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THE OBSTACLE COURSE

BARRIERS TO CAREER DEVELOPMENT FOR BLACK AND MINORITY ETHNIC NHS SUPPORT WORKERS

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The Obstacle Course:

Barriers to Career Development for Black and Minority Ethnic NHS Support Workers

An Exploration of the Obstacles to Health Care Support Staff Applying for the Assistant Practitioner Programme

Sarah Rutherford

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Acknowledgments

I am grateful to the Mary Seacole Awards for giving me the opportunity to carry out this study. I was passionate about the concerns raised by this study, and had long wanted to have the opportunity to undertake this work. The award provided an impetus to ensure its completion and the resulting product is much more substantial and robust than the initial concept.

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The Problem

Since 2002 NHS North-West has provided support workers with the opportunity to undertake assistant practitioner training subject to available posts and success in the selection procedures. Although 25-30% of support workers identify as BME, their representation on the Trainee Assistant Practitioner programme is less than 2%. Lack of access to progression opportunities has an impact on staff well-being and productivity which in turn affects care delivery.

Project Aims

To explore the factors that impact on access to the Assistant Practitioner Training programme by BME healthcare support workers from a Foundation Trust in the North West of England.

Project Objectives

- To survey both white and BME support worker staff to investigate their knowledge and experiences of the Assistant Practitioner training programme in a North-West Foundation Trust Hospital,
- To conduct focus groups with BME support workers to explore in depth the key issues and barriers to access to the Assistant Practitioner training, and
- To develop recommendations for maximising access to training and development opportunities of BME support staff working in the NHS

Methodology

Mixed methods were used. A survey of support worker staff within an inner city hospital Trust provided quantitative data which was analysed with Microsoft Excel™ using simple cross tabulations. Qualitative data was obtained from focus groups of BME support workers and analysed using thematic analysis.

Findings

The five key themes that emerged were:

- Lack of Information about Opportunities.

  This included information not being provided in a timely manner, as well as information and advertisements being hard to locate.

- Lack of Transparency about Recruitment.

  This included the selection of identified staff for training or development with no transparent selection criteria and BME staff being overlooked when opportunities arose.

- Race and Discrimination

The lack of formalised processes for recruitment to the Assistant Practitioner programme means that from the perspective of BME support workers it appears discriminatory.

- Fear of Getting into Trouble.

There were anxieties about challenging the status quo because of fears about disciplinary action.

- A Need for Role Models

Participants in the study held that there was a need for role models who reflect the full diversity of the workforce

Recommendations

The funding for the training of Assistant Practitioners or other education and training must be contingent on evidence of robust actions to ensure equal opportunity in the recruitment and selection of trainees.

Health Education North-West should develop guidance on the equal opportunity processes that must be in place

NHS organisations need to provide a specific regular forum for updates on training and other developmental or progression opportunities for unqualified staff

Outside bodies who are involved in training or education should be invited to the forum when appropriate to meet with potential candidates, offer advice and field questions

Allied to the forum, it is recommended that there are sessions specifically for addressing the concerns of BME staff

The NHS organisations should undertake an internal survey of BME staff to ascertain beneficial interventions by the Trust or Higher Education Institutions to enhance their prospects within the NHS.

HEIs must work with NHS organisations in the recruitment of trainees to ensure robust equal opportunity strategies are in place.

HEIs should provide some additional support for applications for staff from marginalised communities including BME staff.

Key conclusions

Support workers from BME backgrounds are as keen to develop as their white colleagues but are hindered by barriers to progression. In the interests of equality, staff well-being and care delivery, opportunities must be open to all. NHS Trusts, Higher Education Institutions and Health Education North West need to collaborate to ensure that there is open advertisement and dissemination of information about training and development; that equal opportunity processes are in place for recruitment, and selection and additional support is offered to BME staff.

Glossary

Assistant Practitioner A frontline health worker who occupies an intermediate position just below the level of professionally qualified staff but usually above Health Care Assistants (Skills for Health, 2011).

Health Care Assistants (HCA) Unqualified care workers who provide additional support to registered health professionals in the NHS. In the different organisations they may also be referred to as support workers (SW), clinical support workers (CSW), nursing assistants, physiotherapy or occupational therapy assistants or nursing auxiliaries.

Trainee Assistant Practitioner (TAP) Health Care assistants undergoing training for an Assistant Practitioner role

Black and Minority Ethnic (BME) Members of non-white communities in the UK

Foundation Degree (FD) A qualification located at level 5 of The Framework for Higher education Qualifications in England, Wales and Northern Ireland (FHEQ). Foundation Degrees integrate academic and work-based learning through close collaboration between employers and programme providers. They are intended to equip learners with the skills and knowledge relevant to their employment, so satisfying the needs of employees and employers (Quality Assurance Agency (QAA), 2010)

HEI Higher Education Institutions such as universities

Health Education North-West NHS body responsible for the education, training and personal development of every member of NHS staff, and recruiting for values in the North West.

Part 1. Introduction

This project was undertaken for the Mary Seacole Development Awards, supported by the Health Education England who funded the project, but did not write the report. This report provides an account of a pilot project carried out at a large university in the north-west of England and an NHS Foundation Trust in the vicinity. The project aimed to explore the factors which account for and explain the under-representation of black and minority ethnic participants on the Assistant Practitioner training programme undertaken at the University with a view to developing and advising on strategies to address their lack of access.

Around 30% of the population of Central Manchester are from BME groups, this figure rises to around 44% for the areas in closest vicinity to the university and to one of the large hospitals that recruits trainees for the programme. The Workforce Profile 2012-13 for the Trust states that 22% of workers in clinical support services identify as coming from a BME group. However less than 2% of all the Assistant Practitioner Trainees enrolled at the University since its inception in 2002 have come from the BME population.

The Assistant Practitioner role is promoted as a developmental opportunity for unqualified staff to access education and training whilst they continue to earn their support worker salary (NHS Modernisation Agency, 2003). On qualification, the Assistant Practitioner is re-banded under Agenda for Change guidelines, in most cases to Band 4 and they are given a new enhanced job description. The Assistant Practitioner has more autonomy and responsibility than support workers. However very few support staff from BME backgrounds working in the Trust have either applied for the programme or been accepted onto it. The project explored the factors that influence BME support workers access to the Assistant Practitioner training programme. It is hoped that the findings will inform stakeholders in the NHS and Higher Education Institutions as to barriers to participation in education and training.

Part 2. Background to the Research Project

My University in the North-West of England has delivered an educational programme for trainee assistant practitioners since 2002. The programme is delivered in the form of a Foundation Degree in Health and Social Care (FdAHSC) over two years. The role of Assistant Practitioner was developed in a number of then Strategic Health Authorities however the qualification is not uniform nationally across the service. In the North-West, the Greater Manchester Strategic Health Authority (GMSHA) opted for the FD which was the new model of interim qualification for the unskilled workforce (Higher Education Funding Council for England (HEFCE) 2000). Approximately 1500 students have completed the course at the University and have gone on to take up posts as Assistant Practitioners within a number of Trusts in the NHSNW region, a significant number of these in a large Foundation Trust in the vicinity of the University.

Despite these numbers, it is evident that support staff from black and minority ethnic populations are either not applying for the training or not being selected to undertake the course. The project aimed to investigate the factors that prevented this group of employees from participating in the programme. In the absence of BME students on the programme at the university it was necessary to access workers at this level within an NHS Trust to explore their views and understanding of the programme and the recruitment process.

The lack of representation from this community has a number of implications for patient and care and equality of opportunity for the staff. The NHS Trust data reveals that around 38% of the patients are from a black or other minority ethnic background. From the perspective of the care delivery it is important that staff in care environments reflect the population they serve (Manthorpe and Bowes 2010). The needs of patients are met more effectively by a diverse work force which is representative of ethnic, racial, socioeconomic and/or generational difference (Bednarz et al. 2010). There is evidence that investment in training and development results in staff who are happier in their work and this is shown to impact on the patient experience of care delivery (Peltier et al., 2009). Furthermore, there are issues of equality of opportunity with concerns that BME employees in the NHS do not have the same opportunities as their white peers (Gay and Bamford 2007).

Recruitment to the Assistant Practitioner training lacks uniformity and transparency. Some Trusts have opened application to either all support workers within a specialism, or across the whole organisation. Other Trusts have relied upon individual managers to make the choice as to which support workers may apply to the programme. Interview panels do not always include an academic member from the University and they vary as to the degree of formality. From this it can be seen that the reasons for the poor application and/or selection rate from the BME community cannot be surmised.

The investigation of the literature on the training and development of health care workers from BME backgrounds supported the thesis that this group of staff was overlooked when new opportunities

were offered. The need for the workforce to represent the community it serves and provide culturally competent care motivated the researcher to ascertain the obstacles to accessing developmental opportunities in order to develop strategies to overcome them.

Part 3. The Law

3.1. The Public Sector Equality Duty[1]

In April 2011, the Public Sector Equality Duty (PSED) contained in the Equality Act 2010 s.149 came into force. The PSED covers age, disability, gender reassignment, pregnancy and maternity, religion or belief including lack of belief, sex, sexual orientation and race – this includes ethnic or national origins, colour or nationality. It obliges public sector organisations such as the NHS as well as organisations who provide a public function[2] to contribute towards making society fairer by tackling discrimination and ensuring equality of opportunity for all (The Government Equalities Office, 2011).

The PSED has three aims. It requires public bodies to have *due regard* to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- foster good relations between people who share a protected characteristic and people who do not share it.

This means that organisations must consider the impact of their activities on all sectors of society. Policies and services must be appropriate and accessible to meet the needs of different individuals.

In the development of Assistant Practitioners, the Trust is obliged to consider how they act as employers, including in the design, development and evaluation of human resource policies to ensure that members of staff across all ethnic and cultural groups are afforded the same opportunity. The guidance on PSED specifically states that in order to demonstrate *due regard* organisations should consider the need to:

- remove or minimise disadvantages suffered by people due to their protected characteristics;
- meet the needs of people with protected characteristics; and
- encourage people with protected characteristics to participate in public life or in other activities where their participation is low

(The Government Equalities Office, 2011)

This may require that organisations treat some staff members differently or develop a positive action to ensure minimise disadvantages.

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[1] The Equality Act 2010, Part 11 Advancement of Equality, Chapter 1, Public Sector Equality Duty, s.149

[2] A public function is a function of a public nature for the purposes of the Human Rights Act 1998

By understanding the effect of their activities on different people, and how inclusive public services can support and open up people's opportunities, public bodies are better placed to deliver policies and services that are efficient and effective (The Government Equalities Office, 2011). This view is echoed by The Equality and Human Rights Commission (EHRC) which promotes the PSED as good business sense, advising that organisations that meet the diverse needs of their users will conduct their business more efficiently. They argue that productivity is enhanced where there is a supportive working environment and the 'experience of black and minority ethnic (BME) NHS staff is a good barometer of the climate of respect and care for all within the NHS' (West et al., 2012). Crucially the EHRC identified that organisations which draw on a broader range of talent are more able to represent the community that they serve. There is evidence that decision-making and policy development is better informed leading to services that are not only more appropriate to the service user but are also more 'effective and cost effective'.

Part 4. Literature

4.1. Literature Search

The literature search strategy included major search engines such as the Cumulative Index to Nursing and Allied Health Literature (CINAHL), OvidSP, Medline, British Nursing Index (BNI), Social Care Online and Google Scholar. Selected academic literature, scholarly articles, journal articles and books were hand searched. Non-English sources were not searched.

Search terms “support worker” “health care assistant” “assistant practitioner” “BME staff in the NHS” “Equality and Diversity in the NHS” “BME experiences in health care” “cultural competence in healthcare” were used to search for relevant literature.

4.1.1. Equality of opportunity

The Assistant Practitioner Trainee programme has been in existence since 2002. However over this period less than 2% of all trainees have come from the black and minority ethnic (BME) population. This figure does not reflect the number of individuals from the black and minority ethnic population who are working as healthcare support workers or health care assistants in the local area nor is it representative of the local population. Around 30% of the population of Central Manchester are from BME groups, this figure rises to around 50% for the areas in closest vicinity to the university (Central Manchester Clinical Commissioning Group, 2014).

There has been little exploration of the career experience and development of BME support staff in the NHS. Hussein (2011) investigated the experience of BME staff in the care workforce but this work largely focussed on local authority and private sector care organisations although she does identify that that BME care workers are less likely to possess a relevant qualification in comparison with their white counterparts (4% compared with 12%). Literature which examines the lack of promotion or other career development of BME health care staff has largely been from the perspective of qualified professionals (Esmail et al. 2005; Blackman, 2010; Kalra et al. 2009). However, Johns (2005) cites a number of reports (Anwar and Ali, 1987; Baxter, 1988; Admani, 1993; Law, 1996; The Department of Health, 2003) which identify that BME staff across the health care sector are often working at grades which are below their abilities and education. He also states that BME health care staff are to be found disproportionately at support worker level (Bhavnani, 1994 and Owen, 1994 cited in Johns, 2005). Smith et al. (2006) found that in some institutions there was a lack of transparency around career progression. Although he attributes the underachievement of Black and especially African staff to unintentional rather than intentional racial discrimination (Smith et al. 2006).

Around 15% of all NHS staff are from the black and minority ethnic population across all levels (Health and Social Care Information Centre, 2013). However, the literature identifies that they are significantly under-presented at higher levels with only 3% of executives being black or minority

ethnic (Esmail et al. 2005). Findings from research into BME qualified nurses (Ishmael, 2009) demonstrate a struggle for BME nurses to rise through the ranks to positions of authority or influence. Gay and Bamford (2007) state that career outcomes for BME staff are not as positive as their white counterparts despite legislation and policy intended to ensure equity. A survey conducted in 2004 (Harrison, 2004) found respondents who claim that BME staff were less likely to progress in the NHS despite more qualification and working harder. This is supported by Kalra et al. (2009) who state that contrary to the view that BME staff do not have the skills and experience, they are often better qualified that their white peers.

