Race & Employment in the NHS

KING EDWARD'S HOSPITAL FUND FOR LONDON

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Race and employment in the NHS

edited by
Jane Hughes, Allan McNaught
and Imogen Pennell

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Foreword

This booklet deserves a much wider circulation than simply among those who attended the meeting from which it stemmed. Very little has yet been written about race and employment in the NHS, so it is timely. More important, little has yet been done about this crucial matter by health authorities – far less than by local authorities. Indeed, my impression is that few members, senior officers and managers in the NHS have yet recognised the nature, scale and urgency of the problem.

Of course there are large tracts of the United Kingdom where black faces are few and where NHS managers can reasonably claim that race and employment is not a local issue. But in areas where there are large ethnic minorities, such as many of the London Boroughs that form the heartland of the Fund's territory, nobody can properly make any such assertions.

Many people state – at least initially – that there is no discrimination in the NHS on the basis of race. They are wrong. One would certainly hope that discrimination is never legitimised, which means (among other things) that proof will always be difficult to obtain. But before saying anything at all on this topic, whites should ask blacks about their experience and impressions. Cherrill Hicks gives some illustrations in her section of this booklet. It is not only that as individuals we demonstrate racial prejudice, although this, to our shame, is often true. It is also that, in many insidious and unrecognised ways, the employment pack is stacked against blacks, so that they finish up with the worst jobs, or without jobs of any kind.

Consciously and unconsciously, white supremacy in the more desirable jobs perpetuates itself. Blacks are apparently all very well as kitchen staff and SENs, but not (by and large) as managers, secretaries, ambulance drivers and SRNs. Blacks are subjected to recruitment and selection procedures which they suspect to be unfair: weight is given to 'fitting in'

with the existing workforce and with (predominantly white) public expectations; weight is attached to paper qualifications, even when these are not strictly necessary for the job.

What, in any case, *is* fair? Should we accept that because blacks often have relatively low educational qualifications they therefore belong in SEN rather than SRN courses, or should we try to help them overcome educational handicaps, for which they are scarcely responsible? Is it fair that ethnic minorities, even where they form a large element in any local community, should be dependent on health and social services that are dominated by whites? Should large public sector employers, particularly in areas where there is high unemployment, be using positive discrimination to recruit more members of ethnic minorities?

Perhaps because local councillors have to be sensitive to local opinion or perish, local authorities have done far more than health authorities about this dilemma. Examples from Brent and Waltham Forest are included in this booklet. John Whitfield's analysis, based on experience at Waltham Forest, suggests that a cautious approach may be less effective than boldness. Michael Bichard, Chief Executive of the London Borough of Brent, describes a concerted, persistent attempt to carry an equal opportunities employment policy through to action. Despite his disclaimers, it is an impressive story, and his list of six prerequisites for progress makes a great deal of sense.

Among other things, he emphasises that little is likely to be achieved unless people are prepared to commit money, imagination and effort to the venture. He also points out that at some stage controversy and conflict are inevitable. Managers who want a quiet life will prefer to do nothing about race and employment, for fear of stirring up trouble. But there is in fact no excuse for procrastination. Discrimination exists in the NHS and we have to do something about it.

Robert Maxwell
Secretary
King Edward's Hospital Fund for London
1984

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Introduction

This booklet is based on a conference held at the King's Fund Centre on 27 April 1983. We hope it will make a useful contribution towards thought and discussion in health authorities about the issues of race and employment in the NHS.

The NHS, particularly in Britain's cities, is a major employer of people from ethnic minority groups. However, race relations legislation seems to have made little impact on the NHS, although in 1978 the DHSS urged health authorities to

> '. . . do more than seek to secure bare compliance with the provision of race relations legislation; and employment policies and practices should therefore include effective positive procedures to ensure equality of opportunity for members of minority groups. This can best be achieved by developing a policy which is clearly stated, known to all employees, has and is seen to have the backing of senior management, is effectively supervised, provides periodic feedback of information to senior management and is seen to work in practice.' HC(78)36

Fair employment practices are morally and legally important for the NHS. They are also vital if the NHS is to provide effective services in multi-racial and multi-cultural Britain. However, it appears that many health authorities have not yet looked carefully at the implications and responsibilities of employing a multi-racial workforce. Few authorities have developed policies or strategies to cope with race relations issues, despite widespread concern about employment practices and responses to the health needs of ethnic minority groups.

The purpose of the conference was to examine race and employment in the NHS and to consider the practical steps that should be taken by health authorities and individual

managers to ensure equality of opportunity for ethnic minority group employees. This report is divided into three sections. The first gives a variety of perspectives on equal opportunities in the NHS. The second section describes three case studies: one of a health authority and, by way of contrast, two of local authorities where some progress has been made towards implementing equal opportunities policies. The third section outlines some of the main issues discussed at the conference.

Jane Hughes and
Imogen Pennell
King's Fund Centre

Allan McNaught
Polytechnic of the
South Bank

I

Perspectives on equal opportunities in the NHS

Equality in employment: an NHS perspective

AARON HAYNES

The condition of race relations in the NHS is so critical that if diagnosed by anyone in the medical profession, it would result in the patient being despatched immediately to intensive care. Until 1977 the NHS – like local authorities – was outside the ambit of race relations legislation. It was assumed to be a caring service, though the evidence shows that those we entrust with the care of our sick often lack care themselves. The number of black faces in hospital wards and corridors appears to argue against discrimination. Yet whether they are employed as doctors, nurses or ancillary staff, why are so many blacks concentrated in the most unpopular jobs and working in the least favourable conditions? There are certainly areas of health service employment – such as ambulance driving – from which blacks are virtually excluded.

The Commission for Racial Equality's experience of formal investigations into the NHS has revealed that lawyers dealing with racial equality issues are more obstructive than many representing commercial interests. Despite its inclusion in race relations legislation, the health service is not yet committed to racial equality. This may account for some of the established practices that lead to discrimination in the NHS, such as nursing schools which ask prospective nurses for photographs or for information about parental background. Under the Race Relations Act, the introduction of such criteria needs to be justifiable. If they are not justifiable, the schools concerned may be guilty of indirect discrimination. Similarly it is necessary to question the criteria adopted and the procedures followed in the allocation of trainees to SRN or SEN courses. Why is the differentiation so often along racial lines, with blacks relegated to SEN courses?

