Exploring Barriers and Opportunities to Black Nurses' Professional Development

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This paper presents the findings of the lived experience of black and minority ethnic (BME) nurses when applying to access training and development programmes in the National Health Service (NHS). Research has shown that black nurses in particular, are less likely to be selected for training and development programmes when compared to their white counterparts which can impact on the quality of care given to patients. Despite interventions in place to promote equal opportunities, oppressive practices persist.

A conceptual model of issues to be considered in the development of an equality framework has been proposed to help facilitate improvement in training opportunities for black nurses. The framework has been proposed on the basis that taking a collective approach to a longstanding problem to include stakeholders such as black nurses, NHS Trusts and the Government, may help towards improving training opportunities for black and minority ethnic nurses.

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

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Introduction

The discriminatory practices towards black and minority ethnic (BME) nurses working in the NHS 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], 2017). Whilst the term BME is used in this paper, 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 a homogenous group (BBC, 2020). Additionally, Black, Asian and Minority Ethnic people do not share the same experiences therefore the term BME is not equivalent in its usage (BBC, 2020). For the purposes of this paper, 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* (Agyeman, Bhopal & Bruijnzeels, 2005: 1014 – 1018).

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) argues that everyone is protected from discrimination by the Equality Act, 2010 (Equality and Human rights Commission [EHRC], 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 EHRC (2019), there are three types of discrimination which are: direct, indirect and discrimination arising from disability. Direct discrimination refers to treating someone with a protected characteristic less favourably than someone without a protected characteristic, for instance refusing a student entry to education (EOC, 2021). Indirect discrimination is said to have occurred when a policy may place someone 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).

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, as well as 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 that 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 perspective of black nurses. A report produced in 2002 (Eliot et al, 2002), found that progress in terms of career development for senior black nurses was limited. Written almost two decades ago, the report bears parallels to the current situation where the nurses face barriers in the pursuit of their professional goals. It found that black and minority ethnic nurses were being blocked from progressing into leadership positions with representation at the most senior levels being an unusual occurrence. BME nurses are still under-represented in senior positions (NHS England, 2018; Kline, 2014). Due to racial discrimination, they continue to fight an uphill struggle for equality (NHS England, 2019; Stephenson, 2019). This has resulted in difficulty accessing career development training both clinically and managerially, the effect of which is damage to their careers (NHS England, 2019).

As a black woman nurse specialist working for the NHS, I was concerned with the unequitable practices I observed within my organisation, especially as it was reported that levels of discrimination were highest for black employees in the NHS and were 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 my 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 me 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 for me especially when it came to black nurses accessing training and development programmes as compared to their white peers.

With the absence of 'black voices' in clinical practice, it evoked a curiosity as to why little had been done to address this situation. My concern was also with why discriminatory practices appear to remain despite interventions being put 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.

Background

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 central to its existence. 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 mental health and care of the elderly (Ali, Burns & Grant, 2013). Ali, Burns and Grant (2013) assert that having a diverse workforce was often considered a problem by the health service. John (2015) expounds 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: 2) were commonplace.

The NHS was built on a diverse workforce and continues to depend on a diverse workforce (Jones-Berry, 2017), yet a report by the Workforce Race Equality Standard (WRES) expounds that it is apparent that 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). Figures published in September 2017 reported that the NHS was short of 40,000 nurses (RCN, 2017). 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 & Prabhu, 2015). Discrimination against BME staff has been an ongoing concern within the NHS for many years (Kline, 2014, Archibong & 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, 2019, NHS WRES, 2019). This was in contrast to the experiences of white staff in the NHS where discrimination was just 6.6% (NHS WRES, 2019).

Section 149 of the Equality Act 2010 (EHRC, 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 (EHRC, 2010). Public bodies must be transparent and they need to demonstrate how they are complying with the Equality Duty through the publication of relevant information (EHRC, 2021). Additionally, public bodies need to publish information on decisions made and the equality data underpinning those decisions (EHRC, 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. Yet evidence suggests that when attempting to access training and promotion opportunities, whether it be clinically or managerially, black nurses continue to face discrimination in the form of racism in the NHS (Unison, 2019; Kline, 2014).