The explanations for the lack of opportunity for BME staff within the NHS are multi-fold. Hunt (2007) claims that there is little understanding or recognition of cultural differences of BME staff, with behaviour and actions being misinterpreted. The reluctance, for example, of BME nurses to disclose personal details in general conversation can be perceived as an unwillingness to socialise and which, she claims, reduces their status to outsider. The effect of outsider status is that it limits access to the informal social networks where opportunities for promotion and development are brought up (Esmail et al. 2005) as well as restricting access to patronage from senior staff (Kalra et al. 2009). In fact, Smith et al. (2006) claim that there is an over-reliance on informal networks for the dissemination of such information and that promotion is too often based on a system of sponsorship rather than merit. Smith et al. (2006) also state that, in the case of migrant workers, their motives are often misunderstood so that they are not offered development or promotional opportunities because they are not expected to be interested in career or personal progression. Lemos and Crane (2000) cited in Kalra et al. (2009) found that BME staff identified that factors such as a lack of perceived fairness, a lack of consistency and opportunities and a lack of representation at the top of the organisation impacted on their access to career progression and development. In addition the absence of mentors in influential positions from BME backgrounds is detrimental to promotion and career development (Kalra et al. 2009; Kline, 2013).

A number of studies identify that whilst the majority of Trusts (98% in 2005) have equal opportunities policies these often do not translate in to actions (Johns, 2005). Only 61% had action plans to implement the policy. Ninety five percent of Trusts reported that their recruitment and selection processes were evaluated regularly but only 61% of these scrutinised them for equal opportunity (Johns, 2005). Johns (2005) also identifies that Trust managers can be suspicious of 'positive discrimination' which is perceived as hindering the development of the most talented. Gay and Bamford (2007) argue that there is a disconnect between the aims of the NHS organisation and the day-to-day practices in the service environment. They claim that there is a lack of support to implement service strategic aims on equality and diversity. This is compounded by the tendency of managers to measure success through budget control and financial prudence over and above less measurable issues such as equality (Carter, 2000). This view is supported by Johns (2005) who states that success in the NHS has focussed on financial targets rather than issues such as equality and diversity and that many do not see equal opportunities as part of the core business of the NHS (Johns, 2005). In the absence of an effective strategy there is a loss of opportunity for BME staff at every level (Mistry and Latoo, 2009).

4.1.2. Culturally Competent Care

Delivering care to users that is reflective of the local population is of significant importance in helping to meet the diverse needs of the population and to enable user engagement at all levels across health and social care services (Cohen et al. 2002; Manthorpe and Bowes, 2010). Bentancourt et al. (2003) and Saddler (1999) both identify that, where the workforce is unrepresentative of the service users there is the risk of developing services that do not reflect the local population. In addition ethnic diversity in the workforce has been shown improve the quality of care provision to ethnic populations (Bednarz et al, 2010; Bentancourt, 2003). Kalra et al. (2009) also state that in order to ensure that the NHS is developing a workforce that is reflective of the population it is necessary that there are programmes to develop leadership and potential amongst its BME staff.

The health disparities between the white and the black and minority ethnic population have been reported extensively (Anderson et al. 2003; Atkinson, 2001; Lanting et al. 2011; The Marmot Review, 2005; Szczepura, 2004). Bhopal (2009) argues that there is need to have culturally sensitive staff to reduce health disparities and Kai et al. (2007) claim that poor cultural competence amongst health care staff can contribute, in fact, to the disparities. However, a number of studies identify that the training of health care staff is not adequate in addressing cultural competence (Anand and Cochrane, 2005; Davies, 2006; Fleming and Gillibrand, 2009; Hill, 2006). Language and cultural barriers can prevent the delivery of optimum care to those from ethnic minorities (Kai et al. 2007) In addition, staff may be reluctant to address essential issues with individuals due to concerns about 'doing the wrong thing' and not being culturally sensitive (Kai et al. 2007; Richardson et al. 2006).

Investigations of the experiences of health care staff in meeting the care needs of ethnic minorities demonstrate evidence of staff treating all ethnic minorities alike (Vydelingum, 2006) and ethnocentric views that evidence a lack of understanding of other cultures and values (Jackson, 2007; Vydelingum, 2006). These misconceptions are not evidence, however, of a lack of care for patients from ethnic minorities, Jackson (2007) and Richardson et al. (2006) both found their participants were keen to ensure that they were providing the best care and were frustrated when they perceived cultural especially language barriers, prevented this.

4.1.3. The Assistant Practitioner

A number of factors have driven the development of new generic roles for the progression of support workers, health care assistants and nursing assistants within the NHS. These are the need for a skilled work force to address the complexity of needs and the burgeoning older population (Bridges and Meyer, 2007; Hyde et al. 2005), the problems of retention of professional staff (Bridges and Meyer, 2007) and the demand to address labour costs within the NHS (Hyde et al. 2005). The Assistant Practitioner undertakes education and training which enables the delegation of simple and/or routine tasks traditionally performed by professionally qualified staff (Skills for Health, 2011). It was anticipated that the new generic role would span disciplines increasing the flexibility and efficiency of the workforce in order to meet the service needs (Shield et al. 2006). The role was unique in being a chance for unqualified health care workers to progress and develop their careers whilst retaining their current pay and conditions. As such the opportunity needed to be open to all ethnicities.

Since their inception in 2002 there has been research and evaluation of the impact of the roles in service provision. Studies have evaluated the effectiveness of the new roles in meeting the needs of the service (Nancarrow and Mackey, 2005; Spilsbury and Atkin, 2009; Webb et al. 2004). Spilsbury et al. (2008) investigated the utilisation of the Assistant Practitioner role within hospital Trusts. Similar studies have looked at the training undertaken by support workers (Nancarrow et al. 2005; Shield et al. 2006). However there has been little investigation into access to the roles, nor an assessment of the equality of opportunity despite the claim that the initiative offers 'unparalleled career opportunities' and with aims to utilise the 'rich source of talent and skill' in the wider workforce (NHS Modernisation Agency, 2003).

Part 5. Method

The study used mixed methods research. A questionnaire survey provided the quantitative data and qualitative data was obtained from focus groups. This mixed methods approach was utilised in order to both measure the pervasiveness of the experiences including suggestions of the causality in the questionnaire; and to investigate explanations of how and why the phenomena occur through the focus groups (Cresswell, 2009). It was important to evaluate perceived explanations for lack access Assistant Practitioner training which could be obtained through the survey. However the qualitative approach afforded detail and more insight into reasons why they were excluded.

HCAs from all ethnic groups were invited to participate in the survey. The aim of including all staff in the survey was to identify whether BME staff reported different experiences in accessing the Assistant Practitioner training compared with their white colleagues and also whether there was evidence that they had different attitudes to further education or progression within their job.

5.1. Ethical Considerations

Ethics was obtained from the University Ethics Committee (see Appendix 1). The project did not need approval from an NHS Research Ethics Committee because this project was viewed as enquiry for the purposes of educational development (Health Research Authority, 2013). However permission was sought and gained from Research and Development Department within the Foundation Trust who agreed for the project to take place on their hospital sites (see Appendix 2). The questionnaire included information about the research study so that participants could make an informed decision about completing the questionnaire. Informed consent was also important for participation in the focus groups and participants were supplied with an information sheet (see Appendix 3). Data was analysed and stored in a format that participants survey responses and contributions could not be attributed to them

5.2. Data Collection

The study was conducted on two sites, in a university and in a hospital in Manchester. A survey of support worker staff within an inner city hospital Trust was undertaken through direct contact by a trust member of staff to maximise participation. Participants, who wished to, were included in a prize draw for £50 Amazon voucher.

The questionnaire was followed up with a further 3 focus groups with between three and seven participants in each to explore barriers to access and ascertain factors that would encourage participation from BME staff.

5.3. Questionnaire Design, Piloting and Administration

The goal of the questionnaire survey was to capture a broad overview of the reasons why HCAs had not applied or been selected for the Assistant Practitioner training. A survey provided a fast and efficient means of gathering information with regards to the respondents' experiences of accessing this opportunity. However, the researcher was mindful of potential low response rates identified as the limitation of the method (Parahoo, 1994; Wisker, 2001). Parahoo (1994) states that poor responses may be due to lack of time or motivation but suggested that it may also be indicative of attitudes towards the survey topic.

The survey design aimed to address the issue of poor response rates due to lack of time by using self-completion closed questions (see Appendix 4) as they are identified as encouraging responses (Wisker, 2001). In order not to limit those who wanted to contribute more or had alternative responses, there was a section for free text within most of the questions. An internal member of staff distributed and collected those questionnaires completed on the spot; other respondents were supplied with stamped, addressed envelopes to encourage return of the questionnaire.

The questionnaire design drew on the literature which identified the key issues that affects BME staff accessing developmental opportunities. In particular it sought to detect where BME staff had not being offered the same developmental opportunities (Gay and Bamford, 2007) or had been excluded from information about progression (Kalra et al. 2009) and lacked entry qualifications (NVQ3) (Hussein, 2011).

The questionnaire was piloted with a small group of five respondents. As a result an additional option of 'I did not know how to apply' was offered to allow respondents to explain why they had not applied for training.

5.4. Recruitment of participants

The survey was administered to HCAs of all ethnicities to quantify the key experiences and barriers facing HCAs in accessing the Assistant Practitioner programme. Drawing on responses from both white and BME support workers would also give some comparative data between the two groups. However, there was risk that all the respondents might be white. Renert et al (2013) identify that there are frequently barriers to the involvement of people from ethnic minority groups in research. Factors, such as lack of transportation and family commitments (Renert, 2013) (see Focus Group Participants below) as well as a mistrust of the purposes or benefits of research (Vickers et al. 2012) can reduce participation from BME groups.

For these reasons survey participants were accessed through an identified member of staff from the Trust who distributed and collected questionnaires from HCAs. The staff member was himself an Assistant Practitioner so was conversant with the role. He was Black British which contributed to his ability to access the BME staff both through his own social networks within the hospital but also he was trusted by the staff he approached as a member of their community (Renert et al. 2013). The use of an individual to contact possible respondents poses concerns about which staff were responding to the questionnaire, whether staff were being excluded or specific staff identified. However Brown and Scullion (2010) state that it is necessary to employ diverse strategies such as using local contacts to access marginalised communities. There were advantages in the participants knowing the questionnaire distributor. He was able to inform potential participants of the benefits that

participating in the project might bring. He also had access to HCAs working in a number of different environments. While discussions with him, prior to questionnaire distribution, addressed the need to encourage participation, the importance of participants freely completing the questionnaire was stressed. It was also hoped that the involvement of a BME member of staff in the administration of the project would increase the return rate of BME staff, often marginalised in research (Vickers et al. 2012).

Finally, the questionnaire then invited BME HCA's to participate in focus groups to explore the issues in depth. The participants completed the questionnaire and those BME staff who were prepared to be part of a focus group could provide their contact details.

5.5. Focus Groups

Liamputtong (2011) states that focus groups aim to understand a question from the perspective of the participants through the discussion of a common topic (Kitzinger, 2005). In this study the purpose of the focus group was to gain an understanding of access or lack of it from the perspective of BME HCAs.

The data would be generated by interactions between the group participants (Finch et al. 2014). The participants ask questions of each other, comment on each other's contributions and thus, prompt others to disclose more so that the control of interaction is in the hands of the participants rather than the researcher (Liamputtong, 2011). This also reveals the participants' frame of reference on the topic as well as highlighting differences in point of view between the participants (Rabiee, 2004). However the researcher was conscious of ensuring that the dialogue was not dominated by the most vocal (Krueger and Casey, 2005) and that all participants were included. The researcher as the facilitator also used prompts and open questions to explore key points or move the conversation on.

5.5.1. Selection and Recruitment for Focus Group Discussions

Richardson and Rabiee (2001) state that the focus group participants are selected as a sample of a specific population, in this case BME health care assistants. 78% of survey respondents volunteered to participate in the focus group. 67% of these (30) were randomly selected to participate and telephone contact was made by the researcher. Although many respondents volunteered to participate in the focus groups, on contact with volunteers, recruiting was more problematic. There were issues of travel, timing and family commitments. In the end, an unintended snowballing approach (Atkinson and Flint, 2001) was adopted. Snowball sampling can be defined as means of recruiting research participants through the identification of an initial participant who provides contacts for further potential participants (Atkinson and Flint, 2001). One focus group volunteer provided the researcher with contact details for possible additional members for the focus groups from his associates who then supplied details of others. Whilst this provided access to a population which would be hard to reach as a white, university based researcher, the disadvantage was that the focus groups did not reflect the breadth of the BME staff working in the Trust. The Black-British support workers, for example, were not represented within the focus groups.

There were three focus groups of between three and seven participants. The inclusion criteria for participation were that the participant:

- had to be working as an HCA or support worker,

- must identify as Black or Minority Ethnic, and
- must know about the Assistant Practitioner training programme. (They may have applied for but not been selected, or not completed the programme, in the past).

5.6. Data Analysis

The questionnaire data was entered manually into an Excel spread sheet using coding for broad areas of responses. The questionnaire data was analysed using descriptive statistics mainly percentages and proportions. This was summarised and presented in the form of graphs and pie-charts which were appropriate ways of highlighting the findings.

The focus group data was audio-recorded, then transcribed verbatim and analysed using thematic analysis. Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data (Braun and Clarke, 2006). Thematic analysis provides a means of getting close to the data and developing a deeper understanding of the content and for broad patterns to emerge (Boyatzis, 1998). Although Howitt and Cramer (2014) acknowledge that the identification of a few superficial themes is generally quite easy but in order to move beyond this to more depth, the researcher needs to be very familiar with the data. The advice that the researcher should do their own data collection in order to develop familiarity with data (Howitt and Cramer, 2014) was heeded within the project.

Braun and Clarke (2006) state that the researcher needs to decide whether the analysis will provide a detailed account of one aspect or a 'rich thematic description' of the entire set of data. For the purposes of this project it was important that the analysis identified the predominant or important themes. For this reason, the themes within the entire data set were identified, coded and analysed. Braun and Clarke (2006) claim that this a useful method when investigating an under-researched area, or with participants whose views on the topic are not known as in this case. They concede that some depth and complexity is lost but that a rich overall description is maintained.

The data management tool, 'Framework' developed by Ritchie and Spencer (1994) was utilised to aid analysis. Framework provides a matrix for each broad theme, divided into columns of subcategories which are identified through an initial familiarisation with the data (Spencer et al. 2014). The participants were allocated a row and their contributions recorded in the appropriate cell so that it was possible to see unedited contributions from the focus groups members. The process of charting ensures that the analysis stays close to the participant contributions, their subjective viewpoint and expressions before moving on to interpretation (Gale et al. 2013). It provides a means of assessing whether there is enough data for a proposed theme (Gale et al. 2013). A clear audit trail is evident from data to findings.

Part 6. Analysis of Survey Data

The questionnaire data was coded prior to distribution (see Appendix 4). The data was collected & placed into a Microsoft Excel™ spreadsheet. Descriptive analysis was used to describe the distribution and range of responses to each variable and examine the data for discrepancies. Subgroup analysis was applied to some variables. Simple cross-tabulations were used to identify trends and examine possible associations between one variable and another.

