Exploring Barriers and Opportunities to Black Nurses' Professional Development

A thesis submitted to Middlesex University in partial fulfilment of the requirements for the degree of Doctor in Professional Studies in Health

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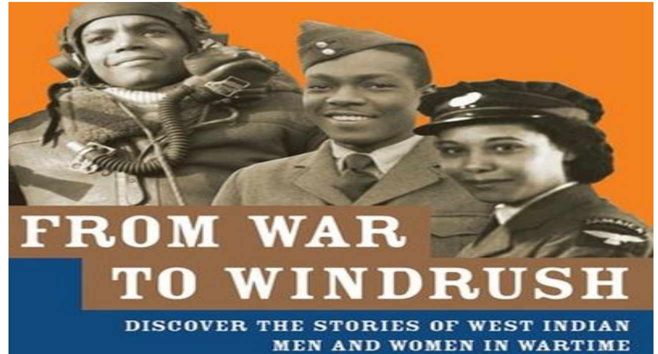

Abstract

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Petula Gordon

The purpose of this study was to explore the lived experience of Black and Minority Ethnic (BME) nurses with a particular focus on black nurses, when applying to access training and professional development activities within the existing National Health Service (NHS) structure. Research has shown that BME nurses are less likely to be selected for training and development programmes when compared to their white counterparts which impacts on the quality of care given to patients. This study was conducted as a baseline to ascertain the current position.

This project was carried out using data from an analysis of survey questionnaires completed by trained nurses across all nursing bands, interviews, a review of the relevant literature and reflective journal. The findings suggest that despite interventions being in place to promote equal opportunities, BME nurses are still subject to oppressive practices which is far from improving.

It has been concluded that Black nurses in particular, have to be more active in addressing the oppressive practices they face through building resilience and wellbeing, as failure to act is likely to result in professional stagnation. Based on the results of data from survey questionnaires, interviews, review of the literature and reflective journal, a conceptual model of issues to be considered in the development of a framework has been proposed to help facilitate improvement in training opportunities for BME nurses. The framework has been devised on the basis that taking a collective approach to a longstanding problem to include stakeholders such as BME nurses, NHS Trusts and the Government, may help towards improving training opportunities for BME nurses. The framework has not been tested.

Keywords

Training and professional development, Black and Minority Ethnic nurses, NHS, Equal opportunities, Oppressive practices.

Statement of authorship

This thesis is written by Petula Gordon and has ethical clearance from the School of Health and Education of Middlesex University. It is submitted in partial fulfilment of the requirements of the School of Health and Education of Middlesex University for the Degree of Doctor in Professional Studies in Health. The author reports no conflict of interest and alone is responsible for the content and writing of the thesis.

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“I can do all things through Christ which strenghteneth me” (Philipians 4:13).

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Glossary of terms

Key Terms	Definitions	Source
British empire	A worldwide system of territories under the authority of the monarchy and British government	Encyclopaedia Britannica, 2018
Change management	Tools or structures intended to keep any change effort under control	Kotter, 2011
Clinical supervision	A forum for nurses and allied professionals to regularly reflect on their practice in order to learn from experience and improve competence	Kohner 1994
Collective leadership	Leadership that allows those with expertise, capability and motivation, to receive leadership power with responsibility for the development and how it will be delivered	West et al., 2014
Cultural competence	Care that is effective and compassionate taking account of the cultural beliefs, behaviours and needs of individuals.	Papadopulous, 2008
Discrimination	The unequal treatment of an individual or group based on their statuses (e.g. age, beliefs, ethnicity, sex) by limiting access to social resources (e.g. education, housing,	Bell, 2013

Key Terms	Definitions	Source
	jobs, legal rights, loans, or political power).	
Ethnicity	Having the common features of a group or nation	BBC Bitesize, 2020
Institutional racism	Racism that is subtle in nature and found in organisations where practices and political structures place Black staff at a disadvantage in relation to the organisation's white majority	Jones, 1997
Followership	Individuals who cooperate to accomplish goals without competing for leadership or power	Kelley, 1992
Health Research Authority	The Health Research Authority protects and promotes the interests of patients and the public in health and social care research	Health Research Authority, 2017
Leadership	The capacity or power to convince others to act; The individual or group that is designated to lead	Bell, 2013
Micro-aggressions	Hostile and negative messages, verbal and nonverbal slights	Sue, 2010, DiAngelo 2018
National Health Service Research Ethics Committee	The National Health Service Research Ethics Committee exists to safeguard the rights,	Health Research Authority, 2017

Key Terms	Definitions	Source
	safety, dignity and well-being of research participants	
Prejudice	A negative attitude that is unjustified and exists solely because of a persons' membership of a group.	Worchel et al., 1988
Race	A social construct **or** A group characterised by their genetic characteristics	Mukhopadhyay et al., 2013 BBC bitesize guides, 2020
Racism	Unfair and negative treatment toward a particular group of people based on their ethnicity or race	Fish and Syed, 2019
Systemic racism	Racism that permeates or is present in all the institutions such as the political and economic, social and structures including social relationships within a society	Feagin, 2013
Transformative leadership	Style of leadership in which the leader identifies the needed change, creates a vision to guide the change through inspiration and executes the change with the commitment of members of the group	Burns, 1978

Key Terms	Definitions	Source
Triangulation	The use of more than one research strategy to arrive at the findings	Guion, 2002

Chapter 1: Introduction: Project background and context

Staff loss contributed to the 11, 400 nurse and midwife shortfall in 2017 which cost the National Health Service (NHS) up to £2.4 billion (Wilson, 2018). This cost was for utilising agency nurses to fill the gaps in both the hospitals and the community. Projected figures suggested that there would be a nurse shortfall of 42,000 in 2020 if steps were not taken to offset the shortage. As a black woman nurse specialist working for the NHS, there was concern with the unequitable practices observed within the organisation. Reports suggested that discrimination was evident with levels notably high for black employees and highest amongst black nurses (Merrifield, 2015). When deciding on a career path, the core values of the NHS (core values explained below) were a factor in choosing to work for the organisation, coupled with the expectation that those entering the nursing profession shared the same beliefs. However, observing staff in action in their various roles, led to a reality that presented a different picture. Behaviours fell short of the NHS's core values with discriminative practices being an ongoing area of concern especially when it came to black nurses accessing training and development programmes as compared to their white peers.

The discriminatory practices towards black and minority ethnic (BME) nurses have led to the loss of valuable staff (Unison, 2019; Nadeem, 2019; RCN, 2017). The term BME is normally used in the United Kingdom (UK) to describe people of non-white descent (Institute of Race Relations (IRR), 2017a). Whilst the term BME is used in this project, the researcher acknowledges that the term is problematic as it conflates physical characteristics with geographical identity and fails to recognize individuality which suggests that BME people are an homogenous group (BBC, 2020a). Additionally, Black, Asian and Minority Ethnic people do not share the same experiences, therefore, the term BME is not equivalent in its usage (BBC, 2020a). For the purpose of this project, the socially recognised concept which is used to describe the term 'Black' is thus: *In practice, it refers to persons with sub- Saharan African ancestral origins with brown or black complexion* (Agyemang et al., 2005 pp. 1014 – 1018).

Although a body of literature exists on discriminative practices towards black nurses within the NHS, research specifically aimed at the proclivity of discrimination within the NHS, the effect this has on individuals and its impact on the wider organisation, has been sparse. Additionally, there is a dearth of knowledge on the development of senior black nursing clinicians within the NHS, an omission which serves as a restriction for the career progression of a younger generation of black nurses. This would appear to be through a lack of available support and access to important knowledge for overcoming discriminatory practices that serves to exclude and hinder career

development. In particular, little is known on the impact of leadership on career advancement, especially from the experience and perspectives of black nurses. This study was conducted as a baseline to ascertain the current position.

With the absence of 'black voices' in clinical practice, it evoked a curiosity as to why little had been done to address this situation. There was also concern with why discriminatory practices seemed to remain despite interventions being in place to address this situation e.g. leadership initiatives such as the 'Breaking Through' programme aimed at improving the work environment and services for BME staff (Coghill, 2014). The decision was taken therefore to explore this phenomenon especially as with occupying the role of Clinical Nurse Specialist in Infection Prevention and Control, there was a notable shortage of senior black nursing practitioners within this area who could provide such insights and to act as positive role models.

In order to give context to the project, the following section looks at the NHS from its inception to its operation today.

1.1 Background of the study

1.1.1 What is race?

Race as a concept is difficult to define as it is said to be a social construct (Delgado and Stefancic, 2001; Mukhopadhyay et al., 2013; Utley, 2016;) which refers to the idea that race is not biologically defined but socially constructed (Bell, 2013). Delgado and Stefancic (2001) assert that the notion of 'races' are categories that are invented by society who manipulates or retires the categories when convenient. There is only one species, namely the human race (Mukhopadhyay et al., 2013). What exists, are nations who are citizens or subjects of a country with legal right of protection (Bell, 2013).

The concept of race was created historically to legitimise social inequality within different groups of people (Montague, 1997). In other words, the concept of 'race' was previously unknown and what existed, were people who were identified by their ethnicity and culture (Smedley and Smedley, 2005). The Romans did not recognise and record 'race' as it is classified today (Olusoga, 2017). Based on colour, black people were not subject to acts of parliament enshrining legal discrimination against them, which is why it was difficult to identify them through records (Chater, 2010) which adds to the argument that race is a social construct as purported by Mukhopadhyay et al. (2013). Put another way, the socially constructed view of reality in this case, is not given by nature but is the result of people legitimising racial discrimination by reproducing that reality and their prejudiced knowledge and interpretation of it. As noted by Tharps (2016), when black people arrived in the Americas, they were collectively referred to as 'Africans' despite having come from different countries, tribes

and cultures. The Spanish term for the colour black was then 'borrowed' by the British colonists and words such as negroes, negrars and nigras emerged, words that were in direct opposition to what was generally assumed to be the 'purity of' a 'race' (Tharps, 2016).

Society became 'racialised' when white people in the so called 'new world' wanted a cheap source of labour in which they could profit. This would be achieved through free labour which came in the form of slavery (Smedley and Smedley, 2005). A society that is racialised, sees race as playing a central role in the structuring and everyday understanding of social interaction, where opportunities are distributed based on those structures and the idea of 'race' (Thomas, 2000). Lowe (2007) argues that many of the negative beliefs that society holds about black people are rooted in the history of slavery, colonisation and the empire. The justification for slavery by the Europeans which can be traced back to the 18th century, took place on the pretext that Africans were inferior to them, backwards and barbaric (Olusoga, 2015). Yet, Olusoga (2016) contends when speaking of barbarism, that it was the British army who massacred black civilians in Jamaica in 1865 in their bid to colonise and build the British empire.

In the craving for power, the colonial object relations were described as the propensity for whites to control blacks in the black-white relationship, a situation which is commonplace in the psyche and in society which is frequently disguised and occasionally invisible (Lowe, 2007). Young (2010) gives one such example of the imbalance of power in society and argues that it occurs in cases of the violation of collective intellectual rights with the adoption of elements of the black culture by the dominant culture otherwise known as cultural appropriation which is a by-product of colonialism and oppression. The concept of racialisation in contemporary capitalist society is employed in this project and is defined as:

> *'A process whereby the socially constructed category of 'race' (or, more usually, specific constructions of particular racial categories), structures the perceptions and interactions of people...' (Thomas, 2000, p. 24*).

In order to understand difference, the next section looks at gender, religion, age and disability.

1.1.2 The birth of the NHS

The NHS is a publicly funded healthcare organisation that was set up in 1948 (Gov.UK, 2016). It was born out of an ideal that good healthcare should be available to all regardless of wealth. Treatment is free at the point of use for people resident in the United Kingdom (Gov.UK, 2016). The NHS constitution which was created to protect the NHS, stipulates that free high-quality care should be at its core. The core values

held by an organisation is important as they shape the company's culture (Linkedin.com, 2015). At its core, the values of the NHS are: Respect and dignity for all individuals; Commitment to quality of care, learning from mistakes; Compassion, where staff are humane to those being served and also to the people they work alongside; Improving lives through the measures put in place to ensure the health and well-being of all; Working together for patients where the needs of patients and communities come first; Everyone counts, where no-one is excluded and resources are used for the benefit of all (Gov.UK, 2016).

After the second world war, there was a call from the British government for black people from the commonwealth countries to help rebuild Britain (Henry, 1985). Nurses from the British colonies were recruited into roles that were difficult to recruit to, jobs that the indigenous people did not want to do such as working in the mental health directorate and care of the elderly (Ali et al., 2013).

The aim of the NHS should be the promotion of health which is rooted in shared values of equality, sustainability and the common good (Bambra et al., 2005) but this period after the war, saw a rise in racism (Carter, 2002; Cregan, 2010; Vonderbeck and Worth, 2015). Ali et al. (2013) asserts that having a diverse workforce was often considered a problem by the health service. Professor John (2015) can identify with this statement as during his eulogy when paying homage to his sister-in-law who came to Britain from the Caribbean in 1969 to train as a nurse, he gives the reader insight of her experience. John (2015) asserts that receiving racial abuse was not unusual for black nurses when tending to patients. Words such as *'Get your filthy black hands off me',* or *'go and get a white nurse to attend to me and go back to where you came from'* (John, 2015, p. 2) were commonplace. In the eulogy, he also shares that there were others in the workplace who would orchestrate situations to put black nurses in trouble with nursing supervisors. Aly (2014) offers an explanation which is analogical to this type of behavior:

> *"Those who achieve success, especially if they are also outsiders, are invariably subjected to side long glances, malicious rumour and libel. At the same time, as enviers know only too well, jealous people gradually poison themselves, becoming ever more dissatisfied and bitter. Thus, they tend to conceal their shameful, base resentment of others behind supposedly more sophisticated arguments - for example, those of racist theory" (Aly, 2014, p. 5).*

Sue (2010) and Lais (2019) describe the experiences John (2015) cites, as micro-aggressions in which victims are subjected to hostile and negative messages, verbal and nonverbal slights. Micro-aggressions are targeted at people based solely on

membership of their marginalised group which can have a powerful effect on individuals. The concept of micro-aggressions will be examined later in the project.

Having looked at the NHS from its inception, the next section looks at what is happening in the NHS today.

1.1.3 The NHS today

The NHS is in crisis (Royal College of Nursing (RCN), 2017). Figures published in July 2017 demonstrated that for the first time in history, the number of UK nurses leaving the NHS exceeded the number of nurses joining the NHS (RCN, 2017). The number had fallen markedly from 10,178 to 1,107 representing a decrease of 89 per cent in 12 months (RCN, 2017). Nurses and midwives were leaving the nurse register before the age of retirement with a notable increase in nurses under the age of 40 leaving the NHS (RCN, 2017).

The five year forward view outlined the changes that were needed in the NHS if the challenges it faced now and in the future were to be overcome (NHS Confederation, 2019). Three significant and widening gaps in the NHS were identified (NHS Confederation, 2014) which were:

- **Health and wellbeing:** The aim is to prevent illness as this would alleviate the pressure put on the NHS by diseases which are preventable e.g. heart disease, diabetes. Supporting people to take care of their own health would also help to avoid unnecessary hospital admissions (NHS employers, 2019b). Helping people to obtain employment and stay in employment would improve mental and physical health as this would in turn preserve livelihoods (NHS employers, 2019b).
- **Care and quality:** With people living longer, a new approach to care is required where the quality of patient care and experience is improved. There is a call to provide a seamless service across healthcare organisations such as GP practices, care homes and hospitals (NHS Confederation, 2019).
- **Funding and efficiency:** It was predicted that there would be a deficiency in the funding gap between patient needs and the resources of the NHS of almost £30 billion each year by the years 2020/21. Spending needed to be conducted more efficiently and with transparency to see where the changes needed to be made (NHS Confederation, 2014).

The health and wellbeing of staff was also included as a priority presenting an overall picture that there were gaps that needed to be closed and supported by the workforce if the future of the NHS was to be viable and sustained. Without it, new models of care

or strategies would not be achieved (NHS confederation, 2019; NHS Workforce Race Equality Standard (WRES), 2019).

The NHS was built on a diverse workforce and continues to depend on a diverse workforce (Jones-Berry, 2017) yet a report by the WRES expounds that it is apparent BME nurses and midwives are severely and persistently disadvantaged in the workplace which in turn has led to an acute shortage of qualified health professionals (Nadeem, 2019). Jones (2000) argues that the first generation of health workers from overseas, experienced discrimination around training and career opportunities which has impacted negatively on the recruitment of the second generation. Workforce difficulties were further compounded, when amongst the negotiations of the withdrawal of the UK from the European Union (EU), (otherwise known as Brexit) Hunt and Wheeler (2016) nurses from the EU were leaving the Nursing and Midwifery Council (NMC), resulting in an increase of 67 per cent leaving in the year from 2016 to 2017 (RCN, 2017).

Discrimination has been described as the unfair and unjust treatment of a person because they possess certain characteristics such as age, race and religion (Equal Opportunities Commission (EOC), 2021). The EOC (2021) argue that **everyone** is protected from discrimination by the Equality Act (2010) as they possess some of the characteristics under the Act such as: age; gender; race; disability; religion; pregnancy and maternity; sexual orientation; marriage and civil partnership and gender reassignment.

According to the Equality and Human Rights Commission (EHRC) (2019) there are three types of discrimination which are: direct, indirect and discrimination arising from disability. Direct discrimination pertains to treating someone with a protected characteristic less favourably than someone without a protected characteristic, for instance, refusing a student entry to education because of their characteristic (EOC, 2021). Indirect discrimination is said to have occurred when a policy may place an individual at a disadvantage in the workplace. For instance, in the case of religion, a person who has to work on a day that they would be attending church would be classed as being discriminated against indirectly (EHRC, 2019). Anyone who has a disability and is treated unfavourably as a result, is said to have been discriminated against (EOC, 2021).

Figures published in September 2017 reported that the NHS was short of 40,000 nurses (RCN, 2017). Another contributory factor was said to be the end of the nursing bursary which had supported nurses through their training (RCN, 2018a). The bursary was replaced by tuition fees which saw fewer applications from students applying for nurse training with numbers down by one third (RCN, 2018a). The RCN's chief

executive - Janet Davies, acknowledged that the NHS had seen years of poor decision making and extensive cost cutting and stated:

> *When the NHS has never been busier, it is haemorrhaging experienced nurses at a faster rate than it can find new recruits* (Scott, 2017, p.3).

BME nurses are disadvantaged when it comes to accessing professional development opportunities as they are less likely to be selected to attend such programmes (Kline and Prabhu, 2015). Discrimination against BME staff has been an ongoing concern within the NHS for many years (Kline, 2014; Archibong and Darr, 2010). With the Chief Executive Officer (CEO) of the NMC describing it as a disgrace, reports suggest that there had been a rise in discrimination against BME staff from 13.8% to 15% in the year from 2018 to 2019 (RCN, 2019a; NHS WRES, 2019). This contrasted with the experiences of white staff in the NHS where discrimination was just 6.6% (NHS WRES, 2019). Data from the WRES (2020) as demonstrated in figure 1.1 below, compares BME staff to their white counterparts in the indicators that were tested. The data shows that whilst there were slight improvements in some of the measures, discrimination against BME staff was getting worse.

KEY				
Green	Year-on-year improvement			
Amber	No change			
Red	Year-on-year decline			
	2016	2017	2018	2019
Likelihood of white applicants being appointed from shortlists compared to BMEs	1.57	1.6	1.45	1.46
Likelihood of BME staff entering formal disciplinary processes vs. white staff	1.56	1.37	1.24	1.22
Likelihood of white staff accessing non-mandatory and professional development training vs. BME staff	1.11	1.22	1.15	1.15
BME staff reporting harassment, bullying or abuse from patients, relatives or public (%)	29.1	28.4	28.5	29.8
BME staff reporting harassment, bullying or abuse from other staff (%)	27	26	27.8	29
BME staff believing they have equal career progression and promotion opportunities (%)	73.4	73.2	71.9	69.9
BME staff experiencing discrimination at work from a manager/team leader or other colleagues (%)	14	14.5	15	15.3

Figure 1.1 NHS race matrix. Source: Kituno, 2020, para 8

An overwhelming culture of staff disempowerment as illustrated in figure 1.1 above, was also cited amongst Mid Staffordshire's failures in the Francis report (Gov.UK, 2013). Research has shown that the NHS tolerates a culture of bullying which is being passed down from the top (Moberly, 2017). In terms of employment, BME staff were less likely to be appointed for jobs once shortlisted; they were more likely to be subject to bullying, harassment and abuse in addition to being disciplined disproportionately and dismissed (NHS BME Network, 2015; Business in the community, 2015; RCN,

2017, 2019b). The inability to access training and development programmes has implications for pursuing professional goals. For instance, under-representation in senior positions was also a concern as despite 43% of the workforce being from a BME background, only 14% of these nurses were in board level positions (NHS WRES, 2019; Kline, 2014). Figures recorded in March 2017, showed that white staff members including white ethnic minorities, meaning those of Eastern European origin (Mctague, 2015) had a board membership of 88% compared to 7% of a combination of all 'other' ethnic minorities with 5% ethnicity unknown (NHS WRES, 2017). NHS Trusts in London, UK, had the highest board membership of 'other' minorities, whilst the lowest number was in the South of England which included the South East and South West of England (NHS WRES, 2017). Out of a total of 244 Trusts, 98 which represents 44%, had no 'other' ethnic minorities on the board whilst over half of the NHS Trusts had at least one board member from the 'other' ethnic group. A total of 25 Trusts representing 11%, had 3 or more board members from the 'other' ethnic group. In the North, the Midlands and East of England, figures for the 'other' ethnic group were similar to the national average with the North yielding 6% and the Midlands and East yielding 7% (NHS WRES, 2017).

In 2018, new figures demonstrated a decrease in the percentage of people from a BME background occupying positions such as chair and non-executive directors (NHS WRES, 2019). The figure which was 15%, fell from almost a half in 2010 to 8% in 2018. Whilst figures in 2017 showed that slow progress was being made in reducing discrimination, it was found that BME nurses still faced an uphill struggle for equality (RCN, 2017). The WRES report (2020) showed BME board membership was low at 8.4%. All these factors were said to impact significantly on the running of the NHS in terms of efficiency and effectiveness (NHS England, 2018) and was having a serious impact on the quality of care patients receive (Kline, 2014; Archibong, 2010) as:

> *Promoting a culture that improves the health and wellbeing of employees is good management and leads to healthy and productive workplaces* (Nice, 2015, p. 1).

Figure 1.2 below illustrates by ethnicity, the percentage of staff who were on Trust board membership across England in 2018 (NHS WRES, 2019).

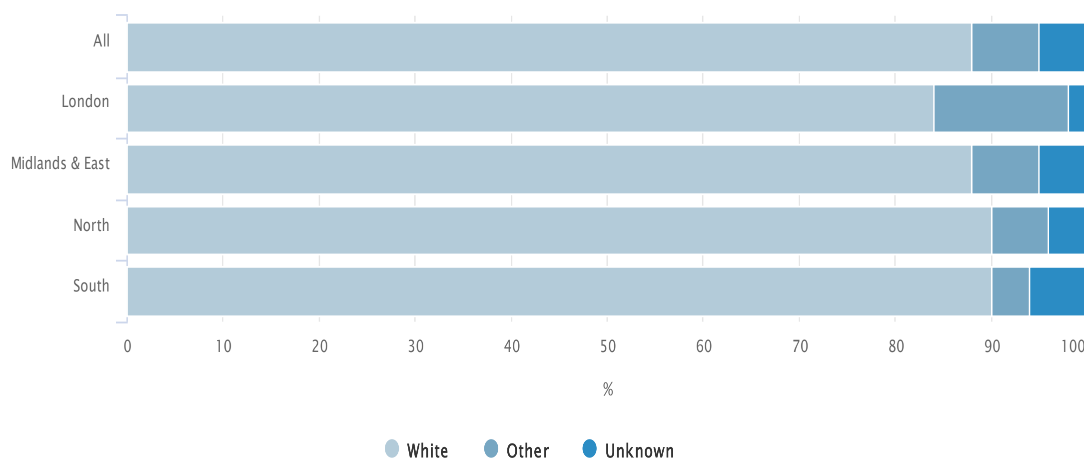


Figure 1.2 Trust board membership by ethnicity across England in 2018. Source: Workforce Race Equality Standard data reporting, 2019, p. 42

The graph above illustrates that there is a disparity when it comes to BME representation on Trust boards. Taking into consideration the discriminatory practices towards BME staff, the researcher posed the question as to whether the culture of the NHS was prejudiced or racist or if it could be both prejudiced and racist. In order to locate this research, the concept of discrimination was explored earlier and the following sections examined the meaning of the terms ‘prejudice’ and ‘racism’ as a means to determine the type of culture the NHS operated in. Organisational culture is also considered in the next chapter.

1.2 Prejudice

Prejudice is defined as:

> *A favourable or unfavourable preconceived feeling or opinion formed without knowledge, reason, or thought, that prevents objective consideration of person, group, or thing* (Bell, 2013).

Allport (1954, p. 9) argues that prejudice is a premature judgment that resists facts and ignores truth and honesty and asserts that, ethnic prejudice is an antipathy based upon a faulty and inflexible generalisation. Worchel et al. (1988) espouse that prejudice is a negative attitude that is unjustified and exists solely because of a persons’ membership of that group. Brown (1995) agrees with Allport (1954) and Worchel et al. (1988) asserting that prejudice is concerned with the derogatory belief and hostile behaviour towards membership of a group based solely on their membership of that group.

The Equality Analysis tool, formerly known as the Equalities Impact Assessment (EIA) which is found within organisational policies, is a tool that is used in evidence-based policy making and seeks to safeguard those people in organisations who have protected characteristics in order to avoid discrimination (Equality and Human Rights

Commission (EHRC), 2015). Protected characteristics include and refers to: disability; gender reassignment; age; sex; sexual orientation; marriage and civil partnership; pregnancy and maternity and race (NHS England, 2019a; EHRC, 2015). The law which comes under the Equality Act 2010, exists to protect people's right to fairness, dignity and respect (EHRC, 2015). Section 149 of the Equality Act (2010) sets out the moral and legal duty that public bodies like the NHS must adhere to and expounds that discrimination, harassment and victimisation is unlawful and should be eliminated. Known as the public sector Equality Duty (EHRC, 2021) it was established by the Equality Act (2010) and came into force in 2011. Public bodies must be transparent and need to demonstrate how they are complying with the Equality Duty through the publication of relevant information (EHRC, 2021). Additionally, they need to publish information on decisions made and the equality data underpinning those decisions (Equality Act, 2010). Although the Equalities Act does not clearly refer to education and training, it could be argued that the right to 'fairness' for professional staff should include access to appropriate education and training that would permit progression within their chosen profession and maintenance of professional standards. Yet evidence suggests that when attempting to access training and promotion opportunities, black nurses continue to face discrimination in the form of racism in the NHS (Unison, 2019; Kline, 2014).

The following sections looks at groups in society who are known to be subject to prejudice as shown in figure 1.3 below:

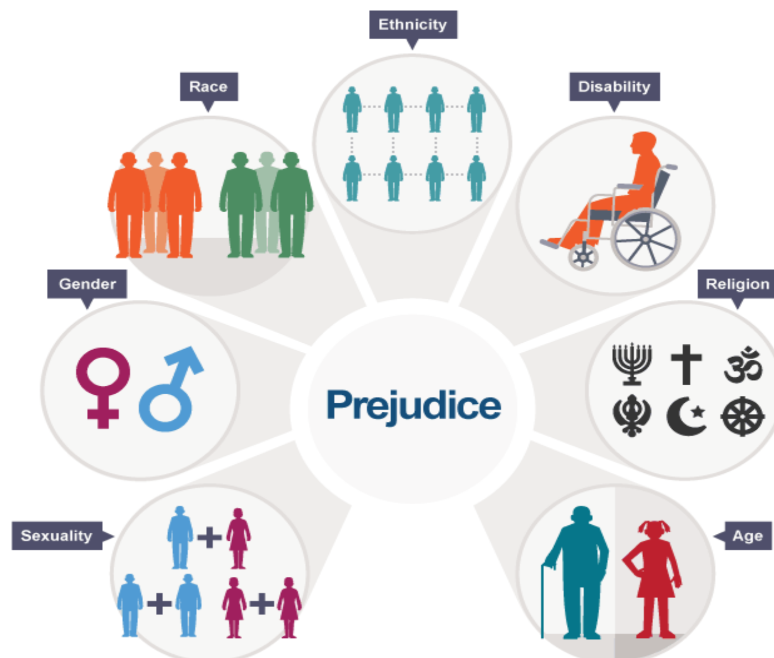


Figure 1.3 prejudice map. Source: BBC bitesize guides (2020, p. 2).

As race is a source of prejudice (Dovidio and Gaertna, 2010) and forms the focus of this research, the next section defines race.

1.2.1 Gender

Gender which is a source of prejudice (Dovidio and Gaertna, 2010) otherwise known as sexism (BBC bitesize, 2020) occurs when an individual is treated differently because of their sex (Equality hub, 2016). Both men and women can be victims of sexism but it mainly affects women (BBC bitesize, 2020). There are individuals who are subject to prejudices on several fronts if for instance they are of colour and female. The Grunwick Strike in 1976 is a case in point where a group of film processing factory workers staged a walkout in protest at their unfair working conditions. The mainly female BME workers were relegated to the lowest paid jobs, tended to be paid less than their white colleagues (Bell and Mahmood, 2016) and were subject to bullying tactics from management (Omerod, 2018). The strike led by workers who were mainly women of East African-Asian origin, lasted two years from 1976-1978 and was said to be one of the longest and most important industrial disputes in British history (Omerod, 2018). This dispute reputedly changed the way trade unions viewed race and the immigrant communities who came to Britain in the 1970s (Omerod, 2018). Prior to the Grunwick strike, the trade unions had ignored the migrant workers more often than not (Wilson, 1978) and were felt to be racist by the said workers who believed they (trade unions) worked with management to keep their wages down in addition to the wages of other women working in the factory.

The fight for equality which has been women's fight for equality, could also be seen in the suffrage movement where women had no place in national politics. They were not allowed to vote or to hold office in parliament, their place was seen as being home makers and child rearers (Fairlie, 2018). Men were viewed as being the political decision makers therefore it was deemed unnecessary for women to get involved in politics. The 6th February 2018, saw the centenary since some women won the right to vote in 1888. During that time, women had to be over 30 years of age and own a house to be able to vote. It took another 10 years before all women could vote (Harper, 2018; Fairlie, 2018). They still have a long way to go however as there were only 208 female members of parliament in 2018 which represented 32% of the total parliament population (Fairlie, 2018). Pankhurst (2018) argues that the problem around gender prejudice and the fight for equality is by no means solved. The violence against women is pervasive in many ways, they continue to face many constraints in what they can do which is evident in culture i.e. film, media, cinema, sports (Fairlie, 2018).

Continuing with the fight for equality, pay parity was the focal debate regarding the gender pay gap in 2018. The gender pay gap is the pay discrepancy between men and women irrespective of their job or position (Palmer, 2018). Some major companies revealed that the pay gap was more than 15% in favour of men for the mean hourly

rate of pay (Palmer, 2018). Following the success of the Suffragettes 100 years ago, '#March4Women,' is an annual march which exists to bring about change and is a platform to vent anger and the pain that was felt at the way in which women were treated whilst fighting for their rights (Fairlie, 2018). Women were vilified, humiliated, beaten, downtrodden and force-fed in what was supposed to be a civilised society. They are still fighting for gender equality (Fairlie, 2018), the fight is for those areas where inequalities between men and women exist, of which follows a few examples. Based on the rate of convergence where businesses need to reduce the entrenched differences in the skills that women gain and develop (Deloitte, 2018) pay parity between men and women is not expected to be achieved until 2069 (Deloitte, 2018). Also, in 2015, 11% of women with young children who had worked during pregnancy, reported that they had lost their jobs as a result of being discriminated against due to their pregnancies (Equality and Human Rights Commission, 2015). Additionally, 1 in 3 women globally were subjected to physical or sexual violence (Fairlie, 2018).

Feminism, known as the modern era, emerged in 1963 and grew out of the fight for equality (Cochrane, 2013). Feminism refers to a range of movements such as ideologies and social and political movements all sharing a common goal which is to achieve equality of the sexes economically, politically and educationally (Hawkesworth, 2006).

A person who identifies as being lesbian, gay, bi-sexual, transgender or intersex (LGBTQI), are often subject to discrimination in many countries (Press, 2015; Amnesty, 2016). The discrimination against people belonging to the LGBTI community can be due to several reasons such as: who an individual is attracted to, otherwise known as sexual orientation. A person may be discriminated against because of gender identity, or how s/he defines self, irrespective of the individual's biological sex or it could be due to how an individual expresses their gender whether it be through clothes, hair or make-up. Discrimination also arise as to how an individual may express themselves through their sexual characteristics e.g. reproductive organs (Amnesty, 2016).

Discrimination of people from the LGBTI community manifests in several ways such as, not being able to obtain employment or when in employment the terms and conditions may be less favourable with less opportunities for promotion and training or unfair dismissal (Unison, 2020b). It has been reported that people from the LGBTI community are often subjected to widespread abuse which occurs all over the world (Press, 2015). The report cites abuse, beatings, being jailed and murders that are committed against them. There were 1,612 reported murders between 2008 and 2014 which occurred in 62 countries (Press, 2015). Despite laws being in place in the UK to protect the rights

of people from the LGBTI community, they are still subject to discrimination (Unison, 2020b).

1.2.2 Religion

Religion is defined as: *The belief in and worship of a superhuman controlling power, especially a personal God or gods* (Oxford dictionary, 2018; Bell, 2013). There are now a diverse mix of religions and beliefs in the UK than at any other time in history (Department of Health (DOH), 2009). Despite the increase in the level of awareness of the different religions and improvements in inter-faith relations, religious intolerance and prejudice still exist in certain areas (DOH, 2009). Discrimination against the organised religions such as Christianity, Judaism and Islam manifests in the workplace, education and in housing despite it being against the law (Citizens advice, 2021). Religious discrimination occurs when people are treated differently based on their religious beliefs and it can lead to them being treated unfairly (Unison, 2020a). Discrimination based on faith was found to be highest amongst Muslims (Merrifield, 2015). Mehreen Faruqui, the first female Muslim senator in Australia (Knaus, 2018) argues that not only had she been the victim of racial abuse but asserted that people took offence at the fact that a Muslim dared to exist and have a voice through taking part in public debate (Knaus, 2018). In Australia, it was brought to the fore that ‘people of colour’ and Muslims, were subject to name calling by politicians who referred to them as ‘cockroaches,’ whilst others referred to them as a disease for which a vaccination was needed to rid Australia of them (Knaus, 2018). Although the term ‘people of colour’ (POC) is used in this project, it is not an accepted term as there is the argument that ‘white’ is also a colour (Lamuye, 2017) but for the purposes of this project, the term POC is used to facilitate understanding.

1.2.3 Age

Although discrimination on the grounds of age or ageism is unlawful when it comes to employment, education, training, provision of services and public functions (Equality Hub, 2016) age is frequently used to group and form stereotypes about others (Nelson, 2004). An individual is deemed to have been discriminated against when s/he is treated unfairly because of their age. Ageism, a term coined by Butler (1969) is mainly used to refer to seniors. However, unlike other areas of diversity e.g. gender, disability and so forth, the ageism stereotype is ubiquitous as we all will be affected by ageism at some point in our lives (Kirton and Greene, 2015). Ageism is also used to include the discrimination and prejudice that exists against adolescents and children as what they have to say is sometimes ignored (Lauter and Howe, 1971). Some younger individuals may be discriminated against early in their careers due to them being viewed as being immature or lacking authority (Kirton and Greene, 2015).

The elderly are often stigmatised and marginalised (Nelson, 2004). The way they are portrayed in the media can have a wider impact on the public's attitude (Equality Hub, 2016). Ageism is not only concerned with discrimination in employment, it can also include other areas such as being refused interest free credit and credit cards or receiving a lower standard of service in shops or restaurants due to the establishments' attitude to older people (Age UK, 2018). Growing older is perceived by many people with fear, anxiety and depression (Nelson, 2004). Greenberg et al. (1992) asserts that ageism persists because people are afraid to face the reality of getting old. Instead, they find it easier to shun the elderly by keeping them out of the workplace and avoiding visits to nursing homes and entertainment venues where they may be present, for example, bingo halls. This avoidance of the elderly is said to be an attempt to avoid the thought processes attributed to older people vis-à-vis death (Greenberg et al., 1992).

1.2.4 Disability

The Equality Act 2010 defines an individual as having a disability if s/he has a *physical or mental impairment that has a 'substantial and 'long-term' negative effect on your ability to do normal daily activities* (Equality Act, 2010, p. 5). The term 'substantial' refers to daily tasks such as getting dressed which takes longer than is normal. 'Long term' refers to chronic illnesses where an individual has been suffering from a health condition for 12 months or more (Equality Act, 2010).

'Scope', the disability charity, was formerly known as the 'Spastics' society. Realising the impact of negative language and the attitudes of people towards the disabled, the term 'spastic' was changed to 'Scope.' Although equality legislation exists and has enabled those individuals with disabilities to have a better quality of life, i.e. greater aspirations, better access to places, visibility and better opportunities than ever before, people with disabilities were still affected by negative attitudes from the public (Aiden and Mcarthy, 2014). According to Aiden and Mcarthy (2014) disabled people were subject to preconceived ideas with 36% of people believing that they were not capable of being as productive as everyone else. It was reported that 67% of the British public felt uncomfortable speaking to disabled people with 21% of 18 to 34 year olds admitting that they had avoided speaking to them because they were not sure how to communicate with them. A reported 85% of the British public believed that disabled people faced prejudice according to the results of a survey that was conducted by Aiden and Mcarthy (2014). The survey results are shown in figure 1. 4 below.

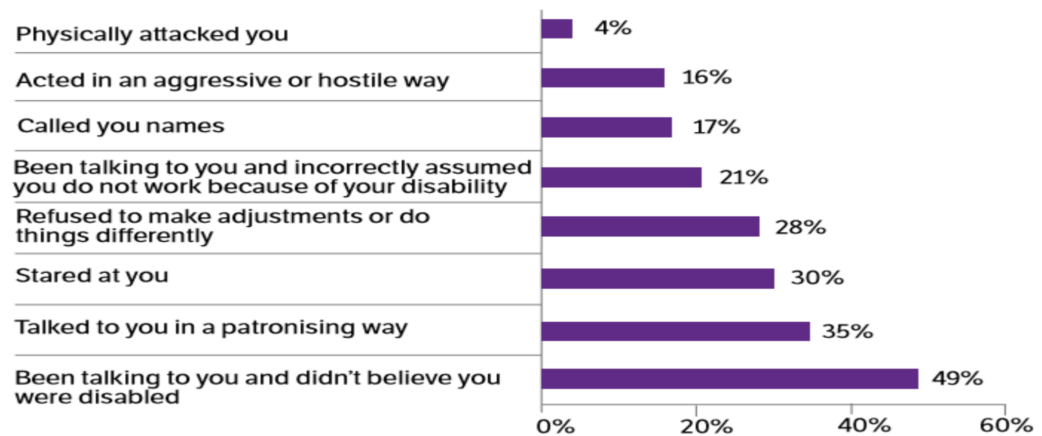


Figure 1.4 Experiences attributed to disability Aiden and Mcarthy, 2014, p.9

The results show the experiences that people with a disability encountered when dealing with members of the public.

1.2.5 Summary

This section looked at the prejudice that exists in various spheres of society against people because of their membership of a certain group whether it be their gender, religion, age, race or disability. This step was taken in order to determine if there is a culture of prejudice that operates against BME nurses working in the NHS, or if it is a culture of racism as the two concepts are different. Racism is addressed in the next section.

1.3 What is racism?

The Human Rights Act 2010 sets out the fundamental rights and freedoms that everyone in the UK is entitled to (Human Rights Act, 2010). The act exists by virtue of the fact that basic rights belong to humans (Equality Hub, 2016). These rights embody key values in society, values such as fairness, equality, dignity and respect (Equality Hub, 2016). This tenet contrasts with British and American racism which has extremely deep and tenacious historical roots (Sherwood, 2001) and is discussed later in the project. Traditionally, racism has been defined as the unfair and negative treatment toward a particular group of people based on their ethnicity or race (Fish and Syed, 2019). This definition has been criticised however for being limited as it fails to take into account the factors that are important in understanding racism, factors such as power and privilege (Cole and Harper, 2017). Racism has thus been defined as:

> *A system of power entwined with practices and beliefs that produce and maintain an ethnic and racial hierarchy. The preservation of this ethnic and racial hierarchy in turn, leads to the superiority, power, and privilege of some, and the oppression of others (Fish and Syed, 2019, p. 5).*

The racism iceberg in figure 1.5 below comprise the factors that compose and perpetuate racism in society.

Figure 1.5 Racism iceberg, Shelter SA, 2019, p.5

Figure 1.5 shows the conscious causes of racism which are those factors above water on the tip of the iceberg, they are the factors that we can see. The factors below the iceberg demonstrate numerous underlying causes that give rise to racism, those factors that are not always visible (Shelter SA, 2019). It is important to look deep below the surface of the iceberg for those factors that we cannot see in order to understand the past and the present, some of which will be examined in this project.

Fryer (2010) asserts that racism is an ideology which is a system of false ideas that is used to justify the exploitation and domination of people. An example of this can be seen in the rise of the Ku Klux Klan (KKK), a white supremacist group who emerged when the African enslaved rejected their subordination (Martin, 2011). The KKK rose to power during the Reconstruction era (1865-1877) in reaction to attempts to empower the newly freed enslaved (Martin, 2011, p.628). Douglas (1995) describes this link between terrorism and white supremacy thus:

> *"He (person of colour) has ceased to be the slave of society. He may not now be bought and sold like a beast in the market, but he is the trammelled victim of a prejudice, well calculated to repress his manly ambition, paralyze his energies, and make him a dejected and spiritless man, if not a sullen enemy to society, fit to prey upon life and property and to make trouble generally"* (Douglas, 1995, p.568).

Hilliard (1992) argues that racism has been described by 'whiteness' scholars as a system that comprise political, economic, social, actions, beliefs and cultural structures that systematically perpetuate unequal distributions of resources, power and privileges

between white people and POC. Being white accrues privilege and status (Fine, 1997). White privilege refers to the unearned benefits white people receive just for being part of the dominant group (Bell, 2013; Home office,1999). Put another way, white people are the beneficiaries to the unequal distribution whilst POC are disadvantaged (Hilliard, 1992; Frankenberg, 1993). A specific dimension of racism is "whiteness" as a social process which are inseparable from systems of injustice (DiAngelo, 2011). Whiteness is purported to be the means by which white people elevate themselves over POC (Mcintosh, 1989; Home office, 1999). This definition contrasts with the prevailing argument in education which proffers that racism is isolated to individuals who may display overt behaviours or behaviours that are more discrete (Mcintosh, 1989). Whiteness has been defined as multi-dimensional and is described by Frankenberg (1993) thus:

> *Whiteness is a location of structural advantage, of race privilege. Second, it is a 'standpoint,' a place from which White people look at ourselves, at others, and at society. Third, 'Whiteness' refers to a set of cultural practices that are usually unmarked and unnamed* (Frankenberg*, 1993,* p.1).

Faruqui in her first Senate speech (Knaus, 2018) concurs with Hilliard (1992) and Frankenberg (1993) as they support the argument of power and privilege being a feature in understanding racism and argue that whilst politicians display public solidarity in condemning the most blatant racism, this is in fact a cover for their role in creating and stirring up racial divisions. This occurs in the case of institutional racism where the behavioural norms of individuals or informal social groups are supported by racist thinking and the instigation of active racism (Home office, 1999). The institutional aspect of racism is the result of its construction within an organisation, having historical roots and being allowed to remain as it goes unchallenged and is not questioned (DiAngelo, 2011). The effect of this is, institutional racism becomes embedded within an organisation, impacting POC negatively as deep rooted structures are allowed to remain where POC constantly face stigma and marginalisation when accessing healthcare and public services, including the justice system, prison service and immigration system (Lais, 2019; Jones, 1997). This is aided by the policies, practices, procedures and the culture of an organisation which largely excludes POC from having a voice and from benefitting from opportunities and resources (Crenshaw et al., 1996). These actions serve to reinforce individual attitudes and prejudices, with POC being marginalised, isolated and stigmatised culminating in sustained trauma.

Having looked at the concepts of prejudice and racism and based on the understanding of both concepts, the researcher viewed the NHS through the lens of racism as a phenomenon as there is a difference between prejudice and racism (Andrews, 2015).

Focusing on individual prejudice avoids dealing with the endemic systematic racism which results in significant inequalities (Andrews, 2015). DiAngelo (2011) who is a white woman, asserts that mainstream definitions of racism are usually some variation of individual race prejudice which can be held by anyone, but in reality, racism is about a social process.

The question was asked earlier as to whether the NHS was prejudiced or racist and having gained an understanding of the structures under which racism operates, the next section outlined the research problem, the research questions and the research objectives.

1.4 Research problem

BME nurses tend to be subject to discrimination when applying to access training and professional development activities within the existing NHS structure giving rise to concern for the care patients receive (NHS England, 2016).

1.4.1 Research question

The following question drove the research:

> *What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?*

1.4.2 Research aims and objectives

The overall aim of this project was to develop a conceptual model of issues to be considered in developing an equality framework. The aims and objectives of this study helped to answer the research question. The main focus of this research was on black nurses as reports suggested that discrimination against black nurses were the highest within the NHS as opposed to any other group. Through gaining an understanding as to why discriminatory practices persist in the NHS, it was felt that this would help to identify approaches that could help to increase BME nurses' participation in training programmes.

The following objectives helped to develop this research.

Objective 1: To examine the role of transformational leadership and followership in bringing about professional development opportunities for BME nurses

Objective 2: To explore whether nurses were trained to provide culturally competent and compassionate care

Objective 3: To explore whether opportunities for clinical supervision existed as a forum for personal and professional development for nurses

Objective 4: To examine the potential for an equality framework to guide individual black and minority ethnic nurses, NHS Trusts, Government and researchers

1.5 Outline of section

In order to give context to this project, the following sections illustrate the potential societal influence on NHS institutional culture. In the following section, an account of the researchers' experience is given as it was one of the drivers for this project. A brief look is then taken of black people historically up to the present day. This is followed by an examination of existing structures in society that serve to facilitate oppressive practices, then a summary of the chapter is given.

1.5.1 Researchers' experience

Sultana (2007, p. 380) argues that for the researcher to engage in ethical research, it is critical that s/he pays attention to positionality, reflexivity, the production of knowledge and the power relations that are characteristic of research processes. With this understanding, I present my own history or my personal experience as espoused by Moustakas (1994) who argues that research should be shaped by biography/personal experience. Denzin (1986) asserts that interpretive research begins and ends with the biography and self of the researcher. Reddie (2007) argues that it is my 'point of departure.' My personal experience is also one source for my theoretical perspective in addition to a review of the literature and my reflection as a nurse (Trafford and Leshem, 2008).

Personal experiences are real and subjective therefore I acknowledge that there is researcher bias which Mehra (2002) asserts is inevitable when conducting research. Some may see my subjectivity as self-indulgent but Bravette (1997) would argue that as a nurse educator and a leader, I am a role model for others. Being objective when having an experience is said by the late philosopher Renee Descartes to be impossible and therefore asserts that we know knowledge with certainty through our ability to think (Burns, 2001). In other words, reality exists because we observe it. Mousakas (1994) proffers that the researcher writes about their own experience and the situation that have influenced their research. Furthermore, Hall (2005) argues that self-narratives are found in every culture and are a uniquely human way of understanding the world. Chang (2008) asserts that self-narratives should be reflected on, analysed and interpreted within their broader social context. In this way, the researcher is contributing to knowledge and serves as a resource to inspire others.

I begin by recounting an experience I had when I secured my first senior role as lead nurse for the Tuberculosis (TB) service in an area of the UK which at the time had the highest rates of TB. I was a standalone practitioner which means I ran the service single handed. I was specifically recruited for this temporary role even though I had no prior experience of this area of medicine. I forged ahead however and quickly learned the role. I moved from novice to expert through developing skills and a sound

educational base along with the experience of working with the client group (Benner, 1982). I achieved this with the aid of key literature, policies and protocols and the help of key staff to assist me e.g. respiratory consultants, specialist nurses and health advocates who acted as translators for those patients who did not have English as a first language.

With increasing knowledge, I achieved well against the key performance indicators i.e. I achieved 89% TB treatment completion rates against the national and global performance target of 85% (TB facts, 2018). Three months into the role, the job was advertised nationally. Believing my experience was insufficient, I did not apply. A white male nurse who had a few years' experience within the field was appointed to the permanent position. After his appointment, I was taken on substantively as his deputy. Shortly after my appointment, he told me that I could not access further training as I had 'had my quota of training' despite the fact I was new to the field and needed the training in order to provide the patients with quality care based on the best available evidence (RCN, 2018b). My black colleague was also not allowed to access training courses in contrast to white staff members who were able to undertake training as part of their development. I eventually left that organisation.

I subsequently worked in another NHS organisation where I had a similar experience. I was denied training and told I would have to wait until the following year to access it despite training funds being available. Staffing was not an issue as the team was fully staffed and two white staff members had declined training. Staffing however was used as the excuse as to why I could not pursue a course even though the training would have mainly been conducted online via the internet. I had reached the top of my nursing band, my pay was capped and there was no place for me to progress further, so I was stagnant, unable to improve further to serve the patients better.

The RCN (2018b) refer to the experiences I cite as workplace incivility which is defined as the condition where low intensity behaviour occurs with the ambiguous intent to cause harm (RCN, 2018b). Rather than foster an inclusive workface where staff are supported to perform well, workplace incivility works against the targeted staff and leads to a toxic culture, a situation which characterises the culture of some workplaces (RCN, 2018b). I wanted to develop my skills as a practitioner and avoid stagnation in order to remain motivated but as this was not allowed, I left the organisation shortly after and worked as an independent contractor. As black professionals occupy senior positions, the issues they face will make it difficult for organisations to retain talent (Atewologun and Singh 2010). 'The '"Problem" Woman of colour in the Workplace' image in chapter 6, aptly describes my lived experience of working in the NHS.

As a reflexive practitioner, I try to make sense of my experiences in the workplace so that the learning can be applied to practice which in turn benefits the patients. Chiavaroli and Trumble (2018) argue that exercising phronesis in matters such as these would prove beneficial to the functioning of organisations as it enables, in this case the practitioner, to use practical wisdom in determining what action to take. Kinsella and Pitman (2012) state that:

> *Phronesis is an intellectual virtue that implies ethics. It involves deliberation that is based on values, concerned with practical judgment and informed by reflection. It is pragmatic, variable, context dependent and oriented towards action* (Kinsella and Pitman, 2012, p. 2).

In exercising practical wisdom, I adopted the concepts from Kolb's (1984) learning cycle in which I reflected on each experience which Kolb (1984) refers to as having a concrete experience. From the experiences, I was drawing conclusions or what Kolb (1984) refers to as abstract conceptualisations where I was making sense of what was happening, reflecting on what I had done and what I already knew. I then moved onto the final stage of Kolbs' (1984) learning cycle which was to act in order to address the situation in question. I did so by requesting a meeting with the manager of the first organisation that I cite.

Figure 1.6 below illustrates Kolbs' learning cycle and the steps I took in an attempt to address the problem.

Figure 1.6 Kolb's learning cycle (1984, p.21)

I expressed my concerns to the manager in a professional manner to *challenge while keeping relationships intact* (Naylor, 2008, p. 5). Without warning, this resulted in a letter summoning me to a disciplinary meeting whilst on annual leave which naturally upset the time I was taking away from the workplace to renew my energy. Being subject to a disciplinary hearing was not something I had faced in all my years of nursing. The usual procedure in bringing a disciplinary against a staff member was not

followed as it is a staged process that progresses through the stages if there is no improvement in whatever the situation may be. The first stage is a verbal warning, followed by a written warning then a disciplinary meeting (Employment law clinic, 2018). This did not happen in my case. I was summoned straight to a disciplinary meeting for voicing my concerns. NHS England (2016) argue that too many NHS organisations move to a formal investigation as the default position without even considering whether it is a necessary course of action. It is situations like this why many nurses are of the belief that equality in the NHS is a myth (Keogh, 2019a). Atewologun and Singh (2010) argue that black professionals often have to oppose the stereotypes that they encounter in those cultures that fail to value diversity. It has been said that the system is not set up for black people, their talent and skills are not valued. In the situations I have described, as a reflexive practitioner, the action I took was necessary for the benefit and the functioning of the organisation (Chiavaroli and Trumble, 2018). The alternative would be to do nothing whilst discriminatory practices go unchallenged and work relations deteriorate further.

