

**An Investigation into the Nature, Extent and
Effects of Racist Behaviours Experienced by
Northern Ireland's Ethnic Minority
Healthcare Staff**

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Executive Summary

Northern Ireland has recently experienced a growth in the minority ethnic population and in the number of racist hate crimes. Although there is a substantial number of minority ethnic people working in both the public and private health sectors we have no indication of the scale of racist harassment and abuse within the health sector in Northern Ireland. As a result of the increase in minority ethnic employees and in recognition of the lack of research on the levels of racism in the health service the Department of Health, Social Services and Public Safety (DHSSPS) commissioned the Institute for Conflict Research (ICR) to investigate the nature, extent and effects of racist behaviours experienced by Northern Ireland's ethnic minority healthcare staff. This report documents the findings from the research.

The Northern Ireland Census of the Population (2001) found that there were 2,186 people employed in health and social work in Northern Ireland who were born outside the United Kingdom or Republic of Ireland (Bell, Jarman and Lefebvre, 2004). A Parliamentary question¹ from Iris Robinson MP, MLA in February 2005 revealed that at the end of January 2005 there were 812 overseas nurses employed by Health Trusts in Northern Ireland. If the figures for doctors and other healthcare staff from overseas and from the indigenous minority ethnic population are included, the contribution from minority ethnic healthcare staff is substantial.

Racism within the health sector has been a familiar issue in the UK as found in a number of studies such as Lemos and Crane (2001). This research aimed to investigate the level of racist behaviour experienced by healthcare staff from minority ethnic backgrounds in Northern Ireland. A range of research methods were employed which aimed to:

- Review past research;
- Investigate current policies, procedures and legal requirements with regard to monitoring and responding to racism within the health sector; and
- Gather information on the experiences of minority ethnic health staff in both the public and private sector.

¹ <http://www.publications.parliament.uk> Parliamentary question 212190.

A survey was designed for distribution among health care staff throughout Northern Ireland. The survey was designed in conjunction with the DHSSPS and the steering group convened for the purposes of this research. The questionnaire was distributed to staff in public hospitals, private hospitals, private residential nursing and care homes and GP practices with 557 returns received. In addition to the survey of employees the various Trusts were also asked to supply information about how they monitor the ethnic background of their staff. Qualitative data was gathered through focus groups and individual interviews with health care staff from minority ethnic backgrounds. In total twelve individual interviews were carried out and five focus groups held with 31 participants.

Summary of quantitative findings

- 33% were permanent UK residents with 32% migrant workers from a non-EU state.
- The largest number of respondents were born in the Philippines (42%), with India (22%) forming the second largest category.
- The majority of respondents had worked in the health sector in the UK for over a year with a small group indicating that they had been here for less than a year
- 77% felt their employer had provided sufficient preparation, information and induction.
- 62% worked in a public hospital and 21% in a nursing or residential home.
- 46% of those who responded had experienced racist harassment at work.
- A substantial minority (13%) experienced racism on a weekly or monthly basis.
- Those who considered themselves to be of Arabic descent were most likely to report having experienced racist harassment at work.
- Racist harassment was experienced in a variety of ways with verbal harassment the most common (racist comments, 36% and unpleasant remarks, 31%).
- Patients refusing care was experienced by 31% of respondents.
- 50% stated that work colleagues were most likely to be the source of racist harassment in the workplace.
- 47% reported having been harassed by patients, 27% indicated friends or relatives of patients and 19% said that they had suffered racist harassment from a manager or supervisor.

- Only 24% of those who had experienced racism in the workplace had made an official complaint.
- Of those who had made an official complaint, 50% were satisfied with how the complaint was dealt with, while 33% were dissatisfied.
- The main reason respondents gave for not making an official complaint was a fear of provoking a reprisal.
- Most agreed that management was supportive of people who had suffered racist harassment.
- Respondents felt that their colleagues and fellow workers were committed to tackling racist harassment
- However, 28% of respondents thought that people who complain about being racially harassed are then victimised.
- Those who had experienced harassment in the workplace were less likely to hold positive views about their working environment.
- 59% experienced racist harassment outside of work.
- Those working in the private sector reported suffering less racist harassment.
- However, those in the private sector were more likely to experience harassment more frequently.

Summary of qualitative findings

- The harassment that staff experienced was noted to occur in different forms.
- Respondents reported being ignored, being blamed for mistakes someone else had made and receiving little help from colleagues on first arriving.
- Many found it difficult to adapt to the culture and some commented on the different sense of humour their Northern Ireland colleagues had, which could sometimes lead to hurt and misunderstandings.
- On occasions where staff had suffered harassment from colleagues, incidents that involved humiliation were found to be the most upsetting.
- Many of those interviewed excused racist comments from patients because they were either elderly and confused or ill and upset.
- Most of those interviewed tended to excuse all but the most blatant racism.
- It was felt that in some cases indigenous staff were not sufficiently prepared for the initial arrival of overseas nurses.

- Some respondents thought that the situation for overseas nurses had improved over the 4 years that they had been here and that they were now 'growing' in confidence.

Recommendations

The following are suggested recommendations to be discussed with the DHSSPS and based upon the research findings:

- the need to design and implement policies and procedures, based on personal experiences, that are effective in dealing with racism in the health service, thus creating a working environment that does not tolerate racism;
- training for staff (at all levels) to make them aware of the ethos of the organisation that racism will not be tolerated and that this is endorsed at all levels;
- training for staff (at all levels) to make them aware of racist harassment and bullying in all forms, from the most subtle to the most blatant;
- specialised training for management on how to deal with reports of racist harassment among staff;
- cultural training to overcome misunderstandings caused by how different cultures interpret actions/humour – e.g. joking/sarcastic behaviour which is common in NI, but not the norm for some cultures who find it hurtful;
- monitoring of the ethnic composition of staff, by trusts and Boards in the DHSS and by the Regulation and Quality Improvement Authority in the private sector;
- mechanism for reporting racist harassment or bullying that is easily accessible, confidential and collated and responded to by a trusted and approachable individual clearly identified to staff; and
- monitoring of all reported racist incidents whether reported by the victim or a third-party and the action taken and outcome.

1. Introduction

Northern Ireland has seen a growing diversity in its population in recent years with a substantial number of migrant workers joining the established minority ethnic population. This increasing ethnic diversity has also experienced a growing problem of racism, of abuse, harassment, intimidation and violence. Although members of minority ethnic communities have been increasingly recruited to work in both the public and private health sectors and news reports and anecdotal evidence indicate that nursing staff have been subject to racist attacks little evidence exists on racism within the health sector. To date there has been no research carried out on levels of racism within the health sector in Northern Ireland. This situation is in contrast to that in England where in 1999-2000 there was an extensive independent research study of racist harassment by Lemos and Crane (2001). The study was based on focus group discussions and a questionnaire survey in 52 Health Trusts across England. The survey assessed incidents of harassment and abuse of: black staff by patients; black staff by members of the public/carers/friends/relatives of patients; black staff by colleagues; black staff by managers and; black patients or members of the public by white patients, members of the public or staff.

This study, commissioned by the DHSSPS, aims to redress the deficit of research by documenting and analysing the nature and levels of racism experienced by minority ethnic staff in the health sector in Northern Ireland.

1.1 Institutional Racism

In 1999 Lord Macpherson, as part of the Stephen Lawrence Inquiry, defined institutional racism as,

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people.

McGill and Oliver (2002) looked at the implications of the Stephen Lawrence Report for Northern Ireland and concluded that,

The first step in Northern Ireland is almost certainly for leaders in all sectors, whether MPs and MLAs, top civil servants, councillors, company directors, trade union officials or members and trustees of voluntary committees to recognise the importance of race as an issue.

The commissioning of this research has shown that race has been recognised as an issue within the health service in Northern Ireland.

1.2 Racism within the health service

The work on minority communities and the health service has focused largely on improving service provision and responding to indirect discrimination. The Northern Ireland Census of the Population (2001) found that there were 2,186 people employed in health and social work in Northern Ireland who were born outside the United Kingdom or Republic of Ireland (Bell, Jarman and Lefebvre, 2004). A Parliamentary question² from Iris Robinson MP, MLA in February 2005 revealed that at the end of January 2005 there were 812 overseas nurses employed by Health Trusts in Northern Ireland. This had risen by over 100 from January 2004. If the figures for doctors and other healthcare staff from overseas and from the indigenous minority ethnic population in the public sector and staff in the private sector are included, the contribution from minority ethnic healthcare staff will be substantial. This research attempted to ascertain figures on the number of minority ethnic employees currently in the health service but as section 5 highlights these figures were not available. However, as an informed guesstimate it is assumed that the number of minority ethnic nursing staff in the private health sector is at least as large as that in the public health sector, and therefore total numbers of minority ethnic staff working in both sectors are likely to be around 2,000 persons.

² <http://www.publications.parliament.uk> Parliamentary question 212190.

'*Racial Harassment at Work: What Employers can do about it*'³ states in the foreword,

To be the target of racial harassment at any time is a terrible thing. But to experience it at work means being in a permanent state of dread, unable to concentrate properly and failing to achieve one's potential. Such tension is contagious and invariably affects others, with potentially damaging consequences for the whole organisation. Often complaints brought forward are just the tip of the iceberg because most of the people who experience racial harassment at work put up with it. There may be several reasons for this: sometimes it is just because they do not want to make a fuss; sometimes because they think they will be blamed for 'ratting' on their colleagues; and sometimes, worst of all, because they do not believe their complaints will be taken seriously.

Racism within the health sector has been a familiar issue in the UK. A report by Allan and Aggergaard Larsen in 2003 focused on nursing staff and examined the experience of overseas nurses coming to work in the UK. Experiences varied depending upon whether respondents were working in the NHS or the private sector. The private sector was heavily criticised for lack of support, with nurses being employed as care assistants during adaptation and feeling isolated, whilst those in the NHS were generally happy with the level of support provided by their employers. However, internationally recruited nurses in the NHS did call for better co-ordinated mentoring, more support from their UK colleagues and local networks of internationally recruited nurses for mutual support. A recent report based on research conducted in Northern Ireland (DHSSPS, 2005) also showed that overseas nurses employed in the HPSS were more positive about their experience than those in the private sector.

In general racism has been noted to be a problem in Northern Ireland with some media sources stating that Northern Ireland is 'the hate crime capital of Europe'⁴. 'A Shared Future: A Consultation Paper on Improving Relations in Northern Ireland' (January 2003) states in the introduction,

³ Racial Harassment at Work: What Employers can do about it (2000) Commission for Racial Equality for Northern Ireland, CRENI: Belfast on Equality Commission Website:

<http://www.equalityni.org/publications/downloadlist>

⁴ O'Hara, M (29.6. 2005) 'Fear and Loathing', Society Guardian.

There are high levels of racial prejudice in Northern Ireland and the situation has recently become worse. The rate of racial incidents here is estimated at 16.4 per 1,000 non-white population, compared to 12.65 per 1,000 in England and Wales.

The PSNI reported a 79.6% rise in reported racist incidents between 2004 and 2005.

In view of these general statistics it is not surprising to read headlines relating to racist abuse of health care staff. One headline in the Belfast Telegraph on 11th September 2004 stated, 'Call to end racial abuse attacks on Asian nurses'. The headline related to incidents where a number of Asian nurses were forced to leave their home in Newtownabbey due to racist attack. This highlights that some overseas nurses are experiencing racism when they come to Northern Ireland and, although to date we can not categorise if this is occurring in the workplace, it is a facet of their lives in the community.

Some work has been conducted by Animate⁵ in 2005 on attitudes among staff in statutory agencies towards minority ethnic groups. One Health Trust area was included in the survey and the findings indicated that there were some staff displaying levels of prejudice. Although the study did not isolate service users and colleagues it is important to note that these attitudes exist and more than likely have implications for staff and service users alike.

As a result of the increase in minority ethnic employees and in recognition of the lack of research on the levels of racism in the health service the Department of Health, Social Services and Public Safety (DHSSPS) commissioned the Institute for Conflict Research (ICR) to investigate the nature, extent and effects of racist behaviours experienced by Northern Ireland's ethnic minority healthcare staff.

⁵ An organisation based in Dungannon, Co Tyrone who provide training to employees in the public and private sector to address racism within the workforce.

2. Methodology

The overall aim of the research was to investigate the level of racist behaviour experienced by healthcare staff from minority ethnic backgrounds in Northern Ireland.

In addition the research also aimed to:

- Review past research;
- Investigate current policies, procedures and legal requirements with regard to monitoring and responding to racism within the health sector; and
- Gather information on the experiences of minority ethnic health staff in both the public and private sector.

A range of research methods were employed including both quantitative and qualitative approaches. The quantitative aspect included distribution of a questionnaire to staff in both the public and private sectors. The qualitative data involved focus group discussions and interviews with health staff in both sectors and interviews with recruitment agencies and the Royal College of Nursing (RCN).

