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Mary Seacole Leadership Awardee

Project Title: The Career Progression of British Trained BME Mental Health Nurses:

Visible yet Invisible!

Project Report
2016/2017
ACKNOWLEDGMENTS

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Berna (Project Admin Support)

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My Family

Einstein’s definition of insanity was to keep doing the same thing and expect different results!
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ABSTRACT

There is evidence and significant concerns that the career trajectory of Black and Minority Ethnic (BME) nurse’s in England in all specialities remains poor. These are not new concerns as statistical trends (Kline, 2014) reveal the professional stagnation of many BME nurses who work in the NHS. This is problematic because it highlights structural and systematic shortcomings in the NHS and gaps in capacity and capability to address this long-standing problem. In addition, it does not give a positive impression to Britain’s multi-cultural and multi-ethnic recipients of healthcare. Equally, newer generations of BME nurses who can potentially enter the nursing profession, would have been witnesses to well-documented and media coverage of the experiences of their overseas counterparts. Consequently, they may possibly assess and reassessed their own career options by considering what was (and still is) an inadequate experience for overseas nurses. Added to that is caution from family members and friends who recount apprehension about becoming a nurse if one is of a BME group.

Those already in the profession will probably think long and hard as to, is it worth their while to progress up in that next position; positions where all talented nurses have a right to pursue. Nonetheless, for various reasons, there may be uneasiness to do so. These include questioning whether the pursuit of such a career progression in the NHS is a price worth paying along with inherent sacrifices; not to mention other factors, such as lack of support, discrimination, isolation and so forth, as narrated by many.

The NHS is a major health care provider and employer; one that employs its most diverse workforce with a visible presence of BME staff who like many other staff, dedicate their skills and experience to this important sector. In the pursuit to attain more senior, decision-making positions however, their knowledge, skills and experience are invisible and as such, does not appear to count for much and is tantamount to hindering ability to reach one’s potential.
The aim of this project is to identify the issues of concern to BME mental health nurses as a significant reminder that for decades, generation of these nurses have been impeded from making a valuable contribution to the NHS workforce at higher levels. It was therefore important to me to find out the extent of which the experience of BME nurses resonate with what has been documented in the literature, where for example, discrimination was reported in up to 80% of NHS Trusts by BME staff. (Merrifield, 2016). Such is the urgency to address the issues, some indicated that the NHS faces a crisis, not only effecting morale, but also recruitment and leadership (Buchan and Seccombe, 2006, Kings Fund, 2017).

Introduction

The terminology BME is a UK abbreviation for Black and Minority Ethnic or those of non-White decent. The groups who fall within BME categories are Asian or Asian British, Mixed, Black or Black British. Their sub-groups include Indian, Pakistani, Bangladeshi, White and Asian, White and White Black African, White and Black Caribbean, African, Caribbean and any other backgrounds (Office of National Statistics, 2011). Throughout this project, the term BME will be used for description of those groups. These are distinguished from overseas nurses who would have gained their nursing qualification outside of the United Kingdom (UK). This project is specifically concerned with BME mental health nurses who trained in the UK.

Historically, the UKs National Health Service (NHS) has over several decades, relied upon British born BME nurses as well as international and overseas nurses to fill labour shortages in its healthcare delivery. These nurses are recognised as belonging to an important workforce, for which their contribution is well known and documented and in the main, much appreciated. Yet, such involvement is not necessarily rewarded when it comes to their status, rank and seniority in the NHS, (Ami, 2014). Many studies, Allan, Larsen, Bryan, & Smith, (2003), Allan, & Larsen, (2003), Alexis, & Vydelingum, (2005), highlight the psychosocial experience of BME nurses in the UK, and specifically their professional stagnation and lack of progression to senior positions, (Pearson, 2003, Kline 2013, Kline 2014).
Nurses from BME backgrounds, tend to be over-represented within the lower, 5 and 6 Bands, but conspicuous in their absence in senior Bands, of 7-9, among the Very Senior Managers (VSM) and at board level. (Ami, 2014). Fundamentally, BME nurses tend to be highly visible within the lower 5 and 6 Bands, and invisible from the more senior Bands from 7, but specifically 8a, 8b, 8c, 8d and 9. This pattern is worrying and disconcerting, particularly as noted by Kline (2014:30) that… ‘London is a city where 41% of NHS staff and 45% of the population are from Black and minority ethnic backgrounds’. Roa et al (2014) and Kline (2013) found evidence of discrimination against BME staff regarding NHS recruitment and career progression. Their research also established that BME staff was disproportionately represented in larger numbers at the lower end of the pay grades and status roles. There is emerging evidence that failure to address these trends can have a detrimental effect upon the health care needs of Britain’s multi-cultural and multi-ethnic population. For instance, West (2013) has found associations between the well-being of BME staff and the health outcomes of patients and Kline (2014) argues that there is benefit from the workforce reflecting the population it serves.

Figure 1 below are statistics for ‘qualified nursing and health visiting staff in NHS Trusts and CCGs in England’ by Ethnicity for the period 2014-2017 presented in tables below.
### 2015 All Ethnicities

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Mixed</th>
<th>Asian or Black or</th>
<th>Chinese</th>
<th>Any Other</th>
<th>Unknown</th>
<th>Unstated</th>
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<td>230,461</td>
<td>3,674</td>
<td>24,358</td>
<td>22,279</td>
<td>1,189</td>
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<td>6</td>
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</tr>
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<td>-</td>
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<tr>
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<td>216</td>
<td>3</td>
<td>17</td>
<td>1</td>
<td>6</td>
<td>13</td>
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<tr>
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<td>112,194</td>
<td>2,105</td>
<td>16,454</td>
<td>13,564</td>
<td>554</td>
<td>5,414</td>
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<tr>
<td>Band 6</td>
<td>84,630</td>
<td>65,903</td>
<td>965</td>
<td>5,832</td>
<td>5,776</td>
<td>372</td>
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<tr>
<td>Band 7</td>
<td>46,756</td>
<td>39,845</td>
<td>464</td>
<td>1,685</td>
<td>2,287</td>
<td>214</td>
<td>715</td>
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<tr>
<td>Band 8a</td>
<td>9,977</td>
<td>8,639</td>
<td>75</td>
<td>212</td>
<td>443</td>
<td>31</td>
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<tr>
<td>Band 8b</td>
<td>2,554</td>
<td>2,305</td>
<td>23</td>
<td>39</td>
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<td>2,081</td>
<td>1,521</td>
<td>25</td>
<td>175</td>
<td>169</td>
<td>9</td>
<td>67</td>
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### 2016 All Ethnicities

