Unions defending and promoting nursing and midwifery: workplace challenges, activity and strategies

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EXECUTIVE SUMMARY

Introduction

In collaboration with RCN and RCM, this research investigates the work, career and union experiences of nurses and midwives in the NHS, the largest employer of women in Europe and one of the most racially/ethnically diverse. Previous research has highlighted career barriers for women and black and minority ethnic workers in the NHS as well as generally deteriorating working conditions for all. Critical issues include pay, job security, working hours, flexible working, career progression, employee engagement and voice, discriminatory practices. This research gives voice to nurses and midwives and provides an evidence base to assist RCN and RCM to improve their understanding of their members' greatest concerns around careers and working conditions and to develop their equality and diversity work.

KEY FINDINGS

Working lives in nursing and midwifery

The findings discussed five major dimensions that define working lives in nursing and midwifery identified by this and previous research: staffing shortages; working hours; low pay and undervaluing; bullying and harassment; equality and inclusion for BAME staff. As shown through direct accounts from nurses and midwives, these dimensions interact and combine to create an extremely testing environment. In general, research participants' accounts painted a picture of two professions experiencing poor morale, low levels of job satisfaction; widespread stress-related ill-health in particular mental health problems; excessive and potentially dangerous workloads; a culture of blame that has to some extent destabilised collegial staff relations; high levels of burnout and intention to quit.

Staffing levels in nursing and midwifery have major implications for working lives: so many of the current challenges currently facing the professions intersect with this fundamental issue. Interviewees described many possible consequences of being continually short-staffed including nurses/midwives retiring as soon as possible, quitting the profession altogether, opting for agency work so as to have less responsibility, high levels of sickness absence, migrant staff leaving for other countries where they believe things will be better. Health and safety risks were another problem exacerbated by staffing shortages and can lead to sickness absence, which compounds the staffing shortages causing the problem.

In context of the pressures created by staffing shortages, bullying and harassment – generally, but particularly of BAME staff – was seen as endemic in the NHS, especially hospitals and other larger workplaces. Reps named it a 'culture' of bullying and harassment because they saw it as normalised to the point where there was some acculturation to it among nurses and midwives, almost acceptance, with staff shrugging off incidents whether emanating from other staff or patients/families as 'just the way it is' which reps believed contributed to under-reporting.

Working hours and work-life-balance are twin issues that also need to be situated within the pressured healthcare context. One of the main topics raised around working hours was the implications for work-life-balance and service delivery of the widespread norm of three 12-hour shifts comprising the standard working week in hospitals and some other healthcare workplaces. In addition to long, busy, tiring shifts, reps reported that many nurses and midwives regularly work through breaks and do unpaid overtime to cover for last minute staffing shortages.

Low pay and undervaluing are longstanding and deeply structural issues that strike at the heart of the professional project within nursing and midwifery. Compared with other public sector professional occupations, nursing and midwifery are certainly not highly paid, although average (median) pay is higher for midwives than nurses. General pay dissatisfaction has become a critical issue in nursing, and to a lesser extent in midwifery. Many nurse participants believed that staff were leaving nursing over pay and with frustration that there has been too little action on the part of government/NHS to redress the issue.

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In view of the negative picture of race/ethnic equality in the NHS England painted by the Workplace Race Equality Standard (WRES), the research focused on this equality dimension in some detail. Reps' on-the-ground experiences typically reflected the national statistics on under-representation of BAME nurses and midwives in senior grades/roles. Part of the problem is that BAME staff may not be as well positioned for promotion because of unequal access to development opportunities and a general lack of recognition of skills and contribution. The often informal or opaque nature of promotion processes and the central role of (white) mentors in career development fuel preferential processes biased both in terms of race and nationality. There was a feeling among some BAME reps that black nurses, particularly ones of a migrant background, often retreat to agency nursing in order to escape the stress of racism in career progression even if it was something they still faced in the everyday. According to reps, feeling like an 'easy target', awareness of inequalities of treatment in disciplinary processes and lack of confidence in procedures among BAME staff leads to under-reporting or late reporting of issues, including discriminatory incidents/treatment. Therefore, as suggested in the above quotation, some reps were of the view that the WRES statistics do not capture the full scale of race and ethnic inequalities of treatment, including racial bullying and harassment, in the NHS and in nursing and midwifery specifically. In addition, many believed that the NHS bullying and harassment policies are not working in all workplaces to protect those most at risk (i.e. BAME staff in the lower bands), including protection against blatant and recurrent forms of racism from patients.

Representing Nursing and Midwifery

The second part of the report looks into the implications for RCN and RCM with regard to how the two professional organisations/unions can work to address the issues and improve the working lives of nurses and midwives. The study confirms some of the difficulties encountered in setting up and maintaining an active network of reps and shop stewards, despite some growth in their number in the two unions. In an ever-pressurized work environment, members seem reluctant to participate in the activities of union branches, let alone taking on additional union responsibilities. As a result, the union representation workload is shifted to a small number of "key" stewards and full-time officers who are under heavy pressure due to crisis conditions in the service.

The research also confirms the absorption of reps' time in problem solving on behalf of individual members, more than meeting and socializing with members collectively, which tends to weaken any form of workplace unionism. The institutionalisation of industrial relations, in particular through the establishment of numerous joint negotiation and consultative committees, reinforces this form of professionalization of trade union activity in the workplace but also at the regional/national level. While the weakening of inter-union rivalries has helped sustain a good partnership at the workplace level, this study highlights certain difficulties, in some workplaces/Trusts, in making consultative and negotiation bodies function properly, particularly due to a lack of staff and resources on both the union and management sides. The study underlines that austerity measures imposed on public services not only have deleterious effects on working and employment conditions, but also on the quality of industrial relations and union representation.

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