The work-life experiences of black nurses in the UK

A report for the Royal College of Nursing
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Executive summary
This report, commissioned by the Royal College of Nursing (RCN), is based on research conducted in the course of three focus groups, carried out between October and November 2007, in which 30 black nurses took part. All were female and a majority had been working in the health sector for in excess of 20 years. Many had dependent relatives, either children or elderly family members here or in countries of origin, and were also the principal earner in their family unit.

Working hours
- Working hours emerged as one of the issues of greatest concern to participants. Long working days, complex and changing shift patterns and particular pressure on those in senior posts to work additional hours, made nursing incompatible with the working lives of many black nurses. Indeed working hours emerged as one of the main factors that had pushed nurses out of acute settings and into community and other forms of nursing, where hours were more regular. However, at the same time some participants had viewed this as having had a negative impact on their levels of earnings, as there were not as many opportunities for career progression in community nursing, as there were in hospital settings.
- Working hours were particularly problematic for participants who had sole responsibility for bringing up children and the research notes that the higher incidence of single parent families among some minority ethnic communities means inevitably that hours of work that are not conducive to childcare arrangements will therefore disproportionately affect black workers.

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1 The term ‘black’ is used in this report to refer to non-white nurses of African, Caribbean, South Asian, Chinese, South East Asian and South American descent to connote their shared experiences of colonialism, migration and racism. This definition was recognised and welcomed by the majority of those that participated in this study. In some places throughout the report the term ‘black and minority ethnic’ is used where we are making reference to information from secondary sources if the phrase ‘black and minority ethnic’ rather than ‘black’ has been used within those reports.
Pay, grading and hours

- The research finds that stereotypical assumptions about the role of black nurses, has categorised them as not having the potential to achieve supervisor or manager status. Consequently, black nurses have found it more difficult to achieve promotion and in the past many have been actively discouraged from seeking it. However, participants more recently had noted a strong pressure on black nurses within their trusts to seek promotion, partly to allow health trusts to meet equality targets. This has created a general scepticism as to the reasons for the current focus on promotion and race equality in the sector.

- Participants strongly believed that procedures for promotion were more rigorously applied to black nurses than to white nurses and those who had gained promotion, believed that they were more closely monitored than white staff. Consequently they over-compensated by working longer and harder.

- The research suggests that there is a lack of transparency in how promotion takes place. Black applicants for promotion spoke of often being told that they had just missed being selected, but it was often not clear to them why the alternative (white) candidate had succeeded. Individuals were left with a strongly held view that discrimination had been a key factor in their non-selection.

- Agenda for change and its impact on grading was seen as an area of major concern. There was general confusion about the allocation of grades and a feeling that the system was unfair or had exacerbated discrimination. There were also complaints about appraisals not being done or of white staff being more likely to be appraised regularly.

- Unfair treatment at work had been more usually dealt with either by moving out of NHS employment altogether or by leaving their existing posts. Participants were less likely to have challenged discrimination through formal procedures because of a range of reasons including lack of support and guidance, concerns about victimisation and repercussions for future employment and a general feeling that there was no point. However, reflecting on the past and on how they had responded to poor treatment at work, some participants now felt that they should have spoken out.

Career and professional development

- There was a generally expressed opinion that personal development was not viewed in a proactive manner by health authority managements and rather
that they had, on occasion, obstructed individuals' access to study leave, particularly during periods where the sector is facing financial constraints.

**Relations with colleagues, supervisors and managers**

- The nature of relationships with colleagues, supervisors and managers defined or characterised all the other issues discussed within this report. It was widely acknowledged that individuals had to have a good relationship, ‘speak the same language as’ and socialise with managers and supervisors in order to have a relatively good quality of working life and especially to have their contribution recognised in their grading or to gain promotion.

- Participants stressed that the systems of social networking that currently operate were not ones that they felt comfortable in engaging with. In some circumstances they were unable to engage with them, as they had home responsibilities that left them with no time to socialise after work. Additionally, there was a view that individuals should not have to conform to social models which differed from their own, simply to gain the right to work and to progress. They wanted to be judged by how they performed their jobs, rather than on how they performed in out-of-work social engagements.

- At the same time, some participants made a strong argument for mentoring and for teaching networking skills, which were considered by them as absolutely vital in relation to their own career progression. Some participants argued that older black staff should and often do feel responsible for providing younger ones with guidance.

**Relations with patients and family members**

- Where participants talked positively about their work and reasons why they continued in the profession, despite facing obstacles to promotion or problems with colleagues and managers, they gained their affirmation largely through their contact with patients who acknowledged their work and the value of the care that they had received.

- At the same time quite a number of examples were provided where participants and their black colleagues had experienced direct and indirect racism from patients and family members. This consisted largely of examples where patients or parents of children had refused treatment by black nurses, but instances of direct racist abuse were also cited. Other factors seem to kick in as a way for staff to balance out these particularly
negative experiences. In particular, their relationship with patients was viewed as so important to them and affirming of their reasons for staying in the profession, that they were willing to overlook or tolerate experiences of racism.

- Although examples were provided of how racism was challenged, only one participant referred directly to the existence of a formal health trust policy of zero tolerance towards racism from the public.

Racism and other forms of discrimination

- The working lives of the majority of black nurses that participated in this study had, to one degree or another, been structured by racism. This had taken various forms: most significantly racist stereotyping by colleagues and the public and institutionalised racism which had meant that work cultures, particularly relations with colleagues and managers, operated to exclude them.
- When probed about whether racism was the only or key form of discrimination that they faced, the majority believed it was. However, participants did refer to other power imbalances, notably of class, gender and age.
- Whilst some argued that there had been a distinct change in their working terms and conditions and were optimistic about the possibility of improvements in the sector, others aired their frustration about the persistence of more subtle systems of racism, now widely known as ‘institutional racism’.

Creating change

- While some participants argued for the need for clear policies and procedures, others complained that these were mere paper exercises that were not being implemented. However, others noted the importance of policy commitments and of clear or transparent procedures, particularly as a way of overcoming difficult situations that would otherwise be determined by individual discretion and subjective preferences. Two important examples of clear policies and procedures related first, to having black representation on all recruitment panels and second, to the usefulness of a written commitment opposing patients’ refusal to be treated by black staff.
- It is important to note here that not all participants were aware of initiatives such as the Breaking Through Programme. There was ambivalence about whether or not such programmes were useful and particularly whether they
had the capacity to deal with more sinister and subtle institutional racism.

Black participation in research

- The RCN requested that we explore this additional area with participants because of the under-representation of black staff in previous pieces of research, irrespective of whether these were qualitative or quantitative.
- In response to the question about why black nurses might not participate in research and discussion about what prompted these particular participants to get involved, there were three key arguments.
- Firstly, many of the women that participated in this study did so because they saw a call specifically for black nurses. This was something that they had not seen before and they also viewed it as an opportunity to meet other black staff and exchange experiences and information.
- Secondly, participants noted frustration with research processes and believed that potential participants would have to be convinced that this was feeding into, shaping and affecting a real agenda for change. They referred to the extent of existing reports on their experience of racism and the relative lack of action. They felt that other black staff would be put off participating in a process that was not seen to be contributing to anything tangible.
- Thirdly, we were reminded of the particularly 'explosive' nature of research on 'race' in the health sector and of the particularly vulnerable position of black staff. This meant that research teams should demonstrate an empathy and understanding of the incidence of racism but also that participants would need to be absolutely sure of confidentiality before agreeing to take part.

Conclusion

This study has provided qualitative material that reflects and deepens understandings in relation to key findings that have emerged in earlier quantitative studies conducted by or on behalf of the RCN. In most part we were able to do this, although in relation to some issues, the particular characteristics of the sample meant that inevitably some gaps persist. As a result a number of areas have been identified by the research team for further research and for the basis of a possible plan of action for the RCN.

In terms of further research, we propose that there would be significant scope for a study that involves a more diverse range of black nurses, particularly at lower grades.
between D and F. Also given that the majority of the sample in this study had trained in or were employed in London, a study that enabled there to be comparisons with the work-life histories of black nurses outside of Greater London would be of interest. Finally, because of the absence of men in this study, we also feel a similar comparison with the experiences of black male nurses in the health sector would be of value.

The RCN asked that the research should canvass members’ views on how it could help improve their working lives. The majority of participants wanted this study to feed into an agenda for action by the RCN. For this reason we feel that it is important that this report contains a set of practical recommendations that can address the key issues that emerged in the study and which have been highlighted in this Executive Summary. Some recommendations are addressed directly to the RCN for it to consider. However, others will require employer support. We have therefore separately grouped our recommendations into those directed at the RCN alone those directed primarily toward employers, but where the RCN could have a role in dialogue with the employer.

**Recommendations directly addressed to the RCN**

- The research has revealed that it is not necessarily the case that the RCN has failed to take action on some of the issues of concern raised in the focus groups. However, its does show that there is a real challenge to the RCN with respect to its ability to communicate better with its black members so that they are aware of what policies are being carried forward.

- The focus groups showed widespread support for a full Race Equality Impact Assessment of the implementation of Agenda for Change. We understand that this is being undertaken, but the information in relation to the matter had not been communicated effectively.

- There was a similar lack of knowledge among the focus group participants on commitments, policies and guidance on the following areas: obligations of Trusts to abide by state commitments to work-life balance; the regulations relating to payment for unsocial hours after the advent of Agenda for Change; enforcement of the Improving Working Lives Agenda by insisting trusts implement a strong policy of zero tolerance towards racism from the public including from patients, carers and family members. In theory all of this information is available to RCN members, but the channels of communication need to be re-visited and improved.

- There was strong support for worker-led black networking groups at a local and regional level, in order to develop collective responses to racism in
individual workplaces and assist with the implementation of the Race Relations Amendment Act 2000. Again, these already exist, but there is a need for better communication in relation to them.

- There is a need to consider strategies that would strengthen RCN representation for black members, by making training on racism compulsory and by overseeing local activist interventions on incidents of racism.
- The RCN should consider strategies to ensure more effective support and representation for its black members in the following areas: job evaluation, appraisals and appeals under Agenda for Change, and where black staff are ‘acting up’. (The RCN cannot ensure that anyone has a better chance of getting a job than anyone else, but can play a role ensuring that the process is fair and transparent and that there is a level playing field)

**Recommendations that would need to be employer led**

- Being more alert to racism and discrimination in the workplace and proactive where it occurs.
- Having robust equality impact assessment processes in place.
- Employers should consider extending the current mentoring schemes, which are generally highly regarded by those black senior staff who have benefited from them, to black staff at all levels.
- Employers need to ensure that there is appropriate black representation at interview panels and furthermore that interview procedures, including the number of members on the interview team, are consistent, as between white and black applicants.
Introduction
This report is an analysis of qualitative data collected between October and November 2007. This short piece of research was commissioned by the RCN in order to collate detailed narratives of the work-life experiences of black nurses from established minority ethnic communities within the UK (rather than more recently arrived Internationally Recruited Migrant Nurses). This report is intended to complement other work that has been carried out by several bodies, including Employment Research Ltd, the Working Lives Research Institute and the RCN.

The main objective of the research was to collate qualitative material in order to help explain some of the key findings of a quantitative analysis, conducted by Employment Research Ltd, of ethnicity data in the RCN’s Annual Employment Surveys 2005, 2003 and 2002 and the Working Well Survey 2005. The key issues that this project sought to explore from the summary findings of that quantitative analysis were as follows:

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

- Work full-time, and to work internal rotation.
- Be in a main ‘bread winner’ role in their family.
- Work longer hours.
- Have additional jobs.
- Feel their grade is inappropriate, relative to their roles and responsibilities.
- Have been bullied and harassed at work.
- Have changed jobs due to negative pressures.

It was our intention to assist the Royal College of Nursing, in drawing out the issues and experiences behind these findings, to gather members’ views about the findings, to provide illustrative examples of the work-life experiences of black nurses in the

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UK and also to encourage a discussion about how the RCN could be involved in helping to improve the working lives of its black members. Wherever possible this report makes reference to the findings of the quantitative analysis.
Research methods
It is important to note that the samples that formed the basis of the quantitative study and those for the qualitative study are substantially different. For this reason, it may be better to view the findings from this report and from the analysis of the quantitative surveys as complementary pieces of work rather than as one building on the other.

The UK qualified BME nurses that responded to the surveys that formed the basis of the quantitative analysis were characterised by the following features - in comparison to white UK qualified nurses they were:
- More likely to be working in independent care homes and bank/agency settings;
- Less likely to be employed on senior grades or in community roles;
- More likely to be employed as staff nurses;
- Very few were clinical nurse specialists and nurse practitioners.

The empirical data that forms the basis of this report was collated through three focus group sessions in October and November 2007 involving a total of 30 black nurses. The Employment Relations Department of the Royal College of Nursing recruited all the participants through email circulars and by placing an advertisement in the RCN Bulletin. A copy of the call for participants is attached as Appendix 1 to this report. The Working Lives Research Institute and the Royal College of Nursing agreed for the call to include a definition of potential participants as nurses who:

‘Were born in the UK with family origins in the Caribbean, South East Asia, the Indian subcontinent, Africa, China and South America OR nurses who have trained in these countries but who have lived in the UK for more than 30 years’

For the majority of respondents, the definition was clear but a few respondents

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suggested that the wording gave them and other potential participants the impression that they had to have been in the nursing profession for at least 30 years. One participant suggested that this misunderstanding could have been the reason for the absence of male participants in this study. Nevertheless there was an overwhelming response to the circular invitation. The participants were self-selecting and initially they were asked to choose from two focus group dates. A third focus group was arranged to pick up on the high response and to ensure that as many voices as possible could be heard during the research process.

Participants were asked to complete a personal biography form before attending the session. A copy of this form is attached as Appendix 2 of this report. The personal biography forms enabled researchers to collate some background information on the participants. Although this qualitative study is not representative, it is useful to profile the participants. The biography form also asked for other information, which has been useful to supplement the qualitative narratives that form the bulk of this analysis. Reference is made to this information in the sections on ‘Working hours’ and ‘Pay, grading and promotion’.

A total of 30 women participated in this qualitative study. In terms of their ethnic origin, 20 defined themselves as African, Caribbean, or Afro-Caribbean; two were of Chinese origin but from different parts of the world; one was South American and another seven participants were of South Asian origin, including from Pakistan, India, Sri Lanka, East African Asian and one from Mauritius. Even though some of the participants were born abroad, all of them had gained their nursing qualification in the UK.

Participants’ working lives ranged from 10 to 43 years. The participant with the longest work history in the sector started nursing in 1965. Four of the participants had been nursing since the 1960s, fourteen of them, almost half the total, had been nursing since the 1970s, seven since the 1980s and three since the 1990s. Two respondents did not answer this question. All except four participants were working in London. The other four were working in the Home Counties. Whilst the largest single group of participants was working within hospitals (13), overall participants represented a wide range of health sector work settings, including a large number of participants that were working in the community (13); for a primary care trust (1); in public health (1); for a strategic health authority (1); in the private sector (2); and in education (1). There was one missing response.

In terms of occupations or roles within their workplaces, the participants reflected in
this study might be viewed as slightly exceptional, as almost half were employed in supervisory or managerial roles at the time of this study. This would not be representative of the positions held by black nurses in general. However, most participants reflected on a range of roles that they had performed within the health sector during the course of their working lives. There were seven general nurses including one bank nurse and one nurse practitioner; two health visitors; four specialist or consultant nurses; one senior nurse practitioner; four matrons or sisters; five team leaders; five managers and one lecturer. There was one missing response.

In contrast to the quantitative sample, this particular sample is weighted more in favour of those in supervisory and managerial positions. This could be explained in many ways, such as in relation to the profile of RCN membership or the likelihood that those in more secure or senior positions are more likely to speak out about their experiences. A third possibility may be that those that are more articulate (and thus more open to taking part in focus groups) are consequently more likely to advance to managerial and supervisory positions. A fourth reason could be that the research method itself was more likely to attract those used to speaking at public events and those that are not working shifts. It is quite possible that general nurses respond better to one-to-one interviews that take place closer to their homes or their workplaces.