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<th>Asian or Black or</th>
<th>Chinese</th>
<th>Any Other</th>
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<th>Unstated</th>
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<tr>
<td>All staff</td>
<td>306,897</td>
<td>231,711</td>
<td>3,889</td>
<td>25,510</td>
<td>22,408</td>
<td>1,165</td>
<td>9,453</td>
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<td>-</td>
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<td>4</td>
<td>15</td>
<td>7</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Band 5</td>
<td>155,548</td>
<td>109,822</td>
<td>2,194</td>
<td>16,707</td>
<td>13,104</td>
<td>553</td>
<td>5,623</td>
</tr>
<tr>
<td>Band 6</td>
<td>87,863</td>
<td>67,850</td>
<td>1,065</td>
<td>6,483</td>
<td>6,113</td>
<td>348</td>
<td>2,813</td>
</tr>
<tr>
<td>Band 7</td>
<td>48,131</td>
<td>40,677</td>
<td>486</td>
<td>1,898</td>
<td>2,459</td>
<td>223</td>
<td>827</td>
</tr>
<tr>
<td>Band 8a</td>
<td>10,677</td>
<td>9,418</td>
<td>87</td>
<td>268</td>
<td>490</td>
<td>30</td>
<td>113</td>
</tr>
<tr>
<td>Band 8b</td>
<td>2,667</td>
<td>2,392</td>
<td>24</td>
<td>46</td>
<td>101</td>
<td>9</td>
<td>20</td>
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<tr>
<td>Band 8c</td>
<td>1,090</td>
<td>1,006</td>
<td>11</td>
<td>13</td>
<td>25</td>
<td>-</td>
<td>5</td>
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<tr>
<td>Band 8d</td>
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<td>289</td>
<td>3</td>
<td>2</td>
<td>6</td>
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<td>-</td>
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<td>88</td>
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<td>4</td>
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<tr>
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<td>2,147</td>
<td>1,609</td>
<td>29</td>
<td>165</td>
<td>163</td>
<td>9</td>
<td>64</td>
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These figures indicate that there has been a slight improvement between 2016-2017, in the number of BME nurses who occupy Bands 8a-8d and for Band 9, but year on year (from 2014-2017) we see that staffing levels in the NHS for all ethnic groups had increased. By continuing to predominantly occupy grades that signify newly qualified status (Band 5 or transition to Band 6) BME nurses’ influence, power and ability to execute key decisions regarding the care of patients and services is limited. This may lead to a deficit This may lead to a deficit in contribution of multiple perspectives in decision making that affects patient care, such as in mental health settings. For example, evidence suggests that young Black male patients tend to be over-represented in acute psychiatric admissions wards, (Priebe, et al, 2009, Dunning et al, 2010). This is not an effective position to inhabit in the NHS and has disadvantages for the NHS, its patients and BME nurses. It is also of particular concern if it is likely to be so throughout one’s career, including an inability to enjoy a healthy income and financial benefits and status associated with occupying upper grades. A failure to make a strategic difference will have significant ramifications for how these nurses are seen to navigate their careers.
To address these trends which have persisted for several decades, even as far back as the Windrush Era of the 1950s and 1960s, the UK has introduced legislation, for instance, the 2010 Equality Act and NHS policy, notably the Workforce Race Equality Strategy (WRES, 2015). Individual organisations also introduce and implement Equal Opportunities policies with a view to redressing imbalances and prevent disadvantage that emerges through these regular patterns. It is therefore not well understood why groups of potentially talented BME nurses are not reaping the benefits and prestige that is almost routinely afforded their White counterparts. There is a plethora of socio-political reasons which may account for this, not least the assumptions that the nurses themselves lack the motivation to pursue senior roles.

This project seeks to explore reasons for the career stagnation observed and to identify some of the barriers and enhancers for career advancement for BME mental health nurses from their perspective. Addressing such important and long held concerns necessitates ‘multi-level, multi-strategy, mutually reinforcing action’ (Priest et al, 2015:2). However, to-date, notable progress has not been sufficiently forthcoming despite equal opportunities policies. Fair employment practices cannot be outside of the scope of the NHS; an organisation that employs a significantly diverse staff and as such, replicates society’s norms, values and practices.
Figure 2 below is the percentage of breakdown of England’s working population aged 16 plus as indicated by the UK 2011 Census population and compared with ethnicity by NHS Agenda for Change grade in 2016.


<table>
<thead>
<tr>
<th>% Ethnic breakdown of England’s working population</th>
<th>% Ethnic breakdown of the NHS workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>White = 87%</td>
<td>White = 78%</td>
</tr>
<tr>
<td>Black or Black British = 3%</td>
<td>Black of Black British = 5%</td>
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<tr>
<td>Asian or Asian British = 7%</td>
<td>Asian or Asian British = 8%</td>
</tr>
<tr>
<td>Mixed = 1%</td>
<td>Mixed = 1%</td>
</tr>
<tr>
<td>Chinese = 1%</td>
<td>Chinese = 1%</td>
</tr>
<tr>
<td>Any other ethnic group = 1%</td>
<td>Any other ethnic groups = 2%</td>
</tr>
<tr>
<td>Not stated/Unknown = 0%</td>
<td>Not stated/Unknown = 5%</td>
</tr>
</tbody>
</table>

Source: Ethnicity in the NHS. NHS Employers, www.nhsemployers.org
Rationale for the Project

The rationale and impetus for exploring the experiences of BME mental health nurses who trained in England, many of whom are British, is two-fold. Firstly, this pertinent topic had a bearing on my own professional background. I acquired my mental health nursing qualification in England and am of a BME ground, i.e. I define my ethnicity as ‘Black British of Caribbean origin’. Secondly, BME nurses are often concentrated in what have in the past been considered the less desirable ‘fields’ or Cinderella services i.e. mental health and elderly/geriatric nursing, (Pearson, 2003), (James, 2015). This may be because BME nurses gravitate toward the mental health ‘field’ compared with adult, learning disabilities or childrens nursing because they see more people like themselves. I wanted, through this research, to explore their experiences to better understand the distinct experiences of nurses in this chosen field and specialism.

The purpose of this project was to explore BME mental health nurses’ experience of working in the NHS, their career progression and success from their perspectives through focus groups interviews. The study is concerned with nurses who obtained their nursing training, qualification and experience in England. During conducting the research, there seems to be a dearth of information regarding this group and a significant gap that needed further investigation. Moreover, this project brings attention to the fact that, despite significant presence in the NHS, the career progression and representation in senior grades of BME nurses is not in keeping with their overall numbers in the workforce as illustrated in the figures.

