

## Research paper

# An exploratory study into the recruitment of black and minority ethnic students to a sponsored NHS trust cancer nursing education programme

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## ABSTRACT

This study was commissioned by a director of nursing concerned about under-representation of black and minority ethnic (BME) nurses on an NHS trust-sponsored cancer nursing course. A literature review, including publications related to cancer nurse workforce planning, unearthed little on the subject. Research was undertaken to find out the views of students concerning the recruitment and retention of both white and BME nurses onto these courses. Questionnaires were sent to two cohorts of students ( $n = 80$ ), and 36 (45%) students responded, 30 (37.5%) returning completed questionnaires. The findings demonstrated that the majority either did not perceive, or were not sure that there were any differences between recruitment and retention of white and BME nurses into cancer care. Key barriers cited were identified as those relevant to general nursing shortages within the NHS. They included poor pay, not being valued, and emotional stress related to caring for terminally ill patients. Factors cited with respect to BME nurses included

language problems, cultural influences, stigma and possible racism. The degree of dissonance between the views of the students and the director of nursing is of interest, as is the dearth of papers on this topic within the nursing literature. It may indicate a possible lack of awareness among the cancer nursing profession about whether BME nurses are under-represented within this specialty. This is in contrast to the prominence this topic has acquired amongst other sections of nursing. The issue of BME representation requires addressing by those involved in cancer nursing workforce planning and recruitment strategies. It is recommended that those involved in cancer nursing workforce planning review the issue of the representation of BME nurses within the specialty.

**Keywords:** cancer nursing, post-registration courses, recruitment of black and minority ethnic nurses, workforce planning

## Introduction

The initiative for this study came from the chief nurse and deputy chief executive of an NHS trust specialising in cancer nursing services. There was concern at the apparently low numbers of black and minority ethnic (BME) nurses applying for trust-

sponsored places on the cancer nursing educational programmes. The trust has a long history of initiating and providing specialist post-qualifying cancer nursing courses. Recruitment to the educational programme includes encouraging those employed by

the trust to apply for a sponsored place, and through external advertisements in nursing journals. The package for successful candidates includes appointment on a permanent work contract as a staff nurse, payment of tuition fees, provision of accommodation and full study leave. The selection criteria require that the applicant has at least one year's nursing experience, which ideally includes six months caring for cancer patients, although exceptions may be considered. Prospective candidates without such experience have the option of joining the D grade rotation programme of the trust, with a guarantee that they will be considered for a sponsored place on the course.

## Black and minority ethnic nurses in cancer care

The UK Department of Health recognises that nurses play a crucial role in the national cancer programme, and has highlighted the need to increase the cancer nursing workforce. An inadequate number of nurses has undertaken specialist cancer education (Department of Health/National Health Service Executive, 2000). However, in discussing the shortage of nurses within the NHS, no reference is made to BME nurses' contribution to cancer care. In contrast, the national nursing strategy *Making a Difference* (Department of Health, 1999) stated that there is still considerable scope to 'secure equality of access to education, development and career advancement for nurses, midwives and health visitors from black and ethnic minority groups'.

## Recruitment of BME students to pre- and post-registration nursing programmes

Iganski *et al* (1998) analysed all 54 194 applications to pre-registration nursing programmes stored in the former English National Board for Nursing, Midwifery and Health Visitors (ENB) admissions database between October 1993 and September 1996. They reported that minority ethnic applicants were less likely than white applicants to have been offered a place, and that a higher proportion was rejected without an interview. This could not be explained by variables such as qualification level, the specialty chosen or age. Mahoney (2001), in a follow-up study, found that 34% of both white and black Caribbean applicants secured a place, compared to just 17% of African candidates. There were also substantial differences between various colleges of nursing in this

regard. Consequently, the educational consortia of the time were advised to: 'give particular attention to considering ways of encouraging people from ethnic minority communities (many of whom live in the areas of greatest shortage) into nursing and other professions, and fostering a climate in the NHS which encourages them to stay' (NHS Executive, 1997).

Equality of access to post-registration nursing education and training is cited as a significant feature of the policy to improve care delivery (Audit Commission, 2001). Baxter (1988) reported that BME staff encountered difficulties in accessing training in higher-status and more popular areas of work. A study conducted in Birmingham (Klem and Notter, 2001) involved interviewing 164 health practitioners (nurses and allied health professionals), of whom 92 (56%) were from BME communities. Of the reported incidents of perceived racial discrimination, 7% were in education and 16% in respect to promotion. Other research that provided similar evidence includes the Commission for Racial Equality (1987), the King's Fund (King's Fund Equal Opportunities Task Force (KFEOTF), 1990), the Policy Studies Institute (Beishon *et al*, 1995) and the English National Board for Nursing, Midwifery and Health Visiting (ENB) (Gerrish *et al*, 1996; Iganski *et al*, 1998).

