DEVELOPING ANTI-RACIST PRACTICE TO SUPPORT BLACK AND OTHER RACIAL MINORITY NURSES AND MIDWIVES WITHIN THE NHS: A RAPID QUALITATIVE EVIDENCE SYNTHESIS

Anna-Theresa Jieman[1,2,3], Dr Juliana Onwumere[4,5], Dr Charlotte Woodhead[1,2], Nathan Stanley[1,2] & Professor Stephani L. Hatch[1,2]

[1]Department of Psychological Medicine, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK

[2]ESRC Centre for Society and Mental Health, King's College London, London, UK

[3]Department of Biological and Experimental Psychology, School of Biological and Behavioural Sciences, Queen Mary University of London, UK

[4]Department of Psychology, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK

[5]South London and Maudsley NHS Foundation Trust, London, UK

Foreword

Improving equity of opportunity for nurses, midwives and care staff of all ethnicities is a top priority for our Chief Nursing Officer (CNO) for England, Ruth May. In 2020, Deputy CNO Hilary Garrett established an action plan which made clear her ambition and goals for development, opportunity and leadership for ethnic minority nurses and midwives.

Over the last year the NHS Confederation Equality Diversity and Inclusion team and their BME Leadership Network has worked closely with the Deputy CNO & Chief Midwifery Officer (CMidO) Ethnic Minority Action Plan Steering Group, and the Nursing and Midwifery Council to ensure that the CNO's ambitions to promote equality of opportunity included practical support for front line staff.

Together we developed the CNO Anti-racist Practice in Nursing and Midwifery project to;

- Begin to build a consensus around steps to take to promote anti-racism in professional practice
- Increase personal responsibility and enhance adoption of anti-racism practice amongst nurses and midwives
- Enhance understanding of how institutional racism contributes to individual practice
- Work in conjunction with the NMC towards embedding anti-racism in regulatory and professional codes of practice, revalidation and education standards
- Embed anti-racist practice in international recruitment and support an appreciation of anti-racism across the whole nursing and midwifery workforce
- Increase confidence for international recruits coming into the NHS and support efforts to increase recruitments into the country

Working with experienced leaders from across nursing and midwifery professions we established an Anti-Racism in Practice Stakeholder Group to explore;

- What does good anti-racist nursing practice look like in the real world?
- What does that mean for individual registrants at all levels to be actively anti-racist?
- What are the competencies and skills individuals need to demonstrate they are actively anti-racist and how can a tool kit be developed to support them to do so?
- How to embed anti-racist practice in our everyday work including ensuring the provision of an anti-racist environment for learning, education and development?
- How can the NMC code and mechanisms of revalidation help to bring anti-racist practice to life?

To assist us in this process we asked colleagues at Kings College London led by Professor Stephani Hatch (Board member of the Race and Health Observatory), to;

- Critically review the available evidence on how organisational culture, policies and procedures can covertly or overtly incentivise discrimination against racialised minorities, including how they can reinforce individual prejudices and are reinforced by them
- Assess how these processes can undermine high standards of professional practice and consequently the quality of care delivered to racially minoritised individuals and communities by NHS nurses and midwives
- Suggest how the relevant professional codes of practice might evolve to address these challenges

The following report sets out the details of their finding of a rapid synthesis review of research, policy recommendations and examples from healthcare practice to support the development of effective anti-racist practice that can help improve the experiences and outcomes of Black and other racial minoritised nurses and midwives in the NHS.

The report is very clear that anti-racism must;

- Challenge racism by actively changing the policies, behaviours, and beliefs that perpetuate racist ideas and actions
- Demand that this work be done at the individual, organizational/ institutional, and cultural levels in order to effectively address systemic racism
- Be an active process is an approach, not an end-point, and thus provides a useful frame for an organisational change process

The report is full of actionable insights that will inform the work of the stakeholder group as they develop a best practice guide assisting front line nurses and midwifes to integrate good anti-racist practice into their daily professional practice. It will also enable their leaders in Trusts and organisations where they work to support and embrace the anti-racist way of working, that will ultimately lead to improved patient care and outcomes.

Best wishes,

Hilary Garrett CBE

Deputy Chief Nursing Officer NHSE

Joan Saddler OBE

Director of Partnerships and Equality, NHS Confederation

Wayne Farah

Co-coordinator BME Leadership Network

Introduction

This report provides a rapid synthesis review of research, policy recommendations and examples from healthcare practice relevant to the development of anti-racist practice in support of improving the experiences and outcomes of Black and other racially minoritised nurses and midwives in the NHS. This review focuses on how anti-racist practice can be developed and the evidence relating to what works in the context of healthcare workforce settings. Because the quantitative data demonstrating the disparities and impact of racism within the NHS is already well documented (e.g., Workforce Race Equality Standard 2020 (WRES Implementation team, 2021); (Kapadia et al., 2022; Rhead et al., 2020), this rapid review aimed to synthesise qualitative data to highlight the lived experience and processes that contribute to racism. For example, narratives (qualitative data) from nurses and midwives from racialised minority groups will help us identify the critical experiences of racial discrimination that are needed to develop the code of conduct that protects them. Such experiences would not have been captured from quantitative data.

This review began with an international scoping exercise of existing anti-racist practice frameworks utilised in healthcare settings and a rapid best-fit framework qualitative evidence synthesis of the research and grey literature (detailed in Methods section below). This provided the basis for creating an adapted framework with relevant concepts and themes. Following presentation of the themes and evidence arising from the review, we then list a series of proposed actionable insights and practical actions for consideration. This review aims to inform the co-development of a guide to inform the integration of anti-racist practice to promote better workplace inclusion where nurses and midwives from all racial and ethnic groups feel respected and valued, as well as physically and psychologically safe (Shore et al., 2011; Woodhead et al., 2021; Jackson, 2022).

Race and Anti-racist practice

It is important to note that race and ethnicity are social constructs not biological distinctions and experiences differ within and across racial and ethnic groups (Hatch et al., 2021). Racism is an ideology, structure and process involving systemic subordination of members of targeted racial or ethnic groups (Gee et al., 2011; Nazroo, 2003; Williams et al., 2003). Racism operates within and across systems and institutions in policies and practices, at interpersonal levels within social interactions and is internalised by individuals; thus, tackling racism requires sustained action at all three levels (Jones, 2000). Moreover, exposure comes in various forms (e.g., interrelated experiences of witnessing, anticipating, and experiencing discrimination) (Gee et al., 2011; Hatch et al., 2016; Williams et al., 2003). For many, racism and racial discrimination are exposures to adversity and trauma from early in the life course; are shaped by multiple statuses and identities; and are entrenched in social contexts and life domains (e.g., education, work, health and social

services, housing). This limits life chances and opportunities required to meet basic needs, particularly in education and occupations (Gee et al., 2011; Hatch, et al., 2016; Lewis et al., 2015; Nazroo, 2003; Wallace et al., 2016; Williams et al., 2003); hence, adoption and implementation of sustained anti-racist practice across sectors is crucial.

Anti-racism is not a new concept. (Bonnett, 2000) defines Anti-Racism as ''forms of thought and/or practice that seeks to confront, eradicate, and/or ameliorate racism'', and more recently, RWJ Barnabas Health (2021) defines Anti-Racism as the active, ongoing process of dismantling systems of racial inequity and creating new systems of racial equity. What is notable across the different definitions and applications of anti-racist practice is that to be successful and to address systemic racism effectively, anti-racism practices must be integrated at the individual, organisational/ institutional, and cultural levels. It should be an ongoing approach, not an endpoint, and thus provides a useful frame for organisational change processes. These processes must actively identify and eliminate racism by changing systems, organisational structures, policies, and practices and attitudes (*APA Presidential Task Force on Structural Racism Glossary of Terms*, n.d.). Therefore, the goal of anti-racism is to challenge racism and actively change the policies, behaviours, and beliefs that perpetuate racist ideas and actions (Kendi, 2019), as opposed to approaches aiming to be 'not racist' (e.g., see Kendi 2019).

