EQUAL OPPORTUNITIES TASK FORCE
OCCASIONAL PAPER NO 6

Racial equality: the nursing profession

TASK FORCE POSITION PAPER

g Edwards's Hospital Fund for London

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INTRODUCTION

Since it was set up in 1986 to help health authorities to tackle racial discrimination, the Task Force has been approached by many people concerned about racial inequality in the nursing profession, including practising nurses at all levels.

This paper documents some of the issues which concern the Task Force – it is not a comprehensive review of equal opportunities in the profession, although the Task Force feels that in view of the wide-ranging concerns which it has identified, such a review is needed.

In the light of the many issues to which this paper refers, it is difficult not to reach the conclusion that the service which black and ethnic minority nurses have given to the NHS has been under-valued and their talent has been squandered. With a staffing crisis approaching the nursing profession, this waste of ability cannot continue. It has been reflected too, the Task Force believes, in the quality of care which black and ethnic minority citizens receive. Complaints that health services are less accessible and unresponsive to the needs of ethnic minority communities arise frequently, and might have been reduced if the expertise of practitioners from these communities had been fully used in the management and decision-taking processes of the profession. The description 'caring profession' must have a hollow ring to many black and ethnic minority nurses.

While preparing the paper, the Task Force received much help from nurses and their organisations. Some of those who met with Task Force members or who contributed to the paper in other ways are listed in the Appendix. Task Force members valued the openness with which professional representatives discussed the issues, and the acceptance of most of them that the Task Force's concerns were justified. The Task Force would like to thank all who contributed in any way to the paper, but particularly those organisations which started to implement change after their discussions with the Task Force. The views in the paper are however, as its title indicates, those of the Task Force.

In its work the Task Force has concentrated on health authorities in England. In this instance the National Boards for Scotland and Wales were invited to comment on the paper, and many of the issues it raises are applicable nationally.

Although the remit of the Task Force is restricted to tackling racial discrimination, much of the action suggested can be applied to the elimination

of inequalities on grounds of gender. Further guidance can be found in the resource and information pack produced by the National Steering Group on Equal Opportunities for Women in the NHS[1] and in the Equal Opportunities Training and Resource pack published by the National Health Service Training Authority (NHSTA).[2]

The paper includes proposals for action which the Task Force feels would help to provide solutions to some of the instances of racial inequality it has identified. Elsewhere, matters are left open for discussion. The Task Force recognizes that the real change which it believes is required has to come from within the profession. The paper is therefore addressed to the statutory and professional bodies in nursing, trade unions, health authorities and individual nurses, concerned to eliminate discrimination and promote equal opportunities, with the hope that it will stimulate action.

The Task Force is very conscious that many of the issues raised in this paper are relevant to midwives and health visitors as well as nurses. The paper is based upon concerns expressed to the Task Force relating to nursing and information was not available to enable it to deal separately with matters specific to midwifery and health visiting. The Task Force hopes, however, that midwives and health visitors, as well as nurses, their organisations and the bodies which regulate and represent them will look at the issues which the paper raises, examine their practices in the light of the views expressed and implement the actions suggested in so far as they are applicable.

1 BACKGROUND

1.1 Black and ethnic minority nurses have been employed in the health service for over 30 years, and the health service continues to be a major sector of employment for ethnic minority communities. There are no national statistics however to show the number of black and ethnic minority nurses presently in the profession; their grades and positions in the hierarchy; the branches of the profession and geographic areas they practice in; comparative promotion and training opportunities offered to them; the number of applicants for nurse training and their comparative success rates; or the number leaving the profession.

1.2 In the absence of statistics, anecdotal evidence has gained wide acceptance – that black nurses are concentrated in second level enrolled nurse (EN) rather than first level nursing grades, in geriatric care and mental

health rather than acute units, and on night shifts; that they do not have equal access to training and career development opportunities, and are under-represented in senior grades in all branches of the profession; that they are under-represented too among applicants for first level nurse training; that black applicants for training are disproportionately unsuccessful; that the number of black applications is declining; and that black nurses are leaving the health service in disproportionate numbers.

2 EVIDENCE OF RACIAL INEQUALITY

2.1 However, evidence is increasingly becoming available which supports anecdotal accounts of inequality. It comes from the Commission for Racial Equality (CRE), industrial tribunal cases, the equal opportunities monitoring data which health authorities are beginning to produce, and published reports.

CRE reports

2.2 A CRE survey published in 1987 showed that black and ethnic minority trainees were under-represented in nurse training schools.[3] In three Inner London nursing schools, only 15 of the 1365 trainees were from ethnic minority groups. A school in Leeds had two black trainees in a total of 425. In some other locations, the proportion of trainees more nearly reflected the local population but disparities between schools in similar demographic areas were shown. The figures available for applications for RGN and RMN training showed that white applicants were twice as likely as black applicants to be selected for training.

2.3 A CRE formal investigation of a unit of South Manchester district health authority, published in 1988, found that black nurses constituted 29 per cent of applicants for promotion but only 8 per cent of those successful.[4] There was some evidence that white nurses were more likely to be encouraged to apply for promotion, and a high proportion of black nurses interviewed felt that the promotion system was racially unfair. While white nurses made more applications for training and received more of certain types of training, black nurses pointed out that they were less likely to be accepted for training and often not asked or encouraged to apply. The CRE found no unlawful discrimination but expressed concern about a number of issues, including the under-representation of black students in training.

Health authorities: ethnic monitoring

2.4 Few health authorities or nurse training schools are yet monitoring the composition of their workforce and trainees, or examining the effect of selection decisions as the CRE and Equal Opportunities Commission (EOC) Codes of Practice[5] recommend. Most authorities are therefore unable to provide information about the composition of their nursing workforce, their trainees or the applications they receive by ethnic origin, and thus have not identified where inequalities are or the action which is necessary to remedy them. The following examples are of health authorities which have embarked on this process.

2.5 Southern Derbyshire Health Authority in their publication *All things being equal*[6] reported that in 1986 16 per cent of their overall nursing workforce was black or Asian. However while these groups constituted 23 per cent of their nurses in grades up to senior enrolled nurse, only 6 per cent of staff nurses and above were from ethnic minority groups.

2.6 The equal opportunities monitoring data produced by West Lambeth Health Authority in 1987[7] showed that of the 518 RGN and RMN trainees in the Nightingale School only 19 were black or Asian (which included trainees from their access course). Whereas 45 per cent of nurses in the community unit and 69 per cent of nurses in the mental health unit were black or Asian, only 16 per cent of nurses in the acute unit were from these groups. On the acute unit nightshift, whereas 17 of the 45 nursing staff were black, none were above enrolled nurse while 25 of the white staff were above this grade.

2.7 West Lambeth is the only health authority known to have used monitoring data to identify and implement significant remedial measures. They have, for example, given priority to monitoring applications from different ethnic groups and their comparative success rates for nursing posts in the acute unit. They also routinely include a positive action statement encouraging applications from under-represented ethnic groups in all appropriate advertisements. Other initiatives taken by the Nightingale School are described below in paragraphs 4.5 and 5.7.