Nevertheless, as is discussed further in the section on 'Pay and grading', the particular makeup of these focus group sessions quite possibly provided a new angle in terms of black nurses’ experiences of promotion and career progression. Moreover, given the length of time that this group of black nurses had been working in the sector, they were able to reflect on many different periods of their careers, as well as on their progression through the rungs.
Working hours

Working hours emerged as one of the issues of greatest concern to participants. Long working days, complex and changing shift patterns and particular pressure on those in senior posts to work additional hours, made nursing incompatible with the working lives of many black nurses. Indeed working hours emerged as one of the main factors that had pushed nurses out of hospital settings and into the community where hours were more regular. However, this had a negative impact on their levels of earnings, as community nursing did not achieve the higher grades represented in hospital posts. The discussion about working hours takes place within the context of a general culture of long hours’ working within the health sector. Moreover, the particularly dynamic nature of the sector (continually undergoing change) and the range of workplace settings meant that a variety of working patterns were reflected in the contributions from participants.

In terms of the quantitative analysis, the following key points were made about working hours and ethnicity. In comparison with their white colleagues, UK qualified black and minority ethnic nurses were found to be:

- more likely to work full-time
- more likely to have dependent children
- after controlling for women with dependents, there was an even more significant difference between the numbers of black and minority ethnic and white women working full-time
- more likely to work internal rotation shift patterns and nights
- more likely to work longer hours, though primarily because they are also more likely to have additional jobs
- Afro-Caribbean respondents were far more likely to have second jobs
- Afro-Caribbean respondents were more likely to say they were the ‘breadwinner’ than any other ethnic group.

In terms of the participants in our qualitative study, the majority were working full-time (21), five listed themselves as working part-time hours and one listed herself as working variable hours because she was a bank nurse. There were three missing responses. In the focus group sessions, there was a great deal of discussion about working extra hours and this discussion is explored in the following paragraphs. However, in terms of the information contained in the biography forms, there were only six full-time workers that stated that they were working more than 37.5 hours per
week. Just over one third of participants (11) stated that they were doing additional jobs. For a few of these this was interest based – a couple were volunteering alongside their full time paid jobs, one was working for a charity that specialises in an area of sexual health and another was writing for a nursing magazine. However, several other participants stated that they had registered themselves as bank staff to fulfil their financial commitments and particularly to top up their regular income whilst raising children. Indeed there was a clear relationship between being the sole or main earner or breadwinner with dependents and either being single or in a relationship where they were the principal earner. Of the 21 participants that saw themselves as the breadwinner in their household, 11 stated that they had dependents including elderly parents and a retired husband and 14 listed themselves as single, whilst a further five listed their partners as retired, self-employed or their partners appeared to have jobs with lower incomes. One participant explained that she had three jobs and that this was entirely for financial reasons, as she was on a low income within the private sector and was also still supporting dependents in her country of origin. Other participants similarly stated that they were supporting families abroad:

“Well also because I have dependants at home in my country so I have, maybe that’s - it’s not the main reason I have two or three jobs at the moment, but that is a big factor why I work.”

“I’ve got a 100-year-old grandmother, who [is in] the Caribbean and obviously [pay] for her care.”

“I would have to send some money to help because I do feel privileged that I’m here in England.”

When it came to questions about how many hours participants were working, it was clear that several participants may, in their personal biography form, have listed hours that they were contracted to work rather than the hours that they had actually been working, because there was a significant amount of discussion about working long hours, over and above contractual hours. Some of this discussion highlighted the burden borne by nursing staff as a consequence of resource issues within the sector. During the discussion, several of the respondents in managerial positions stated that they were working more than their contracted hours. One participant noted that black staff were working ‘hidden hours’. By this she meant that the amount of work allocated was not possible in their stated hours of work and therefore they were taking work home to complete in the evenings, these hours were often unaccounted for:
“What’s hidden is the hidden hours when you do… you do take things home and now with technology can send e-mails back. Because sometimes it’s quiet, you haven’t got the phones, you can get things done, so you tend to take a few hours at home, which is hidden.”

A related point made in the next section of this report is about the insecurity of black staff, especially black managers and the perceived pressure on them to prove themselves. While participants noted that long working hours were part of the general culture within the health service, in relation to supervisory and managerial posts, there was a view that this was a particular challenge for black managers, who felt obliged to work longer hours in order to retain or secure their position, precisely because they saw themselves as always vulnerable to criticism. This is demonstrated in the following excerpt from a conversation between two clinical team leaders that stated on their biography forms that they work between 37.5 to 47.5 hours per week:

A: “We work over, I know my colleague over there said she works 37.5, I can verify that she does much, much more. And basically we do work up to 40 plus hours some weeks.”

B: “Sometimes it’s a feeling that we need to get the job done”

A: “...or there’s targets to be met. And initially I’ve been told by a manager that yes you can work over if you need to get the job done.”

Researcher: “Is it paid overtime?”

B: “No. But we try and take time back but we will never ever take back the amount of time, otherwise we could have a holiday for a year somewhere.”

Working hours were particularly problematic for participants who had sole responsibility for bringing up children and the research notes that the incidence of single parent families among some minority ethnic communities means inevitably that hours of work that are not conducive to childcare arrangements will have a disproportionately negative impact upon black workers. The key issue raised by participants across all three focus groups, in relation to working hours, was to do with the incompatibility of health sector working hours and childcare responsibilities. Almost two thirds of the participants stated that, at the time of the research, they had dependents or that they had had dependents at some point during their working life in the health sector.
Some participants noted the willingness of colleagues and managers to take account of their childcare responsibilities, by applying the ‘work-life balance’ and ‘improving working lives’ agendas, as the following example shows:

“Can I say that I worked for a psychiatric hospital when my children were young and I was going to do two nights and I actually said that I didn’t really want to do two consecutive nights because I felt I couldn’t get the sleep and that wouldn’t be fair to come to work without having any sleep because of the young kids. And she said yes, I’ll split your nights up for as long as you like I’ll split your nights up for you. And I did a Sunday and a Friday or something like that. And they did recognise that you had young kids and that things did happen.”

As we see later in this section, an inability to find a balance between working hours and caring responsibilities has implications for staff retention. Many of the other participants in all three focus groups argued that among management, there was a dominant view that nurses should expect to work long and unsocial hours as one of the conditions of being in the profession:

“And then, I started a family and I remember saying to my manager at the time, who was black, that it’s going to be very difficult for me to do the lates or on call and coming in with a young child. And they provided a crèche at the time as well. And she didn’t want to know; she held up her hand and said ‘that’s your problem’.”

“And I felt like if I’m working all these long hours, I might as well compress them and have another day off. But I was told by my manager, I was turned down twice and told it’s the needs of the service.”

“And I used to do early shift, late shift, early shift, late shift, two days off and then seven nights in a row, and then seven nights off and then back on early shift, late shift. And I actually asked the sister on the ward don’t you think we’ve got a life outside work? It’s not all about working, because even on your days off, even on your nights off everybody else is doing other things and you’ve got nobody to mix with.”

“And I was told by the sister on the ward that ‘you should have thought about that before you came into nursing and you will never get a 9-to-5 job as a nurse’.”
In some cases participants needed to work long or unsocial hours because they were the sole wage earner:

“I always had to do extra work on my days off, my nights off, my holidays. Because the money wasn’t enough to stretch to do all the things, to pay the rent or the mortgage, and the food. I’m a one parent family, I’ve only got one son, just one, and it was hard just having the one. But life can be hard and especially when you’re a one parent family bringing up a child. And I think sometimes the staff used to think that you were just greedy, you just want to work for the money. They don’t realise that you need this extra money to make ends meet. And sometimes some of our people have to send money back home to family in our countries.”

Some participants had moved out of this culture of long hours’ working in order to manage childcare and other responsibilities, to re-assert some control over their lives and to have a better quality of life. They had done this by leaving full time nursing positions and listing themselves as bank or agency staff instead. But almost always this was achieved by having to set aside personal career hopes, as the following example shows where a career as a community midwife had to be abandoned due to the difficulty of combining work and childcare.

“A community midwife, the career for me. That was all I ever wanted to be. But once I started having children, that didn’t fit with the hours, it didn’t fit with the nursery, the child minding, being on call 24-hours and have a young two-year-old. So things had to change and then I went off and did health visiting because it was more family friendly. But even in terms of working as a midwife and you’re in a team, and we all had children, but the anxiety when a child [is ill] and sometimes you had managers who would be sympathetic and understand. …But some of us have had to change our careers to fit with our family life and I think that needs to be acknowledged.”

Even though only nine participants stated in their biography forms that they were working shifts, a number of participants in all three focus groups made the point that they had chosen to work night shifts at some point during their working lives, when their children were young, as a way of managing childcare during the day. As one of the participants noted:

“In the early days I worked nights because obviously my son. But that was
obviously for my convenience that was my choice. And then later as he got older, and started school then I got a job in the community, which obviously was another choice that I made.”

Another made the point that shift systems could offer advantages and disadvantages, particularly when the turns were long, offering fewer working days in the week but longer working hours in the day:

“I work 12 hour shifts but 12 hour shifts they’ve got their disadvantages and their advantages. But you can do, work less days and have more days off, but then it stops you from doing other things. Like if you’ve got an appointment you’ve got to take a whole day off to go to the appointment. Or if you want to go to [an] event, you might not be able to go to [the] event having finished work after 8 and not getting home until after 9, 10 o’clock at night. So I don’t think we always have a choice as to what shifts we want to do because … if that’s their working time then we just have to go with it.”

Where these shifts could be worked within an environment that acknowledged work-life balance, for example by allowing time off to attend appointments, then shift systems were viewed more favourably. However, others noted that, for them, the only alternative had been to change jobs, particularly to work in the community, in order to attain a better work-life balance that properly enabled them to fulfil their childcare and other responsibilities. The following accounts from four different participants demonstrates this:

“I’m a single parent, always have been. And throughout my bringing up of the children I’ve worked in the general hospital care. And then I decided because of the shift patterns, I decided to come out into the community and since I’ve been here really it has benefited me. I worked in the one authority for 28 years and for a certain extent it’s been quite good for me. I’ve had reasonably good managers who have listened and been supportive.”

“And one of the reasons why I moved out to the community was because of the working hours. I enjoyed working in the wards, I worked in A&E, I worked in cardiology, plastic surgery, really enjoyed it. And then they had all these changes coming along like the 12-hour shifts. And I became a Christian, I wanted to go to church on the Sunday, I didn’t ask for every single Sunday off, I just wanted at least one Sunday a month.”
“And lots of them are speaking about I want to work in the community, and what that translates to, I want to be working, if I can… my hours, pick up my children when I can and do my shopping on the way to patient ‘x’.”

“I must say that since I’ve gone into the SHA (strategic health authority) there’s an amazing flexibility which I would never have thought of outside of that. On my first day I was given a computer and told you can use this anywhere. If you come into the office once a week we’ll be quite happy. And I’ve never had that kind of flexibility before.”

However, working in the community could have consequences for career and grading, and one participant spoke of those working in the community being paid at a lower grade:

“I think the difference between the nurses who are working in the hospital setting and community setting is very wide. It’s not been fair at all with all those of us who are working in the community. A staff nurse on X ward who qualified last year is a band 6. Whereas you have a community nurse who is grade G still on band 6. She was at the peak of G grade with what have you, and then this Agenda for Change to put her at the top of this band 6. Whereas a second year staff nurse on the ward is the band 6 nurse.”

Others noted that the fixed shift system that had operated in the past, rather than the current internal rotation system, had worked better for women with dependents because they could choose specific regular shifts and arrange their childcare accordingly:

“There were shift changes years ago when we had permanent day staff and permanent night staff. And obviously nurses that did night shifts had to look at childcare and things so they were able to take their children to school and be able to pick them up and then come and do a night shift. And then they changed to internal rotation…Which caused problems for nurses then and now they’re changing shift patterns.”

One participant argued that the pressure of the new internal rotation shifts now disproportionately fell on black staff:

“It’s affecting the whole, yes. Affecting the whole. What they have cleverly done, which I must also mention here, is there has been a period over two years
ago where the white nurses have been put into positions, management positions. And so there’s only one or two left to carry on these sort of shift patterns. And be cleverly done so that you have more BME nurses doing all this shift work.”

A separate question was raised as to whether, after the implementation of Agenda for Change, nurses were being paid extra for working unsocial hours. Whilst several participants argued that this had become a problem in their workplaces, this point was contested by one of the participants, who was a workplace representative. These conflicting opinions highlighted the absence of clear information amongst nurses on this issue. Moreover, if it is the case that nurses in some workplaces are not being paid extra for working unsocial hours, this could quite possibly have a disproportionate impact upon black nurses. Whilst this was not an issue raised within this study, it was a finding within a separate qualitative study about the working terms and conditions of black staff in the health sector and was closely linked to the way in which social relations amongst supervisors and managers within hospitals unfairly impacted upon black staff, affecting access to preferred working hours, training and peak holiday bookings.4

Managing childcare was the key issue that participants raised in relation to working hours but there were also a number of issues that either had specific implications for black nurses and/or had racial overtones. In some ways there is likely to be an unequal impact upon black nursing staff of a long hours’ working culture. Statistically, black nurses are more likely to occupy lower positions in the health sector and therefore to be on lower incomes. Potentially then, childcare is less affordable for them than for white nurses. This point was made by two participants at the second focus group who pointed out the class dimension to working in the health sector. One pointed to the lack of affordable childcare for nurses at grades E and D, 

4 Dhaliwal, S (2005) The Practices of trade unions and the concerns and apprehensions and participation of racial and ethnic minorities within target workplaces and occupations: A fieldwork report on the UK health sector (accessible online at the Working Lives Research Institute website www.workinglives.org). This report provides complementary data about the workplace concerns of black staff in the sector especially because this study draws upon in depth interviews with general nurses and health care assistants rather than staff in supervisory or managerial positions.
where black nurses are over-represented:

“The NHS don’t look after - if you’re in BT or other jobs, all my brothers and sisters have jobs where they can drop their children off in the work crèche or whatever. In the NHS the doctors hog those places and it’s very expensive. I have twins who are seven and I had to pay £1,200 a month, fair enough I was a director, not a director, I never got there, but the job I had, I was able to afford it. But it was very, very hard out there and if you’re a D grade, E grade, I don’t know how they manage.”

Another participant at the same session highlighted the situation for student nurses whose particularly low income has meant that they are more reliant upon partners and extended family members for childcare. Moreover, there was some discussion around student nurses not being able to be present at all their classes or foregoing career development opportunities, either to attend to their childcare responsibilities or in order to top up their income through second jobs:

“I have a student who comes to sessions and says oh I can’t stay - if they’ve got a 4.30 to 6.30 session they can’t stay because they’ve got to go to another job or they’ve got children to pick up. And during the session [they say] ‘I’ve got to go’… ...So this is what our students are dealing with and newly qualified nurses looking at the next generation of senior people, it’s going to be even harder than I think after...because they’re coming in older with more dependants. And they’re missing out on study days and things like that sometimes because childcare.”

Given that some sections of black communities are also more likely to be single parents and solely responsible for the care and upbringing of their children, the long hours’ working culture and/or lack of flexibility in organising working hours is likely to have a disproportionate impact upon black nurses.

