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**‘A wealth of knowledge’: A survey of the employment experiences of
older nurses and midwives in the NHS**

Abstract (377 words):

Background: The United Kingdom’s National Health Service workforce is ageing, and the specific needs of this sector of its workforce need to be addressed. Nursing and midwifery shortage is a worldwide issue, and with increasing demands for care the retention of older nurses and midwives is crucial.

Objectives: To report on the employment experiences of nurses and midwives with a particular focus on issues relating to age, ethnicity, ill-health and disability.

Design: The postal survey was developed following a literature review and analysis of National Health Service and Government policy documents.

Settings: This was a UK-wide survey of nurses and midwives working in National Health Service Trusts and Primary Care Trusts in the UK.

Participants/methods: A postal survey of nurses and midwives was undertaken between May and December 2005. National Health Service Trusts and Primary Care Trusts (n=44) identified as having policies relevant to the study were contacted regarding the procedure for seeking research governance approval. Thirteen National Health Service Trusts and Primary

Care Trusts participated, with 2610 surveys distributed; 510 surveys were returned (20% response rate).

Results: Nurses and midwives aged 50 years and over had undertaken fewer Continuing Professional Development activities than nurses and midwives under 50. Whilst not related to age, the study also found that twenty percent of the survey sample reported experiencing some form of discrimination. Nurses and midwives did not differ on either quality of life or psychological health using standard instruments. Having a disability did not lead to greater psychological morbidity but did have a negative effect on quality of life. Having a work-related illness had a negative impact on both quality of life and psychological morbidity. In relation to ethnicity, black nurses and midwives reported lower psychological morbidity than other ethnic groups; that is, they enjoyed a higher level of mental wellbeing.

Conclusion: The nursing and midwifery workforce is ageing worldwide with a significant proportion now approaching, or having already reached, potential retirement age. With the recent introduction of the age legislation the working lives of older nurses and midwives in the National Health Service have never been more relevant. Whilst access to Continuing Professional Development is pertinent to the retention of nurses and midwives of all ages, in this study, older nurses reported less access than younger nurses.

Keywords: [between 2-6] age, workforce issues, questionnaire, survey

What is already known about the topic

- 1 The National Health Service nursing workforce is ageing; this is likely to contribute to the existing staffing crisis.
- 2 Recent age legislation has focused the NHS on workforce issues in relation to those age 50+

What this paper adds

- 1 This paper identifies a lack of access to Continuing Professional Development as a key area of inequality for this group of nurses and midwives
- 2 This paper demonstrates that people with ill-health/work-related illness may be at a particular disadvantage in the workforce as they are likely to experience discrimination and face barriers when
- 3 accessing Continuing Professional Development

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INTRODUCTION

The world is in the midst of a global 'age-quake'; the workforce is growing older and worldwide more than one million people turn 60 years old every month (Hatcher *et al.* 2006). Similarly, the nursing workforce is ageing worldwide (Buchan and Calman 2004) and the resultant nursing and midwifery staff shortage is of international concern, as recognised by the World Health Organisation (WHO 2006). In the U.S.A., the Government Accounting Office identified the ageing of the nursing workforce as the most significant factor in the decline in nursing numbers in 2001 (Government Accounting Office 2001). The report identified that, in the year 2000, 35% of the registered nursing workforce were aged between 40-49 years and 9% were younger than 30 years of age. Buerhaus *et al.* (2000) reported that the proportion of the registered U.S. nurse workforce younger than 30 decreased from 30.3% to 12.1% between 1983 and 1998. By 2010, approximately 40% of the U.S. nurse workforce will be over 50 years of age (US Department of Health and Human Services 2005). An online survey conducted by the American Nurses Association found that in those nurses aged 40 or over, more than 82% planned to retire in the next 20 years (Center for the American Nurse 2003).

Outside the U.S.A., the problem is the same; it has been reported that Zambia has only 500 of the 1500 nurses needed, Chile has only 44.4% of its nurses actively working in nursing, and Poland has seen a 70% decline in nurses graduating from its programmes during the previous decade (Booth 2002). In Australia, more nurses are leaving the profession each year than are being

recruited (Duffield et al, 2004). The nursing workforce is very mobile and movements between many countries take place. However, the net effect of the migration of nurses from the developing world to the developed world to stem the shortage of nurses in these richer countries is having a negative impact on the nursing workforce in developing countries (Buchan 2001).

