37. Problems and opportunities in increasing the diversity of healthcare leaders: a narrative review of factors affecting promotion and retention for racially minoritised women[1]

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RESEARCH CONTEXT

The workplace experiences of racially minoritised women[2] are significantly underrepresented in research (e.g. Opara et al., 2020; Cook and Glass, 2014; Kamenou and Fearfull, 2006; Holvino, 2008). The theoretical 'erasure' of Black women in particular is articulated by Crenshaw (1989) in a landmark paper. In practice, the story appears no different: outcomes are often disaggregated, or siloed, obscuring racially minoritised women. For example, in the United Kingdom it was reported that Black and minority ethnic executives were 'entirely' absent, and women 'disproportionately' absent from the boards of all key NHS (National Health Service) national bodies in 2013 (Kline and Habib, 2016: 26).

The 'double jeopardy' of racism and sexism is often linked to underrepresentation, describing the compounded and distinct disadvantages that Black women (Beal, 2008), and other racially minoritised women, face (e.g. Fearfull and Kamenou, 2006; Opara et al., 2020; Likupe, 2015; Esmail et al., 2009; McKinsey & Company, 2020).

Another aspect of the wider context is noteworthy: overwhelming evidence indicates that race and gender-based discrimination underpin inequalities not only in workplaces but in society more generally (e.g. Naqvi, 2019; Esmail et al., 2007; Lane and Piercy, 2003; Opara et al., 2020; Kamenou and Fearfull, 2006; Ross et al., 2020). The disproportionately negative impact of COVID-19 on women and racially minoritised communities testifies to this (e.g. Sealy, 2020; West, 2021a; Ross et al., 2020). Though the United Kingdom is pointed to as an example of related societal inequalities, it is no exception in the Global North.

Both of these contextual factors, the double jeopardy of racism and sexism (at least), and societal inequalities, are pertinent to the lack of racially minoritised women at leadership levels in all sectors (e.g. Dey et al., 2021; TUC, 2020). In healthcare, this is gravely concerning because services do not then reflect the population they serve, undermining health outcomes for those communities (e.g. Kapadia et al., 2022; Kline, 2014).

The occupational segregation of women, i.e. their becoming 'stuck' at lower levels of an organisation, has been widely discussed in healthcare (e.g. Alimo-Metcalfe, 2010; Miller, 2007; Brown and Jones, 2004). Again, only siloed data was found relating to the NHS, the world's fifth largest employer: the percentage of 'Other than White' non-medical staff[3] drops by more than half (from 20.4 to 8.9) when moving from lower to senior positions, i.e. from band 5 or below to band 8c or above in the NHS (UK Government, 2021). Over three-quarters of those affected are likely to be women, given that women comprise 77% of the NHS

workforce (NHS Employers, 2019). Further, the problem of occupational segregation is not unique to healthcare as a sector (TUC, 2020); nor the United Kingdom as a region (Cullen and Grant, 2019), therefore some learnings may be transferable.

A significant literature exists documenting the performance benefits of a diverse workforce (e.g. Dreachslin et al., 2001; Flores and Combs, 2013; Naqvi, 2019; Guillaume et al., 2017). Additionally, hundreds of studies have documented the value of having women in leadership positions in any organisation in any society (e.g. Madsen, 2015; Goryunova et al., 2017). Addressing the lack of racially minoritised women in healthcare leadership is not just a business imperative though; it is a moral and legal one too.[4]

The purpose of this review is to establish and integrate what is known about the lack of racially minoritised women leaders in healthcare in the United Kingdom; and to identify the sub-areas including barriers to and drivers of career progression – defined here as promotion and retention – as well as identify gaps in knowledge. This chapter begins with a consideration of key related concepts and a discussion of methods, before presenting a review of the literature.

