Royal College of Nursing Evidence to the NHS Pay Review Body:

Special remit on seven-day services in the NHS
RCN submission to the PRB call for evidence:
Special remit on seven-day services in the NHS

Introduction
The Royal College of Nursing is clear that variations in outcomes and mortality outside core hours are unacceptable and must be addressed. The public have a right to expect that the treatments and care they need will be available to them when needed and in ways that address their individual situations and circumstances. Nursing staff have a vital role to play in meeting these expectations, but it will also mean increased demands for both the current and future workforce. In order to face these demands, nurses and health care assistants must be suitably trained, equipped and supervised as well as adequately remunerated and supported to achieve work-life balance.

Agenda for Change and unsocial hours
RCN members are committed to seven day services and the majority will, over their careers, work unsocial hours, meaning working hours at nights and weekends that the majority of other NHS staff are not required to do, and expect fair compensation for doing so. However the RCN, and many of its members, clearly interpret the focus of this review as a way of dismantling the existing Agenda for Change (AfC) agreement and particularly unsocial hours payments given that the PRB has been invited to make observations on the barriers and enablers within the AfC system, for delivering health care services every day of the week “without increasing the existing spend.” The RCN objects in the strongest terms to any reforms to unsocial hours payments which disadvantage the largest occupational group in the NHS workforce. A review constrained by this requirement does not and cannot address the key issue of how to deliver seven day services.

Nursing staff already provide a seven day service, ensuring that the NHS operates at weekends and nights. As a predominantly female workforce, any attack to pay, terms and conditions is an attack on women, their economic and professional status.

Preliminary polling of RCN members has indicated the strength of feeling on the issue of unsocial hours pay among nursing staff who work shifts, with three-quarters of respondents to one survey and
two-thirds in another survey stating they would seek not to work unsocial hours if payments were removed or reduced.

“Covering unsocial hours is difficult even with unsocial hours pay, but it means there is more flexibility as people are more accepting of working extra nights or weekends to accommodate colleagues’ personal circumstances and special occasions. Allowing flexibility of shifts within a team is good for morale and peer support. I would certainly look for another job if USH was stopped.”

RCN member

“Those of us who can retire now will, thus creating a massive hole in, not only the wealth of experience, but also the numbers that could leave.”

RCN member

Our surveys also revealed the high level of reliance on unsocial hours payments to sustain the standard of living among nursing staff. Three quarters of nursing staff who do shift work are reliant on these payments indicating the profound impact any detrimental change would have on the large occupational group in the NHS.

“Many nurses rely on unsocial payments, if these are to stop they need to look at increasing our pay to compensate.”

RCN member

Nursing staff are currently facing professional and personal challenges due to staff shortages, increased workloads, organisational changes as well as an ever widening gap between earnings and the cost of living due to the combination of public sector pay restraint and austerity policies. While nursing staff are committed to providing high quality seven day care, we would suggest that at a time of great uncertainty and upheaval, imposed changes to workforce terms and conditions would cause even further distress and risk industrial upset. We would also suggest that during a time of acute recruitment problems in the NHS, imposed changes would simply lead to nurses choosing not to work unsocial hours. Any short-term gains from lower non-basic pay bills would quickly be eclipsed by increased agency and bank usage, higher staffing costs and poorer quality of care.

**The definition and scope of seven day care**

The RCN has further concerns, both about the scope and the realistic progress of further provision of seven day care. The RCN has been an enthusiastic participant into a number of workstreams looking at seven day care, the College of Emergency Medicine’s project review of seven day care for people who enter to the health care system via emergency services and the Academy of Medical Royal College’s project to consider how consultants could be made available where needed on a seven days a week basis. However, we are unclear about the definition and scope of seven day services for the purpose of this review. The remit does not make clear whether the intention is to increase activity eg in evenings and weekends or to maintain current levels of activity but spread over seven days. The
terms of reference for this review are therefore confused and do not facilitate an open and transparent review of the issue and instead focus the discussion around pay and not services.

**Current and future challenges**

Further challenges arise from wider, systemic issues chiefly related to resources. Despite extensive efforts and discussions, the NHS has not managed to shift a significant amount of care from acute to community. This is necessary both for the future sustainability of the NHS and for the provision of seven day care. Providing seven day care will require extra resources, not only in acute services, but in community and primary and services in order to create and support the development of a system-wide, integrated approach, as well as an increase in support or ‘back office’ services such as Finance, HR and maintenance. There are also questions about resources relating to securing safe staffing levels. The Francis Report highlighted the importance of such outcomes as care and patient experience and that these outcomes were nurse-led and as such, dependent on safe nursing staffing levels. This is reinforced by international research demonstrating that improved hospital nurse staffing is associated with improved patient outcomes and a decreased risk of mortality. High quality care rests on safe staffing levels.

**Workforce planning**

Seven day care is inextricably linked to workforce planning, and will require detailed consideration of the impact on the whole workforce, in terms of number of staff needed in the short- and medium-terms, skill levels and decision making authority and learning and development needs, the impact of seven day care on psychological, physical and emotional health and on work-life balance including travel and caring responsibilities. The nursing workforce is predominantly female, and a large proportion has caring responsibilities, with many looking after children, grandchildren and other relatives. Flexibility and levels of pay are therefore important factors when nurses and healthcare assistants are making choices about working unsocial hours. Changes to working patterns or pay levels to the detriment of nursing staff are likely to damage recruitment and retention prospects in the NHS.

There are also particular concerns for older workers, who may well be called upon to work more unsocial hours than at present in order to extend seven day care. The RCN has set out concerns in numerous reports and policy documents about the emotional, mental and physical demands of
nursing on older workers including in the submission to the NHS Working Longer Review.¹ This highlighted particular concerns among older nursing staff about working night shifts, a lower tolerance to working 12 hours shifts and the need for longer recovery time between shifts and breaks within shifts. All these factors need to be considered when planning for seven day care, in terms of the impact on the current and future workforce.

As stated above, the terms of reference for seven day care are as yet unclear and the resources available are limited. Due to these constraints, it may well be that seven day care develops in response to local imperatives and reflective of local needs, rather than rolled out in a systematic manner. In either case, the RCN believes that AfC should be retained as a national system, underpinning and supporting any service change. AfC provides a fair, transparent system which aims to ensure that health care staff are properly remunerated for the work they undertake.

**Recommendation**

The imperative for seven day care is the need to address variations in outcomes and mortality and not the need to further reduce the standard of living of the NHS nursing workforce. We call on the PRB to:

- Acknowledge that its own independence has been severely curtailed by the actions of the Department of Health and that years of below inflation pay awards are threatening morale and motivation, retention and recruitment in the NHS
- Clarify the scope of seven day care and the impact on unsocial hours working
- Acknowledge that changes to NHS services should not be made at the expense of the predominantly female nursing workforce and recommend that any changes are carried out based on a commitment by all parties not to make any detrimental changes to terms and conditions
- Acknowledge that unsocial hours payments are an enabler to seven day care as they provide fair compensation for staff for working unsocial hours and disruption to social and family life
- Recognise that the NHS Staff Council is the appropriate place for any negotiations on Agenda for Change terms and conditions
- Acknowledge the complexity of the implications for workforce planning from seven day services; that better data is needed across the UK health and social care systems on key workforce metrics including vacancies, agency and bank use and pay data and that further development of seven day services is not possible without detailed workforce planning to understand the impact on current and future staff.

