



Leadership Centre

National Nursing Leadership Programme
How Black and Ethnic Minority Nurses
Can Progress Into Leadership
A resource for health and social care
professionals and managers

Getting On Against the Odds





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Getting On Against the Odds

This is a practical learning resource for all those involved in tackling racism in health and employment, mainstreaming equalities initiatives and promoting a more diverse and representative nurse leadership in the NHS.

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What is it for?

This publication aims to encourage managers and clinical professionals to reflect on and share learning and experience of what enables nurses from black and ethnic minority communities to succeed in reaching positions of leadership in the health service.

Based on a survey of nurse leaders from these communities across the country, it explores what has been learnt so far by those who have reached positions of seniority in their health service careers, often 'against the odds'. In particular, it considers:

- How big is the problem of developing and retaining sufficient numbers of senior managers and leaders among black and ethnic minority nurses?
- What are the key issues and challenges from the perspectives of nurses in leadership positions who are themselves from black and ethnic minorities?
- What lessons have been learnt that can help inspire, foster and develop a more representative and inclusive workforce – and crucially, at leadership and senior management levels in nursing?



What is it for? (cont'd)

Several recent government policy requirements have made it clear that far-reaching change is needed if the workforce upon which a modern health service depends is to deliver the standards that patients expect and that staff want to provide. Central to these requirements is the commitment to develop new forms of leadership that reflect the diversity of the workforces and communities served. However, racist attitudes and behaviours prevent many nurses in the health service from developing their clinical and leadership potential to the full. This document and the fuller survey it draws upon support the work needed at local levels to make this commitment to change and improved services a reality, by enhancing and developing minority nurse leadership in the NHS.

Who is it for?

The resource is likely to interest and benefit:

- nurses from black and ethnic minorities who are in, or considering moving into, positions of leadership in health and social care
- managers, professionals and researchers involved in leadership and change management issues across the NHS
- those responsible for policy, strategy and operational work that is engaging with, or complementing, leadership and change management initiatives, workforce development and equality and diversity issues.

Where does it come from?

The National Leadership Centre was launched in April 2001 as part of the Modernisation Agency. The National Nursing Leadership Programme (NNLP) is an early contribution to the Centre's work.

As one of our first activities, we identified a clear need for more nurses from black and ethnic minorities to progress into leadership positions across the NHS. This chimed with other central and local initiatives aiming to address issues of fairness in health and social care employment. Our first concern was to listen to a wide range of black and ethnic minority nurse leaders on the ground about their first-hand experiences of achieving positions of seniority in the NHS. Another was to identify from this exercise practical and sustainable ways of tackling the deep-seated problem of institutional racism that hinders career progression for many. Our aim throughout was to ensure that lessons for action and change in healthcare leadership should be captured and shared for the benefit of individuals, professions and the organisation as a whole – and thus of those who use services.

In response to the specific needs identified, therefore, the NNLP has developed this publication and a longer survey on which it is based⁷ under the title 'Getting On Against the Odds'.

What can you expect to achieve by using the publication?

Depending on needs and interests, you should be in a better position to:

- identify key lessons and findings for professional and workforce development and health care
- situate 'at a glance' these findings within the wider policy and operational background, including the developing legal frameworks within which tackling racism and inequalities in the NHS is taking place
- assess key lessons and their implications for effective strategies for nursing leadership in the NHS and enhanced service delivery
- support effective strategies for learning about 'what works' for your own career progression or within your team, department or organisation
- seek out sources of further information.



'Getting On Against the Odds'

Project sponsors

Professor Jean Faugier, Director, NNLP
John Lancaster, Associate Director, NNLP

Editorial and production

Steve Cranfield, Independent Consultant
Design: Carolyn Hume, S.F.Taylor

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Survey authors

Jacinta Elliott and Reg Walker, Elliott Walker Consultancy
Gweneth Balson and Shani Choudhari, Independent Consultants
Professor Charles Husband, Director, Ethnicity and Social Policy Research Unit, Bradford University

Project Steering Group

Professor Jean Faugier, Director, NNLP
John Lancaster, Associate Director, NNLP
Ali Handscomb, Assistant Project Co-ordinator, NNLP
Nola Ishmael, Nursing Officer, Department of Health
Janet Davies, Nurse Executive Director, Royal Liverpool University Hospital NHS Trust and NNLP Leading Light
Avril Imison, Head of Policy (Therapy Services), Department of Health
Mona Walker, Director of Nursing, Princess Alexandra Hospital NHS Trust and NNLP Leading Light

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FOREWORD

Retaining and developing diverse leadership at every level of an organisation is an important matter for all public service organisations, including the NHS.

The NHS Leadership Centre, as part of the Modernisation Agency, was established just over a year ago to implement the commitment made in the NHS Plan - to 'deliver a step change in the calibre of NHS leadership'.

As key people working in the NHS you will be aware of the important developments that are taking place. What is clear is that among the necessary skills and qualities, there is the need for clear, consistent and insightful leadership to help to transform services to deliver real improvements for patients and staff.

As part of the NHS workforce, black and minority ethnic nurses, midwives and health visitors are a stable and visible part of the NHS workforce. They are represented in all the disciplines within nursing.

Getting on Against the Odds is a timely, practical learning resource aimed at managers and clinical professionals to support the development of nurses, midwives and health visitors from black and ethnic minority communities. The document is about black and ethnic minority nurses, midwives and health visitors and their experiences – their triumphs, successes and at times their struggles. It offers solutions and options and a way forward.

The National Nursing Leadership Programme Team and the Working Group have produced an excellent piece of work. It is at times hard-hitting and candid but it addresses important issues for black and ethnic minority nurses midwives and health visitors in terms of their realities and perceptions.

I am confident that it will contribute to our understanding and strengthen our determination to ensure increased equality of opportunity for all. It will cause us to pause and think about how at all levels NHS organisations we improve support for the leadership development for ethnic minority nurses, midwives and health visitors in the 21st century.

Most importantly, it should make us consider what part we will each play in ensuring that black and ethnic minority nurses, midwives and health visitors are enabled to take on leadership roles within the NHS for our diverse workforce and communities.

Sarah Mullally
Chief Nursing Officer/Director



Section 1

Key findings and recommendations

In this section ...

- key messages are identified
- recommendations are made.

1.1 Key findings

Below is a summary of key findings and messages about issues affecting progression to leadership in the NHS for black and ethnic minority nurses. (See Sections 2–5 for a more detailed discussion of the issues involved.)

Representation at leadership levels

- Many black and minority ethnic nurses are being blocked or deterred from pursuing careers in the NHS and from progressing to senior positions within it
- Approximately 9.3% of qualified nursing, midwifery and health visiting staff in all grades are black, Asian or of other non-white ethnicity. We estimate that non-white representation in the higher grades may be only about 6% at grade F, perhaps 5% at grade G, 4% at grade H and about 3% at grade I.
- At the most senior levels non-white representation is exceptional
- Out of over 400 Directors of Nursing at present only three are 'black'
- In some parts of the country representation is exceptional even at middle management level

Support from managers

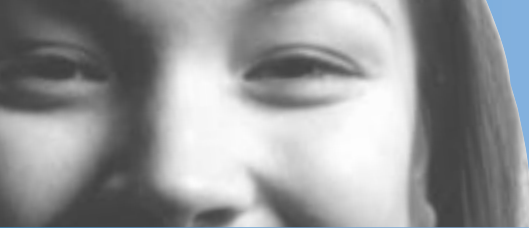
- Support and encouragement from people in senior positions can be pivotal for black and ethnic minority nurses in progressing their careers
- Managers in turn are likely to benefit from support to recognise the importance of their helping role as well as the career development needs of black and minority ethnic nurses

Mentoring and networking

- Effective mentoring and networking are keys to career progression
- Quality of support is often much more important than a mentor's ethnicity, although for some people and in certain circumstances this can be crucial

Clinical supervision

- Clinical supervision can help to enhance many nurses' career development
- Provision is often patchy, in part because of pressures of work but also because of lack of ingenuity in approaches to supervision
- The practice of allocating people to supervisors without much care for the relationship can make for difficulties



Development

- Many black and ethnic minority nurses benefit considerably from leadership development programmes
- Positive action leadership programmes have been influential in terms of advancing careers and building effective networks
- Programmes are, however, strongly opposed by some within the constituency at which they are aimed, on the grounds that they perpetuate racial thinking

Professional, organisational and policy contexts

- Overt and covert forms of racism are tolerated in many parts of the NHS
- While some have positive experiences of the NHS as an employer, for others only a deep passion for the profession of nursing keeps them going in their jobs in the face of prejudice, discrimination, ill-use and abuse
- Many regard action on tackling racism as long overdue and, while welcoming key initiatives on equality and diversity, regard the implementation of policies as frequently inadequate and half-hearted
- Sustained effort is required to convert commitments to equality and diversity into reality. Unless national policy is backed by top-level commitment within Trusts, Workforce Development Confederations and Strategic Health Authorities, not much will change at middle management and frontline levels.

1.2 Recommendations

Below are the aims and key challenges we face. These are drawn from the discussion and analysis of findings and the messages coming through the survey. We have given examples to show how existing and new work can or ought to fit within them.

The NNLP sees these recommendations as an important part of its ongoing work to promote diversity and increased representation of people from black and ethnic minorities in nurse leadership.

We encourage professionals, managers and other local and regional partnerships to consider actively ways in which they can contribute to, or lead on, work to implement the recommendations.

Championing supportive behaviour

AIM 1 Encourage more managers to provide effective career development support to black and ethnic minority nursing staff

Key challenges

- How can we best communicate the value of supportive behaviour of managers to more managers and staff alike?
- How can we involve and support more managers in this important championing role?
- How can we avoid charges of 'tokenism'?

Priorities for work to be developed

- Encourage dissemination and use of this resource at all levels in the organisation – (see 2.8, page 13)
- Integrate the insights provided by the survey (see 2.7, page 12) into leadership, management and human resources components of professional training and development programmes
- Provide well thought through training and support for managers in this championing role, which are sustained in the long term and backed up by accessible resources
- Follow through on gains accruing from existing development programmes for front-line management, such as LEO, and extending the 'support' message to senior levels.



Mentoring

AIM 2 Ensure that access to mentoring is easily facilitated, is transparently fair and that guidance is provided to support mentoring supervision

Key challenges

- How can we extend the availability of mentoring to all parts of the nursing workforce, regardless of race or ethnicity?
- How can we ensure that mentors are sensitive to the needs of mentees from black and ethnic minorities?
- How can we promote awareness that quality of support is often a much more important factor than a mentor's ethnicity, although for some people and in certain circumstances this factor can be crucial?