2.1 Questionnaire

Design

A survey was designed for distribution among health care staff throughout Northern Ireland. The survey was designed in conjunction with the DHSSPS and the steering group convened for the purposes of this research. Consultations with various individuals also took place before the survey was piloted within one health board area. The pilot indicated that no amendments were required.

Respondents were asked about incidents of racism they had experienced personally, or had seen others experience, both in the workplace and in the community. Information was sought in relation to respondents' perceptions of assistance and advice available to them within the workplace in the event of racism from colleagues, patients or visitors. The questionnaire also measured the level of support staff received in the event of reporting racism to managers, action taken and outcomes. The

issues covered in the questionnaire enabled comparisons to be made with the survey conducted by Lemos and Crane in 1999-2000 in England.

Distribution

The questionnaire (Appendix 1) was distributed to staff in public hospitals, private hospitals, private residential nursing and care homes and GP practices. The sample involved staff from a minority ethnic background, either members of the indigenous minority ethnic population in Northern Ireland, or staff recruited from overseas.

Within the public sector the survey was distributed throughout the various Health Trusts. The Chief Executive in each Trust was informed of the research and asked to appoint a named representative to liaise with the research group. The Trusts agreed to distribute the questionnaires to minority ethnic staff through the named contacts including equality managers and Human Resource Departments. A covering letter explaining the purpose of the research and a freepost envelope were supplied with each questionnaire. The envelope enabled the questionnaire to be directly returned to ICR when completed thus ensuring confidentiality. In some cases the personnel or equality units of the Trust also chose to enclose a further letter to their staff, also assuring them of the confidentiality of the research process.

A list of names and addresses of General Practitioners (GP) was requested from each of the four Health Boards. All 697 GP practices were contacted by letter and asked if they had any employees from a minority ethnic background. Of these 88 replied with only 3 indicating that they had an employee from a minority ethnic background. Some of those surveyed telephoned ICR to say they did not employ any minority ethnic staff.

The Regulation and Quality Improvement Authority⁶ supplied addresses for all registered private nursing and care establishments in Northern Ireland. A letter was sent to each of the 562 private establishments explaining the purpose of the research and enclosing a brief questionnaire requesting information on numbers, if any, of

⁶ The Northern Ireland Health and Personal Social Services Regulation and Quality Improvement Authority has responsibility for the registration and regulation of nursing and care establishments in Northern Ireland.

minority ethnic staff employed by them. They were also asked for contact details of a member of staff who would be responsible for distributing questionnaires to any minority ethnic staff they employed. Of the 202 who responded, 49% employed between them 775 staff from a minority ethnic background and the stipulated number of questionnaires was sent for distribution to their staff. As with the NHS staff, a covering letter and freepost envelope was supplied with each questionnaire for the respondents to return the questionnaire directly to ICR.

A telephone call to ICR from management of one private nursing home led researchers to have concerns about the privacy afforded to overseas staff in the private sector when completing the questionnaire. The caller claimed that due to the low level of English among their overseas staff, management would be helping staff to complete the questionnaire. This practice may have influenced responses and needs to be borne in mind when analysing the data from nursing and residential home staff.

2.2 Qualitative Data

Focus groups and individual interviews

Qualitative data was gathered through focus groups and individual interviews with health care staff from minority ethnic backgrounds. At the end of the questionnaire a request was made for contact details to be included if the respondent would be willing to take part in a focus group. Those who included contact information tended to be those who wished to discuss either particularly positive or particularly negative experiences. Many also requested individual interviews to discuss their experiences, which were facilitated. The research team also found the setting up of focus groups difficult due to work shift patterns therefore these individuals also were involved in individual interviews.

Focus groups were facilitated through UNISON and the Royal Group of Hospitals Trust for those working in the DHSS and Four Seasons Healthcare for those in the private sector during February and March 2006. The Royal College of Nursing (RCN) also invited researchers to attend a seminar for overseas nurses, mainly working in the

private care sector, and facilitated opportunities for nurses to talk to researchers and complete questionnaires.

In total twelve individual interviews were carried out and five focus groups held with 31 participants.

3. Legislation and Policy

In Northern Ireland there are a number of pieces of legislation and key policies relating to race relations. This section summarises these documents.

3.1 Legislation

In 1997 the Race Relations (Northern Ireland) Order⁷ was introduced making it unlawful to discriminate on racial grounds in five areas including:

- employment and training;
- education;
- provision of goods facilities and services;
- disposal and management of premises; and
- advertisements.

The Order defined 'racial groups' as 'a group of persons defined by reference to colour, race, nationality or ethnic or national origins'.

The Race Relations Order was updated in 2003 under the Race Regulations Order (Amendment) (Northern Ireland) 2003⁸. On 17 June 1997 the Treaty of the European Community at Amsterdam was revised by the governments of the fifteen Member States. Article 13 of the Treaty provides a legal base for community action to combat discrimination on the grounds of racial or ethnic origin. In Article 13 there is a Directive implementing the principle of equal treatment between persons irrespective of racial or ethnic origin. The Race Directive is similar to the Race Relations (Northern Ireland) Order 1997 but makes some important changes in relation to discrimination and harassment on the grounds of race, ethnic or national origins. The Directive will 'help to ensure that Northern Ireland meets minimum standards of legal protections from racial discrimination across Europe'⁹. The regulations also apply to Irish Travellers.

⁷ Race Relations (Northern Ireland) Order 1997

⁸ Race Regulations Order (Amendment) (Northern Ireland) 2003

⁹ OFMDFM (2003) Race Directive. A Note on Implementation in Northern Ireland.

The amended Order also states that case law considers harassment to be a form of unlawful discrimination and defines harassment as,

*occurring when unwanted conduct, based on the relevant grounds, has the purpose or effect of violating someone's dignity or creating an environment that is intimidating, hostile, degrading, humiliating or offensive to someone.*¹⁰

The regulations are applied where harassment is perceived by the victim to have taken place. This is in line with the Criminal Justice (No.2) (NI) Order 2004¹¹. The Order came about due to the high ratio of racist incidents being reported to the police compared to England and Wales. It creates new legislation for Northern Ireland in the area of 'hate crime'. Article 2(3) defines an offence as,

aggravated by hostility if, either at the time of the offence, immediately before or after its commission, the offender demonstrates hostility to the victim based on the victim's racial, religious or sexual orientation group, or on his/her disability.

The legislation includes a statutory requirement for judges to treat racial and religious aggravation as an aggravating factor when sentencing.

Under Section 75 (1) of the Northern Ireland Act 1998¹² there is a statutory obligation for all public authorities, including health, to have due regard to the need to promote equality of opportunity, 'between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation'. Section 75 (2) states that, '...a public authority shall in carrying out its functions in relation to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group'. Both the Race Relations Order and Section 75 have meant that many public authorities have had to begin to identify and meet the needs of minority ethnic groups in Northern Ireland.

¹⁰ 'Access the Race Directive – A Note On Implementation In Northern Ireland'
<http://www.ofmdfmi.gov.uk/index/equality/race/race-publications.htm>

¹¹ Criminal Justice (No. 2) (NI) Order 2004.

¹² The Northern Ireland Act 1998

3.2 Policies

In the UK the Department of Health's (DoH) publication '*Welcome to the team: NHS Careers*' (2005) has a section on 'Violence, harassment and bullying' (p17). This section acknowledges that some staff may feel harassed and bullied by fellow employees. It also states that hospitals should have a harassment and bullying policy that will inform victims of procedures and whom they should contact to receive support. While it is acknowledged that there will be varying degrees of support available in different organisations, it states that Trusts have a statutory duty to protect their staff.

A policy developed in Northern Ireland is the '*Racial Equality in Health and Social Care: Good Practice Guide*' published jointly by the DHSSPS and the Equality Commission for Northern Ireland (ECNI) (2003). This policy states that,

Both service users and staff may experience racial harassment; patients may be harassed by other service users or staff, and staff by patients or other members of staff.

The Guide identifies four key aspects to addressing inequalities within the health care sector. These can be applied both to patient care and staff relations and are:

- Recognising and valuing diversity;
- Auditing systems and processes within an organisation;
- Creating a more inclusive organisational culture; and
- Challenging individual attitudes and behaviour.

In November 2004 DHSSPS published '*Embracing Diversity: Understanding and valuing ethnic diversity in the HPSS*' (November 2004). This is described as,

A good practice guide on the employment of minority ethnic staff including those recruited from overseas into Northern Ireland's Health and Personal Social Services.

The document states that recruitment from overseas into the health sector in Northern Ireland is likely to continue for some time and aims to ensure that staff from ethnic

minorities are not subjected to racist harassment or abuse in either the workplace or the community. The document also provides examples of best practice employed by Trusts recruiting staff from overseas and provides practical strategies for dealing with the needs of minority ethnic staff. The Guide states,

Harassment or abuse in any form is unacceptable behaviour. It can impact on the health, confidence, morale and performance of those affected by it, and diminishes the effectiveness of the organisation. Such behaviour cannot be condoned or excused and will not be tolerated.

These guides are increasingly important in view of the increasing numbers of minority ethnic employees in the health sector.

4. Demographics and Recruitment

The health service in the United Kingdom has seen a rapid growth in minority ethnic employees, especially the recruitment of overseas nurses. Batata (2005) argues that despite efforts to make nursing a more attractive option, the recruitment of overseas nurses has become vital to the health service in the UK. Efforts such as return to work initiatives, higher pay and more flexible working hours have all been tried in the UK to encourage recruitment and retention of nurses.

4.1 Demographics

The shortage of nurses is a global issue with predictions that by 2010 the shortfall in nurses will be 275,000 in the USA, 53,000 in the UK and 40,000 in Australia. The UK is not the only industrialised country recruiting from overseas and it is thought the trend will increase (Batata, 2005). In 2001–2002 for the first time there were more new entrants on the UK nursing register from overseas than from within the UK.

The first phase of a new preparation programme for nurses recruited from overseas was announced by the Nursing and Midwifery Council (NMC) in March 2005¹³. From September 2005, as part of the assessment and skills of each applicant, overseas nurses are required to pass an international English language test at a higher standard than the NMC currently set. Those whose skills meet NMC requirements will undergo 20 days of protected learning on the Overseas Nurses Programme (ONP) and those needing more training or education will be required to undertake a period of supervised practice for between three and nine months. Reasons given by the NMC for introducing the new system include the increased demand for registration from nurses trained overseas and a concern that overseas nurses were going straight into practice in the UK with little understanding of cultural differences and expectations.

The RCN Northern Ireland Manifesto¹⁴ states that not enough nurses are being trained in Northern Ireland and the shortage will lead to a breakdown in health care provision.

¹³ <http://www.nmc-uk.org>

¹⁴ <http://www.rcn.org.uk>

This emphasises the importance of overseas recruitment. However RCN also state that,

The recruitment of international nurses to ease Northern Ireland's shortages must take place within a coherent and ethical framework that does not compromise standards of care in developing countries.

In the 'Review of Nursing, Midwifery and Health Visiting Workforce' (DHSSPS, September 2005) it is reported that staff recruited from overseas have stayed in Northern Ireland longer than was at first expected. Although recruited initially for a period of two years, many are deciding to apply for residence. Employing overseas staff has been viewed as a generally positive experience. Overseas staff have brought different approaches to nursing and the review finds that they have integrated well with the local workforce. However, some believe that too much time has been spent on assimilation training and aligning methods used by staff trained overseas to methods used here. Overall the response of patients toward overseas staff has been good, although some language difficulties have been experienced by some of the Trusts.

A RCN publication entitled 'Here to Stay? International Nurses in the UK' (2003) examined the policy and practice implications of the rapid growth in overseas nurses. The research involved ten case studies; five employers from the NHS and five from the private sector, all of whom actively recruited nurses from abroad. It was found that the highest levels of internationally recruited nurses were in the private sector, where recruitment had become more systematic. Challenges relating to the recruitment of overseas nurses identified by managers in all the case studies included language barriers, differences in clinical and technical skills, racism within the workplace and the reaction of patients.

4.2 Recruitment

Issues around the recruitment of overseas nursing staff were raised within this research. Many overseas staff are recruited through agencies and issues concerning exploitation have been reported. The following section highlights some of the issues around recruitment. The Department of Health's Code of Practice for the international recruitment of healthcare professionals (2004) 'offers best practice benchmarks to promote the international recruitment of health care professionals in a manner that promotes appropriate ethical principles'. The Code states in its foreword written by the then Minister of State for Health John Hutton that,

More recent times have seen an increasingly large-scale, targeted international recruitment approach by many developed countries to address domestic shortages. ...concerns related to the impact this may have upon the healthcare systems of developing countries also need to be addressed. In recognition of this the World Health Assembly called for countries to mitigate the adverse effects of migration of health personnel.