Industrial tribunal cases

2.8 A number of nurses have successfully brought complaints of racial discrimination to industrial tribunals. In *Khan v Burnley, Pendle and*

Rossendale Health Authority (1987) and *Bapat v Bexley Health Authority* (1989) evidence was presented to the tribunal of continuing discrimination over a number of years. Several complaints have resulted from discrimination in promotion or transfer decisions, including *Banypersad v Bury Health Authority* (1987), *Ramtoul v Bradford Health Authority* (1988), *Chikanya v Parkside Health Authority* (1989) and *Okyne-Turkson v Macclesfield Health Authority* (1990). Mr Banypersad was victimised by not being allowed to act up to charge nurse after bringing an earlier complaint of discrimination unsuccessfully. Mr Ramtoul was rejected for promotion to ward manager, then transferred so that he would work to a fellow Mauritian. In the Chikanya and Okyne-Turkson cases, the conduct of promotion panels was criticized. In another case, *Brown v Newham Health Authority* (1988), a nurse received racist abuse when she made a routine enquiry about her pay.

2.9 In these, and other cases where complaints have not been upheld, tribunals have criticized selection procedures and commented on lack of knowledge of the law and Codes of Practice; examples are *Vincent and Pryme v South West Herts Health Authority* (1987) and *Haarum v Central Birmingham Health Authority* (1987). In several cases, such as *Elahi v Bristol and Western Health Authority* (1989), the tribunal has expressed concern at the lack of adequate ethnic monitoring.

Publications and surveys

2.10 A major report in the Nursing Times in 1987[8] about racism in the profession drew attention to inequalities. A study, reported by Protasia Torkington of Liverpool University, found that 96 per cent of white nurses, but only 45 per cent of black nurses, were promoted to sister/charge nurse within 18 months of qualifying; and that 35 per cent of black nurses, but only 1 per cent of white nurses, had to wait for promotion for 2–6 years after qualifying. Attention was drawn also to the concentration of black and ethnic minority nurses in less prestigious nursing schools and unpopular specialties. Protasia Torkington pointed out that black nurses born and educated in Britain suffered the same experience of discrimination and racism as nurses born overseas.

2.11 More recently, a book by Carol Baxter *The black nurse: an endangered species*,[9] based on the views and experience of black nurses, was published by the National Extension College. The nurses interviewed

confirmed that they had encountered racism and discrimination in their work. They were disillusioned and overwhelmingly would not recommend nursing as a profession to young black people.

2.12 These views were echoed in a study of black nurses in West Yorkshire, *Daughters of Seacole*, published by the West Yorkshire Low Pay Unit in 1989.[10] The nurses interviewed did not plan to leave the profession – they had all been nurses for over ten years and recognized that alternative employment options were limited. The majority of them stressed however that they would not want their children to go into nursing. The study included interviews with 27 Asian sixth formers about their attitudes to nursing. When asked about the disadvantages of being a nurse, the second most frequent reference (after long and unsocial hours) was 'racism and discrimination'.

2.13 An article by Professor Justus Akinsanya published in New Community in Spring 1988, *Ethnic minority nurses, midwives and health visitors: what role for them in the National Health Service?*[11] included a comprehensive review of the relevant literature. He suggested that there was a 'constant denial of overt racial discrimination in the operations of the NHS' in spite of accumulating objective evidence of discrimination against ethnic minority nurses. Professor Akinsanya regretted the 'dearth of factual knowledge about the role of ethnic minority nurses in the NHS'. Noting the under-representation of ethnic minority practitioners within the higher echelons of the nursing and midwifery professions and arguing for the monitoring of their progress, he said 'if no counting is done, then no measurement is possible. In the absence of accurate measurement, the management strategy for ensuring equal opportunities for all staff is likely to be ineffective'. Professor Akinsanya pointed out also that black and ethnic minority professionals were under-represented among the membership and senior staff of the statutory bodies, and appeared to have an inadequate role in the work of the Royal College of Nursing and the Royal College of Midwifery. He concluded that the extent of discrimination was often not appreciated by those in positions of authority simply because it was overlooked, and that the NHS should examine its employment practices to redress the imbalance of ethnic minority nurses as decision-makers.

3 RECRUITMENT AND RETENTION

3.1 The *Black Hole* report prepared by the NHS Regional Manpower Planners' Group[12] reveals the extent of the staffing crisis facing the

service. While the report presents demographic patterns and highlights the falling number of school leavers, it does not recognize that the proportion of the pool of school leavers from black and ethnic minority groups is rising. Nationally, young people from black and ethnic minority communities constitute 6 per cent of the 16–29 age group and 7 per cent of the under 16s. In many local areas the proportion is much higher.

3.2 Some nursing schools are already experiencing difficulty in filling their training places. The ability of many schools to attract sufficient applicants in the 1990s will depend on their tapping in to non-traditional recruitment markets. In many cases these will consist of young men and people from black and ethnic minority communities. Staffing the service will also depend on retaining trained nurses and attracting back those who have left the profession. While job sharing, part-time work and career break schemes will be essential elements, a key factor for black and ethnic minority nurses will be evidence that they will receive equal opportunities in pursuing their career and can expect to work in a non-racist environment. Changing the present image of the profession in black and ethnic minority communities will be essential if black nurses are to be recruited and retained.

4 ENCOURAGING APPLICATIONS FROM BLACK AND ETHNIC MINORITY COMMUNITIES

4.1 A common response from health authority members, managers and nursing professionals to the under-representation of black and ethnic minority nurse trainees is to blame young people, particularly from Asian communities, for not applying to the profession. 'Cultural constraints' are often mentioned. The Department of Health has financed a video to encourage Asian applicants to nursing.

4.2 In the *Daughters of Seacole* study however only seven of the 27 Asian girls interviewed said that their families would not approve of their entering nursing, and not always for 'cultural' reasons. Seventy per cent said that their families would approve. There were two references to uniforms being a disadvantage of the profession – 'They wouldn't mind except for the uniform. It would be OK if I could wear trousers as it would not affect my religion.' There were 15 references to racism and discrimination as disincentives.

4.3 The cultural hypothesis is therefore too simplistic. The under-representation of black and ethnic minority applicants is not restricted to those of Asian origin. Moreover, explanations have to be seen against the lack of data about the numbers of young people from black and ethnic minority communities who are applying for nurse training; their success rates compared to white applicants; the efforts which have been made by nurse training schools and health authorities to attract applicants and ensure that selection is non-discriminatory; and the image of the nursing profession within black and ethnic minority communities. Some nursing schools are known, for example, still to be operating, either formally or informally, a 'skirts not trousers' uniform requirement. None of the recruitment literature which the Task Force has seen refers to a right to wear trousers as part of the nurse's uniform or shows nurses wearing trousers.

