mean) on different aspects of work/life balance, 2002

Family-friendly policies	**Gender**	
	Male	3.2
	Female	3.2
	Ethnicity	
	White	3.3
	Minority ethnic	3.2
	Age	
	Under 30	3.3
	30-39	3.2
	40-49	3.2
	50-59 years	3.3
	60 and over	3.3
	Contract type	
	Full-time	3.3
	Part-time and job share	3.2
	Have medical condition/disability requiring support in the workplace	
	Yes	3.0
	No	3.2
I feel able to work flexible hours if I am needed at home	**Gender**	
	Male	3.1
	Female	3.2
	Ethnicity	
	White	3.2
	Minority ethnic	3.1
	Age	
	Under 30	3.1
	30-39	3.1
	40-49	3.2
	50-59 years	3.2
	60 and over	3.2
	Contract type	
	Full-time	3.1
	Part-time and job share	3.3
	Have medical condition/disability requiring support in the workplace	
	Yes	2.9
	No	3.2

Requests for change work patterns are received positively here	**Gender**	
	Male	3.1
	Female	3.1
	Ethnicity	
	White	3.2
	Minority ethnic	3.0
	Age	
	Under 30	3.1
	30-39	3.1
	40-49	3.1
	50-59 years	3.1
	60 and over	3.2
	Contract type	
	Full-time	3.1
	Part-time and job share	3.2
	Have medical condition/disability requiring support in the workplace	
	Yes	2.9
	No	3.1
My immediate manager is sensitive to work/life issues	**Gender**	
	Male	3.5
	Female	3.6
	Ethnicity	
	White	3.6
	Minority ethnic	3.4
	Age	
	Under 30	3.7
	30-39	3.6
	40-49	3.6
	50-59 years	3.5
	60 and over	3.5
	Contract type	
	Full-time	3.6
	Part-time and job share	3.6
	Have medical condition/disability requiring support in the workplace	
	Yes	3.3
	No	3.6

Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Survey, 2002

- Those with a disability/medical condition requiring support in the workplace are significantly less satisfied with all aspects of work/life balance.
- Doctors and Dentists are the least satisfied job group with family-friendliness (scoring 3.1) and all the other aspects of work/life balance. Senior Managers, on the other hand, are the most satisfied job group about work/life balance in the Trust/PCT; they score 3.5 for family friendliness.
- PCTs have significantly higher satisfaction scores for the family-friendliness scale (a mean score of 3.3) as well as on other items. Teaching Trusts, however, score significantly lower on family-friendliness (a mean score of 3.2) and those items concerning flexibility of work hours (a mean score of 3.0), and working patterns (a mean score of 3.1).

8.3 Key messages and suggestions

The results show that perceptions of the family-friendliness of London NHS employers are improving significantly. Respondents are particularly happy with their manager's sensitivity to work/life issues.

However, it is noticeable, and somewhat ironic, that staff with no caring responsibilities have the highest satisfaction scores on their Trust's/PCT's overall family-friendliness, whilst those with the heaviest burden of responsibility (for both childcare and adults) feel least satisfied. Those with child-care responsibilities only feel relatively happy that they are able to work flexible hours if needed at home, and that their requests for work pattern changes would be received positively. It would appear that NHS employers in London are better disposed towards flexibility with employees who are parents, than with those with eldercare/adult caring responsibilities. These results may also show that family-friendly policies are geared mainly towards those with children.

Overall, staff have become happier over the three years of the survey with the practical aspects of their work/life balance, but are not so sure about their employer's commitment to give equal career opportunities to those with family commitments. Those with both types of caring responsibilities appear to be having a particularly hard time juggling home and work commitments. The results indicate that Trusts/PCTs need to investigate further the types of caring responsibilities people have, and would benefit from making improvements to the relevant policies and practices.

Working Non-Standard Hours

- Almost a quarter of NHS staff in London work part time.
- Part-time working is more prevalent among female staff, older workers, White staff and employees with children. Minority ethnic respondents, however, are significantly less likely to work part time, even if they have childcare responsibilities. Part-time work is encountered more often in the Administrative & Clerical, and Therapy staff groups than in any others.
- The majority of Nurses, Midwives and HCAs/Nursing Auxiliaries work shifts or on a rota. In all other staff groups, most respondents work days. The percentage of staff working days has increased since 2000.
- In general, part-timers are positive about most aspects of working life, and their attitude scores have improved over the three years of the QWL survey. However, part-timers are less likely to have an appraisal or a PDP, or to receive training, compared to full-timers.
- Those working shifts or on a rota are notably less positive than those working days about working life generally, and about aspects of health & safety and equal opportunities. Respondents who do not work days perhaps feel 'left out' from much that is happening in their Trust/PCT.
- People working shifts or on a rota tend to experience a relatively high number of accidents/injuries and incidents of harassment or violence.
- Part-timers are notably more likely to plan to stay with their Trust/PCT than are full-timers.
- Those working shifts or on a rota, however, are a much higher retention risk than those working days.

9. Working Non-Standard Hours

Hülya Hooker

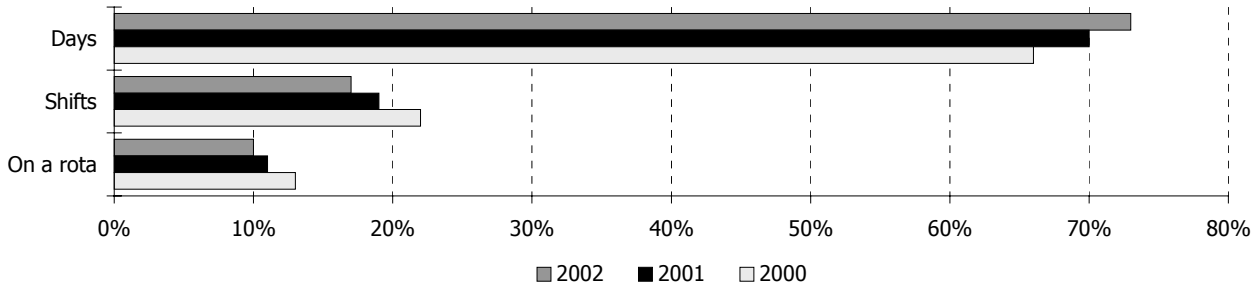
This chapter aims to address some of the issues around working non-standard hours. In the questionnaires administered to London NHS Trusts, respondents were asked about the type of contract they had (full-time, part-time, job-share or bank), and were also asked about their typical working pattern, *ie* whether they were on days, shifts or on a rota. The term, 'non-standard hours' is therefore taken to cover both contract type (not working full time) and working patterns (not working days) of respondents.

9.1 Who works non-standard hours?

In 2002, 23 per cent of survey respondents said they had part-time contracts, and one per cent described themselves as job-sharers. These percentages are almost exactly the same as they were in both 2001 and 2000. To ensure reliability of statistical analyses, part-time and job-share categories were amalgamated, and are referred to as 'part time'.

The figures for working patterns are not as static. In fact, there has been a steady increase in the percentage of staff who work days. In 2000, 66 per cent of respondents reported working days. This increased to 70 per cent in 2001, and 73 per cent in 2002. The trend is in the opposite direction for shifts and rotas, as there has been a steady decrease in the percentage of respondents who work these patterns (see Figure 9.1). Table 2.1 in Chapter 2 gives the percentage in each staff group working shifts or rotas, and shows that the majority of Nurses, Midwives and Nursing HCAs/Nursing Auxiliaries do not work days.

Figure 9.1: Change over time in working pattern (per cent)



Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

9.1.1 Biographical characteristics

The 2002 analysis of non-standard hours, described below, remains very similar to the figures for both 2000 and 2001.

- A gender comparison shows that there are significantly more females working part time (26 per cent, compared to eight per cent of males). However, a significantly higher proportion of males work on a rota (15 per cent, compared to nine per cent of females).
- An age analysis shows that those who are under 30 are significantly less likely to work part time. The position is similar for those who are in their 30s, but not to the same extent. The percentage of part-time staff goes up with age, with the highest proportion in the 60 and over category. The working pattern trend shows that a higher proportion of younger staff, especially those under 30, are working shifts or on a rota, than those who are over 40.
- A higher proportion of White staff work part time; 26 per cent, compared with 13 per cent of their minority ethnic colleagues. White staff are also more likely to work days; 78 per cent, compared with 57 per cent of minority ethnic respondents. Minority ethnic staff, on the other hand, are more likely to work shifts (25 per cent) or on a rota (19 per cent).
- Having a disability/medical condition requiring support in the workplace seems to have no impact on respondents' contract or working pattern.
- A significantly higher proportion of staff with childcare and/or other caring responsibilities work part time; 38 per cent, compared with 13 per cent who do not have caring responsibilities. Staff who have adult/eldercare caring responsibilities are more likely to work days (78 per cent).

9.1.2 Job characteristics

Again, the 2002 analysis is very similar to that of both 2000 and 2001.

- Part-time staff are significantly over-represented among those who work days, and under-represented among those who work shifts or on a rota.
- Respondents who have been with the organisation for a longer period are significantly more likely to work part time than those with less service time — 29 per cent of those with more than five years service work part time, compared with 13 per cent with one year service. Staff with longer service are also more likely to be on a days working pattern. This suggests that valued and experienced staff are more able to negotiate their hours and working patterns than those who have joined relatively recently.
- In terms of job groups, respondents in the Administrative & Clerical group are most likely to work part time (30 per cent), followed by Therapy (28 per cent). The least likely group to work

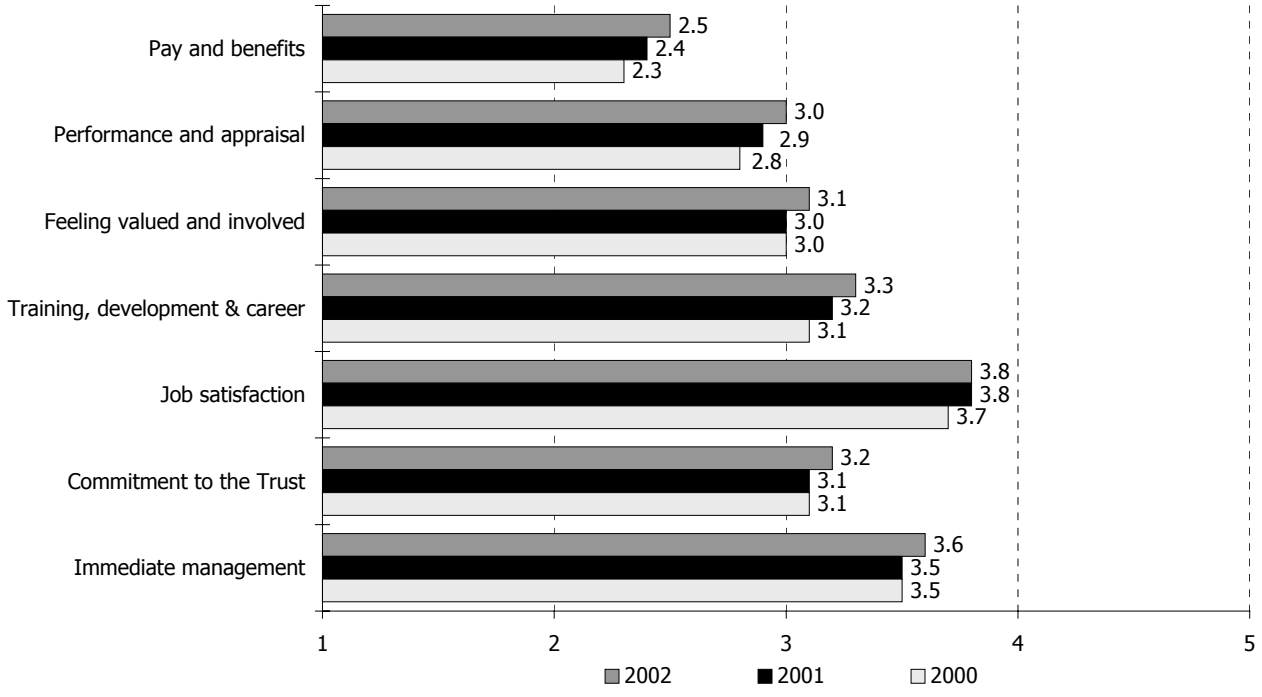
part time are Senior Managers (ten per cent) followed by Support staff (15 per cent), Nurses (17 per cent) and Pharmacists, Scientists and Technicians (18 per cent).

- Type of Trust is also an important factor. PCTs have the highest proportion of part-timers (36 per cent), whilst both Mental Health (18 per cent) and Teaching (15 per cent) Trusts have much lower percentages.
- Almost all Senior Managers (96 per cent), Administrative & Clerical (94 per cent) and Pharmacists/Scientists/Therapists (90 per cent) work days. By contrast, over half of Nursing & Midwifery respondents (54 per cent of Nurses and 63 per cent of Midwives, and 64 per cent of HCAs/Nursing Auxiliaries do not work days.
- Shift working is most commonly found among HCAs/Nursing Auxiliaries (43 per cent), Nurses & Midwives (35 per cent) and Support staff (17 per cent).
- Thirty per cent of Doctors & Dentists, 21 per cent of HCAs/Nursing Auxiliaries, 14 per cent of Nurses & Midwives and nine per cent of Support staff, work on a rota.

9.2 Experiences of staff who work non-standard hours

NHS employees in London were also asked to give their views about a wide range of issues related to their jobs. As part of our analysis, we examined the pattern of responses given by those who worked non-

Figure 9.2: Satisfaction (mean) scores of part-time staff, 2000 to 2002



Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

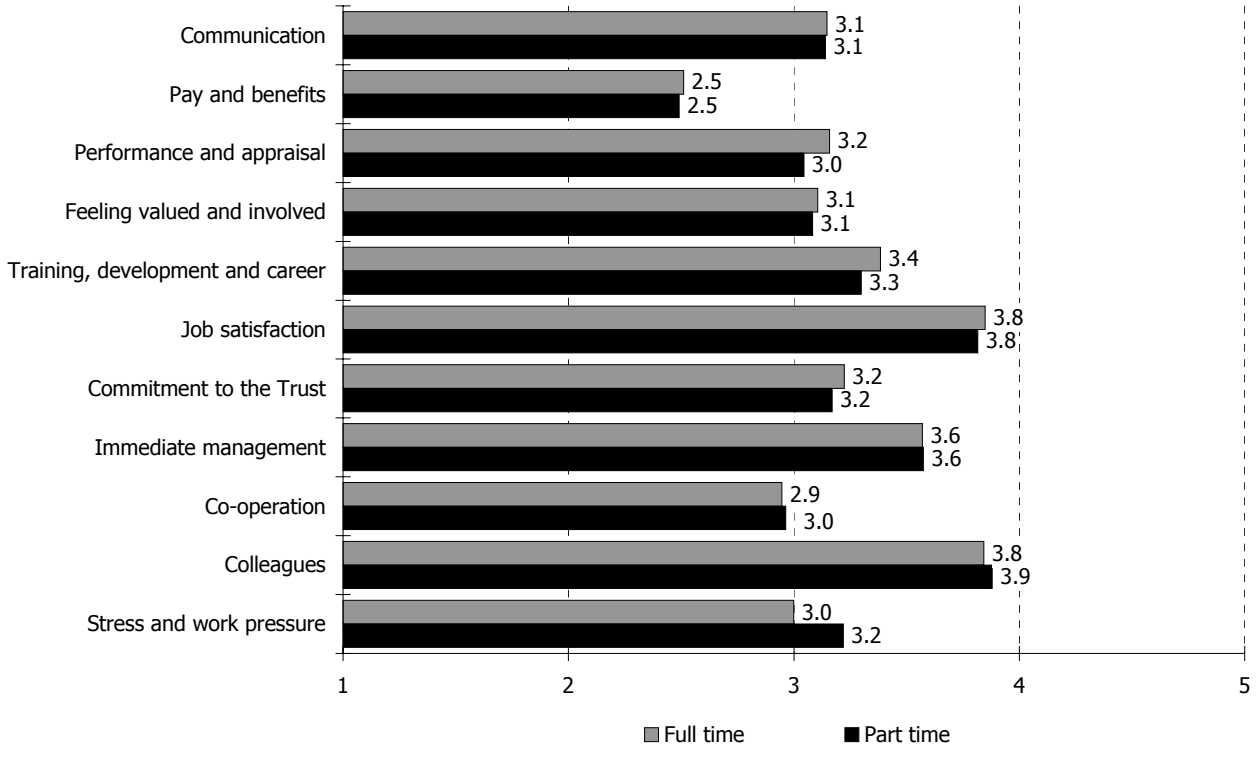
standard hours. If we look at part-time employees' mean scores on selected aspects of their work over the three years (Figure 9.2), we can see that, although the scores on some areas are rather low, the trend is encouraging.