This has led to a list of countries that should not be targeted for international recruitment 'unless there is an explicit government to government agreement'. This issue was also raised by some interviewees and will be further discussed in this section.

Recruitment Agencies

Many overseas health care staff are recruited via recruitment agencies and there has been a notable growth in the number of recruitment agencies in Northern Ireland offering this service. The Royal College of Nursing (RCN) reported that the number of recruitment agencies had spiralled from approximately six to over a hundred in recent years. Some general recruitment agencies have capitalised on the growth in overseas staff for the health sector and have branched into this area of recruitment. The Code of Practice states that,

Healthcare organisations utilising the services of recruitment agencies for international recruitment are recommended to use those agencies that are included on the list of agencies whose business is carried out in accordance with this Code of Practice.

New legislation introduced in Northern Ireland on 14th January 2006¹⁵ allows officers of the Department for Employment and Learning (DEL) to enter and inspect employment agencies in Northern Ireland to ensure they comply with regulations governing their conduct. With regard to the health sector, the Regulation and Improvement Authority¹⁶ are currently in the process of registering agencies that provide agency and bank nurses. A list of those who are registered will be made available to employers wishing to recruit from overseas.

Balmoral Healthcare based in Belfast were involved in recruiting the first round of overseas nurses brought to Northern Ireland to work mainly in hospitals. They have recruited approximately 1,500 nurses, mainly from the Philippines, in the last five years. This recruitment has been for both the public and private sectors. However, they have not been involved in recruitment from overseas in the last two years as none of the major hospitals they worked with have recruited nurses from overseas since 2003. Working with the public sector, Balmoral Healthcare chose to comply with regulations which allowed them to become an approved overseas nursing recruitment agency listed on the DoH website. They felt that this was important both ethically and professionally. There was no equivalent registration in Northern Ireland for recruitment agencies bringing healthcare staff from overseas to avail of.

The regulation that no money was to be taken from nurses who were being recruited to the UK was part of a voluntary compliance entered into by Balmoral Healthcare with the DoH. However, they admitted that this was difficult to police initially and that there was potential for corruption among recruitment agencies based in the Philippines and working with agencies from the UK,

¹⁵ The Employment (Miscellaneous Provisions) (Northern Ireland) Order 2005

¹⁶ Regulation and Improvement Authority was established on 1 April 2005 with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

From our perspective here and the government saying that no money was to be taken (from the nurses being recruited), I didn't realise that that was what they might be doing.

Balmoral Healthcare established a relationship with one main agency in the Philippines who did not charge the nurses who were being recruited. It was highlighted that it costs approximately £1,200 to bring a nurse to Northern Ireland. Balmoral Healthcare's rate to the Trusts and private sector is in excess of this for their own profit margins. However, in the absence of regulations governing the conduct of agencies, some are charging only £400 to the company but asking the nurses themselves for up to £2,000. The system was felt to be unfair for the recruitment agencies who complied with government ethics and for the overseas staff who were being exploited.

Four Seasons Healthcare have 51 residential care homes and employ over 600 staff from minority ethnic groups throughout Northern Ireland. They have recruited in the past from Africa, but have now entered into a voluntary agreement with the DoH in England not to recruit from African countries, which appear on the 'list' compiled to ensure that developing countries healthcare systems are not adversely affected by the depletion of their healthcare staff to the United Kingdom.

The company also recruits from the Philippines and recently began to recruit from Eastern Europe. Four Seasons have started to run a one-week induction course for potential recruits in Poland to inform them about Northern Ireland culture and the level of skill that will be required of them in the care homes. After the induction period recruits are asked if they still want to come to work in Northern Ireland and they are finding that numbers being recruited from Poland are not meeting staffing demands. When wishing to recruit staff from Poland only four to six may be suitable for selection out of over twenty applicants.

The new NMC Overseas Nurses Programme (ONP) begins in October 2006 and Four Seasons have passed selection by Queen's University Belfast to administer the ONP to nursing staff in their care homes. They intend recruiting approximately 50 nurses from the Philippines for the ONP Programme in October and will be paying the fees

for staff taking part in the programme. As Four Seasons bear the cost of the ONP (and formerly for adaptation), they request that staff stay with them for a minimum of two years in order to get a return on their investment. However, they point out that the public sector are no longer recruiting from overseas and can now recruit overseas staff locally when Four Seasons have borne the costs of recruitment and training.

Written agreements are required from agencies recruiting on behalf of Four Seasons that they will not charge a fee to the staff being recruited as Four Seasons pay for the recruitment process and travel arrangements. However, in some cases recruitment agencies are entitled in the countries of origin to charge an administrative fee. This is not generally thought to exceed £150 - £200. This was confirmed by Four Seasons staff from the Philippines and India, although one person from an Eastern European country claimed to have paid £2,500 to come to work in Four Seasons in Northern Ireland, but was unclear as to what this was for or who it had been paid to.

South Tyrone Empowerment Programme (STEP)¹⁷ highlighted an issue where some staff recruited for work in the health sector find on arrival that their qualifications are not recognised and they end up working as cleaners. Since their accommodation and travel are provided as part of a package they are unable to get out of the situation. STEP claim that recruitment agencies are not emphasising the need for a reasonable understanding of English and that the language issue is a huge problem that is not thought through by some recruitment agencies.

¹⁷ A community organisation in Dungannon, Co Tyrone working with migrant workers.

5. Monitoring of Employees

In conducting this research it was not possible to obtain numbers of ethnic minority staff in either the public or private sector. ICR contacted the statistics branch of the DHSSPS, but they do not record ethnicity and the number of ethnic minority staff falls below the threshold required to register as a category on the Labour Force Survey. A letter was also sent to each of the 19¹⁸ Health Trusts in Northern Ireland requesting information about if and how they monitor the ethnic background of their staff. Each Trust was asked if they used any of the following categories in relation to monitoring of staff:

- i) Perceived ethnic background;
- ii) Religion;
- iii) Citizenship;
- iv) Nationality; and
- v) Country of birth.

Trusts were also asked for the figures from monitoring procedures relating to minority ethnic staff for the last five years, numbers of staff who hold work permits and figures relating to the recruitment of minority ethnic staff.

5.1 Public Sector

Of the 19 Trusts contacted for information, 12 responded with information regarding their monitoring procedures. The information provided showed that there is no standard system of monitoring adopted by all the Trusts, although all respondents indicated that they request information regarding ethnic background and religion on their Equal Opportunity Monitoring form for job applicants. All of the Trusts compile an Equal Opportunity Monitoring Report and submit their Employment Monitoring return to the Equality Commission each May. This information is legally required to be submitted to the Equality Commission for the monitoring of applications across the Northern Ireland labour market, however, the monitoring of appointees is not. Nine trusts did however provide figures on ethnicity but the numbers of 'non-determined' were the highest category after 'white' thus providing little information.

¹⁸ Includes the Northern Ireland Ambulance Service Health and Social Services Trust.

One Trust reported that they retain the monitoring data for their own analysis after the statistics have been submitted to the Equality Commission. The information is then used internally to inform decision-making and identify areas requiring action. Three Trusts reported that while they did not monitor citizenship on their application form, as opposed to their Equal Opportunity Monitoring Form, they did capture information regarding EC/Non EC status.

Four of the Trusts reported that they had created original staff databases in the past. One had surveyed existing staff in 2000 requesting information on ethnic background, whilst another carried out an exercise in 2001-2002 involving the voluntary monitoring of the race of existing staff. Two other Trusts created original staff databases in 1990 for religion and in 2000 for ethnic background.

None of the Trusts surveyed had any formal policy or procedure to monitor work permits. Where informal procedures were in place they involved a line manager taking responsibility to ensure that work permits were kept up to date. While no Trusts officially monitored work permits, four of the Trusts surveyed were able to provide figures regarding the current numbers of their workforce on permits. A further Trust stated that at the time the survey was conducted their application forms were being reviewed to ensure that a direct question regarding work permits was included in future. If an appointee indicated possession of a work permit, the Trust would then take responsibility to ensure that the permit remained valid.

5.2 Private Sector

In the private sector the Regulation and Improvement Authority monitor staff with regard to numbers and qualifications, but not ethnicity. At present there is no information on the ethnicity of staff in the private sector and with increasing employment of overseas staff this may be an area the Regulation and Improvement Authority may wish to address in their monitoring procedure. Four Seasons Health Care, which has 51 private residential homes in Northern Ireland and 600 overseas staff, monitor the ethnicity of staff who enter and leave their employment and their destination both within the health sector and geographically.

5.3 Monitoring Procedures

There is a clear need for monitoring of the ethnic background of staff across the Trusts. This needs to incorporate an understanding of the rationale for collecting information to allow monitoring to take place. Information collected in a standard format would allow for monitoring of recruitment, promotion and development and training. It would also become central in promoting diversity, monitoring racism and evaluating anti-racism policy. In view of workforce planning and the movement of overseas staff throughout the UK, the Department may wish to consider a case for data collection that is compatible with the DoH.

DHSSPS already monitors the health service staff in Northern Ireland in the 'NI HPSS Workforce Census' (March 2005). However, this census gathers information on employment grade, gender and age, but does not ask for information on ethnicity of the employee. If this information was requested it would allow a database to be created without requiring a separate survey.

An advantage of the monitoring of ethnic staff would be to allow targets to be set and measured. It would provide statistical justification for measures to be taken to address racism and inequality and allow benchmarking to take place to evaluate strategies and policies and assess the performance of line managers in carrying out their implementation.

In July 2005 the DoH (UK) published 'A practical Guide to ethnic monitoring in the NHS and social care'. The Guide states Trusts should make decisions about which codes and sub-codes should be used to monitor ethnicity with regard to local circumstances, but that the 16+1 ethnic grouping should always be used as a minimum requirement.

The 16+1 system for collecting data for ethnic monitoring became the national standard in the DoH from 1 April 2001. The 16+1 method of ethnic coding was developed by the Office for National Statistics (ONS), for the 2001 Population Census, and the Commission for Racial Equality (CRE) in England and has been used

across government from 2001. Kings College Hospital NHS Trust¹⁹ monitors its workforce using the ONS16+1 codes in order to track staff progress and inform decision-making. Staff attitudes are also monitored through an annual attitudes survey.

In Northern Ireland a public consultation is currently taking place²⁰ examining the questions currently used and changes planned for the 2011 Census of the Population. The consultation has shown that respondents felt that the 'white' category for Ethnic Group and the 'elsewhere' category under Country of Birth failed to capture the growing migrant worker population in Northern Ireland. Academic debate is ongoing on the best method of gathering ethnic monitoring information. The problems encountered in defining 'ethnic identity' categories for the '2002 Northern Ireland Life and Times Survey' led to the suggestion that the best solution might be to offer a 'self ascribing' open question to allow respondents to define their ethnicity²¹.

In gathering information on health service staff from ethnic minority backgrounds for the purposes of this research, self-classification was used for the question 'In which country were you born?' and 'What is your citizenship?' In terms of ethnic background the following options were offered with a box to tick:

- Arabic (North Africa, Saudi, Gulf States, UAE, etc.)
- Black African
- Black British
- Black Caribbean
- Chinese
- Far-East (Filipino, Japanese, Korean, Malay, Thai, etc.)
- Indian Sub-continent (Bangladeshi, Indian, Nepalese, Pakistani, Sri Lankan, etc.)
- Irish Traveller
- Latin American
- Near-East (Iranian, Israeli, Syrian, Turkish, etc.)

¹⁹ In 'A practical Guide to ethnic monitoring in the NHS and social care' DoH (July 2005)

²⁰ NISRA (2005) 'The Future Provision of Demographic Statistics in Northern Ireland (Towards the 2011 Census) Consultation – Summary of Responses' on NISRA website at www.nisranew.nisra.gov.uk/census/2011_census_consultation

²¹ Presentation by ARK at the Incore 'Diversity Conference' 29.11.2005 in the Millennium Forum, Derry Londonderry.

- White (European, American, Australian, etc.)
- Mixed ethnic group (please state) -----
- Other (please state) -----

A Racial Equality Strategy for Northern Ireland 2005 – 10 states,

The fact that ethnic monitoring is key to achieving racial equality in service provision has already been highlighted...It is also essential in employment – for employers to examine the ethnic make-up of their workforce and of applicants and employees.

The information sought for this research suggests that the DHSSPS have to consider a standardised system of monitoring ethnicity for staff recruited to enable a complete picture of the labour work force in the health care sector. The following sections highlight the experiences of minority ethnic staff working in both the public and private sectors.

6. Survey Findings

The survey was administered to staff in both the public and private sector. All respondents were supplied with a freepost envelope to ensure confidentiality. However as pointed out in the methodology some managers within the private sector indicated that they were offering assistance to staff who had lower levels of English. This action, although well intended, was discouraged by the researchers as it was felt that it may influence responses but it must be borne in mind when analysing the results from respondents working in the private sector.