Aims and Research Questions

The aims of this review were as follows:

1. To identify policy documents and reports, i.e., any initiatives exploring the core elements of an organisation's effective anti-racist practice
2. To use the initiative to guide a rapid qualitative evidence synthesis (QES) to develop an effective anti-racist practice to support racial minority nurses and midwives in the NHS.

The overarching review questions were as follows:

1. How might organisational culture, policies and procedures covertly or overtly discourage racism and discrimination against racial minority staff?
2. How might these processes be used to understand how organisational culture within the NHS can undermine the standard of care offered by racial minority nurses and midwives?
3. How can the relevant professional codes of practice evolve to address these challenges

Methods

Methodological approach

Type of review: Rapid best-fit framework qualitative evidence synthesis (QES)

Rapid reviews are accelerated and streamlined systematic reviews to support policy and practice development quicker than the more typical systematic review method (Polisena et al., 2015). Our approach involved generating a rapid best-fit framework (Shaw et al., 2021) which involves identifying existing frameworks from related disciplines (Chartered Institute of Personnel and Development, 2021; Geia et al., 2020; National Education Union, 2021) and adapting it to have relevance for the experiences of Black and other racial minoritised nurses and midwives within the NHS.

Identifying Studies

Scoping exercise

The initial identification of theories or initiatives focused on how effective anti-racist practice works (e.g., scoping exercises) was guided by review key concepts (see **Table 1)**. This scoping exercise enabled a profound and systematic exploration of how an anti-racist practice impacts professional standards. To identify the theories or initiatives, we searched for policy documents and reports documenting approaches to anti-racism practice. Our search was particularly inclusive of reports within the higher education (HE) sector in the UK, as these institutions are currently undertaking extensive related work (e.g., under the Advance, HE Race Equality Charter). Additionally, given the focus on nursing and midwifery practice, we also searched other nursing initiatives across health systems in other high-income countries (HIC).

Tables 1 and 2 below highlight the key concepts and definitions that informed the scoping exercise.

Table 1: Key Concepts and Definitions for identifying reports

Concept	Definition/Rationale
Anti-racist practice	We used a broad definition (i.e., (Bonnett, 2000) to include any initiatives that aimed to eradicate racism within organisational structures
Context	Organisations in high-income countries. To be focused on westernised cultures, to capture racial minoritised groups.

Inclusion/Exclusion Criteria

Through the scoping exercise and consultations, reflections and discussions with clinical and non-clinical researchers from the Tackling Discrimination Experiences in health Services (TIDES) study team, including NHS peer researchers, within the Health Inequalities Research Group at King's College London, we were able to locate initial frameworks documenting racism within nursing and midwifery. From this, we were able to find principles of anti-racism practice, specifically being applied in nursing which influenced the key concepts (see **Table 2)** and inclusion/exclusion criteria (see **Table 3)** used to identify the primary papers.

Table 2: Key Concepts and Definitions for identifying primary papers

Concept	Definition
Population:	"Racialised minorities" to include all non–white nurses and midwives.
Nurses and midwives from racialised minority groups	"Nurses and midwives" include trainee or student nurses across all specialities (i.e., mental health nurse, adult nurse, paediatric nurse)
Topic: Racialised experiences	We will only consider studies investigating experiences related to racialised minority identity (e.g., covert or overt racism) among those working as a nurse or midwife within a healthcare and HEI setting.

To be included in this review, the identified studies needed to meet the inclusion criteria below.

Table 3: Inclusion/exclusion criteria

Item	The reasoning for inclusion/exclusion
Population: Nurses and midwives from racialised minority groups	1. Focus on racial minorities (as defined in the key concepts). We excluded studies with a mixed sample of White and racial minority nurses and midwives where the authors have not specified the racial or ethnic identity of the participants in the reported excerpts. 2. Include nurse or midwife professionals as defined in the key concepts.
Topic: Racialised experience	Investigate racialised experiences (as defined in the key concepts) of working as a nurse or midwife. Where it is unclear if the papers have focused on racialised experiences, papers will be included at the title and abstract phase then a decision will be made after the full-text screening.

Type of Study: Qualitative, mixed methods, including grey literature	Include qualitative or mixed methods (where qualitative data excerpts are available), and methods of collecting data could be ethnography, interviews, focus groups, open-ended survey questions, or any other narrative data collection method.
Publication type: peer-reviewed articles and grey literature	Grey literature to include reports or working papers.
Date:	2012 to 2022
Language:	English
Country:	Studies conducted in the United Kingdom (UK) to capture experiences from UK health services, both provided by the NHS and private practice.
Setting:	1. Focus on healthcare settings to capture how organisational culture influences the standard of care offered by racial minority nurses and midwives within primary, secondary, tertiary and community settings. 2. To include HEIs to capture the training experiences of student nurses and midwives.

Search strategy

The search strategy included both free text and index terms for Boolean searching from the key concepts and definitions. We piloted the search and adjusted terminology and search operators accordingly to support the comprehensive identification of relevant hits. An example of the search strategy and the limitations applied are detailed in **Appendix 1**.

Sources

To identify relevant papers to be synthesised we focused on one key database (CINAHL, an index of the nursing and allied health literature). We chose CINAHL as this is one of the key databases indexing papers related to nursing and midwifery. To identify relevant grey literature that may have been missed in the database searches, we consulted members of the TIDES research team as well as the wider Health Inequalities Research Group, as well as supplemented by reviewing the reference list of recently published relevant literature reviews (Kapadia et al., 2022).

Screening

Once we had identified potentially relevant citations, on databases and journals, the first author imported them into Mendeley to remove duplicates and subsequently imported citations into EPPI-web for screening. The first author conducted the screening in two stages: (1) title and abstract and (2) full-text screening. The abstract and title screening phase aimed to identify potentially relevant studies at a superficial level. The first author screened the citations hierarchically to allow for the most irrelevant literature to be excluded initially.

To ensure rigour, the first author piloted the screening tool on 100 citations and both authors discussed any concerns and modified the tool, where required. Studies that met the inclusion criteria at title and abstract stage were then considered for second-level screening against the full-text. The first author uploaded a PDF copy of each article in EPPI-Reviewer (Thomas, J. et al., 2022) and reviewed each paper against the full-text screening tool. If the article met the inclusion criteria, it was included in the review. During both phases of the screening, if the AJ coded a study "unsure" it was discussed with SH for consensus on inclusion or exclusion.

Quality Assessment

As with other scoping reviews, we did not conduct the quality appraisal of included studies.

Data extraction

Data extraction was conducted in EPPI-Reviewer. After the data extraction tool was piloted on three studies, AJ coded and extracted key study descriptors (study aim, geographical area where the study was conducted, data collection method, data analysis method, sample ethnicity, NHS services covered by the sample, sample size, whether the sample was NHS internationally recruited staff and NHS pay band) and qualitative excerpts (guided by the conceptual framework presented in (Chartered Institute of Personnel and Development, 2021; Geia et al., 2020; National Education Union, 2021). Although the conceptual framework informed the data extraction tool, this stage was an iterative process involving reading the papers and becoming familiar with different emerging themes which were then added as codes to the data extraction tool. Hence, the data extraction tool developed throughout the data extraction process.

