

Black and minority ethnic and internationally recruited nurses

**Results from
RCN Employment/Working Well Surveys
2005 and 2002**



Royal College
of Nursing

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Preface

This paper was commissioned by the Royal College of Nursing and written by Geoff Pike and Jane Ball from the independent research consultancy Employment Research Ltd.

All RCN research is highly dependent on the target research group being sufficiently interested and concerned in the issues raised to participate in the research. It is commendable that so many nurses participate each year in this project. The authors have made extensive use of previous Employment Surveys (primarily 2005, 2003 and 2002 and the Working Well Survey of 2005). Again, we would like to thank all the RCN members who have responded to previous surveys and continue to support RCN research projects by completing these questionnaires.

Employment Research Ltd

Employment Research Ltd is a small independent research consultancy formed in 1995. The consultancy undertakes a range of research and evaluation, and for the last five years Employment Research Ltd has undertaken the annual RCN Employment Survey and conducted the RCN *Working Well* survey.

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1. Introduction

In order to help improve Royal College of Nursing understanding of the employment experiences of internationally recruited nurses and UK trained black and minority ethnic (BME) nurses, the RCN commissioned a secondary analysis to draw together commentary and analysis from previous surveys. Two main comparisons were drawn out of the data:

- 1) the differences between white and BME respondents (including differences between Afro-Caribbean and Asian respondents) and
- 2) differences between nurses who qualified in the UK and those who qualified overseas but started working in the UK since 1999. This group are classified as internationally recruited nurses (IRNs).

The purpose of this paper is to collate and summarise existing data gleaned from previous RCN Annual Employment Surveys (AES) surveys and present additional secondary analysis of data covering IRNs and BME nurses where possible. A further purpose of this research is to point to areas where there are gaps in knowledge of the working lives of IRN and BME nurses.

Classification

Respondents to the RCN AES are asked to provide details of their ethnicity using the Office of National Statistics (ONS) classification of ethnic origin. This is a 16-category question, which, for the purposes of analysis in RCN reports, is conflated to allow sufficient respondents in each group.

In addition, for the last three Employment Surveys, nurses who qualified overseas but started working in the UK since 1999 were classified as international recruits to the UK. A combined variable breaks respondents into four categories: UK qualified (white), UK qualified black and minority ethnic (BME) origin, overseas qualified (white IRN) and overseas qualified (BME IRN)¹.

This report uses the 2002 data as a benchmark, as this survey included more respondents from minority origins than any previous or subsequent RCN survey. The 2003 and 2005 surveys are then used to corroborate or contest findings, and show where there may have been change in the views and experiences of BME/IRN respondents.

The Employment and Working Well surveys

Table 1 below provides an overview of the numbers of respondents involved in each survey that are in BME/IRN groups. Summarising each survey:

AES 2002² – Valued equally? This report provides the most comprehensive coverage of ethnicity, although the IRN variable is perhaps not as accurate as in subsequent reports as the questionnaire did not ask for the date overseas qualified respondents started working in the UK. A booster sample of 1,250 nurses self-classified as from minority ethnic origins was included in this survey so that more detailed ethnicity analysis could be provided. There were more possibilities for further analysis using this dataset than for any of the other surveys. Data from this survey acts as a benchmark for the analysis and the more recent surveys are used to corroborate or question findings from 2002.

¹ There will be two groups in nurses who first qualified overseas that are indistinguishable in these analyses. 1) IRNs who qualified overseas and were recruited into the UK and 2) nurses who qualified overseas and are travelling/visiting/living in UK, independent of their nursing qualification.

² Ball J and Pike G (2002) *Valued equally?* Results from the RCN membership survey 2002, RCN, London

AES 2003³ – *Stepping stones* This questionnaire provided additional coverage of bank and agency working and issues related to morale. The survey achieved 400 responses from BME respondents and 155 from IRNs. This survey is used to double check findings from 2005 when compared to 2002.

AES 2005⁴ – *Managing to work differently* This survey contains additional questions on workload and professional development as well as the core questions used in previous years. 409 responses from BME nurses were received and 213 from IRNs.

WW 2005⁵ – *At breaking point?* Although the base number of respondents from BME and IRN backgrounds is smaller in this survey, the issues covered are important in identifying areas where BME nurses have more negative (or positive) work experiences.

Table 1: Numbers of BME/IRN respondents in each of the recent surveys

	AES 2002	AES 2003	AES 2005	WW 2005
Black and minority ethnic origin (BME)	867	400	409	238
International recruited nurses (IRNs)	307 ⁶	155	213	136
Asian respondents	372	129	183	101
Afro Caribbean respondents	495	198	168	102

Source: *Employment Research/RCN (2002, 2003, 2005)*

Most BME and IRN respondents are based in England and the numbers from Wales, Scotland and Northern Ireland are too small to allow further analysis (Table 2) but are presented below for reference.

Table 2: Numbers of BME/IRN respondents by country

		AES 2002	AES 2003	AES 2005	WW 2005
Wales	BME	9	37	32	24
	IRN	6	13	20	14
Scotland	BME	21	29	18	7
	IRN	13	11	8	7
Northern Ireland	BME	3	19	34	14
	IRN	2	13	28	10

Source: *Employment Research/RCN (2002, 2003, 2005)*

³ Ball J and Pike G (2003) *Stepping stones* Results from the RCN membership survey 2003, RCN, London

⁴ Ball J and Pike G (2005) *Managing to work differently?* Results from the RCN employment survey 2005, RCN, London

⁵ Ball J and Pike G (2005) *At breaking point?* Working Well initiative A survey of the wellbeing and working lives of nurses in 2005, RCN, London

⁶ In 2002 respondents were not asked to say when they started working in the UK so this proxy is not the same as in other years.

2. Biographical information

Approximately 40% of all BME nurses are Black, one in three is from Black African ethnic origins and a further 10-15% are from Black Caribbean origins. Nurses with Asian origins account for around 40% of BME respondents. This figure has increased since 2002 from around 30%. This is accounted for primarily in an increase in the proportion of Asian nurses who first qualified overseas, up from 36% in 2002 to 58% in 2005.

There has been an increase in the numbers of respondents who indicate that they first registered as a qualified nurse in another country, from just under 2% in 2001 to 4% in 2005.

Nurses who qualified and first registered overseas are younger than their colleagues who first registered in the UK, with an average age of 37 compared to 42 years. In 2002 the proportion of men and women in the group initially qualifying overseas was similar to that of those qualifying in the UK. However, this appears to have changed with more men among IRNs (15% compared to 7% among UK qualified nurses). In 2002 nurses initially qualifying overseas accounted for 38% of all BME nurses – this figure seems to have increased to around 47% and 42% classified themselves as from a minority ethnic origin and this figure is now 89%.

The change in the ethnic composition of IRNs is highlighted in Table 3. This shows the proportion of nurses who first registered outside the UK by country/region of first registration. There has been a large increase in numbers from Asia and Africa and a corresponding decrease in numbers from Europe and Australia, New Zealand and Canada⁷.

Table 3: Country of first registration – percentages

	Percentage 2002	Percentage 2005
Australia/New Zealand/Canada	27	4
Europe	13	4
Philippines	21	20
Other Asia	7	29
SA/Zimbabwe	10	18
Nigeria	8	6
Other Africa	7	13
Caribbean	2	3
Other	7	3
<i>Base respondents</i>	<i>490</i>	<i>160</i>

Source: *Employment Research/RCN 2002/2005*

Using the combined classification of ethnicity and overseas qualification, Table 4 highlights some of the key differences between nurses by ethnicity and where they qualified. The figures in brackets show the 2005 figures compared to 2002.

⁷ It is difficult to provide accurate data on the numbers of IRNs because we do not seek information on the nature of their arrival to the UK.

Table 4: Biographical data by ethnicity and qualification domicile 2002 and (2005) – percentages

	UK qualified white	UK qualified BME	IRN BME	IRN white
% men	6 (6)	8 (20)	7 (16)	4 (0)
% age < 36 years	34 (27)	28 (30)	48 (49)	41 (52)
% age >45 years	31 (37)	43 (43)	25 (22)	35 (22)
% with children	55 (55)	59 (57)	45 (55)	41 (35)
% with other caring demands	16 (19)	16 (17)	18 (16)	13 (0)
% with a degree	16 (22)	14 (16)	28 (23)	22 (35)
% working in London	6 (5)	33 (31)	36 (11)	31 (26)
Time qualified (years)	17 (18)	18 (16)	15 (13)	18 (13)
<i>Base cases</i>	<i>3008 (4380)</i>	<i>560 (286)</i>	<i>307 (227)</i>	<i>156 (34)</i>

Source: *Employment Research/RCN 2002/2005*

The key differences to note are that among ethnic minorities:

- ◆ A higher proportion are men and the proportion has increased significantly in recent years from 8% in 2002 to 20% in 2005.
- ◆ In 2002 there was a slightly older age profile; this difference has now reduced although IRNs still have a significantly younger age profile with nearly 50% aged under 36 compared to 27% of UK qualified white nurses and 30% of UK qualified BMEs.
- ◆ A much higher proportion work in London than elsewhere in the UK (33% compared to 6% of white nurses).