Beishon *et al* (1995) identified that little monitoring of applicants' post-registration education was carried out by NHS trusts, and Iganski *et al* (1998) noted a similar situation in colleges of nursing and midwifery. The King's Fund (KFEOTF, 1987) included recommendations such as mandatory equal opportunity training for those involved in recruitment, and avoiding the use of informal visits, unsolicited references and patronage. The ENB (1998) undertook an audit of ethnic monitoring systems in colleges of nursing and midwifery, but this only covered pre-registration programmes. In respect of qualified NHS staff, the Audit Commission (2001) noted that 'the potential for discrimination exists when appraisal and the identification of individual training needs is patchy and unsystematic. Therefore, it is important that trusts monitor appraisal/PDP [personal development planning] coverage, and application for and uptake of training opportunities in relation to ethnic origin'.

## Career development of BME nurses

The Policy Studies Institute explored the experiences of BME nurses and midwives (Beishon *et al*, 1995). The survey comprised:

- 1 a qualitative study of six case study nurse employers across the country, involving interviews with 114

qualified and unqualified staff, 60 with white staff and 54 with ethnic minority staff

- 2 a national postal survey of 23 251 nursing and midwifery staff with 14 330 (62%) completing the questionnaire.

While the data suggested that minority ethnic groups were well represented in the higher grades, a more detailed statistical analysis identified that it took some groups (particularly black nurses) a much longer time to reach those grades, regardless of similar qualifications and experience. Findings identified a big gap between theoretical policies on equal opportunities, such as in recruitment and promotion, and the actual practices undertaken on the ward and in other workplaces.

The Race Relations (Amendment) Act 2000 gives public authorities, such as NHS trusts and higher education institutes (HEIs), a general duty to promote race equality. To help public authorities meet this general duty, the Home Secretary has made an order (under the Act) that gives them specific duties in policy, service delivery and employment. As an example of the latter, they are obliged to monitor by 'racial group': staff in post; and applicants for jobs, promotion and training (Commission for Racial Equality, 2002).

The *NHS Plan* (Department of Health, 2000a) reinforced the need for NHS trusts to demonstrate that their procedures for recruitment, development and promotion should be demonstrably fair and to encourage BME staff to develop their careers within the NHS. More recently Sir Nigel Crisp, the former Chief Executive of the NHS, issued a 10-point *Race Equality Action Plan* (Department of Health, 2004), and reiterated that the NHS must target recruitment and development opportunities for people from different ethnic groups 'whose skills are often underused'.

## Recruitment of BME nurses into cancer services

The representation of BME nurses in cancer services would appear to be a workforce planning issue. However, in an analysis of the evidence base Richardson *et al* (2001) commented that 'Despite the importance of an effective and efficient cancer nursing workforce in ensuring cost-effective and positive patient outcomes, the evidence available on which to base organisational decisions is so weak as to be almost non-existent'. In their review of current practices Richardson *et al* (2002) noted that 'There is still much to be achieved, primarily in the areas of workforce planning, the skill development of non-specific nurses, and research and development'.

A search of the literature (using CINAHL and MEDLINE databases) identified a dearth of research

on BME nurses in cancer care, but several studies highlighted the value of their presence in the workforce. For example, Thomas *et al* (2000), in their study on the efficacy of bilingual health advocacy in an inner London cancer centre, reported that all the healthcare professionals interviewed experienced communication difficulties due to language and cultural barriers.

Olsen and Frank-Strombourg (1994) undertook a survey of African-American nurses applying for participation in a workshop organised by the National Cancer Institute and Oncology Nursing Society. They concluded that African-American nurses favourably influence cancer prevention and screening beliefs and practices for African-American clients. In addition, ethnic and cultural appropriateness of care can be positively influenced by shared values and beliefs between nurses and service users.

CancerLink has recommended that 'Management and care staff at all levels should broadly reflect the local population including black and minority ethnic groups. There should be regular training to raise awareness and promote discussion about the needs of black and minority ethnic people' (ScanLink, 1996).