6.1 Public and Private Sector

Demographics

A total of 557 health care staff in both the public and private sector responded to the survey. The largest number of respondents (231, 42%) indicated that their country of birth was the Philippines, with India (124 respondents, 22%) forming the second largest category. This was also evident in the focus group settings where the majority were from these two countries. The next largest groups were born in the United Kingdom (40 respondents, 7%), or Malaysia (31 respondents, 6%). A listing of birth countries with 3 or more respondents is displayed in Table 1.

Table 1: Birth Country

	Frequency	Percentage
Philippines	231	42
India	124	22
United Kingdom	40	7
Malaysia	31	6
South Africa	16	3
Pakistan	12	2
Poland	12	2
Ireland	9	2
China (Hong Kong)	6	1
Nigeria	5	1
Egypt	5	1
Zimbabwe	5	1
Kenya	4	1
Australia	3	.5
Bulgaria	3	.5

Sri Lanka	3	.5
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The diversity of the healthcare labour force in Northern Ireland is illustrated by the variety of birth countries indicated by at least one respondent. These included: Brazil, Brunei, Burma, Cameroon, Fiji, Finland, Germany, Guyana, Iran, Iraq, Italy, Jamaica, Jordan, Kuwait, Malawi, Malta, Namibia, Nepal, New Zealand, People's Republic of China, Saudi Arabia, St. Vincent and the Grenadines, Singapore, Spain, Sudan, Syria, Trinidad and Tobago, Uganda, United States of America and Zambia.

Citizenship, as opposed to country of birth, differed slightly with more individuals indicating they had UK citizenship and a small number indicating dual citizenship. However both the Philippines and India were still the top two countries of citizenship. A listing of citizenship with 3 or more respondents is shown in Table 2.

Table 2: Citizenship

	Frequency	Percentage
Philippines	226	41
India	111	20
United Kingdom	79	14
Malaysia	25	5
Ireland	15	3
South Africa	14	3
Poland	11	2
Pakistan	8	1
Egypt	5	1
Zimbabwe	4	1
Nigeria	4	1
Bulgaria	3	.5

Again, the diversity of the labour force was illustrated by the variety of citizenship indicated by at least one respondent: Australia, Botswana, Brunei, Burma, Cameroon, Fiji, Finland, Germany, Ghana, Hungary, Iran, Iraq, Italy, Jordan, Kenya, Latvia, Lesotho, Malawi, Malta, Namibia, Nepal, Palestinian State, Singapore, Spain, Sri Lanka, Sudan, Zambia, Dual-Irish/Malaysia, Dual-Jordan/UK, Dual-South Africa/UK, Dual-Australia/UK, Dual – Pakistan/UK and Dual-Thai/UK.

The largest number of respondents, 227 (41%), indicated that their ethnic background was either Far-East (including Filipino, Japanese, Korean, Malay, Thai etc.) or Indian Sub-continent (Bangladeshi, Indian, Nepalese, Pakistani, Sri Lankan, etc.) with 162

respondents (29%). A smaller group indicated that they were White (61 respondents, 11%), Black African (31 respondents, 6%), Chinese (29 respondents, 5%), Mixed (20 respondents, 4%), Arabic (10 respondents, 2%), 'Other' (5 respondents, 1%), Black Caribbean (4 respondents, 1%), Latin American (3 respondents, 0.5%), and Irish Traveller (1 respondent, 0.5%) (Table 3).

Table 3: Ethnic Background

	Frequency	Percentage
Far-East	227	41
Indian Sub-continent	162	29
White	61	11
Black African	31	6
Chinese	29	5
Mixed	20	4
Arabic	10	2
'Other'	5	1
Black Caribbean	4	1
Latin American	3	.5
Near-Eastern	2	.5
Irish Traveller	1	.5

Those who completed the questionnaire were mainly permanent UK residents (184 respondents, 33%), or migrant workers from a non-EU state (176 respondents, 32%). A small number were migrant workers from a EU state pre-1 May 2004 (32 respondents, 6%), a new EU state (27 respondents, 5%), or asylum seekers (3 respondents, 0.5%). Just under 20% of respondents were from an 'other' category (105 respondents, 19%); which included contract workers, highly skilled migrant permit, permit free visa, temporary UK residents, and those holding work permits or visas. Thirty respondents did not include information (5%).

The majority of respondents, 298 (54%), categorised themselves as Catholic, followed by those who were 'other' Christian (57 respondents, 10%), Hindu (50 respondents, 9%), Protestant (50 respondents, 9%), Muslim (39 respondents, 7%), and those who indicated that they were 'none' (23 respondents, 4%) (Table 4).

Table 4: Religion

	Frequency	Percentage
Catholic	298	54
Other Christian	57	10
Hindu	50	9

Protestant	50	9
Muslim	39	7
None	23	4
Orthodox (Greek, Russian, Armenia etc.)	12	2
Buddhist	11	2
Sikh	5	1
'Other' (Jehovah's Witness, 7 th Day Adventist)	5	1
Missing	7	1

Of the sample 182 were male (33%) and 369 female (66%), and a small number did not specify (6 missing). More than half of the sample were 26-35 years of age (322 respondents, 58%) with the second largest category aged 36-50 years (171 respondents, 31%). A small number were younger than 26 (18 respondents, 3%) or older than 51 (46 respondents, 8%) (Table 5).

Table 5: Age of Respondents

	Frequency	Percentage
18-25 years of age	18	3%
26-35 years of age	322	58%
36-50 years of age	171	31%
51-65 years of age	46	8%

Working Experience

The majority of respondents had worked in the health sector in the UK for over a year with a small group indicating that they had been here for less than a year (Table 6). Seventy-seven people (14%) indicated that their qualifications had been gained inside the UK. However, of those who had qualified overseas, 334 stated that their qualifications were recognised in the UK and only 96 (17%) said their qualifications were not recognised. Nearly one quarter, (136 respondents, 24%) reported that they were made to re-train. This would suggest that some respondents view the adaptation programme that overseas nurses are expected to attain before becoming registered with the NMC as a form of re-training.

Table 6: Time in the UK health sector

	Frequency	Percentage
Less than 1 year	54	10
1-3 years	238	43
3-5 years	149	27

5-10 years	49	9
More than 10 years	63	11
Missing	4	.5

When participants began employment in the health sector in Northern Ireland, the majority (77%) felt their employer had provided sufficient preparation, information and induction.

Table 7 shows that more than half of the sample (62%) worked in a public hospital. Fewer respondents worked in a nursing or residential home (21%) or a mental health facility (5%).

Table 7: Workplace

	Frequency	Percentage
Public Hospital	343	62
Nursing or Residential Home	113	21
Mental Health Facility	26	5
Other	23	4
H & SS Centre	20	4
GP Practice	11	2
Private Hospital or Clinic	10	2
Health Centre	4	1

The majority of respondents were registered nursing staff (306 respondents, 55%), hospital doctors (75 respondents, 14%) or senior hospital doctors (37 respondents, 7%). When provided with the space to write in their occupation, 16 respondents (3%) said they were care assistants (Table 8).

Table 8: Occupational Group

	Frequency	Percentage
Registered Nursing Staff	306	55
Hospital Doctor	75	14
Sr. Hospital Doctor	37	7
Other	23	4
Non-Registered Nursing Staff	21	4
Auxiliary Staff	19	3
Care Assistant	16	3
Sr. Nursing Staff	14	3
Administrative Staff	10	2
Other Professional Staff	10	2
Social Services Staff	9	2
GP	6	1
Other Manager or Supervisor	4	1

Mental Health Professional	4	1
Dentist	1	.5
Estate Services Staff	1	.5

Racist Harassment at Work

Forty-six percent, 256 respondents, indicated that they had experienced racist harassment at work. Racism was experienced both within the public and the private health sectors and a comparison of the different experiences of staff working in the two sectors is discussed below in section 6.2. The following section discusses the general experiences of all those who responded to the survey. Of this 46% those who described themselves as of Arabic descent were most likely to report having experienced racist harassment at work (70%). Those of mixed (65%) and Black African (63%) descent also reported high levels of racist harassment in the workplace. Over half of Far Eastern (56%) and Chinese (52%) respondents had also experienced harassment with around a third of Latin Americans (32%) and Indian (36%) also affected. Of those describing themselves as 'White', 21% reported having experienced racist harassment in work.

Over half of the Filipinos surveyed (132 respondents, 58%) reported harassment with 36% of Indians also stating that they had been harassed. It was also interesting to note that those who had been here for 3-5 years were most likely to state that they experienced harassment (54%). This was also reflected in the focus group discussions with many stating that attitudes towards them had improved over the last 2-3 years.

Very little difference was noted between the occupational groups most likely to suffer harassment. Nurses reported slightly more harassment at 50% compared to doctors at 44%. It was however interesting to note that social services staff were the most likely to indicate harassment with 67% stating that they had experienced such behaviour. This may in part be explained by the fact that they are more likely to be in a community setting.

Racist harassment was experienced in a variety of ways. Table 9 shows a ranked list of the most prevalent forms of racist harassment experienced by the 46% of respondents indicating harassment in the workplace. The percentage column shows

those who have experienced the particular form of harassment. As this was a multiple-choice question, respondents may have experienced more than one form of harassment.

Table 9: Incidents of racist harassment in the workplace

	Frequency	Percentage
Racist comments in one's presence	90	36
Co-worker made unpleasant remarks	79	31
Patient refusing care	79	31
Unfairly criticised	73	29
Other discrimination	68	27
Unfairly allocated tasks	60	23
Racist comments directed at you	60	23
Bullying or harassment	58	23
Being intimidated or frightened	58	23
Ignored or excluded at work	56	22
Racially insulted	47	18
Lack of cultural awareness/traditions	38	15
Saw someone else racially harassed	32	13
Denied access to training	26	10
Manager made unpleasant remarks	25	10
Passed over for promotion	20	8
Offensive phone call	15	6

Verbal forms of harassment such as 'racist comments in one's presence' and 'co-workers making unpleasant remarks' were the two most common incidents with 'unfair criticism' also ranking fourth. 'Patients refusing care' was experienced by 34% of respondents. Actions by those in authority over the respondent were less likely to occur such as the 'unfair allocation of tasks' (23%), 'denied access to training' (10%) and 'passed over for promotion' (8%).

Table 10 shows that work colleagues were most likely to be the source of racist harassment in the workplace. Half (50%) of those who reported having been racially harassed at work said their colleagues were responsible and in a further 23% of cases respondents had been harassed by another person working in the same establishment. A large number (47%) also reported having been harassed by patients, with 27% indicating that friends or relatives of patients had racially harassed them. Around a fifth of respondents (19%) said that they had suffered racist harassment from a manager or supervisor.

Table 10: Responsibly for Racist Harassment in the Workplace

	Frequency	Percentage
Colleague	124	50
Patient	115	47
Friends/relatives of patient	67	27
Other co-worker ²²	56	23
Manager/supervisor	47	19
Other visitor	7	4
Other person	6	4

The majority of those who reported having experienced racist harassment in the workplace said that it only occurred occasionally (68%). However, a substantial minority (13%) said they experienced racism on a more regular basis, with 8% stating they experienced racism on a weekly or even daily basis, and a further 5% stating that they experienced racism once or twice a month.

For a third of respondents (33%) their most recent experience of racism was between 1 and 12 months ago, while 28% had experienced racism at work over 12 months ago and 27% within the last month.

Reporting Harassment

Of the 256 people who had experienced racist harassment in the workplace, the majority (76%) had not made an official complaint. Just over half (54%) of respondents were aware that their management had a complaints procedure in place for them to report racist harassment, although 45% of respondents were not. In addition 59% of respondents indicated that they knew where to go for advice and support about racist harassment in the workplace. Table 11 shows the majority of respondents either agreed or strongly agreed that something would be done if they made a complaint.

Respondents who had experienced harassment internally such as from a colleague, manager or supervisor were more likely to report the incident (34%) as compared to those who had experienced harassment from patients or visitors (14%).

²² A co-worker is different to a colleague in that it is someone in a different job title e.g. a doctor as opposed to a nurse

Table 11: Something will be done about complaint

	Frequency	Percentage
Strongly agree	97	17
Agree	222	40
Disagree	41	7
Strongly disagree	13	2
Don't know/can't say	167	30

Of the 60 respondents who had made an official complaint, 50% were satisfied with how the complaint was dealt with, while a third (33%) were dissatisfied. Of those who were dissatisfied about how their complaint was handled, 40% were dissatisfied if the harassment had come from colleagues, but only 13% were dissatisfied if the complaint was in relation to the behaviour of patients or their visitors.