Among IRNs there is a younger age profile, fewer have children, they are more likely to be working in London and more hold a nursing degree level qualification. However, in 2005 fewer IRNs are working in London than was the case in 2002 (11% compared to 36%). It is now the case that IRNs are working across the UK (although mainly in England). More than a third of all respondents from London are BME nurses.

There is little difference by ethnicity in percentages having children and other caring responsibilities but fewer nurses who first registered as a nurse outside the UK have childcare responsibilities (45% compared to 55% of UK qualified nurses).

3. Employment information

UK qualified BME nurses and IRNs are more likely than white UK qualified nurses to be employed in independent care home and bank/agency settings. This is particularly the case among IRNs. More white IRNs are employed in independent hospital and bank/agency settings (Table 5). It is likely that more black and minority ethnic IRNs have been directly recruited to the UK, while white, non-UK qualified nurses are visiting/living in UK independently and selecting their own employment situation.

Table 5: Employer by ethnicity and UK/IRN qualified – percentages 2005

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
NHS hospital	51	55	50	50
NHS community	14	9	1	0
GP practice	8	5	1	0
Independent hospital	2	4	4	27
Independent care home	5	11	31	0
Bank/agency	3	6	9	14
Hospice	3	1	2	0
Other	14	9	2	9
<i>Base N=100%</i>	<i>4365</i>	<i>282</i>	<i>229</i>	<i>34</i>

Source: *Employment Research/RCN 2002/2005*

Since 2002 there has been a large increase in the proportion of black and minority ethnic IRNs employed in independent care homes, up from 16% to 31% in 2005. This is mainly accounted for by a reduction in the proportion employed in NHS hospital settings down from 61% to 50%. White IRNs in 2002 were more evenly distributed across a range of employers with fewer (7%) employed in independent hospitals and NHS hospitals (43%). In 2005 more UK qualified BMEs are employed in NHS hospitals and independent care homes than was the case in 2002 (50% and 7% respectively).

Fewer BME and IRN nurses are employed on senior grades or in community roles and higher percentages are employed as staff nurses (almost all the IRN ethnic minorities). Very few clinical nurse specialists and nurse practitioners are from black and minority ethnic origins.

Table 4: Job title by ethnicity and UK/IRN qualified – percentages

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Staff nurse	38	55	92	57
Community nurse	8	4	0	0
Sister/charge nurse	12	16	3	17
Senior nurse/matron	5	5	2	4
CNS/NP	10	3	1	13
DN/HV/practice nurse	11	8	1	4
Other	16	9	1	5
<i>Base N=100%</i>	<i>4367</i>	<i>289</i>	<i>227</i>	<i>36</i>

Source: *Employment Research/RCN 2002/2005*

As indicated above, many more IRNs proportionally are employed in older people’s nursing but UK qualified BME nurses are more likely to be employed in mental health (17%) than white nurses (7%) and BME IRNs (6%). Many more white nurses are employed in ‘other’ specialties, including education, oncology/palliative care and women’s health as well as across several different specialties.

Table 5: Field of practice by ethnicity and UK/IRN qualified – percentages

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Primary care	17	13	4	18
Community care	6	3	1	0
Older people’s nursing	7	13	37	3
Mental health	7	17	6	3
Adult critical care	11	12	14	21
Adult general	18	24	26	32
Paediatrics	6	3	3	6
Other	28	15	9	17
<i>Base N=100%</i>	<i>4350</i>	<i>287</i>	<i>227</i>	<i>34</i>

Source: Employment Research/RCN 2002/2005

4. Pay and grading

Many more BME nurses and IRNs in particular are employed on D grades and this proportion has increased in the last three years with fewer employed on F and G grades than was the case in 2002. It is also noticeable, although the numbers are small, that many more black and minority ethnic IRNs are employed on D grade than white IRNs (64% compared to 36% of white IRNs). It also seems to be the case that the proportion of BME nurses and IRNs working at D grade has increased since 2002 while the proportion of white UK qualified nurses on D grade has reduced over the same period.

Table 6: Grade by ethnicity and UK/IRN qualified – percentages

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
D	18 (14)	20 (26)	55 (64)	28 (36)
E	34 (30)	34 (29)	26 (25)	30 (15)
F	16 (17)	17 (14)	10 (1)	11 (24)
G	19 (21)	18 (13)	6 (1)	17 (15)
H	6 (8)	5 (5)	1 (0)	5 (0)
I	1 (2)	1 (2)	0 (0)	0 (0)
Other	7 (8)	6 (10)	2 (8)	9 (9)
<i>Base N=100%</i>	<i>3633 (4270)</i>	<i>546 (279)</i>	<i>302 (210)</i>	<i>151 (33)</i>

Source: Employment Research/RCN 2002/2005

In 2002 it was found that some groups of BME nurses were more likely to be ‘acting up to a higher grade’ than white nurses, especially in the case of Afro Caribbean and Asian nurses (19% and 15% respectively compared to white nurses 10%). Data from the 2005 survey suggests a similar disparity (12% and 14% compared to 7% of white nurses). However, it is the black and minority ethnic IRNs that are most likely to report acting up to a higher grade (17% compared to 11% of UK qualified BME respondents and 7% of white nurses).

In addition to this, fewer BME respondents report being paid for acting up to a higher grade 25% compared to 36% of white respondents.

Appropriate grading

In the NHS in 2002 a lower proportion of Afro Caribbean nurses felt they were appropriately graded than is the case among other ethnic minorities. This was even more the case when compared with white nurses (in 2002 30% compared to 49%). In 2005 the difference between Afro Caribbean and other ethnic minority respondents is not as apparent but it remains the case that more BME nurses report being inappropriately graded (53% compared to 45% of white UK qualified nurses). In addition to this, 20% of IRNs say they do not know if they are appropriately graded compared to 6% of all nurses.

These differences were reported as wider still among D-F grades in NHS hospital settings in 2002 but cannot be verified in 2005 due to the smaller sample sizes.

To explore the issues of appropriate grading from a different angle, respondents were asked in 2002 to indicate how often, if at all, they did work that should be paid on a higher grade. Looking within NHS hospital settings there is little difference between men and women but UK qualified BME nurses are more likely to do work that should be paid at a higher grade (61% compared to 51% of UK qualified white nurses).

There was little difference by ethnicity or where qualified in whether or not respondents possessed job descriptions, but fewer BME and IRN respondents in the NHS said that their job description was an accurate description of their role – 60% compared to 68% of UK qualified white respondents. IRNs were less likely to report that their responsibilities had changed since they took up their post. Where respondents had received a role change UK qualified BME respondents were less satisfied with it – 53% compared to 69% of UK qualified white respondents (61% of IRN BME respondents were satisfied).

Household earnings

Table 7 shows that the earnings of male nurses are more likely to represent all, or more than half, of their total household income than is the case among women. Similarly, the income of white nurses is twice as likely to account for less than half their household income as is the case among BME members (both those who qualified in the UK and overseas). Afro Caribbean members are most likely to be in the bread winner role (70% in 2002 and 68% in 2005). Respondents who qualified overseas are also more likely to fall into the bread winner role (52% in 2002 58% in 2005).

Table 7: Earnings as a proportion of household income – percentages 2002 and (2005)

	BME	White	IRN BME	UK BME
All of it	29 (27)	23 (20)	(25)	28
More than half	28 (31)	22 (23)	(35)	28
About half	26 (28)	21 (25)	(28)	27
Less than half	17 (15)	34 (32)	(12)	17
<i>Weighted cases</i>	<i>215 (456)</i>	<i>3759 (4099)</i>	<i>(197)</i>	<i>(259)</i>

Source: Employment Research/RCN 2002, 2005

5. Working hours and ethnicity

The differences between white and BME members in their working hours have been highlighted in several RCN reports. With the additional samples, in 2002 more insight into these differences was possible. First, it can be seen that UK qualified BME members are much more likely to work full-time than their white colleagues and this difference has grown since 2002. High proportions of IRNs also work full-time, but this is partly a reflection of their younger age profile.

Table 8: Mode of working by ethnicity and UK/IRN qualified – percentages 2002 and (2005)

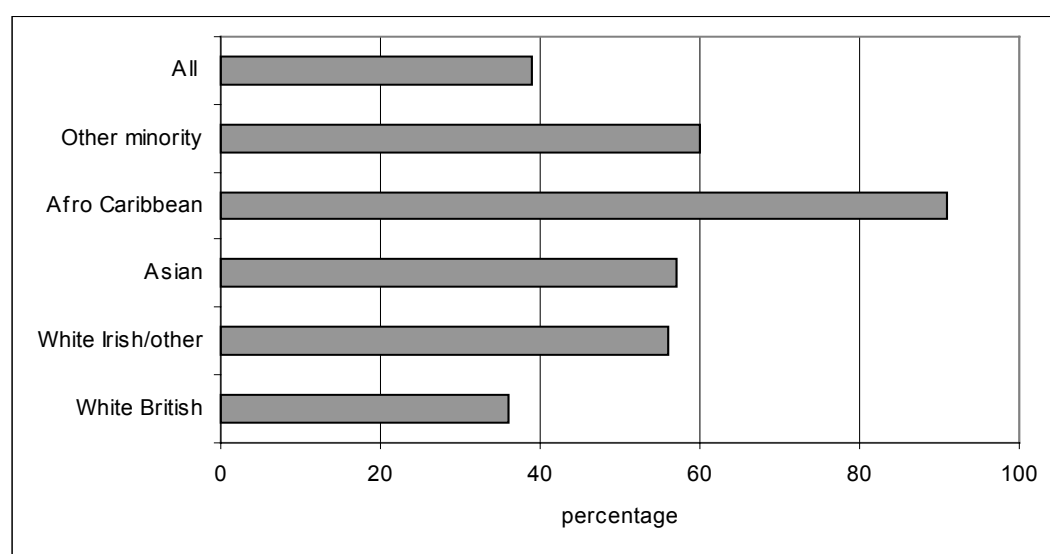
	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Full-time	59 (58)	77 (83)	90 (92)	81 (77)
Part-time	41 (42)	26 (17)	10 (8)	19 (23)
Base N=	3679 (4348)	144 (288)	84 (227)	119 (35)

Source: *Employment Research/RCN 2002, 2005*

As has been shown in the previous section, UK qualified BME respondents are marginally older and more likely to have dependant children than white nurses, so all other things being equal one might expect at least similar proportions to work full-time.