DiAngelo (2018) refers to the experience I cite as 'white fragility' which occurs when white people are protected against 'race' based stress with a lowered ability to tolerate racial stress. For instance, if the assumptions white people hold about race are challenged, the reaction becomes defensive and counterproductive and act as a means of maintaining racial inequality through behaviours such as anger, guilt, fear, aversion, argument and walking away from the stress inducing situation (DiAngelo, 2018; Allen, 2001). DiAngelo, a former professor and lecturer who works as a facilitator and a consultant, is hired by organisations to look at the recruitment of BME staff and to uncover why they fail to stay in organisations. She found that in instances of racial discrimination when BME people challenged white people, this resulted in outrage at the suggestion of them being racist. Although DiAngelo's (2018) remit is to make visible the racist assumptions held about BME people which occurs as a result of the conditioning through living in a white supremist culture, the responses that resulted when questioned or named, yielded the same predictable responses which was that of outrage. DiAngelo (2018) is asked to deliver workshops to help the staff see their racism but when she helps them see the racism, she is met with hostility, anger, argument, silence, defence, withdrawal. In other words, white fragility erupts and functions to protect racial inequality.

The point is illustrated when during one of her workshops she states:

> *I have just presented a definition of racism that includes the acknowledgment that whites hold social and institutional power over people of colour. A white man is pounding his fist on the table. His face is red and he is furious. As he*

> *pounds he yells, "White people have been discriminated against for 25 years! A white person can't get a job anymore!" I look around the room and see 40 employed people, all white. There are no people of colour in this workplace* (DiAngelo, 2011, pp 54 – 70).

To deny that racism exists is known as the new racism as it pertains to ignoring or turning a blind eye to a vice that actually exists (Lee Hall, 2016). In America, it is said that most white people choose to deny that racism exist as a cover to avoid the fear and negative publicity that is associated with supporting it (Lee Hall, 2016).

Reflecting on the strategy of 'white fragility' being just one of many means by which racial inequality is perpetuated and the equilibrium maintained in society, was quite profound and I documented the learning in my reflective journal. This was important to note as I was also wondering why the *status quo* is maintained in the NHS with regards to racial discrimination. The situation has been debated for many years but still there is little change (NHS BME Network, 2015). The learning evoked an epiphany as it reminded me of a seminar I attended on hate crimes in 2018. The following excerpt is taken from my reflective journal:

> *Listening to the lecture, I am deeply concerned with the theory that is being expounded by the white professor who is delivering the presentation on hate crimes. He mentioned that back in the 1980s, black men were responsible for the muggings that were taking place in society. The professor was challenged by a member of the audience who had studied criminology and psychology. The woman related that during her studies, she found that when there was a perceived need to make black people a scapegoat for any societal ill, they were given 'labels.' The term 'mugging' was one of those labels. She then went on to say that white folk were robbing old ladies at the time in question (1980s) but they were labelled 'thieves' as opposed to muggers. The professor who was visibly irritated, conceded after being prompted by the chairperson to respond to the remark, that this indeed was the case. I was left wondering why this man who was deemed 'learned' by his conferred position as a professor, found it necessary to perpetuate this negative stereotype of black people. The experience heightened my awareness as to the undercurrents in society around race and racism.*

(Excerpt taken from my reflective journal, April 2018)

Housee (2018) similar to Lais (2019) responds to my reflective piece by asserting that institutionalised structures, bigoted opinions and insidious discrimination exists in higher education institutions, the establishments that are teaching the future generation. In her book which is described as a manifesto for change, Housee (2018)

calls for a decolonising of the curriculum and contends that minoritized students which refers to people who are culturally, ethnically or racially distinct from the dominant group and viewed as subordinate (Encyclopaedia Britannica, 2018) should be allowed to speak freely, thereby making higher education establishments truly inclusive which she argues is the domain of social justice. Bhopal and Alibhai-Brown (2018) concur with Housee (2018) and contends that the institutions that educate people within today's society are racist and maintains that in the contexts of neoliberalism and policy making, covert and overt forms of racism and exclusion remain in existence which continually operate at all levels of society. In compiling statistics for the previous three years to 2019, the 'Higher Education Statistics Agency' found that there were no black academics in managerial, director and senior official positions and at top universities they were paid on average 26 per cent less than their white colleagues (Lais, 2019). The result of a major study of the English education system using critical race theory (CRT) which is examined below in the literature review section, concluded that when it came to racial inequality, the *status quo* was maintained as a result of educational policy design which was not constructed to eliminate inequality but to sustain it at manageable levels (Gillborn, 2008). Racism is not a recent phenomenon (Olusoga, 2015) which means it is being maintained in society today.

Having looked at the researchers' experience and how racism has contributed to shaping social relations in the UK, thereby providing context to this project, the next section provides the justification for the project or the reason why it was important to conduct this research for all nurses.

1.6 Justification for the project

This research contributes to the existing literature as it proposes actions that connect policy and practice through the enforcement monitoring and reporting of outcomes. The limitation of self-measures has been identified in chapter 7 therefore this research's findings can supplement what is already known on the subject and the components that can underpin or hinder effective implementation of policy.

This research is needed because the omission of the experiences and perspectives of black nurses regarding their professional development in the NHS has consequences (Watson-Druee, 2009). As well as the NHS losing valuable staff, it limits the advancement of leadership potential for younger practitioners and perpetuates the status quo (Kline, 2014). Ignoring the voice and experiences of the small group of black women practitioners who have achieved, creates a blockage for growth and development through a lack of awareness for a younger generation (Kline, 2014). Whilst the focus of this research is on BME nurses, the researcher acknowledges that there are inequalities in other marginalised groups such as gay/transgender or disabled

people but as the literature alludes to, black people are oppressed and do not have any adaptions or laws in place which should protect them. Instead, they are often silenced and told that they are 'playing the race card' when they try to voice concerns (Hirsch, 2020). This research aims to help the reader to understand the phenomenon of racism and its impact on health that may otherwise be difficult to understand or interpret (Eisner, 1991). The researcher was interested in the nurses' accounts of their own experiences and points of view which led to the principal research question:

> *What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?*

1.7 Outline of the thesis

Chapter 1: Looks at the backdrop of racism on a societal level as it is important to try and understand the culture of the NHS as an institution as the people in society are those that staff organisations such as the NHS.

Chapter 2: Conducts a review of the literature as a research methodology in its own right which relates to the topic and locates the research within the context of existing literature. Through an analysis of the literature, this will assist in answering the research question through the development of new insights and will show why work from the professional context of the researcher engages with the practical and academic towards bringing about changes in theory and practice.

Chapter 3: Discusses the methodology of the project which includes how the research design was created.

Chapter 4: Maps the activities of the project which includes where the investigation was conducted; the time period in which the investigation was conducted; the sample group used for the data; the approaches and methods used to collect and analyse the data and the difficulties encountered.

Chapter 5: Presents the findings of the project.

Chapter 6: Discusses the findings of the project and what it means for practice and gives a reflexive account of the researchers' personal learning and professional journey.

Chapter 7: Presents the conclusion and recommendations and contribution to the body of knowledge and the potential impact of the research.

The next chapter reviews the literature that has informed this project.

Chapter 2: Objectives and review of the literature

2.1 Introduction

This chapter reviewed the literature which informed this project in order to critically appraise how different researchers had addressed the issues raised. This was to gain insight to the knowledge relevant to this project. Points of convergence and divergences, strengths and weaknesses were examined including the gaps in the literature. The primary purpose of this review was to uncover why discriminatory practices exist, how it is perpetuated and how the experience of BME nurses could be improved when it came to accessing training and professional development activities within the NHS.

BME nurses are underrepresented in senior positions in the NHS (NHS England, 2018; Kline, 2014). Several assumptions have been made as to why this could be, however, figures demonstrate that due to racial discriminatory practices, BME nurses continue to face an uphill struggle for equality (NHS England, 2019b; Stephenson, 2019). The impact of this amongst other issues, has meant that they experience difficulty accessing professional development training resulting in damage to their careers (NHS England, 2019b). Importantly is the negative effect a lack of training can have on the care of the patients.

This is a health project and as such takes a public health approach to the phenomenon of racism which is the focus of this research. It has been acknowledged by the public health department that racism is a social determinant of health (Castle et al., 2019) and occurs due to the value that is assigned based on how a person looks. For racism to be understood, an examination of the historical impact of systemic racism on the social determinants of health is needed, including those of marginalised populations (Castle et al., 2019).

Research articles published in professional and academic journals and news articles relevant to the research topic, were used for this project. A range of data bases were accessed through Middlesex University's library services and a google search was conducted to gain access to research articles e.g. Cochrane library, CINAHL, Google Scholar. The search terms used when reviewing the literature were: NHS, leadership, clinical supervision, racism, prejudice, training and development, cultural competence.

The next section looks at black people historically to gain perspective on the present because as Lowe (2007) asserts, without looking back in history, racism cannot be understood. Crenshaw (1988) expounds that everything builds on what came before.

2.2 Black people historically

2.2.1 Introduction

The historical aspect is crucial in gaining greater knowledge as it is important in understanding and interpreting social phenomena (Castle et al., 2019). Corfield (2008) contends that history is inescapable, it studies the past and the legacies of the past in the present. Furthermore, history connects things through time and is essential for an adequate understanding of the condition of being human (Corfield 2008). The following paragraphs are necessarily descriptive as it examines the life of black people historically.

Fryer (2010) asserts that black people have systematically been omitted from history to which Olusoga (2016) concurs. There is a broad consensus amongst academics that black people lived in Britain during Roman times and probably before Roman times (Ali and Ali, 1992). When this knowledge was brought to the fore by white University of Cambridge Professor of Classics – Mary Beard, she was vilified and faced a torrent of verbal abuse. Olusoga (2017) an historian of dual heritage (black and white parentage), argues that black British history has been whitewashed as Britain was more racially diverse than is reported in the history books. Forensic evidence has confirmed the African ancestry of one of the richest inhabitants of Roman York in the 4th century known as the 'Ivory bangle lady' whose skeleton buried in a sarcophagus was found with jewellery and other luxurious items (Olusoga, 2017). Another discovery of the first black Briton through forensic means, was the 'Beachy Head lady' found in a quintessentially English village next to East Sussex where she grew up 1,700 years ago (Olusoga, 2017).

Albu (2015) posits that the only time black people are spoken about in history in the United States of America (USA) is when curriculum requirements dictate that slavery, the civil war and the civil rights movement are discussed. Adi (2017) an African historian, argues that the young people of today do not have knowledge of the people and organisations that were in existence in Britain even as recent as the 1960s and the 1970s, not to mention the history of their family, such as their parents, grandparents and what has gone on before like for example ancient history. Adi (2017) asserts that it is important that we understand the world in which we live and this cannot be achieved if its history is to a great extent obscured and distorted. Albu (2015) concurs and argues that the black experience comes into focus only in climatic moments of social change, in other words, when there are changes of significance.

Andrews (2017) contends that it would be naïve to think that the history of Britain could be understood without earnestly studying Africa, Asia and the Caribbean and asserts that Britain's place in the world is entirely dependent on the empire. British history is

black history. The empire refers to a worldwide system of territories under the authority of the monarchy and British government (Encyclopaedia Britannica, 2018). Britain would not be the place it is today if it were not for black peoples' contributions (Maxwell, 2015) as they were the creators of civilisation and the builders of the worlds' first cities (Olusoga, 2017). Nevertheless, many of the negative beliefs that society hold about black people are rooted in the history of slavery, colonisation and the empire (Lowe, 2007). These behaviours contrast with those meted out to the Europeans where over 1 million were enslaved by Muslims along the North coast of Africa between 1530 and 1780 (Davis, 2003). The number of Europeans that were enslaved amounted to more than that of the Africans who were enslaved and taken to the Americas during that time period (Davis, 2003). Slavery however, has been racialised and as such, only black people are viewed as slaves, as bringing the conquest of the Europeans to the fore does not fit with the general theme of modern European world conquest and colonialism and are some of the reasons as to why the conquest of the Europeans has been minimalised (Davis, 2003).

To summarise this section, it looked briefly at how black people's position in society has been minimised through the structures that are in place. The next section examines what it means to be a black person in society today by looking at their experiences. In order to understand the beliefs, learning and behaviour of people, there needs to be an awareness of their experiences and culture from the historical and cultural context as people's experiences differ (Waters and Mehay, 2010).

2.2.2 What it means to be black in society today

This section adds further context to the project by setting the background and looking at five separate incidents that gained the public attention through their (mis)handling. This is important as looking at the inherent processes in society, provides causal explanations of the social world as experienced (Sayer, 1992). Bell (1990) states:

> *Only by listening to those faces at the bottom of society's well would we recover forms of knowledge long represented and long misunderstood and learn from those whom we would teach* (Bell, 1990, p. 198).

Evidence suggests that black people are still subject to racial discrimination today (IRR, 2017; Olusoga, 2016; Sinyangwe et al., 2015; Unison, 2019) this is despite the lessons learned and recommendations from cases such as the Stephen Lawrence landmark case (1999a). On the evening of the 22nd April 1993, Stephen Lawrence, a black British teenager, whilst waiting at a bus stop in London, was chased by a group of white youths and brutally murdered (BBC, 1999b; Dodd, 2018). He was deemed to be a victim of a racially motivated incident (Laville and Dodd, 2011). The murder which was unprovoked, gained notoriety through the parents' fight for justice, exposing the police's

handling of the case which was affected by issues of race (Laville and Dodd, 2011). During the Lawrence's fight for justice, it was reported that an undercover police officer was instructed to seek intelligence that would discredit the family which resulted in a smear campaign being launched against them (Channel 4 news, 2013; Evans and Lewis, 2013). This situation occurred despite the role of the police which is:

> *"The purpose of the police service is to uphold the law fairly and firmly; to prevent crime; to pursue and bring to justice those who break the law; to keep the Queen's peace; to protect, help and reassure the community; and to be seen to do this with integrity, common sense and sound judgement*" (Police Studies Institute (PSI), 2012, p. 12).

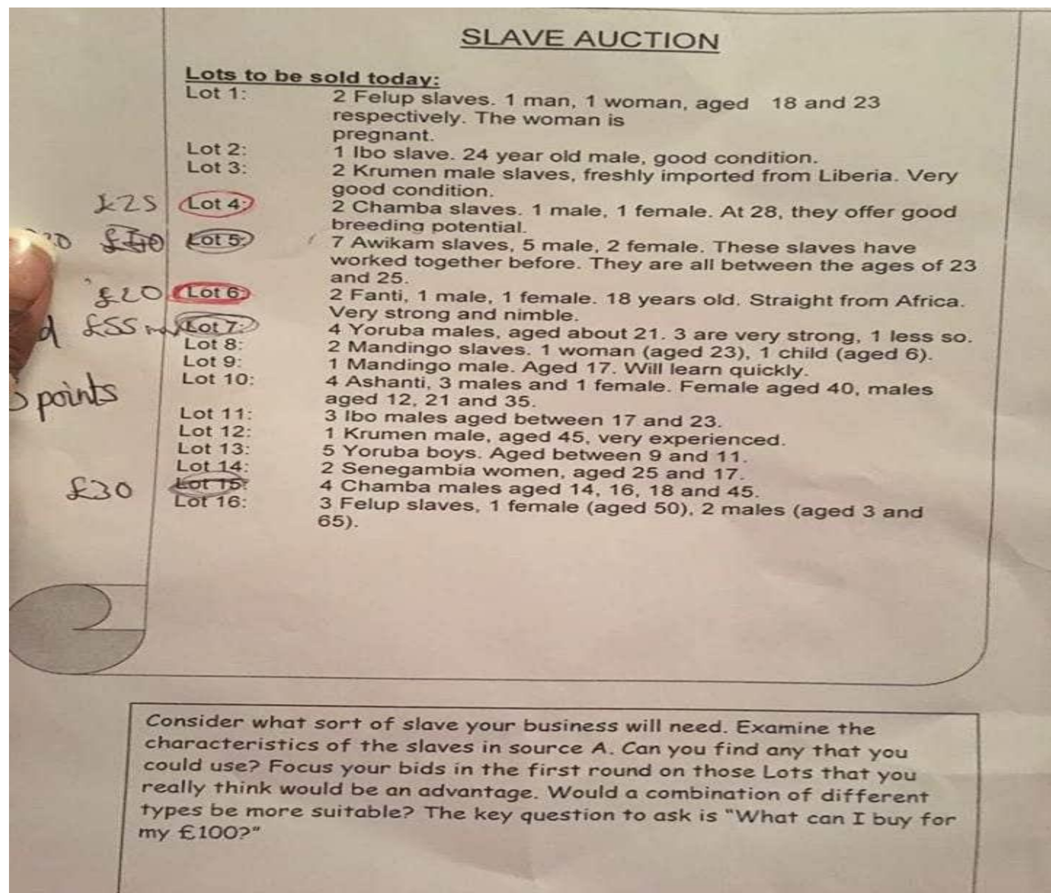
In other words, the police force exists for the maintenance of civilised society (PSI, 2012). In 1998, the Metropolitan police commissioner – Sir Paul Condon, apologised to the Lawrence family admitting that there were failures in the handling of the case (Buncombe, 1998). In the same year - 1998, Sir William Macpherson, a retired British High Court judge led the public inquiry into the murder of Stephen Lawrence. After examining the investigation reports produced by the Metropolitan Police Service (MPS), Macpherson concluded that the MPS were institutionally racist (Freeman-Powell, 2019). Institutionalised racism is subtle in nature and is found in organisations where practices and political structures place black staff at a disadvantage in relation to the organisation's white majority (Jones, 1997). Only two people were convicted of Stephen Lawrence's murder, the other three perpetrators were never brought to justice (BBC, 2012).

In response to the injustices in society where yet another black person was killed unlawfully with the murderer being acquitted (Munro, 2016) the Black Lives Matter (BLM) movement was founded. The movement which is global in the US, UK and Canada was founded in 2013 where its:

> *Mission is to eradicate white supremacy and build local power to intervene in violence inflicted on Black communities by the state and vigilantes* (BLM, 2019, p.1)

The BLM movement gained traction in 2020 with global protests following the death of the black unarmed man George Floyd. The world saw him being audaciously murdered by the police who sat on his neck for 8 minutes and 46 seconds, cutting off the oxygen to his airway (Sabur et al., 2020). Floyd was murdered for a crime he did not even commit, the real 'crime' was that he was a black human being (BBC, 2020b; Holmes, et al., 2020; Sabur et al., 2020). The police were initially fired from their jobs and **faced no charge.** It was only when there was a global outcry that one of the policemen was charged with second degree murder (Holmes, et al., 2020; Sabur et al., 2020).

The third incident which involves the education sector, took place in a secondary school. The negative stereotype which according to Kaufmann (2012) is a means of portraying the history of black people as one of an uninspiring existence, emerged in a grammar school in England causing an outcry after a teacher asked year 8 pupils (12 year olds) to buy slaves with “good breeding potential” during a history lesson (Turner, 2017). Pupils were asked to determine what they could buy for £100 and were given an auction sheet which comprised 16 lots (an item or set of items for sale at an auction, Business dictionary, 2020). From the information contained in the worksheet, the pupils were expected to make their choices based on the characteristics of the slaves. (Turner, 2017). Figure 2.1 below illustrates the worksheet.



SLAVE AUCTION

Lots to be sold today:

Lot 1: 2 Felup slaves. 1 man, 1 woman, aged 18 and 23 respectively. The woman is pregnant.
Lot 2: 1 Ibo slave. 24 year old male, good condition.
Lot 3: 2 Krumen male slaves, freshly imported from Liberia. Very good condition.
Lot 4: 2 Chamba slaves. 1 male, 1 female. At 28, they offer good breeding potential.
Lot 5: 7 Awikam slaves, 5 male, 2 female. These slaves have worked together before. They are all between the ages of 23 and 25.
Lot 6: 2 Fanti, 1 male, 1 female. 18 years old. Straight from Africa. Very strong and nimble.
Lot 7: 4 Yoruba males, aged about 21. 3 are very strong, 1 less so.
Lot 8: 2 Mandingo slaves. 1 woman (aged 23), 1 child (aged 6).
Lot 9: 1 Mandingo male. Aged 17. Will learn quickly.
Lot 10: 4 Ashanti, 3 males and 1 female. Female aged 40, males aged 12, 21 and 35.
Lot 11: 3 Ibo males aged between 17 and 23.
Lot 12: 1 Krumen male, aged 45, very experienced.
Lot 13: 5 Yoruba boys. Aged between 9 and 11.
Lot 14: 2 Senegambia women, aged 25 and 17.
Lot 15: 4 Chamba males aged 14, 16, 18 and 45.
Lot 16: 3 Felup slaves, 1 female (aged 50), 2 males (aged 3 and 65).

Consider what sort of slave your business will need. Examine the characteristics of the slaves in source A. Can you find any that you could use? Focus your bids in the first round on those Lots that you really think would be an advantage. Would a combination of different types be more suitable? The key question to ask is "What can I buy for my £100?"

Figure 2.1 Slave auction worksheet - Source: Telegraph 13th July 2017

The worksheet was criticised by parents and former pupils as being racist whilst the school defended it, arguing that it was used to demonstrate the horrors of the slave trade (Turner, 2017). Kaufmann (2012) argued however that it was wrong and dangerous to present the view that black people were always enslaved. Black children are intelligent and confident until the age of 5 when they enter the school system (Major, 2001; Demie and Mclean, 2017). It is at this point that something happens to change that fact and the child succumbs to a downward trajectory where they are subject to failure. One of the reasons teachers have low expectations of black children could be due to the negative stereotypes as presented above (Demie and Mclean,

2017) because despite them being equal in intelligence if not brighter than white children, they make the least progress, particularly black boys (Major, 2001). Educational institutions including schools are said to legitimise the inequalities by propounding deficit narratives about black people which perpetuates the elitist structures (Doharty, 2018).

The fourth incident, again involving the educational sector, occurred in March 2018 where a secondary school in the South West of England was apparently being investigated by police. This was following an incident in which a black boy, a pupil of the school, was tied with chains to a lamppost in the school grounds and whipped with sticks by at least 7 white boys who were said to be classmates attending the same school (Bennett, 2018; Busby, 2018). Whilst being whipped in what was described as a mock slave auction, the black boy was said to have been subjected to abhorrent shouts of racist abuse with reference being made to the slave trade. Three of the white boys were initially expelled by the headmaster but later allowed to return to the school after the board of governors revoked the decision. They were suspended instead for two weeks (Bennett, 2018; Busby, 2018).

The fifth incident concerns what became known as the ‘Windrush Scandal’ (Hewitt, 2018). ‘Windrush’ refers to the passenger and liner cruise ship that was reported to have transported the first wave of West Indians to England (Olusoga, 2017). The disenfranchisement of black people came to prominence with reports in 2018 that the British government were in chaos as a result of the Windrush scandal (Hewitt, 2018; Dearden, 2018). This was due to an attempt to obliterate the history of black people from the commonwealth countries who came to Britain in 1948 (BBC, 2018b). By destroying documents relating to the nationality of the children of the Windrush generation (Kynaston, 2007; BBC, 2018b) it was almost impossible for the people whose parents came to work for the NHS amongst other jobs, to prove their right to remain in the UK (BBC, 2018b). Those referred to as the Windrush generation were the espoused 492 people who arrived in Britain in 1948.

The Windrush scandal came to the public attention when Theresa May, the former prime minister of the UK from 2016 to July 2019, was the Home Secretary from 2010 to 2016. She produced a document in which she reported that she would create a hostile environment through the implementation of policies that affected migrants (Muir, 2018; Dearden, 2018; Broomfield, 2017). The hostile environment policies were implemented to make life difficult for illegal immigrants in the UK so that they would leave the UK of their own volition (Global Justice Now, 2018; Lambert, 2017). An internal impact assessment was conducted in 2015 and May was warned by the home office (the lead government ministerial department who are responsible for immigration and passports

(Gov.UK, 2016) on more than one occasion, that the polices could cause potential discrimination and hardship but these warnings were ignored (Muir, 2018; Dearden, 2018). The document highlighted that children of the Windrush generation would be affected by the hostile environment May sought to create (Dearden, 2018). The children of the Windrush refer to the children who accompanied their parents on the journey to Britain before 1973 and who were now between 60 to 70 years of age (Hewitt, 2018). These ‘children’ were threatened with deportation if they could not prove that they were entitled to remain in the UK (BBC, 2018b). Although settled legally in Britain from childhood, they were now re-classified as illegal immigrants. The Windrush scandal came to light only because some of the Windrush ‘children’ had lost their jobs and homes as they were unable to prove their British status. Some were held in detention centres and others were denied NHS treatment including one man who needed urgent treatment for cancer (Hewitt, 2018). The people who were being treated as illegal immigrants, were individuals who did not have a connection with the country in which they were born as they came to the UK as infants, they were schooled in the UK and contributed to the advancement of the British economy (BBC, 2018b).

Amanda Rudd, a white MP who was the home secretary in 2018 at the time the Windrush scandal emerged, denied that there had been targets to remove 12,800 immigrants from Britain through enforcement (BBC, 2018a). Rudd later insisted that she was not aware of the targets. It later transpired that she had **lied** and had known of the targets when a letter dated in 2018 was brought to the public attention in which she set out targets for an increase in the enforced deportation of immigrants. Rudd resigned from her post as Home Secretary on the day the letter was published in April 2018 (BBC, 2018a) and was appointed to the post of Secretary of State for Works and Pensions by Theresa May on the 16th November 2018 (Kentish, 2018). A report which looked into the Windrush scandal, concluded that the Home Office was institutionally racist but the report was later ‘toned down for political reasons’ (Telegraph Reporters, 2020; Grierson, 2020).

Whilst the aim of this project was to explore the lived experience of BME nurses and not necessarily about racism ubiquitous to the UK, Castle et al. (2019) argue that whilst sufficient evidence exists in support of the impact of discrimination and racism on an individual level, little, if any attention, has been given to racism in relation to system and structures. The five incidents cited above was mentioned here in order to illustrate the potential societal influence on NHS institutional culture. An example is disproportionality, where black people are severely punished when compared to their white counterparts (Uhrig, 2016).

The next sections explore how racism is perpetuated through the structures that exist in society and how it could affect the culture of the NHS.

2.2.3 Societal structures and racism

The UK has the world's fifth largest economy (Gray, 2017) which is attributed to the legacy of immigration and the hard work of black people in building the infrastructure, helping to make Britain great (Maxwell, 2015). According to Henry (1985) and Olusoga, (2016) racism can be linked to one of the most important events of the 1940s which saw the arrival in Britain of black people from the commonwealth countries after the war when there was a call from the British government for migrant workers to help rebuild Britain (Henry, 1985). This period saw an increase in racism (Carter, 2002; Cregan, 2010; Vonderbeck and Worth, 2015).

> *But having brought diverse minorities into the workforce, the health service as a whole often considers them, implicitly or explicitly, a problem* (Ali et al., 2013, p.24).

Following the emigration of BME peoples from the colonies to Britain, came the construction of 'British' from 'other' as a move to denote supremacy (Sherwood, 2003). In other words, POC were constructed to be inferior to white people and reportedly needed to be civilised. This 'othering' can be seen in the use of language where words are used to place white people above everyone else (Koutonin, 2015, para 2). Put another way, structural racism has a language (Williams, 2020). An example is the term 'expatriate' which is applied to white people who are either a temporary or permanent resident of a country that s/he was not brought up in (Koutonin, 2015). A POC in the same position however, is known as an immigrant, a term that is set aside to denote 'inferior races' (Koutonin, 2015, para 5). These factors all worked to promote racism and Mackenzie (1986) asserts that the way racism spread, was through means such as churches, the media, education system, popular culture, missionaries and imperialist associations like the Royal British Legion. When black people bring this reality to the fore, they are told to shut up and be grateful that they live in a society that is multicultural and the best in the world (Ackah, 2020). This belief is held despite evidence confirming that although historically black people have had a longer presence in Britain than white people (Ackah, 2020; Olusoga, 2016) they are invariably seen as temporary (Ackah, 2020).

Racism as a system is concealed and protected due to the definition which means that to be racist requires conscious intent and therefore practically exempts all white people with some not wishing to be seen as racist (Kivel, 2017). This is due in part to the post-civil rights era where people have been taught that racists are mean with an intentional dislike for others based on their race, including being intentionally hurtful and

consciously prejudiced (Kivel, 2017). Similar to Kivel's (2017) argument, Hefferman (2014) expounds that people are compelled to develop and protect a positive image of self.

The next section examines discriminatory practices within the NHS and the potential impact on patient care.

2.2.4 Discriminatory practices and the potential impact on patient care

Staff shortages in the NHS and the added pressure, have put staff morale at an all-time low which may be affecting the care that doctors and nurses are providing to their patients, according to health experts (Cooper, 2014). There is a known link between staff morale and the quality of care provided to patients (Kline, 2014; Cooper, 2014). In a survey conducted in 2012, more than 8 out of 10 nurses said their ward or team were short staffed at least once a week (Ford, 2013). The results of a survey conducted a year earlier (2012), found that 73% of staff reported that their Trust failed to attach a high enough priority to staffs' health and wellbeing. Results of a survey conducted in 2013 by the RCN corroborates the findings of the aforementioned survey where of the 2000 respondents, 55% had been unwell due to stress (Ford, 2013). A report by NHS Digital for NHS England which looked at health service staff absence between December 2017 and November 2018, found that 17.7 days were lost through sick leave of which 4.2 days were recorded as being due to stress, anxiety, depression or another mental health condition (Lucas, 2019). Unison (2019) found through the survey that they conducted, that the racism faced by black staff added to their mental strain.

Due to staff shortages, pressure was being put on nurses to work whilst sick (Jones-Berry, 2018). Results from the 2017 NHS staff survey demonstrated that 58% of the nurses and midwives that were surveyed, had attended work despite the fact that they were feeling unwell to the point of not being able to perform their duties (Jones-Berry, 2018). Keogh (2017) reported that 1 in 10 nurse sick days were due to stress or depression. A spokesperson for NHS Employers reported that the physical, emotional and mental health of the workface was taken very seriously by NHS organisations (Jones-Berry, 2018). This was in direct contrast however to the results of a wellbeing survey that was carried out in 2019. The results which described nurses' shifts as 'inhumane,' demonstrated that as a result of staff shortages and management failures, the health of nurses were being placed at risk (Keogh, 2019b). Figure 2.2 below illustrate the survey's findings.

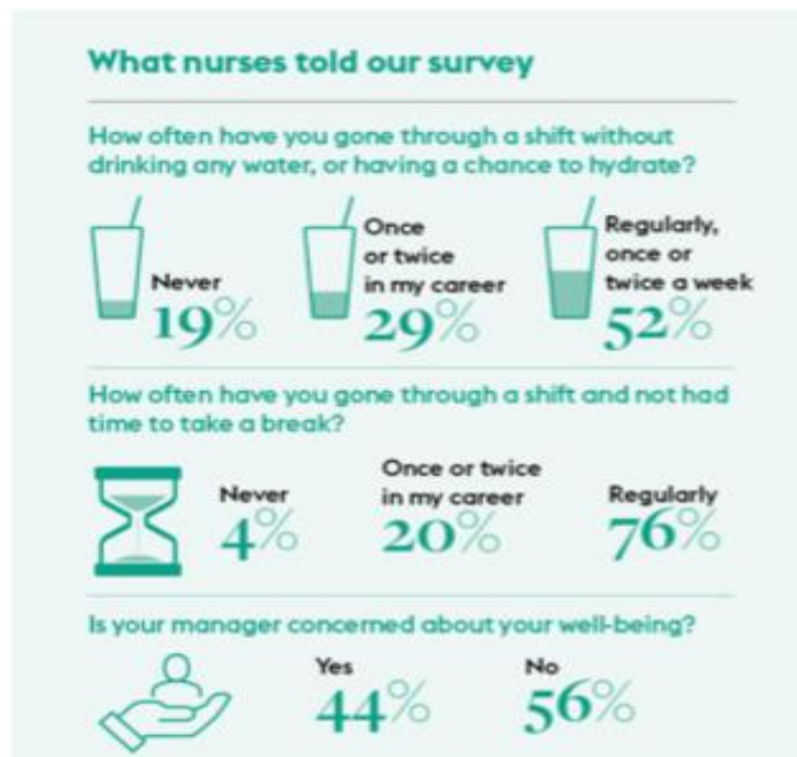


Figure 2.2 Nurse wellbeing survey. Source: Keogh, 2019, para, 15

Three quarters of the nurses surveyed which totalled almost 2, 250, reported that going without breaks was a regular occurrence with 8 out of 10 nurses reporting not having an opportunity to drink water. Only 1 in 5 nurses reported that they were able to have a drink of water regularly (Keogh, 2019b). This situation was allowed to persist, as nurses who took part in the survey argued that management did not care for their staff. This issue is a patient safety concern, as nurses who are not provided with basic needs such as water and rest, are impacted by the quality of care that they can give to patients. Water is important for mental functioning as dehydration can affect decision making, whilst taking breaks can help prevent fatigue related incidents (Keogh, 2019b). Kim Sunley, the RCN's national officer for health, safety and well-being, acknowledged that the lack of access to breaks was a symptom of the wider issue that surrounds the shortage of nurses in the NHS (Jones-Berry, 2019).

A survey conducted in 2017 by the NMC, found that 44% of nurses leaving the register cited work conditions as being the reason. They left the register as a means of protecting their health due to stress (Keogh, 2019b). Selye (2013) looked at the stress response by conducting experiments with rats. He discovered that physiological changes occurred in the body when it was under stress. Selye (2013) observed that when an organism encountered a stress situation such as a threat, the response was one of alarm after which a recovery or resistance stage ensued. If the events that are causing the stress continues, exhaustion sets in otherwise known as 'burn-out.' The symptoms of burn-out include emotional flatness, loss of drive and the dulling of responsiveness to the needs of others (Dewey, 2007-2017).

The Yerkes-Dodson Human Performance Curve (otherwise known as the Yerkes-Dodson law (see figure 2.3 below) illustrates the point at which performance increases with stress and the point at which too much stress results in decreased performance. Yerkes-Dodson assert that some stress is healthy as it helps us to perform well but in excess, stress will hinder performance.

Figure 2.3 The Yerkes-Dodson Human Performance Curve (2008). Source: Journal of comparative neurology and psychology, 2019, p. 459

According to the performance curve, if nurses are excessively stressed, the patients are not receiving the quality care that they should be receiving. Marmot et al.'s (1991) Whitehall 11 Study, found that a combination of factors provided a recipe for stress. The factors included working within a pressurised environment and having high demands placed on individuals, coupled with low control and lack of support. Those staff that were in this position were normally lower down the pecking order and had a shorter life span. The seminal Whitehall 11 Study found that the main factor in developing stress was having low control. Having low control was associated with a greater risk of serious illness which is namely diabetes and heart disease.

An excerpt is taken from the researchers' reflective journal as it encapsulates a description of the powerful reaction stress can have on the body. The narrative is based on the experience of one of the nurses who participated in the interview for this project but only shared this information following the interview:

> *A pattern seems to be emerging as despite assurances prior to the interview that confidentiality and anonymity are part of the research process, once the tape stops running, the interviewees speak of profound experiences which would have provided more rich insights into their experiences within the NHS. For instance, one participant describes how being bullied and harassed*

because she was a person of colour, caused a rift in her family with two of her children leaving the family home. She was arriving home from work each day in tears and the stress she felt as a result of the discriminatory practices she faced was building up. The stress took its toll on her health and this normally healthy person, developed diabetes. She later went on to suffer a heart attack. Her husband also had a heart attack some months later. The nurse attributes her husbands' heart attack to the worry concerning his wife whose very being he saw being eroded in front of his eyes. He felt powerless to ease her stress and this took a toll on his health culminating in a heart attack.

(Interview participant 12 – Hannah (pseudonym), staff nurse).

(Excerpt taken from my reflective journal July 2019)

Bacharach (1989) asserts that theories are used in research to explain and analyse phenomena under investigation, critical race theory was chosen to guide this inquiry and is examined in the next section.

2.2.5 Critical race theory

2.2.5.1 Introduction

Critical race theory (CRT) is a theoretical framework that is used to explore society and culture in relation to law, race and power and is used to look at different forms of oppression (Yosso, 2005). CRT is used as a method in this project to critique the literature and the findings i.e. the role of race and racism that maintains the status-quo of racism (Huber, 2008).

2.2.5.2 The emergence of CRT

CRT emerged in the 1970s in the USA in response to the slow rate at which the racial equality laws were changing (Crenshaw et al., 1996; Cole, 2007). Despite civil laws which stipulate that all human beings living in society are entitled to be free from discrimination and lead happy and healthy lives, free from people and organisational intrusion and unwarranted persecution (Cole, 2007), CRT proffers that societal racism or white supremacy in which white people are privileged, is maintained over time with the law being seen as a contributor (Crenshaw et al., 1996). This is because the laws which are supposed to transform for the better, establishes the rights and privileges that legal reform was set to dismantle. Prejudicial attitudes are institutionalised into laws and structures that favours one race over the other, structures that are created to set up POC to fail through keeping them in oppressive states thereby disempowering them (Crenshaw, 1988). Examples of this can be seen in chapter 1 regarding the Windrush scandal and the five incidents cited.

Utley (2016) contends that race which is socially constructed as opposed to it being biologically grounded and natural, acts as a means to perpetuate the interest of the

white population who constructed it. In relation to CRT, Utley (2016) agrees with Crenshaw et al. (1996) and asserts that legal structures and policies which are biased against POC, contribute to the inequality between the 'races' as through keeping the so called minority groups impoverished, this gives rise to criminality in a bid to survive. Utley (2016) further contends that white people create this difference to ensure an elitist structure is maintained through the social and economic differences they create in labour markets and politics and have no interest in doing away with these practices because it benefits them. Crenshaw (1988) declares that the status quo of oppression is further strengthened as just acknowledging America's history of racism, is seen to be disparaging and unpatriotic and has seen activists like the civil rights movement targeted, placed under surveillance and disrupted by the federal bureau of investigation (FBI). There appears to be a disconnect however as amongst the FBI's job remit, one of its top priorities is purported to be that of protecting the civil rights of people occupying American territory whether they are citizens or non-citizens (FBI, 2016).

Doharty (2018) used CRT to explain the racism that black students faced in a secondary school in England. The pupils were taught black history in a non-statutory black history unit and were reported to be subjected to micro-aggressions whilst studying. The behaviours they experienced were that of micro invalidation, micro insults and micro assaults. Doharty (2018) described the experiences as being symptomatic of wider racist structures that exist within the history curriculum born out of the ideology of white supremacy. It is reasons like this as to why black history month exists as it uncovers the means by which deficit understandings about black people are legitimised in educational institutions including schools (Doharty, 2018).

Other structures to disempower black people and maintain oppressive and elitist structures, include actions such as assassinations which still happens today and were prevalent during the civil rights movement in the USA when those who stood up for the rights of black people became assassination targets (McCalla, 2011). Black people were killed by white supremacists and the killers were never convicted for their crime due to racist governments and police departments. The victims of assassination included black leaders like Martin Luther King Jr, Medgar Evans, Harry and Harriette Moore, Malcolm X. Fred Hammond was also a black activist who worked for social change and was murdered at the age of 21 by the police because of his strong leadership ability (McCalla, 2011). According to the literature, the list is endless of black people who were murdered because they worked to achieve a fairer society for POC. These facts however, do not fall within the scope of this project and is another research project within its own right but is mentioned here to demonstrate how oppression functions.

2.2.5.3 Critical race theory from a different standpoint

Yosso (2005) a professor of education, uses CRT through the lens of a community cultural wealth model to examine POC, as opposed to the traditional deficit model of cultural capital in which POC are viewed as being impoverished and disadvantaged. Yosso (2005) in her work with POC, examined their experiences on an individual and shared level in which they spoke about discrimination and marginalisation in education. Using counter stories, Yosso (2005) brought to the fore, the knowledge, skills and abilities that the POC possessed and challenged the deficit model of CRT. She did this by focusing on cultural wealth which provides learning in the range of cultural knowledge, skills and abilities that socially marginalised groups possess which are often not acknowledged and goes unrecognised. Yosso (2005) argues that theory is a set of knowledge, some of which have been kept from POC with entry into some professions and academia being denied. Therefore, with not being allowed to enter discourse, there is an urgent call for POC to occupy the theorising space that is afforded to white men and women (Anzaldua, 1990).

The question asked concerning the epistemology or the sources of knowledge is: whose knowledge counts and whose knowledge is discounted (Ladson-Billings and Tate, 2000; Delgado- Bernal, 1998, 2002). Lopez (2001) argues that race and racism have shaped the epistemological debate and those individuals who are born into a privileged society are deemed to have knowledge that is of capital value to a hierarchical society. For those who have not been born into a privileged society, social mobility may be achieved through formal education in which the knowledge of the middle and upper classes is accessed (Bourdieu and Passeron, 1990). Based on the strategies that are used to disenfranchise, it is assumed that POC are deficient in the social and cultural capital required for social mobility. In response to the theories and assumptions held about POC, Anzaldua (1990) states:

> *'If we have been gagged and disempowered by theories, we can also be loosened and empowered by theories'* (Anzaldúa, 1990, p. 26).

The argument being put forward is that the voices and presence of POC can be valued through other sources of knowledge such as outsider knowledge. Disempowerment is the means by which hierarchical society is reproduced and maintained and interpreted to be the reason why POC have significantly lower outcomes academically and socially when compared to white people (Bourdieu and Passeron, 1990). In other words, through deliberate means, POC are limited in being able to change social reality by social, political and cultural domination.

DiAngelo (2011) asserts that ignorance is one way through which white people in North America maintains the status quo and argues that the only time they may face

challenge to their understanding of race is when they have to undergo cultural competency training in their workplace. Put another way, she is alluding to the idea that being culturally competent is not solely about race (Kleinman and Benson, 2006) but takes into consideration cultural beliefs, behaviours and needs (Papadopoulos, 2008). DiAngelo (2011) argues that some of the multicultural courses speak candidly about racism or address white privilege and the norm is to use racially coded language when referring to POC with such terms as 'urban,' 'inner city,' and 'disadvantaged.' The terms 'white,' 'over advantaged,' and 'privileged' are seldom used as they serve to produce racist images and perspectives whilst at the same time producing the illusion that race and its problems are what "they" (POC) have, "not us." The suggestion offered as to why those who benefit from racism is not proffered by the facilitators of these courses is that there is no valid analysis of racism by the white facilitators. Facilitators who are POC, have to employ strategies for personal and economic survival in terms of not wanting to lose their job or to become victimised in addition to the pressure from management to keep the courses comfortable and palatable for white people (DiAngelo, 2011).

As this study aims toward social change, attention is now turned to strategies that could be employed in bringing about change in the organisation. The strategies include leadership and followership, cultural competence, clinical supervision and plans to move the NHS forward. These are examined in the next sections.

2.3 Leadership

2.3.1 Introduction

Leadership has been defined as the ability to engage with people effectively and responsibly (Davis, 2020). It is about being involved with processes and programmes to achieve the goals of the organisation, team and the individual (Davis, 2020). As highlighted in chapter 1, evidence shows that there are serious challenges facing the NHS and its future landscape. The following sections discuss the need for effective leadership, the role of the leader in bringing about positive change and future directions of the NHS.

2.3.2 The need for effective leadership

The need for effective leadership is more important now than at any other time in the history of the NHS. Effective leadership is important if sustainable change is going to be achieved. The NHS Leadership Academy (2012) argue that evidence exists to support the fact that in every sector there is a strong relationship between leadership capability and performance. With effective leadership, individuals and organisations can thrive in challenging environments similar to what the NHS is currently

experiencing e.g. anxious staff, high stress levels, low morale, staff shortages, shrinking budgets, uncertainty as to the future and the reported lack of continuity of nurse leadership within the NHS (Jones-Berry, 2017). Research demonstrates that the turnover of nurses who are at director level remains high and half of the chief nurses remain in their posts for three years or less. This suggests that experienced nurses are leaving organisations at a time when nursing needs effective leaders (Jones-Berry, 2017). The retention of senior nurses is important for an effective well-led health and social care system at board level as:

> *"Good staff management offers significant financial savings for the NHS, as its leaders respond to the challenge of sustainability in the face of increasing costs and demands"* (West et al., 2011, p.2).

Effective leadership is important in achieving and sustaining continuous improvement within the organisation (NHS England, 2016). Procter (1986) argues that in order to inspire and change thinking and build open, honest relationships, a transformational leadership style is required. The characteristics of an effective leader are described as those who are passionate and have an inspiring and motivational influence on people, having the ability to maintain group effectiveness (Adair, 2002). Effective leaders should be solution focused, dynamic, use problem solving processes, and possess compassion. The application of these characteristics in practice is not only important in gaining the respect of colleagues, but also important for the survival of the NHS (NHS long term plan, 2019).

Lucas (2019) asserts that leadership within healthcare is not just about the characteristics of those who exert control from the top, but all nurses can act as leaders as they should be leaders of patient care. Leadership is not dependent on the individual's position within the hierarchy but is about having a vision as to how effective services can be developed (Lucas, 2019). (Jolliff, 2019) agrees with Lucas (2019) and contends that organisational performance is not dependent on individual leaders or the quality of leaders but rather on well-developed relationships between leaders. This steers the direction of the organisation, alignment and commitment.

Providing effective leadership requires that nurses develop specific personal qualities and behaviours (Lucas, 2019). According to Cook et al. (2004) the leadership qualities and behaviours that are called for, otherwise known as 'leadership intelligences,' are those of: spiritual, emotional, business or practice and political. The means by which these intelligences are manifested are described thus:

- Spiritual intelligence refers to a persons' purpose, integrity and inner drive for change.

- Emotional intelligence is concerned with the individual’s ability to recognise, manage and apply emotional information to everyday decision-making behaviour.
- Business or practice intelligence is defined as utilising strategic thinking and possessing the ability to anticipate the needs of patients using a person-centred approach.
- Political intelligence is important in helping leaders at all levels of the organisation to understand the context of care which will facilitate the embedding of person-centred care into practice.

The employment of these leadership intelligences could help to make the strategies a success i.e. the ‘10-year plan’ for the NHS which is examined below. Well-led organisations are needed as the evidence suggests that the leadership of the NHS is not working. For example, the alarming rate at which nurses are leaving the profession in numbers not previously seen, are of great concern as detailed in chapter 1. Without sufficient staff numbers to drive the proposed strategies forward (see 10 year forward below), it is likely to fail as Jones (2000) posits that the difficulty in manpower planning was the result of a lack of accurate data to monitor the recruitment and retention of health workers. According to Jones (2000) lessons need to be learned from history which would help the policy makers realise the importance of equitable manpower planning. As Powell and Thompson (2010) assert:

> “*Even with funding held constant, rising demands from an ageing population, together with higher public expectations driven by clinical developments, mean there is likely to be a substantial “funding gap” to be met by improvements in productivity and efficiency”* (Powell and Thompson, 2010 p.47).

The leadership approach where one person has the expertise in a particular area, has been criticised due to the challenges it can present in terms of leaders leaving organisations and there being no designated person in charge. In this type of situation, collective leadership could work (Mckee et al., 2013). Where there are traditional hierarchies of leadership, collective leadership could be considered if the leaders are willing to pay attention to all their staff members and in turn enable them to feel empowered to lead where required (Lucas, 2019). Creating environments that foster different leadership styles, could have positive impacts on tackling racism in the NHS and help to facilitate access to training and development opportunities.

The next section looks at collective leadership, including the leadership styles that are threatening the stability of the NHS.

2.4 Collective leadership

The nurses' role in leadership is demonstrated through optimal practice otherwise known as distributed leadership (Fitzgerald et al., 2013) or collective leadership (West et al., 2014). West et al. (2014) asserts that collective leadership is the key to unlocking cultural change as it provides the optimum basis for caring cultures as opposed to a leadership that employs a command and control structure.

Table 2.1 below illustrates the key differences between traditional and collective leadership.

Table 2.1 Key differences between Traditional and Collective Leadership

	Traditional leadership approach	**Collective leadership approach**
View of organisations	Organisations as machines	Organisations as communities
Structure	Hierarchical, pyramid	Connected networks, flattened structure
Who leads?	Individuals	A team
Who makes decisions?	Top management	Distributed and aligned with areas of responsibility
Basis for authority	Positional power- based on title	Personal power – based on knowledge and strengths
Communications	Top down, holding onto information, exclusive	Multi-directional, more transparent, inclusive
Diversity and inclusion	Less likely for multiple cultural inclusion	More likely for multiple cultural influences
Processes	Directive - people need to be told what to do	Collective - people are capable and trustworthy to do the right thing
Accountability	Buck stops at the top	Shared
Beliefs about success	A few individuals have the skill or talent to create success	Success comes from the diverse perspectives and skills of many

Source: Wilson, 2018, p. 2

Collective leadership allows those with expertise, capability and motivation, to receive leadership power with responsibility for the development and how it will be delivered. Everyone has a stake in making the organisation a success and not just their own job

roles. Leading by example is what counts, not the position within the hierarchy, according to Haligan (2013) The boards of NHS organisations have ultimate responsibility for developing effective collective leadership (West et al., 2014). In other words, those who have demonstrable skills regardless of position, skin colour, gender and so forth, should be allocated leadership power for the good of the organisation where through working collaboratively, change is effected across local health systems. The expected outcome of collective leadership is high quality care that is safe and within budget (Care Quality Commission (CQC), 2018/19; West et al., 2014).

2.4.1 Barriers to collective leadership

There are several factors that currently hinder the effective execution of collective leadership. The main factor of concern and which form the focus of this project, is that of BME staff development. For collective leadership to work, all staff have to be involved in a process of continuous learning and given the opportunity to adopt leadership responsibility in their roles. This is important for the NHS's long term and Sustainability and Transformation Plans (explained below) with the integration of the NHS, local authority and third sector organisations (NHS long term plan, 2019; BMA, 2015; West et al., 2014).

One of the biggest challenges said to be facing the successful delivery of collective leadership is that of corporate psychopaths who are found in leadership roles in organisations (Babiak and Hare, 2006). Corporate psychopathy has been described as a personality disorder which manifests in impaired empathy, manipulation, controlling and extreme intimidation of others especially behind closed doors. They take pleasure in harming others (Boddy, 2011a). Boddy (2011b) argues that some authors contend that the reason why there is a global financial crisis is due to the action of corporate psychopaths. When in senior management positions they can cause extensive damage to an organisation (Walker, 2005; Wisniewski et al., 2017) as they set the tone for the culture of an organisation (Boddy, 2011b). The damaging effects to an organisation can include, low productivity, high staff turnover, absenteeism, conflict, stress and bullying (Boddy (2011b). Boddy (2011b) describes the actions of corporate psychopaths thus:

> *Corporate psychopaths rising to key senior positions within modern corporations where they are able to influence the moral climate of the whole organisation and yield considerable power, have largely caused the crisis. In these senior corporate positions, the corporate psychopath's single-minded pursuit of their own self-enrichment and self-aggrandizement to the exclusion of all considerations has led to the abandonment of the old-fashioned concept of noblesse oblige, equality, fairness or any other real notion of social responsibility"* (Boddy, 2011b, p. 257).

The Mid Staffordshire NHS Trust is one example of an organisation where it was found that the culture of the organisation was not conducive to a healthy working environment. An overwhelming culture of disempowerment and bullying was cited amongst its failings (Gov.UK, 2013). Haligan (2013) argues that the Francis report is the biggest leadership challenge facing the NHS and asserts:

> *I guess we all see what we're looking for. Everyone "knows" who should resign and precisely why and yet these same people, most of us, ironically reflect what Francis writes in his report – wilful blindness, the bystander phenomenon (everyone sees, no one responds) and normalisation of deviance* (Haligan, 2013, para, 2).

Kline (2014) and West et al. (2011) argue that if staff are treated fair and with respect, they are more likely to stay in their posts which in turn would address the serious nursing shortage (RCN, 2017). Hefferman (2014) argues in favour of a culture of quality which she asserts can be achieved through appropriately addressing issues that are public or issues that are known. Neglect in doing so, is to break the law as this omission is known as wilful blindness. Wilful blindness occurs when an individual knows that a catastrophic event is about to happen but chooses to ignore it. Hefferman (2014) suggests that we need to start from a position of blindness and create conditions where it is safe to see what is happening which would be achieved through human interaction.