The most frequently reported outcome of making a complaint was that 'nothing happened' in 33% of cases, while 32% reported that management had spoken to the accused co-worker or discussed the incident with the person reporting the harassment (15%).

Most of those who did make an official complaint at work approached their line manager (47 respondents, 63%). Very few approached Human Resources (4 respondents, 5%) or a Union representative (1 respondent, 1%) (Table 12).

Table 12: To whom official complaint was made

	Frequency	Percentage
Line manager	47	63
Someone else	15	20
More than one	8	11
Human Resource official	4	5
Union representative	1	1

Ethnic background was found to be a factor in willingness to make a complaint to management about racist behaviour, with ethnic groups suffering the most harassment being least likely to complain. Although 70% of Arabic respondents had experienced harassment in the workplace, only 17% had made a complaint. The same was true of the Chinese group, over half of whom had reported suffering harassment, but only 7% had complained. In the case of the Latin American group, a third had been harassed,

yet none made an official complaint. Table 13 gives a breakdown of the respondents who made an official complaint by their perceived ethnic group.

Table 13: Breakdown of those making complaint by ethnicity

	Percentage of ethnic group harassed	Percentage of each group harassed who made complaint
Arabic	70	17
Mixed descent	65	25
Black African	63	33
Far-Eastern	56	27
Chinese	52	7
Indian	36	22
Latin American	33	0
White	21	25
Average		19.5

Table 14 is a ranked listing of the reasons cited for not making an official complaint. The main reason respondents gave for not making an official complaint was a fear of provoking a reprisal; almost 40% indicated that they did not file an official complaint at work because they were fearful of provoking a reprisal. The second and third reasons listed included 'felt nobody would be interested' (30%) and 'complaint would be disregarded' (30%). There was also a feeling among 27% of the sample that nobody would be able to help or the incident was too trivial (24%). These responses are similar to those made by the BME community for not reporting crime to the police (Radford et al, 2006).

Table 14: Reasons for not making an official complaint

	Frequency	Percentage
Scared of provoking reprisal	73	39
Felt nobody would be interested	57	30
Complaint disregarded because minority ethnic	57	30
Felt nobody could help	50	27
Incident too trivial	45	24
Too upset	43	23
Other reason not listed	30	16
Didn't know how to complain	25	13
Didn't know to whom to complain	20	11
Previous poor experience of complaining	13	7
Language difficulties	15	8
Co-workers discouraged complaining	7	4

When asked about policies and procedures in work to deal with racist harassment, over 46% did not know if their management had any policies or procedures aimed at tackling racist harassment, while 9% said that their management did not. Of the 47% who were aware that there were policies in place, 48% thought they were 'quite' or 'very effective', whilst 37% were unable to say whether they were effective or not (Table 15).

Table 15: Effectiveness of policies or procedures at work

	Frequency	Percentage
Very effective	62	18
Quite effective	101	30
Slightly effective	22	7
Not at all effective	30	9
Don't know/can't say	126	37

However, it should be noted that those who had experienced harassment at work were much more likely to indicate that they felt the policies or procedures were not at all effective (18%), compared to those who had not experienced harassment in the workplace (2%) (Table 16).

Table 16: Effectiveness of policies and procedures by those who had experienced harassment or not

	Experience harassment in the workplace (Percentage)	
	Yes	No
Very effective	12	23
Quite effective	24	35
Slightly effective	11	3
Not at all effective	18	2
Don't know/can't say	36	38

Support at Work

Management

While a number of respondents were unsure about the effectiveness of policies or procedures at work, most agreed that management was supportive of people who had suffered racist harassment. In general respondents thought that management were committed to tackling racist harassment, made it clear that racist harassment was

unacceptable and that management would take appropriate action to deal with staff who racially harassed co-workers (Table 17).

Table 17: Support from management

		Frequency	Percentage
Management is supportive of people who have suffered racist harassment.	Agree or strongly agree	321	58
	Disagree or strongly disagree	69	12
	Don't know/can't say	153	28
Management is committed to tackling racist harassment.	Agree or strongly agree	325	58
	Disagree or strongly disagree	63	12
	Don't know/can't say	148	27
Management makes it clear that racist harassment is unacceptable.	Agree or strongly agree	406	73
	Disagree or strongly disagree	41	7
	Don't know/can't say	95	17
Management will take appropriate action to deal with staff who racially harass co-workers.	Agree or strongly agree	335	61
	Disagree or strongly disagree	45	8
	Don't know/can't say	156	28
Management does not care about complaints of racist harassment.	Agree or strongly agree	65	12
	Disagree or strongly disagree	332	59
	Don't know/can't say	144	26

It is important to note that expectations do not appear to match reality when it comes to the support management gives to those who have suffered harassment in the workplace. While the trend is similar, those who had experienced harassment in the workplace were less positive in their attitude toward management. This was especially true for those who had been harassed by another member of staff. Table 18 shows the percentages of individuals who agreed or strongly agreed with positive statements related to the support that management give in tackling racism in the workplace. The columns in the table show the different attitudes displayed by those who have not experienced harassment and those who have experienced harassment from a colleague or a patient or their visitor. It is interesting to note that when it is harassment from a colleague more negative attitudes are present in four of the categories compared to harassment from a patient or visitor. This may also suggest that management are less likely to deal with harassment when it is from a colleague.

Table 18: Strongly agree or agree that management is supportive

	No Harassment	Harassment from a colleague	Harassment from a patient or visitor
Management is supportive of people who have suffered harassment	66%	49%	56%
Management is committed to tackling the problem	67%	46%	62%
Management makes it clear that it is unacceptable	78%	69%	77%
Management will take appropriate action	72%	49%	52%
Management does not care about complaints	6%	19%	11%

Trade Unions and/or Professional Bodies

A generally positive attitude was expressed towards Trade Unions and/or professional bodies. It was felt they were supportive of those who had suffered racist harassment, committed to tackling racist harassment and that they make it clear that racist harassment is unacceptable. Table 19 shows responses to statements relating to trade unions and professional bodies.

Table 19: Support from trade unions and professional bodies

		Frequency	Percentage
Trade Union or professional body is supportive of people who have suffered racist harassment.	Agree or strongly agree	345	62
	Disagree or strongly disagree	32	6
	Don't know/can't say	163	29
Trade Union or professional body is committed to tackling racist harassment.	Agree or strongly agree	335	61
	Disagree or strongly disagree	32	6
	Don't know/can't say	169	30
Trade Union or professional body makes it clear that racist harassment is unacceptable.	Agree or strongly agree	401	72
	Disagree or strongly disagree	25	4.5
	Don't know/can't say	109	20
Trade Union or professional body does not care about complaints of racist harassment.	Agree or strongly agree	34	6
	Disagree or strongly disagree	356	64
	Don't know/can't say	147	26

Unlike attitudes towards management, attitudes towards trade unions or professional bodies were not affected by having experienced racist harassment in the workplace.

Colleagues

Respondents agreed that their colleagues and fellow workers were committed to tackling racist harassment and that they were able to speak openly about racist harassment at work. Table 20 shows the percentages agreeing or disagreeing with the statements.

Table 20: Supportive work environment

		Frequency	Percentage
Colleagues and fellow workers are committed to tackling racist harassment.	Agree or strongly agree	306	55
	Disagree or strongly disagree	82	15
	Don't know/can't say	151	27
You are able to speak openly about racist harassment at work.	Agree or strongly agree	300	54
	Disagree or strongly disagree	128	23
	Don't know/can't say	112	20
You know where to go for advice and support about racist harassment at work.	Agree or strongly agree	329	59
	Disagree or strongly disagree	58	10
	Don't know/can't say	153	28

Victimisation

Although 76% of those who had suffered racist harassment had not made a complaint, the majority agreed or strongly agreed that something would be done about a complaint. Also, in spite of the confidence shown in attitudes of colleagues towards racist harassment, when asked if they thought that people at work who complain about being racially harassed are then victimised, 28% of respondents thought that this would happen and a further 36% were unable to say. Of those who expressed a strong opinion, 9% strongly agreed while 5% strongly disagreed. These results relate to the main reason given for not making an official complaint about racist harassment: a fear of provoking a reprisal. However, only 4% of respondents gave 'co-workers

discouraged complaining' as their reason for not making an official complaint (see Table 14).

As with attitudes towards management, experiences of harassment affected their attitude towards their colleagues. Table 21 shows a series of statements which respondents were asked to answer. Those who had experienced harassment in the workplace were less likely to hold positive views about their working environment. Of those who had never suffered harassment in the workplace, 67% thought their colleagues were committed to tackling racism. However, the percentage who thought their colleagues were committed to tackling racism fell to 33% among those who had experienced racist harassment from someone they worked with. Similarly, when asked if they felt able to speak openly about racist harassment in the workplace, 64% of those who had not suffered racist harassment agreed with the statement. However, where respondents had experienced harassment from colleagues the percentage fell sharply to just over a third (35%), although there was less difference where the harassment had come from patients or their visitors with 61% agreeing that they could speak openly about racism.

In relation to the victimisation of those who report racist harassment, there was little difference between those who had never suffered harassment and those who had suffered harassment only from patients or their visitors with 27% and 30% respectively thinking that those who reported harassment were then victimised. However, the percentage of those who thought anyone who reported harassment would subsequently be victimised rose to 58% among those who had experienced harassment from colleagues (Table 21).

Table 21: Attitudes towards work environment for those harassed at work %

	No Harassment	Harassment from work colleagues	Harassment from a patient or Visitor
Colleagues are committed to tackling racist harassment	67	33	64
Able to speak openly to colleagues about racist harassment	64	35	61
Individuals who complain are then victimised at work	27	58	33

Racist Harassment in the Community

Racist harassment had also occurred for respondents in the wider community. While 46% of the respondents had experienced racist harassment in the workplace this percentage rose to 59% (328 respondents) who had experienced racist harassment outside of work. The most prevalent forms of racist harassment experienced outside the workplace were racist comments in one's presence (51%), racist insults (45%) or racist comments made to them (46%), having something thrown at them in the street (33%) or feeling intimidated or frightened (28%). Again as in the work place verbal comments were the most frequent forms experienced but these were even more prevalent in the community as Table 22 shows. Most racist harassment experienced happened in the street, often on their way to or from work, or in shops.

Table 22: Racist harassment in work and out of work

Type of incident	In work		Outside work	
	Frequency	Percentage	Frequency	Percentage
Racist comments in one's presence	90	36	166	50
Racist comments	60	24	151	45
Racist insult	47	19	149	45

In common with the frequency of incidents in work, racist incidents outside of the workplace happened occasionally (80%) and for 39% the most recent experience was between 1 and 12 months ago, or over 12 months ago (34%). One fifth (20%) of respondents stated that their most recent experience was within the last month.

A reluctance to report harassment also occurred outside work with 80% of those who experienced harassment outside work not reporting the incident. Of those who did report the incident the majority (59%) contacted the police. As with the workplace, a main reason given for not complaining was a fear of reprisals, although many said the incident was too trivial and a minority said they had a previous poor experience when reporting an incident.

Summary

Nearly half of minority ethnic people working in the health sector in Northern Ireland have suffered some form of racism as part of their working experience. And for about one in eight people racism has been a regular occurrence of their working environment.

However, the responses do indicate that those working in the healthcare sector from a minority ethnic background feel that in general there is a commitment from management, trade unions and their fellow workers to tackle racism and that there are policies and practices in place to address the issue.

But, although the general view is that the work environment is supportive, of the over 46% of respondents indicating that they had been harassed at work, only 24% made an official complaint. Of those who did make an official complaint, the majority were satisfied with how the complaint was handled. However, when the source of harassment was isolated it was found that where harassment had come from someone at work complainants (41%) were dissatisfied with how their complaint was handled, compared to 27% who were dissatisfied when the harassment had come from patients or their visitors.

While the number of those who made official complaints was quite low, certain ethnic groups who reported suffering high levels of harassment were also found to be the least likely to complain. These respondents included those from Chinese and Latin American backgrounds. Those from Arabic descent suffered the highest incidence of racist harassment, but were also among the least likely to make a complaint.

Research findings highlight a concern that the number of individuals who are prepared to make an official complaint if they suffer harassment may decline. This is particularly true where individuals who were harassed by someone they work with reported being dissatisfied or very dissatisfied with how their complaint was handled in 41% of cases.

Respondents who experience harassment from someone they work with are more likely to indicate that they feel policies or procedures to address racism in the workplace are only slightly effective or not at all effective; (29%) compared to those who had not experienced harassment in the workplace (5%). They are also less likely to feel that management and the general work environment is providing them with support.