6.1. The respondents' personal details

The number of health care support workers within the organisation is unclear. The Trust's Workforce Profile data in the public domain classifies staff by their Agenda for Change Banding. The majority of support workers are employed at Band 2. The Workforce Profile data shows 1785 employees at this band with 22% of these identified as BME. Band 2, however, may include employees working in other roles such as health care scientists or as administrative support. Support workers are employed across two sites and within a number of hospitals, the main hospital, the eye hospital, the children's hospital and so on but the distribution of support workers across specialities is not public information. The sample was selected from the main site and included the main hospital and the children's hospital. Agency staff were excluded from the survey as they would not have had the opportunity to undertake the Assistant Practitioner training which is only available to NHS employees. The survey was distributed as a paper copy to 120 support workers with a 47% return rate (n. 56).

The applicants' ages ranged from 18 to 64 with the majority between 25 and 34 (Chart 1). It was possible that the age of the respondents might have an impact on their motivation to undertake university level study.

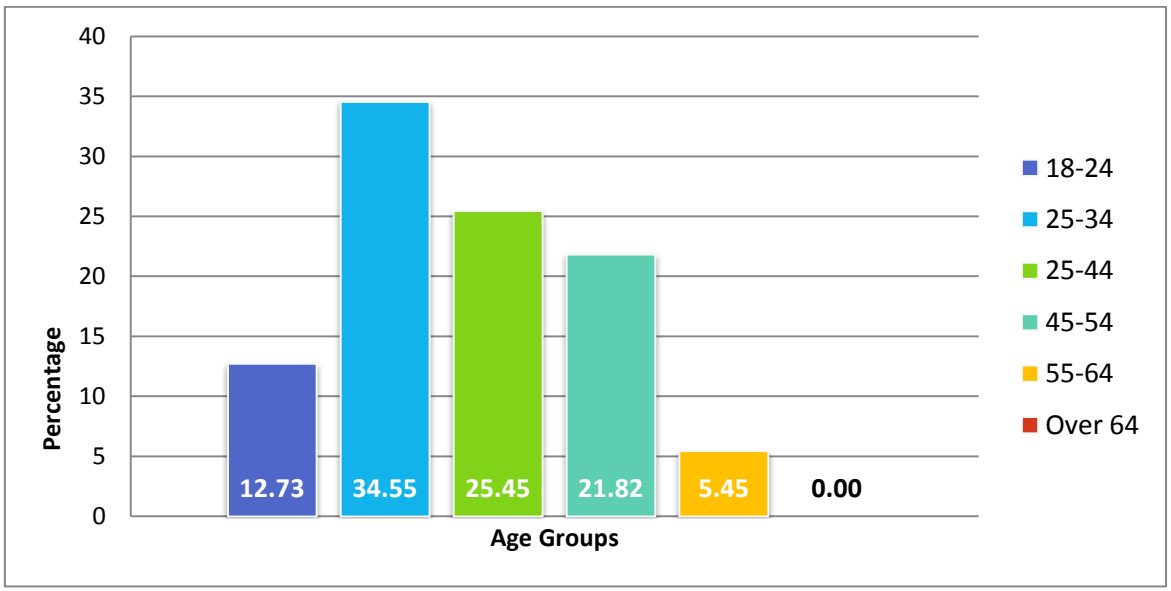


Chart 1. Age of Respondents

However as over half the respondents were under 34, there would plenty of motivation in terms of the length of their working life and the possibilities for doors to be opened for further development especially for registered nurse or allied health professional training. The majority of the respondents were female (Chart 2) with 96% working in the gender they were assigned at birth (Chart 3).

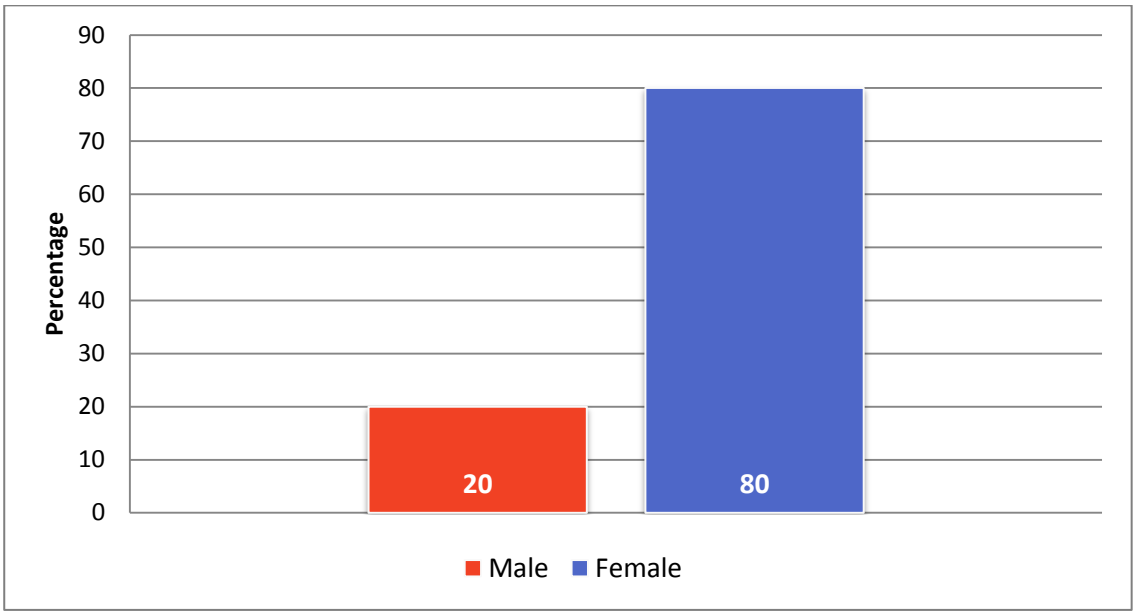


Chart 2. Gender of Respondents

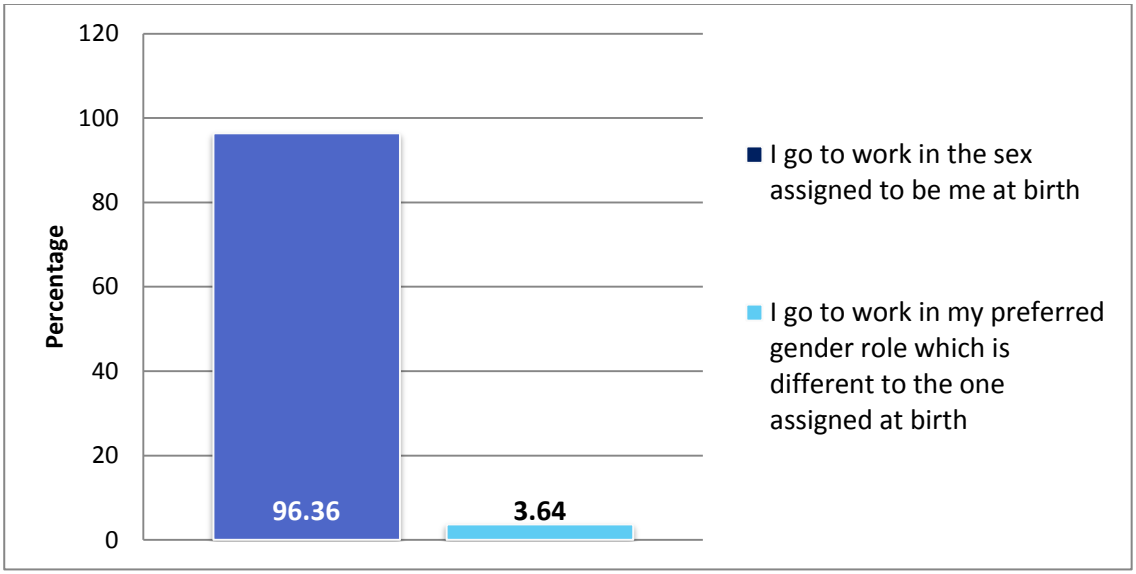


Chart 3. Gender Identity of Respondents

Chart 4 presents the ethnicity of the respondents. The following categories were included but not completed by any respondent: Bangladeshi, Chinese, Other Asian, Mixed Race Caribbean, Mixed Asian, Other mixed race and Not Stated.

The largest single group is White British however there were over 50% of respondents who were Black or other minority ethnic (Chart 5). The largest group of these were African. This fitted with the responses to the requests for focus group attendance. The greatest number of responses came from African workers especially Nigerian workers.

This is addressed further in the discussion of focus groups.

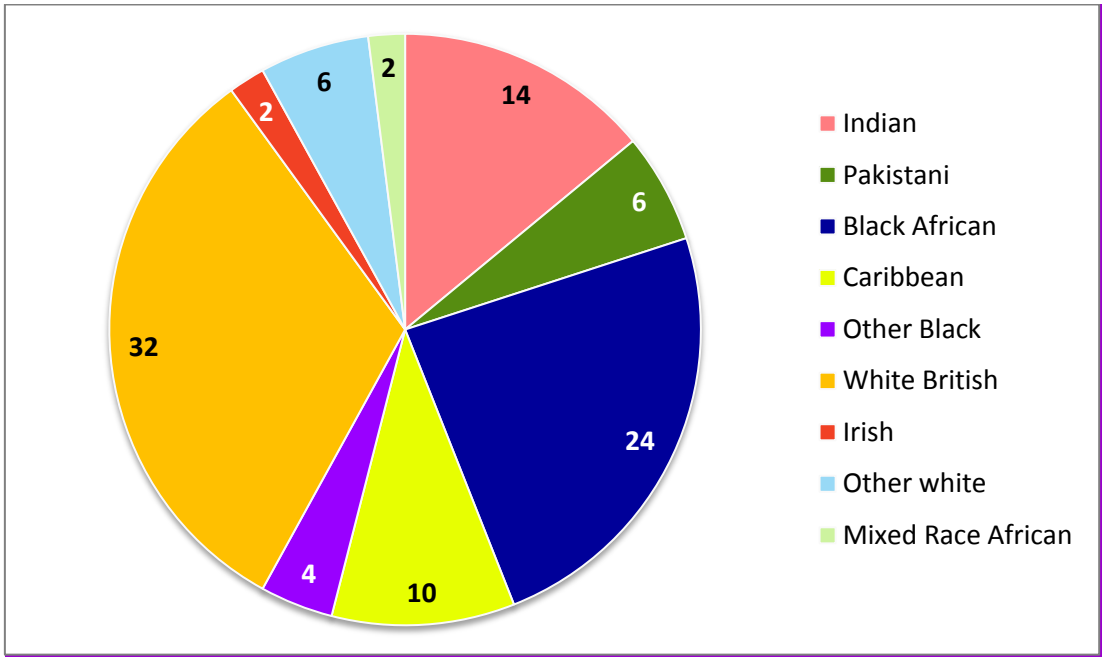


Chart 4. Ethnicity of Respondents (Percentage)

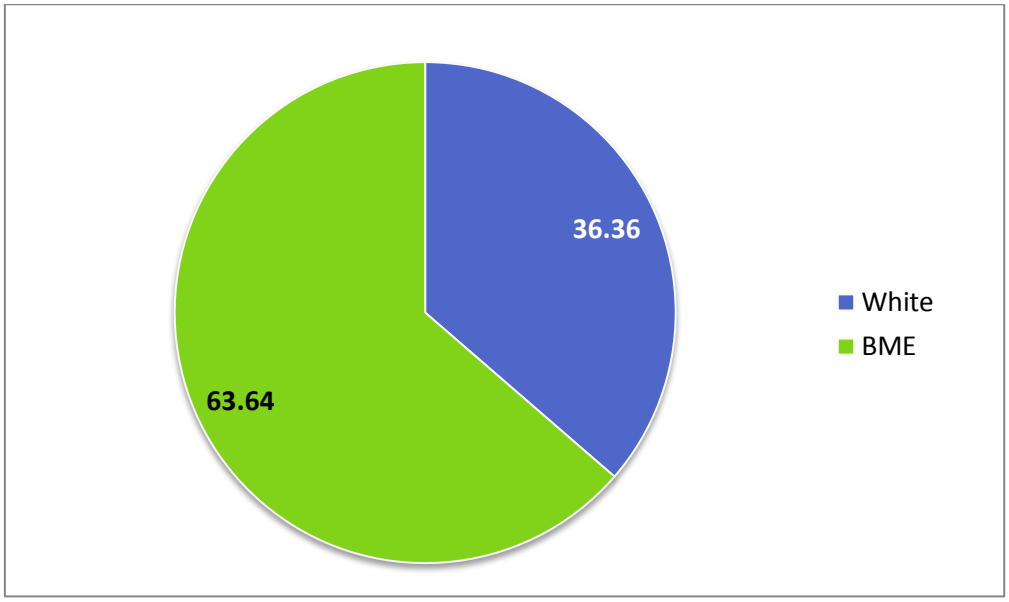


Chart 5. White and BME Respondents (Percentage)

6.2. Qualifications

Although National Vocational Qualification 2 or 3 is not a prerequisite for entry to the programme, a number of clinical areas request that applicants have completed this qualification before being considered for the Foundation Degree. Discussions with current students prior to the commencement of this project demonstrated that they had all successfully obtained NVQ 3. The survey sought to ascertain whether not having acquired this level of qualification was inhibiting career progression. However, Chart 6 evidences that over 90% of respondents do have NVQ 3 with an almost equal distribution between the White and BME support workers (Chart 7).