Several participants in the third focus group session felt their white colleagues monitored the number of hours worked by black staff in a way that they would not note or comment upon in relation to white migrant nurses from New Zealand, Australia or Canada. One participant explained that her colleagues frequently questioned her about any overtime she was doing as if expressing a concern for her health. However, in her view they were more concerned that she was earning more money than they were, as they did not seem to notice or comment upon the extensive number of overtime hours worked by white migrant nurses at the same hospital.
“And [we] have girls from like [from] New Zealand and Australia doing, they could work seven days a week. They don’t watch it, but you as a black person like you said ‘oh how many days a week are you working?’ And they were watching how many days you’re working because they don’t want you to earn any more than they do. And I’m not earning any more than they are. But if it’s a white girl doing it, they won’t mind, they don’t care if they work seven days a week every week. But once you’re a black person they’ll be saying ‘how many shifts are you working, aren’t you tired?’”
Pay, grading and promotion

Grading and promotion were the two most important issues for participants in all three focus groups. Everything else appeared to relate to these or have a direct impact upon these aspects of working life. Stereotypical assumptions about the role of black nurses categorised them as not having the potential to achieve supervisor or manager status. Consequently, the research concludes that black nurses have found it more difficult to achieve promotion and in the past many have been actively discouraged from seeking promotion. However, there is currently strong pressure on black nurses to seek promotion, partly to allow health trusts to meet equality targets. This has created a general scepticism as to the reasons why race equality is being highlighted.

In relation to pay, grading and promotion, the quantitative analysis\(^5\) made the following key findings. In comparison to white UK qualified nurses and white internationally recruited nurses, black and minority ethnic UK qualified nurses and internationally recruited nurses were found to be more likely to:

- have the view that their grade is inappropriate relative to their role and responsibility - the widest gap was between the responses of white and Afro Caribbean nurses where in 2002 30% of white nurses complained of inappropriate grading, the figure for Afro Caribbean nurses was 49%
- more likely to be employed on D grades and this proportion had increased by 2005 with fewer employed on F and G grades than was the case in 2002, whilst the proportion of white UK qualified nurses on D grade has reduced over the same period
- were more likely to be ‘acting up to a higher grade’ than white nurses but fewer BME respondents report being paid for acting up to a higher grade
- UK qualified BME nurses were more likely to report that they were doing work that should be paid at a higher grade (61% compared to 51% of UK qualified white nurses)

promotion - there was no difference in terms of applications for a higher post and very little difference in success rates between white and BME UK qualified nurses. If anything, BME respondents showed higher levels of career motivation. However, white nurses had progressed to their current grades more quickly than BME nurses

changing Jobs - the reasons explored in the quantitative analysis for changing jobs can be 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 workplace). A higher proportion of BME respondents mentioned work/life balance as a reason for changing jobs. Moreover, they were also more likely to change jobs because of negative pressures such as dissatisfaction, bullying/harassment, training reasons and dismissal

In terms of the key findings from this qualitative study, it is useful to subdivide the discussion into the following areas: promotion; Agenda for Change and grading; acting up and changing jobs. All of these issues have direct implications for pay. Therefore points about pay will be made throughout the section and have also been touched upon in the previous section.

1. Promotion

The starting point for this issue was the legacy of black nurses in the UK health sector, in terms of their structural position and experiences. Participants referred to two particular features of this legacy. Firstly, the experience of direct and indirect racism had meant that first generation black nurses actively discouraged their children and relations from joining the health service. This was highlighted by the experience of one Caribbean participant. Now a nurse consultant, she received the following reaction from her mother when she decided to join the nursing profession in the 1980s:

“When I was 11-years-old my mum became a nurse, she did her enrolled nurse training and she told me that I definitely do not want to do nursing. Do not go into nursing, that is not for you, you won’t enjoy it, there’s a lot of racism, it’s really, really hard, you don’t want to do nursing. I said I do, I don’t want to do anything else but nursing.”

Secondly, some participants were still dealing with or were aware of others whose working lives had been shaped by the fact that they were channelled into State Enrolled Nursing (SEN) and discouraged from studying for state registered nursing (SRN):
“I met loads of black nurses that had done the enrolled nurse training that had even more O levels than I did at the time but they were encouraged to do the enrolled and they didn’t know any difference. And it was easier and shorter so they did it. Whereas there were very few black nurses at that time that did the registered general nursing.”

Another participant, this time an Asian nurse, now working in London as a nurse specialist, makes a similar observation:

“I started in the 80s and I did my enrolled nurse training and I didn’t have all the O levels some of the others did. And I enjoyed my training, it was hard work and I was an enrolled nurse for about four years. And unfortunately I didn’t get on to a conversion course but I did a three-year RGN course from scratch. And I worked with lots of nurses from the Afro Caribbean community and I learnt a great deal. And when I started training in the 80s a lot of them were enrolled nurses because they couldn’t do their RGNs or the SRN. They were encouraged to go into enrolled nurse training and a lot of them could have been staff nurses.”

For second generation black nurses, their mothers’ advice and experience had been pertinent and in some cases it meant that they had been able to avoid the SEN trap. The same Caribbean nurse cited earlier explained:

“And she made me promise her that if I did do nursing that I wouldn’t become an enrolled nurse. Because she said if you’re an enrolled nurse you do all the ‘donkey work’ and you never get a chance to get into management. So at 18 when I applied to do nursing, and my five O levels, went for my interview, they offered me the enrolled nurse course, although I applied for the registered general nursing, or state registered nursing as they called it then. And they said why don’t you do a two year course because it’s just as good as the three year one, it’s just a shortened course. And I said no, no, I have to do the RGN because my mother said. And it’s only because my mother said, I wouldn’t have known a difference otherwise because they were telling me at my interview that I could do the two year one. But my mother had made it very clear do not do the two year one... So I know that’s what’s helped me to get where I am today because I didn’t go down the enrolled nurse route, then to do the RGN and everything else you have to jump through hoops when you do your enrolled nurse training, to actually get to where you want to go.”
Another participant, who started nursing in the 1970s and eventually moved to a position in the community, explained what it meant for her to do enrolled rather than the registered nurse training:

“But I didn’t have a mother who knew the difference between enrolled nursing and registration. And I actually trained as an enrolled nurse and actually it’s held me back over the years. …But I then had to leave, I had to resign from, is it (name of hospital) then, to do the conversion course.”

Project 2000 attempted to change the two-tier system of nursing staff by creating a uniform system of nurse training and removing the distinction between enrolled and registered nurses. However it is clear from the findings of the quantitative analysis cited at the beginning of this section that black nurses are still over represented in the lower grades. Additionally, despite Project 2000 claims to have established a system of progression for health care assistants to become qualified nurses, a separate qualitative study of black staff in the National Health Service found the persistence of a racialised two tier system of workers in the sector, with a predominance of black staff as health care assistants, porters and cleaners. The health care assistants talked about the difficulties they had experienced in trying to move out of these positions and become fully qualified nurses.6

Moreover, the discussion within the focus groups that provided the qualitative material for this study highlighted the persistence of a culture of racist stereotyping that created ongoing obstacles to promotion for black staff in the sector. Many participants complained about obstacles to promotion. The following participants described the existence of a glass ceiling for black staff within the sector. Sometimes this would be expressed through seemingly supportive comments, aimed at suggesting

that managerial roles would be too stressful. As one participant noted:

“So they employed another tactic. So my line manager started saying ‘do you really want to be a director? Do you - look at what so and so has to put up with’.”

In other cases, white colleagues’ discomfort was more evident, as this participant noted when she was appointed to a senior managerial role:

“People just couldn’t cope with a black person wanting to be a director of nursing just like that; you have to have paid your dues.”

Another participant described her experience of racist stereotyping, where seeing black nurses in supervisory or managerial roles is met with surprise and disquiet by some white students and colleagues:

“I’ve been a teacher in the university and I’ve been in the classroom one week, come back the next week, there’s a new student there. There’s all white people, I’m the only black person standing in front, teaching everybody. And one of the student nurses that came in that wasn’t there the week before said ‘are you one of the students?’ And I thought well how can I be one of the students when you’re all the students and you know the students that’s in your class, how could I be one of the students? And it’s only afterwards thinking about it that I thought obviously she must have thought she’s a black person, she has no right to be in that position. And also I had a temporary secretary who when I was, the day that I was in uni, I didn’t see her, so she was always there on the day that I was in uni. And they allowed her to use my office and one day I came into the office and she asked me whether I was the secretary that she was covering for. And I said ‘no, this is my office’. ‘This is YOUR office?’ I said ‘yeah, all those files there, all those letters’. ‘You mean to tell me this is your office!’ And she was so blatant, it was so blatantly obvious, she goes ‘do you know such and such?’ And she mentioned the name of another black person that was in a top position and I said ‘I’ve heard her name but I don’t know who she is’. And she said ‘she’s like you and she’s got a good job as well’.”

One participant who shared her own experience of being denied promotion and being treated badly by her colleagues highlighted the impact of racist stereotyping upon black nurses. This participant recounted how she was forced to continue in the same job because of childcare commitments. Her job dissatisfaction led to her moving jobs.
as soon as her children were grown up. However, it was clear from her testimony that she was still feeling the pain of these experiences:

“I don’t know. I just felt well; I’ve wasted most of my life. I’ve brought up my children but as you say, promotion was denied me. I spent many years as an enrolled nurse and I was doing all the dogsbody work and so forth and I spent I think how many years as an enrolled nurse, must be probably the best part of my years as an enrolled nurse, bringing up the children, doing all this. But it’s only in the last I’d say 8 years that I’ve thought about probably looking at something different.”

Moreover, others pointed out that they had witnessed white nurses, trained by black staff, rising above black staff and yet still relying on the skills and experience of their black colleagues, to see them through in their new role. This was the cause of considerable anger:

“I think sometimes that really hurts more than anything, the post will go to that person but then they’re looking to you to teach the person, to train them up etc.”

“So for me it was about well, I didn’t go into this to become a sister or whatever or whatever, I came in to do a particular role. But then I became, so the catalyst for me is, I’m sick of letting you become senior to me and then coming to me to ask me what should I do in these different positions.”

In October 2003, the National Health Service started its Breaking Through Programme, as part of a package attempting to tackle racism within the service and implement the Race Relations Amendment Act 2000. The Breaking Through Programme is intended specifically to move black and minority ethnic nurses into senior positions, such as Director and Chief Executive positions including through mentoring and leadership training. The focus groups in our study took place quite soon after the programme’s fourth annual conference. Views about the Breaking Through programme are discussed in more detail in the section on Targeted Programmes within the Creating change section of this report.

One participant initiated the discussion about promotion in her session when she narrated her experience of trying to move through the rungs and later on of the Breaking Through Programme. She started nursing in 1976 and found she was able to move through the rungs until she reached I Grade. At this stage she encountered a glass ceiling and moved workplaces in order to overcome this. However, she found
life as a senior manager very difficult. Despite working hard and achieving targets, it was clear to her that she was not supported in that role:

“Because I knew they were wanting to get rid of me because for some unknown reason, although I’d got the job, my merit was there, everything was there. They definitely made me know that I shouldn’t have had the job. And I knew my time was limited. And I thought well I’ve got the I grade job; they can’t take that away from me.”

However, she persisted, took up training programmes within the service and moved workplaces in order to continue to progress. However, she explains that despite undergoing all the necessary training and taking up all promotion and progression related opportunities, she encountered hostility, which in her view amounted to direct racism and felt she was eventually pushed out of a second job:

“And I developed hypertension and everybody just made things very difficult for me. I was doing my Masters in Health Promotion and my staff threw all my questionnaires (in the bin), knowing full well that you’re doing the programme and it’s very limited… … And you write letters, you’re meant to be a manager and your secretary doesn’t type the letters. She goes to take it to somebody else to look at it and if she deems it OK then the letter gets typed and stuff like that. So you’re managing an uphill struggle all the time.”

This particular participant moved onto another workplace and went on to try the Breaking Through Programme but spoke candidly about how her senior colleagues within the National Health Service could not move beyond their prejudices:

“And so anyway, I came back to the NHS and I was trying to get a director of nursing job but from teaching it’s a big leap and people just couldn’t cope with a black person wanting to be a director of nursing just like that, you have to have paid your dues… … I was happy to get a manager’s job and I got on the breakthrough programme, another leadership programme, this was my fourth one! So breakthrough, so I thought OK I’m a manager now with a breakthrough programme, I’m definitely going to get the director’s job and then I’m going to get the chief exec’s job. Why not! Born in Britain, I’m 50, I was 50 in April and why shouldn’t I have that dream? Why shouldn’t I?... I was giving them everything. I left my babies in bed and did the job, I was meant to be there at nine, I got there at seven, because I really wanted to do this… So I went straight up there and said ‘(name), I was on your interview panel and you gave me this
opportunity to be mentored by you’. So he was my mentor. But every time we met, he said ‘(name) do you really want to be a chief exec?’ I said ‘why not? Why not?’ I thought I’m going to work on this because I’m going to make him change his mind and make him know I’m as good as he is… And I thought, I’ve got to work through this.”

However, she felt that she was eventually forced out of her job and is now working as a bank nurse. Having listened to her experience, other participants raised their concerns:

“I think for myself, listening to (name) account, I think both myself and (name) are currently on the Breaking Through Programme. And I think for me I felt a sense of sadness because I think I’m years behind you in the sense that I would like to see myself as a director. I’d like to see myself progressing within the National Health Service. And I think my career has been similar to yours in the sense that I think I’ve done reasonably well in my own personal achievements as to where I am today. But I think I can see that there will come a time, I think the NHS or the organisation allows you to reach a certain level and that is the level where they expect you to maintain at. It could be they allow you to maybe reach a director’s level but there are very few BME or black people that reaches further than a director. And yes, you see directors who are from BME backgrounds putting in far more hours, which (name) described, than their counterparts. And I tell myself well it’s just really unfair because yes, you go on the Breaking Through programme and you’re told that you can reach whatever heights you want. And you come away with that sense of yes, I can become a chief executive, but listening to (name) it makes me actually wonder to go through that pain and torture, is it worth it.”

Nevertheless, some participants had decided that not only could they aspire to managerial posts, but also that they ought to, given that they had the ability to do so:

“I think there are very subtle things that happen at different layers that discourage people from even thinking about applying for senior posts. Because I went through the EN RDN route and it was, when I think about the reasons I applied for promotion, it’s not because I’ve felt initially that I was able to do it, it was because I was sick and tired of people who were less experienced than me getting into these positions and coming to me and asking me the questions that enable them to do their senior job.”
“The fact that the Government themselves recognise that there is a lack of BME professional nurses. We are the majority at grass roots level and why do we always have to be the majority at grass roots level. Certainly there are some of us with that skill to be director, associate director, chief exec.”

At one of the sessions, however, an ex nurse, now a lecturer, reminded all present that the participants at the session did not necessarily reflect the experiences of the majority of black nursing staff who are in fact concentrated in the lower nursing grades. The lecturer confirmed that her students had complained about problems accessing promotion:

“What the Breakthrough programme is an interesting one because I think that, and I just think many people here are at quite senior levels. And my work is mostly, across the board with pre and post reg people. And my interest is particularly with those of the pre reg kind of level, but they’re not seeing people in the senior roles representing themselves.”

However, although some participants were able to point to the opportunities presented by the Breaking Through Programme, others complained that a new focus on black staff and on statistics or targets had meant that black staff were now being pushed into going for managerial positions even if that was not the route they wanted to take. Moreover, two participants complained about the pressure on black staff to seek promotion. It was argued that since 2000, the combined effect of the introduction of targets for promoting black nursing staff and the introduction of Agenda for Change, which potentially links appraisals to career progression, had lead to an over emphasis on vertical progression. Both participants explained that they were not interested in moving to managerial positions and were adamant that they had chosen the profession because they wanted to work directly with patients. Indeed, it was their work with patients that gave them the most validation and job satisfaction. However, they were concerned that this was viewed as a lack of aspiration and as one participant noted, just because she had chosen not to seek promotion did not mean that she lacked the ability to undertake a more onerous role. She had undertaken significant self-study but all of this had been for personal satisfaction and achievement, not to enable her to get a different or better job:

“And I don’t actually agree that everybody has got to be a manager and therefore part of a BME group and you’ve got to be a leader or you’ve got to be a chief exec. I think it’s something called personal choice and I think that should be respected. But that is my choice as well, to stay on a grass roots
level, but then I have got academic qualifications and I’m now doing a Law degree. So I think it’s what somebody wants out of life, not what you’re being told or fed into as a student nurse.”