Overall, the views of part time staff show that the mean scores have increased over the three years. In particular:

- their views on pay and benefits are shifting to dissatisfied in the 2002 survey (from being very dissatisfied in the earlier years)
- performance and appraisal scores are moving towards neutral, from a previously dissatisfied position
- scores on feeling valued and involved are more on the satisfied side (from being neutral before)
- scores for training, development & career and commitment to the Trust/PCT are becoming more clearly satisfied
- views on job satisfaction and the relationship with line managers are going from strength to strength as part-time staff report being very satisfied with these aspects of their working life.

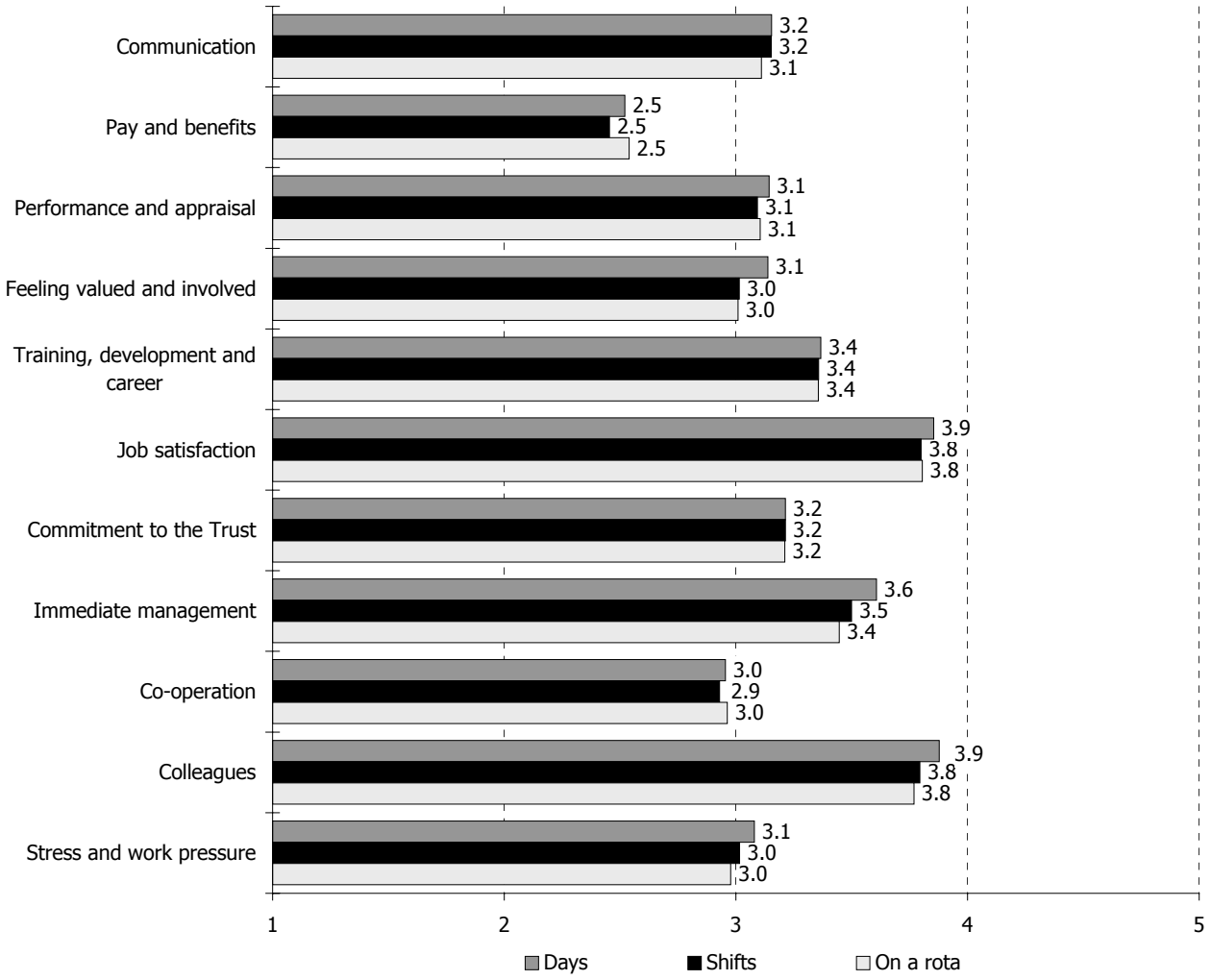
Figure 9.3 gives a comparison of the attitude scores of full-timers and part-timers. For most aspects, there is little difference in views. Part-timers, however, are more satisfied with levels of stress and work pressure, and less satisfied about issues to do with appraisal and careers. The mean scores of those who work shifts or on a rota have also increased over the three years for the same areas of working life.

Figure 9.3: Satisfaction scores, by contract type, 2002



Source: IES NHS Staff Attitude Surveys, 2002

Figure 9.4: Working pattern and attitude clusters, 2002



Source: IES NHS Staff Attitude Surveys, 2002

However, compared to part-timers, shift and rota workers tend to score lower. Figure 9.4 shows the comparative scores of those working days, shifts and on a rota.

9.3 Training and development opportunities

Do employees who work non-standard hours have different experiences with regards to their training and development opportunities?

9.3.1 Training days

Overall, the average number of formal training days experienced by London NHS respondents in 2002 was 5.2. However, the number for part-time staff was 3.5, compared to 5.8 for full-time employees (see Table 9.1). The difference between full-time and part-time staff is most significant for higher numbers of training days, *ie* the 6-10 days and over ten days categories. There are significantly fewer part-time staff in these categories in all three years' surveys.

Table 9.1: Average training days (mean) of those working non-standard hours, 2000 to 2002

	2002	2001	2000
Overall	5.2	5.3	5.5
Full-time	5.8	5.9	6.1
Part-time	3.5	3.6	3.9
Days	4.7	4.8	4.8
Shifts	7.1	7.1	7.9
On a rota	6.5	6.4	5.8

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

As can be seen in Table 9.1, staff who work shifts or on a rota are significantly more likely to have a higher number of training days than those who work days. This is, to some extent, linked to job group (see 9.1.2 above), as Nursing staff tend to experience more training than support categories. Although there has been a decrease in the average training days for shift workers over the three years, rota workers have seen a significant increase in their training days.

The trend also show that compared with staff working days, there is a significantly higher proportion of shift and rota workers with a higher number of training days, *ie* 6-10 and over ten days, in all three years' surveys.

9.3.2 Performance appraisals

Respondents were asked if they had a formal performance appraisal in the last 12 months. The figures show that part-time staff were significantly less likely to answer 'yes' to this question than was expected, in both 2002 and 2001. A significantly lower than expected proportion of shift workers said 'yes' to having had a formal performance appraisal in 2002, but not in 2001. There were no significant differences in the responses of those who worked on a rota in both the 2002 and 2001 surveys.

9.3.3 Personal Development Plans

In terms of having a Personal Development Plan (PDP), the figures were similar, as part-time staff were significantly less likely than was expected to have a PDP. The outcome is rather different for shift and rota workers as a slight, but significantly higher than expected proportion of these workers in 2002 answered 'yes' to having a PDP. A slightly higher than expected proportion of shift workers answered 'yes' to having a PDP in the 2001 and 2000 surveys, but there were no significant differences in the responses of rota workers in these years.

9.3.4 Access to less-formal development opportunities

When asked how they rated their access to less-formal development opportunities, part-time staff were fairly positive. A relatively high

proportion of part-timers rated their access as 'good' or 'excellent' in the 2002 survey — 26 per cent, compared to 18 per cent rating it as poor. This is a more positive picture than in 2001. Staff who work shifts or on a rota were more evenly balanced in their ratings of access in both the 2001 and 2002 surveys.

9.4 Views on health and safety at work

9.4.1 Accidents and injuries

In general, part-time staff have a significantly fewer number of accidents and injuries than full-timers, and the number has also fallen over the three years of the survey (Table 9.2). Overall, however, those who work shifts and on a rota experience a significantly higher number of accidents and injuries than those working days. This finding is related to respondents' job group (see 9.1.2 above). Although the trend is encouraging for rota workers (as it shows a small but steady decrease over time), it is not so encouraging for those who work shifts, as these respondents have seen a small increase since the 2001 survey.

Table 9.2: Average number (mean) of accidents and injuries per survey respondent, 2000 to 2002

	2002	2001	2000
Full-time	0.35	0.37	0.40
Part-time	0.20	0.20	0.23
Days	0.22	0.24	0.24
Shifts	0.57	0.53	0.60
On a rota	0.55	0.56	0.57

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

9.4.2 Attitudes towards health and safety

As can be seen in Table 9.3, part-time staff have positive views on some aspects of the health and safety and not so positive, or rather neutral, views on other aspects. However, the trend is encouraging, as scores show a significant improvement over time, in particular:

Table 9.3: Part-time staff mean scores on different aspects of health and safety, 2000 to 2002

	2002	2001	2000
Physical work environment	3.1	3.1	3.0
Health and safety training	3.3	3.3	3.2
The cleanliness of the working environment	2.9	2.8	—
Access to staff counselling	3.2	3.1	3.1
Managers' attitudes to health and safety	3.5	3.5	3.4

Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

- mean scores on managers' attitudes to health and safety have shifted to very satisfied
- satisfaction scores on health and safety training and access to staff counselling have also gone up significantly over time
- scores on the physical work environment have moved into the satisfied range (from neutral in the 2000 survey)
- although the lowest mean scores are given to the cleanliness of the working environment, there has been an improvement since the 2001 survey.

When analysed by working pattern, the trend shows a similar improvement in satisfaction scores of shift and rota workers over time. One notable difference between staff working days and those working shifts or on a rota, was that both shift and rota workers had rather negative scores (mean of 2.9 in 2002 and of 2.8 in 2001) for workplace security, whilst those working days had higher scores (mean of 3.1) in both years.

9.5 Equal opportunities

Respondents were asked to indicate the extent to which they agreed or disagreed with a series of statements about equal opportunities in the workplace. The comparisons of full-time and part-time staff did not reveal any significant differences. The trend over time was significant only for family-friendly policies, where satisfaction increased over the three years (from a mean score of 3.1 to 3.2). Shift and rota workers, on the other hand, had slightly lower scores on all but one aspect (disability policy) than did those who work days (Table 9.4). The trend over time was encouraging, however, as there has been a steady increase in satisfaction scores for most aspects over the three years.

9.5.1 Experiences of harassment

In general, part-time staff are under-represented among those who have experienced incidents of harassment or violence at work. When we break down these incidents by different types of harassment, part-time staff are more likely to experience verbal harassment, closely followed by harassment from patients/relatives. They are less likely

Table 9.4: Satisfaction scores (mean) on different aspects of equal opportunities, 2002

	Days	Shifts	On a rota
Equal opportunities and fair treatment	3.5	3.4	3.4
Family friendly policies	3.3	3.2	3.1
Racial discrimination policies	3.5	3.4	3.3
Sex discrimination policies	3.5	3.4	3.4
Disability policy	3.0	3.0	3.0

Measured on a scale from 1 'very dissatisfied' to 5 'very satisfied'

Source: IES NHS Staff Attitude Surveys, 2002

to have experienced incidents of racial harassment, sexual harassment or acts of violence.

However, staff working shifts or on a rota are significantly much more likely than expected to have experienced incidents of harassment or violence at work. In terms of type of incidents, shift workers and rota workers are particularly likely to experience an act of violence, racial harassment and harassment from patients and/or their relatives. They are also more likely than expected to mention incidents of sexual harassment and verbal harassment. Shift and rota workers have a relatively lower number of incidents of harassment from colleagues and from managers, however.

9.6 Career intentions of staff working non-standard hours

When asked about their career intentions with respect to the Trust/PCT, part-time staff were over-represented among those who said they would stay for at least a year, and correspondingly under-represented among planned leavers. Fifty-four per cent of part-timers said they would stay for the foreseeable future, compared to 43 per cent of full-timers. There has been no change in this trend over the three years.

Those working shifts or on a rota are less likely to plan to stay (66 per cent of shift workers, and 62 per cent of those on a rota, plan to stay for at least a year, compared to 72 per cent of day workers). However, the percentage of shift and rota workers who are likely to stay has increased over the three-year period.

9.6.1 The Trust/PCT as a place to work

Respondents were asked whether the Trust/PCT was a better, a worse or the same place to work, compared with two years ago. Those with less than two years service were filtered out of this analysis. When we examined part-time staff ratings of their Trusts/PCTs, we could see that there were no significant differences in the way part-time and full-time staff viewed their Trusts/PCTs. Although rota workers were more likely to rate their Trusts/PCTs as worse (26 per cent, compared with 23 per cent on shifts and 24 per cent on days in the 2002 survey), there were no significant differences on other ratings, *ie* better or the same. This picture stayed very much the same over the three years.

In the questionnaires, staff are also asked to write down the two best things about working for the Trust/PCT. The trend shows that in general, hours are one of the frequently mentioned thing in respondents' lists (always in the top ten). When we examined the list of those who worked part time, we could see that hours (shifts, flexi, suit home circumstances) were actually the second most frequently mentioned thing in the part-time staff list, whilst it was the eighth for full-time staff. There were no differences in the lists of those who

work days, shifts or on a rota. Interestingly, hours also get mentioned in respondents' list of suggestions for improvements, and are also placed in the top ten of the list. However, the lists did not reveal any significant differences amongst those working non-standard hours.

9.7 Conclusions

Overall, part-time staff appear to benefit less from formal training opportunities and procedures than do their full-time colleagues. They have fewer training days, are less likely to have a formal appraisal in the last 12 months, and are also less likely to have a PDP. However, the picture is much more positive, especially in the 2002 survey, with regard to their perceptions of access to less-formal development opportunities such as secondments, coaching and mentoring. There are other indications that part-time staff have a positive experience at work in the London NHS:

- they have a significantly fewer number of accidents and injuries, and the number has fallen over the three years of the survey
- they are significantly less likely to experience incidents of harassment or violence at work
- they are as happy as full-time staff about most aspects of their working life, and these scores are improving over time
- their satisfaction scores on health and safety issues are also quite similar to those of full-timers, and they are improving
- they are as happy as full-time staff about the different aspects of equal opportunities
- in general, part-timers are more likely to stay than full-timers, and the trend over time shows increased intention to stay
- hours (shifts, flexi, suit home circumstances) are the second most frequently mentioned 'best thing' about working for the Trust/ PCT, in the part-time staff list, and it also gets a higher place (in the top ten) in their list of suggestions for improvements.

The picture about shift and rota workers in London NHS Trusts/ PCTs is somewhat different than that of part-timers. This group of employees:

- are significantly more likely than day workers to have a higher number of training days; although there has been a small decrease in shift workers' average number of days since 2000, those working on a rota have seen an increase in their training days
- are more likely to have a PDP, although fewer shift workers than those on a rota have a formal performance appraisal
- are less positive than day workers about their access to less-formal development opportunities

- have a significantly higher number of accidents and/or injuries; the trend fluctuates for shift workers, but there has been a steady decrease for rota workers
- have lower satisfaction scores on attitude clusters
- are also less positive about health and safety at work; in particular, scores are very low for security in the workplace, but the trend shows improvement over time
- are less positive about equal opportunities
- experience a significantly higher number of incidents of harassment or violence at work.