KEY CONCEPTS

Four interconnecting concepts have guided this review in its scope, focus and search strategy: inclusion, intersectionality, decoloniality and leadership. Inclusion is widely considered essential to stymie the marginalisation of disadvantaged staff groups (e.g. Guillaume et al., 2017; West et al., 2015). And much evidence indicates that inclusivity necessitates an intersectional approach (defined below) – the second premise. Decoloniality is the third: systems of knowledge production in leadership have been – and to a large extent continue to be – overwhelmingly colourblind (Collinson, 2005; Ospina and Foldy, 2009). Without decoloniality as a premise, other identities and power dynamics overlapping with race would be even more overlooked (Rodriguez et al., 2016). This topic is expanded upon in Chapter 22 of this volume written by Abdoulie Sallah on decolonising the leadership narrative. Conventional – and still predominant – leadership theory (the fourth premise) ultimately renders particular groups invisible, neglecting the 'intersectionality of leadership' (Liu, 2019: 1101). Each of these four interlocking premises is now expanded upon.

Inclusion

There is limited agreement on the conceptual underpinnings of the term 'inclusion' (Shore et al., 2011). Inclusion may be thought of in relation to equality and diversity, however. Equality is about 'ensuring that every individual has an equal opportunity to make the most of their lives and talents' (Equality and Human Rights Commission, n.d.). The subsequent shift towards diversity has been described as a 'move from legal compliance to embracing difference' (Bolden et al., 2019: 10). More recently, there has been a move from diversity to inclusion in the literature (Bolden et al., 2019). Inclusion is about the enactment of equality, and the harnessing of diversity. Given the applied context of this review, emphasis is on the inclusion of marginalised staff in healthcare leadership, at times more so than on 'women' or 'racially minoritised' groups. This is also to ensure a holistic – and intersectional – stance.

Intersectionality

Gender and diversity scholarship has been considerably advanced by intersectionality (Rodriguez, 2018). Though definitions of intersectionality are elusive (Rodriguez, 2018; Collins, 2015), there is agreement that interlocking identities and power dynamics impact discrimination and privilege (Rodriguez et al., 2016: 1). Beyond this, intersectionality is understood as a framework (Knapp, 2005), heuristic device (Rodriguez, 2018) and 'analytic sensibility' (Crenshaw, 2015), for example. These definitions themselves overlap, and span both the conceptual and the practical – an aim of this review also.

The genesis of the term 'intersectionality' is pertinent to the study population: in a seminal paper, Crenshaw (1989: 139) highlighted the dangerous tendency 'to treat race and gender as mutually exclusive categories of experience and analysis'. A distorted analysis ensues, she asserted, depicting only a portion of a deeply complex phenomenon (Crenshaw, 1989). The solution? Address the needs of those who are most disadvantaged, then others who are singularly disadvantaged would also benefit (Crenshaw, 1989: 166). Despite all women – and all marginalised staff – then standing to benefit from intersectional perspectives and practices, conflicts within British feminist theory are worth mentioning. Dominant historical feminist narratives have been critiqued as reproducing racial inequities. How do racially minoritised women negotiate with White feminists the significance of race to stop perpetuating race issues in the workforce? (Mousa, 2022, personal communication).

Decoloniality

UK societal and workplace racial inequalities are understood as a legacy of colonial history and involvement in the slave trade; and the related social construction of 'race' (Delgado, 2017; Lee and Tapia, 2021; Prasad, 2005). There is alignment here with critical race and post-colonial theories (Delgado, 2017; Lee and Tapia, 2021; Prasad, 2005). Awareness of the extent to which this review itself is 'colonised', and mitigation wherever possible has been strived for. 'Decolonisation' is understood as a deeply complex endeavour with 'intellectual, epistemic or praxical' aspects (Quijano, 2000, cited in Decolonizing Alliance, 2021). Each of these areas is engaged with to varying degrees. In epistemic terms, for example, the Global North has long dominated leadership and management literature, leaving out the contributions of African and other non-Western perspectives (Nkomo, 1992; Prasad, 2005; Nkomo, 2011). The colonisation of leadership theories, and the implications for this review are discussed following explanation of how leadership is construed here.