There was a fairly even split regarding the source of workplace harassment, with approximately half coming from colleagues and half from patients. This was evident in the three most frequent forms of harassment; racist comments, co-worker making unpleasant remarks, and patients refusing care. The confidence displayed in the procedures and intent to tackle racism in the workplace is not reflected in the reality for those who are victims of harassment. Of particular concern is that while 72% of those who have not experienced racist harassment in the workplace feel that management will take appropriate action if they do, the percentage drops to 49% for those who have suffered racist harassment from colleagues.

6.2 Private Sector Comparisons

There was a total of 123 questionnaires (22% of total) returned from staff from minority ethnic backgrounds working in the private sector including nursing and residential care homes and private hospitals and clinics.

The addresses of 562 private and residential homes in Northern Ireland were provided by the Regulation and Quality Improvement Authority and each home was sent a short questionnaire asking them how many, if any, of their staff were from a minority ethnic background. Of the 202 nursing and residential homes that responded, 98 currently employed 775 staff from a minority ethnic background between them. The number employed in each nursing or residential home ranged from one to thirty. All but two who replied and had staff from a minority ethnic background indicated that they were willing to distribute questionnaires to those members of staff.

Various methods of recruitment were reported by the nursing and residential care sector. Of those who responded, 34 recruited exclusively through overseas

recruitment agencies, 31 used both recruitment agencies and local advertising and job markets and 34 only recruited locally through advertisements and the local job market. Some who used a mixture of recruitment strategies said they recruited nurses through overseas agencies and care assistants through local advertising. As stated, two nursing homes refused to distribute a questionnaire to their ethnic minority employees. Both of these recruited exclusively through a recruitment agency and while one said they carried out adaptation, the other said they had an induction programme for all new employees.

Of the 202 responses, 49 of those who recruit overseas nurses through recruitment agencies indicated that they provide adaptation training to gain NMC Registration and their PIN to work as registered nurses in the NHS.

Those working in the private sector reported suffering less racist harassment than those in the public sector; 39% compared to 48% in the public sector. However, as Table 23 shows, harassment in the private sector was more likely to come from co-workers (other than direct colleagues) and managers or supervisors than for those in the public sector. In addition those in the private sector were more likely to experience harassment more frequently with 6% reporting either daily occurrences (3%) or 3-4 incidents a week (3%) compared to 1.5% in the public sector reporting the same experiences (1% and 0.5% respectively).

Table 23: Sources of harassment in the workplace

	Public		Private	
	Frequency	Percentage	Frequency	Percentage
Patient	89	45	24	52
Friend/Relative of patient	51	26	15	33
Other visitor	8	4	2	4
Colleague	104	53	20	44
Manager/Supervisor	36	18	11	24
Other co-worker	32	16	22	48
Other	7	4	2	4

Those in the private sector were more likely to make an official complaint when they did suffer harassment in work; 38% compared to 20% in the public sector. The majority had complained to their line manager (72%) compared to 59% in the public

sector. However, no one in the private sector had made a complaint to a human resources manager or a union representative, although it should be noted that in the public sector only 8% of complainants had gone to a human resource manager and only 1% stated having reported harassment to a union representative.

When an official complaint was made, similar satisfaction levels were recorded for how the complaint was dealt with. There was a slightly higher percentage of those in the private sector (46%) who agreed or strongly agreed that they were satisfied compared with 43% in the public sector and 38% who were dissatisfied in the private sector compared with 42% in the public sector.

Summary

There appears to be less evidence of harassment in the private sector, although where it did occur staff in the private sector were more likely to suffer it on a regular basis, either daily or 3-4 times a week.

When staff in the private sector suffered harassment they were more inclined than those in the public sector to make an official complaint about it, normally to their line manager. However, when levels of satisfaction about how a complaint was dealt with were compared, results were similar in the private and public sectors.

7. Qualitative Findings

Twelve individual semi-structured interviews and five focus groups with 31 participants were held between December 2005 and March 2006. Three of the focus groups were conducted with overseas nurses from the Philippines in large Trust Hospitals. Two were organised by the Royal Group of Hospitals Trust and the other in the Ulster Hospital by the public sector trade union UNISON. The other two focus groups were conducted with staff in the private sector and organised by Four Seasons Healthcare care homes. In depth interviews were also conducted with representatives from Balmoral Healthcare Agency²³, the Royal College of Nursing, Four Seasons Healthcare and STEP²⁴.

The following section highlights the main issues/themes that emerged from the individual interviews and focus groups.

Harassment

The harassment that staff experienced was noted to occur in different forms including subtle and verbal.

Subtle Harassment

One nurse who has been here for four years reported experiencing harassment during the first two years. The harassment was subtle rather than overt, for example where a respondent was ignored when explaining that it was a student who had made mistakes that he was being blamed for. Another respondent reported a lack of help when they arrived during the first influx of overseas nurses with local staff stating '*sorry, I can't help you*' when asked a question.

While one respondent thought the situation for overseas nurses had improved in the 'past few years' he also remarked that at Christmas the only staff on duty in the area he worked were Filipino because all the local nurses had been told they could leave

²³ Balmoral healthcare Agency has recruited 1,500 overseas nurses to work in Northern Ireland since 2000, mainly from the Philippines.

²⁴ A voluntary organisation providing services to migrant workers and based in Dungannon.

early. He felt that this was unfair, although highlighted that if management discussed the situation many Filipino nurses would probably have volunteered.

Interviewees and focus group participants commented on the different sense of humour their Northern Ireland colleagues had which could sometimes lead to hurt and misunderstandings. However, it was difficult to be clear on whether someone was really attempting to make a joke or was using it as an excuse when their behaviour was challenged,

At first I had a very bad experience. Very, very bad. There's just some people who feel that it is a joke, that they think it's a joke. They don't realise that it's not a very good joke because our culture is very different. We would not say things unless we mean it.

In all the focus groups held in hospitals Filipino nurses said when they first arrived they kept missing their tea breaks because no one told them they should be taking a break at an allotted time. Other staff just disappeared without saying anything or making any effort to include them,

It's different here. Here once it's time for tea break you just go, but back home you have to wait to be told. We didn't know where to go. We were actually lost for the first few months.

And then you are left there and it's your break, but you are not going for your breaks because you don't know.

In one case a nurse felt that she now had the confidence to initiate being friendly and this was having an effect on her colleagues,

But they can learn from us as well. Before they are not calling to anyone, even locals when they go for tea. Nowadays they are starting to learn from us because we always call whoever is on the list with us, whether they are Filipino or local, we always call them to go for tea and now they are starting to adapt.

Verbal Harassment

On occasions where staff had suffered harassment from colleagues, incidents that involved humiliation were found to be the most upsetting. On one occasion a Filipino member of staff reported being loudly verbally criticised by a colleague in the presence of patients. When she spoke to him privately about the matter she was told that if she was upset she should report his behaviour to management. Another nurse also recounted her experience during her adaptation period. The ward sister asked her about a patient's condition but as she was not familiar with the patient's medical history she could not answer the questions posed. She was consequently chastised in front of the patient and found this experience humiliating. Another reported being harassed by the relative of a patient in front of other patients. She was very upset by the experience and two of her colleagues (local) were supportive and filed an incident report on her behalf.

Many focus group participants talked about their growing confidence since arriving. Many stated that the culture here was so different and that in their home country they would not challenge behaviour whereas here they felt they had to. It was found in many cases that the victims themselves were reluctant to report the incident, but another colleague would do so on their behalf,

Most of the Filipinos are quite reserved. They won't speak even if they are hurt. ...But if it happened to me I would do an incident report.

One Filipino nurse in the group told of how she had reported an incident to the Sister on her ward on behalf of a Filipino colleague,

Cause she can't say, she doesn't want the Sister to know what happened....I just told Sister not to tell her (the victim). So it was my decision to tell the Sister, or it will just get worse. Sister talked to the member of staff involved and he apologised to her (the victim). She was shocked because she didn't know I told the Sister

One person who had been in Northern Ireland for 15 years reported problems with colleagues and felt there was no support from management. They reported that their

line manager repeatedly verbally harassed them when they reported incidents and offered no support. When they wrote to senior management to complain, the letter was ignored. This individual also felt that racist harassment had increased in general throughout Northern Ireland during her time here. The respondent felt that in her own local town that this was in part due to the influx of various minority ethnic communities and migrant workers with local people feeling more at 'threat' than before.

Normalisation of Behaviour

Many of those interviewed felt that racism was not an issue confined to Northern Ireland, although they also realised that Northern Ireland had not been a cosmopolitan society until now and that there were still inter-ethnic issues in addition to new ones,

Racism problems in Northern Ireland are partly due to ignorance of other cultures and races.

This was also the case in the private sector where staff thought elderly residents were not accustomed to seeing people from overseas in Northern Ireland,

The management has been extremely supportive, helpful and very supportive of us. We have experienced a bit of racism from the residents. I mean they are elderly and have probably never seen a black person before.

However, a manager in the private sector pointed out that the same excuse cannot be made for the families of those in care and said that racism toward their staff from relatives of residents was not acceptable. There had been occasions when relatives had been asked to leave when they were abusive to staff.

Some interviewees in the public sector pointed out that their colleagues had tackled racism from patients on their behalf which they found encouraging,

Everybody supports us, the doctors and nurses.

For me the doctor was the one who actually told the patient that if you do that again he was going to send him home and (he) would not be admitted again to this hospital. So that patient stops doing that.

Many of those interviewed excused racist comments from patients because they were either elderly and confused or ill and upset. Most of those interviewed tended to excuse all but the most blatant racism, while some said they thought 'banter and joking' were something they were not used to in their culture and were therefore confused as to whether racist comments were being made or not.

Cultural Differences

It was reported by a senior hospital doctor that cultural differences had led to some problems in hospitals. Some local staff may be resentful of a strong work ethic displayed by overseas nurses. This was suggested as the reason why a Filipino nurse was tied to a chair by two of her colleagues²⁵. Several other interviewees also pointed out the different work ethic that migrant workers were bringing to the workplace. Overseas staff are here specifically to work, often leaving their families and sending money back home. Some felt that harassment came from those who did not appear to want to work very hard and they felt that they were resented for the standards of work they were setting,

Those who work hard are friendly and those who do not want to work resent us.

It was felt that in some cases indigenous staff were not sufficiently prepared for the initial arrival of overseas nurses. Where nurses in public hospitals were over-worked and expecting the recruitment of overseas staff to ease their workload, the reality was that they had additional work to do in mentoring overseas staff who had to go through adaptation and get used to a different culture. This led in some cases to resentment as it had not been made clear that this was a long term strategy rather than an 'instant fix',

²⁵ 'Tied to a chair....That's what Ulster nurses did to their Filipino colleague for working too hard' Sunday Life, 21st November 2004

We are bringing people in to fill a nursing shortage and there are not the nurses on the ground to be able to give them the time so they are coming in and having to go through an adaptation programme. That's more work for a nurse who is already busy and probably thinks they haven't time for that. It's seen as "great, we're going to get more nurses", but those nurses won't really be ready for three or four months, maybe six months. ...it's not as if they are coming in and ready to hit the ground running.

Balmoral Healthcare highlighted the importance of preparing the existing staff when overseas staff were being recruited, particularly in the independent sector,

...take a single nursing home. We would have talked to the staff beforehand and done cultural awareness training for their staff and spoken to the relatives of the people who were in the nursing home. We would have done an introduction.

It was also pointed out that in the Philippines there are no residential homes as families provide any care that may be necessary and therefore residential care homes are a completely new concept for those from the Philippines.

Filipino nurses in focus groups talked about how different they find the healthcare system in Northern Ireland. They explained that for example when a patient is being discharged from hospital and needs continuing care, there is a social worker, occupational therapist and possibly the need to find a place in a residential care home,

Professionally you have a different system, different tiers. Back home we have only to deal with the family and the doctor.

Some professional differences appeared to be based around the confidence of the Filipino staff,

When I arrived here there were some Filipinos ahead of me in the department I am working in. They were finding it very hard to adjust, but for me I didn't find it difficult because I had worked in Saudi and I know how to get along with foreign nationals. So when I arrived here I know what I am capable of and I showed them.

Differences were also noted around the confidence the indigenous staff had in the training Filipino nurses had in the healthcare system in the UK,

They didn't trust you, they always checked. Do you really know this one.

Others said that they found it difficult to learn different procedures for tasks they were familiar with,

It's like starting from zero, well not really zero, but starting from second year student. It's like learning everything again – doing the same thing but doing it differently.

It's like you need to get training to do things we've done at home. We're fully trained. Most of us are degree holders.

Following adaptation one nurse said that she felt that she was not being given the opportunity to expand her experience. This was leading to a degree of frustration on her part,

For example on the medical ward you are the only Filipino there. You are not actually being given the chances. They have given more of the chances to their own qualified students or locals rather than us. But now we are trying to voice what we want and they are starting to give us all the chances.