A common practice among NHS ancillary grades is 'word-

of-mouth' recruitment and this can become discriminatory. Promotion procedures and informal methods of testing also need re-examining. The message from these examples is clear: to overcome discrimination in employment in the NHS it is necessary to tackle *systems*, not just individual decisions.

The CRE will be better able to offer assistance to organisations such as the NHS once Parliament approves the CRE's draft Code of Practice.* The Commission was asked to formulate a Code of Practice as part of its function of administering the 1976 Race Relations Act. A draft was soon produced, but tortuous consultations and ministerial inaction have prevented its appearance. If it is finally approved, it should encapsulate all the guidelines that good employers would try to implement in their organisations. It will cover recruitment, training, promotion and the whole spectrum of employment. It will require employers to examine their procedures to ensure that they are neither directly nor indirectly discriminatory. A number of local authorities have started to do this and it is a challenge which the NHS must also meet.

* The CRE's Code of Practice came into effect on 1 April 1984. Copies can be obtained from CRE, Elliot House, 10–12 Allington Street, London SW1E 5EH, price £1.

The experience of black nurses in the UK

CHERRILL HICKS

In 1982 I conducted some interviews with a group of black nurses in the West Midlands. The following quotes are taken from these interviews.

From a midwifery sister: 'When I was on the ward, doctors and visitors would walk past me looking for a white face. They'd approach a porter, an ancillary, even a patient. "Who's in charge?" they'd ask. "Where's sister?".'

From a tutor: 'I've heard the director of nursing education say, "these people are best fitted to do practical nursing", or "when these people are given a chance they do work hard". She doesn't even remember I am one of them.'

From a health visitor: 'If we get one or two of us at sister level we're meant to be grateful. I personally think they have a quota on how many blacks they employ in particular posts.'

These nurses were insistent that neither their names, nor hospitals, nor schools be revealed. They feared that any publicity would only make matters worse. Most of them had been recruited, as thousands of others had, from the West Indies to train in Britain in the 1950s and 60s. They were mostly approaching middle age, very experienced, well-qualified and intensely frustrated by what they felt were barriers which had been put in the way of their careers.

All told the same story of continual job rejections, difficulties getting accepted for post-basic training, and poor promotion prospects. If a black nurse wants promotion it seems she must go into certain fields – the 'Cinderella services'. Yet discrimination by managers is really only the thin edge of the wedge. What these nurses also described was that the attitudes of their white colleagues – often people they had worked with for years – revealed an insidious prejudice which affected relationships in their everyday lives. Most striking was the feeling of isolation and lack of support they

experienced from their white colleagues, particularly when dealing, for instance, with racism from patients. Not surprisingly, none of the nurses considered England as home even though they had been here for twenty years or more.

Many might argue that there are plenty of reasons for failure that have nothing to do with colour. There is little national data which can either confirm or contradict these claims. But consider when you last saw a black face where it really counts in nursing – on the new statutory bodies, for example, or on a union executive, or at an annual conference of senior nursing managers. All the evidence I have come across carried the same message: that the experience of these nurses was the rule rather than the exception.

I also talked to a number of nurse managers about racism. They tended to be very edgy and defensive about their own patches, and there was a yawning gap between their perception of race relations in the NHS and the experience of black nurses themselves. They seemed to be living in two different worlds. Many managers used official sounding phrases, such as 'the NHS reflects our multi-racial society', or claimed never to judge anyone by the colour of their skin, or said that they were totally indifferent to people's colour. They would cite individual examples of promotion – an Indian midwifery sister, an acting SNO who was West African – and always maintained that appointments were made on the basis of individual merit.

The NHS can only really reflect the racial attitudes of the rest of society. But I suggest there might be something in the 'collective nursing psyche' which makes it especially vulnerable to prejudice. This includes qualities which are often criticised by nurses themselves – the rigid pecking order, a non-questioning hierarchical tradition, and a refusal to get involved in anything which might be vaguely political.

The nursing profession has one of the largest proportions of black people to be found in any workforce in this country and should be taking the lead in urging health authorities to set up and monitor policies to promote racial justice. How-

ever, equal opportunity policies in themselves will make no difference unless nurses – and indeed all of us – are prepared to look, painfully perhaps, at our own racial attitudes.

The experience of black nurses in the UK

GEORGE AGBOLEGBE

Regional health authorities say that they do not know the number of black people they have in their employment. Indeed, most authorities argue that they never look at the colour of the people they employ. While this may be true, it does not make for good management. On the face of it, 'colour-blindness' by itself does no harm. However, the underlying assumption that 'colour-blindness' equals non-racism is spurious and dangerous.

There is a disproportionately large number of black employees in the ancillary and nursing auxiliary grades, compared with the minute numbers and, in some cases, total absence of black employees at middle or top management levels within the NHS. It is no accident that most black doctors and nurses are found working in the less attractive departments like geriatrics, psychiatry, and in hospitals for the mentally handicapped and on night duty. There are also more black than white nurses working through private agencies where no sick pay, paid holidays or uniform allowances can be claimed.

The economic recession and the imposed cash and manpower restrictions are giving racism respectability. In an economic climate where all newly-qualified nurses have difficulty obtaining employment the system creates even greater difficulties for the black nurse. Prior to the financial restrictions, some schools of nursing had difficulty filling places on courses and recruited students from Malaysia, the Philippines and the West Indies. The carrot offered to recruits was not only training but also the opportunity of work on successful completion of the course. The Department of Employment (DoE) and the Home Office (HO) regulations concerning employment and immigration rates have now effectively pushed this carrot out of reach. The

DoE decrees that any vacant post must be advertised and attempts must me made to fill the post from indigenous applicants, overseas applicants to be considered only when there is no suitable British applicant available. This rule is linked to the issue of work permits from the DoE. Prior to qualification, the overseas student nurse is classified by the HO as a student whose right to stay in the country is subject to continuation of the course for which a visa has been granted. Without a work permit, termination of employment for the newly qualified overseas nurse is governed by the terms of the training contract. Furthermore, most advertisements for trained nurses tend to stipulate a period of six months' post-registration or enrolment experience as a pre-requisite for the post. Employers seeking to recruit someone requiring a work permit must surmount indescribably tedious and expensive bureaucratic hurdles.