2.5 Leadership academies approach

The leadership academies model was introduced to address the concerns relating to organisational failures like Mid Staffordshire and other NHS Trust. It purposed to bring about change for the better. The model was categorised under three headings with the first one being: *'Provide and justify a clear sense of purpose and contribution'* (Storey and Holti, 2013, p. 6). This category addressed behaviours and skills that focused on the needs and experiences of patients/service users and the quality of care provided. The second category: *'The motivation of teams and individuals to work effectively*'' (Storey and Holti, 2013, p. 6), was concerned with collaborative working and the ability to work across organisations. Emphasis was placed on valuing both staff and service users in addition to staff development and rewarding performance. The third category: *'Focus on improving system performance*' (Storey and Holti, 2013, p. 6), focused on service improvement and bringing about evidence-based change.

The leadership model seeks to develop and recognise leaders at all levels of the organisation, even those who are not in formal leadership roles. The aim is to engage and empower staff and provide a caring environment in which to work, resulting in compassionate patient care (Leadership academy, 2021). The leadership academy will

be supporting the leadership and talent management needs of the NHS long term plan (Leadership academy, 2021) which is examined later in this study.

2.5.1 Transformational leadership, followership and change

Haligan (2013) asserts that we know a leader when we see one. This is because they invoke inspiration within their team members which makes them determined and in turn inspires them to go further in executing their work tasks. This characterises transformational leadership where the emphasis is on the leader providing inspirational motivation in addition to having an awareness of the needs of their followers (Bass, 1985). This requires good teamwork as Adair (2002) contends that when there is good teamwork amongst individuals who are patient focused, this has a major impact on performance. Employing a transformational leadership style is reported to be predictors of quality outcomes in healthcare settings (West et al., 2015).

Research identified five management practices which is invariably associated with successful implementation of change initiatives (Page, 2004). These practices include: safety; the creation and maintenance of trust throughout the organisation; actively managing the change process; involving staff in work decisions such as work design and flow and establishing the organisation as an institution of learning and employing knowledge management practices (Page, 2004). Effective leadership facilitates change and determines the atmosphere and direction of the organisation (Adair, 2002; Alimo-Metcalfe, 2003). Also of importance for change, are those leaders who are politically aware both from an organisational and national perspective and are able to match their leadership approach to the teams in which they work (Adair, 2002; Alimo-Metcalfe, 2003).

Where there are leaders, there are followers (McCallum, 2013) with roles containing different attributes but roles which should be interdependent (Leadership academy, 2012). Kellerman (2004) contends that leaders need followers and the ability to engage in order to achieve the objectives of the organisation. Naylor (2008) argues that leaders and followers should be able to engage in dialogue in order to achieve the delivery of high-quality health and social care services. There needs to be an understanding of others' roles and values. Whilst leaders need the ability to engage and motivate staff, there must be good followership with the willingness to be led as it enables empowerment of the leadership (Hay, 2010). This is not to suggest that followership is a position of subservience where the follower accepts and obeys the dictates of the leader in authority, rather, Cox et al. (2010) argue that followership is interactive with the follower being in control of the choices made. Kellerman (2007) expounds that there are different types of followers which she defines by their level of engagement. A good follower is described as one who actively supports effective and ethical leaders

whilst appropriately responding to bad leaders. In contrast, bad followers are described as those who make no contribution and they support bad leaders (Kellerman, 2007). Naylor (2008) asserts that for collective leadership to be effective, active followership is needed as it is a key variable in bringing about transformational change in leadership (Naylor, 2008).

One of the required changes that Francis documented in his report was the lack of compassionate care (Gov.UK, 2013) which also considers people's needs and cultural beliefs (Papadopoulos, 2008). Based on the understanding of cultural competence, the researcher also employed this concept as an agent for change and addresses this in the next section.

2.6 Cultural competence and compassionate care

Due to the reported discriminatory practices and the projects' aim to effect change, the study looked at whether nurses were trained to provide culturally competent care as having an awareness and understanding of cultural diversity in healthcare is important in delivering best practice (Kleinman and Benson, 2006). Whilst this study was concerned with the experiences of BME nurses when applying to access training and development programmes, being culturally competent which is a learning need, is also about being clinically competent. This is because the care provided will be evidenced based and therefore effective as it takes into account the specific needs of individuals (Papadopoulos, 2008).

Papadopoulos (2008) argues in favour of cultural competence, a process in which nurses have the capacity to provide care that is effective and compassionate and which takes into consideration the cultural beliefs, behaviours and needs of individuals. Calkin (2013) concurs with Papadopoulos (2008) and asserts that having an awareness and understanding of cultural diversity in healthcare is important in delivering best practice. Kleinman and Benson (2006) also agree that best practice can be achieved through using cultural competence.

Cultural competence is defined as:

> *A set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals that enables them to work effectively in cross-cultural situations* (Cross et al., 1989, p. 7).

An example of why being culturally competent is important and the link with CPD, is ascribed to the results of studies which has shown that as a result of the inequalities in the maternity units of the NHS, when compared to their white counterparts, black women are five times more likely to die as a result of complications in pregnancy whilst the death rate for Asian women are two times more than white women (NPEU, 2017).

This situation has been attributed to the care given which is not culturally competent but rather care that is administered because it is 'written in the guidelines.' The care given to BME patients fails to take the individual and their needs into consideration, it is arbitrary, not evidence based and reported to have risk assessments that are racist (NPEU, 2017). For instance, the belief that black people are not as sensitive to pain as white people (BBC, 2019) places black women at higher risk of death in childbirth as when complications arise and they complain of severe pain, they are not taken seriously until the situation becomes critical (BBC, 2019). Being trained to provide culturally competent care also enables the practitioner to examine their own personal value and belief system and to recognise and challenge racism as well as other discriminative and oppressive practices (Papadopoulos, 2008).

Papadopoulos and Pezzella (2015) recognising the cultural competence gap in health and social care, presented the knowledge base which underpins the need for change in practice in order to provide culturally competent care and to comply with national policy. A four-stage model was implemented to develop culturally competent and compassionate healthcare professionals (Papadopoulos et al., 2008). Figure 2.4 below presents the model for developing culturally competent and compassionate healthcare professionals.

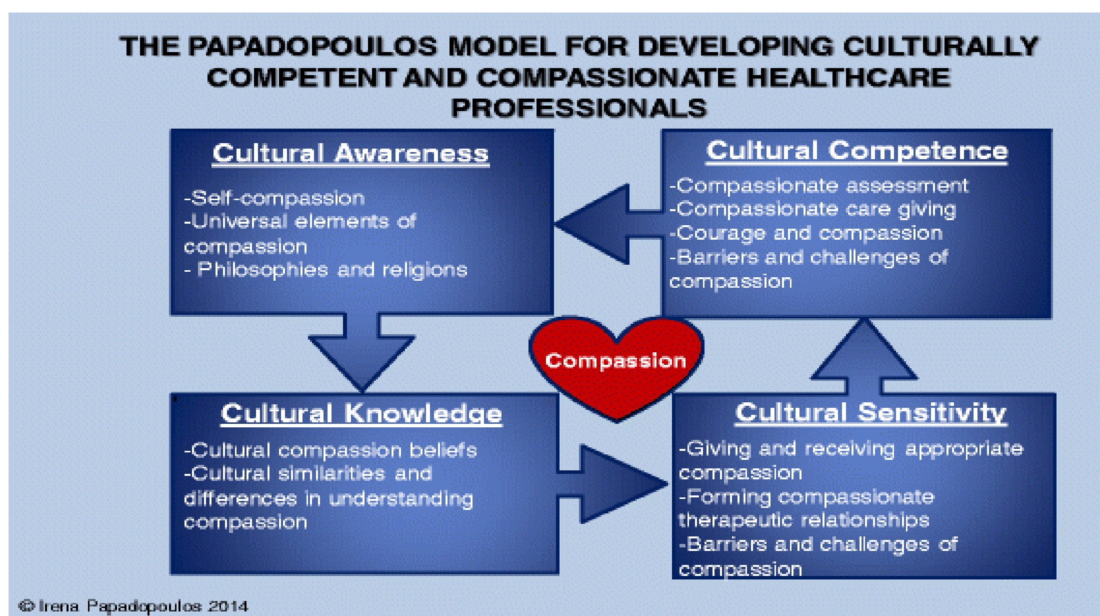


Figure 2.4 Adapted from Papadopoulos, Tilki, and Taylor (1998 b) Model of Transcultural Care: A guide for Health Care Professionals. p.1

Each stage of the model is progressive starting with cultural awareness. During this stage, the practitioner examines his/her own personal value and belief system. The second stage is the accumulation of knowledge which can be gained in various ways e.g. through reading or engaging with people from different ethnicities. The third stage is where professionals foster a relationship of equality with clients in order to achieve

culturally sensitive care. In the fourth stage the professional needs to combine the previous stages and apply it in practice (Papadopoulos, 2008). This stage also requires the professional to recognise and challenge racism as well as other discriminative and oppressive practices.

Whilst interventions have been put in place to tackle the lack of compassionate and culturally competent care and its effects, there is still a long way to go as poor patient outcomes are on the rise despite the availability of information and data. The Francis report found one of the of the main issues affecting patient care was a lack of compassion, patient safety was being compromised and they were dying needlessly in hospital (Gov.UK, 2013). Sadiq (2013) argues that information and data are an organisation's greatest assets but are often underutilised which she attributes to the failure to recognize the data as assets or their inability to manage them effectively. Sadiq (2013) further posits that information management in organisations are problematic and is the cause of rising operational costs resulting in reduced productivity and efficiency in its operations. An example of persistently high, poor patient outcomes despite the availability of data demonstrating the shortfalls in the service, can be seen in maternity services as mentioned earlier, when it comes to black and Asian women giving birth (Garcia et al., 2015). There is a disparity in maternal and birth outcomes when compared to the majority which has resulted in a call for the assurance of culturally competent care provision (Garcia et al., 2015).

The NHS is regulated by two organisations which have come together under one leadership known as 'NHS Improvement' (NHS Providers, 2015). The organisations which are 'Monitor' and the 'Trust Development Agency' (TDA), regulates Foundation Trusts (which are semi-autonomous) and NHS Trusts, through its oversight framework (NHS Providers, 2015). In supporting providers to provide financially sustainable, safe, high quality and culturally competent care, NHS Improvement supports all Trusts to develop the ability to enhance and apply evidence-based improvement methodologies (NHS Improvement, 2019).

Despite these regulations being in place, it has been said that staff are being failed. The case of an employee who worked for an NHS Trust that was reportedly failing its patients and staff as a result of leadership problems, came to the public's attention in 2017 (CQC, 2016). The hospital Trust where the sacked employee Dr Vivienne Lyfar-Cisse worked, was the Brighton and Sussex University Hospitals NHS Trust. The hospital Trust is overseen by the Trust Board. The chairman and non-executive members are appointed by NHS Improvement on behalf of the Secretary of State for Health. The Nomination and Remuneration Committee of The Board of Directors, appoints the executive members (Brighton and Sussex University Hospitals NHS Trust,

2019). In attempting to carry out her role in the organisation in which she was employed as the head of racial equality, a role that she assumed in 2014, Lyfar-Cisse, a black woman and a Principle Clinical Biochemist by profession, was sacked from the Trust where she had worked for 32 years (Baska, 2019). It was alleged that she told a white colleague that he was everything she despised in a white manager (Apen-Sadler, 2019). She was apparently dismissed on the grounds that she harassed her co-worker because of his 'race.' Lyfar-Cisse lost an unfair dismissal claim that she brought to an employment tribunal against the Trust in which she had worked (Apen-Sadler, 2019). Although the full details of this case are unknown, what is known in the public domain would suggest that Lyfar-Cisse was treated harshly, especially when following an inspection of the Brighton and Sussex NHS Trust by the CQC, it was put in special measures in 2016. This action was taken by the CQC because in addition to numerous failures, it found that discrimination, harassment and victimisation against BME staff was rife within the Trust (CQC, 2016; ITV News, 2016).

Having examined the experiences of black people in society and the concept of cultural competence, attention is now turned to what it means for black nurses to be bi-culturally competent.

2.6.1 Bicultural competence

Whilst there is a call for nurses to be culturally competent in their practice (Papadopoulos, 2008), Gordon (2007) also calls for a move towards bi-cultural competence. Put another way, she is calling for black people to become competent in their own culture as well as the dominant culture in order that blockages on a personal as well as a professional level can be removed. Gordon (2007) argues that this can be achieved through an investigation and understanding of the individual's own life world in order to make sense of double consciousness and in turn become transformed. In other words, gaining an understanding of their own life world is likely to lead the nurses to change. This is important now more than ever as it has been expounded that a stark lens is being shone on the inequalities faced by BME nurses in the NHS. This is through exposure to the coronavirus that they are having to face in executing their duties (Ford, 2020). Coronavirus, otherwise known as Covid-19, is a highly infectious disease which causes respiratory illness or lung disease amongst other symptoms (Boseley et al., 2020). At the time of writing in the month of May, 2020, Covid-19 had affected 6,190,767 people in over 180,000 countries with a reported 38,376 deaths in the UK and 371,465 deaths globally as of 31st May 2020 (Worldometer, 2020). It emerged that BME nurses felt they were being targeted to work on Covid-19 wards in contrast to their white colleagues (Ford, 2020). Most BME nurses are known to be graded at band 5 which means that they were mostly working on the frontline and

therefore more exposed to Covid-19 than nurses in senior level positions (Stephenson, 2020).

Data showed that the deaths per 100,000 of the NHS workers in England were: BME staff- 42 and white staff - 6 (ITV News, 2020). A survey with over 2,000 UK healthcare respondents, conducted by ITV News (2020) into the Covid-19 crisis, found that 84% more BME nurses and doctors were deployed on the frontline with more exposure to the virus. Seventy-three per cent of BME respondents also reported that there was a lack of personal protective equipment (PPE) for them to carry out their tasks and they were less likely to be risk assessed to work in Covid-19 areas in contrast to white staff. Fifty-three per cent of the workers were afraid to speak out about the dangers that they faced daily in executing their duties. When asked why they were afraid, the overwhelming response was that they were not cared for (ITV News, 2020). Some BME staff reported that they would be leaving the NHS as they were constantly discriminated against in addition to whenever they tried to voice their concerns, they were given short shrift, being told to keep quiet and carry on. Other BME staff did not feel able to speak up about the dangerous conditions that they were working in due to lack of representation, therefore, they kept quiet for fear of losing their jobs (ITV News, 2020).

What also became apparent, giving rise to concern, was the under-representation of BME nurses in the media coverage of the Covid-19 pandemic which only showed white nurses, thereby giving the appearance that BME nurses were not instrumental in helping to fight the disease (Stephenson, 2020). It was only when it came to public attention that the first 10 doctors and nurses who died from the Covid-19 infection were from a BME background, that the full extent of their involvement in caring for affected patients came to the fore (Stephenson, 2020; Ford, 2020).

This project is about change. As clinical supervision is a strategy for change, it was used in this study as research found that it is an important support mechanism as well as being an important aspect for nurse professional development (Bush, 2005). Clinical supervision is examined in the next section.

2.7 Clinical supervision

Clinical supervision (CS) is integral to this project because its purpose is to do with change. It functions along lines similar to participatory action research (PAR) which is an approach where the participants research their own self along with their cultural settings and experiences (Letts, 2003). As with CS, knowledge is generated and participants feel nurtured, liberated and empowered through the deliberate actions that are taken (Letts, 2003). In the absence of effective leadership, where the nurses face barriers accessing training and development programmes, CS is a forum where nurses

can reflect on their practice and explore their own personal and emotional reactions to their work as a means of providing high quality, safe and effective patient care (Nursing in practice, 2013). CS has been described as a process that benefits nurses as it functions to provide an emotionally safe space where they can engage in critical reflection which in turn positively impacts their emotional well-being. Reflective practice and shared experiences are part of continuing professional development (CPD) (RCN, 2021). CS helps to reduce workplace stress and helps the organisation to retain staff (Nursing in practice, 2013). It enables nurses to speak freely about their practice in a confidential environment where they can share experiences and receive feedback on their skills. This enables them to engage in professional development, facilitating identification of their development needs and supports the nurse revalidation process (Nursing in practice, 2013).

There is often confusion as to what CS is which stems from the variety of definitions (Bush, 2005; Cottrell, 1999). The following statements are some of the definitions that have been given in the literature:

> *"Supervision can be an important part of taking care of oneself, staying open to new learning, and an indispensable part of the individual's ongoing self-development, self-awareness and commitment to learning" (Hawkins and Shoet, 2006, p.5).*
>
> *"Clinical supervision is an exchange between practising professionals to enable the development of professional skills" (Butterworth and Faugier, 1992, p. 171).*
>
> *"Clinical supervision is a formal relationship in which there is a contractual agreement that the therapist will present their work with clients in an open and honest way that enables the supervisor to have insight into the way in which the work is being conducted. The supervisor is understood to be accountable to the professional body to which the supervisee has allegiance" (Wheeler, 2003, p8).*
>
> *"Clinical supervision is a formal arrangement that enables nurses to reflect regularly on their practice with other experienced professionals in order to learn from experience and improve confidence" (Kohner, 1994, p. 162).*

All the definitions cited above have common themes running through them which are: communication; a focus on clinical practice; improving patient treatment and care; outcomes and development which highlight that staff development is important in achieving quality of care. Platt Koch (1986) argues that one of the goals of CS is to develop autonomy and self-esteem. It has also been said that CS benefits clinicians as it is instrumental in reducing emotional exhaustion and de-personalisation (Butterworth et al., 1997). The Department of Health (2000, 2004) asserts that there is a clear

expectation for NHS Trusts to invest in the professional development of nurses as a quality improvement measure. Coupled with that is the fact that nurses need 'time to care' as expounded by the Francis report (Health, 2013). The introduction of CS in the workplace would suggest that there was/is a need for this strategy therefore it is important to go back to the beginning to find out why and how CS was introduced in the NHS.

CS has its roots in significant failures of care in the 1990s (Bush, 2005). Cited among the failures were the Bristol heart surgery tragedy and cervical screening mistakes that occurred at Kent and Canterbury Hospital (Cottrell and Smith, 2000). The nurse Beverley Allitt whose case sparked an outcry when it was discovered that she was deliberately harming children in her care, is also another case in point where these incidents highlighted the potential for adverse outcomes when health service systems fail. CS in the workplace was introduced as a way of using reflective practice and shared experiences as a part of CPD (RCN, 2002). CPD refers to a professional's learning whereby the skills, knowledge and experience s/he acquires formally or informally are tracked, documented and reflected on (Johnston, 2019). The individual is engaging in a process of reflection and action which is ongoing, a process in which s/he takes control of their own learning (Megginson and Whittaker, 2007). CPD is a means of enabling learning to be conscious and proactive rather than reactive and passive, it details learning activities that develops and enhances the individual's abilities (CPD, 2021). Through having a structured, practical approach to learning, this facilitates the retention of key staff, developing their skills and knowledge within the organisation. It also provides continual upskilling of the individual so professional and academic qualifications do not become outdated or obsolete (CPD, 2021).

CPD comprises a combination of approaches and includes activities such as work based learning where an individual reflects on experiences in the workplace; engages in formal courses; presents at conferences; self-directed learning where an individual reads books; journals, articles and so forth (Health and Care Professions Council, 2019). After professionals qualify in their field, whether they are newly qualified or with many years' experience, CPD is important because it ensures that they remain competent in their profession. Policy documents have reiterated that CPD should be a partnership between the individual and the NHS organisation, providing equal opportunities for all staff members (Department of Health (DOH), 2001; 2003; 2004). CPD, a process which continues throughout the professional's career, serves to advance the body of knowledge and practice through the promotion of evidence-based practice. This in turn safeguards the professionals' career, the public and the employer through the provision of enhanced patient care (CPD, 2014) and professional recognition and membership for the individual.

Professionals such as radiographers, physiotherapists, dieticians and so forth, are required to engage in CPD, a directive which is usually found in their individual 'Codes of Professional Conduct.' For instance, doctors working in the specialist field of obstetrics and gynaecology, are expected to maintain up to date knowledge, thereby developing clinical and professional skills which ensures patients receive safe and quality care (GMC, 2012). This in turn supports the processes of appraisal and revalidation as in order to remain on the register, CPD standards have to be met (HCPC, 2017). If standards are not met, this could result in removal from the register, culminating in a fitness to practice process where concerns about conduct and competence are brought into focus (HCPC, 2017). Employers therefore have a duty to ensure their employees practice safely and stay on the register (HCPC, 2018).

The RCN (2018b) assert that improving and maintaining practice is a patient safety issue and as a means of ensuring this, the NMC introduced the process of revalidation. Part of the 3 yearly nurse revalidation process in which nurses must demonstrate that they are providing safe and effective practice so as to remain on the nursing register, includes signing a confirmation. They have to demonstrate that they provide effective and safe care through a process of activities which includes 35 specified practice hours and continuous professional development (NMC, 2018). Training needs to be pertinent to the individual's scope of practice be it as a nurse, midwife or nursing associate (NMC, 2018).

Following the publication of the NHS Long Term Plan, a new set of principles setting out the investment in CPD for nursing staff was published in 2019 by a working party which comprised organisations from across health and social care (Ford, 2019). The initiative eliciting the support of employers, was established to create a culture of continuous learning and workforce development including the retention of nurses and other staff across health services. Of importance, were patient/service users' safety and the standards of care they received, therefore, the initiative was implemented to improve their outcomes. Additionally, in relation to CPD, the document highlights the shift of power from health education institutions, with funding going to employers who are charged with identifying the needs of service users in order to determine the relevancy of the learning that staff undertake (Ford, 2019).

The DOH (1993) acknowledges the link with CPD and clinical supervision and defines the role of clinical supervision in learning as:

> *"A formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex clinical situations"* (DOH, 1993).

Clothier et al. (1995) argue that the advent of CS was necessary in order to protect standards and public safety through the increased vigilance of staff. CS and leadership are integral to effective clinical governance and have both been identified as being key factors in enabling effective scope of practice in the health sector (Victorian Healthcare Association, 2008). CS is instrumental in achieving elements of clinical governance as it can support quality improvement and help with risk and performance management (Proctor, 1986). Clinical governance is a term used to describe activities that help sustain and improve high standards of patient care, for instance clinical audit. Clinical governance is described as:

> *"A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."* (Scally and Donaldson 1998, p.61).

McSherry et al. (2002) suggest that through the process of CS, practitioners can make changes when problems are encountered. Learning is a constructive process (Cooper, 1993) and is central to what nurses do as healthcare practitioners caring for patients. Megginson and Whittaker (1996) argue that self-development is our potential *for learning and for changing what we do* (Megginson and Whittaker, p.1). CS helps staff to try out new ideas (RCN, 2002). The CQC (2013) assert that CS provides an opportunity for staff to reflect on and review their practice and change or modify their practice and identify training and continuing development needs. Butterworth et al. (1997) argue that the central purpose and principle benefit of CS is improvement in patient care, it is also a place where practitioners can discuss issues in a constructive manner. CS enables individuals to present issues in a systematic way (Gibbs, 1998) and is a tool that can satisfy the need for improvement in practice and patient care through a structured approach to deep reflection on clinical practice. This allows staff to identify room for improvement (RCN, 2002).

All NHS organisations are accountable for continually improving the quality of their services. CS is about improving quality, its purpose is to facilitate reflective practice and push forward a patient centred focus (Butterworth and Faugier, 1992). Reflection is having the capacity to reflect on action in order to engage in a process of continuous learning (Schon, 1983) and can lead to a deeper understanding of patients' needs and subsequently to personal and professional development (Clifton, 2002). Reflection has an outcome. Bolton (2010) argues that examining one's practice reflectively and reflexively leads to developmental insight.

CS has a restorative function (Proctor, 1986). The resulting effect of this is improved patient outcomes. If managers are committed to CS, this will enable clinicians to have

the time needed to develop and enhance their practice (Clifton, 2002). Driscoll (2007) argues that management have their own agenda which is concerned with developing a safe and accountable professional whilst the professional is seeking continued personal learning and support. Driscoll (2007) asserts that both agendas appear to describe the functions of CS.

The processes, systems and structures that healthcare organisations put in place must demonstrate that standards are maintained e.g. safety and quality of care (Proctor, 1986). It has been recognised in recent years that the emotional needs of nurses and how to manage their needs, need to be taken into consideration in addition to their wellbeing (RCN, 2020). This situation was highlighted during research workshops run by the RCN where discussions took place between expectations, time, and the conflicts between them (RCN, 2020). Figure 2.5 below illustrates the clinical supervision process and what it entails.

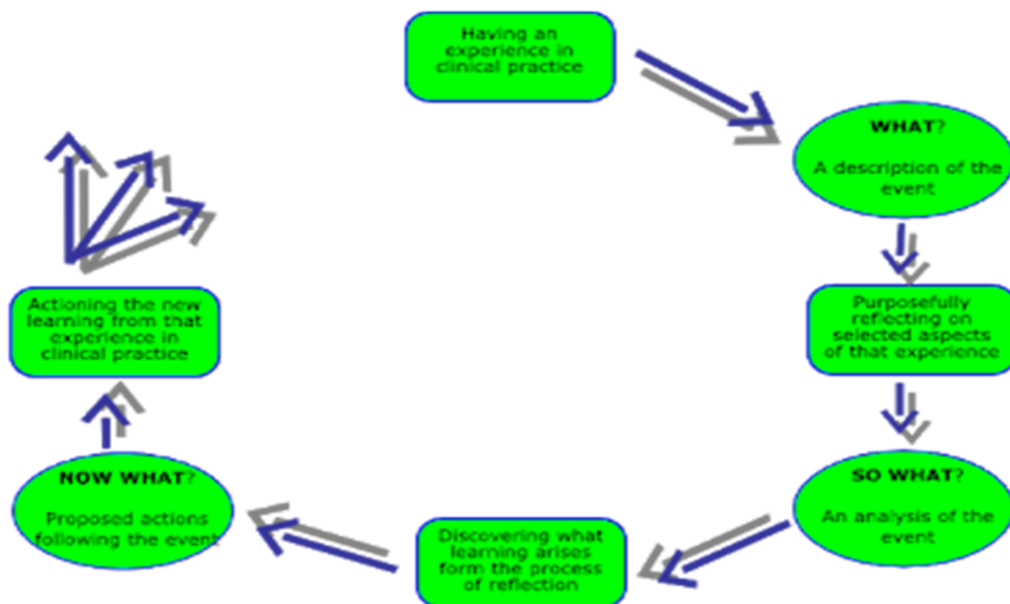


Figure 2.5 Clinical supervision cycle, taken from Driscoll (2007), p.44

The diagram in figure 2.5 above illustrates how having an experience in practice and being able to analyse that experience, enables learning which in turn leads to action. The action is then applied to practice. Clinical supervision enables the development of professional skills (Butterworth and Faugier, 1992) and enhances the professional functioning of the participants (Consedine, 2004). CS is about creating *'A culture based on continual learning through support and best-practice methods which will empower and motivate staff'* (Frankel, 2008, para 10).

The Kings Fund, a charity set up to improve health and care in England (2012) assert that:

There is strong evidence that leaders who engage staff, patients and others deliver better results on a range of measures (Kings Fund, 2012, p.5).

In an effort to move the NHS forward, the 10-year plan has been established and is examined in the next section.

2.8 Future Plans: Moving the NHS Forward

2.8.1 The 10-year plan for the NHS

The purpose of the 10-year plan (also known as long term plan) is to gather intelligence as to how to make the NHS fit for the future and make it economically viable. The plan has been a collaborative effort, drawn up by those with a vested interest such as frontline health and care staff, patient groups and experts in the field who know the NHS best (NHS long term plan, 2019). The 10-year plan will run from 2019 to the 2029.

The plan looks at how vast improvements can be made from maternity care and birth, through to delivering world class care for major health problems such as cardiovascular issues, mental health issues and dementia care to name a few. Emphasis is placed on collaborative working across primary and community care to provide seamless services where patients can have more of a voice in the care they receive and where the care is received (NHS long term plan, 2019). In other words, patients will be given a choice and supported where viable, to be cared for in their own home environment for as long as possible, thereby avoiding unnecessary admission to hospital.

Stakeholders of the 10-year plan acknowledge that to achieve the ambitions contained within the plan, will need staff to drive it forward as one of the major challenges are staff shortages in the NHS, coupled with a growing demand for services (NHS long term plan, 2019). There is a commitment to do things differently as illustrated in table 2.2 below:

Table 2.2 Adapted from Papadopoulos, Tilki, and Taylor (1998 b) Model of Transcultural Care: A guide for Health Care Professionals. p.1

How the ambitions of the NHS long term plan will be delivered	
Focus	**Action**
1. Doing things differently	Patients to be given more control over their own health and the care they receive Collaborative working between GPs and community services to become ‘Integrated Care Services’ to plan and deliver care which meets the needs of their services

How the ambitions of the NHS long term plan will be delivered	
Focus	**Action**
2. Preventing illness and tackling health inequalities	NHS to improve services to those significant causes of ill health such as: stopping smoking, overcoming drinking problems (alcohol), avoidance of type 2 diabetes with a focus on the communities most affected by these health problems
3. Backing our workforce	Increasing the workforce through recruitment and provision of training Making the NHS a better place to work to retain staff enabling them to make better use of their skills improving the patient experience
4. Making better use of data and digital technology	Provision of convenient access to health information for patients through the introduction of the NHS App. Better access to digital tools for staff and to patient records Improvements to the planning and delivery of services based on the analysis of patient and population data
5. Getting the most out of taxpayers' investment in the NHS	Working with doctors and other healthcare staff to identify ways of avoiding duplication in the delivery of clinical services Using combined power to source and buy commonly used commodities more cheaply and in turn reduce administrative costs

Source: Adapted from the NHS act plan, 2019, p. 2

The ambitions of the long term plan will be taken forward through the development of 'Sustainability and Transformation Plans' (STPs) which is a part of the five year forward view as mentioned above, through an 'Integrated System of Care Planning' (ISCP) which will implement strategies that sets out how the plans will be turned into local

action (NHS long term plan, 2019; BMA, 2015). With the NHS facing challenges of sustainability in the face of increasing costs and demands (West et al., 2011) and financial and service pressures that are unprecedented in its history, it is crucial that the leadership of the organisation sustains high quality care that improves continually (West et al., 2014).

The long term plan includes a commitment to making the NHS a better place to work and in turn retain staff. This includes providing staff with training which will help the utilisation of skills to better effect (Long term plan, 2019). The plan makes no mention however as to how inequalities will be tackled but another document published on the 30th July 2020 known as the 'NHS people plan', places emphasis on staff and its vision of enabling the delivery of the NHS long term plan (NHS Employers, 2020). The plan includes a 'people's promise' setting out the behaviours that staff can expect from leaders as well as colleagues in a move to improve the experience for all staff working in the NHS (NHS Employers, 2020). The people's plan provides guidance, tools and resources for NHS employers to address nine areas of which equality and diversity and health and well-being form a part. The WRES has informed the plan as to the work that is needed in order to systematically eliminate discrimination in all areas of the NHS (NHS Employers, 2020). An action plan accompanies the people's plan with those national bodies responsible for executing the action(s) e.g. NHS Improvement, Employers within the NHS, Health Education England. A timeline as to when the actions should be completed is also in place (NHS Employers, 2020). Invoking the Equality Act 2010 which exists to promote fairness, dignity and respect (EHRC, 2015) should help in establishing an NHS with services fit for the future as set out in the long term plan (Long term plan, 2019).

The long term plan is in its infancy as it was published in January 2019, therefore its effects are not yet known especially with the impact of the Covid-19 pandemic which has slowed processes somewhat. What is clear however is if the aims of the 10 -year plan are to be achieved, NHS organisations will need an inclusive workforce where there is collective leadership (Jolliff, 2019) and culturally competent staff (Papadopoulos and Pezzella, 2015; Jolliff, 2019). Initiatives such as the WRES (purpose of WRES described above) although implemented in 2015 and despite the resources in place, data demonstrates that processes could have been executed better as very little has changed in tackling racism in the NHS. BME nurses are still subject to barriers when applying to access training and development programmes.

2.9 Summary and conclusions

To summarise, this chapter looked at the NHS at its inception and data revealed how black nurses working in the NHS were not welcome. Today the evidence from the

literature suggests that nothing has changed. Racism in the NHS is as prominent today as it was in 1948 when nurses from the Caribbean and people from India, answered the call from the British government to work in Britain's hospitals as well as other industries. The Covid-19 crisis illuminated the system of racism that exists and it showed the inequalities faced by BME nurses who were/are dying disproportionately.

This chapter also examined critical race theory to explore how racism is perpetuated in society. It then looked at different leadership styles and how the application of effective leadership styles to practice is important for the functioning of the NHS. The study then examined the strategies that could be used to bring about change e.g. adopting a culturally competent and bi-culturally competent way of working and engaging in clinical supervision as a development tool.

Presenting a review of the literature was important in focusing this research in addition to helping to build on existing knowledge. This helped to facilitate the communication of ideas, enabling understanding of the human experience which was central to this project.

The next chapter looks at the methodology and methods used in conducting this study.

Chapter 3: Research methodology and design

3.1 Introduction

This chapter outlines the approach used in conducting this study. The key question that this research sought to address was how to extend and improve knowledge of the experiences of BME nurses when seeking to access training and development programmes within the NHS. This was in response to a review of the literature which demonstrated that BME nurses were at a disadvantage when compared to their white counterparts but the conversation had rarely included their experiences. This project employed the use of survey questionnaire for circulation to nurses of all racial backgrounds as it was felt that the study could have wider implications for those employed in the NHS, where discriminatory practices could transcend a range of ethnic groups.

The methods considered most suitable to collect the data were to be linked to the project research question as recommended by Halcomb and James (2019). It was planned that the information would be collected systematically and objectively, extracting data relevant to this study in order to analyse and establish the facts. Using systematic procedures helps to reduce bias and determine the viability of a project (Costley et al., 2010). Best and Kahn (2005) argue that systemic research enables development of results which lead to answers to certain questions and facilitates a deeper understanding of the problems. The research approach which stems from the research philosophy, sought the research strategy best suited to the project.

In this chapter, the objectives of the research, the data collecting techniques and data analysis methods are discussed including the rationale for the choice of methods. The chapter also includes a discussion of the validity and reliability of the research and the ethical considerations employed in this project. The difficulties that were encountered whilst undertaking the research is also expanded on later in the project.

3.2 Ontology

Ontology is concerned with the world view that the researcher holds (Letts et al., 2007). Blaikie (2010) expounds that ontology refers to the perception an individual has of what is factual. Being influenced by a post positivist perspective, the researcher chose to adopt a constructivist stance which is a qualitative approach. This approach was adopted as this research sought to explore the experiences of the participants. It sought to understand the social world from their standpoint in it and the meaning they attributed to the context in which events that have meaning, occurred (Letts et al., 2007). This approach is in contrast to a positivist stance which argues that there is a

single reality or truth which exists independently of any consciousness (Crotty, 1998; Denzin and Lincoln, 2011).

3.2.1 Epistemology

Saunders et al. (2012) argue that epistemological stances are philosophical perspectives which are concerned with the theory of knowledge. The epistemology or reality is based on experience, it is the researchers' perception of reality that is individually derived (Costley et al., 2010). Kawulich (2012) argues that epistemology questions the nature of knowledge and truth, it seeks to investigate the reliability of the sources of knowledge. It enables *engagement with what is real in our lives* (Bravette, 1997, p. 314). Based on the research aim and the research question which was to explore the experience of participants with regards to the phenomenon under study, the stance adopted for this project was subjectivism which determines how knowledge is known (Crotty, 1998). Utilising an objective stance would not fit with the research's aim as Charmaz (2006) argues that it would separate and fragment the experience of the participants making it atomistic or put another way, unconnected.

3.2.2 Axiology

Axiology is a branch of philosophy which involves ethics, judgement and aesthetics. Axiology is a philosophical approach that impacts social science research (Carnaghan, 2013). Social inquiry is involved in this approach where the researchers' philosophical standpoint is reflected in the content of their work and can be seen in the methods employed to conduct the research such as data collection techniques and data analysis (Carnaghan, 2013). Axiology is relevant to this study because it is fundamental to the notion of value and worth (Saunders et al., 2012).

3.2.3 Research philosophy

According to Saunders et al. (2009) research philosophy is divided into three sections which enables the researcher to choose which approach to take depending on his/her world view. The three sections are: ontology, epistemology and axiology as mentioned above. There must be agreement with the ontology and epistemology of the researcher (Crabtree and Miller, 1992).

The first question that was addressed when establishing the research methodology, was the subject of the research philosophy that would be appropriate for the underpinning of this project. The research question asked:

> *What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?*

Bryman (2012) argues that a research philosophy is the set of beliefs concerning the nature of the reality that is being investigated with a detailed account of how research data should be collected, analysed and used. Grinell and Unrau (2010) concur with Bryman (2012) adding that the research philosophy determines the analysis of the data based on the research questions.

3.3 Choosing a theoretical framework

When choosing a theoretical framework, it was important that a paradigm or theoretical model which provided the opportunity to gain deep exploration of the participants' lived experience could be utilised. The word paradigm is used to describe a theoretical model that is used to provide answers to difficult research problems (Kuhn, 1977) and refers to the set of beliefs and agreements as to how problems should be understood and addressed (Kuhn, 1977).

3.3.1 Constructivism

The paradigm or belief system that is congruent with the epistemology (Gray, 2013) and which is used to conduct this research, is that of constructivism where the researcher constructs their own reality. A constructivist methodology starts with the researcher observing phenomena and then formulating theories as a result of the observations (Goddard and Melville, 2004). This is important as the research question calls for real life contextual understanding, multi-level understanding and cultural influences (Creswell and Plano Clark, 2011) and fits with the principal research question which is detailed above.

The researcher planned to situate the research within a constructivist paradigm because the project was concerned with generating new insights from practice as an insider researcher (the concept of the insider researcher is expanded on later in the project) who is concerned with the interpretation of reality in order to discover underlying events (Roulston, 2011). Constructivism allows the researcher to focus on social and subjective meaning and on human agency (Charmaz, 2006). A constructivist approach assumes that there is no single truth therefore reality needs to be interpreted (Husserl, 2004). Experiences are subjective and deals with people's experiences (Husserl, 2004). This is in contrast to a positivist approach which utilises an objective measure. For example, in a study that was conducted where researchers were looking at the recovery of mental health service users in clinical practice, a positivist approach was used which assumed that the recovery of the service users was a single state with the only difference being a variation in severity of illness (Kutney, 2006). It was suggested that the service users experienced the same set of variables (Kutney, 2006). Whilst Denzin and Lincoln (2005) argue that there is no single interpretative truth, they concur with the view of the aforementioned study as they assert that a single

identifiable truth does exist in the world (Denzin and Lincoln, 2011). This approach would not fit with the aim of this research due to its lack of individuality in contrast to interpretative phenomenology which argues that there is no single truth (Smith et al., 2009). A positivist approach in contrast to a post-positivist approach, as in the study mentioned above, fail to take into account a personal view of recovery (Byrne et al., 2013) in which reality is created by individuals.

As this research was concerned with exploring the feelings of participants, a qualitative approach was deemed to be more appropriate as it would enable the participants to describe and explain the phenomena that was being studied. A qualitative approach is valuable in illuminating the experience of the participants, it gives voice to those whose views are rarely heard (Sofaer, 1999). Additionally, this research was concerned with social justice and is in alignment with the argument espoused by Lyons, et al. (2013) who state:

> "*Qualitative research contributes to social justice when researchers promote the following principles: equity, access, participation, and harmony for culturally diverse populations, those currently most at risk for acts of social injustice"* (Lyons, et al., 2013, p. 10).

A post positivist approach was therefore deemed to be congruent with the researchers' philosophical stance as it would allow the move to interpretivist ideas to collect qualitative data and identify details which quantifiable data would not detect (Denscombe, 2012). Table 3.1 below outlines the features of qualitative and quantitative research which provides the rationale as to why a qualitative approach was chosen for this study. It is then followed by an examination of the inductive strategy that was chosen for this project.

Table 3.1 features of qualitative and quantitative paradigms

Qualitative	Quantitative
Findings arrived at from real world settings, phenomena under study unfolds naturally (Patton, 2002)	Findings arrived at by means of statistical procedures or other methods of quantification (Strauss and Corbin, 1990)
A naturalistic approach is used to understand phenomena in context specific settings (Patton, 2002)	Seeks causal determination, generalisation and prediction of findings (Hoepfl, 1997)
Methods such as interviews and observation predominate, surveys are supplementary (Glesne and Peshkin, 1992)	Surveys predominate, interviews and observations are supplementary (Glesne and Peshkin, 1992)
Embrace involvement within the research process (Patton, 2002)	Disassociation of the researcher from the research process (Winter, 2000)
Need for credibility which refers to the extent to which research is believable and appropriate (Mills, 2010)	Need for credibility which refers to the extent to which research is believable and appropriate (Mills, 2010)
The researcher is an instrument. Credibility of the research is determined on the effort and ability of the researcher (Patton, 2002)	Credibility of the research depends on instrument construction e.g. tests (Patton, 2002)
There is a focus on possible transferability from group to group rather than generalisation (Smith et al., 2009)	Generalisability said to be the ultimate goal of any research (Smith et al., 2009)

3.3.2 Inductive approach

An inductive approach is usually used in qualitative research (Bryman and Bell, 2007). It starts with the researcher observing phenomena and then formulating theories based on the observed phenomena (Goddard and Melville, 2004). It moves from the specific to the general (Bryman and Bell, 2007) through observing phenomena and then seeks patterns in the data (Beiske, 2007). Following interview of the research participants where specific phenomena is examined, patterns in the data may be examined between the participants (Flick, 2011).

> *The inquiry is sharpened by IPA's inductive, interpretive analysis, providing an illumination of what is presented but importantly grounding that firmly in a close examination of what the participant has said* (Smith and Osborn, 2015, pp. 41-42).

As cited above, an inductive approach was chosen for this project in agreement with Smith and Osborn (2015) as opposed to a deductive approach, although, Saunders et al. (2009) argue that a deductive approach could be employed with qualitative methodologies. In using a deductive approach however, which uses hypothesis testing, the research would have to be formulated differently as deductive reasoning formulates hypotheses and then tests the results statistically to an accepted level of probability (Snieder and Larner, 2009). Deductive reasoning is therefore better suited to the positivist approach (Snieder and Larner, 2009) and was not suited to the aims of this study. Table 3.2 below provides comparisons between inductive and deductive reasoning and demonstrates why an inductive approach was better suited for this project.

Table 3.2 Inductive reasoning versus deductive reasoning

Basis for comparison	**Inductive reasoning**	**Deductive reasoning**
Meaning	Inductive reasoning connotes the argument in which the premise gives reasons in support of the probable truth of the conjecture	Deductive reasoning is the fundamental form of valid reason wherein the premise gives guarantee of the truth of conjecture
Approach	Bottom-up approach	Top-down approach
Starting point	Conclusion	Premises
Based on	Patterns of trends	Facts, truth and rules
Process	Observation > Pattern > Tentative Hypothesis > Theory	Theory > Hypothesis > Observation > Confirmation
Argument	May or not be strong	May or not be valid
Structure	Goes from specific to general	Goes from general to specific
Draws inference with	Probability	Certainty

Source: Surbhi, 2018, p.2

3.4 Choosing a methodological approach

A methodological framework was sought where emphasis was on a conscious knowledge enabling the research participants to convey what was perceived, sensed and known, based on their experience (Moustakas, 1994). Smith and Osborn (2015) argue that this type of approach as described by Moustakas (1994) enables exploration of the participants' lived experience and what the experiences mean to them. As a black woman nurse practitioner with experience of the phenomenon under investigation, a methodological framework was sought which took account of the researchers' own assumptions and philosophical values. This was in line with Mays' (2011) argument as he suggests that the researchers' choice of research methodology is dependent on the subject or phenomenon being investigated.

Various methodologies centred around phenomenology were examined as the researchers' epistemology was concerned with studying consciousness as it is experienced in oneself and in others (Cohen and Daniels, 2001) in other words, how human behaviour and experience is comprehended. The various phenomenological methodologies are discussed below.

3.4.1 Phenomenology

Phenomenology which has its traditions in philosophy and psychology, is a research approach based on the work of the principle founder Edmund Hursserl (Bell, 1990). Phenomenology places emphasis on the importance of personal experience and multiple perspectives in the construction of knowledge (Gray, 2013) and is an effective medium for elucidating and clarifying fundamental issues in the healthcare sector (Llamas, 2018). Phenomenology's emphasis on looking closely at the lived experiences in specific settings rather than abstract theorising about human nature, appeals to academics and practitioners (King and Horrocks, 2010, p.181). It has also played an important role in many practice-oriented disciplines such as education and the health professions (Smith and Osborn, 2015).

As espoused by Cohen and Daniels (2001) when conducting research using phenomenology as a research tool, the researcher must set aside their own biases, experiences and pre-conceived ideas. This is so that the researcher can gain understanding as to how the phenomenon appears to the participants rather than how it is perceived by the researcher. This is otherwise known as bracketing (Cohen and Daniels, 2001). Holloway (1997) acknowledges however that the researcher cannot be separate from the phenomenon that they are studying and therefore it is not possible to be neutral and objective since both researcher and participants have their values which are always present (see researchers' experience, section 1.5.1). Phenomenology therefore requires the researcher to interpret what the experiences means for participants within their particular context (Noon, 2017).

Phenomenology is divided into two groups which is that of descriptive and interpretive phenomenology (Rapport and Wainwright, 2006) and is examined in the next sections.

3.4.2 Descriptive phenomenology

Descriptive phenomenology which refers to a phenomenon that is experienced by the participants, forms the focus of the research rather than the phenomenon being the focus of the subject (Giorgi, 2009). Moxham and Patterson (2017) state:

> *"The descriptive and explanatory nature of phenomenology embodies experiential meanings, as lived by individuals, and aligns with their understanding of their world"* (Moxham and Patterson, 2017, p.7).

Descriptive phenomenology also implies that having more than one reality leads to lack and doubt of the phenomenon (Rapport, 2006). This is also known as transcendental or pure phenomenology as developed by Husserl (2012).

3.4.3 Interpretative phenomenology

Interpretive phenomenology otherwise known as hermeneutics, seeks to interpret the meaning of the participants' experiences (Pringle et al., 2011). Interpretative phenomenology brings out the hidden in human experiences to make it known, going beyond the experience to gain meaning in life (Pringle et al., 2011). Interpretative phenomenology asserts that there are numerous realities and posits that we have interpretation because description is an interpretative process (Rapport, 2006). This is also known as existential phenomenology which was developed by Heidegger (Heidegger et al., 1962).

3.4.4 Interpretative phenomenological analysis (IPA)

IPA *is a philosophy and research method that studies experienced events and objects using the sense*s (Bell, 2013). It is a qualitative research approach which assumes that there is an essence to shared experience (Letts, 2003; Marshall and Rossman, 2006) and is a patient focused approach that is used in informing clinical practice (Biggerstaff and Thompson, 2008).

When utilising IPA as a methodology, the researcher must be mindful that s/he does not lose sight of the fact that it is mainly an interpretative approach (Smith, 2010). It has been argued that the failure in applying sufficient interpretation when analysing data, results in descriptive IPA which lacks depth and bears resemblance to thematic analysis (Smith, 2010). Smith (2010) is referring to the semantic themes in contrast to the latent themes in thematic analysis which looks beyond the description of what has been said and interprets and explains it (Braun and Clarke, 2006). The semantic themes mean the researcher is not looking for anything beyond the surface meaning of what a participant has said or written (Braun and Clarke, 2006).

The positioning of the researcher within their research, where the values and beliefs are made known, are important to bring to the fore as it demonstrates the influence the researcher has had on the research (Sultana, 2007). The personal experience section of the researcher in chapter 1, section 1.5.1 above, outlines the researchers' positionality.

3.4.5 Chosen methodology: Interpretative phenomenological analysis (IPA)

IPA was chosen to analyse the interview data as it places emphasis on the researcher being involved in the process of interpretation (Smith and Osborn, 2015). It seeks to

describe in precise detail, a phenomenon that is experienced by the individual and places focus on the subjective experiences of the individual and is personal (Smith and Osborn, 2015). IPA was deemed an appropriate framework for this project as it fitted with the research's aim which sought to gain an insight into the research participants' experiences in order to understand the phenomenon of a lived experience (Letts, 2003). The researcher needed a research approach that would enable engagement with the research question at an idiographic level or put another way, an individual or unique level (Flowers et al., 2005). As Flowers et al., (2005) assert:

> *The participant's 'lived experience' is coupled with a subjective and reflective process of interpretation, in which the analyst explicitly enters into the research process* (Flowers et al., 2005, p. 20).

With IPA, the researcher remains on familiar territory which means that inferences can be made from the collected data to participants (Flowers et al., 2005). IPA has a focus on convergence, in other words, a 'merging' and divergence, or a 'moving away from,' which enables the researcher to compare the participants' experience of the phenomenon under study (Smith et al., 2009) which was in line with the research question thus:

> *What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?*

The next section looks at the method that was originally considered for use in this project and the methods that were actually used.

3.5 Ethnography – Alternative methodology

The researcher was originally going to conduct an ethnographic study as being an insider researcher with experience of the phenomenon under study, it was felt this methodology of which there are several approaches, would be congruent with what the research sought to achieve. Whilst some ethnographers follow the approach in which researchers immerse themselves in the life of the people they are studying which in this case would be the nurse participants, other researchers follow the approach where documents are analysed and interview of participants utilised to understand the phenomena under study (Naidoo, 2012).

Table 3.3 below distinguishes between phenomenology and ethnography to provide further support as to the reason why a phenomenologically based methodology was chosen for this study.

Table 3.3 Comparison of ethnography and phenomenological research

Ethnography	Phenomenological research
Study of culture	Study of the 'lifeworld' human experience
Discovering the relationship between culture and behaviour	Exploring the personal construction of the individual's world
Studying sites	Studying individuals
As many informants as possible	Between 5 and 15 participants
Use of observation and some interviewing	Use of in-depth unstructured interviews
Unit of analysis: event	Unit of analysis: meaning unit
Reliability: triangulation	Reliability: confirmation by participants

Source: Adapted from Tesch, 1994

Ethnography is more focused on culture whilst phenomenology is concerned with human experience of the 'life world' (Tesch,1994). The researcher acknowledges that this study has a cultural aspect which pertains to organisational culture where behaviour is learned and shared within a community of interacting human beings (Useem and Useem, 1963). Put another way, employees are 'programmed' to think and behave in a certain way (Hofstede, 1984; Lederach, 1995; Linton, 1945) behaviours that become institutionalised which impacts on the way different individuals are treated. In this study however, it was the experiences of the individual participants in their 'life world' environment, in this case an NHS setting that was common to all the participants, that were being analysed. In other words, it was the 'Interpretative' component of IPA, which is concerned with interpreting and critically analysing the lived experience of the participants that was the focus.

With ethnography on the other hand, sites tend to form the focus of the study rather than the individual (Tesch,1994). The prime mode of data collection for phenomenological research are interviews as used in this study, whereas ethnographers tend to collect data through observation either as a participant or an outside observer (Denzin and Lincoln, 2013; Gray, 2013).

Other reasons for not opting to conduct an ethnographic study were, being an independent contractor with no permanent base. It was felt that due to the sensitive nature of the topic, it may prove to be a blockage in gaining access to the organisation also, the researcher did not want to place participants at risk of being identified. Therefore, for the reasons given, ethnography was discounted for this study.

3.6 Introduction: Data collection strategy

Based on the aims and objectives of this research, this section details the projects' design and includes the participant sample used for this study, data collection tools and includes the ethical considerations.

Table 3.4 below links the research objectives, the research methods and data collection.

Table 3.4 Linking research objectives, methods and data collection

Research objectives	Research methods	Data collection techniques
To examine the role of transformational leadership and followership in bringing about professional development opportunities for BME nurses	Qualitative method	Interview/reflective journal
To explore whether nurses are trained to provide culturally competent and compassionate care	Qualitative method	Survey questionnaire (normally quantitative) but this research more interested in opinions than numerical data questionnaire/interview/reflective journal
To explore whether opportunity for clinical supervision exists	Qualitative method	Interview/reflective journal
To develop an equality framework to guide individual BME Nurses, NHS Trusts, Government and Researchers	Qualitative method	Synthesis of findings from the research with lessons learned from the review of the literature

3.6.1 Sampling

During the proposal stage of the project, the aim was to choose a purposive sample as this study sought to examine the experiences of those participants who had a direct experience of the phenomena under study i.e. black nurses. A purposive sample would help to address the research question as mentioned above in section 3.4.5. It was decided for the main study however, that the sample population would include nurses from all nationalities to gain a full picture of what was happening in practice. The inclusion criteria were that the nurses had to be fully trained, occupying bands (grades) from 5 to 9 and working within the NHS or having previously worked in the NHS. The

exclusion criterion for the project was untrained nurses. The focus was on nurses as examination of the person in the environment is as important as the phenomena that is experienced (Quest, 2014). Eatough et al. (2008) argue that the researcher should focus on the context of the lived experience of participants which is dependent on the social, historical and cultural factors.

