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Perspective

Analysing UK Equal Opportunity Policy and Legislation. Has it Influenced the Progression of BME Nurses?

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Abstract

For more than 50 years, the UK government has sought to tackle concerns of racism and discrimination, isolation and lack of career support experienced by Black and Ethnic Minority (BME) people through legislation and policy initiatives. The first Race Relations Act was passed into legislation in 1965. Since then another four pieces of legislation dealing with similar issues was voted for through parliament - Equal Opportunity Act, 2010 being the most recent. Alongside the legislation, government reports, policies, initiatives and professional frameworks have also tried to address the situation of inequality. Despite this legislative activity, racial equality has continued to be an issue of concern across many sectors. In this essay, the progression of BME nurses in the NHS is discussed.

Introduction

Exploring the progression of BME nurses in the NHS is not new. Both historically and contemporary, many signs point toward a long-held and continuing pattern that BME nurses do not generally reach senior positions. Instead, official workforce statistics reveal that they are concentrated at, and near the bottom tiers of the NHS strata. Trevor Philips who headed the Commission for Racial Equality [2] during its inception, liken this observation to "Snow Capping". Coghill [1] went on to describe the workforce in the "NHS as resembling a pint of Guinness with Black nurses at the bottom". The trend of inequity seems to continue apace suggesting that for many BME nurses, Equal Opportunities Trusts' policies has so far failed in its obligations as a fair employer. In turn, the ability to have a meaningful impact on the career aspirations of these nurses who strive to attain higher-ranking positions in the NHS, can leave BME patients not receiving care that meet their ethnic and cultural health requirements [3,4].

Why is the nursing workforce an interesting one in terms of BME progression? This is largely because that since the Windrush Generation, during late 1940s, 1950s and early 1960s, the NHS has depended on overseas nurses to sustain its workforce. Both the Windrush and the inception of the NHS mark their 70th year in 2018 so this is just as relevant in 2018 and beyond as it was then. Tellingly, official statistics do not demonstrate that these nurses have progressed in the organisation despite these Acts to outlaw discrimination. This is particularly worrying when the reason does not appear to be a lack of qualification or professional development. England's chief nurse, Professor Jane Cummings was alarmed by this trend stating that…'BME nurses are extremely well qualified and have done leadership programmes, but they still cannot get through that glass ceiling' [5].

Such are these shortcomings, that serious consequence for Britain's multi-cultural and multi- ethnic recipients of healthcare as well as its staff can leading to a deficit in making decisions that affect patient care. There is evidence to suggest a link between the treatment of BME staff, patient experience and their health outcomes [6,7]. For BME nurses who continue to predominantly occupy grades that signify newly qualified status, (Band 5 or transition to Band 6) means that obtaining a position where power and ability to influence decisions and policies regarding patient care will ultimately remain unrecognised to the detriment of the NHS.

What this Essay Adds

This essay explores the equal opportunity and legislation landscape in the UK since the 1960s, analysing its impact on BME

nurse's progression specifically in the NHS. During the research for this paper, five pieces of legislation and fourteen government and other policies were identified, all having a generic aim of improving equal opportunity. Against this background, the paper also analyses nursing workforce data to explore how BME nurses have progressed within the NHS over this period. Finally, it will discuss implications of the analysis.

The UK Equal Opportunity and Race Relations Legislation: 1960s Onwards

The influence of International and Commonwealth nations to condemn the Apartheid regime in South Africa was a key impetus to the 1960 Race Discrimination Bill. A couple of years prior to the Bill, what was happening politically and economically nationally in the UK, include inner city race riots of Notting Hill and Nottingham. Despite such social unrest, the Labour backbencher, Fenner Brokeway, made nine unsuccessful attempts at presenting the Race Relations Bill to Parliament [8]. It was not until the Race Relations Act of 1965 that the first piece of legislation was passed, by which time the 1962 Commonwealth Immigrants Act had passed under Harold Macmillan's Labour Government. The 1965 Race Relations Act aimed to address unlawful discrimination based on colour, nationality, race and ethnicity. Dealing with racial discrimination in public places was also a focus. Nevertheless, for the estimated one million immigrants who had settled in the UK, the 1965 Act did not go far enough, particularly regarding housing and employment, but which was not a feature in it. (Race Discrimination Parliamentary Archives). Instead of dealing with these weaknesses and gaps, another legislation was announced.