For the black employee the work place is like a mine-field. Individual racism is rife. It is not uncommon for a white doctor to walk past a black ward sister to give instructions to a white nursing auxiliary. Racist jokes in staff common rooms are supposed to indicate friendliness and black people are expected to laugh at these dehumanising jokes, to not take offence or react angrily. White staff may deliberately and consistently exclude black people from day-to-day social intercourse which takes place at work. In addition to all this is the white patient who, when approached by a black nurse, says: 'Get your black hands off me, why don't you go back to the jungle and look after the monkeys?'

An added twist to discrimination at work is the colour-blindness adopted by trade unions and professional organisations. The irony of colour-blindness in these organisations is that paid-up members too readily accept that these organisations offer them no service. Unions have not sought to identify the needs of their black members nor have they defined any clear policies for them.

This picture is but the tip of the iceberg. What is not in doubt is the effect of racism on those who suffer racial

discrimination. Evidence suggests that racism not only demoralises, it also dehumanises the black labour force. Black people become so scared that they lose the ability to even make public the indignities they suffer. Feelings of inadequacy, powerlessness and hopelessness culminate in the alienation of the black labour force. This alienation manifests itself in increased sickness and absence, apathy, anger, indifference and diminished output. These symptoms are often cited as the cause rather than the effect of racist employment practices. Every employer, including the NHS, seeking to maximise the performance of its labour force should adopt fair and equitable employment practices. If nothing else, it makes good economic sense to ensure that the labour force feels, and is seen to be, fairly treated.

Black people employed in the NHS will also have to reappraise their roles within the organisation. The few black employees who are in first-line and middle management will have to examine their own racist attitudes.

There is already a Black Doctors' Association which helps and supports black doctors. There is now, more than ever before, a need for a national association for the advancement of black nurses, charged with the responsibility of articulating the needs of black nurses. This organisation could begin a dialogue with trade unions and professional organisations. The structure of the association should enable nurses of all shades of colour who feel strongly about racism to participate in its activities. Black nurses should, as a matter of urgency, also join trade unions and professional organisations, participate actively in their deliberations and seek nomination and election onto the policy-forming bodies.

The belief that if racism is left alone it may go away is a dangerously naive and fatalistic attitude. It is no longer enough to say that 'if God is with us who can be against us?'

A trade union perspective on implementing equal opportunities policies

GODFRY EASTWOOD

There are a variety of conditions of employment in the NHS which give rise to institutional racism. Most pernicious is the ghetto-style employment pattern which was encouraged by management in the 1950s and 60s. In many hospitals the porters might be British-born whites, the cooks Spanish, other catering staff Portuguese, domestics largely West Indian, and so on. The worst jobs of all are often relegated to the Filipinos who tend to be the common scapegoat for all the other groups. Hence, racism within the NHS is a far more complex issue than it appears. Moreover, weak management over the last 20 years has allowed entry into these sections to be 'controlled' by the workforce in many ancillary departments. Typically, word-of-mouth recruitment restricts entry to a certain group and prevents movement between jobs. This situation presents many problems for a trade union. In NUPE, 60 per cent of NHS shop stewards and branch lay officials in London are black. But unfortunately many of them, having come to terms with a pre-existing white trade union, tend to operate as a traditional white branch secretary might. A younger generation of black activists are now beginning to change this, but in general NUPE is a mirror of society, and at present it has no black full-time officer.

Dealing with the racism of white union members is another problem. In the mid-1970s a NUPE branch was formed at two psychiatric hospitals where there had been a COHSE branch in which the blacks had democratically taken over all the elected officer posts and the whites objected. NUPE condoned this by accepting the disgruntled whites into the union. This is an example of the worst features of inter-trade union rivalry in the NHS. While this goes on locally alongside earnest policy statements made by

trade unions at national level, it is hardly surprising that people are cynical about the way unions work. NUPE's resolve to tackle racism in employment began with the invitation to various black groups and people involved with the CRE to produce an education and information pack on equal opportunities. The result was a unique and highly successful publication designed for use at union shop floor level. It included an important section on how to set up positive action programmes in employment.

It was then necessary to devise a strategy for using the information pack. The normal practice of mailing everything out to shop stewards seemed inappropriate when the major difficulty was to win over some of the old-style activists who (like white racists in local authorities) argued at conference after conference that 'we're all right – leave it to us'. It was therefore decided to target certain areas. At the same time, a code of practice was being introduced by the CRE to stop some of the racist recruitment practices that some union members are party to, as well as health authorities. This should ultimately help to change attitudes too.

For the same reason, NUPE has since 1980 placed a lot of emphasis on organising basic skills courses. So far these have involved local authorities and the University of London, rather than health service staff, but the experiment is shortly to be used in the NHS, involving managers and shop stewards from the start. The courses will be open to all members of a particular work group and not just NUPE members. The rationale for these courses lies in the limited value of an equal opportunities policy to some members of the workforce – those who have been unable to develop basic skills inside or outside the working environment; in the NHS, this is at least one-third of the workforce – mostly ancillary staff. A natural development of introducing basic skills courses will be the workforce's ability to argue about opportunities at work and the fact that management has never explored the talents of its existing employees.

For workers with greater skills and qualifications – such as

certain nursing groups and professional and technical staffs – the major problem is the institutional racism of the career structure. For all groups of workers the trade unions must be positive, consistent and persistent in developing equal opportunities policies.

It is totally inadequate to send national policy statements out to shop stewards urging them to start negotiating with local management as if for a bonus scheme. This traditional 'broad brush' approach encourages unions to believe that they have tackled the problem when in reality it is bound to fail. It certainly does not change attitudes. The most it can achieve is to end some racist employment practices through a code of practice and to fight individual acts of racism. Trade unions have a bad record on this and as a direct result there are now some black groups scrutinising the handling of individual cases, and they are doing a commendable job.

A strategy at district level using the code of practice could be to insist collectively that a named member of the DMT (why not the district administrator?) and perhaps a named member of the DHA should put a policy into action, arguing for this inside and outside the authority. They would also have the responsibility for monitoring what is happening in management, but must involve the trade unions too. This may be a bureaucratic approach, but it will at least give the issue the priority it needs.

Trade unions must make it clear to their own members, as well as to management, that they have a will to participate in changing some of the practices that their members have 'thrived on' for years. NHS unions must be unequivocal in demanding that restrictive practices that are, in effect, racist must be changed by negotiation. A constant process of education is necessary to win trade unionists over. A membership strengthened by a basic skills programme will be better able to participate democratically and so undermine racist lay officials.