Many studies highlight experiences of BME nurses in the UK (Larsen et al 2005, Dywili et al 2005, Alexis et al 2007, O’Brien, 2007, Dhaliwal and McKay 2008, Allen et al 2016), specifically, what amounts to ‘professional stagnation’ and their lack of progression into the higher strataums of NHS positions. This includes BME and women representatives on Trust Boards. In 2014, BME Trust Board membership of people from BME backgrounds was 40, compared with 464 for their White counterparts. The figure for women (in the same year) was 202, compared with 311 men.
REVIEW OF THE LITERATURE

Summary review of the literature and context of the project

There are two main sections that underpin the focus of this report. The first is a review of literature aimed at exploring the experience of BME minority mental health nurses, who acquired their qualification in the UK. In the second section, the themes and issues which emerged following testimonies from the participants are reported. The literature included testimonies of BME nurses describing hindering factors which impacted upon the chances of them being recruited to more senior roles. Factors identified as helping factors are also discussed in the literature. The themes identified from the literature were:

Effect of ethnicity on employability

Academic performance

Work experience

Extra-curricular activities

Negative stereotypes of BME nurses

Effect of Ethnicity on Employability

Research which has investigated the effects of ethnicity and employment identified a complex and multifaceted relationship between ethnicity and employment, not least because employability is distinct from employment. The former can be described as an accumulation of personal attributes, skill sets and achievements that enhance the chance of being employable. The latter described as consequently gaining employment thereby benefiting one’s community, the workforce and economy. In between those spectrums, are hidden subtleties that can occur prior to the outcome of a job application is established, for instance Kirnan et al (1989) considered the ‘recruiting source effectiveness’. This study was concerned with the activities of candidates who applied to work as life insurance agents for a large insurance company.
The study's aim was to measure ‘hire successes’ of the differences between ‘informal’ and ‘formal’ recruiting sources for applicant quality. Their definitions of formal recruiting sources include categories such as advertising through the media, newspapers, radio, public places, employment agencies, TV and professional journals. Informal recruiting sources tended to be employee referrals, referrals made by family or friends, self-initiation applications and walk-ins. Kirnan et al (1989) claimed that the informal recruiting sources elicited what was ‘superior new hires relative to hires recruited via formal sources’. Similar claims have been made by other studies, Breaugh, 1981; Decker & Cornelius, 1979; Gannon, 1971. Accordingly, it was claimed that informal sources delivered superior employees, due to what Ullman (1966) in Kirnan et al (1989:2) drew attention to the, “extensive pre-screening of applicants”. This process apparently equipped informal applicants with a clear advantage over formal applicants. This is because “screeners” are furnished with the benefit of being familiar with both the job as well as the individual.

There is an appreciation that employability can provide an explanation of inequalities based on ethnicity. We can analyse this assumption in the context of gender, and as stated by Kirnan et al (1989:3), ‘Despite findings supporting the superiority of informal recruiting sources, concern was expressed in the recruiting source literature (Hill, 1970). There were issues regarding groups underrepresented in a job type, i.e. women and ethnic minorities who would be adversely affected by the pervasive use of informal sources and networks’. The logic was that if the current workforce were predominantly male and non-minority, then current employees would most often prefer applicants like themselves, e.g., other white males. We know also that employers place a great deal of importance on three key elements related to the application form. According to Cole et al (2007), these are academic performance, work experience and extra-curricular activities.
Academic Performance

Academic performance, work experience and extracurricular activities will now be discussed and analysed in turn. Regarding academic performance, it has been well documented that ethnic minority graduate students do not tend to acquire 1\textsuperscript{st} class degrees. According to the Higher Education Academy (2012:3) ‘The percentage of UK-domicile BME students studying in higher education, at all levels, is statistically higher than that of White students, with the proportion of UK-domicile BME students having increased from 14.9\% in 2003\textendash{}04 to 18.1\% in 2009\textendash{}10 (ECU, 2011). However, data evidenced that 66.5\% of White students studying first degrees received a first or upper 2\textsuperscript{nd} class honours degree, with only 49.2\% of BME students achieving this and 38.1\% of Black students (ECU, 2011)’. The situation for Asian students, overall tend to be comparable with White students and in some cases Asian students out-perform their white counterparts academically. The reasons for the low educational attainment of Black students are multiple. Like the experiences of BME nurses, there a culmination of factors that point to low level status. These include accounts of low teacher expectations, under-valuing, prejudicial attitudes, lack of student educational support, discriminatory practices and so forth, be they overt or covert. (Hopkins, 2007)

Higher Education Funding Councils for England (HEFCE, 2002) funded a study in 2002 into access to higher education. They were interested in the following ‘socially disadvantaged’ groups, i.e. students from socioeconomic disadvantaged backgrounds, mature and BME, to improve employment outcomes for these graduates. The report compiled by Blasko (2003:5) at the Centre for Higher Education Research Information (CHERI) found, ‘the findings support other studies which indicate that success in the labour market is to some extent associated with the background characteristics of the graduates.

In general, Higher Education Data Analysis (HESA) data indicated that BME graduates face greater difficulties in obtaining an initial job but are not less likely than other graduates to be in graduate level jobs. In further acknowledgment of this similar tendency when BME graduates leave their institutions, a concerted response to this was investigated by seven HEIs (Higher Educational Institutions).
Those HEIs applied for and successfully secured the maximum HESA funding of £500,000 enabling them to embark upon a ground-breaking remedial initiative. This initiative, referred to as the ‘Inclusive Curriculum Framework’ was developed by Kingston University in 2017. It is a project aimed at working to a Value Added Matric, with an emphasis on promoting an inclusive curriculum. The required outcome, is for future BME graduate students to leave these institutions having significantly increased their chances to attained 1st class degrees or at the very least, a 2:1, hence improving their production in the workforce.

It would be to everyone’s benefit to see this implemented more widely to improve the chances of BME student nurses attaining grades and degree classifications so that it becomes more of the norm rather than the exception. As Senior Lecturer who delivers pre-registration nursing programmes at Higher Education Institution (HEIs), I have seen disproportion in acquiring 1st class degrees. My impression is that BME nurses in all fields tend to lag in their acquisition of 1st class degrees.

Although exploring the educational attainment of BME students is not the remit of the project it is important to allude to ethnicity pertaining to different levels of educational attainment, transposed to the job market and specialist workforce. By making these comparisons, it sets the debate in context as well as providing an indication as to why the situation is as it is. Something that cannot be ignored is a theme of disadvantage and an accumulation of social injustices experienced over a life span that must be considered in the light of facts and prevailing figures.

Work Experience

Another factor that may contribute to performance is ‘work experience’ and the value placed upon it by employers. According to Knouse (1994) the ability to document exposure to relevant work experience is valuable. In many cases students (including student nurses) struggle to make ends meet; financial hardship being an unfortunate consequence of studying. With that in mind, Herweijer (2009:4) state that, ‘Ethnic minority students often have lower socioeconomic backgrounds and are more likely to take additional jobs for financial reasons than for résumé-building.'
Due to this stronger financial necessity, it is possible that ethnic minority students have less opportunity to focus on relevant work experience or (unpaid) internships as they are generally less able to make such sacrifices. I have observed, over many years the profile of ethnic minority mental health nurses and students, who tend to be mature; many of them raising families and studying. (RCN, 2003, 2005). Additionally, some are responsible for families abroad, and committed to assisting with what they deem as their financial obligations. Accordingly, these nurses work any shift they can get (Bank, Agency) but occasionally it comes at a cost to their grades and eventual career development.