A third participant, explained that she had made a choice not to go for promotion because of the fact that she had dependents and did not want to take on that extra responsibility or work, despite being encouraged by her colleagues and supervisors:

“I worked in ITU, neurosurgery and I worked in surgery. I do those kind of areas. And then when my children started coming along I realised that I didn’t want to work in those areas any more because I then had to look after my kids.”

Others were sceptical, not solely on the grounds that the Health Trusts were more interested in superficial manifestations of ‘equality’ than in being genuinely committed to the development of black staff, but also that the current focus on Black staff was principally a response to demographic changes and an increasingly ageing population, rather than to do with promoting equality of opportunity.

In terms of the issue of differential workloads, the lack of accreditation for doing this extra work on a systematic basis has been raised as a concern by lower graded Black nurses and health care assistants in a separate study on the UK health sector7. This concern, which is one that potentially applies to all nurses in the health sector, was raised by one of the participants who spoke of her Trust was gradually replacing higher grade nursing staff with lower grade nursing staff in order to save on costs and despite employing them to do exactly the same work:

“What the managers are now saying, what my manager has said, is that, we had a meeting a few weeks ago and she looked across the board at the amount of band fives and band sixes that had been employed. And one of the things that

she would like to bring in is health care assistants on band threes, to do the jobs that we’re doing.”

However, there were also a couple of participants who complained about black staff who had moved into managerial positions, for seemingly ‘pulling up the ladder behind them’. The critical nature of the discussion about black staff in managerial positions highlighted the particular insecurity of their circumstances as a result of greater scrutiny of their work. It was suggested that black managers were under greater pressure to ‘fall in’ with other white colleagues and institutionally racist systems and/or distance themselves from black networks and social circles, in order to prove themselves as ‘objective’, ‘professional’ and ‘competent’:

“But as soon as they climb the ladder and they are up there, they took the ladder away so that the rest of us now, or whoever is below them, will not come up. I think insecurity is the thing that is worrying the black minority groups who are supposed to be part of managers now. And then the other ones at the top there with them, they used them against the rest of the team so that, whatever they cook upstairs, they give it to them to go and give to the rest of the nurses.”

Moreover, those participants that had managed to progress or gain promotion became the butt of frustration of white nurses in lower grades. One participant explained that despite being more qualified than her white colleagues, her promotion to an F grade was questioned by white nurses trying to move from a D to an E grade who could not come to terms with her more senior ranking. Another documented the difficulties she had experienced with a white colleague, who was resentful of her higher grading. The situation became so difficult that in the end she took redundancy and left the job:

“And it’s like she was frustrated and she put her frustration on me because I was an F grade. She wanted an E grade and she was a D grade, and she wasn’t an E grade. And there was me being an F grade. And whenever I was working with her, there was always this tension. Because she wanted this grade and she was white and I was black and she probably thought why should she be an F grade when she’s Black and I’m white and I can’t get an E grade. And it’s like she used to work part-time and it’s like whenever I did the off duty they put her to work with the same shift to frustrate me. And we were forever disagreeing. There was always tension between the two of us. Eventually when the hospital closed, I took voluntary redundancy and left.”

One point that emerges clearly from the discussion on promotion was the lack of
transparency in how higher grades were awarded. This lack of transparency inevitably led nurses, who had been passed over for promotion, to conclude that this had occurred on the grounds of race discrimination, although often they had been reluctant to voice this over concern as to the consequences for their career:

“I think it’s one of the areas where minority nurses might be more vulnerable and/or might feel discriminated against. Because if things aren’t quite clearly documented, i.e. after this period of leave or acting up or whatever it is you’re doing, that you will return to ‘x’. But sometimes people might feel the reason I don’t get back into my job or something is because I’m black or something like that. And that also may be a part of it and it may not be. But I think that sometimes people in minority groups might be more vulnerable in terms of asking, being assertive and pushing.”

Participants also spoke of being told that they had ‘nearly’ got the job, but there was always a candidate who had the edge over them:

“Your paperwork and your qualifications show that you can do this job. And at the end of the day you always hear at the interview, oh you were just pipped you know. You were just pipped and you think well why was I just pipped? And you think well, - you question that, that pipping. And you question that, what is the pipping?”

A small number of participants refused to see their rejection for promotion as a consequence of discrimination, and this was a stance more likely to be taken by younger participants, who were slightly more reluctant to associate the treatment they had received as being a consequence of discrimination:

“And I don’t think it’s - if I didn’t get a job it’s not because I wasn’t white or because - I just didn’t get it because I didn’t perform well on that day or I missed something. Or there was something that went wrong.”

There was also a feeling that on occasion small concessions were made, principally to ward off any possible race discrimination claims. A black nurse might be offered a slight improvement in pay and conditions where the post that she had wanted was being offered to a candidate who was less qualified but who was white:

“So I know that there was some sort of collusion to offer me this lesser post with a little add on to make me feel better because it’s my specialism.”
2. **Agenda for Change and clinical grading**

In all the sessions there was a considerable amount of discussion about Agenda for Change (AfC). The key difficulties related to: discrepancies in grading; the irregularity of appraisals; and the level of support participants had gained during the job evaluation process in the transition to the new unitary pay spine.

Clinical grading brought the greatest level of dissatisfaction. A number of problems were identified. Moreover, many of the contributions in this area were tied to comments about a role for the RCN - dealt with in the section *Creating change*.

Firstly, the starkest comment about the impact of the structure for black nurses was made by one participant who had been a member of an appeals panel assigned with the task of reviewing decisions over clinical grading. She had found it demoralising to see that the overwhelming number of appellants before her were black:

> “I went to the appeals, I used to represent the staff side and appeals for clinical grading. Twenty of these, all BME staff, and there was never one, I’ve never been to a white person… It was always, and after 20 I said I’m not going to any more. It was so demoralising, listening to all their knowledge, their skills, their expertise…”

Other participants noted the lack of support they or black colleagues had experienced during the job evaluation process:

> “I was fortunate, I was banded a band seven and assessed by a team and they came and talked about what we were doing. One of my colleagues was banded a band six in the same room. And she just signed her documentation, took it back to the nursing office, not realising, and it’s caused a lot of problems.”

Several participants noted pressure from trusts to agree to grades that they did not feel reflected their workloads, their responsibilities or their skills:

> “I think we all feel the same. But also there have been some people that have been called in by the managers to sign the papers. You either sign it or leave
your job more or less. That kind of threat has been going on as well in some of the trusts or PCTs.”

“Actually I work for the (name of trust). And we were told as well to just sign those forms, whether we like it or not. We were told to sign those forms. Yes you can actually appeal but again I’m being paid at a band six, most of us are paid at a band six. And the particular community team that I work in, the majority of us are BME staff working with very chronic patients. And as I said, we’re doing phlebotomy, I’m also doing phlebotomy and other particular duties. And I do feel that we should be on band seven but we’re not.”

Others noted that the appeals’ process on grading was a very difficult process to undertake, involving the completion of long and complicated forms thereby raising concerns about the impossibility of black nurses challenging their grading without some kind of effective workplace representation:

“Can I just ask, none of you asked when you questioned your banding… When you contest your banding, you send your form which is a 70-page document and you have to fill it in. It took one of my colleagues two weeks to fill those in.”

In the context of the participants’ views on the lack of support during the evaluation process and their later comments about ineffective workplace representation, it is likely to be the case that, even though the process for appeal is the same for all staff, black and white, there may be a differential impact upon black nurses going through the appeals process.

Indeed the suggestion that AfC would bring uniformity in grading within the health sector and across individual workplaces was strongly contested by participants in this short study. In addition to the points made above about perceived discrimination within the process that has resulted in nurses not getting the grade they felt they deserved because of their race, the other reason for differences appeared to relate to the level of discretion accorded to individual trusts negotiating localised agreements. As one participant explained, nurses at her hospital were being paid at a lower grade than nurses at a neighbouring hospital. Another participant argued that nurses working in the community in her borough were awarded a higher grade than the nurses working in the hospital. Given that the black respondents in the quantitative analysis were less likely than white nurses to be employed in community positions, this could have a disproportionate impact upon black staff in the sector and a number of participants raised this point, as the comments below, from three separate
participants, demonstrate:

“Yes, can I start that one off. I have a real burning about this. We wrote our job descriptions at Agenda for Change for school nursing. And got a letter from our RCN colleague who actually was on the Agenda for Change, saying that yes, you’ve got a band seven. And so we’re very happy and started to tell people and then it was recalled that it was a mistake. And then it went out again, we had to alter something that they didn’t like. So we wrote the job description, in the places they didn’t like again, and it went forward again and came back ‘you’ve got a band seven’...Because the district nurses didn’t write a good job description and the health visitors didn’t write a good job description, she could not give us band seven because she was afraid the district nurses wouldn’t agree and the health visitors wouldn’t agree....So we’re sitting on a band six at the top of that band six, can’t move anywhere. No gateways to go through. And we are just doing the work and not getting the pay. “

“And so therefore they have this discrepancy, every time you go to a meeting, it’s always these are the grades of nurses that are overworked. And yet they are underpaid because they are all on band six. And we were supposed to be in this category of other trusts have messed up and they have to even out the money or something so they couldn’t pay us.”

“And it transpires that some senior nurses at the (name of hospital) are getting paid a band nine. Band nine! But their colleagues at another hospital within the trust, I won’t name it, are being paid a band eight for their jobs.

Participants were unhappy about the way in which grading was being determined and suggested that subjective factors had not altogether been eliminated:

“They call it positive action because they say now we’ve got knowledge and skills framework, you have to produce the evidence that you’re actually doing the job. But the evidence is what each individual manager wants, not what is required globally. So I think it has created a lot of, how shall I put it, what’s the word, inequalities. And it’s not really doing justice to the people who actually have got the knowledge and skills. So I think the banding really needs to be looked at, not like three NHS trusts have amalgamated and have been on different points, because it’s in a terrible mess, it’s in a terrible mess.”

Participants noted that the implementation of AfC had lead to a lot of problems within
their workplaces and indeed had exacerbated existing tensions or suspicion between ethnic groups:

“But what it has done is it has created a lot of competition and has created a lot of uneasiness, even among the BME staff themselves. And I have to be very honest because it’s like black against the Asian or black against the other one, just because she’s Asian she’s got it. And just because she’s black she’s got it.”

Several participants noted that they were not receiving regular appraisals. Whilst one of them argued that this was the case for all the nurses on her ward, others believed that white colleagues were being appraised more regularly than black nurses. The following participant also pointed out the implications for pay where appraisals have a direct impact upon salary increments and movement from one band to the next:

“I think it’s important… we have got something called the KSF (Knowledge and Skills Framework) and you have to work - you can’t just work within your little parameters now to say this is where I want to be. In order for you to get your incremental points and to get your salary or whatever you have to get through these gateways. So if for example, if we haven’t put in structures in there to say, because I know quite frankly my nurses say to me that ‘my ward manager hasn’t put me through my KSF. It’s not that I haven’t met my skills, it’s because I think she hasn’t bothered to do my appraisal. And she hasn’t done the appraisal because she’s done the other girls and the other girls happen to be white.’ And they see it as a form of discrimination. So while I hear you say that you don’t, this is where you want to be, the KSF tells you that you have to work and get beyond that as well.”

3. Acting up
Several participants, across the three focus groups, provided examples of where they had been acting up for colleagues. In some instances they had been remunerated for this increased responsibility, however, they believed that they were not reimbursed to
the same scale as their white colleagues and furthermore that they were less likely to be successful at interview once the post was advertised. This perception was supported by the quantitative survey analysis which found that although BME nurses were more likely to be ‘acting up to a higher grade’ than white nurses, fewer BME respondents report being paid for acting up to a higher grade.\(^8\) Sadly the participants in this qualitative study talked about the consequences of enduring this process as having led to demoralisation and ill health and in some cases, as leading to a decision to leave the job:

“The job was advertised and somebody else applied who I’d done one of my courses with, who I knew had less experience than me but was white. And she got the job, and so many of the team just couldn’t understand why this person with less experience, new to the hospital. I’d worked on that ward how many years - and why they’d appointed her. And the matron’s reasoning was that I’d been an E grade on that ward, I’d done an acting job, but they felt that they needed somebody new with some new ideas. Yet, for that year I’d been paid, I don’t know, £40 or £50 extra a month and was good enough for that year and I’d implemented changes and did lots of things. But they then felt no, they wanted somebody with a new - and that just soured my whole relationship and I left.”

Another participant, a theatre nurse with over 30 years of nursing experience, explained that she faced greater scrutiny when she applied for the permanent post that she had been ‘acting up’ for:

“Yes, and can I just say that when I went, when it was the F grade I was acting in an acting role for about a year to eighteen months. And the sister on the ward who also …and we were going for G grade. And she went to her interview and it was the manager herself and somebody from, I think HR or another person.

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And then when they called me for the interview, my manager called. There was herself, somebody from HR, there was the theatre manager and also there was another individual in the room so there were four people interviewed me and my colleague, there was only the manager and somebody else…. I said I found it very strange… considering I’d been acting in that role for nearly 18 months and nobody recognised that until I posted the RCN and said that I feel that I am going to bring my full time officer in… Because my colleague had said ‘oh no, it’s fine, because we’ve both been acting up, you’re theatre sister and I was ward sister. You’ll be fine, this is how my interview went’. And her casual talk - 'we know you’ve been acting in the role for 18 months' and of course when it was my turn it was a full-blown interview.”

The following participant noted the link between social relations in the workplace and being successful in gaining promotion into a post that nurses had already been acting up in:

“Another I encountered was, I was running the ward, the sister who was in charge, her husband died and she had a long time off. And I was taking care of the ward, running the ward, doing whatever. And then the job came up and somebody else got it. And plus as well knowing that she hasn’t got the experience that you had, and there was just - in fact it’s who you know. If you can talk your way out, and if you can make jokes and go with them socially, that’s fine. But you are the mug who is doing it for so many months and was doing quite well, and didn’t get the job. Then they turned around and said ‘well you don’t possess the leadership that this girl possessed’, who was less qualified.”

4. Changing jobs

Dissatisfaction about grading and obstacles to promotion lead to people leaving their jobs or talking about the possibility of leaving their jobs. The following participant exemplified the spurned aspirations, resignation and disappointment of several other participants in the sessions. She started out as one of the few black nurses at a prestigious London hospital in the 1980s and eventually qualified as a neo-natal nurse where she began to plan her career. However, her application for promotion at that hospital was denied and eventually rather than live with the pain and embarrassment of not being able to progress, she left her job and her specialism and resigned herself
to becoming a health visitor with no expectation of promotion. Her description of this slow movement towards resignation and despondency is worth quoting at length:

“And I just wanted to mention very quickly about changing, going back to changing jobs. I did my general nurse training at the (name) hospital and I went in there and I was like yes, you could spot the black faces. But I was very proud because at the time we wore the … uniform, (I was) very proud of my uniform, very proud. I qualified, went into neo-natal intensive care… And if anyone had told me I was going to leave neo-natal intensive care I would have said ‘you’re lying’ because that’s where I felt I would spend the whole of my career. Because I absolutely loved it at the time… I applied for a G grade on my unit and actually at another hospital. Got the G grade at (name of other hospital) and I had to make the decision, should I move to (name of other hospital) or should I wait and apply for the one here. I turned down (name of other hospital), hoping that I’d get the one here… and my whole life fell apart because I turned down (name of other hospital) and I felt I’d become a laughing stock. Because - hahaha, you thought you were going to get the G grade and you didn’t get it. And that’s when, yeah my whole life fell apart because I had to now start to rebuild my life. I didn’t get the job which I’ve been in neo-natal probably nine years and I dedicated that whole time and it was something that I was really passionate, really enjoyed it. Developed so many policies, set up a parents’ support group. So for me it was a real bitter choice to have to make. I didn’t have a choice, I couldn’t stay there any longer. And then I decided yes I’ll go into health visiting and that’s hence why I made the change in career. But it wasn’t because that’s where I wanted, I thought I really wanted to be in neo natal intensive care.”