The ageing of the nursing workforce is having a particular impact on the UK National Health Service (NHS) by bringing a greater proportion of the workforce nearer to retirement age. The NHS is the largest employer in the UK, and the largest section of employees within this organisation are nurses and midwives. The age profile of nurses and midwives is changing, with the mean age of working registered nurses increasing by more than four years between 1983 and 1998; this reflects the large intakes of newly qualified young nurses in the 1970s and early 1980s (Buchan 1998).

The average age of a student nurse currently qualifying is 29 years (Ball and Pike 2005). In comparison, the majority of nurses qualifying in the 1960s were 20 or 21 years of age, depending on whether they had undertaken enrolled nurse or registered nurse training (Ball and Pike 2005). No direct comparison can be made with midwives because, in the 1960's, midwives undertook midwifery training after becoming registered nurses. There is now direct entry into midwifery but the average age of students entering training to be midwives is 34 years, indicating a similar issue for midwifery (RCM 2006).

The growth of alternative career opportunities and rising wages for women

relative to men may have further reduced the pool of prospective younger nursing and midwifery students as many women chose to enter other careers (Buerhaus *et al.* 2000).

The consequence for this sector of the workforce will be a significant staff shortage, especially in the primary care sector (Buchan and Seccombe 2005). The nature of the shortage may echo the age profile currently seen in the NHS - according to the Department of Health (DoH), 6% of hospital nurses are aged 55 or older compared with 12% of practice nurses, 19% of agency nurses, and 19% of nurses employed in nursing or residential homes (DoH 1997). The oldest age profile is of community staff nurses, health visitors and district nurses (Watson *et al.* 2003, Buchan and Seccombe 2005); hence this may be where the shortage will be most evident. The Royal College of Midwives (RCM) estimates that 10,000 more midwives are needed across the UK to deliver one-to-one care for new mothers. Many new midwives leave before being in practice for three years because of work pressure and staff shortages, leaving fewer midwives to fill the gap left by retiring midwives (RCM 2006).

Patient admissions have increased from 10.2 million in 1995/6 to 12.1 million in 2003/4 (HES online 2006). This indicates that even more nurses and midwives will be needed to meet the increased demand for patient care and to deliver the health care agenda. Hirsch (2003) stated that the NHS is on 'an apparent march.....towards an ever more severe staffing crisis, despite the available alternative of nurturing an already trained pool of older labour' (p14).

Despite recruitment and retention initiatives, the so-called 'greying of the NHS' (Buchan 1999) continues. The work lifespan of current nursing and midwifery recruits is, therefore, significantly less than it once was. With the onset of recent age legislation, the NHS in the UK is focusing attention on the working lives of this group of employees.

The significance of an ageing workforce is two-fold. First, greater numbers of nurses and midwives are at an age when they can potentially retire, with many others due to reach such an age in the near future (Buchan 1999). Second, as nurses and midwives age, they are likely to have different requirements and attitudes to nursing work. There is growing evidence that the needs of this sector of the workforce are not being met; indeed, it is in response to the identified concerns around age - for example, with reference to ill-health/disability discrimination and ethnicity (Watson *et al* 2003) that this study was conceived.

THE STUDY

The study took place between September 2003 and September 2006; the data were collected between May and December 2005.

Aim

The principle aim of the study was to examine the employment experiences of older nurses and midwives in the NHS, with a particular focus on age, ethnicity, ill-health and disability. Both NHS Trusts and Primary Care Trusts

were targeted. Trusts are part of the Secondary Care provision in the NHS. They provide specialised treatment, usually provided by hospitals. Trusts employ the majority of NHS staff including doctors, nurses, therapists and support staff (DoH 2002). Primary Care Trusts are usually the first point of contact for patients via their local GP. Staff include GPs, nurses, health visitors. PCTs are free-standing NHS organisations with their own boards, staff and budgets. PCTs are responsible for about 80% of the total NHS budget (DoH 2002).