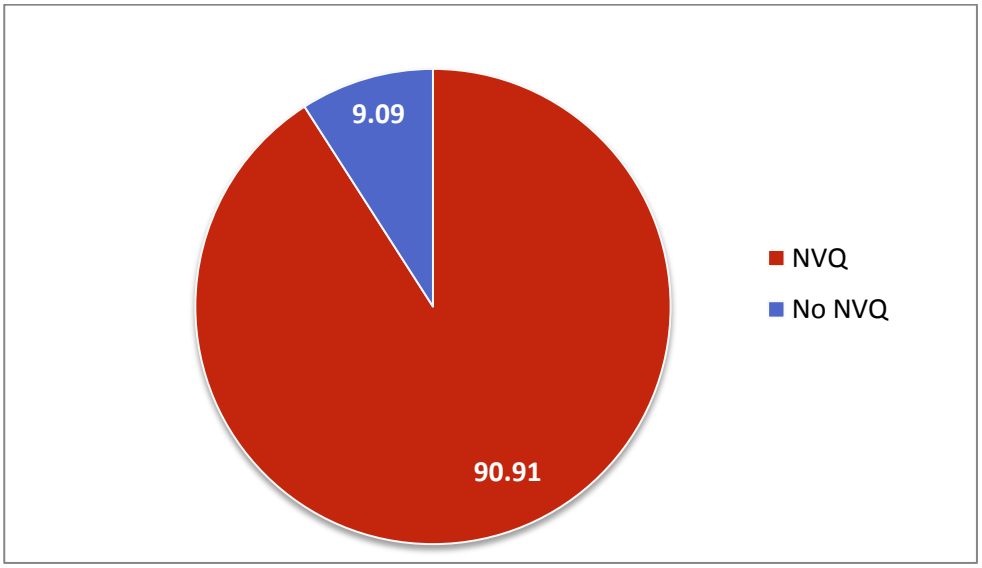


Chart 6. Percentage of Participants Who Have National Vocational Qualifications

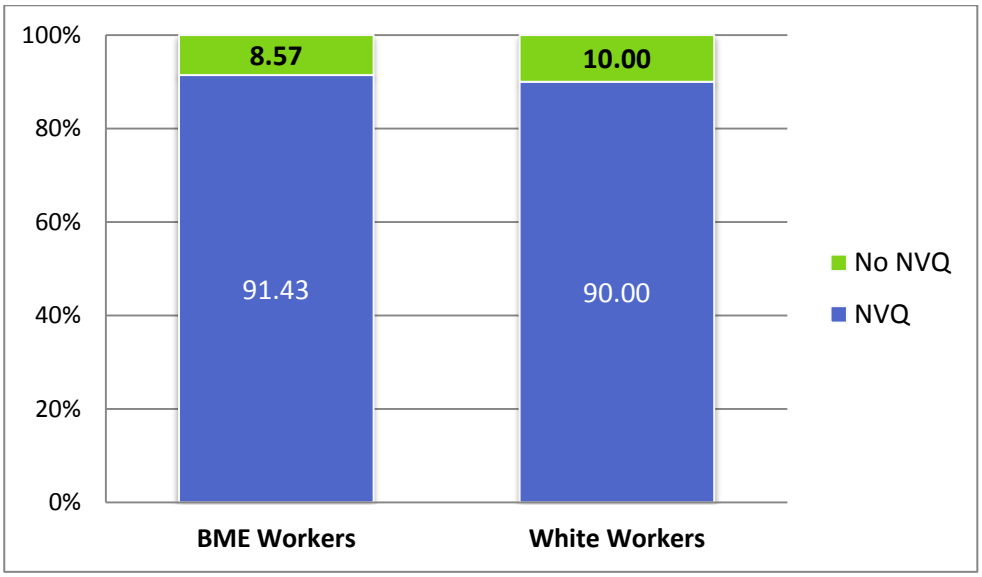


Chart 7. BME and White Respondents Who do/do Not Have NVQ's (Percentage)

6.3. Knowledge about Assistant Practitioner Role

It was important to be sure that the respondents knew about the Assistant Practitioner training for health care assistants and that their poor representation on the course was not solely down to a lack

of awareness of the possibility for development. Chart 8 demonstrates that the 90% of respondents knew about the Assistant Practitioner and that there was little difference in the numbers of BME and White support workers who knew of the programme (Chart 9). However around 32 % (n15) stated that they did not know much about it including not knowing how to apply as is demonstrated in Chart 15

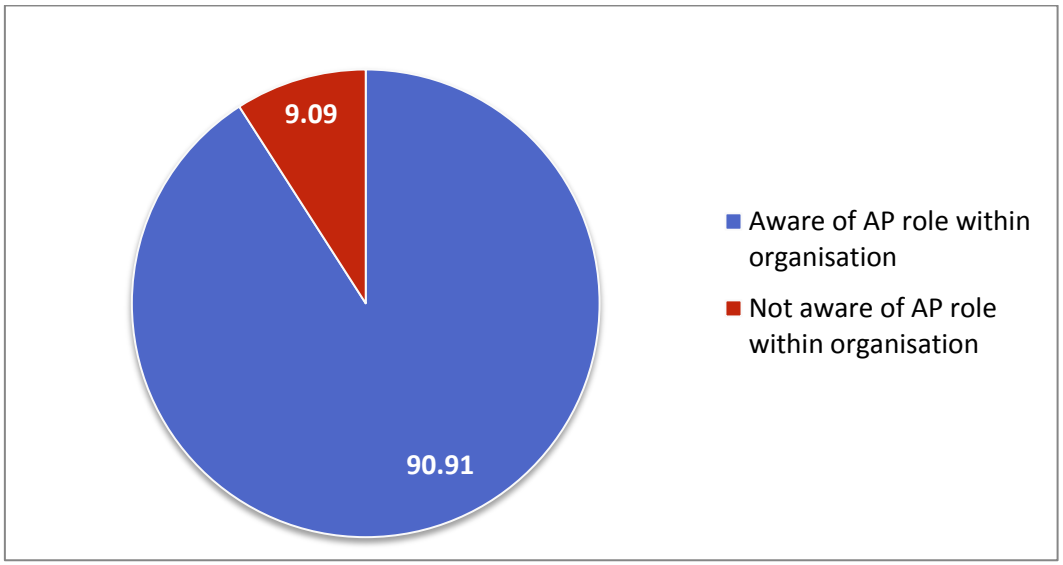


Chart 8. Percentage of Participants Aware of Assistant Practitioner Role within the Organisation

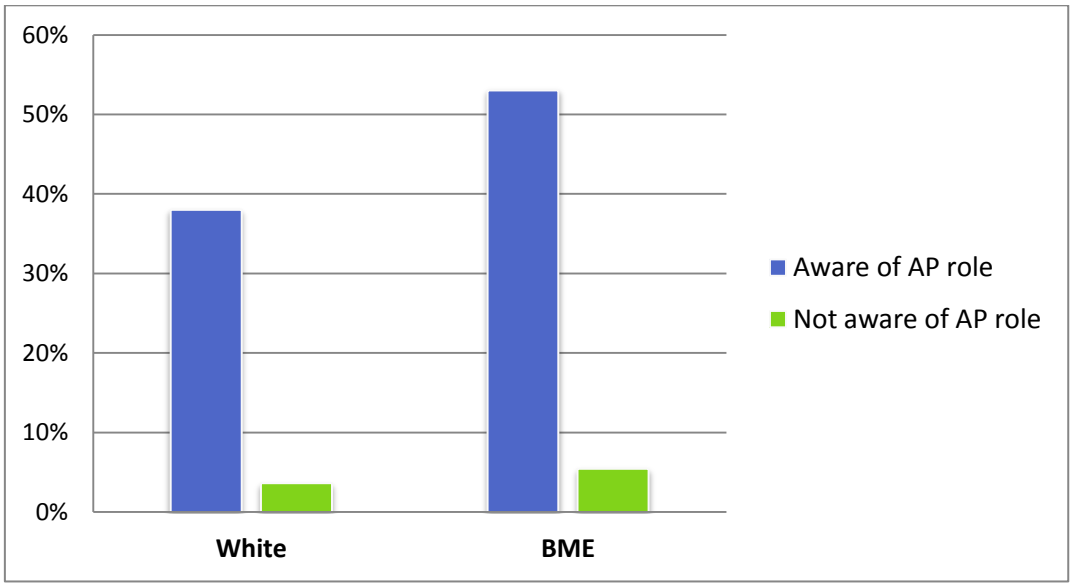


Chart 9. Percentage of Respondents Aware of the Assistant Practitioner Role

Respondents were provided with the Assistant Practitioner role description from Skills for Health (2011) and were asked whether this was a role they would be interested in by indicating yes or no (Chart 10). There were similar levels of interest in the role, with 90% of both groups demonstrating interest in the possibility of enhancing their role (Chart 11).

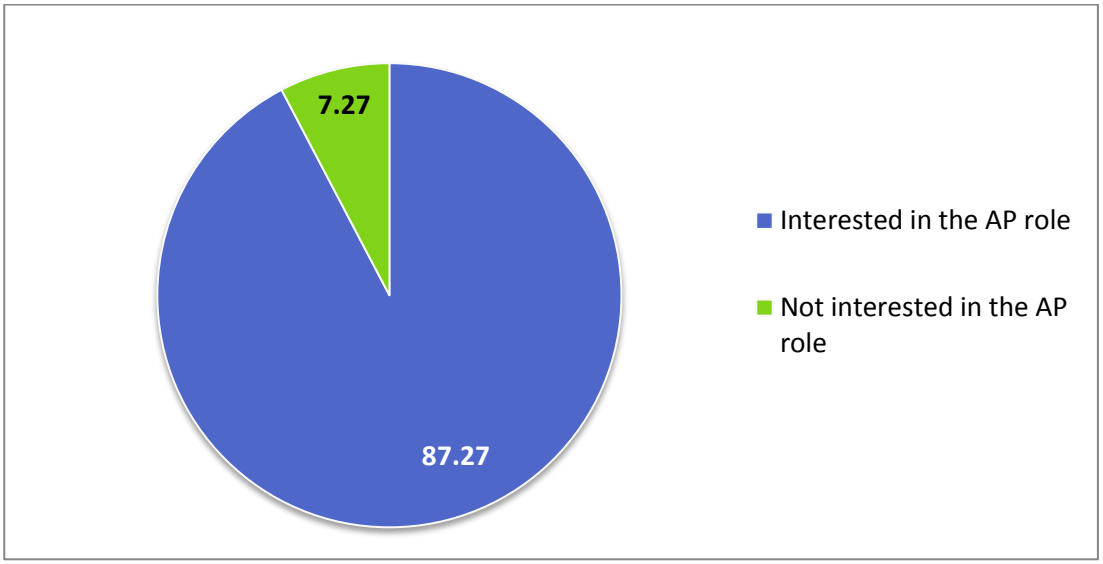


Chart 10. Respondents Interested in the Assistant Practitioner Role? (Percentage)

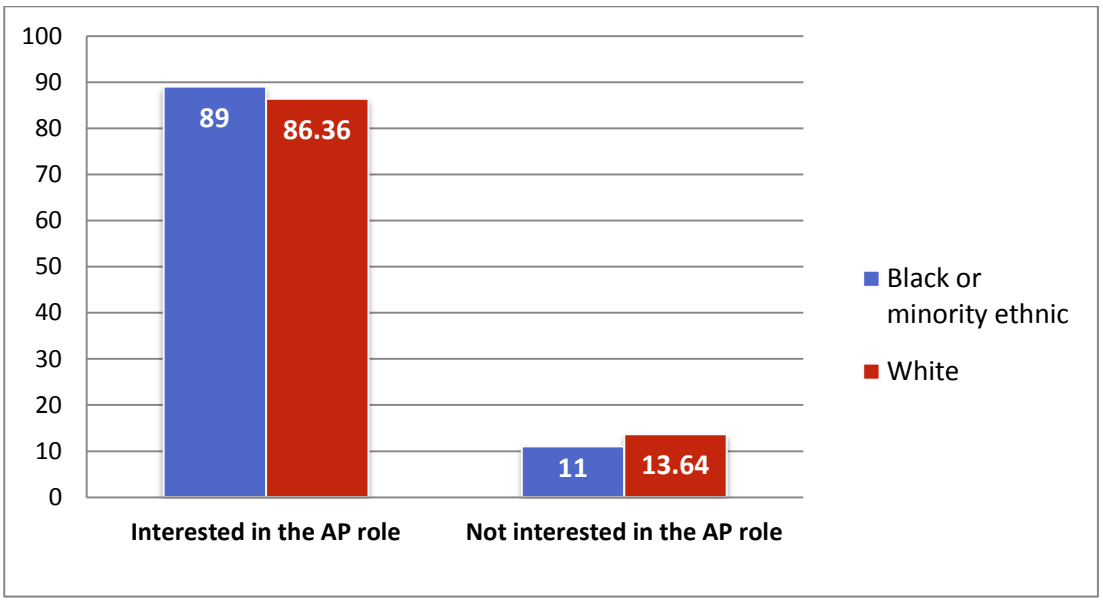


Chart 11. Respondents Interest in the Assistant Practitioner Role by Ethnicity (Percentage)

Respondents were asked how they knew about the Assistant Practitioners. The questionnaire aimed to test whether this was an advertised opportunity or whether it was through knowing people who were doing the job. In discussions with trainees who were undertaking the programme a number said that they had been advised about the opportunity through their manager who had suggested that they apply.

As can be seen in Chart 12, 60% of respondents knew about the role through contacts and over 54% knew about it because there were Assistant Practitioners in their clinical areas. Less than 20% of respondents stated that they knew about it from advertising.