The plan was for the researcher to target at least 100 participants to take part in the survey questionnaire in order to try and obtain a representative sample and 12 to 15 participants for the interviews.

3.7 Data collection methods

3.7.1 Survey questionnaire

The data corpus included utilising an online survey questionnaire (see appendix 4) as a means of exploring how nurses access professional development so that an idea of the breadth of the issue being investigated could be ascertained. Sofaer (1999) argues that the data enhances understanding of the context of events as well as the events themselves. This was in line with this study which sought to give an authoritative voice to the practitioner working within the NHS amongst their professional peers. The development, piloting, administration and how the target participants were approached, is expanded on in the next chapter (chapter 4). Table 3.5 below demonstrates the advantages and limitations of using a survey questionnaire.

Table 3.5 The advantages and limitations of survey questionnaire

Advantages	Disadvantages	Strategies employed to overcome disadvantages
Allows larger amounts of data to be collected in a shorter time frame Data collected through survey questionnaire more efficient and less expensive than interviews Allows standardisation of questions, making the collection of responses easier Participants can respond to questionnaires at their own pace	Survey questionnaire can be too lengthy	Following pilot of the survey questionnaire to test content validity and to assess if it measured what it set out to measure, adjustments were made for ease of use.

Source: compiled from: Wood and Kerr, 2010; Lambert and Loiselle, 2007; Bresee, 2014; Fautrel et al., 2017; Nardi, 2015

3.7.2 Semi-structured interviews

In line with the research question, semi structured interviews with scripted questions were compiled to allow for the flexibility to probe the participants' answers (Laverack, 2005). The interview questions were developed to align with the methodology of the study and the gaps in the researchers' knowledge. Smith et al. (2009) suggests that when undertaking IPA in doctoral study, 4 to 10 data points are recommended. Flowers et al. (2005) and Cohen and Daniels (2001) assert that it is better to interview fewer participants in order to conduct a deeper examination as opposed to more participants where the result may be a shallow and descriptive analysis. As mentioned above, 12 to 15 participants were the target number for this study. The interviews were to be conducted either face to face or via telephone. It was important for the researcher to consider contextual feasibility of the study and to ensure that the participants were agreeable with the data collection methods (James et al., 2019; Polit and Beck, 2017). Semi-structured interviews were considered for this study as they are not as time consuming as unstructured interviews can be to conduct and analyse when using an approach such as IPA. IPA is a method that is popular in exploring qualitative data

(Pringle et al., 2011; Laverack, 2005). Individual interviews, focus groups, diaries and documents are the most common collection methods or research instruments used in IPA (Smith et al., 2009). Individual interviews were best suited for this study as it would enable the participants to describe their experience in-depth, thereby providing more meaningful explanations (Tahan and Sminkey, 2012). Individual interviews would also enable further exploration of the emerging themes through the data collected via the survey questionnaire and reflective journal.

Being able to interview the participants would allow the building of rapport between the participants and researcher as it was paramount that a trusting relationship was established (Tahan and Sminkey, 2012). This would help to overcome any barriers and fears that may impinge on the research process which could prevent honest disclosure (Trier-Bieniek, 2012). The advantages and limitations of interview are outlined in table 3.6 below.

Table 3.6 The advantages and limitations of interview

Advantages	Limitations
• Facilitates divergence which allows the researcher to pursue ideas in more detail and in-depth • One-to-one interview allows development of rapport between researcher and participant • Face-to-face interviews: can see non-verbal interaction such as facial expression which can add context • Telephone interviews useful in situations when topic is of a sensitive nature as virtual communication can limit emotional distress Convenience related to geographical considerations	• Can be time consuming and costly • With telephone interviews, unable to see facial expressions, gestures and posture which may be meaningful. (Online skype was offered to the participants but this was declined) • Cannot be used to collect data from a large population of participants

Source: compiled from: (Laverack, 2005, Trier-Bieniek, 2012, Mealer, 2012, Novick, 2008)

3.7.3 Reflective journal

A reflective journal was commenced at the start of the project as a learning tool and a means of being transparent where the researchers' experiences, thoughts, feelings and opinions would be visible (Ortlipp, 2008). Flowers et al. (2005) recommend for researchers engaging in IPA, that through making notes and looking back over the course of their learning journey, they should be able to chart their development. The journal serves as a means of self-reflection for the researcher in which thoughts and feelings can be critically analysed and in turn facilitate the development of new perspectives where the researcher is able to explore further and move forward leading to behavioural changes (Freshwater et al., 2008).

3.8 Validity and reliability

Validity is *when a measurement accurately reflects what is measured* (Bell, 2013) or measures what it is intended to measure (Field, 2005). In terms of this project, in order for the collected data to be valid, it needed a good sample group (Simon, 2011). In other words, the participants needed to be members of the group that was under study (Simon, 2011) who currently or previously worked in the NHS.

The questionnaire used as a tool to gather data, would need to be validated to ascertain if it measured what it claimed to measure (Boynton and Greenhalgh, 2004) a process otherwise known as face validity (Collingridge, 2014). The check would also need to be performed to ascertain if the required information was being yielded (Simon, 2011). This would be carried out through utilising the knowledge and experience of the academic supervisory team who advise on the research process. By reading through the questionnaire in the first instance, the supervisors could assist in evaluating whether the questions effectively captured the topic under investigation as suggested by Collingridge (2014). All decisions around necessary changes and development of the questionnaire would be taken by the researcher following the pilot study. The steps taken to pilot the research instruments are discussed in chapter 4 which is the next chapter.

3.8.1 Triangulation

The researcher sought to triangulate the data using two or more independent measures in order to increase reliability and validity of the collected data and increase confidence in the findings (Lewis-Beck, 2004). Triangulation, of which there are several types, e.g. methodological triangulation, theoretical triangulation, investigator triangulation and so forth, refers to using more than one research strategy to arrive at the findings (Guion, 2002). Methodological triangulation mixes qualitative methods although it can also use a mix of qualitative and quantitative methods, whilst theoretical triangulation as the name suggests, uses several theories to analyse data from which comes an integration. Investigator triangulation uses several researchers to code the data and includes researcher-participant corroboration (Guion, 2002). Data triangulation was deemed appropriate for this project as it would allow for a more robust study and allow the researcher to check validity of the study by using several perspectives to analyse the research question (Maxwell, 2009; Guion, 2002). This study used survey questionnaire, interviews, a review of the literature and reflective journal to collect data. Using different methods generate data which informs the results from different angles and serve as a means of increasing trustworthiness of the data (Maxwell, 2009). This would ensure that the research findings were supported by the evidence (Guion, 2002). Mathison (1988) and Patton (2002) acknowledge that triangulation of various data sources does not always lead to a singular proposition but can in fact result in inconsistent and contradictory evidence. Patton (2002) argues however that this should not be seen as a weakening of the evidence but rather as an opportunity to discover deeper meaning in the data.

Nurses working in two organisations on different wards/departments, were used to collect data.

3.9 Ethical considerations

The researcher pondered on the question as to how important and how relevant it was to undertake this project before doing so. It was decided that it was extremely important to conduct this research as safeguarding the wellbeing of patients, staff and the general public should be central to the functioning of the organisation. Raising awareness of the impact that behaviours which fall short of the required standard can have on the wellbeing of patients and staff, is of the utmost importance (Gov.UK, 2016).

3.9.1 Harm

Saunders et al. (2012) argue that when data is collected, analysed and reported, this process should be guided by a set of moral principles otherwise known as ethics. Ethical standards require that researchers do not cause harm as a result of their research (Research ethics guidebook, 2015) therefore ethical factors were a consideration in choosing the methods for this project. It is the responsibility of the researcher to ensure that the participants are fully aware of the nature of the study and the potential risks involved before gaining informed consent which is central to ethical practice (Research ethics guidebook, 2015). The researcher would ensure that participants were made aware that the study was confidential and also that there were instances when confidentiality may have to be breached, for instance, if it was felt that someone was at risk of harm. This is in accordance with membership of the NMC where a disclosure would need to be made to the relevant authority (NMC, 2018). It was essential therefore that participants could decide whether they wished to take part in the study and give informed consent despite any risks (Research ethics guidebook, 2015). Systems would need to be put in place to deal with the effect of participation, for instance, stirring up painful memories. The researcher would have a list of organisations that participants could be referred to for emotional support if required. Participants would be free to withdraw from the study at any stage of the process and any data collected would be destroyed.

3.9.2 Consent

A participant information sheet (PIS) would be given to each potential participant which explained the purpose of the study so that they could make an informed decision as to whether they wished to take part (see appendix 3). The PIS contain information advising that participation was completely voluntary and withdrawal from the research was permissible at all stages of the project. The ethical principles applied in conducting this research included:

1. Before commencing data collection, the researcher would obtain ethical approval from the Research Ethics Committee of Middlesex University’s School

of Health and Education, Health and Social Care Ethics Sub-committee (see appendix 1).

2. Participants would be assured of anonymity and confidentiality by the researcher. Wherever there was the possibility that a participant could be easily identified, the data would not be used.
3. The RCN states that the: *identity of research participants should not be recognisable in research reports detailing study findings or in any presentation of findings* (RCN, 2009 p. 5). Polit and Hungler (1999) argue that researchers need to exercise care in ensuring that the rights of individuals and institutions are safeguarded.
4. Participants would be made aware through the PIS, that completing and submitting the survey questionnaire implied consent to taking part in the study.
5. Recordings of the interviews would be kept securely and once the interviews were transcribed, the recordings would be destroyed.

3.10 Summary

In chapter 3, the reasons as to the decision to choose the methodological stance and philosophical position utilised for this project, were given. The rationale was also given as to why a qualitative, constructivist philosophical stance and an interpretative phenomenological approach was adopted.

The activities of this project are examined in the next chapter.

Chapter 4: Project activity

4.1 Introduction

This chapter provides an outline of the activities of the project. Figure 4.1 below maps the activities of the project. The difficulties encountered whilst collecting the data are also addressed in this chapter.

Figure 4.1 Map of project activity

4.1.1 Activities of the project

Before embarking on the project, a programme plan, otherwise known as a research proposal, was prepared which gave an outline of the intended area of study. A research proposal summarises the research, setting out the issues that the researcher intends to address (Denscombe, 2012). Once the proposal was approved by the University's programme approval panel, the researcher sought to gain ethical approval to undertake the study. The decision tool to check if the project required NHS research ethics committee (REC) approval was consulted and the results indicated that NHS REC was not required (HRA, 2017) (see decision tool, appendix 2). Before embarking on data collection, an email was sent by the researcher to the then potential hospitals' learning and development director explaining the nature of the research and that access was being sought to collect data for the study from nurses and midwives. An email was received from the hospitals' learning and development director inviting the researcher to speak via telephone about the project. The telephone conversation was positive and once the learning and development director had spoken to the director of nursing to gain approval for data collection access, as directed, a letter was written by the researcher to the director of nursing of the hospital Trust requesting a letter of consent to gain access to potential participants. Approval was also sought from Middlesex University's Health and Social Care Ethics Sub-committee to undertake the research. Once approval to undertake the project was granted (see appendix 1), the data collection phase commenced. Phase one of data collection with the online survey questionnaire commenced in March 2017 with Sunny Vale hospital (pseudonym) a medium sized general hospital. Each of the steps outlined in figure 4.1 above will be discussed in sequence.

4.2 Designing, piloting and implementation of the survey questionnaire

When formulating the questions that were going to be included in the survey questionnaire, the structure of the questions was designed in such a way as to link it to the objectives of the research study (Johnson and Christensen, 2008). From the answers given in the survey questionnaires, the plan was to identify what would be considered information-rich data, based on the principal research question (Abrams, 2010; Bryman, 2015). In other words, those participants who shared information that warranted further investigation, would be interviewed to enable an in-depth examination of the research issue.

Before embarking on the main research study, a pilot study otherwise known as a feasibility study (Teijlingen and Hundley, 2001) was conducted to test the research instrument (Kim, 2010) which in this case was the survey questionnaire. Undertaking a

pilot study is important because it facilitates good study design and it can alert the researcher to potential failure of the main project (Teijlingen and Hundley, 2001; Perry, 2001). Whilst conducting a pilot study is a key factor in good study design, it does not provide guaranteed success when conducting the main study (Teijlingen and Hundley, 2001). When conducting the pilot study, the survey questionnaire was sent to a sample of five participants to collect preliminary data to test the research instrument, or in this case the survey questionnaire. This action was taken to help identify any aspects of the research tool not foreseen to be problematic and which if present, could then be addressed before embarking on data collection for the main study. The participants were asked for feedback on the survey questionnaire including comments on ease of understanding and any ambiguities, as recommended by Teijlingen and Hundley (2001). From the sample of five participants, responses were received from three participants and based on the feedback, changes were made to the survey questionnaire to make it more user friendly e.g. removal of ambiguous terms where possible. The time taken to complete the survey questionnaire was gauged and adjusted on the participant information sheet (PIS) as originally the completion time was over-estimated.

4.2.1 Survey questionnaire administration

For the full-scale survey, a request was made to Sunny Vale hospitals' co-ordinator to circulate the survey questionnaire to the potential participants which were approximately 300 nurses. The survey questionnaire was circulated to nurses of all nationalities and grades to ascertain their experience of accessing professional development. Adopting this approach reduced bias as widening the research to include all ethnicities, included a representative sample of respondents (McColl, et al., 2001) in the community of practice. The inclusion criteria/homogenous group used for the sample therefore, were nurses who had all qualified through nurse training across different specialities i.e. general nursing, mental health nursing, midwifery and so forth. Demographic information for the survey questionnaire and interview groups are shown in chapter 5.

In order to maintain the integrity of the data, the facility to record Internet Protocol (IP) addresses which serves as a means of identification (Postel, 1981) was turned off.

4.2.2 Survey questionnaire response rate

Whilst the online survey questionnaire has various advantages (Wood and Kerr, 2010) it soon became clear that a major disadvantage was the lack of response from participants (Braithwaite et al., 2003). During the questionnaire stage of Sunny Vale hospital ten participants agreed to be interviewed for the study by including their email address at the end of the questionnaire but when invited to be interviewed, only five

participants responded to the request. There was no response to three further reminders. The intention was to interview approximately 12-15 participants to allow for rigour or trustworthiness.

As the response rate was very low, the head of services of Sunny Vale hospital was contacted by the researcher to request that a reminder be sent to the nurses. Paper copies and an online version of the survey questionnaire were made available. The online survey was proving problematic in some instances with some of the respondents reporting difficulty accessing it. This meant that the survey needed to be re-sent electronically via email on several occasions where requested, to those who were experiencing difficulty and had asked for help. There is the possibility that this situation could have also contributed to the initial low response rate as some respondents may have just given up if accessing the survey proved difficult.

Following the reminder from the head of services and despite the fact that the survey questionnaire was circulated three times to remind and encourage the potential participants of Sunny Vale hospital, a total of 29 responses from the online survey questionnaire were received from the hospital which employed approximately 300 nurses. This situation needed to be addressed as low response rates bring the research into question due to the subject of validity (Burns et al., 2008). In other words, the findings of the collected data should be representative of the phenomenon that is being measured (Burns et al., 2008). This should not have come as a surprise as Cook et al. (2009) argue that the response rate to surveys amongst health professionals usually falls below 60%. A study undertaken into the response rate for nurses undertaking surveys showed that response rates varied between 11% to 71% (Meyer et al., 2012). As the sample size was not representative of the nursing community under study due to the low response rate, a second hospital was sought so that further data could be collected.

4.3 Difficulties in gaining access to organisations

Contact was made with the unit manager and gatekeeper of a second NHS Trust hospital who consented to granting the researcher access to potential participants for data collection. A date and time was scheduled with the manager to discuss the research further via telephone but the call to the manager was not answered on the allotted day. Repeated telephone calls to discuss the logistics of the data collection however were futile so further attempts were abandoned. A third NHS organisation was approached and the nature of the research was explained to the head of services. It was explained that the research sought to explore the experiences of nurses when applying to access professional training and development programmes. The head of services asked to see a copy of the survey questionnaire which was duly sent. There

was no response to the email so a follow up email was sent after one week to check the position and to ascertain if access would be granted to collect data. Again, there was no response so no further attempts to gain access to this NHS Trust were made. A fourth hospital was approached and permission was sought to gain access to collect data but this too was turning out to be fraught with difficulty and time consuming so the researcher went ahead to the next stage of the research process with the 29 completed survey questionnaires.

4.4 Ethical considerations

Realisation began to emerge at this stage of the research process that different NHS Trusts have differing requirements of the researcher, a factor that had not been considered when writing the research proposal. The fourth NHS Trust advised that an Integrated Research Application System (IRAS) form needed to be submitted. IRAS is a single system for applying for permission to conduct health, social care and community research in the United Kingdom (IRAS, 2018). The IRAS form details a statement of events and includes a schedule of activities (types of data collection). This would involve applying for IRAS. During the project planning and proposal stage of this research, the NHS Research Ethics Committee (REC) tool (see appendix 2) which *exists to safeguard the rights, safety and dignity and wellbeing of research participants* (Health Research Authority (HRA), 2017, p. 1) had been consulted. The tool indicated that NHS REC approval for sites in England was not required. It appeared that the research and development co-ordinator of the fourth hospital had assumed that an application had been made for HRA) / NHS REC approval via IRAS. It was explained that another hospital had been used for the initial data collection and after ethical approval had been granted from Middlesex University, the Trust had granted permission to collect data and provided a letter of access. It was also explained that this research was viewed as service evaluation as it sought to define or measure current practice within the NHS.

The fourth NHS hospital Trust - Lofty Heights (pseudonym) which is a large mental health hospital Trust in England and which was subsequently used for data collection, was advised of the process that had been undertaken with Sunny Vale hospital and an explanation given that patient information was not being accessed. Lofty Heights was also advised that data would be collected from qualified nurses across all nursing bands via an online survey questionnaire in addition to individual interviews. As this research was deemed to come under the auspices of service evaluation and therefore not requiring approval from the HRA nor the NHS Research Ethics Committee, permission was granted to collect data on the proviso that the services within the NHS Trust from which the data was to be collected, were agreeable for this to happen.

Gatekeeper letters were obtained from each of the services before the survey questionnaire was circulated.

Using an additional hospital meant a re-application needed to be made to the ethics committee of the University in order to gain approval for another NHS Trust to be added which slowed the data collecting process. Once ethical approval was granted by Middlesex University for an amendment to the existing ethical approval, the survey questionnaire was circulated to the nurses of Lofty Heights hospital. The response rate in this instance was also extremely low. Despite repeated reminders, 5 responses were received from approximately 100 nurses. As some of the nurses from Sunny Vale hospital had reported difficulty accessing the online survey, it was decided with permission from the service director, to attend Lofty Heights hospital in person to collect data. This course of action was taken as it would eliminate any computer access issues and it also meant that there would be a captive audience by administering hard copies of the survey questionnaire along with a confidential and secure location to submit the anonymously completed forms.

On arrival at Lofty Heights hospital, the nurse manager chaperoned the visits to each ward/department within the hospital to engage participation of those nurses who wished to take part in the survey. Explanations concerning the nature of the research were given to the staff on each ward/department and paper copies of the questionnaire were distributed to those who were interested in taking part. Some of the nurses appeared to be hesitant in completing the survey questionnaire. There was a sense of anxiety and the question was asked of the researcher as to who would see the questionnaires once completed. Reassurance was given that the data was strictly confidential and would be viewed only by the researcher. The questionnaires were left within each locality and collected later in the day from a designated box or tray where the completed forms were to be deposited. Envelopes for the completed questionnaires were also given to the staff to maintain anonymity and provide reassurance of confidentiality. Some staff failed to complete the questionnaires saying that they were too busy, others said they would complete the online version. A total of 14 hard copies of the survey questionnaires were completed and collected and 1 was completed online.

Three staff members from Lofty Heights hospital consented to being interviewed but only 1 person took part in the interview. Discussion of the interviews is presented below in chapter 6.

Following receipt of the completed survey questionnaires, phase two of the data collection process commenced in July 2017 with the recruitment of the participants for interview.

4.4.1 Emotive nature of the research

Whilst conducting the interviews for this research, some sessions were charged with emotion. It became apparent that some of the participants started to become distressed as they re-lived their experiences, the pain was almost palpable. There was a strong sense of hopelessness about the situation they found themselves in. In a few instances during the interview, the researcher moved on to the next question when it became clear that painful memories were being stirred up. A list which included names and telephone numbers of organisations who the participants could phone if they needed to talk e.g. 'Samaritans,' was available to them if they required it following the interview. As stated in the participant information sheet (PIS) and prior to interview, the participants were reminded that they could stop at any point during the interview if they needed to.

4.4.2 Ethical issues

There was a strong perception of fear during some of the interviews. As the experiences of the nurses unfolded, it became clear why they were afraid. They did not want to deal with any more trouble than they were already having to deal with in their places of work. This was certainly the case with one of the participants where the first five minutes prior to recording the interview, was spent reassuring him that interviews were confidential and material would not be used if it was felt that individuals could be identified. It was only then that he relaxed sufficiently to go ahead, having the confidence to be totally open and honest. After the interview, he even commented that it was cathartic being able to speak about his experiences as a black nurse.

Despite all the participants having received and read the 'Participant Information Sheet' (PIS) (see appendix 3) some of them felt unsafe disclosing certain information especially whilst being recorded. It could also have been attributed to an excerpt from the PIS which states:

> *"As nurses and midwives 'you must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing"* (PIS, p.4).

With the pervading fear, a considerable amount of rich data was provided following the interviews once the recording stopped.

4.5 Sampling

The research question asked:

What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?

Examining the lived experience is central to the research philosophy of IPA which argues that the only reality that we know is that which we have experienced (Llamas, 2018). In line with the research topic, a purposive sample would consist purely of black nurses in order to create an homogenous group so that the research was relevant and of personal significance to the participants where they have experienced a particular phenomenon (Noon, 2017). However, whilst the issue being dealt with had a focus on the discriminatory practices experienced by black nurses in the NHS, the decision was taken to widen the participant group to include nurses across all ethnic groups. The reason this decision was taken was two-fold. Firstly, due to the sensitive nature of the subject matter i.e. exploring the lived experience of black nurses when applying to access training and development programmes, it was felt that gaining access to the nurses to collect data would be fraught with difficulty. For instance, it may have repercussions for those taking part and place participants at risk of recriminations (Bankert and Amdur, 2006). Or the organisation may view the research suspiciously and refuse the researcher access to collect data. Secondly, James et al. (2019) asserts that collecting data presents the opportunity for the researcher and participant to connect and gather information that will form the findings of the study, therefore it is paramount that the data is aligned with the aims of the research to allow for robust analysis.

4.5.1 Interviews: Pilot

As with the survey questionnaire, a pilot study of the interview questions was conducted. Two participants who had previously completed the online survey questionnaire took part. The pilot study allowed an understanding of how to engage with the participants and formulate appropriate questions (Kim, 2010). Some of the scripted semi-structured questions within the interview questionnaire were modified and underwent iterative changes as the themes developed during the interviews which allowed a deeper understanding of the participants' experience (Thorne, 2008). Smith et al. (2009) recommend that interview schedules should not be lengthy and should start with general questions in order to allow the participants to set the parameters. This is so that the researcher does not force or impose their understanding of the phenomenon under focus on the participants' story. The participants spent between 30 to 40 minutes completing the interview. The pilot also proved essential in improving the researchers' interviewing technique in addition to understanding the research environment better (Sampson, 2004).

4.5.2 Main interviews

After collating the responses following the pilot, interviews for the main study was the next stage. The questions contained within the survey questionnaire were used as the basis for the interviews after grouping them into themes (see appendix 5). As this study used a phenomenological framework, it required that the interviews should consist of open-ended questions which allows the participants to relate to their experience of the phenomena under study (Llamas, 2018). Although the survey questionnaire was circulated to nurses of all nationalities where they could also opt to take part in the interviews by including their email addresses for contact, the participants who took part in the interviews were all from a BME background, none of the white nurses who had completed the survey questionnaire and had agreed to be interviewed initially, responded to the email inviting them to take part in the interview.

The participants were given the choice as to whether they wanted to be interviewed face-to-face or via telephone. Interview times were scheduled at their convenience and they were advised that interviews would be audio recorded. A total of 6 participants were interviewed at the initial stage of the interview process. Due to the low response rate, the names of potential participants for the study were given by some of the nurses who had taken part in the interviews. Those staff members were initially contacted via email and then followed up with a phone call. They all agreed to take part in the study but failed to respond to the email which contained the participant information sheet (PIS) and the online survey questionnaire. Halcombe and James (2019) argue that the researcher should be sufficiently flexible to adjust the data collecting process as the project progresses or if circumstances are not as predicted. In an effort to recruit more participants, the decision was taken to widen the search by snowball sampling in which the existing participants who had taken part in the project, helped to recruit their colleagues from the community of practice. This action yielded a further 6 participants and a total of 12 nurses were interviewed for the study. It was noted that the participants who took part in the interviews were mainly in the older age group category. The demographic information of the interview participants can be found below in table 5.6 of chapter 5.

It was found that a main disadvantage of employing semi structured interviews, is that unlike unstructured interviews, this method does not readily allow the researcher to ascertain if the participant(s) has grasp of a concept, a factor that one needs to be mindful of during the interview sessions. This issue was addressed by periodically checking the participants' understanding whenever it appeared that questions were not fully understood. Although a pilot of the interview questions had previously been conducted, success during the main project is not always guaranteed (Teijlingen and

Hundley, 2001). Some of the participants were not familiar with concepts such as 'cultural competence' and 'clinical supervision,' therefore explanations were required.

All interviews were uploaded and secured in a repository.

4.5.3 Transcribing the interviews

Once the interviews were transcribed, a copy of each transcript and the audio recordings were sent to the supervisors for review. All the interviews were transcribed verbatim which means the verbal data was reproduced word-for-word (Poland, 1995). In other words, the recorded information was replicated in a written format. This approach was taken to ensure the accurate capture of meaning and perception of what was shared during the interviews and was important for the context of the research and the research question as reiterated above in section 4.5.

4.5.4 Respondent validation

The researcher needed to ensure when transcribing the audio recordings of the interviews to the written word, that it represented an exact match of what had been conveyed as human interaction is intersubjective and therefore transcribing is an interpretative activity (Poland, 1995). In order to address this situation and to ensure validity of the data, encrypted copies of each transcript was sent to each of the 12 participants to check that the researcher had accurately captured what had been communicated by them (Poland, 1995). A timeframe of one week was given for the participants to respond with comments and any required changes. Five of the interviewees responded acknowledging receipt of the email but there were no requests for changes to be made.

4.6 Data analysis methods

4.6.1 Data analysis: Survey questionnaire

Based on Braun and Clarke's (2006) recommendation, thematic analysis was used to analyse the survey questionnaire data as illustrated in table 4.1 below. Key criteria were used in selecting this approach which are outlined as follows. The main criterion for choosing thematic analysis was being a novice researcher and as suggested by Creswell (2009) thematic analysis is suited to those who are new to research. Additionally, Maguire and Delahunt (2017) assert that thematic analysis is arguably the most influential approach in the social sciences because it uses a framework that is clear and usable. Braun and Clark (2006) also recommend thematic analysis as a first qualitative method as it equips the researcher with the core skills that are advantageous for conducting numerous types of analyses. Additionally, as thematic analysis is a method as opposed to a methodology, it provides flexibility as it is not tied to a particular epistemological or theoretical perspective (Clarke and Braun, 2013) and

would take into account the audience that this study would address i.e. nurses, midwives. Thematic analysis also has flexibility in providing a rich and detailed account of data when trying to find out about people's experiences, it identifies, analyses and describes themes within the data and is also compatible with a constructivist paradigm (Braun and Clarke, 2006) which is employed in this project.

The survey questionnaire data was collected through Qualtrics – a web-based survey tool (Qualtrics, 2015). Data was also collected via hard copies, in other words, paper copies of the questionnaire (see questionnaire, appendix 4). The web-based survey questionnaire recorded a total of 44 respondents, but close examination revealed that 25 respondents had actually completed the questionnaire. Five of the respondents answered a few questions out of the 17, therefore these were taken out of the study in order to clean the data, whilst 14 respondents failed to answer any of the questions. Twenty-five web-based questionnaires were therefore used for data analysis in addition to 15 paper copies, equalling a total of 40 survey questionnaires.

4.6.2 Challenges of thematic analysis

Thematic analysis tends to be subjective as the researcher uses his/her judgement in analysing the data therefore there is a need to reflect on own interpretations and choices. This includes ensuring that what is picked up in the data is actually there and not obscured. In order to address this situation, the personal experience section of the researcher in section 1.5.1 of chapter 1 above, outlined the researchers' positionality. Additionally, an inductive approach to data analysis was adopted as opposed to a deductive approach. A deductive approach refers to the researcher having preconceived ideas as to what themes s/he would expect to find in the data based on what is already known or on existing literature. An inductive approach however, allows the data to determine the themes that are generated or to put it another way, the researcher develops codes and themes through an interpretation of the data (Holliday, 2002). Another common danger with thematic analysis according to Clarke and Braun (2013) pertains to the researcher using the interview questions as the themes therefore summarising the data as opposed to analysing the data. To avoid the aforementioned pitfall as espoused by Clarke and Braun (2013) the steps outlined in Braun and Clarke's (2006) framework for thematic analysis were used. Table 4.1 below outlines the steps the researcher used in the thematic analysis process.

Table 4.1 Stages of thematic analysis

	Phases	Description of Analysis Process
1	Familiarising self with the data	• Transcribing the data • (Re)reading the data and noting down initial ideas
2	Generating initial codes	• Coding interesting features of the data in a systematic fashion across entire data set • Collating data relevant to each code
3	Searching for themes	• Collating codes into potential themes • Gathering all data relevant to each potential theme
4	Reviewing themes	• Checking if themes work in relation to the coded extracts • Checking if themes work in relation to the entire data set • Reviewing data to search for additional themes • Generating a thematic map of the analysis
5	Defining and naming themes	• On-going analysis to refine the specifics of each theme and the overall story the analysis tells • Generating clear definitions and names for each theme
6	Producing the report	• Selection of vivid, compelling extract examples • Final analysis of selected extracts • Relating the analysis back to the research question, objectives and previous literature viewed

Source: Braun and Clarke, 2006, page 87

4.6.3 Data analysis: Interviews

The interviews utilised IPA as a tool for data analysis. As a new researcher and based on the understanding of the IPA framework and how it engages with the research questions, this was deemed to be an appropriate method of choice for this project.

Smith et al. (2009) acknowledges that IPA is a complex method for novice researchers but recommend that the IPA framework they created, should be followed by novice researchers as a guideline for analysis. Similar to Creswell (2009), Smith et al. (2009) argue that IPA requires the development of skills in order to achieve the depth of analysis that is required. Once the researcher develops more knowledge about the IPA framework and becomes more adept in its use, s/he can become more creative and deviate from the established steps. When using IPA, the transcripts of participants are usually qualitatively analysed, systematically (Smith and Osborn, 2015). IPA is about understanding the meaning that the participant attributes to their lived experience (Smith, 2003).

When analysing the data, Smith (2003) asserts that the researcher needs to engage in an interpretative relationship with the transcript, as meaning is central to understanding the content and complexity of the meanings rather than measuring the frequency. This contrasts with thematic analysis where codes that do not appear often in the data are discarded as they are not deemed to be relevant (Smith, 2003).

Following transcription of the interviews, each transcript was read and re-read to engage with the content and to gain familiarity with the data. Data from the qualitative open-ended questions were analysed as a volume of recurring themes. A sample of an analysed transcript is included in appendix 6. As recommended by Flowers et al. (2005) who assert: *a key commitment of IPA is analysis should be developed around substantial verbatim excerpts from the data* (Flowers et al., 2005, p.22), this was considered by the researcher. Inductive coding of the data was conducted through generating themes. *Inductive and iterative procedures of IPA are intended to help the researcher to develop an initial 'insider's perspective' on the topic* (Flowers et al., 2005, p.22).

Table 4.2 below illustrates Smith et al.'s (2009) six steps of IPA which was used to guide analysis of the interviews.

Table 4.2 The six steps of interpretative phenomenological analysis

Step	Description
1	Embed yourself in the data – read and reread transcripts to obtain a good understanding of what is going on
2	Start taking notes – while reading the transcripts, code everything that comes to mind based on content and form
3	Compile emergent themes using the codes
4	Consolidate the themes into superordinate categories
5	Move onto the next case and repeat the process
6	Once all cases have been analysed, look for connections across cases

Source: Smith et al., 2009, p. 82

Looking at the generated data as a whole allowed coding of the data where the researcher was able to identify features that were pertinent to the research question (Braun and Clarke, 2006) and repeated patterns and themes could then be drawn out. Although the option to code the data through NVivo (software for qualitative analysis) was explored, the data from the interview questions were coded manually as it was felt the nuances in the data could be missed, thereby prohibiting immersion in the data (Waring and Wainwright, 2008). Also, the decision to code the data manually was taken after examining the differences between manual and electronic coding and deciding which method was applicable for this project. The differences between the two methods of coding are shown in table 4.3 below.

Table 4.3 Manual Vs Electronic Coding

	Manual coding	**Electronic coding**
Tools	Paper, Pens, pencil, note cards, hard copy of the transcripts or documents, artifact to be coded	Computer aided qualitative data analysis Software (CAQDAS) such as Nvivo, Atlas ti and Transana
Usability	Easy to use especially when data is small	Need to familiarise with the function of the software before analysing the data Forcing meaning as opposed to emergence by using software generated coding (Glaser, 1992)
When to use	**Small data** Recommendation: At the initial stage of data collection when familiarising yourself with the data	**Large data** Including videos and audios that have not been transcribed
Organisation	Time consuming	Easy to organise codes, run queries and code frequencies, explore the relationship between codes and do 'memoing'

Source: Adapted from Adu, 2015

4.6.4 Challenges of IPA

Once the data was coded and compiled into emergent themes, it was initially organised into 2 superordinate themes and 4 subthemes. On examining the data again however, it was found that some of the subthemes were essentially one and the same thing, therefore the subthemes were consolidated and the process was started from the beginning. Following further examination of the data and thinking more broadly about the emergent themes and the factors at play, the researcher organised the data into 4 superordinate themes and 4 subthemes.

4.7 Adopting a reflexive approach

Figure 4.2 below illustrates how reflexivity was used in the pilot and the main study. As this research used an interpretivist approach, reflexivity needed to be employed (Holloway, 1997; Charmaz, 2006) so that the researcher develops new understanding (Levy, 2003). As the interpretative stance is one in which knowledge is acquired through social and cultural construction, the views and assumptions have to be taken into account by the researcher and how it has impacted upon the research process (Holloway, 1997; Charmaz, 2006). This enables the researcher to consciously interpret the many complicated realities or experiences that emerge (Holloway, 1997; Charmaz, 2006). Put another way, the researcher is cognisant of what s/he is interpreting when developing new understanding. Ruby (1980) asserts that adopting reflexivity in research is a means of being honest and ethical.

The reflexive diagram illustrated below in figure 4.2 helps to illustrate the reflexive process undertaken by the researcher during the pilot study and the main project.

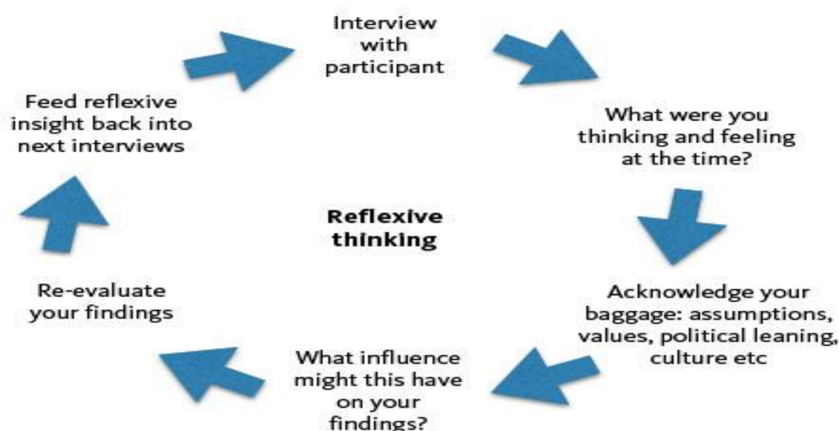


Figure 4.2 Reflexive thinking cycle, Source: (Cxpartners, 2015, n.p.)

The diagram represents reflexive thinking where the researcher reflects on self to provide more effective and impartial analysis (Wilkie, 2015; Engward and Davis, 2015). In other words, the diagram helps to demonstrate the process of thinking. Thinking reflexively is about self-awareness, making the research process a point of analysis which helps to reduce the influence of personal experience. Reflexivity allows the researcher to examine and consciously acknowledge the assumption and preconceptions that is brought into the research based on personal experience (Wilkie, 2015) (see researchers' personal experience in chapter 1, section 1.5.1). Reflexivity allows transparency of the decisions that are taken in the research process and in developing research quality (Engward and Davis, 2015; Flowers et al., 2005).

4.8 Summary and conclusions

In this chapter, the activities of the project were presented. The chapter commenced with a discussion of the design and implementation of the survey questionnaire which began with a pilot study. The administration and difficulties experienced in administering the survey questionnaire were discussed as well as the difficulties encountered in attempting to gain access to organisations to collect data. The interview process and ethical considerations including the emotive nature of the research were also presented. This chapter also discussed the sampling strategy for the interviews and how the data was transcribed and validated as well as the data analysis strategy including the challenges of the methods that were used. The rationale as to why it was important to use a reflexive approach in this project was also presented.

Having gone through the process of the projects' activities and with the benefit of hindsight, the researcher gained valuable insight as to what would be done differently and to better effect if this project were to be repeated. Snowball sampling for instance would have cut down on the valuable time that was lost in attempting to recruit research participants.

Analysis of the data and the research findings of the project are presented and discussed in chapter 5 below.

Chapter 5: Presenting the research findings

5.1 Introduction

This chapter presents the findings of the data. The first section looks at the data which was collected via the online questionnaire and the second section examines the interview data. Excerpts from the researchers' reflective journal is interspersed within the two sections. The chapter concludes with a summary of the findings.

5.2 Results: Survey questionnaire

Two themes and 6 subthemes evolved from a thematic analysis of the data collected through the **survey questionnaire**. Three superordinate themes and 6 subthemes evolved through an analysis of the **interview data** through IPA. The findings for both the survey questionnaire and the interviews will be discussed separately followed by a discussion of the meaning of the results in chapter 6.

Table 5.1 below shows the demographic profile of the participants who took part in the survey but there are some blank fields where the participants did not answer the question(s) posed. A total of 27 females participated in the survey, whilst there were only 13 male participants. There was a higher response rate amongst BME nurses. Thirty nine of the 40 respondents answered the question on ethnicity and 8 of the respondents described themselves as 'British' thereby skewing the data as it was unknown whether they were BME or white British.

Table 5.1 Demographic profile of survey questionnaire participants

Participant code & pseudonym	Gender	Job title	Ethnicity	Year of birth	Number of times quotes used from each participant
1 – Patricia	Female	Senior Sister	Black African	1974	0
2 – Monica	Female	Sister	White British	1960	0
3 – Michael	Male	Staff Nurse	Black African	1964	1
4 – Robert	Male		Black African	1978	0
5 – Rachael	Female	Senior Sister	British	1976	1
6 – Grace	Female	Research Nurse	Black African	1971	0
7 – Hilda	Female	Research Nurse	German	1977	0
8 – Alfred	Male	Staff Nurse	Black African		3
9 – Esme	Female	Middle Manager	Black British	1955	0
10 – Steven	Male	Ward Manager	Black African	1973	1
11 - Amanda	Female	Specialist Nurse	White British	1958	0
12 – Mark	Male	Registered Nurse	British	1977	0
13 – Carol	Female	Lead Nurse	British	1956	0
14 – Amy	Female	Nurse	Black African	1960	1
15 – Linda	Female	Nurse	Black British	1994	0
16 – Emily	Female	Practice Development Nurse	White British	1972	1
17 – Neil	Male		British	1986	1

Participant code & pseudonym	Gender	Job title	Ethnicity	Year of birth	Number of times quotes used from each participant
18 – Ruby	Female	Midwife	Asian	1974	1
19 – Sara	Female	Ward Manager	Asian	1966	0
20 – Sita	Female	Practice Development Nurse	Asian	1961	0
21 – Karen	Female	Midwife	White British	1962	1
22 – Sharon	Female	Practice Development Nurse	British	1962	0
23 – Tracy	Female	Clinical Educator	British	1980	1
24 – Casey	Female	Clinical Educator	British	1967	0
25 – Stacey	Female	Nurse	Black Caribbean	1968	0
26 - Miranda	Female	Staff Nurse	White British	1996	0
27 – Kay	Female	Nurse	Black British	1979	0
28 – Sindy	Female	Clinical Team Leader	White British	1988	2
29 – Gita	Female	Nurse	Asian		0
30 – Regina	Female	Clinical Team Leader	Black African	1958	0
31 – Beata	Female	Staff Nurse	European	1978	1
32 - Reece	Male	Ward Manager	Asian	1964	0
33 - Karl	Male	Staff Nurse	Black African	1980	1
34 - Danny	Male	Nurse	Black British	1983	2
35 - Femi	Male	Staff Nurse	Black African	1968	1

Participant code & pseudonym	Gender	Job title	Ethnicity	Year of birth	Number of times quotes used from each participant
36 - Tony	Male	Nurse	British	1969	1
37 - Paul	Male	Clinical Team Leader			1
38 - Ray	Male	Staff Nurse	Asian	1963	1
39 - Holly	Female	Lead Nurse	Black British		1
40 - Anne	Female	Staff Nurse	Black Caribbean	1959	2

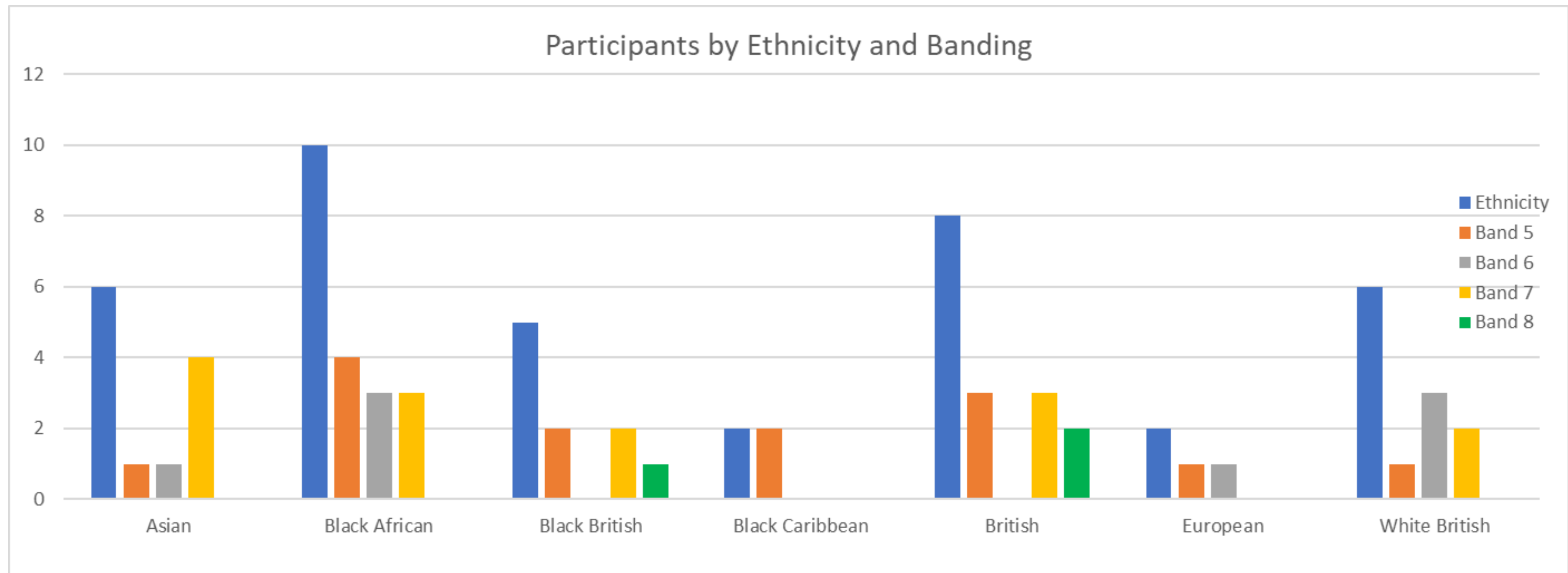


Figure 5.1 participants by ethnicity and banding

The data showed:

- British nurses had the highest banding compared to the other ethnic groups listed
- Asian nurses featured in higher than lower bandings
- Black Caribbean nurses tended to work within the lowest banding
- Black African nurses had the widest spread across the bandings

5.2.1 Themes

Using Braun and Clarke’s (2006) framework, in which they assert that the researcher needs to become familiar with the data by reading and re-reading, this was duly done. The initial codes were then generated from the data and grouped into themes. After generating the initial codes and the themes, they were reviewed and modified further. The researcher had originally organised the data into 4 main themes which were: **Accessible training opportunities; Unable to access training; Training inequality** and **inequality across nationalities** as when coding the survey data, these themes seemed to feature prominently and were relevant to the research question. However, there was overlap between the themes but they were distinct themes in themselves so existing codes were modified and new codes generated. The data was also organised into subthemes in order to capture significant findings as after reviewing the themes, it was felt that there were themes within themes. For instance, the preliminary theme ‘training inequality’ overlapped with the theme ‘inequality across nationalities’ as supported by the data. An example is given in table 5.2 below which shows the initial coding and themes.

Table 5.2 Worked example of thematic analysis

Theme: Accessible training opportunities	**Theme: Unable to access training**	**Theme: Training inequality**	**Theme: Inequality across ethnic minorities**
Codes:-	**Codes:-**	**Codes:-**	**Codes:-**
Feels valued	**Training barrier**	**Inequality sometimes**	Not valued
Training opportunities available	**Training restricted**	Inequitable management practices	Black people oppressed
Nurses to take responsibility for own professional development	Staff shortages	**Nepotism**	**Inequality**
Respected	Lack of professional development	Training only available for selected staff	**Nepotism**
Opinions heard and respected		**Training barrier**	**Training barrier**
			Training restricted

During the modification process, the main themes were organised into broader themes with subthemes. Some of the codes fitted more than one theme and has been highlighted in bold as shown in table 5.2 above. The codes that were similar, were grouped into categories as recommended by Creswell (2003) and formed into new themes and subthemes. This process was repeated and the final themes and subthemes which were drawn out, are detailed below. Examples of the themes that were identified in the data (survey questionnaire and interviews) are shown in appendix 6.

The themes and codes that were drawn out from the survey questionnaire and used to analyse the data are shown below in table 5.3. The first theme which is that of 'training,' was originally specified as 'accessible training opportunities' but after reviewing the themes, this did not really work as too much information was being fitted into one theme, themes which were distinct in themselves. The theme was re-named and broken down into 3 subthemes.

Table 5.3 Reworked themes

Theme 1: Training context	Theme 2: Employee relations
Subtheme 1: Training opportunities **Codes:** Respected Feels valued Training opportunities available Nurses to take responsibility for own professional development **Subtheme 2: Inaccessible training** Training barrier Training restricted Staff shortages Lack of professional development **Subtheme 3: Improving training access** **Codes:** Nurses to take responsibility for own professional development Access online courses Discuss training with line manager	**Subtheme 1: Nurses feel valued** **Codes:** Respected Opinions heard Able to make decisions Given autonomy Contributions valued **Subtheme 2: Not valued** Opinions not heard No feedback Lack of communication Views heard but not acted on Expendable **Subtheme 3: Inequalities** **Codes:** Black nurses oppressed Training barrier Training restricted Not valued Training only available for selected staff Nepotism Inequality across nationalities Inequitable management practices

The first subtheme was ‘training opportunities’ the second subtheme was ‘inaccessible training opportunities’ and the third subtheme was ‘improving training access’ which will be examined in turn. Each of the themes are discussed below and quotes from the

survey participants are included where pertinent. The first main theme looked at training.

5.2.1.1 Theme 1: Training context

A total of 40 survey questionnaire respondents expressed their opinions on training within their respective organisation. Some of the respondents had concerns with training provision, whilst other participants reported having accessible training programmes in place.

Subtheme 1: Training opportunities

The data showed that of the 40 nurses who participated in the survey, training was encouraged and the majority of them were able to access training. There were instances however when the intention was there but attending courses was difficult due to staff shortages. In a few cases, a lack of funding made it difficult to access training but this was also dependent on management as to who was allowed to attend training courses. Some nurses reported that whilst mandatory courses were promoted, training courses outside of this was difficult for some staff to access. In other words, only select staff could attend training outside of the mandatory courses.

Of the 40 respondents, 36 reported that there was a culture of training and development within their organisation and they were able to access training programmes. Of those participants who were able to access training, they reported a good working relationship with their manager. There was a distinct correlation between those nurses who were able to access training, with feeling respected, being valued as a member of the team and being part of the decision-making process (n= 16).

One participant said:

> *"The Trust continues to offer training as needed"* **(Danny, participant 34, Nurse)**

The participant reported that the Trust made training available for those staff who needed it as and when required.

> *"There's opportunity for academic progress"* **(Tony, participant, 36, Nurse)**

According to another participant, if staff wanted to progress academically, the opportunity was there for them to do so, a sentiment also shared by the following participant:

> *"There are lots of training opportunities available"* **(Karl, participant 33, Staff Nurse)**

The hospital Trust in which the participant worked provided many training opportunities for staff.

There was consensus that nurses needed to take responsibility for their own training and development. One participant felt that nurses should take ownership of training through their appraisals. Another participant suggested that nurses should identify their own learning needs, whilst another suggested online learning and study days as alternative modes of training. Other suggestions included approaching the line manager, being proactive in identifying training courses, online training and meeting with educational institutions.

A participant stated that training could be accessed through:

> "*Communication and personal development review plans"* **(Stacey, participant 28, Nurse)**

The participant explained that training could be accessed through communicating with those concerned with training and through the personal development review (PDR) process where staff review their work progress. PDRs are normally undertaken with the line manager where the training needs of the staff member are identified. Relevant courses are then usually booked and undertaken before the next PDR meeting.

Subtheme 2: Unable to access training

The next subtheme that emerged out of the data was training inaccessibility. Some of the nurses reported that there was inequality when it came to accessing training and development opportunities. The nurses who did not feel valued within the organisation, gave several reasons as to why they felt this way. One nurse stated that she only felt valued if things were going well and accessing training was dependent on the manager. Another nurse said training was only available for those whose 'face fitted' as only select staff were allowed to attend training programmes.

One participant said:

> *"The intention is there but staff shortages make it difficult."* **(Karen, participant 21, Midwife)**

The participant explained that although the importance of training was recognised, nurse shortages meant it was difficult to allow staff time off from their respective wards/departments to attend training.

Another participant reported:

> "*Mandatory training is promoted but other training is difficult to access for some staff."* **(Steven, participant 10, ward manager)**

Whilst mandatory training was promoted for all staff, the participant said that some staff found it difficult to access training courses outside of those required by law.

Similar to the previous participant, another nurse said:

"Make certain courses accessible to all staff." **(Paul, participant 37, clinical team leader)**

The participant was indicating that whilst training courses were available, only certain staff were allowed to access particular courses and he wanted all staff to be able to access those courses. Similarly, other participants reported that there were training restrictions and cited a lack of professional development as an issue within the NHS.

Although 36 of the respondents reported that they had access to training, this was not always the case which became evident as subsequent answers within the survey questionnaire demonstrated. For instance, of the 36 staff who reported that they had access to training, some of them also cited staff shortages as a barrier and not having the time to attend training due to work commitments.

It was reported that there was a culture of nepotism and only select individuals were allowed to access certain courses with one participant stating:

"Promotion is through nepotism." **(Alfred, participant 8, staff nurse)**

In order to get ahead in the organisation, the participant reported that those in positions of power favoured their friends when it came to training, therefore it was those nurses who gained promotion within the organisation.

Another participant stated:

"Favouritism is rife in some places in the Trust." **(Tracy, participant 23, clinical educator)**

The participant reported the unfair practices that existed within the Trust which she attributed to favouritism.