The objectives of the project were to:

- 1) Examine employment policy and procedure in relation to the employment of nurses and midwives with a particular focus upon age, ethnicity, ill-health and disability.
- 2) Identify a range of positive or 'good' practices with regard to support for older nurses and midwives in the workplace.
- 3) Provide recommendations to support future anti-discriminatory practice in this field.

This paper reports on the survey undertaken to examine the first of these objectives.

Methodology/data collection

The principal means of data collection was a postal survey. Postal surveys offer a higher degree of confidentiality and anonymity than other methods, which is advantageous when asking questions of a personal or sensitive

nature (eVALUEd 2006).

The survey was developed following a review of the literature and analysis of NHS Human Resource policy documents and Department of Health policy documents (not reported on in this paper). A draft questionnaire was piloted among community nurses in a Primary Care Trust (PCT). Thirty pilot questionnaires were distributed and ten were returned, representing a 33% response rate.

The survey tool collected data on the following subjects:

- Demographic details (e.g. Gender, age, ill-health/disability, marital status, dependant status, ethnic origin)
- Education and professional qualifications
- Employment status
- Continuing Professional Development (CPD) activities
- Flexible working
- Retirement and pension's advice
- Free text comments

Two widely-used, commercially available, reliable and validated psychometric instruments – considered to be 'gold standards' in this field - were used to collect data on respondents' mental and physical health. The General Health Questionnaire 12 (GHQ-12) was used to measure the psychological health of respondents. It comprises twelve questions, asking informants about their general level of happiness, experience of depressive and anxiety symptoms,

and sleep disturbance over a fixed period. There has been some debate about the use of GHQ-12 among older age groups as it has been suggested that scores can be heavily influenced by the presence of physical symptoms; however, research has shown that GHQ-12 can be used among older people with reliability (The Stationery Office 2005). The validity of the original GHQ-30 (Goldberg & Williams 1988), from which the GHQ-12 is derived, is well established and the internal consistency of the GHQ-12, using Cronbach's alpha, is 0.85.

The second instrument used was the Short Form 8-item scale (SF-8) which measures Quality of Life. The SF-8 assesses each of the eight domains of health from the SF-36 Health Survey with a single item; it is comprehensive but quick and convenient to use, and is hence suitable for use in studies involving large samples and group-level comparisons (Quality Metric 2008). The total score of this 8-item scale was used; the validity of the original SF-36 scale is well established and the internal consistency of the SF-8, using Cronbach's alpha, has been reported at 0.9 (Garrouette et al 2004).

Ethical Considerations

Multi-regional ethical approval was received from the Leeds (West) Research Ethics Committee. Direct access to the contact details of nurses and midwives was not possible, thus we approached the Trusts and PCTs to send out the survey on our behalf.

Sampling Strategy

NHS Trusts and PCTs (n=554) were contacted to provide information on types of policy held and 50% (n = 277) responded. Of that number, 119 were found to have policies directly relevant to the research aims and were included in the study. Policy documents were received from 44 institutions (26 NHS Trusts and 18 PCTs); these institutions were then contacted regarding the procedure for seeking research governance approval. Nineteen applications were submitted to Research and Development departments, and 23 institutions agreed to participate. This reflects the fact that, in some cases, research governance covered more than one Trust/PCT. Of the remaining 25 Trusts and PCTs, the information requested was submitted, but no final approval was received or no response was received.

Some Trusts and PCTs from whom research governance approval had been obtained were unable to identify an individual within their Trust to distribute the surveys. Therefore, of 23 Trusts and PCTs from which ethical approval had been obtained, the total number of Trusts and PCTs that finally participated was 13.

All qualified nurses and midwives aged 50 and over, and a 20% random selection of qualified nurses and midwives under 50 years of age, were sampled in each of the NHS Trusts (n=3) and PCTs (n=10). This 20% sample of under-50s reflects the higher total numbers of midwives and nurses in this younger age group. Hence, the sample of 100% of those aged over 50 and 20% of those aged under-50 generated approximately equal numbers from each age group. This subset of under-50s enabled a comparison to be made

of the experiences of older and younger nurses and midwives.

Response

The survey was distributed by mail between May 2005 and December 2005; 2,610 surveys were distributed and 527 were returned using a freepost envelope. Some surveys returned were excluded (n=17) because they had been sent in error; for example, to unqualified health care assistants or student nurses or because the respondent had omitted their age or their occupation. The total number of valid responses was 510, representing a response rate of 20%.