Staff working shifts or on a rota (especially rota workers) are more likely to rate their Trust/PCT as getting worse, compared with two years ago. They are also less likely to stay for at least a year than are day workers.

The fact that working patterns have such an impact on perceptions of working life may indicate that further investigation and action on the part of Trusts/PCTs is warranted.

Minority Ethnic Staff in the London NHS

- The London NHS employs significant numbers of people from an ethnic background that is other than White. A quarter of respondents to the 2002 QWL survey were from a minority ethnic group. This is almost certainly an underestimation of the percentage actually in the workforce, as minority ethnic respondents tend to be under-represented in survey data.
- The Labour Force Survey shows that 29.4 per cent of the population of working age in London from a minority ethnic group. The London NHS appears to reflect the local population reasonably well, although minority ethnic respondents are clearly under-represented in two staff groups — Therapy and Senior Management.
- Minority ethnic staff are more likely than their White counterparts to work full time, and to have a working pattern involving shifts or rotas. The latter finding is, to some extent, related to the jobs they do; minority ethnic respondents are particularly likely to work as hospital-based Nurses, Midwives and HCAs/Auxiliaries.
- Respondents in all minority ethnic groups are more likely than White respondents to say that they have experienced harassment or violence at work. Within the minority ethnic workforce, Black, Mixed and Other respondents are particularly likely to have experienced such incidents.
- Minority ethnic employees (especially Black respondents) are less positive about equal opportunities than are their White colleagues — particularly about racial discrimination policies and fair treatment. Black and Mixed groups are also notably less positive about their Trust's/PCT's 'family-friendliness'. This is of concern, given that minority ethnic respondents are more likely to have caring responsibilities than are White respondents.
- Analysis of training and development issue indicates, encouragingly, that there is not a clear picture of minority ethnic disadvantage in these areas, in contrast to some other research findings.

10. Minority Ethnic Staff in the London NHS

Robert Barkworth

10.1 Introduction

The brief for this chapter was to explore the experiences of minority ethnic employees and present a portrait of this population, their characteristics, views and experiences. The survey collected data in terms of ethnicity in 16 categories but, due to the analysis being carried out, it was necessary to condense these into the main categories as used in the recent census, otherwise the groups would be too small to analyse. The groups are as follows:

- White (British, Irish, other White)
- Mixed (White & Black Caribbean, White & Black African, White & Asian, other Mixed)
- Asian or Asian British (Indian, Pakistani, Bangladeshi, other Asian)
- Black or Black British (Black Caribbean, Black African, other Black)
- Chinese
- Other Ethnic Group (Iranian, Filipino, Egyptian, Arabian, Vietnamese, Middle Eastern, Malaysian, Mauritian).

10.2 Demographic details

10.2.1 Gender

Females form the majority of all employees in the 2002 survey, at 79.6 per cent of the sample. The gender mix does differ by ethnic group, as Table 10.1 shows. Whilst all the ethnic groups reflect the overall trend that the majority of employees are female, there are statistically significant differences between the groups, with the Black employees having the least males, at 16 per cent, and the Asian group having the largest proportion of males, at just over 30 per cent.

Table 10.1: Gender distribution by ethnic group (per cent)

Gender	White	Mixed	Asian	Black	Chinese	Other	Total
Male	19.8	18.7	30.1	16.0	22.4	29.2	20.4
Female	80.2	81.3	69.9	84.0	77.6	70.8	79.6

Source: IES NHS Staff Attitude Surveys, 2002

Table 10.2: Mean age, by ethnic group

	Mean Age	Standard deviation	Rank	N
White	40.3	10.7	2=	20,448
Mixed	38.8	10.3	3=	527
Asian	38.5	10.7	3=	2,088
Black	40.5	9.5	2=	2,716
Chinese	42.5	10.2	1	394
Other	38.8	10.5	3=	537
Total	*40.2*	*10.6*		*26,710*

Source: IES NHS Staff Attitude Surveys, 2002

10.2.2 Age

The analysis of variance statistical test was used to determine whether a significant difference existed between the ethnic groups in terms of age. The test revealed a difference existed, and analysis then revealed which groups were significantly different. The results are shown in Table 10.2, and show that the Chinese group had a mean age significantly higher than all other groups. The next groups were the Black and White groups, with no differences between them, and then the Mixed, Asian and Other groups.

10.2.3 Disability/medical condition

Of the 2002 sample, just under five per cent of all employees consider themselves to have a disability or medical condition that requires support in the workplace. However, when this is analysed by ethnic group, it is revealed that significant differences exist. The White group of employees report less disability/medical conditions than the other groups (Table 10.3), and the employees in the Mixed group have the highest proportion of disability/medical conditions reported.

Table 10.3: Reported disability/medical condition, by ethnic group

		White	Mixed	Asian	Black	Chinese	Other	Total
Disability/ Medical Condition	Count	889	43	120	207	24	35	1,318
	% within Ethnic group	4.3	7.9	5.6	7.1	5.9	6.2	4.8
No disability/ medical condition	Count	19,936	499	2,021	2,711	385	529	26,081
	% within Ethnic group	95.7	92.1	94.4	92.9	94.1	93.8	95.2
	Base	*20,825*	*542*	*2,141*	*2,918*	*409*	*564*	*27,399*

Source: IES NHS Staff Attitude Surveys, 2002

10.3 Job characteristics

10.3.1 Job category

A stated aim of many diversity policies is to reflect the diversity of the local population in the workforce. With this in mind, the ethnic mix of each job category was calculated, and is presented below (Table 10.4). In order that comparisons with the local population can be made, data from the Labour Force Survey (LFS) has been included, which shows the proportion of each ethnic group in London.

In general, White respondents are over-represented in the survey, compared with the local population. This finding needs to be treated with caution, as response analyses carried out for several individual Trusts/PCTs indicates that minority ethnic staff have lower survey response rates than White staff. The percentage of Black respondents in the QWL survey and in the LFS population, however, is identical.

One striking find is that all the minority ethnic groups are under-represented in the Senior Management and Therapy groups.

Table 10.4: Job category, by ethnic group (per cent)

	Ethnic group						
Job Type	**White**	**Mixed**	**Asian**	**Black**	**Chinese**	**Other**	**Total**
LFS*	70.6	2.5	12.4	10.6	0.9	3.1	7,407,044
All Job Categories in survey	76.0	2.0	7.8	10.6	1.5	2.1	27,477
Qualified Nursing & Midwifery	67.0	2.4	8.8	15.6	2.4	3.8	8,378
Health Visitors, District & School Nurses	76.6	1.7	3.6	14.9	2.6	0.6	1,120
Nursing Auxiliary & HCAs	61.3	2.6	6.5	26.4	0.4	2.8	1550
Doctors & Dentists	73.7	1.9	15.9	4.2	2.4	1.9	2,333
Therapists & Therapy Support	88.2	1.8	5.8	3.1	0.5	0.6	2,876
Pharmacists	72.7	1.5	11.3	8.0	5.5	1.0	399
Scientists	83.7	1.9	7.1	4.5	1.4	1.4	1,133
Technicians	77.2	2.5	9.3	6.5	1.5	3.0	710
Administrative & Clerical	81.5	1.5	6.5	8.7	0.6	1.1	6,035
Senior Managers	86.7	1.6	4.6	5.8	0.8	0.5	2,035
Support	79.5	2.5	5.3	10.1	0.4	2.3	487
Other	80.8	2.1	8.6	5.9	1.0	1.7	421
Base	*20,875*	*547*	*2,155*	*2,923*	*409*	*568*	*27,477*

* The Labour Force Survey (LFS) is a continuous, household survey, conducted by the Office for National Statistics on behalf of the Department for Education and Skills, which provides a wide range of data on labour market statistics and related topics such as training, qualifications, income and disability.

Source: QWL Survey, 2002 & Labour Force Survey, 2002

Table 10.5: Working hours by ethnic group

Work pattern		White	Mixed	Asian	Black	Chinese	Other	Total
Full-time	Count	15,276	447	1,781	2,517	343	494	20,858
	% within Ethnic group	74.7	84.7	83.7	88.1	85.8	89.2	77.5
Part-time and job share	Count	5,184	81	347	339	57	60	6,068
	% within Ethnic group	25.3	15.3	16.3	11.9	14.3	10.8	22.5
	Base	*20,460*	*528*	*2,128*	*2,856*	*400*	*554*	*26,926*

Source: IES NHS Staff Attitude Surveys, 2002

10.3.2 Working pattern

There are differences between the ethnic groups in terms of their working patterns. Two aspects of working pattern were analysed, namely contract type (either full-time or part-time/job share) and when these hours are worked (either days, shifts or on a rota). Again, significant differences were found between the ethnic groups. A greater proportion of White employees work on a part-time basis than any other group (Table 10.5). There are a number of reasons why this may be the case, such as a preference for part-time hours, only being able to secure part-time employment, being able to afford to work part time, or having more flexibility or say over the hours they work. It is beyond the data to answer this question for us, but it might be worth considering if access to part-time working is available to all. Chapter 9 contains more analysis on the theme of working non-standard hours.

Along with the finding that more White employees work on a part-time basis, is the finding that a greater proportion of White employees work days, as opposed to working shifts or on a rota (Table 10.6). This could be a reflection of the earlier finding that a greater number of minority ethnic employees than would be expected work in roles such as Nursing, that are subject to shift/rota working. At this level of analysis, it is difficult to draw conclusions, but if working days is seen as a more favourable option, it might be worth re-visiting policies and practices relating to working patterns.

Table 10.6: Working pattern by ethnic group

Work pattern		White	Mixed	Asian	Black	Chinese	Other	Total
Days	Count	15,859	331	1,308	1,492	226	226	19,442
	% within Ethnic group	77.7	62.5	62.7	53.4	56.2	42.4	72.7
Shifts	Count	3,016	130	373	793	100	180	4,592
	% within Ethnic group	14.8	24.5	17.9	28.4	24.9	33.8	17.2
On a rota	Count	1,539	69	405	510	76	127	2,726
	% within Ethnic group	7.5	13.0	19.4	18.2	18.9	23.8	10.2
	Count	20,414	530	2,086	2,795	402	533	26,760

Source: IES NHS Staff Attitude Surveys, 2002

Table 10.7: Mean length of service, by ethnic group

	Mean	Rank	N
White	7.1	2	20,516
Mixed	6.1	3=	523
Asian	6.1	3=	2,118
Black	6.3	3=	2,860
Chinese	9.1	1	398
Other	5.9	3=	554
Total	*6.9*		*26,969*

Source: IES NHS Staff Attitude Surveys, 2002

10.3.3 Length of service

The mean length of service for an employee is just under seven years. An analysis of variance was conducted to see if any differences existed between ethnic groups in terms of length of service, and two differences were found (Table 10.7). The Chinese group of employees have a mean length of service significantly greater than any other group, and the White group of employees has the second highest mean length of service. No differences were found among the other groups.

The differences found here are very similar to the findings of mean age of employees by ethnic group (Table 10.3). As Chinese employees were found to have the highest mean age, it might be quite intuitive that they would also have the greatest length of service. To control for the length of age, a further test was conducted, namely a statistical technique which calculates if differences exist after controlling for another variable (in this case, age of employee). The results of this test reveal that length of service differences between the groups still exist, independent of age.

Table 10.8: Ethnic group, by Trust type

Trust type		White	Mixed	Asian	Black	Chinese	Other	Total
Acute	Count	6,944	176	813	947	123	204	9,207
	%	75.4	1.9	8.8	10.3	1.3	2.2	100
Teaching	Count	6,436	180	658	781	158	222	8,435
	%	76.3	2.1	7.8	9.3	1.9	2.6	100
Mental Health	Count	3,020	95	331	646	69	95	4,256
	%	71.0	2.2	7.8	15.2	1.6	2.2	100
PCT	Count	4,558	102	364	574	60	48	5,706
	%	79.9	1.8	6.4	10.1	1.1	0.8	100
Base	*Count*	*20,958*	*553*	*2,166*	*2,948*	*410*	*569*	*27,604*
	%	*75.9*	*2.0*	*7.8*	*10.7*	*1.5*	*2.1*	*100*

Source: IES NHS Staff Attitude Surveys, 2002

10.3.4 Trust type

Significant variations in the type of Trust in which certain ethnic groups work were revealed (see Table 10.8). A greater proportion of Black employees are working in Mental Health Trusts than any other type of trust. White employees are more likely to work in Primary Care Trusts than any other type of trust. The other ethnic groups show relatively similar proportions across the Trust types.

10.4 Experiences of harassment

Just over 25 per cent of employees have been subject to some form of harassment at work, be it from colleagues, managers or patients/ relatives (see Table 10.9). Analysis of the incidents of harassment has revealed that significant differences exist between ethnic groups. White employees report fewer incidents than any other group. Coupled with this finding is the fact that many of the incidents are perceived to be racially motivated. Between 38 and 53 per cent of minority ethnic employees reporting harassment (dependent on the particular ethnic group) say that the harassment was racially motivated.

Table 10.9: Employees' experiences of harassment, by ethnic group

		White	Mixed	Asian	Black	Chinese	Other	Total
Experienced	Count	5,021	175	558	927	120	187	6,988
	%	24.3	32.5	26.6	32.5	29.9	33.7	25.8
Not Experienced	Count	15,600	364	1,542	1,921	281	368	20,076
	%	75.7	67.5	73.4	67.5	70.1	66.3	74.2
	Base	*20,621*	*539*	*2,100*	*2,848*	*401*	*555*	*27,064*

Source: IES NHS Staff Attitude Surveys, 2002

These findings suggest that the zero tolerance policies launched in 2000 might need to be revisited, especially with regard to their impact on minority ethnic groups.

10.5 Equal opportunities

The survey contained items that assessed respondents' agreement with the working of various equal opportunities policies. The scale on which these statements were rated was a five-point scale, varying from one to five, with the midpoint of three reflecting an opinion of neither agreeing or disagreeing. The higher the score, the more the respondent agreed with, or felt positive about, the statement. The responses to these statements were then analysed by ethnic group, to examine whether any differences existed. The results of this analysis appear in Table 10.10.

Table 10.10: Employees' attitudes to equal opportunity policies

	White	Mixed	Asian	Black	Chinese	Other	Total
Racial discrimination policy	3.6	3.3	3.3	3.1	3.3	3.3	3.5
Sex discrimination policy	3.5	3.4	3.4	3.4	3.4	3.4	3.5
Disability/medical condition policy	3.0	3.0	3.1	3.1	3.0	3.1	3.0
Family-friendly policy	3.3	3.1	3.2	3.1	3.2	3.3	3.2
Equal opportunities and fair treatment	3.5	3.3	3.3	3.2	3.3	3.4	3.5

Source: IES NHS Staff Attitude Surveys, 2002

10.5.1 Racial discrimination policy

The overall findings (see Table 10.10) suggest that employees are more likely to agree than disagree that racial discrimination policies are working. However, the White group of employees are more positive about the effectiveness of the policies than any other group, and the Black group of employees are less positive than any other group. This finding suggests that respondents in groups particularly susceptible to racial discrimination perceive policies designed to prevent this occurring as less effective.

10.5.2 Sex discrimination policy

Table 10.10 shows that there is very little difference between the mean scores of all groups, and these scores show that employees generally are in agreement that such policies are having some effect. Again, the White group of employees perceive less sex discrimination than do the minority ethnic groups.