When addressing the question on training accessibility, another participant responded with some hesitancy saying:

"Unable to explain." **(Michael, participant 3, staff nurse)**

The participant was cognisant that there was a difference between the way different nationalities were treated but was 'unable to explain it,' as he puts it.

Another participant said:

"We don't get enough support as we may have wished." **(Amy, participant 14, nurse)**

Nurses were feeling unsupported as support was not forthcoming in the way that they would like or need, as explained by the participant.

Subtheme 3: Improving training access

The next subtheme that was drawn out from the data was 'improving training access.' When asked how nurses could improve training access, some of the participants felt that access to training opportunities could be achieved by various means. They felt in order to advance their practice, the onus on accessing training courses should be on the individual nurse where they take ownership for their training and development needs. Some of the participants said nurses should identify their training needs and speak to their line manager about accessing any identified course(s) or link their appraisals with training and development activities. Other participants suggested nurses should access online training.

Several of the participants wanted more time allocated to attend training courses during the working day whilst others wanted to see equal access to training for all staff.

When asked how training access could be improved, another participant said:

> *"Nurses should enquire more, look through the website. Discuss with line manager"* **(Sindy, participant 28, clinical team leader*)***

The nurse was suggesting that each nurse should take responsibility for their own training and development needs by exploring various means including discussing his/her training needs with management.

Another participant stated:

> *"By identifying training needs and discussing gaps in service provision."* **(Alfred, participant 8, staff nurse)**

The participant was advocating for a system whereby any identified training need(s) could be discussed with management and then linked with any identified gap(s) in service provision in order to address it.

In response to the same question as to how access to training could be improved, another participant said:

> *"By identifying the relevant courses."* **(Ray, participant 38, staff nurse)**

The participant wanted a system whereby whenever a nurse perceived a training need in terms of their practice, a course that would address that need could be undertaken.

Another participant thought training access could be improved thus:

> *"By booking on available courses."* **(Beata, participant 31, staff nurse)**

This participant along with some of the other nurses, felt that the onus should be on the individual to take responsibility for their own development.

According to the data however, their suggestions would only work for those nurses who were able to attend training courses. For the nurses who faced training restrictions i.e. only able to attend mandatory training, identifying training courses and speaking to the manger would not necessarily prove to be viable options.

5.2.1.2 Theme 2: Employee relations

This theme was coded: ‘employee relations’ as the data supported this description. The respondents were asked if they felt valued and of the 40 nurses who took part in the survey, 31 answered that they felt valued, whilst 6 answered that they did not feel valued, 1 participant did not know if she was valued, whilst another participant was unsure if he was valued. The data was split into 3 subthemes which were: ‘nurses feel valued’; ‘not valued’ and ‘inequalities’. The first subtheme looks at: ‘nurses feel valued’.

Subtheme 1: Nurses feel valued

The first subtheme in this section that was drawn out from the data was that of ‘nurses feeling valued.’ When asked the question as to why they felt valued, the participants equated it with several factors and gave similar responses. They largely attributed being valued with respect, having a voice, being able to perform their role unhindered and feeling supported. Most of the nurses reported that having their opinions heard and being part of the decision-making process gave them a sense of being valued. Other nurses reported that being respected gave them the sense that they were valued in addition to being able to carry out their roles autonomously without being micromanaged. The responses where given, are grouped together and displayed in table 5.4 below for ease of presentation:

Table 5.4 Subtheme: Nurses feel valued

Question	Why do you feel valued?	Job role	Ethnicity
Answer:	Treated with respect	Sister	White
	Treated with respect, contributions valued	Ward Manager	Black
	Respected	Staff Nurse	White
Answer:	Provide a quality service	Staff Nurse	Black
	Able to deliver a service	Middle Manager	Black
	Allowed to work autonomously	Practice Development Nurse	White
	Asked to do different things	Midwife	White
Answer:	Opinions heard	Senior Sister	British
	Opportunity to express views	Research Nurse	Black
	Able to make decisions	Staff Nurse	Black
	Involved in all decision making	Ward Manager	Black
	Consulted and opinions counted	Midwife	Asian
	Opinions and experiences listened to	Midwife	Asian
	People seek my opinion	Practice Development Nurse	British
	Seniors value my contribution	Nurse	Black
Answer	Support available for new nurses	Clinical Educator	British
	Supportive Line Management	Clinical Team Leader	White
	Given recognition, team supportive	Nurse	Asian

Subtheme 2: Not valued

The next subtheme in this category was ‘not valued.’ Some of the participants equated not being valued with being unsupported whilst others argued that they did not have a voice. Four participants reported that training was not accessible and expressed that they were not valued as members of the team. One of the 4 participants stated that staff were only valued if their ‘face fitted’ or if things were going well on the ward. Another reported that staff were treated as though they were expendable and management lacked interest in the staff. Another participant said training access was

dependent on the individual manager, whilst 4 participants reported that mandatory training was encouraged but other training courses were difficult to access. Those participants who said their views were listened to, also said that their contributions were never acted on. Table 5.5 below shows the responses of some of the participants who did not feel valued.

Table 5.5 Subtheme: Not valued

Why don't you feel valued?	Job role	Ethnicity
Just not valued	Nurse	Black
Not enough support	Nurse	Black
Views heard but not acted on	Nurse	British
Staff treated as though expendable	Clinical Team Leader	Not given
Valued if all is going well	Lead Nurse	Black
Only valued if face fits	Staff Nurse	Black

One participant said:

> *"Unsure whether valued as there is no feedback."* **(Holly, participant 39, lead nurse)**

The participant could not answer the question definitively as feedback was not forthcoming. There was no communication in this regard therefore it was difficult to gauge how she was perceived by her manager and team members.

Subtheme 3: Inequalities

The next subtheme that evolved from the data was 'inequalities'. This theme featured significantly in the data and fitted into the theme of 'employee relations'. Whilst coding, although there was overlap with the subtheme 'not valued,' the data was also distinct from it. The barriers faced by some of the participants are discussed below.

Some of the nurses reported that there was inequality when it came to accessing training and development opportunities. Other nurses reported that there was inequality across the nationalities. One nurse reported that a fairer approach to training access was required whether the nurse was coloured (sic) or white. Several nurses called for equal access to training for all regardless of nationality. A few nurses suggested that nepotism was evident and training access was dependent on whether the 'face fitted.' Another nurse said training access was dependent on the relationship with the manager.

Seven respondents reported that there was no equality across the ethnic groups. The following participant said:

> *"It (inequality) is obvious."* **(Rachael, participant 5, senior sister)**

The participant did not provide further details as to why she made this comment when she indicated that the inequality within the organisation was apparent for people to see.

Another participant said*:*

> *There is still colour/racial discrimination when it comes to appointments or offering top positions. Also, coloured (sic) people are prone to be disciplined quicker than white counterparts. We want equal opportunity and fair approach whether coloured (sic) or white."* **(Alfred, participant 8, staff nurse)**

The participant was reporting the inequalities faced by POC when trying to gain access to employment in addition to gaining senior positions. He called for a fair system where there is a level playing field for all people, a system where everyone has an equal chance of gaining employment and progressing within the NHS.

Another participant stated:

> *"There is institutional racism."* **(Ruby, participant 18, midwife)**

The participant conveyed that racism was inherent in the NHS which is systemic, meaning that there were disparities in the way BME people were treated in contrast to their white counterparts.

Another participant, who was of the same opinion as the participant above, reported that there were inequalities between black and white nurses as the black nurses were not developed professionally like their white counterparts. The participant said:

> *"Not enough opportunities. Observed white nurses move up to more senior roles, they are supported to assume a more senior role."* **(Anne, participant 40, staff nurse)**

The nurse reported how she observed the lack of support for black nurses. She said support was given to white nurses in order for them to gain promotion in their roles but these same opportunities were lacking for black nurses. One participant stated:

> *"Minorities are not represented in top jobs."* **(Neil, participant 17, job role not given)**

The participant explained that 'minority' staff do not occupy senior positions, rather, they are overrepresented in junior positions.

Several of the nurse participants reported that being of a different skin colour was an issue in the NHS. A participant stated:

> *"Colour discrimination in appointments and prone to disciplinaries."* **(Danny, participant 34, nurse)**

The participant explained that people of colour were at a disadvantage when it came to obtaining jobs and were disproportionately represented when it came to disciplinaries.

Similarly, another respondent said:

> *"A series of unfairness tend to follow."* **(Edmund, participant 16, practice development nurse)**

The participant reported that staff were not treated equally across all nationalities but did not expand on why he made the claim. This was noted by the researcher and the intention was to follow this up in the semi-structured interviews as he had indicated on the questionnaire that he was willing to be interviewed. He failed to respond however when the researcher sent out invitations to set up the interview appointments.

When asked if there was equality across the nationalities the following participant said:

> "*No comment."* **(Femi, participant 35, staff nurse)**

The participant refused to elaborate when answering the question as to whether all nationalities were treated equally.

The researcher noticed that there was a certain degree of hesitancy in answering some of the survey questions and noted this in her reflective journal. The following is an excerpt from my reflective journal:

> *There seems to be a pervading fear amongst some of the participants in answering some of the questions, especially when it comes to the topic of equality. This is despite them having seen a copy of the participant information sheet which specifies that the research is anonymous. It appears that there is something deep at play here.*
>
> **(Excerpt taken from my reflective journal April, 2018)**

In response to the same question as to whether there was equality across the nationalities, another participant said

> *"There is institutional racism."* **(Anne, participant 40, staff nurse)**

The participant suggested that there was no equality across the nationalities as the organisation in which she worked was institutionally racist.

The next section examines the findings from the interview data.

5.3 Results: Interviews

For this project, 12 nurses were interviewed and asked about their experience of accessing training and development activities within the NHS. The charts and tables that follow illustrate the findings. The profiles of the interview participants are shown below in table 5.6.

Table 5.6 Demographic profile of the interview participants

Participant Code	Gender	Job title	Ethnicity	Age range	Nurse band	Highest educational attainment	Experience as a nurse in the NHS (yrs)	Number of times quotes used from each participant
Int – 1 **Ruth**	Female	Lead nurse	Black African	40-50	7	BSc Nursing	12	1
Int – 2 **Naomi**	Female	Senior sister	Trinidadian Indian	50-60	7	MSc	25	0
Int – 3 **Michael**	Male	Staff nurse	Black Nigerian	50-60	5	BSc Nursing	3	5
Int – 4 **Matthew**	Female	Staff nurse	Black Caribbean	50-60	5	Diploma	10	1
Int – 5 **Deborah**	Female	Sister	Black Caribbean	60-70	7	BSc (Hons)	25	5

Int – 6 **Abigail**	Female	Staff nurse	Black British African	50-60	6	MSc	36	3
Int – 7 **Esther**	Female	Staff nurse	Black British	40-50	5	BSc	5	4
Int – 8 **Dinah**	Female	Staff nurse	African	30-40	5	MSc	<1 year	5
Int – 9 **Luke**	Male	Clinical educator	British African	40-50	6	PhD	16	3
Int – 10 **Mary**	Female	Staff nurse	Jamaican	50-60	5	BSc	18	4
Int – 11 **Martha**	Female	Staff nurse	Caribbean	60-70	5	BSc	48	1
Int – 12 **Hannah**	Female	Staff nurse	Other Asian	50-60	5	BSc	35	3

The data shows that the 12 nurse participants were from a BME background with ages ranging from 40 to 70. The participants had a total of 234 years of nursing experience between them. The highest nursing band achieved within the participant group was a band 7. Nurse bands for trained nurses range from 5 to 9 (NHS Employers, 2019a).

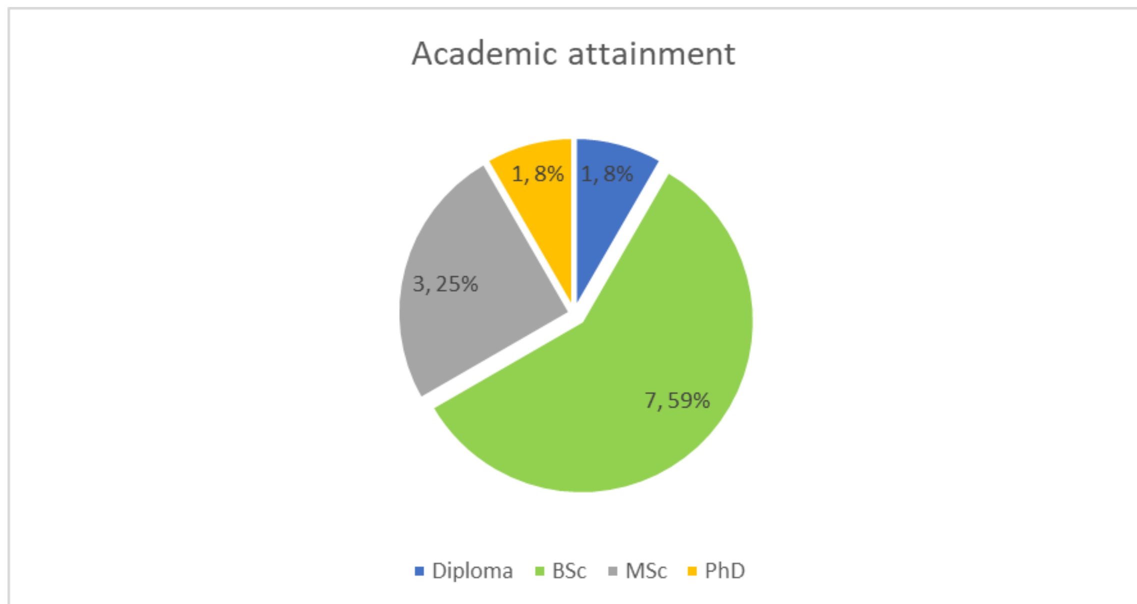


Figure 5.2 Academic attainment of the interview participants (total = 12 participants)

Figure 5.2 above shows that the highest academic achievement amongst the participant group was a PhD degree with the lowest attainment being a diploma. Three nurses had MSc degrees and 7 nurses had BSc degrees.

5.3.1 Themes

Based on Smith et al.'s (2009) IPA framework, the transcripts of the 12 participants were read and re-read to gain an understanding of what was happening in their respective ward/departments of the NHS. As the themes evolved, these were coded after which they were consolidated into superordinate categories (Smith et al., 2009). The process that was used to derive at the themes and subthemes is given in the activities section of the project in section 4.6 - table 4.1. The themes were centred around 3 superordinate themes and 6 emergent subthemes which are shown in table 5.7 below.

Table 5.7 Interview superordinate themes and subthemes

Superordinate theme- 1	Superordinate theme - 2	Superordinate theme - 3
Structures within NHS make it difficult to progress **Subthemes 1:** 1a. Racism 1b. Powerlessness 1c. Oppression **Codes:** Staff racist Bullying Nepotism Barriers Poor communication	Cultural competence and compassionate care lacking **Subthemes 2:** 2a. Uncaring **Codes:** Insensitive Indifferent No compassion	No outlet for staff **Subthemes: 3** 3a. Hopelessness 3b. Unvalued **Codes:** Expendable Nepotism Disrespectful Poor communication Unsupported

5.3.1.1 Superordinate theme: Structures within NHS make it difficult for black nurses to progress

The experiences of the black nurses who took part in this study suggest that they are still subject to hostile behaviours in the NHS. The participants voiced their concerns with the way structures within the NHS worked against black nurses. The comments made by the participants were analysed further and grouped into subthemes which were 'racism,' 'powerlessness' and 'oppression.' Each of the subthemes are discussed below.

Subtheme 1a: Racism

The first subtheme in this category was that of 'racism.' When speaking of their experiences when trying to access training and development programmes, 10 of the interview participants explained how difficult it was gaining access. They were able to undertake the mandatory training courses which are a requirement of the organisation and in some cases are government directives (courses that are 'policed' by the independent health regulators known as the Care Quality Commission). However, courses that would enable them to develop professionally were not forthcoming.

The following excerpt is taken from the transcript of one of the participants as it encapsulates much of the feelings of 9 of the other participants. The question was asked around equality:

It's unfortunate that when you're talking about training and development and then when you are talking about race and equality and diversity, you somehow… I just realised at the beginning of the interview, I was really talking quite heatedly about experiences that I went through. So when you say training, when you say professional development, then race somehow rears its nasty head in there. It's very difficult to separate sometimes, so I'm sorry about that. **Abigail, interviewee 6**

Attempting to access training and development activities within the NHS was synonymous with racism according to the participant. Put another way, she equated training with racism. Reflecting on her negative experiences caused the participant to describe her interaction during the interview as 'speaking heatedly.'

The following excerpt is taken from my reflective journal:

After the interview session, I thought about the participants' words, her apology for 'talking heatedly.' That certainly had not been my perception, what I heard during that interview was a person with passion, there was certainly no need for an apology. I wondered if she was coming from a place of trauma, where as a black person, to speak passionately invariably culminated in the age old accusation of aggression, a method to silence one's voice…

(Excerpt taken from my reflective journal, December 2019)

During the interview process, one participant related the inordinate number of obstacles black nurses faced just to be able to undertake training courses unlike their white counterparts. Being prevented from developing professionally was reported to have a negative impact on practice as it led to stagnation and under-representation of black nurses in senior positions. With nothing changing although having addressed the issues with management, black nurses were leaving the profession in large numbers or taking long term sick leave due to stress.

The following excerpt is taken from another transcript which supports the previous account when asked if there was equality across all ethnic groups:

When they talk about equality, they talk about erm, equity and all these things but it's just erm, written on the paper but they don't apply that. You do ask for the training, they will ask you a few things, so many things to complete. But when a Caucasian comes, they don't even need to complete what they've been asked for, they just put them on that training straight away, …obviously if you are from, if you are a different, erm, erm, let's just say if you are a black person like I am." **Esther, interviewee 7**

The participant described the difficulty she had to undergo when trying to access training and development courses. In order to access a particular course that she was interested in pursuing, she was told that she had to complete various courses beforehand. However, when she spoke to her colleague who is white, the access requirements were different. Her colleague asked to attend the same course and was told to put his name down and gained immediate approval to attend. The participant put this down to colour, she is black.

Another participant had the following to say regarding the question of whether there was equality across all ethnic groups:

> *No way! I believe they are not treated fairly. First of all, wherever there is a minority, there'll be some form of inequality because there will be a lack of support and lack of understanding of the staff culture.* **Dinah, interviewee 8**

The participant perceived 'minorities' as being synonymous with inequality and therefore unfair treatment. She felt that whilst staff were encouraged to learn about the different cultures of the patients they cared for, staff were not encouraged to learn about other cultures within the staff group. She felt this gap prevented an understanding and respect for others' culture creating hostility towards the 'minority.'

The participants shared how racism/discriminatory practices impacted on clinical practice. The following is an excerpt from one participant:

> *Because they ill-treat the workers, it's the patients in the end who bear the brunt because when an extra nurse or carer could be there to help wash the patient, feed the patient, they're not there, because they are probably off sick because they're overworked. People are lying in bed, sometimes people are ill, they can't feed themselves and they haven't touched it because they can't reach the food, they can't help themselves.* **Mary, interviewee 10**

The participant shared the impact of racism/discriminatory behaviours on clinical practice. She reported that when nurses left their posts as a result of the racism they faced, it was the patients who suffered because it left the ward short of nurses which meant they were unable to carry out the standard of nursing care required.

One of the participants reported anecdotally that patients were literally starving and malnourished with some even dying as a result of the staff shortages because there was no-one to feed them. This was due to the competing priorities that nurses were having to negotiate.

The following is an excerpt taken from my reflective journal:

It is a real shame that good nurses who are humane and full of compassion are having to leave the NHS because of the abhorrent behaviour towards them based on skin colour. I am just dumbfounded that those in positions of leadership fail to acknowledge that the racism reported by the nurse participants are not addressed. Racism affects everyone, not just the victims who tend to take sick leave through stress or terminate their contracts. The patients are impacted negatively through staff shortages and those nurses who are having to absorb the staff shortfall are negatively affected.

(Excerpt taken from my reflective journal October 2019

When speaking about inequality, another participant said:

You know, you start to see yourself in a very negative way which is not good. That's not how a nurse wants to see herself. A nurse wants to see herself like someone who is able to do the job although she might not do it well at some point but she's able to do the job. **Esther, Interviewee 7**

As a result of her experience as a black nurse, the participant had started to lose her confidence. She was cognisant that her practice may not always be perfect but she was doing her job to the best of her ability. The negative experiences caused her to question her abilities.

The data indicated that institutional racism was not only visible, for example, being subjected to derogatory name calling, it was also about the micro-aggressions which were non-verbal as well as verbal. An example of the lived experience of micro-aggressions conveyed by the participants during the interview process when analysing the data, suggested that several years of nursing experience and academic attainment did not count for anything as black nurses were often overlooked for job promotions in favour of white nurse colleagues who were often less experienced and less qualified.

In relation to the above paragraph, one participant said:

Well I find that erm, there was discrimination, there was inequality and erm no matter how hard you work, you didn't seem to, you know, be up to scratch, you know, in some people's eyes. You were undervalued and erm, you know, you couldn't do anything to please anyone, no matter how hard you try, so… **Luke, interviewee 9**

The participant felt that whatever he did was never good enough despite his best efforts.

One black nurse with 16 years' nursing experience working at a band 6 level as a clinical educator and educated to PhD level (see table 5.6 above), was unable to secure a band 7or 8 position. This was despite him being the one imparting the

knowledge and clinical skills to the white junior nurses who were being promoted as a result of their upskilling. The experience of this nurse and most of the other black nurses who were interviewed for this study, were the same as they were met with silence when trying to get answers as to why they were not able to progress further within the NHS. The managers were not prepared to provide feedback and evaded questions when asked why they had been overlooked for promotion.

Subtheme 1b: Powerlessness

The next subtheme extracted from the data was that of powerlessness. The interview participants indicated that as nurses working within the NHS, they were subject to control and oppressive practices unlike their white counterparts. The consensus of the interview data was that black nurses were not valued so any opinions they tried to convey to managers were not heard. They reported that they were largely ignored when they requested feedback when overlooked for training courses and progression within the NHS. The reality of not having a voice was not only confined to the rebuff from managers but the white junior nurses and nursing assistants who observed the treatment of black nurses by managers, saw this as license to behave in the same manner, having no respect, thereby perpetuating the discriminatory practices. Progression within the organisation tended to occur only if it suited management.

One participant said:

> *You go to work and er you get bullied by other staff and you can't talk. If you go to talk, you go to a supervision, you never get any of the support. I mean you will never get, even if they listen to you, they will never support you based on what you said until something happens. I've always you know, I don't… when this happens, you don't feel like there's anything you need to report because you know that it's not going to be sorted out. And then you feel frustrated when you go to work because you don't like your job anymore but you only go because you need income* **Esther, interviewee 7**

The participant related that she no longer reported any issues that arose in the workplace like bullying for instance as they were never acted on. She now only attended work because she needed an income.

The following excerpt is taken from my reflective journal:

> *It is sad that the once spirited nurses who entered the nursing profession with hope and confidence and a value system to help those in need, are now reduced to a shadow of their former selves because the system works against them.*

(Excerpt taken from my reflective journal October 2019)

The interview participants also reported that there was never any recourse to address the racism they experienced and expressed that they were reluctant to complain as the environment tended to become even more hostile and stressful. Another nurse who was interviewed for the study reported that when she was 'racially' abused by a peer and complained to management, all the staff on the ward in which she worked did not speak to her for several months.

Another participant conveyed:

> *Well erm, there's a lot of politics in there, bullying and harassment. Er, I got involved in this er, grievances because of bullying and it was not er, also I was not er like trained, I was not given another trainings, like er, unlike the others who were having training every six months or every year for their promotions.* **Hannah, interviewee 12**

The participant explained that she was not allowed to attend training as she had complained to management about being harassed and bullied. Due to her complaint, she was not able to keep up to date with clinical practice, a situation which was meted out as a form of punishment.

In relation to a further incident of bullying, another participant said:

> *I reported it to the manager but the only reason it was sorted is because when the bullying happened, everybody else was there and those people were surrounding the bully. And that was the only time I was heard because the witnesses were there.* **Esther***,* **Interviewee 7**

The participant felt powerless, the only time an issue of bullying from another staff member was addressed was when there were witnesses who encouraged her to write a statement, witnesses who were all white. This forced the manager to act on the bullying which otherwise would have been ignored.

Subtheme 1c: Oppression

The next subtheme that was extracted from the data was 'oppression.' Most of the interview participants described not being able to self-actualise or fulfil their potential in a job that they were trained to do. The nurses reported that they were not free to be who they were as a result of the oppressive and controlling behaviours of their managers, behaviours which did not appear to be meted out to their white counterparts. Whilst interviewing one participant, her voice quivered periodically and there was a sadness to her resigned tone. She reported that nurses of other nationalities were able to progress providing they were not black. She started to sound distressed but was aware that she was free to pull out of the interview at any stage.

When speaking of his experience as a nurse wishing to progress his career further, one of the participants said:

> *For a black person to move forward, then it has to be a situation whereby they highly need somebody to manage the difficult situation over there. In that particular ward, the majority of them are black in which they want a black manager over there. But if they are white, there is still a bit of pressure to manage people not of the same colour and the only reason is that the colour 'identifies your quality,' that is what I consider about it.* **Michael, interviewee 3**

The participant stated that black nurses were only promoted in areas that were fraught with difficulties and unless they took up those roles, they were unlikely to move forward with their career. The participant also asserted that a 'minority' manager would face difficulty in their role if they were managing white staff, whereas a white manger would not face the same difficulties when managing staff across all nationalities. When probed further about his assertion the participant said:

> *The easier way I can say it is, if you are to manage the white people, actually if you are white people, managing you may be less stressed managing people because the activities may not be scrutinised and may not be called out for every aspect of work that you are doing. They can overlook most of the things if you make a mistake, but if you are a minority, it will definitely not be there. They will not overlook your mistake and make it less easy for you. You will definitely feel less worthy if you were to make a mistake.* **Michael, interviewee 3**

The participant explained that black managers were subject to being micromanaged. When mistakes were made, the so called minorities were made to feel inadequate, which had an impact on their self esteem and confidence. When it came to the white managers however, they were not subject to scrutiny and their mistakes tended to be overlooked.

Similar to the previous participant, another participant explained:

> *As a black person, you always have to fight your way. Number 1, you're being criticised, number 2, you're being humiliated in various ways, never that you are being praised for what you've done, the praise goes to somebody else and basically you feel demoralised.* **Deborah, interviewee 5**

The participant was explaining that black nurses suffer discriminatory behaviour just because of skin colour, their hard work was never recognised. She also asserted when explaining an incident of oppression:

> *…And it was horrendous that night and they moved most of the black nurses onto the ward because obviously they will do the job to a good standard and*

moved the white nurses and put them on a cushy ward. I was moved off from my ward when it's not often I have a quiet time. The first time I'm having a quiet time, I'm moved from my ward to a horrendous nightmare. **Deborah***,* **interviewee 5**

The participant described the experiences of black nurses in the work environment. As well as being demoralised in the line of duty, they were always given the wards where the work was heaviest. The participant spoke of the ward where she was based which was an extremely busy ward. One night however, the ward was unusually quiet and she was moved from that ward and placed on another heavy ward so she was always working under stressful conditions.

This was also the experience of another participant who stated:

…You have how many bays - 1,2,3 ,4 bays. Bay A and B and then bay C and D. They made sure without question that erm, er, the hardest bays were meant for ethnic minorities. But they tried as much as possible to make sure the white English nurses worked together and the ethnic minorities worked together. I don't know why they did that but they did that. **Abigail, interviewee 6**

The participant stated that the wards with the hardest bays were always reserved for BME nurses. This situation was found to be a recurring theme when interviewing the participants for this study. There was also this separation or division where the ethnic minority nurses were grouped together to work and the white nurses were grouped together to work. If BME nurses were being put in the hardest bays then it stands to reason that they would be grouped together as the white nurses reportedly worked in the less challenging bays.

The following is an excerpt taken from my reflective journal:

This learning journey is shedding light on the small things I may not have taken much notice of in the past, things like the insidious nature of racism. The illumination of the actions that at first may appear to be innocent, but rather, they are meant for harm. The humanity that defines black people like love, warmth and acceptance is negated through discriminatory actions and the use of language which denigrates and villainies them.

(Excerpt taken from reflective journal November 2019)

When speaking of oppressive practices, another participant said:

You might have somebody come in with infections for instance, infection like they might have TB. Then you're allocated as a black person to work in that area. And I eventually did have symptoms. Anytime you're on a ward and there's somebody with MRSA, TB or any infection like that, you can bet it was

> *always the black nurses, Filipino nurses that are allocated on, on that bay and at the end of the bay where these people are, inside rooms and all that* **Mary***,* **interviewee 10**

The participant shared that it was mainly the black nurses and those from ethnic minority groups that were invariably allocated to work with patients who had infectious diseases and therefore placed at higher risk of contracting infection.

A participant said when speaking of oppression:

> *I cannot find any good examples for equality because there are a lot of bad things really going on.* **Hannah***,* **interviewee 12**

The participant was overwhelmed with the degree of discriminatory practices she faced within the NHS organisation in which she worked, to the extent that she could not find one good thing to say about it.

5.3.1.2 Superordinate theme 2: Culturally competent and compassionate care lacking

When asked if training was provided in culturally competent care, most of the nurses who took part in this study were not sure what the term 'culturally competent' meant. A few of them guessed what they thought it might mean but the consensus following explanation, was that training in cultural competence was not provided. There was also the suggestion from some of the nurses that if training in cultural competence was provided, in reality, culturally competent care would be difficult to execute due to the shortages of nurses in the NHS. The subtheme of 'uncaring' was extracted from the data and is discussed below in relation to culturally competent and compassionate care as IPA allows this flexibility.

Subtheme 2a: Uncaring (participant nurses felt uncared for including the care they saw being delivered to patients)

There was a prevailing view amongst the participants that there was insensitivity towards black nurses from the white nurses who did not have any inclination or wish to take their feelings into consideration, rather, they were treated with contempt and chose to make their culture the object of ridicule. There was a sense of the leadership being transactional as opposed to transformational whereby the participants were ordered about rather than being involved in professional discussions.

On interviewing the participants, a note was made in the researchers' reflective journal as follows:

> *If patients are not receiving culturally competent care, it is not surprising that the nurses are not being treated in a culturally competent manner by their*

colleagues. Training in cultural competence could also raise cultural awareness amongst all nurses and yield respect for difference.

(Excerpt taken from my reflective journal, September 2019)

When asked if nurses were trained to provide culturally competent and compassionate care, one participant said:

> *Well, they might have to patients but maybe not to colleagues.* **Abigail, interviewee 6**

The participant felt that compassion **may** be shown to the patients but not towards fellow colleagues.

Another participant who felt that compassion was lacking stated:

> *I feel I can do nursing because I then think I can get a job and some people go for it in that way. When they do this, you then recognise their actions. Sorry, these people are doing this job because of money not because they are compassionate to do it, yeah.* **Michael, interviewee 3**

The participant was explaining that he felt some nurses entered the nursing profession due to money and not because of a genuine desire to provide a nursing service where compassion is at the centre.

When asked the same question if nurses provided culturally competent and compassionate care, another participants' response was similar to the previous participant. He stated:

> *I don't see that it's always competent or compassionate, you know. Sometimes, people do it just because it's their job, they are doing it and they're doing it for you know, their reward rather than the patient's benefit* **Luke***,* **interviewee 9**

The participant explained that some nurses were only doing nursing as a job and not necessarily as a vacation. He suggested that they were in the job for monetary gain and not necessarily for the benefit of the patient.

The following excerpt is taken from my reflective journal:

> *Having spoken to the research participants, it is becoming increasingly clear that the nurses who are being recruited to train and become nurses are not of the type who were entering the nursing profession in the early days. The salary a nurse received was poor but the rewards in helping people back to good health far outweighed the monetary gain. It was this mindset that saw those with a value system of care and compassion that tended to enter the profession.*

(Excerpt taken from my reflective journal September 2019)

Another participant commented on what it meant to be compassionate:

> *I think it should, part of it should be within you. Because you want that person to be treated the same way you want to be treated. So, it should really come from you. I think because you can't learn to do it when yourself, you don't even know how to be compassionate. It needs to come out from you.* **Ruth, interviewee 1**

The participant was suggesting that compassion is not an emotion that is taught, it should come from within, in other words, it should be innate.

This statement prompted a moment of reflection in which the researcher thought back to an entry in her reflective journal which shone a light on the disparities in the care some black patients receive which impacts negatively on care outcomes. The entry was thus:

> *A white nurse did not think it was possible to notice when a black person was being starved of oxygen despite the classic signs that are visible whatever a person's skin colour e.g. blue nail bed, rapid breathing, shortness of breath, fast heart rate. These are basic principles that are taught in any school of nursing and therefore suggests that the nurse could not be bothered as the black patient was not important and was held with the same contempt that the interview participants described when speaking of their experiences in the NHS.*
> **(Excerpt taken from my reflective journal October 2019)**

Another participant explained when referring to the care given by nurses:

> *Some of them would provide compassionate care although some nurses would be clerical than hands on so they would rather have clerical training than the patient care work. I think it would be better if it was covered in training. But even so, you still will find that some nurses, no matter how much they train, you get the clerical nurses that will sit down on the wards and they skive. They are not hands on nurses.* **Maria, interviewee 4**

The participant was explaining that training in compassionate care was not provided but did not think it would make a difference with some nurses as they were not interested in caring for the patient, they were more interested in the administrative side of nursing. Training in compassionate care for these nurses would therefore be wasted in her opinion.

When speaking about cultural competence and what it meant to her, one participant said:

> *Because we are all from different backgrounds and talk differently, we have staff that we feel they constantly judge us based on our accents, what we eat, the hair style. That's just my own personal experience.* **Dinah, interviewee 8**

The participant felt that her colleagues did not accept the black nurses and treated them in an insensitive way. Difference of culture was not embraced, rather it was the subject of ridicule.

The same participant also went on to say:

> *One thing I've come to realise for the past one year is that we are encouraged as professionals to get to know about patients, their culture, their background and know what not. But I don't think we talk about how to get to know our colleagues. You know, how they talk, the body language, their culture and all what is similar with patients.* **Dinah, interviewee 8**

The participant indicated that whilst nurses were taught to learn about patients and their different cultures, there was a gap as the same principle was not applied to colleagues who were not from the dominant culture. She stated further:

> *But in terms of practice, I think in practice it is hard because it isn't something that… because every individual, I don't know, sorry, it is something that every individual will have to find out how to apply it. It is hard to be told to be compassionate, we are humans and it is a criteria everyone has. But not everyone uses it.* **Dinah, interviewee 8)**

The participant explained that compassion is something that is innate in humans but we need to know how to apply it and when to use it.

In response to whether nurses received training in culturally competent and compassionate care, another participant conveyed:

> *Erm, I say from training, I think it depends on the person er, if erm, you know it comes within you if you are really compassionate with what you're doing, it will go, because it will come out because if you see a patient like er, who needs compassionate care, soon it will come out really within you. But aside from that, we had also training when we were student nurses, we had ethics as a subject, so yeah, I think.* **Hannah**, **interviewee 12**

Being compassionate was something that came from within according to the participant. She asserted that if a patient needed compassionate care, it would be given by a nurse who was naturally compassionate. She added that training in compassionate care was also undertaken as part of the student nurse curricular.

5.3.1.3 Superordinate theme 3: No outlet for staff

The data collected through interview of the participants, indicated that most of the nurses did not take part in clinical supervision but that they received practice supervision. A survey questionnaire was also used to collect data and included a question regarding access to clinical supervision. The survey questionnaire did not lend itself to the deep probing afforded with semi-structured interviews and as data was collected from the same organisations, the researcher made the assumption that the survey participants were referring to the practice type of supervision in common with the interview participants. This suggested that the nurses did not have a forum that provided a confidential and safe space in which to share concerns with colleagues and develop their practice. Having no outlet in which the nurses could discuss issues and share practice without being penalised, emerged as a theme. The subthemes which were extracted from the data were: 'hopelessness' and 'unvalued'.

Subtheme 3a: Hopelessness

The subtheme of 'hopelessness' was extracted from the data as it described the despair and lack of hope that the participants felt. This was largely due to the inability to progress in their chosen nursing career due to discriminatory practices. A snapshot of the participants' profiles for this subtheme is displayed in table 5.8 below for ease of presentation (full participant profile is shown in table 5.6 above). The profile highlights the participants' job role, years as a nurse, ethnicity, highest academic attainment and their nurse band.

Table 5.8 Snapshot of participants' profile including job role and band, years as a nurse and academic attainment

Job role	Years as a nurse	Ethnicity	Highest academic attainment	Nurse band
Staff Nurse	48	Caribbean	BSc	5
Staff Nurse	35	Other Asian	BSc	5
Clinical Educator	16	British African	PhD	6
Staff Nurse	35	Black British African	MSc	6
Senior Sister	25	Caribbean Indian	MSc	7

The data indicates that experience as a nurse and educational attainment was of no consequence as progression in the NHS for black nurses were limited. One participant had 48 years nursing experience but was not allowed to progress beyond a band 5.

Despite repeated attempts to progress by applying for a higher banding, she was unsuccessful but never received feedback despite attempts to obtain it. The profile of another participant (see table 5.8 above) shows he had 16 years' experience as a nurse and had attained a PhD but only managed to progress to a band 6 role as a clinical educator. Similar to the participant with 48 years' experience, he had never received feedback as to why he had been unsuccessful in securing a promotion. According to the participant data, this contrasts with that of white nurses who tended to gain promotion shortly after qualifying.

The following excerpt is taken from one of the participants speaking about clinical supervision when asked if it was available as a forum for personal and professional development:

> *I don't think that, that support (clinical supervision) is available. It may be available, but I don't think I am aware of it. When I have problems, I meet people, if I meet a senior nurse and I always ask them like, "when you go through issues like this, what do you do?" It's a shame that when you go for advice to your fellow minority people, they infuse fear in you because they're like "you can't win, you know if you're not happy, just leave.* **Dinah, interviewee 8**

The participant indicated that clinical supervision was not available for the nurses therefore she sought solace in those who would listen. Black nurses who had experienced the difficulties she faced, told her to leave the organisation as she would never win.

The following excerpt is taken from my reflective journal:

> *This learning journey has highlighted the extent to which the black mind has no idea of 'self.' This is attributed in part to not being taught their history at school or indeed not having true knowledge of their history. The mind that has been conditioned to believe that their history was purely one of enslavement, is going to think differently to the mind who knows that black people were living in civilised societies and were kings and queens before the rape and the enslavement of their people and continued pillage of their countries by the Europeans.*
>
> **(Excerpt taken from my reflective journal December 2019)**

Another participant who shared the same sentiment as the previous one said:

> *And I don't think we treat each other fairly as we should, we need each other, we can't do this job on our own but we don't encourage each other and look after each other as we should and erm, this is a big issue and it drives people*

away because the things that people experience are sickening you know, it's not fair and it's not right. **Mary, interviewee 10**

The participant indicated that there was no teamwork but rather hostile practices which culminated in driving nurses away from their jobs. She called for a coming together of the nurses as individualism was not working.

The following is an excerpt taken from my reflective journal:

> *I think it is sad that in 21st century society, people are being made to feel 'less than' and 'othered' just because of skin colour. Britain is supposed to be a 'civilised' society but there is nothing civil about the hostile behaviour black people face on a daily basis. Within the narrative, I hear the nurse saying, "**We are the ones we have been waiting for."***
>
> **(Excerpt taken from my reflective journal December 2019)**

Another participant shared the following:

> *And in that case, if you wanted to take any case forward, you will take care before you take it because you don't want to be, you don't want to be a nuisance to yourself unnecessarily, you don't want to feel less valued when you are in pain sat at home……* **Michael, interviewee 3**

The participant felt unable to whistle blow on the discriminatory practices he faced because the repercussions would be more severe.

Another participant said:

> *I've heard other people's stories from ethnic backgrounds like myself who I've witnessed worked hard and later on they say I've left the (name) long ago, because they treated me so bad, I couldn't stay there, it hurt. I have not heard one white person complain about anything like you know, people are picking on them and finding fault or treating them anyway inferior that they had to leave. Not one white person has ever said that to me.* **Mary, interviewee 10**

The participant described the pain former colleagues felt through the racism and oppression they were subjected to. No amount of hard work was ever good enough resulting in them terminating their employment because the pain was too much to bear.

During the interview, one participant shared how the black mind is conditioned. When speaking about management and the fear of retribution. He said:

> *Erm, in my personal opinion, it is a bit easier for a white manager to manage a team because if a white manger is managing black, then the manager will expect that the black people will be respecting this guy as 'oh It's a white guy.' Whatever he says I will need to take it on board because if he takes me up, the*

upper people will look at it very clearly and carefully, then the person may feel that he or she may lose their job. But then, if it's white, and those people involve the manager, they do listen to them better than compared to the black people they are managing. **Michael, Interviewee 3**

The participant was explaining that if concerns were raised by black staff, a white manager tended not to listen, but rather, expected them to conform otherwise they were at risk of losing their job, whereas with the white staff, the approach was different as concerns were listened to.

The following excerpt is taken from my reflective journal:

During one of the interviews when it was nearing the end, one of the participants said: "have you switched your tape off now? when you do, I'd like to talk to you." This excerpt was noted as it demonstrates that whilst the interviewee consented to taking part in the interview, it was clear by her statement that she did not feel safe to share certain pieces of information on tape. The researcher got the impression that as a result of the deep-rooted feelings of her lived experience, it felt safer to share her experience whilst not being recorded. This came as no surprise because when initially trying to collect data for this project, nurses were reluctant to take part and I sensed there was a fear of being identified and in turn ostracised or even lose their jobs.

(Excerpt taken from my reflective journal, September 2019)

Subtheme 3b: Unvalued

The subtheme of 'unvalued' was extracted from the data as the nurse participants described how they were made to feel worthless by their managers and colleagues. There was consensus amongst the participants that the culture of the NHS organisation in which they worked, demonstrated attitudes of indifference towards them as if they did not count for anything. Despite having substantial years' experience between them, the highest nursing attainment in the group were band 7s.

One participant said:

You don't feel valued when you've done your best and you don't feel…you don't get any praise for it. **Deborah, interviewee 5**

The participant echoed the sentiments of most of the other participants in explaining that the hard work that they contributed to the NHS was never acknowledged.

Another participant said:

And I don't think actually they value us in the sense that, well I might be wrong in my definition of value here because I'm actually talking about the sense of

somebody actually acknowledging. Rather than actually to always point the misgivings or something that is not done, say 'what has been done well or actually, let's see what can be the solution.' **Luke, interviewee 9**

The participant asserted that there was always fault finding when it came to black nurses. There was always a focus on the things that did not go well rather than an acknowledgement of those things that did go well.

The following participant reported an incident she encountered some time ago in her nursing career and related it to the theme of 'unvalued' stating:

Now a black patient became generally unwell and eventually died. Now, my question to the nurse was: 'how had this patient deteriorated so quickly? Did you observe the colour of his lips, hands? 'It was a white nurse and she turned to me and said, 'how can I tell because he's black anyway'? **Deborah, participant 5**

The participant related how racism not only affected black nurses, it also affected the black patients too in terms of the care they received. Although the trained white nurse was left in charge of the ward to look after the patients, her manner appeared to be one of unconcern for the rapid deterioration of the black patients' health. In an offhand manner, she suggested that there was no way of telling when a black patients' condition declined.

The following is an excerpt from my reflective journal:

The incident mentioned above is one that happened a long while ago but it is certainly a situation that would need to be brought to the attention of the clinical governance committee today whose remit is to maintain and improve the quality of patient care within the NHS.

(Excerpt taken from my reflective journal December 2019)

Staying with the theme of feeling unvalued, a participant had the following to say:

When there was say career development or what's the word I'm looking for, to excel yourself you know, and even though you have the qualifications and you do work well and your skills and everything is good, sometimes you're overlooked. **Martha, interviewee 11**

The participant conveyed how she was overlooked for promotion despite having a strong work ethic and the requisite skills. This was the experience of most of the participants who took part in this study as demonstrated by the data.

5.4 Summary and conclusions

This chapter firstly presented the results of the data collected via the participants through survey questionnaire. Themes were extracted from the survey questionnaires using thematic analysis to identify the emergent themes and the other data sources e.g. interview questions using IPA and reflective journal and related to the findings from each of the research methods used. This action was taken as the themes should be able to accurately reflect the “big picture” (Braun and Clarke, 2006) and in turn answer the research question. The data was organised into a framework which identified key elements of the respondents’ experiences (Ollerenshaw and Creswell, 2002).

Following coding of the data from the survey questionnaires, 2 themes and 6 subthemes were drawn out. The theme of **‘training’** with subthemes of ‘accessible’; ‘inaccessible’ and ‘improving training access’ were derived. The other theme was **‘employee relations’** with subthemes: ‘nurses valued’; ‘not valued’ and ‘inequalities’. The themes that evolved from the interviews were as follows: The first superordinate theme was **‘structures within NHS make it difficult to progress’** with 3 subthemes of ‘racism,’ **‘**powerlessness’ and ‘oppression’. The second superordinate theme was: **‘cultural competence and compassionate care lacking’** with 1 subtheme: ‘uncaring’. The third superordinate theme was **‘no outlet for staff’** and the subthemes were ‘hopelessness’ and ‘unvalued.’

This chapter presented excerpts from the survey questionnaires and interviews. The themes allowed the researcher to develop a conceptualised model of issues for consideration in developing an equality framework which was one of the objectives of this project. The emergent themes form the discussion and personal reflections of the next chapter.

Chapter 6: Discussion and personal reflections

6.1 Introduction

This chapter used the concept of critical race theory, first described in chapter 2, in discussing the main findings of this study in relation to the experiences of BME nurses when trying to access training and development activities within the NHS. The research question was:

> *What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?*

This chapter also linked the findings from the research with the findings from a review of the literature to illuminate the contribution made to the gap in knowledge as a result of undertaking this study. The implications for practice were also considered.

The next section examines the lived experience of BME nurses.

6.2 The lived experience of BME nurses

The researcher set out to explore the experiences of BME nurses when applying for training and professional development courses. This was to gauge what was currently happening in the clinical setting. Several themes and subthemes such as **racism, powerlessness** and **hopelessness** were extracted from the data which suggested that black nurses in particular, faced work environments that were not conducive to good health both mentally and physically as a result of the culture of the NHS organisations in which they worked. This account was also supported by recent findings of the report into the Covid-19 outbreak in 2020 which discovered that BME healthcare staff were overrepresented in the mortality figures (Ford, 2020). It was found that despite BME staff being at an increased risk of contracting Covid-19, in part attributed to the likelihood of them having co-morbidities e.g. diabetes, cardio-vascular disease as a result of the health and social inequalities (Marmot, 1991) they were losing their lives through working on the frontline caring for patients. BME nurses were being moved from their own wards to work on the Covid-19 wards in contrast to the white staff who were not experiencing the same treatment (Stephenson, 2020).

Institutionalised racism is subtle and affects BME people in those organisations where practical and political structures place them at a disadvantage to the white majority (Home office, 1999). Lais (2019) argues that the micro-aggressions suffered by black people in particular, did not emerge in a vacuum but bares a significant European legacy which established a power structure that for centuries characterised black people as medically or psychologically abnormal which continues today. According to

Lais (2019) it is this history that has anchored the national identity of black and minority ethnic people and shaped the western meta-narrative on race consciousness.

When black nurses came over to Britain during the Windrush era, they were viewed by the British government with hostility and were not welcome although it was the British government who travelled over to those countries to recruit the labour (The unwanted, BBC, 2020). With this apparent incongruence, it would have come as no surprise to Jaggi (2001) when the Windrush scandal came to public attention as he espoused that Britain naturally excludes black people from British society which Ackah (2020) and Olusoga (2015) assert is due to it being an institutionally racist country. Olusoga (BBC, 2019) concurs with Ackah's assertion as he argues that in the call for labour following the second world war, black people were never welcome in Britain, it was people from the white commonwealth countries e.g. Australia; New Zealand; Canada and white former war criminals from the German military regiment (BBC, 2019) that Britain wanted to help rebuild the country. However, it was black ex-servicemen and black women who came from the Caribbean to Britain – 'the motherland.'

Tackling race inequalities within the NHS has been a longstanding problem. Bhopal and Alibhai-Brown (2018) concur with John (2014) and Douglas (1995) in asserting that racism is structural and is woven into the very fabric of society and exists at all levels of society including higher educational institutions. According to Crenshaw (1988) racism is structured disadvantage where laws establish actual practices of exclusion and disadvantage. Despite the strategies put in place to combat the inequalities e.g. organisational policies, diversity training and so forth, the evidence from the literature and data suggests that there have been no significant changes. It has been espoused that policies only serve as a box ticking exercise and is the inevitable result of a top down imposition (Times Higher Education, Author anonymous, 2020). The former Equality Impact Assessment tool mentioned previously, used as part of policy making is cited as one example. It was criticised and said to be non-performative and served only to avoid any accusation of institutional racism (IRR, 2017b). Being non-performative and the failure to eliminate inequality, is one explanation for the insidious nature of this situation which has also been attributed to unconscious bias (IRR, 2017). Unconscious bias is defined as a process that we are unaware of and which happens outside of our control (Equality Challenge Unit (ECU), 2013). This bias has been described as occurring automatically and is activated by our brain making quick assessments and judgments of people and circumstances which is influenced by our background, cultural environment and personal experiences (ECU, 2013; Acas, 2019). Unconscious bias theory however is in direct contrast to Gillborns' (2008) theory as he asserts that race inequality is not accidental but rather, a deeply entrenched permanent feature of the system that is legitimised through national policies, schools and

academic selection. Put another way, Gillborn (2008) is expounding that a process cannot be unconscious as the very act of putting measures in place to disenfranchise individuals is a conscious act, it has been thought of. Additionally, Lais (2019) argues that although claims are made that education has inoculated society against colour bias, he contends that our centres of learning ironically promote marginality and alienation as alluded to by the research participants.

Hefferman (2014) asserts that the hierarchies in organisations make people at the bottom feel that their concerns will never be heard, which in turn make those at the top feel like they can get away with anything with impunity, like for instance, the policemen who proudly murdered George Floyd (Sabur et al., 2020). The black nurses reported that whenever they were wronged, no-one was held to account which left them feeling helpless and hopeless as there was never any recourse to address the racism they experienced. They expressed that they were reluctant to complain as the environment tended to become even more hostile leaving them disempowered, dehumanised and voiceless.

The means by which discriminatory practices are maintained within the NHS emerged from the data and is examined in the next section to determine how the learning can be applied.

6.3 How are discriminatory practices maintained?

The means by which discriminatory practices persist in the NHS became clear through the data. Whilst several contributory factors around discrimination emerged, racism was a prominent feature. The evidence suggests that racism persists because of the structures that are in place to maintain the status-quo. The literature demonstrated that racism is structural and underpins the operation of the NHS (John, 2014; Douglas, 1995) which implies that it operates along the same racist structures that is endemic in British society. In other words, those who hold a core belief that is very strong (racists in this case), despite being presented with evidence that works against that belief, will not accept it. The feeling that the evidence creates when brought to the fore is one of discomfort. This according to Owuor (2017) is attributed to white people expecting black people to carry the burden of proving that racism exists even though it is white people that mostly cause the discriminatory practices. Owuor (2017) asserts that even when it is proven that racism exists, black people face the resultant backlash and are subjected to excuses. One nurse who was interviewed for the study reported that when she was ‘racially’ abused by a peer and complained to management, all the staff on the ward in which she worked did not speak to her for several months. These behaviours are likely to exist to frustrate and maintain the status quo as the NMC (2019) argues that communication is key to the effective running of any organisation and is a

requirement of the revalidation process as explained later in this chapter. If managers refuse to communicate with their staff, it would most likely be difficult for progress to occur within the organisation. As cited in chapter 1, the CEO of the NMC exclaimed that the racism against BME staff in the NHS was a disgrace with the result of discrimination seeing these staff being subjected to lower pay and limited career progression. She also asserted that the discrimination needed to stop and called for employers and policy makers with the assistance of trade unions, to address the situation of systemic racism (RCN, 2019a).

Like institutional racism, systemic racism is described as racism that permeates or is present in all the institutions such as the political, economical, social and structures including social relationships within a society (Feagin, 2013). Systemic racism, a theory developed by a white sociologist - Joe Feagin, contends that society is racist in nature and favours the white majority which is manifested in institutions, practices, policies behaviours and ideas at the expense of other races (Feagin, 2013). Whilst systemic racism is a theory that was developed in response to the racist history of the US, this theory is employed to explain how racism functions all over the world (Owuor, 2017).