Differences in the administration of drugs to patients was an issue that emerged in all focus groups involving Filipino nurses and in interviews with Balmoral Healthcare. When Balmoral were carrying out recruitment in the Philippines they made visits to hospitals to find out if there were any particular differences in nursing procedures. Due to the nursing experience of those from Balmoral Healthcare, it was possible to make comparisons with procedures in Northern Ireland and predict that staff from the Philippines would find the system of drug administration very different. Some nurses discussed their feelings after fifteen years of nursing experience in the Philippines with one Filipino nurse saying that her experience was not recognised even when it was proven to be correct,

Even calculating the drugs, we have experience. We are told in our nursing (in the Philippines) the basic, that there is a standard computation, but they are not used to that. They just want to calculate it by calculating it in their mind, you know. But we have a standard. I am dependent on that. I am confident I am right, but she (senior nurse) will say no, that's not right, where did you get that formula? I say I got that from my nursing and she says we will check with the pharmacy. And I am right.

Cultural differences were also highlighted by a senior hospital doctor from overseas where, for example, some cultures see admission of a mistake as a weakness. When they then deny having made a mistake they are perceived to be lying by their local colleagues. Similarly, claiming to have experience in a procedure rather than admitting no knowledge and asking for help is also seen in some cultures as a weakness and can lead to errors when carrying out procedures. Lemos and Crane discussed that the fear of reprisals for reporting harassment to management did '*not bode well for reporting of other concerns relating to human resources or indeed clinical matters*'.

Several doctors from overseas reported experiencing problems with other doctors that they felt were linked to cultural differences. In some cases female senior doctors had experienced male doctors from minority ethnic backgrounds refusing to take instructions from them because they were women. They interpreted this as a cultural rather than a gender issue, which at times lead to difficulties in the wards.

Inequality

A GP reported that doctors from overseas have to continually prove themselves and be,

20% to 30% better than their colleagues. Not to be equal, but to be in the league as it were...Irish society is inherently racist. I have colleagues in this practice who cannot tolerate me.

This GP also reported that some doctors have achieved the equivalent of a Fellowship in India or Pakistan but this is not recognised by the NHS. Thus when they arrive in

the UK they have to do menial tasks until they *'are able to get into the system where they have to struggle for five or six years, ten years maybe, to get local Fellowships or memberships. So, discrimination is rife in medical circles and the BMA²⁶ has accepted that'*.

In addition racism was not only being seen against colleagues but patients as well. Some interviewees reported that the recent influx of migrant workers appears to have made racism in the community more overt. The respondent stated that he was aware of colleagues in the medical practice refusing to register migrant workers. *'There is still (racism), even though these are 'educated' doctors.'*

It was also perceived that the situation had become more difficult in the community, especially racist abuse from young men under the influence of alcohol. The respondent said he had experienced racist comments by many local male youths who when not drunk were usually polite,

If I go out, especially at night, because they call me a 'black bastard', I don't go out without the car and go to an hotel or something. ...Drunk young people are the worst, even though I have seen a generation of them grow up and the majority say 'hello Doctor, how are you?' But not if they are drunk and want trouble.

Changing Attitudes

One doctor felt that the DHSSPS and BMA were not doing enough to protect staff from an ethnic minority background from assault by patients. However, another doctor working in a large hospital said he had reported incidents of staff being harassed or assaulted by patients and had found the Trust more supportive than in the past.

Nurses who were interviewed and who took part in focus groups were generally agreed that the situation for overseas nurses had improved. Many felt that this was in part due to the growing confidence among nurses, some of whom have been here for five years. Nurses from the Philippines in particular said they were by nature non-

²⁶ British Medical Association

confrontational, but had grown in confidence and felt that their skills were now being recognised by their colleagues. Indeed many stated that they were now acting as mentors for student nurses. Many also stated that they had become trade union members and are now more capable of articulating their needs to management,

Because back in our country if you need something sometimes you are shy to tell others. It's part of our culture, but I have learned you have to be straightforward in what you need. You have to tell them exactly. That takes time.

We wouldn't want to offend. We are thinking we would offend someone.

Racism outside work

While racism in the community was not the main purpose of this study, it was found that there was potential for it to impact on the retention of overseas nurses. Four Seasons reported that 70% of those who left the private sector, having completed adaptation in Northern Ireland, would go to work in the NHS in England or go to Australia or America. Losing overseas staff in the public sector was also found to be an issue and one of concern considering the shortage of nurses and the need to retain current staff. One reason overseas staff gave for considering leaving Northern Ireland was the rise in racist hate crime,

Some teenagers in a park. I thought they were going to ask me about something and they just punched me. I thought of leaving Northern Ireland.

We were waiting for a bus in (name of town) and a man said "You black people are getting all of our benefits. If I had the chance to stab you in the back I would".

Others talked about the adverse effect of hearing reports of race hate crime in the media,

Tell you what, honestly there are some Filipino nurses and when they get their residency they might move to England because there is one nurse in the Ulster Hospital who was petrol bombed and she was interviewed (in the media).

Most of the overseas staff who reported having racist abuse shouted at them in the street blamed young people and children. One Filipino nurse said that he and his friends liked Northern Ireland and would like to settle here. However, they had discussed the fact that they would not like to bring up children here as they found young people and children to be undisciplined. These sentiments were echoed by many overseas staff, particularly men who seemed to be the main targets for racist comments from young people in the street,

Foreigners here are afraid of children, not adults. Children in Northern Ireland do what they want.

In an article in the Belfast Telegraph²⁷ referring to an attack on a Filipino nurse and her family in Dundonald, Patrick Yu from the Northern Ireland Council for Ethnic Minorities said, *'these people who are so vital to our health service could leave'*. This would have severe implications for our health service in Northern Ireland.

Summary

The situation for overseas staff in the health sector in Northern Ireland has improved. This is in part due to action taken by those with responsibility for management of staff in both the private and public sector, but probably has as much to do with the growing confidence of overseas staff themselves and their willingness to integrate with their colleagues. They are also forgiving of racism, feeling that the influx of people from overseas has been difficult for the local community to adjust to.

Racism in the community influences how overseas staff view their future in Northern Ireland. While staff in general find adults in Northern Ireland to be friendly, they felt that young people and children were more likely to display racist behaviour. Incidents reported in the media encouraged them to think about going elsewhere to utilise their skills and minimise their risk of attack.

²⁷ 'Racist attacks could break health service' Belfast Telegraph, Friday 24th February 2006.

8. Comparison with Lemos and Crane Study

Whilst this study is the first to be conducted in Northern Ireland to assess the nature and extent of racism within the health service, research conducted by Lemos and Crane (2001) in the NHS in England in 2000 found that racist harassment of both staff and patients was a serious and unacceptable problem.

Lemos and Crane found that 46% of respondents working in all areas of the health care sector had experienced racism in the workplace in the last 12 months, 38% had witnessed racism and 58% had either experienced or witnessed racism. Front-line staff were found to have been 1.5 times more likely to have suffered harassment in the previous 12 months; 50% compared to 31% in other staff groups²⁸.

In Northern Ireland the same percentage (46%) of staff had experienced racism in the workplace, although not necessarily in the past 12 months. When the percentage of those in Northern Ireland who had experienced harassment in the last 12 months was examined, the percentage fell to a third (33%). This was borne out in focus groups and interviews where staff felt that the situation had improved in the last few years. The majority of those surveyed (70%) had been in Northern Ireland between 1 and 5 years and the ethnic group most likely to experience work-based racism were those of Arabic descent (70%), while the Lemos and Crane study found that Chinese respondents reported the highest levels of harassment.

In both studies the most frequent source of harassment was colleagues (50% in NI compared with 33% in England), followed by patients (47% in Northern Ireland and 29% in England). It was also found that staff in Northern Ireland were less likely to be harassed by managers than staff in England (19% in NI and 23% in England).

Common to both studies was under-reporting of incidents and the main reason for this was a fear of provoking reprisals. In England most staff were not aware of policies and procedures for reporting incidents although in Northern Ireland over half (54%) of respondents said they knew of policies and procedures that were in place and 59%

²⁸ In the study a respondent's assessment of what constituted racism was accepted in line with the Lawrence Report recommendations.

said they would know where to go for advice and help. Despite this increased awareness in relation to measures to deal with harassment, in common with their counterparts in England the majority of those who had been harassed (76%) had done nothing about it. In both studies therefore, as few incidents were reported, few were followed up or investigated, but of those that were, there were more negative than positive feelings from the victims about how their complaint was dealt with by management.

In both studies the most common form of racism from patients or their relatives was verbal abuse, with the second being a refusal to be treated by minority ethnic nurses. However it was also found in the study in England that there was an acceptance among minority ethnic staff, their colleagues and management that the refusal of care on racist grounds was a legitimate choice for patients. The qualitative research in this study also showed that ethnic minority staff readily excused racist behaviour of patients because they were ill or confused because of drugs or their age. However, it was not evident that colleagues were willing to excuse racism from patients with incidences of colleagues being protective or making a complaint on behalf of their ethnic minority colleague being recounted.

Lemos and Crane also found that harassment from colleagues was subtle and took the form of verbal abuse and being ignored or excluded, both within and outside work. Filipino nurses in this study also reported being excluded from tea breaks but in general participants stated that in Northern Ireland notifications of social events were posted on the notice board and were inclusive of all staff who wished to sign up for them. In England managers were also reported to pass over the opportunity of training or allocate tasks unfairly. While being denied access to training was not found to be a particular issue in Northern Ireland, being allocated tasks unfairly was mentioned in qualitative research, not only by nursing staff, but also by doctors.

Many parallels can be drawn between the two pieces of research despite the fact that the presence of ethnic minority staff in the health sector in Northern Ireland is a relatively new phenomenon. However, from the evidence in focus groups and individual interviews, ethnic minority staff in Northern Ireland appear to see their position improving with time. This may be partly explained by minority ethnic staff in

the health sector in Northern Ireland being seen as a finite group that 'people are getting used to' or indeed realising their valuable contribution.

9. Monitoring of Racist Incidents

In light of the findings from this study there is a need to record and monitor racist incidents within the health service. This would enable a more accurate picture to be captured of the situation facing health care staff over a period of time. Many within the focus groups felt that their experiences were improving but without recording of incidents there is no means of proving if this is actually the case.

9.1 Introduction

Defining racist incidents

The Race Relations Order (Amendment) Regulations (Northern Ireland) 2003 amends the 1997 Order²⁹, which did not include a definition of racist harassment. The regulations insert in the 1997 Order a definition of racist harassment occurring where ‘unwanted conduct has the purpose or effect of violating someone’s dignity or creating an environment that is intimidating, hostile, degrading, humiliating or offensive to someone’.

The following definitions of racist harassment and bullying are taken from the University of Dundee ‘Harassment and bullying policy Statement and Guidelines’.

Racist Harassment

Can be defined as a hostile or offensive act or expression made by someone of one ethnic group toward a member of another ethnic group. It may also include inciting someone else to behave in such a way that creates a hostile or intimidating environment for employees. Such behaviour includes name-calling, insults, racist jokes, verbal threats, physical acts that can range from gestures to physical attack and ridiculing someone because of their cultural or linguistic differences. Differences in attitude and culture and the misinterpretation of social signals can mean that what is interpreted as racist harassment by one person may not appear as such to another.

²⁹ Race Relations (Northern Ireland) Order 1997

Bullying

Not necessarily overt, but can be quite insidious. It is not confined to insulting remarks or open aggression, but can also be subtle and devious and only obvious to the perpetrator and victim. Bullying can occur in the workplace when professional abrasiveness is affected by vindictiveness allowing people to be singled out and devalued. The experience of bullying can lead to an employee feeling isolated and because the bullying can be so subtle it can be difficult to impart the experience to a third party.

Examples of bullying include:

- picking on people and criticising them in front of others;
- punishing people by refusing to delegate responsibilities to them which they are competent to fulfil;
- unfounded criticism of the performance of work tasks; and
- shouting at people to get things done.

Harassment and Bullying in the Workplace

Robust policies need to be in place to deal with harassment and bullying. However, there is little point in having such policies if they are not implemented. Those who are subjected to bullying must be confident that if they make a complaint about bullying or harassment it will be taken seriously and dealt with quickly. Where this is seen to be the case, a clear message will go out that such behaviour will not be tolerated and the policy will become part of the established ethos of the organisation. Annual staff surveys can be used to measure the success of such policies.

Management are key in the implementation of anti-bullying/harassment policies. Whether or not always linked to race, a successful policy of this type will make for a happier workplace environment for all staff. Training of management to implement the policy is central. One person with responsibility to co-ordinate reporting, enquiry, discipline and outcome will allow for tighter control of the process.

Bradford City Teaching Primary Care Trust state that the implementation of their Equality and Diversity Strategy³⁰ will

depend upon clear accounting care responsibilities and active ownership at all levels and by all staff.