In 2002 it was possible to explore this issue a little further and control for other explanatory factors; women (with children) in the NHS, employed as staff nurses were selected. If anything, the differences widen with nearly two thirds of UK qualified BME respondents (63% and 82%⁸ in 2005) working full-time compared to just 36% (33% in 2005) of white UK qualified respondents. It would seem this difference has widened in the last three years. More striking still, 91% of Afro Caribbean nurses in this category work full-time as do 57% of Asian respondents.

Figure 1: NHS, female, staff nurses with children working full-time – percentages by ethnic group (2002)



Source: *Employment Research/RCN 2002*

Possible explanations of these differences include (2002):

⁸ Based on 38 BME respondents.

- ◆ **Economic activity** – the economic activity rates of women vary by ethnic group, as does the size of family and likelihood of being lone parents.⁹ Other surveys have found that BME nursing staff are much more likely to be working full-time than their white colleagues¹⁰.
- ◆ **Greater financial need** – for example it is worth noting that two thirds (70%) of all female, Afro Caribbean respondents working in the NHS as staff nurses are the major bread winner (accounting for more than half their household income). This compares to 44% of the equivalent white group of nurses.
- ◆ **Access to part-time working** – are certain specialties less conducive to part-time working eg. mental health, where high proportions of BME (especially Afro Caribbean) respondents work?
- ◆ **Discrimination** – do staff have equal access to part-time working?

Shift working

In 2002 it was reported that in general, BME nurses also seemed to work internal rotation shift patterns more than white nurses with UK qualified BME nurses more likely to work rotating shifts (46%) compared to 39% of UK white nurses, after controlling for other factors. In addition, in 2002 71% of overseas qualified BME nurses were working rotating shifts. However, this was also correlated with their relative inexperience i.e. more recently qualified than white UK qualified nurses.

The questionnaire design changed between 2002 and 2005 but in 2005 90% of black and minority ethnic IRNs worked shifts compared to 65% of white IRNs, 69% of UK qualified BME respondents and 52% of white UK qualified nurses. There was little difference between BME nurses from different origins.

Of those working shifts black and minority ethnic IRNs are the most likely to work rotating shifts (61%) and permanent nights (13%), equivalent figures for UK qualified ethnic minorities 59% and 11%, and white UK qualified 52% and 10% permanent nights.

Table 9: Shift working by ethnicity and UK/IRN qualified – percentages 2005

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Internal rotation	52	59	61	48
Daytime shifts	38	30	26	52
Permanent nights	10	11	13	0
Base N=	2415	212	210	21

Source: *Employment Research/RCN 2005*

In the event of working additional hours, black and minority ethnic IRNs are much more likely to be paid overtime (53% compared to 33% of white and UK qualified BME nurses) and less likely to be offered time off in lieu. This is partly a function of grade but not entirely, with more IRN D grades being paid overtime (52% compared to 43% of UK qualified BME and 34% of white respondents).

IRNs are less likely to have to work in excess of their contracted several times a week or more (27% compared to 43% of UK qualified nurses). There is little or no difference between white and BME UK qualified nurses.

⁹ Jones T (1993) *Britain's ethnic minorities*. London: PSI.

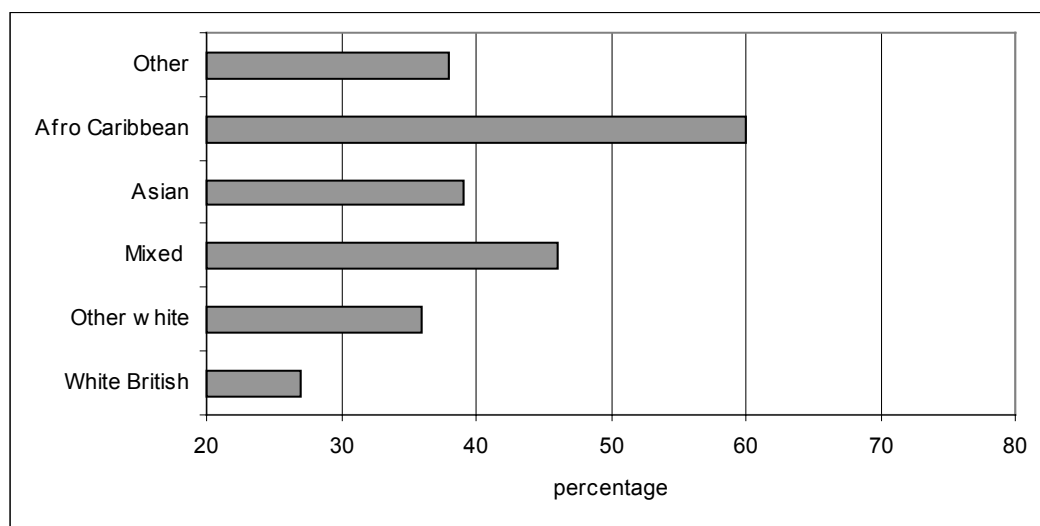
¹⁰ Beishon S, Virdee S and Hagell A (1995) *Nursing in a multi-ethnic NHS*. London: PSI.

It is worth noting from the Working Well survey in 2005 that there is little or no difference by ethnicity or where nurses qualified in whether or not they would prefer to work a different shift pattern. Black and minority ethnic IRNs, however, were much more likely to say that they ‘find it hard to plan life outside work because their hours vary so much’ (44% compared to 35% of UK qualified BME respondents and 24% of UK qualified white respondents). Fewer also say that they are able to get to work the shifts/times they want (47 of black and minority ethnic IRNs compared to 67% of white UK qualified and 56% of BME UK qualified respondents).

Additional jobs

RCN members working in additional jobs are concentrated in certain groups and areas. In London in 2002, 45% (same in 2005) of all members have additional jobs, compared to 28% elsewhere. But the largest differences, and in addition to regional variation, are by ethnicity where 60% of Afro Caribbean respondents have second jobs (Figure 2). This is also linked to the fact that more Afro Caribbean respondents are the main ‘bread winners’ than is the case among other ethnic groups, including white nurses. In 2005, these figures are similar to those reported in 2002, 52% of Afro Caribbean respondents have additional jobs compared to 25-30% of all other ethnic groups.

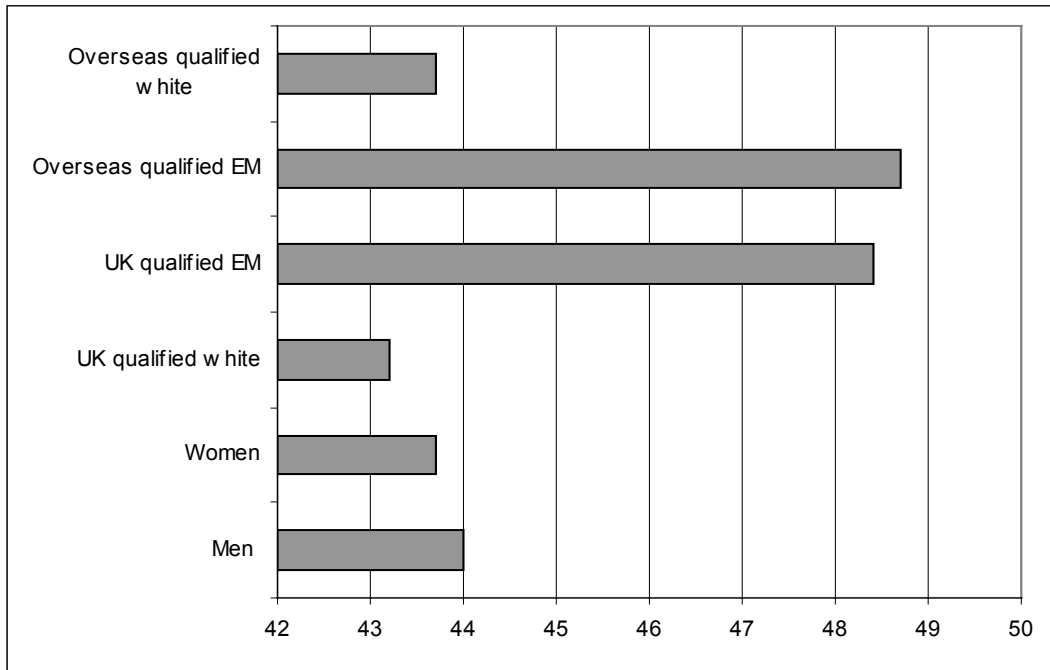
Figure 2: Nurses with additional jobs by ethnic origin – percentages 2002



Source: *Employment Research/RCN 2002*

In 2002, to explore equal opportunities issues, data for staff nurses in the NHS were presented showing variation in working hours by ethnicity and gender. There is very little difference in the total working hours between men and women. But the major disparity is by ethnicity. On average, UK qualified BME staff nurses in the NHS on full-time contracts work 5.2 hours per week more than their white UK qualified colleagues, with Afro Caribbean respondents working about 6.5 hours more than their white colleagues (Figure 3). This difference is primarily accounted for by differences in the hours worked in additional jobs for different ethnic groups.