10.5.3 Disability/medical condition policy

The overall finding (see Table 10.10) is that employees neither agree nor disagree to statements such as *'This Trust is good at supporting disabled employees'*. This may suggest a lack of awareness about such policies. There are significant differences between ethnic groups however; Black and Asian employees are slightly more positive about such policies.

10.5.4 Family-friendly policies

Chinese, Other, and White employees hold a more positive view of the effectiveness of family-friendly policies than do the other groups. Those in the Black and Mixed ethnic groups are significantly less positive about family-friendliness (see Table 10.10).

10.5.5 Equal opportunities and fair treatment

Overall, White employees perceive more equality and fairness generally in their working lives than do those in minority ethnic groups.

It is clear that White employees perceive more equity than those in minority ethnic groups overall, and that different minority ethnic groups have varied views about different aspects. This finding will be of interest to those responsible for diversity and equal opportunities within the London NHS. It also indicates the need for such schemes as 'Positively Diverse', which is about to be launched in the NHS.

10.6 Access to training and development

To assess whether the various ethnic groups experienced any differences in access to training and development, three areas were examined:

- number of days training in the last year
- having a performance appraisal or not in the last year
- having a personal development plan (PDP) or not.

10.6.1 Doctors & Dentists

No significant differences were found between ethnic groups in terms of the number of days training received, or whether or not they had a PDP. The only significant difference found was in terms of having had a performance appraisal. The Chinese group were the most likely to have had such an appraisal, followed by the Other and White groups. The least likely to have an appraisal are the Asian, Black and Mixed group of Doctors & Dentists.

10.6.2 Qualified Nurses & Midwives

In terms of training days, the Black group had a statistically significant greater amount of training days than the other groups.

The only significant finding in relation to performance appraisal is that White employees are more likely to have had one than Mixed, Asian, or Black groups. However Black, Chinese and Other groups are more likely to have a PDP than other groups.

10.6.3 Administrative & Clerical

The only aspect of training and development to reveal differences between ethnic groups in this job category, is the number of days of training received. The difference observed here is that Black employees received significantly more training than did White, Mixed and Asian groups.

10.6.4 Nursing HCAs & Auxiliaries

The analysis carried out requires at least 30 people from each ethnic group; as there are fewer than ten Chinese employees in this category, they were excluded from the analysis.

Black employees received more training than White or Asian staff. No other differences in terms of training were identified. Also significant was having a PDP, with Black staff more likely to have one than either White or Asian employees. There was no difference related to performance appraisals between the ethnic groups.

10.6.5 Therapy

There were insufficient numbers of Chinese and Other employees for them to be included in the analysis. Asian employees received significantly more training than Black or White employees. White employees were more likely to have had a performance appraisal than either Asian or Black employees. There were no differences in the likelihood of having a PDP.

10.6.6 Senior Managers

Again, Chinese and Other employees were not included in this analysis, due to insufficient numbers. Mixed and Black employees received more training than both Asian and White employees. White employees were more likely than Asian or Black employees to have had a performance appraisal. Black and White employees were more likely to have a PDP than Asian employees.

10.6.7 Pharmacists, Scientists and Technicians

For these job categories, it was only possible to include White, Asian, and Black employees, as the numbers in the other groups were too small.

For all three aspects of training and development, the statistical tests revealed that there were no differences between any of the ethnic groups.

10.6.8 Career intentions

Minority ethnic respondents are significantly more likely to say that they intend to leave their Trust/PCT than are their White colleagues. Overall, 28 per cent of White respondents plan to leave (either as soon as possible, or within the next year), compared to 33 per cent of the Other ethnicity group, 34 per cent of Asian respondents, 36 per cent of Black respondents, 27 per cent of the Mixed ethnicity group, and 41 per cent of Chinese respondents. It is noteworthy that at least 20 per cent of respondents in all the minority ethnic groups plan to leave as soon as possible, compared to only 12 per cent of White respondents.

Evidence from questions in the 2003 QWL survey about accommodation, suggests that minority ethnic staff have more difficulty finding accommodation within a reasonable distance of their place of work. In these circumstances, workplace location becomes more important than it might otherwise be. In the 2002 survey, respondents

from minority ethnic groups are significantly more likely than White respondents to cite location as one of the best things about working for their Trust/PCT. This suggests that one of the main reasons for moving to another Trust/PCT, for minority ethnic staff, might be to find a suitable job closer to home.

10.7 Access to less-formal development opportunities

The QWL survey also asked respondents about access to less-formal development opportunities such as secondments, coaching, multi-disciplinary group working, and special projects. This question was scored on a five-point scale, with one representing the respondent viewing his/her access to less-formal development as 'excellent', and a score of five as 'non-existent'. The data were analysed to see if there was any difference in views between the ethnic groups within job categories.

10.7.1 Doctors & Dentists

No significant differences were found between ethnic groups in terms of views of ease of access to informal development opportunities.

10.7.2 Qualified Nurses & Midwives

There were significant differences between groups in this job category. The Other and White groups of employees perceived better access to less-formal development opportunities than did Mixed and Black groups. The Asian employees perceived better access than the Mixed group, and the Chinese employees did not differ significantly from any other group.

10.7.3 Administrative & Clerical

The Other ethnic group perceived better access to informal development opportunities than the Mixed, White and Black employees. In turn, Asian and White employees felt they had better access than Black employees.

10.7.4 Nursing HCAs & Auxiliaries

The analysis carried out requires at least 30 people from each ethnic group; as there were insufficient numbers of Chinese employees in this category they were excluded from the analysis.

The only significant difference found in this job category was that Black employees viewed their access to informal development opportunities more favourably than did both Asian and White employees.

10.7.5 Therapists & Therapy Support

There were insufficient numbers of Chinese and Other employees for them to be included in the analysis. In this group, the only difference reaching significance was between the Black and White employees, with the latter viewing their access to less-formal development opportunities more favourably.

10.7.6 Senior Managers

Again, Chinese and Other employees were not involved in this analysis. There were no differences between the Black, Mixed and White employees, but they all viewed their access to less-formal development opportunities as being better than the Asian group.

10.7.7 Pharmacists, Scientists and Technicians

For this job category, it was only possible to include White, Asian, and Black employees, as the numbers from the other groups were too small. There were no significant differences between the ethnic groups in terms of perceptions of access to less-formal development opportunities.

10.8 Summary

This chapter has described the population of minority ethnic employees in terms of demographics, job characteristics and job experiences. The main findings follow.

- Although all the ethnic groups followed the overall trend of having a majority of female employees, there were differences by ethnic group. The Asian group had the highest proportion of male employees (30 per cent), and the Black group had the highest proportion of female employees (84 per cent).
- The Chinese group have the highest average (mean) age — 42.5 years. They also have the highest average length of service, but interestingly, this is statistically independent of age.
- Minority ethnic employees are more likely to have a disability/ medical condition than are White employees.
- There are variations of ethnic mix by job category. Minority ethnic employees are under-represented in the senior management job category. This is an important finding given that at this level, the ability to influence and change the organisation is comparatively high. Minority ethnic employees are also under-represented in the therapy professions.
- Minority ethnic employees are more likely to be working full time, and on a shift or rota basis, than their White colleagues.

- A higher than expected proportion of Black employees work in Mental Health Trusts, and a greater than expected proportion of White employees work in Primary Care Trusts.

The experiences and attitudes of minority ethnic groups were also examined, with the following key results.

- Minority ethnic employees are more likely to experience harassment (particularly racial harassment) in the workplace than their White colleagues.
- White employees hold a more positive view of the overall effectiveness of equal opportunities policies and practices.
- Access to training and development (training days, appraisals, PDPs, and less-formal development opportunities) was assessed to see if minority ethnic groups were disadvantaged in any way. The results show that even though there are some differences between groups, there is not a clear picture of minority ethnic disadvantage in these areas.

Finally, minority ethnic staff are significantly more likely than their White colleagues to say that they plan to leave their current Trust/ PCT. This appears, at least in part, to be related to accommodation difficulties.

Experiences of London NHS Employees with a Disability/Medical Condition

Staff with a disability/medical condition that requires support in the workplace:

- are loyal employees, as demonstrated in their longer length of service, but many will be receptive to better offers from other employers
- juggle responsibilities in demanding jobs. They are just as likely to work non-standard hours as their colleagues, and carry a greater burden of caring responsibilities.
- are less satisfied with many aspects of the quality of their working lives, and are more likely to experience an accident/ injury or to be harassed or subject to violent attack
- struggle to access the same development and career opportunities enjoyed by their colleagues, and are disappointed that their skills and greater experience are not better valued by Trusts/PCTs
- are spread throughout all job groups and in different kinds of Trust, making their needs harder to address
- take issue with the extent to which Trusts'/PCTs' statements and policies about equal opportunities are translated into practice. However, where Trusts/PCTs demonstrate a commitment to fair treatment and equal opportunities, pay equitably, enhance job satisfaction, and reduce stress and work pressure, staff reward their employer with their intention to stay.

11. Experiences of London NHS Employees with a Disability/Medical Condition

Hannah Mitchell

In this chapter, we explore the characteristics and experiences of respondents with a disability/medical condition working in the London NHS. It draws comparisons between the responses of those with a disability/medical condition and those without, and seeks to answer the following questions.

- Who are they and what jobs do they do?
- How do they feel about the quality of their working lives, health and safety, and equal opportunities in the London NHS?
- Do they have similar development opportunities and career intentions to their colleagues?
- Why do they stay with their Trust/PCT?

11.1 Identifying staff with a disability or medical condition

This chapter is about the experiences and opinions of staff with a disability or medical condition, but what is meant by this phrase?

The definition of disability in the survey used is deliberately broad. Given the difficulties in categorising disabilities and medical conditions, and in the interests of confidentiality, no further information regarding the nature of the disability/medical condition was sought.

Instead, respondents were asked about their health in relation to the assistance they needed at work, namely whether they had 'a medical condition or disability which requires support in the workplace'. This definition does not align with either the narrow (now outdated) 'registered disabled' criteria, nor the new, broader Disability Discrimination Act definition. The QWL definition instead concentrates on the way in which disabilities/medical conditions interrelate with the quality of working life, and hence is the most appropriate to use in this context.

11.2 How many?

The workforce with a disability or medical condition requires support in the workplace is large in number — over 1,300 staff in total in 2002. This represents 4.8 per cent of staff in the London NHS. The number of staff classifying themselves in this way has varied slightly across the three-year survey period. In 2000, 4.2 per cent of the respondents classified themselves as having a disability/medical condition, compared to 5.1 per cent in 2001.

11.3 Who are they?

Men are no less likely than women to report a disability/medical condition. However, as the majority of the London NHS working population are female, we find that 79 per cent of respondents with a disability/medical condition in 2002 are female.

However, staff reporting a disability/medical condition do differ from other workers in the London NHS in a number of ways.

- The 2002 data shows that having a disability/medical condition is significantly related to age. Among the under 30s, only 2.3 per cent of staff report a disability/medical condition, rising to 7.6 per cent of the 50-59 age group, before tailing off slightly for the 60 plus group (7.2 per cent, see Table 11.1). Overall, nearly one-third (31.5 per cent) of respondents with a disability/medical condition fall into the 50-59 age group, compared to one in five (19.1 per cent) of their colleagues. A similar pattern in the age distribution for employees with a disability/medical condition is apparent for the three-year survey period.
- A higher proportion of staff in some ethnic groups are affected by a disability/medical condition than others. In fact, all ethnic groups report higher rates of disability/medical conditions than their White colleagues. In 2002, 34 per cent of employees with a disability/medical condition were minority ethnic, compared to 22 per cent of employees without a disability/medical condition. A closer examination of the divisions between minority ethnic groups reveals significant differences (see Table 11.1). Throughout

Table 11.1: Percentage of staff with a disability/medical condition, by biographical characteristics

Age	%	Ethnicity	%	Caring responsibilities	%
Under 30	2.3	White	4.3	Children under 16	3.5
30-39	3.6	Mixed	7.9	Other caring responsibilities	10.9
40-49	5.5	Asian	5.6	Both	9.0
50-59 years	7.6	Black	7.1	Neither	4.3
60 and over	7.2	Chinese	5.9		
		Other	6.2		

Source: IES NHS Staff Attitude Surveys, 2002

the three-year survey period the proportion of Black and Asian respondents with a disability/medical condition has been larger than that seen among White staff. Chapter 10 profiles Black and Minority Ethnic employees in the London NHS in greater detail.

- The caring demands upon employees with a disability/medical condition are often higher than those experienced by their colleagues. In 2002, 47 per cent of employees with a disability/ medical condition have some form of caring responsibilities at home, compared with 40 per cent of employees without. One in ten staff with care responsibilities for adults, or both adults and children, have a disability/medical condition (Table 11.1). This pattern has been fairly consistent over the three-year period.

11.4 What sort of work do they do?

The location of staff with a disability/medical condition in Trusts/ PCTs is interesting. They are more likely to be found in certain occupations and types of Trust, and differ in their length of service. These differences are explored further in this section.

11.4.1 Staff groups

Some occupations have higher proportions of staff with a disability/medical condition than do other occupations. As Table 11.2 shows, 11.1 per cent of Support staff report a disability/medical condition, compared to just 2.8 per cent of Doctors and Dentists.

Looking at the most common occupations of staff with a disability/medical condition reveals that in 2002, 37 per cent of respondents with a disability/medical condition were Nurses or Midwives and 23 per cent worked in an Administrative & Clerical role. Both of the aforementioned staff categories are the largest staff groups within the survey data.

Table 11.2: Percentage of staff with a disability/medical condition, by job characteristics

Staff group	%	Type of Trust	%
Qualified Nursing & Midwifery	5.1	Acute	5.2
Nursing Auxiliary & HCAs	6.9	Teaching	4.1
Doctors & Dentists	2.8	Mental Health	5.9
Therapists & Therapy Support	4.0	PCT	4.6
Pharmacists, Scientists & Technicians	3.9		
Administrative & Clerical	5.1		
Senior Managers	3.7		
Support	11.1		
Other	7.4		

Source: IES NHS Staff Attitude Surveys, 2002

11.4.2 Trust type

Employees with a disability/medical condition do not cluster in any one Trust type alone, although some statistically significant differences (using the Chi Square test) are apparent (Table 11.2). A higher proportion of staff in Acute and Mental Health Trusts have a disability/medical condition.

11.4.3 Length of service

Employees with a disability/medical condition are loyal employees — they have stayed with their Trust/PCT for longer than their colleagues. On average, staff with a disability/medical condition have been with their employer for 9.8 years, compared with 6.7 years for other employees.

The 2002 data shows that only nine per cent of employees with a disability/medical condition have served less than one year, compared to 17 per cent of employees without a disability/medical condition. At the other end of the service spectrum, 43 per cent of employees with a disability/medical condition have served for over ten years, compared with 27 per cent of employees without a disability/medical condition.

11.4.4 Working pattern

Interestingly, there are no significant statistical differences in the proportion of staff with a disability/medical condition between:

- full-time and part-time staff
- those working days, shifts or rotas.

Staff with a disability/medical condition are just as likely as their colleagues to work 'non-standard' hours.