Analysis

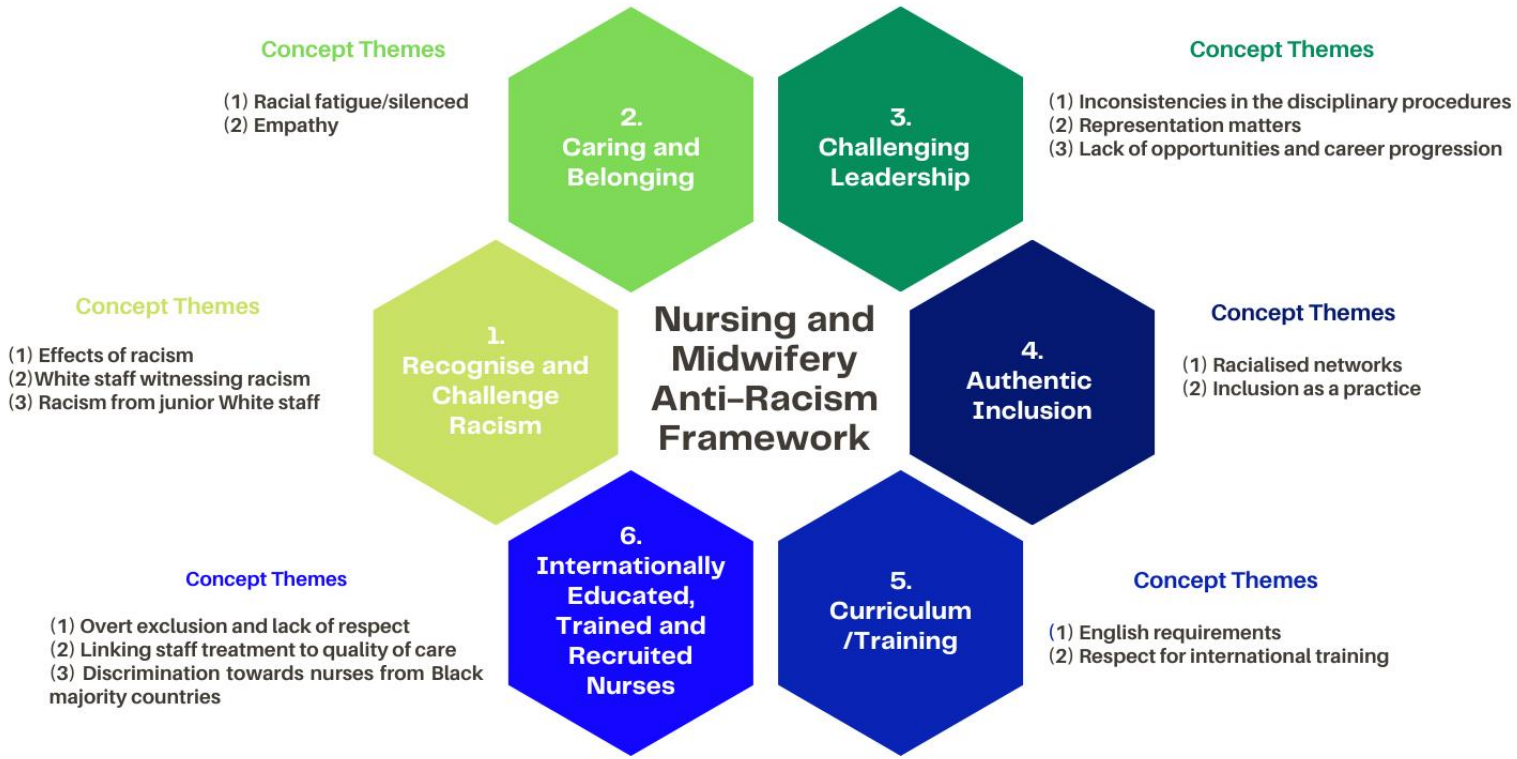
We used a *best-fit framework synthesis approach* (Carroll et al., 2011, 2013) to analyse the extracted qualitive excerpts. The best-fit framework approach is a type of thematic analysis in which thematic categories are constructed via data coding. Themes are identified *a priori* from the initial conceptual framework and used to guide the initial inductive coding process. Themes change as the review progresses through thematic analysis of the data resulting in an adapted framework (Thomas et al., 2008). We also included stakeholder engagement via a workshop with the Anti-racist practice Nursing and Midwifery Stakeholder group and had discussions with and received

feedback from the TIDES research team. Additionally, we incorporated basic participatory approaches used within the TIDES research team as part of our analysis.

Results

Our search on CINAHL retrieved 1378 hits and hand-searching retrieved an additional 15 hits. After deduplication, AJ screened 1332 hits. Seventy-five publications were eligible for full-text screening. After full-text screening, 13 publications were included the in the analysis (Allan et al., 2016; Groothuizen et al., 2019; Hallett et al., 2021; Hammond et al., 2017; Likupe, 2015; Likupe et al., 2013; Qureshi et al., 2020; Scammell et al., 2012; Stanley et al., 2022; Stubbs, 2017; Tuffour, 2022; Walker et al., 2022; Woodhead et al., 2021) and were included in the synthesis. **Figure 1 in Appendix 1** describes the number of studies that were excluded at each stage of the screening process and a table that includes a description of the studies included is available on request. Below we summarise the key findings and actions from the analysis and from input from the Anti-racist practice in Nursing and Midwifery Stakeholder group workshops.

Figure 2



Final conceptual framework adapted from the analysis findings and other sources (Chartered Institute of Personnel and Development, 2021; Geia et al., 2020; National Education Union, 2021)

Below we present six framework concepts identified in the literature and adapted from other sources, and we identified specific relevant themes across the included papers that mapped on to these framework concepts. For the relevant themes, we provide quotes from the literature that exemplify each theme. This is followed by proposed actionable insights and proposed practical actions for each framework concept.

Framework concept: Recognise and Challenge Racism

Recognising racism should be the responsibility of all nurses and midwives, regardless of their race. Racism impacts all staff, not just those on the receiving end of the racist attitudes and behaviours. There is often a focus on whether there was intent. However, this detracts from the necessary focus on the *impact* of racism.

Concept themes: (1) Effects of racism (2) White staff witnessing racism (3) Racism from junior White staff

1. Effects of racism

The effects of racism included racial minority nurses being silenced (Groothuizen et al., 2019) and feeling undervalued and underappreciated by patients and other staff at all levels (Hallett et al., 2021; Likupe, 2015; Stanley et al., 2022; Tuffour, 2022; Woodhead et al., 2021), exclusion from training and career-development opportunities, and from career-enhancing networks (Stanley et al., 2022; Woodhead et al., 2021). In turn, many were left feeling as though there was no room for career development and no point in trying to succeed (Likupe, 2015; Stanley et al., 2022). Additionally, many reported feeling physically ill and needing to take time away from work, while others felt micromanaged which had psychological impacts (Likupe et al., 2013). However, some nurses reported this provided impetus to building resilience against these experiences and working harder to succeed (Hammond et al., 2017).