Figure 3: Total hours worked for full-time NHS staff nurses by ethnicity and gender (hours)



Source: *Employment Research/RCN 2002*

Interestingly, despite the findings reported above, there is little or no difference in views between white and BME nurses in relation to satisfaction with their pay. This was the case in 2002 and remains so in 2005.

6. Careers in an equal opportunity context

The largest survey to date that has looked specifically at ethnicity and nursing careers in the UK, the PSI report,¹¹ found that nurses' chances of reaching F, G or H grades are influenced by their ethnicity. The authors point to limitations of the study design, in that the findings cannot explain why ethnicity affects career progression, simply that it does. Several possible explanations for the difference in career progression between white and BME nurses were put forward in the PSI report. Firstly, that career motivation may be less among BME nurses (perhaps through disillusionment). Secondly, that BME respondents may be less likely to apply for a higher grade post. Thirdly, that BME nurses are less successful in applications to higher grade posts due to active discrimination.

The 2002 RCN survey collected data on each of these three issues – career motivation, application rates for higher-grade posts, and success in getting higher-grade posts. It was therefore possible to look at these issues in conjunction with ethnicity, for nurses of different grades.

In 2005 more BME respondents had applied for a post of a higher grade – 30% of black and minority ethnic IRNs and 27% of UK qualified BME respondents, compared to 22% of UK qualified white nurses. This suggests that BME respondents show higher levels of career motivation. There is little difference by ethnicity or country of qualification in relation to the success rates, with 62% of BME respondents successful in their application for a higher grade post and 66% of white nurses. However, UK qualified BME nurses are slightly less successful (56%).

In 2002 there was little or no difference in terms of ethnic origin in the proportions changing jobs in the previous 12 months and this remains the case in 2005.

The reasons given for changing jobs were subsequently summarised into four main categories – career factors (experience, promotion, prospects), pay, work-life balance (change in hours, family circumstances), and negative factors with previous job (dissatisfaction, bullying and harassment, closure of work place). Results by ethnicity are presented in Table 10.

Table 10: Summarised reasons for job change by ethnicity 2002

	White	BME
Career (positive 'pulls')	68	58
Pay	24	25
Dissatisfaction (negative 'pushes')	44	52
Work-life balance	38	46
Other	13	10
<i>Number weighted cases</i>	853	34

Source: *Employment Research/RCN 2002*

In 2002 a higher proportion of BME respondents mention work/life balance factors and they are also more likely to change jobs as a result of dissatisfaction with their previous work. Table 11 presents similar data for 2005 showing different motivations of white and BME nurses changing jobs. BME respondents are more likely to have changed jobs due to bullying/harassment, training reasons and dismissal.

¹¹ Beishon S, Virdee S and Hagell A (1995) *Nursing in Multi Ethnic NHS*. London: PSI.

Table 11: Reason for changing jobs – percentage of cases 2005

	White	BME
Better pay	30	18
Change in working hours	28	11
Stress/workload	25	11
Bullying/harassment	5	11
Training reasons	6	14
Promotion	35	24
Dismissed (fairly/unfairly)	0	2
<i>Number weighted cases</i>	<i>968</i>	<i>95</i>

Source: *Employment Research/RCN 2002*

There is little difference in the proportions changing employer in the 12 months prior to the 2005 survey between BME and white respondents or between IRN and UK qualified, around one in ten. This said, more white IRNs said they changed employer in the previous 12 months (23% of 35 cases).

Career plans

UK qualified BME nurses aged under 50 are most likely to report that that they intend to leave nursing within two years and IRNs are most likely to say they intend to leave their employer within 2 years (50% compared to just 28% of white UK qualified nurses and 43% of UK qualified BME nurses).

Table 12: Career intentions by ethnicity and UK/IRN qualified – percentages 2005 (under 50 only)

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Leave nursing within 2 years	8	17	5	15
Leave employer within 2 years	28	50	43	57
<i>Base N=</i>	<i>3197</i>	<i>188</i>	<i>185</i>	<i>28</i>

Source: *Employment Research/RCN 2005*

Ethnicity and seniority

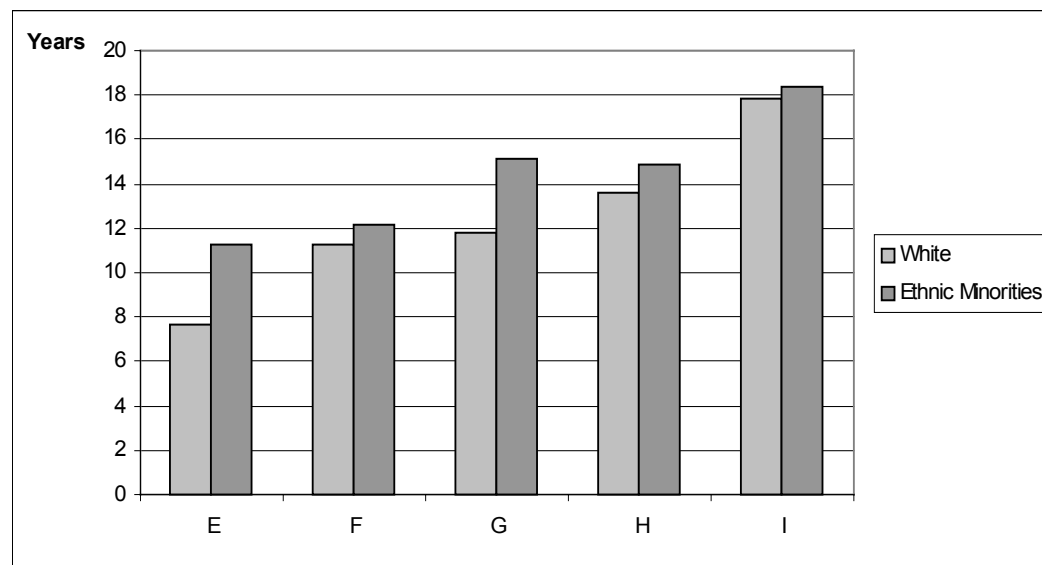
In 2002 analysis was undertaken to explore the ethnic make-up of different grades of staff and of different jobs. Within NHS hospitals, and looking at UK qualified nurses only, there was no apparent difference in the seniority of white and BME nurses when looking at their job titles. In 2002 there was also no obvious relationship between grade and ethnicity but in 2005 it seems from Table 6 above that there is a higher concentration of BME respondents and IRNs employed on D grades compared to the more senior grades.

In 2002 the differences became more apparent when grade relative to job title is explored. Within NHS hospital nurses (UK qualified), 33% of BME ward sisters are G grades or above, compared with 46% of white ward managers¹².

¹² This difference cannot be explored in the 2005 data due to insufficient cases.

Also, the results for NHS hospital nurses who first qualified in the UK show that, on average, white nurses had reached their current grades more quickly than BME nurses (Figure 4). For example, white nurses had taken an average of 11.8 years (excluding breaks) to reach their current G grade post, whilst the average for BME nurses was 15.1 years – more than three years longer. And this difference exists despite the fact BME nurses are more likely to work full-time. Focusing the analysis on full-time staff alone, suggests the differences are even greater, although the numbers, even in 2002, were too small to test reliably.

Figure 4: Average time (minus breaks) to reach current grade by ethnicity (UK qualified, NHS hospital only)



Source: Employment Research/RCN 2002

Overall, ethnicity appears to make little difference as to whether or not a nurse had applied for a job of a higher grade in the previous 12 months. Within the UK qualified population, there is also little or no difference in the success rate of white and BME nurses (54% of white UK qualified, 53% of BME UK qualified nurses).

Those who qualified outside of the UK however, are less likely to have been successful whether white (48%) or ethnic minorities (40%). Looking specifically at the NHS and those applying for higher grades, again there is little difference by ethnicity, on any of the grades looked at, although BME respondents who were D grades seem slightly more likely to have been successful in their job applications than white nurses.

It might be thought that the apparent lack of difference by ethnicity is because more BME respondents work full-time and are men. But even when only full-time NHS hospital nurses (again qualified in the UK) are examined, there is no significant difference between white and BME nurse in applying for and getting jobs of a higher grade.