Leadership

A huge leadership literature exists with many theories and approaches. Though leadership theory has evolved to include social constructivist and critical sensibilities amongst others, 'entity' perspectives continue to dominate mainstream leadership theory and practice (Mabey, 2013), where leadership essentially equates to the traits of the leader. However, over time support has grown for attention to leadership rather than leaders, particularly among social constructivist and critical scholars who find it imperative to consider (moving) contexts and relationships (Crevani et al., 2010; Ciulla, 2014; Sinclair, 2007). They

find meanings (of leadership) are produced and reproduced (Fairhurst and Grant, 2010: 173). Such conceptualisations are apt for complex settings such as healthcare (Bolden et al., 2019).

Social constructivist leadership scholars themselves vary widely in orientation (Fairhurst and Grant, 2010; Grint and Jackson, 2010); this review draws upon critical/emancipatory subfields. Though this too comprises several approaches, all critical leadership scholars 'challenge hegemonic perspectives … that tend both to underestimate the complexity of leadership dynamics and agency of followers' (Collinson, 2011: 181). Liu (2019: 1109) highlights 'power-neutral assumptions of a leadership ideal untouched by dynamics of race, gender, sexuality, age and class'. She argues that even 'intersectional leadership' research neglects wider contexts such as patriarchy and White supremacy. Attempt is made not to do the same here. As Rodriguez (2021, personal communication) puts it: 'there is a lack of consideration of how racialised experiences shape understandings of leadership and ability to lead and be good at it'. In so doing, she says, Western leadership tends to reproduce rather than interrupt forms of exclusion.

Finally, it is difficult to meaningfully consider 'leadership' without considering 'management'. It is beyond the present scope to articulate the various distinctions made between the two, however, the traditional view of leaders as 'changemasters' and managers as 'taskmasters' (Fairhurst and Grant, 2010: 179) is noted. The binary nature of this, and similar analyses (e.g. Grint, 2005; Bertocci, 2009; Zaleznik, 1981), has been criticised by scholars such as Peck (2010), Sinclair (2007), and Fulop and Day (2010). They demand more nuanced, fluid thinking that takes into account followers, as well as 'everyday' and 'collective' leadership. Notably, collective leadership is also espoused in the complex 'social and situational context' (Fulop and Day, 2010; West, 2014) of healthcare. So, 'leadership' here includes that enacted by management – as well as others.

In sum, a conceptualisation of leadership is adopted that is anchored in critical, intersectional and decolonising theories. It is also expansive, complicated and (intentionally) 'indefinable', drawing on the view that 'the very "indefinability" of leadership offers important insights into what kind of phenomenon it is' (Ladkin, 2010: 2).

LITERATURE REVIEW METHODS

Scope and Context

Literature from 1 January 2000 to 20 May 2021 was searched; the former because of the proliferation of attention to 'inclusion' after the year 2000 (Oswick and Noon, 2014). After careful consideration, the literature reviewed predominantly included that from the United Kingdom as opposed to further afield.[5] However, not being a systematic review, 'new' relevant concepts were not deliberately excluded based on geography – or year of publication.

Narrative Review, Thematic Analysis, Systematic Approach

A narrative review was conducive to the aims outlined above (Booth and Grant, 2009). No fixed/agreed protocol exists in the field for thematic analysis in narrative reviews. Here it involved description and critique of the literature; and pertained to the frequency of themes as

well as their explanatory value (Noyes and Lewin, 2011). Given the existence of relevant literature on race and gender separately, an inductive approach was justified (Noyes and Lewin, 2011) with some abductive elements (Saunders, 2019).

A systematic review was not considered optimal for reasons including the relevance of a multitude of disciplines; and decolonising sensibilities (Nkomo, 2011). Instead, a systematic approach (Popay et al., 2007) mitigating selection and publication bias was adopted, following guidance from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Moher et al., 2009).

