

Nurses over 50

Options, decisions and outcomes

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Introduction

Individuals' decisions to retire and remain in retirement or to re-enter the workforce are influenced by available working options, the existing labour market and income conditions (Hirsch, 2000). A single transition from work to retirement at a standard retirement age is no longer the norm. There has now been a shift towards a transition from full-time work to no employment at an earlier age than in previous years, when it was more common to work to the state retirement age of 65 for men and 60 for women (Phillipson, 1998). Notwithstanding the forthcoming extension of the state retirement age for women to 65 in order to comply with European legislation, it is common for men and women to cease employment at anything from 50 onwards (Phillipson, 1998). This, of course, means that people are leaving the labour market with many active years of life before them; they often seek alternative occupation, if not actual employment, and the whole notion of retirement is challenged as a result.

The research project reported here was commissioned by the Joseph Rowntree Foundation (JRF) under its 'Transitions after 50' research programme, which addresses the issues facing society, including employers, as people make decisions about full-time employment any time beyond the age of 50. Research for the programme has addressed issues such as what are the employment options, what is the reality of life outside the labour market and what are the financial and social implications of retiring at or after 50 (Hirsch, 2000; Bardasi and Jenkins 2002; Barnes et al, 2002; Mooney et al, 2002).

In order to address some of these issues, against a specific background of the current crisis in staffing the NHS with nurses (which may eventually have an adverse effect on the independent sector, which lies outside the NHS) (Watson and Manthorpe, 2000), this project sought to explore the options, decisions and outcomes for nurses over 50 as a means of shedding light on aspects of employment transitions more generally. The project, conducted at the University of Hull, took a UK perspective on nurses over 50 by involving nurses in three categories:

- those who were currently employed by and remained in the NHS;
- those who were outside the NHS working elsewhere, for example, the private sector, or not working; and
- those who had returned to NHS employment after a career break or were considering returning.

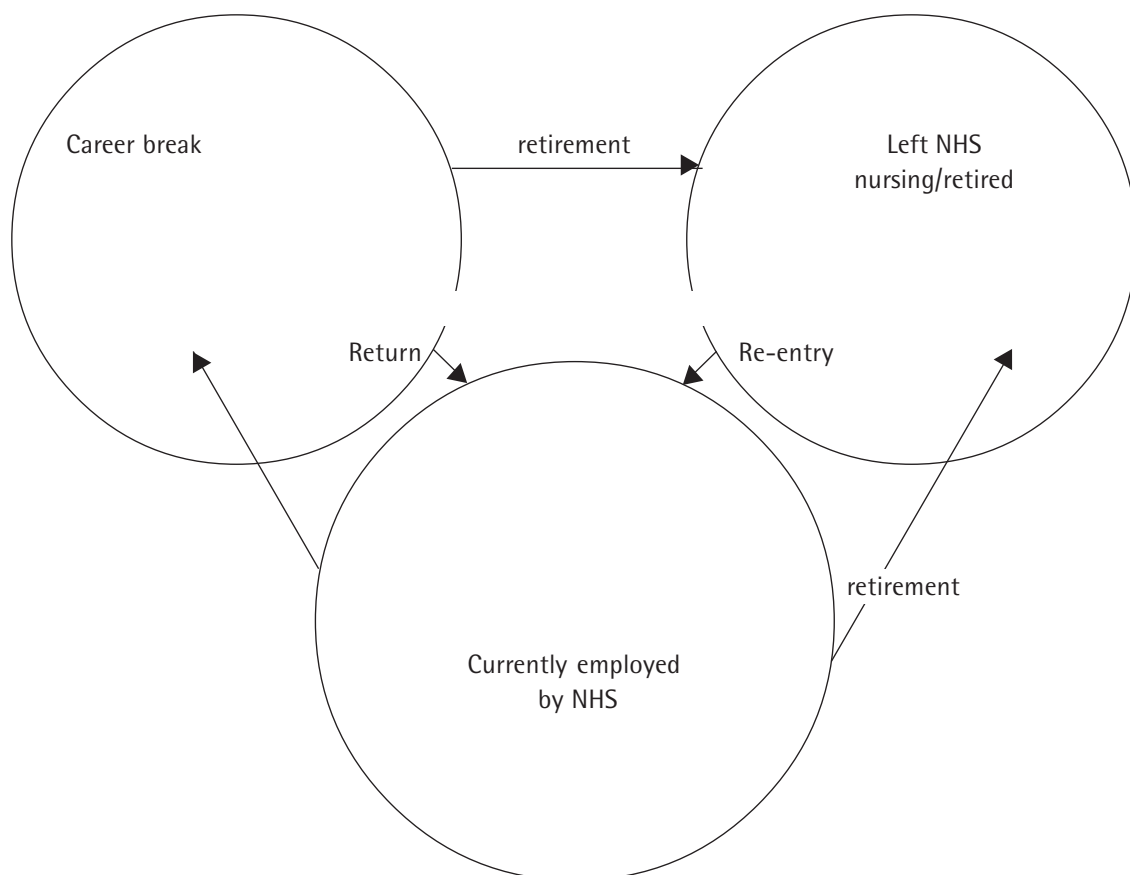
In addition, a range of other stakeholders across the UK were interviewed, including employers, senior nurses, advisers such as trades unions and pensions advisers, and policy makers at the Department of Health. The remainder of this report starts, in Chapter 2, by contextualising the aims of the research and reviewing the issues with reference to existing literature and evidence. Chapter 3 looks at employment issues for older workers, Chapter 4 considers the needs of nurses returning to work, Chapter 5 examines equal opportunities and Chapter 6 discusses older nurses' and other stakeholders' perspectives on options and decisions. The final chapter draws together the conclusions and provides recommendations for good practice.

The background

The NHS is the UK's largest employer and, within its workforce, nurses form the largest occupational group. This research considers older nurses' choices and decisions in the context of three options: retirement, re-entry or return to the profession and remaining in nursing. These three options, illustrated in Figure 1, permit an exploration that goes beyond the usual work–retirement dichotomy, since

nursing is one occupation where a shortage of nurses is particularly evident and there is a commitment to encouraging return to the profession as a solution to current workforce shortages. At the same time, nursing permits specific examination of issues affecting women and minority ethnic groups (the vast majority of nurses are women and 8% are from minority ethnic groups) (Beishon et al, 1995).

Figure 1: Pathways in and out of nursing for NHS nurses over 50



Note: This diagram divides nurses according to whether they are currently working for the NHS, have left the profession or are taking a career break. The distinction between the last two of these categories is inevitably arbitrary, but is intended to rest on the attitudes and intentions of the individual. The main point of the diagram is to show that exit from the NHS is not necessarily a one-way street.

The government has developed a strategic approach to tackling the shortage of nurses in the context of population ageing and overall rising demands for nursing care (NHS Executive, 2000). The ageing profile of nursing staff as an occupational group provides a further dimension: for example, the proportion under the age of 30 has recently halved. Nursing is a gendered occupational group which arguably has hitherto been able to recruit young students in sufficient numbers to tolerate early retirement and high drop-out rates. Davies (1995) considered that this 'disposability' has enabled employers to offer minimal flexibility and to construct part-time work as marginal. Such 'wastage' is no longer sustainable, however, and the NHS has established a Recruitment and Retention Unit within the NHS Executive with regional task forces led by nurses. To a certain extent, the NHS has located these issues within an equality framework of gender (see NHS Executive, 2000), but also of ethnicity. *Making a difference*, an influential report on nurse education reform (DoH, 1999a), pointed out that 25% of nurses over 55 years of age are black or Asian (compared to 3% of those under 25).

Decisions about retirement have generally been studied with respect to men. Cliff (1991), for example, has raised interesting questions about how some older (male) workers are able to negotiate their own flexible retirement. Those who returned to work after 'retirement' valued work for its financial, but also intrinsic, satisfactions. Similarly, Phillipson (1998) has observed that in a 1988 Office of Population Censuses and Surveys (OPCS) survey women cited enjoyment of work as their main reason for taking late retirement. There may also be a number of competing factors to consider, such as their potential to act as informal carers and their likelihood of limited pension contributions (see Ginn and Arber, 1999; Bernard et al, 2000).

Another relevant debate concerns the extent to which the workplace values and adapts to its older workers' needs. Yeatts et al (2000) have recently argued that older workers have needs, values and interests that must be met at work if they are to accommodate workplace or professional change and thus remain in work. In addition, the retirement industry may stress early preparation for retiring from work (see Anderson et al, 2000) but it is also suggested that opportunities for training decline with age

(Alferoff, 1999). Such complex and, at times, conflicting pressures are explored by the present research.

Finally, by studying those who re-enter or return to nursing over the age of 50, we will explore specific return to work (in nursing this is known as return to practice) initiatives and their sensitivity to age-related issues. Studies of schemes providing a bridge back to work through education or labour market initiatives (for example, Marshall and Macfarlane, 2000) reveal that most focus on long-term unemployment and are either general, or directed at young people. This research explores the phenomena of multiple possible trajectories for the older nurse – staying in the profession, returning to nursing or taking retirement.

In this report 'retirement' is defined as 'having left employment as a nurse in the NHS'. The term 'older people/nurses', in relation to employment, is used within the report to refer to nurses in their fifties and over.

3

Employment issues for older workers

With the ageing of the UK workforce, increasing attention is being paid to older individuals and the factors that influence their employment participation. A decade ago, for example, the Carnegie Enquiry into the Third Age identified key issues in turnover among older employees that will be examined here: the changing nature of work, ageism and the transition to retirement (Carnegie UK Trust, 1993).

There is evidence that older employees prefer more flexible working arrangements (Purcell, 2000) and such flexible employment has clear benefits for employers (DWP, 2002b). This pattern of work may include early retirement from full-time 'core' employment, but with a continued participation in work outside this core.

The value of older employees is often underestimated and there is strong evidence of ageism by employers. A recent study found that a considerable number of older workers experience ageism directly in the workplace (Loretto et al, 2000, p 279). There is also evidence that age discrimination in the labour market "damages workers.... It harms useful older workers by limiting their training and progression opportunities and keeps older people who wish to work out of employment" (Hornstein, 2001, p vi).

The transition to retirement

The age of 50 can be said to mark the onset of transition into retirement (Carnegie UK Trust, 1993). (This does not mean that the phase begins at the same age for everyone, but studying people's experiences above this age is a useful analytical tool.) Preparation for this phase

is sometimes marked by a desire to leave full-time employment for more flexible part-time employment, and possible involvement in community activity. The period may also be marked by negative aspects such as fear of the unknown and possible feelings of incapacity in dealing with the suddenness of the change (Carnegie UK Trust, 1993, p 29).

There is a link between financial security and an individual's decision to retire (DoE, 1990, p 10). Those most likely to be affected by a lack of financial security include women who are single, divorced or separated. Among working women generally, "sharing a husband's pension, and entitlement to a survivor's pension, are of most importance" (Cabinet Office, 2000, p 179).