¹ RCN (2013) *NHS Working Longer Review RCN submission*  
1. What are the services that the NHS would like to be able to provide seven days a week, but which it does not provide at the moment, and why?

1.1 While there is no universally agreed definition of seven day care, or seven day services, the RCN believes that however it is defined, “fundamentally seven day care should be about having access to high quality care in settings most appropriate to the need and circumstance of those individuals using NHS services.”²

1.2 Seven day care is usually considered in the following terms:
   - People admitted to hospitals over the weekend or at public holidays being given equal standards of care to those admitted during the week
   - People accessing emergency care services over the weekend or at public holidays being able to access all of the necessary treatment options, as they would if admitted during the week
   - Integrated care systems, with a focus on older people who are frail, people living with long-term conditions, or those who fall into both groups.

1.3 The taxonomy above indicates the wide scope in the definition of seven day care, and this scope implies wide variations in the type and location of services provided, how patients, clients and their families and carers are affected, the staff involved and the associated cost. Yet the RCN has major concerns about the lack of clarity with which the Department of Health considers to be the scope for seven day care, and which services and professions would be affected. It is not clear whether the intention is to increase activity eg in evenings and weekends or to maintain current levels of activity but spread over seven days. Without this clarity, it is extremely difficult to make a judgment about the scope of seven day care.

1.4 The RCN believes that ‘the public have a right to expect that the treatments and care they need will be available to them when they need them and in ways that address their individual situations and circumstances.’³ However, for this to happen, the UK’s health care systems must facilitate both extra resources and a shift of a sizeable amount of care from acute to community settings. Seven day services requires the creation of ‘system-wide approaches to meeting the needs of an ageing population and creating tailored care packages for the increasing numbers of people with multi-morbidities. Creating and supporting integrated services that can deliver seven day care will need

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² RCN (2014) Seven day care: A briefing for RCN Congress 2014
³ RCN (2014) ibid
sound and strategic planning if we are to deliver safe, effective and person-centred care seven days a week.  

1.5 The Berwick review, published by the Department of Health, recommends that 'healthcare organisations should ensure that staff are present in appropriate numbers to provide safe care at all times'\(^4\) while the Keogh Review of hospital trusts in England concentrated on problems with emergency care, particularly at weekends and at night demonstrating differences in interpretation of seven day care.\(^5\) In order to proceed on further developing seven day services, there must be much greater clarity about the term, better distinction between the impact on elective care and urgent and emergency care and a fuller analysis of the need for integrated care.

2. **What seven-day services/unsocial hours’ services are currently provided and what is the cost differential compared to normal working hours?**

2.1 The terms of reference conflate seven day services with unsocial hours services. It is our understanding that the term seven day services refers to the three models set out in section 1. The term unsocial hours refers to the working patterns and models of remuneration associated with working at weekends, public holidays and nights. The contractual requirement to undertake these hours lies greatest with nurses who have a seven day contract in contrast to other staff groups who have a Monday-Friday 9am-5pm contract. With reference to unsocial hours working, there are different working patterns and models of remuneration between and within different groups of staff.

2.2 The RCN is clear that seven day care is about access to high quality care in settings most appropriate to the need and circumstance of those individuals using NHS services. Unsocial hours working is about the model of working which can facilitate seven day care.

\(^4\) RCN (2014) ibid
3. Which staff groups will be needed to provide the desired seven-day services and what will be the impact on staffing levels on each day of the week? (i.e. what is the model for the workforce?)

<table>
<thead>
<tr>
<th>Levels of service provision</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 0</strong> – <em>Five days a week e.g. Monday to Friday, 9am - 5pm, 8am – 4.pm (routine eight hours service)</em></td>
</tr>
</tbody>
</table>
| **Level 1** – *Monday to Friday at departmental level, extended hours e.g. 8am – 8pm*  
Services limited to one department or a service that is beginning to deliver some services beyond 8am - 6pm Monday to Friday services. This could be extended working days and some weekend services however, does not deliver equitable services irrespective of the day of the week. |
| **Level 2** – *Services are delivered seven days a week, but limited range of services on a Saturday and Sunday*  
Services that are delivered seven days per week, but not always offering the full range of services that are delivered on week days. This limited range of services goes beyond “on call” and emergencies only and facilitates some clinical decision making and discharge, though is likely to be one service and not integrated with other service delivery, (e.g. pharmacy services offering a limited range of services with several staff available, radiology offering weekend lists for inpatients). |
| **Level 3** – *Services offered seven days a week with several departments working together to provide services across the organisation*  
A whole service approach to seven day service delivery that requires several elements to work together in order to facilitate clinical decision making or treatment, often covering more than one workforce group (e.g. stroke services integrating acute stroke clinicians, imaging, specialist nurses, TIA clinics, thrombolysis). |
| **Level 4** – *An integrated seven day service across the organisation*  
A whole system approach to seven day service delivery by integrating the requirements for elements of seven day services across more than one speciality area (e.g. across several departments and services within an acute trust, integration of several services across health and social care to reduce admission to the acute sector). |

Source: NHS Improving Quality (2012) *Equality for all. Delivering safe care - seven days a week*  
[www.gmccsn.nhs.uk/files/5113/5246/5921/NHS_Improvement_-_Equality_for_all_-_Delivering_safe_care_-_seven_days_a_week.pdf](http://www.gmccsn.nhs.uk/files/5113/5246/5921/NHS_Improvement_-_Equality_for_all_-_Delivering_safe_care_-_seven_days_a_week.pdf)

NB: These levels are not intended to be interpreted as levels of progression. For example, some services may only require level 1.

3.1 The box above extends the three step taxonomy set out in section 1 and sets out the five stages of service provision as defined NHS Improving Quality. It is clear that the staff groups needed for seven day care will be dependent on the level of service provision. Levels 3 and 4 describe the most advanced stages of seven day care, yet these cannot be achieved without also extending the support
from other areas such as community and social services, in order to ensure continuous and integrated care throughout the health system, a point which was stressed by the Seven Day Forum. 

3.2 The box above highlights the broad range and depth of services affected by seven day care and also shows the need for staffing decisions to be based on the service being delivered, setting out requirements for capabilities rather than particular ‘staff groups.’ Any decision about seven day care should involve a service specification, from which a whole workforce model can be developed setting the types of disciplines or professions and settings involved, which may include the private sector, charity/voluntary sector social care as well as the NHS.

3.3 The available evidence on seven day care is somewhat limited, usually based on case studies. On the one hand, this makes it difficult to draw general conclusions about the impact of developing seven day services on costs, the workforce, the quality of services and patient experience. On the other hand, the case studies also point to the need to consider seven day services in the context of local requirements and circumstances. Seven day care will be more appropriate in some areas and contexts than others and it would not be appropriate to impose requirements or targets.