**Extra-Curricular Activities**

There does not appear to be much information on extra-curricular activities in relation to ethnic and employability. However, there is some evidence to suggest that BME nurses do not always have much time to engage in extra-curricular activities, largely due to family responsibilities and the need to juggle many competing demands (RCN, 2006, 2008). This leaves them at a disadvantage because employers hold the view that, “involvements in various extracurricular activities are associated with stronger communicative, initiative, decision-making, and teamwork skills”. (Nemanick and Clark, (2002) Rubin, Bommer, and Baldwin, (2002).

**Negative Stereotypes of BME Nurses**

Nursing involves interpersonal skills and techniques to carry out the responsibilities required for all specialisms of health care practitioners, Stein-Parbury (2014). As such, this would be at the forefront of nurse recruitment screening procedures. During the process of selecting a nurse candidate for a post, the person (usually a Manager or Human Resources Personnel) sifts through applications, links up information on the application form with the job specification. This seems relatively straightforward enough and according to Heilman (1983) Perry (1997) the ultimate decision would be dependent upon ‘the fit’ between perceived attributes of the applicant and perceived job requirements. In other words, the better the fit, the more suitable an applicant appears, thereby enhancing any probability that the person in question will be recruited.
However, there is some evidence that BME candidates face bias at recruitment that can lead to discrimination. For instance, Krings and Olivares (2007:1) led a study of discrimination influenced by applicant ethnicity, job type and raters’ prejudice in Switzerland. It was concluded that ‘…bias and discrimination are more likely when foreign applicants who belong to disliked ethnic groups apply for jobs that require high interpersonal skills, and when raters are prejudiced against immigrants. Subjects were Swiss university students who evaluated Swiss, Spanish, and Kosovo Albanian fictitious applicants.

All participant applicants had similar schooling and language proficiencies but differed with respect to ethnicity. As predicted, discrimination was only observed for members of the disliked ethnic group (Kosovans and Albanians) and not for members of the well-accepted group (Spanish). This reverberates an opinion of ‘fit or suitability’ (as described earlier) may be biased by group or job stereotypes and, thus, lead to discrimination. By way of example, is the experience of discrimination against many Irish nurses. Although, these nurses occupied an indistinct and ambiguous position in ways, not only in terms of their White European identity, but, by dint of them being an ethnic minority, they fall into the social category of ‘other’.

Ryan, (2007) studied the ethnic identity of Irish nurses. Acknowledgement of paradoxes of the racialized black/white dichotomy, also intersect or interact with ‘gender, identity, location and occupational ascriptions and experiences of Irishness’ is also noted. Ryan (2004:14) emphasises this point, stating that...‘in some hospitals Irish nurses had to construct their identities and assert their professional competence through a complicated negotiation of negative gender, class and ethnic stereotypes’.

Despite Irish nurses representing a sizable and prominent feature in the British labour force, as skilled white-collar workers (Walter, 1989) and society in general, they tend to be a largely under-researched group, particularly that of nurses. This alludes to shifts away from the one-dimensional expressions of identity, and offers an account of the complexities and analyses how certain dynamics change within such a group who straddle various ambiguous locations. (Ryan, 2007)
Smith et al (2006) navigated the pecking order and hierarchy of nurses that exits between different ethnic groups. Similarly, the location and experience of African nurses were explored by Lipuke (2013) who investigated managers’ perception of working with those nurses specifically based on their assertions of discrimination, racism, and equal opportunities in relation to career progression. Overall, it was felt that, ‘Managers seemed to treat British and other overseas nurses more favourably than they did Black African nurses’. (Lipuke, 2013:227). African nurses, apparently cite more negative, as opposed to positive experiences of workforce encounters and contributions to the NHS, than many other ethnic minority group.

Prominent similarities existed between overseas nurses, namely lack of recognition and depreciation of skills (Hardill & MacDonald 2000, RCN 2003b, Withers & Snowball 2003) and in the main they disclosed feeling undervalued (RCN 2003a). It was revealed that these nurses’ practical experiences are by-and-large on par with those in the UK, but African nurses were discouraged from performing certain tasks, particularly if it required higher levels of skilful procedures. The routine of medication administration, pressure sores and wound dressing, for instance, undermined their competence and proficiency, confidently acquired and performed in their country of origin. However, this is not far removed from complaints made by other overseas nurses’ who report lack of exposure to clinical techniques customarily executed back home, Henry (2007), Alexis et al (2007), Brunero et al (2008) Nichols and Campbell (2010).

One of the key findings to appear from some of these studies encompassed disclosure of negative experience in the form of discrimination and racism. This was played out in various ways including unequal pay and conditions such as unpopular shift patterns, over-representation of low-skilled job roles, inequitable treatment by management, occupying unattractive specialities (such as learning disability and mental health) and lack of meaningful career progression. Sheilds and Wheatley Price (2002) indicated in their study that allegations of racial discrimination were a major problem operating within the NHS and that Black nurses had suffered a legacy of enduring racism under it. These nurses also described defining factors of racial harassment in the workplace and its impact upon job satisfaction including the motivation to quit one’s job.
The evidence from the literature seems to suggest that despite their ‘visibility’, BME nurses are still very much ‘invisible’ in those grades that command respect, promote leadership, influence policy directives and authority in service delivery. The trends observed are not new, for instance, Hicks (1985:14) in 1982, conducted interviews with a group of BME nurses from the West Midland and one of them (a midwife sister) disclosed that, “when I was on the ward, doctors and visitors would walk right past me looking for a White face. They’d approach a porter, an ancillary, even a patient…who is in charge? Where’s sister”.

Impact on Patients

The very nature of admission to hospital, renders patients as vulnerable, therefore, for example, ‘...the importance of responding to health needs of the Asian community in an area such as Southall...arriving at the right mix of staff to serve the local population’ (Lyne, 1984:47). Notwithstanding one does not deny some of the challenges the NHS might be confronted with health care provisions for ethnic minority patients, such as language barriers, (Likupe, 2006). Nevertheless, studies that have argued for a ‘business case’ (Esmail, 2005) support “the link between the treatment of staff and patient experience and outcomes, and, the links between patient experience and the treatment of black and minority ethnic staff” (Kline, 2014:1). In that regard, it is incumbent upon NHS staff, that they are representative of those whom they offer their services to. Despite concerns (maybe cultural), the benefits of a diverse workforce significantly outweigh not having differences of opinions and perceptions, Denley (2017). Such differences of opinion need not represent conflict or lack of structure. Instead, these differences can be integrated to compliment various components; particularly so for the multicultural and multi-ethnic society the UK has become over several decades. By encouraging a variety of perspectives, this enables health care professionals to challenge the status quo.
NHS Employers (2015) sums up the many advantages for ensuring that the NHS operate under a system of fairness for all who use its services:

“The key benefits of a diverse workforce are numerous and include: customer care and marketplace competitiveness; corporate image, brand, ethics and values; recruitment and retention of talent; designing and delivering products and services; increasing creativity and innovation; being an employer of choice; complying with legislation and corporate responsibility”

**METHODOLOGY**

**Study Design and Methods**

At the heart of this project is the need to affirm participants’ voice and to credit their experience as having meant that may contribute to future perspectives with the need for active change to materialise. Consequently, the study utilises a qualitative approach seeking to gain insight into human behaviour and experience (Denzin and Lincoln, 2007, Creswell, 2013).