Health considerations appear crucial to this age group. It has been found that among older individuals, "Increased levels of work-related stress may manifest themselves..." (Evandrou, 1997, p 167). Furthermore, "adequate income for later decades is essential, particularly as healthcare needs arise" (Moore and Biordi, 1995, p 62). This may be important in influencing the retirement decisions of older workers.

The ageing nursing workforce

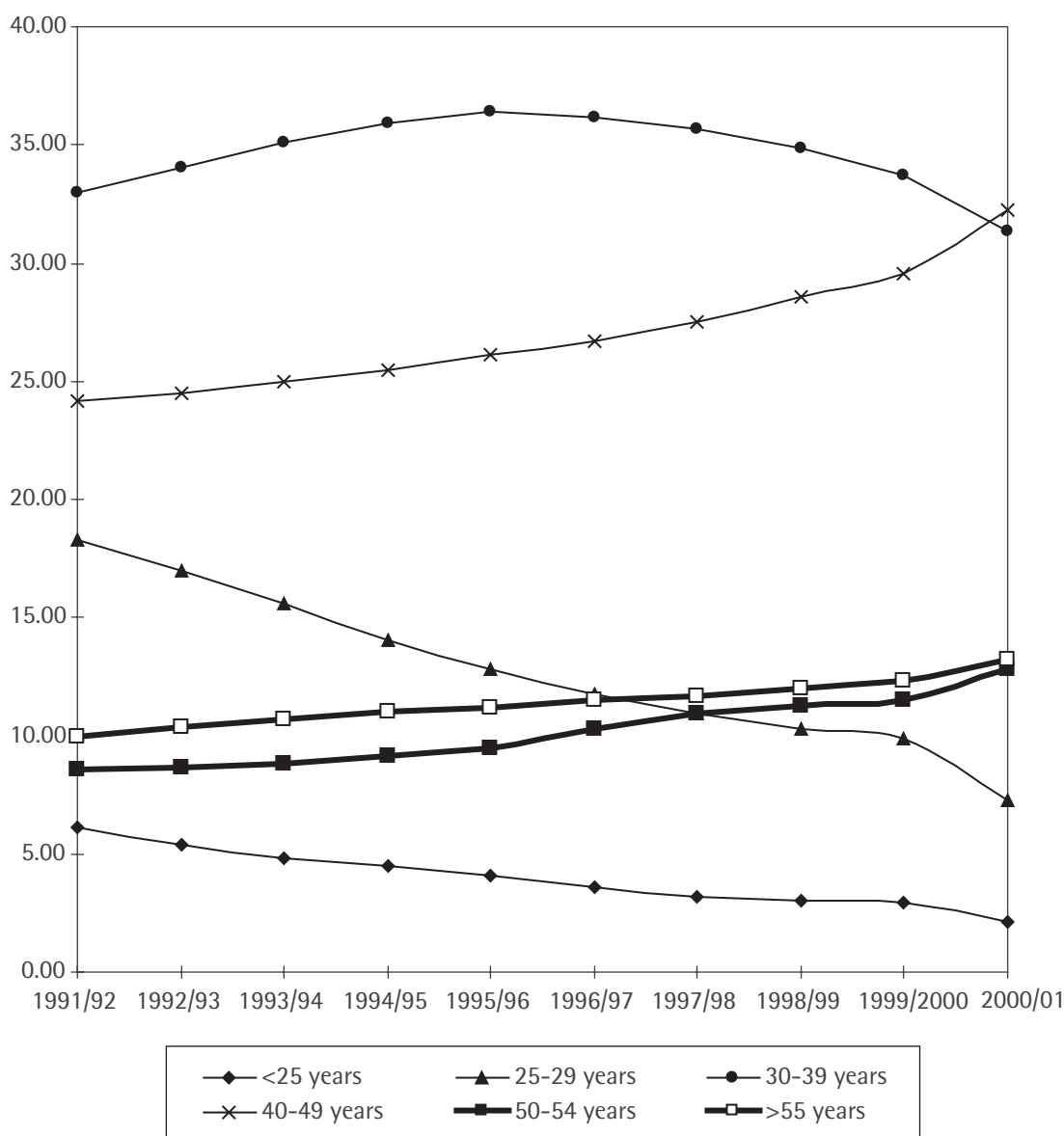
The ageing of the UK nursing workforce is a major challenge to the profession, to employers and to the wider community to whom nursing applies (Phillipson, 1998; White, 2002). This is compounded by the fact that: "This age shift is occurring at a time when nursing shortages are becoming more apparent than for any time in the last ten years" (Buchan, 1998a, p 1). Figure 2 shows clearly a gradual increase in the

proportion of registered nurses over 50, and a sharp decline in the proportion under 30 – from a quarter to under a tenth of all nurses in a decade. According to the Royal College of Nursing in 2002 (www.rcn.org.uk/news/2002/february/nursing_shortages.html), among a nursing workforce of approximately 300,000, more than 73,000 are expected to retire in the next 5-10 years. More than 30% of nurses and midwives are over 45 years of age, with 1.5% retiring each year. This age profile and the retirement rate need not in themselves create a crisis – particularly if retirement takes place at age 60 or 65 – but must be seen against a background of high attrition rates and staffing shortage. For example, in 2000 about 7% of nurses (21,000) left the nursing register, and, with

insufficient recruitment to replace these nurses there were 9,200 full-time equivalent vacancies. Moreover, the demographic composition could age further, as it is doing in other countries: a third of nurses and midwives being over the age of 45 may not be particularly imbalanced, but in the US it has been forecast that 40% of nurses will be over 50 by 2010 (Buerhaus et al, 2000).

Nursing is not a homogeneous profession. Within the qualified groups, “the oldest age profiles [are] ... amongst community staff nurses, health visitors and district nurses. Age of nurses is not uniformly distributed across the profession, with one in four district nurses (25%), health visitors (29%) and community staff nurses (24%) aged over 50” (Buchan, 1998a, p iii), whereas

Figure 2: The ageing of the pool of registered nurses: % on the register (1991–2001)



only 16% of the current NHS nursing workforce is over 50 (Buchan and Secombe, 2002). The age profile of nurses also differs between care sectors, with higher percentages of nurses aged 55 and older working within the nursing and residential home (19%) and bank nurses (19%) sectors, compared with practice nurses (12%) and NHS acute nurses (6%) (Buchan, 1999, p 3).

Those with specific responsibility for workforce issues thus need to address the employment-related needs of the growing numbers of older nurses, and the impact of the ageing nursing workforce in relation to patterns of retaining and attracting retired nurses back to the profession (Cole, 1996, pp 22-3). In light of nursing shortages, the UK government set a target for the return of 20,000 nurses to the workforce (NHS Executive, 2000) by 2004 and it appears that this target will be met (DoH/Cabinet Office, 2002), with over 11,000 nurses returning to work between December 1999 and July 2002.

However, the campaign to increase levels of returners has had an uneven impact. For example, Buchan (2000) found that the London region, with more than a third of nursing vacancies, attracted only 11% of the returners but Trent, with 5% of the vacancies, attracted 14% of the returners (Buchan, 2000, p 22). However, most of those who have returned have not returned to the sectors with the highest vacancy levels: the number of those returning to work in nursing homes outside the NHS, for example, almost trebled in the 1990-99 period (Queen Margaret University College, 2000).

Many nurses are entering a period of their working lives when they could retire, although this does not mean that they will. However, existing conditions appear to increase the likelihood of early retirement being chosen:

- Opportunities for retirement with actuarially-reduced pensions are now available to everyone over the age of 50.
- Retirement on full pension at the age of 55 for female nurses and mental health officers (nurses) remains available for today's cohorts.
- Opportunities to be re-employed in the peripheral workforce, such as residential or nursing home care, for example, also present an option.
- People in this age group are often in a favourable financial position, and are less likely to have large mortgages or very young

children, factors which previously may have acted as incentives for them to stay on in work.

- Increasingly, many people are seeking less stressful lives and are not necessarily dependent on a high or stable income.
- The changing nature of work within the NHS (which employs the largest proportion of UK nurses) has eroded an emotional contract or loyalty between employer and employee. With the advent of competitive tendering and the contracting process, nurses have less of the long-term security which in the past may have made relatively lower levels of pay acceptable. Furthermore, with increasing skill-mix changes and the substitution of cheaper labour, acquiring professional skills no longer guarantees long-term commitment from employees.
- Nurses generally feel that their role is undervalued (King, 1996, pp 26-8), while the demands of working in the NHS are great.

Fewer older nurses aged 50-54 work in nursing than younger counterparts (59% compared to 88%). As Buchan adds, "In the next five to ten years, therefore, it is likely that the profession will lose, through retirement, many of its most experienced practitioners" (Buchan, 2000, p 21).

The needs of nurses returning to work

Factors influencing nurses' decisions to retire or return to work are linked to broader social policy and employment contexts. These relate to greater flexibility within work for older nurses, greater flexibility in pensions provision and improved access to continuing professional development. One study found that initiatives which appear to make the greatest difference in encouraging or enabling nurses to return to work include:

- greater availability of part-time work, with more flexible working hours or job sharing;
- up-to-date refresher courses;
- less bureaucracy and greater contact with patients in order to carry out 'hands-on' nursing care;
- increased opportunity to acquaint/reacquaint oneself with nursing before making a long-term commitment;
- better resources to do the job;
- more opportunities for the development of skills (*Nursing Standard*, 1998).

These factors are similar to those that appear to influence nurses' decisions to remain in work rather than retiring, and are areas of policy that need to be addressed to encourage both retention and return or re-entry.

The government recognises the importance of flexible working hours for older nurses with care responsibilities (Buchan, 1996; DoH, 2000a). This may be in the form of part-time work, job sharing, 'flexi-time', or school term-time working for older nurses with care responsibilities for children (DoH, 2000b). Research on those with care responsibilities has found that they are more likely to work part time (Cole, 1996). There are significant implications here for nursing and the

NHS (DoH, 1999b), in particular since women are more likely to be informal carers than men (see Phillips, 1994, pp 143-52) and the NHS nursing workforce is 75.9% female (www.doh.gov.uk/HPSSS/TBL_D3.HTM).

Other sources of influence on nurses' retirement decisions

Income

The literature reveals that many nurses take career breaks and spend periods of time doing part-time or occasional work and their resulting reduced contributions to occupational pensions schemes may influence their retirement behaviour. Brown, for example, identified the need to enhance pensions provision as one reason why nurses work beyond the age of 50 (Brown, 1998, pp 10-11).

Physical fitness

The ability of older nurses to cope with the stress and workload of nursing, particularly in 'high-tech' areas of theatre and intensive care, has been questioned by some nurse managers (Gould, 1998, p 7). There is justification for questioning the physical capacity of some nurses over 50 for some aspects of nursing. This is demonstrated by research on back injuries, for example, which identified close links to nurse turnover. It has been found that: "Older nurses are more likely to suffer from back injuries ... the frequency of back injury among nurses rises from five per cent of those aged 18-25 to 15 per cent at 46-55 and over 18 per cent of those over 55"

(Gould, 1998, p 7). This factor inevitably affects performance, as: “Nurses who have suffered a back injury were more likely to answer workload ... questions negatively than colleagues who had not” (Secombe and Ball, 1993, p 3). These observations may be linked to older nurses being increasingly employed within NHS Direct services or other areas involving less strenuous physical activity. However, there may be other perspectives to consider, such as changes to work practices and better use of equipment.