Other more general points were made about changing jobs. Some of these were about the changing priorities of the sector rather than concerns about promotion. One participant, who had achieved a masters’ degree and had wanted to be a nurse consultant, found that her experiences of the NHS had led her to question whether it was a sector she wanted to continue working in:

“But I’m not sure that I want to stay within the NHS because it’s just - just the way it’s going. I don’t agree with it, - it’s not about working with the patients or caring, it’s all about targets and in the end it’s supposed to help patients but it’s all ticking the boxes, or that’s how I see it.”

However, for many other participants, it was their experiences of discrimination that
had caused them to leave previous jobs but they were also aware that this was not necessarily tackling problems within the sector in the long run:

“Each time something happens you just change jobs and so whoever it is, it just perpetuates the same problem in the area, because what we do is we change jobs for an easier life.”
Career and professional development
The quantitative analysis that complements this study found that, when compared to white nurses, fewer BME respondents had: participated in most of the continuous professional development activities listed in the questionnaire; undertaken CPD activities for personal interest; or gained financial support for such activities. Moreover, more BME nurses left their current position because of training reasons.9

In terms of this qualitative study, very closely linked to the issue of promotion and grading was the issue of access to professional development. The preceding sections have already touched on this issue in relation to: low income workers foregoing staff development opportunities to do second jobs or to look after their children; the lack of regular appraisals and the lack of effective support during the job evaluation process, leading to unrepresentative grading. Career and professional development is also discussed in the later section on Creating change, under Targeted programmes, which looks at participants’ experiences of the Breaking Through Programme.

There was very little additional discussion on this area within the first and second focus groups. However, during the third focus group, as one participant spontaneously narrated her experience of being denied study leave this was met with a resounding echo of similar stories, albeit divergent responses. The following participant, who started nursing in 1989, noted the particular incompatibility of taking study leave and working 12 hour shifts. Moreover, she was particularly unhappy about the way that her manager at the time had pushed her to use her annual leave as study leave, so much so that she decided to leave the hospital environment and work in the community:

“She [her manager] didn’t want to give me study time. She wanted me to use my annual leave as study time and I ended up leaving because I felt that I was being victimised. And that’s probably what forced me to leave the actual

hospital environment... the management changed and I think, she made it quite obvious that she had likes and dislikes. I’m going to be honest about it, she had likes and dislikes. If your face fitted then you would get what you wanted. I mean, the time that she came in, I was studying and it became a problem to her, it became a real issue. So I decided to leave.”

Two other participants in the same session pointed out that they had the same experience in relation to accessing study leave. For one of them this was also the reason she left her job:

“When I was doing the Infection Control course, I was not allowed to have any study days to go through it; I did it in my own time... that’s why I’m doing agency (now).”

“I don’t know if that’s a common issue, I’ve had something very recently where work pressures are impacting and I’m doing more. And then the first option are supposed to be supportive measures, where ‘or maybe you need to give up, consider not doing your course’. And I thought to myself, is this a supportive measure or is it something that’s happening with you? Because I would not think of supportive staff as a first option, asking them to give up a course. And my manager basically, she’s done an MSC and I’m sure that was not her first option when the work pressures became a bit intolerable.”

Another participant highlights the connection between obstacles to staff development and obstacles to promotion or progression:

“But the organisation I now work in and just the current changes we’ve got, financial constraints and all the rest of it. And it seems that that’s the first thing that goes and that’s the first thing that people think well, we won’t bother with development or anything for people. So that seems to be the culture that we don’t, if people want to progress or people want to develop themselves then that’s just seen as taking time out of the day job.”

There was also a view that for black staff to have access to career development, they needed to demonstrate in advance that they were ‘better’ than white staff:

“You have to be twice as good, I think to get half as much in terms of development, in terms of career progression.”
We would suggest that one of the reasons for such little discussion about access to career and professional development in two of the three sessions, relates not only to its inextricable link with other issues discussed in this report but also refers us back to the characteristics of the participants in this study. Whilst one participant, an ex-health sector worker and now a lecturer, was able to reflect on the difficulties encountered by students and junior nurses, a significant number of the participants were themselves managers and therefore it is unsurprising that they also talked about balancing CPD with resource issues or the ‘needs of the service’:

“I think it has to be difficult… As a manager I would say if I have six members of the team and two of them wanted to do an MSc, and I know that people are booked to do long term sickness or whatever. I would say this year that only one person could do their MSc. But the fact that it’s on your PDP means that it will be acknowledged but you’ve got to be reasonable that the ward’s got to be covered. And that I would always send somebody but I would balance it. And I would honour it to say that I couldn’t send you this year, so and so will go, but I will consider you the next year.”
Relations with colleagues, supervisors and managers

Importantly, the nature of relations with colleagues, supervisors and managers defined or characterised all the other issues discussed within this report. Participants’ comments across the focus groups appear to indicate that it is these relations that have provided the basis for the persistence of institutional racism within their workplaces.

It was widely acknowledged that you had to have a good relationship, ‘speak the same language as’ and socialise with managers and supervisors in order to have a relatively good quality of working life and especially to have your contribution recognised in your grading or to climb the ladder. Career progression was thought impossible without some kind of support from colleagues and managers or without mastering this kind of ‘friendship-networking’.

Quite a few of the examples of racism recounted by participants occurred against a backdrop of problematic relations with managers and supervisors. In one instance, a participant was told that she did not get the promotion that she had applied for because she did not consult her supervisor before submitting the application. The supervisor appeared to be unhappy that this participant had submitted her application direct to the Human Resources Department, following a formal procedure set by the Trust. However, she later discovered that she had been penalised for following this formal procedure. Her manager had clearly been expecting her to operate under some kind of system of patronage, in which loyalty and tight relations with managers would be rewarded with career progression or professional development:

“I have never mentioned this before, apart from to one person. Just the fact that my managers changed quite a bit because of organisational change. My manager called me apart and said ‘you know what (name), I had a lunch meeting with my manager... But you never showed me your application form which I thought you should show to me. And so you never got the job you wanted’. And she was white, our manager was white. And I thought ‘oh, I thought I was doing you a favour because you were so busy. So I took my application to the HR rather than giving it to you. At the time you were so very busy’. (but that’s) why I never got that position. I was very shocked, I was too shocked to mention it to anybody.”

Another participant, nursing since 1982 and now a nurse specialist, recounted how her white colleagues excluded her within her ward team until she attended one of their social functions. She noted that many of her colleagues were already well connected because they were the daughters of senior members of staff. So, prior to gaining
acceptance, her white colleagues would encourage her to go home early, in her view, so that they could continue with their own social clique in the ward:

“I was the first non-white person and nobody spoke to me on that ward, no staff nurses, for three months, unless it was something related to a patient. Nobody socialised with me or spoke to me until I went to the Christmas night out and then they spoke to me… and sometimes on a Sunday, because I always worked on a Sunday, there was a clique of little nurses who were trained there, or their dad was this and their dad was that. And they said ‘it’s quarter-past-seven, do you want to go home?’ I said ‘oh no, I’ve got my patients'. They wanted me to go home because then they could do what they want and I would never say anything. I just got on with my work, they would send me home at five o’clock ‘do you want to go home?’ I said ‘no, no, I’m here all day, I’ve got to do my work’. Because they didn’t want me to be there.”

Another participant narrated the psychological impact of these subtle social pressures:

“But I’ve worked in (name of hospital) now for four years. When I qualified I worked there and I had a really terrible experience on the ward that I worked on and that could have been partly because I didn’t get on - it was an acute medicine and I didn’t get on with the other staff. And it wasn’t because being malicious or anything, but I think the sister took a disliking to me for some reason. But I’ve come back to work and I still have this feeling of, I’m not quite sure what it is… But there seems to be, you have to be within a certain group to get to a certain position. That’s the impression I get and I don’t like being part of cliques, so I don’t want to be a part of that… I mean this is the kind of feeling I get, maybe it’s being paranoid.”

Another participant surmised that working, and more importantly surviving, in the NHS was less about being able to do the job and more about being able to manage the politics in the workplace, in reality being able to ‘play someone else’s game’ in order to override the institutionalised racism that she saw as an inherent part of workplace politics:

“And I went into the Breaking Through programme and then came out because I had what I thought was a really horrible experience of being on a course with a guy who was very well intentioned but actually was doing a session around presenting yourself in a senior role… And what it was basically about for me, or perhaps that’s what I heard, was that you will never get anywhere in the system
because your hair looks too un-white. And I think I kind of fell on to that because I just felt it was really, really insulting. And then I kick myself now because I should have gone back to the organisers and said this is really, really poisonous. And instead of that I just withdrew from it and I thought I’ve had enough of it, sitting around in hotels talking about strategies that were kind of watered down… Because it’s not really about what’s written on the job description, it’s about being able to deal with people at the political level and being able to gauge what’s going on in the room and being able to sort of counter attacks at that level.”

An additional point linked to this was the more indirect impact upon Black nurses, where core concerns about the workplace were being discussed and decided in the wine bar or at a social gathering outside of work hours:

“They go to the same wine bars. ….. They’ve prepared themselves; they help each other with their summaries, job summaries and get the positions.”

References to social networking in bars emerged in more than one focus group and there was a general feeling throughout all three focus groups that to succeed in nursing, individuals needed to be part of the crowd that socialised outside working hours. Those who did not got nowhere:

“You get nowhere, and that is what is happening with me at the moment. No matter what I do, I work my guts out, I give 2000% and you’re not thought of. And another person comes and that’s it. Once you can suck up to these people, you are there, the local bar, you’re going out and all these things, you are there. But if you don’t do these things because you have other commitments, you are not one of the crowd, the in crowd, that’s it. So what do you do? You just take things every day as it comes and you just go along. But these people know within their hearts that they do things wrong but I don’t know how they live with themselves.”

One participant pointed out that black nurses’ ability to participate in this social networking was more likely to be restricted by the need to get home and tend to childcare and other responsibilities. Another participant suggested that things might be different for young black nurses, who shared ways of socialising with young white nurses:

“When it comes to ethnicity, it’s not a black thing to go to the wine bar after
work generally. You look at all your friends; we don’t go to the wine bar straight after work so we always lose out. Because we go home and look after the children, as a single parent we run home. So although I know the group that goes to the wine bar, but I won’t be going to the wine bar with them so I always would miss out.”

“But I think the younger generation tend to be assimilating a lot more and going to the wine bars and going to those places and [they’re] networking probably slightly better than we are. Because they know how to do it.”

From these examples that a number of things come together here – the social networks, culture and the fact that many of the participants were single parents or primary carers. These features appear to act together in order to ensure that black nurses are far less likely to progress through social networks that rely on continued contact outside the workplace or outside of work hours.

In two out of three of the focus groups, there was a significant amount of discussion about how to counteract such insidious practices. The option of receiving mentoring within the ‘Breaking Through’ programme was posited as one way of learning how to work the system:

“But sometimes you have to, take a different framework. Because otherwise these things are going to constantly happen, we have to try and slip through under, sideways, network and find the people who will help you through. And there are people out there and I’ve found it over the years, who want to help other people to make it… I know about the policies, I know about all of these things, I know it’s wrong. But also I can say how am I going to individually try and make a change.”

However, the question of whether or not one should learn to play the game in order to counter its negative effects was a very contentious point. Other participants in the same sessions were adamant that their career should not hinge on their ability to socialise but rather on their ability to do the job:

“But there are boundaries. I don’t go to the pub; I’m not going to go to the pub with anybody. I don’t smoke and I’m not going to force myself to smoke. I’m not going to do things, be conditioned to do things because people want me to do it. I’m intelligent, I’m educated, I’ve got a mind of my own and I can use my brains. And no one’s going to force me to do what I don’t want to do to fit in
In contrast to what they saw as examples of white colleagues and managers operating systems of patronage, examples were given of black nurses, including some of the participants themselves, who, having been promoted to supervisory or managerial levels, were expected to ensure and demonstrate that they were ‘non-partisan’ to assure white colleagues of their ‘professionalism’. For instance, they were expected to be divorced from any black staff networks, so as to avoid accusations of misconduct or favouritism. At the same time it is important to stress that there were also a number of examples where Black nurses had been supported and encouraged by white colleagues, either in dealing with patients’ refusals to be treated by black staff or in pursuing professional development or promotion. These examples simultaneously highlighted the real difference this made in terms of how black nurses felt about their workplaces. This issue clearly also has implications for staff retention and for levels of sickness.
Relations with patients and family members

The discussion about relations with patients, carers and family members required some prompting. It was not an issue that was raised by the participants as a primary concern. This has to be viewed in the context that when asked why people chose nursing, aside from two participants that stated they fell into it accidentally and a couple that were reluctant to give up nursing after investing so much in it, the majority talked emphatically about their contact with patients, about staying in nursing because they were sure that they were making a difference to the lives of sick and vulnerable patients:

“And what is keeping me in the profession is because I feel I can make a difference to the service that we are providing to the public at large.”

“But thankfully I did the registered general nursing and one of the reasons why I remained in nursing, because I do enjoy my work, I enjoy the job satisfaction of it, I like meeting people, talking to people. I work in the community so I don’t deal with just a condition or one person but a whole family. I really do enjoy it.”

“And I am working now as a community psychiatric nurse. I don’t know, I believe that I’ve made a difference to my patients. And I’ve also been a very good mentor to many other people coming into nursing.”

“Nobody in their job on this planet makes a difference to people’s lives the way we do. And they will never ever forget you. You may forget them in your 20 years of your life, but they will never ever forget you. And I remember walking down the street with my niece in a buggy, a little baby, and this man tapped me on the shoulder, I was so scared, I thought he was going to hit me. And he said ‘I just want to say thank you to you…because you pumped my stomach about a year ago’. But he never forgot me. He didn’t mean to scare me but I just thought the fact that he remembered me 18 months down the line.”

Where participants talked positively about their work and reasons why they continued in the profession, despite facing obstacles to promotion or development or problems with colleagues and managers, they gained their affirmation largely through their contact with patients who acknowledged their work and the value of the care that they had received. One participant noted that particularly within the current climate of staffing and resource shortages, patients do express their gratitude when they receive good quality care:
“But patients look at you and they’re just very grateful to find someone that’s delivering good care. If you’re delivering good care, I don’t think they think about where you’re from, the colour of your skin. The fact that you are delivering care and you’re caring about them is what matters to them. And I think more so today because there are lots of nurses that are coming through that don’t deliver the high standards of care and are rather slap dash. They’re just grateful that they’ve got somebody with the knowledge and the skills to be able to deliver the care, assess the problem, and give them what they need, that’s what they’re looking for.”

As already noted above, for some participants, this is clearly linked to how they see their roles, their reasons for joining the profession. Validation of their work is largely located within narratives about patient care and making a real or tangible difference to patients’ lives. On one level then, contact and relationships with patients offers a sanctuary or a way of balancing out all the negative experiences in the workplace. But what happens when these experiences become tarnished by racism from patients, their carers and/or family members?

Quite a number of examples were provided where participants and their black colleagues had experienced direct and indirect racism from patients and family members. This consisted largely of examples where patients or parents of children had refused treatment by black nurses, but instances of direct racist abuse were also cited. Each of the following examples has been selected to demonstrate not only the way in which such refusal takes place but also the variety of responses from the participants themselves or from their colleagues and managers.