4. What are the pay, staffing and motivational barriers and enablers to seven-day services in the NHS? Are there examples of how any of these barriers have been overcome?

4.1 Seven day working is reliant on effective workforce planning which can facilitate both temporal and functional flexibility, ie flexibility in terms of numbers of workers and the functions of those workers. Temporal flexibility is facilitated by the use of part-time working, overtime, shift and on call working while functional flexibility can be facilitated by team working and skill mix adjustments.

4.2 The primary temporal flexibility enabler to seven day nursing services is unsocial hours payments, made to nursing staff who work unsocial hours as part of their normal working week. The payments are in addition to basic pay, are pensionable and are a matter of negotiation at NHS Staff Council level. Meanwhile functional flexibility has been enabled in recent years by nursing staff carrying out an ever increasing range of tasks.

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*NHS England (2013) NHS Services, Seven days a week, Board paper for the NHS England Board*  
4.3 The history of unsocial hours payments for nursing staff demonstrates both the complexity of the issue and the inherent difficulty of developing a system that fairly rewards nursing staff for working unsocial hours while ensuring that these hours are adequately staffed.

4.4 Going back to 1968, the National Board for Prices and Incomes identified difficulties in staffing wards at nights and weekends - a problem compounded by the use of split shifts and insufficient notice for staff of planned duty rosters. It recommended a system of “special rates which directly reward those who work at socially unpopular hours” and that split shifts should no longer be used. This was followed by an independent inquiry into nurses’ pay in 1972 headed by Lord Halsbury which went on to recommend the reduction of the number of special duty payment rates but an increase in their value.

4.5 Under the previous Whitley arrangements, nurses were paid for each unsocial hour worked. If they did not work these hours, they received basic pay. Prior to the introduction of AfC in 2004, unsocial hours payments were not paid on annual leave or sickness absence. This meant that an individual’s pay could fluctuate on a month by month basis dependent upon what unsocial hours and whether they had annual leave or not, a problem which the parties sought to address in the introduction of a new ‘prospective pay’ unsocial hours system within Agenda for Change. However, the negotiations around the unsocial hours payment element of AfC were in turn highly complex and drawn out as all parties struggled to reach a satisfactory agreement.

4.6 The initial Agenda for Change agreement in 2003 contained proposals for a new harmonised system for rewarding staff for working unsocial hours, based on the extent of their commitment to working such hours. This was known as a ‘prospective system’ where people were paid a supplement, the level of which was dependent upon the amount of unsocial hours they were committed to undertake in a month. Assessment of the early implementation stage found ‘evidence of significant difficulties’ in operating the prospective system and concluded that it should not be rolled out and that an interim holding arrangement should be introduced while the NHS Staff Council undertook a review.

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8 National Board for Prices and Incomes (1968) Pay of Nurses and Midwives in the NHS. Report Number 60
9 Since 2013, changes to the Agenda for Change agreement in England mean that unsocial hours payments are no longer paid on sickness absence.
4.7 Following this review, negotiations took place around principles for a new ‘harmonised system’
including the requirement that they ‘provide incentives, not disincentives for staff to work unsocial
hours’ and that ‘staff who commit to working in standard hours, at times of the day and on days of the
week (and at night) should receive enhanced reward. This is to compensate for possible disruption to
their lives outside the workplace. It is also recognition that dedicated NHS staff are providing the
highest possible standards of patient care 24hrs a day and 7 days a week.’

4.8 A final version was agreed in 2008 and remains in place today. In the main, the principles of the
new system mirror the previous Whitley arrangements in that people are paid an enhancement for
work done during set unsocial hours periods. However the new system also enables employers to put
in place a ‘prospective system’ allowing for a consolidated payment to staff based on the percentage
of hours they will be available to work. These systems provide a transparent payment system for
recruiting and compensating staff for working outside of standard hours and responds to a need to
recruit and retain a workforce that is able to deliver services over a seven day working week.

4.9 Seven day care also depends on functional flexibility to ensure a committed, skilled, adaptable
workforce who can respond to change. In turn, this relies on education, training, and opportunities for
career progression and professional development, as well as safe staffing levels. This was underlined
by the Seven Day Forum Review which predicted that challenges to the implementation of seven day
working will include the recruitment and retention of skilled staff, rostering and matching supply of
appropriately skilled workers with demand.\textsuperscript{11} This is the key issue. Even if unsocial hours
enhancements were to be removed or altered there would remain the need to ensure that
appropriately skilled staff were available over the full service.

4.10 There are currently significant barriers to functional flexibility including an over reliance on
agency and bank nursing staff, with NHS Foundation Trusts in England spending £4.3 billion between
2010/11 and 2013/14 on agency and temporary staff and other NHS Trusts spending £1.2 billion in
2013/2014.\textsuperscript{12} Meanwhile, the total expenditure on bank and agency staff across NHS Wales from April
to September 2013 was £22 million, accounting for 1.5% of the total NHS budget.\textsuperscript{13} Other worrying

\textsuperscript{11} NHS England (2013) \textit{NHS Services, Seven days a week, Board paper for the NHS England Board}
\textsuperscript{12} \url{www.parliament.uk/business/publications/written-questions-answers-statements/written-
question/Commons/2014-10-22/211600/}
\textsuperscript{13} RCN Wales (2014) \textit{Update Report February 2014}
indicators from recent RCN employment surveys include limited access to training and continuing professional development (CPD) as well as considerable levels of stress in the workplace, with nursing staff reporting heavy workloads, staff shortages and feeling pressured to work beyond their scope. All of these factors combine to put barriers in the way of ensuring a safe level of staffing.

4.11 Other barriers arise from insufficient investment and commitment to specialist and senior nursing roles, which have seen a reduction of almost 4,000 posts since 2010. Specialist nurses who work in advanced and extended roles often work across organisational boundaries, lead multidisciplinary teams, providing expert knowledge and advice, while senior nurses undertake vital management and leadership, as well as clinical roles. However, many specialist and senior roles are often limited to five day weekday working. In some cases senior nurse deployment in acute areas at weekends is limited as employers are reluctant to pay enhanced rates for this work. However, even if senior nurses were to be deployed at weekends there would still be the need to ensure that there was such senior cover in the week as well. The RCN’s position is that senior nurse leadership must be available across the system of care provision, and that these roles are additional to any nurses assigned to specific patients or to clinical specialist roles. ‘This strengthening of the supervisory role of the nurse leader, across whichever system involved in delivering seven day care, will ensure that team performance is able to be managed across shifts and schedules. This will lead to equity of experience for patients, irrespective of which day or what time of day they receive care.’