The 1968 Race Relations Act was introduced to further address those initial areas; attention was also paid to goods, services and advertising [9]. Notable positive changes had been found to result from this Act, for instance, the reporting and investigation of racial discrimination which extended to criminal proceedings if necessary. However, elements of this Act were considered flawed too, specifically regarding its overall execution to enforce it in a workable way [10,11]. Also, cases bought forward to the Race Relations Board did not reflect the true scale of inequity experienced by some ethnic minority groups, thus, it was established that only four cases were sent before the Attorney General during the period up to 1968 [11]. Discriminatory acts such as violence against West Indians and anti-Semitic speeches were voiced. The loose and ambiguous definition of discrimination and many of its dimensions made proof of wrong-doing towards them, difficulty for the victim. For instance, indirect incidences of discriminatory practices occurred which sometimes emphasised immigrant deprivation. A lack of credibility of the Act being effectively implemented led to an inability to resolve certain complaints and these concerns were summed up by Roy Jenkins, the then, Home Secretary.

'I have accepted the argument that these weaknesses have impaired our ability to ensure equality of treatment and weakened the credibility of the legislation in the eyes of the minority communities. I have drawn the conclusion that unless we can swiftly devise measures to keep the promise inherent in the Race Relations Act, people will lose confidence in the good faith of Governments. That erosion of confidence is something we cannot permit' [8]. Out of the 1968 Act, came the Community Relations Commission (CRC) which set up various departments and divisions nationally, comprising education, employment, housing, social services, and youth and community. The CRC however, was abolished by the 1976 Race Relations Act and in this context the Commission for Racial Equality (CRE) emerged as a publicly funded non-governmental body led by Trevor Philips, under David Callaghan's Labour government of 1974. The principle aim of the CRE was to raise public awareness relating to all areas pertaining to racism, prejudice and discrimination, with a view to promoting good race relations. Their remit was to liaise with government departments, providing advice to local and voluntary organisations. The CRE also made recommendations in its Code of Practice to ensure that positive action was reinforced. However, this did not prove to be a straightforward ambition as attempts to engage employers was more likely to be based upon a pragmatism and self-interest than moral obligation to equality [12] (Table 1).

Name of policy	Target group	Aim/Intervention	Outcome/Results	Race Relations Board
Race Discrimination Bill 1960	International/Commonwealth nations to condemn the apartheid regime in South Africa.	Unlawful to refuse employment (or promotion) in any business, trade or Industry	Initiated the 1st Race Relations Act.	
1st Race Relations Act 1965	Unlawful discrimination based on colour, nationality, race/ ethnicity	To address racial discrimination in public places. To eradicate a "colour bar".	Was not felt to go far enough in tackling wider aspects to include housing and employment.	

2nd Race Relations Act 1968	Unlawful discrimination based on colour, nationality, race, ethnicity or national origin.	Extended the scope of legislation to tackle discrimination in housing, advertising and employment.	Extended the powers of the Race Relations Board to deal with complaints and set up a body called the Race Relations Commission.	
3rd Race Relations Act 1976	Established that direct and indirect discrimination based on colour, nationality, race/ethnicity is unlawful and pertains to victimisation.	Unlawful to be treated less favourably in housing, employment, education, acquisition of goods, services and facilities.	Publication of the McPherson Report following murder of Black teenager, Stephen Lawrence and the Race Relations Amendment Act was introduced in 2000. For the first time, it included the police.	
Human Rights Act 1998	Sets out the rights and freedoms of everyone in the UK. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic British law.	Under various 'articles' are 13 'rights': to life, freedom from torture, slavery, freedom of expression, belief/expression, fair trial, no punishment without law, right to marry & start a family, right to liberty & security, right to peaceful enjoyment of property, to education, right to take part in elections, abolition of death penalty	In the event of people's rights being violated, effective measures and steps are in place to access the correct challenges to remedy such violations. It requires all public bodies, e.g. courts, police, local authorities, hospitals and publicly funded schools, and other bodies carrying out public functions to respect and protect your human rights.	
Race Relations Amendment Act 2000	Public duty for local services to prioritise the promotion of racial equality as central to their activities.	Eradicate racial discrimination by promoting good relations between different racial groups, specifically in areas of employment, training recruitment & selection.	Public services (schools, colleges, secondary schools, NHS, Social Services, etc) are required to implement a Race Equality Scheme that monitors the effects of race equality policies.	
Equality Act 2010	Those covered under 'protected characteristics' based on: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation.	Consolidates over 116 separate pieces of legislation into one 'Act'. When combined, they make up a single 'Act' that provides a legal framework to protect the rights of individuals and advance equality of opportunity for all.	Include discrimination by perception as well as discrimination by association. Provides guidance on how to comply with equality law. Encourages the implementation of good practice in all aspects of employment including recruitment, pay, working hours, managing staff and developing policies	
NHS Confederation (1998)	Employees from black and minority ethnic (BME) backgrounds	To ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.	Study outcomes show that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety.	