Priorities for work to be developed

- Extend the infrastructure of development programmes for mentors and mentees
- Provide opportunities for mentors to keep abreast of current developments in diversity and trans-cultural healthcare
- Incorporate insights from the survey into mentoring guidance.

AIM 3 Provide options for mentees in choosing the ethnicity of their mentor

Key challenges

- How can we increase the number of available mentors from black and ethnic minorities when there is a likely shortage at senior levels and in some localities?
- How can we avoid the presumption that mentees will want to be matched with mentors in terms of ethnicity?

Priorities for work to be developed

- Enlarge and enrich the mentoring pool through collaboration with neighbouring Trusts, Social Service departments and the voluntary sector on a reciprocal basis
- Incorporate insights from the survey into mentoring guidance.

Clinical supervision

AIM 4 Expand the development of clinical supervision initiatives

Key challenges

- How can we increase the availability and accessibility of quality clinical supervision for nurses from black and ethnic minorities?
- How can we encourage more creative uses of supervision and better allocation of people?

Priorities for work to be developed

- Integrate insights from the survey into clinical supervision guidance
- Produce a short guide to creative approaches to supervision
- Monitor clinical supervision as a specific form of development.



Positive action - continuing the debate about 'special programmes'

AIM 5 *Continue to support successful positive action leadership programmes for staff from black and ethnic minorities, while being sensitive to different views for and against such programmes*

Key challenges

- How can we increase knowledge and awareness of positive action leadership programmes?
- How can we help staff to make informed judgements about the value of these programmes?
- How can we prepare participants' organisations for these programmes so that their benefits are not lost?

Priorities for work to be developed

- Publicise the existence of programmes for black and ethnic minority staff
- Monitor the effectiveness and acceptability of programmes
- Facilitate debate about programmes so that staff have opportunities for dealing openly with the sensitive issues they raise.

Ensuring national policy is put into practice

AIM 6 *Ensure that key commitments to equality and diversity are being put into practice at strategic and operational levels*

Key challenges

- How can we ensure that statutory duties and requirements are followed through?
- How can we ensure that recruitment and internal promotion arrangements are inclusive and fair?
- How can we assure those, including many nurses from black and ethnic minorities, who see effective action in tackling racism in health care and employment as long overdue?

Priorities for work to be developed

- Provide opportunities (e.g. conferences, workshops) to examine best practice in promoting race equality
- Provide networking opportunities for all those committed to promoting race equality
- Each Strategic Health Authority Chief Executive to take appropriate steps to monitor diversity within their Health Authority area
- Discuss with the Commission for Health Improvement (CHI)¹ the production of a framework of criteria for assessing Trust performance and improvement in regard to equality and diversity.

¹Due to become the Commission for Healthcare Audit and Inspection (CHAI) in 2004.



Section 2

The survey – context, purpose and overview

In this section ...

- the background context of the NNLP's survey is described
- a descriptive overview of the survey is provided
- a perspective is given on the kinds of insights provided by the survey
- potential uses of this publication and the full survey are identified
- key terms and definitions are discussed.

2.1 Tackling racism

The NHS workforce has been criticised for failing to reflect the profile of the community it serves. There is growing evidence that minority ethnic groups have unequal access to education, promotion and continuing learning compared to their white counterparts and this has a consequent impact on staff retention. The comparative lack of black and ethnic minority staff at senior levels of the organisation is particularly notable. Accordingly, better recruitment materials, improved monitoring of data and more effective anti-racism policies are being introduced and more comprehensive policies to tackle racism across health and social care services are being promoted.

Evidence has been presented to show that career progression and job satisfaction for black and ethnic minority medical practitioners in the UK is unsatisfactory³. A similar picture of a lack of adequate representation has emerged from the NNLP's own survey of nurses from black and ethnic minority communities in positions of leadership in health (*see below*)¹. For example, while Caribbean, African, Asian and black British nurses represent about 9% of the nursing workforce, out of over 400 Directors of Nursing at present only three are 'black'. There is, however, encouraging early evidence in the diversity of senior appointments within PCTs. If one takes an overall view of leadership positions, whilst figures are still very low, there are representatives of black and ethnic minority nurses at Regional and government levels.

Racial prejudice and discrimination have been identified as problems for health care by communities, practitioners and government⁴. As a consequence many NHS organisations have identified the need to monitor and assess the effectiveness of systems in place to pick up overt discrimination against black and ethnic minority employees.

Institutional racism – those submerged discriminatory attitudes and values which are embedded in the organisation as a whole – has taken longer to be identified and accepted as a major obstacle to service improvement. There is now an increasing acknowledgement, for example, that institutional racism and bias have an important negative impact on professional education, access to services and workforce planning and delivery^{5,6,7}.

There is now also a significant commitment on the part of government to encourage public services to probe, recognise and respond more effectively to forms of racism, to promote fair employment and to ensure equal opportunities in employment in the NHS (*see below*). Changes called for include the acknowledgement of covert as well as overt discrimination in health care systems, strategic planning and a clearly articulated decision by senior management to address the problems^{2,8}.



2.2 Promoting a diverse nursing workforce at all levels

The impetus to promote diversity at all levels in the nursing workforce signals an important shift in how the NHS thinks and acts as an employer. Where is this shift coming from? And how does it fit into the policy context and operational background within which tackling racism and mainstreaming equalities in the NHS are taking place? Many professionals and managers will want to make sense of the disparate pressures, initiatives and directives involved by drawing these into a coherent, manageable agenda.

Several interconnected forces and drivers for change are coming into effect, within and beyond the health service and the realm of professional practice. These can be broadly grouped as follows:

- **pressures on the work environment** – e.g. recruitment, returning and retention, Improved Working Lives initiative, leadership and accountability, new regulatory frameworks
- **changes in the delivery of health and social care services** – e.g. expanding community and intermediate care, greater focus on public health, partnership/interagency working, plurality of providers
- **changes in society and the community** – e.g. demographic and social changes, patient empowerment and involvement, information technology, international changes, social entrepreneurship.

The drive towards diversity in nursing employment and leadership is reinforced by other closely related factors. These include:

- effects on performance – creating a productive environment in which everyone feels valued, where their talents are fully utilised and in which organisational goals are met
- new legislation – (see 2.3 below)
- equal opportunities policies – aiming to create an integrated workforce from many different cultures and sections of society
- positive action – giving preference to groups who are poorly represented in management or the workforce
- ethics and morality – exclusion and discrimination are recognised as social and moral problems in organisations
- public relations – no organisation wants to be recognised as discriminatory^{9,10}.

2.3 Tackling issues around diversity—why now?

Health and social care services, like many other public services, face difficulties in recruiting and retaining enough staff. The problem of recruitment and retention is an obstacle to achieving some of the major improvements that underpin the government's plans for a modern NHS. Failure to attract and retain staff is linked to a number of factors, including for example rising economic prosperity, widening job opportunities elsewhere, negative images of services and institutional racism. While some employment and human resources (HR) initiatives have proved successful, there is still evidence that institutional discrimination impacts on access to services, employment, and training and development. Accordingly, promoting race equality and eliminating discrimination are both policy priorities and legal obligations for the NHS. Developing a representative workforce is part of compliance with the Race Relations (Amendment) Act 2000, and is likely to be an aspect of the Disability Discrimination Act. This goal is also central to NHS policy such as *The Vital Connection*⁸, the NHS Plan¹¹, and other government and local authority policy requirements. Important drivers here include the following:

- the Commission for Racial Equality has published a draft code of practice for the public sector, setting out the implications of the new 'duty to promote racial equality' – public sector organisations are required to comply with the code, which came into effect at the end of May 2002, and to have in place an effective Race Equality Scheme¹²
- the Improving Working Lives Standard¹³ sets a model of good human resources practice against which NHS employers will be kite-marked – existing and newly established NHS organisations are required to achieve the Practice stage of the Standard by April 2003



- a heightened focus on local employment and representation issues, linked to service delivery, is likely to come through the user involvement processes being set up by the Local Strategic Partnerships
- new powers of scrutiny for local authorities under the NHS and Social Care Act 2001.

In a nutshell, as demonstrated by local Modernisation Reviews, the health and social care system will be unable to meet the requirements of the NHS Plan without a diverse and representative workforce.

2.4 Embodying inclusive models of leadership

In furthering this ambitious agenda for change the modernisation of leadership in the NHS has a key part to play. A modern leadership will embody more inclusive models and images of leadership, valuing diversity and difference and promoting genuine equality of opportunity, while at the same time seeking to recruit, retain and develop staff who reflect the diversity of the communities they serve¹⁴.

NHS leaders are also being required to ask themselves whether they can do more as employers, perhaps in partnership with others, to devise strategies for developing the potential of sectors which they may have overlooked in the past⁷.

2.5 Increasing the presence of black and ethnic minority nurse leaders

Encouraging and developing more leaders and senior managers from black and ethnic minorities in nursing, as in other clinical professions, is a central plank in the modernisation process. Reasons include the following:

- the presence of more non-white nurses in positions of leadership is a demonstrable sign of the organisation's commitment at senior level to tackling racism
- a clear anti-discriminatory message is sent to junior staff from black and ethnic minorities as well as filtering through to staff in general, helping to change perceptions and make racial harassment and discrimination less likely
- black and ethnic minority leaders can act as powerful role models, strengthening staff from minorities in their conviction that they also can progress on equal terms with others in their own careers
- having more such leaders fosters recruitment of under-represented groups in the workforce
- such leaders help to build links with minority ethnic communities, including promoting greater awareness of issues that affect the delivery of health care in minority communities.

'It's a white middle-class male-dominated organisation. There are no black people in senior positions, not on our board nor in the executive building.'

'Above Ward Manager level there are virtually no black people in senior leadership posts.'

'There are no black people in senior posts that matter ... The highest is as Matrons ... I've heard comments made by senior white staff that "they can't complain that we discriminate now" – because they have appointed some black people as Matrons.'

Contributors to the survey

Note. In some but not all instances contributors' job titles are given.

We have decided not to attach racial or ethnic categories to quotations.



How many black and ethnic minority nurse leaders are there?

Estimates of the numbers of black and ethnic minority nurses in leadership positions in the NHS are subject to some uncertainties. In Autumn 2000 the headcount of qualified nursing, midwifery and health visiting staff was just below 317,000, of whom 36% are in grades F, G, H and I, so there are about 114,000 nurses in those grades.

Nurses are treated as 'non-medical' staff in DOH statistics, which give national estimates of the proportions of nursing staff in the ethnic categories 'white', 'black', 'Asian', 'other' and 'unknown'. However, there are no breakdowns by grade or region and ethnicity. DOH staffing statistics, therefore, supply only rough estimates of the number of non-white nurses in higher grades. Moreover, these figures need to be interpreted with caution as they are based on incomplete returns.