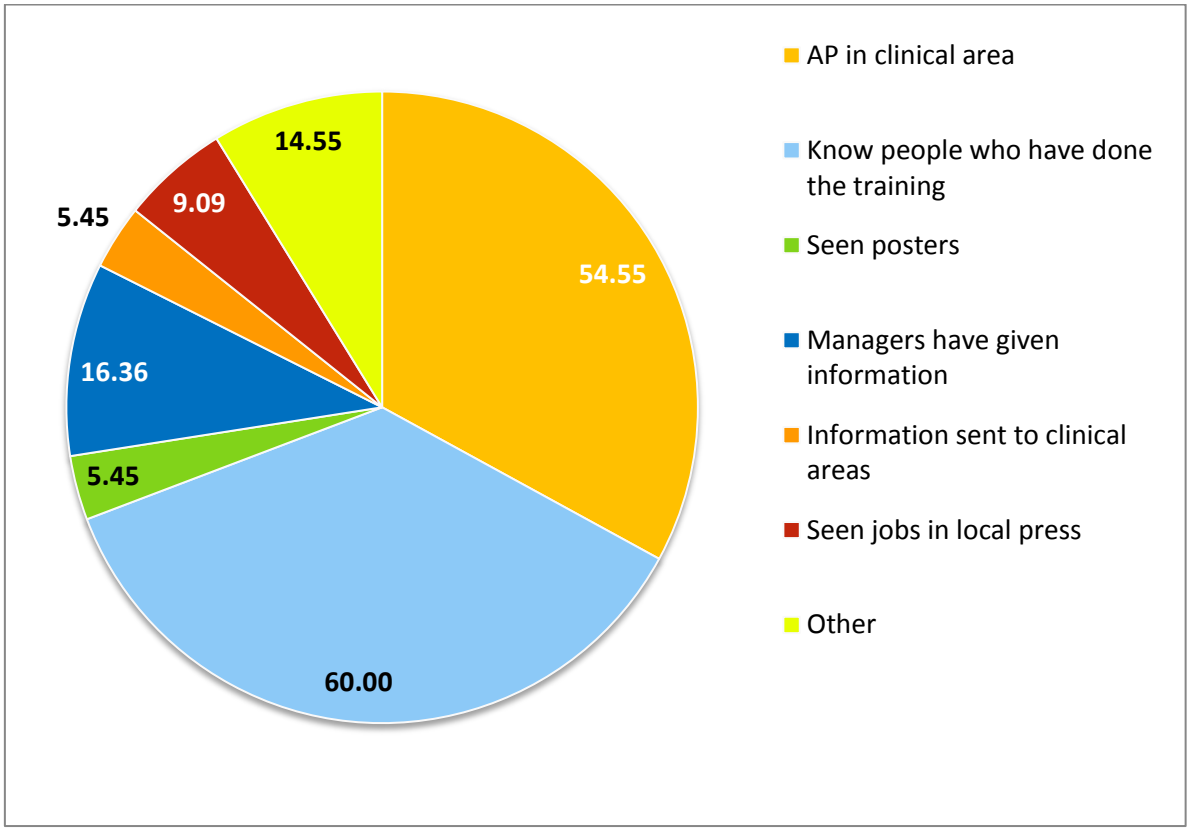


Chart 12. How the Respondents Know About the Assistant Practitioner Role (Percentage)

6.4. Application and Selection

6.4.1. Application

There is evidence that, at application, shortlisting and interview for jobs and promotion within the NHS, candidates from BME backgrounds are less successful than white applicants (Harris, 2013; Hudson and Radu, 2011; Kline, 2013). The questionnaire sought to establish if any respondents had been either unsuccessful in their applications or unable to complete the course. The aim was to analyse the data to establish whether there was any difference in the rate of or likelihood of acceptance onto the course based on ethnicity. In the end, the numbers who had applied to do the assistant practitioner's programme in this sample were too small to allow any meaningful analysis. Only three of all the respondents had ever applied to do the training (Chart 13). One applicant was not shortlisted, another was unsuccessful at interview (see Chart 12) and the third was waiting to hear from her application. No conclusions can be drawn from these figures.

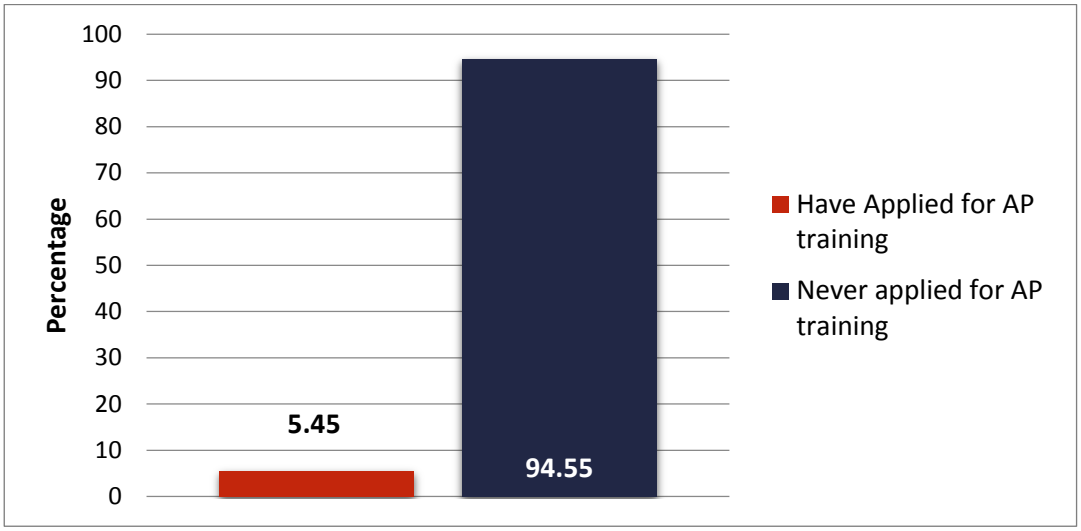


Chart 13. Respondents Who Have Applied for Assistant Practitioner Training

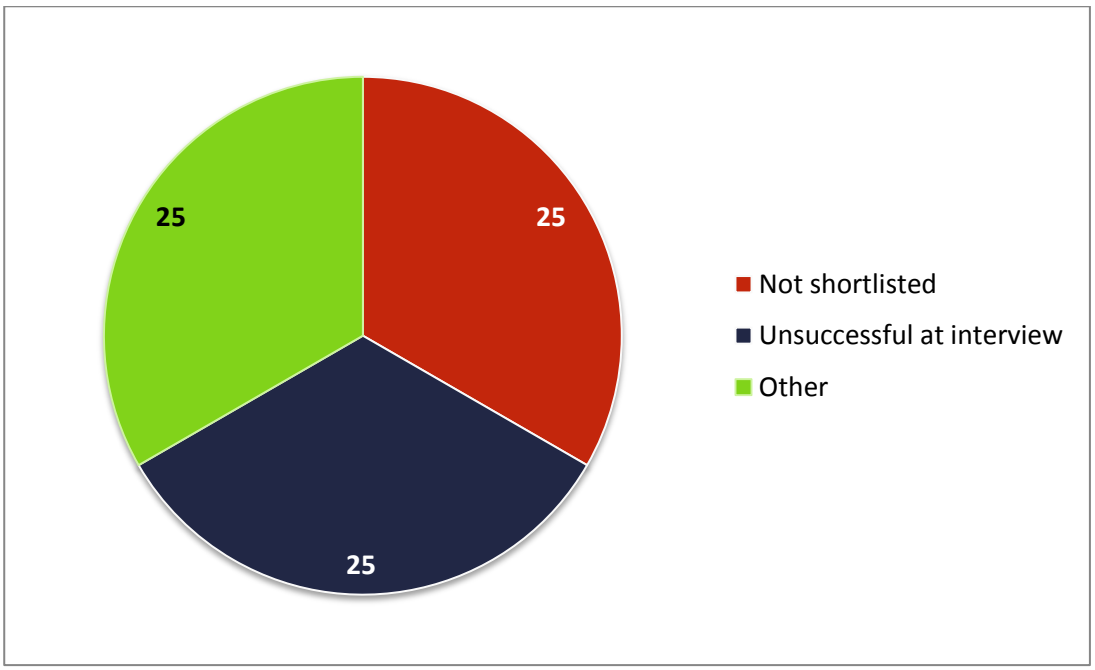


Chart 14. Why Respondents Who Applied for Assistant Practitioner Training were Unsuccessful at Selection (Percentage)

The final question (Chart 15) asked respondents what factors had prevented them from applying for training as an assistant practitioner with the aim developing strategies to address and overcome barriers to access.

Despite the fact that the majority of respondents knew about the Assistant Practitioner role (Chart 8), 51% (n24) of all applicants stated the reason for not applying was not knowing how to do this. BME support workers account for 66% (n16) of those who were unaware of the application process (Chart 16). Nearly 40% stated that while they were aware of the role they did not know much about it with 61% of these being BME (Chart 17). This finding fits with responses to question 8 (Chart 12)

which indicates that the post is not widely advertised. Issues of lack access to information were explored more fully in the focus group discussions.

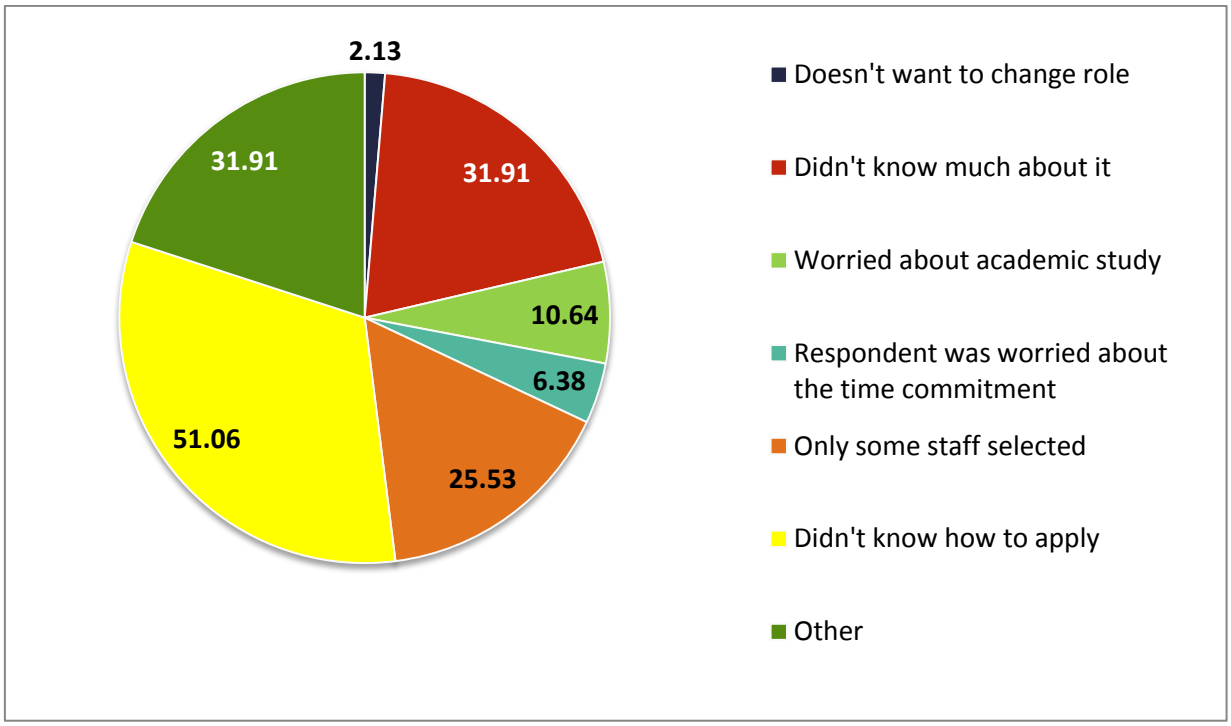
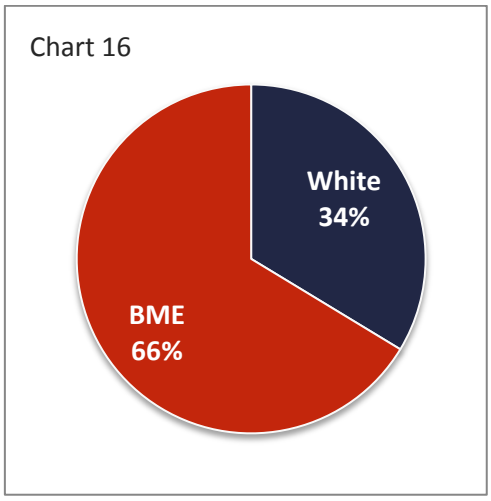


Chart 15. Reasons why respondents have not applied for Assistant Practitioner training (Percentage)



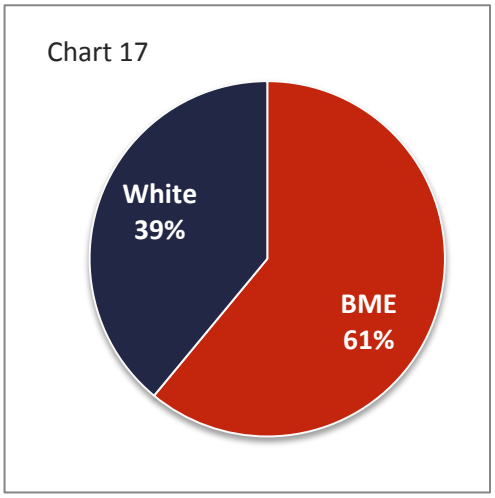


Chart 16. The Respondent, by Ethnicity, did not know how to apply for the Assistant Practitioner course

Chart 17. The Respondent, by Ethnicity, did not know much about the Assistant Practitioner Course

Lack of knowledge about the Assistant Practitioner role and training supports the anecdotal evidence from current students studying on the programme. They stated that their own successful selection and recruitment to the course had occurred as a result of support and encouragement from

managers rather than recruiting advertising or information. Smith et al. (2006) identified that overseas trained nurses (OTNs) working in the UK found that promotion was often dependent on a 'system of sponsored promotion and patronage'. The OTNs stated that some staff would be offered support by their managers for their application. The nurses claimed that selected candidates were pre-selected and coached prior to their interviews whilst others were ignored or received inadequate support (Smith et al., 2006). Others in the study claimed that information about promotions or career opportunities were not adequately disseminated and they were unable to find out information. Whilst Smith et al.'s (2006) research explored the experiences of OTNs working in the UK, the questionnaire findings in this study supports the thesis that the opportunity for development was offered to selected staff with 30% of all respondents stating that only some staff were selected to do the programme.

Further analysis of the responses shows 48% of BME support workers stated that only some staff were selected to do the training (Chart 18) compared with 8% of the white respondents.