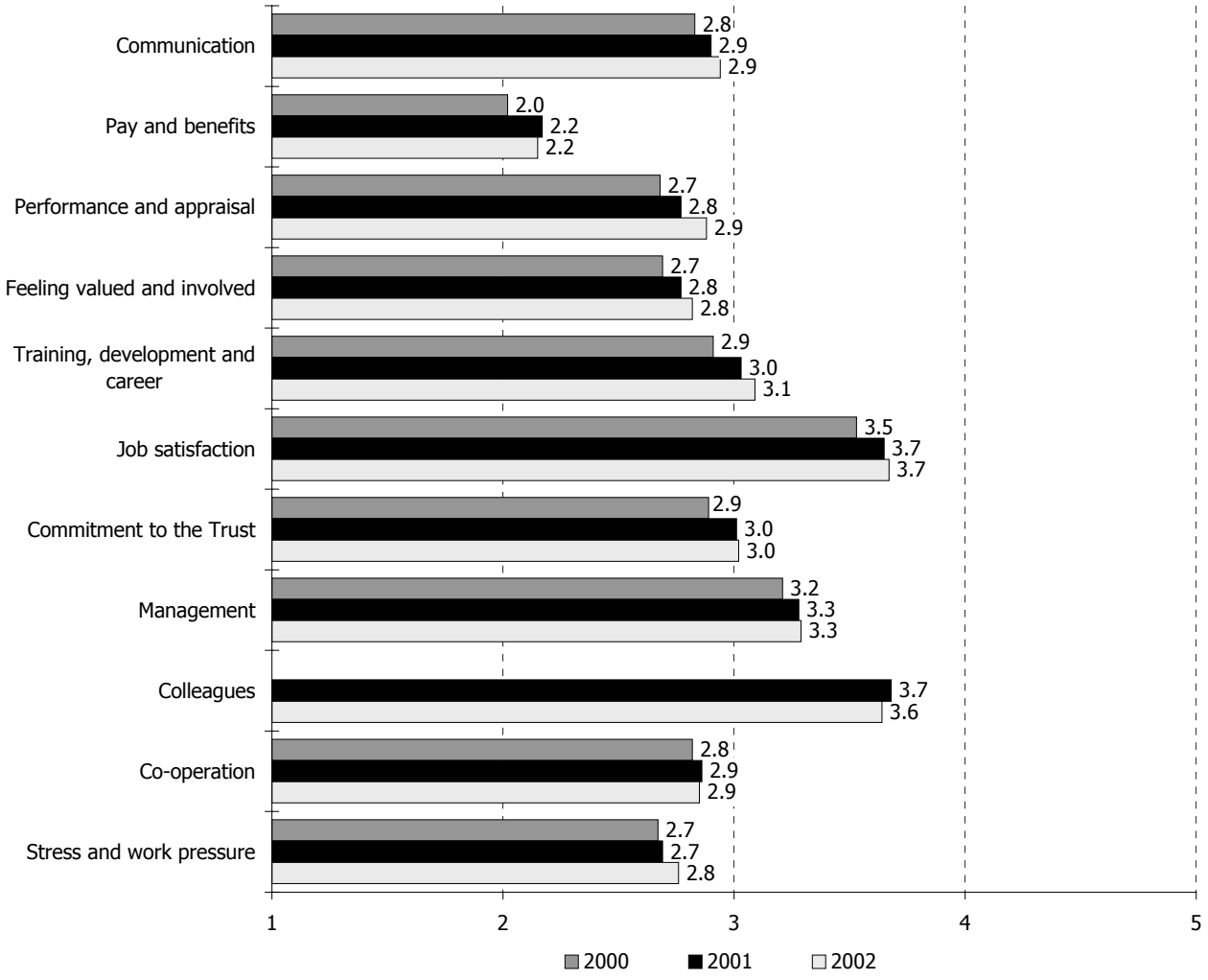
11.5 Experience of working in the NHS in London

11.5.1 Perceived quality of working life

The questionnaire collected a large number of attitude statements, *eg* 'I am treated with dignity here'. Using a technique called 'factor analysis', it is possible to identify sets of attitude statements that sit together statistically, and are related to a unifying theme or concept such as job satisfaction. These individual statements can then be combined into 'clusters' or scales — for the list of scales created, see Figure 11.1. This offers an advantage as scales made up from items that are related statistically are more reliable than scores derived from replies to individual attitude statements.

Figure 11.1 displays the average scores for each of the eleven working life attitude clusters for employees with a disability/medical condition for the three-year survey period. A value of three represents the mid-

Figure 11.1: Working lives attitude clusters for employees with a disability/medical condition over the three-year period



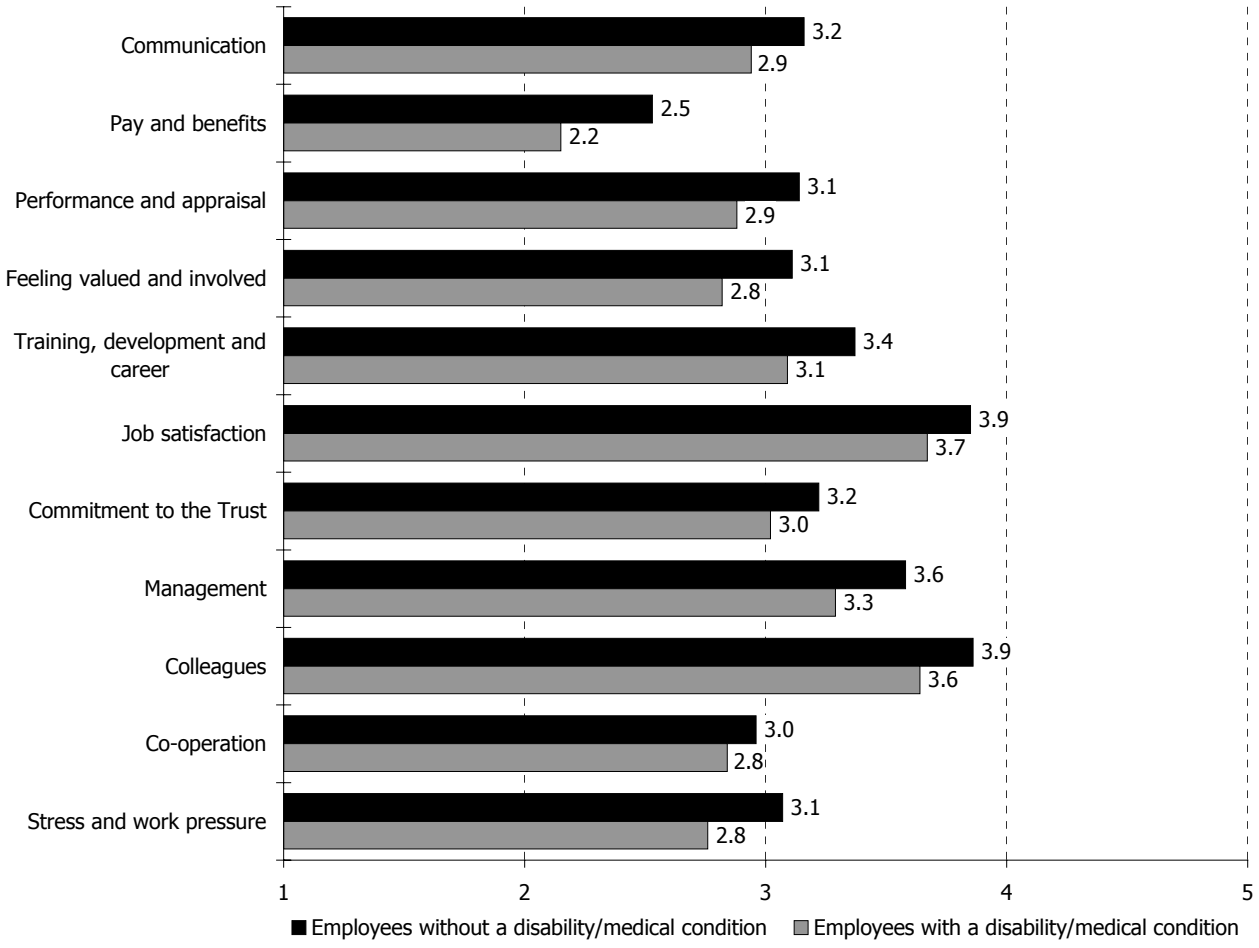
Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

point, so values greater than three denote satisfaction, while values less than three indicate dissatisfaction.

The graph illustrates a general improvement over the three-year period. There has been a statistically significant (using the t test of significance) change of the mean score of each attitude item from one year to another. Job satisfaction (3.67) and colleagues (3.64) have the highest mean scores, and pay and benefits (2.15) has the lowest mean score. In this respect, staff with a disability/medical condition are similar in the things they find most and least satisfying about their work. However, a comparison of the responses of employees with a disability/medical condition with those without, using the 2002 data, reveals that those with a disability/medical condition are much less satisfied overall. Figure 11.2 illustrates these differences.

These differences are all statistically significant (using the t test of significance). As shown in Figure 11.2, respondents with a disability/ medical condition rated pay and benefits, and stress and work pressure, lowest. These areas are also where the largest average

Figure 11.2: Working lives attitude cluster, average scores



Source: IES NHS Staff Attitude Surveys, 2002

differences lie between employees with a disability/medical condition and those without. Other scales also illustrate interesting differences. In particular, staff with a disability/medical condition are close to neutral about communications, and dissatisfied with both performance and appraisal, and feeling valued and involved, whereas their colleagues are satisfied with each of these aspects. Staff with a disability/medical condition are also notably less satisfied with their line manager, and with training, development and careers.

11.5.2 Health and safety concerns

Over the three years of the survey, respondents with a disability/ medical condition were more likely to have experienced an accident or injury at work in the 12 months covered by each survey, than respondents without. In the 2002 data, 27 per cent of respondents with a disability/medical condition had experienced an accident or injury at work, compared to 15 per cent of their colleagues.

Table 11.3 displays the trend in the number of accidents/injuries experienced by respondents with a disability/medical condition. Although the number of accidents this group experiences has decreased year-on-year, the number of accidents experienced by

Table 11.3: Accidents/injuries experienced by respondents with a disability/medical condition (per cent)

	Trend	2000	2001	2002
None	Up	68.9	69.0	73.1
One	Down	16.0	13.8	13.9
2 to 5	Down	14.1	12.2	11.9
6 to 10	Up	0.6	4.7	0.8
11 or more	Down	0.4	0.3	0.2

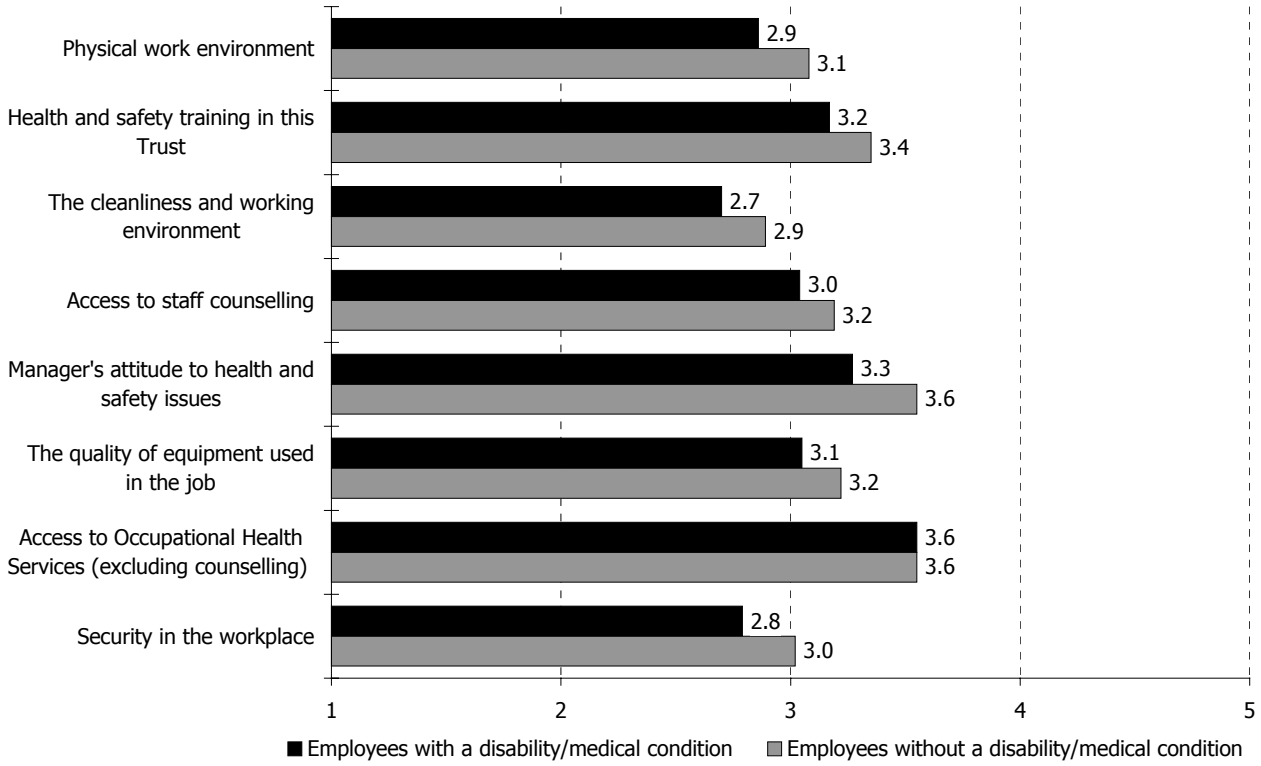
Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

respondents with a disability/medical condition is still substantially higher than that experienced by respondents without a disability/medical condition. On average, every member of staff with a disability/medical condition experienced 0.56 accidents or injuries across 2002, whereas among their colleagues, the average was 0.30. Looking at it another way, in 2002, five per cent of respondents without a disability/medical condition experienced between two and five accidents/injuries, compared to 12 per cent of respondents with a disability/medical condition.

It is a disturbing statistic that two out of every five employees (40.8 per cent) with a disability/medical condition reported in 2002 that they had been harassed or subject to violence over the previous 12 months. This compares to one in four (25.1 per cent) of staff without a disability/medical condition. As noted in Chapter 11, staff with a disability/medical condition are more likely to attract racial harassment than are their colleagues (11 per cent, compared to five per cent). Also, verbal harassment from colleagues is also more common. Seventeen per cent of employees with a disability/medical condition report this kind of harassment, compared with eight per cent among the rest of the workforce. The same is true of both verbal harassment from managers (15 per cent and five per cent) and verbal abuse from patients/relatives (21 per cent and 16 per cent).

In light of the higher incidence of both accidents and injuries, and harassment and violence, it is perhaps unsurprising that staff with a disability/medical condition are less satisfied with a number of aspects of health and safety in their Trusts/PCTs than respondents without a disability/medical condition. Figure 11.3 shows the average scores of eight health and safety aspects of working life measured in the survey. Only in respect of access to Occupational Health services are staff with a disability/medical condition equally satisfied. Otherwise, the differences between the average scores of the two groups are statistically significant (using t test of significance).

Figure 11.3: Satisfaction with health and safety, average scores

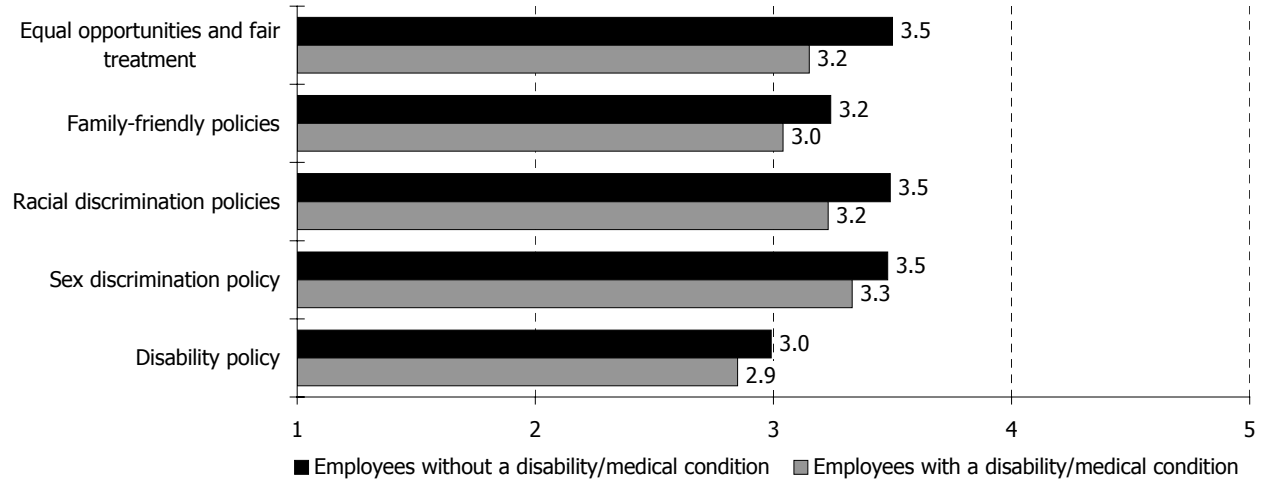


Source: IES NHS Staff Attitude Surveys, 2002

11.5.3 Equal opportunities?

Factor analysis was again used to create five measures of satisfaction regarding equal opportunities at work (see section 11.5.1 for further details). Figure 11.4 displays the average scores in 2002 for respondents with a disability/medical condition, compared to those without. Employees with a disability/medical condition display less satisfaction for all aspects of equal opportunities; most of the average scores are close to 3.0, indicating a neutral response.