Human behaviour albeit complex, remains exciting in its richness and scope essential to understanding everyday life in various dimensions, Lynch (2014). For Creswell (1998) in Draper (2004:642) it is asserted that qualitative methods occupy distinct features, namely...'The research builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting'. Furthermore, qualitative researchers opt to view the world under the lens of social constructs and thus, conclude their findings in terms of its social phenomena. Answers concerning ‘how’ and ‘why’ human behaviour are what it is or what it displays, are key to understanding the mechanisms and conditions by which they occur. In this case, to appreciate ‘how’ intersectional markers might explain inequalities of employment opportunities. Added to the point of the impact upon mental health nurses; either aspiring to or attaining the higher grades pertaining to the NHS career structure. This is guided through the prism of utilising a phenomenological approach.
Phenomenology, an approach consistent with the purpose and values of this study is the methodological framework adopted for this study. Phenomenology is often cited as a philosophical standpoint that enlightens the consciousness of those who experience a phenomenon (or first-person perspective). This is to locate the lived experience of those under the microscope of social inquiry. A key aim of this study is to explore the issues that matter to BME mental health nurses and their understanding, perception and experiences in relation to how they evaluate and reflect upon their career.

Preparation for well-structured focus groups also helps to facilitate discussion surrounding taboo or sensitive subjects like discrimination, exclusion, stereotypes and others. The way in which I aim to conduct this study is to work towards building rapport and to gain the trust of participants, to alleviate any anxieties, preconceived ideas about the study or general concerns. I aim to achieve this through a high degree of respect for participants’ feelings. It is therefore essential to design a research study that would ensure that the world of these participants - a sample of 10 British trained BME mental health nurses who work in the NHS, was captured in a way that records ‘rich data’. It is also crucial to use data collection methods which enable the nurses to authentically communicate their story (Morse, 2000). It is envisaged that such data reflects the true depth of responses, to assign meaning and understanding of what these participants reveal in answer to various pertinent questions to this project.

**Timeline of the Project Process**

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<th>2016</th>
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Ethical Approval and Considerations

An application for ethical approval through the Integrated Research Application System (IRAS) via the Health Research Authority (HRA) was successfully obtained and the project assigned an ID reference number to be quoted on all correspondence. A ‘Letter of Research Access’ was obtained from the Trusts’ Research & Development Office, permitted me to physically utilise the Mental Health NHS Trust site. Abiding by the ‘NHS Confidentiality Code of Practice and Data Protection Act of 1998’, stipulating the storage and retrieval of participants’ personal data was also a requirement.

The question and eventual decision to introduce an incentive to improve the chances of participation can be a tricky prospect on many fronts, such as issues around bribing people to engage in research. However, I am in favour of offering participants’ incentives due to the commitment of being involved in research that encourages and expands knowledge. As a token gesture for participation, gift vouchers from well-known retail stores were given and greatly received.

The techniques used for conducting research in which human subjects are involved, must adhere to a stringent process and an ethical code, such as The British Psychological Society’s ‘Code of Human Research Ethics’ (2006, 2009). This code highlights a set of general principles which researchers must follow to respect the rights and dignity of those being studied. These principles apply to and are intended to cover all aspects of research concerning human participants. In respect of the principles that govern health care research, Beauchamp and Childress (1994) highlight the importance of respect, autonomy, beneficence, non-maleficence.

Recruitment of Participants

Participants needed to be informed about the study in some way, be it word-of-mouth or advertisements on the Trusts’ Intranet; both methods were utilised. Liaising with a member of staff (and her deputy) who occupied a senior position in the Trust was very helpful for making further contacts. I designed a flyer for staff, specifying that qualified mental health nurses who self-identified as BME to kindly get in touch.
A series of pre-preparation was necessary prior to commencing the focus groups interviews. Disseminating information about the study at a range of forums, such as Trusts’ team meetings and other staff events, seminars, workshops and conferences, were initiated. However, prior to gaining full commitment from participants, there were lengthy time lapses, due both to my professional workload as well as the participants own constraints. Regular contact was kept up in between arranging dates/times to commence the focus groups. It was advised that due the busy and pressurised nature of staff workload, it would be much more expedient for me to approach them on their territory.

Prior to tape recording of the focus groups interviews, the aims and objectives of the project was reiterated, thereby enabling participants to voice any queries or concerns before giving consent. The participants were requested to read through the consent form and to sign as confirmation of understanding the project and agreeing to take part. There was added reassurance that withdrawal was permitted at any stage in the process. Tape recordings were transcribed verbatim from a dicta phone following a USB device was stored in a locked safe and password protected. Personal information was not detailed enough to elicit individual participants’ profile i.e. individuals were assigned coded identification by their initials, gender and age. Steps were taken to maintain confidentiality and anonymise names of individuals and institutions participating in the research and to securely store and archive hard copies of data. Data on the USB of the tape recordings was kept as secure as possible. Another responsibility included assurance to participants that the data would not be shared with anyone. Adherence to the Data Protection Act, 1998, the Data Protection Code of Practice for Research & Personal Data, was part of those responsibilities. Notwithstanding, I was contented to maintain those principles, ensuring that mutual trust and respect was agreed. Importantly, from a professional perspective and as stipulated in the Nursing & Midwifery Code of Conduct (2015), nurses should: prioritise people, practice effectively, preserve safety, promote professionalism and trust. The nurse’s mantra is to ‘do no harm’.
Inclusion Criteria and Participant Profile

It was specified that participants should be:

- BME Mental Health Nurses
- Currently occupying a permanent position (not Agency staff) between Band 5-9 as stipulated by the *Agenda for Change* pay scale.
- Self-identifies as belonging to a BME under the NHS ethnic coding descriptors
- ‘live’ Nursing and Midwifery Council (NMC) PIN
- Male & Female
- Available to participate in the focus groups

<table>
<thead>
<tr>
<th>Band</th>
<th>Female</th>
<th>Male</th>
<th>Age</th>
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<th>Ethnicity</th>
<th>Nursing Qualification Other HE Qualification</th>
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<td>Black African</td>
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Of the 10 participants, there were four Band 5 nurses, one Band 6, three Band 7s and two Band 8a. The gender composition was equal and the age range from 25-57. In terms of nursing experience, this was between 6months – 23 years. Their mental health nursing qualification was either BSc or PGDip and three of them acquired an MSc qualification. Regarding ethnicity, eight self-identified as African and two are Afro-Caribbean.
In the pursuit of bringing this study to ‘life’, remaining focused was important to get the message across and reaffirming the significance of the study. At times, there was a need to take a step back to analyse and evaluate the direction of the project and to reaffirm its aims and proposed outcomes. This project is a study that promotes the benefits of bringing the factors contributing to BME nurses’ career stagnation, to the attention of key stakeholders. It is envisaged that such data would reflect the true depth of responses, to assign meaning and understanding of what these participants reveal in answer to the various pertinent questions, such as: *What do ethnic minority nurses perceive as hinder ing and helping factors in their career progression to senior positions in the NHS?*