Health authorities have failed abysmally to develop and follow through a strategy of equal opportunities. To over-

come this, trade unions must, through education, develop members' awareness of their own racism and prejudice. Race awareness courses are particularly valuable, especially for senior managers and lay activists.

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Implementing equal opportunities policies: three case studies

Racial discrimination and management: death by a thousand buts

NIGEL WEBB

The riots of 1981 undermined the assumption that racism was a simple issue and that attitudes were improving inexorably. They shattered illusions about progress taking its natural course through the Race Relations Acts, public proclamations of good intent and the trade unions.

Liverpool Health Authority began to take a token interest in race relations prior to 1981 – issuing the usual policy statements, ensuring that the authority would not be liable for prosecution – but very little was achieved. At this time Merseyside County Council organised a conference on race and employment. As many blacks at the conference pointed out, there was no doubt that the interest it attracted was due largely to the recent riots in Toxteth. Nevertheless, it was a catalyst for a number of employers, including the health authority, to start taking practical action.

The first step towards combating racial discrimination in employment is to establish precisely how and where it manifests itself. Getting basic information is extremely difficult. A well thought-out survey has to be undertaken, using CRE assistance where possible. This is what was done in Liverpool Health Authority. First, managers were asked to conduct a subjective survey of the people they thought might be racially disadvantaged in employment in the various departments. When the results were set against data obtained about the indigenous population, it became clear that Liverpool Health Authority (which employs some 14000 people – 12000 whole-time equivalents) was employing significantly less than half the number of blacks that would have been expected. And that was a conservative estimate as all errors were on the side of caution.

There is no systematic monitoring of health service staff in

general, let alone of ethnic minorities. The NHS does not have the autonomy of the local authorities, nor is it an integrated part of the DHSS. The NHS really knows very little about the people it is responsible for. There are no up-to-date statistics on how many people the service employs and their social characteristics. The recent impetus given to manpower planning and information ought also to include ethnic monitoring. An effective mechanism for monitoring – acceptable to managers and trade unions alike – has to be established for staff in post and for job applications.

There remains the difficulty of recruiting and contacting more people from ethnic minorities, since they, with justification, still regard employers as racially discriminatory and are loathe to submit themselves continually to the humiliation of interviews only to be told that the position is filled or the post frozen. Liverpool Health Authority undertook a seven-month survey of job applicants, monitoring vacant posts, the way they were filled, where they were advertised, and so on.

The results were not very encouraging as it appears that black people in Liverpool still do not apply for health service posts in significant numbers. The reason for this is that they have experienced discrimination in insidious and subtle ways at school and in the past. They therefore assume that they won't get the job. When they do apply for a post, a further obstacle to employment is the poor performances of many black people in interviews. This is a problem which health authorities, as employers, must address in some way.

While recognising that discrimination had not yet been eliminated from the organisation, Liverpool Health Authority tried to increase the number of ethnic minority job applications. They started taking positive action, discovering what local journals, groups, community workers and employment agencies existed in the black community, and went out of their way to recruit blacks. One of the key organisations proved to be an employment agency run by blacks for blacks.

Practical issues which needed to be tackled in the health authority included traditional employment practices such as word-of-mouth recruitment, especially among ancillary workers. This is not usually a question of managers asking for names of friends and relatives, but the other way round, especially in areas of high unemployment. It is very convenient for managers because it avoids the cost, delay and inconvenience of advertising, and usually means that someone can start the next day. It also gains some popularity for the supervisor. The problem, of course, is that this system perpetuates a white workforce. In Liverpool the Personnel Department took early action on this by contacting managers and unit administrators – with the full approval of the DMT – to say that every post in the authority was to be advertised. This has probably been successful across 80–90 per cent of the authority but needs close monitoring to maintain. Unfortunately, such progressive moves tend to be vitiated by other problems in the NHS, such as constant reorganisation and economic cuts. For these reasons fewer jobs are now available.

Health authorities should take more positive action to encourage black people to apply for jobs. To achieve this, it is necessary to contact and win the confidence of community groups and agencies. But it is equally important for the health service (and other employers) to find ways of providing training in basic skills; for example, filling out application forms, handling interviews, and so on, and to participate in this type of training. Health authorities must get out into the community that they serve. 'If they won't come to us, we've got a responsibility to go out to them: all the "buts" are no reason for inaction.'

Brent Council's approach to race and employment

MICHAEL BICHARD

So far Brent Council has barely scratched the surface of the problem of race and employment, and it has made a number of mistakes. Brent should not be thought of as a shining example but as a learning model.

Why does Brent Council believe that race and employment is an important issue?

One-third of Brent's population live in households where the head of the household was born in the New Commonwealth or Pakistan – a higher proportion than in any other London borough. As the Council itself is the largest employer in the area, apart from the NHS, its policies have a considerable impact on the local labour force. It is hoped that it will also influence other large employers in the area.

The Council believes that the composition of the workforce has a profound effect on the way in which its services are provided. An all-white housing office, for example, will find it difficult to respond sensitively to the needs of a largely black estate. A racially balanced workforce will also change the way in which services are perceived by ethnic minority groups.

What did the Council do?

The first step was to draw up an equal opportunities employment policy and give it wide publicity. This is insufficient in itself because it needs supporting structures and procedures to give it practical effect. However, clearly setting out the commitment to action in this field encourages an openness which allows the policy to be challenged and avoids the

misunderstandings which are rife in British race relations. It also encourages some ethnic minority job applications.

Publicity and advertising

An equal opportunities employment policy needs widespread and imaginative publicity on public notice boards, in local personnel offices, articles in the local press, letters to existing staff and ethnic groups in the community. It needs to be advertised (for example, '. . . is an Equal Opportunities Employer') particularly in the ethnic minority press, though we must accept that it will take a long time to overcome the scepticism of blacks about our policies. For this reason it is also important to develop networks within the community and to take every opportunity of explaining our personnel policies and procedures.

Recruitment procedures

Brent Council was worried about two recruitment practices in particular. First, many posts were being filled by internal promotion, without advertisement. This is increasingly common in large organisations and is often legitimised as 'career development'. By restricting the range and quality of applicants, it also perpetuates the existing composition of the workforce, consolidating racial disadvantage. Brent now demands that all council posts are advertised externally.