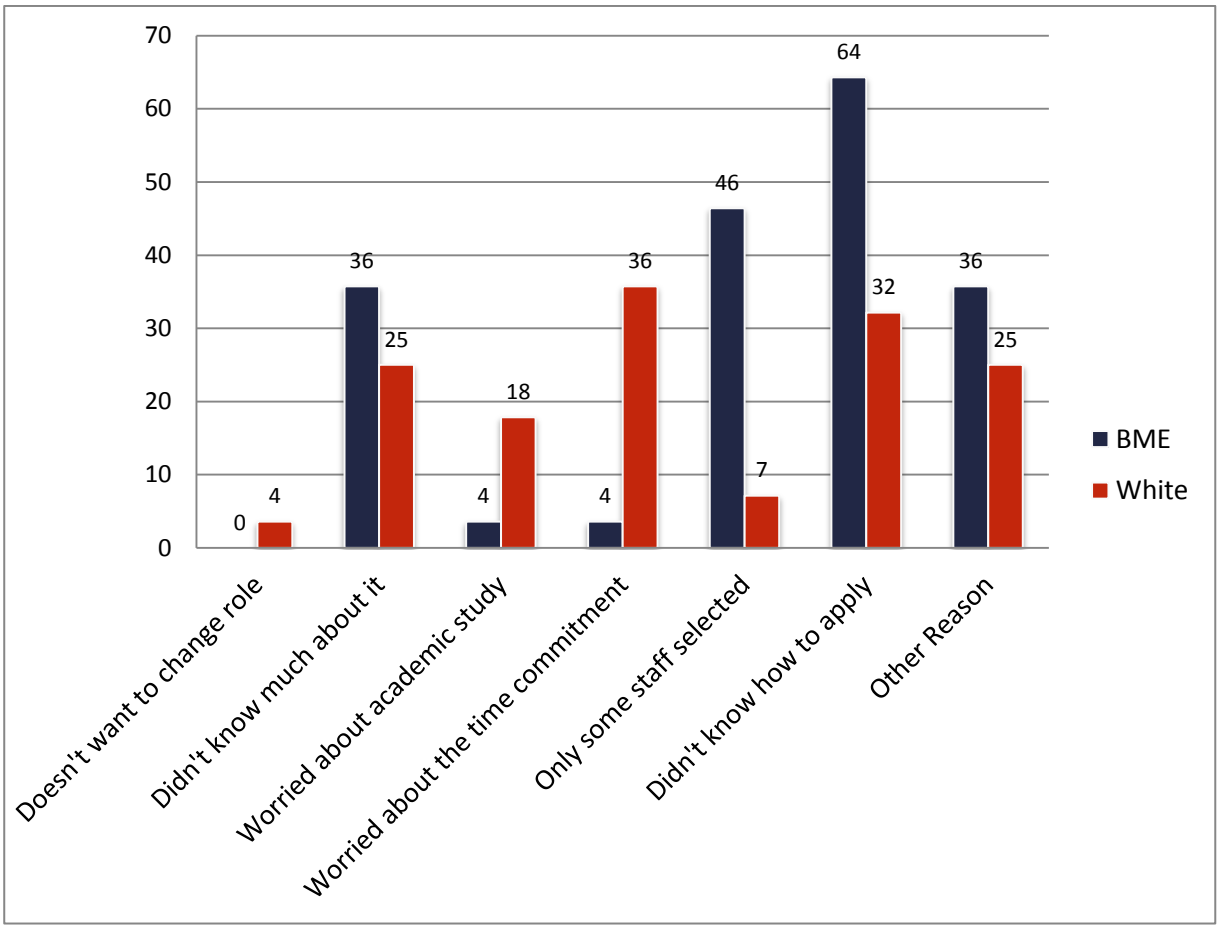


Chart 18. Reasons Given by Respondents, according to ethnicity ,for not applying for Assistant Practitioner training (Percentage)

As a statement of fact this response poses concerns about the equality of opportunity for all staff. If, however, in addition, BME staff perceive themselves to be blocked from accessing to developmental opportunities, which would enable them to grow and develop, the motivation and engagement of those staff is affected. This, in turn, impacts on patient satisfaction, mortality rates and Trust financial performance (West et al. 2012)

The identification of individuals, rather than open recruitment and selection may contribute to the over 60% of BME respondents who stated that they did not know how to apply.

Questions arise about whether it is the pre-selection of specific staff for development which excludes others from getting further information about application and recruitment or whether some staff do not have the initial information so are not able to put themselves forward. Kalra et al. (2009) state that membership of informal networks and groups is often based on racial and gender lines. BME workers can find themselves excluded from these networks, which diminishes their access to key information. In the absence of prescribed processes for recruitment to training opportunities and where information is disseminated informally membership of such networks or groups is essential.

The research aimed to establish whether BME HCAs were eliminating themselves from contention. As can be seen in Chart 18, the figures demonstrate that only 5% of BME support workers are excluding themselves through concerns about academic study or worries about the time commitment. No BME respondents stated that they did not want change roles. In combination with the level of interest expressed in the position, there is evidence of aspirations to develop their career and take up education or training opportunities but these remain unrealised by a lack of knowledge about the process.

6.5. Comments

Questionnaire respondents were given the opportunity to offer different explanations to Question 8: How they knew about Assistant Practitioners; Question 10: Lack of success with application (if they had done so) and Question 11: Why they had not applied for Assistant Practitioner training. These are marked as 'other' on the tables. The key comments highlighted frustrations with a lack of opportunity and funding:

> *I've not been given the opportunity*

> *I never get the opportunity to apply*

> *I was told not enough funding for the course on my ward, and an Assistant Practitioner not required*

> *I would like the role but not to change post. There's no money, no future. It's very disheartening. The course was stopped*

Respondents also indicated that poor communication together with issues about timeliness and clarity about application eligibility were a factor in not accessing the course:

> *My manager received an email but the deadline was missed*
>
> *No-one mentioned that support workers could apply*

There was also evidence of respondents wanting to progress:

Becoming an Assistant Practitioner is something that would interest me as I would like to move up a level

It's something I'm interested in, I'm interested in developing further

Part 7. The Focus Groups

7.1. Focus Group Interviews with Black and Minority Ethnic Health Care Assistants

7.1.1. Participant Demographics

In addition to the questionnaire, there were three focus groups. Participants included a range of ages and ethnicities and both men and women participated. Please see Tables 1-3 below for a description of the participants:

Table 1. The Age of Focus Group Participants

Age group	No.
18-24	0
25-34	7
25-44	8
45-54	1
55-64	0
Over 64	0

Table 2. The Gender of Focus Group Participants

Age group	No.
18-24	0
25-34	7

Table 3. The Ethnicity of Focus Group Participants

Ethnicity	No.
African	7
African-Caribbean	3
Indian	5
Pakistani	1

7.2. Sampling Strategy: Accessing the Focus Group Participants

Managing the practicalities of recruiting a sample was difficult due to a number of considerations. There was a lack of direct contact with potential participants by the researcher; the participants all worked different shifts so finding an agreed time was problematic and there were complications attached to casual contracts such as last minute shift changes; there was a lack of understanding of the purpose of the focus group and unfulfilled expectations. The questionnaire had a contact sheet

attached to recruit focus group participants. Morgan (2007) advises that focus groups should be over recruited by 2% to compensate for non-attendance however the complications of ensuring attendance resulted in a much greater than 2% non- attendance. A number of volunteers did not respond to emails, texts and direct calls despite indicating a willingness to participate and had provided contact details. Three potential participants advised that they would attend the focus group but then did not do so. Another two were requested by their managers to change shifts at the last minute. A significant number of people contacted me who were under the impression that the focus group was a process for recruiting or selecting applicants for the programme. I had to ensure that it was very clear that membership of the focus group would not result in offers of jobs or training. This resulted in some declining to participate; but others recognised that participation would provide an opportunity to have their voice heard and to express their frustrations at the barriers to their progression. It would also be a means of getting their perceptions and experiences to managers or human resources.

As a consequence, recruitment became dependent on a 'snowball effect' whereby one individual contacted provides contact details for others they know in the same situation (Liamputtong, 2011). This sampling approach has proven effective when the researcher aims to carry out research with marginalised groups often difficult to reach for research purposes. Due to the aim of the study it was important to hear these voices. The impact of this was that the groups tended to be comprised of participants who had similar background experiences within the NHS. Group 1 had all African participants, Group 2 was African-Caribbean and Group 3 was largely comprised of Indian nationals. Discussions demonstrated a considerable overlap in the experiences and perspectives of access to Assistant Practitioner training between the different minority ethnic groups (see below) but also focused on experiences unique to them and their backgrounds when they joined the NHS as health care assistants.

The third focus group is of particular note. Using snowball sampling, one Indian support worker indicated an interest in participating in a focus group and then provided contact details for colleagues so that there were five (and one other non-Indian) at the focus group. These HCAs were, in fact, registered nurses who had qualified in India and had come to the UK with a view to undertaking the Adaptation programme[3]. Their arrival in the UK coincided with restrictions placed on overseas nurses with regard to language proficiency. The NMC imposed a level 7 IELTS for overseas nurses[4], a standard they were unable to reach then and since, achieving a level 6.5 average despite repeated attempts. This group (and further colleagues) took posts as HCAs to use their skills, in the hope that they would achieve the required standard of English or to develop their careers via a different route in the NHS. They now found themselves with an out-of-date Indian nursing qualification that would need updating in order to re-apply for the adaptation courses. Their failure to achieve the required level 7 IELTS also bars them from accessing pre-registration nursing programmes.

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[3] An adaptation programme is designed to compensate for significant differences in registered nurse training and experience obtained overseas, compared against the minimum EU and United Kingdom (UK) training standard in order to practice in the UK

[4] IELTS is the International English Language Testing System. IELTS conforms to the highest international standards of language assessment. It tests the four language skills – listening, reading, writing and speaking

7.3. Facilitating the Focus Groups

Potential members were invited to the focus group. Information about its purpose was sent to participants (Appendix 3). Three days before the session, each member was called by telephone and reminded to attend. The key questions for the moderator were:

- Why the group participants thought they could not access to Assistant Practitioner training
- What they thought needed to change in order to improve access to the programme by health workers from the BME community.

The focus groups lasted one hour each. The participants were welcomed and given a brief explanation of the purpose of the group meeting. They were asked for their consent for tape-recording of the session and were also provided with a copy of their signed consent agreement form. Refreshments were provided because the sessions were held after their shift and it also provided a few minutes ice-breaking time prior to commencing the discussion. In order to promote participation by all the group members and ensure that the participants could all see each other they were seated in a circular arrangement around a table. The initial questions were directed to individuals with time for responses.

Being conscious of the imbalance of power within the focus group (Serrant-Green, 2010) and that as a researcher outside their cultural and ethnic group, my own views and perceptions might become central to the discussion. I endeavoured not to lead the discussion but to follow the direction of the issues raised by the group members. In one focus group, there was a co-facilitator with me from the same racial group (although not nationality or ethnicity) who provided support (Serrant-Green, 2010). The second issue with the imbalance of power was that the focus group participants were motivated to attend because they wanted access to training and I was perceived as facilitator to that. The initial discussions were explaining the limits of my authority in providing access to opportunities. The interactions then became more spontaneous between participants although there was a tendency to direct responses the moderator.

The transcription of the focus groups was carried out by a transcribing service. Thematic analysis was employed to interpret the focus groups data. Initials identified the individual participants who took part in the focus groups.

The analysis approach was inductive. Existing concepts such as manager support, lack of information, application process informed the analysis framework. Discovering emergent themes that challenged and questioned assumptions were essential in order to provide a theory as to why there was a gap in the ethnic composition of assistant practitioners.

7.4. Findings: Perceived Barriers to Access

Thematic analysis of the focus group data generated themes of:

- Lack of Information;
- Lack of Transparency in Recruitment and Selection Processes
- Race and Discrimination,
- Getting into Trouble

7.4.1. The Lack of information

The questionnaire asked respondents why they had never applied for assistant practitioner training to which the most frequently chosen response was 'I didn't know much about it'. In all the focus groups the BME participants stated that lack of information about the course and the means by which candidates were selected was a significant barrier to HCAs from BME backgrounds accessing the Trainee Assistant Practitioner. Participants stated that they would find that colleagues had begun the training but that they had not seen any information about it.

> *I think the issue is that the information is there, especially in the big hospital like this. It's just that some people get the information, others don't get the information. (J-Focus Group 1)*

They stated that information was distributed too late to be of use to them, that it might be sent out by email but if they were not working for a few days or did not have access to email in that time, they would miss the deadline. They expressed ideas that the application information was given to chosen individuals but was not widely disseminated and that emails were sent out to appear that it was an open process information but often too late. Certainly anecdotal evidence from current students confirms that they were personally identified for development or advised to submit an application.

> *I haven't but I've heard of it. It's just like you get the information when things are late. Many you don't get the information at the exact time when you're meant to have it. (P-C – Focus Group 1)*

> *I'll give you a kind of scenario that happened about two years ago. An advert came up for assistant practitioner. Before the advert come up or something like that, some people have already – they are already aware of what was going on, and at that end of the day the next thing you hear is people have been taken to go for such programme. (J-Focus Group 1)*

7.4.2. The Lack of Transparency in Recruitment and Selection Processes

The participants expressed a sense of disempowerment in the face of systems which lack transparency.

> *I don't know how to access the course, so anyway I didn't get any opportunity to get through. On my ward, there is no Assistant Practitioner s, and nobody was talking about any training or anything. (A-Focus Group 3)*

There was a feeling that however much an individual wished to progress his or her career or develop their role it was impossible to find out the information about how to go about it. The importance of supportive managers and mentors is essential for the development of talent (Powell et al. 2012)

> *So the manager just choose [P's friend to become an AP]. That is when I knew about assistant practitioner. I started enquiring because I was doing access course by then. I ask them, I said "Please how… you go to uni. What is the subject you do?"*

She started telling me something "on most wards we are doing access." I said "Okay, that's right, I can also do assistant practitioner?"

I said "Do you have NVQ?" She said "No." I said "How do you go there?"……. She said "please don't ask me too many questions. Just know that the manager choose me."

I said "Okay." Anyway, I go and ask my own manager but he said [our ward] isn't getting one. I really want to but don't know if I can apply through UCAS or what to go into it, so I didn't bother to apply. (P- Focus Group 1)

Managers were frequently cited as barriers to developmental opportunities. The members of one focus group claimed that managers would be reluctant to chase up information even if the support worker drew their attention to an advertised trainee post or if they heard from colleagues that there were posts available.

M and me are working the same ward. We are going to the manager and asking to get any opportunity to get… Anything.

They're never interested. We always asking. (E- Focus Group 1)

Managers are viewed as the gatekeepers to accessing training and that if you are not chosen, there is no way to progress.

Definitely. If your manager doesn't choose you there's no way you can go on the course, they don't advertise, so that's where permission comes in. So some people get the information first. (J- Focus group 1)

The participants voiced concerns that there was a lack of open opportunity for training and that some workers were identified for development whilst others were overlooked.

Sometimes they tell you the manager recommended some persons to go for the course, so you sit and watch and see how things go. You might not have the information. (C-Focus Group 1)

The perceptions of participants in this sample reflect trends in the literature. Kline (2014) identifies that BME nurses are less likely to be put forward for promotion and developmental opportunities. This is supported in the findings from the focus groups. Participants in the focus groups expressed frustration at the selection process for assistant practitioner training:

I approach [my manager] again to say "all the other wards are doing [assistant practitioner], why are our ward not doing it?" He said "it's not in his hands, it's in management's hand who is in charge of him". Anyway, we leave it, didn't hear anything about it. When we go onto other ward … because I do bank shifts so therefore I go to other wards … "are you doing the Assistant Practitioner?" and when I tell them what my Ward Manager said to us they said "no, our Ward Manager just signed the form, we sent it off and if the university accept us then we'll get it". V – focus group 2

They complained that there is no desire to develop staff even if the individual would support himself or herself through the programme.