Policy documents have reiterated that continuous professional development (CPD) should be a partnership between the individual and the NHS organisation, providing equal opportunities for all staff members (DOH, 2001; 2003; 2004). CPD which refers to a professionals' learning, is a means of enabling learning to be conscious and proactive rather than reactive and passive. Through having a structured, practical approach to learning, this facilitates the retention of key staff, developing their skills and knowledge within the organisation and also provides the continual upskilling of the individual so professional and academic qualifications do not become outdated or obsolete (CPD, 2021; RCN, 2018). It safeguards the individual and their career, the public and the employer (CPD, 2014) as practice based on the latest evidence, ensures patient safety and public protection through the provision of a quality service (RCN, 2018) and professional recognition and membership for the individual.

Based on my concerns, the research question for this study 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?

Research design

A research approach was sought that would enable me to engage with the research question at an idiographic level, in other words, an individual or unique level (Flowers et al, 2005). Interpretative phenomenological analysis (IPA) is a method that is popular in exploring qualitative data (Pringle et al, 2011, Laverack, 2005) and was therefore utilised for this study. Individual interviews, focus groups, diaries and documents are the most common collection methods or research instruments used in IPA (Smith et al, 2009). IPA was chosen for this study as it places emphasis on the researcher being involved in the process of interpretation and seeks to describe in precise detail, a phenomenon that is experienced by the individual with the focal point being on the subjective experiences of the individual and it is personal (Smith & Osborn, 2015; Letts, 2003).

A diary in the form of 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 that researchers engaging in IPA, should by being able to make notes and look back over the course of their learning journey, enable the charting of the researchers' development and allow the opportunity to make sense of anything new that emerge, like new concepts. The journal served as a means of self-reflection for me the researcher, in which thoughts and feelings could be critically analysed and in turn facilitate the development of new perspectives enabling further exploration. This was to facilitate a moving forward, leading to behavioural changes (Freshwater et al, 2008).

Literature review

Following a review of the literature, critical race theory (CRT) was used as a framework in the project to critique the literature and findings regarding the role of race and racism that maintains the status quo of racism (Huber, 2008). CRT emerged in the 1970s in the United States of America (USA) in response to the slow rate at which the racial equality laws were changing (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 possible contributor (Crenshaw et al, 1996).

Sampling

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 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). The qualifying inclusion criteria for the sample group were that they had to be trained nurses from a BME background who currently or previously worked in the NHS. The exclusion criteria were untrained nurses.

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 is 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 apparent discriminatory practices experienced by black nurses in the NHS, the decision was taken to widen the participant group to include trained 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 experiences 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 in the study and place them at risk of recriminations (Bankert & Amdur, 2006) or the organisation may view the research suspiciously and refuse the researcher access to collect data. Secondly, James et al (2019) assert 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 was paramount that the data was aligned with the aims of the research to allow for robust analysis.

Online survey questionnaire

The data corpus included utilising an online survey questionnaire as a means of exploring how nurses access professional development in order to ascertain an idea of the breadth of the issue being investigated. Sofaer (1999) argues that the data enhances understanding of the context of events as well as the events themselves. This was in line with the study which sought to give an authoritative voice to the practitioner working within the NHS amongst their professional peers. Phase one of data collection with the online survey questionnaire commenced in March 2017 with a medium sized general hospital. Before embarking on the main research study, a pilot study otherwise known as a feasibility study (Teijlingen & Hundley, 2001) was conducted to test the research instrument (Kim, 2010), which in this

case was the survey questionnaire. Undertaking a pilot study was important because it facilitates good study design and it can alert the researcher to potential failure of the main project (Teijlingen & Hundley, 2001, Perry, 2001). The survey response rate was low despite sending 3 reminders to the hospital. 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.

As the response rate for the survey questionnaire was low, another organisation, which was a hospital for the mentally ill, was approached to gain access to potential participants. Access was granted and the survey questionnaire was circulated to the nurses. The response rate in this instance was also extremely low. Despite repeated reminders, 5 responses were received from approximately 100 nurses. It was decided with permission from the service director, to attend the hospital in person to collect data. This course of action was taken as it would eliminate any computer access issues which had occurred in the previous hospital. It also meant that there would be a captive audience by directly administering hard copies of the survey questionnaire along with a confidential and secure location to submit them anonymously. A total of 15 participants completed the survey questionnaire of which 14 hard copies were completed manually and 1 completed online. A total of 40 survey questionnaires were completed and used in the research project. I then went onto phase 2, which was the interview stage.