> *"I've had a few teams that I've been in, where I've actually been told… not to speak too much, because there are white people around. And… I've always thought… you know, I've always looked at myself as an equal to everybody else, […] regardless of… whatever their race or, and age, or anything… But yeah, there are quite a few people who look at… […] and… you're basically discouraged from speaking up. Just because of… your colour…* Mental health nursing student" (Groothuizen et al., 2019)

> *"I think one is opportunities available. It's gonna be, it's a lot harder for people to, I mean people from this from these backgrounds to actually be able to get to those, because they're not exposed to the opportunities that are available and you know, there's a lot of they have to work 10 times harder to get to those roles. And I think there's always an issue once they get there, there's a lot of frustrations and they can't really stay on top for a really long time.* ...Nurse" (Stanley et al., 2022)

> *"I think the nurses get the brunt of it yeah, um. But then that has a knock- on effect on the patients because they're so stressed and they're like, "I haven't got time to um deal with this*

> *situation, and then maybe the healthcare assistants will deal with it because then they'll be like "healthcare assistants, de- escalate this situation or deal with this situation with the patient, I haven't got time I need to be in the office, I need to do this I need to do that. Because the manager's on my case."* (Woodhead et al., 2021)

2. White staff witnessing Racism

White staff witnessed racism, but they often did not attribute the poor treatment of racialised staff to racism. It was often described as being a part of "ward culture" where students need to be mistreated to learn (Walker et al., 2022) or favouritism (Hammond et al., 2017; Likupe, 2015; Stanley et al., 2022).

> *"There are even others [nurses of Black ethnic backgrounds] who had placement on that ward, but they will not take her, even though they find her to be competent, they will not take her but they will take another person."* (Hammond et al., 2017)

Senior White staff responsible for recruitment were also aware of discrimination being perpetuated in their processes, but they did not make any efforts to eliminate the biases (Likupe, 2015).

> *"We know that on the application form you have to write down where you had your education or professional qualifications so you can identify individuals who were not educated in this country according to that. I also know that at the interview they have got some kind of a point scoring system. I am not suggesting that people don't work within equal opportunities but I am saying if somebody knows that person whether they can be truly objective I don't know."* (Likupe et al., 2013)

3. Racism from Junior White Staff

Racially minoritised staff reported that White junior staff, particularly students, often disrespected their line managers or mentors if they were from a racialised minoritised background. White British students felt that racialised staff were not familiar with British culture or training, so they were not in a position to advance their training (Scammell et al., 2012).

> *"The last student was making up her own rota that she actually didn't have time, not even a week to spend with me. She spent most of her time with some other nurses and she asked me to sign [her practice assessment] and I said no. I don't know how she did it but she managed to get some other mentors to do it for her*...Internationally Recruited Nurse" (Scammell et al., 2012)

Proposed Actionable Insights:

- Everyone must be equipped to challenge racism (covert and overt) in the workplace, whether from patients or other staff members, regardless of seniority

- All acts of racism and its cumulative effects must be recognised, particularly in processes such as disciplinary proceedings
- Recognise that division across racially minoritised groups is a primary tool of racism, particularly in multi-ethnic/multi-racial contexts
- Recognise White privilege; reflect on the meaning of whiteness in terms of helping people recognise racist behaviour
- Recognise colourism and how it is utilised in affording privilege to some and not others across and within racial minoritised groups

Proposed Practical Actions:

- Stop using "BAME" and other aggregate terms unless unavoidable (e.g., preserving confidentiality), and recognise the differences which exist within groups; these terms can be experienced as stigmatising, depersonalising and 'othering.' The terms can also signal an unwillingness and discomfort among White staff to acknowledge the heterogeneity in the experiences of specific racial and ethnic minority groups (Bunglawala, 2019; Hatch et al., 2021)
- Be an active bystander; silence on witnessed racism is often interpreted as collusion

Framework concept: Caring and Belonging

The discourse regarding race and racism should be led with kindness to enable nurses and midwives to share and reciprocate. True workplace inclusion is evident when staff feel a sense of belonging and are valued; where they are psychologically and physically safe to be authentically themselves at work and share divergent views and opinions without repercussions (Shore et al., 2011; Woodhead et al., 2021). However, staff must be mindful of racialised trauma and 'racial battle fatigue' (Smith, 2008) due to lifetime exposures to racism and discrimination. This concept was initially focused on guidance relevant to having conversations about race. However, feedback from stakeholder engagement workshops highlighted that caring and belonging were also significant elements of patient care. Hence, we have also included actions focused on patient care.

Concept themes: (1) Racial fatigue/silenced and (2) Empathy

1. Racial Fatigue/Silenced

While racialised staff wanted to have conversations about race and their experiences to support their White colleagues, they found it exhausting and demotivating when their White colleague did not understand.

> *"I don't bother telling anyone because I do not think that people can listen to me. You don't have a sense of belonging."* (Likupe et al., 2013)

2. Empathy

Racialised staff reported awareness that White staff were not comfortable around them because of their racialised identity. They emphasised being feared as a racialised individual and the necessity to have open conversations about the source of that fear.

> *"I think people do feel threatened by us. But sometimes we also need to understand their emotions to understand our moves…if somebody is feeling threatened, they might behave in a certain way, but it is about you understanding and saying, 'okay, how can I make this person understand that actually, I'm not here to take the cake, but I want us to share'."* (Tuffour, 2022)

Proposed Actionable Insights:

- Communication should openly acknowledge that participating in conversations about race and racism is challenging and sometimes can be uncomfortable
- Feeling 'uncomfortable' about having discussion about race(ism) in the workplace should not be weaponised or used as a collective excuse to avoid having conversation. Conversations about race are difficult
- Racially minoritised groups are not responsible for making non-racialised minority staff groups feel more comfortable in having discussions about race; this should not be seen as a valid assumption amongst colleagues and management
- Case examples from existing research can help people see what racism looks like

Proposed Practical Actions:

- Hold race conversations in collaborative, psychologically safe spaces, with acknowledgements of positionality, power, and the need for transparent solution-focused outcomes
- Create a meaningful teaching and learning space for majority-white nursing and midwifery colleagues and students to discuss the tensions and transformations within their experiences over time
- Create reflective practices and work collaboratively toward reform in teaching, learning and practice

Framework Concept: Challenging Leadership

Leadership from all racial groups in universities (or other institutions where nurses and midwives receive training) and in the NHS should be challenged to lead by example and through action. Leaders must take racism and its effects on health, occupational outcomes and patient care more seriously. This requires an open acknowledgment of the deleterious effects of racism on health, occupational outcomes, and patient care. Cultural change necessitates White leaders to have the responsibility to stand with their colleagues from racial minoritised groups in dismantling oppressive practices in the health system.

Concept themes: (1) Inconsistencies in Disciplinary Procedures, (2) Lack of Opportunities and Career Progression and (3) Representation Matters

1. Inconsistencies in Disciplinary Procedures

Racialised staff reported submitted grievances or complaints were often overlooked, misplaced or mismanaged (Walker et al., 2022).

> *"So with the training, yes, we get the training and they will tell you channels for reporting. But I have put in, like, three or four grievances in the last several years. They've all been mismanaged even where there is overwhelming evidence beyond reasonable doubt. They have all been mismanaged and said, this is not found, that is not found."* (Walker et al., 2022)

Black staff were also aware that if they were to make a mistake their disciplinary procedures would be more severe compared with their White colleagues (Likupe et al., 2013; Tuffour, 2022).