NHS Executive (2003)	Designed to help NHS providers develop cultures that enable and sustain continuously improving, safe, high quality and compassionate care.	Describes a wide range of different interventions. However, they are underpinned by common principles, such as: compassion, compassionate, inclusive leadership and the five cultural elements.	Given the widespread discrimination against minority groups in the NHS (West et al 2015), succession planning must reinforce principles of equality and diversity (including offering flexible working), to improve morale and performance. This helps secure leaders who represent the communities they serve, as well as their staff. Assessments need to be objective and scrutinised by senior leaders to ensure they are high quality, fair, compassionate and continually improving.	
NHS Race Equality Plan (2004)	Targets recruitment and development opportunities at people from different ethnic groups whose skills are often underused.	Pays greater attention to meeting the service needs of people from ethnic minorities. Makes race an important dimension of strategy for the next five years through more focus on helping people with chronic diseases - where morbidity is high amongst people from black and minority ethnic backgrounds - and on health inequalities - where ethnic minority communities are often disadvantaged.	It intends to assist drive to recruit more staff, increase skill base and introduce new working patterns. It anticipates helping the standards both for improved services and health outcomes in the long term and to hit short term targets.	
NHS confederation (2011) Engaging with BME communities: insights for impact	To help ensure that national health services meet the needs of BME communities. It provides members with a strong collective voice and a platform to engage with policymakers and key opinion formers from across the healthcare sector.	Main mission is to support, develop, inspire, and positively promote BME healthcare leaders of the future and to encourage all NHS leaders to improve the health of their communities through working on prevention and better clinical interventions that consider issues of ethnicity, race and faith.	Several Initiatives across the NHS promote equality, such as the Mary Seacole Awards, which highlight worthy examples of empowering NHS staff and communities to help reduce health inequalities. We will continue to champion the efforts of BME staff who make a real difference to reducing health inequalities.	

NHS confederation BME forum funded by the health foundation	Black and minority ethnic(BME) communities in London's NHS trusts and health authorities	Aims to affirm the importance of the leadership provided by BME NEDs to identify good practice and lessons learned to help NHS bodies maintain and improve current levels of BME involvement to look at how changes in the NHS could impact on the stability and number of BME NEDs to highlight areas in which there is room for improvement, and suggest ways forward.	The current levels of representation of people from BME communities among NEDs can be welcomed, with 25 percent of the 500 NEDs serving in London's health trusts being from BME communities. However, between 2003 and 2005 there was a drop in the number of NEDs from BME communities from 139 to 123. The reduction maybe small, but it is worth noting. One of the aims of this publication is to promote the importance of sustaining current numbers and avoiding complacency around the recruitment and retention of BME NEDs.	
NHS equality and diversity council (2011) evaluation of the equality delivery system (EDS) for the NHS	Patients, carers, communities and staff.	The purpose of phase one of the evaluation is to provide an independent assessment of how the EDS is being implemented, how it is benefiting organisations in terms of meeting their public-sector Equality Duty (PSED) and how improvements can be made, and support provided to ensure the tool is able to effect change within the current and new NHS.	The biggest impact of EDS implementation to date has been strengthening equality processes such as improving engagement mechanisms, prioritisation of equality issues, identifying gaps in equality data and better partnership working around equality and engagement. The EDS has provided NHS organisations with the impetus in which to do this in a structured way. There is also evidence of impact around changes in perceptions and behaviour within NHS organisations, the most notable being raising the priority of equality work with senior leaders. There's also evidence that the EDS has led to increased awareness and commitment of equality across organisations, including equality in the workforce and evidence of the EDS helping to change attitudes and behaviours of wider staff around equality. Most of survey respondents have high aspirations for the EDS and hope it would lead to improved health outcomes for patients, carers, communities and staff in the future. For most this meant seeing changes within 1-3 years.	