SEARCH STRATEGY

Search Sources

Healthcare leadership and inclusion are both key domains for this review, given the overall purpose to establish and integrate what is known about the lack of racially minoritised women leaders in healthcare in the United Kingdom. Healthcare leadership and inclusion each draw on several disciplines, including medical; social and psychological; and business and management. See Table 37.1 for databases and sources. Some of these were identified via stakeholders such as NHS leaders and academics. This facilitated ongoing examination of relevant literature, as well as access to more obscure sources, especially 'grey' literature. Papers were also found via forward and backward chaining. Database searches were carried out at intervals between March and June 2021.

Table 37.1 Search databases and sources

1. *Medical*
   a. *CINAHL (Cumulative Index to Nursing and Allied Health Literature)*
   b. *Medline*
   c. *British Medical Journal (BMJ) Leader*
2. *Social and psychological*
   a. *Emerald Insight*
   b. *Web of Science*
   c. *Race Relations Abstracts*
   d. *Proquest (general)*
3. *Business and management*
   a. *Business Source Premier*
   b. *Emerald Insight*
4. *Google scholar*
5. *Grey literature*
   a. *Health Management Information Consortium (HMIC)*
   b. *Health Services Journal (HSJ)*
   c. *NHS bodies such as NHS Leadership Academy, NHS Confederation, NHS People Directorate*
   d. *Business in the Community (BITC)*
   e. *News outlets such as The Guardian (UK) and The Financial Times*

Search Terms

Four categories of search terms were developed iteratively. Combinations of words from each were entered into the databases (or sources). See Table 37.2.

Eligibility Criteria

Eligibility criteria are described in Tables 37.3 and 37.4.

Initially, articles were screened by title and abstract, as inclusion and exclusion criteria were developed. If relevant, articles were added to reference management software (Zotero). Subsequently, the methods (if empirical), discussion, and conclusion sections were scanned with respect to inclusion and exclusion criteria, and coded according to inclusion or not. Duplicates were removed. A total of 431 papers were screened; 35 were included in the review: see Table 37.5. Two of these 35 articles were inaccessible despite contacting the authors.

Table 37.2 Search terms

1. NHS OR 'National Health Service' OR healthcare OR 'health service' OR 'health sector' OR 'health management' OR 'health leadership' OR 'Health New Zealand' OR Medicare*
AND
2. leader OR 'middle manager*' OR manager OR management OR strategy OR policy OR organisation OR organization OR career OR promotion OR progress* OR advanc* OR hiring OR recruit* OR select* OR assess* OR retention OR 'intention to leave' OR 'intention to quit' OR 'intention to stay' OR 'staff turnover' OR retain* OR workforce OR employ* OR staff OR professional* OR intervention OR initiative OR driver OR barrier OR 'diverse workforce'*
AND
3. 'BME women' OR 'BAME women' OR BAME OR BME OR Black OR African OR Caribbean OR Asian OR Filipino OR Chinese OR Māori OR indigenous OR aboriginal OR native OR pacific OR migrant OR race OR ethnic OR minorit* OR 'people of colo*' OR 'mixed race' OR 'dual heritage' OR racialised OR sex OR women OR woman OR female OR gender OR intersection* OR inclusi* OR equality OR equity OR diversity OR cultur* OR 'equal opportunities' OR discrim* OR stereotyp* OR microaggression OR racism OR sexism OR 'positive action' OR representation*
AND
4. UK OR England OR Wales OR Scotland OR Northern Ireland OR Britain OR 'United Kingdom' OR 'New Zealand' OR Australia[6]

Table 37.3 Inclusion criteria

• Related to the UK health workforce (e.g. Empirical studies where at least part of the sample was from the health sector)
• Focussed primarily on examining career progression, promotion, or retention of all women and/or racially minoritised employees; and tightly related concepts frequently found and with a high explanatory value (Noyes and Lewin, 2011) such as 'organisational culture' and 'discrimination'
• Related to clinical and non-clinical areas, from any professional group (e.g. nursing, pharmacy)