Figure 11.4: Satisfaction with equal opportunities, average scores



Source: IES NHS Staff Attitude Surveys, 2002

Sadly, the disability policy itself receives the lowest average rating from both those with a disability/medical condition (2.84) and those without (2.99). Unlike their colleagues, staff with a disability/medical condition do not believe that Trusts/PCTs are good at supporting disabled employees, and neither group believes that their Trust/PCT provides good facilities for disabled employees.

The biggest difference in perceptions between staff with a disability/ medical condition and their colleagues lies in the area of equal opportunities and fair treatment. Staff with a disability/medical condition are much more likely to believe that to be accepted here 'your face has to fit' than are their colleagues. They are also notably less confident that they are treated fairly at work.

Staff with a disability/medical condition also have less confidence in the way their Trust/PCT operates. They are less likely to feel that they have a fair chance to apply for internal vacancies, or that the Trust/PCT makes clear its commitment to equal opportunities. Most agree that their Trust/PCT provides a service to patients that is free from discrimination, but their colleagues who do not have a disability/medical condition are more confident still. Staff with a disability/medical condition are lukewarm about the extent to which their work environment is free from bullying and harassment — their colleagues are much more confident that it is.

11.6 Career development

11.6.1 Attitudes towards training, development and careers

Staff with and without a disability/medical condition have different experiences of training and development in the London NHS. For example, in 2002, the average staff member with a disability/medical condition received 4.7 days of formal, off-the-job training, during the past 12 months, whereas their colleagues received 5.3 days. Not only do staff with a disability/medical condition receive less training on average, but they are also more likely to be excluded from formal training altogether — 28 per cent indicated that they experienced no training at all. This is a larger percentage than their colleagues without a disability/medical condition (22 per cent).

Respondents with a disability/medical condition are also less likely than their colleagues without a disability/medical condition, to have experience of performance review and formal development procedures. In 2002, 47 per cent of respondents with a disability/ medical condition had a performance appraisal, compared with 53 per cent of respondents without a disability/medical condition. The results are replicated when examining the differences between the two groups with regard to personal development plans. However, there are some encouraging results. Looking back to 2001, there has been an increase in the percentage of both groups having a performance development plan or experiencing an appraisal.

Employees overall tend to respond somewhat negatively regarding views on access to less-formal development opportunities. However, respondents with a disability/medical condition are even more likely to say that their access to development opportunities are 'poor' or 'non-existent'. Fifty-six per cent of these employees feel that access to less-formal development opportunities is less than adequate, compared with 43 per cent of respondents without a disability/medical condition. This pattern of responses is similar to the 2001 survey.

It may also be true that staff with a disability/medical condition feel even more keenly than their colleagues that their skills and experience are not well recognised by their employers. They are less satisfied with their opportunities to develop new and better ways of doing their job, and they are also more likely to believe that good suggestions from staff tend to be ignored.

11.6.2 Career intentions

Taken as a whole, staff with a disability/medical condition express greater satisfaction with their Trusts/PCTs in 2002 than they did in 2001. However, in comparison to those without a disability/medical condition, they remain less positive than their colleagues (see Table 11.4).

This lack of enthusiasm is also reflected in the career intentions of staff with a disability/medical condition (Table 11.5). One in four intend to leave as soon as the opportunity arises (24.3 per cent), and a further one in eight (11.9 per cent) plan to leave within the next year. By contrast, among staff without a disability or medical condition, the equivalent figures are 14.5 and 14.9 per cent respectively.

Among staff with a disability/medical condition, there has been little change in intention to stay or quit over the three-year survey period. However, back in 2000, a higher proportion of staff with a disability/ medical condition planned to stay for the foreseeable future than do currently. The reverse is true among staff without a disability/ medical condition, where the proportion intending to stay with the Trust/PCT for the long term has increased from 43.1 to 45.8 per cent.

Table 11.4: How the Trust/PCT rates as a place to work, compared with two years ago* (per cent)

	2001		2002	
	Employees with a disability/medical condition	**Employees without a disability/ medical condition**	**Employees with a disability/medical condition**	**Employees without a disability/ medical condition**
Better	13.3	16.4	17.5	21.6
The same	45.1	50.3	40.9	49.9
Worse	37.2	29.0	37.3	24.5
Don't know/Not applicable	4.4	4.2	4.4	4.0

*Staff with 2 or more years service only

Source: IES NHS Staff Attitude Surveys, 2001, 2002

Table 11.5: Career intentions of respondents with a disability/medical condition overall (per cent)

	2000	2001	2002
Plan to leave as soon as the opportunity arises	23.3	24.7	24.3
Likely to leave within the next year	12.0	11.9	11.9
Likely to stay for at least a year	18.2	19.2	19.0
Plan to stay for the foreseeable future	46.5	44.2	44.8

Source: IES NHS Staff Attitude Surveys, 2000, 2001, 2002

11.7 Why stay in the London NHS?

Given that this group of employees tend to be less satisfied than average, what makes them stay in their jobs?

The answer can be illuminated with the statistical technique of logistic regression. Logistic regression is used to predict the presence or absence of a characteristic (such as intention to stay) based on values of a set of predictor variables. Using logistic regression, it is possible to identify the characteristics and attitudes that explain why this group of people remains working within the London NHS.

As possible predictors we used:

- a number of key biographical and work-related indicators (*ie* gender, staff group, ethnicity, work pattern, performance appraisal, personal development plan, experience of harassment or violence, experience of accidents, age, length of service, how the Trust/PCT compares as place to work, compared to two years ago)
- our attitude scales (communication, pay and benefits, performance and appraisal, feeling valued and involved, training development and career, job satisfaction, commitment to Trust/PCT, immediate management, co-operation, colleagues, stress and work pressure, health and safety, equal opportunities and fair treatment, family friendly policies, racial discrimination, sexual and disability discrimination policies).

Responses to the intention to stay/leave question were combined to create a simple intention to stay or leave variable.

The statistics can explain an unusually large proportion of the differences in intention to stay among staff with a disability/medical condition. The logistic regression model accounted for 39 per cent of variance in the predicting factors that influence employees with a disability/medical condition to stay working for the NHS in London.

In order to compare this group to respondents without a disability/ medical condition, logistic regression was also run to identify why the latter group of employees stay working for the London NHS.

After analysis, we are able to say that the following factors influence the retention of staff with a disability/medical condition.

- Fair treatment and equal opportunities is the most important factor to influence the decision to stay. For every one point increase in score on the scale, the odds of staying increases by 64 per cent. Interestingly, fair treatment and equal opportunities is also an influencing factor for employees without a disability/ medical condition, but not to the same extent. For every one point increase on the satisfaction scale, the odds for this group increase by 43 per cent.
- Pay and benefits is also an important factor influencing the decision to stay. However, for respondents with a disability/ medical condition, pay and benefits are more influential. For every one-point increase on the satisfaction scale, the odds that this group will stay increase by 62 per cent. In comparison, for respondents without a disability/medical condition, every one point increase on the satisfaction scale leads to the odds that they will remain working for their NHS employer increasing by 25 per cent.
- Job satisfaction also affects intention to stay. For both groups of employees, a one point increase on the satisfaction scale for job satisfaction increases the odds they will stay by 34 per cent.
- Stress and work pressure is also a significant predictor of intention to stay or leave. For both groups, greater satisfaction with their level of stress and workload leads to a greater likelihood of staying. However, this is more important for those who do not have a disability/medical condition; each increase on the satisfaction scale will increase the odds of staying by 31 per cent, compared to 22 per cent for respondents with a disability/medical condition.
- For both groups of respondents, the greater the length of service, the less likely they are to leave.
- Female respondents who do not have a disability/medical condition are more likely to stay. The reverse is true of female respondents with a disability/medical condition; these staff are less likely to stay.

11.8 Summary and suggestions for action

- Staff with a disability/medical condition are more likely to be older, to be from a minority ethnic group, and to have caring responsibilities. *As such, Trust/PCT policies in respect of discrimination/ fair treatment, and family-friendly working practices will be examined carefully by this group. Trusts/PCTs must therefore ensure that positive statements are backed up with practice.*
- However, the proportion of staff with a disability/medical condition varies greatly among staff groups, with Support staff having the highest proportion, and Medical and Dental staff the lowest. Mental Health and Acute Trusts/PCTs have a slightly higher percentage of staff reporting a disability/medical

condition. *This means that they are spread throughout all job groups and in different kinds of Trust, making their needs harder to address.*

- Respondents with a disability/medical condition are less satisfied overall with many aspects of working life. Although generally satisfaction is increasing, there is still a discrepancy between employees with a disability/medical condition and those without. *However, like their colleagues, those staff with a disability/medical condition report high levels of job satisfaction, and are very positive about their colleagues. These are dimensions of work which are amenable to enhancement.*
- Health and safety is a key issue for many employees with a disability/medical condition. These employees are more likely to experience an accident or injury at work, and to be harassed or violently abused, and consequently are less positive about all the health and safety aspects of working life. *Trusts/PCTs should examine why their staff with a disability/medical condition are much more likely to experience these often devastating occurrences. Anything which Trusts/PCTs can do to minimise the number of these events will be rewarded by greater satisfaction.*
- Employees with a disability/medical condition are less satisfied with equal opportunities policies and procedures. *They need Trusts/PCTs to make clear their commitment to supporting disabled employees by improving facilities for them, and ensuring equal opportunities and fair treatment in a range of Trust/PCT procedures, from internal recruitment to tackling bullying and harassment.*
- Staff with a disability/medical condition appear to be loyal in that they are longer serving on average. However, the evidence suggests that staff with a disability/medical condition face greater difficulty in accessing the full range of career development opportunities. In particular, they are less likely to have an appraisal, or a PDP, than their colleagues without a disability/ medical condition; are less positive about access to less formal development opportunities; and feel that their accumulated knowledge and experience could be better utilised by Trusts/PCTs. *Trusts/PCTs could explore the barriers that staff with a disability/ medical condition experience in accessing development and careers, and then improve access.*
- Unlike their colleagues, staff with a disability/medical condition tend not feel that their Trusts/PCTs are very much better to places to work than they were two years ago, and a higher proportion intend to find alternative employment as soon as possible. This could lead to frustration, as it might be harder for people in this group to find another job. However, we now understand what motivates staff with a disability/medical condition to stay with their Trusts/PCTs. *Trusts/PCTs could better demonstrate their commitment to fair treatment and equal opportunities and equitable pay, enhance job satisfaction, and reduce stress and work pressure. Our analysis suggests they will be rewarded by better retention.*

In Their Own Words

Staff in the London NHS find much to praise about their working lives — nearly all find something to applaud about their work. The people in the NHS are considered by employees to be its greatest asset.

They are also very engaged with their employment — almost everyone made constructive and helpful suggestions about how their working lives could be improved. A wide range of suggestions were made, with most emphasis being placed on working conditions, staffing levels, pay and workplace facilities.

However, although staff are willing to commit their suggestions and preferences to paper, their confidence in the staff opinion survey process is not high. Therefore, it is now up to Trusts/PCTs to take up the gauntlet, and make real their stated commitment to acting upon staff suggestions. Staff have spoken — who is listening?

12. In Their Own Words

Sarah Perryman

Staff attitude surveys are wonderful tools for collecting a wide range of information about how staff feel about their working lives. However, nothing beats the directness and immediacy of hearing the opinions of staff expressed in their own words.

London NHS employees find much to celebrate in their working lives. They also have constructive suggestions about what could improve the quality of their working lives.

This chapter looks at unprompted suggestions by staff about what makes their work rewarding, and what could be done to enhance their experience of working in London NHS Trusts/PCTs.

12.1 The best things about working in the London NHS

It is encouraging that, when asked what are the two best things about working in their particular Trust/PCT, nearly everybody (84 per cent) feels engaged enough to offer their opinion. Their answers have been categorised to make it easier to see patterns in these very rich data.

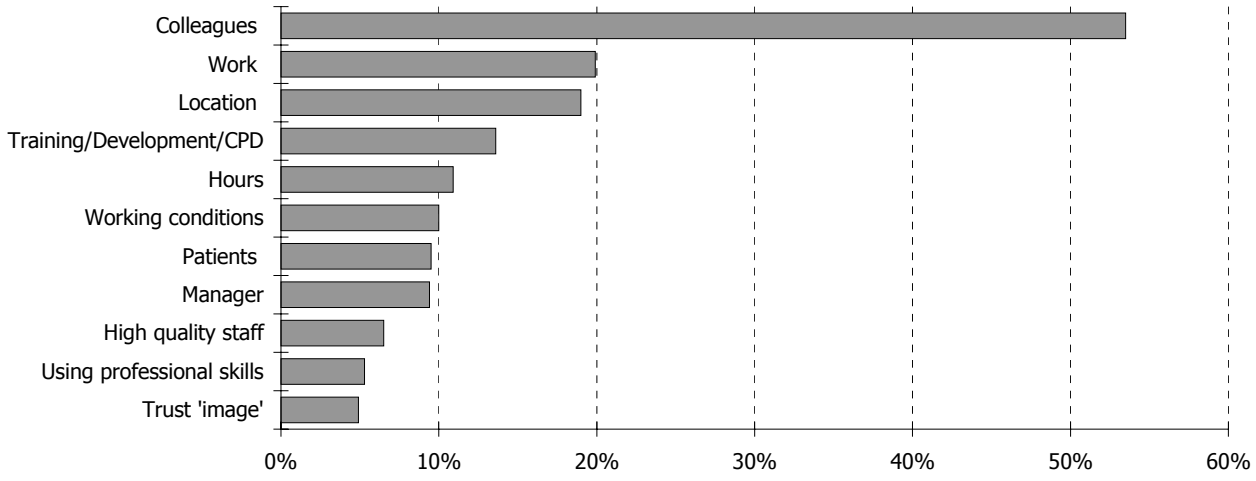
Staff in the London NHS mention a number of factors, but their friendly and supportive colleagues top the list by a wide margin. More than half of those answering the question mention their colleagues as one of the best things about their work.

They also enjoy the work they do and the location of their place of work — each mentioned by around one in five respondents. Next, they value the training and development opportunities their employers provide (14 per cent). Hours of work, working conditions, patients and the immediate manager were listed by around one in ten. Working with high-quality staff, using professional skills, and the image or standing of the Trust/PCT they work for, were listed by five per cent or more of staff .

Figure 12.1 shows these 'best things', all mentioned by 1,000 people or more, and they are explored in greater detail below. Other aspects of working life worthy of comment include:

- doing a worthwhile job — being valued and appreciated by the public (over 900 nominations — four per cent of those offering an answer)

Figure 12.1: The best things about working here



Source: IES NHS Staff Attitude Surveys, 2002

- conditions of service — pay, pension, sick pay, maternity leave, special leave (nearly 700 — three per cent)
- good equipment and facilities (approximately 450 — two per cent)
- job security/stability/regular income (nearly 400 — two per cent)
- family-friendliness — (over 300 — one per cent)
- good communications — (nearly 300 — one per cent)
- wide variety of cultures, ethnicities, *etc.* (over 200 — one per cent)
- familiarity (over 200 — one per cent)
- opportunities for disadvantaged groups —minority ethnic employees, women (approx. 150 — one per cent).