NHS Diversity and Equality Workforce Survey (2013)	Employees from black and ethnic minority (BME) backgrounds.	The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and ethnic minority (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The move followed a number of reports, which highlighted disparities in the number of BME people in senior leadership positions across the NHS, as well as lower levels of wellbeing amongst the BME population.	Currently carrying out a detailed examination of progress against the original strategy and, where progress has not matched the pace we desire, we are escalating both risks and mitigating actions. We are highlighting the importance of understanding data and social science techniques to acknowledge and effectively address inequalities in all that we do. Recognising the culture of employment shapes not only how the organisation looks, but also how it performs in the delivery of both strategy and commissioning of services, consequently affecting the population we serve.	
Department of Health (1999) Guidance on International Nursing Recruitment	Healthcare professionals from abroad.	To promote high standards in the recruitment and employment of healthcare professionals from abroad. Also concerned with the protection of developing countries and seeks to prevent targeted recruitment from developing nations who are themselves experiencing shortages of healthcare staff.	The principal policy instrument in the United Kingdom, the Code of Practice on International Recruitment, has not ended the inflow of nurses to the United Kingdom from sub-Saharan Africa.	
Department of Health (2000) The NHS Plan: A Plan for Investment, a Plan for Reform	A health service designed around the patients.	This is a plan for reform with far reaching changes across the NHS. The purpose and vision of this NHS Plan is to give the people of Britain a health service fit for the 21st century: a health service designed around the patient.		
Department of Health (2000a) The Vital Connection: An Equalities Framework for the NHS	To ensure that the NHS is a fair employer achieving equality of opportunity and outcomes in the workplace.	To recruit, develop and retain a workforce that can deliver high quality services that are accessible, responsive and appropriate to meet the diverse needs of different groups and individuals. Also, to ensure that the NHS is a fair employer achieving equality of opportunity and outcomes in the workplace.	Numerous case studies show models of good practice and illustrate the practical implementation of principles. Annexes show equality indicators, equality standards and a draft working lives standard.	
Department of Health (2000b) Positively Diverse	Improves services to patients, through staff who feel respected and valued.	Aims to address equality and diversity within the workforce and wider NHS organisation	Demonstrating leadership across all Equality and Diversity strands. Developing competencies that are measurable and have an impact on better service outcomes. 11 Developing a more competent workforce.	

Department of Health (2001) A Health Service for all Talents: Developing the NHS Workforce	Medical, dental, managerial, and other clinical and non-clinical staff.	Sets out the reasons why the current workforce-planning arrangements need to be changed. It emphasises the importance of taking a team approach: the needs of patients, not the job titles of staff, should be central to workforce development.	A properly-resourced implementation team needs to be established to drive through the changes recommended.	
Department of Health (2002) Towards Racial Equality: An evaluation of public duty to promote race equality and good race relations in England & Wales	Promoting race equality for staff and patients.	Summarises a range of work undertaken by the Healthcare Commission and looks at the extent to which the NHS in England is meeting the legal basic building blocks in promoting race equality.	It was found that there were difficulties with providing the evidence to demonstrate that the NHS had: Monitored their workforce, particularly in terms of the numbers of people from minority ethnic communities who had applied for and received training, been promoted or "experienced detriment".	

Table 1: Time-line of legislation to promote equality of BME groups.

The figures in the table 2 below are from the NHS Hospital and Community Health Services (HCHS) Qualified nurses (excluding health visitors) in NHS Trusts and CCGs in England by ethnicity. It shows a marginal improvement in the number of BME nurses who obtained Bands 8a-8d and Band 9 occurred between 2016-2017. However, year on year from 2014- 2017, the table show that staffing levels of all ethnic groups (excludes Health Visitors) in the NHS had increased, which might or might not explain this slight upward shift for BME nurses.