Approximately 9.3% of qualified nursing, midwifery and health visiting staff in all grades are black, Asian or of other non-white ethnicity. The NNLP's survey estimates that non-white representation in the higher grades may be only about 6% at grade F, perhaps 5% at grade G, 4% at grade H and about 3% at grade I.

At the most senior levels non-white representation is exceptional. In some parts of the country it is exceptional even at middle management level.

Source: Elliott *et al.* 2002¹

2.6 About the NNLP's survey

A brief descriptive overview of the survey¹ is provided below. (*For a fuller account of how the work came about and its choice of methodology, including the use of methods drawn from an approach known as 'Appreciative inquiry', please refer to the survey report.*)

Aims, purposes and method

With the above key leadership considerations in mind, the NNLP commissioned an independent survey of black and ethnic minority nurse leadership development. We decided to target currently serving leaders and focus on the analysis of their career achievements to date, in order to:

- make their success stories more widely available
- encourage by example other minority nurse leaders and potential leaders in the NHS
- enable organisations as well as individuals to consider ways of learning from ideas and approaches that have worked for others.

The survey draws upon qualitative data gathered from structured face-to-face interviews with 104 nurses, midwives and health visitors in leadership positions.

Contributors were contacted mostly through a network of special advisers and some nursing directors. Interviews were carried out between July and November 2001. Nearly all were done by the three women in the research team – respectively black, British Pakistani, and Irish, by their own self-definitions of ethnicity.

Profile of contributors

The focus was mainly on people of Caribbean, African, Asian and black British origins, but some people of other minority ethnicities were also interviewed (see *Table 1*).

All contributors had spent most of their careers as practising nurses, midwives or health visitors (HVs), but almost a quarter of them now had jobs that are nursing-related but do not involve regular clinical practice.

For the definition of 'leadership' used, see 2.9 on page 14.

Geographical spread Contributors were evenly spread across six of the NHS regions, but only a small number were based in the Eastern region and only one in the South West.



Ages Over half were under 45 years of age, the largest group were aged 35–39, and over one-third were under 40. Of the 10 contributors in the most senior or highest profile jobs, half were under 45.

Gender Eighty contributors were female, 24 male. This is a much higher proportion of men than among qualified nursing, midwifery and HV staff nationally, where the balance is 88% female, 12% male.

Ethnicity Contributors' preferred descriptions of their ethnicity are set out in Table 1. The most frequently used terms were 'black', 'Caribbean', 'African' or 'Afro', and 'British', 'English' or 'Anglo'. Younger contributors were twice as likely to use 'black' and four times more likely to use 'British' – usually combined with another term or terms.

Table 1 Contributors' preferred descriptions of their ethnicity (n=104)

Preferred descriptions (with or without hyphens)	No. of contributors
Caribbean, Afro Caribbean, Black Afro Caribbean, African Caribbean, Black Caribbean, Black West Indian, Trinidadian, Anglo Caribbean, British Caribbean, Black Caribbean-British, Asian Caribbean	35
Black, Black British, Black English, Black Other	19
African, Black African	11
Indian, Anglo-Indian, Indian Asian	9
Mauritian, Black Mauritian, Mauritian Asian, Asian (Mauritian), Indian/Mauritian, born in Mauritius of Indian origin	7
Afro-Asian, Asian, British Asian, British Asian (Punjabi), British (Ugandan) Asian, Asian Other	7
Mixed, Mixed race, Mixed – Black other, Mixed Asian*/White (*South-East Asian in this case)	4
Pakistani, Pakistani British	3
Latin American, Cuban British, Guyanese – British born	3
Serbian	1
Data omitted or can't say	5

Work histories Ninety-five contributors had been in nursing for more than 20 years. Almost one-third had been in their current post for less than a year, reflecting the organisational changes affecting many health services. Only 28 were in post longer than five years – but 6 were in the same job for over twenty-one years, and one person had been in the same job for twenty-nine years. For almost two-thirds (66) nursing was their first job or qualification. There was no pattern to the others' prior experience; and in only a few cases was this nursing-related.

Prior higher education qualifications Only two started with a degree: one in nursing studies and the other with a BSc.

Qualifications since entering nursing Over 90% of the sample had other additional qualifications, including clinical and teaching qualifications. Sixty-five have or are studying for degrees, including forty-two at Masters level and three at doctoral level.

The 'SEN' factor A few had remained State Enrolled Nurses (SENs) for a long time, while some managed to progress to other professional qualifications very quickly. Exactly half of those identified as SENs (16 out of 32) had or were in the process of obtaining degrees. Notably, three of the contributors in the most senior or highest profile jobs were SENs.



Current jobs (see Table 2)

Table 2 Range of contributor's current jobs (n = 104)

Note. Where people have dual roles, they are classified according to the primary one.

Type of Job	No. of contributors
Senior Clinical Practitioner (various titles)	15
Specialist Practitioner or Clinical Lead (various titles)	11
Matron, Hospital Manager	3
Operational management – hospital settings	25
Operational management – community settings	10
Health Visitor, Community Psychiatric Nurse, Health Practitioner	6
Practitioner Tutor/Lecturer or Academic	8
Advisory, developmental and support management	18
Assistant Directors and Directors of Nursing, and policy-makers at regional and national levels	8

While the sample was not statistically representative, there are some interesting comparisons between contributors and national figures. One eighth (13) of the sample work in mental health – in hospital, community or policy-making settings. Nationally, black, Asian and other minority ethnic staff are significantly over-represented in mental health nursing relative to their presence in the total workforce, constituting about 9% of the total nursing workforce, but about 12% of staff in community psychiatry and 12.7% of those in other psychiatric services. They are also significantly over-represented in midwifery (11%) but under-represented in paediatric nursing (5%). Only three of the survey contributors specialise in midwifery, and five have jobs that are directly or broadly paediatric.

Types and levels of responsibility At operational level contributors were involved in, among other activities, clinical practice (30), clinical and staff supervision (58), budgets (38) and training (34). Twenty-nine were operating at or above senior management level. At 'strategic' level there were two diversity managers with clearly strategic roles and direct Board access, two senior academic posts, the director of a clinical unit with national importance, and two Directors of Nursing. At 'regional or national' level there were two people with regional executive roles and two senior DOH staff.

2.7 What kind of insights does the survey provide?

For a summary of the main findings of the survey see Section 1, pages 3–4.

Shedding light on the 'how tos' of leadership career progression

The survey highlights many of the factors involved in successful career progression for nurse leaders from black and ethnic minorities. These insights will be of interest and benefit to individual practitioners and managers as well as teams, networks and organisations.

The term 'successful', however, needs to be interpreted with care in this context (see 3.1, page 15).



While staff consultation and involvement are important, people from ethnic minorities employed by the NHS are understandably often irritated when approached for their 'views' on race and equality. Many feel there has been quite enough research and not enough action about matters affecting non-white staff in the NHS. The survey differs from some others in maintaining a steady focus on the actions and forms of support underpinning people's career achievements. Indeed, it was largely this approach which clinched some people's agreement to take part.

Highlighting areas of inequality

The work represented by the survey complements other work being carried out locally and nationally to identify and combat inequalities in health care and employment (see 2.1–2.4, pages 7–9). It is also intended to fit in with the emphasis on the culture of open communication, 'empowerment', innovation and flexible leadership being fostered by the NHS Plan.

The fuller survey contains a commentary on the findings by Professor Charles Husband, Director of the Ethnicity and Social Policy Research Unit at Bradford University. This provides an account of contemporary understandings of the nature of racism, with frameworks for policy and action, as well as exploring key concepts such as 'race thinking' and 'institutional racism'.

Offering 'snapshots' of achievements ...

This publication offers a taster of the rich case material contained in the full survey. The survey contains a wealth of 'snapshots' describing in their own words the experiences, achievements and aspirations of a wide variety of nurse leaders from black and ethnic minorities. Together these snapshots provide a powerful, cumulative picture of important aspects of individual achievement. This unique source material will, we trust, be widely shared and used and spur on many others in the NHS.

Significant lessons for leadership development generally will, we hope, also be drawn from the survey and this shorter publication. We trust that these lessons will stimulate reflection and debate in this important area.

... but not the whole picture

The survey profiles a selected group of nurses' career progression at a single given moment in time. Likewise, ethnicity is an important but not the sole defining factor needing to be taken into consideration when assessing their achievements. Other variables affecting leadership success will include age, gender, environment, life experience and other intrinsic and extrinsic factors.

2.8 How might the publication be used?

This publication and the fuller survey can be used:

- as an individual – for example, for study and reference and to find out sources of further information
- with individuals and teams within departments and organisations – for example, for briefings, agenda setting, workshops and reference
- with individuals, teams and groups from different departments, organisations, systems and networks – for example, for workshops, and to help structure reviews and planning
- by those designing leadership development programmes
- by leaders – to understand the experience of nurses from black and ethnic minority communities and to reinforce their role in creating a culture that values diversity and does not tolerate racism.

Both resources are available in electronic format on the NNLP's website (see 6.2, page 37).



2.9 Key terms and definitions

'Leadership' In a large, complex organisation like the NHS, capacity for leadership is widely dispersed and its distribution often bears little relation to formal power structures. Many leaders double up as followers, leadership may be shared among teams, and some occupy leadership roles in certain work contexts but not in others. Opinion formers within the professions can have a powerful leadership role but not see themselves as top management. Many survey respondents commented on the fluid nature of 'leadership' and on the need to recognise and understand different styles of leading. No overarching model or definition of leadership emerged from interviews, nor was one sought. These important provisos aside, in the NHS 'leadership' is usually endorsed by seniority as evidenced by grade status. For the purposes of the survey, therefore, 'leadership position' was defined as **being at grade F and above**.

'Ethnicity' There is much debate about terminology relating to race and ethnicity and about whether any term (e.g. 'non-white') can claim to be accurate, appropriate, sensitive or value free. We can only touch on the existence of this debate here. No single term is entirely adequate and none will serve all purposes, as most commentators observe. Clearly, however, some choice of terms has to be made. Accordingly, a range of 'umbrella' terms is used in this publication. For a fuller discussion of terminology please refer to the fuller survey.



Section 3

Succeeding, against the odds

In this section ...

- the factors affecting individual success of black and ethnic minority nurse leaders are identified
- aspects of individual encouragement and support that leaders have found helpful or essential to their career development are discussed
- accounts by black and ethnic minority nurse leaders are provided in their own words.