Data Analysis

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 11.5 for Windows. Prior to analysis, the data were checked for inconsistencies and entry errors. Chi-square test was used to analyse relationships between categorical variables such as ethnicity, (age group below 50 or 50 and older) and gender. An independent t-test was used to analyse mean differences in Quality of Life and General Health against grouping variables (Yes/No) including childcare arrangements, caring for an older person, caring for a disabled person, being disabled, and having a work-related illness. One-way ANOVA was used to analyse mean differences in Quality of Life and General Health against ethnic grouping. Pearson's correlation was used to study the relationship between continuous variables.

RESULTS

Demographic details

The majority of the respondents were aged 50 or over (62.1%); most were female (89.8%). Regarding ethnic origin, 90% of respondents were white, 7% were black and 1.6% were Asian. Seventy percent of the respondents were nurses, 9.4% were midwives, with the remainder either having other job titles (18.6%) or unspecified roles (1.4%). Of those disclosing a disability, 62.5% (n=10) had a musculo-skeletal problem and 25% had a hearing impairment.

Summary

Analysis of the survey data found only one area that was significant in relation to age, and this was in relation to accessing Continuing Professional Development (CPD) activities. The main findings of the data analysis are detailed below.

Age and Continuing Professional Development

Age group was related to accessing Continuing Professional Development (CPD) activities ($\chi^2=6.41$, $df=1$, $p<0.001$) with older nurses reporting less access than younger nurses; 73% of the sample aged 50 and over had not accessed any CPD activities in the last two years compared with 27% of the under 50 sample.

The percentage of nurses and midwives undertaking CPD activities did not differ significantly, but being a midwife was related to greater barriers in accessing CPD activities than nurses ($\chi^2=6.89$, $df=1$, $p=0.03$). Having a work-related illness did not limit undertaking CPD activities but did provide greater

barriers to accessing CPD ($\chi^2=8.08$, $df=1$, $p=0.004$). Men accessed more CPD than women ($\chi^2=5.776$, $df=1$, $p=0.16$), and women experienced greater barriers to accessing CPD than men ($\chi^2=8.08$, $df=1$, $p=0.004$). Other examples of barriers mentioned were not being given time off to attend CPD sessions, not being funded to attend and not being given staffing cover to attend. Distance to courses, limited places on courses, and availability of courses in area of practice were also cited as barriers. Part time staff and staff working nights also experienced barriers to accessing CPD.

Disability/ill-health/work-related illness

Twenty percent ($n=99$) of the survey sample reported experiencing some form of discrimination. It was found that the likelihood of having experienced some form of discrimination did not differ between nurses and midwives or between people with or without a disability (Table 1) and was not related to age. However, having a work-related illness was positively related to experiencing discrimination ($\chi^2=14.32$, $df=1$, $p<0.001$) (Table 1). Midwives experienced more discrimination on the grounds of ethnicity than nurses ($\chi^2=8.89$, $df=2$, $p=0.012$), and nurses experienced more discrimination on the grounds of gender ($\chi^2=7.58$, $df=2$, $p=0.023$) (Table 2). The percentage of nurses and midwives experiencing discrimination on the grounds of sexual orientation or being disabled or having ill-health were consistently low and did not differ between nurses and midwives.

[Tables 1 and 2 here]

Respondents were, on average, bordering or near the threshold for

psychological morbidity, with a mean score of 23.62. Fifty nine percent of the sample scored less than 24, representing 'robust' psychological health, and 41% of the sample scored 24 or more, representing potential psychological distress.

Quality of life (SF-8) and psychological morbidity (GHQ-12) were also analysed in relation to key variables (Tables 3 and 4). Nurses and midwives did not have significantly different quality of life or psychological morbidity. Having a disability did not lead to greater psychological morbidity but did have a negative effect on quality of life. Having a work-related illness had a negative impact on both quality of life and psychological morbidity. Women tended to have a lower quality of life and higher psychological morbidity than men but this was not statistically significant. Caring responsibilities did not have an impact on quality of life or psychological morbidity.