Stress

Occupational stress among nurses continues to be an area of considerable concern, and a significant proportion of nurses feel that they are under too much pressure at work (SCMH, 2000). It has been argued that nurses working in mental health services face particular pressures: “Stress management needs to be seen as part of an overarching strategy to support staff through protecting and promoting their mental and physical well-being” (SCMH, 2000, p 91). Although one study found that older nurses generally find the profession attractive, and would choose nursing again if given a choice of careers (Leighton and Reilly, 1995), it also identified significant stress factors such as staff shortages, excessive paperwork and insufficient time to complete tasks properly. Stress management is linked to job satisfaction, which in turn affects decisions to leave or remain in nursing. However, a recent campaign by the Department of Health has identified stress among midwives as one of the foremost areas to be addressed in order to encourage midwives to return to the profession (www.rcm.org.uk/template/nes/detail.cfm/56).

Other factors affecting the nursing workforce may be only indirectly related to age but can have a cumulative effect; further research would help clarify their relevance. For example, the psychosocial elements of stress in relation to risk of injury at work continue to attract attention. UNISON has produced figures which show that “40% of health service staff have experienced violence at work in the past year (1995) while two-thirds felt more concerned about violence than they had a year ago.... Just 17% of respondents said their employers had introduced measures to combat violence” (Allen, 2001, p 1). Other research noted that “the risk of violence ...

[leaves] staff demoralised and distressed” (Coombes, 1996, p 21). This factor has been identified as contributing to staff shortages, particularly in the mental health specialty: “Only 2.1 per cent of mental health nursing posts were deemed hard to fill, researchers found, but 85 per cent of Trusts reported difficulties in recruiting and retaining nurses, especially in mental health” (SCMH, 2000, p 7).

The Royal College of Nursing (RCN) noted that “a study of 11,000 employees shows that staff in the NHS are substantially worse, in terms of mental health, than the rest of the workforce. The average percentage of people at work who may have psychiatric problems is estimated to be around 17%, while the figure for nurses is 28.4%, doctors 27.8% and managers 33.4%” (*Nursing Standard*, 2000; SCM, 2000, p 25). Indeed, promotion of better mental health has been identified as a priority workplace issue (Coombes, 1996, p 21; see also DoH, 1999b, pp 55-62).

In addition, the RCN further argued that “nurses need stability and the use of temporary staff may be destabilising if it becomes the rule rather than the exception” (*Nursing Standard*, 2000). This was also noted in a Sainsbury Centre report which found that “the use of agencies to cope with understaffing ... destabilised mental health teams” (SCMH, 2000).

Care responsibilities

A significant proportion of older nurses also have caring responsibilities in their private lives as well as their work lives. The Department of Health (DoH, 2000b) has noted how people who work in healthcare are often expected to do more for other family members when it comes to caring for relatives. Similarly, research from the NHS in Scotland reported that: “Within nursing, which makes up the greatest proportion of NHS staff, 6 out of 10 nurses have care responsibilities at home with an estimated ... 16% of nurses ... [having] care responsibilities for elderly parents or adults” (NHS Scotland, 2000, p 14).

Pay

Salaries have been linked to workforce issues. An RCN membership survey (RCN, 2000) placed

'better pay' at the top of the list of factors that would encourage nurses to remain in nursing. "Newly qualified nurses' pay was calculated in the late 1990s as being between 15 and 57% behind that of similarly qualified recruits to 'competitor' occupations" (Waters, 1997, p 12). Trades unions have warned that low pay in nursing is causing hardship, as "one in four nurses [is] ... the sole bread winner in their household..." (RCN, 1993) and that "one in four nurses have second jobs ... [and] three quarters of nurses would not recommend their job to anyone else..." (RCN, 1993, p 1). In its evidence to the nurses' pay review body, the NHS Confederation emphasised the recruitment crisis. The Confederation reported that most (78%) managers had difficulties recruiting and retaining nurses and midwives at all grades (Grimshaw, 1999, pp 323-4). The RCN has warned: "If there isn't a major boost to nursing salaries, nurses will continue to leave the profession and we will fail to attract new recruits" (Lipley, 1998, p 5).

Flexible working: pros and cons

In the NHS, some problems have been identified with working on rotational shifts, which may cause particular difficulties for carers, "and most staff [have] said that they would much prefer to work fixed shifts" (Brewer, 2001, p 17). However, flexible working hours constitute one of the demands continually made by nurses, including older nurses with care responsibilities. This may explain why a significant proportion of those aged 55 and over are found among bank staff (a pool of nurses to meet staffing shortages) (Northrop, 1999, p 32). The use of bank and agency staff is escalating rapidly. "In 1999-2000 NHS spending on agency staff grew by a third (to £360m in England and £8m in Wales) and on bank staff by 14% (to an estimated £430m in England and £10m in Wales)" (Buchan, 2000, p 21). One of the advantages of working 'on the bank', for example, is that "It offers you flexibility in terms of balancing work and caring commitments" (Buchan, 1999, p 3).

However, bank nurses face many disadvantages: they are not entitled to all standard employment rights (there is no protection for workers under discrimination law, they have no right to maternity leave and are not able to claim unfair dismissal); they are not entitled to annual leave, occupational sick pay or temporary injury

allowance; and although bank nurses can make contributions to the NHS pensions scheme, normal retirement and ill-health retirement benefits are calculated on the basis of final year's pay. Furthermore, bank nurses are not automatically entitled to training and may have to pay for any training undertaken (Cloud, 1999, p 22).

International recruits

The government, in *The NHS Plan*, has agreed to a short-term solution to staff shortages through a strategy of international recruitment, largely from the European Union, 'developing' countries and Commonwealth member states (DoH, 2000c). This is accepted as only a partial solution as "... many international recruits tend to stay on the register for a comparatively short time and the [government] ... will have to face growing competition from the USA, Canada, Ireland and other countries attempting to solve their own shortages by international recruitment" (Buchan, 1997, pp 22, 25). It has been found that these workers often "have to cope with unhelpful managers and racist attitudes" (D'Cruz, 1996). Most Filipinos in healthcare, for example, have been employed as ancillary workers (Daniel et al, 2001, p 254). One study concluded that "Our research on the expectations and experiences of Filipino nurses emphasises the importance of career prospects and salaries, and these may well be more significant in the longer term. Consequently, attention should be given to ensuring equal opportunity" (Daniel et al, 2001, p 264).

Morale among nurses

Many nurses claim to feel undervalued and morale linked to job satisfaction remains generally low (*Nursing Times*, 2001). Certainly this issue has historical roots: "Salary comparisons with lavatory attendants only add to the feeling of undervalue" (Daphne Heald Research Unit, 1994). Rightly or wrongly, many nurses feel that they are not respected, and this could have a strong bearing on staff retention (Crouch, 1998, p 20).

One particular complaint concerns discrepancies in terms of the promotion of long-serving staff. It is felt in some areas of nursing that "Most are

sidelined in promotion and recognition, and less experienced (sometimes newly qualified) nurses are pushed through ... for staff from the UK's ethnic minority communities, sidelining almost invariably occurs simply because the European's face will more often 'fit'" (Pierre and Agorom, 1999, p 7; see also Chapter 6). Ongoing recruitment difficulties, which have increased the tendency in health trusts for internal appointments, may have exacerbated this problem.

Valuing nurses is intrinsically linked to their rewards, to the people management skills of their managers and to giving them clear 'tokens' of recognition. One study of employment policies in the UK found that "Increased employee commitment was associated with employees who thought the establishment had a caring ethos" (www.jrf.org.uk/knowledge/findings/socialpolicy/S112.asp). In the recent climate of change in the NHS, nurses may feel that they have not had a chance to contribute positively to reform. This can lead to perceptions of disempowerment. In this light, nurses need not only fair remuneration, but also intangible rewards in terms of recognition and sensitive management approaches.

Trades unions

There is increasing awareness among health service unions of a need to address the implications of an older workforce, not least of which are the physical demands of nursing on older staff. UNISON has observed that: "There are health and safety issues employers have to address. Safe practice should be followed closely. Older staff have to be extra careful not to strain their bodies because if they are careless, for example with lifting, they are more at risk of permanent damage" (Mashta, 1998, p 13). UNISON has encouraged health trusts to introduce more flexible working hours to encourage older nurses to remain in the profession: "Younger staff are more likely to accept working long unsocial hours, but as they get older and have more family commitments they are less mobile and are not prepared to put up with poor working conditions" (Mashta, 1998, p 12).

Equal opportunities and nursing employment

Ageism

The government recognises that older workers have a great deal to contribute to the employment market and this is expressed in the Green Paper on Work and Pensions (DWP, 2002a). The UK is due to come in line, by 2006, with the rest of Europe in raising the retirement age of women to 65, thereby equalising the upper retirement age for men and women. In addition to eradicating this element of discrimination on the grounds of gender, the government is also legislating against discrimination by employers on the grounds of age. However, it is recognised that working longer may not mean working full-time up to retirement, and the Green Paper contains proposals which seek to make it profitable for men and women to work longer, under flexible employment arrangements whereby they may step down from full-time work or to lower levels of responsibility in later years. There are proposals to protect pensions rights at 65 and to permit people to work for a company after retirement for a salary while continuing to draw a pension or without harming pensions rights on retirement. Working longer often makes good economic sense for older people because the longer money is earned and saved, the less money is actually required in retirement because of greater savings and the reduced length of time for which savings are required. The Green Paper refers to some companies, such as B&Q, which have no maximum retirement age, as examples of good practice which could be followed by other companies. However, one of the proposals contained in the Green Paper is the raising of the minimum retirement age from 50 to 55, and this

may not be suitable for all workers who have the opportunity and the finances to retire at 50.

The battle against ageism is strongly backed by the NHS Confederation, which has observed that “there has been a history of age discrimination among employers, including the NHS, which we’ve fought hard to try to combat. Older staff are valuable. They have a wealth of experience and maturity which they apply to their work” (Buchan, 1998). However, as the following quote shows, there is subtle ageism at work, for example, in advertising for nursing jobs:

I read the article about the ageing workforce (*News Analysis*, March 10) with interest. However, in the same issue, a prison advertised for an RN to fill the post of healthcare officer. Among the requirements was a specified age 20 to 49.5. I have to ask why? A nurse who is over 50 is likely to have had a long experience of nursing and have developed life skills that would equip them to deal with people.... With regard to physical ability, I note that the advert welcomes applications from disabled people. It does not exclude women or suggest a minimum height. So why exclude people in their 50s? I want employers to consider individual abilities and not hold stereotypical views of people. (Secombe and Ball, 1993, p 7)

Employers need to be more sensitive to ‘age-proof’ employment practices, in relation to equal opportunities policies. An ‘action list’ constructed by Buchan (1998) included the following questions specifically addressed to nursing:

- Have age-related criteria, unless objectively justified, been removed from all areas of recruitment and employment practice?
- Do recruitment and 'returner' programmes for nurses provide sufficient scope for the updating of skills, confidence building and the mentoring of older recruits?
- Do older nurses have equal access to training and career development activities?
- Is the delivery of 'lifelong learning' accessible and relevant to older nurses?
- Is there a system of flexible work hours provision in place, and does this adequately meet the needs of nurses with responsibilities for caring for elderly relatives?
- Has there been job redesign to limit heavy physical workload and stress for all nurses; is moving and handling training provided for all nurses (including 'returners')? Do nurses participate in the selection of moving and handling equipment?