4.12 Full consideration also needs to be made of the relationship between shift working and physical and mental health and wellbeing. Shift working is disruptive to family and social life. It is also disruptive to sleep patterns and is associated with a range of adverse physiological and physical symptoms. Some evidence suggests that particular patterns of shift working and types of rotation have worse impacts on health than others, while other research has considered whether shift working has a greater impact on older workers. From this research it is not possible to categorically state that shift work is worse for older age groups than it is generally, but one major and unambiguous finding is that older workers are less tolerant of shifts of twelve hours or more and need longer recovery times. The review goes on to conclude that ‘shift working is not popular and is an important influence on decisions to leave a particular job.’ While it is not usually possible to move to a job with the same employer that does not involve shifts, the need to work unpopular shift patterns can lead to people retiring or moving into other types of work. RCN research conducted in 2008 found that tolerance to

14 Royal College of Nursing (2014) Frontline First. More than just a number.
15 RCN (2014), Seven day care: A briefing for RCN Congress 2014
shift work varies widely, but that between 20 and 25 per cent of people reject and leave shift work at an early stage due to chronic ill health.

4.13 As stated above, shift working is disruptive to family and social life. Different working patterns also require consideration of the other services needed to support their operation. A key consideration will be the necessary transport infrastructure for both staff and patients to get to and from home and any extra costs they might incur.

4.14 The combination of all factors point to the need for robust and rigorous workforce analysis and planning, undertaken alongside, and aligned to, service development plans, adopted on a multidisciplinary basis, in addition to a commitment to education and training. These factors also point to the necessity of key components of the Agenda for Change infrastructure which provides employers with a comprehensive system to develop workforce teams that can deliver seven day care. The job evaluation and the knowledge and skills framework (KSF) provides tools to support multi-professional team working, service modernisation, and fair and equal treatment of staff. The job evaluation scheme measures the responsibilities within jobs and ranks those jobs against existing role, and links job weight to pay. KSF supports staff in their development, and the terms and conditions framework provides flexible rewards in situations where care needs to be structured over a 24/7 structure. Although the framework does not tell employers or staff how to provide the care, it does provide tools to support the development of new job roles and person specifications.  

5. What evidence do you have on the willingness of staff to work on every day of the week? Does willingness vary by staff group, and/or by the availability of premium payments? If so, how?

6. What would be the likely long term impact on recruitment for posts that require seven-day working, compared to posts that do not require seven-day working?

11. What are the pay, staffing and motivational issues and costs around any transition to seven-day service provision?

5.1 Consideration of questions 5, 6 and 11 requires an understanding of the extent of unsocial hours among nursing staff and the demographics of that section of the nursing workforce that undertakes unsocial hours working. There is very little available data in NHS datasets, but analysis of the Labour Force Survey (LFS) and RCN surveys provide a good indication of the scope of unsocial hours working among nursing staff. In general:

- Shift working is more prevalent among nursing staff than the UK working population

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16 RCN (2014) ibid
The incidence of night, evening and weekend working is generally higher among the nursing workforce who work shifts than those working shifts in the general working population. The areas of work in which nursing staff are more likely to work shifts are: critical care, older people’s care, adult general/medical/surgical wards, paediatric wards and in women’s health/midwifery. In critical care, adult and paediatric wards and in women’s health/midwifery, nursing staff are most likely to work on internal rotation than any other type of shift. Shift working is strongly linked to age and seniority, being much more prevalent among younger and more junior nursing staff and consequently it is this group of nursing staff that relies most heavily on unsocial hours payments to sustain their standard of living. The link between shift working and age is also a function of work location, as older nursing staff are less likely to work in acute settings than younger colleagues, tending to favour community settings.

5.2 Looking first at LFS data, this provides an estimate of unsocial hours working among the whole working population and nursing staff. Analysis below shows the high level of shift working among nursing staff.

5.3 Figure 1 indicates that while just 15 per cent of those in employment in the UK undertake some form of shift working; over half of nurses (54 per cent) and nursing auxiliaries and assistants (55 per cent) and two thirds (68 per cent) of midwives work shifts.

5.4 Figure 2 indicates that among all those in employment who undertake shift work, 45 per cent usually work nights, 69 per cent work evenings, 62 per cent work Saturdays, 54 per cent work Sundays and 87 per cent work days. The incidence of night, evening and weekend working is generally higher among the nurses, midwives and nursing auxiliaries and assistants who work shifts than those working shifts in the general working population.

Figure 1: Shift work is done in respondent’s main job

Source: Analysis of Labour Force Survey April-June 2013

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17 Analysis of respondents’ data who indicate they work in the public sector and in occupations as defined by standard occupation classification (SOC) codes 2231 (nurses) and 2232 (midwives) and nursing auxiliaries and assistants (6141)
5.5 This data accords with the data drawn from the RCN Employment Survey conducted in 2009 of 4,787 nursing respondents. This provides an indication of the areas of nursing where shift working is prevalent, as well as the age and job profile of nursing staff who undertake shift working. Among all the nursing staff surveyed, just over half (55 per cent) stated they worked shifts, with a third of these working daytime shifts only, 56 per cent working internal rotation and 11 per cent working permanent night shifts.

5.6 Table 1 suggests that the areas of work in which nursing staff are more likely to work shifts are in critical care, older people’s care, adult general/medical/surgical wards, paediatric wards and in women’s health/midwifery. In critical care, adult and paediatric wards and in women’s health/midwifery, nursing staff are most likely to work on internal rotation.

5.7 If it is the intention to extend seven day working further into emergency and critical care, then it would appear that shift/unsocial hours working is currently widespread and well established among the nursing workforce in these areas of work.
### Table 1: Areas of work and types of working patterns

<table>
<thead>
<tr>
<th>Area of Work</th>
<th>% Working Shifts</th>
<th>% Daytime Shifts Only</th>
<th>Internal Rotation (mix of day &amp; night shifts) %</th>
<th>Permanent Night Shifts %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatric critical care (e.g., ICU, SCUBU, neonates)</td>
<td>92.6</td>
<td>7.1</td>
<td>85.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Adult critical care (e.g., ITU, CCU, A&amp;E)</td>
<td>90.6</td>
<td>16.9</td>
<td>76.5</td>
<td>6.7</td>
</tr>
<tr>
<td>Older people’s nursing</td>
<td>78.7</td>
<td>45.6</td>
<td>33.1</td>
<td>21.3</td>
</tr>
<tr>
<td>Adult general/medical/surgical</td>
<td>78.2</td>
<td>28.9</td>
<td>59.1</td>
<td>12.0</td>
</tr>
<tr>
<td>Rehabilitation/longer term care</td>
<td>75.7</td>
<td>40.0</td>
<td>49.4</td>
<td>10.6</td>
</tr>
<tr>
<td>Paediatric general</td>
<td>72.4</td>
<td>15.5</td>
<td>76.1</td>
<td>8.5</td>
</tr>
<tr>
<td>Women’s health/midwifery</td>
<td>63.4</td>
<td>22.7</td>
<td>59.1</td>
<td>18.2</td>
</tr>
<tr>
<td>Mental health</td>
<td>51.1</td>
<td>31.4</td>
<td>58.6</td>
<td>10.1</td>
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<tr>
<td>Learning disabilities</td>
<td>49.4</td>
<td>39.1</td>
<td>52.2</td>
<td>8.7</td>
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<tr>
<td>Oncology/palliative care</td>
<td>47.6</td>
<td>25.7</td>
<td>61.9</td>
<td>12.4</td>
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<tr>
<td>Community care</td>
<td>23.2</td>
<td>74.3</td>
<td>8.6</td>
<td>17.1</td>
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<tr>
<td>Primary care</td>
<td>19.2</td>
<td>60.7</td>
<td>29.3</td>
<td>9.9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>54.8</strong></td>
<td><strong>32.9</strong></td>
<td><strong>55.7</strong></td>
<td><strong>11.4</strong></td>
</tr>
</tbody>
</table>

Source: RCN Employment Survey 2009

5.8 Figures 3 and 4 clearly show the higher incidence of shift working among younger nursing staff, with over half of those aged 20-39 working shift patterns. Among staff aged under 40 who work shift patterns, the majority work on internal rotation shifts. Just over half (53 per cent) of nursing staff aged under 29 who undertake shift work reported working 12 hour shifts, compared to just under half (43 per cent) of those aged 30 to 44 and around a third of those aged over 44.