[Tables 3 and 4 here]

Ethnicity

Ethnic origin was collapsed into four categories for analysis. Quality of life was not related to ethnicity (Table 5), but black nurses reported lower psychological morbidity than other ethnic groups (Table 6). The mean score of black nurses and midwives was 20.57, placing them well below the threshold for psychological morbidity. This contrasts with the scores of white nurses and midwives (23.83), Asian nurses and midwives (23.63), and nurses and midwives of 'other' ethnic origin (24.86): these scores represents borderline or potential cases of psychological morbidity.

[Tables 5 and 6 here]

DISCUSSION

There were several limitations attached to the study. The Trusts and PCTs were selected on the basis of having policy documents relevant to the study's aim. Arguably, this pre-selected sample is more likely to engage in more positive practices. This may explain why only one area of significance in relation to age was found.

An exact response rate was difficult to estimate because the research team was reliant on R&D departments forwarding questionnaires on their behalf and unused questionnaires were not always returned. Of the 13 institutions participating in the study, 10 were PCTs. This meant that the overall number of NHS Trusts taking part was comparably very low; therefore, these results may have more relevance to PCTs. However, the demographic profiles of the respondents indicate that this is broadly representative of the workforce. 9.4% of the sample were midwives, and this approximately reflects the ratio of midwives to nurses within the NHS. The number of nurses and midwives with a BME background was higher than average at 10%.

The principle aim of this study was to examine the employment experiences of older nurses and midwives. One finding of this study was that there was only one major area of statistical significance related to age and that was access to Continuing Professional Development activities. Studies of discrimination in the NHS have tended to focus on ethnicity and gender.

However, this study indicated that discrimination was not related to age, gender, job role, disability, ethnicity or sexual orientation. Significant findings in this study were evident in several key areas and each of these is now examined in turn.

Age and Continuing Professional Development

Only one area of statistical significance was identified from the survey data in relation to age when compared with all other key variables. This was in relation to accessing Continuing Professional Development activities. Comparing older and younger nurses and midwives it was found that older nurses and midwives accessed fewer CPD activities and this result was statistically significant. Seventy three percent of the sample aged 50 and over had not accessed any CPD activities in the last two years compared with 27% of the under 50 sample.

The difference between older and younger staff in relation to CPD accessed may reflect genuine discrimination against older nurses and place them at a disadvantage when opportunities are made available. This reflects Watson *et al.*'s findings (2003) that ageing nurses experienced discrimination by omission in the areas of CPD, return to practice and pensions/retirement advice and Meadows (2002) found that older nurses and midwives find it more difficult to access training and professional development than their younger colleagues. Duncan and Loretto (2004) also found that access to training opportunities was reduced because of older age. Hatcher *et al.* (2006) reported a decade of under-investment in CPD for older nurses in the U.S.

However, it may well be that older nurses and midwives with their wealth of experience and knowledge may themselves choose to access less CDP activities.

A majority of the nurses aged 50+ in a U.S. study by Wheeler (1994) highlighted the need for CPD to ensure professionalism and ongoing clinical competence. To maintain competent practice within nursing and midwifery, lifelong learning opportunities are essential, and an important challenge will be to respond to the differing learning needs of older nurses and midwives in their 40s and 50s who may have another potential 10-20 years of service to contribute.

Practice could be improved by implementing some or all of the following: acknowledging the valuable contribution older nurses and midwives make; addressing the needs of older nurses and midwives through CPD/return to practice initiatives; making flexible working options more available without affecting pension provision; allowing older nurses and midwives to move to less stressful areas of practice, and for the NHS to work collaboratively with the independent sector (Watson *et al.* 2003). Making CPD more accessible through convenient learning opportunities - for example, through long-distance learning, self-tutorials, on-site training and videoconferencing could improve take up of CPD activities (Hatcher *et al.* 2006)

Although employers and policy makers recognise the contribution that older nurses and midwives returning to the NHS could make to the current staffing

crisis, policy is not necessarily translated into practice. Whilst it is evident that the NHS is striving to improve practice, it is equally evident that significant work is required to address inclusion in the workplace (Meadows 2002, Watson *et al.* 2003, Equal Opportunities Commission 2003).