In the UK, the results of a national survey of over 65 337 patients with cancer from over 170 NHS trusts (Airey *et al*, 2002) are of interest: 2% ( $n = 1307$ ) classified themselves as other than white; of these, half were black and one-third South Asian and nearly half were in the London region. Thirty-six percent of black and 42% of South Asian patients said that they did not have confidence in all nurses, compared with 27% of all patients (Airey *et al*, 2002).

In a postal survey of doctors and nurses at the Royal Marsden NHS Trust Aspinall *et al* (2002) found that one of the most frequently mentioned single measures thought to best contribute to improving access for BME populations was a wider use of staff from minority ethnic groups in a range of roles.

It was disappointing that an evaluation of the Macmillan Lead Cancer Nurse Initiative (Booth *et al*, 2001) gave no information about the ethnic group of the respondents based in 12 sites, nor did it discuss representation of BME nurses within cancer care. It is also regrettable that the Royal College of Nursing (RCN) makes no mention of BME nurses in cancer services in its framework for adult cancer nursing (RCN, 2003).

## Conduct of the study

The aims of the study were to:

- describe the ethnic group profiles of those applying and of those accepted for an NHS trust-sponsored place on cancer nursing courses between September 1999 and September 2002

- elicit the views of students in the September 2001 and 2002 cohorts concerning recruitment and retention into cancer care of both white and BME nurses.

The survey used a postal questionnaire that was designed to find out the views of students concerning issues relating to white and BME nurses undertaking cancer care nursing. The course organiser provided a profile of the students undertaking the courses. Following approval from the local NHS trust research ethics committee, the study was undertaken between April 2001 and December 2002.

The timeframe for the study period allowed the purposive recruitment of students in two cohorts. While there were an initial 48 students in the first cohort that commenced in September 2001, there were only 43 remaining at the time the questionnaire was distributed. In the second cohort, all 37 students that started in September 2002 were approached to participate in the study.

The questionnaire design was kept simple but focused. Closed and open-ended questions were generated to target responses to the issues being studied (de Vaus, 2001). Information about personal and professional profiles, motivation to do cancer nursing, sources of information about the course and the outcome of the recruitment process were requested. Respondents were also asked their views about career prospects in cancer nursing, possible barriers to recruitment and retention of cancer nurses, both white and BME.

Questionnaires, together with an information sheet, invitation letter and consent form and a stamped addressed envelope were sent out to the remaining 43 students of cohort 1 in April 2001, and to the 37 cohort 2 students in November 2002. A reminder was sent to non-responders within two weeks. The responses rate of the two cohorts combined was 30 (37.5 %) with full details set out in Table 1.

Statistical data analysis was carried out using the SPSS version 10 software package. Descriptive statistics,

**Table 1** Questionnaire response rates from cohort 1: September 2001 ( $n = 43$ ) and cohort 2: September 2002 ( $n = 37$ ), total = 80

	Returned <i>n</i> (%)	Completed (valid responses) <i>n</i> (%)
Cohort 1	21/43 (48.8)	16/43 (37.3)
Cohort 2	15/37 (40.5)	14/37 (37.8)
Total	36/80 (45)	30/80 (37.5)

including frequency and percentage distribution, together with the range and mean values were calculated for some numerically coded variables (Punch, 1998). The small numbers in the study did not allow differences in BME numbers across cohorts to be subjected to inferential statistical analysis. Analysis of the written responses to open-ended questions was carried out using a thematic analysis approach, with coding and categorisation of data and generation of themes (Punch, 1998).

## Findings

### Ethnic group composition of the four cohorts

In order to detect trends in recruitment of BME students, the ethnic group profile of four cohorts between 1999 and 2002 was obtained from the human resources department and is shown in Table 2. The ethnic group of five (13.5%) students in the 2002 cohort was either not known or not stated. This

**Table 2** Profile of four cohorts of students by ethnic group sponsored by the NHS trust on cancer nursing courses between September 1999 and September 2002

Cohort year	White <i>n</i> (%)	BME/other <i>n</i> (%)	Not stated <i>n</i> (%)	Total
September 1999	43 (89.5)	3 (6.3)	2 (4.2)	48
September 2000	45 (90)	2 (4)	3 (6)	50
September 2001	39 (81.25)	6 (12.5)	3 (6.25)	48
September 2002	24 (64.8)	8 (21.6)	5 (13.5)	37

compares with a range of 4.2% to 6.25% in the three previous cohorts. Overall, there was an observable increase in the percentage of BME students enrolled on courses over this four-year period, from 6.3% in 1999 to 21.6% in 2002.