5.9 Figures 5 and 6 go on to show that shift working is inversely related to seniority, with nursing staff in bands 1 to 5 more likely to work shifts than those in bands 7 to 9. It appears that among those nurses employed on bands 7 to 9 who do work shifts, they are as likely to work rotational patterns as daytime shifts.

5.10 There are clear differences in the demography of the current nursing workforce depending on whether or not staff work shifts. This is primarily due to senior nurses not being eligible for unsocial hours payments and older nursing staff seeking to affect their work-life balance. Any extension of seven day care will need careful workforce planning which seeks to fully understand and take account of working preferences and restraints.
Figure 3: Working patterns by age

Source: RCN Employment Survey 2009

Figure 4: Types of shift worked by age

Source: RCN Employment Survey 2009
**Figure 5: Length of shift worked by age**

![Bar chart showing length of shift worked by age](chart5.png)

Source: RCN Employment Survey 2009

**Figure 6: Working patterns by Agenda for Change pay band**

![Bar chart showing working patterns by Agenda for Change pay band](chart6.png)

Source: RCN Employment Survey 2009
5.11 Using data from the Health and Social Care Information Centre for England, it is estimated that 61 per cent of qualified nursing, midwifery and health visiting staff in England receive shift payments, at an average of £3,875 per year. Average total earnings for all qualified nursing, midwifery and health visiting staff are £30,769, with shift payments accounting for 7.7 per cent of total earnings. However, it should be noted that this is an average figure for all qualified, nursing, midwifery and health visiting staff in bands 5 to 9 and that it includes all additional payments including on call, any redundancy payments, and geographical allowances such as London weighting. Equivalent data is not available for Wales.

5.12 A closer look at HSCIC data shows the prevalence of shift working according to area of work and job title. Figure 8 shows 88 per cent of neonatal nurses, 78 per cent of qualified nursing staff working in maternity services, 70 per cent of paediatric nurses, 69 per cent of nurses working in other learning disability settings than community and 67 per cent working acute, elderly and general settings receive shift payments. Meanwhile figure 9 shows that two thirds of district nurses, and the majority of children’s nurses and midwives receive shift payments.
Figure 8: Shift payments according to area of work (qualified nursing, midwifery and health visiting nurses)

Source: Health and Social Care Information Centre

Figure 9: Shift payments according to job title (qualified nursing, midwifery and health visiting nurses)

Source: Health and Social Care Information Centre
5.13 It is estimated that 43 per cent of staff providing support to doctors and nurses in England (which includes health care assistants) receive shift payments, averaging £3,222. Average total earnings for all staff providing support to doctors and nurses are £17,679, with shift payments accounting for 7.1 per cent of total earnings.

5.14 A 2014 union membership survey asked respondents working in the NHS about whether they relied on additional Agenda for Change payments to sustain their standard of living. Figure 3 above indicated that shift working is more prevalent among younger nursing staff and Figure 9 goes on to show the importance of unsocial hours payments among this group of staff, with three quarters of nursing staff aged under 30 and well over half (58 per cent) of those aged 31-40 stating they rely on these payments.

5.15 As shown above, there is a strong inverse link between shift working and seniority and again this is confirmed in Figure 10, which shows that around two thirds of nursing staff in AfC bands 1-5 are reliant on unsocial hours payments to sustain their standard of living, compared to two fifths of staff in band 6, a quarter of those in band 7 and just nine per cent in bands 8 and 9.

Figure 9: Respondents who rely on unsocial hours payments to sustain their standard of living according to age

Source: 2014 Joint union survey on pay and conditions (Analysis of responses from nursing staff)
Figure 10: Respondents who rely on unsocial hours payments to sustain their standard of living according to Agenda for Change band

<table>
<thead>
<tr>
<th>Agenda for Change bands</th>
<th>8 and 9</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>1-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rely on unsocial hours payments</td>
<td>8.9</td>
<td>25.1</td>
<td>40.6</td>
<td>67.7</td>
<td>62.2</td>
</tr>
<tr>
<td>Do not rely on unsocial hours payments</td>
<td>91.1</td>
<td>74.9</td>
<td>59.4</td>
<td>32.3</td>
<td>37.8</td>
</tr>
</tbody>
</table>

Source: 2014 Joint union survey on pay and conditions (Analysis of responses from nursing staff)

5.16 The survey asked about the likely impact of any cuts to the level of unsocial hours payments. Three quarters (74 per cent) of all respondents stated they would seek not to work unsocial hours while two thirds (67 per cent) stated it would damage their work-life balance and half said that they would leave the NHS.

5.17 Table 5 shows that across all nursing reliant on unsocial hours payments, staff aged 31-40 are most concerned about the impact of removal on childcare costs caring responsibilities and their work-life balance, while staff aged 21-30 are most worried about the impact on travel costs.

Table 2: Impact of removal of unsocial hours payments according to age

<table>
<thead>
<tr>
<th>Age group</th>
<th>No impact %</th>
<th>Increase childcare costs %</th>
<th>I would have to reorganise caring responsibilities %</th>
<th>Increase travel costs %</th>
<th>I would leave the NHS %</th>
<th>It would damage work-life balance %</th>
<th>I would seek not to work these hours %</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>0.6</td>
<td>14.5</td>
<td>14.2</td>
<td>21.4</td>
<td>49.7</td>
<td>73.9</td>
<td>73.9</td>
</tr>
<tr>
<td>31-40</td>
<td>2.0</td>
<td>21.0</td>
<td>20.6</td>
<td>15.8</td>
<td>52.3</td>
<td>71.7</td>
<td>73.1</td>
</tr>
<tr>
<td>41-50</td>
<td>2.0</td>
<td>8.6</td>
<td>14.4</td>
<td>15.6</td>
<td>50.1</td>
<td>66.7</td>
<td>73.8</td>
</tr>
<tr>
<td>51+</td>
<td>2.6</td>
<td>2.1</td>
<td>7.9</td>
<td>14.5</td>
<td>47.9</td>
<td>60.6</td>
<td>74.6</td>
</tr>
<tr>
<td>All</td>
<td>2.0</td>
<td>10.0</td>
<td>13.7</td>
<td>16.2</td>
<td>49.8</td>
<td>66.8</td>
<td>73.6</td>
</tr>
</tbody>
</table>

Source: 2014 Joint union survey on pay and conditions (Analysis of responses from nursing staff)

5.18 Data from the Family and Childcare Trust shows that most childcare costs have risen by between 8 and 30 per cent since 2010 (table 3) in England and by between 18 and 32 per cent in Wales (table 4). Additional data from the Northern Ireland Childcare Cost Survey 2013 shows the relatively high
costs of childcare in that country (table 5). The Family and Childcare Trust report goes on to model costs for a single earner with a salary of £31,000, who would receive just £994 help with childcare costs through working tax credit and expected to contribute £8,886 or 28.7 per cent of gross income to pay for childcare. This shows the high costs already borne by parents, and that any increase in costs due to change in circumstances would have a detrimental impact on nursing staff.