A comparison of the answers for 2001 and 2002 shows consistent patterns in what staff value about their work. As a result, this chapter will be based on answers given in 2002.

12.1.1 Colleagues

First and foremost, staff value their colleagues. Fifty-four per cent of all employees nominating something good about their employment mention their co-workers. They enjoy:

- their friendly working relationships:

  'We are like a family': HCA, PCT

  'Friendly ancillary staff': Doctor, Acute

  'Friendly and supportive colleagues': Doctor, Mental Health.

- working as part of a team, be it a ward or service team, in conjunction with health and social welfare colleagues outside of the Trust/PCT, or even within a job role:

  'Excellent locality team (community and ward based)': Doctor, Mental Health

'Everyone works as a team – no distinction': Scientist, Acute

'Good team working in departments and integration with other medical departments': Pharmacist, Acute

'We have opportunities to work with social services and voluntary organisations in an integrated manner': Administrative & Clerical, PCT

'Being able to work as a job share, thus sharing the highs and lows of the job!': Therapist, PCT

- and a supportive atmosphere:

'Good working relationships and Trust': Senior Manager, Mental Health

'The team I work with are very supportive': Nurse, PCT

'Great colleagues – very supportive team': Therapist, PCT.

Staff especially appreciate the support they receive from their colleagues working in difficult circumstances:

'Very supportive, close team on my ward in cancer care – against the odds!': Nurse, Teaching

'The poorly paid clerical staff are approachable and friendly and efficient, considering how poor is their working conditions. The same applies to the nursing staff': Doctor, Teaching.

12.1.2 Work

The nature of the work in the London NHS is rated highly by staff. They find work varied, not boring:

'Large, varied Trust with range of different opportunities available': Senior Manager, Mental Health

The also think their work is interesting, challenging and, ultimately, satisfying.

'I love my work here: It's challenging, varied and stimulating': HCA, Mental Health

'Job satisfaction in terms of client relations and seeing therapy results': Therapist, PCT

'I enjoy being a District Nurse, when I feel I have time to do my job properly': District Nurse, PCT.

12.1.3 Location

There are many things about the location of their work that staff find satisfying. Firstly, staff who leave nearby find this a boon:

'Convenience – close proximity to home and schools': District Nurse, PCT.

Secondly, for some Trusts/PCTs, their location on the fringes of London is an asset, but other locations can also be attractive:

'Central London location': Pharmacist, Teaching

'Nice and close to [mainline railway] station so we can get out of London easily but central enough for other things too': HCA, Acute

'Its peaceful and semi-rural location – pleasant surroundings; village, woods, green nearby': Senior Manger, Teaching

'Near to all convenient shopping facilities and transportation': Nurse, Acute.

Shortened travelling times are also valued:

'I live in the same borough – not far to travel': Health Visitor, PCT

'I don't have to travel far': HCA, PCT

Local 'character' is important to some:

'Area – enjoy working in South London communities': Nurse, Teaching.

12.1.4 Training/development/CPD

Elsewhere in this volume, the importance and value placed by staff on access to training, development and continual professional development are outlined. These findings are confirmed in the comments made by staff which suggest they take a share of the responsibility for their own development:

'Opportunity to increase skills and improve through training': Health Visitor, PCT.

The range of training/development methods are also recognised and appreciated:

'Continuing professional development, forums, study days and opportunities for audit work': Nurse, Teaching.

Some staff not only wish to advance their own skills profile, but enjoy the opportunity to share and spread what they have learned to their colleagues:

'Opportunities to attend relevant, specialist training regarding client group, and also to present training to others': Therapist, PCT.

12.1.5 Hours

Shifts, flexi-time and flexibility in hours to suit personal circumstances were also mentioned by a large number of employees, as one of the best things about their employment.

'Straight shifts which lets me have more time with my family': Support, Teaching

'Regular working hours, no shifts': Nurse, Acute

'I work the hours suited to my present lifestyle, ie *mother':* Administrative & Clerical, Acute.

12.1.6 Working conditions

Staff enjoy their working environment, in terms of the facilities on offer, the physical infrastructure, and also the atmosphere at work.

'Access to current research with much improved internet/intranet options': Therapist, Mental Health

'Canteen open 24 hours – very good when working nights': Doctor, Acute

'Research facilities': Therapist, Teaching

'The new building': Therapist, Teaching

'Low rise buildings': HCA, Mental Health

'I have a good working environment. There aren't too many restrictive rules. There is good team spirit': Administrative & Clerical, Mental Health

'Generally a friendly working environment': Nurse, Teaching

'Relaxed environment': Administrative & Clerical, PCT.

12.1.7 Patients

London NHS employees enjoy the 'people side' of their work greatly.

'It's always a pleasure to work with clients': Health Visitor, PCT

'I love my residents': HCA, PCT.

They also find real satisfaction in helping a wide range of patients:

'To care and support patients for their various needs': HCA, Acute

'Seeing children get better': Administrative & Clerical, Teaching

'The Trust treats a wide racial mix of people': Doctor, Teaching.

12.1.8 Their manager

Immediate managers have an important role to play in staff satisfaction with the quality of their working life. For example:

'the new ward manager who in a short time has changed the atmosphere on the ward' Nurse, Mental Health

'Support and encouragement from manager and Director': Administrative & Clerical, Acute.

Many staff single their line manager out for praise, particularly for their support.

'Support from consultant/line manager': Doctor, Mental Health

'Good department manager – as long as we do our work OK, we do not get any hassle': Scientist, Acute

'Managers have been very supportive of me and my personal situation': Health Visitor, PCT

'Understanding line manager': HCA, PCT

'Positive attitude of immediate manager': Therapist, Acute.

Good working relationships and feeling valued by line managers are also mentioned.

'My own line manager is very accommodating and friendly': Nurse, Mental Health

'The attitude of managers re: willingness to get things done/try alternative ways of working': Therapist, PCT

'Approachable manager who is open to staff opinions and welcomes new ideas': Nurse, Mental Health.

12.1.9 High-quality staff

Among a workforce who rate their relationships with colleagues so highly, it is perhaps not surprising that another of the things awarded praise is the high calibre, professionalism, reputation, skills and expertise of co-workers:

'Commitment of staff who take their jobs seriously': Senior Manger, Teaching

'Leading-edge clinicians in many areas': Nurse, Teaching

'Staff genuinely wish to provide the best possible service to patients': Administrative & Clerical, Teaching

'My department is generally supportive and friendly – the service they offer is a very good one and helps a lot of people. The Therapists really care for their patients. Genuine interest and concern to improve the quality of their lives.': Administrative & Clerical, Acute.

12.1.10 Using professional skills

Having the freedom, independence and autonomy to exercise their professional skills, and the ability to demonstrate those skills to colleagues, is another source of satisfaction for staff.

'Autonomy of my work': Health Visitor, PCT

'Opportunity to do what I think is best for my patients': HCA, Teaching

'It is a job I know I can do well': Nurse, Acute

'The opportunity to see many conditions and diagnoses and learning how to treat them': Therapist, Teaching

'Experience. You will encounter different cases and challenges to deal with: Nurse, Acute

'Involvement in research projects by the technical staff with the medical staff and communication between both groups': Technician, Teaching.

12.1.11 Trust/PCT 'image'

Employees take pleasure in working for Trusts/PCTs they describe as forward thinking or 'go ahead' organisations, that benefit patients.

'The Trust is open to change according to the current conditions, within the scope of the job': District Nurse, PCT

'Stimulating and challenging services': Nurse, Teaching

'Specialist care – one of the few centres in the country': Nurse, Teaching

'I believe the Trust is evolving to meet the demands of today's society': District Nurse, PCT.

However, the important role of staff in making a Trust/PCT forward thinking was also observed.

'Team support allows for imaginative/innovative areas of work to develop and progress': Senior Manger, PCT

'Working for a Trust that is actively changing, expanding and therefore inspiring people': Nurse, Acute.

A Trust/PCT with a good reputation was also a valuable feature of working life.

'It is good to work for an organisation with international recognition of clinical excellence': Administrative & Clerical, Teaching.

Finally, a Trust/PCT that is forward thinking in the way in which it relates to its employees is also valued.

'Good leadership. Family-friendly ethos supported by CEO – sensitivity and understanding of individuals' personal circumstances: Senior Manger, PCT.

12.1.12 Variations among groups

Among the different types of Trust, colleagues are the most commonly mentioned thing, but even higher proportions of staff in PCTs (57.2 per cent) and Acute Trusts (55 per cent) refer to colleagues. The 'top five' for each type of Trust are laid out in Table 12.1.

Table 12.1: The best things about working in Trusts/PCTs of different types

Acute	Teaching	Mental Health	PCT
Colleagues (55%)	Colleagues (51%)	Colleagues (51%)	Colleagues (57%)
Location (24%)	Work (22%)	Work (20%)	Work (20%)
Work (18%)	Training/Development/CPD (18%)	Training/Development/CPD (16%)	Location (17%)
Working conditions (14%)	Location (27%)	Location (16%)	Hours (14%)
Hours (11%)	Patients (10%)	Manager (13%)	Manager (12%)

Source: IES NHS Staff Attitude Surveys, 2002

Colleagues top the list among all of the different staff groups, and location and the nature of the work also appear in the lists for every group. However, there are some variations, as outlined in Table 12.2.

12.2 Suggested improvements

London NHS employees were also given the opportunity to make suggestions about what two things could most improve the quality of working life in their Trust/PCT. Again, the majority (85 per cent) could think of at least one improvement. On the whole, staff took this chance to offer constructive criticism to their employers.

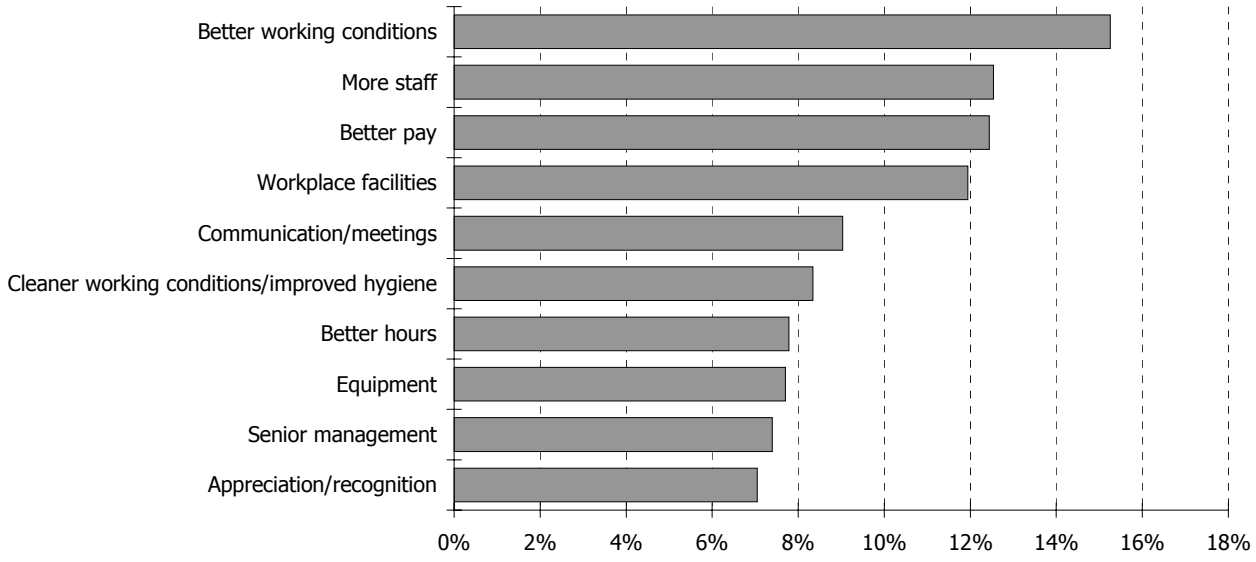
The range of suggestions made was very wide, and as with the 'best things', answers were coded into categories for analysis. The 'top 10', all mentioned by 1,700 people or more, are displayed in Figure 12.2.

Table 12.2: Five 'best things' among staff groups

Staff Group					
Qualified Nursing & Midwifery	Colleagues (50%)	Location (19%)	Training/ Development/ CPD (18%)	Work (18%)	Hours (11%)
HCAs & Nursing Auxiliaries	Colleagues (49%)	Patients (20%)	Work (18%)	Location (15%)	Training/ Development/CPD (14%)
Doctors & Dentists	Colleagues (61%)	Work (22%)	Location (13%)	Working conditions (12%)	High-quality staff (12%)
Therapists & Therapy Support	Colleagues (57%)	Training/ Development/ CPD (20%)	Work (20%)	Location (14%)	Manager (12%)
Pharmacists, Scientists and Technicians	Colleagues (51%)	Work (23%)	Location (22%)	Training/ Development/ CPD (12%)	Working conditions (11%)
Administrative & Clerical	Colleagues (57%)	Location (25%)	Work (20%)	Hours (15%)	Working conditions (10%)
Senior Managers	Colleagues (53%)	Work (23%)	Location (15%)	Manager (12%)	Trust 'image' (11%)
Support	Colleagues (46%)	Location (20%)	Work (19%)	Hours (12%)	Working conditions (10%)
Other	Colleagues (51%)	Work (23%)	Location (15%)	Training/ Development/ CPD (12%)	Patients (12%)

Source: IES NHS Staff Attitude Surveys, 2002

Figure 12.2: Suggestions for improving quality of working life



Source: IES NHS Staff Attitude Surveys, 2002

The figure shows that, unlike the 'best things' list, there is little consensus in suggestions for improvement.

The most common suggestion is for improved working conditions (15 per cent). One in eight employees ask for more staff, better pay and better workplace facilities. Nine per cent suggest better communications/more meetings, and seven to eight per cent call for improved cleanliness, better hours, better equipment, improved senior management and more appreciation/recognition. These suggestions are explored in more detail in the following sections.

Briefly, other suggestions from staff (made by one per cent or more) included:

- with approximately 1,500 responses each (six per cent for each suggestion)
  - better administrative/secretarial/clerical/ITC backup
  - car parking facilities/bike racks
  - more teamwork
- changes to the line manager/team leader (nearly 1200, five per cent)
- with around 800 responses (four per cent each)
  - better/more training
  - less workload/pressure/fairer distribution of work
- with over 700 responses (three per cent each)
  - more development opportunities
  - crèche/childcare facilities
  - better quality/more reliable staff

- safety/security (over 600, three per cent)
- around 550 responses (three per cent each) for
  - fewer agency/temporary workers
  - be treated more fairly/equally/with less arrogance
  - Personnel/HR
- more funding/stability in funding (approximately 400, two per cent)
- with around 300 responses (one per cent each)
  - more efficient organisation/administration and accountability
  - grade structures
  - housing/accommodation
  - support for getting further qualifications/training
  - more respect for patients
  - fewer Government/NHS initiatives or bureaucracy; periods of stability
  - recognition/support/counselling for personal problems
  - appraisals
  - improved public transport links/subsidised or free transport
- with around 250 nominations (one per cent each)
  - fairer pay rises
  - dealing with bullying/harassment
  - resources matched to workload.

12.2.1 Better working conditions

Staff call for less cramped, safer, more suitable, brighter and better decorated working conditions.

> *'Physical environment in which we work which is very poor':* Therapist, PCT
>
> *'More space':* Doctor, Mental Health
>
> *'Stop the roof leaking through the light fitting by my desk when it rains':* Scientist, Teaching
>
> *'More space in the workplace to enable more efficient running of service and enable service development':* Health Visitor, PCT
>
> *'Some buildings need urgent repair!':* Senior Manager, Teaching
>
> *'Better infrastructure,* ie *premises, IT facilities, equipment':* District Nurse, PCT

'[This building] is miserable to work in with draughty windows and poor facilities for staff and patients': Nurse, Teaching

'Improving working environment – better access to light, PCs, desks, chairs, etc.': Pharmacist, Acute.