> *" I did not make a mistake, but I just decided to omit medication to get some clarification and the manager blew it out of proportion. But I was right. And then my colleague who was white made a drug error and they did not say anything. So, I will be felt that it is because of who I am that's why things are happening like that…I felt unsupported then I left."* (Tuffour, 2022)

2. Lack of opportunities and career progression

The lack of opportunities to progress was highlighted across the majority of studies included in this review (Hammond et al., 2017; Likupe, 2015; Likupe et al, 2013; Qureshi et al., 2020; Stanley et al., 2022; Tuffour, 2022; Walker et al., 2022; Woodhead et al., 2021). White British staff were aware that they would encounter less barriers with patients and staff and subsequently, how this may affect the availability of opportunities and their progression within the NHS. This was evident early in their careers as placement students:

> *"Um, also I think I'm White and I'm British and, um, with certain patients that seems to…that seems to seem like a good thing. Um, older patients seem to like the fact that I'm British and I've heard them, yeah, moaning about um patients from other…nurses from other countries before."* (Walker et al., 2022)

> *"In contrast some participants, mostly from a 'white' self-declared background, described situations where they perceived they were treated favourably and there was less need to make any accommodation. They talked of situations where 'If your face fits', the barriers are reduced. In one example, a student recalled being invited to apply for a job by a manager, despite the fact that she did not have the six months experience requested on the job description."* (Hammond et al., 2017)

Racialised staff members with more experience felt that career progression was based on networking with White senior staff and not merit:

> *"They [White staff] will always find it easier to progress, because remember that with the NHS it's very hierarchical. And, um, progression -a lot of the progression, and it's not peculiar to the NHS. It's about who you know and who you socialize with."* (Stanley et al., 2022)

3. Representation Matters

Evidence emerged reinforcing the importance of representation, particularly regarding race and gender. Racial minoritised students reported being apprehensive about continuing to pursue a nursing career as they did not see many staff that looked like them:

> *"Um I mean it's too early for me to tell at the moment, but I do get moments where I don't really see um enough people like um, who are* [two minoritised groups] *at the same time doing what, you know, in the profession that I'm aspiring to get into. So I can feel like there could be some barriers stopping people progress within that field because of that."* (Walker et al., 2022)

Male nurses discussed the absence of male colleagues:

> *"I don't think I've had any contact with a senior Asian male nurse in my entire career…… I've been nursing for 36 years now."* (Qureshi et al., 2020)

Internationally recruited nurses preferred mentors that were not White British, as they felt White British mentors would not be able to empathise with their experiences:

> *"If the mentor is someone from the outside like us it would be more helpful because they have adapted and they know the problems one faces. My mentor was someone who was not from England and I found it helpful with things like contract phone…My mentor could also relate to me when I said I missed home, if your mentor can understand that it is much easier."* (Stubbs, 2017)

Without the appropriate mentorship, racial minoritised staff were left feeling as though it there was no point in trying to progress within the NHS:

> *"We already perceive ourselves that we do not go high up any way; what is the point of trying…there are no opportunities anyway. So that is from one side. But from the management side…when they create these little jobs to occupy us at the bottom, you hardly have opportunity to march up at the top because they will create quite a few…and more jobs at the bottom where you will be happily managing and there is no corresponding senior level of the kind."* (Tuffour, 2022)

Proposed Actionable Insights:

- Leaders should demonstrate how they value the voices and experiences of racial minority staff by encouraging conversations about race and racism at work; conversations should not be confined to racialised networks or equality and diversity initiatives/meetings
- Develop a transparent anti-racism practice that all staff can enforce; this will ensure that managers and leaders at all levels are held accountable
- Ensure leaders are championing inclusivity and hold them accountable as a part of their core responsibilities
- Anti-racist practice requires training on how to challenge racist practices and advocate for change

Proposed Practical actions:

- Provide training on how to challenge racist practices among all healthcare professionals
- Monitor and take action where leaders and other staff engage in resistance and collusion against the anti-racist practice (e.g., active/passive bystander behaviour)
- Look at the talent pipeline and actively engage in searches and reporting at corporate level structures with a focus on transparently demonstrating commitment to increasing diversity and active inclusion
- Incorporate adherence to anti-racist practice into line manager appraisals with associated actions
- Be prescriptive about equality, diversity, and inclusion objectives and goals; properly resource and fund programmes leading to concrete action and change
- Require clearer action from CQC on anti-racism, particularly regarding regulations and sanctions
- Ask NMC to work collaboratively on how they are advising staff on disciplinary processes
- Publish data on racism related allegations, cases and outcomes (work, health and retaliation) within organisations, as well as regionally and nationally
- Publish regional fitness-to-practice data to assess and understand the nature of racist practice.
- Provide an anti-racism charter across regulatory bodies

Framework concept: Authentic Inclusion

At least two types of inclusion are needed to achieve authentic inclusion, inclusion in the change process and engaging in the practice of inclusion. Nurses and midwives from racial minoritised groups should be actively and authentically included in dismantling and reforming racist structures in healthcare and institutions responsible for education and training. Further, studies reported the particularly deleterious impact of workplaces characterised as highly racially and ethnically diverse but having low levels of inclusivity on staff cohesion, group identity and the likelihood of racial tensions and conflicts (Jackson et al, 2011; Woodhead et al., 2021).

Concept themes: (1) Inclusion as a Practice and (2) Racialised Networks

1. Inclusion as a Practice

Inclusion as a practice was a recurring theme across multiple studies highlighting that the NHS culture supported staff operating in "cliques" (Hammond et al., 2017; Woodhead et al., 2021). This impacted patient outcomes as staff did not work well with staff that were not part of their group. In some instances, when ethnic minority staff were grouped with White majority staff, they felt silenced and did as they were told (Tuffour, 2022). However, this was also dependent on the nature of the workplace context and the racial and ethnic composition of the workforce (Woodhead et al., 2021).

> *"I'm not going to work with her", "Why?", "I don't understand her English" […] he refused, and he was telling her in her face, "your English is ridiculous. I don't want you to be my team leader."* (Woodhead et al., 2021)

2. Racialised networks

Ethnic minority staff reported the importance of being amongst other individuals from ethnic minority groups; it is where they felt social and professional support:

> *"Sometimes you feel you do not get supported. But ever since we had this BAME group, things are better, and I can see myself progressing with the support of that group."* (Tuffour, 2022)

Proposed Actionable Insights:

- Everyone should take time to reflect on their own biases and experiences regarding race before engaging in work on anti-practice practice
- Wider community involvement can provide better understanding of how the wider context of racism impacts staff
- Dedicate resources to ongoing improvement of the generation and quality of qualitative and quantitative data to assess progress and address ongoing challenges
- Include the wider nursing and midwifery family into co-developing anti-racist actions and practice as a prevention approach
- Include lived experienced practitioners to describe their witnessing and experiences of racism and racial discrimination within the system
- Inclusion as a practice should be integrated from student/early career across the career trajectory

Proposed Practical Actions:

- Engage and build networks with the wider community to gain and share insights
- Involve lived experienced practitioners and community organisations as "critical friends"
- Disaggregate nursing and midwifery data at organisational, system and regional levels

- Examine the pipeline from the racial and ethnic distribution of student applicants and across every career stage
- Support and integrate representation from staff networks, patients and carers into decision-making committees and boards
- Integrate opportunities for decision making and the power to act on all relevant committees and working groups
- Embed and integrate anti-racist practice and training across the wider workforce to encourage cultural change; this cannot be limited to equality, diversity, and inclusion exercises

Framework concept: Curriculum/Training

The curriculum (nursing and midwifery training and CPD within the NHS) must acknowledge that institutionalised racism is embedded in the healthcare system and racism is embedded within the curriculum and training content (i.e., whiteness is the norm in medical training). Further, there is evidence of a 'hidden curriculum' during training processes not made available to nurses and midwives from racial minoritised groups (Woodhead et al., 2021; Walker et al., 2022). Further, at the intersection of race and migration status, nurses noted that speaking English at a level that allows them to communicate with patients was sometimes not seen as adequate with biases around accents.

Concept themes: (1) English requirements for non-EU nurses (2) Respect for International Training

1. English requirement for non-EU nurses

Non-EU nurses were frustrated by how the English language requirement was assessed (Allan et al., 2016; Stanley et al., 2022; Tuffour, 2022). For instance, they mentioned that the International English Language Testing System (IELTS) did not reflect the language required to communicate with patients and their relatives. They reported that the current assessment guidelines were conducive towards ticking a recruit guideline box, so the NHS can meet specific regulations and were not necessarily related to patient safety/care or the medical training requirements of internationally educated nurses.