This appears to refute two of the possible theories put forward to explain the career progression differences found between white and BME nurses in the PSI study, since there are no discernible differences in either the job application behaviour or success rates of white and BME nurses. However, these data report on nurses' experiences in the last 12 months, not the entire duration of their careers. The third argument explaining ethnic differences in career progression is that BME nurses may be less career motivated. These surveys found the opposite to be true; BME nurses display stronger career motivation, with 25% agreeing strongly that they are '*interested in career progression*' compared to 16% of (UK qualified) white nurses.

Differences in the grades reached and rate of career progression will clearly relate to experiences during the whole course of a career, not just the last 12 months. And it may also be that recent attention to institutionalised discrimination has reduced the disadvantage experienced by BME nurses in the last year or so, as witnessed by similar success rates in job applications.

Multivariate analysis undertaken in 2002 showed that ethnicity is a factor affecting the chances of reaching higher grades, and appears to be more important than gender in all three regression models used. It ranked sixth as a predictor of current grade and fifth as a predictor of reaching senior grades (F and above, G and above).

- ◆ BME nurses are more likely to change jobs because of negative factors. 14% said they changed jobs due to bullying or harassment (11% in 2005).
- ◆ White nurses had progressed to their current grades more quickly than BME nurses, but there was no difference in the proportions applying for or getting higher-grade posts in the last 12 months.
- ◆ In conjunction with length of career (excluding breaks), nursing qualification, field of practice and mode of work, the factors of having taken a career break and respondents' ethnicity both contribute to the chances of reaching higher grades.

7. Professional development

Table 13 shows that fewer BME respondents, and in particular black and minority ethnic IRNs, indicated that they participated in most of the continuous professional development (CPD) activities listed in the questionnaire, over the previous 12 months. The AES 2005 analysis found that age explained most variation in participation, with younger nurses more likely to have indicated participation in courses, while older nurses mentioned in service training and conferences/seminars more. Notwithstanding the age related influence (and sector differences), ethnicity and being internationally qualified are also correlated with participation rates.

Table 13: Participation in CPD activities by ethnicity and UK/internationally qualified – percentages

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Study days	82	73	64	74
In service session	48	40	23	46
Conferences/seminars etc	48	34	29	54
Study based on journals etc.	44	31	25	37
Lectures/demonstrations	42	33	30	49
Courses	28	24	21	31
Internet based study	25	13	11	15
Visit HE institution/library	23	21	12	37
Interest group meeting	20	10	4	11
Shadowing	11	7	2	20
Distance learning	10	10	3	9
RCN cont. ed. Articles	8	14	15	9
RCN Nursing Update	5	17	17	14
Secondments/exchanges	5	3	1	6
Other	3	2	0	6
Days spent on CPD	12.3	12.3	9.7	26.0
Hours spent on CPD	85	86	44	90
Base cases	4294	270	221	35

Source: Employment Research Ltd/RCN 2005

There is also a significant difference between black and minority ethnic IRNs and all other nurses in the time spent on CPD activities in the year to April 2005. White IRNs said they had completed 26 days of CPD, more than twice as much as the other groups. UK qualified respondents (BME and white) had done 12 days while black and minority ethnic IRNs had done less than 10 days CPD. These data suggest that IRN (predominantly BME) are not accessing as much training as other nurses. Fewer BME nurses undertake CPD activities for personal interest, and it should be noted from above that more BME nurses left their current position because of training reasons than was the case among UK qualified nurses.

There is no difference by ethnicity and country of qualification in the proportion of respondents who have a personal training and development plan. However, more BME respondents report having their manager actively involved in drawing up the plan (30% compared to 20% of white respondents).

In terms of employer support, BME respondents (particularly IRNs) are much less likely to report receiving financial support (23%) compared to 38% of white UK qualified respondents in the NHS. And fewer report having access to a professional/continuing education department (31% compared to 42% of UK qualified respondents). Fewer black and minority IRNs also get time off – 24% compared to 33% of UK qualified BMEs and 42% of white UK qualified nurses in the NHS.

There is little difference by ethnicity or country of qualification in proportions maintaining a personal professional portfolio and, again, similar proportions have met with their manager to discuss it.

8. Ethnicity and working well

The Working Well survey sought data and views from nurses on a range of topics related to working lives. The following sub sections highlight from the recent survey the main areas where a difference was noted between BME, white IRN and UK qualified nurses.

- There is very little difference between these groups of nurses in their access to employee friendly working patterns.
- Fewer black and minority ethnic IRNs have any health problems/disabilities that they expect to last a year or more (8% compared to 19% overall).
- Many more black and minority ethnic IRNs report that they do not know if their employer provides access to an occupational health service (19% compared to 5% across all respondents) and similarly, more do not know if they can access it without referral (38%). A similar difference is also apparent in respect of access to counselling services.
- When asked to indicate if nurses were currently receiving counselling, there is some evidence that BME/IRN nurses are less likely to use counselling services – all but 2 of the 68 cases (i.e. 97%) receiving counselling are UK qualified white nurses.
- Black and minority ethnic IRNs are also more likely to have taken sick leave (48%) compared to 27% of other nurses.

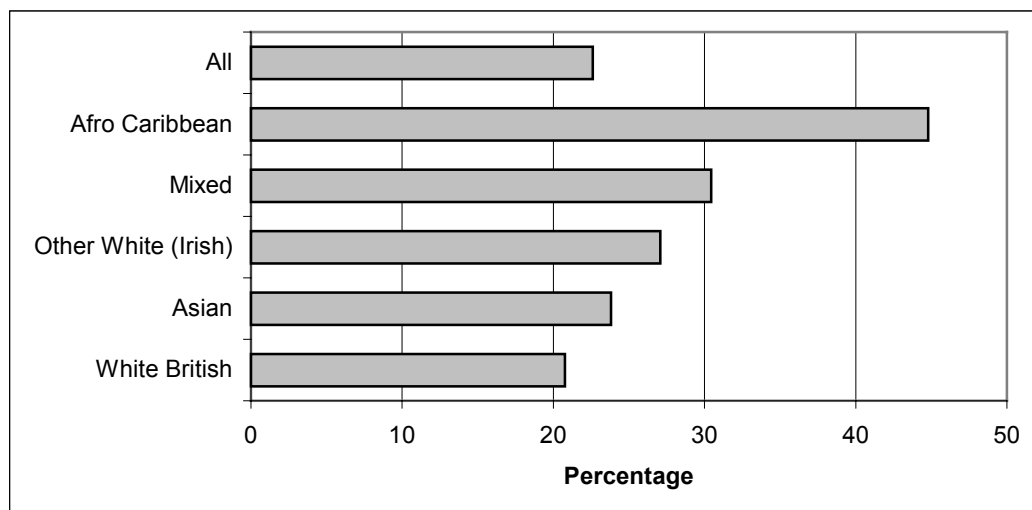
Bullying/harassment

It was noted in 2000 that there was a higher incidence of bullying/harassment reported among BME nurses and this remained the case in 2005, with 36% of BME nurses reporting that they have been bullied/harassed by a member of staff in the last 12 months compared to 21% of white respondents. There is no difference between IRN and UK qualified BME respondents.

Figure 5 shows that Afro-Caribbean nurses are most likely to report being bullied/harassed in the 12 months prior to the survey (45%). A previous survey conducted by the Policy Studies Institute found that more than a third of ethnic minority nurses had been racially harassed by colleagues¹³.

¹³ Policy Studies Institute 'Nursing in a multi-ethnic society'. 1995 London. (As reported in 'Challenging Bullying and Harassment' RCN. London. 2001.)

Figure 5: Bullied/harassed by a member of staff in previous 12 months by ethnic origin – percentages



Source: *Employment Research, 2005*

It is also the case that a higher percentage of IRNs report having been bullied/harassed (36% compared to 22% of UK qualified nurses although ethnicity accounts for most of the variation). These variables explain most of the variation in response to this question.

Table 14: Main focus of bullying and harassment by ethnicity – percentages (2000)

	White	BME	All nurses
Gender	10 (4)	13 (11)	11 (5)
Race	4 (2)	61 (56)	13 (6)
Nationality	4 (-)	43 (-)	10 (-)
Religion	1 (-)	1 (-)	1 (-)
Age	9 (4)	11 (16)	9 (5)
Sexuality	3 (2)	4 (2)	4 (2)
Personality clash	- (38)	- (40)	- (38)
Trade union membership/role	2 (-)	3 (-)	2 (-)
Disability	2 (-)	1 (-)	2 (-)
None of the above	77 (67)	30 (36)	70 (64)
<i>Base N (2005)</i>	<i>455</i>	<i>90</i>	<i>545</i>

Source: *Employment Research, 2005*

Nearly two thirds (61%) of BME nurses said that the bullying and harassment was racially influenced and 43% said it was connected to nationality. White nurses are more than twice as likely to say that the incident(s) is not linked to any specific minority issue (77% compared to 30%).

There is some evidence that BME nurses are more likely to report being harassed/bullied by a supervisor/manager (31% compared to 22% of white nurses).

Respondents who had been bullied or harassed by a member of staff were asked whether or not they had made their employer aware of the problem. More white nurses (67%) had made their employer aware of the problem than BME nurses (51%).

Perhaps partly reflecting this lack of support, only 21% of IRNs were satisfied with *how* their employer handled the situation compared to 60% of UK qualified nurses. In addition, 60% were satisfied with the eventual outcome, despite, in most cases, there not being any formal outcome from the incident. In this case BME nurses are less likely to be satisfied with the outcome (30% compared to 62% of white nurses).