Evidence from the present study suggests that while some nurse managers may view older workers positively in terms of their experience, reliability and productivity, many actually viewed them negatively in terms of their resistance to change, decline in health and lack of ambition. The Carnegie Enquiry, however, noted that, "In general age is a poor proxy for ability" (Carnegie UK Trust, 1993, p 93).

Black and minority ethnic groups

The NHS is the largest employer of minority ethnic workers in the UK (DoH, 1997). Continuing problems in the recruitment of minority ethnic nurses are linked to racial harassment from patients and colleagues, and lack of promotion prospects (Queen Margaret University College, 2000). Research on migrant Caribbean nurses, most now nearing retirement age, reveals institutional racism in the nursing sector to be a long-standing problem for this cohort of nurses who have made a considerable contribution to British nursing (Culley, 2001, p 249).

The Policy Studies Institute (PSI) undertook one of the first major national studies of nursing employment in the UK (Beishon et al, 1995), on behalf of the Department of Health. It consisted of a postal survey of 14,330 staff, together with

150 interviews and a qualitative study of six employers. This revealed two main ways in which older nursing staff from minority ethnic groups have been disadvantaged: that after allowing for controlling factors such as qualifications, length of employment and so on, nurses from minority ethnic groups have been less likely to reach higher grades of nursing; and minority ethnic staff were more likely to be working in specialities such as mental health and learning disabilities than in the more prestigious medical and community-based specialisms. Progress in terms of equitable representation of minority ethnic groups at all levels in the NHS (including professional staff groups) became a priority with the 1993 'Programme of Action for Ethnic Minority Staff'. Similar problems affect migrant nurses recruited more recently by NHS trusts to offset staff shortages and may mean that the difficulties and discrimination encountered by older nurses recruited in the 1960s and 1970s are replicated in future cohorts.

Gender

Gender is highly relevant to equal opportunities policies. As noted earlier, the majority of nurses are female (www.doh.gov.uk/HPSSS/TBL_D3.HTM). This factor may be viewed as less significant in workforce planning terms than the ageing of the nursing workforce as a whole. However, Finlayson (1998) found that in terms of the position of men and women in nursing men, who are more likely to work in mental health/learning disabilities, were more likely to be found in the higher grades for all three types of nurse. An explanation for men's career advantage in nursing could be linked to the additional findings, for example, such as the need for career breaks, working particular shifts and working part-time.

Nonetheless, gender differences may explain some of the differences in expectations, perceptions and attitudes of nurses. This study found that, whereas women were more orientated towards non-instrumental rewards such as satisfying and interesting work, men were more orientated towards instrumental rewards such as pay and prospects of promotion. Furthermore, men were more likely than women to expect to move to a better job (higher grade or preferred speciality) in the near future. One in

six women were expecting to be engaged in raising a family in the near future (Finlayson, 1998).

Implementation of European Union policies

A study by Secombe and Smith (1996) found that a significant proportion of nurses reported working night shifts, ranging from 8.25 hours to 12.5 hours. Such practices may exacerbate the recruitment difficulties of the NHS by making jobs less enjoyable and more stressful. However, a key element in the EU work programme has been the 1993 Working Time Directive, which placed a ceiling on the maximum average number of hours an employer can require employees to work, and which was adopted by the UK in 1998. It remains to be seen whether or not this will help to recruit and retain nurses.

Chapters 2 to 5 have raised a number of questions:

- How do the perspectives and perceptions of policy makers, advisers and employers relate to the choices open to older nurses?
- Within this context, what factors and mechanisms are identified by employers, advisers and policy makers to be salient in informing older nurses' decisions about their employment?
- What are the opinions of nurses themselves?

The following chapter reports on research which sought to provide some answers to these questions.

Summary

The ageing of the nursing workforce is an issue for the NHS and society as a whole, with the growing shortage of nurses being the most obvious impact. The evidence has shown that, "retirement [as] ... the main reason for leaving ... may hide a multitude of sins. A number [of nurses] had retired early because they were fed up at work and disillusioned by problems within the health service" (Williams et al, 1991).

Evidence suggests that a challenge remains to address the attitudes and requirements of this cohort of nurses and future cohorts by way of:

- appropriate flexible working hours, family-friendly policies and employment cultures;
- enhanced career development opportunities;
- attention to equal opportunities issues;
- professional and management leadership.

6

Options, decisions and outcomes: other stakeholders' and older nurses' perspectives

Introduction

This study interviewed a range of people, including those involved in management and policy making and older nurses themselves. For convenience, the first group are referred to here as 'stakeholders' and the latter as 'older nurses'. Interviews were conducted with:

18 *stakeholders*: employers, advisers and policy makers linked to the nursing labour market, including the chief executives of national boards for nursing, and key human resources and policy personnel from England, Scotland, Wales and Northern Ireland – sampled on the basis of their responsibility for formulating and implementing policies relevant to an ageing nursing workforce (Table 1). The content of the questions (Table 2) was determined by the review of the literature and interviews were conducted by telephone (13) or face-to-face (5). Interviews were recorded (with consent), transcribed and analysed thematically.

84 *older nurses* in London and Yorkshire, Scotland, Wales and Northern Ireland, in three categories: remaining in the NHS, retired from nursing, or returned to nursing (Table 3). One focus group was held with older nurses who 'remained' in the NHS, in Scotland (11), and the rest of the data were collected by means of face-to-face and telephone interviews (73). The content of questions for older nurses was determined by the literature review (Table 4). Again, interviews were recorded (with consent), transcribed and analysed thematically.

Table 1: Stakeholders interviewed

Stakeholder	Interview method
Chief executive, Scotland	Telephone
Chief executive, Wales	Telephone
Chief executive, Northern Ireland	Telephone
Regional director of nursing	Face-to-face
Chief executive, Wakefield Workforce Confederation	Face-to-face
Chief executive, Central and North London Confederation	Telephone
Policy representative on pensions	Telephone
Policy lead on 'Improving Working Lives' programme	Telephone
Representative, UNISON	Face-to-face
Acting chief executive, major nursing organisation	Face-to-face
Chief executive, major pensions fund for nurses	Telephone
Retention and recruitment adviser, North Yorkshire Workforce Confederation	Telephone
Senior researcher, Royal College of Nursing	Telephone
Director, major patients' organisation	Telephone
Deputy head, major human resources organisation	Telephone
Manager, major pensions organisation	Face-to-face
Director, an acute NHS trust	Telephone
Deputy director, an acute NHS trust	Telephone

Implications of the ageing nursing workforce: stakeholders' views and responses

Responses among employers to the issue of the ageing nursing workforce ranged from ignorance of the potential problems that this might raise to placing this as a top priority for employment initiatives. Despite recognising the recruitment and retention crisis in nursing some employers actually seemed unaware that the nursing workforce was ageing and that this might be relevant to the current crisis. However, there was evidence of a desire to create a diverse NHS workforce and to include age in this diversity. In fact, there was recognition of a possible interaction between workforce diversity on

ethnic grounds and ageing, as one employer said:

“Well I think that the NHS is striving to build a diverse workforce and in the workforce included in that diversity is an acceptance that we need older workers as much as we need younger workers. There’s also an issue about the diversity of the workforce because in the fifties and sixties we brought many people in from overseas and they are now also an ageing [group]. When those people disappear, if we haven’t attracted the younger people from the ethnic minorities we will discover also the small percentage that we have will disappear all together.”

Table 2: Interview questions for stakeholders

Question 1	What is your view of the ageing nursing workforce? Is this an issue? How does it relate to other competing pressures?
Question 2	Do you have knowledge of any proposals/solutions relevant to older nurses? In your experience does the NHS in your area respond with any particular strategies?
Question 3	Are you aware of any retention policies/initiatives that are relevant to older nurses? Where would older nurses go for advice? In your view, are these sources of information/advice adequate?
Question 4	What factors seem to you to most influence the decisions of older nurses about working? Do you have views of particular pensions arrangements? What about ageism? Does this have any impact?
Question 5	Do you have knowledge of 'return to practice' initiatives that focus on older nurses, or are these more general? How are these organised? What priority are they given in terms of education by the NHS and relevant organisations?
Question 6	Is the issue of older nurses reflected in your organisation's future plans?
Question 7	Any other issues

Table 3: Distribution of interviews with older nurses

Category	Scotland	Wales	Northern Ireland	Yorkshire	London	Total
Remaining	11 (focus group)	8	5	8	8	40
Returned	1	5	1	8	8	23
Retired	2	1	2	8	8	21
Total	14	14	8	24	24	84

Table 4: Interview questions for older nurses

Question 1	What factors influenced your decision to retire/return/remain in nursing?
Question 2	Did you receive any information about options open to you before making a decision to retire/return/remain in the nursing workforce? If so, what sort of advice? Did you consider this advice adequate?
Question 3	Do you feel that there are adequate policies addressing older nurses at your place of work?
Question 4	Would you return to nursing? [For retired nurses only]
Question 5	What other factors do you think would encourage other nurses to return or remain in the profession?

These responses varied across the UK. For instance, a chief executive in Northern Ireland referred to a deliberate aim of having more older nurses in the workforce. London respondents noted a problem maintaining older workers in the nursing workforce due to the cost of living there. Nurses owning houses in London reportedly found it more profitable to sell up and retire to a cheaper area of the country than to continue working in London.

Despite some recognition of the issue of the ageing nursing workforce and the fact that stakeholders considered that there should be policies related to older workers, it was uncommon to find local policies and practices relating to older workers. There was a lack of 'joined-up thinking' in this regard and an admission that the ageing of the nursing workforce was just one of several pressing issues. Human resources departments appeared stretched and, according to one employer, "you would be hard pressed to find a human resource plan that was looking at any sort of systematic way of dealing with the current [situation]".

In terms of trying to retain older nurses, none of the stakeholders worked in organisations where there were strategies in place aimed specifically at older nurses. Employers referred to UK government policies such as 'family-friendly' policies and 'improving working lives' programmes within the NHS. While these were aimed at all age groups they only partly addressed issues relevant to older nurses. Also mentioned under retention policies were some overarching aspirations such as increasing the job satisfaction of nurses and improving morale and better pension options for those remaining in work. However, the visibility of any of these policies on the ground was unclear, as one employer said: "There are some retention policies or initiatives, for example we have recruitment and retention campaigns. Some people make noises about family-friendly policies, but it doesn't happen in reality".