Influences and factors are explored in relation to:

- helpful factors
- personal qualities
- supportive behaviour
- recognition of talents
- highs in professional life
- chances to demonstrate capabilities.

3.1 'Success': a note of caution

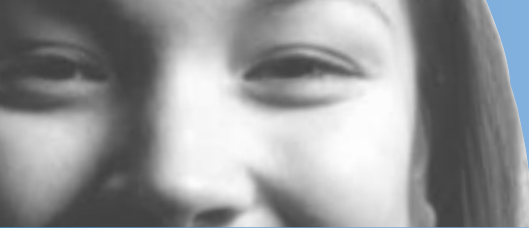
A note of caution needs to be sounded at the outset to avoid complacency about the notion of 'success'. For several contributors to the survey personal success has come very belatedly, after prolonged disappointment and frustration. For some others achieving one of the higher grades does little to relieve a situation and outlook that in their view is unremittingly bleak. It should also be recognised that some nurses from black and ethnic minorities will have left the profession because they were so worn down or outraged by what they experienced.

Similarly, some contributors were resistant to the phrase 'getting on against the odds' when first approached to become involved. Some hold the view that their careers have not been affected at all by their skin colour, so for them the notion of getting on against the odds is wrong. Arguably, they might wish to reconsider their opinion about this phrase in the light of the weight of evidence subsequently collected by the survey.

3.2 Who or what has helped most?

The most frequently mentioned helping factors were:

- 1 Determination
- 2 Encouragement by managers, consultants, tutors and colleagues
- 3 Qualifications and professional ability
- 4 Being pro-active and willing to learn
- 5 Mentors, developing political awareness and learning to use networks
- 6 Upbringing, family and partner's support.



'You need to be twice as good or twice as determined. I knew what I wanted and nobody was going to stop me. You need the right qualifications, and then to find someone who believes in you – as well as belief in yourself. Accepting your disappointments and pick yourself and start again ... My partner was very supportive and encouraging. My first break was getting F grade and then G grade. I worked with someone who believed in me and supported me. She was a brilliant role model.'

Lead Cancer Nurse

Factors going with determination included belief in self, personal drive, keeping focused and motivated, not letting others set limits, and tenacity.

Encouragement from others is equally crucial. This includes tutors, peers and colleagues, line/senior managers, consultants and directors.

'I had good bosses. I had wonderful senior people who allowed me to be who I am. They encouraged me, supported me and allowed me to develop my talents further and at no time said "you can't" ... I found strategies to overcome racism and blocking behaviour as and when it arose – and it did.'

'On the negative side, for a long time there was lack of opportunity for black and ethnic minority staff – the opportunities were there but ... there was an assumption that you're there [in a given post] and you couldn't go beyond that level. I was never satisfied with staying where I was all the time – but it's very easy to just give up. I'm also saying that people, black or white, have to be discovered. I feel I've been discovered ten years too late.'

Their **professional ability** and **commitment to nursing** is intimately related to contributors' sense of self-worth. **Qualifications** loom large in many contributors' minds – as a personal achievement and a mark of professional standing.

Being pro-active and willing to learn covers taking the initiative to develop skills to equip oneself for promotion, seeking out development opportunities and looking for role models. It also covers asking questions, taking risks, learning from mistakes, rising to challenges, and being willing to change – 'thinking outside the box', as the following example illustrates.

'I have been prepared to move and take chances with posts and the experience they provide. On the whole this has worked out well and people I have worked with have been very supportive. I have worked with so many good role models, both nursing and general management. ... My education in terms of [action] learning sets in ... and an advanced nursing learning set have been very significant. I watch so many people in terms of how they manage and lead – including the bad ones that are too many to mention ... Moving regularly also helps you to address your mistakes and reapply yourself afresh as does working with new people and challenges. My different upbringing also means I think that I tended to question more and not take things for granted so easily. I also think matching words and deeds has been important.'

Regional Director



For those who have had the benefit of it, **mentoring** matters not only for the support, encouragement and fresh thinking it can bring, but also for helping to develop awareness of organisational politics, the tactics of career progression, and learning how to use networks pro-actively. **Networking** is one of the main attractions of development programmes.

'My champion was a friend from church who offered me guidance and support – offering me help to improve my application forms and interview techniques, like asking for feedback as to why I was unsuccessful – and telling me that someone will discover me! She made me learn to develop my support system ... I have learned how to manage people [in ways that] my nursing career had not prepared me for. [For example] I was pushing to go on a management course, I was told to do a degree in nursing instead, but I got onto the management course and identified my own mentor and clinical supervision off my own back ... I know now that if I can't get into one area for experience or knowledge, I can get it somewhere else – lateral thinking works! I've learnt to be reflective about my career progression.'

Outpatients Sister

Upbringing, family support and a **supportive partner** are rated as highly as mentors and networks.

'My husband has been a key factor. He has always believed 100% that I could make a difference. My previous manager has also been hugely influential. She helped me develop my skills and encouraged me to set my sights high. A previous Director of Nursing who is Chinese also influenced me positively, and maybe in ways that he may not realise.'

3.3 Personal qualities

While there is great variety in what contributors value most about their personal qualities certain factors stand out, as summarised in Table 3, which shows how frequently particular attributes featured in responses to the question about this.

Table 3 Personal qualities

(I.e. those mentioned ten or more times in response to a direct question about personal qualities, with double-counting of multiple responses)

Attribute	No. of contributors who mentioned it
Approachability, empathy, interpersonal skills	29
Honesty, self-awareness, openness, integrity	25
Commitment to service, its development & making a difference	18
Professional competence, high standards and self-discipline	16
Determination, being self-motivated, stamina	16
Supportive team-working	14
Being pro-active, creative, making things happen	13
Respect for clients/patients and colleagues	12
Not being afraid to challenge, take risks, give and take criticism	10
Giving 100%, always doing your best	10
Positive approach to problems, adaptability, flexibility	8
Fairness	6
Setting an example, being a positive role model	6
Ability to lead and influence change	6



Naturally enough, the overall pattern reflects the ethos of nursing. At the same time, it reflects some welcome changes in culture. For one thing, for each person who is quietly confident in her or himself there is another who revels in his or her talents and abilities, and is therefore unlikely to comply with any expectation to be traditionally complacent. Secondly, qualities such as being pro-active and being prepared to challenge the status quo are unlikely to have been emphasised as much a decade ago. And, whether consciously or not, the pattern of qualities mentioned is fairly similar to some well-known models for professional success – e.g. the qualities which form the basis of Pedler, Burgoyne and Boydell's (1994) much-used *A Manager's Guide to Self-Development*¹⁵, and Stephen Covey's (1989) best-seller *The Seven Habits of Highly Effective People*¹⁶.

3.4 Examples of supportive behaviour

'Lift as you climb. It's much better than stepping on people to get where you want to go.'

The question here was about situations where other people had gone out of their way to give support to contributors, and with what results. About ten contributors could not cite such an instance, while several talked about people being supportive in incidental or generalised ways but without any sense of people going out of their way to be helpful. In a few cases, ambiguous responses relate as much to some people's need to independently control their careers as it does to low expectations of help from others, as the following comment explains.

'Wouldn't say anyone's gone out of the way to help ... One of my managers supported me to attend a course in counselling. That opened up other development opportunities for me. Our previous Assistant Director of Nursing offered informal support and has asked me to apply for other senior jobs, but I am happy where I am. I am doing the Ward Manager's job anyway.'

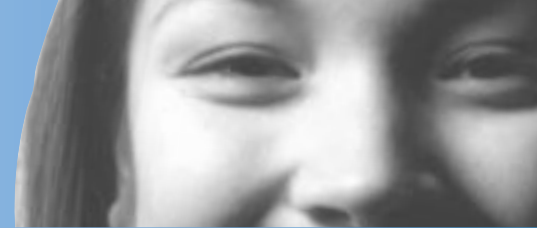
On the other hand, just under 100 disparate examples of support were cited by about 80 contributors, including instances of people certainly going out of their way to be supportive. Of those examples, 50 refer to line managers, other senior managers, consultants and directors, another 16 refer to colleagues and staff, while 10 refer to tutors, and 10 to mentors. Following are some examples of such support and who provided it.

*'The **Director of Nursing** and **Chief Executive** supported me in the development of the black and ethnic minority staff support network. I was able to by-pass middle managers and go higher up – but I had logical arguments and supportive evidence and it was on that basis that I got the backing. The Chief Exec also attended first meeting.*

Manager, diversity

*'Before I was promoted, a **manager** gave me a chance of managing a ward and that boosted my confidence. More recently I wanted to do counselling and I got a lot of support and help from the **consultant**.'*

Clinical Nurse Supervisor



*'I was trying to develop a course for ward Sisters. Initially there was a lot of apprehension but the **Director of Nursing** was very supportive. She suggested ways to improve how the course was being sold to my peers. That changed things. She put herself on the line ... and the course was successful.'*

Ward Manager

*'I applied for a job as Assistant Director of Corporate Affairs. I was the only female and people were visibly shocked to see me at the interview. I reported this experience to the **Chief Exec.** at the Health Authority. She had had a similar experience and helped me get a secondment. After that many doors opened. Key senior colleagues have been significant in helping me to develop. That's been important.'*

Assistant Director of Nursing

*'As a student in training, all the hard work, I have always found it hard to study. **My tutor** me under her wing and gave me one-to-ones. It was a gift. I've always had exemplary **ward Sisters**, especially one ... And in my present role, **my nursing colleague.**'*

Project Manager

*'My first placement as a student on Project 2000, **Sister** on the ward was a great mentor, very frank; honest and telling me to learn the tricks and skills by observing others. She took time to help me. I learned to be suspicious when people said I am not ready for this yet!'*

Nurse ConsultantProject Manager

*'**My boss** when I worked in neuro. I needed to change from a student to a work permit. I had written the letter and passed it on to Personnel. Then I discovered that my application hadn't been processed, Personnel "didn't agree with employing me". My boss went ballistic and came with me to see the Personnel Officer. My boss said "We have lots of foreign doctors so why can't we have a foreign nurse? And I want her to work for me." She stood by me throughout. I still had to wear an auxiliary's uniform for a month while my application for a work permit was being processed. Now I have permanent residency.'*

Clinical Skills Tutor, teaching hospital



Support that matters most at present

The kinds of support most frequently mentioned are: general support of **line/senior managers**, of **professional peers, colleagues** and **staff**. Also important is the support of family and friends, and of mentors. Constructive feedback, honesty and openness are particularly valued.