4.4 Recruitment initiatives include national press and television advertising to attract applicants to nursing. The campaign received criticism for portraying a white, female profession and appearing to be directed to the traditional recruitment market, and some changes have been made. Advertisements do not however specifically encourage black and ethnic minority applications and only about two of the nursing school entries in the Nurses Central Clearing House applicants' handbook carry this message. In the experience of the Task Force, much nursing careers publicity and information material does not pay sufficient regard to the need to attract, recruit and retain black and ethnic minority nurses.

Action points

All nursing organisations, the Department of Health and training schools to review their publicity and careers recruitment literature to ensure that:

pictures include black and ethnic minority nurses;

black and ethnic minority nurses are portrayed positively and in senior positions;

the text includes an equal opportunities statement and is attractive to potential applicants from black and ethnic minority communities;

where black and ethnic minority nurse trainees are under-represented, a positive action statement is included encouraging applications from these communities.

4.5 The Nightingale School (West Lambeth) has recruited an outreach worker to encourage black and ethnic minority applications for nurse training. She works with schools, clubs, community groups and the careers service and her job encompasses vetting the suitability of recruitment literature. Other health authorities have created similar posts but without the race equality brief.

4.6 An assessment of the outreach worker's role has concluded that changing attitudes in black and ethnic minority communities to employment in the NHS and to nursing is a long-term task and will depend on real change being seen to take place in the profession. There is concern too about one health authority financing an initiative which may benefit other authorities equally.

Action points

Health authorities employing nurse recruitment officers to include an equal opportunities remit in their job description.

Health authorities and nurse training schools to consider the joint financing of outreach workers.

5 ENTRY TO FIRST LEVEL NURSE TRAINING: ACADEMIC CRITERIA

5.1 The United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) have statutory responsibility for the minimum educational requirements for entry to nurse training. At present these include:

5 'O'/GCSE levels

5.2 This was raised from two 'O' levels in January 1986 to standardise the educational requirements of the National Boards. Others means of entry are based on an equivalent academic standard.

5.3 A 5 'O'/GCSE level requirement could discriminate indirectly against some ethnic groups. Discrimination and disadvantage within the education system have resulted in under-achievement for some members of ethnic minority communities, whose academic attainments do not adequately measure their abilities. If challenged, it would be for the

UKCC to justify the requirement by reference to the demands of training and subsequent needs of the job. The UKCC did not undertake a validation exercise when the change from two to five 'O' levels was made.

5.4 Nurse training schools set their own academic entry requirements, subject to the UKCC statutory minimum. They differ in the subjects they require at 'O'/GCSE level and the maximum number of sittings permitted. Some are thought to demand or give preference to applicants with more than the minimum requirements, such as two 'A' levels. It would be for schools to justify their own requirements if they were found to discriminate indirectly.

DC test

5.5 Applicants without five 'O'/GCSE levels may enter training if they reach the specified pass standard in an educational test approved by the UKCC. The approved DC test was developed by the Nurse Selection Project at Leeds University School of Education, and introduced about four years ago. The UKCC has commissioned the Nurse Selection Project to validate the test. The Project was not asked to use ethnic origin as a variable in developing and validating the test. Although the researchers have recently tried to incorporate this aspect in their work, they have been unable to do so satisfactorily because the sample of black and ethnic minority nurse trainees which they could identify was too small. Applicants taking the test are not asked to specify their ethnic origin and data about those successful in the test who apply for training is not yet analysed by the Nurses Central Clearing House (see paragraph 7 below).

5.6 Many directors of nurse education dislike the DC test because of the high failure rate, and some nursing schools do not offer it or accept it for entry. One training school has stopped using the test partly because they found the failure rate for black applicants was particularly high. The only monitoring data which the Task Force has seen of DC tests results are from one health authority, based on a sample of 114 applicants taking the test during a six month period in 1989 and three months in 1990. Sixty of those taking the test were white and 54 of African, Caribbean, Asian or UK Black ethnic origins. Two of the black and ethnic minority applicants (4 per cent) passed the test, whereas 20 (33 per cent) of the white group were successful. While this sample is very

small and taken over a short time span, if the results are in any way typical urgent investigation of the test and its administration is required.

Access courses

5.7 For an experimental period the UKCC approved entry to training at the Nightingale School (West Lambeth) and the Princess Alexandra College of Nursing (Tower Hamlets) through access courses for students aged over 21 years without the requisite academic qualifications. Students who successfully completed the one year courses were guaranteed training places. The majority of students participating in the access courses were from black and ethnic minority groups. The access courses mirrored those which have been used by other professions, such as social work and teaching, in seeking to remedy under-representation of black and ethnic minorities. They were commended by the House of Commons Employment Select Committee which recommended that 'wider use be made of schemes of this type'.[13]

5.8 An informal interim validation of the access courses has been undertaken by the Nurse Selection Project, although this was restricted by the low total number of students only a few of whom had by that time entered training. A final evaluation can only be carried out when all the access students have completed training.

5.9 The UKCC has meanwhile decided that only access courses which are approved for entry to higher education will be recognized for entry to nurse training. Many such courses demand the achievement of an educational standard which is higher than five 'O'/GCSE levels or the DC tests. The UKCC has taken this decision to broaden the range of options available to students completing access courses.

5.10 There is a great deal of interest in access courses, particularly from authorities in inner-city, multi-racial areas. Several have set up or are going ahead with plans for access courses. Students are at present however having to aim for entry to training through the DC tests or an alternative 'recognized' qualification.

Vocational and other qualifications

5.11 Other means of entry to training include an enrolled nurse qualification and certain vocational qualifications. The UKCC has some discretion to accept alternative qualifications as equivalent to five 'O'/

GCSE levels. They are also planning means of entry for the new health care assistants through the NCVQ route.

5.12 The UKCC has said that it is seeking to widen the entry gates to nursing by extending the qualifications and experience accepted as alternative to 'O'/GCSE levels. They wish to 'attract and recruit into nurse preparation persons with a variety of life experiences and from a wide age range who have potential for success in nursing'.

5.13 The Task Force is concerned however that while the range of vocational and other qualifications recognized for entry has been increased, opportunities for academic under-achievers to enter the profession are being limited. It would like to see some opportunity for those with practical skills, the ability to undertake training and to practise safely, but who do not have certificated qualifications, to enter the profession.

5.14 It will be necessary to ensure however that students entering the profession with other than the traditional qualifications are not seen as unusual or different. Education within the nursing profession may be necessary to ensure that such students subsequently enjoy the same career development and promotion opportunities as those nurses entering by presently recognized routes.

Action points

The UKCC to ensure that:

academic criteria for entry to nurse training do not discriminate indirectly on racial grounds;

the preparation and validation of selection tests and other research includes ethnic origin as a variable where appropriate;

applicants taking the DC tests are asked to provide their ethnic origin; that the resulting data is analysed to assess the comparative success rate of applicants from different ethnic groups; and that the tests are amended as necessary if they are shown to have a disproportionately adverse impact on any particular ethnic group;

maximum flexibility is exercised in determining the range of alternative means of entry accepted as equivalent to the academic minimum, consistent with safe practice;

consideration of wider entry gates to the profession pays particular attention

to the need to improve access for academic under-achievers and for students from under-represented black and ethnic minority communities.