With regard to retention policies, many employers referred to the stress of working in some areas of nursing, and some highlighted the need for attention to be paid to the subsequent impact on the mental health of nurses. One employer reported taking steps to address the mental health needs of those working in particularly stressful areas of nursing, but it was

not clear if these related to the employment and retention of older nurses in particular.

The cost-effectiveness of retaining older nursing staff, identified widely in the literature, was recognised by some employers. There was a general perception that support for staff by employers could not only increase employee loyalty, but also retain valuable staff and reduce the need to spend on recruitment:

"... they recognise that actually losing members of staff is really costly to the organisation and if you can input help and support during periods where members of staff have extra responsibility, then [they] have a loyalty to the company that keeps them on for a much greater time.... Also you then don't lose very experienced, very valuable staff who take thousands of pounds to replace in training...."

In terms of maintaining an adequate workforce it was not clear if the connection between recruitment and retention was actually understood. A study by the Sainsbury Centre for Mental Health (2000) showed that nurses seem to leave as fast as they are recruited and one adviser, involved in this study, said that he was not sure that there was a recruitment problem, just a retention one. However, another employer considered that recruitment into nursing needed greater priority than retention and saw retention policies as being "well motivated" but also "a source of frustration to the human resources' managers that have to implement them".

'Push' factors influencing older nurses' employment decisions

Employers, policy makers and advisers all identified a range of influences on nurses' employment decisions, including a lack of flexible hours, the stress of work, pension-related expectations and the pace of technological change. Some of these related to negative aspects of work that led nurses to leave; others to the presence, or otherwise, of positive factors in nursing or in pension options.

The pace of technological change

One significant view, shared by stakeholders and by nurses themselves, was that the pace of technological change was likely to influence the ability of nurses to cope with their jobs and hence impact on their employment decisions. This is not unique to older nurses but older nurses are less likely to be familiar with new technology and, while they may be able to learn quickly, managers may fear that they will not.

One employer, acknowledging the pace of change in the NHS and increases in new technology, believed that “many older nurses find it more difficult to maintain the practice competence and respond to challenges”. Another employer shared this view with respect to nurses returning to work, an issue which is dealt with separately below, and said:

“I think that the only time some of the older nurses coming back into practice struggle, is with some of the more technical stuff that has come in since they were last in practice. So sometimes it does take longer for them to complete their course....”

The pace of technological change was alluded to by some older nurses and, as one retired nurse said: “If you put me in the middle of an acute surgical ward with all of these pumps and machines going, I am not up to it”. Underlying any consideration of the involvement of older nurses in the nursing workforce and any alternatives to employment was agreement between some employers and older nurses that things had moved on considerably and rapidly since older nurses first became involved with the NHS. This may be related to ageist attitudes among employers and older nurses themselves, and this will be explored further below.

Stress and older nurses

Nursing is recognised to be a stressful occupation and this was mentioned by employers, advisers and policy makers and confirmed by the older nurses themselves. One retired nurse with an interest in returning to nursing was not in favour of returning to the stress of clinical nursing but would have taken “a desk job like policy or management”. Older nurses remaining in the NHS were witnessing their colleagues becoming

worn out – “run to a frazzle” as one nurse put it – with little evidence of support from management. In this light one nurse, still working, said that she would be considering retiring, and admitted “I just feel exhausted every evening when I go home” and it was often reported that there was no recognition for the extra hours worked and they did not even have time off in lieu. This finding is in line with that of Allen (2001, p 1) who reported that “Ward sisters and charge nurses rarely complained of a heavy workload as such. However, most found it difficult to manage their time effectively. Many of them reported that they worked longer hours than required, often completing administrative and management tasks at home”.

There was a widespread feeling among the nurses interviewed, whether remaining in the NHS or retired, that stress and the associated burnout were major influences on decision making with regard to employment over the age of 50. The problem of stress was said to be compounded by staff shortages in the NHS. To some extent, encouraging nurses over 50 to remain or to return could alleviate this, but their continued departure adds to the problem. One retired midwife had left the NHS as a result of work-related stress and, in the face of having to continue with low staffing levels, said “that was the crunch and my notice went in”. However, some good practice did emerge, such as in Preston Acute Hospitals, which has been identified as having a vacancy rate of only 4.5% compared to the average nurse vacancy rate of 12% (Robinson et al, 1999, p 25). There seems to be a link between some local initiatives taken by this trust, and the low turnover rate. For example, the trust has in place a staff care project aimed at assisting staff to identify whether they are at risk from stress, the source of stress and ways to prevent any problems from the stress getting out of hand. The trust also tries to keep the use of temporary staff at a minimum, since it has discovered a possible link between patient falls and medication errors and the usage of temporary staff. The higher the registered nurse skill mix, the lower the incidence of adverse occurrences, and hence the better the quality of clinical care as a whole.

'Pull' factors influencing older nurses' employment decisions

Flexible working hours for older nurses

Flexible working hours were identified by employers, advisers and policy makers as a key factor in encouraging older nurses to remain in or return to work. As one representative of the NHS pensions department explained:

“The Improving Working Lives Campaign has been a standard since 1997 in the NHS, and the idea is that we try and ... develop employment policies that suit a whole range of employment needs.... Improving Working Lives was specifically designed around developing family-friendly policies and trying to better meet the [needs of] workforce nurses, particularly because of the recruitment issue.”

However, examples of flexible working schemes were not evident, despite this knowledge. Many older nurses mentioned flexibility in conjunction with a supportive working environment in relation to their own decisions and options about working in the NHS beyond the age of 50. Connected to this were employment-related matters such as continuing professional development as well as external factors such as caring for older relatives. It was certainly considered by some that they could have “gone on a lot longer” if greater flexibility and support had been available. Older nurses questioned their own physical fitness for some aspects of the job, as described below, but accepted that there were some jobs, for example, in outpatient departments, where the hours were often more regular and sociable and less strenuous than work in the other areas of nursing, such as long-term care. Lack of options in this regard had led to some older nurses simply leaving the NHS before their retirement date. Nevertheless there were some examples of good practice in relation to older nurses, as one older nurse remaining in the NHS reported:

“... my manager ... is a person that is very much in touch with her workforce, which I feel is better than other managers, and ... goes to some degrees to appreciate there are problems whether health [related or otherwise]. In the past she has given some

people reduced hours, she has taken them out of the area [elderly care] and put them into a less stressful area....”

Financial influences on older nurses

A major influence on older nurses' employment decisions was money, and this was recognised by both nurses and the stakeholders. Money can be said to act as a 'pull' factor in one of two directions – either as an incentive to keep on working if the individual depends on their salary and does not feel they can afford to retire, or wants to build up a bigger pension; or conversely as an incentive to retire if available pensions are adequate. Stakeholders acknowledged that many older nurses were the sole wage earners in their households and this made financial considerations more significant than may have been the case previously. One adviser said that “one of the big determinants of whether nurses work or not used to be spouse earnings”, but with a rising divorce rate and earlier retirement by male spouses, who would have been the traditional 'breadwinners', this was less often the case. As one retired nurse commented, “times have changed, and husbands have died or people have divorced”, and this was considered to be a deciding factor by some in decisions about employment. Nurses frequently mentioned money as an issue in deciding whether to continue in work, retire or return. Nurses over 50 who were married and remaining in work or returning to work were doing so in order to help out with the finances at home. One retired nurse, who had remained in work beyond the age of 50 reported: “I always felt I would help my husband in financing the education of my youngsters”. Of course, male nurses who are over 50 may have been the sole wage earner if their spouse did not work, but no insight into this was gained in the present study of this largely female occupational group.

As well as earnings, pension considerations played a crucial role. Nurses working in the NHS have the option of contributing to a superannuation scheme and this provides a pension based on years of service and final salary. Pensions considerations, therefore, are closely related to the financial considerations described above. The level of pension a nurse is going to receive will influence decisions about

whether to retire at any particular point or whether it is worth working for a few more years in order to increase the pension. Taking some of the factors mentioned above, such as the increasing divorce rate and changes to traditional patterns of male and female employment, the pension which a nurse over 50 is going to receive will become increasingly important. Essentially, the pension has to make retirement a viable financial option.

The House of Lords decision in 2001, preventing pension schemes from excluding part-time workers, which was found to discriminate against women, has made occupational pensions still more important a part of the equation for nurses. One pensions adviser commented:

“In hindsight family units change,... so that changes women’s ideas of their own independence and their own sustainability.... They are the bread winner.... Our scheme was set in 1948, and although we have changed ... it hasn’t always reflected the fact that the make-up of women has changed beyond recognition. We are not a Doris Day movie anymore ... a lot of single parents are heading families ... a lot of people are divorced. So the needs are all very different. So in terms of our [pensions] scheme modernisation, we ... consider the ways that the scheme can reflect the fact that your circumstances might change.”

Employers generally praised the NHS superannuation scheme as being, for example, “the biggest and best in Europe” and one with which “people would be highly satisfied”. Employers, advisers and policy makers, however, did recognise the need for some change to the superannuation scheme if it was going to permit the kind of flexibility which older nurses wanted. Also, if older nurses are going to pursue more flexible options for working beyond the age of 50, in the ways discussed above, without putting themselves at a disadvantage, then the superannuation scheme will have to be adapted. For example, charge nurses may wish to leave full-time employment and return part-time to a less senior post, such as a staff nurse; at the moment this could have a detrimental effect on their pension and, in fact, may lead to premature retirement as the financial benefits of continuing may not be viable. One policy maker recognised

this problem and suggested that the highest benefits accrued could be “banked” such that when retirement came the older nurse who had stepped down to part-time or less senior work would benefit in pension terms from their highest salary and not, necessarily, their salary upon retirement. A representative from the Pensions Policy Department at the Department of Health confirmed that changes to the superannuation scheme to accommodate greater flexibility for nurses over 50 were being considered. Buchan (2000) describes one such scheme at Portsmouth Healthcare Trust, where there are provisions in place for the positive protection of earnings. Nurses redeployed to a job with lower pay than their previous position may have their earnings protected at the level of their previous job for up to nine years, including the past five years of service on which their pension is based. In this way staff need not be scared into early retirement to protect their pension.

The NHS superannuation scheme may be admirable in many ways but older nurses were less enthusiastic about it than employers. A large proportion of the nurses interviewed were remaining in work purely to put in place adequate pensions provision. Specifically, one nurse commented: “There are financial considerations and the fact that if I left too early my pension would be affected”. One part-time nurse reported that she had resigned at the age of 56 as there was no point in working longer. She had worked part time for many years and was not superannuated. Another retired nurse reported how she had been forced to retire at 60 when she thought that she still had some years of service to offer the NHS. The above examples suggest that pension incentives as well as flexibility can help encourage older nurses to return or remain in the workforce.

Continuing professional development and returning to practice

If older nurses wish to remain in practice or to return to practice then they are entitled to continuing professional development and return to practice training. The latter is mandatory for nurses who have recorded a break in their practice or registration with the professional body for nurses (the Nursing and Midwifery Council [NMC], formerly the United Kingdom

Central Council for Nursing, Midwifery and Health Visiting [UKCC]).