Other kinds of support mentioned include the following:

- respect as a person, their views valued
- recognition
- support without undue interference
- appreciation of differences in priorities
- more contact with manager and G grades
- feeling free to phone somebody, having a sounding board
- support to be creative
- support when speaking frankly
- real inclusion in decision-making
- political guidance
- help with time pressures, resource constraints
- development resources
- opportunities to update knowledge/skills
- support to do advanced practitioner course
- support to progress to the next level.

Twelve of the 104 contributors feel distinctly under-supported, out on a limb.

'There's always a price to pay for success ... I have no support at moment. Have taken this up as an issue. The flip-side, if you are black and ask for help, is you are seen as not coping and that is the label attached to all black people.'



3.5 Times when their talents were recognised

Table 4 summarises the responses to the main part of the question about talents being recognised by somebody else.

Table 4 Times when talents were recognised by others (n = 112)

Responses have been classified according to overall emphasis, with some allowance for multiple responses.

Type of recognition mentioned	No. of contributors	
Positive feedback, appreciation and support from managers, peers and staff	19	48
Top level recognition and support	15	
Recognition from clients	5	
Consultant support to develop clinical ability	4	
Opinion being sought	3	
Fair, effective appraisal interview	2	
Opportunity to join/lead project or trial initiative	13	26
Opportunity to write paper or report or make presentation	6	
Policy development opportunity	4	
Secondment to manage project	3	
Encouragement to go for job, being head-hunted	8	12
Getting job is recognition	4	
Awards – achieved, nominated	4	7
Particular development opportunity	2	
Representative role in BBC video	1	
Own sense of achievement	9	9
Insufficient recognition, support, reward	10	10

Responses here prompt some observations. One is the fairly obvious point that most contributors are very finely tuned to **positive feedback** and recognition. Secondly, recognition can take various forms including status, financial reward and verbal appreciation, including that of service users (examples were given of staff having been approached by appreciative service users and family members several years after the event). Thirdly, for many the chance to exercise their talents matters at least as much as someone else’s endorsement; they expect to be **self-motivating**. And lastly, they all like being given **responsibility**; they run with it.

Clearly the question of recognition also arouses many complex and often deeply-felt reactions to being given or deprived of recognition, support and positive feedback. Some feel the rewards are justified while some feel the rewards are unfair, as the following comments show.

‘My brief was to set up [a national project] ...The Director of Nursing said to me “I have under-estimated your talents”. That was because she had suggested a way of doing things which I didn’t think would work. I asked her for time to prove it my way. She agreed and I pulled it off.’

Senior Nurse, mental health

‘Through a recruitment and retention initiative I managed to turn around a surgical unit from being in a state of near crisis to a smooth-running unit. The Chief Exec. of that Trust was very appreciative.’

Director of Nursing



'This was such a reward for me. I hoped that other young black people watching it would look at it and say – with tenacity and persistence, this can be me.'

Service Manager

'In the last 6 months I've been fully recognised and my talents exploited. I use the word advisedly because of the attitude of senior managers. I have been chosen to lead —. Instead of it being given to an experienced person, they gave it to me. So they knew I had the [ability] and this has been fully exploited but not valued in terms of pay. Other colleagues are getting more pay for same job. One was encouraged to apply for more money, but I was not.'

Project Manager

'In my current role I'm autonomous, I don't feel I have to prove my worth all the time, I'm around people who treat me with respect, praise me, value me. In my previous job I was only told I did a good job on the day I was leaving.'

Development facilitator

3.6 Highs in professional life

Asking about 'highs' in the contributors' professional lives yielded a different perspective on what drives and satisfies them. The responses are summarised in Table 5.

Table 5 Highs in professional life (with double counting n=156)

Type of situation described	No. of contributors
Achieving a certain status	38
Gaining qualifications	32
An aspect of nursing practice	32
A successful project, making something work	16
Making a presentation, public speaking, writing, publishing	16
Awards of various kinds	12
A unique or unusual opportunity	4
Development opportunities	3
Ambiguous or negative responses	3

The 'high' of achieving a particular status can represent validation of self-worth, reward for effort, a benchmarking of professional ability, or a stepping stone to fulfilling further ambitions, including ambitions to 'make a difference'.

Awards individual contributors have gained include the following: RCN Nurse of the Year, the Mary Seacole award, Best Diversity Manager – British Diversity awards, at least three OBE's and a CBE. Also included in this category are two contributor-led projects that won awards, being nominated for a national leadership award, achieving five distinctions for essays in nursing studies, and being awarded a distinction for teaching practice.



3.7 The chance to show their capabilities

Some contributors talk about quietly getting on with their job, because that is their personal disposition or because they have had to keep their heads down. However, they are well outnumbered by the ones who delight in a challenge. Some of the many examples of achievements include:

- developing and implementing new approaches to bed occupancy, managing discharge and the transition to home care
- introducing preventative work supervision with other health professionals as a way of dealing with staff mental health problems
- championing a healthcare apprenticeship scheme
- turning around within 2 years a service which had previously closed down three times due to mis-management and under-performance
- developing an inter-agency agreement to enable clarity about information sharing and confidentiality
- driving through an international recruitment project
- championing a refuge for people fleeing domestic violence
- leading innovative projects, e.g. the first water birth in a hospital that was very traditional in its approach
- securing research funding for a Trust.





Section 4

Development strategies – what works?

In this section ...

- leadership development activities and initiatives that have worked for black and ethnic minority nurses are discussed
- further first-hand accounts of nurse leaders are provided.

Professional and personal development issues are explored from the following angles:

- situations found to be beneficial for career development
- participation in the LEO (Leading Empowered Organisations) programme or the RCN Clinical Leadership programme
- involvement in other development activities, formal or informal
- involvement in career development initiatives specifically for black and ethnic minority people
- differences in support received.

4.1 Developmental situations

Contributors have found a wide range of developmental situations to be useful to their career development. These include:

- a challenging job or project – e.g. 'I did lots of projects along the way which were very useful for my development.' (Director of Nursing)
- the opportunity to 'act up' – e.g. 'Mostly developing others – I have developed myself while I was concentrating on developing other people.' (Ward Manager)
- a supportive manager or colleague, which is especially important early in people's careers – (see 3.4, page 18)
- studying
- mentoring
- learning from teaching
- learning from difficult experiences – e.g. 'When I was getting knocked back applying for F grade jobs my manager told me that he thought I would never be F grade material. He gave me a videotape of my interview – I saw how I needed to develop.' (Director of Nursing)
- extra-curricular activities – e.g. 'Being a school governor changed a lot of things for me – because I began to understand how to develop political skills to survive.' (Senior Nurse)

4.2 The LEO and RCN programmes

LEO (Leading Empowered Organisations) is a three-day workshop, while the RCN programme runs for eighteen months and involves the release of practitioners for 25% of their time.

Of the 104 contributors, 27 had taken part in LEO at the time of the survey and another 11 were scheduled to do so. There were only 6 RCN programme participants, with another 3 scheduled for it. Three contributors are LEO trainers and one is a RCN facilitator. Some people who had opportunities to take part in either programme opted not to because they felt they had covered the ground already, in a Masters programme or other leadership programme.



Participants' comments on both programmes are nearly all favourable. For some people these programmes provide a fresh perspective; for others, they provide welcome confirmation of how they have been trying to work or extend their repertoire of leadership skills.

See also 6.2, page 37.

4.3 Other development activities

All but three of the contributors have been involved in some other kind of developmental activity in recent years, formal or informal. Some of the numerous activities are:

- mandatory professional development
- upgrading clinical skills and various means of keeping up-to-date with clinical developments
- research projects
- management and leadership programmes
- numerous Masters degrees
- mentoring and being a mentor for others
- leading and contributing to learning sets and educational groups
- going to conferences
- community development and other voluntary work
- being active in support groups of various kinds – for patients, for minority groups.

Distinction between formal, informal and self-directed development activities can be fine, since any kind of development is grist to the mill for many of these people. Some are so committed that even formal development may be in their own time and self-funded. However, needing to fund themselves for professional development is a bone of contention; some cannot afford it, and it causes resentment if there is unfairness in the allocation of development funding.

4.4 Black and ethnic minority career development initiatives

Many of the contributors are involved in development forums, support groups and networks that operate within and across specialisms, agencies and regions. Several of them act as mentors or trainers on development programmes. The networks formed by those who have been involved in leadership programmes for people categorised as black or Asian are particularly strong, often categorised as **positive action** programmes. Twenty-four contributors have taken part or are currently participating in the 'Beacon' leadership programme or the one run by the King's Fund (see 6.2, page 38). Mentoring is an integral part of both programmes.

While they do not suit everyone, there is no doubt that these leadership programmes have been a powerful force for good. Some participants see them as a turning point in their lives, and as genuinely empowering. Others, however, voice opposition in principle to programmes for which selection is racialised.

'Going on the [King's Fund] BEL programme changed things for me ... Having a mentor enabled me to follow my intuition and I felt confident in the advice she gave me about what was useful to me or not. I became more aware of my skills and abilities. I became proactive and not reactive, recognised I am more of a reflector. I have the confidence now to challenge and disagree, which five years ago I would never have done.'

Child Protection Adviser



“The whole thing [Beacon] was based on action learning, very integrated. For instance, the mentoring and networking all linked up with your personal development plan. Everything we had to do was “live”, not just an exercise. And real feedback on every module ... But the network just as crucial – people in a position to make things happen – direct contact with very senior people, chief executives ...

... One feature lacking in the Beacon course – preparing the organisation for my return. The organisation was not prepared in the least for what I was doing. For example, I got a place on the Nurse Reference Group for the NSF for ——. So I knew what was coming. I was feeding all this back to my Trust but no-one was paying attention. It was like sending me on the Beacon course was complying with something ... Rather than face the challenge my manager was putting me down ... Participants’ line managers need to be more part of the programme, like the mentors. Too often managers want an easy life, not having the kind of debate I was having with my mentor.’

Senior Practitioner

‘In 1995 I attended “Moving Up in the NHS” for black women ... It acted as the catalyst for me to do the Certificate in Management Studies and progress to the Diploma in Management Studies [both self-financed and done in own time] ... I am not comfortable with the focus being just for black people. It does not benefit black people. We do not need special help. Black people need to be fully integrated, and to be positively focused ... Don’t treat us as special but as equal.’

Community Services Manager

‘It needs to be “a leg up, not a hand out”.’

DOH official

This debate about positive action programmes runs right through the range of views about organisation structures and cultures which are discussed in Section 5.

4.5 Any difference in support?

Contributors were asked whether the kind of development support they have experienced is in any way different to what others can get.

- One third of the contributors feel that there is **little or no difference** in the kind of support they have received compared with others.
- About a quarter feel they have had and/or are getting **less support** than colleagues or feel they have been discriminated against.
- About one in eight simply **have not expected support** – they have managed it themselves
- One in six think they have had **more support** than colleagues – because of lucky breaks, being fortunate to have supportive bosses, having backing from the right people, or because it came with their position.