12.2.2 More staff

Those working in the London NHS feel the need for more staff, but often see this as a symptom of a general lack of resources.

'Lack of pressure of time – ie *more staff': District Nurse, PCT*

'Increased resources for adequate staffing (eg community nurses, occupational therapists': Doctor, Mental Health.

Many different roles/occupations were listed as being required to support existing employees in their job roles, and to deliver better patient care.

'More clinical staff to meet the needs of patients and reduce waiting list': Doctor, Mental Health

'Higher staff to patient ratio': Nurse, Acute

'Less bank/temporary nursing/medical staff – a lack of continuity of care and accountability (not just here but all NHS Trusts!)': Administrative & Clerical, Acute.

Staff also suggest more forward planning of recruitment, as well as replacing leavers.

'More thought given to ensure we have adequate numbers of support staff and Administrative support': Senior Manger, PCT

'More staff where needed, because calling an agency, at times is not all that good. More bank staff': HCA, PCT

'More staff and more permanent staff. Permanent staff who have been there a long time should take turns to move around.': Nurse, Acute

'More resources – many nursing staff leaving with vacancies NOT being filled': Nurse, Teaching.

12.2.3 Better pay

Staff would like not only to be more highly paid, but to have their pay better reflect their experience and the level of responsibility they hold.

'A better pay structure': Nurse, Mental Health

'Reward – not in £s – but in days off for long-service staff': Health Visitor, PCT

'Increased pay – have to do on-call to get an average wage': Scientist, Acute

'The hourly rates should be increased to reflect the cost of living and expenses': Support, Teaching.

12.2.4 Workplace facilities

Canteens, social clubs, sports facilities and staff rooms are all suggestions made by London NHS staff.

'Proper staff-only facilities for eating at lunchtimes and breaks': Therapist, Teaching

'AFFORDABLE workplace crèche/nursery': Administrative & Clerical, Acute

'Shower facilities for those of us who cycle to work': Nurse, Acute

'Improved access to staff facilities, sandwiches etc.': Senior Manager, PCT

'An on-site childcare facility': Therapist, Acute

'Secure storage space for bikes': Therapist, Acute.

12.2.5 Communication/meetings

Staff would appreciate being kept up to date about what is going on in their Trust/PCT, particularly regarding future developments. Smoothing communications between different parts of the organisation was seen as important.

'Clearer communication up, down and across the organisation': Nurse, Teaching

'Improved communication with external departments': Therapist, PCT.

Equally importantly, they would also appreciate being listened to, and having their ideas considered.

'sharing of ideas': Nurse, Mental Health

'Much more narrowing of the 'us and them' gap that exists in the NHS': Administrative & Clerical, Teaching

'To influence changes in my area of work': Support, Teaching.

Current approaches to communications within Trusts/PCTs are critiqued by staff:

'If the Trust management team really understood how to communicate effectively. It's not just about issuing staff news letters or consultation documents which then aren't acted on. Don't consult if you then dismiss the views you hear': Senior Manager, PCT

'***Listening*** *to staff, and acting upon it':* HCA, PCT.

12.2.6 Cleaner working conditions/improved hygiene

Many groups of staff, not only those involved with direct patient care, suggest improvements to cleanliness and hygiene in all parts of Trust/PCT buildings, but especially wards and theatres.

'Cleanliness around the hospital, especially the windows': Administrative & Clerical, Teaching

'Terrible working conditions, eg *sewage leaks, ants and mice':* Pharmacist, Acute

'*Cleaner ward areas':* Nurse, Teaching

'Cleaning stair wells and lifts – they are FILTHY': Doctor, Acute

'The cleanliness could be massively improved', Nurse, Teaching.

12.2.7 Better hours

Access and control over shifts, flexi-time, fixed pattern and daytime working were all suggestions for improvements.

'A more "family-friendly" environment/work pattern': Nurse, Mental Health

'*Peak hours of travelling is a nightmare … Flexibility of working hours':* Health Visitor, PCT

'Flexible working shifts or patterns': Nurse, Acute.

12.2.8 Equipment

Better, more up-to-date, safer, more efficient equipment, and equipment with more and useful features, would be welcomed by staff.

'*… access to computerised patient records':* Doctor, Mental Health

'The equipment which is not good, out of date and dangerous must be improved': Support, Teaching

'More up to date equipment – this is 2002 not 1970!': Nurse, Acute

'Not having to keep chasing things that should be in place, eg *consistent good cleaning of work premises, provision of* ***basic*** *equipment,* eg *photocopier, internet link. It's like living in the dark ages at times.':* Therapist, PCT.

12.2.9 Senior management

Regrettably, senior managers in Trusts/PCTs are often seen as remote, unappreciative, patronising, bureaucratic and, occasionally, incompetent. Staff suggestions for improvements rarely suggest

replacing specific individuals, but instead address these concerns regarding the distance between senior mangers and other staff.

'More contact with higher up management and support': Nurse, PCT

'Senior managers who listen and act on concerns of front line staff': Nurse, Teaching

'Feeling that senior managers and directors have time for ***us*** *and the patients, especially at events where their attendance had been confirmed then does not happen, but also on a more day-to-day basis':* Administrative & Clerical, PCT

'*Management to work along with the clinical area':* Nurse, Mental Health

'*More dialogue with higher level of staff':* Nurse, Mental Health

'Management to be more responsive, ie. *when staff shortages':* Nurse, PCT

'The managers to be more in line with the way staff think and work and be work friendly and understanding': Support, Teaching.

12.2.10 Appreciation/recognition

Staff report that their working lives would be improved if they were better valued, that their efforts and skills were rewarded, and would appreciate being thanked for jobs well done.

'To feel valued by management for the work I already do': Therapist, PCT

'To be more appreciated and not just used because we are cheap but reliable with plenty of experience': HCA, Acute

'*Releasing the potential of poorly-paid staff who are skilled but not recognised':* Senior Manager, Teaching

'*I feel that the Trust should try to include part-time staff in all its ideas of practice':* District Nurse, PCT

'Respecting one another more – regardless of rank': HCA, PCT

'If all members of the team (mainly doctors) took time to understand your role within the team and respected the need for therapy for patients': Therapist, Teaching

'Listening to opinions/ideas of lower grades and non-clinical staff': Administrative & Clerical, Teaching.

12.2.11 Variations among groups

Staff working in different types of London NHS Trusts have slight differences in their suggestions for improvement. The 'top ten' for each type of Trust are laid out in Table 12.3. Better working conditions top the list for Teaching, Mental Health and PCTs, and appears in second place for Acute Trusts. Car parking facilities/bike racks only appear on the Acute Trusts list, perhaps reflecting the problem of

Table 12.3: Suggested improvements in Trusts of different types

Acute	Teaching	Mental Health	PCT
More staff (15%)	Better working conditions (15%)	Better working conditions (13%)	Better working conditions (18%)
Better working conditions (14%)	Better pay (14%)	Senior management (12%)	More staff (12%)
Better pay (13%)	Workplace facilities (13%)	Communication/meetings (11%)	Communication/meetings (11%)
Workplace facilities (13%)	More staff (11%)	Better pay (11%)	Workplace facilities (10%)
Car parking facilities/bike racks (10%)	Cleaner working conditions/ improved hygiene (10%)	Workplace facilities (10%)	Better admin/secretarial/ clerical/ITC backup (10%)
Equipment (9%)	Equipment (9%)	More staff (9%)	Better pay (10%)
Cleaner working conditions/ improved hygiene (8%)	Communication/meetings (8%)	Better hours (9%)	Senior management (8%)
Better hours (8%)	Better hours (8%)	Cleaner working conditions/ improved hygiene (8%)	Appreciation/recognition (7%)
Communication/meetings (7%)	Teamwork (7%)	Appreciation/recognition (8%)	Better hours (7%)
Appreciation/recognition (7%)	Appreciation/recognition (7%)	Better admin/secretarial/ clerical/ICT backup (8%)	Equipment (7%)

Source: IES NHS Staff Attitude Surveys, 2002

their locations. Increased teamworking only appears on the Teaching hospitals list. Staff in both Mental Health and PCTs call for improvements to Senior Management, with respondents in Mental Health Trusts placing this quite high in the list of suggested improvements.

Most of the different staff groups call for better working conditions first (see Table 12.4). The exceptions are HCA/Nursing Auxiliary and Support staff, who call for better pay. Increasing the number of staff is the primary request of Qualified Nursing and Midwifery staff, and more staff is a high priority among HCA/Nursing Auxiliary staff, Doctors and Dentists, and Therapy staff.

12.3 Taking the messages on board

London NHS staff are committed to their employers, and can be effective ambassadors for their Trusts/PCTs. For example, 40 per cent say that they 'speak highly of this Trust/PCT to their friends'. Consequently, whatever Trusts/PCTs do to bolster those aspects of working life from which staff take so much enjoyment, will be a worthwhile investment, given that staff invest so much in their work:

> *'I feel like this place is part of my life and other staff I work with like my family':* HCA, PCT

Table 12.4: Suggested improvements by staff groups

Qualified Nursing & Midwifery	Nursing Auxiliary & HCAs	Doctors & Dentists	Therapists & Therapy Support	Pharmacists, Scientists and Technicians	Administrative & Clerical	Senior Managers	Support	Other
More staff (15%)	Better pay (18%)	Better working conditions (15%)	Better working conditions (21%)	Better working conditions (18%)	Better working conditions (18%)	Better working conditions (17%)	Better pay (21%)	Better working conditions (16%)
Better working conditions (12%)	More staff (14%)	More staff (15%)	More staff (15%)	Better pay (16%)	Better pay (16%)	Workplace facilities (16%)	Communica-tion/ meetings (12%)	Better pay (13%)
Workplace facilities (11%)	Communica-tion/meetings (11%)	Workplace facilities (14%)	Better pay (12%)	More staff (15%)	Workplace facilities (11%)	Communica-tion/ meetings (12%)	Senior management (10%)	Workplace facilities (11%)
Better pay (11%)	Workplace facilities (10%)	Cleaner working conditions/ improved hygiene (10%)	Workplace facilities (12%)	Workplace facilities (14%)	Communica-tion/ meetings (11%)	Better admin/ secretarial/ clerical/ICT backup (10%)	Better working conditions (9%)	Senior management (11%)
Better hours (9%)	Equipment (9%)	Better admin/ secretarial/ clerical/ICT backup (10%)	Cleaner working conditions/ improved hygiene (9%)	Cleaner working conditions/ improved hygiene (9%)	Cleaner working conditions/ improved hygiene (10%)	Senior management (9%)	More staff (9%)	Communica-tion/meetings (10%)
Communica-tion/meetings (9%)	Appreciation /recognition (9%)	Equipment (8%)	Equipment (8%)	Car parking facilities/ bike racks (8%)	Appreciation /recognition (8%)	More staff (8%)	Better hours (9%)	Better hours (9%)
Equipment (8%)	Teamwork (8%)	Senior management (8%)	Better admin/ secretarial/ clerical/ICT backup (8%)	Better hours (7%)	Equipment (8%)	Cleaner working conditions/ improved hygiene (7%)	Teamwork (9%)	Appreciation/ recognition (8%)
Car parking facilities/bike racks (7%)	Better hours (8%)	Better hours (7%)	Communica-tion/ meetings (8%)	Communica-tion/ meetings (7%)	Senior management (8%)	Better hours (6%)	Equipment (8%)	More staff (7%)
Appreciation/ recognition (7%)	Cleaner working conditions/ improved hygiene (8%)	Better pay (7%)	Better hours (7%)	Senior management (7%)	More staff (8%)	Better pay (6%)	Appreciation /recognition (8%)	Teamwork (7%)
Cleaner working conditions/ improved hygiene (7%)	Better/more training (8%)	Communica-tion/ meetings (6%)	Senior management (6%)	Appreciation /recognition (7%)	Better admin/ secretarial/ clerical/ICT backup (8%)	Teamwork (6%)	Workplace facilities (7%)	Better/more training (6%)

Source: IES NHS Staff Attitude Surveys, 2002

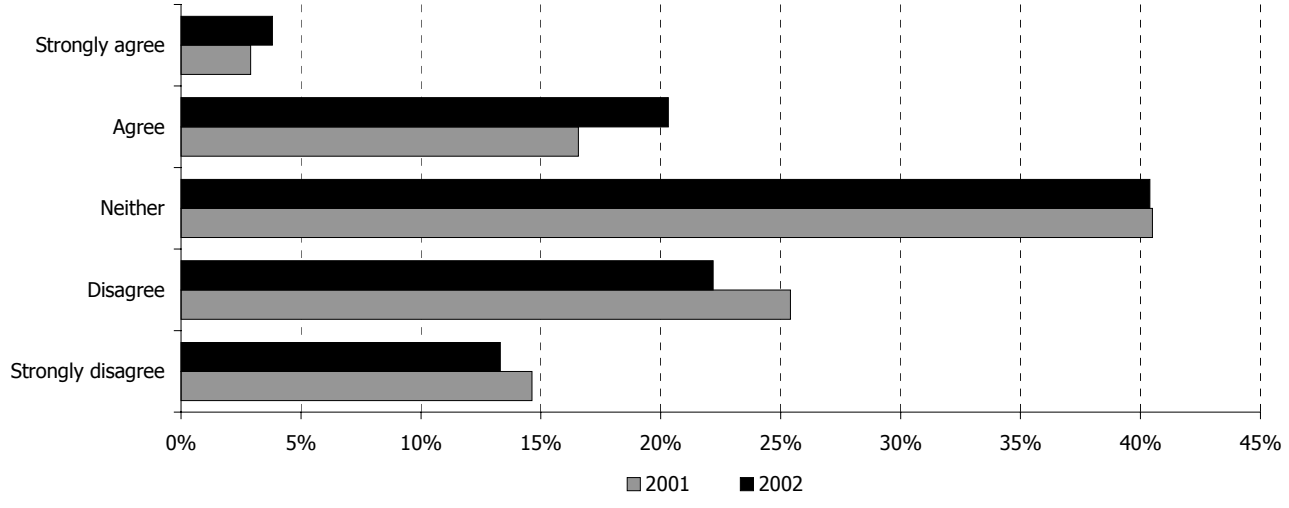
Similarly, though Trusts/PCTs cannot address all of the suggestions for improvement (for example, better pay), there are many suggested improvements which could be actioned at relatively low cost, *eg* demonstrating appreciation/recognition. Sadly, one in three (37 per cent) of staff believe that good suggestions tend to get ignored at their workplace. What is more, consulting staff but not acting on the results can have a demotivating effect.

> *'Staff are often asked for comments but they feel decisions have already been made by senior management':* Senior Manager, PCT.

It is, therefore, encouraging to see that between 2001 and 2002, there was a small improvement in confidence in the QWL opinion survey process. As Figure 12.3 shows, the proportion of staff who agree or strongly agree with the statement: 'I am confident that the results of this survey will be acted upon', has increased. A comparison of the mean score for this statement for 2001 and 2002, shows an increase from 2.7 to 2.8; a statistically significant increase. However, as the mean score is below 3, staff on the whole remain to be convinced that their opinions and suggestions will be taken into consideration.

In conclusion, it will not be sufficient to promote the things about work that staff enjoy, and to enact their suggestions for improvement, although this would be a good start. In addition, Trusts/PCTs must convince staff that their opinions are of value, that making suggestions is worthwhile, and that all staff have an active role to play in shaping the future of their Trust/PCT.

Figure 12.3: 'I am confident that the results of this survey will be acted upon'



Source: IES NHS Staff Attitude Surveys, 2001, 2002