Respondents from all sectors considered that continuing professional development was not geared towards the needs of older nurses. As stated by one nurse adviser, there is a tendency among employers to concentrate resources for continuing professional development on younger nurses. Older nurses knew that continuing professional development was available, but availability varied between locations. There were few reports of experiences of continuing professional development by older nurses but it is not clear if this was because they were not encouraged to attend or because they were not motivated. The reports from attendance were largely negative and one typical response came from a nurse who had returned to practice and questioned the relevance of the course she attended to what she was actually doing: "It actually meant nothing when I came back to work because all of the stuff I had learnt and the specialisms that I had acquired didn't make any difference ... in actual fact it is a waste of money for the Trust".

Return to practice initiatives are part of the government's drive to increase the number of nurses in the NHS and there is meant to be a relevant scheme in each NHS trust. Despite the potentially valuable resource of nurses over 50 who wish to return to work no courses were identified that catered specifically for their needs. One employer was quite specific that return to practice courses were designed to encourage younger nurses back into the workforce. Another employer raised doubts about the ability of older nurses to grasp some of the technological changes that had taken place since they left practice and considered that older nurses performed differently on these courses.

Nurses wishing to return to practice reported that courses were not well advertised and that information about the courses rarely contained information about the options after returning to practice, such as part-time work or flexible hours. Those who had returned to practice having taken a relevant course were concerned about the extent to which courses met the need of older nurses. One nurse said:

"... coming back into practice and acting in a way where you shadow somebody for a

while would help. That isn't what happened for me. You know, I came back as the new grade nurse ... and I remember going home thinking I don't know what ... I am doing."

There were further concerns about how such courses addressed the needs of nurses from different areas of work, and some reported doing their own study, often on the Internet, to supplement the courses. Other returning nurses felt that there was too much time in the classroom: "I understand we need a refresher course ... but to me it would be better if the refresher course was spent in the field".

Older nurses themselves reported that they lacked confidence to participate in return to practice courses, asking "would I be able to cope?" and wondering, in particular, if they would be able to work with the new technology.

Problems were acknowledged in designing courses for nurses on the basis of age; this could be construed as ageism, even if it was presented as positive discrimination. On the other hand, employers perceived differences in ability between older and younger nurses, and some older nurses themselves echoed this. Certainly, there appears to be a need for some consideration of age in continuing professional development and return to practice courses. Continuing professional development tends to be geared to the needs of the employer, training staff to cope better with new technology, for example. In the case of older nurses there appeared to be a need to develop continuing professional development which would help them to take on new roles late in working life, such as moving to other, perhaps less physically demanding, clinical areas where some training would help them to adapt and, thereby, retain them in the workforce.

Advice and information about work options

Nurses over 50 frequently think about their options with regard to remaining, retiring or returning to work. But where and how do they get relevant advice? Employers, policy makers and advisers had little to say about the provision of advice to nurses over 50. In contrast, nurses

had a great deal to say about the lack of adequate information; almost all of them reported that no information regarding their work options was offered to them. “I wasn’t given any advice at all” one retired nurse stated. There was only one instance of such advice being volunteered by employers and this had been printed on the back of salary slips.

However, it was quite common for nurses to make their own enquiries about employment and retirement options without the aid of their employer, using such resources as the Internet. It was very uncommon for individualised face-to-face advice to be offered and information came from informal advice from colleagues in canteens, by word of mouth or, in one case by “one little form that kept getting photocopied”. There were varied responses to the information provided from adequate to confusing. A picture emerges of nurses at a stage in their life and career who require sound advice prior to making any decisions but who are, essentially, left to their own devices. It appears, more generally, that the NHS has not been good at communicating its policies to staff. For example, these findings are congruent with those of Bagilhole and Stephens (1999, p 246) exploring another policy area, who found that “in particular, the general uncertainty among managers concerning the hospital’s official sexual and racial harassment policy, coupled with a lack of precision about the extent of such harassment and the desire of managers to deal with such matters informally whenever possible, risked leading not only to inconsistency in the handling of cases, but also to a failure to signal to all staff (and patients) that such behaviour will not be tolerated”.

Age and ageism

Some employers admitted that they preferred to employ younger nurses and that policies, including return to practice initiatives, were not designed for older nurses. These views seemed to rest on a perceived lack of potential among older nurses to grasp new technology, along with apparent declining physical fitness and a perceived inability to cope with the stress of the job. One employer was candid in admitting “it is the younger ones who are obviously important for the future, and that is therefore where our

attentions are more focused”. Some older nurses were, themselves, anxious about their ability to cope with some aspects of nursing:

“I think you slow up ... and I think the management needs to understand.... You shouldn’t have to go cap in hand and say ‘look I’m slowing up’ sort of thing. [Management needs] to be more aware that people do have different needs when they get older.”

One retired nurse said that she had received unfair treatment at the hands of her employer, based on her age, forcing her to eventually resign. Having rendered many years of “faithful service” as a contractual night duty nurse, she was told by a recently appointed manager that her contract was not “worth the paper it was written on”. Having been told this in front of her colleagues (much to her embarrassment), she was further advised that she would have to work day shifts. Despite her explanation that she had daytime care responsibility for a disabled parent, this managerial decision remained unchanged. After a very lengthy process of appealing to the hospital management to be allowed to work in accordance with her contractual agreement, the older nurse in question decided to resign. She felt betrayed and violated by the hospital’s management.

However, in general, older nurses did not feel that they experienced overt ageism from their employers. More often, they felt pressure from other colleagues, young and old, to retire soon and to open up a job for a younger person. Many older nurses we interviewed said that they were coping well with the physical and mental demands of nursing over 50, as one considered: “there are some people who are old at 45, and some people that are young at 65, and somebody should acknowledge that we [older nurses] are not all the same. Age has nothing to do with it”. And this view was reflected by some employers who thought that any categorisation of older nurses should be based on their own perceptions of individuals’ physical health and abilities and not principally on the basis of their age. One employer said:

“I think there is ageism around in the population. I mean, the thing that always irritates me is ... organisations ... talk about the over fifties as if suddenly when you are

50 you move over into this sort of dotage era.... This categorisation of people at a certain age into a certain box, we should start moving away from this....”

Employers voiced many positive views about older nurses in the workforce; they emphasised that older nurses should be valued and not channelled into certain areas of nursing. In their experience, older nurses had particular qualities, sometime lacking in younger nurses, of courtesy and commitment. One considered that the retail industry recognised this far more than the NHS, and this sector had developed “a policy for bringing older workers in because they are generally more polite, they are more committed often, [and] they turn up to work everyday”. A retired nurse recalled an example that illustrated how experienced nurses can put patients at their ease:

“... another example is of a man coming back from a colonoscopy ... he was on a monitor, his hands were sticking out, he was as rigid as anything.... We couldn't interfere with what the girl [nurse] was doing.... While she went to lunch ... I spoke to the man and I said, 'How are you feeling? You don't look awfully comfortable'. By the time that girl [nurse] came back in 30 minutes that man was propped up a bit, having a cup of tea and smiling. We are almost over technified [sic] if you see what I mean. We are too reliant on these machines, and they don't go back to the person ... these are things machines wouldn't do, and I don't think they are taking time to teach good nursing.”

Summary

- Despite the ageing of the nursing workforce and the current crisis in the recruitment and retention of nurses, not all stakeholders recognised the implications of these trends.
- Local human resources policies and practices did not reflect the ageing nursing workforce and there were no policies aimed specifically at older nurses.
- It was unclear to some employers whether the staffing crisis in nursing was a recruitment or a retention problem and, therefore, there was

little recognition of the part older nurses could play by remaining in or returning to work.

- A range of factors influence older nurses' decisions about continued employment or returning to employment in the NHS. Employers and nurses agreed that flexible hours were important and both agreed that the physical and mental stress of the job also had to be addressed. Older nurses and employers agreed that the pace of technological change was an issue in some areas but older nurses identified nursing work, such as in outpatient departments, to which they thought they were more well suited.
- Older nurses identified financial considerations as being crucial to their decision to remain in or return to work. Employers were more positive about the superannuation scheme than older nurses and greater flexibility here, with less emphasis on final salary, might be an incentive to remaining in work on reduced hours or with lower levels of responsibility. Generally speaking, information on retirement and other options over 50 was poor and a great deal of information was simply discovered by older nurses rather than being provided to them systematically.
- Education and training options for older nurses were variable. Older nurses who are going to remain in work recognise their need for continuing professional development as much as, and perhaps more – in view of technological change – than their younger counterparts. Older nurses returning to work after substantial career breaks need return to practice courses which cater for their needs. However, there was no evidence of continuing professional development or return to practice courses which were geared specifically towards older nurses.
- While there was some evidence of ageism among employers, they also reported positive attitudes towards older nurses and the special qualities that they could bring to the NHS, which was often lacking in younger nurses. Older nurses themselves were often negative about their own abilities and had experienced ageism from their colleagues who expected them to retire and presumably make way for younger nurses.

The following chapter discusses the implications of the above findings, in light of the literature reviewed earlier.

Conclusion and recommendations

We interviewed nurses over the age of 50 who were either remaining in the NHS, who had left the NHS or who had returned to working in the NHS, as well as other stakeholders including employers, advisers and policy makers. The purpose of these interviews was to explore the different perspectives which these people could offer on the options, decisions and outcomes for nurses over 50 and to see how experience ‘on the ground’ matched the rhetoric of government policy. We found, in short, that there was a considerable gap between policy and practice.

Today the traditional pattern of working up until retirement age is less common and more flexible working arrangements are becoming the norm. This study focused on a single occupational group, nurses in the NHS who, at age 50 and beyond, may begin to think about ceasing work in the NHS or who may already have left. Some of the nurses may have had new family responsibilities in the shape of caring for older relatives. Alternatively, some of the nurses who may have undertaken their nurse education and training many years previously may now actually be free of family responsibilities and therefore may wish to return to working in the NHS. This study was concerned solely with options, decisions and outcomes related to those employed by the NHS. The intention was to investigate the options provided by the NHS, the decisions made by nurses over 50 in relation to the NHS and, wherever possible, to report on the outcomes of such decisions. However, results related to this last aim were inconclusive as the relationship between the options available and any specific outcomes was rarely made clear by the nurses. In general, they knew little about their options and had received little information to help them with their decisions. Outcomes,

therefore, were more usually by default rather than informed decision.

Contextualising the findings

As described earlier, there is a nursing recruitment crisis in the NHS, and the nursing workforce more generally, in common with other areas of the workforce, is ‘greying’. This can create serious problems where the recruitment of younger nurses fails to such an extent that the net loss of nurses from the profession continues. The recruitment crisis is being addressed in several ways, including a radical overhaul of pre-registration nurse education, advertising campaigns to recruit more nursing students and return to practice initiatives for nurses who have taken a career break from nursing, or simply left the profession. However, little of this is actually directed at nurses over 50, which means that the Department of Health may be overlooking a potentially valuable resource.