'I have always supported my own development – I have helped myself. Being black you are treated differently and have to work twice as hard as white peers to be recognised.'

Diversity Project Manager

'In my present post ... everyone is able to access support. In previous posts, how people were perceived determined the level of support they received. I was lucky, in that I was perceived as someone who could "deliver". People who had been doing the same job for a long time were sometimes dismissed as being incapable, without necessarily being given the chance to prove themselves. The flip side of this was there were higher level staff in the organisation who could "talk the business" and received lots of development opportunities, but who consistently failed to deliver. Often it was those managers who suppressed their own staff's aspirations.'

Team Leader in Health Authority

'It's hard today but I imagine that what others can get I can also access. It depends on your relationship with your manager. The support mechanisms are not that formal and a lot of it is down to how well you get on with people. But black nurses do not get the same support as white nurses.'

Diversity Project Manager

'I don't feel I've ever had a buddy, pal or mentor.'

Ward Sister

'It would appear that whereas I have had to work 120% and jump through all kinds of hoops to get where I am, others can be slotted into posts simply because they complain about their current situation or because they get on well with senior management.'

Lead Clinician

'You see people who have come behind you climbing the ladder quicker and you don't feel your skills are valued. Sometimes when a black person makes it to the top they change because they are afraid of being accused that they are looking after own kind of people.'

Clinical Practitioner

'I have had such a mix of brilliant and awful it is hard to know ... I don't think it was average or typical. What you do as an individual is what matters. You must take responsibility for finding the "right" people to support and enable people from diverse backgrounds – this is a clear responsibility for senior NHS staff.'

Director of Nursing



Section 5

Making the most of potential

In this section

- positive experiences and challenges for change at the organisational level are considered
- practical strategies for making the most of people's potential are set out
- further first-hand accounts of minority nurse leaders are provided.

*'To be in a position to influence change,
To be respected, valued, taken seriously
To never stop listening to everyone else.'*

Specialist Nurse, listing three wishes for her own potential

5.1 Changing the organisation's culture

Initiatives designed to promote equality and tackle racism play a central part in the modernisation process of the NHS (see 2.1–2.4, pages 7–9). Putting these initiatives into practice calls for a level of commitment and change across the organisation as a whole. But how easy is this to achieve? There is a growing recognition that following through on this ambitious agenda requires something of a sea-change in the NHS's established culture and its ways of leading and working, and that such a **change is unlikely to happen overnight**.

Contributors are strikingly fair-minded about the challenges of effecting long-lasting change in attitudes and behaviour in the NHS with its inherent complexity, deeply rooted traditions and the kinds of power dynamics common to many large scale public sector services.

For example, as we have seen (see 4.4, page 26), people have mixed opinions about the value of positive action programmes on the wider organisation: some think that they only serve to make some white people dig their heels in deeper, or deflect attention from wider problems, while others point to their beneficial impact on team functioning.

What, then, are some of the other experiences of change for the better?



5.2 Positive experiences of change

Contributors can point to encouraging examples of change which is already happening.

'I am sure there are barriers but I have noticed that within the CHT they have really tried to have fair representation from all sides. That's my perspective and experience within the Trust. I won't say I have not come across barriers, but if you want to get on you can do. On an individual level there could be blockages and that's down to personality. The old hierarchical structure is still there but policies such as Making a Difference are having an impact and I feel that I am taking advantage of it.'

'My Trust has a track record of willingness to address barriers ... For example, the Chief Exec. and Directors are prepared to admit we've got a problem, and take the time and put money into it ... In the past initiatives ... were not sustained – but this has changed. There is positive support strategically – from the Chief Exec. and Directors of Planning and HR.'

'The reason the organisation is so great is that it is led by a Chief Executive of extraordinary calibre, who genuinely believes that the NHS can only achieve modernisation and change through its staff. Therefore, the organisation is committed to staff development – at every level from reception to director level. Staff have regular briefings about changes and the implications thereof. There is commitment to staff development throughout the organisation. The atmosphere is happy and free of the usual petty office politics/tensions and people will make every endeavour to help each other out in pressurised situations. Visitors who come to see me here have often commented on how courteous and welcoming staff are here. I very much hope that in the changes to come this is not lost.'

Ideas for facilitating change include focusing on removing the barriers in the system, for example, by putting on programmes for senior white managers to explore how they either hinder or support black and ethnic minorities from progressing into senior management (see also 3.4, page 18).

A number of contributors also point to the positive effect of their involvement in the NNLP's survey and how it has helped them to reflect on their career development and achievements to date while also reinforcing their convictions and expectations about the need for further organisational change in the health service.



5.3 Challenges to change

Contributors are highly critical of a number of failures of the system to manage change or make a difference, including in the following areas:

- cultural insensitivity and prejudice
- double standards
- lack of commitment to genuine diversity
- failure to follow through on equality policies
- unfair rewards
- institutional racism
- absence of non-white people in senior positions.

Uneven commitment to diversity

Contributors are aware that much effort is being invested in promoting the NHS as an employer committed to diversity and eliminating racism. Some point to encouraging examples of good management and leadership in dealing with the day-to-day practices that are known to be detrimental to progress in this area. However, commitment to diversity can be half-hearted or inadequately followed through.

'Lack of diversity from board level down. When you attend board meetings people look at you and you're not made to feel welcome.'

'To be honest, I don't think the needs of minority staff are on the agenda. The excuse may be given that [it's] to do with frequent organisation changes and national targets. But in NSF workforce planning, diversity is on the back page.'

Failure to follow through on equality policies

There is widespread disappointment with the ways in which policies on equality are side-lined or diluted and often fail to filter through and deliver at operational level. Many are also dissatisfied by what they perceive as rhetoric on race and equality as opposed to real and sustained action.

'They do not value their workforce ... there is no real commitment to addressing "racism" within the organisation. Whatever attempt is made to address the issue is carried out in a half-hearted manner with no clear co-ordinated or structured approach to solving the problem. [In that Trust] there are perhaps less than five black people in management positions. We work in isolation and with questionable support.'

'Some attempts at positive action have been counter-productive because of all the back biting and resentment that followed. It's a fertile ground for rumours.'



Unfair rewards

Several point to the lack of recognition and fair rewards they receive and how minority ethnic staff and others can be exploited in this respect.

'Black people often do all the development of their skills and so on but don't get the other part – the fair reward. I've lots of examples. You can do as much as you can to equip yourself, but unless the other part happens too ... you can't give your best, and the organisation loses.'

'I am sure that it is not just ethnic minorities who suffer because of top-level favouritism.'

'But I ask myself why I am still here doing the same thing. It's not as if I don't want to move up ... There has been a lot of cases of acting up and then other people get the job – people who are more friendly with the management. That's a barrier – a lack of fair play.'

Institutional racism

Contributors provide several examples and many insights into the working of institutional racism, that is 'those established laws, customs and practices which systematically reflect and produce racial inequalities in society'³. Covert and unconscious forms of racism can be particularly hard for many people to bring to light and discuss rationally. Many contributors point to the value of adopting what might be called a 'whole systems' approach when tackling this difficult subject. In this respect the survey corroborates the conclusions of other recent research in tackling racism in health care.

'Institutional racism cannot be removed by individuals. It requires the collective intent and action by the whole system. Combating institutional racism and promoting anti-racism is about educating people for a new society that values and promotes social justice ... There will be the inevitable resistance to change, which will take the form of anger, denial and sabotage. Yet, the participation of many will be necessary for the creation of a culture in which human values will be esteemed above self-interest.'

Source: Coker, 2001: 238²



Below are some selected comments from leaders from the full survey.

'Bluntly, institutional racism. But it's not only institutional. It's a white middle-class male culture – they don't want to work with people who are different but they have to be politically correct. Also, the organisations are too big, people get lost. So it becomes almost impossible to apply good practice across the whole of the organisation. For example you may have good practice in one department but it doesn't get applied in another. How can one department influence another when there is so little integration? Also deeply entrenched historical attitudes.'

'Post Stephen Lawrence there must be recognition and acknowledgement of institutional racism ... no matter how uncomfortable.'

'I had to make three attempts to get G grade [At previous attempts she did well at interview, but ...] ... then another blue-eyed blonde came along and got it. Eventually they ran out of excuses.'

'We were plucked from our country and then told to be English, and then when it suited we were to be foreign again. I was expected to be able to interpret for Bangladeshis – I didn't even know where Bangladesh was. When I got over the crudeness of this approach I was very angry.'

Absence of black and ethnic minority role models at senior levels

(See 2.5, page 9.)

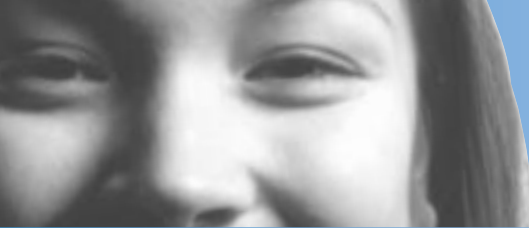
Home truths

While contributors are happy to cite good practice where they see it, they are not afraid to face uncomfortable home truths. These include issues such as self-esteem, communication and assertiveness skills, mutual support and the controversial topic of 'playing the race card'.

'It could also be that black nurses do not push themselves enough. It's necessary to talk to your manager. Sometimes they can open a closed door, or point you in the right direction.'

'Black people are not supportive of each other. We are our own worst enemies. We do not want to form alliances. One is singled out as the champion and then colludes with the system to keep others out because they want to be recognised. It happens all the time ... It's the racist trap of letting only one through.'

'Part of the reason I get disconcerted by the race issue is that I feel some people use it as an excuse for their own failures.'



'The organisation had a number of black people in post who were appointed on merit. Then they played the system: went off sick each time there was real work to be done ... All the black staff were given the opportunity to study for a higher degree – guess what, the dissertation period was taken as sick leave to do the work. Their course evaluations showed problems: managers were obstructed from taking action because they played the race card. There is a personal situation for me here: I had to address issues with a member of staff [black] who went to the union complaining of racism, harassment, accused me of being a coconut.'

5.4 Things to do, things to avoid

It is important to consider change at the organisational level because only at that level can certain deep-seated problems and inequities be addressed. But how do insights about the organisation and change translate into the day-to-day pressures and dilemmas facing individual black and ethnic minority nurses, including those in front-line jobs who may be considering moving into leadership or wishing to realise their career potential in other ways?

Many will be working with multiple demands and priorities competing for time. They may see all too clearly how and why the organisation needs to change. They may be less certain of how they as individuals might need to change or progress, or how they may contribute to the wider change agenda.