April 2017	**All Ethnicities**	**White**	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Chinese**	**Any Other Ethnic Group**
All staff	**308,362**	**231,614**	**3,948**	**26,305**	**22,892**	**1,118**	**9,820**
Band 1	8	5	-	-	-	-	-
Band 2	12	9	-	-	2	-	-
Band 3	13	10	1	-	1	-	1
Band 4	81	54	2	14	4	-	3
Band 5	153,962	107,973	2,158	16,873	13,176	526	5,871
Band 6	89,877	69,007	1,138	6,907	6,433	324	2,888
Band 7	48,964	41,148	504	2,073	2,550	221	879
Band 8a	10,969	9,638	98	295	498	31	113
Band 8b	2,702	2,427	26	48	105	11	19
Band 8c	1,113	1,012	10	16	33	-	6
Band 8d	344	316	5	2	7	-	-
Band 9	122	108	-	3	2	-	-
Sept 2016	**All Ethnicities**	**White**	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Chinese**	**Any Other Ethnic Group**
All staff	**306,897**	**231,711**	**3,889**	**25,510**	**22,408**	**1,165**	**9,453**
Band 1	14	7	-	1	1	-	-
Band 2	11	8	-	-	2	-	-
Band 3	7	5	1	-	1	-	-
Band 4	221	169	4	15	7	1	6

Band 5	155,548	109,822	2,184	16,707	13,104	553	5,623
Band 6	87,863	67,850	1,085	6,483	6,113	348	2,813
Band 7	48,131	40,677	486	1,898	2,459	223	827
Band 8a	10,677	9,418	87	268	490	30	113
Band 8b	2,667	2,392	24	46	101	9	20
Band 8c	1,090	1,006	11	13	25	-	5
Band 8d	317	289	3	2	6	-	-
Band 9	101	88	-	2	4	-	-

Sept 2015	**All Ethnicities**	**White**	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Chinese**	**Any Other Ethnic Group**
All staff	**302,997**	**230,461**	**3,674**	**24,358**	**22,279**	**1,189**	**9,030**
Band 1	7	1	-	-	-	-	-
Band 2	8	6	-	-	1	-	-
Band 3	5	3	-	-	2	-	-
Band 4	275	216	3	17	1	-	6
Band 5	157,355	112,194	2,105	16,464	13,564	554	5,414
Band 6	84,630	65,903	985	5,832	5,776	372	2,726
Band 7	46,756	39,945	464	1,685	2,287	214	715
Band 8a	9,977	8,859	75	212	443	31	99
Band 8b	2,554	2,305	23	39	82	13	19
Band 8c	1,012	937	9	10	26	1	5
Band 8d	274	250	2	1	4	-	-
Band 9	84	77	-	1	2	-	-
Sept 2014	**All Ethnicities**	**White**	**Mixed**	**Asian or Asian British**	**Black or Black British**	**Chinese**	**Any Other Ethnic Group**
All staff	**301,432**	**229,525**	**3,605**	**23,534**	**22,852**	**1,242**	**8,983**
Band 1	1	1	-	-	-	-	-
Band 2	14	10	-	1	2	-	-
Band 3	6	4	-	-	2	-	-
Band 4	246	196	4	20	8	-	2
Band 5	159,440	113,586	2,131	16,379	14,340	588	5,507
Band 6	81,806	64,059	914	5,282	5,618	371	2,640
Band 7	45,283	39,036	403	1,442	2,192	212	636
Band 8a	9,372	8,333	80	190	398	30	89
Band 8b	2,553	2,318	25	37	64	11	19
Band 8c	914	843	8	11	25	1	4
Band 8d	250	231	2	1	3	-	1
Band 9	55	50	-	1	2	-	-

Table 2: NHS Hospital and Community Health Services (HCHS) Qualified nurses (excluding health visitors) in NHS Trusts and CCGs in England by ethnicity.

The research and figures both validate and paint a picture of very little advancement for BME nurses, indicating that workplace discrimination exist against BME staff in the NHS today with its origins spanning several decades. A Royal College of Nursing (RCN) Employment and Working Well Survey for 2005 and 2002 [13] undertook a large -scale study pertaining to various categories linked to well-being and working lives. For instance, it was revealed that BME nurses who had full time contracts, worked on average of 5.2 hours more per week compared to their White counterparts and Afro-Caribbean nurses were illustrated as working in excess 6.5 when compared to White nurses. Amongst other employment issues, on the question of bullying and harassment, the report following the survey found that 35% of BME nurses disclosed having experienced bullying in the previous 12 months compared to 21% of White nurses.