I also want to do assistant practitioner ……And I found out it's in Bolton and I asked my manager if I could. She said yes you could go for it, but we're not paying, which means you might lose your job. So if I'm going to school, losing my job, so if I come back so how will I get the job? So now you don't think between going to school and getting a job. (E- Focus group 1)

In particular, the group of Indian HCAs stated that, in their opinion, it was not in the interests of the Trust to develop them further as they already had skills and knowledge from their original training which meant they were very effective and productive workers.

They just want you to stay as a support worker. They don't want you to move up and develop or anything.

No, and they say "We know you are [a nurse] … You are a good worker. Don't move from this ward." (M- Focus Group 3)

They also expressed frustration that the Trust's development strategy obliges them to obtain NVQ 2 despite the fact that their skills and knowledge far exceed its requirements and that the process of putting them through it is costs the NHS money. And conversely they are not permitted to study beyond NVQ 2.

I keep on asking them because I just finished NVQ2. I don't need to go all the training session, just do the online training because I know the information and things like that. I keep on asking them, but they said everybody is asking NVQ 3. You don't need to NVQ 3 in this ward (J – Focus Group 3)

7.4.3. Issues of Race and Discrimination

Kline (2013) conducted a survey of applicant data from random NHS Trusts. The study demonstrated that white applicants for NHS posts were nearly six times more likely to be appointed than BME applicants. The lack of formalised processes for recruitment to the Assistant Practitioner programme the selection process means that numbers are harder to quantify. What is clear is that from the perspective of BME support workers it appears discriminatory.

I think what goes wrong with the whole Assistant Practitioner thing, if we as black people or black minority go for certain positions we won't get it. And it's not only the Assistant Practitioner posts, all the other posts, you won't get it. [M – Focus group 2]

The university's records reveals that of the approximately 1500 students who have undertaken the Assistant Practitioner programme less than 2% have come from BME backgrounds. This explains the observations of the two focus group participants below.

I have never seen a black assistant health practitioner. [P – Focus group1]

This is the biggest hospital in Europe, but you can count how many black assistant practitioners [E- Focus group 1]

In absence of qualified BME Assistant Practitioners and the perceived reluctance on the part of managers to promote developmental opportunities such as Assistant Practitioner training to BME HCAs, the exclusion from opportunities appears discriminatory on account of their colour.

I think it's just the way the whole thing is set up, because if it's somebody else … what I look on, when I approach for it I didn't get it and then two other girls came in and who wasn't black….they get it [V – Focus group 2].

BME staff are not able to prove their worth or capabilities because so few are offered further educational opportunities. This leads to a vicious circle whereby BME support workers are not selected because there is no evidence that they will be successful. The added consequence is that bright, ambitious care staff, who are BME, move on.

Nobody gives us a chance, and most of the [black] girls who were on that ward at the time with me, they've all gone because there was no opportunity for them to move forward. [V- Focus Group 2]

Participants perceive that white staff are given opportunities that are not available if the individual is from a BME group.

[if] I was a white Support Worker I would get that Assistant Practitioner job long time ago, without a doubt, because I'm good at what I do, I understand what people need. [V – focus group 2]

They stated that they were often reliant on obtaining news about opportunities from white colleagues and that it seemed that white health care assistants have information that is not available to BME staff.

I've got assistant practitioner information twice. The first one, I went to another ward by transferring a patient and I got to know through a friend of mine "Oh, are you still a support worker. I said "Yes." "Why not go for this course [assistant practitioner]?" [he said]. I said "Really?" He transferred his information, he's a white. [E- Focus group 1]

The issue of race was particularly evident for the Indian support workers who experienced EU nurses being able to practice within the NHS although their English was evidently poor but who were not obliged to meet the IELTS 7 restriction on account of their EU status.

EU nurses are coming, they don't know English. They don't have any problem. How do they communicate to the patients?

How NMC giving them pin number?

Yes, because of the EU union, they are giving the pin number. How are NMC doing different rules? They don't know any English……What's the reason why they're taking the Spain and the Union nurses without knowing English? We know the English. At least we can speak. They are not accepting we understand. So NMC is not doing it the correct way.

[They] can ignore us because we are Indian [B- Focus group 3]

7.4.4. Anxieties about 'Getting into trouble'

One of the unexpected threads of discussion was the issue of 'getting into trouble'.

I have purposely kept the language of the support workers because it is indicative of a situation which is not as serious as being disciplined, but denotes an attitude felt by these workers that they are not treated as equals and are constantly at risk of being chastised. This leaves workers feeling vulnerable and inhibits them from requesting information about training and promotion.

> *But like me, I'm very nosey, so I always know what's going on, but other people will never know, because they don't come forward, they feel like if they come forward they're going to get in trouble. [V- focus group 2]*

Having said that, there is data in the Workforce Profile of the Trust that demonstrates that BME staff in the organisation are more likely to be disciplined than white staff.[5] This experience of BME workers is supported by the literature elsewhere. Santry (2008) states that although staff comprise 16% of the NHS workforce, they make up 34% of capability reviews; 44% of bullying and harassment cases; 31% of grievances and 29% of disciplinary proceedings. So it is with a sense of justification that the participants are wary of challenging the status quo.

> *People in my position, they won't [say anything], because they're scared, they're scared of losing their job, they're scared of being told off or suspended – [F – focus group 3]*

> *….black people, they're afraid, because they have this thing that if they say anything they're going to be sacked, they're going to be disciplined, they're going to be moved to another ward, they're going to…– [E – focus group 1]*

7.4.5. The Need for BME Role models

All the focus group participants identified the need for role models who reflect themselves. The participants recognised that the absence of leaders from BME backgrounds impacted on their opportunities for progression. There is extensive literature on the poor BME representation at leadership level within the NHS (Esmail et al. 2007; Johns, 2005; Kalra et al. 2009; Kline 2013; Kline, 2014). While much of the work focuses on the lack of opportunities for qualified NHS staff the contributions from the focus group participant demonstrates however the impact of this is felt throughout all levels of employees.

[5] The relevant documents have not been referenced to ensure the confidentiality of the Trust and its employees, but is available from the Researcher.

What would help is if more black people have more positions in high places, they will think "I see Sister so-and-so, I see Brother so-and-so, I can go there" but there's nobody to represent them so they feel [M-Focus Group 2]

….although she's black, that doesn't mean to say she understands but at least they will have an insight in what's going on and how to approach certain situations or how to tell you "you can do this". You don't get that, you just have to search, search, search to get things for yourself. [J – Focus group 1]

They observed that there were not many managers who were black or minority ethnic.

Very rare you see a black Ward Sister. You go on other wards you hardly see a black Ward Sister. So it's not only just the Foundation Degree position but all the other positions. You don't have any black leaders, I don't know why, I don't know if it's because they're black … I know people go for the positions but they don't get it. [V- Focus Group 2]

However the participants in group 3 expressed the view that it was not enough to have ward managers who were BME as they did not have sufficient influence over decision making and they themselves were constrained by those above them. The BME representation needed to go higher than ward or clinic level.

Our manager is Indian, so we can't say that. Maybe she doesn't have any voice at all. She's always quiet.

Only higher people can make decisions. But she's not going up and asking them.

Maybe she afraid of something, my ward manager. I don't know. [A-B – Focus Group 3]

Part 8. Discussion

The lack of representation from BME health care assistants and support workers on the Assistant Practitioner programme is a matter of concern on a number of counts. There are issues of equality of opportunity, questions about the quality and cultural appropriateness of care delivery where staff at all levels are not representative of the population they serve, as well as evidence about staff dissatisfaction impacting on the delivery of care.

It was essential to explore the reasons for low representation on the Assistant Practitioner course with the staff themselves in order to discover what were their explanations for not applying to the course, and to propose or implement interventions which would promote the access of BME support workers to Assistant Practitioner training.

In this study, BME staff, apart from a very small number, articulated a desire to advance their careers. This was not just evident from the responses to the study's questionnaire, and the focus group discussions, but also from the numbers who contacted the study's Researcher, thinking that she was recruiting for the assistant practitioner programme.

The key factors ascertained from the questionnaires and focus groups were:

- A lack of Information about training opportunities,
- Information not provided in a timely manner,
- A lack of transparency in recruitment and selection,
- Individual staff being identified and selected for development, with no transparent selection criteria, rather than open application,
- Recruitment practices which were experienced as being racist,
- BME staff being overlooked when opportunities arose,
- Anxiety arising from the sense that BME workers were more likely to be chastised or disciplined if they challenge the status quo,
- A need for BME Role Models to represent the real level of BME diversity, at all levels of the workforce.

Whilst the concept of ward or clinical area managers identifying staff who demonstrate ability and appear suitable for an enhanced role sounds promising, ensuring that this is delivered fairly is hard to monitor. Forming judgements about workers in a team is dependent on levels of knowledge about the individual that may not be obvious to managers. The principle behind this practice is the opportunity to develop talented staff to enhance their role. However recognition of talent is dependent on cultural understandings and expectations as well as the quality of the relationship between the support worker and the manager. Managers may lack the objectivity to recognise those staff who would benefit from development and enhance the care delivery within the organisation. The opportunity for training can be seen as a reward for longevity of service, diligence or willingness

rather than the training and education of the most able. If this method of offering training and promotions is to continue, there must be:

- checks and balances imposed to ensure that all staff are considered,
- external members on interview or assessment panels, and
- objective evidence, and rationales as to why any particular staff member was finally selected.

The issue of mentors and BME role models and managers has been explored extensively in the literature. A drive to ensure that there are more BME managers at all levels will enhance possibilities for staff across all levels. In the first instance, though, there is the need for BME champions within organisations to ensure that information about developmental opportunities is disseminated across all staff. A BME champion should have capacity to offer help and advice on applications and promote these to this group of staff.

There is evidence of a high demand for developmental programmes and training from all staff at this level. The impact of exclusion and discrimination of this kind affects BME individuals' perceptions of themselves and their worth (Kalra et al. 2009). Ensuring that there is equality of opportunity must be a priority for managers and organisation policy. Esmail (2004) states that the current processes, structures and priorities disadvantage BME staff and users of the service. This study supports those conclusions.

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Part 9. Conclusions & Recommendations

9.1. Conclusions

There is evidence from the questionnaire responses and the focus groups that support workers from BME backgrounds are as keen to develop as their white counterparts. They endeavour to access opportunities for progression within the NHS but are unable to navigate the barriers in the way. The support workers find that it is difficult to access information and that there is not a uniform means of disseminating knowledge about opportunities in a timely fashion. BME staff find themselves excluded from the informal networks where information is shared including knowledge about promotion and progression opportunities. There is a perception that opportunities are offered by managers to identified staff members without an open recruitment process with the consequence that there is a lack of clarity or fairness about the criteria for application or selection. A scarcity of BME role models and managers prevents the patronage and mentoring of BME staff at lower levels which hinders their progression within the organisation. It is not evident that selection and recruitment for the training, and the Assistant Practitioner role, is provided as an equal opportunity for all staff within the Trust.

Educational Institutions, NHS organisations and Commissioning services have to work together in order to overcome the barriers to training and promotion identified by participants in this study. This includes:

- the North-West Universities which deliver the Assistant Practitioner programme,
- the NHS organisations which employ the support workers and Assistant Practitioners and who have the responsibility for advertising and recruitment of the posts, and
- Health Education North-West which commissions and funds the training of Assistant Practitioners.

The other key stakeholders are the BME support workers themselves. Strategies to effect fair access to development opportunities must include BME staff to ensure that these meet the needs of the population.

9.2. Specific Recommendations

1. The funding for the training of Assistant Practitioners, or other education and training must be contingent on evidence of robust actions to ensure equal opportunity in the recruitment and selection of trainees. Proposals submitted by NHS organisations to HENW, in order to secure funding for the training of Assistant Practitioners in specified roles or disciplines, must be audited to ensure these elements are included.

2. Health Education North-West needs to develop guidance, with input from the BME staff working in the region, on the equal opportunity processes that should be in place to ensure fairness and parity in recruitment and training opportunities.
3. NHS organisations need to provide a specific regular Forum for updates on training and other developmental or progression opportunities for unqualified staff so that there is an identified dissemination point rather than a reliance on informal networks.
4. Outside bodies who are involved in training or education should be invited to the Forum when appropriate to meet with potential candidates, offer advice and field questions so that all individuals are equipped the knowledge and information to submit an application.
5. Allied to a Forum, it is recommended that there are sessions specifically for addressing the concerns of BME staff with additional advice or support to encourage their application to further training.
6. The NHS organisations should undertake an internal survey of BME staff to ascertain what they, themselves identify as beneficial interventions by the Trust or Higher Education Institutions to enhance their prospects within the NHS.
7. HEIs must work with NHS organisations in recruitment of trainees to ensure robust equal opportunity strategies are in place.
8. HEIs should provide some additional support for application for staff from marginalised communities including BME, such as advice sessions about HEI expectations or admission criteria or processes.

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Appendix 1: Faculty Ethical Approval

[redacted]

FACULTY OF HEALTH, PSYCHOLOGY AND SOCIAL CARE
M E M O R A N D U M
FACULTY ACADEMIC ETHICS COMMITTEE
To: Sarah Rutherford
From: Prof Carol Haigh
Date: 06/06/2013
Subject: Ethics Application 1183
Title: An exploratory study of the factors that impact on BME support workers access to Assistant Practitioner training programmes.

Thank you for your application for ethical approval.

The Faculty Academic Ethics Committee review process has recommended approval of your ethics application.

We wish you every success with your project.

Prof Carol Haigh and Prof Jois Stansfield

Chair and Deputy Chair

Faculty Academic Ethics Committee

Appendix 2: NHS Trust Ethical Approval

[redacted]
NHS Foundation Trust

Research & Development
[redacted]

[redacted]

Ref: R03339 Ltr 24a-[redacted]

Dear [redacted]

PIN: R03339 (Please quote this number in all future correspondence)
Research Study: An exploratory study of the factors that impact on support workers access to Assistant Practitioner training programmes.

Further to the above study being registered with [redacted] NHS Foundation Trust, I can confirm that the study documentation received and listed in the table below, has now been reviewed and ethical approval is not required in accordance with the new GAfREC guidelines.

We acknowledge that the [redacted] has accepted the role of Research Governance Sponsor for this study.

I am pleased to confirm that the Trust Director of Research & Innovation has given approval for the project to be undertaken.

The Trust aims for its research projects to recruit their first participant within 30 days of the recruitment start date. If you do not tell us your actual recruitment start date, we will use this approval date. This information is important for monitoring Trust recruitment performance for internal and external assessment. I would like to take this opportunity to wish you well with your research.