One participant narrated an instance of direct racist abuse:

“I have encountered racism quite blatant someone said ‘I’m not having that effing Paki look after me’ in an open area. And the sister did nothing about it, and I said I’m sorry, I’m not doing his dressing. I’m not doing it because I know what will happen… I was just so scared and I said I can’t do it and someone else did it.”

However, her supervisor was very unsupportive:

“Well it was quite open and he was in an open area, she (the sister) just looked at me and I said ‘look after what he’s just said sister, I can’t do’. ‘(name), go and do it’. I said ‘no, I’m sorry, I can’t do his dressing’. And he lived literally
five minutes away from where I lived. I knew who he was and I was so scared if he sees me on the street, he might come after me. Because he was known to be racist. I remember going to school with his brother and I was just so scared and I thought, no I don’t want to do anything to antagonise him for it to come back. And I was just scared of a backlash, but the sister was so unsupportive.”

Other examples of racism from patients and family members related wholly to refusals to be treated by Black staff and were met with varying responses. The following participant, a bank nurse in a hospital, is talking about an incident where white parents do not want their child to be treated by a Black member of staff. In this example, the participant believes that the white colleague has colluded with the family and a different worker is provided:

“Okay, yes. Racism is there, too. It was the first time that did it happen to me, it was about three to four years ago. That there was a white family... she said the family didn’t want her to look after the child because she was black? I came across it in an indirect manner. It was the first time since I’d been nursing that I’ve actually experienced, - apparently one of the white nurses actually told me, that’s how I found out. That the family did not want black nurses to look after their child. … This was in London. And there was a clinical nurse specialist, I think she instigated it and she supported it. And I know she did and I wanted the direct evidence.”

Whilst this particular participant is less concerned about being taken off the job than about the behaviour of her white colleague, giving into refusals to be treated by black staff invariably fosters cultures of racism within the workplace.

Another participant, now working in the community, recalls an example of patient racism when she was a nurse within a hospital. In this example, there appears to be absolute clarity and unity amongst nurses and doctors in the ward about how the situation ought to be dealt with:

“I remembered when I was doing my enrolled nursing and quite young, 18. And there was this South African patient who was really racist, he fell out of bed and another African nurse went to pick him up. And he said to her ‘don’t you put your hand on me, you black whatever he called her’. And because we saw him on the floor, we all ran towards him and the nurse was so shocked that she stood and she looked at him. And somebody said ‘aren’t you going to get him off the floor?’ And he said ‘I don’t want HER to put her hand on me, she
comes from the bush in Africa’. And he said ‘I don’t mind if you pick me up because you speak English’. And I said ‘I am not going to pick you. I’m just as black as she is, doesn’t matter where I come from, because I’m not picking you up.’ And the consultant passed by and we just stood and he said ‘why is he on the floor?’ I said ‘well he fell out of bed and he doesn’t want a black African to pick him up. And since my forefathers must be African and black, I’m not picking him up’. So the consultant said to him ‘I’m sorry, you’re just going to have to wait until your white relatives come in to pick you up’. And so he stayed there until he decided that he didn’t mind anybody picking him up. And all the white nurses saw him on the floor and left him there. But in the end, he just mellowed and one white nurse and one black nurse picked him up.”

Another participant recalled that as a student nurse she had come across a patient who was racist, but here again the authority had acted quickly to stop the unacceptable behaviour.

“As a student nurse we did have a patient, a white patient, who had this thing about he didn’t want any black person next to him. Because you know the old Nightingale wards, and I think he had an Asian in the next bed to him. So he literally got out of his bed and took the brake back and pushed the bed. Pushed this other patient’s bed away because he didn’t want that person next to him. But I can well remember that the charge nurse at the time called the senior nurse and the doctors and they discharged him promptly from the ward.”

It was only one participant, in the third focus group, that talked about the existence of clear health trust policies against patient refusals to be treated by black staff:

“I’ve been in the office with other managers where the clients have refused. But we have a policy and we give them whatever staff we have, we don’t condone this sort of behaviour, asking us not to have a black nurse or whatever…well certainly in the offices where I worked it was seen through that no, you want a service, we will provide it, black and white…it’s not just zero tolerance but there is a specific policy in that respect…if they refuse the nurse or whatever, they won’t get treatment. So there’s a whole process, they can’t say I don’t want a black nurse…it’s a policy, we wouldn’t tolerate that.”

Nurses also noted individual responses to patient racism, including one participant who explains that racism from patients has had a direct bearing upon the quality of care that she subsequently provides. In particular, she explained that she would
respond to patient requests more slowly.

On one level it appears that other factors kick in to balance out these particularly negative experiences – one of the key mediating factors here appears to be the engrained role of care giver and notions of patient-carer relationships, where the patient is allowed to be difficult to some extent, to be moody and possibly even abusive but professionals need to rise above that because they are in a position of power and responsibility. This is demonstrated in the following example:

“How far back do you want to go? And yet again it was elderly care and it’s quite funny really, you laugh about it. There was a group of us as students working on the ward and originally the elderly person, who was probably verging on senile so it wasn’t her fault. She used to repeatedly say things and then she changed it after we had the group of black nurses coming ‘call the police, call the police, the black nurse is gonna kill me!’ She kept repeating this, so we would laugh about it but wasn’t - but yet again you’ve got to say all the different circumstances. There was a group and interactions and things like that but nobody took it seriously because of all the other external factors. Was she fit mentally as well, and I think we just thought, really just found it very, very amusing, and we used to go ‘(name), don’t do this’. This was many moons ago but she kept repeating it and it was because there were like four of us … And every visit to her ‘the black nurse is gonna come, call the police, call the police, she’s gonna kill me’. But that wasn’t her fault totally.”

Patient racism that raises the issue of physical contact with blackness as some form of sinister intrusion is both a remnant and reproduction of dominant discourses on ‘race’ and health, where black people are associated with the spread of disease and infection and branded as unclean or unhygienic. One participant astutely referred to patient racism as ‘a fear of being contaminated’ because of the way that resistance to contact with black staff is intermingled with comments and references to their hygiene, washing of hands and fear of black staff administering injections:

“And there is this thing, it’s not about skills, it’s about being touched by a person who’s of a dark colour.”

Without renouncing the responses of our participants and their colleagues, the majority of whom had sought to work around patient racism rather than to challenge it, it is important to note that acceptance of patient racism could potentially contribute to or reinforce a workplace culture where racism goes unchallenged and is reinforced
and reproduced. One participant voiced this concern, when reflecting on her not having challenged racism from patients in the past:

“And so I think, I probably put up with a lot of things I shouldn’t have done, because you think well, you’re a professional, you’re trying to do what you’ve come to do. You try to appease people, try to look at it from their point of view. And I think looking back it’s actually quite damaging to people in various different ways to try to ignore that.”
Racism and other forms of discrimination

It is often not possible to separate out one experience of discrimination from another and where issues could not be deemed as either one form of power imbalance or another, they were sometimes about the simultaneous experience of both. Moreover, in some instances participants talked about the experiences of racism when giving examples of the lack of work-life balance and the impact upon their childcare responsibilities. This demonstrates that white colleagues, in circumstances where they too are on lower grades, in older age groups, and/or are women with children or other dependents, also share some of the concerns of black nurses.

The working lives of the majority of black nurses that participated in this study had been to one degree or another structured by racism. This has taken various forms, most significantly racist stereotyping by colleagues and the public and institutionalised racism which has meant that work cultures, particularly relations with colleagues and managers has had the effect of excluding them. One participant provided the following example of racist stereotyping:

“I think there’s a subtlety because one of my very first experiences when I was a sister and I was managing a particular consultant’s list, and I’d known him but not in that role as sister. And he said to me, actually ‘where are you from?’ So I was thinking I’m a sister, he wants to know what my clinical background is so that, am I going to be any good at the stuff that he’s there for. And I said ‘oh I’ve worked at … …and I’ve done this’. He said ‘no, no, no, what country are you from?’ And I thought ‘what’s that got to do with anything?’ And he wasn’t malicious about it, he was quite naive about it… …And then when we got to know each other …after about a year or so, one of the sisters who was actually sister on one of his wards if you like. And he came and he said ‘do you know, so and so’s got a degree’. And thought!  - laughing. And I just said ‘really?’ And I just said ‘well there’s nothing unusual in that, lots of nurses get degrees’. But it wasn’t that she had a degree, it was because she was black and she had a degree.”

She goes on to talk about the impact of such stereotyping in terms of the jobs that black nurses get access to:

“I worked for a particular London hospital that had something like 12 theatres at the time. And there was one black sister in the whole of that - and two staff nurses at the time….And I was thinking - I’m not going to put my head on that
parapet because surgeons could be particularly… there are more doctors from minority groups. The senior ones still tend to be the same white British men and sometimes because of their experience of working with black women in particular, it’s not been on a par, it’s been quite difficult.”

Another nurse commented on the prevalence of racism within the sector:

“Career wise I think it does take BME nurses a lot longer to get to where they want to be. Just in terms of, and also understand - because we will go down the route and think well you know, you want to do a degree or you want to develop anyway. But you do all of that but it’s not enough, you have to be twice as good, I think to get half as much in terms of development, in terms of career progression. And like you say, people will sail through and you think well I know that that person hasn’t got the level of skill, hasn’t got the level of competence and all the rest of it. And I’ve been here ten years, fifteen years and have done in that ten years, fifteen years, have done ‘x’ amount far more. So sometimes it’s actually quite difficult to know what it is that’s required to get on, I think. It is twice as difficult and because it’s sort of hidden, it’s quite difficult for people to actually know what they need to be doing to move on really.”

Other subjects discussed in relation to racism in the workplace included how black people were stereotyped:

“If I talk, I have an attitude, if anybody else talks they have no attitude, it is acceptable.”

One participant, who had worked outside London had experienced racism from colleagues:

“But when I did go into Sidcup in Kent, which is a very conservative rural area, that’s when it really hit me in the face, the racism that I encountered as a sister on the ward from the consultants, from the managers, from the junior staff who had been there for years doing a set pattern of work which I was not really quite in favour of, the practices. And people would just walk past me and looking for the sister, go to a nursing auxiliary and say ‘oh’ and you’ve got this bright blue dress on that nobody could actually miss even if you can’t see the face.”

When probed about whether racism was the only or key form of discrimination that
they faced, the majority believed it was. However, participants did refer to other power imbalances notably of class, gender and age. As mentioned in the section on ‘Working hours’, being a parent and particularly a single parent had had a significant impact upon quite a number of participants in this study and their feelings about their working lives. Points about class were also made in relation to the cost of childcare and the way in which race, class and gender coincide and act together against black nurses in one parent households, who are more likely to be employed in the lower grades and therefore less able to afford the cost of childcare. Moreover, this situation was also experienced as an obstacle within the workplace in terms of getting access to time off in order to manage childcare responsibilities.
Creating change

Many of the participants reflected on the position of black nurses over the two or three decades that they themselves had been in the health service. Whilst some argued that there had been a distinct change in their working terms and conditions and were optimistic about the possibility of improvements in the sector, others aired their frustration about the persistence of more subtle systems of racism, now widely known as ‘institutional racism’:

“Because at the end of the day, we are in a very difficult situation, we were talking about this in the 1960s since we’ve come here and our parents. And nothing really has improved and the Breaking Through Conference has indicated that. We have to take a different mode and look at things very, very differently and see where we as a people can actually network and start to strategically develop ourselves. The Breaking Through allows for us to question chief executives etc. Yet there was no black person or person in any of those who chaired that day. And you questioned why and all of those things, but now hopefully there’s a new ethos where we say OK there was a glass ceiling but we’re prepared to break through it. It’s going to be very uncomfortable. And it’s helping others to break through it because otherwise we can sit all day and yet, it’s not going right.”

However, the discussion about creating change can be divided into four distinct areas. Each of these is discussed in turn below.

1. Effective policies and procedures

Whilst some participants argued for the need for clear policies and procedures, others complained that these were mere paper exercises that were not being implemented. For instance, some staff noted that their hospitals had equality and diversity policies

\[\text{\small Footnote: Indeed it is the case that there were no black staff on that particular panel but this is because at present there are no black Chief Executives and this was a panel comprising only Chief Executive Officers.}\]
but that these had not any real tangible impact upon the working conditions of Black staff:

“But the thing is, all these diversity and equality policies that they put into place, they’re just words on paper, but they don’t work, and they don’t practice it.”

“They should take the equality and diversity policies seriously. I don’t think they’re serious, because I’ve got the diversity and equality booklet and I don’t - it’s all on paper. And it looks official but I don’t think they take it seriously and they need to start taking it seriously.”

“I think it just leaves a very sad, sad message that unfortunately in a lot of organisations there is that thing about just ticking the box to say we are doing it, we are doing it. When in actual fact it’s not something that’s genuinely done, it’s just something that we’re doing just to tick the box.”

However, others noted the importance of policy commitments and of clear procedures, particularly as a way of overcoming difficult situations that would otherwise be determined by individual discretion and subjective preferences. Two important examples of clear policies and procedures related firstly to having black representation on all recruitment panels and the other related to the usefulness of a written commitment opposing patients’ refusal to be treated by black staff.

2. Targeted programmes

Participants referred to a number of specific initiatives within the health service. Some of these, such as the Improving Working Lives and Work-Life Balance agendas were not specifically targeted at black workers. However, they did appear to address some concerns and contain possibilities that could specifically improve the situation of Black workers in the sector. For instance, as has already been mentioned above, both of these agendas can potentially add strength to the need for workers to balance their working hours with other commitments such as childcare and looking after elderly dependents. When one takes account of the particular incidence of one-parent families amongst Afro-Caribbeans in Britain, it is possible to argue that a stronger commitment within the sector to Work-Life Balance policies could have indirect benefits for black nursing staff and have a connected impact upon staff retention. Moreover, since Improving Working Lives also includes an element that looks at the incidence of stress and violence and abuse, it creates the space to establish policy
commitments and good practice that could potentially alter the response of other workers and managers in the hospital to racism, including from colleagues, managers, patients, carers and family members.

However, participants also noted that since 2000 there have been specific programmes targeted at Black nursing staff. Several participants referred to the Breaking Through Programme and the related conference. This programme was viewed as an attempt to promote black staff and to draw them into managerial positions within the National Health Service, thereby countering long histories of discrimination in the promotion process. It is important to note here that not all participants were aware of these initiatives, most notably the clinical nurses, rather than the team leaders and that there was an ambivalence about whether or not such programmes were useful and particularly whether they had the capacity to deal with more sinister and subtle institutional racism, such as highlighted in preceding sections in relation to the discussion about relationships with colleagues and managers. Certainly, some participants were very sceptical, stating that in the absence of a genuine will within the national health service to respect and support black staff, such initiatives would be meaningless and become tied to bureaucratic demands to fulfil targets. One participant had been very disappointed, having participated in the programme:

“And I went into the Breaking Through programme and then came out because I had what I thought was a really horrible experience of being on a course with a guy who was very well intentioned but actually was doing a session around presenting yourself in a senior role, a lot of them had titles very similar to that. And what it was basically about for me, or perhaps that’s what I heard, was that you will never get anywhere in the system because your hair looks too un-white. And I think I kind of fell on to that because I just felt it was really, really insulting.”

However, as has been noted in the research methods section of this report, a significant number of participants held supervisory and managerial level positions. Moreover, several had attempted to make use of the Breaking Through Programme and talked about their experiences. Several participants noted that there had been a recent, and seemingly sudden, focus on black staff. Some suggested that this was more about replacing an ageing labour force, than about a commitment to tackling racism within the sector. However, others felt that these programmes included the potential for mentoring, so that black staff could be actively supported, in order to progress through the system, including by teaching them how to network and
counteract more subtle workplace processes:

“And the few that I do network with, because one of the good things with all the leadership programmes that I’ve been on, four to date, is that you do learn how to network.”