Unfortunately it was not possible to undertake an analysis by ethnic group of those who were accepted or rejected for a sponsored place during this four-year period. This was due to the completed application forms not being retained, or the information not being stored on a database.

## Respondents' profiles

There were three males and 27 females, with a mean age of 29 years. Twenty-eight out of 30 gave details of their country of birth. The majority (20) were born in the UK and the remainder were born in the following countries: Ireland (2), the Philippines (2), Finland (1), Malaysia (1), Zimbabwe (1) and South Africa (1). The ethnic groups as stated by the respondents showed that in cohort 1, 10 (68.8%) were white (including one Manx), and six (31.2%) were BME nurses. In cohort 2, 12 (85.7%) were white and two (16.6%) were BME nurses.

Out of the 30 respondents, the large majority (70%) were registered in the UK (18 in England, three in Scotland), with two in Ireland, two in the Philippines and one each in Singapore, Zimbabwe, South Africa and Australia. One respondent did not state the country of registration.

With respect to the above, 10 respondents had completed the three-year pre-registration programme leading to the registered general nurse (RGN) qualification. Another 11 had completed the diploma in higher education (adult nursing), seven had completed a degree in nursing and two had undertaken a postgraduate diploma in nursing.

Across the two cohorts there were differences in the length of time respondents had been registered. In cohort 1, the length of time the respondents had been registered ranged from one to 10 years, with a mean of 4.7 years. In the second cohort, the minimum was one year and the maximum 29 years, with a mean of 7.2 years. Fourteen respondents indicated that they would continue to degree-level study. Nine were not sure, five stated that they already held a first degree and two stated that they were planning to leave the course. Seventeen out of 30 respondents (57%) had had experience of a cancer care placement during their pre-registration nursing course, seven had not and six did not respond. All respondents had professional experience in cancer care, 17 having worked in this specialty for up to two years.

## Sources of information

Fourteen respondents (46.6%) learnt about the sponsored places programme from a nursing journal, and 12 (40%) from working at the trust. Other sources of information included an overseas recruitment agency (2) and by 'word of mouth' (1).

## Motivation to do cancer care nursing and perceptions of career prospects

All 30 responded to this question. Career opportunities within the context of professional development appeared to be a prime motivator. Cancer nursing was perceived as being both challenging and rewarding due to the complexity of the condition and the variation in patient outcomes. Three respondents were not clear about the reasons for coming into cancer nursing, indicated by 'drifted into' and 'wanting a change'. Only one person mentioned the influence of a placement during the initial pre-registration training programme.

Respondents acknowledged that the specialty provided 'a lot of job opportunities, promotion prospects and professional development'. However, progression to the higher F grade and specialist clinical practice grade was seen as limited and competitive. *The NHS Cancer Plan* was perceived as promising nurses a varied career pathway (Department of Health, 2000b). The positive aspects of oncology nursing were identified (the cohort and respondent number are given in brackets):

'Oncology is actually a popular and "trendy" area of nursing at present.' (C1, 12)

'... once [nurses] have worked in oncology many really enjoy it and therefore stay.' (C1, 14)

## Barriers to recruitment and retention in cancer nursing

Fourteen of the respondents thought that there were barriers, 11 were not sure and four stated that there were no barriers.

'... no more than in nursing generally.' (C1, 13)

'... generally I think there are major recruitment and retention problems in nursing.' (C1, 12)

Some felt undervalued and that their concerns are often not heard. The nature of the work in oncology was perceived as being stressful and depressing.

'Nurses often have to face [the] reality of their own fragility with regards to death and dying.' (C2, 3)

The emotional and psychological aspects of working in cancer care were also identified.

'Maybe some perceive it as an emotionally draining job that only some can manage appropriately.' (C2, 11)

'It can be very stressful ... I have met nurses in the past who have "burned out" whilst working in oncology.' (C2, 2)

A further barrier cited by one respondent was:

'... lack of exposure to specific oncology placements as a student nurse.' (C2, 13)

Finally staffing levels and poor pay were also identified:

'Not enough staff to care for these patients fully and holistically as it is very time-consuming.' (C2, 5)

'Poor pay (all nursing but also relevant to oncology).' (C2, 7)

'Lack of decent money affects retention.' (C2, 8)

## Barriers to recruitment of BME nurses

Only two (6.6%) students (no. 8 and no. 3 in cohort 2) thought that there were any particular barriers to the recruitment of BME nurses into cancer nursing. Reasons included:

'... certain cultural barriers may influence this.' (C2, 8)