Nurse training schools to ensure that their academic criteria for selection to training do not discriminate indirectly on racial grounds.

6 ENTRY TO FIRST LEVEL NURSE TRAINING: SELECTION CRITERIA AND PROCEDURES

6.1 Apart from the minimum educational requirements nurse training schools determine their own selection criteria, which vary widely. They commonly include subjective factors which are difficult to assess, such as motivation and personality. Some criteria which have come to the Task Force's attention appear to be culturally biased. Shortlisting is sometimes undertaken by one person and responsibility for selection is allocated widely, often to untrained selectors. Selectors have not always agreed the criteria to be used or taken steps to ensure consistency in the standards applied. Few nursing schools are aware of or comply with the CRE and EOC Codes of Practice.

6.2 The Nurse Selection Project has undertaken research into selection procedures and methods for assessing professional potential. They found that 95 per cent of the nursing schools they surveyed relied heavily upon an interview for selection. They pointed to the tendency for interviewers to favour applicants with the same attitudes, racial background and gender as themselves. They found also that interviewers had no clearly defined criteria for selection and did not rely on factual, observable evidence or systematic selection procedures.[14]

6.3 Nurse training schools have to deal with a large volume of applications within short time scales. Assessing applications is often the responsibility of hard pressed nurses, for whom selection is an additional burden. It is essential that the overall effect of individual decisions should be supervised. Few nursing schools at present however use the information provided about ethnic origin on the Nurses Central Clearing House application form to monitor the success rates of applicants from different ethnic groups, or record the reasons for the rejection of applicants. Such information is essential if training schools are to identify discriminatory criteria or procedures and undertake appropriate remedial action.

Action points

Nurse training schools to:

examine their selection criteria to ensure that they are not culturally biased and do not discriminate either directly or indirectly on racial grounds;

involve more than one person in shortlisting and selection decisions, or ensure that such decisions are checked;

ensure that all staff involved in recruitment are trained in non-discriminatory selection techniques;

maintain records of the ethnic origin of applicants for nurse training and the reasons for rejection of applicants;

analyse the data to assess the comparative success rates of applicants from different ethnic groups and review their selection practices if disparities are revealed;

use equal opportunities monitoring data to identify where particular groups are under-represented amongst applicants and in nurse training and take appropriate positive action, such as encouraging applications from under-represented groups, and setting up access courses.

7 STATISTICAL DATA

7.1 The lack of statistical data about the ethnic origins of applicants for nurse training and the position of existing nurses is noted in paragraph 1.1 above.

Applicants for training

7.2 Applications for basic nurse training in England are dealt with through the Nurses Central Clearing House (NCCH) operated by the English National Board for Nursing, Midwifery and Health Visiting (ENB). The ENB operates the Clearing House on behalf of the 14 regional health authorities, for whom they act as agents. It sends out about 40,000 application packages and deals with about 25,000 applications each year, holding the only complete record of applicants to nursing.

7.3 The NCCH seeks information about ethnic origin on its application form but has not so far analysed the information. They started this

process from April 1990. The Task Force welcomes this development, which will assist health authorities and nurse training schools with monitoring their equal opportunities policies.

7.4 Six monthly statistical reports will gradually become available from the NCCH which will include applicant and institutional profiles. Applicant profiles, available on a national and regional basis, will show numbers of applicants:

not possessing minimum statutory educational requirements (these applications are not processed);

entering the clearing house process;

accepting an offer;

accepting an offer but not commencing training;

commencing training;

entering the regional clearing pool;

receiving an offer from the clearing pool;

accepting an offer from the clearing pool;

withdrawn from the clearing pool after one year.

Institutional profiles, available for individual training schools, will show the number of applicants at each stage of the selection process:

applications received;

rejected before interview;

not processed;

withdrawn during processing;

not attending interview;

rejected after interview;

offers made;

offers accepted;

offers rejected;

offers accepted but withdrawn by the institution;

offers accepted but withdrawn by applicants;

offers accepted but applicants not commenced training;

commencing training.

7.5 Each category in applicant and institutional profiles will be broken down by age, gender and ethnic origin. Ethnic origin categories will be those to be included in the 1991 census. As information becomes available, the ENB will be discussing the best method of presenting the data with selected regions, districts and institutions to ensure that a relevant service is provided. Eventually, information will become available for all regions and institutions.

Scotland and Wales

7.6 The NBS (National Board for Nursing, Midwifery and Health Visiting for Scotland) is developing proposals for a Central Applications to Training Clearing House (CATCH) system. In Wales, applications for training are dealt with by individual health authorities and there is no central clearing house. The WNB (Welsh National Board for Nursing, Midwifery and Health Visiting) therefore holds details of students in training, but not of all those who have applied. The WNB index form at present seeks information about country of birth, home country and nationality, but not ethnic origin.

7.7 The Task Force would like to see the NBS and WNB adopt methods for undertaking equal opportunities monitoring similar to those developed by the ENB, compatible with their systems for dealing with applications. In Wales, monitoring of applicants for training and their success rates would need to be undertaken by individual health authorities, and the WNB should encourage them to do this. The Board itself could produce data about those registered for training, replacing the present information sought about country of birth and nationality with a voluntary ethnic origin question. The WNB appreciates the need for consistent data and will be discussing a common approach with the ENB. Discussion would be required with district health authorities in Wales and health boards in Scotland as to how effective monitoring systems could be introduced. These proposals would ensure that eventually consistent data about the ethnic origins of those applying for and entering training became available on a national basis.

The professional register

7.8 The UKCC maintains a register of qualified nurses in different branches of the profession together with an 'active register' which recognizes those who are presently practising, and the specialist training they receive. Each nurse is identified by a personal identification (PIN) number. Nurses who wish to remain on the active register must re-register every 3 years.

7.9 The information on the register, cross-referenced by ethnic origin, would yield invaluable information about racial equality in the profession. It could be used by many other bodies in the profession to determine appropriate policies and initiatives to ensure equal opportunities. It would be useful, for example, for individual health authorities who want to set realistic recruitment 'targets' to know about the ethnic composition of the relevant recruitment pool.

7.10 The UKCC has not so far formally considered including ethnic origin amongst the data sought for the register. They have some doubts concerning the sensitivity of such information and nurses' reaction to its collection. Furthermore, only the Task Force has so far sought the information.

7.11 The Task Force recognizes that the collection of ethnic origin data by the UKCC would require careful explanation and planning. The provision of information by nurses would, of course, be voluntary. Consultation with nursing professional associations and trade unions would be necessary, and they could do much to encourage the cooperation of their members (see paragraph 13). Nurses would need assurance as to the confidentiality of the data (which would fall within the scope of the Data Protection Act), and that it would be used only for statistical analyses which could not identify individuals. Provided such safeguards were met, and assurances were given that the information would be used to enhance equal opportunities, the Task Force hopes that what it proposes would achieve widespread cooperation within the profession. The Task Force would encourage nursing organisations, trade unions and health authorities who would support the inclusion of ethnic origin information on the register, and use the analyses which could be produced, to make their views known to the UKCC.