Contributors' ideas and recipes for getting more minority nurses into leadership positions – and encouraging nurses at all levels of the organisation to survive and thrive – are many and diverse but tend to highlight three key ingredients:

- the **need for transparent fairness** in regard to career development opportunities, both formal and informal, and in promotion procedures
- the potential for applying diversity policies **dynamically**
- the importance of investment in **coaching, mentoring and shadowing**.

Given real support, many contributors are willing to be active themselves in such roles.

Certain key messages also come across consistently as likely to be more effective as general approaches to getting on against the odds.

- **Take the initiative** – e.g. 'If you don't know what's available and how to access it, you won't get access to it.'
- **Look at the big picture and see yourself in it** – e.g. 'You need to see that you are part of something bigger and have an equal part to play ... I see the NHS as a giant puzzle. Each person has to find where they fit in, and maybe change it a bit along the way. How you do it remains with you as a person and remains entirely your responsibility.'
- **Talk about your aspirations** – e.g. 'Make contact with senior people, and ask them how they got where they are.'
- **Take chances** – e.g. 'Stick your neck out despite barriers. Be persistent and push for what you want ... Challenge decisions you feel are unfair and unjustified.'
- **Be clear about what you want, but open to change** – e.g. 'Don't be pushed into route that you don't want to go down. Have a vision or focus of where you want your future to be. Have something to aim for, even if you change.'
- **Value your own identity** – e.g. 'Don't let other black people's experiences limit you. '; 'Black people get labelled as being aggressive in our communication ... You need to adapt your communication style to the cultural norm, but do it without losing your cultural identity.'

Contributors were asked to offer advice on things to do and avoid doing to make the most of one's potential. What four actual nurse leaders – a Diversity Project Manager, a Nurse Consultant, a Team Co-ordinator and a Senior Lecturer – had to say follows.. (See *fuller survey for more*.)



As with any list of 'dos and don'ts' tips and ideas need to be weighed against individuals' own experience as well as other forms of evidence for 'what works'. But we hope that these ideas – the fruit of much wisdom – will stimulate others to identify pointers for reflection and debate, including helping to build agendas for further action and research.

Diversity Project Manager

Things to do

- Do the best you can in any situation, regardless of what you are told. Set your own standards high and do your best to achieve them.
- Seek constructive feedback on your performance
- Network with a range of people in power that can support you and act as a champion for you even when you are not there
- Educate yourself to the highest level you can and don't let anyone discourage you
- Seek knowledge, understanding and awareness – not just inside the organisation but outside it. Look beyond your professional group. Nurses should know what is happening for doctors, clinical specialists, scientists, etc.
- Learn to challenge other people assertively – by being professional, not aggressive. It's about learning the language, not losing your identity.

Things to avoid

- Complacency in yourself and others
- Negative thoughts about your ability
- Staying in a job you hate – it's not good for you.

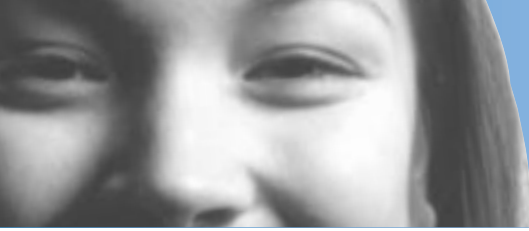
Nurse Consultant

Things to do

- Have a clear picture, a vision of where you want to be
- Be open to advice, to receiving support – that'll enable you to get the good from it but not put you down
- Have passion – you really want to do it and get excited by it
- Get a mentor and professional support independent to your area – let them be your eyes and ears
- Be open to learning and developing your skills – be reflective
- Keep your sense of humour and humanity
- Don't ask the question if you're scared of the answer
- Influence events – create your own future, don't let the future create you
- Give your best and do your best
- Like what you do.

Things to avoid

- Being too soft-skinned – see the good in things, not the bad
- Being closed to new ideas and suggestions
- Being all things to all people – delegate what you're not good at
- Jobs that don't challenge you. I've gone for jobs that scared me – that is where the really big learning is.



Team Co-ordinator in Health Authority

Things to do

- Organise regular supervision sessions with a trusted, balanced mentor/manager/senior figure
- Have your own personal and professional development plan, with objectives, milestones, timescales and outcomes. Compare views with your mentor/manager's.
- Have people you can offload to in confidence. It is better to have people outside your own employing organisation for this, if possible.
- Choose courses, conferences with care – you must come away from the event or programme with something you wanted
- Always be friendly and professional with colleagues, at whatever level. One day you might need their support or advice, whether you are going up or down the career ladder.
- Become familiar with IT systems.

Things to avoid

- Thinking your organisation owes you something – think what you can do to improve your organisation – and why you in particular can do it?
- Depending on work to fulfil all your social and emotional needs. Make sure you have a solid network of dependable friends, family and a balanced social life.
- Bringing work home – work late if you need to rather than bring the office home
- Constantly reacting to crises – start thinking of ways to prevent them occurring
- Thinking about professional demarcation lines – we are moving into a new NHS which requires creative solutions that stretch boundaries
- Demurring to the medical profession
- Saying nothing, keeping your head down
- Thinking you won't get the job because you're from an ethnic minority!

Senior University Lecturer

Things to do

- Identify what you want, link it with your employer's goals
- Work your needs into an annual development plan
- Identify a variety of strategies that may lead to the same end result, and rank them in order of preference
- Think of ways that you can demonstrate benefits to the employer organisation – to get managerial support
- Be proactive so as to meet application rounds etc (some employers only consider requests for resources once a year)
- After a development opportunity – how can the learning be shared? A good way to get support for own development. Needs organisational support.
- Perhaps produce a one-year-on report to demonstrate how the employer organisation has benefited.

Things to avoid

- Putting all your eggs in one basket
- Going for things that are too immediate (it may not get resourced)
- Relying on others to represent you (e.g. to speak to your application)
- Mouthing off if your application is rejected (sour grapes and gossip gets back, spoils your chances another time)
- Doing things that you do not have managerial or organisational support for, blaming others for failures.



Section 6

Sources and resources

Depending on the focus of your concerns, you are likely to find it useful to:

- consult the resource and case material about nurse leadership and ethnicity contained in the survey 'Getting On Against the Odds' (see page v for further details)
- talk to specialists in leadership research and development – inside and outside your own organisation
- link into leadership development programmes being offered through the NHS and other bodies
- seek out further guidance and research evidence on nursing, race and ethnicity, health care leadership and employment.

6.1 Working with specialists in leadership development

There are people you can access who have considerable knowledge of leadership research and development. Often they can be found in Nursing Directorates and Human Resources (HR) departments, Lifelong Learning teams or faculties of health sciences and management studies at higher education institutions. If you cannot locate them in or through your own organisation, your Regional Directorate of Health and Social Care or local Workforce Development Confederation (WDC) will be able to point you in the direction of a local resource.

The NNLP (see 6.2) also provides information and links to leadership research and development resources.

6.2 Linking into leadership programmes

National Nursing Leadership Programme (NNLP)

The central contact point for the RCN and LEO programmes (see below) and for leadership initiatives in nursing nationally. The NNLP works closely with Nursing Executive Directors and Trust Boards to ensure that nursing, midwifery and health visiting leadership is

placed firmly on the national agenda. It also works across multi-professional teams with Allied Health Professionals and others in health care settings such as prisons.

www.nursingleadership.co.uk/

NNLP's Leadership Development Programme

A national e-learning programme over the internet for leadership development. The programme is free and can be undertaken at work or at home. It consists of a number of courses that can be taken at your own pace, whenever and wherever you want to study, and in 'bite-sized chunks' to fit in with your work and life. Courses include: leadership skills; conflict resolution; personal effectiveness; dealing with stress; problem-solving; effective communication; presentation skills; budget management; and project management.

www.nursingleadership.co.uk/resource/r_elearn.htm

For further information about the programme email David Dawes at:

dave@nursingleadership.co.uk

NHS Leadership and Management Development Programmes

The NHS provides a range of leadership and management training programmes for senior managers and those new into, or seeking a post in, general management.

www.doh.gov.uk/learningzone/programs.htm

Royal College of Nursing (RCN) Clinical Leadership Programme

An 18-month day release programme designed to assist healthcare practitioners to develop patient-centred leadership strategies to deal with the realities of their day-to-day practice

www.nursingleadership.co.uk/rcn_leo/rcn_info.htm

Leading Empowered Organisations (LEO)

A 3-day programme designed for professionals from all disciplines and with all levels of expertise and experience, LEO is offered by the Centre for the Development of Nursing Policy and Practice (CDNPP) at the University of Leeds

www.chcm.com/summary/leo/frameset.html



King's Fund Leadership programmes for professionals and managers from Black Minority Ethnic Communities (BEL)

The BEL programmes are designed to help health care managers from minority and ethnic communities compete equally in the senior management marketplace. Programmes are designed according to client needs and range from 10 days over 6 months to 20 days over a year, usually as 3-day modules coupled with some single-day events.

www.kingsfund.org.uk/eLeadership/html/redress.html

Positive action training programmes

The NHS has funded a number of positive action training programmes for black and ethnic minority staff at all levels, and has supported ethnic minority women managers' networks. For more information contact your regional NHS Directorate of Health and Social Care, HR department or WDC.

Other leadership/management programmes

A wide variety of leadership and management development programmes is available, ranging from short courses to those at certificate, diploma and degree levels offered by institutions of higher education. Some focus on clinical leadership. Others focus on generic leadership and management skills and are designed for a range of professionals within and beyond health and social care. Still others are designed for women managers, for example, or centre on cross-sectoral and collaborative forms of leadership.

Accredited leadership degree programmes (e.g. the Masters level Leadership London Programme at www.llweb.co.uk/) are being sponsored by the NHS. Contacts are as for "Positive action training" above.

Leadership programmes, including for people from ethnic minorities, are also offered by independent consultants and the non-statutory sector.

6.3 Seeking out further research evidence, information and guidance

The following are some suggested starting points you may find useful and are not intended as a comprehensive list of resources. Preference has been given to resources which are widely available on the internet.

Race, equality and health care

Coker, N. (ed.) 2001. *Racism in Medicine: An Agenda for Change*. London: King's Fund

Comprehensive collection of first-hand accounts, historical perspectives, research studies and good practice examples which explores the reality of racism in the NHS and sets out an agenda for change. While the focus is on medical practitioners, many of the lessons learnt can be applied to other professionals.