Table 3: Average weekly childcare costs in England, 2014

<table>
<thead>
<tr>
<th></th>
<th>Cost per week</th>
<th>Change 2013-2014</th>
<th>Change 2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery 25 hours (under 2 years old)</td>
<td>£110.95</td>
<td>2.2%</td>
<td>26%</td>
</tr>
<tr>
<td>Nursery 25 hours (2 and over)</td>
<td>£106.19</td>
<td>0%</td>
<td>30%</td>
</tr>
<tr>
<td>Childminder 25 hours (under 2)</td>
<td>£100.74</td>
<td>1.7%</td>
<td>21%</td>
</tr>
<tr>
<td>Childminder (2 and over)</td>
<td>£101.51</td>
<td>4.4%</td>
<td>22%</td>
</tr>
<tr>
<td>After-school club 15 hours</td>
<td>£48.40</td>
<td>-2.6%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Source: Family and Childcare Trust Childcare Costs Survey 2014

Table 4: Average weekly childcare costs in Wales, 2014

<table>
<thead>
<tr>
<th></th>
<th>Cost per week</th>
<th>Change 2013-2014</th>
<th>Change 2010-2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery 25 hours (under 2 years old)</td>
<td>£103.17</td>
<td>2.2%</td>
<td>32%</td>
</tr>
<tr>
<td>Nursery 25 hours (2 and over)</td>
<td>£102.28</td>
<td>0%</td>
<td>29%</td>
</tr>
<tr>
<td>Childminder 25 hours (under 2)</td>
<td>£94.24</td>
<td>1.7%</td>
<td>19%</td>
</tr>
<tr>
<td>Childminder (2 and over)</td>
<td>£94.24</td>
<td>4.4%</td>
<td>18%</td>
</tr>
<tr>
<td>After-school club 15 hours</td>
<td>£45.98</td>
<td>-2.6%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Source: Family and Childcare Trust Childcare Costs Survey 2014

Table 5: Average weekly childcare costs in Northern Ireland, 2013

<table>
<thead>
<tr>
<th></th>
<th>Cost per week</th>
<th>Change 2012-2013</th>
<th>Change 2010-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursery (full-time)</td>
<td>£154</td>
<td>-1.9%</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Childminder (full-time)</td>
<td>£161</td>
<td>6.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>Nursery (25 hours)</td>
<td>£127</td>
<td>Average 1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>Childminder (2 and over)</td>
<td>£107</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>After-school club</td>
<td>£84</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Source: Northern Ireland Childcare Cost Survey 2013

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18 Employers For Childcare Charitable Group, Northern Ireland Childcare Cost Survey 2013
19 Family and Childcare Trust, Childcare Costs Survey 2014
www.familyandchildcaretrust.org/childcare-costs-surveys
5.19 Table 6 shows that men are slightly more likely than women to state they would either seek not to work unsocial hours or leave the NHS if payments were removed.

Table 6: Impact of removal of unsocial hours payments according to sex

<table>
<thead>
<tr>
<th>Sex</th>
<th>No impact</th>
<th>Increase childcare costs</th>
<th>I would have to reorganise caring responsibilities</th>
<th>Increase travel costs</th>
<th>I would leave the NHS</th>
<th>It would damage work-life balance</th>
<th>I would seek not to work these hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>2.2</td>
<td>10.5</td>
<td>14.0</td>
<td>15.8</td>
<td>48.5</td>
<td>66.5</td>
<td>72.9</td>
</tr>
<tr>
<td>Men</td>
<td>1.2</td>
<td>8.0</td>
<td>12.6</td>
<td>18.7</td>
<td>57.4</td>
<td>69.3</td>
<td>77.6</td>
</tr>
<tr>
<td>All</td>
<td>2.0</td>
<td>10.0</td>
<td>13.7</td>
<td>16.2</td>
<td>49.8</td>
<td>66.8</td>
<td>73.6</td>
</tr>
</tbody>
</table>

Source: 2014 Joint union survey on pay and conditions (Analysis of responses from nursing staff)

Table 7: Impact of removal of unsocial hours payments according to Agenda for Change pay band

<table>
<thead>
<tr>
<th>AfC pay bands</th>
<th>No impact</th>
<th>Increase childcare costs</th>
<th>I would have to reorganise caring responsibilities</th>
<th>Increase travel costs</th>
<th>I would leave the NHS</th>
<th>It would damage work-life balance</th>
<th>I would seek not to work these hours</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>1.5</td>
<td>9.2</td>
<td>15.4</td>
<td>21.5</td>
<td>56.2</td>
<td>72.3</td>
<td>64.6</td>
<td>4.5</td>
</tr>
<tr>
<td>5</td>
<td>1.4</td>
<td>11.4</td>
<td>13.5</td>
<td>16.8</td>
<td>51.8</td>
<td>66.0</td>
<td>72.5</td>
<td>37.9</td>
</tr>
<tr>
<td>6</td>
<td>2.6</td>
<td>10.4</td>
<td>15.2</td>
<td>15.7</td>
<td>48.0</td>
<td>70.2</td>
<td>78.7</td>
<td>28.5</td>
</tr>
<tr>
<td>7</td>
<td>4.2</td>
<td>6.2</td>
<td>10.4</td>
<td>13.5</td>
<td>41.3</td>
<td>62.5</td>
<td>73.0</td>
<td>22.1</td>
</tr>
<tr>
<td>8-9</td>
<td>0.0</td>
<td>3.4</td>
<td>24.1</td>
<td>17.2</td>
<td>37.9</td>
<td>62.1</td>
<td>75.9</td>
<td>7.0</td>
</tr>
<tr>
<td>All</td>
<td>2.0</td>
<td>10.0</td>
<td>13.7</td>
<td>16.2</td>
<td>49.8</td>
<td>66.8</td>
<td>73.6</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: 2014 Joint union survey on pay and conditions (Analysis of responses from nursing staff)

5.19 The survey also looked at the working pressures on those nursing staff who work unsocial hours. Of those respondents stating they rely on unsocial hours payments to sustain their standard of living, the majority (97 per cent) state that in addition they also worked beyond their contracted hours with over three quarters (79 per cent) stating they do so frequently or always in a typical week. Two fifths (43 per cent) stated that additional hours working is usually unpaid and almost a quarter (23 per cent) reported that they usually get time off in lieu.