Action points

The ENB to:

use equal opportunities monitoring data from the NCCH in its other work, for example to encourage applications from under-represented ethnic groups in the course of their advisory work with potential nurse trainees.

The UKCC to:

seek ethnic origin information from nurses entering or re-registering on the active register;

consult professional associations and trade unions about ethnic monitoring proposals and the provision of data, seeking their cooperation in achieving a high response rate;

discuss with the CRE and/or the Task Force, nursing professional organisations, trade unions and health authorities how such information might most usefully be analysed;

use ethnic monitoring analyses in its other work, for example to identify any remedial action required to ensure equal access to the profession.

8 PROMOTION, ACCESS TO TRAINING AND CAREER DEVELOPMENT OPPORTUNITIES

8.1 A major cause of dissatisfaction for black and ethnic minority nurses rests with their promotion prospects. Monitoring data which health authorities are now producing confirms that, particularly in the light of their length of service in the profession, black and ethnic minority nurses are under-represented in senior positions as well as in teaching hospitals and acute units. A significant number of industrial tribunal cases have involved career development issues. A finding of indirect discrimination by the industrial tribunal in *Pratt v Walsall Health Authority* (1987) depended on their acceptance that steady upward mobility in the nursing hierarchy was more difficult for black than white nurses to achieve.

8.2 Often promotion prospects are dependent on prior training and/or types of experience. Again, black and ethnic minority nurses complain that training opportunities are not advertised or made equally available

to them, that white nurses are encouraged to apply for training while they are not, and that their career development is not adequately considered.

8.3 Issues of equality of opportunity in promotion and career development must be addressed within the profession. It is essential that black and ethnic minority nurses are seen to occupy the senior and managerial positions which their ability and length of service justifies. Without this, increased efforts to recruit from black and ethnic minority communities will either fail or will produce a further generation of black nurses disillusioned by the discrimination and disadvantage which they encounter, who will not see their long term future in the health service.

8.4 Many of the criticisms made of selection to basic nurse training can be applied equally to selection for post-basic training, promotion and career development opportunities – that selection criteria are not formulated, adhered to or sufficiently objective; that selection is the responsibility of one person; that nurses in supervisory positions are not trained in non-discriminatory selection techniques; that monitoring of equal opportunities in the selection process does not take place; and that appropriate positive action measures are not considered. All these are recommended in the CRE and EOC Codes of Practice.

Action points

Health authority management/directors of nursing to ensure:

that nursing staff in supervisory positions and responsible for selection decisions are aware of and comply with the CRE and EOC Codes of Practice;

training, promotion and career development opportunities are advertised;

criteria and procedures for selection are reviewed to ensure that they do not discriminate either directly or indirectly;

selection is not carried out by one person or, if so, such decisions are checked;

nursing staff involved in selection are trained in non-discriminatory selection techniques;

reasons for selection decisions are recorded;

the allocation of training opportunities and promotion decisions are monitored;

ethnic monitoring analyses are used to identify disparities and where action is required to ensure equal access to all levels in professional hierarchies;

positive action by way of encouragement and training is undertaken where black and ethnic minority nurses are under-represented in senior positions.

9 RACIAL ABUSE AND HARASSMENT

9.1 Racial abuse and harassment by other staff and patients is of serious concern to many groups of black and ethnic minority staff in the health service, including nurses. Grievance and discipline procedures should make specific provision for discrimination, abuse and harassment by staff to be dealt with. Many health authorities have taken such steps. Forthcoming guidance from the National Union of Public Employees (NUPE) warns that those who fail to act to stop or prevent racial harassment may find themselves liable under the Race Relations Act.

9.2 However, abuse and harassment of black and ethnic minority staff by white patients and/or their relatives is a problem which largely goes unrecognised by management. It most commonly becomes an issue when black staff are disciplined for retaliating, when account is rarely taken of the original cause of the incident.

9.3 Health authorities claiming to be equal opportunities employers should take all reasonable steps to provide a working environment for their staff free of racial abuse and harassment. Authorities need to have a policy and procedures for dealing with both staff and patient abuse and harassment, which are made known to all employees. These should ensure that complaints are dealt with and that support is offered to the victims.

9.4 Authorities should seek to create a climate which discourages abuse and harassment. Publicizing the authority's equal opportunities aims is one such step, together with references on posters and patient information leaflets about behaviour which is consequently unacceptable. When, nevertheless, racial abuse or harassment by patients and/or relatives is reported, procedures should ensure that the matter is taken up with them by a senior member of staff and the unacceptability of their

actions to the management and staff of the authority as a whole is made clear. The Task Force is considering publishing further guidance on this issue.

9.5 Black and ethnic minority staff who suffer racial abuse and harassment need support. In many circumstances, the victim will continue to provide professional care to the perpetrator. Some employers outside the health service nominate a senior member of staff who can be approached for advice and counselling when discrimination, abuse or harassment occur. Health authorities should consider whether this would be appropriate in the NHS.

9.6 All reports of racial discrimination, abuse and harassment by patients, their relatives or staff should be recorded, together with an account of the action taken. Analyses of such incidents should form part of the regular report which is made to health authority members and the management board about progress towards equal opportunities. Members and management should review their procedures in the light of such reports, and take remedial action as required.

Action points

Health authorities to:

review staff discipline and grievance procedures to ensure that cases of racial discrimination, abuse and harassment are included;

develop a policy and procedures for dealing with racial abuse and harassment of staff by patients and/or their relatives;

ensure that policies and procedures are made known to all staff, and followed;

refer to their equal opportunities policy and the unacceptability of racist behaviour by patients and/or relatives in publicity materials and information leaflets;

provide support for staff who suffer from discrimination, abuse or harassment on racial grounds;

maintain a record of all cases of discrimination, abuse and harassment and action taken, to be reported regularly to members and management for them to review processes as required.

10 THE CODE OF PROFESSIONAL CONDUCT: ALLEGATIONS OF PROFESSIONAL MISCONDUCT

10.1 While statistics are not available, the Task Force has received reliable reports that black and ethnic minority nurses are over-represented amongst those reported for investigation of alleged professional misconduct. At present such cases are investigated by the National Boards. Appropriate cases are referred to the UKCC, which decides whether behaviour has occurred in breach of the Code of Professional Conduct[15] and, if so, determines penalties. Only the UKCC may rescind professional registration. If registration is withdrawn, nurses cannot practice.

10.2 Black and ethnic minority nurses have complained that their cases are more likely to be referred for investigation than white nurses in the same or similar circumstances. In one industrial tribunal case, *Bapat v Bexley Health Authority* (1989), the tribunal found that in 1979 an approach to the then General Nursing Council by a senior nurse had been an inappropriate attempt 'to call the applicant's professional status into question'.