As mentioned in preceding sections, learning to network was considered absolutely vital in relation to career progression and some participants argued that older black staff should and often do feel responsible for providing younger ones with guidance.

3. Black workers’ groups

Specific groups for black staff were discussed in two ways: as Diversity Working Groups, initiated by employers, and as Black workers’ groups, initiated by employees. One participant argued that the Chief Executive of her employer had initiated a diversity working group and a related launch event, but that her actual and real commitment to the initiative started to be questioned when she turned up late to the event and it was clear that she had not prepared anything to say. As a consequence, Black staff at the event thought the initiative was merely a token gesture.

Bearing in mind that many of the participants in this study were managers or even senior managers, it is important to note that some of the participants had in fact used this obligation under the Race Relations Amendment Act 2000 to initiate Black workers’ networks. For strategic reasons they had had these endorsed by the Chief Executives of their Trusts. One particular participant recounted her method and the related success of the group:

One of the things as you say, rather than saying this is all terrible and it’s all happening to me, is to, one of the things that we’ve done in the last year is to set up a BME network in our organisation. Initially we struggled and I got a lot of support from the advisory group… we had a big launch and invited our chief exec and director of nursing and director of HR and everybody to come. And we gave them their speech - basically said what we wanted them to say about what their views are. Because a third of our workforce is from a BME background so to say what they’re doing and how they support BME issues. So they were sort of put on the spot a little bit but because they had a room full of people and they had to openly say we think this is really fantastic… We got their endorsement if you like and so the network is growing from strength to strength because they can’t go back on it now because they’ve actually said. And so we’re now being invited to comment on things like ethnic monitoring
Whilst some participants questioned the value of having separate groups for Black workers, one participant made a strong case for these:

They then think oh, I don’t want to be singled out, I don’t want special treatment, I just want the same as everybody else. But we have to recognise that we’re not starting on a level playing field and what we’re saying that this is one of actually getting the same as everybody else. Because we’re invisible at the end of the day within the NHS, 30 per cent of the workforce, but we’re invisible. So it’s actually making ourselves visible and that’s the sort of starting point. But it is difficult, as you say, that is what we should have.

From this flowed a lengthy discussion about the need for autonomous Black workers’ groups not only within hospitals but also connected at regional and national level. There was some difference of opinion about whether or not these should be connected to RCN structures.

In America they have the National Black Nurses’ Association right across the board. In this country we have different groups in different small areas. We need to come together, like in America and have a stronger force and have one big network than have a little small group…

So I think the force should be from the RCN

No, no, no, the RCN aren’t going to do it for us, we have to do it.

However, all were reminded by one particular participant in that focus group session that Black workers may avoid activism because of their particular vulnerability to victimisation; that whilst the power imbalance that defines their position within the sector necessitates collective action, it can also mitigate against challenges, unless Black workers feel protected and empowered by this action.

5. **Trade union support and intervention**

There was a lot of scope and demand for trade union intervention and support. Several participants identified areas where they felt the RCN could intervene, to raise issues affecting Black staff or even to empower them during the recruitment, job evaluation and appraisal process:
…somebody needs to speak out. Because you’re an RCN member, even by the RCN somewhere, someone ought to be saying, where do these people come from, where was the post advertised? I didn’t get the opportunity to apply

They’re not representative of the individual, they’re not supportive

I think RCN may be of use here, set something up, maybe this group will be a target group for RCN. Sit them down, let’s work out what is possible. Because the Trust are just doing nothing but working every one of us to our bones and we are getting tired of it.

A strong point was made about the role that the RCN should be playing in relation to ensuring that there is no discrimination in the implementation of Agenda for Change. This ties in with points raised in the section on ‘Pay, promotion and grading’ that Black nurses have not received sufficient support during the job evaluation and appraisal process. As a result they still feel that they are not on the appropriate grade. This could have been caused by differences in information about and support during the process. Alternatively it could reflect a deeper problem with the policy itself, especially where the racism that results in differential workloads is hidden and, despite years of work experience, is not accounted for, in decisions about pay and grading. The continued dissatisfaction around grading makes it worthwhile for the RCN to consider its role in conducting a Race Impact Assessment (as per Race Relations Amendment Act 2000) on the implementation of Agenda for Change.11

Several examples were provided where RCN membership or representation was thought to have assisted in protecting staff from racism and victimisation and strengthening their individual position in the workplace. For instance, one participant made the following point about being a workplace representative:

I came into nursing as a mature student when I had two kids. And obviously

11 The RCN has subsequently informed us that the NHS and trade unions are working on an impact assessment and that a report is due in Summer 2008.
childcare was very important, even from being a student. And one of the things I found out which helped me a lot was as a student I became a steward. And one of the things that scares managers out of their wits is being faced by a steward.

There were in fact very few instances cited where participants had actually lodged formal grievances. Rather they seemed to have raised things informally or left their jobs or workplaces.

However a number of concerns were raised about the quality of RCN representation for Black workers at a local level, as well as wider points about the RCN’s national structure and direction on the issue of tackling racism in the health service. Firstly, a general point was made that the RCN was seen as ‘very white, very middle class’ however at the same time this participant also acknowledged that there had been some changes.

I think there are positive things from the last 5 years to now. But we still have a long way to go in relation to recognising that ethnic minorities need to be reflected across the board.

One participant pointed out that union representatives are also connected to the social networks within the hospital because they are also employees of the hospital and so it is unsurprising that they also reproduce the same processes:

You know sometimes when you have union reps to represent you, these union reps have their friends within these organisations, hospital trust. And therefore when they’re supposed to represent a member, they don’t do it effectively because they don’t want to upset the balance. And it’s so wrong. They shouldn’t be a union rep if they can’t treat people fairly and equally. And I think that’s what happens.

Another participant notes the ineffectiveness of RCN representation because of the quality of their training and supervision, especially in relation to understanding and dealing with ‘race’ cases:

A lot of the reps, people who have the desire to become reps, they’re not trained well. There is a course you can go on but then it doesn’t really qualify any more. And I’m wondering if the reason why we’re finding that they’re so toothless is because of the calibre of representatives that we have... but then it’s who you have afterwards to supervise you to see that you’re doing a good job and so on. Maybe there’s something lacking in there and that maybe there
should be some supervisor to supervise that you are coming to, you’re working at a certain level.

A third participant called for RCN to be more proactive:
I’ve just in a sense, I’m almost still going through the process with the RCN. I found they could be a lot more proactive. I found that several of us were made redundant and what I felt was that I had to do a lot of work myself before I had support from them. And I felt it would have been good if there was, they knew that the whole Trust was making a tranche of people redundant. They should have been there from day one to explain to them, to the staff that yes we know, and this is the process, this is what we’re going to do for you. This is what you need to do. And nothing happened until I went to look for someone and then it was so difficult.
Black participation in research

In response to the question about why Black nurses might not participate in research and/or what encouraged the participants to attend these sessions, there were three key points. Firstly, many of the women that participated in this research did so in response to a call specifically for Black nurses to speak out about their situations. Several said they saw the email and bulletin information and had not previously seen a call focusing specifically on Black staff or that they had never directly been asked to speak about their working lives. One illustrated this point:

And most nurses in the NHS, enrolled nurses were Afro Caribbean, Black if you want to think of another word. And no one ever asked them until now what it felt like to have to do your EN training. And when one of our colleagues said ‘my mum told me not to do my EN training’, some of the others didn’t have a mother to tell them that. And no one’s realised all these years down the line what was it like for them. Were they hindered from being able to progress in their profession, had they wanted to, but they weren’t allowed to. And no one’s ever asked people till now.

When researchers asked participants why Black nurses might be under-represented amongst respondents to the RCN’s Annual Employment Survey, one participant questioned publicity about the survey, stating that she had not heard of its existence. Of course the fact that the survey is a random survey does mean that not all RCN members will be aware of its distribution and unless its findings are widely publicised members are likely to remain ignorant of its content and purpose.

Many participants saw the focus group sessions as an opportunity to meet other Black nurses, exchange information about their experiences and even as a possibility establish a network, as the following two examples demonstrate:

I was wanting to meet other nurses, other Caribbean nurses, to just come and meet them and talk.

I think for me, again I’m very interested in the research, and also I’d like to be able to network more and find out if, like you were saying, there needs to be some kind of, a group… …where I can get contacts, where are these groups. I can go to meetings and network more, definitely, that’s what I came to find out as well. And what contacts other people have that could benefit me.

Secondly, several participants noted frustration with research processes because of what they saw as a lack of follow through. They noted that reports had already been
published on the position and experiences of Black workers in the health sector and elsewhere, but that these had not necessarily had any real impact upon the working terms and conditions of Black staff. They noted the need for potential participants to be convinced that any piece of research was actually going to feed into real change:

“We want something positive …we’ve been here since the 60s and beyond, it’s been an issue of our fore parents, etc. And we’re going to keep having these surveys telling you the same thing. Stephen Lawrence, I could have written that report and racism in the institution. We all could have written that report… it’s what we live and meet daily. But yet again you think to yourself OK they’ve gone through that report, what has actually happened, what is different? Otherwise it becomes a paper exercise. And we’re tired of paper exercises, we want something positive to come from them …otherwise people won’t participate because they’ve been there before, they’ve heard it before.”

Another participant made a similar point at the beginning of the second focus group:

“In terms of where it goes in the end, so you’ve been commissioned by the RCN. Is it then going to be hidden within the RCN? What are they planning to do with it? Do they plan to publish it somewhere else?”

Participants wanted to see this particular piece of work shaping or affecting the RCN’s agenda in the sector and their work on the ground. However, linked to this was the question of whether or not the RCN has a strong enough position in individual workplaces or in the health sector overall to implement recommendations or take action as a key outcome of their research processes:

“RCN is weak, and not effective, they’re not going to take part. And I’ve known district nurses who are going through all this renewal at the moment and they’re not using the RCN …but they joined the district nursing forum and so on to speak for them, to represent them. So if you’re not going to be effective people are not going to (participate).”

The third point relates to issues of confidentiality and the possibility that participants might be vulnerable to victimisation. It was clear from this short piece of research that participants wanted to be sure that their contribution would be anonymised. This reassurance should be seen in light of the discussion above about the particular vulnerability of black workers to systems and structures of racism. Linked to this, points were made about empathy and trust during the research process. One
participant noted that research, reports and articles about the relationships between health and race or ethnicity have been problematic. One participant described it as an ‘explosive area’ (pointing to debates linking race with the incidence of HIV/Aids and infectious diseases) and that often research also acts to reproduce myths and racist stereotypes. For this reason, it was felt that black staff might feel more confident with Black researchers. This was distinguished from an approach that involved black only research teams, on the basis that it was not necessary for black people to be the only people that conduct research on black staff but rather that researchers needed to demonstrate an understanding of the issues, particularly of the impact of racism on black workers’ lives.
Conclusion and recommendations

This study attempted to provide qualitative evidence in order to enable RCN to reflect upon key findings of other complementary quantitative studies. In most part we were able to do this. This report provides a great deal of insight into the working lives of black nurses and particularly new insights into Agenda for Change and targeted programmes such as the Breaking Through Programme. However, on some issues, the particular characteristics of the sample meant that some gaps remain and these form the basis of our suggestions for further research.

In terms of further research, we found significant scope for a study that involves a more diverse group of black nurses particularly at lower grades between D and F. Also given that the majority of the sample in this study had trained in or were employed in London, there is a need for comparisons with the work life histories of black nurses outside of Greater London. Finally, because of the absence of men in this study, we feel a similar comparison with the experiences of black male nurses in the health sector would be of value.

Moreover, the focus group participants urged researchers to ensure that the key findings from this study would feed into an agenda for action by the RCN. As has been discussed at different stages throughout the report and particularly within the section 'Creating change', a number of suggestions were made about the RCN's role in creating change and in representing its black members. In relation to this, we have formulated the following recommendations in the hope that these will be considered as the basis of an agenda for action on the part of the RCN. As indicated in the Executive Summary, these recommendations are addressed both to the RCN directly and also through it to the health sector employers, as significant changes will not be achieved and the issues raised in this report will be inadequately addressed, unless employers in the sector make an equal commitment to supporting black health care staff.

**Recommendations directly addressed to the RCN**

- The research has revealed that it is not necessarily the case that the RCN has failed to take action on some of the issues of concern raised in the focus groups. However, there is a real challenge to the RCN to communicate better with its black members so that they are aware of what policies are being carried forward.
- The focus groups showed widespread support for a full Race Equality Impact Assessment of the implementation of Agenda for Change. We
understand that this is being undertaken, but the information in relation to this had not been communicated effectively

• There was a similar lack of knowledge among the focus group participants on commitments, policies and guidance on the following areas: obligations of Trusts to abide by state commitments to work-life balance; the regulations relating to payment for unsocial hours after the advent of Agenda for Change; enforcement of the Improving Working Lives Agenda by insisting Trusts implement a strong policy of zero tolerance towards racism from the public including from patients, carers and family members. In theory all of this information is available, but the channels of communication need to be re-visited and improved.

• A combination of processes appears to have come together in order to hinder the development of black representation at the level of the general council. The under representation of black workers in RCN membership and as workplace activists makes it more difficult for Black members to be elected to the council. Given the comments above about the lack of confidence in the RCN to represent black members concerns; about problems with workplace level representatives and perceptions of RCN as a white union; the authors of this report would suggest that one way forward would be for the introduction of a system of reserved seats for black members on the general council as an interim measure whilst action is taken to strengthen confidence amongst black nurses and black members, in the RCN's ability to represent their concerns. In the long term, a concerted focus on issues affecting black members should lead to a strengthening of confidence which in turn should lead to increased activism and an increased likelihood that black members will stand for and be elected onto the general council of their own accord. However, until such time, reserved seats would be an important measure for ensuring representation and also with regards to perceptions about the union.

• There was strong support for the establishment of worker-led black networking groups at a local and regional level, in order to develop collective responses to racism in individual workplaces and assist with the implementation of the Race Relations Amendment Act 2000. Again, these may already exist but there is a need for better communication in relation to them.

• There is a need to consider strategies that would strengthen RCN representation for black members, by making training on racism compulsory and by overseeing local activist interventions on incidents of racism.
• The RCN should consider strategies to ensure the more effective support and representation for its black members in the following areas: job evaluation, appraisals and appeals under Agenda for Change; and whilst black staff are ‘acting up’ to ensure that they stand a better chance of getting the permanent positions.

Recommendations that need to be employer led
• Being more alert to racism and discrimination in the workplace and proactive where it occurs.
• Having robust equality impact assessment processes in place.
• Employers should consider extending the current mentoring schemes, which are generally highly regarded by those Black senior staff who have benefited from them to Black staff at all levels.
• Employers need to ensure that there is appropriate Black representation at interview panels and furthermore that interview procedures, including the size of the interview team, are consistent as between white and Black applicants.
Appendix

1. Request for nurses to take part in focus group at the RCN

The Employment Relations Department of the Royal College of Nursing is looking for 20 nurses from the London region to take part in a focus group discussion at Cavendish Square on either Wednesday 31st October 4.00pm – 6.30pm or Saturday 3rd November 10.00am – 12.30pm.

We are specifically looking for nurses who were born in the UK with family origins in the Caribbean, South East Asia, Indian Subcontinent, Africa, China and South America OR nurses who have trained in these countries but who have lived in the UK for more than 30 years.

The purpose of the research is to find out about the experiences of British nurses from minority ethnic backgrounds who are currently working in a health care setting and to gather their views on the findings from recent RCN’s membership surveys.

Participants will be asked to provide details about their family origins either at the session or in advance. Refreshments will be provided on the day and as a thank you each nurse that attends will receive a £20 Marks and Spencer gift voucher.

Feel free to pass on this request to any of your colleagues who you think might be interested in participating and who fits the above selection criteria.