The second worrying practice was word-of-mouth recruitment. Evidence shows that this leads to discrimination against ethnic minorities, as well as being extremely inefficient in securing the best candidates.

A third recruitment problem which is causing increasing concern is 'over-qualification'. This is a consequence of economic recession and means, for example, that large numbers of applicants with degrees are chasing basic administrative posts. Those responsible for recruiting who are not persuaded on grounds of racial discrimination that such applicants may be unsuitable, should recognise that there are

good arguments against it on personnel grounds. An over-qualified appointee soon becomes frustrated and often leaves at the earliest opportunity.

Selection procedures

Brent has been criticised for involving local elected members in shortlisting and interviewing procedures. This situation arose because elected members did not feel that the equal opportunity policy was being implemented within the departments.

More generally, good personnel practices can go a long way towards combating discrimination. For example, job specifications should be issued for all posts, describing precisely what the employer is looking for in the people being appointed. This should bring any discrimination clearly into the open. It is not difficult to find job descriptions that make it clear that the desired candidate is white, male and middle-class. It is helpful for senior officers to check shortlisting and interviewing procedures and to have a code for shortlisting (which could include strictures on over-qualification, for example) and interviewing.

A question which needs consideration is whether notes should be kept of all interviews. Some people believe that interview records reduce the likelihood of discrimination and assure applicants that they are being treated fairly. Others maintain that anyone motivated by racial prejudice could explain away an adverse decision on other grounds.

Finally, in reforming recruitment and selection procedures the whole issue of training is absolutely crucial. Brent introduced a staff training course this year which was unsuccessful because of a mistaken decision to involve outside consultants. Now the Council is working with the Local Government Training Board to develop a programme to be run internally with specially recruited staff. The aim is to put all the 700 Council staff who are responsible for recruitment and selection through the course, as well as all elected

members who are involved in interviewing and recruitment. After a specific period, it is hoped that only those members of staff and elected members who have undergone the training course will be allowed to participate in selection and recruitment. Without such a sanction, courses would only be attended by people the directors can release, rather than by those who need the training.

Ethnic monitoring and record keeping

All local authorities trying to take race relations initiatives have started by discussing whether or not to keep ethnic records. Some are still debating it. Because it is a subject that people get bogged down in, it tends to prevent other anti-discrimination measures from being introduced. Moreover, if you want to keep ethnic records you must persuade the community of the reasons for doing so, and of your genuine commitment to helping that community. Instead of being paralysed by a failure to resolve the monitoring issue, it is important to take other initiatives in employment and service delivery. It is then possible to go back to the community and say, 'Look, we've proved that we are serious but we can't do anything further unless we've got more information'.

While recognising the fears that exist within communities, without ethnic records we lack the factual information necessary to accept or refute allegations of racial discrimination. Such information provides a basis for formulating our policies, and it highlights patterns of discrimination which might have occurred totally unintentionally, but which lead to racial disadvantage. Moreover, it provides the only means of monitoring the impact of policies and ensuring that they have the desired effect. It is no good introducing reforms and just hoping that they hit their target.

Brent began by conducting pilot projects on existing staff in three departments on a voluntary and anonymous basis. The response rate ranged from 85 per cent in one work area to 15 per cent in another. Job application forms had a tear-off slip for the voluntary recording of ethnic background.

Eighty-five per cent of applicants responded. Brent will soon be keeping ethnic records on the delivery of all services and all staff. Although current policy backs voluntary and anonymous records, there is a debate within the Council as to whether monitoring should be compulsory in certain circumstances. Ideally, records should be kept of applications, of staff employed, of training and of promotion. But the data obtained are only as good as the use to which they are put. It is no good keeping ethnic records and just filing them away. They must be used to monitor policies and to change them.

Related issues which need to be considered

Brent has been revising its job application forms and these should be scrutinised to check that they do not, for example, place too much emphasis on paper qualifications. Brent is appointing a race adviser in the personnel division in the belief that effective changes in policies and procedures cannot be achieved without such a resource. The Council is also considering special arrangements for helping young local black people to gain access to the professions. This will probably involve introducing an 'access grade' to enable entry without the formal qualifications that are currently necessary to become, say, a librarian or a planner, and will entail people working their way through to a level where they can enter those professions. This demands liaison with polytechnics and technical colleges, making clear that they need to provide courses very different from existing ones. Brent Council is, in fact, discussing with one of the polytechnics the possibility of providing 'access' courses.

However, it is not only a question of bringing black people into the organisation and into the professions. It is equally important for local authorities and health authorities to start employing more local people rather than commuters. This would help to promote a rational employment policy for the area and make authorities more sensitive to local needs and feelings.

Other issues which need investigating include grievance and disciplinary procedures – which are often criticised as being discriminatory – and ways of increasing training opportunities for ethnic minorities.

Some prerequisites for progress on race and employment

Commitment, impetus and direction is needed from senior management and from leading authority members. In local authorities this means the chief executive. In the NHS it means not just the district administrator but the district management team. Race initiatives do not apply just to the periphery of the organisation, they go to its very roots. It is therefore vitally important that the DMT takes the lead. There also needs to be leadership from a very senior member of the health authority. Brent's experience has also shown that having black members on the authority gives great momentum to race issues.

An effective strategy on race and employment must involve the whole of the service, not just parts of it. There is a tendency to marginalise race relations by setting up a race relations subcommittee or appointing a race relations adviser, and then assuming that everything is all right. But you have to tackle the service comprehensively – which is why commitment and involvement from 'the top' is essential.

Policies in themselves are useless. It is nice to have them on show, but discrimination takes place in procedures not in policies. You have to start examining your procedures and changing them if you are going to tackle racial discrimination. You cannot change attitudes overnight, and if that is your main objective you will fail. But you *can* change procedures and you can actually change behaviour – that is where the emphasis should be.

Changing procedures and organisation needs a systematic,

analytical approach. It should be slow, methodical and pay attention to detail.

It is important to accept from the outset that at some stage conflict will arise – with staff, with authority members, and perhaps with the public. Unless you face up to this there is a danger that you will duck out of the whole issue. Try to reduce conflict through education, training and by consultation.

Finally, none of this can be done without resources (any more than other aspects of our work), and it is a sign of commitment to make resources available.