Table 37.4 Exclusion criteria

- Studies that focussed on national or global factors, rather than organisational or individual
- Primarily focussed on medical students, graduates, or executive boards
- Commentary/discussion pieces
- Not published in English
- Unpublished
- Focussed on the corporate sector
- Theoretical in nature, given the applied nature of this review
- Books, book chapters and theses, given that journal articles and grey literature are the primary sources of research in healthcare leadership and inclusion. However, if chanced upon and relevant, these were not excluded
- Less complete versions of a report
- Of low quality, defined as not meeting several quality assessment criteria suggested by Hannes (2011). One paper was excluded on this basis: a case scenario, since no information was found regarding context or why the case was chosen.

Table 37.5 Search strategy outcomes

Database/source	*Number of items screened (beyond abstract) according to inclusion/exclusion criteria*	*Number of papers included*
CINAHL + Medline	49	0
British Medical Journal Leader	12	2
Emerald Insight	18	3
Web of Science	59	4
Race Relations Abstracts	6	0
Business Source Premier	25	2
Google Scholar	41	7
Proquest General	14	0
Grey literature (i.e. HMIC, HSJ, BITC, NHS organisations e.g. Leadership Academy and Confederation, King's Fund, The Guardian and Financial Times)	59	6
Snowballing and other sources of academic and grey literature (e.g. personal recommendation)	148	11
Total	431	**35**

Coding of Themes

An inductive approach with abductive elements (from earlier scoping reviews) elicited key themes. Using software, 33 articles were read and 'tagged' with key data (e.g. empirical or not); and what subsequently became first order concepts and second-order themes (Gioia et al., 2013). See Figure 37.1.

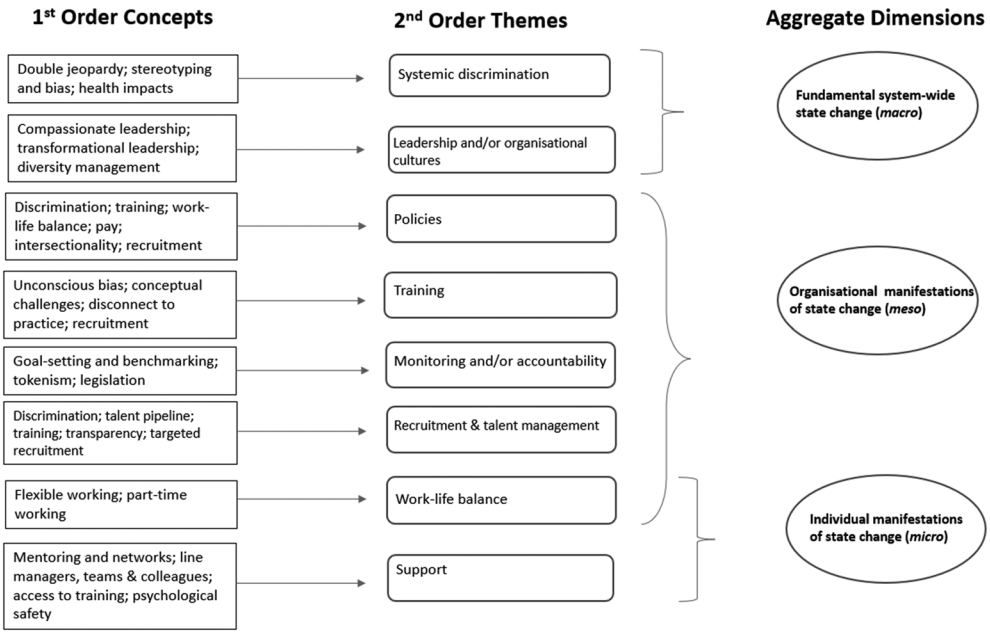


Figure 37.1 Coding outcomes

The frequency (though not the only consideration) of second-order themes is shown in Table 37.6.