Interviews

After collating the responses following the pilot study of the interview questions, the interviews were the next stage for the main study. The intention was to interview approximately 12-15 participants to allow for rigour and trustworthiness but only 6 participants from the general hospital responded so another hospital was sought which as mentioned in phase 1, was the hospital for the mentally ill. However, although 3 staff members consented to being interviewed, only 1 participant presented for interview. 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 acquaintances from their community of practice. 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. This action yielded a further 6 participants and a total of 12 nurses were interviewed for the study. Data collection was completed in 2019.

The questions contained within the survey questionnaire were used as the basis for the largely semi structured interview questions after grouping them into themes. As the study used a phenomenological framework, it required that the interviews should also consist of open-ended questions, which allows the participants to relate to their experience of the phenomena under study (Llamas, 2018). Scripted questions were compiled as it allowed 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. Individual interviews were chosen as it enabled the participants to describe their experience in more depth thereby providing more meaningful explanations (Tahan & Sminkey, 2012). Individual interviews also enabled further exploration of the emerging themes through the data that was collected via the survey questionnaire. Additionally, being able to interview the participants allowed the building of rapport between the participants and researcher as it was paramount that a trusting relationship was established (Tahan & Sminkey, 2012). This would also help to overcome any barriers and fears that may have impinged on the research process which could prevent honest disclosure (Trier-Bieniek, 2012).

The interviews were conducted face to face or via the telephone. It was important 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 & Beck, 2017). Semi-structured interviews were chosen for the study, as they are not as time consuming as unstructured interviews can be to conduct and analyse when using IPA.

Ethics

Permission to undertake this research was applied for and granted by all the institutions involved in this study. The research participants were made aware through the participant information sheet (PIS) that completing and submitting the survey questionnaire implied consent to taking part in the study. The participants were also made aware that if they decided to take part in the study, they were free to withdraw at any time without giving a reason.

Analysis of the data

Survey questionnaire

Based on Braun and Clarke's (2006) recommendation, thematic analysis was used to analyse the survey questionnaire data. Key criteria were used in selecting this approach, which are outlined as follows. 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 Clarke (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. Creswell (2009) argues that thematic analysis is suited to those who are new to research.

Interviews

The interviews utilised IPA as a tool for data analysis. Based on my 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 recommends that the IPA framework, which they created, should be followed by novice researchers as a guideline for analysis. Like Cresswell (2009), Smith et al (2009) argue that it 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 & Osborn, 2015). IPA is about understanding the meaning that the participant attribute to their lived experience (Smith, 2003). The interviews were transcribed and a copy of each transcript and audio recording was sent to the academic 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. An encrypted copy of each participant's transcript was sent to them 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. There were no requests for changes to be made.

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 one's own interpretations and choices. This includes ensuring that what is picked up in the data is actually there and making sure that data is not obscured. This was addressed by including my positionality in the research project.

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.

Findings

Survey questionnaire

Two themes and 6 subthemes evolved from a thematic analysis of the data that was collected through the survey questionnaire. Twenty-seven females and 13 males participated in the survey. There was a higher response rate amongst BME nurses with 24 taking part. Eight white British nurses and 7 nurses describing themselves only as British also took part, with 1 person omitting to answer the question.

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

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 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 questionnaire 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 were 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.

During the modification process, the main themes were organised into broader themes with subthemes. Some of the codes fitted more than one theme. 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 themes and subthemes were

finalised. The final themes and subthemes that were drawn out from the survey questionnaire and used to analyse the data were as follows:

Theme 1: Training context

A total of 40 survey questionnaire respondents (nurses) 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. Three subthemes evolved from the data.

Subtheme 1**:** Training opportunities; Subtheme 2: Inaccessible training; Subtheme 3: Improving training access.

Subtheme 1: Training opportunities

The majority of the respondents shared that they were able to access training but there were instances 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 the manager as to who was allowed to attend training courses.

Of those participants who were able to access training, they reported a good working relationship between them and 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).

Subtheme 2: Inaccessible training

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 this was the case. One nurse reported that she only felt valued if things were going well and that training was dependent on the manager. Another nurse expressed that training was only available for those whose ‘face fitted’ as only select staff were allowed to access training.