The NHS Plan recognises that the biggest constraint on the NHS today is that of human resources, not finance (DoH 2000a). Retention is a key issue for the NHS in terms of cost; it costs about £34,000 to train a nurse (first level entry) and £4,900 to recruit and induct a replacement. The Royal College of Nurses (RCN) estimates that an investment of £5 billion has already been lost because 30% of trained nurses are not part of the current workforce (RCN 2001). Buchan (2000) estimated that there were over 70,000 registered nurses not employed in nursing in the UK at the time of his survey. The majority of these nurses were 50 years or older, with only 7% actively seeking employment in nursing. The UK has seen a general increase in early retirement and, until recently, it was common for men and women to be leaving the workforce from 50 years old upwards (Phillipson 1998). The cost of pensions has put increasing pressure on the NHS which has to bear much of the cost. In addition, people were leaving the labour market with many active years in front of them and often sought alternative occupation, if not employment (Watson *et al.* 2003). Meadows (2002) found that older staff leave the NHS because they feel they are under too much pressure and that increased workload, lack of recognition, a culture of long working hours, lack of staff and support, physical wear and tear, continual change and the critical way the media portray the NHS are contributing factors.

Disability/ill-health/work-related illness

In addition to age, the study also focused on other demographic details and identified key issues for the workforce in relation to ill-health and disability. Although these are two distinct issues, they are often discussed synonymously in the literature. Whilst not a primary feature of our study, the workforce is arguably more prone to ill-health retirement as a consequence of musculo-skeletal injury, stress-related illness and long-term disability, and this can often be work-related: around 70% of disability is acquired (DoH 2000b). Work-related injuries cost the NHS millions of pounds in terms of sickness annually; back pain is the leading cause of sickness absence and costs the NHS £481million a year to treat (RCN 2006). The impact on the individual is equally substantial and results in physical, mental, psycho-social and financial costs.

Respondents with ill-health and/or disability reported experiencing discrimination, barriers to accessing CPD and a poorer quality of life and psychological health. In a study by Robinson and Perryman (2004), nearly 5% of NHS staff in London surveyed reported having a disability and/or medical condition that required support in the workforce (over 1300 staff in London alone); 79% of these were women. In addition, nearly one-third of the respondents with a disability/medical condition fell in the 50-59 age group. *Equalities and diversity: strategy and delivery plan to support the NHS* (DoH 2003) talks of a widely accepted belief that there is a significant under-representation of disabled staff in the NHS.

Experienced older nurses, midwives and health visitors who acquire a disability are more likely to become unemployed than redeployed (Scullion 2000). Morrell *et al.* (2002) found that one in ten nurses who had moved to NHS Direct reported that illness, disability or injury had been an important motivation. Experiences of discrimination may well be a factor influencing the decision to leave the workforce. There is a perception that disabled people will need to take more sickness absence than their colleagues. However, many studies have shown Ball and Pike (2005) higher levels of sickness absence among younger nurses despite the fact that they suffer less long-term ill-health problems (Ball and Pike 2005, Giorgianni 2005). An Australian study by Winwood *et al.* (2006) also found that younger nurses were more prone to fatigue than their older counterparts. Programmes like *Positively Diverse* (DoH 2000c) have challenged the 'assumption and prejudice that disabled people perform poorly at work and suffer poor health and higher sickness absence,' (RCN 2003a, p7). Experience shows that 'sickness absence among disabled staff is often lower than among colleagues,' (RCN 2003b, p8).

As part of the review of the Injury Benefits System, NHS Employers - with the Trade Unions - are also looking at staff sickness and injury within the NHS, including prevention, improving occupational health services and supporting staff to 'step down' so that they can be redeployed within the NHS or work part-time (NHS Employers 2007).

Working conditions can directly affect a nurse or midwife's ability to remain healthy, committed and able to deliver quality care. The RCN (2003c) cited the importance of addressing problems in the working environment if the NHS wants to address the problems of retention, recruitment, return to practice, sickness absence and productivity.