> *"I think just lessen a bit. And they had [have] to see how many years I'm here and if we are really able to communicate with our patients. Those who are already here for five years, working in healthcare setting, I think we have had enough experience that we are able, capable to communicate well."* (Stanley et al. 2022)

> *"Like in my point of view, people who are already overseas nurses and who [are] working as a nursing assistant here, I think they should have decreased IELTS level because you know they do have qualifications and everything. So I think, but I don't know if the NMC could decrease the IELTS for people…"* (Allan et al, 2016)

2. Respect for International training

International training was often seen as inferior to British nursing and midwifery training (Likupe et al., 2013; Scammell et al., 2012; Stubbs, 2017; Tuffour, 2022). Some reported that it made them regret their decision to migrate to the UK:

> *"You come over as an Overseas Nurse, you don't have your Registration and you are not allowed to do a" "lot of stuff that you would be doing on a regular basis…it gets a little stressful…and you are not so confident… That transition period was quite difficult because it's not just about you…You can do things but you are not qualified, that was the worse bit."* (Stubbs, 2017)

Internationally, educated and recruited nurses also noted that they were often overly scrutinised and treated like placement students:

> *"Student (White): 'We were taking staples out, and he [IRN] was teaching us. (…) Then quite a senior staff nurse said 'oh my goodness me (…) he shouldn't have been allowed because you know he may not have been trained and be showing you the correct procedure'.(…) I said, 'no, no the procedure was exactly like I'd been shown'. But it was…'oh well I need to show you."* (Scammell et al., 2012)

Proposed Actionable Insights:

- Begin training and education on anti-racist practice among students at the earliest stage
- Students need to see what "good" looks like or they will adopt what they see
- Increasing the understanding how racism is imbedded in structural inequalities can lead to change in inequities in career progression and access to training and opportunities
- The curriculum should acknowledge racial health inequalities and how whiteness as the norm in training impacts patient care and working relationships with colleagues
- No development programme should be complete until goals are achieved; see development as stretch opportunities for careers (e.g., executive development pathway)

Proposed Practical Actions:

- Identify and address the hidden curriculum: identify and tackle practices in training/placements reinforcing inequity
- Ensure training providers are system leaders that reflect on anti-racist practice in training/curriculum of nurses and midwives
- Use staff case studies to discuss racism in context and develop responses and solutions
- Socialise students into anti-racist practice, through training and education as well as in their understanding of ward and group culture

- Focus on sponsorship and opportunities beyond development programmes to lead to tangible cultural shifts
- Ensure anti-racism is explicitly written into the NMC code and revalidation

Framework concept: Internationally Educated, Trained and Recruited Nurses

This concept is related to curriculum and authentic inclusion. However, we have kept it as a separate concept highlighting the significant need for interventions to ensure that internationally educated nurses are provided with opportunities to succeed within the NHS. Notably, there was very limited inclusion or focus on midwives in this research area. Furthermore, respect for international training was a recurring theme across the many of the studies, highlighting notable and important changes in their nursing roles and the importance of integrating relevant best practices from outside the UK that are appropriate for this ethnically diverse patient population.

Concept themes: (1) Overt Exclusion and Lack of Respect, (2) Linking staff treatment to quality of care and (3) Discrimination towards Nurses from Black majority countries

1. Overt Exclusion and Lack of Respect

Internationally educated and recruited nurses also highlighted difficulties adjusting to British culture, most notably as a result of witnessing the disrespect and racial discrimination experienced by senior staff from racial and ethnic minoritised groups (Stubbs, 2017). Studies highlighted that placement students were aware of the lack of respect for internationally recruited nurses on the ward, which reinforced that the students could also disrespect them and create their own schedule (Scammell et al., 2012). Internationally educated and recruited nurses also noted that they were often explicitly rejected and excluded by doctors and by some patients (Scammell et al., 2012):

> "*On the ward, doctors will go 'I don't want a Filipino nurse, I want an English nurse*." (Scammell et al., 2012)

> *"When I came here, because of the adaptation programme and the NMC we were not allowed to do any- thing so that has affected my confidence. That's quite traumatic, and one of the toughest parts you work in ITU, you have to take your patient where you can- not do anything and you tend to lose your skills. That really affected my confidence."* (Stubbs, 2017)

Regarding career progression, internationally educated and recruited nurses felt that there was a point scoring system which led them to being excluded at recruitment, as they were required to list the country that they received their training (Likupe et al., 2013). This is a notable example of way in which the recruitment and progression processes inherently create bias even in the presence of processes designed to counter bias (e.g., blind recruitment).

2. Linking staff treatment to quality of care

When they had more autonomy and were treated as equals in the UK, some internationally recruited nurses felt that patient care in the UK was better when compared with care provision in the countries they were recruited from (Stubbs, 2017):

> *"When I was working in India I was literally following the orders of the doctor, no questions asked, that's what happens there. Another thing, you don't really think what you are doing you just follow orders but here it is different people are trying their level best to make the care better."* (Stubbs, 2017)

3. Discrimination towards nurses from Black majority countries

Studies suggest that Black nurses were often treated worse by staff and/or patients compared to other ethnic minority nurses (Likupe, 2015; Likupe et al., 2013; Scammell et al., 2012; Woodhead et al., 2021):

> *"It could be anybody from Hungary, the Philippines it could be someone, but because you are coming from Africa there's lack of respect. We are all professionals trained and if someone comes to a ward and doesn't know the ward, the way it works, obviously the person will ask some questions. Africans are treated not nicely at all."* (Likupe et al., 2013)

Black female nurses experienced double jeopardy discrimination based on their race and gender, particularly from White male patients:

> *"(Black African IRN) and (White student) administered medications to Mr A (White patient) and then gave some personal care. Whilst with another patient, Mr A called out to (Black African IRN), 'What you up to now, big bum! (laughing) Don't take me wrong, I'm not harassing, just my humour!"* (Scamell et al., 2012)

Proposed Actionable Insights:

- There is a lack of research on the experiences and outcomes of internationally educated and recruited nurses and midwives, particularly at the intersection of race and migration status
- Cultural awareness training needs to incorporate processes of cultural safety (e.g., working directly with staff to determine what is needed to be psychologically safe; Ramsden, 1991) and cultural humility (e.g., engaging in process of self-reflection and understanding one's own implicit and explicit biases; Miller et al., 2019) to better reflect the multicultural aspects of British culture, as well as respect for the cultures of nurses and midwives' countries of origin

Proposed Practical Actions:

- Explore preferences for language to describe internationally educated, trained and recruited nurses
- Resource prospective qualitative data collection, with a particular aim of improving inclusion of midwives and better documentation of the racialised experiences and outcomes of internationally educated and recruited nurses and midwives
- Co-develop cultural awareness training with internationally educated and recruited nurses, including cultural safety and cultural humility with an emphasis on how respect for cultures can be demonstrated in practice

- Provide qualitative data on internationally educated nurses (e.g., the 2019/2020 cohort) and prospectively follow cohorts to build an evidence base
- Utilise existing data sources to disaggregate experiences and outcomes

Conclusion

The purpose of this review is to help identify and define the core elements of robust and effective anti-racist nursing and midwifery practice. This report considers relevant evidence to inform the development of anti-racist practice for nursing and midwifery with the aim of improving the experiences and outcomes of racial minoritised nurses and midwives in the NHS. Following a scoping exercise of initial frameworks documenting racism and how anti-racist practice impacts professional standards within nursing and midwifery, we conducted a rapid synthesis of research, policy recommendations and examples from healthcare practice relevant to the development of anti-racist practice. This, alongside stakeholder engagement and input, resulted in the creation of an adapted framework for anti-racist practice with six concepts and related themes, as well as proposed actionable insights and practical actions for further consideration.