Subtheme 3: 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. Participants felt that in order to advance their practice, the onus to access training courses should be on the

individual nurse in which 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.

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.

Subtheme1: Nurses feel valued

When asked the question as to why they felt valued, the respondents equated it with several factors and gave similar responses. They largely attributed feeling 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.

Subtheme 2: Not valued

Some of the participants equated not being valued with being unsupported; 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 participant reported that staff were treated as though they were expendable and management lacked interest in the staff, whilst another said training access was

dependent on the individual manager. Four 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.

Subtheme 3: Inequalities

This theme featured significantly in the data and fitted into the theme of employee relations. Although whilst coding there was overlap with the subtheme 'not valued,' the data was also distinct from it. 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 for all, regardless of nationality. A few nurses suggested that there was nepotism and training 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 equity across the ethnic groups.

An excerpt taken from the transcript of one participant stated:

> *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 (pseudonym), staff nurse**

The participant was reporting the inequality faced by people of colour (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.

Interviews

For the project, 12 nurses (participants) were interviewed and asked about their experience of accessing training and development activities within the NHS. The participants were all 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, 2019).

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 going on. As the themes evolved, these were coded after which they were consolidated into superordinate categories (Smith et al, 2009). Three superordinate themes and 6 subthemes evolved through an analysis of the interview data through IPA and are as follows:

Superordinate theme 1: Structures within NHS make it difficult to progress

The experiences of the black nurses who took part in this study suggested that they were 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.

Subtheme 1a: Racism

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

The following excerpt is taken from a 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 (pseudonym)***,* **Staff nurse**

Based on the lived experience of the participant, whenever she attempted to access training and development activities within the NHS, it appears that she equated it with racism as her experiences had been negative. Reflecting on the experiences caused the participant to describe her interaction during the interview as 'speaking in a raised voice.'

Subtheme 1b: 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 the management.

Subtheme 1c: 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 nurse participants reported that they were not free to be who they are as a result of the oppressive and controlling behaviours of their managers, behaviours that did not appear to be equally meted out to their white counterparts. Whilst interviewing one participant, her voice quivered periodically and there was a sadness to her voice. 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.

The following excerpt is taken from the transcript of one of the interviewees as it describes the sentiments of the majority of the interviewees:

> *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 (pseudonym)*, Staff nurse***

The participant was explaining that black nurses suffer discriminatory behaviour and just because of skin colour, their hard work was never recognised.

Superordinate theme 2: Cultural competence 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 was meant by the term 'culturally competent.' 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.

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

There was a prevailing view amongst the participants that there was insensitivity towards black nurses. This insensitivity came from the white nurses who did not have any inclination or wish to take the feelings of black nurses into consideration; rather they treated them 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.

The following excerpt is taken from the transcript of a nurse when asked if nurses were trained to provide culturally competent and compassionate care:

> *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 (pseudonym), Staff nurse**

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

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 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 that 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 the discriminatory practices. 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. Another participant 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. Like 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 participants, this experience contrasted with that of white nurses who tended to gain promotion shortly after qualifying.

The following excerpt is from a participant speaking about the hopelessness of her work situation:

> *…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 (pseudonym), Staff nurse**

The participant indicated that there was no teamwork but rather hostile practices that ended in nurses being driven away from their jobs.

Subtheme 3b: Unvalued

This subtheme 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 to them as if they did not count for anything. Despite having substantial years' experience between them, the highest nursing attainments in the group were band 7s.

On the theme of not feeling valued, one of the participants stated the following:

> *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, (pseudonym), Staff nurse**

The participant conveyed how she was overlooked for promotion despite having a strong work ethic and the requisite qualifications and skills.

Discussion

The researcher set out to explore the experiences of black and minority ethnic 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 the black nurses faced work environments that were not conducive to good health both mentally and physically as a result of the discriminatory culture of the NHS organisations in which they worked.

The omission of the experiences and perspectives of black nurses regarding their professional development in the NHS has consequences (Watson-Druee, 2009), such as losing valuable staff, limiting the advancement of leadership potential for younger practitioners and perpetuating the status quo (Kline, 2014). 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 had a negative impact on practice as it led to stagnation and under-representation in senior positions. With nothing changing despite addressing the

issues with management, black nurses were leaving the profession in large numbers or taking long-term sick leave due to stress.