Key data

Table 37.7 summarises key data extracted from the 33 papers.

Critique of the literature

Appraisal criteria (validity, reliability/dependability and where relevant, objectivity) from Hannes (2011) guidance were adapted for relevance to quantitative as well as qualitative research. A further criterion of 'decoloniality' was deemed important to include. See Table 37.8.

FINDINGS: BARRIERS AND DRIVERS OF PROMOTION AND RETENTION FOR RACIALLY MINORITISED WOMEN LEADERS

Eight (second-order) themes, or factors, affecting the career progression of racially minoritised women leaders were identified, as in Figure 37.2. These were then categorised as macro, meso and/or micro aspects of a 'gear shift' or 'state change' toward inclusivity. The theme of 'work–life balance' is unique in straddling meso and micro levels, given the connection to organisational policies as well as individuals. Each theme may be considered potentially both a driver and barrier to career progression (two sides of the same

Table 37.6 Frequency of second-order themes

Theme	*Number of articles*	*Empirical*	*Non-empirical*
Systemic discrimination (e.g. bias and stereotyping)	29	19	10
Support (e.g. from mentoring, networks, line management, or access to training)	25	16	9
Recruitment and talent management	20	11	9
Policies (e.g. pay)	18	11	7
Leadership and/or organisational cultures (e.g. gendered leadership)	16	9	7
Training (e.g. unconscious bias or anti-discrimination)	13	7	6
Monitoring and/or accountability	13	7	6
Work–life balance (e.g. flexible/part-time working)	11	10	1

Table 37.7 Key data summary

Key data	Number of papers (from total of 33)
Empirical	*21*
Grey literature	*9*
Qualitative (majority interviews)	*12*
Quantitative (surveys)	*6*
Mixed methods	*3*
Papers related to nursing[7]	*8*
Studies of racially minoritised professional women in various workplaces, with at least a portion of the sample from healthcare (as opposed to the whole sample)	*2*
Method	**Sample sizes (number of participants)**
Interview	from 2 to c.70
Focus groups	From 11 to 24
Survey	from 188 to 51,300
Focus of research questions or aims (empirical papers)	
• career progression including promotion • retention/intentions to leave (solely rather than alongside progression) • career progression and discrimination in tandem • discrimination • intersectional experiences	

Table 37.8 Literature critique

Validity

Internal validity amongst empirical papers, mainly peer-reviewed, was generally conferred by verbatim quotes, multiple researchers, and attention to negative cases (Hannes, 2011). Two studies, Brown and Jones (2004) and Lane (2000), did not report the ethnic composition of their sample, undermining external validity and decolonising principles by implying a colourblind approach. Others did not discuss limitations (such as Henry (2006) or Larsen (2007)). Several quantitative studies with large samples appeared to have strong external validity. Some studies were not assessed for external validity if they did not aspire to be representative but to examine in-depth accounts, such as Larsen (2007).

Reliability and dependability

In general, peer-reviewed literature appeared more reliable (replicable): fuller explanations of methods were given, notwithstanding the much greater number of peer-reviewed papers compared with grey literature. There were exceptions to this e.g. Esmail et al. (2007). A small sample of both empirical and grey literature utilised more than one method, enhancing dependability (e.g. Sealy, 2020; Ross et al., 2020; Magee and Penfold, 2021; Likupe, 2015).

Objectivity

This criterion was applied where relevant, given agreement with Isaac (2020) that objectivity may be both a strength and weakness. Relatively few papers demonstrated reflexivity despite this being a measure of quality (Hannes, 2011). Exceptions included Larsen (2007) and Iheduru-Anderson (2020). Two grey literature articles commendably looked inward to their own organisations as the starting point for reflexivity and improvement (Ross et al., 2020; Esmail et al., 2007). Most empirical papers provided an audit trail of methods and analysis, indicating findings were confirmable through being grounded in the data.