It should be noted that the evidence-base on the experiences and consequences of racial inequities among nurses and midwives in the UK is very limited. Furthermore, there was a paucity of evidence on experiences and changes for these groups over time, and it was particularly striking how little attention and underrepresentation there was to midwives and internationally educated and recruited nurses in the research. In addition to following cohorts over time with quantitative surveys and through administrative datasets, there is also the potential to build a rich source of evidence through longitudinal qualitative studies to better capture and understand the racialised experiences with the workplace context as well as the wider community social context for nurses and midwives.

This review summaries the available evidence to inform the co-development and revisions of the Nursing and Midwifery Council code of conduct and the content of a professional practice guide to assist NHS nurses and midwives in meeting the code requirements. It is also imperative that anti-racist practice is incorporated into future regulatory reviews and standards-setting and reflected in the Nursing and Midwifery Council revalidation process. It will enable nurses and midwives to improve their professional practice and patient care by assisting them to understand what anti-racist practice is in an NHS context and how to identify and challenge racism at individual, organisation and system levels.

Funding Information and Acknowledgements

This review was commissioned by the NHS Confederation.

SLH and JO are part-funded by the NIHR Biomedical Research Centre at South London and Maudsley NHS Foundation Trust. SLH and CW are supported by the ESRC Centre for Society and Mental Health at King's College London (ESRC Reference: ES/S012567/1). NS is funded by the Wellcome Trust (203380/Z/16/Z). The TIDES study is funded by the Wellcome Trust [203380/Z/16/Z] and the Economic and Social Research Council (ESRC) [ES/V009931/1]. ATJ is supported by the ESRC via the London Interdisciplinary Social Science Doctoral Training Partnership (LISS- DTP). The funders had no involvement in study design, data collection, analysis, interpretation or the decision to submit for publication. The views expressed are those of the author(s) and not necessarily those of the funders.

Thanks to the Anti-Racist Practice in Nursing and Midwifery stakeholder group – Nursing & Midwifery Council, NHS Confederation and NHS England and NHS Improvement; the TIDES Advisory Board & Stakeholder Opinion Group; Challenge Consultancy; the TIDES Study team: Monalisa Bora- White, Zoe Chui, Naomi Clifford, Luke Connor, Anna Ehsan, Lucy Ensum, Cerisse Gunasinghe, Stephani Hatch, Hannah Harwood, Shirlee MacCrimmon, Paula Meriez, Amy Morgan, Jessica Jones Nielsen, Juliana Onwumere, Rebecca Rhead, Nathan Stanley, Nkasi Stoll, Charlotte Woodhead; and TIDES collaborators/partners.

References

Allan, H., & Westwood, S. (2016). Non-European nurses' perceived barriers to UK nurse registration. *Nursing Standard*, *30*(37), 45–51. https://doi.org/10.7748/ns.30.37.45.s41

APA Presidential Task Force on Structural Racism Glossary of Terms. (n.d.). Retrieved May 31, 2022, from https://www.psychiatry.org/psychiatrists/structural-racism-task-force/glossary-of-terms

Bonnett, A. (2000). *Anti-racism*. Routledge.

Bunglawala, Z. (2019). *Please don't call me BAME or BME!* Civil Service Blog.

Carroll, C., Booth, A., & Cooper, K. (2011). A worked example of "best-fit" framework synthesis: A systematic review of views concerning the taking of some potential chemopreventive agents. *BMC Medical Research Methodology*, *11*. https://doi.org/10.1186/1471-2288-11-29

Carroll, C., Booth, A., Leaviss, J., & Rick, J. (2013). "best-fit" framework synthesis: Refining the method. *BMC Medical Research Methodology*, *13*(1). https://doi.org/10.1186/1471-2288-13-37

Chartered Institute of Personnel and Development. (2021). *Developing an anti-racism strategy*.

Gee, G. C., & Ford, C. L. (2011). Structural racism and health inequities: Old Issues, New Directions. *Du Bois Review*, *8*(1), 115–132. https://doi.org/10.1017/S1742058X11000130

Geia, L., Baird, K., Bail, K., Barclay, L., Bennett, J., Best, O., Birks, M., Blackley, L., Blackman, R., Bonner, A., Bryant AO, R., Buzzacott, C., Campbell, S., Catling, C., Chamberlain, C., Cox, L., Cross, W., Cruickshank, M., Cummins, A., … Wynne, R. (2020). A unified call to action from Australian nursing and midwifery leaders: ensuring that Black lives matter. *Contemporary Nurse*, *56*(4), 297–308. https://doi.org/10.1080/10376178.2020.1809107

Groothuizen, J. E., Callwood, A., & Allan, H. T. (2019). The 'values journey' of nursing and midwifery students selected using multiple mini interviews: Evaluations from a longitudinal study. *Nursing Inquiry*, *26*(4), N.PAG-N.PAG. https://doi.org/10.1111/nin.12307

Hallett, N., Wagstaff, C., & Barlow, T. (2021). Nursing students' experiences of violence and aggression: A mixed-methods study. *Nurse Education Today*, *105*, 105024. https://doi.org/10.1016/j.nedt.2021.105024

Hammond, J., Marshall-Lucette, S., Davies, N., Ross, F., & Harris, R. (2017). Spotlight on equality of employment opportunities: A qualitative study of job seeking experiences of graduating nurses and physiotherapists from black and minority ethnic backgrounds. *International Journal of Nursing Studies*, *74*, 172–180. https://doi.org/10.1016/j.ijnurstu.2017.07.019

Hatch, S.L., Gazard, B., Williams, D. R., Frissa, S., Goodwin, L., SELCoH Study Team, & Hotopf, M. (2016). Discrimination and common mental disorder among migrant and ethnic groups: findings from a South East London Community sample. *Social Psychiatry and Psychiatric Epidemiology*, *51*(5), 689–701. https://doi.org/10.1007/s00127-016-1191-x

Hatch, S.L., Woodhead, C., Rhead, R., & Connor, L. (2021). *Improving Race Equality in Health and Social Care*.

Jackson, D. (2022). When niceness becomes toxic, or, how niceness effectively silences nurses and maintains the status quo in nursing. Journal of Advanced Nursing. https://doi.org/10.1111/jan.15407

Jackson, S. E., & Joshi, A. (2011). Work team diversity. In S. Zedeck (Ed.). In *APA handbook of industrial and organizational psychology, Vol 1: Building and developing the organization.* (Vol. 1, pp. 651–686). American Psychological Association. https://doi.org/10.1037/12169-020

Jones, Camara. P. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health*, *90*(8), 1212–1215. https://doi.org/10.2105/AJPH.90.8.1212

Kapadia, D., Zhang, J., Salway, S., Nazroo, J., Booth, A., Villarroel-Williams, N., Bécares, L., & Esmail, A. (2022). *Ethnic Inequalities in Healthcare: A Rapid Evidence Review*.

Kendi, I. X. ,. (2019). How to be an antiracist. One World.