Waltham Forest: the benefits and disbenefits of caution

JOHN WHITFIELD

Waltham Forest is an outer London borough – with many of the characteristics of an inner borough – on the eastern bank of the River Lea, stretching from wealthy Essex to impoverished Leytonstone. After being a Labour authority from 1971 to 1982, there is now no overall political control but a minority Conservative administration with six Liberal councillors holding the balance.

According to the 1981 Census, 17.3 per cent of the population of Waltham Forest live in households where the head of the household was born in the New Commonwealth or Pakistan – the ninth highest in London. Among under-16s, 29 per cent live in such households, and 22 per cent of 16–24 year olds. In some wards only 2–3 per cent of the population are from ethnic minorities, while in the south of the borough it is 32 per cent. There is one ward where 48 per cent of the under-16s are black. These statistics show the growing importance of tackling racial discrimination. Moreover, as 41 per cent of the people living in New Commonwealth households in Waltham Forest were born in the United Kingdom, it is not a question of policies for immigrants, it is a question of how black British and white British people relate.

Employment in Waltham Forest

Of the 74000 jobs in Waltham Forest about 15 per cent are provided by the Borough Council itself (Table 1). The four largest public sector employers together offer about 25 per cent of the jobs in the borough. By contrast the largest private employer provides only 1.5 per cent of the jobs in the borough.

Table 1 The major employers in Waltham Forest

		%
Total jobs	74000	100
Borough Council	11000	15
Health Authority	4000	6
London Transport	1000	1.5
GPO/British Telecom	1000	1.4
	17000	23.9
Largest private employer	1100	1.5

How the public sector recruits for these jobs, therefore, has a major impact on the quality of life in the borough. Racial discrimination in recruitment is likely to have a profound and increasingly damaging effect as young British blacks grow up. The impact on services is equally great, as most of the public sector jobs in the borough are services to people who live there. The local health authority is the second largest employer in the borough, and anyone who has an influence over the disposal of employment on that scale needs to be very clear about the impact of their decisions.

A brief chronology of Waltham Forest's equal opportunities policy

In March 1977, the Council's Policy Coordinating Committee received a report on the 1976 Race Relations Act and noted its provisions, particularly the obligation on local authorities 'to eliminate unlawful discrimination and to promote equality of opportunity and good relations between persons of different racial groups'.

Three years later, in June 1980, the Staffing Committee considered the question of an equal opportunities policy:

they drafted the Statement;

they called for future reports on the training needed by officers to fulfil the aims of the policy, the development of positive discrimination to recruit suitable young people from ethnic minorities and to ensure equal opportunities for members of ethnic minorities already in council employment;

an equal opportunities slogan was to appear in all advertisements;

they would consult with trade unions and the Community Relations Council;

no records of ethnic minorities were to be kept.

Just three weeks later the committee decided that they *would* keep ethnic employment records after all. Five months later, in November 1980, the Staffing Committee recorded that:

there should be further trade union talks;

personnel was assessing procedures for monitoring the ethnic composition and training of the council workforce;

the equal opportunities policy advertising slogan was to be changed.

Two months later, in January 1981, the slogan was amended again.

The history of Waltham Forest's equal opportunities policy shows that there is still a struggle to be won in the detail of implementation. Leadership from chief executives, senior officers and members is vital. Their backing makes it easier to take on colleagues and superiors, and change people's behaviour.

Waltham Forest Council has agreed to keep ethnic housing records. In education and social services policy changes are being made but implementation is yet to come. There is

still a long way to go. The borough has now completed the first year's ethnic monitoring of new council recruits (November 1981–October 1982). About 4000 applications were made for just under 200 APT and C (white collar, non-teaching, non-manual grade) jobs. Table 2 shows the percentage of those from ethnic minorities at each stage of the recruitment process.

Table 2 Recruitment to APT & C posts (1981–82)

	% from ethnic minorities
job applications	11
people interviewed	10
appointees	4

In response to this data, the Staffing Committee minute reads, 'We consider that the Equal Opportunities Policy should be developed further. As a first step we ask the officers to consult the unions about extending the monitoring of recruitment to cover manual workers, craftsmen, teaching and lecturing staff and the carrying out of a census of existing employees. We noted that a development of the implementation of the policy could not be undertaken within the existing resources of the Personnel Department except at the cost of other essential work'.

This seems to be a recipe for not doing very much rather slowly. Despite real financial stringency, there is a question of priorities. There is also a need to take account of the economic impact of the local authority's (or health authority's) employing power. What will be the ethnic composition of the borough in 10–15 years time? This must be almost the last chance to develop a serious policy. It is necessary to start planning now to avoid creating difficult social problems for the future.

The council has now decided to appoint a race relations adviser. Whoever is appointed is likely to have a difficult job because of a bitter subdued row over the job description,

Table 3 A schematic outline of the benefits and disbenefits of a cautious approach to equal opportunities

BENEFITS	DISBENEFITS
INTERNAL TO THE EMPLOYER	
* Avoidance of open acrimony; savings on training and monitoring (expensive in human and financial resources). * Fewer organisational stresses (structural interference with other departments very threatening).	* Loss of best recruits/ promotees (very inefficient not to recruit from widest pool of ability and therefore a crude management principle as well as a moral/political argument). * Continued discrimination increases risk of action at industrial tribunals. * Difficulties for certain staff (unrepresentative staff unable to respond to the population's needs in delivery of services, causes problems for staff themselves). * Loss of experience for future (generational impact – won't be able to respond to increasing demands).
EXTERNAL TO THE EMPLOYER	
* Public proclamation and a muted political impact (does not put political issue on the boil).	* Sheer disbelief in public proclamation. * Alienation of ethnic minorities – price too high for white society. * Protest outside established democratic channels (riots of 1981). * Additional pressure on services by abusing economic and recruitment power and impact of local authority, ie, making worse the social problems that local authority services are intended to meet.

about the adviser's powers and authority, and so on. It is creating entirely proper procedural difficulties.