Yours sincerely
pp

[redacted]
Research Operations Manager
Date: 15/11/2013
Letter 24a - GAfREC study approval not [redacted] sponsored
Documents Acknowledged/Approved

Appendix 3: Participant Information

PARTICIPANT INFORMATION SHEET

Study Title: **An exploratory study of the factors that impact on BME support workers access to Assistant Practitioner training programmes.**

Invitation

I would like to invite you to take part in my research study which is being undertaken to identify the factors that have impacted on whether you undertook the Assistant Practitioner training programme. Before you make your decision whether to be involved or not, please read the information below about the study and why it is being undertaken. It is important to read this sheet carefully so that you are fully aware what is required.

If you require any further information or clarification on any part of the information sheet, please do contact me using any of the contact details at the end of the information sheet. You may also talk to others if you wish.

Purpose of the study

The aims and objectives of this chosen study is to explore the factors that impact on the uptake of the Trainee Assistant Practitioner programme through the Foundation degree. The study aims to examine who takes part in the training programme and who doesn't, and the factors that impact on their decision.

Why have I been invited?

You have been invited because you work as either a health care assistant or support worker or have been involved in the Assistant Practitioner training programme.

The findings from the study are crucially important to inform organisations on the factors that impact on access to Assistant practitioner training.

Do I have to take part?

No. It is up to you to decide whether or not to take part. You can stop taking part in the study at any time, without giving a reason. Your employment and confidentiality rights will not be affected if you decide not to take part or withdraw from the study. All you need to do is contact me using any of the details below.

What will I have to do if I take part?

If you are able to take part in the study, you will be asked to complete a short questionnaire which will consist of a range of questions which will take no longer than 5 minutes to complete.

I am also inviting people who have completed the questionnaire to take part in discussion groups. These groups will consist of 6 - 8 participants. All participants will be health care support workers. The discussion groups will take place at [redacted] The discussion group will last approximately 1 hour. The information you provide will be audio recorded to help with analysing the data for the study. You will not be identified in the study and any comments you make will be anonymous. Only the researcher will listen to and analyse the data. The tape recordings will be destroyed once they have been analysed.

What are the possible disadvantages and risks of taking part?

There are no risks or disadvantages to taking part in the study and all data is collected and analysed anonymously and in the strictest confidence.

What are the possible benefits of taking part?

There are no personal benefits; however, the hope is that the study will promote awareness among employing organisations about increasing access to training to all staff at this level .

What happens when the research study stops?

The study will result in a journal article summarising the findings of the study. It will not be possible to identify you during any part of the study, from the study findings or from any resulting publication.

What if there is a problem?

If you have any concerns about taking part in the study, please contact me. My details are provided at the end of this sheet. If you decide to withdraw from the study, then the information you have provided to the point of withdrawal will be used, however, all personal contact details will be destroyed.

Will my taking part in this study be kept confidential?

Yes, all of your information will be treated with the strictest confidence and all legal and ethical considerations will be adhered to. All data will be kept safely and all computer stored information will be protected with a password only known to the researcher. No personal or organisational details revealing the participant will be included in any part of the report or any publication.

Who is organising the research?

This research has been organised by [redacted] who is a Senior Lecturer at [redacted] The study has been approved by the University where the researcher is employed.

What will happen to the results of the research study?

The anonymised notes and the recordings from discussion groups will be safely destroyed.

Who has reviewed the study?

To protect participants, the study was subjected to [redacted] Ethical Review of research for approval. Details of this are can be found at: [redacted]. The information has also been approved by [redacted] Foundation Trust

Further information and contact details

If you require any further information here are some contact details

[redacted]

Research Approval

[redacted]

Thank you for taking the time to read this study information sheet.

Appendix 4: The Questionnaire

£50 Amazon Voucher to be won in draw for completing this survey

Survey:
Access to Assistant Practitioner Training

This survey should take you **no more than 5 minutes to complete**.

This survey aims to identify the barriers to health support staff applying for Assistant Practitioner training.

All responses will remain confidential

To be entered in the prize draw for completing this survey please complete the **Contact Form**

Give the **Survey and the Contact From** back to your Hospital Contact:

XXXXXXXX

This survey should take you **no more than 5minutes to complete.**

SR HCA/SW questionnaire

INFORMATION ABOUT THIS SURVEY

This survey should take no longer than 5 minutes to complete

You are invited to complete this short survey to discover what would be the best ways to encourage you and other Health Care Assistants (HCA) or Support Workers (SW) to apply for Assistant Practitioner Training.
By completing this survey you will help find out:

- What support staff know about training as an Assistant Practitioner
- How HCAs and SWs find out about training as an assistant practitioner
- Why some HCAs and SWs choose to train as an Assistant Practitioner and why some do not.

Your responses will provide useful information about how developmental opportunities, such as the Assistant Practitioner training can be made available to all staff.

The survey will be anonymous.
It is your choice whether or not you complete this survey.
If you choose not to complete this survey, it will not affect your current or future employment in any way.

If you complete the survey please also complete the Contact Form, and you will be entered in a prize draw for a £50 Amazon voucher.

If you would like more information about the survey or if you wish to receive a copy of the final report, please ensure you complete your contact details on the included form.

Please give or send your completed questionnaire and other forms to your Hospital Contact:

XXXXXXXXXX

Or send or give your completed survey to

XXXXXXX

If you have any questions about this please email us at:
XXXXXXXXX

This survey forms part of a project for the 'Mary Seacole Development Award'

SR HCA/SW questionnaire

Page 1

SOME INFORMATION ABOUT YOU

YOUR AGE

1. Age: *Which age group do you belong to?*

18-24		1
25-34		2
35-44		3
45-54		4
55-64		5
older than 64		6

YOUR SEX

2. Sex: *What is your Birth Sex?*

Male		1
Female		2

YOUR GENDER IDENTITY

3. Gender: *Do you go to work in the gender assigned to you at birth?*

Yes—I go to work in the same gender role as that assigned to me at birth		1
No—I go to work in my preferred gender role which is different from the gender assigned to me at birth.		2

For Office Use Only

V1

V2

V3

SOME INFORMATION ABOUT YOU

YOUR ETHNICITY

4. Please *tick the box that best describes your ethnic group*

			For Office Use Only
Asian or Asian British:			
Asian or Asian British Bangladeshi		1	
Asian or Asian British Chinese		2	
Asian or Asian British Indian		3	
Asian or Asian British Pakistani		4	
Asian or Asian British Other Asian		5	
Black or Black British			
Black or Black British African		6	
Black or Black British Caribbean		7	
Black or Black British Other black		8	
White			
White British		9	
White Irish		10	
Other white		11	
Mixed Race			
Mixed Race or Mixed Race British African		12	
Mixed Race or Mixed Race British Caribbean		13	
Mixed Race or Mixed Race British Asian		14	
Mixed Race or Mixed Race British Other mixed		15	V4
Other Ethnicity			
Other ethnic group – not stated		16	

NVQ QUALIFICATIONS

5. NVQ's: *Have you completed an **NVQ 2** or **NVQ 3**?*

YES		1	V5
NO		2	

ABOUT ASSISTANT PRACTITIONERS

6. Are you aware *of the Assistant Practitioner Role within your organisation?*

YES		1
NO		2

If you answered **YES** then follow this arrow and Answer question **8**

V6

If you answered **NO** then follow this arrow and answer question no.

ONLY answer this question if you have not heard before of the role of Assistant Practitioner .

PLEASE Read the statement below

What is the Assistant Practitioner?

"Assistant practitioners work in a broad range of areas, primarily but not exclusively, with patient contact. In clinical areas, they will usually be managed by a healthcare professional, for example, a dietician, nurse, occupational therapist, midwife, physiotherapist, operating department practitioner or healthcare scientist.

Assistant Practitioners undertake two years of university study which is funded by NHS Northwest to obtain a Foundation Degree. 80% of their learning takes place in their usual place of work where they will have a mentor to support them in their learning.

Assistant practitioners are usually paid at band 4 of the Agenda for Change system." (Skills for Health 2011)

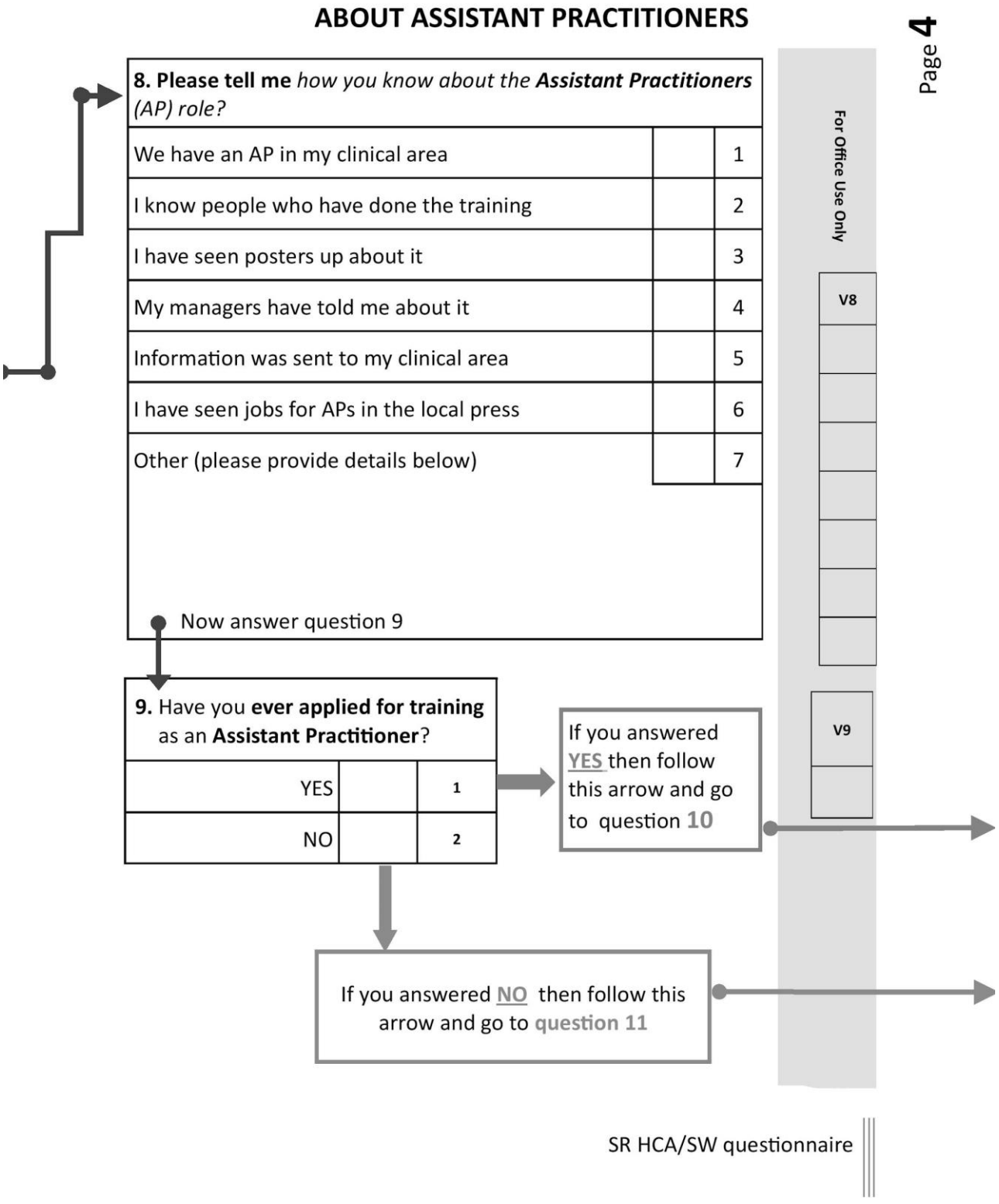
7. Having read the information *above, would you be interested in this health care role?*	Yes		1
	No		2

V7

For Office Use Only

You have now finished, thank you for your time.

SR HCA/SW questionnaire


ABOUT ASSISTANT PRACTITIONERS
Page 4
For Office Use Only
8. Please tell me how you know about the Assistant Practitioners (AP) role?
We have an AP in my clinical area 1
I know people who have done the training 2
I have seen posters up about it 3
My managers have told me about it 4
Information was sent to my clinical area 5
I have seen jobs for APs in the local press 6
Other (please provide details below) 7
V8
Now answer question 9
9. Have you ever applied for training as an Assistant Practitioner?
YES 1
NO 2
V9
If you answered YES then follow this arrow and go to question 10
If you answered NO then follow this arrow and go to question 11
SR HCA/SW questionnaire

Page 5

ABOUT ASSISTANT PRACTITIONERS

10. You have applied to train as an Assistant Practitioner in the past, but you are **NOT** working as an assistant practitioner, **Is that because** (please tick one option only):

I applied but I was not shortlisted for interview		1
I was shortlisted but I was unsuccessful in the interview		2
I began the course but was unable to continue		3
I was offered a place but I turned it down due to personal factors		4
Other (please specify)		5

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V10

You have now finished the questions,
PLEASE would you read the information on participating in a focus group

Continue to question 11

Continue to question 11

ABOUT ASSISTANT PRACTITIONERS

11. Please tell us the reasons **why you have not applied for training as an Assistant Practitioner.**		
I like my current job and did not want to change role		1
I didn't know much about it		2
I'm not sure I could cope with academic study		3
I was worried about how much time it would take		4
Only some staff were selected to do the assistant practitioner training		5
I didn't know how to apply		6
Other (please specify below)		7

For Office Use Only

V11

You have now finished the questions,
PLEASE would you read the information on participating in a focus group

Thank you very much for completing this questionnaire

The Focus Groups

Following on from this survey, the next and
very important stage will be
local focus groups

We wish to improve the experience and access of black and minority ethnic health workers to the Assistant Practitioner programme. Hearing the views of BME health workers is important to us. If you identify as coming from a BME group and would be willing help us by taking part, please fill in your contact details below and tick which group you could attend.
The focus groups will be held at the MMU building on Hathersage Road opposite the hospital. The groups will be held just after a hospital shift ends, and there will be more than one focus group. Each group will take around 1 hour.
Refreshments will be provided.

To be entered into the Prize Draw, Please complete the Contact Form and return it to Your Hospital Contact: **XXXXXXXXX**
Or return it with this form to:
XXXXXXXX

SR HCA/SW questionnaire

Rutherford, S (2014) **The Obstacle Course: Barriers to Career Development for Black and Minority Ethnic NHS Support Workers. An Exploration of the Obstacles to Health Care Support Staff Applying for the Assistant Practitioner Programme.**

Department of Health Professions, Manchester Metropolitan University.