Ethnicity

In this study, black nurses reported a higher level of mental well-being than other ethnic groups. This result is surprising, given the wealth of literature regarding the experiences of Black and Minority Ethnic (BME) nurses and midwives in relation to racial harassment and job satisfaction. In relation to CPD, Henry (2007) found that Ghanaian nurses working in the NHS were disadvantaged in terms of adequate support and training for career progression. However, Shields and Wheatley Price (2002) found that where equal opportunities policies were in place within an organisation, racial harassment by staff was reduced significantly. The opportunity to report incidents provided by such policies could also have a beneficial effect on staff mental well-being. However, the finding could also be explained by the fact that a higher proportion of black nurses in this study were employed in the community by PCTs rather than trusts. Possibly, working in the community settings provides more autonomy and is less stressful; this is supported by the literature (Bakker 1996, Sandall 1998).

The Department of Health has already undertaken significant work in this area, producing *Improving Working Lives: Tackling Racial Harassment in the*

NHS - Good Practice Guidance (DoH 2001) and A Practical Guide to Ethnic Monitoring in the NHS and Social Care (DOH 2005). Programmes such as 'Breaking Through' (NHS Institute for Innovation and Improvement 2006) are also increasing the number of nursing and midwifery leaders from Black and Minority Ethnic communities and this may further mitigate against discrimination.

CONCLUSION

The nursing and midwifery workforce is ageing worldwide, with a significant proportion now approaching, or having already reached, potential retirement age. Improved access to CPD is pertinent to the retention of nurses and midwives of all ages, but this study found that older nurses reported less access than older nurses. Nurses and midwives underpin the work of the NHS, and the continued employment of experienced, committed and resilient older workers is essential to the delivery of patient care. The introduction of the recent age legislation will help encourage the retention of older nurses and midwives in the workplace.

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Table 1: Factors relating to experiences of discrimination

Factor	X^2	df	p	sig
Job Title	1.25	2	<0.536	ns
Disabled Person	3.7	1	<0.054	ns
Work related Illness	14.32	1	<0.001	sig

Table 2: Comparison of nurses and midwives experiences of discrimination

Factor	χ^2	df	p	sig
Age	0.07	2	<0.965	ns
Ethnicity	8.89	2	<0.012	sig
Gender	7.58	2	<0.023	sig
Sexual Orientation	1.43	2	<0.489	ns
Ill Health	1.33	2	<0.513	ns
Disability	1.25	2	<0.536	ns

Table 3: Factors related to quality of Life

Factor	Yes		No		p
	Mean	(n)	Mean	(n)	
Childcare	16.24	208	16.65	102	<0.563
Caring for an older person	17.35	75	16.06	235	<0.098
Caring for a disabled person	17.79	28	16.62	282	<0.181
Being disabled	20.89	19	15.89	489	<0.000
Work-related illness	19.65	78	15.31	421	<0.000

Mean scores on the SF-8 are shown and the differences between means was analysed using a t-test. For multiple comparisons the Bonferroni test was applied meaning that results with $p < 0.01$ are considered statistically significant.

Table 4: Factors Influencing General Health

Factor	Yes		No		p
	Mean	(n)	Mean	(n)	
Childcare	23.84	207	23.59	101	<0.714
Caring for an older person	23.79	75	23.75	233	<0.961
Caring for a disabled person	23.18	28	23.82	280	<0.561
Being disabled	23.11	19	23.63	485	<0.681
Work-related illness	26.10	78	23.12	418	<0.000

Mean scores on the GHQ-12 are shown and the differences between means was analysed using a t-test. For multiple comparisons the Bonferroni test was applied meaning that results with $p < 0.01$ are considered statistically significant.

Table 5: Ethnicity and quality of life

Ethnic Origin	Mean score (n)	F	p	sig
White	16.09 (457)	1.234	<0.297	ns
Black	15.33 (36)			
Asian	19.50 (8)			
Other	15.00 (7)			

Mean scores on the SF-8 are shown and the differences between means was analysed using one-way ANOVA. For multiple comparisons the Bonferroni test was applied meaning that results with $p < 0.0125$ are considered statistically significant.

Table 6: Ethnicity and general health

Ethnic Origin	Mean score (n)	F	p	sig
White	23.83 (454)	4.031	<0.008	sig
Black	20.57 (35)			
Asian	23.63 (8)			
Other	24.86 (7)			

Mean scores on the GHQ-12 are shown and the differences between means was analysed using one-way ANOVA. For multiple comparisons the Bonferroni test was applied meaning that results with $p < 0.0125$ are considered statistically significant.