**Data Collection Methods**

My choice of method for this project implemented a focus group interviewing approach. Focus groups are a form of group interview where people with similar characteristics and or common experiences are gathered together to discuss a particular topic, (Pollitt and Hungler, 1999). This method was chosen because it is widely acknowledged and one of the more frequently used methods in qualitative healthcare research (Gill *et al* 2008). There is evidence suggesting that focus groups provide a ‘naturalistic’ environment for data to be collected which can offer important perspectives about human behaviours. This type of forum enables participants to contribute within a group setting about a topic that might be sensitive, emotive or both, (Krueger and Casey, 2000). Within these groups, the researcher has the responsibility to decipher contents of discussions, considering such things as tone of voice, emotions, mannerisms and so forth. The meaning behind which, requires the researcher to study. Because race, ethnic and discrimination are sensitive topics, I also wanted the flexibility of being able to carry out one to one semi-structured interviews with anyone who wanted to take part in the study but who was not uncomfortable discussing such experiences with others. It is considered that this data collection approaches are consistent with the underlying philosophical standpoint of phenomenology and is judged as appropriate for this type of study. Moreover, other similar studies which have an interest in this topic had also provided a sound rationale for using this method of data collection. (Creswell, 2014)
The two focus groups were scheduled on different days carried out between March and April 2017 at the NHS Trust premises, accompanied by several email correspondences to those who expressed an interest in the study. A total of 10 participants were recruited for the project. In terms of sample size participation, although researchers have differing opinions of focus group size, the general agreement suggests between 6-12 members to yield an effective focus group discussion. (Colucci, 2007)

**Themes Emerging from the Findings**

In this second section, the key findings from the research project point and the themes identified are presented. The themes emerged from analysing experiences of the BME mental health nurses who trained in the UK and gave insight into their perceptions of the factors that influenced their career trajectories in the NHS.

1. **Lack of Transparency in Job Advertisement**
2. **Application process**
3. **Interview preparation**
4. **Politics and ‘fitting in’**
5. **Discrimination**

**Lack of Transparency in Job Advertisement**

It is the expectation as part of the selection and recruitment process, that ‘transparency’ is a given when applying for a job. However, if this is questioned, it means the selection and recruitment system is flawed, disadvantaging certain people who genuinely feel that they ‘have what it takes’ to apply for that job. There was evidence of dissatisfaction with what is perceived as a lack of transparency relating to some NHS Trusts job advertisements. Consequently, this can lead to inadequate hiring, based not on merit, but on who you know. For some, the level of confidence displayed by White candidates upon hearing that a particular job is being advertised maybe attributable to them being aware of who the panel members are.
Conversely, many BME nurses did not know the panel members in advance, but where that was the case (which was rare), they did not feel particularly comfortable or at an advantage. Participants’ responses suggest that there are issues and concerns about the way in which the whole recruitment process is structured and a perception that these processes inadvertently disadvantage BME nurses. For instance, hearing about a certain job through the grapevine, does not allow for sufficient time to prepare and to do the necessary research required.

**Application Process**

There was evidence from some participants that they placed a lot of emphasis and invested greatly in the application process. Concerted efforts were made to match up the job description and specification with personal attributes, knowledge, skills and experience. It was also apparent that most of them thought about the benefits of having their form proof read as an important element of the application process. A lot of time had been invested to reflect on the whole process as the starting point towards communicating with an employer.
Aligned to questions about the application process, the different levels of confidence emerged in terms of thoughts about progressing to the next band, be it soon or further down the line. For instance, some trepidation was detected in response to questions about moving up the ladder to bolster one’s career. There appear to be dilemmas and concerns that once a successful application had been made, then thoughts about perceived difficulties that a higher-ranking post would entail, soon came to the forefront if occupying such a post became a reality. This was summed up by one participant who discussed pursing a band 8a post.

"Erm in terms of applying I’m very confident but in terms of following it through I start having questions about is it really worth it, erm and compared with what...so you see your colleagues the higher you go the harder you fall the more demands of time and you know you look at yourself... one band worth sacrificing what you have, the security of being on the front line is tough compared to going to management there’s a lot of things to consider. I am confident with the application, I am confident in going for interviews but always have concerns when it comes to following it through...in terms of like, do I want this hassle... yeah so I would say maybe I’m better off where I am"

Interview Preparation

Participants were asked to share how they prepared for interviews. This was to ascertain the likelihood of them being shortlisted. Many participants engaged in some ground work and went to great lengths by researching the post in preparation for interviews and most agreed, was key to success. Responses regarding steps taken to prepare for interviews ranged from physically visiting the place where they applied to work; they wanted to get a feel of the environment. Some researched the Trust (if moving from Trusts) and the service if they were already working for that Trust. Engaging in mock interviews and networking with the hierarchy was another activity participants factored in to increasing the chances of selection. This type of preparation was a notable feature for the most part in relation to senior roles, noting its benefits to gaining confidence during the interview process.
Politics and ‘fitting in’

We know that humans have a great urge to belong and maybe the underlying issue for this participant (highlighted in the above quote) is that they did not feel able to ‘fit in’ at a senior level after all. This was despite having reached the half-way stage of being shortlisted twice. By putting themselves through this, maybe it was some sort of test of ability to get through as confirmation that the application and experience is of the standard required of a Band 8a nurse. On the other hand, it seemed that this participant did not feel confident to pursue the next stage where one is under the spotlight during interviews. Not feeling able to ‘fit in’ was blamed for inherent politics that exists in the NHS. There was mention that if you do not belong to the ‘in-group’ then you are somewhat destined to working quite hard to get on despite actively engaging in CPD (Continuing Professional Development). It was noted that many participants took opportunities to pursue in training of some sort but it was not apparent that CPD was utilised as acquisition of skills, qualifications and training were not utilised e.g. acting up in a higher role. For instance, one of the younger participant already had a Master’s degree and was not entirely sure in what capacity it enhanced her current role. There was a sense that this did not amount to much if you are not the right person; do you speak the same ‘language’ are you able to socialise and go for a pint after work.
Discrimination

From what the respondents said, there seemed to be certain ‘first impressions’ characteristics of a person’s identity, including gender, ethnicity, disability, age, which may leave them feeling less than confident to proceed through to the interview stage. Some participants expressed feelings that they were discriminated against. In addition to the stories themselves and the value of these stories which included material examples of behaviours and treatment, was a perception from BME staff that they were treated differently to their white counterparts. The BME participants seemed to find inherent value in having the opportunity to tell their stories of discrimination, perceived discrimination and injustice. This was highlighted when asked to describe hindering factors associated with their career progression.

“I want to say something controversial, being Black is a hindrance. The reason I say that is if I look back at my career, some people who I see, jump over me. I don’t see anything special they have done”.