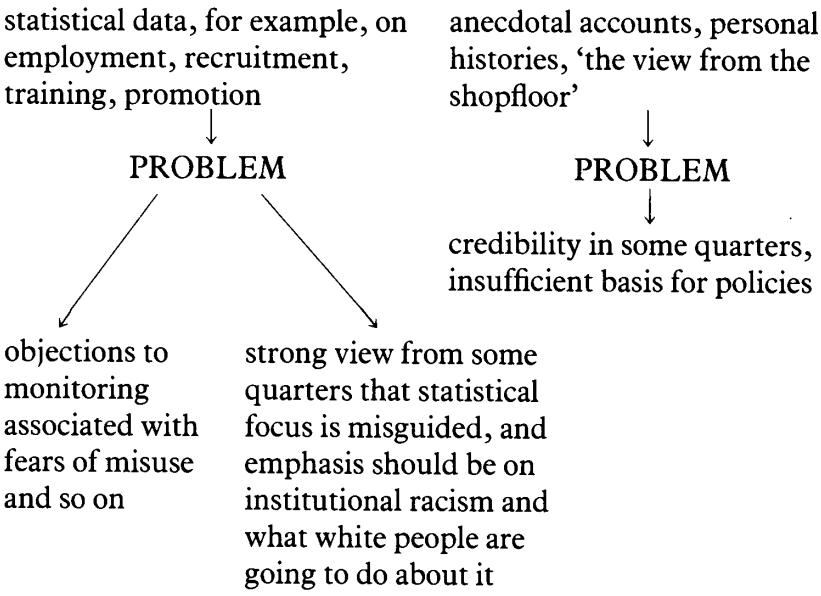
It is worth examining and thinking about some of the benefits and disbenefits of a cautious approach to race and employment. These are summarised in Table 3 and probably apply equally to the NHS.

3
Issues debated at the conference

Monitoring and the collection of statistical information

This was a thread that ran through the conference and the subject of much strong feeling. The polarities that emerged can be summarised schematically as follows.

Sources of information about racism



This debate was started by Eric Moonman who argued that so much of the existing evidence about racism was anecdotal and 'that doesn't wash with people who are likely to take decisions'. He believed that it was vital to obtain detailed and sophisticated statistical information in order to gain credibility and create a solid base for implementing and monitoring anti-racist policies. In the USA such information was readily available, but in Britain the issue continues to be highly sensitive and there is great resistance to giving information.

Aaron Haynes said that the problem was not the unwillingness of people to give information; it was the fact that people were not convinced that the information would be used in *their* interests. Even the USA has the Fifth Amendment to protect people from giving self-incriminating evidence. He pointed out that it was necessary to take account of the environment in which we live – the whole debate about record-keeping is coloured by the general political climate and how likely the government is to use such records.

While Dr Haynes agreed on the need to obtain a reliable data base, he thought it would only be possible if those wanting the information could overcome this crisis of confidence by convincing the black community of the tangible benefits. In Bradford, for example, public cooperation had been won after several important initiatives on equal opportunities had been taken.

Geoff Hunt said that in his experience NHS trade unions were very ambivalent about research that produced data on the employment of ethnic minorities. Unions often say that they want this information to be able to protect their members, but at another level they do not want it. Mr Hunt went on to defend the use of anecdotal information. He felt that the subjective experience of individual black workers in the NHS was as valid as any statistical data because it allows *them* to define their problems and reveals the mechanisms through which discrimination operates. It is their experiences that we need to investigate. Cherrill Hicks took a similar view, believing that unless white people can understand and relate to people's personal experiences of racism there will be no will to overcome it. Other conference participants developed this line of argument further by emphasising that irrespective of statistical information, the major complaint of black people is about attitudes of mind – towards both employees and recipients of the service.

On a practical note, Godfry Eastwood described the lengthy and tortuous debate that had taken place among black NUPE activists in the London Race Advisory Commit-

tee four years ago. They finally decided that ethnic record-keeping had to be part of a serious strategy for tackling racism in the NHS.

The relationship between racism in employment and racism in service provision

A recurring theme of the conference was that the recruitment, training and promotion of black workers in the NHS is not only a question of creating equal opportunities in employment, it is also a question of improving the provision of health services within a multi-racial society.

The discussion was initiated by Maggie Lyne who spoke of the importance of making the health service more responsive to the needs of the Asian community in an area such as Southall. When setting up the new nursing structures she had made a special effort to appoint Asian nurse managers. She and some senior black colleagues were also keen on the positive recruitment of more Asian nurses and health visitors, to arrive at 'the right mix of staff' to serve the local population. She was aware of the kind of comments that could be made in reverse, however, and was looking for some guidance on how to proceed.

A consensus emerged that if NHS appointments were to meet service needs in Britain today, the concept of 'the best candidates for the job' would have to be redefined. Currently this is given little thought because, as one speaker put it, there is usually a subconscious image of what constitutes a suitable person. This may not include women and is highly unlikely, at present, to include blacks. There was agreement at the conference that new indices of suitability were required to match changing needs within a multi-cultural society. A personnel officer from Croydon, Eileen Fairclough, pointed out that although the stereotyped image of a manager is still predominantly white, male and middle class, during the last ten years more female managers have been appointed. This has not happened by accident. It is the result of well-publicised discussion about women and employment which has forced personnel managers to examine some of their own prejudices. It was suggested that the same pro-

cesses must now be brought to bear by NHS personnel officers on race and employment.

On another note, Eileen Fairclough said that there was a tendency to assume that the NHS recruits mainly from the unemployed. With professional and technical staff, however, only people with a specific qualification can be appointed. Unless there are enough people from ethnic minorities in training for occupations such as physiotherapy, radiography and biochemistry they cannot be employed by the NHS. The professions themselves, who have an influence over the intake of training schools, must be encouraged to look into this. Stephen Watkins believed that people from disadvantaged backgrounds (not just blacks) should be admitted to medical school and other health service training with lower educational qualifications than people from privileged backgrounds. He stressed that this was not discriminating in favour of the disadvantaged, but recognising that to get a 'B' at A-level from a slum school actually demonstrates a higher level of academic attainment than to get an 'A' at a public school. He concluded by urging that such differences of social background should be taken into account in setting admission policies.

The undemocratic nature of health authorities

As the conference progressed this issue appeared to assume increasing importance. Every discussion of the need for 'leadership' or 'initiative from the top' in tackling racism in the NHS foundered on the lack of a democratic mechanism for bringing this about.