Lewis, T. T., Cogburn, C. D., & Williams, D. R. (2015). Self-reported experiences of discrimination and health: Scientific advances, ongoing controversies, and emerging issues. *Annual Review of Clinical Psychology*, *11*, 407–440. https://doi.org/10.1146/annurev-clinpsy-032814-112728

Likupe, G. (2015). Experiences of African nurses and the perception of their managers in the NHS. *Journal of Nursing Management*, *23*(2), 231–241. https://doi.org/10.1111/jonm.12119

Likupe, G., & Archibong, U. (2013). Black African Nurses' Experiences of Equality, Racism, and Discrimination in the National Health Service. *Journal of Psychological Issues in Organizational Culture*, *3*(S1), 227–246. https://doi.org/10.1002/jpoc.21071

Miller, K. L., Re Cruz, A., & Ala'i-Rosales, S. (2019). Inherent Tensions and Possibilities: Behavior Analysis and Cultural Responsiveness. Behavior and Social Issues, 28(1), 16–36. https://doi.org/10.1007/s42822-019-00010-1

National Education Union. (2021). Framework for developing an Anti-racist approach. In *Neu.Org*.

Nazroo, J. Y. (2003). The structuring of ethnic inequalities in health: Economic position, racial discrimination, and racism. *American Journal of Public Health*, *93*(2), 277–284. https://doi.org/10.2105/AJPH.93.2.277

Polisena, J., Garritty, C., Kamel, C., Stevens, A., & Abou-Setta, A. M. (2015). Rapid review programs to support health care and policy decision making: A descriptive analysis of processes and methods. *Systematic Reviews*, *4*(1), 1–7. https://doi.org/10.1186/S13643-015-0022-6/PEER-REVIEW

Qureshi, I., Ali, N., & Randhawa, G. (2020). British South Asian male nurses' views on the barriers and enablers to entering and progressing in nursing careers. *Journal of Nursing Management*, *28*(4), 892–902. https://doi.org/10.1111/jonm.13017

Ramsden I. 1991.Kawa whakaruruhau: Cultural safety in nursing education in Aotearoa. Wellington: Nursing Council of New Zealand.

Rhead, R. D., Chui, Z., Bakolis, I., Gazard, B., Harwood, H., MacCrimmon, S., Woodhead, C., & Hatch, S. L. (2020). Impact of workplace discrimination and harassment among National Health Service staff working in London trusts: results from the TIDES study. BJPsych Open, 7(1), e10. https://doi.org/10.1192/bjo.2020.137

Scammell, J. M. E., & Olumide, G. (2012). Racism and the mentor-student relationship: Nurse education through a white lens. *Nurse Education Today*, *32*(5), 545–550. https://doi.org/10.1016/j.nedt.2011.06.012

Shaw, L., Nunns, M., Briscoe, S., Anderson, R., & Thompson Coon, J. (2021). A "Rapid Best-Fit" model for framework synthesis: Using research objectives to structure analysis within a rapid review of qualitative evidence. *Research Synthesis Methods*, *12*(3), 368–383. https://doi.org/10.1002/JRSM.1462

Shore, L. M., Randel, A. E., Chung, B. G., Dean, M. A., Holcombe Ehrhart, K., & Singh, G. (2011). Inclusion and Diversity in Work Groups: A Review and Model for Future Research. *Journal of Management*, *37*(4), 1262–1289. https://doi.org/10.1177/0149206310385943

Smith, William. A. (2008). Higher Education: Racial Battle Fatigue. In *Encyclopedia of Race, Ethnicity, and Society* (Vol. 1). SAGE Publications, Inc. https://doi.org/10.4135/9781412963879.n248

Stanley, N., Woodhead, C., Stoll, N., Morgan, A., Onwumere, J., Jieman, A.-T., Ehsan, A., Paula, M., Ahmed, F., & TIDES Study Team. (2022). Career Progression and the Relationship to Power in the NHS: a qualitative study examining racial inequities in career progression. *TBC*.

Stubbs, F. (2017). Recruitment of nurses from India and their experiences of an Overseas Nurses Program. *Nursing in Critical Care*, *22*(3), 176–183. https://doi.org/10.1111/nicc.12181

Thomas, J., & Harden, A. (2008). *Methods for the thematic synthesis of qualitative research in systematic reviews*. https://doi.org/10.1186/1471-2288-8-45

Thomas, J., Graziosi, S., Brunton, J., Ghouze, Z., O'Driscoll, P., & Bond, M. Koryakina A (2022). EPPI-Reviewer: advanced software for systematic reviews, maps and evidence synthesis. EPPI-Centre, UCL Social Research Institute, University College London

Tuffour, I. (2022). It is like 'judging a book by its cover': An exploration of the lived experiences of Black African mental health nurses in England. *Nursing Inquiry*, *29*(1), 1–12. https://doi.org/10.1111/nin.12436

Walker, C. R., Ehsan, A., Ahmed, F., Harwoood, H., Gunasinghe, C., Meriez, P., Stanley, N., Stoll, N., Woodhead, C., Hatch, S. L., & Rhead, R. (2022). Ethnic inequalities during clinical placement: a qualitative study of student nurses' experiences within the London National Health Service. *TBC*.

Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom. *American Journal of Public Health*, *106*(7), 1294–1300. https://doi.org/10.2105/AJPH.2016.303121

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. In *American Journal of Public Health*. https://doi.org/10.2105/AJPH.93.2.200

Woodhead, C., Stoll, N., Harwood, H., Alexis, O., Bora-White, M., Chui, Z., Clifford, N., Connor, L., Ehsan, A., Ensum, L., Gunasinghe, C., Harwood, H., MacCrimmon, S., Meriez, P., Morgan, A., Jones Nielsen, J., Onwumere, J., ... Hatch, S.L. (2021). "They created a team of almost entirely the people who work and are like them": A qualitative study of organisational culture and racialised inequalities among healthcare staff. *Sociology of Health and Illness*, *44*(2), 267–289. https://doi.org/10.1111/1467-9566.13414

WRES Implementation team. (2021). *Workforce Race Equality Standard 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups*.

Appendices

Appendix 1: Search Strategy

Date searched	Journal/Database	Search string	Limitations	Hits
21.03.2022	CINAHL	TI (NHS or "national health service" or uk or united kingdom or england OR university or "Higher education" or "HEI") OR AB (NHS or "national health service" or uk or united kingdom or england OR university or "Higher education" or "HEI") AND TI (nurse or nurses or nursing or "student nurse" or "registered nurses" or midwife or midwives or midwifery or "student midwife" or "birth attendant" or "traditional birth attendant") OR AB (nurse or nurses or nursing or "student nurse" or "registered nurses" or midwife or midwives or midwifery or "student midwife" or "birth attendant" or "traditional birth attendant") AND TI (Arab or Africa* or Afro* or Asian or Bangladesh* or Black or Caribbean or Chinese or India* or Irish or Multi*rac* or Pakistan* or Roma or travelle Gipsr* or Gyps* or Sikh* or Hindu* or Muslim* or Islam* or jew* or Hispanic or Latin or Caucasian or European) OR AB (Arab or Africa* or Afro* or Asian or Bangladesh* or Black or Caribbean or Chinese or India* or Irish or Multi*rac* or Pakistan* or Roma or travelle Gipsr* or Gyps* or Sikh* or Hindu* or Muslim* or Islam* or jew* or Hispanic or Latin or Caucasian or European)) OR TI (racism or "Racial Prejudice" or "Racial Prejudices" or "Racial Bias" or "Everyday Racism" or "Racial Discrimination" or "Racial Discriminations" or "cover racism" or "overt racism" ethnic minorit* or racial minorit* or ethnic group or BAME or BME) OR AB (racism or "Racial Prejudice" or "Racial Prejudices" or "Racial Bias" or "Everyday Racism" or "Racial Discrimination" or "Racial Discriminations" or "cover racism" or "overt racism" ethnic minorit* or racial minorit* or ethnic group or BAME or BME)	English Language Date – 2012 to 2022	1378

Figure 1: Prisma Diagram showing identification of studies