Decoloniality

Engagement with decoloniality was largely assessed implicitly; only two articles explicitly discussed this (Opara et al., 2020; Likupe, 2006). Even then, question marks remained regarding how embedded their decolonial lens was e.g. Whether authors centred themselves on the knowledge generated about participants; or the tone of works (was there any 'saviour' aspect?). Isaac (2020: 106) speaks of findings being 'revealed' which implies so. Whether researchers spoke on behalf of participants rather than tapped into their narratives was also considered; Jongen et al. (2019) do not seem to ground their suppositions in the voices of participants. The treatment of data in relation to norms was also noted: Larsen's (2007) study appears a good example of divergent findings presented as an additional way of understanding a problem, thus embedding a decolonial lens.

coin) with the exception of 'systemic discrimination'. All eight themes will be discussed in turn, starting with the macro. Figure 37.2 was generated following the coding process outlined above. Each interconnecting line (and the numbering of themes) reflects the ensuing discussion.

Note, these themes are not limited to racially minoritised women as a disadvantaged group, but perhaps combine in a way for them that they become insurmountable (Esmail et al., 2009: 109). Finally, though it is acknowledged that career progression is a 'reciprocal' activity (Marchington and Sparrow, 1998, cited in Fearfull and Kamenou, 2006: 889), evidence suggests that most racially minoritised women are very motivated to advance (Iheduru-Anderson, 2020).

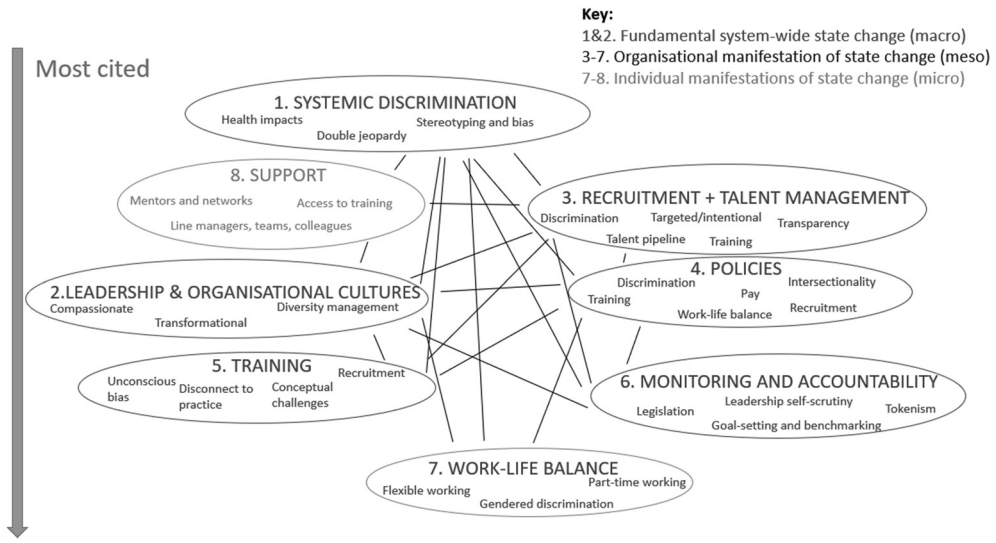


Figure 37.2 *Barriers and drivers of promotion and retention for racially minoritised women leaders in healthcare: macro, meso and micro dimensions*

MACRO LEVEL STATE CHANGE: BARRIERS AND DRIVERS OF PROMOTION AND RETENTION

Systemic Discrimination

'Institutions can be racist whether or not the individuals in that institution are racist or prejudiced' (Fearfull and Kamenou, 2006: 896). Such 'systemic discrimination' encompasses institutional racism and sexism, and describes direct or indirect discrimination that transcends workplace, organisation, geography and time (Pager and Shepherd, 2008).