Of concern is that despite the legal processes to deal with it, in the absence of these legal processes, many cases would not have been brought to light. One such case was that Central Manchester NHS Foundation Trust was labelled as 'institutionally racist' in 2012 when they unfairly dismissed a nurse manager (Mr Elliot Browne) who endured "persistent discrimination" and "an intimidating environment". Because of a 'campaign of bullying and harassment, his health suffered, and he contemplated suicide. Mr. Browne was awarded £1m in damages [14].

Discussion

In 2001, the Cabinet Office's reported, "Racial discrimination may also interact with other forms of discrimination such as gender or disability, thereby heightening its impact and occurrence within organisations in multiple forms. It is important to note that as racial discrimination has persisted, different patterns emerged. Notably, overt forms of discrimination are less frequently observed, while covert indirect forms of discrimination, has been more widely recognised". Such important and long-held concern necessitates a 'multilevel, multi-strategy, mutually reinforcing action' [15]. The Macpherson Report [16] following an inquiry into the death of Stephen Lawrence, exposed the extent of institutional racism in public sectors (the NHS included) with a view to putting in place, effective systems [17] to remedy these occurrences.

The ability to adopt equal opportunities policies for such a large, but a complex organisation as the NHS is fraught with operational and systematic difficulties. These is noted especially with current systems, set up to collect and collate ethnic monitoring data, particularly compared with earlier times when accurate breakdown of ethnic groups was not easily accessible in a quantifiable or measurable format. This was a major critique of the 1965 Race Relations Act; its need for effective monitoring 'systems'. Such inaction to introduce systems of some sort was again requested in 1984 when the Kings Fund published a booklet following a conference held in April 1983, 'Race and Employment in the NHS'. At the time, the contributing authors' shed light on this 'crucial matter' signalling that Local Authorities had not sufficiently dealt with concerns about the state of the NHS regarding race relations. It can be argued that fragmentation on such a large scale is unacceptable for the future of the NHS.

Contemporaneously, the question that needs to be answered for and by equal opportunities policy makers is to what extent (if at all) these initiatives have sought to overturn the trend aimed at improving the career trajectory of BME nurses. BME nurses still endure workforce discrimination and who by-and-large remain disadvantaged as a healthcare workforce compared with their White colleagues. Another related contention, discussed previously, is surrounding the approach to implementing Equality and Diversity policies where the gap between rhetoric and 'positive action' needs to close [12]. Use of unsophisticated measures such as tick box exercises and rudimentary attempts at on- line Equality and Diversity training programmes (including unconscious bias training) do not get to the heart of the problem. What's more, application in practice, tend not to be sufficiently followed through; largely influenced by, and dependent upon respective government priorities at any given time.

A point in note is the RtH, Theresa May's 'Race Disparity Audit' report published in 2017, by-and-large tell us what is already known, but nothing substantial is offered by way of resolution. Consequently, these policies are apt to fail with varying and multifarious degrees; lessons not learned from previous failures, such as non-existent or flawed monitoring systems has been a major shortcoming of many statutory bodies. Furthermore, the introduction of consecutive NHS Equality and Diversity policies, Acts and legislation have resulted in the emergence of reports, frameworks, tools, standards and charters, models of widening participation, training schemes and programmes; many of which claim to be innovative and vowing to bring about much needed sustainable change. A prevailing failure by NHS Trusts to implement and activate equal opportunities policies by means of evocating or sustaining progress is to ask the question, what then is working?

How Do Equal Opportunities Polices Work in Practice?

There are many benefits to organisations having Equal Opportunities policies in place. One, being that employers view them as confirming its statutory commitment to ensure their service functions equitably. A key objective should be to promote equality thereby minimising discrimination and is governed by the premise that everyone has rights. Accordingly, in most cases, Equal Opportunities Policies are written documents with a section on 'statement of intent', 'code of practice', and occasionally some contain a 'code of conduct'. Giving an example, on each section, the 'Heart of England Foundation Trust documented their statement of intent, along the lines that, 'The Trust is committed to providing equality of opportunity and will strive to identify and remove

any barriers to this'. Their code of practice 'set out the practices which employers should adopt to ensure equal opportunities at work'. The code goes on to explain that it does not have statutory provision. However, it lays down well-defined operating practices for employers which, if not followed, may have the effect of supporting legal action taken via an Employment Tribunal' Heart of England Foundation Trust [18].