Verbal/physical assault from patients/public

BME/IRN nurses are no more likely to report having been harassed or assaulted by patients/clients or their relatives in the 12 months prior to the survey.

However, it is interesting that BME nurses, especially IRNs, are less likely to report having been *verbally* abused (53% of BMEs and 49% of BME IRNs compared to 69% of white nurses). Especially given that more BME nurses work in specialties where there is a high incidence of verbal abuse i.e. mental health and learning difficulties.

BME/IRN respondents are also less likely to report having been physically assaulted in the last year (20% to 28% of UK qualified white nurses). However, of those who have been assaulted BME nurses experienced more assaults - 3.3 compared to 1.5 for white nurses. More BME nurses are employed on D/E grades but controlling for grade (BME n=29) still shows BME nurses to have been assaulted more frequently than white nurses. Across all categories the average number of times nurses reported being assaulted by patients/members of the public in the previous 12 months was 1.6, but D grade nurses had been assaulted 2.7 times and E grade 1.9 times.

When asked how their employers responded, just 27% of BME respondents (14% of black and minority ethnic IRN nurses) said that they were 'offered immediate support' compared to 46% of white UK qualified nurses. However, more BME respondents (29%) said that the assailant was issued with a verbal warning (12% of white respondents).

Respondents were also asked to respond to the statement '*I am confident that my manager would support me if I were physically assaulted at work*'. Overall 80% agreed with the statement. However, this figure was lower for IRNs, reinforcing the above findings - just 67% of IRNs agreed compared to 81% of white UK qualified respondents.

Perhaps reflecting BME/IRNs' perceived lack of support from employers, only 14% of black and minority ethnic IRNs were satisfied with *how* their employer handled the situation compared to 52% of black and minority ethnic UK qualified respondents and 62% of UK qualified nurses white nurses.

Overall, 62% were satisfied with the eventual outcome, despite, in most cases, there not being any formal outcome from the incident. BME nurses are less likely to be satisfied with the outcome (30% compared to 62% of UK qualified white nurses – black and minority ethnic IRNs 14%).

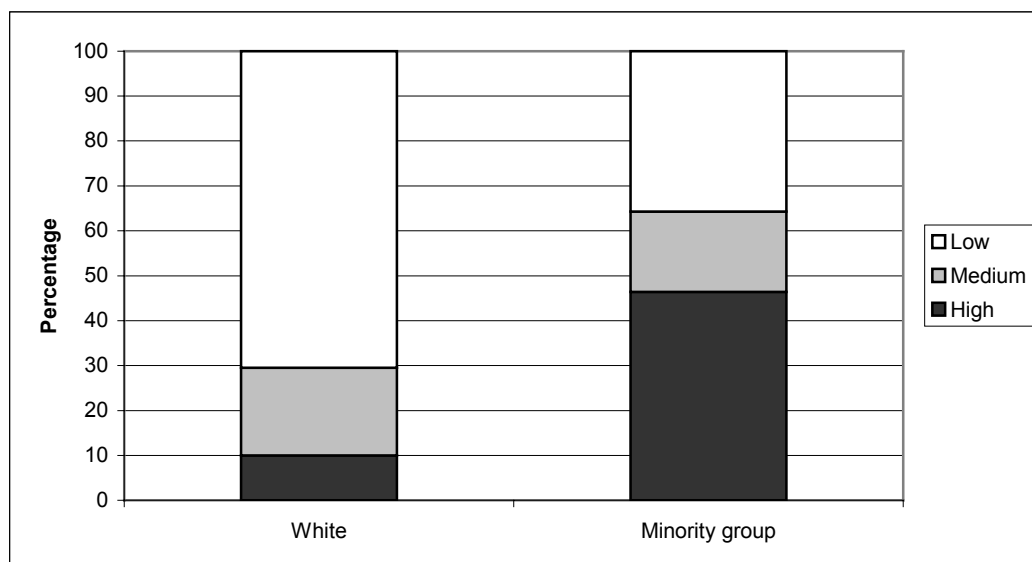
Needlestick injuries

Overall, 35% of nurses reported having been stuck with a needle or sharp that had been used on a patient. This figure is lower for BME respondents (21%).

In 80% of cases the incident drew blood and in 89% of cases the nurse knew which patient the needle/sharp had been used for. BME nurses were less likely to report that the incident drew blood (62%) or know who the patient was (22%).

In most cases (69%) where a respondent has been stuck with a needle or sharp, the level of risk of contracting a blood borne disease is perceived to be low. However, in 12% of all cases the level of risk was considered high and in 19% it was seen as a medium risk. There is a significant difference between BME nurses and white nurses in their response to this question. Only 10% of white nurses see the risk of contracting a blood borne disease as ‘high’ but nearly five times as many BME nurses do (46%) - see Figure 6.

Figure 6: Perceived risk of blood borne disease – percentages by ethnicity



Source: *Employment Research, 2005*

Respondents working in paediatrics are more likely to perceive low risk from their cut/needle stick (80%), while fewer nurses in mental health (56%) and adult acute care (60%) perceive low risk both of which employ, relatively, a higher proportion of black and minority ethnic nurses.

HSE stress indicator

The HSE has developed a set of six Stress Management Standards to identify and tackle work-related stress. Six dimensions of work design are identified by the Standards that, if not properly managed, may become sources of workplace stress. These areas are:

- demands – such as workload, working patterns and the working environment
- control – the extent which individuals can control the way they do their work
- support – level of support from the organisation, line managers and colleagues in terms of encouragement, sponsorship and resources. (The items on this theme produce two scales – one related to peer support and the other management support)
- relationships – such as promoting positive working to avoid conflict and dealing with unacceptable behaviour
- role – understanding role within the organisation and avoidance of role conflict
- change – management and communication of organisational changes (both big and small).

To support these standards, the HSE devised an indicator tool, covering 35 items that relate to the six primary stressors listed above. Using this tool the HSE has compiled a substantial data set against which the performance of specific groups of staff can be contrasted¹⁴ (more detail is provided in *At Breaking Point?*). The scores of negative items were reversed so that all the item scores indicate how positive respondents are, and the data is comparable with the HSE benchmarking data. Seven scales were computed relating to the HSE Stress Management Standards,

Overall, there was not much variation by ethnicity and country of qualification (Table 15). The main differences are that BME nurses, and particularly IRNs, are more positive than white UK qualified respondents about the demands of their job and slightly more positive about their role, but are significantly less positive about the peer support they receive and their relationships at work.

Table 15: HSE Management Standards – mean scores by ethnicity and IRN/UK qualified

	UK qualified white	UK qualified BME	IRNs BME	IRNs white
Demands	2.9	3.1	3.2	3.2
Control	3.5	3.4	3.5	3.3
Manager support	3.3	3.3	3.4	3.2
Peer support	3.8	3.7	3.5	3.8
Relationships	3.8	3.6	3.5	4.0
Role	4.2	4.3	4.4	4.0
Change	3.1	3.1	3.2	3.3
<i>Base N=</i>	<i>2409</i>	<i>141</i>	<i>136</i>	<i>18</i>

Source: Employment Research, 2005

For example, in relation to ‘demands’ of their work, 22% of black and minority ethnic nurses say they never have to neglect some tasks because they have too much to do while just 5% of white nurses respond similarly. Conversely, 21% of BME nurses say they always have to work very fast compared to 10% of white nurses.

In terms of ‘relationships’ at work though, black and minority ethnic nurses respond less positively than white nurses. For example, 52% say they are at least sometimes subjected to bullying at work compared to 36% of white nurses.

CORE measure of psychological health and wellbeing

The Working Well surveys use a measure of psychological health and wellbeing that combines the scores of respondents across 34 statements. In terms of the aggregate CORE score there is little difference between respondents in relation to ethnicity and country of qualification, but on individual items there was some significant variation. Table 16 highlights the statistically significant differences. It is difficult to summarise these differences with BME/IRN respondents more positive on some items but less so on others.

¹⁴ HSE (2004) Psychosocial Working Conditions in Great Britain in 2004.

Table 16: Individual item CORE-OM scores by ethnicity and IRN/UK qualified¹⁵

Negatively framed items Scale: 0 (not at all), 1 (occasionally), 2 (sometimes), 3 (often), 4 (most or all the time)	UK qualified white	UK qualified BME	IRN BME	IRN white
I have felt terribly alone and isolated	0.8	1.0	1.0	0.7
I have felt tense, anxious or nervous	1.3	1.1	1.0	0.9
* I have felt I have someone to turn to for support when needed	1.4	1.9	1.9	1.7
I have felt totally lacking in energy and enthusiasm	1.6	1.4	1.2	1.0
Talking to people has felt too much for me	0.5	0.7	0.8	0.8
* I have been happy with the things I have done	1.0	0.8	0.8	0.9
I have been disturbed by unwanted thoughts and feelings	0.4	0.5	0.8	0.5
I have had difficulty getting to sleep or staying asleep	1.1	0.8	0.8	1.0
* I have felt warmth or affection for someone	1.2	1.8	2.0	1.5
* I have been able to do most things I needed to	1.0	1.2	1.1	0.8
I have been irritable when with other people	0.8	0.5	0.5	1.0
I have felt humiliated or shamed by other people	0.4	0.6	0.7	0.4

* Scores reversed on items that were positively framed

Source: Employment Research, 2005 / PTRC, University of Leeds

9. Ethnicity and feeling valued (analysis from 2002¹⁶)

Although there is little difference between UK qualified BME and white nurses in the degree to which they feel their work is valued in general, the extent to which they feel valued by different groups does vary.