10.3 The Task Force takes the view that the incidence of referrals to the National Boards and the UKCC, and their outcome, should be monitored by ethnic origin. This would enable a more accurate view of the position than the present picture based on impression and anecdote. It would enable comparisons to be drawn between the way in which referrals from different ethnic groups are dealt with and the penalties imposed, thus enabling any racial inequality to be identified and remedied. If analysis of the ethnic composition of the nursing profession as a whole became available from the UKCC register, it would provide a benchmark against which to assess the extent of any over-representation of black and ethnic minority nurses featuring in professional misconduct referrals.

10.4 It has been suggested to the Task Force that if black and ethnic minority nurses are over-represented in misconduct referrals this may result from their concentration in work with the elderly and in mental health, which attract a high incidence of complaints. If correct, it would render black and ethnic minority nurses liable to double disadvantage. The UKCC undertakes some analysis of professional misconduct referrals in order to make recommendations where appropriate to nursing and other health service bodies. The Task Force would like to see the

UKCC making recommendations to increase racial equality, based on the ethnic monitoring recommended above.

10.5 A further cause for concern is that the Task Force understands that those investigating and deciding upon cases of alleged professional misconduct rarely include black or ethnic minority nurses. This results substantially from the under-representation of black and ethnic minority practitioners amongst the membership and senior staff of the statutory bodies. It is however particularly unfortunate if, as is alleged, black and ethnic minority nurses are more likely to be referred. Particularly in cases where racial discrimination is an issue or may be an underlying factor, it is desirable that black and ethnic minority professionals should be involved in the investigation and resolution of referrals. Taken with the inequalities which black and ethnic minority nurses may have encountered elsewhere in their professional practice, judgements reached by panels composed entirely of white practitioners could lead to lack of confidence in the profession's self regulatory system. The statutory bodies, and the Department of Health which appoints some of their members, should consider what action can be taken to ensure that those responsible for maintaining standards within the profession include sufficient black and ethnic minority professionals to enable appropriate representation in this significant aspect of their responsibilities.

10.6 The Code of Professional Conduct sets out the professional accountability of nurses, midwives and health visitors and indicates the manner in which they should practice 'to justify public trust and confidence, to uphold and enhance the good standing and reputation of the profession, to safeguard the interests of individual patients and clients.' The Code requires practitioners, for example, to 'promote and safeguard the well being and interests of patients/clients' and to 'have regard to the environment of care and its physical, psychological and social effects on patients/clients . . .'

10.7 Although the Code requires nurses, midwives and health visitors to 'work in a collaborative and cooperative manner with other health care professionals and recognize and respect their particular contribution to the health care team' and to 'take account of the customs, values and spiritual beliefs of patients/clients', it does not spell out that racial discrimination against either patients/clients or other health care professionals would be incompatible with the standards of conduct which the Code requires. The Task Force recommends that the Code should explicitly recognize that nurses, midwives and health visitors are

practising in a multi-racial, multi-cultural society and that professional accountability requires that they carry out all their duties so as to ensure equality of opportunity for all racial groups in both health care provision and employment.

Action points

The National Boards and the UKCC to:

maintain records of the ethnic origins of nurses referred for investigation of allegations of professional misconduct;

analyse the number, types of case and outcomes by ethnic origin;

if disparities are shown, take remedial action or make appropriate recommendations to other bodies.

The UKCC to:

include in the Code of Professional Conduct a duty to comply with equal opportunities legislation and to practise at all times so as to enhance equal opportunities in a multi-racial, multi-cultural society.

11 PROJECT 2000

11.1 The introduction of Project 2000, creating one level of trained nurse with health care assistants, has significant consequences for racial equality in the profession – such as equality of access to the new nurse training; the position of existing second level enrolled nurses; whether black and ethnic minority applicants will apply for health care assistant posts; and, if so, how it will be ensured that they receive equal opportunities in their career progression.

Conversion courses

11.2 Recruitment to the second level enrolled nurse qualification is ceasing as Project 2000 is adopted. Although statistics are not available it is generally acknowledged, and health authorities monitoring data confirms, that black and ethnic minority nurses are concentrated in the EN grade.

11.3 Enrolled nurses may convert their second level qualification to first level standard by obtaining conversion training. The UKCC has

recognized the problems for existing enrolled nurses of implementation of the Project 2000 proposals. It has regularly relaxed the entry requirements and length of training required for conversion. However, the availability of conversion courses remains limited and there is evidence that the wide variety of paths to conversion are not being used to full advantage. Health authorities are faced with financial and resource obstacles since EN work has to be covered while training takes place. Furthermore, some enrolled nurses lack confidence in their ability to resume academic study after many years and may require encouragement or preliminary 'learning to learn' courses.

Action points

The UKCC to:

ensure that the variety of methods for conversion are widely publicized in the nursing profession and encourage their full use;

continue to consider the position of enrolled nurses after implementation of the Project 2000 proposals, making available the widest possible opportunities for conversion.

Health authority management/directors of nursing and nurse education to:

provide individual career counselling for enrolled nurses, including encouragement and help where appropriate to enable them to resume training;

wherever possible, make opportunities available for conversion training;

ensure that the widest possible use is made of the variety of opportunities made available by the UKCC for conversion;

ensure that opportunities for conversion training are made know to all potential applicants and that selection methods are non-discriminatory;

monitor applications and the allocation of places on conversion courses to ensure that there is equal opportunity for all ethnic groups;

use ethnic monitoring analyses to identify where remedial action is required, including positive action, to ensure equal access to conversion opportunities.

12 TRAINING CURRICULA

12.1 There is concern that basic and post-basic training curricula are not sufficiently relevant to health service provision for a multi-racial, multi-cultural population. The National Association of Health Authorities' report, *Action not words: a strategy to improve health services for black and minority ethnic groups*[16], recommended that all national bodies with responsibility for education and training should 'review their curricula and syllabi to ensure that the multi-racial and multi-cultural dimension becomes an integral part of professional education and training'. This recommendation is echoed in the recent Health Visitors' Association publication *Entitled to be healthy: health visiting and school nursing in a multi-racial society.*[17]

12.2 Although the guidelines which the ENB issued for Project 2000 courses emphasize the need for students to learn about different patient groups and stress the importance of the cultural and community setting, there are few specific references to racial issues. In guidance for the Common Foundation Programme (CFP), for example, the only reference to ethnicity is in relation to examining social divisions in society. Whereas the content of the CFP could help to make service provision more accessible and relevant to the needs of ethnic minority groups, experience is that unless their needs are spelled out, together with the need to tackle discrimination and racism, they are more often than not overlooked.

12.3 Equal opportunities in service provision and employment are inextricably linked. Black and ethnic minority nurse trainees are alienated at an early stage if the training they receive is irrelevant to or takes no account of the needs and circumstances of their communities, and does not acknowledge or challenge the discrimination and racism which is part of their and black and ethnic minority patients' life experience.