There was evidence that some participants may have experienced discrimination, particularly the more experienced, older nurses, thereby signifying a generational issue. This view maybe to do with many years of experience and having witnessed various injustices. Those who had made the leap to apply for senior grades maybe felt intimidated by the process and were reluctant to make the transition to the interview stage, i.e. being interviewed by a ‘consultant’. In that regard, it transpired this situation was about a ‘Nurse Consultant’ (on the panel) and not a Consultant Psychiatrist on the panel. Conversely, those who had not reached the stage of applying for senior roles overwhelmingly felt that their interview experience was positive. Those who went for the higher grades did not display such level of confidence. However, discrimination was not equivalently experienced, as there was a distinctive difference in response between the higher and lower grades. One of the younger Band 6 participants did not perceive or recognise discrimination as a hindering factor.
It was important to ascertain if they thought being BME nurses had any influence on healthcare of minority patients. There was agreement across the board that their presence helped to minimise misunderstanding that sometimes occur in mental health settings. It was observed that the number of BME and particular Black people are disproportionately admitted to psychiatric hospitals as “they are more in the system” as one participant noted. In that regard, it was surmised that BME nurses possess skills and appreciation of those patients, on the basis they were better equipped to intervene in a positive way. Many thought that discrimination was to do with a lack of understanding and that White staff were not always aware of the needs of Black patients largely from a cultural perspective. It was therefore left to BME nurses to advocate for patients as well as involve other staff towards a better understanding of diversity.

**Discussion**

My impressions are that, these nurses approached ‘telling their story’ with great honesty. Their accounts demonstrated elements of frustration over the status of BME nurses in 21st century health care settings. However, this forum enabled them to voice these concerns in a safe and open manner. The findings outlined in this project relate to: Lack of transparency in job adverts, Application process, Interview preparation, Politics and ‘fitting in’ and Discrimination. All these elements influence each other and have a significant impact upon the success (or not) of a candidate’s career.

“Erm, well on the whole…I haven’t got a lot of negative things or hindering factors to say because it’s been generally quite positive”
A lack of transparency in job adverts can cost the NHS dear, not only financially when it becomes clear that the wrong person has been hired, but also lead to serious cost to reputation. The application process is also difficult if a potential candidate is not aware of how to sell themselves on an application form. This includes having an up-to-date CV, producing a sound covering letter and to establish what exactly employers are looking for. Such knowledge will enhance the ability to adequately prepare for Interviews.

Politics and ‘fitting in’ resonates with issues of discrimination. For instance, as predicted, many of these nurses expressed similar experiences of discrimination, like that of overseas colleagues, because they did not feel they belonged or able to ‘fit in’. Although it was established that not much had changed (as suggested also by figures past and currently), this fact will further shed light on the need for urgent ‘action’ that is meaningful; something well over due.

Some of the findings reinforced certain aspects of previous arguments and concerns relating to the status of BME nurses in the NHS. Significantly, that they remain visible within the lower, newly qualified grades, yet invisible within senior grades. There is also a sense that much of the findings from this study are consistent with key findings from others such as alarm regarding the systematic failings to respond to the overwhelming calls to stamp out glaring inequities in the NHS. There is an element of frustration (both from BMS staff and patients) that change has not kept up apace with the lengthy discussions and debates relating to this topic. That the issue of ‘privilege’ of certain groups in society, rings true with the legacy of the lack of career advancement for BME staff over several decades.

The themes that emerged can be considered within the context of the wider literature. In Walton and Cohen (2007) study on social fit, race and achievement, they conducted two social experiments. The first one analysed, what they termed as belonging uncertainty, and the issue of stigmatisation among ethnic minority students. Such uncertainty can manifest itself by the ‘psychological consequences of stigmatization’.
According to Walton and Cohen (2007) those groups who tend to be targets for negative stereotypes, sometimes experience what they term *attributinal ambiguity*. In other words, they tend to be highly mistrustful of the motives behind another person’s treatment of them, Crocker, Voelkl, Testa, & Major, 1991. Another context is described whereby such individuals possibly will also experience *stereotype threat*, which is the fear of confirming to a negative stereotype about the intelligence of their group (Aronson, 2002; Steele, 1997). In addition, they may expect to be socially rejected based on their race (Mendoza-Denton, Downey, Purdie, Davis, & Pietrzak, 2002; Shelton & Richeson, 2005). Finally, given the underrepresentation of their race in academic and professional circles, minority group members could suspect that they would not “fit in” in these settings; a perception that can increase stress and dissatisfaction (Lovelace & Rosen, 1996). I suspect this might have been the position that some of the participants in my study emanating from the themes.

A major concern that resonates with some of the factors highlighted is the issue around effective leadership in the NHS. The Kings Fund (in collaboration with carried out an investigation with Health Service Journal (HSJ, 2014) Future of the NHS Inquiry on leadership. Here are some of the concerns from their findings:

- **A third of NHS providers have at least one board-level position not permanently filled**
- **Excessive regulation appeared to be stifling progress and a change in behaviour and focus is needed for modelling new ways to approaching healthcare.**
- **There are serious vacant posts particularly at senior and board levels. For instance, with Nursing Board Directors posts remaining vacant for on average of 9.1 months before being filled.**

According the Kings Fund (2014), left unchecked, this has a detrimental effect on patient care, and I would add, particularly BME patients who we know are vulnerable under the care of those who might not acknowledge what health/illness means to them. The question is then, why are BME nurses not being given the opportunity to fill these leadership vacancies?
Had the NHS invested in its staff over the years, the current situation might not be a talking point whereby a waste of talented BME nurses are being passed over in these challenging, yet rewarding roles. This statement by the then Sir Robert Naylor, Chair of the inquiry and chief executive of University College London Hospitals NHS Foundation Trust, makes an important observation.

“What is crystal clear is that we cannot continue with this continuous ‘churn’ of leadership. Equally clear is that we need to encourage the abundant talent we have in the NHS to take up senior level roles – particularly our clinicians.’

Project Limitations

The small sample size of 10 might be considered as methodological limitation however, this was a small scale qualitative study seeking to gain initial insights from informants and in the data collection phase. Data saturation was achieved even with the modest sample. One female participant was interviewed on a one-to-one basis. It was not the intention to interview just one person but the other volunteers who initially agreed to participate on that occasion, were required to respond to an emergency on the unit. Therefore, the initial plan for a group interview during this time was not possible. Albeit a little limiting, such unpredictable occurrences, is the nature of psychiatry and something I am aware of in my previous nursing role.

In terms of the composition of the sample, only two BME groups participated, i.e. Black Africans and Afro-Caribbean’s. This means that BME categories such as Asian or Asian British, Mixed, Black or Black British and their sub-groups, including Indian, Pakistani, Bangladeshi, White and Asian, White and Black African, White and Black Caribbean, were not in the study. This would have provided another dimension and possible open up the debate to include, for instance class and gender. My own ethnicity could have had a bearing on lack of response from other groups. Based on this, some caution is required in the application of the findings; views and issues that emerged to the wider NHS as the finding of this study can make only limited claims to being representative of BME nurses.
'Time’, is always an inhibiting factor (less than 1 year to complete this project) as one can always benefit from the luxury of having more of it to dedicate to such an important activity, particularly so with other competing demands, such as my full-time job.