Nyatanga (2014) argues that POC's status and the history of racism has made it difficult for them to have a strong voice in influencing directions. Hirsch (2020) asserts that many British people are ignorant to the facts of racism and how it works but contends that when black people try to explain their experiences, it is denied. This situation is described as an educational apartheid in which explaining racism and providing an analysis of how it works, impacts negatively against those on the receiving end (Hirsch (2020). It tends to culminate in the favoured phrase of 'playing the race card' which is a means of silencing the voices of black people as opposed to any other form of racism (Abbey, 2019) so that they always end up the losers. To put it another way, by being accused of using the 'race card', black people are shamed or threatened into silence so that nothing changes when injustices are brought to the fore (Abbey, 2019).

DiAngelo (2018) argues that white fragility functions to protect racial inequality. This is reflected in the data which indicates that the victims become the victimised. An example of this is the account given by one of the participants who as a result of the bullying she was experiencing, reported it to management and the bullying worsened. Bullying is said to be tolerated by the NHS and passed down from the top (Moberly, 2017). As a result of the stress the nurse underwent, she had no choice other than to leave her job and her stress subsequently culminated in a heart attack. As evidenced by the outcome, in the absence of a forum like clinical supervision, the nurses need to

think of their own wellbeing otherwise there are health consequences due to the stress response (Selye, 2013) which is examined later in this chapter.

Diversity programmes which are implemented as a means to enable, empower and support BME staff (Coghill, 2014) are often opposed within organisations such as the educational and employment sectors as they are deemed to be racist in reverse (Owuor, 2017). An example of one such programme was the ‘Breaking Through’ programme as mentioned in chapter 1. The programme was designed to be transformational in its approach so that BME staff could realise their full potential. It was accused of being unfair as it ‘singled out BME staff for special treatment’ despite it being legitimate. The programme was a positive action initiative in which BME staff were being helped to be the best they could be (Coghill, 2014). Positive action contrasts with positive discrimination which is illegal in the UK as it is illegal to treat a person less favourably (Legislation.Gov, 2011).

In an effort to maintain the status quo of white domination, Gilley (2017) calls for a re-colonising of countries and proffers that colonialism has had a bad name for the last 100 years. He is of the belief that colonialism was both beneficial and legitimate in the countries where it was found and also contends that those countries who welcomed colonisation fared better in terms of development than those countries who were against it. DiAngelo (2018) addresses this sentiment as being the result of the failure to understand the powerful forces of socialisation in the individual’s life. She argues that this attitude is the result of possessing a simplistic understanding of racism which is consciously focused on conscious attitudes or actions that are intentionally offensive. It was these types of attitudes that the participants described being subjected to.

Bhopal and Alibhai-Brown (2018) assert that despite talk of a post-racial society, we live in a society in which white identities are privileged. A post-racial society refers to a society where success is not hampered based on one’s ‘race’ and ethnicity as barriers no longer exist (Mirza, 2010). There is suggestion however that the reality is a society where the status-quo is unchallenged and where the more things change, the more they remain the same (Bhopal and Alibhai-Brown, 2018). Beckford (2000) refers to this pernicious situation as ‘fixing’ and argues that it is an act of racism. With fixing comes the negative characteristics that are applied to black people in which they are ‘fixed’ to be inferior and are all labelled as ‘being the same,’ whatever that means.

If racism is being used as a means to prevent black nurses from reaching their full potential through a lack of training opportunities, this is likely to impact on the care that patients receive. The next section examines the impact of undeveloped nurses.

6.4 The impacts of undeveloped nurses on patient care

Engaging in revalidation to remain on the nurse register was not evident according to this projects' findings as the black nurses reported not being allowed to attend training courses. Signing up to the revalidation process is important as it is confirmation that nurses are engaging in a practice that incorporates the 6 'C's' which are: care; commitment; communication; compassion; competence and courage (NMC, 2019). Statistics in 2017 showed that 50% of nurses failed revalidation as they failed to meet the stipulated 35 hours CPD requirements over three years (RCN, 2018b). The failure was attributed to work pressures as a result of staff shortages (RCN, 2018b), a recurring theme that was found when analysing the data.

Under the Equality Act (2010) employers have a responsibility to ensure that those staff members who share a protected characteristic as defined in chapter 1, should not be impacted negatively by any training policy and practice, there should be no unlawful discrimination. Training should be offered to the individual based on their training needs and/or according to the needs of the organisation (EHRC, 2021). It is one of the directives of the long term plan which stipulates that staff should be provided with training to utilise their skills to better effect (Long term plan, 2019). Ultimately it is the patients who could suffer as the care they receive are likely to fall below the required standard if nurses are not trained to provide them with optimum care based on current research evidence.

The next section examines the leadership and followership within the NHS.

6.5 Leadership, followership and maintaining the status quo

The data gathered in this project suggests that there are system failures which impacts black nurses negatively and disproportionately. They begin their nursing careers with alacrity and a value system that believes nurses are caring and compassionate as reported by the participants. The reality appears to be different however as 'The "Problem" Woman of colour in the Workplace' image in Figure 6.1 below alludes to. It is a flowchart that depicts the lived experience as described by the interview participants.

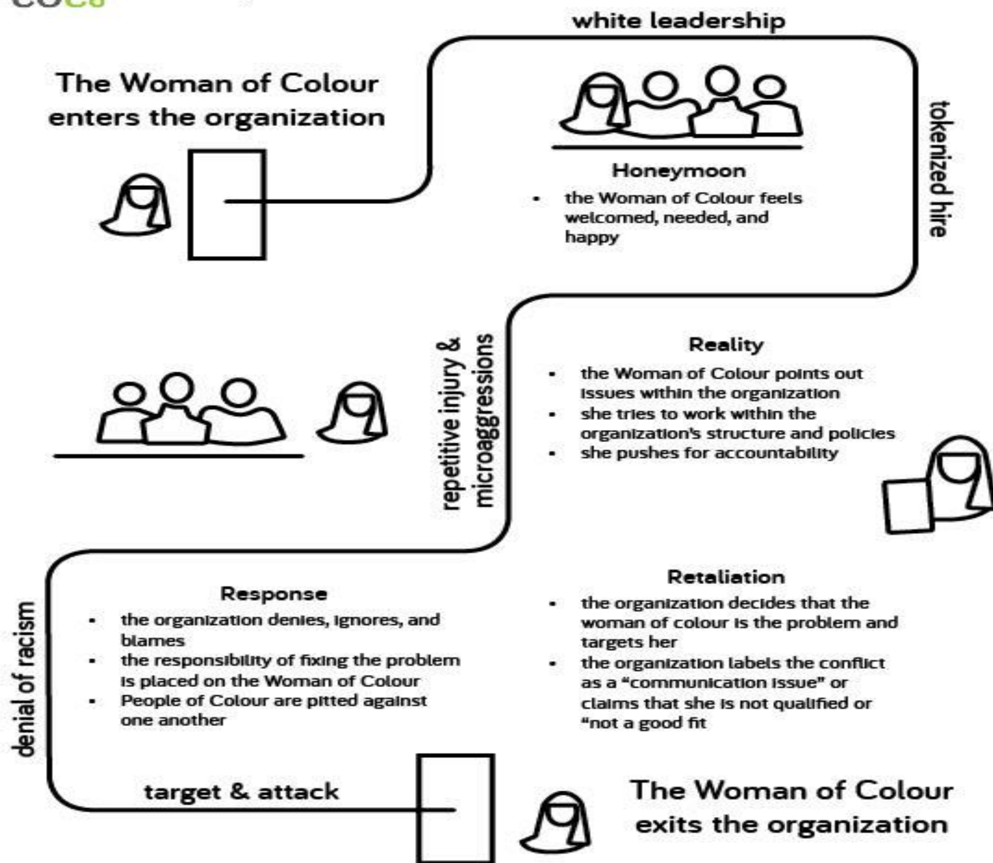


Figure 6.1 The "Problem" Woman of colour in the Workplace. Source: CoCo, 2018, p.4

The flowchart illustrates the system that perpetuates the self-devaluation, disempowerment and oppression when a person of colour speaks up. Looking at the evidence as a whole, suggests that there is a systems failure that begins at school and ends in the grave. Being taught as a black person that your history started as a slave does not serve to instil confidence but rather to disempower and 'keep you in your place.' This is the type of experience that the data attests to and which according to participant data, happens frequently in the NHS.

The findings demonstrate that the NHS is 'haemorrhaging' nurses which brings into question its sustainability and leadership succession strategies as there is indication that rather than the wellbeing of patients and staff being at the centre of the organisation, there is a craving for power as characterised by corporate psychopaths who tend to work their way into leadership positions (Boddy, 2011a). This implies that effective leadership and followership is lacking. Kelley (1992) asserts that effective followers are able to think critically in addition to being active and independent which

are the attributes of a good leader. The literature which argues in favour of collective leadership rather than the command and control structures, asserts that it provides the optimum basis for caring cultures (West et al., 2014). What appeared to be lacking according to participant data was a caring and compassionate culture in the NHS environment. This is important according to West (2013) who argues that:

> *Being compassionate should see problems being dealt with effectively and compassionately in the interests of patient care and staff wellbeing* (West, 2013, p.1).

In the absence of collective leadership, clinical supervision could function as a change agent as it is a forum that encourages openness and self-development. It is where staff can learn and change what they do (Megginson and Whittaker, 1996). For instance, they can learn from errors, near misses and incidents (West et al., 2014). Collective leadership alongside clinical supervision could enhance practice and assist in cases where complaints and errors would be seen as opportunities for system learning rather than as a means to blame staff.

6.6 What the findings mean in practice

The inability to access training and development programmes would suggest that this serves as a means of ensuring that progression in the NHS is stunted. BME nurses need to therefore challenge the systemic obstruction they face in the NHS. Not only is racial discrimination harmful to individuals, it is also harmful to the wider NHS as the quality of healthcare is reduced as evidenced by patient satisfaction indicator scores which are lower (Priest et al., 2015; West et al., 2011).

The literature review section of this study has shown the results of staff shortages and the impact it has in the workplace with staff missing breaks and some not even having time to stop to drink water. These situations affect the body negatively. The Yerkes-Dodson model has demonstrated the effect of the stress response on the body, a situation that the participants reported that they worked under daily. The stress response is one of the determinants of ill health (Marmot et al., 1991) with BME people at a higher risk of developing heart and circulatory disease e.g. high blood pressure (British Heart Foundation, 2020). Stress was cited as a contributory factor in the disproportionate numbers of BME nurses and doctors affected and or dying from the Covid-19 virus (Davis, 2020). This is evidence that there needs to be a change and soon.

The transformational leader could be the potential for change. The leadership model commissioned by the NHS Leadership Academy (Storey and Holti, 2013) for leadership development within the NHS could be utilised to good effect.

With the leadership model introduced by Storey and Holti (2013) the follower would be enabled to develop and hone their leadership qualities (Kelley, 1992). This was not the experience of the interview participants however as they reported not being allowed to think for themselves, being treated inhumane, degraded and expected to be subservient. Working in this type of environment has seen many nurses resign from their jobs. The 5-year plan to build a better NHS (NHS Confederation, 2019) is likely to fail if nurses continue to leave their posts as the plan needs manpower to make it work.

A proposed equality framework based on the findings of this study, has been suggested in the recommendations section of this project which may help to address the barriers faced by black nurses when attempting to progress their careers.

6.7 Limitations of research

Every study has limitations, research is not absolute (Yin, 2003) and this fact became evident during this project. The factors which had the potential impact on the quality of the findings are included below.

6.7.1 Interview process

Roulston (2011) argues that when interviewing participants, insight can be gained as to whether the research design is effective in yielding the data to inform the research questions. As the interviews for this project progressed, key issues emerged which indicated that a further question was needed that would have enhanced the reliability of the findings (Mays and Pope, 1995) and add further depth and richness to the interview questionnaire to protect against bias, which is a criticism of qualitative research (Ortlipp, 2008). Whilst being interviewed, the majority of the participants reported that racial discrimination was evident in their respective organisations and that they were discriminated against by white managers when it came to accessing training and development programmes. The question that emerged as being important for this research would have been to ask whether the participants were at any point in their nursing career, managed by a BME manager. If this were the case, the participants would then have been asked to give an account as to what this experience was like as during the interviews, two of them reported having BME managers who were brutal to them. Burrell (2010) suggests that the reason this occurs is because the brainwashed becomes part of the brainwashing team. Put another way, the abused becomes part of the abusers and the chief perpetrator of black people's own victimisation.

The researcher is cognisant that as an insider interviewer identifying with the participants, another limitation could be taking the information shared by the participants for granted and therefore failing to apply the level of probing an outsider might apply.

It must be acknowledged that the experiences the nurse participants cite is not a uniform experience in the community, the intersectionality of the situation needs to be addressed e.g. the difference in experiences between black male nurses and black female nurses. The omission from this research has been recognised as a limitation but it is beyond the scope of this study.

6.7.2 Interview participants

The interview participants were predominantly from the older age range (see chapter 5) therefore data on the experiences of the younger nurses were limited. This led the researcher to make several assumptions as to why this could be:

- The younger nurses may have been hesitant to take part in the study for fear that they may be identified and face reprisals. Historically, black people have been murdered for speaking about their injustices
- The nurses in the older age group could have felt that they have less to lose as they are close to retirement and therefore unafraid of any reprisals
- Young black people may be less likely to enter nursing as a profession after witnessing the results of the systematic abuse of relatives/friends who are nurses
- Since the introduction of the nurse training loan scheme in August 2017, there is probably a reluctance for young black recruits to enter nurse training especially as they face the prospect of having a huge bill at the end of training with poor prospects of progressing in their career
- White minoritized nurses (of Eastern European origin, Mctague, 2015) did not take part in the interviews which would have helped in gaining insight into their lived experience of working in the NHS
- The research is a small study and cannot be generalised

6.7.3 Barriers to professional development

Those participants who reported not being able to develop professionally through training, were never given a definitive reason as to why training and development requests were refused as managers invariably declined to provide feedback. In the absence of this data, the researcher made assumptions as to the reasons why black nursing staff were not progressing within NHS organisations. It was thought that it could possibly be due to:

- The effects of slavery where the far-reaching effects of colonisation have left the black nurses with a slave mentality preferring to remain at grass roots level, deferring to those in senior positions

- Attributed to helplessness due to being taught that they 'cannot do it for themselves' and are thus dependent which embraces the concept of 'learned helplessness' (Burrell, 2010).
- Another assumption was, the lack of progress could be due to human behaviour where individuals, in this case the nurses, are irresponsible or lack capability and therefore not qualified to progress into more senior roles.

However, data from the literature and the data collected from the survey questionnaires and interviews, provided evidence that black nurses face racial discrimination in the NHS and as a result are at a disadvantage when it comes to accessing training and development programmes despite possessing the requisite qualifications (see table 5.6, chapter 5). The common denominator when trying to access training and development programmes and facing barriers was that of colour whilst the reverse was true for white nurses.

6.7.4 Insider researcher

The insider researcher has been described as a person who shares the same characteristics as the researched, characteristics such as culture, ethnicity or gender (Mercer, 2007). This study was based on the observation of staff working within the NHS and therefore socially derived or developed in conjunction with other human beings (Goddard and Melville, 2004) where the researcher is a participant in the community of practice. Adler and Adler (1994) defines the insider researcher as a person belonging to the group that is under study. In contrast, an outsider researcher is described as a person who does not share the same characteristics as the insider researcher (Mercer, 2007) and would therefore find it difficult to engage with the study in terms of understanding what is being researched. This would result in difficulty in justifying the findings of the study (Merton, 1972).

6.7.4.1 Advantages of being an insider researcher

An insider researcher conducting research in an organisation or culture to which they belong, allows him/her to position themselves within the knowledge field (Hewlitt-Taylor, 2002). This helps in understanding the research and the phenomenon under study (Saidin and Yaacob, 2016) and enables the researcher to collect in-depth data (Hewlitt-Taylor, 2002). As an insider researcher having knowledge of the phenomenon under research, is beneficial as it means more value is placed on the research and it facilitates self-development (McClintock et al., 2003). Participating as a member of the group enables social interaction with the participants (Breen, 2007) and facilitates the extraction of true data as the researcher is able to relate well to the participants (Bonner and Tolhurst, 2002). Another advantage of being an insider researcher is that s/he is already familiar with organisational culture which saves time as the issue being

researched is already understood (Smyth and Holian, 2008). The positionality of the researcher (see personal experience section of chapter 1, section 1.5.1) was disclosed from the outset in order to recognise and limit the potential for unconscious bias.

6.7.4.2 Challenges of being an insider researcher

Being an insider researcher has its difficulties not least of which is the need to remain objective. This was especially true of this project as the focus of the research was a phenomenon that was personal to the researcher. In order to overcome this challenge, the rules of research ethics were followed (see ethics section 3.8 above) to ensure that the objectives were achieved without bias (Saidin and Yaacob, 2016).

Smyth and Holian (2008) argue that as data is easily accessible to the insider researcher, there is a risk of overlooking the confidentiality and sensitivity of information which may inadvertently lead to a breach. Saidin and Yaacob (2016) argue that another challenge the insider researcher may face is the failure to notice issues that they do not consider to be important unlike the outsider researcher who may be more sensitive and alert to the issues or information. There is also the potential for bias when interpreting the data due to the insider researcher sharing the same background as the participants, giving rise to the question as to the objectivity of the study (Hewlitt-Taylor, 2002). Merton (1972) refutes this argument however as he asserts that, just because people belong to the same group does not mean that they share the same opinions and likewise with the researcher and participants. The challenges of the researcher therefore, are not only based on whether s/he is an insider or outsider (Merton, 1972).

6.8 Future research

The limitations discussed in this research could be overcome in future research by:

- **Survey questionnaire –** Devising the questionnaire to include the omitted question which would ask whether the participants were at any point in their nursing career, managed by a BME manager
- **Sampling -** Using a purely snowballing method to collect data as opposed to the mainly purposive sampling technique that was employed in this project
- **Sample size** - Using a bigger sample of black nurses in other locations
- **Barriers to professional development -** Implement the suggested equality framework (see figure 7.1 below)

6.9 Reflexive account of personal learning and professional journey

6.9.1 Why undertake this project?

Drucker (2007) argues that when conducting research and formulating research questions or research problems, those which demonstrate a promising gap in the knowledge, are those problems or questions that does not feel safe but is the right way to go. The reality of racism is ugly, it is visceral and without logic. The result of failing to acknowledge racism is a failure to act on it (Bhopal and Alibhai-Brown, 2018). Therefore, in expressing the reason why it was important that I conducted this research as an insider researcher having personal experience of the researched phenomenon, Bravette (1997) sums up what I was feeling, thus:

> *"I had become tired of …the humiliating experiences of being devalued in comparison to white colleagues…spoken to …lied to… not accorded moral regard because of a perception of me as 'other'…" (Bravette, 1997: 34-5).*

6.9.2 Daring to speak

It became increasingly clear, especially from the data collected from the participants who took part in this study, that one of the reasons racism persists in the NHS is because black nurses are afraid to speak up having been silenced for so long, coupled with the fact that they do not want to be seen as disruptive. Speaking truth to power is seen as being incalcitrant and disruptive (Coffield, 1999). Their lived experiences have taught that to speak of the problem, is to become the problem (Ahmed, 2016). When they dare to speak, they face character assassination which is analogical to the so-called black activists who dare(d) to speak against the injustices in society and were/are eliminated through assassination (McCalla, 2011).

Looking back on my doctoral journey, researching the topic of racism was challenging and complex as there was the need for the project to be authentic but it was also important to make sure that it was written in a way that could be understood. Uncovering previously unknown information and bringing it to the fore is often seen to be controversial and disruptive. As a nurse educator, I chose my doctoral project as a platform to impart knowledge to others (Eastman and Maguire, 2016) knowledge that related to and is rooted in my professional practice (UKCGE, 2019). By telling my story which included my journey of self-development, my aim was to acquire insights for working with colleagues in my community of practice. The hope was that I would be able to work in a way that is transforming and liberating for black and 'minority' nurses. The assassinated black activist Dr Martin Luther King Jr, if alive, would disagree with remaining silent over injustices as he believed that:

> *The ultimate measure of a man is not where he stands in moments of comfort and convenience, but where he stands at times of challenge and controversy* (Martin Luther King Jr, 1963, p. 20).

King (1963) is asserting that a persons' true morality comes to the fore in times of deep struggle and challenge rather than in times of peace. Today, part of black people's and indeed black nurses' struggles, are still a fight for liberty. As John (2014) asserts:

> *"It behoves us all to address the many structural issues that impede the human liberation of Africans in the Diaspora and in the Motherland, acknowledging our strengths, overcoming our weaknesses, building alliances with other progressive forces in the struggle against all forms of oppression and not, nonchalantly, handing our power over to those who have historically disenfranchised us and who have an expectation that we will continue to acquiesce in our own subjugation" (Professor Gus John, 2014).*

6.9.2.1 The way forward

Having gone through this journey of discovery, my outlook on life has changed. I am aware that it would be unrealistic to expect that I am going to make an instant change in the workplace. In seeking organisational change, what has become clear to me is that change must begin with me as '*even small changes can have a positive impact, especially if the change involves an action that is repeated often* (NICE, 2007 p. 4). More than just pointing out the existing problem in embarking on this learning journey, I have committed myself to becoming part of the solution as leader, follower and practitioner.

6.10 Summary and conclusions

This chapter examined the lived experience of BME nurses working in the NHS and demonstrated how discriminatory practices were maintained. The main findings of the study were discussed in relation to the research question and literature and what the findings meant in practice. The impact that undeveloped nurses could have on patient care was also presented. The role of leadership and followership was considered and the research's limitations presented. A reflexive account of the researchers' learning journey was given which also demonstrated why it was important that this research was conducted.

The main findings of the research have been considered in providing recommendations to stakeholders and an equality framework has been proposed which may help to address the barriers faced by black nurses when attempting to access training and development activities in the NHS. The draft development of the framework for equality is presented in chapter 7.

Chapter 7: Conclusion and recommendations

7.1 Introduction

This chapter presents how the question and the objectives of the research were addressed and gives an overview of the research findings and the implications for policy and practice. The recommended strategies to address the issues that were found during this research are also presented. The contributions to the body of knowledge and the impact of the research are discussed including recommendations for further research. Finally, in addressing the research's principle aim, a framework is proposed to address the barriers faced by BME nurses.

The question for this research was:

> *What are the lived experiences of BME nurses when trying to access training and development activities through clinical supervision and leadership including the NHS's stance on cultural competence training for nurses?*

The following objectives helped to develop this research:

Objective 1: To examine the role of transformational leadership and followership in bringing about professional development opportunities for BME nurses
Objective 2: To explore whether nurses are trained to provide culturally competent and compassionate care
Objective 3: To explore whether opportunities for clinical supervision exists as a forum for personal and professional development for nurses
Objective 4: To examine the potential for an equality framework to guide individual black and minority ethnic nurses, NHS Trusts, Government and researchers

7.2 Achievement of research objectives

The research approach used to achieve the objectives designed to achieve the overall research aim is shown in table 7.1 below. The table outlines how the aim and objectives were addressed through the methods that were used to collect and analyse the data.

Table 7.1 Research objectives devised to achieve the overall research aim and linked to the research question.

Research aim: To develop an equality framework to guide individual BME nurses, NHS Trusts, Government and researchers		
Research Objectives	**Method of achievement**	**Related chapters in thesis**
Research objective 1 To examine the role of transformational leadership and followership in bringing about professional development opportunities for BME nurses	Interviews & reflective journal	Chapter 5
Research objective 2 To explore whether nurses are trained to provide culturally competent and compassionate care	Interviews & reflective journal	Chapter 5
Research objective 3 To explore whether opportunities for clinical supervision exist as a forum for personal and professional development for nurses	Synthesis of research findings	Chapter 2, 3, 4, 5, 6,
Research objective 4 To develop an equality framework to guide individual BME nurses, NHS Trusts, Government and researchers		Chapter 7

The findings from this research indicate that BME nurses still face discrimination when attempting to access training and development programmes with black nurses being more disadvantaged than other marginalised nurses. The evidence denotes that change within the NHS is needed if it is to survive. This situation points to the NHS needing a joined-up approach where individual nurses, NHS Trusts and government bodies work together to address the issues the findings raise. Improvement strategies such as the 5 year forward (see chapter 2) have been implemented but it may not achieve sustainability in the absence of behavioural change, change in organisational culture and effective staff management. These are needed in an organisation where financial savings need to be made with the increasing costs (NHS Confederation, 2014; West et al., 2011) especially if the costs for staffing are increasing through the use of agency nurses to fill the staffing shortfall.

This project set out to explore the lived experience of black nurses when attempting to access training and development activities within the NHS and the principle aim was to develop an equality framework to guide individual BME nurses, NHS Trusts, Government and researchers in response to concerns that black nurses in particular were at a disadvantage when trying to access training and development programmes within the existing NHS structure. The proposed equality framework with recommended actions, addresses the everyday discriminatory practices the nurse participants reported that they faced and the perceived NHS's inaction in addressing the situation.

Based on the findings, the evidence indicates that for their health and wellbeing, black nurses need to develop self-love. Papadopoulos and Pezzella (2015) concur with Burrell (2010) as they expound the virtue of self-love where you love yourself for who you are. Self-love is about respecting yourself and understanding who you are and loving your fellow human being (Papadopoulos and Pezzella 2015). *Self-pride is the catalyst for achievement and there is no greater truth than knowing yourself* (Addai-Sebo, 2017, p. 11). A good starting point for black nurses is to affirm their black identity through knowing their own history so that they become bi-culturally competent (see chapter 2) which means being competent in their own culture as well as the dominant culture in order that blockages on a personal as well as a professional level can be removed.

There is a need to develop 'race' based self-esteem to pull together as a unit to get the issues that they are faced with resolved (Burrell, 2010). For black nurses in particular, to develop and improve their self-identity, they need to build professional identities through periods of study which is a continuous process through their work life. The effects could then be measured by the discrimination scale which was launched by Harvard professor - David Williams, in 1997. The scale measures health outcomes and captures the way in which those people who are not valued in society, are treated with dignity and respect increasingly less, on a daily basis (Williams et al., 1997; Williams, 2006). The scale has demonstrated that there is a link between discrimination and an increased risk of a wide range of diseases such as mental health, heart disease, obesity, in addition to low birthweight infants and premature mortality (Gee, 2016).

Burrell (2010) a black man who is a marketing communications pioneer, argues that black people have learned to devalue themselves as a result of the oppressive structures that are in place to control them and has much to do with mental or ontological conceptualisation of slavery which starts from school (Azikiwe, 2013). This gives profound meaning to the following quote which states:

> *The man who is not able to develop and use his mind is bound to be the slave of the other man who uses his mind* (Lewis, 2009, p.75).

Black people are depicted as not having a past before they were enslaved which has an impact on the sense of 'self', a position which was sensed when collecting data from the research participants. With this in mind, the researcher looked back in history to determine the lived experiences of black people as Corfield (2008) asserts that studying the past is necessary for 'rooting' people in time because if people feel rootless, this is how they live. This state of rootlessness or having no settled place or position in society, causes damage to themselves in terms of self-esteem as well as others. People who grow up without a sense of placing whether it be within the family or the wider world, lack a sense of belonging, with others experiencing a great sense of oppression (Corfield, 2008). Wilson (2002) asserts:

> *"To re-discover one's history is not only an act of self-discovery, it is an act of self-creation, a resurrection from the dead, a tearing away of the veil, a revelation of the mystery"* (Wilson, 2002, p. 52).

The nurses need to be 'rooted' in time, able to build resilience and wellbeing and 'find their voices.' Whilst black nurses have been silenced for so long, thereby keeping people comfortable, this silence is 'killing' others. They need to reflect on what they do to themselves and focus on the internal locust of control before they can deal with other people (Burrell, 2010). Eliciting change is about undoing the conditions that have been done to them, they need to decolonise their minds. Based on the research evidence, these actions may help the nurses to feel empowered and more confident to take steps such as invoking the public sector equality duty (EHRC, 2021) in instances of discrimination, including tackling the barriers they face when attempting to access training and career progression. Based on the evidence, change will not be achieved if these nurses continue to do what they have always done. This is not to suggest that the onus is solely on them to elicit change, but rather, failure to act is likely to result in professional and personal stagnation.

In order to address the findings of this research, it is recommended that strategies are put in place such as NHS Trusts implementing stringent monitoring systems in relation to training that is outside the managerial remit of the specific clinical sector, whereby if discriminatory incidents concerned with professional development and training needs occur but are not addressed, they can be independently identified and those Trusts held to account. This would also include monitoring training access as per the public sector equality duty (EHRC, 2021) which stipulates that discrimination, harassment and victimisation is unlawful.

7.3 Research findings overview and implications for policy and practice

Table 7.2 below summarises the main findings of the key issues and challenges facing BME nurses and includes the recommended strategies. The issues are linked to the recommendations and shows the actors who are responsible for driving forward the changes. The content of the proposed framework in figure 7.1 which appears later in this chapter, is derived from the issues that were found whilst undertaking this project.

Table 7.2 Summary of main findings of the key issues.

Reference	Issue	Recommendations to stakeholders and	Responsibility
See chapter 2 (literature review) and chapter 5 (results)	BME nurses face discrimination when accessing training and development programmes	In addition to the training available in the organisation, BME nurses to have a stake in their own learning by: • Undertaking personal and professional online training • Shadow individuals in area of interest; reading appropriate material • When making training requests, link training requirements with that discussed with manager in appraisal • Training for revalidation as a nurse on the NMC register • To invoke the public sector equality duty (EHRC, 2021) in instances of discrimination including the barriers to training and progression. • Human resources/training department of the NHS needs to establish a system whereby not only mandatory courses are monitored, mandatory stringent monitoring systems need to be implemented that audits the personal and professional development of black nurses in	BME Nurses

		particular, with managers being held to account if they are not being developed	
See results section chapter 5	BME nurses feel disempowered	BME nurses need to restructure their way of thinking. All nurses to have a nurse mentor/coach of their choice	BME nurses
See literature review section on bi-cultural competence	BME nurses viewed with disdain and indifference	There is a need to change the narrative, the more confident the nurses, the better the quality of care given to patients	Individual BME Nurses NHS Trusts Government
See results section chapter 5	BME nurses subject to racist incidents	Transparency around annual monitoring needed. All racist incidents to be monitored and action plans implemented to address the issues with outcomes documented	NHS Trusts NHS England

		Lack of training and development on everyday racism to be addressed	Relevant Trade Unions and BME representatives
See results section chapter 5	Lack of strong leadership	A culture of collective leadership to be adopted resulting in distribution of power Need for succession management / training	Individual nurses Specific NHS Trusts Government Managers of Stepping Up - Programme Managers of Ready Now - Programme Bevan NHS Leadership - Programme
See results section chapter 5	Lack of awareness of what it means to be culturally competent and compassionate	Role specific training to be provided for all nurses/staff working within the NHS	Specific NHS Trusts
See results section chapter 5	Lack of clinical supervision as a forum for personal and professional development in the NHS	Clinical supervision to be implemented and made mandatory across all NHS organisations Reporting of staff wellbeing Review of annual monitoring on staff attitudes / survey Exit interviewing and annual reporting on general findings	Specific NHS Trusts Government NHS England

Table 7.2 above demonstrates the issues that were found through undertaking this study into BME nurses and their lived experience when attempting to access training and development programmes. Strategies that have been put in place to address discrimination have not proved successful thus far e.g. Equality and Diversity policies in NHS Trusts (NHS England, 2019b), the 'Breaking Through' programme which although instrumental in helping some BME staff to progress their careers, it failed to change the systems, attitudes and behaviour of the people in the NHS as the culture remained the same (Coghill, 2014).

Suggestions have been put forth as to how the nurses can help to circumvent the training barriers such as: undertaking online training, linking training with appraisal outcomes, shadowing nurses in their area(s) of interest and reading appropriate material in their area(s) of interest. It is recommended that clinical supervision is made available as a confidential forum where nurses can share practice and discuss issues of concern. Through sharing ideas, the forums should serve to facilitate personal and professional development. The participants also reported that there was a lack of cultural awareness within the NHS, therefore it is recommended that training in cultural competence to address this issue should be included in all NHS Trusts' training programmes to help with co-existence and social inclusion.

Practice monitoring to be implemented and action plans put in place where indicated. However, these suggestions will need buy-in from major actors e.g. NHS leaders, government, and nurses. In order to effect change, NHS leaders need to work collaboratively with staff to achieve the aims. The collective leadership model has been recommended (see chapter 2) where staff are enabled to use their individual skills and expertise for the good of the organisation.

Using the metaphor of disease for the racial discriminatory practices experienced by black staff in the NHS, rather than just treating the disease, the root cause cannot be ignored, it needs to be addressed. A public health approach is needed to get to the root cause and in doing so, this project has highlighted the apparent reasons as to why discriminatory practices persist in the NHS. The fact that advisory bodies, tasks forces and committees exist to combat racism in the NHS (West et al., 2015) indicates that there is a serious problem, not just on a local level but on a national level. Racial inequality is not receding as with it being so deeply entrenched in society,

discriminatory practices are maintained (Gillborn, 2008). Niro (2003) asserts that race has been employed for the justification of systematic oppression and states:

> *Race is also a monster because of the exacting tenacity with which it survives despite more than a few deliberate and sophisticated attempts to remove the concept from our ideological lexicon* (Niro, 2003, p.1).

The literature suggests that people are not born racist (see chapter 2), it is learned behaviour that is passed on through the generations thereby perpetuating the racist, oppressive structures.

Lais (2019) argues that unless Britain can reckon with their imperial past, many Britons will continue to labour under an historical amnesia and culture of liberal denial where the traumatic experiences of black people will continually be devalued. Lord Woolley, a black political and equalities activist, argues that there needs to be a transformation of the systems of inequality because it is only then that the narrative will change (Merrick, 2020). As the data alludes to, if black nurses are being oppressed where their culture and humanity is incessantly being placed on trial, logic would dictate that they cannot expect the oppressors to change things for them. Until such time as there is a systems change, they have to be the change they want to see. Black nurses cannot influence what people think of them but they have full control as to how they respond to them. Using the euphemism for the lynching of George Floyd, black nurses need 'to get those knees off their necks so that they can breathe (BBC, 2020b; Holmes, et al., 2020; Sabur et al., 2020).

The DOH (2000a) assert that there is a clear expectation for NHS Trusts to invest in the professional development of nurses as a quality improvement measure. Financial incentives are being offered to nurses and midwives in the form of personal training budgets in NHS settings in England e.g. hospitals, GP surgeries, community. The budget of £1000 per nurse, will be allocated over a period of 3 years (RCN, 2019c). This step has been taken in line with the NHS long term plan in the government's bid to secure a sustainable NHS. Supporting the nurses through their learning and development, will help them to develop new clinical skills, gain advance practice qualifications and advance their careers. It is hoped that this move will help in improving recruitment, staff retention and staff morale (RCN, 2019c) and that the training will help in the nurse's revalidation cycle and enhance the care patients receive

(HM Treasury, 2019). The funds for the personal training budget, will be managed centrally and independently of the control of individual clinical sector managers, utilising an individually targeted approach. Steps will be taken by the government through working with the NHS, professional trade unions and employers, to ensure that the funding reaches those staff on the frontline, priority areas and where there are skill shortages (HM Treasury, 2019).

What appears to be lacking in the NHS is accountability for poor practice. The human resources/training department of the NHS need to implement and oversee a system whereby not only mandatory courses are monitored but a mandatory, stringent monitoring system needs to be established that audits the personal and professional development of black nurses in particular. The department would also be accountable if staff were not being developed.

7.4 Contributions to the body of knowledge and impact of research

In this section, a conceptualised model of issues for consideration in developing an equality framework which is the researchers' contribution to the body of knowledge, is proposed to address the issues that were found through undertaking this project. With the current heavily debated topic of race and racism, it is envisaged that the impact of this project's findings will be far reaching for various reasons. It should prove useful to stakeholders as it has come at a time where the hard evidence through the research, speaks to the pandemic of racism. Importantly, the project also contributes to the black lives matter (BLM) movement which may be a force in moving the project forward. The BLM movement as mentioned previously, is an organisation that exists to fight injustices such as exploitation and violence that black people globally, face daily. This cause may help to strengthen the identified need for the provision of clinical supervision for black nurses needing a safe space to share concerns, especially following the trauma suffered by those who witnessed the murder of George Floyd. As a contractor and trained clinical supervisor, the researcher plans to forge links with NHS Trusts in order to establish clinical supervision sessions for black and other marginalised nurses.

Addressing the identified needs requires a multi-pronged approach with the intervention of different stakeholders as current efforts demonstrate that they are not

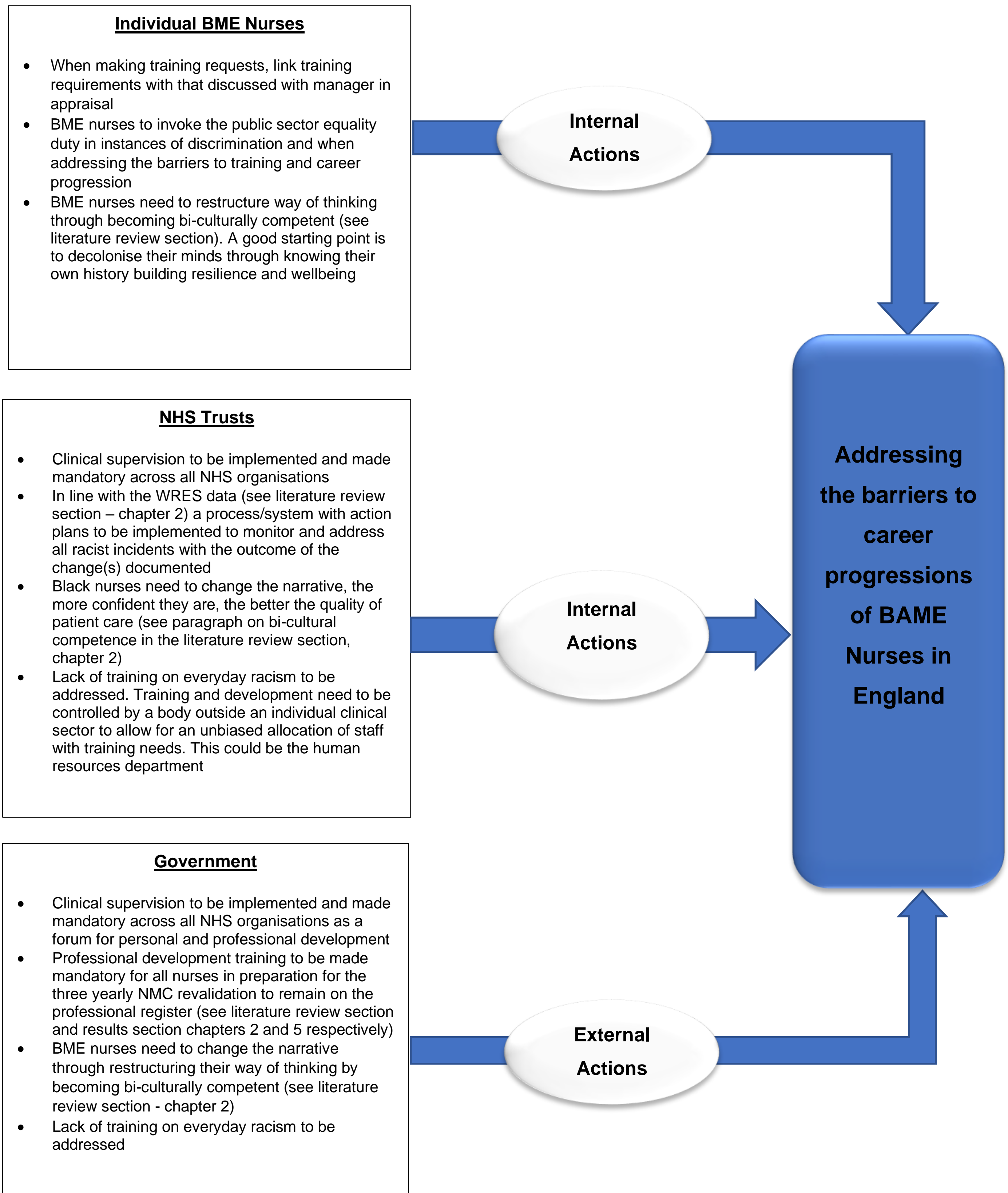
enough to bring about the needed change. The proposed ‘equality framework’ to address the issues found during this research (see figure 7.1 below), has not been tested but the content is intended to serve as a guide in its development and can be the focus for future study.

Through the dissemination of the project, its findings would be instrumental in informing policy and professional bodies like the NMC.

7.5 Recommendations for further research

A conceptual model of issues to be considered in the development of an equality framework to address the barriers faced by black nurses is proposed. The points in model 7.1 below have been derived from this research though the ‘framework’ has not been tested in any way.

Figure 7.1 proposed equality framework to help address the training barriers to career progressions of BME Nurses in England.



7.6 Plan for findings

The plan for the findings of this project is to undertake future research and further develop the equality framework and publicise in peer reviewed journals and /or books in collaboration with academic supervisors. The research could be disseminated in various ways e.g. digital dissemination where scholarly journals and books online have become increasingly popular (Ross-Hellauer et al., 2020). Other digital methods include platforms such as social media and the use of blogs. Other forms of research dissemination include conference presentations and presentations to stakeholders.

7.7 Summary and concluding comments

This chapter addressed the achievement of the research aim and objectives and gave an overview of the research findings and the implications for policy and practice. Recommendations based on the projects' findings were put forth and the contributions to the body of knowledge was presented. A conceptual model of issues to be considered in the development of a framework to address the barriers faced by black and minority ethnic nurses was also proposed. The plan for the dissemination of the project and further research was also presented.

It is hoped that this project has provided a means of bringing fresh understanding to the historical contexts black people have lived through and continue to live through and the resultant impact on their lived experience today. It is important to have contexts and a starting point as espoused by Corfield (2008). In doing so, the hope is that black nurses will build upon a secure foundation and through this process elicit change. It is this change that will help them to survive in the NHS environment.

References

Abbey, N. (2019). *Think Like a White Man*. Edinburgh: Canongate Books.

Abrams, L. S. (2010). 'Sampling 'hard to reach' populations in qualitative research. The case of incarcerated youth,' *Qualitative Social Work, 9*(4), pp.536-550.

Acas. (2019). *Acas | Making working life better for everyone in Britain* [Online]. Available at: https://www.acas.org.uk/ (Accessed: 4 March 2020).

Ackah, W. (2020). Time to Shut Up! Racism, Royalty and the Limitations of Britishness [Blog] *Birkbeck Comments*. Available at: http://blogs.bbk.ac.uk/bbkcomments/2020/01/21/time-to-shut-up-racism-royalty-and-the-limitations-of-britishness/ (Accessed: 8 February 2020).

Adair, J. (2002). *Effective Strategic Leadership*. London: MacMillan.

Addai-Sebo, A. (2017*). Black History 365* [Online]. Available at: https://www.blackhistorymonth.org.uk/article/section/interviews/akyaaba-addai-sebo/ (Accessed: 27 October 2018).

Adi, H. (2017). *The Young Historians Project in Britain: An Interview with Hakim Adi*.

Adler, P.A. and Adler, P. (1994). 'Observational techniques' in Denzin, N.K. and Lincoln, Y.S. (eds) *Handbook of qualitative research.* California: Sage, pp.377–392.

Adu, P. (2015). *Qualitative data analysis: When to utilize manual coding or software-aided coding such as nvivo* [Online]. Available at: https://www.slideshare.net/kontorphilip/qualitative-data-analysis-when-to-utilize-manual-coding-or-softwareaided-coding-such-as-nvivo-56347603 (Accessed: 8 December 2019).

Age UK (2018). *Ageism* [Online]. Available at: https://www.ageuk.org.uk/information-advice/work-learning/discrimination-rights/ageism/ (Accessed: 29 November 2019).

Agyemang, C., Bhopal, R. and Brujnzeels, M. (2005). *Journal of Epidemiology and Community Health;* 59: 1014 – 1018 doi: 10.1136/Tech. 2005.035964.

Ahmed, Y. (2016). 'Racist hate crime is so out of control that even white British people are being attacked,' *Independent,* 14 October [online]. Available at: http://www.independent.co.uk/voices/brexit-racism-hate-crime-figures-rise-white-british-being-attacked-a7360836.html (Accessed: 16th January 2018]

Aiden, H.S. and McCarthy, A. (2014). *Current attitudes towards disabled people.* London: Scope. [online]. Available at: https://research-information.bris.ac.uk/ws/portalfiles/portal/88783477/Aiden_and_McCarthy_2014.pdf (Accessed: 20 September 2018).

Albu, R. (2015). *Black history is bigger than slavery. We should teach kids accordingly* [Online]. Available at: https://www.theguardian.com/commentisfree/2015/jul/10/black-history-slavery-civil-rights-education#img-1 (Accessed: 4 August 2017).

Ali, A. and Ali, I. (1992). *The Black Celts: An Ancient African Civilization in Ireland and Britain.* Cardiff: Punite Publications.

Ali, S., Burns, C. and Grant, L. (2013). 'Scaling the NHS's diversity problems', *Health Service Journal* [Online]. Available at: https://www.hsj.co.uk/leadership/scaling-the-nhss-diversity-problems/5065264.article (Accessed: 10 October 2017).

Alimo-Metcalfe, B. (2003). 'Leadership stamp of greatness', *Health Service Journal,* 113(5861), pp.28-32.

Allen, A., McCartan, P. and McClymont, J. (2010). *Professional/Clinical Supervision Handbook for Allied Health Professionals 2010 High Challenge High Support* [Online]. Available at: http://www.careerframework.nes.scot.nhs.uk/media/50523/prof-clini-super-_ahps_2__nhsl_2010.pdf (Accessed: 14 May 2020).

Allen, R.L. (2001). 'The globalization of white supremacy: Toward a critical discourse on the racialization of the world', *Educational Theory*, 51(4), pp.467-485.

Allport, G. (1954). *The Nature of Prejudice.* 25th edn. Massachusetts: Addison-Wesley.

Aly, G. (2014). *Why the Germans? Why the Jews?* New York: Metropolitan Books.

Amnesty. (2016). *Amnesty International* [Online]. Available at: https://www.amnesty.org/en/what-we-do/discrimination/lgbt-rights/ (Accessed: 22 June 2020).

Andrews, K. (2015). ‘Racism is still alive and well, 50 years after the UK’s Race Relations Act’, *The Guardian,* 8 December [Online]. Available at: https://www.theguardian.com/commentisfree/2015/dec/08/50-anniversary-race-relations-act-uk-prejudice-racism (Accessed: 11 August 2019).

Andrews, K. (2017). ‘It’s a dangerous fiction that one exam will decolonise Oxford’s history degrees’, *The Guardian*, 30 May [Online]. Available at: https://www.theguardian.com/commentisfree/2017/may/30/oxford-decolonise-british-history-degrees-rhodes-must-fall (Accessed: 2 September 2017).

Anzaldúa, G. (1990). *Making Face, Making Soul / Haciendo Caras. Creative and critical perspectives by women of color.* California: Aunt Lute Book.

Apen-sadler, D. (2019). ‘NHS racial equality boss sacked for discrimination against white man,’ *Mail Online*, 30 March [Online]. Available at: https://www.dailymail.co.uk/news/article-6868361/Brighton-NHS-racial-equality-boss-sacked-discrimination-against-white-coworker.html (Accessed: 25 July 2020).

Archibong, U. and Darr, A. (2010). *The involvement of black and minority ethnic staff in NHS disciplinary proceedings.* Bradford: University of Bradford.

Atewologun, D. and Singh, V. (2010). ‘Challenging ethnic and gender identities,’ *Equality, Diversity and Inclusion: An International Journal*, 29(4) [Online]. Available at: https://www.deepdyve.com/lp/emerald-publishing/challenging-ethnic-and-gender-identities-an-exploration-of-uk-black-INWbxiS0fi (Accessed: 21 August 2019).

Azikiwe, N. (2013). *Emancipated from Mental Slavery: Selected Sayings of Marcus Garvey*. 1st edn. California: CreateSpace.

Babiak, P. and Hare, R. (2006). *Snakes in Suits: When Psychopaths Go to Work.* New York: Harper Collins.

Bacharach, S.B. (1989). ‘Organizational Theories: Some Criteria for Evaluation,’ *Academy of Management Review,* 14(4), pp.496-515.

Bambra, C., Fox, D. and Scott-Samuel, A. (2005). ‘Towards a politics of health’. *Health Promotion International,* 20(2), pp.187–193.

Bankert, E.A. and Amdur, R.J. (2006). *Institutional Review Board: Management and Function.* 2nd edn. Massachusetts: Jones and Bartlett.

Baska, M. (2019). 'Racial equality boss sacked for discrimination against white colleague', *People Management,* 2 April [Online]. Available at: https://www.peoplemanagement.co.uk/news/articles/racial-equality-boss-sacked-discrimination-against-white-colleague (Accessed: 28 July 2020).

Bass, B. (1985). *Leadership and performance beyond expectation.* New York: Free Press.

BBC. (1999a). 'Lawrence: Key recommendations'*, BBC News,* 24 March [Online]. Available at: http://news.bbc.co.uk/1/hi/uk/285537.stm (Accessed: 24 March 2020).

BBC. (1999b). 'Profile: Sir William Macpherson', *BBC News*, 24 February [Online]. Available at: http://news.bbc.co.uk/1/hi/special_report/1999/02/99/stephen_lawrence/281332.stm (Accessed: 24 Mach 2020).

BBC. (2006). 'Lawrence detective denies claim'. *BBC News*, 31 July [Online]. Available at: http://news.bbc.co.uk/1/hi/uk/5232372.stm. (Accessed: 2 July 2017).

BBC. (2012). 'Stephen Lawrence murder: Gary Dobson and David Norris guilty', *BBC News*, 3 January [Online]. Available at: https://www.bbc.co.uk/news/uk-16347953 (Accessed: 24 March 2020).

BBC. (2018a). 'Amber Rudd resigns as home secretary', *BBC News,* 30 April [Online]. Available at: https://www.bbc.co.uk/news/uk-politics-43944988 (Accessed: 24 March 2020).

BBC. (2018b). 'Windrush scandal: Facing the threat of deportation', *BBC News*, 22 April [Online]. Available at: https://www.bbc.co.uk/news/av/uk-politics-43858865/windrush-scandal-facing-the-threat-of-deportation (Accessed: 11 June 2020).

BBC. (2019). 'Why are black mothers at more risk of dying?', *BBC News*, 12 April 2019 [Online]. Available at: https://www.bbc.co.uk/news/uk-england-47115305 (Accessed: 5 April 2021).

BBC. (2020a). ‘Theatre drops use of “outdated” term BAME’, *BBC News*, 17 July [Online]. Available at: https://www.bbc.co.uk/news/uk-england-coventry-warwickshire-53446837 (Accessed: 20 July 2020).

BBC. (2020b). ‘This is why we are protesting’, *BBC News,* 1 June [Online]. Available at: https://www.bbc.co.uk/news/av/world-us-canada-52883494/george-floyd-death-this-is-why-we-are-protesting (Accessed: 5 June 2020).

BBC Bitesize. (2020). *Prejudice and discrimination*. Available at: https://www.bbc.co.uk/bitesize/guides/zcb42hv/revision/2 (Accessed: 15 January 2020).

Beckford, R. (2000). *Towards Post-Colonial, Post-Modern, Black Churches in Britain* [Online]. Available at: www.pctii.org/wcc/beckford95.html (Accessed: 1 April 2020).

Beiske, B. (2007). *Research methods. Uses and limitations of questionnaires, interviews, and case studies.* Munich: GRIN Verlag.

Bell, B. and Mahmood, S. (2016). ‘What did the “strikers in saris” achieve?’ *BBC News*, 10 September [Online]. Available at: https://www.bbc.co.uk/news/uk-england-london-37244466 (Accessed: 26 March 2020).

Bell, D. (1990). *Husserl*. Abingdon: Routledge.

Bell, K. (2013). ‘prejudice’, *Open Education Sociology Dictionary* [Online]. Available at: https://sociologydictionary.org/prejudice/ (Accessed: 19 July 2019).

Benner, P. (1982). ‘From novice to expert’, *American Journal of Nursing*, 82(3), pp.402-407.

Bennett, R. (2018). ‘White pupils ‘tied up black boy for mock slave sale’, *The Times,* 14 March [Online]. Available at: https://www.thetimes.co.uk/article/white-pupils-at-bath-school-tied-up-black-boy-for-mock-slave-sale-drhdlzm2x (Accessed: 11 June 2020).