12.4 Subject to approval by the ENB, it is left to individual nurse educators to decide how curricula guidelines should be interpreted in their training programmes. Since training programmes reflect local circumstances, few nurse tutors accord priority to ensuring that training has an anti-racist perspective and fits pupils to nurse in a multi-racial, multi-cultural setting, although many may subsequently do so in the course of their careers. The under-representation of black and ethnic minority nurse tutors may also contribute to appropriate issues being excluded, and should be rectified.

12.5 Problems include:

reluctance by nurse educators to introduce race equality issues into the curricula;

lack of understanding of racism and discrimination by nurse educators and the knowledge, expertise and confidence to introduce anti-racist training;

lack of appropriate training materials;

concentration in training on sessions about the culture and religious customs of different ethnic groups, such as naming systems, diets and 'special needs', rather than integrating equal opportunities and anti-racism into the curricula as a whole;

inappropriate reliance on equal opportunities advisers and others outside the profession to provide training;

lack of support in the work environment for students who have received appropriate good practice training.

Action points

The ENB to:

provide further and more explicit guidance about incorporating race equality issues in training than is available in the present guidelines;

urge nurse educators to tackle issues of racism and discrimination and ensure, through their education officers, that all training courses adopt an anti-racist perspective and equip nurses to practise in a multi-racial, multi-cultural environment;

provide training and guidance for education officers so that they are able to tackle such issues with confidence and provide guidance on them;

together with the NHSTA, seek to ensure that appropriate training materials are made available.

Directors of nurse education to:

examine their curricula to ensure that the content is appropriate for nursing in a multi-racial, multi-cultural environment;

ensure that tutors are trained to enable them to provide training from an anti-racist standpoint and integrate racial equality and equal opportunities issues throughout the curricula.

Scotland and Wales

12.6 In Scotland and Wales the NBS and WNB carry the responsibilities for training curricula undertaken by the ENB in England. At the time of approval of institutions, the NBS seeks to ensure that there is teaching on racial issues within each course. The NBS also points out that within the approval function, the Board is in a position to require that proposed selection procedures are not discriminatory against any particular group. The WNB acknowledges that reference in its guidelines to such issues is implicit rather than explicit. The Task Force would wish to see the action points it has suggested in relation to training curricula implemented also by the National Boards and training institutions in Scotland and Wales.

13 THE ROLE OF PROFESSIONAL ORGANISATIONS AND TRADE UNIONS

13.1 The CRE Code of Practice includes recommendations for trade unions (which apply also to professional associations) pointing out that they have a dual role as employers and providers of services. The Code recommends that trade unions should press for effective equal opportunities policies and cooperate with management in their implementation, recognizing that this will involve training and information for union representatives. Other recommendations relate directly to the unions' role vis-a-vis their members, such as representation in grievances and ensuring that all racial groups are appropriately represented in union posts.

13.2 The TUC Charter for Equal Opportunities[18] provides a checklist to assist unions with their equal opportunities progress. This advocates the adoption of an equal opportunities policy; consideration of advisory committees and specialist officers to assist equal opportunities initiatives; efforts to attract black members and ensure that they are adequately represented in union positions; the provision of education and training about equal opportunities issues; the effective handling of grievances involving racial discrimination; and collective bargaining objectives – including ethnic monitoring, positive action and equality targets.

13.3 The development of equal opportunities policies in the health service has resulted mainly, although not exclusively, from management

initiatives. There are examples of staff-side taking the lead in joint working groups set up to develop equal opportunities policies. Some staff representatives also play an active role on their health authority's equal opportunities committee. However, pressure has too rarely come from staff-side and often their attitude has been described as apathetic. The Task Force has heard of some instances where staff representatives have opposed equal opportunities measures. Complaints have been heard too from black and ethnic minority nurses who have not found their trade union or professional association supportive of their concerns or prepared to help them with complaints of racial discrimination.

13.4 The following paragraphs indicate some of the equal opportunities measures which have been adopted by professional associations and trade unions representing nurses, midwives and health visitors.

13.5 The Royal College of Nursing (RCN) has 280,000 members and 450 employees. In September 1988, its Council approved a position statement which stressed the unacceptability of discrimination on grounds of race, nationality, beliefs, culture, gender or sexuality in nursing practice, between patient and nurse, and between colleagues. The statement recognized the vital importance of the RCN addressing the serious issues involved. Nevertheless, the RCN accept that nationally they have not so far adequately addressed equal opportunities issues and that black and ethnic minority nurses are under-represented amongst their officials. A draft equal opportunities policy is being considered and a publication about nursing in a multi-racial society is in preparation. An adviser to the General Secretary has recently been appointed to devise an equal opportunities strategy and action plan. Some branches of the RCN have taken their own initiatives, including the Wessex region whose equal opportunities sub-group in 1989 surveyed progress made on implementing equal opportunities policies by all health authorities in their region.

13.6 The Royal College of Midwives (RCM) has 35,000 members and 70 employees. Its Council agreed a brief statement relating to racial equality objectives in 1988. A working group which was proposed to formulate a programme of action was not however set up due to pressure of other work. The College has accepted that priority must be given in 1990 to equal opportunities issues. They recognize that black and ethnic minority members are under-represented in College positions, and that if they are to persuade health authorities to take action to ensure racial equality they must put their own house in order. Measures

have been proposed in relation to the College's role as a professional organisation and as employer. A comprehensive equal opportunities policy statement has been agreed in principle committing the College to adopt the recommendations of the CRE and EOC Codes of Practice and to pursue an effective programme for promoting equal opportunities. An equal opportunities sub-committee will be set up whose brief will include disseminating the policy, training initially for RCM staff and later for Council members and stewards, developing monitoring procedures both as employer and professional association, and reviewing the College's recruitment and selection procedures.

13.7 The Health Visitors' Association (HVA) has about 17,000 members and 30 employees. It set up a racial issues working party in 1986 with broad terms of reference, commissioned to put forward detailed recommendations for change in the Association. Members of the working party undertook race awareness training. In October 1989 the HVA published *Entitled to be healthy* which aims to increase awareness of racism amongst members and contains practical guidance for health visiting and school nursing in a multi-racial, multi-cultural society. The publication includes recommendations to central government, health authorities, national boards and training institutions and will be used for educational purposes in local HVA centres. The HVA is now giving further attention to developing its equal opportunities employment work. It adopts positive action to ensure that where possible black and ethnic minority members are represented on its committees.

13.8 The Confederation of Health Service Employees (COHSE) has 135,000 nurse members. It adopted an equal opportunities policy in 1978 and published a guide to branches about negotiating for equal opportunities in the NHS.[19] This includes a checklist of the content of an effective equal opportunities policy. The union has a national equal opportunities committee which is a sub-committee of the National Executive Committee. There is also a black and ethnic minorities working party reporting to the equal opportunities committee. The working party has recently recommended ethnic monitoring of the union's membership, which has been agreed by the National Executive Committee. Monitoring of full time officials and elected officers has already begun. The union has developed education courses for full time and lay officers about tackling racism in nursing and providing representation in race discrimination cases. It also seeks to ensure that the equal opportunities implications of all policy statements are taken into account.