**Personal Reflections of the Process**

Being offered the opportunity to embark upon a project such as this, enabled me to explore and contribute to providing another dimension to understanding of the position of BME nurses in England, which has been largely, a positive experience. On balance, I feel that there are many aspects which contribute to concluding that the process turned out to have gone very well. For instance, I developed skills in the art of managing and conducting a focus group for the first time and listening to participants describe their experiences. This meant that suddenly the aims of the project was coming to life.

My attendance at the Royal College of Nursing International Nurses Research Conference in April 2017 (with the other two Mary Seacole Awardees) in Oxford was a valuable way to place the project, as well as myself, in the spotlight. There are many advantages and benefits that can be associated with what I consider to be the art of networking. If done in a skilful way it can reap some useful rewards which proved to be so for me.

During the swapping of contact details with an editor of the journal, ‘Nursing Management’, I was invited to become one of the journal’s reviewers; something I had not embarked upon before and a good way to see the publication process from the reviewer’s perspective. Not only had I reviewed an article for the first time in July 2017, but since then, I have written an opinion piece about my Mary Seacole Award experience, and enthusiastically looking forward to imminent publication. Moreover, in recognition of the Mary Seacole Award, the Press Department at my place of work (at the University of Greenwich) highlighted details of this honour, in November 2016. Such wide coverage, it is hoped, will inspire other nurses to apply.
I was able to attend various conferences such as ‘Women onto Boards’, seminars and workshops helped me to think more broadly about my various ‘identities’. Not only am I encouraged to think more about my race and ethnicity, but also my gender; future contributions and life as an academic, including how these characteristics can enhance my career as a researcher, a Mary Seacole Scholar and where that might take me in future. I am confident that on-going contact with both my critical friends/mentors will enable me to focus upon my future career pathway, including pursing a PhD as an element of the Award.

There is something about being engaged in such a process that helps to boost confidence to go beyond one’s comfort zone. An example of which is when I applied to present at an International Conference in Singapore in July 2017, and having sent an abstract of the Mary Seacole project, my paper was accepted as an ‘extended abstract’. I was greatly looking forward to having another string to my bow, but on this occasion, the Steering Group Members did not feel that the timing was right. Instead, it was advised that more timely consideration should be given to completing and establishing my project further. To hear this, of course, felt disappointing, but sometimes one should take a step back before going forward, and I fully respected their decision.

Conclusions

This project set out to explore the visibility and invisibility as opposites which explained the experience of a small sample of BME nurses who trained to be mental health nurses in England. Not only is this an issue for nurse, but such disparity is notable across many sectors. The nurses who were candid and forthright in their honesty, provided a real-life account which exposed the need for urgent attention. It is also a plea to acknowledge what is happening in our current climate of major shortage of nurses and of course, the consequences of Brexit which to date, is an unknown entity. Attention to this is needed even more so now than ever before as the political landscape of the NHS is very much in a state of flux. Those organisations responsible for implementing Equality of Opportunities policies at Trusts’ and national level are in a significant position and hold a key responsibility to make the necessary changes that invites a better outcome for BME nurses in the NHS and consequently, its patients.
Four key recommendations generated from the findings of the project were considered as contributing to the helping factors to enhance their career.

**Recommendations**

1. It would appear that many of the participants in the study over-compensated with CPD having acquired additional qualifications, with the hope that they would be ready for when the right post came along. NHS Trusts should operate systems that more reliably promote equality of opportunity. Such an approach will help to improve the current informal system that disadvantages BME staff and privileges, particularly White males. This will enhance transparency regarding how posts are advertised. One way of addressing this, is to ensure that informal, unadvertised opportunities, like secondments, are opened so that all staff have the opportunity to ‘act up’. These are opportunities that tend not to be advertised or circulated; instead they go to friends and inner circles. Response to questions: how did you hear about this post should be monitored.

2. That NHS Trusts should introduce integrated Continuing Development Programmes (CPD) that prepare and develop BME staff to identify career enhancing opportunities through mentoring opportunities. This will enable them to be more prepared for interviews and have a consistent system of giving comprehensive objective feedback to candidates. Also, they should offer coaching for job interviews, specifically soft skills e.g. with regard body language techniques, self-awareness, self-promotion, public speaking, networking with the ‘right’ people and so forth.
3. That NHS Trusts’ enlist and employ Equal Opportunities Consultants (permanently or on part-time contracts) to work with and liaise with Human Resources Personnel. Those who occupy such positions will be tasked with the responsibilities of ensuring that NHS Trusts’ apply the Workplace Race Equality Strategy (WRES) correctly, thereby minimising some of the current issues of misunderstandings and anomalies. The rationale would be to robustly collate figures/stats/tables of the profile of those BME nurses who successfully or unsuccessfully apply for senior posts. Essentially the outcome being to address any shortcomings. For instance, an important feature would include auditing of trends and patterns that emerge to address any related issues. There will also be a focus on ensuring that NHS Trusts’ adhere and apply their legal obligation of implementing their Equal Opportunities policies in a sustainable way.

4. The Rt. Hon (PM) Theresa May’s comprehensive ‘Race Audit’ claims to have laid bare, social, class and racial injustices that exists contemporary Briton. Organisations such as the NHS, Police, schools, and so forth, should hold government to account for stringent systems to minimise such disparities.
REFERENCES


Centre for Higher Education Research Information (CHERI) http://www.open.ac.uk/ Accessed 15/08/2017


Denley, E (2017) How do you handle it when others don’t agree with you or want to do things differently, especially at work? http://www.heartfulnessmagazine.com/diversity-at-work/


Esmail E, Kalra V, and Abel P (2005) A critical review of leadership interventions aimed at people from black and minority ethnic groups: A report from the Health Foundation


Heath, J (2011) Fairness in Interviews. The Equality Academy


[https://www.hesa.ac.uk/](https://www.hesa.ac.uk/) Accessed 03/10/17


Kings College London. *What does BME mean?* [https://www.kcl.ac.uk/hr/diversity/race/terminology.aspx](https://www.kcl.ac.uk/hr/diversity/race/terminology.aspx). Accessed 30/09/17


Lyons, E and Coyle, A (2016) 2nd ed Introduction to Qualitative Psychological Research, chapter 2 in, Analysing Qualitative Data in Psychology. SAGE


Pearson, J (2003) For too long, the potential of mental health nurses from black and minority ethnic backgrounds have gone unfulfilled in the health service. *Mental Health Practice*. July 2003 vol, 6 no 10, 25

Accessed 08/09/17

Nursing and Midwifery Council (2015) Code for nurses and midwives
https://www.nmc.org.uk/Code
Accessed 10/08/17


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