The central issue is that health authority members are appointed – either by the DHSS or by the RHAs – rather than democratically elected. By contrast, local authorities are elected and hence more likely to represent the ethnic composition and needs of the community. Aaron Haynes noted that it was those local authorities with the largest proportion of black elected members which had made the greatest progress in the equal opportunities field. Because blacks have started to make their political presence felt, local authorities have started to respond.

'To whom do health authority members consider they are responsible?', asked Aaron Haynes. 'What is their view of their constituency?' In the view of Mr G Duncan, the average RHA or DHA member sees racial discrimination as a less pressing issue than, say, implementing the government's contracting-out policy. Mr Duncan identified a further problem: there is no 'chief executive' in the health service structure. In local authorities, members can make a decision and the chief executive's office will implement it. The NHS operates by consensus. Mr Duncan said he would not like to be a personnel officer – armed with powers given to him by the health authority – going into the 'mysterious temples' of the nursing and medical professions to winkle out information they did not want him to have.

The conference Chairman, John Dunwoody, said that although there were no arrangements for the representation of ethnic minorities on health authorities, it was important for authorities to liaise with such groups in the community.

Moreover, individual health authorities have considerable autonomy, and therefore power to influence events in their own patch.

Concluding remarks

The contributors to the conference have demonstrated the urgent need for health authorities to act to ensure equality of opportunity for ethnic minority employees. They have argued that the current 'colour-blind' approach to employment in the NHS is particularly short-sighted, especially in the light of the recent 'disorders' and subsequent rediscovery of race as a political issue.

Rapid and effective action by health authorities on equal opportunities would not only help to redress the disadvantages suffered by their ethnic minority employees, it would also be likely to have a wider impact on race relations in Britain. A health authority's employment policies, as John Whitfield's paper shows, have important consequences for the local workforce. We should not underestimate the influence these policies will have on other local employers in multi-racial areas. Neither should we overlook the implications patterns of employment have for the services provided by the NHS. A health service workforce which reflects the ethnic composition of the community it serves is likely to meet health needs more effectively. This in turn will help to build the confidence of the community in the health authority. Furthermore, the NHS is used by the vast majority of people in this country and as one of our most visible national institutions, its promotion of racial equality could play a significant role in shaping public opinion.

A practical starting point for local action on equal opportunities is provided by the recommendations in the CRE's booklet *Ethnic minority hospital staff*. These include

adopting a statement of equal opportunity policy and publicising it within the authority and locally;

clear allocation of responsibility for implementing and monitoring this policy to a particular committee or senior officer;

provision of appropriate training for staff in contact with the public and for those with responsibility for the appointment of staff.

The two local authority case studies described in this book indicate that important requirements for the success of any initiative are a strong lead from the 'top' of the organisation and a corporate approach to race issues. In the NHS, this implies that commitment to an equal opportunity policy and its implementation must be gained from health authority members and chief officers. As the CRE points out, 'without commitment to action, equal opportunities can remain a well-intentioned ideal'.

The most crucial factor for a health authority appears to be the determination of the district management team to implement a programme of action. The DMT is also likely to need a great deal of energy and sensitivity. Fortunately, there are now a number of organisations and individuals willing to assist health authorities to develop their strategies and approach to equal opportunities. The challenge is, of course, great, but the rewards are considerable in terms of strengthening management and developing services attuned to the needs of multi-racial Britain.

Useful publications

Camden Committee for Community Relations. Racial equality and the health service. London, CCCR, 1983.

Cheetham J. ed. Social work and ethnicity. London, George Allen and Unwin, 1982.

Commission for Racial Equality. Ethnic minority hospital staff. London, CRE, 1983.

Commission for Racial Equality. Equal opportunity in employment: a guide for employers. London, CRE, 1983.

Commission for Racial Equality. Equal opportunity in employment: why positive action? A guidance paper. London, CRE, 1983.

Commission for Racial Equality. Equal opportunity, positive action and young people. London, CRE, 1983.

Commission for Racial Equality. Implementing equal opportunity policies. An information note for employers and employees. London, CRE, 1983.

Commission for Racial Equality. Monitoring an equal opportunity policy: A guide for employers. London, CRE, 1983.

Commission for Racial Equality. The race relations code of practice for the elimination of racial discrimination and the promotion of equality of opportunity in employment. London, CRE, 1983.

Commission for Racial Equality. Why keep ethnic records? Questions and answers for employers and employees. London, CRE, 1983.

Crowe V. Racial equality in public sector employment. RIPA Report, Autumn 1983. Vol 4, no 2, 8–10.

Department of the Environment. Local authorities and racial disadvantage. Report of a Joint Government/Local Authority Association Working Group. London, Department of the Environment, 1983.

Department of Health and Social Security. The Race Relations Act 1976. London, DHSS, 1978. HC(78)36.

Doyal L and others. Migrant workers in the National Health Service: report of a preliminary survey. London, Polytechnic of North London, Department of Sociology for the Social Science Research Council, 1980.

Hicks C. Racism in Nursing. Nursing Times. Vol 78, no 18, 5–11 May 1982, 743–744 and no 19, 12–18 May 1982, 789–791.

Jacob M. Raising the race issue. Health and Social Service Journal, 8 December 1983, 1469.

McNaught A. An anti-racism strategy for the National Health Service. Radical Community Medicine, 1983. No 16, 61–65.

McNaught A. Race relations in the NHS. Hospital and Health Services Review, March 1982. 86–88.

National Union of Public Employees (London Division). Equal opportunities in employment: a pack for negotiators. Black and ethnic minority workers. NUPE London Division, 1981.

Race Relations Act 1976. London, HM Stationery Office, 1976.

Young K and Connelly N. After the Act: local authority policy reviews after the Race Relations Act 1976. Local Government Studies 1984, vol 10, no 1, 13–25.

Race and employment in the NHS

Very little has been written about race and employment in the NHS and little has been done about it by health authorities. To assert that there is no racial discrimination in the NHS is wrong. This booklet describes the insidious and often unrecognised ways in which racism operates to exclude black people from the more desirable jobs. It also considers what can be done to overcome discrimination in employment and ways of moving towards racial equality in the NHS.

Race and employment in the NHS is based on a conference organised by the King's Fund and the Polytechnic of the South Bank which examined the practical steps that health authorities and managers should take to ensure equal opportunities for people from ethnic minority groups. Some useful guidelines for action are provided by case studies of one health authority and two local authorities that have begun to implement equal opportunity policies.

£2.00