13.9 NUPE has about 100,000 nurse members. It has an equal opportunities policy, a national race equality advisory group and an equal rights officer. In 1986, a race equality working party report was published, which includes a programme to combat racism and discrimination.[20] Anti-racism training is provided for officials, which is compulsory for full-time officers and is targeted also at key opinion makers in the union. The equal opportunities implications of all policy papers are considered through prior consideration by the race advisory committee before submission to the National Executive Committee. The union has agreed to ethnic monitoring of its membership and a pilot exercise is being undertaken in the London region. Training is provided to assist officials to represent members in industrial tribunals in race discrimination cases, and guidance in dealing with cases of racial harassment will be issued shortly.

Action points

Professional associations and trade unions to:

adopt equal opportunities policies with programmes for implementation encompassing employment and all their activities;

work towards ensuring that black and ethnic minority members are appropriately represented on decision making and consultative committees and amongst employees;

encourage officers to negotiate equal opportunities policies in health authorities and their membership to support implementation programmes;

provide anti-racist education and training for full-time and lay officers, including guidance to enable them effectively to support members with complaints of racial discrimination and harassment;

ensure that all education and training provision for nurse members adopts an anti-racist perspective and reflects good practice for nursing in a multi-racial, multi-cultural society;

keep records of grievances raised by members which involve racial discrimination, abuse or harassment; monitor their incidence, the type of complaint and outcome, and the degree of support provided; use monitoring analyses to identify where remedial action is required, and to make recommendations as appropriate to other bodies;

ensure that all national policies take account of equal opportunities considerations;

encourage other professional bodies, such as the National Boards and the UKCC, to implement effective equal opportunities programmes.

14 PLANNING FOR EQUAL OPPORTUNITIES

14.1 Tackling racial inequality and promoting equal opportunities does not come about through good intentions, half-hearted or piecemeal measures. There must be a specific policy with an individual or group responsible for achieving results. An effective policy requires strategic planning, defined objectives, a timetabled programme of action, systematic implementation, evaluation of progress and regular review. This section comments on the development of equal opportunities policies in the profession and describes some structures and mechanisms which have been used in other sectors to ensure progress.

Equal opportunities policies and action programmes

14.2 Most health authorities now have equal opportunities employment policies and some have parallel policies covering their service provision. These are however too rarely translated into effective programmes of action. Overall responsibility for employment policies normally rests with the director of personnel and for service provision with district or unit general managers. In the nursing field, responsibility for ensuring equal opportunities within their area of responsibility and for developing appropriate action programmes should be allocated to chief nursing officers and directors of nurse education. Many of the issues raised in this paper come within their area of control.

14.3 Statutory bodies, professional associations and trade unions should also adopt equal opportunites policies and programmes of action to tackle the issues raised in this paper. The steps already taken by trade unions and professional associations are described in paragraph 13. The ENB adopted an equal opportunities policy in 1989 and has a draft code of practice for employment. It is now considering equal opportunities in relation to their other activities and responsibilities. The WNB is currently formulating an equal opportunities policy, and the NBS is taking similar steps. The UKCC has no formal equal opportunities policy.

Equal opportunities committees and specialist officers

14.4 A number of health authorities and some trade unions and professional associations have appointed specialist advisers and set up equal opportunities committees to assist with the development of their policies. The Task Force has published guidance about both equal opportunities advisers and committees in the NHS. They can bring expertise and momentum to the development and implementation of equal opportunities programmes. The Task Force has taken the view that advisers and committees, while helpful, are not essential – but that those organisations which decide not to use them must devise alternative means of developing their equal opportunities initiatives and ensure that adequate time and resources are allocated to do so effectively.

Equal opportunities 'proofing'

14.5 Achieving equal opportunities depends not only on the development of a policy and associated initiatives. It must become a thread running through all policy development, planning and activities. This demands the review of existing policies and procedures and the consideration of equal opportunities effects when new policies or practices are introduced. In the Civil Service and some other organisations, including health service unions, this is achieved through equal opportunities 'proofing' – the routine and formal consideration of equal opportunities implications in all policy and planning documents and reports. This ensures that equal opportunities aspects are not overlooked and that new policies and procedures are not introduced which are detrimental to or undermine equal opportunities activities.

Equal opportunities progress: annual reports

14.6 Many health authorities prepare regular reports for authority members about their progress in implementing their equal opportunities policy. An annual report provides the opportunity both to review progress and to set objectives for the coming year. Health authority reports should include a review by chief nursing officers and directors of nurse education about progress achieved and future plans for working towards equal opportunities.

14.7 Other nursing bodies could usefully follow this example. A regular formal equal opportunities report not only helps to ensure progress but

underlines the importance which the organisation attaches to the subject and to achieving change. Annual conferences of trade unions and professional organisations provide the opportunity to report to members and for them to express their views.

Action points

Health authorities, trade unions, professional associations and other nursing bodies to:

adopt an equal opportunities policy encompassing employment and their other activities with an associated action programme;

allocate appropriate responsibilities for implementing and developing the policy to chief nursing officers, directors of nurse education and senior officials in other organisations;

consider employing a specialist adviser, setting up an equal opportunities committee, or ensure that alternative methods are devised for obtaining expertise and ensuring progress;

review the effect on equal opportunities of existing policies and procedures and ensure that the equal opportunities effect of all new policies and procedures is assessed and taken into account;

make an annual report on progress in implementing and developing their equal opportunities policy.

15 CONCLUSIONS

15.1 Racial inequality in the nursing profession is wide ranging and deep seated. It has been entrenched for a long time and will be difficult to remedy. There are no easy answers.

15.2 However, failure to recruit and retain black and ethnic minority nurses will severely limit the ability of the profession to deliver adequate and appropriate health care to Britain's multi-racial, multicultural population. The perspective, skills and knowledge which black and ethnic minority nurses bring to the profession must be seen to be recognized and positively valued. The nurse staffing crisis approaching in the 1990s means that, for self-interest if no other reason, equal opportunities issues can no longer be ignored.

15.3 Although this paper refers predominantly to nurses, the Task Force believes that similar issues arise in relation to midwives and health visitors. It therefore hopes that both individuals and organisations concerned will look carefully for evidence of racial discrimination, and identify and implement remedial action in the way this paper has proposed.

15.4 This paper includes some instances of good practice. The Task Force knows that there are many more and would like to acknowledge the example of individual nurse managers, educators and other professionals who, sometimes without support or encouragement, are seeking to introduce anti-racist practice into their work. What is evident, however, is that there has been no concerted effort by the profession as a whole to identify and tackle race equality issues. This has to change.

APPENDIX

Consultation

The Task Force would like to thank all those named below and many others, for either meeting with them, providing information, commenting on or contributing to this paper in other ways. However, it wishes to emphasize that the views expressed in the paper are those of the Task Force.

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