Commission for Health Improvement (CHI) 2001. *Providing NHS Services for Ethnically Diverse Populations*. London: Commission for Health Improvement

Report about work CHI has carried out to ensure that its clinical governance reviews and other work can effectively assess how the NHS provides services to meet the needs of an ethnically diverse population

www.chi.nhs.uk/eng/comm/2001/nov/item10.pdf

Department of Health (DOH) 2000. *Positively Diverse Report 2000*. London: Department of Health

The 'Positively Diverse' initiative brings together a service-wide consortium of healthcare and other partners to improve access and participation for all sections of local communities in the healthcare workforce. The report describes what 37 pilot organisations discovered during the first phase of the programme.

www.doh.gov.uk/nhsequality/posdiv.htm

DOH 2000. *The Vital Connection: An Equalities Framework for the NHS*. London: Department of Health

Introduces a package of indicators, standards and monitoring arrangements and sets national targets for the NHS from April 2000 on disability, tackling harassment, achieving a representative workforce and board training on equality and diversity

www.doh.gov.uk/nhsequality/nhsequalitiesframework.htm



DOH 2001. *Improving Working Lives: Black And Minority Ethnic Staff Networks: Guidance*. London: Department of Health

Guidance for senior managers on active and well-supported black and ethnic minority staff networks

www.doh.gov.uk/nhsequality/improvingworkinglives/improvingworkinglives.pdf

DOH 2001. *Tackling Racial Harassment in the NHS: Evaluating Black and Minority Ethnic Staff's Attitudes and Experiences*. London: Department of Health

Analyses the attitudes of black and ethnic minority staff about racial harassment they have experienced, the effectiveness of their employers in tackling it, and evaluates current practices to tackle racial harassment

www.doh.gov.uk/raceharassment/evaluating.htm

DOH 2001. *Tackling Racial Harassment in the NHS: Good Practice Guidance*. London: Department of Health

Includes a framework for ensuring that all NHS employers have effective policies in place to tackle racial harassment; covers key elements of a harassment policy for NHS organisations and how these can monitor progress against the national targets on harassment

www.doh.gov.uk/raceharassment/trhguide.htm

Khan, U. 2001. *Equality Standards in Health and Social Care*. London: Department of Health, Equality Strategy Unit

A scoping study which discusses the equality agenda and performance management, provides an introduction to standards and toolkits and methods for evaluating models

www.doh.gov.uk/race_equality/equalitystandards.pdf

Smaje, C. 1995. *Health, 'Race' and Ethnicity: Making Sense of the Evidence*. London: King's Fund

Comprehensive account of the health of people from minority ethnic populations in Britain. It looks at their use and experience of health services, and the attempts by policy makers to address their needs.

Virdee, S. 1995. *Racial Violence and Harassment*. London: Policy Studies Institute (PSI)

A critical evaluation and assessment of the sources of racial violence and harassment and how these can be tackled. The book provides useful contextual reading for an understanding of racial harassment in health care employment.

Nursing and ethnicity

Bharj, K. K. 1995. *Nurse Recruitment: An Asian Response*. Bradford: Bradford College Race Relations Research Unit

Explores the reasons for under-representation of black and ethnic minority people in the nursing profession and offers strategies to overcome a range of obstacles faced by them

English National Board (ENB) 1996. *Research Highlights 21* (July 1996). London: English National Board

An examination of the extent to which pre-registration programmes of nursing and midwifery education prepare practitioners to meet the health care needs of minority ethnic communities

ENB 1998. *Research Highlights 30* (May 1998). London: English National Board

Key findings from a research project examining the national pattern of applications, from members of minority ethnic groups, to pre- and post-registration nursing, midwifery and health visiting courses

Both ENB publications are available at the Nursing and Midwifery Council website at:

www.nmc-uk.org/cms/content/publications/

Hastings-Asatourian, B. and Cortis, J. D. 2000. *Gatekeeping Inequity and Cultural Assessment in Nursing*. Bradford: Bradford College Race Relations Research Unit

Describes how recruitment and selection practice enabled racism and sexism in a college of nursing and identifies a need to address racism in the nursing profession at the level of recruitment and delivery of health care



Leadership in nursing, health and social care

Cabinet Office 2001. *Strengthening Leadership in the Public Sector*. London: Cabinet Office

An excellent review of the complex and growing research literature on leadership, drawing together evidence and models from a variety of fields and disciplines. A summary of the report or the full report can be accessed via the NNLP website.

www.nursingleadership.co.uk/pubs/piu_report.htm

Carlisle, D. 1997. 'Minority positions'. *Health Management*, 1, 9, 14–15

Review of representation of black and ethnic minority managers and the need for more

DOH 2000. *Black and Ethnic Nurses, Midwives and Health Visitors Leading Change: A Report of the Mary Seacole Leadership Award – The First Five Years*. London: Department of Health

The Mary Seacole Leadership Award honours significant achievements by black and minority ethnic nursing, midwifery and health visiting leaders. The report provides examples of winners of the award in leading change in the promotion of health and the provision of health care.

www.doh.gov.uk/maryseacoleaward/maryseacole.pdf

NHS Executive London 2000. *Embodying Leadership in the NHS*. London: NHS Executive

Resource providing a concise overview of the individual qualities and actions that are central to the exercise of good leadership in a modernised NHS

www.doh.gov.uk/london/leadership/

Equality and diversity in employment

Cabinet Office 2002. *Employment and Ethnicity: Interim Analytical Report*. February 2002. London: Cabinet Office

Comprehensive synthesis of existing research evidence on the comparative labour market achievements and outcomes of ethnic minorities, how achievements are changing over time and key drivers and determinants of those outcomes. Contains a map of government policies and initiatives.

www.cabinet-office.gov.uk/innovation/2001/ethnicity/scope5.html

Pathak, S. 2000. *Race for the Future: Ethnicity in Education, Training and the Labour Market*. Department for Education and Skills (DfES) RTP01. London: DfES

A summary of the research evidence
www.dfes.gov.uk/statistics/DB/RES/r0143/

Also available from the NNLP

Dawes, D. and Dobson, K. 2001. *Nurses on Board: An analysis of Nurse Leadership in 1st and 2nd wave PCTs*. Manchester: National Nursing Leadership Project

DOH 2000. *Code of Practice for NHS employers involved in the international recruitment of healthcare professionals*. London: Department of Health

DOH 2001. *The NHS Plan - an action guide for nurses midwives and health visitors*. London: Department of Health

Faugier, J. and Woolnough, H. 2001. Whistleblowing and the implications for developing leadership. *Mental Health Practice*, 5, 3
Above publications available at:

www.nursingleadership.co.uk/pubs.htm

6.4 Other useful web sites and contacts

Commission for Racial Equality

Publicly funded, non-governmental body set up under the Race Relations Act 1976 to tackle racial discrimination and promote racial equality

Tel: 020 7828 7022

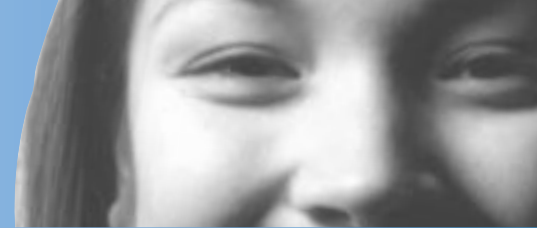
www.cre.gov.uk

Department of Education and Skills (DfES) Race Relations Employment Advisory Service (RREAS)

Free and confidential strategic advice to employers and others so that they can develop and implement policies. Publishes a booklet on Positive Action.

Tel: 0121 452 5447/8/9

www.dfes.gov.uk/rreas



Department of Health and NHS sites

Further information and resources on Leadership Development initiatives in the NHS can be accessed at the Modernisation Agency site at:

www.modernnhs.nhs.uk/

The NHS web site provides links to regional teams and other organisations and networks:

www.doh.gov.uk/nhs.htm

The NHS Workforce Development Confederations (WDCs) site provides links to WDCs in England, with information on NHS careers:

www.wdconfeds.org/

The Department's race equality web-site provides key information about the Department's work in this area, including the implementation of the Race Relations (Amendment) Act 2000. It also provides a suggested template for devising a paper for Boards on developing their race equality strategy.

www.doh.gov.uk/race_equality/
www.doh.gov.uk/race_equalityresource/board-papertemplate.rtf

Further information and guidance on nursing, training and development, equality, diversity and related issues, including good practice advice for managers and leaders, can be found at:

Chief Nursing Officer's Bulletin (Sarah Mullally)
www.doh.gov.uk/cno/bulletinindex.htm

International recruitment guidance

www.doh.gov.uk/international-recruitment/index.htm

NHS Equality and Diversity in Employment

www.doh.gov.uk/nhsequality.htm

Human Resources (HR) Performance Framework

www.doh.gov.uk/hrstrat.htm

HR Directors' Bulletin

www.doh.gov.uk/hrbulletin

Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare

www.doh.gov.uk/nurstrat.htm

NHS Beacons

www.modernnhs.nhs.uk/nhsbeacons

Improving Working Lives

www.doh.gov.uk/iwl/

Positively Diverse

www.doh.gov.uk/positivelydiverse/

Royal College of Nursing: RCN Connect

Networks and networking tools for encouraging understanding and challenging the barriers black and ethnic minority groups face in the workplace. Offers training for members on confidence-building, interview skills and participation in public and political events.

www.rcn.org.uk/news/campaigns_rcnconnect.html

Runnymede Trust

UK-based independent think tank on ethnicity and cultural diversity which conducts policy research to challenge racial discrimination, influence anti-racist legislation and promote a successful multi-ethnic Britain

www.runnymedetrust.org

The Transcultural Nursing and HealthCare Association (TCNHA)

Promotes knowledge and understanding of transcultural issues in nursing and healthcare and provides a forum for discussion about transcultural issues for practitioners, teachers and managers

www.fons.org/networks/tcnha/

For membership enquiries contact Christine Hogg, Lecturer in Nursing, Department of Nursing, University of Salford, Peel House, Albert St, Eccles, Manchester M30 0MM. Tel: 01612 955 000. Email at c.hogg@nursing.salford.ac.uk or Paula McGee at paula.mcgee@uce.ac.uk

For other useful links visit the NNLN website at:

www.nursingleadership.co.uk/resource/r_links.htm



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NOTES

NHS Leadership Centre
Richmond House
79 Whitehall
London SW1A 2NS
General enquiries: 020 7725 2564
Web address: www.nhs.uk/modernnhs

**The NHS Leadership Centre is part
of the NHS Modernisation Agency,
within the Department of Health**



2nd Floor,
Gateway House,
Piccadilly South,
Manchester,
M60 7LP

Tel: 0161 237 2459
Fax: 0161 237 2016

E-Mail: enquiries@nursingleadership.co.uk
Web Address: www.nursingleadership.co.uk