The data also indicated that black nurses were still subject to disciplinary action, harassment, dismissal and bullying when compared to their white peers (NHS BME Network, 2015; Kline, 2014; Limb, 2014; Archibong & Darr, 2010). This was in keeping with the data where the subthemes of **inequalities** and **not being valued** evolved. The participants reported having their negative experiences within the NHS minimised. Rather than being celebrated for all the hard work they put into building the NHS, they were being denigrated. 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.

Tackling race inequalities within the NHS has been a longstanding problem. Bhopal and Alibhai-Brown (2018) concur with John (2014) and Douglas (1995) in arguing that racism is structural and is woven into the very fabric of society and exists at all levels of society including higher educational institutions which trains nurses. Despite the strategies put in place to combat the inequalities e.g. organisational policies, diversity training, the evidence from the literature and data suggests that there have been no significant changes.

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 that 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.

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, and to defer 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 questionnaire and interviews, provided evidence that despite educational attainment and years of nursing experience, 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. The research suggested that the common denominator when trying to access training and development was that of colour. Black nurses were declined training and career growth whilst the reverse was true for white nurses.

I am aware 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.

Conclusion and Recommendations

The findings from the research indicate that change within the NHS is needed if it is to survive. Black nurses in particular are at a disadvantage when trying to access training and development programmes within the existing NHS structure, giving rise to concern for the care patients receive (NHS England, 2016) as quality care should be based on the best available evidence (RCN, 2018). As black professionals occupy senior positions, the issues they face will make it difficult for organisations to retain talent (Atewologun & Singh 2010).

The following are proposed action points to address the findings of this study:

- The NHS needs a joined-up approach where individual nurses, NHS Trusts and government bodies work together to create an NHS which is more successfully and accountably committed to the goal of organisational justice.
- Professional organisations and trade unions also have a part to play in supporting their members to achieve the highest standards of practice through promoting CPD and lifelong learning.
- 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. A good starting point is for black nurses to know their own history, build resilience and wellbeing and 'find their voices.' These actions would hopefully help the nurses to feel empowered to take steps such as invoking the public sector equality duty (EHRC, 2021) in instances of discrimination including the barriers they face when attempting to access training and career progression. Failure to take action is likely to result in professional and personal stagnation, as change will not be achieved if they continue to do what they have always done.
- Accountability for poor practice with regards to unchallenged discriminatory behaviour appears to be lacking. The human resources/training department of the NHS need to implement and oversee a system whereby not only mandatory courses are monitored but a stringent monitoring system needs to be established which audits the personal and professional development of black nurses in particular. The department would also be held accountable if staff were not being developed.
- BME nurses to familiarise themselves with the financial incentives that 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 is an allocation of £1,000 per nurse over a period of 3 years (RCN, 2019). It is hoped that this move will help in improving recruitment; staff retention and staff morale (RCN, 2019) and the training will help to 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).

- This research identified the need for the provision of clinical supervision for black nurses needing a safe space to share concerns. This is especially pertinent at this time for those who may have been left traumatised after witnessing the audacious murder by police of the unarmed man now known globally as George Floyd. The world looked on as the killing took place which sparked global protests as his 'crime' was being black (Sabur et al, 2020). As a contractor and trained clinical supervisor, I plan to forge links with NHS Trusts in order to establish clinical supervision sessions.

Future research

Future research will be required as this research only focused on England. It would be useful to examine the progression of BME nurses in other countries such as the USA to determine what other studies have found. This is particularly important where the pervasive issue of race and racism has recently gained prominence. For instance, the Black Lives Matter (BLM) movement established in 2013, gained traction in May 2020 in response to yet another unwarranted murder by the police of a black person, which in this case was George Floyd. The BLM movement exists to eradicate white supremacy and build local power in order to take action on the exploitation and violence inflicted on black communities by the state and vigilantes (BLM, 2019).

This paper arose from a research study (Gordon, 2021). The issues that were found whilst undertaking this project are to be addressed through future research where the plan is to develop a conceptualised model of issues for consideration in developing an equality framework. It is proposed that the framework will guide individual BME nurses, NHS Trusts and researchers. The hope is to elicit change, as it is this change that will help black nurses survive in the NHS environment.

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