Best, J. and Kahn, J. (2005). *Research in Education.* 10th edn. London: Pearson

Bhopal, K. and Alibhai-Brown, Y. (2018). *White privilege: the myth of a post-racial society*. Bristol: Policy Press.

Biggerstaff, D.L. and Thompson, A.R. (2008). 'Interpretative phenomenological analysis (IPA): A qualitative methodology of choice in healthcare research', *Qualitative Research in Psychology,* 5, pp.214-224.

Black Lives Matter. (2019). 'About', *Black Lives Matter* [Online]. Available at: https://blacklivesmatter.com/about/ (Accessed: 26 July 2020).

Blaikie, N. (2010). *Designing Social Research*. 2nd edn. Cambridge: Polity Press.

Boddy, C. (2011a). *Corporate Psychopaths: Organizational Destroyers.* London: Palgrave.

Boddy, C. (2011b). 'The Corporate Psychopaths Theory of the Global Financial Crisis', *Journal of Business Ethic,* 102(2)*,* pp.255-259.

Bolton, G. (2010). *Reflective practice, writing and professional development.* 3rd edn. California: Sage Publishing.

Bonner, A. and Tolhurst, G. (2002). 'Insider/outsider perspectives of participant observation', *Nurse Researcher, 9(4), pp.7-19.*

Boseley, S., Devlin, H. and Belam, M. (2020). 'What is Covid-19?' *The Guardian*, 27 February [Online]. Available at: https://www.theguardian.com/world/2020/feb/27/what-is-covid-19. (Accessed: 10 May 2020).

Bourdieu, P. and Passeron, J. (1990). *Reproduction in Education, Society and Culture*. 2nd edn. California: Sage.

Boynton, P. M., and Greenhalgh, T. (2004). 'Selecting, designing, and developing your questionnaire', *British Medical Journal*, 328(7451), pp.1312-1315.

Braithwaite, D., Emery, J., de Lusignan, S. and Sutton, S. (2003). Using the Internet to conduct surveys of health professionals: a valid alternative? *Family Practice*, 20(5), pp.545–551.

Braun, V. and Clarke, V. (2006). 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp.77–101.

Bravette, G. (1997). *Transforming lives: Towards bicultural competence: researching for personal and professional transformation.* PhD dissertation. Bath: University of Bath.

Breen, L.J. (2007). ‘The researcher ‘in the middle’: Negotiating the insider/outsider dichotomy’, *The Australian Community Psychologist*, 19(1), pp.163-174.

Bresee, L.C. (2014). ‘An introduction to developing surveys for pharmacy practice research’, *The Canadian Journal of Hospital Pharmacy*, 67(4), p.286.

Brighton and Sussex University Hospitals NHS Trust. (2019). *Home* [Online]. Available at: https://www.bsuh.nhs.uk/ (Accessed: 28 July 2020).

British Heart Foundation (2020). *Ethnicity* [Online]. Available at: https://www.bhf.org.uk/informationsupport/risk-factors/ethnicity. (Accessed: 5 June 2020).

British Medical Association. (2015). *Sustainability and transformation partnerships* [Online]. Available at: https://www.bma.org.uk/collective-voice/policy-and-research/nhs-structure-and-delivery/nhs-structures-and-integration/sustainability-and-transformation-plans. (Accessed: 4 December 2018).

Broomfield, M. (2017). *How Theresa May’s “hostile environment” created an underworld* [Online]. Available at: https://www.newstatesman.com/2017/12/how-theresa-may-s-hostile-environment-created-underworld (Accessed: 1 May 2018).

Brown, R. (1995). *Prejudice: Its Social Psychology*. Oxford: Blackwell Publishers Ltd

Bryman, A. (2012). *Social research methods*. 5th edn. Oxford: Oxford University Press.

Bryman, A. (2015). *Social Research Methods*. 5th edn. Oxford: Oxford University Press.

Bryman, A. and Bell, E. (2007). *Business research strategies.* Oxford: Oxford University Press.

Buncombe, A. (1998). ‘Condon’s apology is not enough, say Lawrences’. *Independent* 2 October [online]. Available at: https://www.independent.co.uk/news/condons-apology-is-not-enough-say-lawrences-1175564.html (Accessed: 24 Mar. 2020).

Burns, J.M. (1978). *Leadership*. New York: Harper and Row.

Burns, K.E., Duffett, M., Kho, M.E., Meade, M.O., Adhikari, N.K.J., Sinuff, T. and Cook, D.J. (2008). ‘A guide for the design and conduct of self-administered surveys of

clinicians', *Canadian Medical Association Journal,* 179(3) [Online]. Available at doi:10.1503/cmaj.080372 (Accessed: 10 January 2016).

Burns, W. E. (2001). *The scientific revolution: an encyclopedia* California: ABC-CLIO.

Burrell, T. (2010). *Brainwashed: Challenging the Myth of Black Inferiority*. 1st edn. California: Smiley Books.

Busby, E. (2018). White pupils 'tied up and whipped black student for mock slave auction', *Independent,*14 March [Online]. Available at: http://www.independent.co.uk/news/education/education-news/mock-slave-auction-black-student-white-pupils-bath-school-whipped-tied-up-a8255206.html (Accessed: 14 March 2018).

Bush, T. (2005). *Overcoming the barriers to effective clinical supervision* [Online]. Available at: http://www.nursingtimes.net/nursing-practice/clinical-zones/management/overcoming-the-barriers-to-effective-clinical-supervision/204072.article (Accessed: 6 March 2014).

BusinessDictionary.com. (2020). *What is problem? Definition and meaning* [Online]. Available at: http://www.businessdictionary.com/definition/product.html 4 (Accessed: 28 June 2015).

Business in the Community. (2015). *Race*. [Online]. Available at: https://www.bitc.org.uk/race/ (Accessed: 25 March 2020).

Butler, R.N. (1969). 'Age-ism: Another form of bigotry,' *The Gerontologist,* 9(4 part 1) [Online]. Available at: https://academic.oup.com/gerontologist/article-abstract/9/4_Part_1/243/569551 (Accessed: 2 June 2019).

Butterworth, A. and Faugier, J. (eds) (1992). *Clinical supervision and mentorship in nursing.* London: Chapman and Hall.

Butterworth, T., Carson, J. and White, E. (1997). *It is good to talk: An evaluation of clinical supervision and mentorship in England and Scotland*. Manchester: University of Manchester.

Byrne, L., Happell, B., Welch, A. and Moxham, L. (2013). 'Reflecting on holistic nursing: the contribution of an academic with lived experience of mental health service use', *Issues in Mental Health Nursing*, 34(4), pp.265-272.

Calkin, S. (2013). *Cameron calls on new nurses to be care makers* [Online]. Available at: www.nursingtimes.net/nursing.../cameroncalls...care.../5053268.article (Accessed: 16 June 2015).

Care Quality Commission. (2013). *Supporting Information and Guidance: Supporting Effective Clinical Supervision*. London: Care Quality Commission.

Care Quality Commission. (2016). *CQC recommends that Brighton and Sussex University Hospitals NHS Trust is placed into special measures* [Online]. Available at: https://www.cqc.org.uk/news/releases/cqc-recommends-brighton-sussex-university-hospitals-nhs-trust-placed-special-measures (Accessed: 27 July 2020).

Care Quality Commission. (2018/19). *Well-led | Care Quality Commission*. [Online]. Available at: https://www.cqc.org.uk/keywords/well-led-0 (Accessed: 18th August Mar. 2019).

Carnaghan, I. (2013). *Philosophical Assumptions for Qualitative Research* [Online]. Available at: https://www.carnaghan.com/2013/03/philosophical-assumptions-for-qualitative-research/ (Accessed: 19 November 2019).

Carter, B. (2002). *Realism and Racism: Concepts of Race in Sociological Research*. Abingdon: Routledge.

Castle, B., Wendel, M., Kerr, J., Brooms, D. and Rollins, A. (2019). 'Public Health's Approach to Systemic Racism: A Systematic Literature Review', *Racial and Ethnic Health Disparities*, 6(1), pp.27-36.

Chang, H. (2008). *Authoethnography as method*. California: Left Coast Press.

Channel 4. (2013). 'Baroness Lawrence couldn't believe smear claims', *Channel 4 News,* 1 August [Online]. Available at: https://www.channel4.com/news/baroness-lawrence-couldnt-believe-smear-claims-video (Accessed: 11 November 2018).

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* California: Sage.

Chater, K. (2010). *Untold Histories: Black People in England and Wales During the Period off the British Slave Trade, c. 1660-1807.* Manchester: Manchester University Press.

Chiavaroli, N. and Trumble, S. (2018). 'When I say … phronesis', *Medical Education*, 52(10), pp.1005–1007.

Citizens Advice. (2021). *Discrimination because of religion or belief* [Online]. Available at: https://www.citizensadvice.org.uk law-and-courts/discrimination/discrimination-because-of-race-religion-or-belief/discrimination-because-of-religion-or-belief/ (Accessed: 30 May 2021).

Clarke, V. and Braun, V. (2013). 'Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning', *The Psychologist*, 26(2), pp.120-123.

Clifton, E. (2002). 'Implementing clinical supervision', *Nursing Times*, 98(9), p.36.

Clothier, C., Macdonald, C.A. and Shaw, D.A. (1995). *The clothier report – The Allitt inquiry*. London: HMSO.

Cochrane, K. (2013). '1963: the beginning of the feminist movement', *The Guardian,* 7 May [Online]. Available at: https://www.theguardian.com/lifeandstyle/2013/may/07/1963-beginning-feminist-movement (Accessed: 26 August 2019).

COCo. (2018). *The "problem" woman of colour in nonprofit organizations*. [Online]. Available at: https://coco-net.org/problem-woman-colour-nonprofit-organizations/#How_to_Use_the_Tool_in_Your_Nonprofit_Organization (Accessed: 6 June 2020).

Coffield, F. ed. (1999). *Speaking truth to power. Research and policy on lifelong learning.* Bristol*:* Policy press.

Coghill, Y. (2014). Ready Now: positive action to realise the potential of senior BME leaders [Blog] *NHS Leadership Academy.* Available at: http://www.leadershipacademy.nhs.uk/blog/ready-now-positive-action-to-realise-the-potential-of-senior-bme-leaders/ (Accessed: 3 November 2019).

Cohen, A. and Daniels, V. (2001). 'Review of literature: Response to Empirical and Hermeneutic Approaches to Phenomenological Research in Psychology, A Comparison', *Gestalt,* 5(2). [Online]. Available at: http://www.g-gej.org/52/reviewlit.html. (Accessed: 2 September 2017).

Cole, E.R. and Harper, S.R. (2017). 'Race and rhetoric: An analysis of college presidents' statements on campus racial incidents', *Journal of Diversity in Higher Education*, 10(4), pp.318–333.

Cole, M. (2007). *Marxism and Educational Theory: Origins and Issues*. Abingdon-on-Thames: Taylor and Francis.

Collingridge, S. (2014). *Validating a Questionnaire.* California: Sage Publishing.

Consedine, M. (2004). *Clinical supervision – value and possibilitie.* [Online]. Available at: http://www.tidal-model.com/clinical_supervision.htm (Accessed: 25 February 2014).

Cook, J.V., Dickinson, H.O. and Eccles, M.P. (2009). 'Response rates in postal surveys of healthcare professionals between 1996 and 2005: An observational study', *BMC Health Services Research*, 9 [Online]. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2758861/ (Accessed: 27 March 2019).

Cook, S., McCaulay, S. and Coldicott, H. (2004). *Change Management Excellence: Using the Four Intelligences for Successful Organizational Change.* London: Kogan Page.

Cooper, C. (2014). 'NHS hospitals flatlining: Staff morale falls to new low after Coalition "bashing"', *The Independent,* 21 January [Online]. Available at: https://www.independent.co.uk/life-style/health-and-families/health-news/nhs-hospitals-flatlining-staff-morale-falls-to-new-low-after-coalition-bashing-9075793.html (Accessed: 9 August 2017).

Cooper, P.A. (1993). 'Paradigm Shifts in Designed Instruction: From Behaviorism to Cognitivism to Constructivism', *Educational technology*, 33(5), pp.12-19.

Corfield, J. (2008). *Why History matters - Articles - Making History* [Online]. Available at: https://archives.history.ac.uk/makinghistory/resources/articles/whyhistorymatters.html (Accessed: 30 July 2018).

Costley, C., Elliott, G. and Gibbs, P. (2010). *Doing work based research: approaches to enquiry for insider-researchers*. London: Sage Publishing.

Cottrell, D. (1999). 'Supervision', *Adv Psych*, 5(83), p.88.

Cottrell, S. and Smith, G. (2000). *The development of models of nursing supervision in the UK* [Online]. Available at: www.clinicalsupervision.com/ conference%20address.htm (Accessed: 5 February 2021).

CPD. (2014). *The importance of continuing professional development* [Online]. Available at: https://continuingprofessionaldevelopment.org/why-is-cpd-important/ (Accessed: 17 March 2021).

CPD Explained (2021). Available at: CPD Explained | What Is Continuing Professional Development (CPD) | The CPD Certification Service (cpduk.co.uk) (Accessed: 17 January 2021).

Cox, R., Plagens, G. and Sylla, K. (2010). *The International Journal of Interdisciplinary Social Sciences*, 5(8) [Online]. Available at: http://doi.org/10.18848/1833-1882/CGP (Accessed: 21 November 2016).

Crabtree, B. and Miller, W. (1992). *Doing qualitative research: Research methods for primary care.* California: Sage Publishing.

Cregan, E. (2010). *Independence and Equality (World Black History).* Oxford: Raintree.

Crenshaw, K., Gotanda, N., Peller, G. and Thomas, K. (1996). *Critical Race Theory: The Key Writings that Formed the Movement.* New York: The New Press.

Crenshaw, K. (1988). 'Race, Reform, and Retrenchment: Transformation and Legitimation in Antidiscrimination Law', *Harvard Law Review,* vol. 101, p.1331.

Creswell, J. W. (2003). *Research design: qualitative, quantitative, and mixed methods approach.* California: Sage Publishing.

Creswell, J.W. (2009). *Research Design Qualitative, Quantitative and Mixed Methods Approaches.* California: Sage Publishing.

Creswell, J.W. and Plano Clark, V.L. (2011). *Designing and Conducting Mixed Methods Research.* 2nd edn. California: Sage Publishing.

Cross, T., Bazron, B., Dennis, K. and Isaacs, M. (1989). *Towards a culturally competent system of care, volume I.* Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center

Crotty, M.J. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process.* California: Sage Publishing.

Cxpartners. (2015). *Improve your research technique - Reflexive thinking, 5 practical tips* [Online]. Available at: https://www.cxpartners.co.uk/our-thinking/improve-your-research-technique-reflexive-thinking-5-practical-tips/ (Accessed: 20 March 2019).

Davis, N. (2020). 'Who is most at risk of contracting coronavirus?' *The Guardian*, 21 February [Online]. Available at: https://www.theguardian.com/world/2020/feb/21/who-is-most-at-risk-of-contracting-coronavirus (Accessed: 8 May 2020).

Davis, R. (2003). *Christian Slaves, Muslim Masters: White Slavery in the Mediterranean, the Barbary Coast, and Italy, 1500-1800*. London: Palgrave Macmillan.

Davis, R. (2020). *The Distinction Between Leadership and Supervision* [Online]. Available at: https://richtopia.com/effective-leadership (Accessed: 19 January 2021).

Dearden, L. (2018). 'Theresa May ignored Home Office warnings about potential discrimination from "hostile environment" policies', *Independent*, 19 April [Online]. Available at: https://www.independent.co.uk/news/uk/home-news/theresa-may-ignored-home-office-warnings-migrant-policies-hostile-environment-windrush-immigrant-a8312996.html (Accessed: 20 April 2018).

Delgado Bernal, D. (1998) 'Using a Chicana feminist epistemology in educational research', *Harvard Educational Review*, 68(4), pp.555–582.

Delgado, R. and Stefancic, J. (2001). *Critical Race Theory: An Introduction*. New York University Press.

Delgado Bernal, D. (2002). 'Critical race theory, Latino critical theory and critical raced-gendered epistemologies: recognizing Students of Color as holders and creators of knowledge', *Qualitative Inquiry*, 8(1), pp.105–126.

Deloitte. (2018). *Women in STEM: how can businesses tackle the gender pay gap?* [Online]. Available at: https://www2.deloitte.com/uk/en/pages/growth/articles/technology-career-pathways-gender-pay-gap.htm (Accessed: 4 March 2018).

Demie, F. and Mclean, C. (2017). *Black Caribbean underachievement in schools in England.* London: Schools' Research and Statistics Unit.

Denscombe, M. (2012). *Research Proposals: A Practical Guide*. London: Open University Press.

Denzin, N.K. (1986). 'Postmodern Social Theory', *Sociological Theory*, 4(2), p.194.

Denzin, N. and Lincoln, Y. (2005). 'Introduction: The discipline and practice of qualitative research' in Denzin, N.K. and Lincoln, Y.S. (eds.) *The SAGE handbook of qualitative research.* 3rd edn. California: Sage Publishing, pp.1-32.

Denzin, N. and Lincoln, Y. (2011). *The Discipline and Practice of Qualitative Research.* London: Sage.

Department of Health. (1993). *A Vision for the Future: Report of the Chief Nursing Officer.* London: NHS Management Executive: Stationery Office, London.

Department of Health. (2000a). *Improving working lives standard*. London: The Stationery Office.

Department of Health. (2000b). *Making a difference. Clinical supervision in primary care* [Online] Available at: www.dh.gov/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4061520.pdf (Accessed: 20 February 2015).

Department of Health. (2001). *Working Together – Learning Together*. London, The Stationary Office

Department of Health. (2003). *The NHS Knowledge and Skills Framework (NHS KSF) and Development Guidance – Working Draft*. Department of Health Publications.

Department of Health. (2004). *Knowledge and skills framework*. London: HMSO.

Department of Health. (2009). *Religion or belief: A practical guide for the NHS* London: HMSO.

Dewey, R. (2007- 2017). *Frontiers of Psychology* [Online]. Available at: http://www.psywww.com/intropsych/ch14-frontiers/index.html (Accessed: 26 January 2018).

DiAngelo, R. (2011). ‘White Fragility’, *International Journal of Critical Pedagogy*, 3(3), pp.54-70.

DiAngelo, R. (2018). *Why It’s So Hard for White People to Talk About Racism*. Massachusetts: Beacon Press.

Dodd, V. (2018). ‘Stephen Lawrence murder: police say they have run out of leads’, *The Guardian*. 11 April [Online]. Available at: https://www.theguardian.com/uk-news/2018/apr/11/stephen-lawrence-murder-police-say-they-have-run-out-of-leads (Accessed: 11 November 2018).

Doharty, N. (2018). ‘“I FELT DEAD”: Applying a racial micro-aggressions framework to black students’ experiences of Black History Month and Black History’, *Race Ethnicity and Education,* 22(1) [Online]. Available at: DOI: 10.1080/13613324.2017.1417253. (Accessed: 7 April 2019).

Douglas, F. (1995). *The Color Line*. Virginia: University of Virginia.

Dovidio, J. and Gaertner, S. (2010). ‘Intergroup bias’ in Fiske, S.T., Gilbert, D.T. and Lindzey, G. (eds) *The Handbook of Social Psychology.* 5th edn. New York: Wiley.

Driscoll, J. (2007). *Practising clinical supervision: A reflective approach or healthcare professionals.* 2nd edn. Edinburgh: Bailliere Tindall Elsevier.

Drucker, S.J. (2007). ‘Editor’s Note’, *Qualitative Research Reports in Communication*, 8(1), pp.1–1.

Eastman, C. and Maguire, K. (2016). ‘Critical autobiography in the professional doctorate: improving students’ writing through the device of literature’, *Studies in Continuing Education*, 38(3), pp.355–372.

Eatough, V., Smith, J. and Shaw, R. (2008). ‘Women, Anger, and Aggression: An Interpretative Phenomenological Analysis’, *Journal of Interpersonal Violence*, 23(12), pp.1767-1799.

Eisner, E.W. (1991). *The enlightened eye: Qualitative inquiry and the enhancement of educational practice.* New York, NY: Macmillan Publishing Company.

Employment Law Clinic. (2018). *Disciplinary action flowchart - guide for a disciplinary process* [Online]. Available at: http://employmentlawclinic.com/disciplinary-action-flowchart/#flowchart (Accessed: 11 June 2018).

Encyclopedia Britannica. (2018). *Encyclopædia Britannica* [Online]. Available at: https://www.britannica.com/ (Accessed: 22 March 2020).

Engward, H. and Davis, G. (2015). 'Being reflexive in qualitative grounded theory: discussion and application of a model of reflexivity', *Journal of Advanced Nursing,* 71(7), pp.1530-1538.

Equality Act. (2010). *Guidance on matters to be taken into account in determining questions relating to the definition of disability* [Online]. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/570382/Equality_Act_2010-disability_definition.pdf. (Accessed: 31 May 2020).

Equality and Human Rights Commission. (2010). *The Human Rights Act | Equality and Human Rights Commission* [Online]. Available at: https://www.equalityhumanrights.com/en/human-rights/human-rights-act (Accessed: 6 January 2018).

Equality and Human Rights Commission. (2015). *Pregnancy and Maternity-Related Discrimination and Disadvantage* [Online]. Available at: https://www.equalityhumanrights.com/sites/default/files/pregnancy-and-maternity-related-discrimination-and-disadvantage_0.pdf (Accessed: 4 March 2018).

Equality and Human Rights Commission. (2019). *What is discrimination* [Online]. Available at: https://www.equalityhumanrights.com/en/advice-and-guidance/what-discrimination (Accessed: 9 April 2021).

Equality and Human Rights Commission. (2021). *Public Sector Equality Duty* [Online]. Available at: https://www.equalityhumanrights.com/ en/advice-and-guidance/public-sector-equality-duty (Accessed: 31 March 2021).

Equality Challenge Unit. (2013). *Unconscious bias in higher education* [Online]. Available at: https://www.ecu.ac.uk/wp-content/uploads/2014/07/unconscious-bias-and-higher-education.pdf (Accessed:2 June 2015).

Equality Hub. (2016). *Age* [Online]. Available at: https://equalityhub.org/2016/07/06/age/ (Accessed: 4 January 2017).

Equal Opportunities Commission. (2021). *What is Discrimination* [Online]. Available at: https://www.eoc.org.uk/what-is-discrimination/ (Accessed: 9 April 2021).

Evans, R. and Lewis, P. (2013). 'Police "smear" campaign targeted Stephen Lawrence's friends and family', *The Guardian*, 23 June [Online]. Available at: https://www.theguardian.com/uk/2013/jun/23/stephen-lawrence-undercover-police-smears (Accessed: 11 November 2018).

Fairlie, M. (2018). 'Mps Call For End To Political Gender Gap At Westminster', *ITV News*, 21 November [Online]. Available at: https://www.itv.com/news/2018-11-21/mps-call-for-end-to-political-gender-gap-at-westminster/ (Accessed: 21 November 2018).

Fautrel, B., Morel, J., Berthelot, J. M., Constantin, A., De Bandt, M., Gaudin, P. and Solau-Gervais, E. (2016). 'Validation of FLARE-RA, a self-administered tool to detect recent or current rheumatoid arthritis flare', *Arthritis and Rheumatology.* 69(2), pp.309-319

Feagin, J. (2013). *Systemic Racism*: *A Theory of Oppression.* Abingdon: Routledge.

Federal Bureau of Investigation. (2016). *Civil Rights* [online]. Available at: https://www.fbi.gov/investigate/civil-rights (Accessed: 9 March 2021).

Field, A. (2005). *Discovering Statistics Using SPSS.* California: Sage Publishing.

Fine, M. (1997). 'Witnessing Whiteness' in Fine, M., Weis, L., Powell, C. and Wong, L. (eds.), *Off White: Readings on race, power, and society.* Abingdon: Routledge. pp.57-65.

Fish, G. and Syed, M. (2019). *The Multiple Levels of Racism, Discrimination, and Prejudice.* Minnesota: University of Minnesota Press.

Fitzgerald, L., Ferlie, E., McGivern, G. and Buchanan, D.A. (2013). 'Distributed leadership patterns and service improvement: Evidence and argument from English healthcare', *The Leadership Quarterly*, 24(1), pp.227-239.

Flick, U. (2011). *Introducing research methodology: a beginner's guide to doing a research project.* California: Sage Publishing.

Flowers, K., Reid, P. and Larkin, P. (2005). ‘Exploring lived experience’. *The psychologist,* 18, pp.20-23.

Ford, S. (2013). ’Exclusive: Nurses feeling under pressure, understaffed and undervalued’*, Nursing Times,* 30 September [Online]. Available at: https://www.nursingtimes.net/roles/nurse-managers/exclusive-nurses-feeling-under-pressure-understaffed-and-undervalued-30-09-2013/. (Accessed: 3 August 2020).

Ford, M. (2020). ‘BAME groups “two to three times more likely” to die of Covid-19, finds study’*, Nursing Times,* 7 May [Online]. Available at: https://www.nursingtimes.net/news/research-and-innovation/bame-groups-two-to-three-times-more-likely-to-die-of-covid-19-finds-study-07-05-2020/ (Accessed: 10 June 2020).

Frankel, A. (2008). ‘What leadership styles should senior nurses develop?’ *Nursing Times* [Online]. Available at: https://www.nursingtimes.net/clinical-archive/leadership/what-leadership-styles-should-senior-nurses-develop-29-08-2008/. (Accessed: 3 August 2020).

Frankenburg, R. (1993). *White Women, Race Matters: The Social Construction of Whiteness.* Minnesota: University of Minnesota Press.

Freeman-Powell, S. (2019). ‘What has really happened since Macpherson’s report’, *BBC News,* 24 February [Online]. Available at: https://www.bbc.co.uk/news/uk-47300343 (Accessed:9 February 2020).

Freshwater, D., Taylor, B. and Sherwood, G. (2008)*. International Textbook of Reflective Practice in Nursing.* Oxford: Blackwell Publishing.

Fryer, P. (2010). *Staying Power: The History of Black People in Britain Get Political*. 2nd edn. London: Pluto Press.

Garcia, R., Ali, N., Papadopoulos, C. and Randhawa, G. (2015). ‘Specific antenatal interventions for Black, Asian and Minority Ethnic (BAME) pregnant women at high risk of poor birth outcomes in the United Kingdom: a scoping review’, *BMC pregnancy and childbirth*, *15*(226) [Online]. Available at: doi:10.1186/s12884-015-0657-2 (Accessed: 22 August 2017).

Gee, G. (2016). 'Unhealthy Treatment', *UCLA Public Health Magazine,* 2015 [Online]. Available at: https://ph.ucla.edu/news/magazine/2015/autumnwinter/article/unhealthy-treatment (Accessed: 20 November 2019).

General Medical Council. (2012). *Continuing Professional Development: guidance for all doctors* [Online]. Available at: https://www.gmc-uk.org/education/standardsguidance-and-curricula/guidance/continuing-professional-development (Accessed: 31 March 2021).

Gibbs, G. (1998) *Learning by doing: A guide to teaching and learning*. London: FEU.

Gillborn, D. (2008). *Racism and Education: coincidence or conspiracy.* Abingdon: Routledge.

Gilley, B. (2017). 'The case for colonialism', *Third World Quarterly* [Online]. Available at: doi:10.1080/01436597.2017.1369037 (Accessed: 1 November 2019).

Giorgi, A. (2009). *Descriptive Phenomenological Method in Psychology: A Modified Husserlian Approach.* Pennsylvania: Duquesne University Press.

Glaser, B. (1992). *Basics of Grounded Theory Analysis: Emergence Vs. Forcing*. 1st edn. California: Sociology Press.

Glesne, C. and Peshkin, P. (1992). *Becoming qualitative researchers: An introduction.* New York: Longman.

Global Justice Now. (2018). *The hostile environment for immigrants.* [Online] Available at: https://www.globaljustice.org.uk/resources/hostile-environment-immigrants. (Accessed: 5 January 2019).

Goddard, W. and Melville, S. (2004). *Research Methodology: An Introduction*. Cape Town: Juta and Company Ltd.

Gordon, G. (2007). *Towards bicultural competence: beyond black and white*. Stoke-on-Trent: Trentham Books Limited.

GOV.UK. (2016). *The NHS Constitution for England*. [online] Available at: https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england. (Accessed: 24 July 2017).

Gray, A. (2017). 'The world's 10 biggest economies in 2017', *World Economic Forum* 9 March [Online]. Available at: https://www.weforum.org/agenda/2017/03/worlds-biggest-economies-in-2017/ (Accessed: 27 July 2017).

Gray, D. (2013). *Doing research in the real world*. London: Sage.

Greenberg, J., Solomon, S., Pyszczynski, T., Rosenblatt, A., Burling, J., Lyon, D., Pinel, E., and Simon, L. (1992). 'Why do people need self-esteem? Convergent evidence of an anxiety-buffering function'. *Journal of Personality and Social Psychology,* 63, 913-922.

Grierson, J. (2020). 'Labour MPs warn ministers not to water down Windrush review', *The Guardian*, 21 February [Online]. Available at: https://www.theguardian.com/uk-news/2020/feb/21/labour-mps-government-windrush-review-institutionally-racist (Accessed: 9 March 2020).

Grinell, M. and Unrau, Y. (2010). *Social Work Research and Evaluation: Foundations of Evidence-Based Practice.* Oxford: Oxford University Press

Guion, L. (2002). 'Triangulation: Establishing the Validity of Qualitative Studies', *IFAS Extension University of Florida,* 2002(6) [Online]. Available at: https://journals.flvc.org/edis/article/view/108267 (Accessed:5 June 2014).

Halcomb, E. and James, S. (2019). 'Collecting data in research', *Nurse Researcher*, *27*(2), pp.6-7.

Haligan, A. (2013). 'Investing in leadership post-Francis', *Health Service Journal* [Online]. Available at: https://www.hsj.co.uk/leadership/investing-in-leadership-post-francis/5054916.article (Accessed:19 March 2018).

Hall, B. (2005). *Among Cultures: The Challenge of Communication*. California: Thompson Wadsworth.

Harper, E. (2018). 'Votes for women 100 years on and the region remembers', *Anglia News*, 6 February [Online]. Available at: http://www.itv.com/news/anglia/2018-02-06/votes-for-women-100-years-on-and-the-region-remembers/ (Accessed: 6 February 2018).

Hawkesworth, M.E. (2006). *Globalization and Feminist Activism*. Maryland: Rowman and Littlefield.

Hawkins, P. and Shohet, R. (2006). *Supervision in the Helping Professions* 3rd Edition. Maidenhead: Open University Press.

Hay, M. (2010). ‘Embracing Collaborative Working in the NHS’, *Health Service Journal* [Online]. Available at: https://www.hsj.co.uk/hsj-knowledge/best-practice/embracing-collaborative-working-in-the-nhs/5016800.article (Accessed: 9 February 2014).

Health (2013). *Francis report on Mid Staffs: government accepts recommendations* [online]. GOV.UK. Available at: https://www.gov.uk/government/news/francis-report-on-mid-staffs-government-accepts-recommendations (Accessed: 20 Mar. 2019).

Health Research Authority. (2017). *Research Ethics Committees overview* [Online]. Available at: https://www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/research-ethics-committees-overview/ (Accessed: 29 March 2017).

Health and care professions council. (2017). *Professional development and your registration* [Online]. Available at: continuing-professional-development-and-your-registration.pdf (hcpc-uk.org) (Accessed 1 April 2021).

Health and care professions council. (2018). *CPD information for employers* [Online]. Available at: CPD information for employers | (hcpc-uk.org) (Accessed 31 March 2021).

Health and Care Professions. (2019). *What activities Count as CPD?* [Online]. Available at: https://www.hcpc-uk.org/ /cpd/your-cpd/cpd-activities/ (Accessed 31 March 2021).

Hefferman, M. (2014). *How can we combat wilful blindness to ensure a culture of quality?* Available at: https://www.kingsfund.org.uk/sites/default/files/media/Heffernan.pdf (Accessed: 21s June 2020).

Heidegger, M. (1962). ‘Sein und Zeit’ in *Jahrbuch für Phänomenologie und phänomenologische Forschung* 8; trans. J. Macquarrie and E. Robinson, *Being and Time*, London: SCM Press.

Henry, Z. (1985). 'The New Commonwealth Migrants 1945-62', *History Today*, 35(12) [Online]. Available at: https://www.historytoday.com/archive/new-commonwealth-migrants-1945-62 (Accessed:11 September 2015).

Hewitt, G. (2018). 'Windrush is a chance to end British intolerance dating from slavery', *The Guardian*, 1 August [Online]. Available at: https://www.theguardian.com/commentisfree/2018/aug/01/windrush-scandal-shows-britain-ill-ease-race-migration (Accessed: 5 August 2018).

Hewlitt-Taylor, J. (2002). 'Inside Knowledge: issues in insider research', *Nursing Standard,* 16(46), pp.33-35.

Hilliard, A. (1992). *Racism: Its origins and how it works. Paper presented at the meeting of the Mid-West Association for the Education of Young Children*. Madison: WI.

Hirsch, A. (2020). 'The 'playing the race card' accusation is just a way to silence us', *The Guardian*, 16 January [Online]. Available at: https://www.theguardian.com/commentisfree/2020/jan/16/playing-the-race-card-racism-black-experience (Accessed: 21 January 2020).

Hoepfl, M.C. (1997). 'Choosing qualitative research: A primer for technology education researchers', *Journal of Technology Education, 9(1)* [Online]. Available at: https://pdfs.semanticscholar.org/62fe/bfcd5ab235a8b20e009cdb2282103e4ddb8e.pdf (Accessed: 9 April 2014).

Hofstede, G. (1984). *National cultures and corporate cultures*. In L.A. Samovar and R.E. Porter (Eds.), *Communication Between Cultures*. Belmont, CA: Wadsworth.

Holliday, A. (2002). *Doing and writing qualitative research*. London: Sage.

Holloway, I. (1997). *Basic concepts for qualitative research*. Oxford: Blackwell Science.

Holmes, O., Sullivan, H., Singh, M., Aratani, L., Greve, J.E. and Pengelly, M. (2020). 'George Floyd protests: curfews set in with US soldiers reportedly poised outside Washington – live', *The Guardian,* 2 June [Online]. Available at: https://www.theguardian.com/us-news/live/2020/jun/02/george-floyd-protests-violence-overnight-donald-trump-threat-army-live-updates (Accessed: 2 June 2020).

Home Office. (1999). 'The Stephen Lawrence inquiry', *GOV.UK,* 24 February [Online]. Available at: https://www.gov.uk/government/publications/the-stephen-lawrence-inquiry (Accessed: 3 November 2018).

Housee, S. (2018). *Speaking Out against Racism in the University Space*. London: Trentham Books.

Huber, L. (2008). 'Building Critical Race Methodologies in Educational Research: A Research Note on Critical Race Testimonio', *FIU Law Review,* 4(1) [Online]. Available at: https://ecollections.law.fiu.edu/cgi/viewcontent.cgi?article=1052andcontext=lawreview (Accessed: 12 June 2015).

Hunt, A. and Wheeler, B. (2016). 'Brexit: All you need to know about leaving the EU', *BBC News*, 12 December [Online]. Available at: https://www.rexsresources.com/uploads/6/5/2/1/6521405/brexit__all_you_need_to_know_about_the_uk_leaving_the_eu_-_bbc_news.pdf (Accessed: 16 January 2018).

Husserl, E. (2004). 'Ideas: General Introduction to Pure Phenomenology'. Taylor and Francis, Florence. In S. T. Fiske, D. T. Gilbert, and G. Lindzey (Eds.), *The Handbook of Social Psychology* (5th ed., Vol. 2). New York: Wiley.

Husserl, E. (2012). *Ideas: General introduction to pure phenomenology*. Abingdon: Routledge.

IRAS (2018). *IRAS Help - Documentation - Updates to IRAS* [Online]. Available at: https://www.myresearchproject.org.uk/help/hlpupdates.aspx (Accessed: 29 March 2018).

ITV News. (2016). 'Bullying and discrimination "rife" in hospital trust', *ITV News,* 17 August [Online]. Available at: https://www.itv.com/news/2016-08-17/bullying-and-discrimination-rife-in-brighton-and-sussex-university-hospitals-nhs-trust-placed-in-special-measures/ (Accessed: 27 July 2020).

Jaggi, M. (2001). The Guardian Profile: Caryl Phillips', *The Guardian,* 3 November [Online]. Available at: https://www.theguardian.com/books/2001/nov/03/fiction.artsandhumanities (Accessed: 7 January 2020).

James, S., Desborough, J. and McInnes, S. (2019). 'Strategies for using non-participatory video research methods in general practice', *Nurse Researcher*, 27(2), pp.32-37.

John, G. (2014). *Global African Diaspora: transforming the state we're in?* [Online]. Available at: https://www.obv.org.uk/news-blogs/global-african-diaspora-transforming-state-we-re (Accessed:6 February 2019).

John, G. (2015*). Eulogy - Celebrating Jean Mary Griffiths.* 24 February, Cathedral of the Immaculate Conception, Grenada.

Johnson, B. and Christensen. (2008). *Educational Research: Quantitative, Qualitative, and Mixed Approaches*. 3rd edn. California: Sage Publishing.

Johnston, L. (2019). What is Continuing Professional Development? Available at: What is Continuing Professional Development (CPD)? - career-advice.jobs.ac.uk (Accessed 17th January 2021).

Jolliff, T. (2019). 'Inclusive leadership: how ready are we to learn?' *Kings Fund*, 8 August [Online]. Available at: https://www.kingsfund.org.uk/blog/2019/08/inclusive-leadership (Accessed: 10 March 2020).

Jones-Berry, S. (2017). 'Racism in the NHS: are things getting better or worse for BME staff?', *Nursing Standard,* 2 October [Online]. Available at: https://rcni.com/nursing-standard/newsroom/analysis/racism-nhs-are-things-getting-better-or-worse-bme-staff-152681 (Accessed: 20 March 2020).

Jones-Berry, S. (2019). 'Brexit, retirement and stress: why nurses are leaving the register', *Nursing Standard,* 8 May [Online]. Available at: https://rcni.com/nursing-standard /newsroom/news/brexit-retirement-and-stress-why-nurses-are-leaving-register-148571 (Accessed 20 March 2020).

Jones, J. (1997). *Prejudice and Racism.* 2nd edn. New York: McGraw-Hill.

Jones, T. (2000). 'Shades of Brown: The Law of Skin Color', *Duke Law Journal*, 49(6) [Online]. Available at: doi:10.2139/ssrn.233850 (Accessed: 8 July 2019).

Kaufmann, M. (2012). 'Slavery shouldn't distort the story of black people in Britain', *The Guardian*, 17 October [Online]. Available at:

https://www.theguardian.com/commentisfree/2012/oct/17/slavery-black-history-month (Accessed: 2 October 2017).

Kawulich, B. (2012). ‘Selecting a research approach: Paradigm, methodology and methods’ in Wagner, C., Kawulich, B. and Garner, M. (eds) *Doing Social Research: A global context.* New York: McGraw Hil, pp.51-61.

Kellerman, B. (2004). *Bad leadership. What it is, how it happens, why it matters.* Boston, Harvard Business School Press.

Kellerman, B. (2007). ‘What Every Leader Needs to Know about Followers.’ *Harvard Business Review*. (December 2007).

Kelley, R.E. (1992). *The power of followership*. New York: Doubelday.

Kentish, B. (2018). ‘Amber Rudd appointed as work and pensions secretary in return to Theresa May’s cabinet’, *Independent* [Online]. Available at: https://www.independent.co.uk/news/uk/politics/amber-rudd-cabinet-work-pensions-secretary-theresa-may-brexit-return-a8637456.html (Accessed: 3 August 2020).

Keogh, K. (2017). ‘Exclusive: One in ten nurse sick days down to stress or depression’, *Nursing Standard,* 27 September [Online]. Available at: https://rcni.com/nursing-standard/newsroom/analysis/exclusive-one-ten-nurse-sick-days-down-to-stress-or-depression-118881 (Accessed: 28 August 2019).

Keogh, K. (2019a). ‘NHS becoming less diverse at board level, report reveals’, *Nursing Standard,* 8 June [Online]. Available at: https://rcni.com/nursing-standard/newsroom/news/nhs-becoming-less-diverse-board-level-report-reveals-149871 (Accessed: 10 June 2019).

Keogh, K. (2019b). ‘Well-being survey: ‘inhumane’ shifts leave no time even for a sip of water’, *Nursing Standard*, 30 September [Online]. Available at: https://rcni.com/nursing-standard/newsroom/analysis/well-being-survey-inhumane-shifts-leave-no-time-even-a-sip-of-water-152611 (Accessed: 2 October 2019).

Kim, Y. (2010). ‘The pilot study in qualitative inquiry: identifying issues and learning lessons for culturally competent research’, *Quality Social Work,* 10(2), pp.190-206.

King Jr, M.L. (1963). *Strength to Love*. New York: Harper and Row.

King, N. and Horrocks, C. (2010). *Interviews in Qualitative Research*. London: Sage.

Kinsella, E. and Pitman, A. (2012). *Phronesis as professional knowledge: practical wisdom in the professions.* Rotterdam: Sense Publishers.

Kirton, G. and Greene, A. (2015). *The Dynamics of Managing Diversity: A Critical Approach.* Abingdon: Routledge.

Kituno, N. (2020). 'Exclusive: Discrimination against BME staff getting worse, finds NHSE report', *Health Service Journal* [Online]. Available at: https://www.hsj.co.uk/workforce/exclusive-discrimination-against-bme-staff-getting-worse-finds-nhse-report/7026916.article (Accessed: 21 June 2020).

Kivel, P. (2017). *Uprooting Racism 4th Edition - Paul Kivel*. [Online]. Available at: http://paulkivel.com/books/uprooting-racism-4th-edition/ (Accessed: 23 October 2019).

Kleinman, A. and Benson, P. (2006). 'Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It'. *PLOS Medicine*, 3(10), p.e294.

Kline, R. (2014). *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England* [Online]. Available at: www.mdx.ac.uk/__data/.../The-snowy-white-peaks-of-the-NHS.pdf (Accessed: 7 June 2015).

Kline, R. and Prabhu, U. (2015), 'Race inequality of NHS staff is putting patients at risk', *Health Service Journal* [Online]. Available at: https://www.hsj.co.uk/leadership/race-inequality-of-nhs-staff-is-putting-patients-at-risk/5082766.article (Accessed: 3 August 2020).

Knaus, C. (2018). 'Mehreen Faruqi warns against "normalisation" of racism in first Senate speech', *The Guardian*, 21 August [Online]. Available at: https://www.theguardian.com/australia-news/2018/aug/21/mehreen-faruqi-warns-against-normalisation-of-racism-in-first-senate-speech (Accessed: 25 March 2020).

Kohner, N. (1994). *Clinical Supervision in Practice*. Dorset: The Kings Fund Centre.

Kolb, D.A. (1984). *Experiential Learning: Experience as the source of learning and development.* New Jersey: Prentice Hall.

Kotter, J.P. (2011). *Corporate Culture and Performance*. New York: Free Press

Koutonin, M.R. (2015). 'Why are white people expats when the rest of us are immigrants?', *The Guardian*, 13 March [Online]. Available at: https://www.theguardian.com/global-development-professionals-network/2015/mar/13/white-people-expats-immigrants-migration (Accessed: 29 January 2020).

Kuhn, T.S. (1977). 'Objectivity, value judgment, and theory choice' in Kuhn, T.S (ed) *The Essential Tension.* Chicago: University of Chicago Press, pp.320-339.

Kutney, A. (2006). 'An examination of psychiatric-mental health outcomes from the perspectives of logical positivism and phenomenology', *Journal of the American Psychiatric Nurses Association,* 12(1), pp.22-27.

Kynaston, D. (2007). *Austerity Britain 1945-1951.* London: Bloomsbury.

Ladson-Billings, G. and Tate, W.F. (2000). 'From the Editors', *American Educational Research Journal*, 37(1), pp.305–305.

Lais, H. (2019). 'Racism is rife in modern Britain. Nothing can change until we admit it'. *The Independent*, 25 October [Online]. Available at: https://www.independent.co.uk/voices/black-history-month-racism-institutional-britain-slavery-education-employment-culture-colonialism-a9170841.html (Accessed: 25 June 2020).

Lambert, J. (2017). 'How Theresa May's "hostile environment" created an underworld.' *New Statesman,* 19 December [Online]. Available at: https://www.newstatesman.com/2017/12/how-theresa-may-s-hostile-environment-created-underworld (Accessed:1 May 2018).

Lambert, S.D. and Loiselle, C.G. (2007). 'Health Information - Seeking Behavior', *Qualitative Health Research*, 17(8), pp.1006–1019.

Lamuye, A. (2017). 'I am no "person of colour", I am a black African woman,' *Independent*, 31 July [Online]. Available at: https://www.independent.co.uk/voices/phrase-people-person-of-colour-bme-

black-woman-women-different-experiences-race-racism-a7868586.html (Accessed 16 June 2020).

Lauter, P. and Howe, F. (1971). *Conspiracy of the Young.* New York: Meridian Press.

Laverack, G. (2005). *Public health, power, empowerment and professional practice.* Basingstoke: Palgrave Macmillan.

Laville, S. and Dodd, V. (2011). 'Stephen Lawrence killed because of "the colour of his skin"', *The Guardian*, 16 November [Online]. Available at: https://www.theguardian.com/uk/2011/nov/16/stephen-lawrence-murder-trial (Accessed: 24 March 2020).

Lee Hall, R. (2016). *Denying Racism Is the New Racism* [Online]. Available at: https://ezinearticles.com/?Denying-Racism-Is-the-New-Racismandid=9562754 (Accessed: 4 January 2020).

Lederach, J.P. (1995). *Preparing for peace: Conflict transformation across cultures.* Syracuse, NY: Syracuse University Press.

Legislation.gov.uk. (2011). *Race Relations (Amendment) Act 2000* [Online]. Available at: http://www.legislation.gov.uk/ukpga/2000/34/contents (Accessed: 20 March 2020).

Letts, L. (2003). 'Occupational therapy and participatory research: A partnership worth pursuing', *American Journal of Occupational Therapy,* 57, pp.77-87.

Levy, P. (2003). 'A methodological framework for practice-based learning research in networked learning', *Instructional Science*, 31(1-2), pp.87-109.

Lewis, R. (2009). 'The Legacy of Marcus Garvey', *Journal of Liberty Hall,* 1 [Online]. Available at: https://liberty-hall-the-legacy-of-marcus-garvey.business.site/ (Accessed: 17 June 2019).

Lewis-Beck, M.S., Bryman, A. and Liao, T.F. (2004). 'Triangulation', *The SAGE Encyclopedia of Social Science Research Methods* [Online]. Available at: doi: https://dx.doi.org/10.4135/9781412950589.n1031 (Accessed: 4 April 2019).

LinkedIn. (2015). *Core Values - Why are they so important to your company?* [Online]. Available at: https://www.linkedin.com/pulse/core-values-why-so-important-your-company-nicolas-schoenlaub/ (Accessed 3 August 2020).

Linton, R. (1945). *The Cultural Background of Personality*. New York.

Llamas, J.V. (2018). 'The Influence of Phenomenology on Nursing Research,' *Minority Nurse* [Online]. Available at: https://minoritynurse.com/?s=phenomenology (Accessed: 18 September 2018).

Long Term Plan. (2019). *The NHS Long Term Plan - a summary* [Online]. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/the-nhs-long-term-plan-summary.pdf (Accessed: 14 August 2019).

López, G.R. (2001). 'Re-Visiting White Racism in Educational Research: Critical Race Theory and the Problem of Method', *Educational Researcher*, 30(1), pp.29–33.

Lowe, F. (2007). 'Colonial Object Relations: Going Underground Black-White Relationships', *British Journal of Psychotherapy*, 24(1), pp.20–33.

Lucas, B. (2019) 'Developing the personal qualities required for effective nurse leadership', *Nursing Standard,* 8 April [Online]. Available at: doi: 10.7748/ns.2019.e11274 (Accessed: 3 March 2020).

Lyons, H.Z., Bike, D.H., Ojeda, L., Johnson, A., Rosales, R. and Flores, L.Y. (2013). 'Qualitative Research as Social Justice Practice with Culturally Diverse Populations', *Journal for Social Action in Counseling and Psychology*, *5*(2), pp.10-25.

MacKenzie, J. (ed.) (1986). *Imperialism and Popular Culture* Manchester: Manchester University Press.

Maguire, M. and Delahunt, B. (2017). 'Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars', *Aishe,* (3) [Online]. Available at: https://ojs.aishe.org/index.php/aishe-j/article/viewFile/335/553 (Accessed: 18 May 2019).

Major, L.E. (2001). 'Black children more likely to fail at school, report claims,' *The Guardian*, 7 August [Online]. Available at: https://www.theguardian.com/education/2001/aug/07/highereducation.uk4 (Accessed: 9 March 2020).

Marmot, M.G., Smith, G.D., Stansfeld, S., Patel, C., North, F., Head, J., White, I., Brunner, E. and Feeney, A. (1991). 'Health inequalities among British civil servants: the Whitehall II study', *The Lancet*, 337(8754), pp.1387–1393.

Marshall, C. and Rossman, G. (2006). *Designing Qualitative Research*. 4th edn. Thousands Oaks: Sage Publication.

Martin, G. (2011). *The SAGE Encyclopedia of Terrorism*. 2nd Edn. Thousand Oaks Calif: Sage.

Mathison, S. (1988). 'Why Triangulate?', *Educational Researcher*, 17(2), pp.13–17.

Maxwell, J. (2009). 'Designing a qualitative study', in Bickman, L. and Rog, D. (eds.) *The sage handbook of applied social research methods.* 2nd edn. California: Sage Publishing, pp.214-253.

Maxwell, K. (2015). 'Black History Month: Here's how black people have helped make Britain great,' *Independent,* 5 October [Online]. Available at: http://www.independent.co.uk/voices/heres-how-black-people-have-helped-make-britain-great-a6680371.html (Accessed: 27 July 2017).

May, T. (2011). *Social research: Issues, methods and research*. London: McGraw-Hill International.

Mays, N. and Pope, C. (1995). 'Qualitative Research: Rigour and qualitative research,' *British Medical Journal*, 311(6997), pp.109–112.

McCalla, C. (2011). 'The Top 5 Assassinations of Black Leaders,' *Newsone*, 26 October [Online]. Available at: https://newsone.com/1602245/top-5-assassinations-black-leaders (Accessed 26 March 2020).

McCallum, S. (2013). 'Followership: The other side of leadership,' *Ivey Business Journal* [Online]. Available at: www.iveybusinessjournal.com/.../followership-the-other-side-of-leadership/ (Accessed: 30 July 2015).

McClintock, D., Ison, R., and Armson, R. (2003). 'Metaphors for Reflecting on Research Practice: Researching with People,' *Journal of Environmental Planning and Management,* 46(5), pp.715-731.

McColl, E., Jacoby, A., Thomas, L., Soutter, J., Bamford, C., Steen, N., Thomas, R., Harvey, E., Garratt, A. and Bond, J. (2001). 'Design and use of questionnaire: a review of best practice applicable to survey of health service staff and patients', *Health Technology Assessment,* 5(31) [Online]. Available at: DOI: 10.3310/hta5310 (Accessed: 5 April 2017).

Mcintosh, P. (1989). *White Privilege: Unpacking the Invisible Knapsack*. [Online]. Available at: https://psychology.umbc.edu/files/2016/10/White-Privilege_McIntosh-1989.pdf (Accessed: 20 November 2019).

McKee, L., Charles, K., Dixon-Woods, M., Willars, J. and Martin, G. (2013). '"New" and distributed leadership in quality and safety in health care, or 'old' and hierarchical? An interview study with strategic stakeholders,' *Journal of Health Services Research and Policy*, 18(2), pp.11–19.

McSherry, R., Kell, J and Pearce, P. (2002). 'Clinical supervision and clinical governance', *Nursing Times*, 98(23), pp.30–32.

McTague, T. (2015). Eastern European migrant surge sees Poles become Britain's second biggest 'ethnic minority' Available at: Poles become Britain's second biggest 'ethnic minority' Daily Mail Online (Accessed: 18 January 2021).

Megginson, D., and Whittaker, V. (1996). *Cultivating Self Development*. London: Institute of Personnel Development.

Mehra, B. (2002). 'Bias in Qualitative Research: Voices from an Online Classroom,' *The Qualitative Report*, 7(1), pp.1-19.

Mercer, J. (2007). 'The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas,' *Oxford Review of Education,* 33(1), pp.1-17.