Looking firstly at nurses' reports that employers value their work: Black and minority ethnic NHS nurses are more likely to be positive about the extent to which their employer values their work than white NHS nurses. In the case of Afro Caribbean respondents, the differences are wider still; only 47% say their employer only values them a little or not at all, compared to 64% of white respondents. This, in itself, is surprising because a much higher proportion of Afro Caribbean nurses feel inappropriately graded (see above), which is demonstrated as a key determinant of whether or not an NHS nurse feels valued by their employer.

Also, nurses in London are more positive about their employers than nurses based elsewhere in the UK. This suggests that employers in London may be doing something right which results in their nurses valuing them more highly than employers elsewhere.

Although nearly a half (48%) of all Afro Caribbean NHS nurses work in London, the more positive views of Afro Caribbean nurses holds true both in and outside London. Other UK based black and minority ethnic nurses also feel more positive about their employer than white nurses.

¹⁵ Items selected where there exists a significant difference by ethnicity/country of qualification

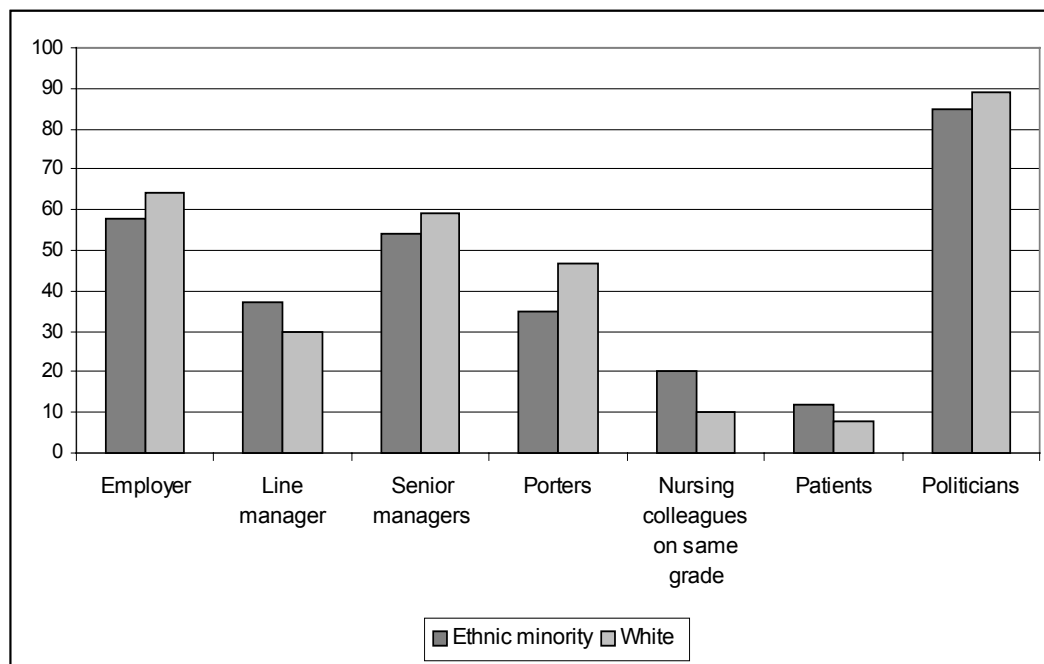
¹⁶ These questions were unique to the 2002 survey.

However, BME nurses are less likely to report that their contribution is valued by nursing colleagues of the same grade. The same is true when reporting about their supervisors. One in five BME nurses say that their nursing colleagues only value them a little or not at all, compared to one in ten white nurses.

It may be that some of this variation can be explained by incidences of bullying and harassment. BME nurses are more likely to have been bullied or harassed in the previous 12 months (28% compared to 16% of white nurses). Other RCN research¹⁷ found that in most cases where nurses had reported being bullied and harassed it was an immediate supervisor or a colleague who had been the perpetrator.

Finally, there are some differences in the degree to which BME and white nurses feel their work is valued by patients and their relatives. Although similar proportions feel patients value their work either ‘a lot’ or ‘quite a lot’ (89% of BME nurses and 92% of white), BME are more likely to have given this item the top value score. 54% of BME nurses feel their work is valued ‘a lot’ by their patients and 45% say the same about the value placed by patients’ relatives on their work. The equivalent figures for white nurses are 62% and 52%.

Figure 7: Work is valued ‘a little’/‘not at all’ by ethnic origin – NHS only,



percentages 2002

Source: Employment Research/RCN 2002

Taking these findings together suggests that BME nurses perceive that the people they have to work most closely with i.e. nursing colleagues and patients, value them less than the equivalent perceptions of white nurses. Conversely, they seem more positive than white nurses about the views of employers, senior management and staff with whom they have less contact.

Despite BME nurses being more likely to work in mental health and learning disabilities than white nurses, they are less likely to report having been assaulted/harassed by patients in the previous 12 months.

¹⁷ Ball J et al (2002) *Working Well?* RCN: London and Ball J et al (2006) *At breaking point? Working Well Survey 2005*. RCN, London

More than half (56%) of nurses are satisfied with the way last incident was handled by their employer. Bank and agency nurses are less likely to feel satisfied with the way their employer handles incidents of harassment or assault (41%), while respondents in independent nursing homes (67%) and GP practices (75%) are more likely to be satisfied. There is little difference between different groups of nurses in terms of their ethnicity or gender. However, younger nurses are less likely to feel satisfied with the way in which the last incident was handled (52% of under 40s compared to 58% of over 40s).

- ◆ BME nurses are more likely than white nurses to be positive about the extent to which employers value their work, but less positive about the extent to which they valued by their colleagues or patients.
- ◆ BME nurses are more likely to have been bullied or harassed than white nurses.

10. BME and IRN summary of attitudes

Compared to white UK qualified nurses, black and minority ethnic nurses and internationally recruited nurses are more likely to:

- ◆ work full-time, and to work internal rotation
- ◆ live in London
- ◆ be in a main 'bread winner' role
- ◆ work longer hours
- ◆ have additional jobs
- ◆ feel their grade is inappropriate relative to their role and responsibility
- ◆ have been bullied and harassed at work
- ◆ have changed jobs due to negative pressures.

Also,

- ◆ UK qualified BME nurses are more likely to be in older age groups and IRNs in younger groups.

No significant differences were found in 2002 in the grades (this appears to have changed though in last few years), or rate of job applications by ethnicity, although on average the career progression of BME nurses was slower than that for white nurses.

Looking at nurses who qualified in the UK, comparing differences in views and attitudes between BME and white nurses: across all the items in 2002, white nurses were more positive on 22 items, and on 19 items BME nurses are more positive. In 2005 the equivalent figures are 23 and 16, suggesting that BME nurses are slightly less positive overall than was the case in 2002.

In 2002 the difference was statistically significant on only eight items and in 2005 seven items. The items on which biggest differences were found in 2005 are shown in Figure 8.

In 2002 BME nurses were more likely to respond positively about being able to find another job using their skills (59% agreeing compared to 49% of white nurses) and displayed interest in career progression (84% compared to 61% in 2005). These differences remain broadly the same in 2005 and more BME nurses say they would recommend nursing as a career.

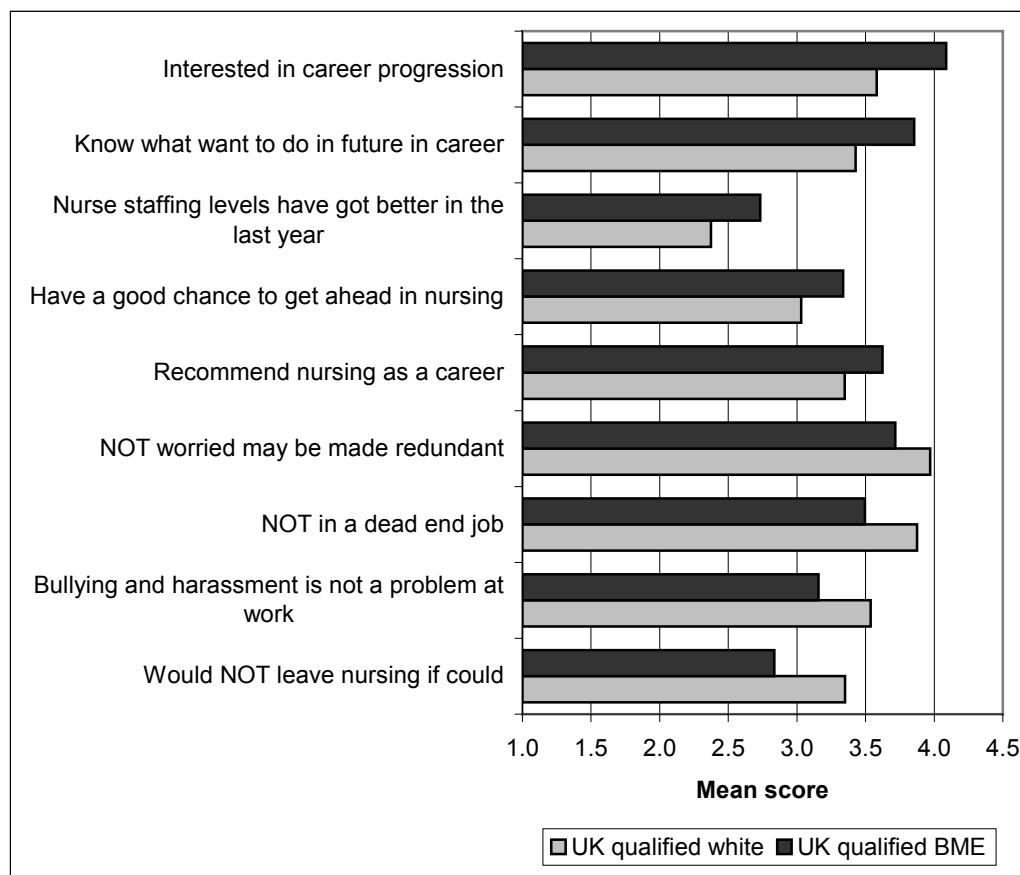
However, in 2002 more BME nurses reported that they felt the quality of care is good where they work, but this has changed in the last three years with fewer BME nurses (76%) agreeing compared to 87% of white nurses.