If you are able to attend one of the focus groups, please contact Danielle Boyle on 02076473565 or by email on Danielle.boyle@rcn.org.uk giving your contact details and preferred date.
2. Personal Biography Form

Personal Biography Form
Name:

Where were you born – if born overseas, when did you come to the UK; if you were born in the UK please state how you define your ethnic origin?

When did you first start nursing?

Is there a history of working in health care in your family?

Where did you gain your nursing training and qualification?

Which part of the UK and/or London do you work in?

Type of employment e.g. hospital, care home, district nurse:

Job title and any specialism e.g. elderly, mental health:

How long have you been working for your current employer?

How many hours do you work?
Are you full time or part time?

Do you work shifts?

Do you do any other jobs? E.g. second job? What is it and how long have you been doing it?

Marital / cohabiting status:

Partner’s occupation, if relevant:

Do you have any dependents?

Do you see yourself as the main wage earner in your family unit?
3. Focus Group Schedule

FOCUS GROUP SCHEDULE FOR RCN PROJECT

Introduction and practical issues: (10 minutes)

Welcome, thank you for taking the time out of your busy lives to participate in this study
Introduction to selves by Sonia McKay and Sukhwant Dhaliwal
Group to introduce themselves – name, job title / area of work

Aim of the session:

This study is intended to complement other work that has been carried out by several bodies, including ourselves, for the RCN;
The main aim of this short piece of research is to provide some narrative or real life experiences that add detail to the findings of the RCN’s Annual Employment Surveys. This project will focus on collating qualitative material from two groups of Black nurses: A) nurses born in the UK with family origins in the Caribbean, South East Asia, the Indian subcontinent, Africa, China and South America; B) nurses, wherever trained, from the above, who have been in the UK for at least 30 years. This project will explore the following areas: reasons for joining the nursing profession and expectations; feelings about work and workplace; problems in the workplace and obstacles to professional development or change; experiences of discrimination; and also external factors that impact upon participants’ working lives.

In this study the term ‘Black’ is being used in the political sense to refer to nurses of Caribbean, African or Asian descent including those from the Indian subcontinent, South East Asia and China that have some shared experiences of British state in terms of colonialism and migration and experiences of racism. Of course we acknowledge that there is diversity within this broad category but the term Black is being used to refer to all these communities

Check if anyone has any questions about the objectives of the study

Explain recording, transcription and anonymity (please turn off mobile phones as interferes with recording)

Ask people to please speak one at a time and please state their name before they make their contribution (helps us to transcribe)

How the session is organised plus practicalities

Please do not be put off by us scribbling this down, this is as much for us to remind ourselves of key points that are being made and of the need to may be ask additional questions later
Speaking honestly and openly – we are aware that one of the biggest problems with collecting information and views through focus groups is that of an emerging consensus which can act to silence some voices so we want to emphasise that we are interested in hearing all voices and views so if you don’t agree with what is being said, if your experience differs from what people are saying or if you want to suggest alternative solutions to the ones that other people in the group are proposing, please speak up and say so. We will of course try, at regular stages, to ask whether any one disagrees with what has just been said but feel free to put forward a different experience or perspective if you wish to. If of course you do share others experiences or agree with their views then we would like to know that as well.

IMPORTANT circulate and ask people to sign consent forms – explain that asking participants to sign consent forms before the session starts is good research practice and is important in terms of us being sure that those that participate understand what they are participating in, and that participants themselves have written confirmation that we will anonymise any extracts that are used from the recording of this session and that we will retain the information according to Data Protection Act 1998. It also lets you know that have the opportunity to withdraw yourself and your comments from the study at any stage.

Collect any outstanding personal biography forms
Current work situation (10 minutes)
For the first 10 minutes or so we would like to explore your working life overall, ask you to talk about what motivated you to join the nursing profession, what sort of expectations or hopes you had, whether any of these have been realised, whether you are happy with your job, with your duties or your role, whether you would like any of this to change.

Opening question: May be we can just start by going round and finding out what job you are doing at the moment, why you joined the profession, when you joined the profession. What are the things that make you want to stay in the profession and what are the things that might make you want to leave?

Probes:
- What are the things that give you job satisfaction?
- What are the things you don’t like? Have you tried to change this? If not, why not?
- What is the prospect of changing this?
- How do you feel about the place where you work?
- Has your experience of nursing matched the expectations or fears that you had when you first started? Could you tell us how?
- If you could change something about your working life, what would it be?
- We referred to this a bit in the bio sheet but I wonder if you could tell us whether you see yourself as the main breadwinner in your family? Does this have any particular impact on your life?

Working Hours (10 minutes)
Opening Question: We would like you to talk about the hours / shifts that you work and whether these are by choice or not. Perhaps we could also discuss whether your working hours or shifts fit with your other responsibilities or if you wished to, could you change them?

Probes:
- Did you choose to work full time or part time?
- Are there specific reasons why you work these hours?
- Are you happy with the hours that you are working? Would you prefer to work more hours or less hours? If you would like to change your hours or
wish that you were working different hours, what is stopping you from doing so?

- Do you also put yourself down for over time / as bank staff / do agency work elsewhere? Why is this?
- Do you think everyone has the same access to increasing or reducing their hours such as to part time working, overtime, bank listing?
- Does anyone here work shifts? Was this part of your terms and conditions when you started or did you choose to do this or was there a change at some point that led to this? Are there people in your department that don’t work shifts and why?
- Do you get to choose the shifts that you work? Is anyone here working shifts that other people don’t want to work? Why do you think this is? What hours would you prefer to work? Is there any competition or tension in your workplace about the allocation of working hours? Do you have any views about how this is dealt with?
- Are you working shifts as part of internal rotation? How did this come about? How do you feel about this? If not happy, have you tried to change the situation? What has been the outcome of that attempt (s)?
- Do you work longer hours than your white colleagues? Reasons why?
- How many hours do you work in total in a week? Or on average? Do you have additional jobs on top or does that figure include some of these? Any particular reason you are doing an additional job or overtime?

Pay and grading (10 minutes)

Opening question: We know that sometimes it is difficult for you to talk about pay and grading but we would like you to say whether or not you feel that you are on the appropriate grade for the role and responsibilities you undertake? Perhaps you could also say if you have ever tried to get your grade changed and what happened.

Probes:

- Do you think you should be on a lower of higher grade? Why do you think this is? Have you attempted to raise this?
- Has any one here moved up grade / changed position? Can you tell us about this?
- Would you say it was relatively straightforward or difficult to address problems with pay or grading?
- Has Agenda for Change had an impact on your grade or salary or generally in your workplace? Has this been positive or negative and why? For those
that don’t think it has made any difference, do you think it should have? In what way? But why do you think it hasn’t?

- Has anyone here ever acted up in for a white colleague and not been paid for it? Would you be willing to tell us about this?

Career Advancement and Professional Development (15 minutes)

*Opening Question:* We would like to explore issues that have come up for you in terms of career advancement and professional development. May be we can start by asking whether anyone here has ever tried for a promotion and what happened?

*Probes:*

- Can you tell us about this? What did you apply for and what was the outcome?
- If you got it, are you pleased? Has it improved the way you think about your working life?
- If you didn’t get promotion, why didn’t you get it? Did you challenge this decision? Anyone tried more than once for a promotion and not gotten it?
- Is the same or different for other nurses in your department?

*Opening Question:* Lets move onto training and let’s start by looking at what is available and whether or not there are problems in getting training. Has anyone ever asked for training and if so, what was the outcome? Has anyone ever had to pay for training that they think their employer ought to have paid for?

*Probes:*

- Do you receive info about training events, conferences and other one off events? If not, why not? Have you ever gained or been refused time off to attend these? Is this the case for others in your department?
- What is the procedure for getting paid time off?
- Is it followed equally for all?
- Do you think you have been treated differently in any way? On what basis?

*Opening Question:* What about study days? Has anyone here ever asked for access to study leave?
Probes:
Do you have information about your entitlement to study days or study leave?
- If denied – reason given? Happy with this reason?
- Any challenges made?

**Opening Question:** Place list of career advancement or professional development items up on flipchart paper:

- In-service session
- Conference or seminars
- Study based on journals
- Lectures or demonstrations
- Courses
- Internet based study
- Visit HE institution library
- Interest group meeting
- Shadowing
- Distance learning
- RCN cont ed articles
- RCN nursing updates
- Secondments
- Exchanges
- Other

Then ask: please take a look at this list. Are there any other career or personal development issues / days that you have had access to or that you have been denied?

Probes:
- What reasons given for refusal? Do you believe this reason? If none, then what do you think? Why?
- What is the procedure?
- Is it followed equally for all?
- Do you think you have been treated differently in any way? On what basis?
Opening Question: Do you / have you paid for your own courses or has it been possible to get these paid for by your employer / manager?

Probes:
- What is the procedure?
- Is it followed equally for all?
- Do you think you have been treated differently in any way? On what basis?

Opening Question: Have any of the problems you and others have experienced in accessing promotion, training or any other professional development arrangements, payment for the courses or related time off lead to you wanting to leave your job?

Changing jobs or workplaces (10 minutes)
Opening question: Has anyone here ever left a job, changed departments, changed professions or workplaces in order to get away from a problem at work? Would you be willing to explain what happened and why you chose to deal with it in this way?

Probes:
- What were the reasons?
- Why might others want to change their jobs? Explore factors - 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).

Opening Question: Future plans – are any of you thinking of changing your job or your workplace or changing the terms and conditions of your work? Can we explore the reasons why you are thinking of doing this and what you hope you will achieve?

Relationships with colleagues and managers (10 minutes)
Opening Question: We would like you to think about your relationship with others in your workplace. Can you start by telling us a bit about your relationship with colleagues? Please feel free to discuss openly any problems that you have experienced in relation to colleagues, supervisors or manager.
Probes:

- With supervisors?
- With managers?
- With white colleagues?
- With IRN nurses? (BME IRNs – would you say they were treated the same as or differently to other Black staff? Better or worse?)
- Have you ever experienced racism from any of these groups?
- Have you ever been bullied or faced harassment in the workplace?
- Do you know of others that have? OR Do you know if this is an experience shared by others at your workplace?
- Would you mind telling us about these experiences? What happened? How it was dealt with? Whether and how it was resolved?
- Have you ever taken time off work or changed your job because of problems with colleagues or managers?
- Do you feel supported in your workplace? Where do you get most of your support? If you do not feel supported, what sort of support would you be looking for and from where?
- Do you feel valued in your workplace? By your colleagues? By managers? By patients and their families?

Relationships with patients, their carers and family members (10 minutes)
Opening question:
We would like you to talk to us about your contact with the public, with patients, their carers or family members and perhaps discuss what difficulties you or other nurses may have experienced in these relationships.

Probes:

- What sorts of issues have come up – complaints, violence, abuse, refusal to be treated by you?
- Have you ever been assaulted by a patient, their carers or family members?
- Do you know of other black staff that have been assaulted?
- Would you be willing to tell us what happened and what you tried to do about it? What happened? Who did you/they report it to? What was the outcome?
- Do you think any complaints from patients, family members or carers about your or your colleagues have been dealt with fairly? If any difference in treatment is noted, ask further
- Have you ever experienced or witnessed racism from any of these groups?
• Have you ever taken time off work or changed your job because of the problems you have just identified?

Racism and other discrimination (15 minutes)

*Opening Question:* We would like now to look a little closer at experiences of racism and other discrimination. Has anyone here experienced racism in their working lives? Would you be willing to talk about what happened and what if anything you decided to do about it? More generally, what is your view about the structures in place in the workplace and do they encourage or mitigate against racism?

*Probes:*

• Has anyone witnessed or heard of other experiences of racism in their workplace? Do you know how these were tackled?

• Run through some experiences of racism that have been noted in other studies: racism from the public, patients, their carers and family members; racism from colleagues and managers; DoH examples of racism facing first generation black workers in the health sector.

• How about structural racism – *put up flip chart paper with definition* – where would you say the black staff are located in the hospital? Can you think of any black supervisors, matrons or managers?

• How about institutional racism – *put up flip chart paper with definition* – and discuss

• What has been the response of others to your experience of racism i.e. you colleagues and managers to patient racism for instance?

• Patient racism – is there a difference between this and general abuse and violence towards staff? How would you say it’s different? Do others in your workplace recognise it’s different? Do you report instances of verbal abuse? If not, why not? If so, who to and what is the outcome? Do you feel supported by your colleagues when there is racism in the workplace, whatever form that takes?

• Have any of you experienced any other kind of discrimination in the workplace? Would you be willing to tell us about it and about what you tried to do about it if anything and if you decided not to do anything about it, why this was the case?

Creating Change (15 minutes)

In this final part of the focus group session we would like you to talk about what you think is important in terms of changing some of the problems / obstacles that you may
have identified during the course of this discussion. Of course, if you can point to examples of good practice in other departments within your workplace or at other workplaces, this would be very useful. If you would like to make any recommendations we would also welcome these.

Opening question: We are assuming that since you have all found out about this study through the RCN that you are members of RCN. Would that be a correct assumption? Have you always been members of the RCN since entering nursing? Can you talk about your experiences of RCN or any other workplace representation generally and in relation to your own situation? Can you also suggest if there are any things that the union could do to improve the situation for black nurses today?

Probes:

- Have you ever attempted to change your situation or deal with any of the problems identified above either through collective action or individual grievances?
- What was the action and what was the outcome?
- Did you have a RCN or other workplace representative?
- How did you feel about this representation? What was good about it? What were the problems with it? How could it have been better?
- What is required to tackle the problems that you have raised above: remind of all problems identified and go through what participants feel needs to happen in relation to each
- Can you think of / identify any positive initiatives in your workplace that have attempted to deal with these issues either on an individual or group basis? What worked about this initiative?
- What has been tried that in your view, hasn’t worked and why?
- Do you get a chance to talk about problems at work? Such as by participating in a black workers group, the Hospital’s Diversity Working Group or by influencing the Improving Working Lives agenda at your health trust? If so, how? If not, why?
- What sorts of recommendations would you like to make in relation to this project?

Black workers’ participation in research
Finally we want to just ask you a question about participating in research. Historically, RCN have found it difficult to recruit British black nurses to take part in
research and thought it would be good to get your insights into reasons why British black nurses may not be willing to get involved in research of this kind or in general surveys. Does anyone have any views on this?

Concluding the session (5 minutes)
- Thank you very much for participating in this session.
- What happens next – dissemination event sometime early next year, you all will be invited and you will receive copies of the report.
- Sort out payment and expenses claims.
4. *Flipchart sheets with lists of discussion topics*

**AREAS TO COVER:**

FEELINGS ABOUT WORK AND WORKPLACE
PROBLEMS AT WORK
OBSTACLES TO PROFESSIONAL DEVELOPMENT AND CHANGE
EXPERIENCES OF DISCRIMINATION
EXTERNAL FACTORS

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**ISSUES:**

- WORKING HOURS:
- CHOICE?
- SHIFTS / INTERNAL ROTATION?
- ANY TENSIONS?
- PAY AND GRADING:
- BREADWINNER?
- APPROPRIATE GRADE?
- ACTING UP?
- CAREER ADVANCEMENT AND TRAINING:
- PROMOTION
- ACCESS TO TRAINING
- ACCESS TO OTHER FACILITIES
- WHO PAYS FOR IT?
- PROCEDURE EQUAL FOR ALL?
- RELATIONSHIPS WITH COLLEAGUES, SUPERVISORS AND MANAGERS
- RELATIONSHIPS WITH PATIENTS, CARERS AND FAMILY MEMBERS
- DISCRIMINATION
- CHANGING JOBS AND REASONS WHY
- CREATING CHANGE
- PARTICIPATING IN RESEARCH
- AND ANYTHING ELSE THAT YOU THINK IS IMPORTANT FOR BME NURSES