5.21 This indicates the high incidence of working beyond contracted hours, and particularly unpaid working, among nursing staff working unsocial hours. Nursing staff indicate that they mainly work additional hours because it would be impossible to do their job and provide the best care possible otherwise, to catch up on paperwork and to cope with staff shortages. As the quotes show in Box 1, many nursing staff already feel aggrieved about the amount of additional hours they work often unpaid, and

5.22 A further survey of conducted by RCN representatives among 362 members found that the majority (both those who do undertake shift work and those who do not) feel that unsocial hours pay is important to compensate for the inconvenience of working unsocial hours. Furthermore, the
majority of those who undertake shift work rely on unsocial hours payments to make ends meet and would look for another job if payments were stopped.

Table 8: Shift pay compensates for the inconvenience of working unsocial hours

<table>
<thead>
<tr>
<th></th>
<th>Work shifts %</th>
<th>Work ‘office hours’ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>83.7</td>
<td>75.3</td>
</tr>
<tr>
<td>Agree</td>
<td>12.5</td>
<td>14.0</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>2.7</td>
<td>6.5</td>
</tr>
<tr>
<td>Disagree</td>
<td>0.0</td>
<td>3.2</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Source: RCN representatives survey on unsocial hours payments

Table 9: Attitudes to unsocial hours payments among nursing staff who undertake shift work (n=266)

<table>
<thead>
<tr>
<th></th>
<th>I rely on unsocial hours payments to make ends meet %</th>
<th>If unsocial hours payments were stopped I would look for a different job %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly agree</td>
<td>73.3</td>
<td>62.6</td>
</tr>
<tr>
<td>Agree</td>
<td>18.9</td>
<td>20.2</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>5.8</td>
<td>12.8</td>
</tr>
<tr>
<td>Disagree</td>
<td>2.1</td>
<td>3.7</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>0.0</td>
<td>0.8</td>
</tr>
</tbody>
</table>

Source: RCN representatives survey on unsocial hours payments

Figure 11: How often do you work in excess of your contracts hours (respondents who undertake shift work) n=266

Source: RCN representatives survey on unsocial hours payments
The survey also asked respondents to provide more information about unsocial hours working. The comments given have been grouped in themes. Several members gave feedback that they were already working hard and often working over their contracted hours.

**Box 1: Working over contracted hours**

“Many staff who work in the NHS already subsidise their employers by working unpaid overtime because they care for their patients. Although the NHS is a 24 hour, 7 days a week 365 days a year, it is not a reason why people who work in it should be expected to be paid basic pay for unsocial hours.”

“I came into nursing profession with the realisation that sometimes the job lends itself that you just can’t leave on time. Working within the setting I do this is more so, however due to staff levels and sickness these excess hours are a regular occurrence and considered the norm. Unfortunately I feel our goodwill is being taken to the extreme.”

Many members viewed unsocial hours payments as fair compensation for working weekends and nights and that any detrimental change would have an impact on recruitment and retention.

**Box 2: Recruitment and retention**

“I provide 24hr care to vulnerable patients who without us would not be able to be seen in their home. A cut to unsocial hours pay would make a lot of nurses leave the service and recruitment would also be affected which in turn would affect the quality of care provided. Not many people choose to work the hours we do they are called unsocial for a reason and the pay should reflect this. We are over stressed, undervalued and work beyond our contracted hours as it is, often working in the middle of the night alone. The pay needs to reflect what we do and the responsibility we have.”
“Covering unsocial hours is difficult even with USH, but it means there is more flexibility as people are more accepting of working extra nights or weekends to accommodate colleagues’ personal circumstances and special occasions. Allowing flexibility of shifts within a team is good for morale and peer support. I would certainly look for another job if USH was stopped.”

“I have an extensive experience of working as a HCA in different hospitals and most, especially the busiest ones, are permanently short of staff. Flat payment is going to make the situation even more difficult.”

“As a manager, I would find it increasingly difficult to cover additional hours that cover is required for. ‘Goodwill’ keeps the NHS running. It would be instantly lost with this change.”

“If unsocial hours are made compulsory without extra payment I will bring forwards my retirement by 5 years.”

“Those of us who can retire now will, thus creating a massive hole in, not only the wealth of experience, but also the numbers that could leave.”

Other members predicted that detrimental changes would damage morale and motivation among nursing staff.

**Box 3: Morale and motivation**

“Nursing pay is by no means acceptable in this day for what is required of us. We have more an extended nursing role than ever before and pressures are ever increasing. Seldom are we out on time and the overtime and breaks we do not take are already unpaid. I can foresee a surge of our nursing workforce moving abroad and elsewhere where pay and conditions are better. I also foresee a decline in job satisfaction thus care standards will drop dramatically as a result.”

“Shifts/off duty is already difficult to do but knowing you aren’t even going to get paid for the nights etc would mean they would be difficult to cover and I think would cause friction between staff.”
Several members pointed to the impact that unsocial hours working has on health and work-life balance and that extra payment is due compensation.

**Box 4: Health and work-life balance**

“The physiological impact of night time working on wellbeing and life expectancy is well evidenced and well documented. Healthcare workers should be compensated for this in a targeted way. Paying enhancements achieves this.”

“Night working especially is not only unsociable but not good for your health either so having the little extra pay makes things a little more bearable.”

“I would simply find a nursing/healthcare job from 9-5pm. Why should I sacrifice family/home life for no remuneration?”

“Working these hours means working when it’s dark, working alone and working while the majority of workers are at home having family time.”

“Working these hours interferes with my physical, social and psychological well being affecting not only myself but my family too. The slight financial benefit makes things a little easier. Staff will refuse to work unsociable hours if there are no enhancements.”

Another common theme was a feeling that nursing staff have already been subject to a pay freeze and that any further detrimental impact would be a step too far.

**Box 6: Low pay in the nursing profession**

“Our pay is low enough. If we are forced to work weekends and unsocial hours with no incentive I consider this to be yet another lack of care of NHS staff. The NHS has run on goodwill for a long time but times are tough and everyone has to consider their worth and the ability to provide a standard of living for themselves and their families.”

“The pay rise for this year is derisory particularly on the lower paid staff members. To take away enhancements for unsocial hours is grossly unfair and adds to the feeling among the hardworking staff of being undervalued while providing essential care.”

“Many nurses rely on unsocial payments, if these are to stop they need to look at increasing our pay to compensate.”

“Nurses are paid a humiliatingly low salary. Unsocial hours and extra bank shifts are the only way to make ends meet and to start paying bills.”
As set out above, a large proportion of nursing staff working shifts rely on unsocial hours payments to sustain their standard of living and any reduction or removal would have a large financial impact.

Box 7: Financial impact of reduction/removal of unsocial hours payments

“Working unsocial hours is bad for your physical, emotional and psychological health especially when coupled with the stresses of NHS life. The risk is bad enough without involving financial stress too by removing 'compensatory' pay. Removing incentives will result in inconsistent cover, lower standards... and ironically greater cost to the NHS by feeding external staffing agencies...which seems to be its perpetual cyclical fate.”