They also state that there may be occasions when the Trust may need to monitor behaviour and reinforce the expectations the Trust has of employees. Where the strategy is breached or ignored, disciplinary action will be taken within agreed procedures and it goes on to say that *'Employees will also be entitled to expect that unacceptable behaviour by others (including users) will be dealt with promptly and decisively'*.

Sheffield Care Trust³¹ developed a harassment and bullying strategy to run alongside its diversity strategy. The Trust provided training for staff on harassment and bullying, specifically targeting managers to develop their skills in using anti-racism policies and procedures. A network of contact advisors were also trained and the harassment policy advertised through a poster campaign. The success of the policy is measured using the annual staff attitudes survey.

This research has found that minority ethnic staff who experience racist harassment from fellow staff or patients and their relatives are unlikely to make a complaint for a variety of reasons. Parallels can be drawn with the reporting of hate crime in the community where the rise in racist hate crime incidents reported to the PSNI can be partly explained by an increased confidence among the black and minority ethnic population to report such incidents (Radford et al, 2006). Many of the reasons for not reporting racism in the workplace were found to be the same as in the community including feeling intimidated, fear of reprisals and thinking nothing could or would be done. It was also found that within the community people from black and minority ethnic groups had become accustomed to having racist comments shouted at them in the street and felt that these incidents were too trivial to report. Attitudes towards the reporting of incidents in the workplace were found to be similar and although most of

³⁰ Bradford City tPCT 'Equality and Diversity Strategy' (Revised October 2004). - (Bradford City tPCT is currently creating a new Equality and Diversity Strategy)

³¹ DoH 'Equalities and Diversity in the NHS – Progress and Priorities' (October 2003) Human Resources Directorate

those surveyed said they knew who to report such incidents to, most indicated that they were unlikely to do so.

9.2 Monitoring

The monitoring of racist incidents needs to be central to the Race Strategy of any organisation and the information collected used to inform a race policy working document. The DHSSPS 2004 publication 'Embracing Diversity' states,

The first step in preventing racial harassment in the workplace is for employers to acknowledge that it might happen or could be happening in their organisation, and decide to take a stand against it (p.26)

In relation to monitoring the document says,

The only way an organisation can know whether its policy and procedures are working is to keep careful track of all complaints of harassment and how they are resolved. An employer should be able to say how many complaints of racial harassment have been made in a year, how many were resolved informally, how many were investigated formally, how long each investigation took and what the outcomes were.

The monitoring information should be used to evaluate the policy and procedures at regular intervals, with changes recommended when something is working well. If the information also reveals a greater incidence of harassment complaints in certain departments or branches, action should be taken straightaway to investigate them and deal with any problems. (p.30)

Over a year after 'Embracing Diversity' was published, there is no standard collection of ethnic monitoring data across Health Trusts.

9.3 Reporting Mechanisms

Any reporting system must be simple to use, confidential and treated with sensitivity and promptness. Reluctance to act appropriately and promptly allows a vacuum in which resentment, gossip and isolation may occur. A general reluctance to report incidents, or to feel they are too trivial, prevents a full picture of the situation emerging. It is not only by recording incidents where a formal complaint has been made that contribute to assessing the situation and value of any adopted strategies, but also recording incidents where a report is made, but the victim requests that no further action be taken.

Third Party Reporting

The PSNI and the Community Safety Unit of the Northern Ireland Office have introduced, Project RIOH³², to overcome a reluctance on the part of some victims to report incidents to the PSNI. Project RIOH is a pilot scheme where incidents can be reported to a range of organisations within the community, voluntary and statutory sectors. It is hoped that this scheme will encourage more people to report incidents to enable the development of better services for victims and prevent further incidents.

Within this research some interviewees indicated that colleagues had reported to management, on their behalf, incidents that had occurred. Advantages of third party reporting mean that incidents which may be considered too trivial by the victim, or where the victim does not have the confidence to report, would allow management to build a picture of what problems may be occurring and where and target those areas with training and/or posters.

Third party reporting would also allow a picture of what is actually happening as well as what is reported to emerge. Mechanisms for third party reporting should allow incidents to be reported anonymously and to a particular trained member of staff and fed back to a central point. Third party reporting would alert management when victims of racist harassment are not reporting incidents and allow training to be focused in those areas. This research showed that staff are unlikely to report racist

³² Recording Incidents of Hate.

incidents. Several reasons emerged as to why staff were reluctant to report, one being the they were afraid of reprisals thus emphasising the need for a confidential means of reporting to a trusted member of staff. Another reason was a lack of faith that anything would be done, making the case for swift and decisive action to be taken where incidents of racist harassment occur. If managers do not have confidence in what they should be doing about racism, they will appear to be indifferent thereby undermining any mechanisms that the organisation may have in place to protect its staff.

Policies at senior management level have to be put into practice from middle management down to the staff who are affected. Having a robust equality strategy is commendable, but unless it is impacting on the staff it is designed to protect and changing behaviour, it is of little use.

Training

An organisation wide approach must be taken to ensure that every member of staff is aware of both legislation and Trust policy with regard to ethnic discrimination and racist harassment and bullying. Training must inform staff of the subtle forms of racism as well as overt racism and include an understanding of how certain behaviours may be perceived by different cultures.

Training for managers in managing multi-cultural teams is important. The health sector is becoming increasingly multi-cultural, creating a need for positive management so that diversity is respected and modelled in the workplace. In the NHS in England Performance Management Systems are in place for managers which include measures on responding to equality and diversity needs. Middle and senior management require specific training in handling sensitively any complaints of harassment either directly from the victim or through third party reporting.

Bradford Teaching Hospitals in responding to the recruitment of overseas nurses implemented sessions on working in an inter-cultural environment with existing staff. This was a strategy adopted by Balmoral Healthcare when recruiting overseas staff for the private sector in Northern Ireland where it was explained to existing staff and the

relatives of those being cared for the reason for the recruitment of overseas nurses, what would be involved in their adaptation and some information about their cultures. This approach proved to be valuable in helping overseas staff to settle in a new environment.

10. Conclusions and Recommendations

This research has begun to highlight the scale and nature of racist harassment and abuse within the health sector in Northern Ireland. Despite the absence of figures to indicate the number of minority ethnic staff in the health service guesstimates suggest that there are over 800 overseas nurses from outside of the UK and Republic of Ireland. As this figure is for nurses only we can be sure that the number of minority ethnic staff and overseas staff is even greater and their contribution to the health service is vital. Therefore, when these staff are subjected to racist harassment and abuse the impact of this cannot be ignored. Indeed if it is the prediction made by Patrick Yu of NICEM will become a reality, 'these people who are so vital to our health service could leave'.

In spite of many participants throughout this research indicating that their situation had improved incidents of racism, although at times described as 'subtle' were and are still occurring. Of the 557 staff who completed the questionnaire 46% (256 staff) had experienced racist harassment at work. Examples of such incidents were recounted in the focus groups with staff explaining that these could vary from being ignored to verbal abuse. The most common form was racist comments experienced by 36% of respondents who encountered harassment, followed by co-workers making unpleasant remarks (31%) and patients refusing care (31%).

Racist harassment was most likely to be from work colleagues with half of those who had experienced such behaviour indicating their colleagues were responsible. However 47% also reported being harassed by patients but in discussions this was more likely to be excused due to the patients either being ill or elderly. Nearly one-fifth (19%) of respondents said that they suffered racist harassment from a manager or supervisor. One interviewee stated that her line manager had not offered any support and indeed suggested that it was her own fault that she was experiencing racism. When she tried to complain to senior management her complaint was not acted upon. Such responses from management seek to exclude and isolate staff further leading them to either accept such behaviour or seek new employment elsewhere.

As with racist incidents in the community there was reluctance among staff to report incidents with only 24% having done so. The main reason for not reporting incidents was a fear of provoking reprisals. Also many within the focus groups highlighted that their culture did not encourage them to speak out or indeed stand up for themselves. However for those who had been in Northern Ireland for a few years they now realised that this was now a necessity to enable them to work and succeed in their environment. If this is the case more may now speak out about their experiences and indeed report incidents. Thus, there is a need for an effective reporting and monitoring procedure.

The policies and procedures in place to deal with racist harassment are challenged when harassment occurs. Those who experienced racism were more likely to indicate that policies and procedures were not effective than those who hadn't. Therefore lessons need to be learnt from those who have 'tested' the system and policies and procedures adapted accordingly.

The impact of racist harassment outside the workplace cannot be ignored. Over half of those surveyed (59%) reported experiencing incidents outside work. Many in the focus groups recounted incidents of colleagues being targeted at home. Recent media reports of attacks on the homes of Filipino nurses indicated the reality of the situation and made them question if they wished to remain in Northern Ireland.

When comparisons were made between the private and public sector those in the private sector reported suffering less racist harassment. However, they were more likely to suffer it more often either daily or 3-4 times a week. Reports from the private sector indicate that staff leave to enter the public sector but it cannot be assumed that this will ensure less racist harassment.

Staff at all levels reported incidents and recounted experiences. Although many staff have now settled into Northern Ireland cultural difficulties were still evident and the lack of understanding of the indigenous population was one of the factors, which many overseas staff found difficult to accept. This highlights the need for more preparation for existing staff before the arrival of overseas staff, an initiative already being carried out by one recruitment agency.

Recommendations

The following are suggested recommendations based on the research findings and to be discussed with the DHSSPS:

- the need to design and implement policies and procedures, based on personal experiences, that are effective in dealing with racism in the health service, thus creating a working environment that does not tolerate racism;
- training for staff (at all levels) to make them aware of the ethos of the organisation that racism will not be tolerated and that this is endorsed at all levels;
- training for staff (at all levels) to make them aware of racist harassment and bullying in all forms, from the most subtle to the most blatant;
- specialised training for management on how to deal with reports of racist harassment among staff;
- cultural training to overcome misunderstandings caused by how different cultures interpret actions/humour – e.g. joking/various forms of irony including sarcasm which is common in NI, but not the norm for some cultures who find it hurtful;
- monitoring of the ethnic composition of staff, by Trusts and Boards in the HPSS and by the Regulation and Quality Improvement Authority in the private sector;
- mechanism for reporting racist harassment or bullying that is easily accessible, confidential and collated and responded to by a trusted and approachable individual clearly identified to staff; and
- monitoring of all reported racist incidents whether reported by the victim or a third party and the action taken and outcome.

11. References

- Allan, H. and Aggergaard Larsen, J. (2003) "We Need Respect" experiences of internationally recruited nurses in the UK'. RCN: London.
- Batata Amber, S. (2005) International Nurse Recruitment and NHS Vacancies: A Cross-Sectional Analysis, Cambridge University.
- Bell K, Jarman N and Lefebvre T. (2004) 'Migrant Workers in Northern Ireland' ICR: Belfast
- DHSSPS (November 2004) Embracing Diversity: Understanding and valuing ethnic diversity in the HPSS. DHSSPS: Belfast.
- DHSSPS (September 2005) *Review of the Nursing, Midwifery and Health Visiting Workforce* Final Report. DHSSPS: Belfast.
- DHSSPS and ECNI (2003) 'Racial Equality in Health and Social Care: Good Practice Guide' DHSSPS: Belfast.
- DoH (2004) Code of Practice for the international recruitment of healthcare professionals. DoH: London.
- DoH (2001) 'Tackling Racial Harassment in the NHS: Evaluating Black and Minority Ethnic Staff's Attitudes and Experiences'. DoH: London.
- DoH (2005) 'Welcome to the team: NHS Careers'. DoH: London.
- DoH (2003) 'Equalities and Diversity in the NHS – Progress and Priorities' Human Resources Directorate. DoH: London.
- Lemos and Crane (2001) 'Tackling racial harassment in the NHS: Evaluating black and minority ethnic staff's attitudes and experiences' DoH: London.
- Macpherson, W. (1999) The Stephen Lawrence Inquiry. Report of an Inquiry by Sir William Macpherson of Cluny. Cm 4262-1, HMSO.
- McGill, P and Oliver, Q. (2002) A wake-up call on race. Implications of the Macpherson Report for Institutional Racism in Northern Ireland. Equality Commission for Northern Ireland: Belfast.
- OFMDFM (2005) 'A Racial Equality Strategy for Northern Ireland 2005 – 10'. Racial Equality Unit, OFMDFM.
- OFMDFM (2003) 'A Shared Future: A Consultation Paper on Improving Relations in Northern Ireland'.
- Racial Harassment at Work: What Employers can do about it (2000) Commission for Racial Equality for Northern Ireland, CRENI: Belfast.

Radford K, Betts J and Ostermeyer M. (2006) 'Policing, Accountability and the Black and Minority Ethnic Community in Northern Ireland' ICR: Belfast

Royal College of Nursing (2003), *'Here to Stay? International nurses in the UK'* RCN: London.