In 2005, again similar to 2002, bullying and harassment is more likely to be reported as a problem among BME nurses (27% agreeing there is a problem compared to 22% of white nurses in 2002). In 2005, 32% of BME nurses reported it as a problem where they work. In 2002 bullying and harassment was found to be of particular concern in London. Here, there is little difference between white nurses in London compared to elsewhere in reporting a problem with bullying/harassment, but 39% of BME nurses in London said *bullying and harassment is a problem* where they work compared to 26% of BME nurses working elsewhere in the UK. This suggests that the problem of bullying and harassment among BME nurses is more acute in London.

BME nurses are also more likely to report negatively about possibilities of redundancy.

Finally, in 2002 46% of BME nurses would leave nursing if they could, compared to 33% of white nurses and this difference is similar in 2005.

Figure 8: Differences in views by ethnicity UK qualified only – mean scores (2005)



Source: Employment Research/RCN 2005

It should be noted here that BME and IRN respondents are concentrated disproportionately in London where, shown in 2002, career opportunities are better than is the case elsewhere in the UK.

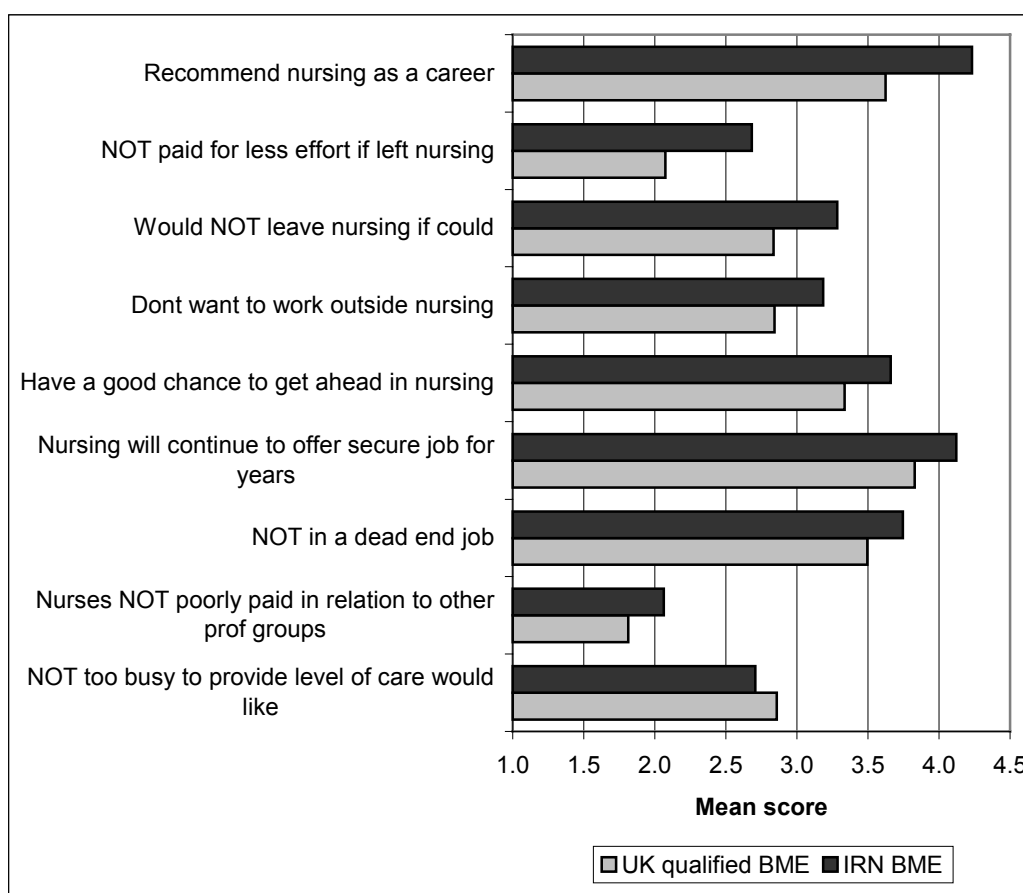
IRNs (non-UK qualified)

Nurses who first qualified outside the UK are different to UK qualified nurses. Those who first qualified outside UK include a proportion, the size of which could not be identified in 2002, who are recent IRNs. In 2005 compared to 2002 more IRNs are identified as black and minority ethnic nurses with only a small minority describing themselves as white nurses. The main difference between UK qualified and internationally recruited nurses is that IRNs are on average younger and less likely to have childcare responsibilities.

BME nurses who qualified overseas are more likely to respond positively to most items. The only item where they responded significantly more negatively is *'I am too busy to provide the level of care I would like'*.

On 8 items the views of black and minority ethnic IRNs are more positive than UK qualified BME nurses otherwise there is little difference. In particular, they are more positive about nursing as a career (87% would recommend nursing as a career compared to 63% of UK qualified BME nurses and 56% of UK qualified white nurses). They are also more positive about pay and career opportunities – just 45% say they could be paid more for less effort if they left nursing compared to 71% of UK qualified nurses irrespective of ethnicity.

Figure 9: Differences in views by where qualified UK/Overseas – mean scores (2005)



Source: Employment Research/RCN 2002

Table 17 highlights the percentage agreeing with each attitude statement by ethnicity and country of qualification, for NHS nurses only. The shaded areas draw attention to where each group is more positive than the other groups. These data summarise many of the findings of this report.

Table 17: Percentage agreeing with positive items – NHS only 2005

	UK white	UK BME	IRN BME	
1	I would recommend nursing as a career	55	61	81
2	I think nursing is a rewarding career	77	71	78
3	I could NOT be paid more for less effort if I left nursing	11	9	20
4	Most days I am enthusiastic about my job	80	72	69
5	My workload is NOT too heavy	17	14	14
6	I know what I want to do in the future in my career	54	70	75
7	I can determine the way my career develops	56	65	64
8	Nursing will continue to offer me a secure job for years to come	70	69	80
9	I am NOT under too much pressure at work	22	18	25
10	Considering the work I do I am paid well	16	13	18
11	It will NOT be difficult for me to progress from my current grade	28	36	40
12	I am ABLE to take time off for training	55	50	54
13	I am NOT worried that I may be made redundant	80	67	63
14	I have a good chance to get ahead in nursing	35	53	58
15	Nurses are paid WELL in relation to other professional groups	6	8	8
16	I am NOT in a dead end job	74	58	71
17	I would not want to work outside nursing	37	24	41
18	I DO know where my career in nursing is going	44	50	51
19	I would NOT leave nursing if I could	53	34	47
20	Career prospects in nursing are NOT becoming less attractive	33	37	33
21	My employer provides me with the opportunities to keep up with new developments related to my job	60	52	53
22	Opportunities for nurses to advance their careers have improved	57	73	61
23	I am interested in career progression	63	87	91
24	There is open dialogue about my career with my manager	46	37	38
25	The quality of care provided where I work is good	87	76	81
26	I feel satisfied with my present job	62	54	58
27	I'm proud to work in this organisation	52	64	71
28	Too much of my time is NOT spent in non-nursing duties	26	37	42
29	There are sufficient staff to provide a good standard of care	25	21	20
30	The effort I make to update my skills is valued by my employer	45	50	58
31	I am NOT too busy to provide the level of care I would like	32	37	28
32	I would find it easy to get another job using my skills	45	55	62
33	I am satisfied with the choice I have over length of shifts I work	61	55	63
34	I feel my work is valued	55	54	71
35	Bullying and harassment is not a problem where I work	59	43	39
36	I feel able to balance my work and home lives	57	48	64
37	Nurse staffing levels have got better in the last year	14	27	25
38	I am satisfied with my input in planning my own off duty/times of work	63	60	56
39	I am confident I would be treated fairly if I reported being harassed at work by a colleague	52	45	43

Source: Employment Research Ltd/RCN 2005



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