“I would not be able to afford to live if it were not for the enhancements. I took a huge pay cut to work for the NHS as I really want to do my nursing degree but it is being made harder and harder to achieve.”

“It’s unlikely that I would look for another job, because I’m approaching 60 and don’t think I would find one. However, I have always worked shifts and the enhanced hours are part of my pay and conditions. A change would very much affect my income and pension.”

“Working unsocial hours means we take time away from our own family and friends to look after others. Working nights days and weekends often leaves us feeling exhausted. The extra money for unsocial hours is often only enough to cover the cost of bills.”

“If people in the retail sector don’t get compensated the same as the NHS - that is not the fault of NHS staff who have spent many years working to get a decent wage. They should aspire for what we have.”

“I have chosen to work office hours to balance work and home - the loss of USH is the price I paid. I strongly oppose any cuts to USH as this will affect recruitment and retention. Nurses feel they are not valued and terms and conditions are under constant threat.”

“Any reduction in USH would disproportionately disadvantage nursing staff. No doubt reductions are sought to help fund higher paid professions to move to 24/7 working. We must resist any attempt to this given the significant pay reduction.”

Summary

5.23 This section has gone some way to demonstrate the complexity of working patterns in the NHS, and the motivations and preferences of nursing staff who do and do not work shifts. Yet this only goes some way to describe the picture. Much more analysis is required to answer the questions posed around the willingness of staff to work every day week, the impact on recruitment and retention, pay staffing and motivation of transition to seven day care. The RCN would point out that failure to understand these labour market considerations and make contractual changes could well lead to nursing staff simply choosing not to work unsocial hours. In turn this would lead to increased agency and bank use and push up wage costs.

5.24 The nursing workforce is predominantly female, and a large proportion has caring responsibilities, looking after children, grandchildren and other relatives. Flexibility and levels of pay are therefore
important factors when nurses and healthcare assistants are making choices about working unsocial hours. Changes to working patterns or pay levels to the detriment of nursing staff are likely to damage recruitment and retention prospects in the NHS.

7. What are the implications of equality policies and legislation for seven-day working?

7.1 The RCN sees the most important factor in terms of the impact on seven day care being the need to ensure that data monitoring and analysis is improved. It would be necessary to improve data collection in order to assess whether there is a differential impact on sections of the workforce. The RCN is not confident that the breadth and depth of workforce data collection and analysis currently allows meaningful monitoring of a change of policy and assessment of whether the impact has been disproportionate among certain members of the workforce.

8. What evidence can be provided on the impact for patients of seven-day services?

8.1 There is a strong body of national and international evidence showing the higher risk of mortality from being admitted to hospital in the weekend. NHS England go on to argue that lack of seven day services has an adverse effect not only on mortality, but all five outcomes in the NHS outcomes domain; mortality amenable to health care, treatment of long term conditions, outcomes from acute episodes of care, patient experience and patient safety. Most evidence in this area concludes that a weekday model of care has significant impact on 30 day mortality. While there may be statistical confounders associated with these findings as people may wait till the weekend before seeking help, it is likely that most of the explanation can be attributed to system and infrastructure factors such as the lack of availability of diagnostic and specialist interventions over the weekend, as well as the reduction in staff, the reliance on less experienced staff and the increase in staff stress over the weekend.

8.2 While patient safety is a clear issue, the Francis Report also highlighted the wider impact on patients the current models of weekend care can have, stating that: “This feeling of vulnerability is exacerbated at weekends and holiday times, when the staff absences and shortages are more

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noticeable to patients.”

The report highlighted the importance of such outcomes as care and patient experience and that these outcomes were nurse-led and as such, dependent on safe nursing staffing levels.

8.3 This is reinforced by international research demonstrating that improved hospital nurse staffing is associated with improved patient outcomes and a decreased risk of mortality. For example, the RN4CAST study showed that variation in hospital mortality is associated with differences in nurse staffing levels and educational qualifications. This study by Aiken and colleagues provides evidence in favour of appropriate nurse-patient ratios and also provides support for graduate education for nurses. Meanwhile Krueger et al point to the range of evidence which shows the improvements seen in nurse productivity and patient outcomes of improved nurse staffing including: a reduction in failure to respond; decreased length of stay; reduced incidence of MRSA; a positive correlation between staffing levels and in-hospital mortality; reduced staff turnover; improved patient satisfaction and improved staff satisfaction.

9. How has the demand for the delivery of seven-day services altered in recent years and what are the reasons for this? How do you see the demand for seven-day services changing in the future both in terms of changing patients’ demographics and the additional choices that seven-day services would give to patients?

9.1 The need for seven day services was highlighted by the Francis enquiry which among other things, highlighted the risks to care of low staff levels during the weekend. However, the Francis report was certainly not the first to highlight the problems with weekend care and it mainly served to accentuate the growing demand for seven day services. For example, in 2011 Dr Foster Intelligence published findings showing that mortality in NHS Trusts was higher in the weekend, and attributed this risk to lack of consultant-grade presence.

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27 Francis, R (2013) ibid
28 Dr Foster Intelligence (2011) ibid
9.2 The Keogh Mortality Review was published as a response to the Francis Report, and reviewed 14 Trusts with persistently high mortality rates. The Review added to the growing weight of evidence of seven day care by finding that treatment of emergency patients was especially worse at the weekend and nights. Importantly, it also found that there were low numbers of nursing staff in combination with an overreliance of temporary nursing staff in wards at night and at the weekend. This highlighted the inextricable link between seven day care and other salient issues such as nurse staffing numbers and continuous training. The Keogh Review led to a report by NHS England stating that the NHS should move to provide routine care seven days a week.

9.3 Following the Keogh Review, the Seven Day Forum was established to provide evidence and insight to commissioners and health care providers to implement seven days a week NHS routine services. The forum established five thematic work streams to explore issues critical to the delivery of seven day working.

1. Clinical standards
2. Workforce and organisation
3. Finance and costing
4. Incentives, rewards and sanctions
5. Service Models

9.4 One of the major recommendations of the forum was for the NHS to adopt ten evidence based clinical standards by 2016/17 to end variations for patients admitted to hospital over the weekend. The NHS England Board accepted all recommendations and indicated that it will use all its commissioning tools and levers to implement this and has secured the support of Health Education England (HEE) and the Care Quality Commission (CQC).

9.5 The Royal College of Physician’s ‘Future Hospitals’ commission was another major catalyst to the discussion of seven day care. The report looked at best practice in five areas:

1. Organisation of medical care and teams
2. Education, training and deployment of medical staff
3. Building a culture of compassion and respect
4. Management, economics and leadership
5. Information systems

9.6 Seven day care is seen as an essential component of a new model of delivering care, and interlinked with the notion of meeting rising needs and expectations of the UK population, providing continuous care along the patient pathway and delivering first-class patient experience.

10. What is the underlying cost model for the delivery of seven-day services? What would be the costs and savings?

N/A