'Some cultures don't mention death or shun away from it as it is frightening.' (C2, 3)

One respondent, although not sure of any barriers, offered the following insight:

'There are no barriers at all. It's only that a lot of them do not like looking after "terminally ill patients" since cancer is viewed as a chronic terminally ill disease.' (C1, 9)

Fourteen (46.6%) thought there were none, 13 (43.3%) were not sure and two did not respond. Examples of comments included

'... did not know enough to comment.' (C1, 4)

and

'... nothing that I am aware of.' (C1, 1)

However, they still expressed their views about the following possible barriers:

'The only possible barrier I can think of is that sometimes language can be an obstacle.' (C1, 5)

'... they need to be able to speak, read and write the language of the country they work in well.' (C1, 6)

'None that I am aware of, although a recent talk from a representative of Cancer Black Care informed us that cancer diagnosis has stigma attached in certain ethnic groups as something that occurs as punishment for behaviour.' (C1, 13)

'I am not sure, but working at the [trust] presently, certainly does not show an equal proportion of non-white ethnic minority nurses.' (C1, 15)

'I don't think there is a problem because there are quite a few ethnic minority nurses doing this course this year but if you consider the ratio of ethnic minority nurses to the total student population you may consider that they comprise a very small fraction.' (C1, 16)

Justifications for stating that there were no specific problems in the recruitment of BME nurses included:

'There is a good mix of different cultures in the ward.' (C2, 9)

'I have worked with many nurses from varied countries/cultures. Many have held high nursing grades.' (C2, 8)

## Discussion

There appears to be a dearth of literature concerning the representation of BME nurses within UK cancer care services, in contrast to the debate about their recruitment and career progression within the NHS in general.

This study reinforces the utility of ethnic monitoring as a tool to track the profile of nurses enrolling on cancer care courses. The value of ethnic monitoring for organisations is clearly set out in the updated guide produced jointly by the Department of Health, the NHS Health and Social Care Information Centre and NHS Employers (2005). It allows organisations to monitor fairness in recruitment and selection and learning and development opportunities, and to identify under-represented groups so that recruitment drives can be targeted to increase the organisation's attractiveness to them.

This particular cancer care NHS trust had been concerned about the low numbers of applications received from BME nurses and was actively attempting to recruit more onto their educational programmes. This resulted in a significant increase in their representation from 6.3% in September 1999 to 21.6% in September 2002 (cohort 2 in this study). In cohort 1 (September 2001) the proportion of BME students was 12.5% compared to 4% in the previous cohort. This may be one of the reasons why most of the students in this study did not perceive any major barriers to the recruitment of BME nurses into cancer nursing. A few did, however, highlight the low proportion of BME nurses in the trust, particularly in the higher grades.

Students chose a career in cancer nursing because of career development, personal interest and professional satisfaction. Experience of a specialty during training often leads students to consider working in that specialty. Fifty-seven percent of the respondents in this study had such an experience. This supports the findings of Marsland and Hickey (2003) who reported that 82% of nurses qualifying considered working in

oncology because of their experiences of the specialty. Barriers to recruiting nurses into cancer care were viewed as similar to those of the NHS in general. They included poor pay, staff shortages and not being listened to and valued. Specific examples for cancer nursing included emotional stress, that is to say 'burn out', and the image of cancer as a depressing, frightening, and terminal illness.

Only two out of 30 students perceived that there might be particular barriers to the recruitment of BME nurses into cancer care. Possible factors included language problems, the stigma of cancer, and nursing terminally ill patients. Two respondents noted the possible impact of racism, either at a personal or institutional level.

Reasons for perceiving no barriers to the recruitment of BME nurses included: the existence of equal opportunity employment policies, their own experience of working with nurses from different cultures (some at senior levels), and 'the influx of Filipino nurses'.

## Conclusion

The low response rate in this study limits the ability to draw any general conclusions from the findings. Nevertheless, the majority of students did not view recruitment of BME nurses into cancer services as an issue. This was in stark contrast to the view of the director of nursing who had been concerned for some time at the low numbers of BME applicants to the courses.

The degree of dissonance is of interest, as is the dearth of papers on this topic within the nursing literature. It may indicate a possible lack of awareness among the cancer nursing profession about whether BME nurses are under-represented within this specialty. This is in contrast to the prominence this topic has acquired amongst other sections of nursing. The issue of BME representation requires addressing by those involved in cancer nursing workforce planning and recruitment strategies.

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## CONFLICTS OF INTEREST

None.

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