Merrick, R. (2020). 'Boris Johnson has 'zero plans' to tackle impacts of racism, warns ousted government adviser,' *Independent,* 10 October [Online]. Available at: http://www.independent.co.uk/news/uk/politics/boris-johnson-racism-inequality-black-lord-wolley-b9116 (Accessed: 4 April 2021).

Merrifield, N. (2015). 'Nursing debate questions long-term impact of "6Cs" values', *Nursing Times* [Online]. Available at: https://www.nursingtimes.net/archive/nursing-debate-questions-long-term-impact-of-6cs-values-23-03-2015/ (Accessed: 20 March 2019).

Merton, R.K. (1972). 'Insiders and Outsiders: A Chapter in the Sociology of Knowledge,' *American Journal of Sociology*, 78(1), pp.9–47.

Meyer, K., Bjork, I., and Eide, H. (2012). 'Intensive care nurses' perceptions of their professional competence in the organ donor process: a national survey,' *Journal of Advanced Nursing,* 68(1), pp.104-115.

Mills, A.J., Durepos, G. and Wiebe, E. (eds). (2010). *Encyclopedia of Case Study Research, Volumes I and II.* California: Sage Publishing.

Mirza, M. (2010). 'Rethinking race', *Prospect Magazine*, 22 September [Online] Available at: https://www.prospectmagazine.co.uk/magazine/munira-mirza-multiculturtalism-racism. (Accessed: 6 June 2017).

Moberly, T. (2017). 'Bullying culture in NHS starts at top, says royal college head,' *British Medical Journal*, 356(j1192) [Online]. Available at: https://www.bmj.com/content/356/bmj.j1192 (Accessed: 20 September 2019).

Montague, A. (1997). *Man's most dangerous myth: The fallacy of race*. 6th edn. California: Altamira Press.

Morgan, E. (2020). 'Discrimination' on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff', *ITV News*, 13 May [Online]. Available at: https://www.itv.com/news/2020-05-13/discrimination-frontline-coronavirus-covid19-black-minority-ethnic-bame-deaths-nhs-racism/ (Accessed: 14 May 2020).

Moustakas, C. (1994). *Phenomenological research methods*. California: Sage.

Moxham, L. and Patterson, C. (2017). 'Why phenomenology is increasingly relevant to nurse researchers', *Nurse Researcher*, 25(3), pp.6–7.

Muir, H. (2018). 'The Windrush scandal is institutional racism, pure and simple,' *The Guardian.* 30 April [Online]. Available at: https://www.theguardian.com/commentisfree/2018/apr/30/windrush-scandal-institutional-racism-amber-rudd-discrimination-black-britons (Accessed: 1 February 2020).

Mukhopadhyay, C., Henze, R. and Moses, Y. (2013). *How Real Is Race?: A Sourcebook on Race, Culture, and Biology.* Maryland: Rowman and Littlefield.

Munro, A. (2016). 'Shooting of Trayvon Martin | United States history', In: *Encyclopædia Britannica* [Online]. Available at:

https://www.britannica.com/event/shooting-of-Trayvon-Martin (Accessed: 26 July 2020).

Nadeem, S. (2019). *Evaluation of the NHS Workforce Race Equality Standard (WRES)*. [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/09/wres-evaluation-report-january-2019.pdf (Accessed: 21 November 2019).

Naidoo, L. (2012). *An Ethnography of Global Landscapes and Corridors*. IntechOpen.

Nardi, P.M. (2015). *Doing survey research*. London: Routledge.

Naylor, D. (2008). *An investigation into how public sector and community-based practitioners authorise constructively awkward interventions* [Online]. Available at: http://eprints.mdx.ac.uk/6894/ (Accessed: 16 April 2017).

Nelson, T. (2004) *Ageism: Stereotyping and Prejudice against Older Persons*. 1st edn. Massachusetts: The MIT Press.

Nelson, T. (2017) *Ageism: Stereotyping and Prejudice against Older Persons*. 2nd Edn. Massachusetts: The MIT Press.

NHS BME Network. (2015). *Why NHS BME Network | NHS BME Network*. [Online]. Available at: http://www.nhsbmenetwork.org.uk/about/why-nhs-bme-network/ (Accessed: 20 August 2015).

NHS Confederation. (2014). *NHS finances: A service at boiling point?* [Online]. Available at: https://www.nhsconfed.org/resources/2014/07/nhs-finances-a-service-at-boiling-point (Accessed: 14 August 2019).

NHS Confederation. (2019). *Five funding priorities for the NHS Briefing ahead of the 2019 Spending Round* [Online]. Available at: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Five-funding-priorities.pdf (Accessed: 10 June 2020).

NHS Employers. (2019a). *NHS Terms and Conditions (AfC) pay scales 2019/20*. [Online]. Available at: https://www.nhsemployers.org/pay-pensions-and-reward/agenda-for-change/pay-scales (Accessed: 6 January 2020).

NHS Employers. (2019b). *Health and Wellbeing* [Online]. Available at: https://www.nhsemployers.org/retention-and-staff-experience/health-and-wellbeing/protecting-staff-and-preventing-ill-health (Accessed: 14 August 2019).

NHS Employers. (2020). We Are the NHS – a summary of the NHS people plan 2020/21. Available at: https://www.nhsconfed.org/news/2020/07/nhs-people-plan-summary (Accessed: 18 January 2021).

NHS England. (2016). *Workplace experiences of BME and white staff published for every NHS trust across England*. [Online]. Available at: https://www.england.nhs.uk/2016/06/wres-publication/ (Accessed: 16 June 2020).

NHS England. (2018). *CNO Black and Minority Ethnic (BME) Leadership* [Online]. Available at: https://www.england.nhs.uk/nursingmidwifery/delivering-the-nhs-ltp/cno-black-and-minority-ethnic-bme-leadership/. (Accessed 6 January 2020).

NHS England. (2019a). *NHS England and NHS Improvement Information Governance Policy* [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2019/10/information-governance-policy-v5.1.pdf (Accessed: 29 December 2019).

NHS England. (2019b). *NHS England » Workforce Race Equality Standard report*. [Online]. Available at: https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/workforce-race-equality-standard-2019-report (Accessed: 16 February 2020).

NHS Improvement. (2019). *NHS Improvement* [Online]. Available at: https://improvement.nhs.uk/home/ (Accessed: 25 July 2020).

NHS Leadership Academy. (2012). Introduction to the NHS leadership academy core programmes [Blog] *Leadership Academy*. Available at: https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/10/NHSLeadership-Blog-Resource-CoreProgrammes-KL-20121026.pdf (Accessed: 3 August 2020).

NHS Leadership Academy. (2021). *About us* [online]. Available at: https://www.leadershipacademy.nhs.uk/impact/about/. (Accessed: 22 May 2021).

NHS Providers. (2015). *Provider regulation* [Online] Available at: https://nhsproviders.org/topics/regulation/provider-regulation (Accessed: 25 July 2020).

NHS WRES. (2017). *2016 Data Analysis Report for NHS Trusts* [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/03/workforce-race-equality-standard-data-report-2016.pdf (Accessed: 19 September 2017).

NHS WRES. (2019). *2018 Data Analysis Report for NHS Trusts* [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/12/wres-2018-report-v1.pdf (Accessed: 20 August 2019).

NHS WRES. (2020). *2019 Data Analysis Report for NHS Trusts* [Online]. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf (Accessed: 25 March 2020).

NICE. (2007). *How to change practice* [Online]. Available at: https://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/Support-for-service-improvement-and-audit/How-to-change-practice-barriers-to-change.pdf (Accessed: 22 June 2017).

NICE. (2015). *Healthy workplaces make for effective employees* [Online]. Available at: https://www.nice.org.uk/news/article/healthy-workplaces-make-happy-and-effective-employees (Accessed: 22 June 2017).

Niro, B. (2003). *Transitions Race.* New York: Palgrave Macmillan.

NMC. (2016). *New figures show an increase in numbers of nurses and midwives leaving the professions* [Online]. Available at: https://www.nmc.org.uk/news/news-and-updates/new-figures-show-an-increase-in-numbers-of-nurses-and-midwives-leaving-the-professions/ (Accessed: 14 July 2017).

NMC. (2018). *The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates* [Online]. Available at: https://www.nmc.org.uk/standards/code/ (Accessed: 12 January 2020).

NMC. (2019). *Standards of proficiency for registered nurses* [Online]. Available at: https://www.nmc.org.uk/standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/ (Accessed 20 January 2020).

Noon, E.J. (2017). ‘An Interpretative Phenomenological Analysis of the Barriers to the Use of Humour in the Teaching of Childhood Studies’, *Journal of Perspectives in Applied Academic Practice,* 5(3), pp.45-52.

NPEU. (2017). *MBRRACE-UK reports | MBRRACE-UK | NPEU* [Online]. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/reports (Accessed: 15th October 2019).

Nursing in Practice. (2013). *The basics of clinical supervision*. [online]. Available at: https://www.nursinginpractice.com/professional/the-basics-of-clinical-supervision/. (Accessed: 3 February 2021).

Nyatanga, L. (2014). ’Slavery and the science of racism’, *BBC*, 2 March [Online]. Available at: http://www.bbc.co.uk/derby/content/articles/2007/03/02/abolition_nyatanga_2007_feature.shtml (Accessed 25 March 2020).

Ollerenshaw, J.A. and Creswell, J.W. (2002). ‘Narrative Research: A Comparison of Two Restorying Data Analysis Approaches’, *Qualitative Inquiry*, 8(3), pp.329-347.

Olusoga, D. (2015). ‘Black History Month needs a rethink: it’s time to ditch the heroes,’ *The Guardian*, 9 October [Online]. Available at: https://www.theguardian.com/commentisfree/2015/oct/09/black-history-month-ditch-heroes (Accessed: 11 June 2020).

Olusoga, D. (2016). ‘The reality of being black in today’s Britain,’ *The Guardian*, 30 October [Online]. Available at: https://www.theguardian.com/commentisfree/2016/oct/30/what-it-means-to-be-black-in-britain-today (2 May 2018).

Olusoga, D. (2017). *Black and British: A Forgotten History*. British Isles: Pan Macmillan.

Omerod, P. (2018). ‘Story of landmark factory revolt takes to the stage’, *Luton Today* [Online]. Available at: www.lutontoday.co.uk (Accessed: February 2018).

Ortlipp, M. (2008). ‘Keeping and Using Reflective Journals in the Qualitative Research Process’, *The Qualitative Report*, *13*(4), pp.695-705.

Owuor, M. (2017). *What is Systemic Racism?* [Online]. Available at: worldatlas.com/articles/what-is-systemic-racism.html(Accessed 5 August 2020).

Oxford Dictionaries. (2018). *Religion | Definition of religion in English by Oxford Dictionaries* [Online]. Available at: https://en.oxforddictionaries.com/definition/religion (Accessed: 13 January 2018).

Page, A. (2004). 'Creating and Sustaining a Culture of Safety'*, National Center for Biotechnology Information* [Online]. Available at: https://www.ncbi.nlm.nih.gov/books/NBK216181/ (Accessed: 18 February 2020).

Palmer, K. (2018). 'Gender Pay Gap: More Than 500 Firms Reveal Their Figures', *BBC News*, 6 January [Online]. Available at: https://www.bbc.co.uk/news/uk-42580194 (Accessed: 14 January 2018).

Pankhurst, H. (2018). '100 years after the Suffragettes' success, we march for women still fighting for their rights,' *New Statesman,* 1 March [Online]. Available at: https://www.newstatesman.com/politics/feminism/2018/03/womens-march-london-suffragettes (Accessed: 4 March 2018).

Papadopoulos, I., Tilki, M., and Taylor, G., (1998 b) *Transcultural Care: a culturally competent approach.* Philadelphia: F.A. Davies.

Papadopulous, I. (2008). *Transcultural Health and Social Care*: *Development of Culturally Competent Practitioners.* Edinburgh: Elsevier Health Sciences.

Papadopulous, I., Miller, J.E., Leininger, M., Leuning, C., Pacquiao, D., Andrews, M. and Ludwig-Beymir, P. (2008). 'Transcultural Nursing Society position statement on human right', *Journal of transcultural nursing, 19*(1), pp.5-7.

Papadopoulos, I. and Pezzella, A. (2015). 'A snapshot review of culturally competent compassion as addressed in selected mental health textbooks for undergraduate nursing students,' *Journal of Compassionate Health Care,* 2**(**3) [Online]. Available at: https://doi.org/10.1186/s40639-015-0012-5 (Accessed: 19 April 2016).

Patton, M. (2002). *Qualitative Research and Evaluation Methods*. California: Sage Publishing.

Perry, S. (2001). 'Appropriate use of pilot studies,' *Journal of Nursing Scholarship,* 33(2), p.107.

Phillipians 4: 13, Holy Bible. King James Version. Available at: https://www.kingjamesbibleonline.org/Philippians-4-13/ (Accessed: 7 July 2019).

Platt-Koch, L. (1986) 'Clinical supervision for Psychiatric Nurses,' *Journal of Psychological Nursing,* 26(1), pp 7-15.

Poland, B.D. (1995). 'Transcription Quality as an Aspect of Rigor in Qualitative Research,' *Qualitative Inquiry*, 1(3), pp.290–310.

Policy Studies Institute. (2012). *The Role and Responsibilities of The Police*. [Online]. Available at: http://www.psi.org.uk/publications/archivepdfs/Role%20pol/INDPOL-0.P.pdf (Accessed: 22 April 2019).

Polit D.E. and Beck, C. (2017). *Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 10th edn. Philadelphia: Wolters-Kluwer.

Polit, D.E. and Hungler, B.P. (1999). *Nursing Research, Principles and methods.* Philadelphia: Lippincott.

Postel, J. (1981). *Internet Protocol – DARPA Internet Program Protocol Specification, RFC 791*. University of Southern California: Information Sciences Institute.

Powell, T. and Thompson, G. (2010). *Value for money in the NHS* [Online]. Available at: www.parliament.uk/...issues/Key-Issues-Value-for-money-in-the-NHS.pdf. (Accessed: 10 June 2015).

Press, A. (2015). 'LGBT people suffer widespread violent abuse, discrimination: new UN report,' *The Guardian,* 2 June [Online]. Available at: https://www.theguardian.com/world/2015/jun/02/lgbt-people-suffer-widespread-violent-abuse-discrimination-new-un-report (Accessed: 23 June 2020).

Priest, N., Esmail, A., Kline, R., Rae, M., Coghill, Y. and Williams, D.R. (2015). 'Promoting equality for ethnic minority staff – what works?' *British Medical Journal,* 351(h3297) [Online]. Available at: https://doi.org/10.1136/bmj.h3297 (Accessed 10 August 2016).

Pringle, J., Drummond, J, McLafferty, E. and Hendry, C. (2011). 'Interpretative phenomenological analysis: a discussion and critique', *Nurse Researcher*, 18(3), pp.20-24.

Proctor, B. (1986). 'Supervision: A cooperative exercise in accountability' in Marken, M. and Payn, M. (eds.) *Enabling and ensuring supervision in practice.* Leicester: National Youth Bureau and Council for Education and Training in Youth and Community Work.

Qualtrics. (2015). *The Leading Research and Experience Software* [Online]. Available at: http://www.qualtrics.com (Accessed: 3 February 2017).

Quest, D.A. (2014). *Out of the Way and Out of Place: An Interpretative Phenomenological Analysis of the Experiences of Social Interactions of Bisexually Attracted Young People.* Portland: Portland State University.

Rapport, F. and Wainwright, P. (2006). 'Phenomenology as a paradigm of movement,' *Nursing Inquiry*, 13(3), pp.228-236.

Reddie, A. (2007). 'Editorial', *Black Theology*, 5(1), pp.7–10.

Ross-Hellauer, T., P-Tennant, J., Banelytė, V., Gorogh, E., Luzi, D., Kraker, P., Pisacane, L., Ruggieri, R., Sifacaki, E. and Vignoli, M. (2020). 'Ten simple rules for innovative dissemination of research', *PLOS Computational Biology*, 16(4), p.e1007704.

Roulston, K. (2011). 'Working through Challenges in Doing Interview Research,' *International Journal of Qualitative Methods,* 10(4), pp.348-366.

Ruby, J. (1980). 'Exposing yourself: Reflexivity, anthropology and film', *Semiotica,* 30(1-2), pp.153-179.

Sabur, R., Sawer, P. and Millward, D. (2020). 'Why are there protests over the death of George Floyd'? *The Telegraph*. 7 Jun [online]. Available at: https://www.telegraph.co.uk/news/0/us-america-riots-george-floyd-death-protests/ (Accessed 11 June 2020).

Sadiq, S. (eds.) (2013). *Handbook of Data Quality: Research and Practice* [Online]. Available at: https://www.springer.com/gp/book/9783642362569 (Accessed 5 August 2020).

Saidin, K. and Yaacob, A. (2016). 'Insider Researchers: Challenges and Opportunities,' *Proceedings of the ICECRS*, 1(1) [Online]. Available at: http://ojs.umsida.ac.id/index.php/icecrs/article/view/563 (Accessed: 26 July 2019).

Sampson, H. (2004). 'Navigating the waves: the usefulness of a pilot in qualitative research,' *Qualitative Research,* 4(3), pp.383-402.

Saunders, M., Lewis, P. and Thornhill, A. (2009). *Research methods for business students*. 5th edn. Harlow: Pearson Education Limited.

Saunders, M., Lewis, P. and Thornhill, A. (2012). *Research Methods for Business* Students. 6th edn. Harlow: Pearson Education Limited.

Sayer, A. (1992). *Method in Social Science, a Realist Approach.* 2nd edn. London: Routledge.

Scally, G. and Donaldson, L. (1998). 'Clinical governance and the drive for quality improvement in the new NHS in England,' *British Medical Journal*, 317(7150), pp.61-65.

Schon, D. (1983). *The reflective practitioner, how professional think in action*. New York: Basic Books.

Scott, K. (2017). 'Making History,' *RCN Bulletin,* 358 [Online]. Available at: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/bulletins/2017/december/bul-358.pdf?la=en (Accessed: 3 August 2020).

Selye, H. (2013). *Stress in Health and Disease.* Oxford: Butterworth-Heinemann.

Shelter, S.A. (2019). *I am tired of being treated like a second- class citizen! Racial Discrimination in the Private Rental* Market. [Online]. Available at: https://www.sheltersa.asn.au/site/wp-content/uploads/190430-Shelter-SA-Research-Report-on-Racial-Discrimination-in-Private-Rental-FINAL.pdf (Accessed: 13 May 2020).

Sherwood, M. (2001). 'Race, Empire and Education: Teaching Racism,' *Race and Class,* 42(3), pp.1-28.

Sherwood, M. (2003). 'White Myths, Black Omissions: the historical origins of racism in Britain,' *International Journal of Historical Teaching, Learning and Research,* 3(1), pp. 45-53.

Simon, M.K. (2011*). Dissertation and scholarly research: Recipes for success.* Seattle: CreateSpace Independent Publishing Platform.

Sinyangwe, S., Fridell, L. and Stoughton, S. (2015). 'Why do US police keep killing black men?' *BBC News*, 26 May [Online]. Available at: https://www.bbc.co.uk/news/world-us-canada-32740523 (Accessed: 24 March 2018).

Smedly, A and Smedly, B. (2005). 'Race as Biology Is Fiction, Racism as a Social Problem is Real: Anthropological and Historical Perspectives on the Social Construction of Race', *American Psychologist*, 60(1), pp.16-26.

Smith, J.A. (eds.) (2003). *Qualitative Psychology: A Practical Guide to Research Methods*. London, Sage

Smith, J.A. (2010). 'Evaluating the contribution of interpretative phenomenological analysis', *Health Psychology Review*, 5(1), pp.9-27.

Smith, J.A., Flowers, P. and Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Smith, J. and Osborn, M. (2015). 'Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain,' *British Journal of Pain*, 9(1), pp.41-42.

Smyth, A. and Holian, R. (2008). 'Credibility Issues in Research from within Organisations' in Sikes, P. and Potts, A (eds.) *Researching education from the inside*. Abingdon: Routledge, pp.33-47.

Snieder, R. and Larner, K. (2009). *The Art of Being a Scientist: A Guide for Graduate Students and their Mentors*. Cambridge: University Press.

Sofaer, S. (1999). *Qualitative methods: what are they and why use them?* [Online]. Available at: http://www.ncbi.nlm.nih.gov/pubmed/10591275 (Accessed: 20 March 2014).

Stephenson, J. (2019). 'Leading profiles: Career experiences of senior nurses from BME backgrounds,' *Nursing Times*, 3 October [Online]. Available at: https://www.nursingtimes.net/news/workforce/leading-profiles-career-experiences-of-senior-nurses-from-bme-backgrounds-03-10-2019/ (Accessed: 20 November 2019).

Stephenson, J. (2020). 'Exclusive: Are we whitewashing coronavirus?' *Nursing Times* 12 April [Online]. Available at:

https://www.nursingtimes.net/news/coronavirus/exclusive-are-we-whitewashing-coronavirus-12-04-2020/ (Accessed: 6 May 2020).

Storey, J. and Holti, R. (2013). *Towards a New Model of Leadership for the NHS.* London: NHS Leadership Academy.

Strauss, A. and Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* California: Sage Publishing.

Sue, D.W. (2010). *Micro-aggressions in Everyday Life: Race, Gender and Sexual Orientation.* Ist edn. New York: Wiley.

Sultana, F. (2007). 'Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research', *ACME*, 6(3), pp.374–385.

Surbhi, S. (2018). *Difference Between Inductive and Deductive Reasoning (with Comparison Chart) - Key Differences* [Online]. Available at: https://keydifferences.com/difference-between-inductive-and-deductive-reasoning.html (Accessed: 18 April 2019).

Tahan, H.A. and Sminkey, P. (2012). 'Motivational interviewing: building rapport with clients to encourage desirable behavioural and lifestyle changes', *Professional Case Management,* 17(4), pp.164-172.

TB Facts. (2018). *TB Facts - Information about TB – TB Facts* [Online]. Available at: https://tbfacts.org/ (Accessed: 5 May 2019).

Teijlingen van, E. and Hundley, V. (2001). 'The importance of pilot studies,' *Social Research Update* [Online]. Available at: http://www.soc.surrey.ac.uk/sru/SRU35.html. (Accessed 6 June 2018).

Telegraph Reporters. (2020). 'Windrush draft report that called Home Office institutionally racist "was watered down," *The Telegraph,* 21 February [Online]. Available at: https://www.telegraph.co.uk/news/2020/02/21/windrush-draft-report-called-home-office-institutionally-racist/ (Accessed 9 March 2020).

Tesch, R. (1994). 'The contribution of a qualitative method: Phenomenological research', in M. Langenbach, C. Vaughn and L. Aagaard (eds), An Introduction to Educational Research. Needham Heights, MA: Allyn and Bacon

Tharps, L.L. (2016). *Same family, different colors: confronting colorism in America's diverse families*. Boston: Beacon Press.

The Institute of Race Relations. (2017a). *Definitions* [Online]. Available at: http://www.irr.org.uk/research/statistics/definitions/ (Accessed: 5 July 2017).

The Institute of Race Relations. (2017b). *Fatalities and racism* [Online]. Available at: http://www.irr.org.uk/research/deaths/ (Accessed: 3 August 2017).

The King's Fund. (2012). 'About Us,' *The King's Fund* [Online]. Available at: https://www.kingsfund.org.uk/about-us (Accessed: 18 August 2019).

The Unwanted: The Secret Windrush Files. (2020). BBC Television 13 June.

The Research Ethics Guidebook. (2015). *A resource for social scientists*. [online]. Available at: www.ethicsguidebook.ac.uk/sitemap (Accessed: 25th July 2019).

The Royal College of Nursing. (2002) *Clinical Supervision in the Workplace: Guidance for Occupational Health Nurses*. London: Royal College of Nursing

The Royal College of Nursing. (2009). *Research ethics: RCN guidance for nurses.* RCN, London.

The Royal College of Nursing. (2017). *The RCN is 'deeply concerned' by further evidence of the devastating impact of racism in the workplace* [Online]. Available at: https://www.rcn.org.uk/news-and-events/news/deep-concern-over-bme-report (Accessed: 14 July 2017).

The Royal College of Nursing. (2018a). *Investing in a Safe and Effective Workforce: Continuing professional development for nurses in the UK* [Online]. Available at: https://www.rcn.org.uk/professional-development/publications/pdf-007028 (Accessed 19 September 2018).

The Royal College of Nursing. (2018b). *RCN Bulletin 368: October 2018* [Online]. Available at: https://www.rcn.org.uk/news-and-events/rcn-magazines/bul-368 (Accessed: 3 October 2019).

The Royal College of Nursing. (2019a). *Rise in reported racial discrimination in the NHS a disgrace* [Online]. Available at: https://www.rcn.org.uk/news-and-events/news/rise-in-reported-racial-discrimination-in-the-nhs-a-disgrace. (Accessed: 3 April 2019).

The Royal College of Nursing. (2019b). *Bulletin 380: October 2019* [Online]. Available at: https://www.rcn.org.uk/news-and-events/rcn-magazines/bul-380 (Accessed 9 October 2019).

The Royal College of Nursing. (2019c). *Government announces £1,000 personalised training budgets to nurses* [Online]. Available at: https://www.rcn.org.uk/news-and-events/news/uk-personalised-training-budgets-for-nurses-030919 (Accessed 17th January 2021).

The Royal College of Nursing. (2020). *Emotionally demanding| RCN Bulletin* [Online]. Available at: https://www.rcn.org.uk/magazines/bulletin/2020/march/emotionally-demanding (Accessed 3 Aug. 2020).

The Royal College of Nursing. (2021). *Professional development* [Online]. Available at: https://www.rcn.org.uk/professional-development (Accessed 30 May 2021).

Thomas, H. (2000). *Race and Planning: The UK Experience.* London: UCL Press.

Thorne, S. (2008). *Interpretive Description.* California: Left Coast Press.

Times Higher Education. (2020). *Box-ticking is the inevitable result of top-down impositions* [Online]. Available at: https://www.timeshighereducation.com/opinion/box-ticking-inevitable-result-top-down-impositions (Accessed: 27 January 2020).

Trafford, V. and Leshem, S. (2008). *Stepping stones to achieving your doctorate: focusing on your viva from the start.* Maidenhead: Open University Press.

Trier-Bieniek, A. (2012). 'Framing the telephone interview as a participant-centred tool for qualitative research: a methodological discussion,' *Qualitative Research,* 12(6), pp.630-644.

Turner, C. (2017). 'Outcry after grammar school pupils asked buy slaves with "good breeding potential" in history class,' *The Telegraph*, 13 July [Online]. Available at: http://www.telegraph.co.uk/education/2017/07/13/grammar-school-criticised-asking-pupils-buy-slaveswith-good (Accessed: 29 September 2017).

Uhrig, N. (2016). *Black, Asian and Minority Ethnic disproportionality in the Criminal Justice System in England and Wales* [Online]. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/att

achment_data/file/639261/bame-disproportionality-in-the-cjs.pdf (Accessed: 10 January 2020).

UKCGE. (2019). *4th International Conference on Developments in Doctoral Education and Training* [Online]. Available at: http://www.ukcge.ac.uk/events/icddet4-129.aspx (Accessed: 18 July 2018).

UNISON National. (2019). *Race discrimination* [Online]. Available at: https://www.unison.org.uk/get-help/knowledge/discrimination/race-discrimination/. (Accessed: 19 February 2020).

UNISON National. (2020a). *Religious discrimination* [Online]. Available at: https://www.unison.org.uk/get-help/knowledge/discrimination/religious-discrimination/ (Accessed: 19 February 2020).

UNISON National. (2020b). *Transgender discrimination* [Online]. Available at: https://www.unison.org.uk/get-help/knowledge/discrimination/transgender-discrimination (Accessed 23 June 2020).

Useem, J. and Useem, R. (1963). *Human Organizations*, 22(3).

Utley, E.A. (2016). 'Humanizing Blackness: An Interview with Tommy J. Curry,' *Southern Communication Journal*, 81(4), pp.263–266.

Victorian Healthcare Association. (2008). *Clinical Supervision and Leadership In Community Health Literature Review* [Online]. Available at: http://www.healthcaregovernance.org.au/docs/lit-review-clcs- (Accessed 3 September 2014).

Vonderbeck, R. and Worth, N. (2015). *Intergenerational Space.* London: Routledge

Walker, I. (2005). *Psychopaths in Suits*. Ultimo: Australian Broadcasting Corporation.

Waring, T. and Wainwright, D. (2008). 'Issues and Challenges in the Use of Template Analysis: Two Comparative Case Studies from the Field,' *Electronic Journal on Business Research Methods,* 6(1), pp.85-94.

Waters, M. and Mehay, R. (2010). *A Deeper look at Constructivism ontology and epistemology* [Online]. Available at: https://www.coursehero.com/file/24713200/A-Deeper-look-at-Constructivismdoc/ (Accessed 1 April 2020).

Watson-Druee, N. (2009). 'Why BME nurses lack opportunities in today's NHS', *Nursing Times,* 20 April [Online]. Available at: https://www.nursingtimes.net/why-bme-nurses-lack-opportunities-in-todays-nhs/5000641.article (Accessed: 2 April 2017).

West, M. (2013). 'Now is the time to transform NHS cultures,' *The Kingsfund,* 10 September [Online]. Available at: https://www.kingsfund.org.uk/blog/2013/09/now-time-transform-nhs-cultures (Accessed 10 May 2020).

West, M., Armit, K., Loewenthal, L., Eckert, R., West, T. and Lee, A. (2015). 'Leadership and leadership development in health care: the evidence base,' *The Kings Fund,* 25 February [Online]. Available from: http://www.kingsfund.org.uk/publications/leadership-and-leadership-developmenthealth-care (Accessed 3 August 2020).

West, M., Dawson, J., Admasachew, L. and Topakas, A. (2011). *NHS staff management and health service quality*. London: Department of Health.

West, M., Eckert, R and Passmore, B. (2014). 'Developing collective leadership for health care,' *The King's Fund,* 21 May [Online]. Available at: https://www.kingsfund.org.uk/publications/developing-collective-leadership-health-care (Accessed: 2 April 2020).

West, M., Randhawa, M. and Dawson, J. (2015). 'Making the difference,' *The Kings Fund,* 16 December [Online]. Available at: https://www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs (Accessed: 25 July 2017).

Wheeler, S. (2003). *Research on supervision of counsellors and psychotherapists: a systematic scoping search.* Rugby, BACP.

Wilkie, A. (2015). *Improve your research technique- Reflexive thinking, 5 practical tips* [Online]. Available at: https://www.cxpartners.co.uk/our-thinking/improve-your-research-technique-reflexive-thinking-5-practical-tips/ (Accessed: 20 July 2018).

Williams, D. (2006). *How racism makes us sick* [Online]. Available at: https://ed.ted.com/lessons/oRaEODBk (Accessed 12 October 2016).

Williams, D., Yu, Y., Jackson, J.S. and Anderson, N.B. (1997). 'Racial differences in physical and mental health: socio-economic status, stress and discrimination,' *Journal of Health Psychology,* 2(3), pp.335–351.

Williams, P. (2020). 'Language is part of the machinery of oppression – just look at how black deaths are described,' *The Guardian*, 10 June [Online]. Available at: https://www.theguardian.com/commentisfree/2020/jun/10/language-is-part-of-the-machinery-of-oppression-just-look-at-how-black-deaths-are-described (Accessed 10 June 2020).

Wilson, A. (1978). *Finding a Voice: Asian Women in Britain.* London: Virago.

Wilson, A. (2002). *The falsification of Afrikan consciousness: Eurocentric history, psychiatry and the politics of white supremacy*. New York: Afrikan World InfoSystems.

Wilson, J. (2018). 'NHS increasingly desperate for nurses and midwives as applications continue to fall,' *The Telegraph,* 27 July [Online]. Available at: https://www.telegraph.co.uk/news/2018/07/27/nhs-increasingly-desperate-nurses-midwives-applications-continue/ (Accessed 24 January 2020).

Wilson, R. (2018). *Collective Leadership - The What, Why And How* [Online]. Available at: https://growingorganisations.com/wp-content/uploads/2018/08/blog-collective-leadership-the-what-why-and-how.pdf (Accessed: 1 July 2020).

Winter, G. (2000). 'A Comparative Discussion of the Notion of 'Validity' in Qualitative and Quantitative Research', *The Qualitative Report*, 4(3), pp.1-14.

Wisniewski, T., Yekini L., Omar, A. (2017) Psychotic Traits of Corporate Leadership as Predictors of Future Stock Returns *Social Science Research Network*

Wood, M. and Ross-Kerr, J.C. (2010). *Basic Steps in Planning Nursing Research: From Question to Proposal.* Massachusetts: Jones and Bartlett Learning.

Wood, M.J. and Ross-Kerr, J.C. (2011). *Basic steps in planning nursing research: from question to proposal*. Massachusetts: Jones and Bartlett Learning.

Worchel, S., Rothgerber, H., Day, E.A., Hart, D. and Butemeyer, J. (1998). 'Social identity and individual productivity within groups,' *British Journal of Social Psychology,* 37(4), pp.389–413.

Worldometer. (2020). *Coronavirus Toll Update: Cases and Deaths by Country of Wuhan, China Virus - Worldometer* [Online]. Available at: https://www.worldometers.info/coronavirus/ (Accessed: 31 May 2020).

Yerkes, R. and Dodson, J. (2019). 'The relation of strength of stimulus to rapidity of habit formation', *Journal of Comparative Neurology and Psychology,* Vol 18, No 5. Available at: https://Onlinelibrary.wiley.com/toc/15507149/18/5 (Accessed: 11 December 2019).

Yin, R.K. (2003*). Case study research: Design and methods*. 3rd edn California: Sage Publications.

Yosso, T.J. (2005). 'Whose culture has capital? A critical race theory discussion of community cultural wealth,' *Race Ethnicity and Education*, 8(1) pp.69–91.

Young, J. (2010). *Cultural appropriation and the Arts*. New Jersey: Wiley Blackwell Pub.

Appendix

Appendix 1

School of Health & Education
The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 020 8411 5000

01st November 2016

HEESC APPLICATION NUMBER: NO96 Petula Gordon

Dear Petula

Re your application titled: "Exploring barriers and opportunities to nurse professional development"

Thank you for submitting your application. I can confirm that your application has been given approval from the date of this letter. This approval is valid until 1st December 2018. If you require an extension to this end date please complete Form E which can be found at http://ethics.middlesex.wikispaces.net/Health+Studies

Please ensure that you contact the ethics committee HEethicsSubC@mdx.ac.uk if there are any changes to the study to consider possible implications for ethics approval. Please quote the application number in any correspondence.

The committee would be pleased to receive a copy of the summary of your research study when completed.

Good luck with your research.

Yours sincerely

Kay Caldwell

Professor Kay Caldwell
Health and Social Care Ethics Sub-Committee

Appendix 2

NHS
Health Research Authority

Do I need NHS REC approval?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Advancing Professional Development of the Black Female Practitioner: Speaking Power to Truth

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC approval for sites in England.** However, **you may need other approvals.**

You have answered ***'YES'*** to: Is your study research?

You answered ***'NO'*** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?
- Is your study a clinical trial involving the participation of practising midwives?

Question Set 2

- Will your study involve research participants identified from, or because of their past or present use of services (adult and children's healthcare within the NHS and adult social care), for which the UK health departments are responsible (including services provided under contract with the private or voluntary sectors), including participants recruited through these services as healthy controls?
- Will your research involve collection of tissue or information from any users of these services (adult and children's healthcare within the NHS and adult social care)? This may include users who have died within the last 100 years.
- Will your research involve the use of previously collected tissue or information from which the research team could identify individual past or present users of these services (adult and children's healthcare within the NHS and adult social care), either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve research participants identified because of their status as relatives or carers of past or present users of these services (adult and children's healthcare within the NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or deceased on premises in the UK, but not Scotland, without an appropriate licence from the Human Tissue Authority (HTA)? This includes storage of imported material.
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent from the donors, and the research does not come under another NHS REC approval?
- Will your research involve the analysis of DNA from bodily material, collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor?

Question Set 4

- Will your research involve at any stage intrusive procedures with adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving prisoners?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health?

Appendix 3

MIDDLESEX UNIVERSITY
SCHOOL OF HEALTH AND EDUCATION

Participant Information Sheet

Please click on the link below to return to the survey questionnaire:

https://mdxl.eu.qualtrics.com/SE/?SID=SV_bvKSKNX4gIIQpuZ

1. Study title

Exploring barriers and opportunities to nurse professional development

2. Invitation to take part in study

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

The aim of my research is to bring understanding and fresh perspectives to the impact that opportunities and barriers can have on the professional development of nurse practitioners working within the National Health Service (NHS). The research is expected to last approximately two years.

4. Why have I been chosen?

My sample group are nurses. You have been chosen because you are a nurse working within the NHS.

5. Do I have to take part?

It is up to you to decide whether to take part. If you do decide to take part, you will be asked to sign a consent form where appropriate. If you decide to take part, you are still free to withdraw at any time and without giving a reason.
It is envisaged that approximately 100 nurses will be involved in the survey and 12 to 15 nurses in the interview.

6. What will happen to me if I take part?

If you decide to take part in the study, you will be asked to complete a survey questionnaire which is estimated to take 15 minutes or less to complete. The aim of the survey questionnaire is to collect information.
Completion and submission of the survey questionnaire will be deemed as consent to take part in the study.

Please note that, to ensure quality assurance and equity, this project may be selected for audit by a designated member of the audit committee. This means that the designated member can request to see signed consent forms. However, if this is the case, your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What do I have to do?

You will be asked to complete a survey questionnaire. In addition to the survey, the research will also consist of semi-structured interviews where a small number of participants who complete the survey will be asked if they would be willing to be interviewed. The interview will last approximately 1 hour. Those participants willing to be interviewed will be asked to send a separate email to the researcher confirming that they would be happy to be contacted to take part in an interview. Interviews will take place at your work location.

8. What are the possible disadvantages and risks of taking part?

The time taking part in the interview (approximately 1 hour) could be considered a possible disadvantage. There are no known risks in participating in this project.

9. What are the possible benefits of taking part?

Those taking part in the study will be awarded a certificate. The certificate will demonstrate the reflective process that a participant

has undergone through taking part in both the survey and the interview. This can be used towards the nurse revalidation process.

10. Will my taking part in this study be kept confidential?

The research complies with the relevant Data Protection Legislation. All information that is collected about you during the research will be kept strictly confidential. Any information about you which is used will not have information that identifies you so you will not be recognised from it.

For UK registered nurses and midwives

NMC code www.nmc-uk.org/Nurses-and-midwives/The-code/ states that as nurses and midwives 'you must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing'.

11. What will happen to the results of the research study?

A summary report will be published as part of the research study. It is anticipated that the results will be published in the latter part of 2018. A copy of the published results can be obtained by contacting the researcher. Participants will not be identified in any report/publication.

12. Who has reviewed the study?

This study has been reviewed by the: Research Ethics Committee of the Middlesex University School of Health and Education, Health and Social Care Ethics Sub-committee

13. Contact for further information

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Thank you for taking part in this study.

Please click on the link below to return to the survey questionnaire:

https://mdxl.eu.qualtrics.com/SE/?SID=SV_bvKSKNX4gIIQpuZ

Appendix 4

Professional learning and development Questionnaire

Initials ……………………………………………………………………………

Date of birth……………………………………………………………………

Ethnicity………………………………………………………………………...

Please tick either yes or no to the answers that apply

1. Do you/did you work for the NHS? Yes/No

2. What is/was your position within the organisation?...

3. Do/did you feel valued as a member of the team? If yes, explain why, if no, explain why

……………………………………………………………………………………………

4. Do/did you think the organisation fosters a culture of staff development through education and training? Yes/No

5. Do/did you access training and development activities within the organisation? Yes/No

6. In your opinion, do you/did you think staff are treated equally across all ethnic groups? Yes/No

7. If you have answered no, give the reason for your answer

……………………………………………………………………………………………

8. Is/was clinical supervision available for staff? Yes/No

9. If available, do/did you access clinical supervision? Yes/No

10. If clinical supervision was available but you did not access it, explain the reason why.

………………………………………………………………………………………….

11. If you access(ed) clinical supervision do/did you find it helpful? Yes/No

12. Explain your answer to question 11

…………………………………………………………………………………………

14. How do you think practitioners can help improve access to professional development activities?

…………………………………………………………………………………………

15. Are you employed in a substantive capacity or on an agency/interim basis? If you are an agency/interim practitioner, please answer question 16

…………………………………………………………………………………………

16. Can you explain why you work on an agency/interim basis?

………………………………………………………………………………………….
.

17. We would like to interview a selection of participants, if you would like to participate please provide your email address below. Please note, data will be analysed anonymously

Appendix 5

Professional learning and development interview questionnaire with themes

Demographic Information

1. Which nationality and culture do you identify with?

2. What is your position and banding within the organisation?

3. What is your highest educational qualification

4. Male/female

5. Age range: 20-30 30-40 40-50 50-60 60-70

6. Number of years as a nurse? Number of years at this hospital?

Equity

7. Do you feel valued as a member of the team?

8. Do think staff are treated equally across all ethnic groups?

9. Are there any examples where you feel that good or not so good practice was evident with regards to equality?

Training and development

10. Do you access training and development activities within the organisation?

11. Do you think the organisation fosters a culture of staff development through education and training?

12. Do you feel that nursing practitioners are trained and developed in providing culturally competent and compassionate care?

13. Going forward with your career, what future training and development would you like to undertake?

14. How likely is it that you will have the opportunity to take up any future training and development plans?

15. How do you think practitioners can help improve access to professional development activities? Are there any other positive points, issues or concerns that you would like to mention, with reference to your professional development or practice learning in the NHS?

16. Are there any examples of good or other practice that you can recall with regards to training and development?

Clinical supervision

17. Is clinical supervision available for all nursing staff? If available, do you access it? If so, do you find it helpful and why? If available but you do not access it, explain why

Employment status

18. Are you employed in a substantive capacity or on an agency/interim basis?

19. If you are an agency/interim practitioner, can you explain why you work on this basis?

Thank you for taking part in this study, please feel free to mention anything that you would like to say about the theme of nurse training and development that has not already been addressed.

Appendix 6

Sample of themes identified from qualitative data analysis

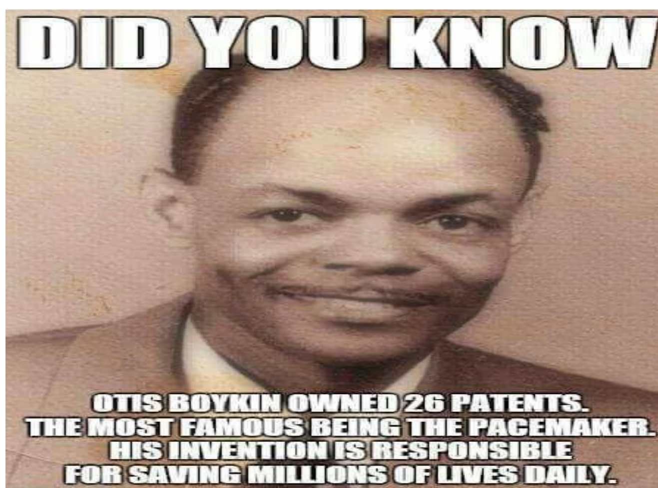
Themes	Number	Sample description of the themes
Nepotism	3	*"In my opinion, people get promoted according to whom they know or associated with"*
Equality	3	*"From the few days I have been working within the hospital - I believe staff are treated equally. It appears the opportunity to ask questions and be listened to without being dismissed immediately are present. The hospital is recognising the diversity and is accommodating this"*
Valued	4	*"I get a lot of positive feedback from members in my team"*
Training accessibility	6	*"We are all given same opportunity in terms of development"*
Not valued	8	*"Only valued if face fits"*
Inequality	11	*"Looking at minorities within the organisation, one could observe that certain treatment and approach are not ideal when the matter is between ethnic minority groups. The inequalities are of big issue and very difficult to tackle"*
Staff shortages	4	*"Make it more available and if you do go on training, don't pull us off due to chronic staff shortages"*
Staff racist	13	*"There is institutional racism"*
Respected	4	*"Opinions and decisions respected"*
Training ownership	3	*"Be more proactive in knowing what training is available, being open to attending training in their own time as study leave is limited, booking themselves onto a training event"*
No clinical supervision	10	*"Not available"*

Appendix 7

Notable Black figures

Olaudah Equiano was a former slave and writer who became involved in the British abolition movement.

Source: literary ramblings.com & http://www.bbc.co.uk/history/historic_figures/equiano_olaudah.shtml



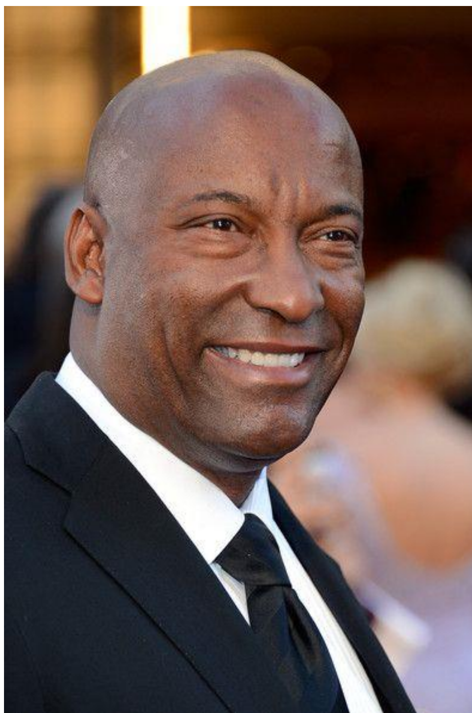
Source: https://www.bing.com/images/search?q=Otis+Boykin+Heart+Pacemaker&id=9BCD87B3573D2C06A8BB8C38D6407E1071F1CD7E&FORM=IDBQDM

Maggie L. Walker an African American teacher and businesswoman was the first female bank president and the first woman to charter a bank in the United States

Source: projectblackman.com

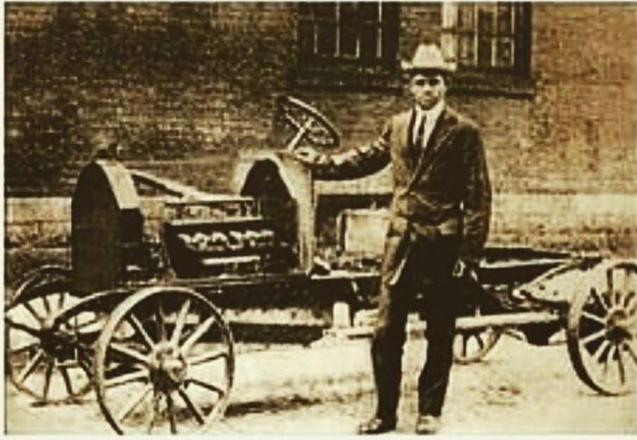
Source: wisdom-sa.blogspot.com

Source: whotalking.com



John Daniel Singleton was the first African American as well as the youngest person ever nominated for best film director.

Source: eurweb.com & biography.com



Source: http://stalkture.com/c/nelvomedia/

Source: https://s-media-cache-ak0.pinimg.com/564x/52/bd/0c/52bd0c94a865bdbd6773ad120e6e294c.jpg

Source: https://s-media-cache-ak0.pinimg.com/originals/1b/79/0e/1b790e7687d3cc4e3370043e52126747.jpg

Source: The Shakespearean Authorship Trust; www.bardweb.net.

Michelle Obama! The first, first lady to attend an Ivy League University for undergrad, (and the second one to attend an Ivy League at all) Michelle Obama is one of the most academically accomplished first ladies. She skipped second grade, graduated salutatorian at her magnet high school for gifted students, went to Princeton (graduating cum laude) and then Harvard Law School. -The Huffington Post #29daysofBlackHistory

Source: https://twitter.com/search?q=%2329daysofblackhistory&lang=en

https://s-media-cache-ak0.pinimg.com/originals/bd/7b/1e/bd7b1e9eea5e6be4757b2a3bd1674b8c.jpg

Queen Charlotte, patron of the arts, founder of the royal botanical Kew gardens, Richmond, London

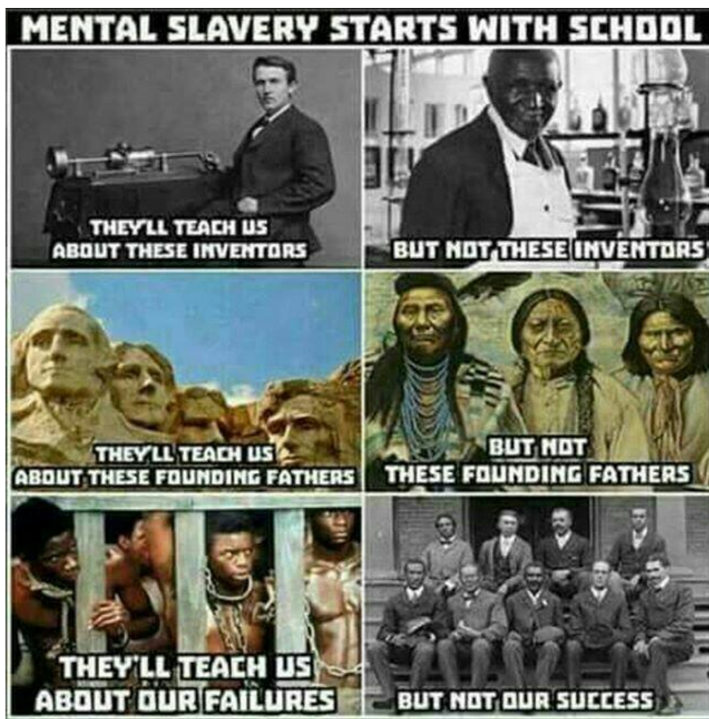
Photograph: Guardian 12th 2009

In Honor of Black History Month

BLACK INVENTORS

PRODUCT	INVENTOR	DATE
Air Conditioning Unit	Frederick M. Jones	1949
Almanac	Benjamin Banneker	1791
Auto Cut-Off Switch	Granville T. Woods	1839
Auto Fishing Device	George Cook	1899
Baby Buggy	William H. Richardson	1889
Biscuit Cutter	Alexander P. Ashbourne	1875
Blood Plasma Bag	Charles Drew	1945
Chamber Commode	Thomas Elkins	1897
Clothes Dryer	George T. Sampson	1971
Curtain Rod	Samuel R. Scrottron	1892
Curtain Rod Support	William S. Grant	1896
Door Knob	Osbourn Dorsey	1878
Door Stop	Osbourn Dorsey	1878
Egg Beater	Willie Johnson	1884
Electric Lamb Bulb	Lewis Latimer	1882
Elevator	Alexander Miles	1867
Eye Protector	Powell Johnson	1880
Fire Escape Ladder	Joseph W. Winters	1878
Fire Extinguisher	Thomas Marshall	1872
Folding Bed	Leonard C. Bailey	1899
Folding Chair	Nathaniel Alexander	1911
Fountain Pen	Walter B. Purvis	1890
Furniture Caster	David A. Fisher	1878
Gas Mask	Garrett Morgan	1914
Golf Tee	George T. Grant	1899
Guitar	Robert F. Fleming, Jr.	1886
Hair Brush	Lydia O. Newman	1898
Hand Stamp	Walter B. Purvis	1883
Ice Cream Scoop	Alfred L. Cralle	1897
Insect Destroyer Gun	Albert C. Richardson	1899
Ironing Board	Sarah Boone	1887
Key Chain	Frederick J. Loudin	1894
Lantern	Michael C. Harvey	1884
Lawn Sprinkler	John H. Smith	1897
Lemon Squeezer	John Thomas White	1893
Lock	Washington A. Martin	1893
Lubricating Cup	Elijah McCoy	1895
Lunch Pail	James Robinson	1887
Mail Box	Paul L. Downing	1891
Mop	Thomas W. Stewart	1893
Peanut Butter	George W. Carver	1896
Pencil Sharpener	John L. Love	1897
Record Player Arm	Joseph H. Dickinson	1819
Rolling Pin	John W. Reed	1864
Shampoo Headrest	Charles Orren Bailiff	1898
Spark Plug	Edmond Berger	1839
Stethoscope	Thomas A. Carrington	1876
Straightening Comb	Madam C. J. Walker	1905
Street Sweeper	Charles B. Brooks	1890
Phone Transmitter	Granville T. Woods	1884
Thermostat Control	Frederick M. Jones	1960
Traffic Light	Garrett Morgan	1923
Tricycle	Matthew A. Cherry	1886

Source: https://www.pinterest.co.uk/pin/446982331747447507/



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