Recruitment is not the only method for addressing the staffing crisis which has, in part, also been caused by attrition. If the shortage of nurses in the NHS is going to be addressed then retention as well as recruitment must be tackled. We could find no evidence of any policies addressing the retention of older nurses. The key issue in retaining older nurses, as well as attracting them back to the NHS, is flexibility and, while the study identified some examples of good practice, the more usual picture is one of lack of flexibility, particularly in the area of superannuation. Many reasons combine to persuade a nurse over 50 to remain in the NHS or to retire, but, ultimately, the decision is often based on whether or not retirement is financially

viable. A system that penalises nurses who require flexibility, in terms of their pension prospects, discourages retention. It is currently possible for an older nurse to remain in work and actually have decreased pension rights at any given point in the future if they reduce their hours of work or move to a less demanding area of work commanding a lower salary. Protecting pension rights is thus an essential feature of extending flexibility for older nurses.

Older workers, older nurses

Older workers have previously been studied in occupations, including nursing. However, the research indicates that older nurses may not be valued as much as younger nurses, despite evidence from other occupations that older workers are a valuable asset. Older workers do not in reality fit the stereotypes created around them; in general they are flexible and committed.

Older nurses were quite frank about the effects of ageing: generally, they felt less fit for the more physical aspects of nursing and so held views which were congruent with employers' views. However, if there is an awareness that some older nurses are less physically fit, in addition to the increased likelihood of suffering stress and burnout, then these could be catered for through policies which helped older nurses – that is, those who wanted to – to take up more flexible patterns of work.

Both older nurses and employers were able to provide examples of where having older nurses in the workforce was valuable due to their increased knowledge, skills and general attitudes. Any policies directed at older nurses should be couched in these terms in order that older nurses feel valued and respected by their younger colleagues. Continuing professional development and return to practice initiatives clearly have a part to play in this. However, the experience of older nurses about such initiatives was not positive – they have not succeeded in giving older nurses the confidence to return to work because they have not to date been directed to the specific needs of this group.

Age and ageing

There is a perception that older nurses may not be as 'fit' for the job as younger nurses, and the physical effects of ageing – which do not, it must be said, affect all people uniformly – undoubtedly are affected by the physical aspects of the job of nursing.

In recent years, the lifting and handling of patients has improved greatly with the introduction of more lifting aids and the cessation of physical lifting by nurses. However, many nurses currently over 50 will have 'lifted and shifted' patients before the changes in manual handling policies were introduced in the last decade and may now as a result, be injured or simply unable to carry out other physical tasks. Even with the advent of manual handling policies and mechanical aids for lifting patients, however, nursing remains a very physical job and there is still considerable physical patient contact, bending and stretching to carry out many aspects of nursing care. Nursing is rarely a job that involves sitting at a desk on a routine basis.

Returning to nursing

Employment policy in relation to the NHS addresses such issues as increasing the diversity of the workforce, encouraging nurses to return to the NHS and family-friendly policies. While employers in the study were certainly aware of these policies, they did not uniformly acknowledge the implications of an ageing nursing workforce and the study found a paucity of evidence of any specific practices to address this. This is, at the very least, an oversight given the current recruitment crisis and the fact that such things as fitness for work and adaptability to new technologies were a concern for employers.

Older nurses, in common with any nurses who return to work, cannot simply be expected to turn up in the clinical areas ready for work. The NHS is a fast moving organisation and in recent years has seen an increase in the availability of and expectation that information technology will be used in the clinical areas. The introduction of clinical governance has changed the culture of the NHS to one where accountability is more visible; there is a much greater requirement than

before for record keeping and patients may now have access to their records. Decisions are more often taken within a framework and against protocols and procedures which have only recently been produced. Nurses and other health professionals are leaving the NHS due to these changes which many have found demotivating and stressful; thus those returning to practice must be more carefully prepared. Once a return to nursing has been made the older nurse, again, in common with younger returning nurses, requires and is entitled to continuing professional development, both for personal satisfaction and to be fit for purpose in the NHS. Such continuing professional development is as relevant, of course, to older nurses remaining in the NHS, and may also be relevant, in the shape of pre-retirement courses, for nurses who wish to leave the NHS.

The views of older nurses certainly supported the reports by stakeholders that specific policies related to older nurses were, essentially, non-existent. Older nurses wanted flexibility if they were to remain in the NHS and they also had financial concerns if they were to reduce their hours, reduce their responsibilities or even retire. A need for information was identified and this was what was most lacking for older nurses making such decisions. In particular, older nurses wanted information on pensions and retirement options and this was especially hard to obtain with the result that nurses often relied on colleagues passing on information of dubious quality or searching for information themselves – using the Internet on some occasions. What they really wanted was someone to talk to and they also felt that such information should be volunteered by employers rather than having to be sought on an individual basis. With such management of staff at the end of their careers, where it is acknowledged that stress and burnout are taking their toll, it seems that the problem of a nursing shortage is being compounded – people are unlikely to remain in the NHS if they do not feel cared for. In the light of the views of some nurses that staff shortages are leading to increased levels of stress and burnout the NHS may have created an almost intractable problem for itself. Unless it breaks the vicious cycle of stress, burnout and premature retirement with policies and practices which specifically address the special circumstances of nurses over 50, the nursing shortage is likely to remain unsolved.

Family-friendly policies

The rhetoric of family-friendly policies was evident in discussions with managers and policy makers, and the NHS has been at the forefront of developing approaches to attract or retain those with family responsibilities, including developments such as job sharing and flexible shifts. However, for older nurses many of these developments were less relevant. The interpretation of family-friendly policies for the workplace appears based on a narrow definition of a family and is centred around looking after young children. There were very few examples of older nurses seeing any benefit from family-friendly policies for their circumstances, which often related to the more difficult and unpredictable demands of supporting disabled or ill older relatives. Even among those who did not currently have heavy caring responsibilities, there was little confidence that the workplace would be able to respond in any way other than providing ad hoc leave. This lack of confidence may relate to the difficulty any of those interviewed for this study had in reporting examples of good practice around their support of carers. There is a certain irony here in that the NHS, of all employers, should be able to offer itself as a role model for other organisations and learn from the experience of supporting carers about what is valued and effective practice. Moreover we found no examples of the NHS, locally or nationally, considering former carers as a group worth targeting for recruitment. The experience of former carers may thus be underutilised and contrasts with the efforts being made in some parts of the NHS to recruit former users of its services, for example, people who have received care and treatment in mental health settings.

Wider issues

There are a number of issues beyond the immediate needs of older nurses which may have an influence on their options, decisions and outcomes in relation to working in the NHS over the age of 50. The NHS is trying to recruit more nurses from overseas but this has not been without its problems in terms of the suitability of some recruits for working in the NHS, the potential drain of valuable nursing resources from less 'developed' countries and competition from other countries where nurses have better

terms and conditions of employment, particularly in North America. This strategy is unlikely to address the current recruitment crisis in nursing and this brings us back to the opportunity which may be being missed by the NHS in its older nurses. The matter of terms and conditions raises the issue of morale among nurses in the NHS: this is generally perceived to be very low due to some of the factors mentioned above but, essentially, because nurses feel undervalued as a profession, and this is bound to have considerable influence on older nurses, perhaps more than on younger nurses, who may be more idealistic about nursing and working in the NHS. The nursing trades unions recognise this phenomenon whereby older nurses are less likely to put up with poor working conditions.

Issues of ageism, gender and, for a considerable proportion of NHS nurses, ethnicity must be considered. These are issues which will have to be addressed at some level in order for other policies and practices regarding older nurses to be effective. It is pointless to try to retain or recruit older nurses if institutional ageism exists in the NHS; such ageism may be manifest through concentrating training resources in younger nurses, providing greater flexibility for younger rather than older nurses, and generally perpetuating an environment in which older nurses do not feel valued. This last point may be compounded for some older nurses by unfamiliarity with new technologies and new practices in the NHS. Gender is also important as the nursing workforce is predominantly female and there is no point in treating older nurses in the same way as male workers have been traditionally treated, nor is there any point in treating older nurses as earners of second incomes. Increasing divorce and different patterns of living have meant that many more women are bringing up families alone or will have responsibility for older relatives. Their pensions position may be very complex.

Career and life choices

While the focus of this study was on decision making for retirement it became clear that for the nurses interviewed much of their thinking related to difficulties in managing what is becoming known as work–life balance. This may be a more fruitful way of looking at decisions around employment and retirement since it recognises

that the choices are not simple decisions about when to leave work but rather processes that involve ‘push’ as well as ‘pull’ factors. We identified that older nurses may find the demands of full-time NHS employment stressful after many years in a demanding occupation. Nurses, however, have not always had opportunities to review their career pathways and much continuing professional education emphasises new skills, technologies and systems. There may be a case for exploring ways in which older nurses with long service may undertake new projects, move to different areas of work or undertake forms of mentoring or practice development. None of the nurses we interviewed reported any opportunities to discuss their ‘career’ and current or future options. Neither did any report opportunities which are to be found in other parts of the public sector or some commercial organisations in a ‘step-down’ from full-time employment. We found no examples, although these may exist on an unofficial basis, of ‘exit’ interviews for older nurses, informing them of ways in which they might still retain some connection with the NHS, such as staying on the ‘bank’ or being available for emergency or times of staff shortages. In this way we consider that retirement from nursing is largely seen as definitive both for nurses and the NHS and marks a period where contact is generally severed. This then leads nurses to explore opportunities in the private care sector where there is great demand for their skills and experience.

Conclusion

Policy/practice gap

The most obvious conclusion from this research is that there is a significant gap regarding older nurses between the rhetoric of policy at government level and the rhetoric of policy at NHS trust level. Older nurses are not actually identified as a group despite their growing numbers in the NHS and the contribution they could make to the current shortage of nurses in the UK. Older nurses expressed a desire to stay in the NHS or to return to work but there were many barriers to their retention and recruitment. For those who remained, there was little provision for them despite the fact that

employers could identify positive aspects of having older nurses in the NHS.

Lack of provision for older nurses

Existing policies and practices, such as family-friendly policies, continuing professional development and return to practice courses, are, in principle, ideally applicable to older nurses; however, in practice, they rarely are. Such initiatives are in fact often aimed solely at younger nurses:

- family-friendly policies refer to younger nurses with children despite the increasing number of older nurses who also have caring responsibilities for older relatives;
- continuing professional development is aimed at younger nurses with many years left in the NHS while there are obvious professional development needs of older nurses who may lack confidence with new technology or who may need to undertake training to work in less stressful and less 'heavy' areas of nursing;
- return to practice is ideally relevant for older nurses but no courses designed for older nurses were identified; rather, older nurses who may have been returning to practice after many years out of the NHS were participating in return to practice courses alongside younger nurses who may only have left the NHS a few years previously.

Lack of information

There was a real lack of information on options for working over 50 for older nurses. Such a major decision as leaving work to take up a pension or making any adjustment to working life which might influence pension options appeared, largely, to be left to chance and hearsay. Older nurses obtained more information from their colleagues than from their employers.