A Critique of NHS Equal Opportunities Policies Implementation

Notwithstanding, a complex issue remain. To fully appreciate the context in which the NHS (as a highly multifaceted political system) operates, require a historical explanation for such apparent lack of impact. Even after periods of endeavours to initiate its inception in tandem with the Race Relations Act (1976), moving these policies from theory to practice has been patchy and woefully piecemeal. The aims remain the same, for instance, a key target has been to reduce the differences between White staff career progression, treatment and experience in the NHS and that of their ethnic minority counterparts. The Workforce Race Equality Standard (WRES, 2015) although a new standard, has already reported a lack of vigorous execution on the part of NHS Trusts. For WRES, despite well- meaning intentions by many NHS Trusts to commit to equal opportunities policies, its baseline report indicated that some managers were not cognisant acquainted with how to undertake or adhere to their responsibilities. Thus, interpretation and recording of data was not always consistent with the reality of staff experiences. The WRES, recognises however, that those Trusts considered as demonstrating 'good practice' have an important role to play as exemplar, not least for the diverse patient population they serve, and not least, because they are conspicuous in their leadership, governance and transparency.

It was not until the first major large-scale study was conducted by the Policy Studies Institute (PSI) on behalf the Department of Health, that some light was shed on the problematic nature of the issue. 'The study consisted of a postal survey of 14,330 staff together with 150 interviews and a qualitative study of six employers. Its findings showed two main ways in which nursing staff from minority ethnic groups were disadvantaged. First, some had fallen behind in the stakes to compete for senior nursing posts. There was no significant difference in the grading between 'white' and 'non-white' nurses'…However, the extent of claims regarding non-significance in differences between white and non-white nurses was not indicate. 'Second, minority ethnic staff were more likely to be working in specialities such as mental illness and learning disabilities, rather than in the more so -called prestigious medical and community-based specialities' [17,19]. For Beishon et al. [19] it was found that, 'little evidence (if any) of those responsible for formulating a policy were analysing the outcomes in ways which would help them to decide whether it was being carried out, or whether it was having the desired effect. Quite a lot of monitoring information was collected; only some of it was ever processed; hardly any of it was analysed and assessed'. Albeit, some inference can be drawn that, when the PSI study emerged during 1990s the NHS functioned under a different model than it does today and underwent various structural changes. From 1991, NHS Trusts were establishing themselves as 'providers' which meant taking responsibility for their own budget and implementing equal opportunities policies then, was not a priority. This similar notion or rationale may well still be prevalent into the 2010s, hence the re -emergence of such a predominant issue.

Dickens [20] note two key reasons for compliance (or not) whereby some NHS organisations endorsed equality initiatives whilst others displayed trepidation. This leads onto examining influences of the NHS from what is a macro level standpoint, liken to Dickens [20] 'social justice' interpretation. Dickens' [20] raises the debate to consider that organisations invariably function with 'self-interest' in mind, an example, can be made with past and current recruitment crisis whereby ethnic minority nurses are usually only favoured during labour shortage gaps in the NHS. Nonetheless, regarding implementing equal opportunities policies, another question is who it most benefits, patients and/or staff? Reverting to the 'business case', [6] put forward an argument of the benefits from an organisational leadership and management perspective. In [17] point out, that it is all too easy for managers to allow the employment of minority ethnic staff to become their main response to developing appropriate services for minority ethnic communities'. A similar notion expressed by Buchan [21] argues that for many, adopting mass recruitment of ethnic minority nurses' can be a solution to any recruitment crisis that might afflict the NHS at any given time. Incidentally, currently, there is a 40,000-national vacancy for nursing post.

Conclusion

It may not be surprising therefore that outlay for investing in equal opportunities training programmes has been considered a resource intensive exercise regarding staffing levels. There is an appeal for its consideration that can be lost in the argument for making savings in the cash-strapped predicament of the NHS. There is also the question of 'capacity' to deliver on the agenda of equality training and who is going to take charge and of initiating it? Given the overwhelming evidence provided to suggest that despite a range of Equal Opportunities policies operating under our legal framework, one can that it has not influenced the progression of BME nurses in the NHS. It is felt that the key reason for this lies with the motive and measures behind effective implementation followed by the extent to which there is a commitment to change.

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