Recommendations

- The valuable contribution that older nurses could make to the NHS must be recognised by individual employers in their treatment of nurses and the opportunities they offer, not just in terms of system-wide rhetoric.
- The needs of older nurses with regard to working over 50 need to be addressed specifically in continuing professional development and return to practice initiatives.
- Information on work and retirement over 50 should be more readily available to older nurses.
- Flexible working options for older nurses should be more available, recognising the physical and mental stress which many older nurses experience.
- Working options should include moving to less stressful areas of work where older nurses can make a valuable contribution, and flexible hours of working.
- Pensions for older nurses should not be affected adversely by taking flexible working options.
- Good practice should be disseminated by the NHS which needs to address retention as well as recruitment, and thus demonstrate commitment to diversity within its workforce.
- With due regard to the amount of NHS provision being transferred to the independent sector, the NHS needs to work collaboratively with the independent sector to ensure that the above recommendations are applied across both sectors.

References

- Allen, I. (2001) *Stress among ward sisters and charge nurses*, London: Policy Studies Institute.
- Alferoff, C. (1999) 'Older workers: flexibility, trust and the training relationship', *Education and Ageing*, vol 14, pp 51-60.
- Anderson, M., Yaojun, L., Bechhofer, F., McCrone, D. and Stewart, R. (2000) 'Sooner rather than later? Younger and middle-aged adults preparing for retirement', *Ageing and Society*, vol 20, pp 445-66.
- Bagilhole, B. and Stephens, M. (1999) 'Management responses to equal opportunities for ethnic minority women within an NHS hospital trust', *Journal of Social Policy*, vol 28, pp 235-48.
- Bardasi, E. and Jenkins, S.P. (2002) *Income in later life: Work history matters*, Bristol/York: The Policy Press/Joseph Rowntree Foundation.
- Barnes, H., Parry, J. and Lakey, J. (2002) *Forging a new future: The experiences and expectations of people leaving paid work over 50*, Bristol/York: The Policy Press/Joseph Rowntree Foundation.
- Beishon, S., Virdee, S. and Hagell, A. (1995) *Nursing in a multi-ethnic NHS*, London: Policy Studies Institute.
- Bernard, M., Davies, V., Machin, L. and McIsaac, S. (2000) *Women ageing: Changing identities, challenging myths*, London: Routledge.
- Brewer, S. (2001) 'Notes and queries...', *Nursing Standard*, vol 15, no 25, p 17.
- Brooker, C., Davies, S., Ellis, L., Laker, S., Philp, I., Walker, A. and Warnes, A. (1997) *Promoting autonomy and independence among older people*, Sheffield: University of Sheffield.
- Brown, J. (1998) 'Over 50 does not mean over the hill', *Nursing Standard*, vol 12, no 28, pp 10-11.
- Buchan, J. (1996) 'Pool of returner nurses is steadily shrinking', *Employing nurses and midwives*, no 1, p 15.
- Buchan, J. (1997) 'Magnet hospitals: what's the attraction', *Nursing Standard*, vol 12, no 7, pp 22-5.
- Buchan, J. (1998) *Carry on nursing? The implications of the ageing nursing workforce for employer and employee*, London: Royal College of Nursing.
- Buchan, J. (1999) 'The greying of the United Kingdom workforce: implications for employment policy and practice', *Journal of Advanced Nursing*, vol 30, pp 818-26.
- Buchan, J. (2000) 'Nursing a statistical hangover', *Nursing Standard*, vol 15, no 13, pp 21-2.
- Buchan, J. and Seccombe, I. (2002) *Behind the headlines*, London: Royal College of Nursing.
- Buerhaus, P., Staiger, D. and Auerbach, D. (2000) 'Implications of an aging registered nurse workforce', *Journal of the American Medical Association*, vol 283, pp 2948-54.
- Cabinet Office (2000) *Women's incomes over the lifetime*, London: The Stationery Office.
- Carnegie UK Trust (1993) *Life, work and livelihood in the third age: The Carnegie inquiry into the third age: final report*, Fife: Carnegie UK Trust.
- Cliff, D. (1991) 'Negotiating a flexible retirement: further paid work and the quality of life in retirement', *Ageing and Society*, vol 11, pp 319-40.

- Cloud, J. (1999) 'Let flexibility be a friend', *Nursing Standard*, vol 13, no 32, pp 22-3.
- Cole, A. (1996) 'Older and wiser', *Nursing Times*, vol 92, no 39, pp 22-3.
- Coombes, R. (1996) 'From carers to custodians', *Nursing Times*, vol 92, no 42, pp 19-21.
- Crouch, R. (1998) 'Independence day', *Nursing Standard*, vol 13, no 6, p 20.
- Culley, L. (2001) 'Equal opportunities policies and nursing employment within the British National Health Service', *Journal of Advanced Nursing*, vol 33, pp 130-7.
- Daniel, P., Chamberlain, A. and Gordoni, F. (2001) 'Expectations and experiences of newly recruited Filipino nurses', *British Journal of Nursing*, vol 10, pp 254-65.
- Daphne Heald Research Unit (1994) *The morale of nurses working in the community: Summary of a three year study*, London: Royal College of Nursing.
- Davies, C. (1995) *Gender and the professional predicament in nursing*, Buckingham: Open University Press.
- D'Cruz, S. (1996) 'Welcome to Britain', *Nursing Times*, vol 92, no 39, pp 38-9.
- DoE (Department of Employment) (1990) *Too old, who says?*, London: DoE.
- DoH (Department of Health) (1997) *Statistical bulletin: NHS hospital and community health services non-medical staff in England, 30 September 1996*, London: DoH.
- DoH (1999a) *Making a difference*, London: DoH.
- DoH (1999b) *Caring about carers: A national strategy for carers*, London: DoH.
- DoH (2000a) *Working lives: Programmes for change: Reduced hours*, London: DoH.
- DoH (2000b) *Working lives: Programmes for change: carers*, London: DoH.
- DoH (2000c) *The NHS Plan*, London: DoH.
- DoH/Cabinet Office (2002) *Making a difference: Reducing burdens in hospitals*, London: DoH/Cabinet Office.
- DWP (Department for Work and Pensions) (2002a) *Simplicity, security and choice: Working for saving and retirement*, London: DWP.
- DWP (2002b) *Flexible retirement*, London: DWP.
- Finlayson, L. (1998) *Gender inequalities in nursing careers*, PSI Report No 854, London: Policy Studies Institute.
- Ginn, J. and Arber, S. (1999) 'Changing patterns of pension inequality: the shift from state to private sources', *Ageing and Society*, vol 19, pp 319-42.
- Gould, M. (1998) 'Universities want all graduate profession', *Nursing Standard*, vol 12, no 28, p 7.
- Grimshaw, D. (1999) 'Changes in skills-mix and pay determination among the nursing workforce in the UK', *Work, Employment and Society*, vol 13, pp 295-328.
- Hirsch, D. (2000) *Life after 50: Issues for policy and research*, York: York Publishing Services.
- Hornstein, Z. (2001) *Outlawing age discrimination: Foreign lessons, UK choices*, Bristol/York: The Policy Press/Joseph Rowntree Foundation.
- King, P. (1996) 'Keeping the baby boomers on board', *The Health Service Journal*, vol 106, no 5506, pp 26-8.
- Leighton, D. and Reilly, T. (1995) 'Epidemiological aspects of back pain: the incidence and prevalence of back pain in nurses compared to the general population', *Occupational Medicine*, vol 45, pp 263-7.
- Lipley, N. (1998) 'Employers opposed to staging of pay award', *Nursing Standard*, vol 13, no 1, p 5.
- Loretto, W., Duncan, C. and White, P.J. (2000) 'Ageism and employment: controversies, ambiguities and younger people's perceptions', *Ageing and Society*, vol 20, pp 279-302.

- Marshall, B. and Macfarlane, R. (2000) *The intermediate labour market*, York: York Publishing Services.
- Mashta, O. (1998) 'The time of their lives', *Nursing Standard*, vol 12, no 24, pp 12-13.
- Mooney, A., Statham, J. and Simon, A. (2002) *The pivot generation: Informal care and work after fifty*, Bristol/York: The Policy Press/Joseph Rowntree Foundation.
- Moore, K. and Biordi, D. (1995) 'Nurses retirement preparation', *Journal of Nursing Administration*, vol 25, pp 62-7.
- NHS Executive (2000) *Recruiting and retaining nurses, midwives and health visitors in the NHS – a progress report*, London: DoH.
- NHS Scotland (2000) *Family-friendly policies*, Edinburgh: The Partnership Information Network.
- Northrop, J. (1999) 'Family-friendly policies', *Nursing Management*, vol 6, no 4, pp 28-32.
- Nursing Standard* (1998) 'Huge increase in tele-consultations may help retention of older nurses', *Nursing Standard*, vol 12, no 44, p 7.
- Nursing Standard* (2000) 'Staffing crisis in mental health', *Nursing Standard*, vol 14, no 43, p 8.
- Nursing Times* (2001) 'Watchdog's verdict: millions squandered, nurses neglected', *Nursing Times*, vol 97, no 36, pp 10-11.
- Phillips, J. (1994) 'The employment consequences of caring for older people', *Health and Social Care in the Community*, vol 2, pp 143-52.
- Phillipson, C. (1998) *Reconstructing old age*, London: Sage Publications.
- Pierre, S. and Agorom C. (1999) 'Respectability', *Nursing Standard*, vol 6, no 1, pp 7-8.
- Purcell, P.J. (2000) 'Older workers: employment and retirement trends', *Monthly Labour Review*, October, p 30.
- Queen Margaret University College (2000) *Making up the difference: A review of the UK nursing labour market in 2000*, London: Royal College of Nursing.
- RCN (Royal College of Nursing) (1993) *Do nurses need a pay rise?*, London: RCN.
- RCN (2000) *Membership survey*, London: RCN.
- Robinson, D., Buchan, J. and Hayday, S. (1999) *On the agenda: Changing nurses careers in 1999*, Institute of Employment Studies Report No 360, Brighton: Institute of Employment Studies.
- SCMH (Sainsbury Centre for Mental Health) (2000) *Finding and keeping: Review of recruitment and retention in the mental health workforce*, London: SCMH.
- Seccombe, I. and Ball, J. (1992) *Motivation, morale and mobility: A profile of qualified nurses in the 1990s*, IMS Report No 233, London: Institute for Manpower Studies.
- Seccombe, I. and Ball, J. (1993) *Back injured nurses: A profile*, A discussion report for the RCN, London: RCN.
- Seccombe, I. and Smith, G. (1996) *In the balance: Registered nurse supply and demand a summary*, London: RCN/Institute of Employment Studies.
- Waters, A. (1997) 'Amber light for green budget', *Nursing Standard*, vol 12, no 11, p 12.
- Watson, R. and Manthorpe, J. (2000) 'The UKCC and the independent sector', *Generations Review: Journal of the British Society of Gerontology*, vol 10, no 4, pp 17-18.
- White, C. (2002) 'Ageing workforce will exacerbate NHS staffing crisis', *British Medical Journal*, vol 325, p 1382.
- Yeatts, D., Folkes, W. and Knapp, J. (2000) 'Older workers' adaptation to changing workplace: employment issues for the 21st century', *Educational Gerontology*, vol 26, pp 565-82.