A central facet of present-day systemic discrimination is its covert manifestation: a rise in covert discrimination was reported 25 years ago (Dovidio and Gaertner, 1996, cited in Esmail et al., 2009: 106). This trend appears not to have abated in the NHS and especially at higher levels (Larsen, 2007; Esmail et al., 2009). Such discrimination is characterised by 'good' people with good intentions (Esmail, 2004, cited in Esmail et al., 2009: 106). Covert discrimination is hard but not impossible to detect (Esmail, 2004): in 2016, the relative likelihood of minority ethnic staff entering formal disciplinary processes compared with White staff was 1.56 (Kituno, 2021, para. 4). There is a recent indication of some improvement, however (Kituno, 2021). Covert discrimination includes microaggressions: seemingly innocuous everyday exchanges that disrespect racialised minorities (Sue et al., 2007, cited in Bolden et al., 2019: 12), women, and/or other groups with less societal power (Coury et al., 2020). Much of the following discussion on systemic discrimination relates to this covert kind.

Triple Jeopardy?

'Double jeopardy' refers to the compounded and distinct disadvantages racially minoritised women often face. Add to this anti-blackness (e.g. Likupe, 2015; Bailey, 2018;

Iheduru-Anderson, 2020; Alexis et al., 2007), and double jeopardy appears the minimum to expect for some. The term 'misogynoir' names such anti-Black misogyny (Bailey, 2018; Teixeira et al., 2021). The scarcity of extant intersectional literature precluded a more nuanced understanding of intergroup differences, other than Black African nurses as most likely to be harassed by colleagues compared with Black British or Black Caribbean women (Likupe, 2006).

Racially minoritised women are more frequently subject to microaggressions, often being the 'onlys' in any given setting, a large-scale US study found (Coury et al., 2020). Such women are three times more likely to think regularly about leaving their jobs (Coury et al., 2020). The 'work' done by marginalised groups to promote their own inclusion is significant: e.g. maintaining 'White comfort' (Iheduru-Anderson, 2020: 667); or emphasising 'Britishness' (Fearfull and Kamenou, 2006; Opara et al., 2020) to appear more professional as deemed by the majority (Fearfull and Kamenou, 2006; Opara et al., 2020). Flexing in this way has been described as 'bicultural stress' by some, and advantageous by others ('British cultural capital') in a study of Black British-born NHS mental health nurses (Isaac, 2020). This study calls intersectional analysis a 'necessity' to better understand workforce inequalities (Isaac, 2020: 108).

The prevailing discourse in the NHS may be summed up thus: 'women (particularly BME women) … put themselves under pressure to fit into a system they feel does not fully recognise them or they "choose" not to apply [for roles]' (Sealy, 2020: 52).

Bias and Stereotyping

Unfavourable assumptions about racially minoritised staff, and women, often based on unconscious bias are a manifestation of systemic discrimination. Such bias, e.g. the tendency for both men and women to prefer male leaders (Eagly, 2007), explains the dearth of women in healthcare leadership positions, argues Alimo-Metcalfe (1999, 2002, cited in Miller, 2007). Insufficient attention to diversity within a population is a trademark of stereotyping, such as Black women as dominant (Opara et al., 2020); or accents themselves as indicative of ability (Bond et al., 2020; Isaac, 2020). Repercussions include poorer pay, fewer chances of promotion or poorer access to professional networks (Opara et al., 2020). Less tangibly, stereotyping may lead to experiences of 'unbelonging', not to be underestimated given that 'belonging' is the third most critical human need after physiological needs (Maslow, 1943). Negative impacts of stereotyping on retention rates, as reported by Robson and Robson (2016), are unsurprising. Worse, the threat of stereotyping may induce adverse career progression consequences itself (Kenny and Briner, 2014).

Health Impacts of Discrimination

'Overwhelming' evidence supports the relationship between discrimination and adverse long-term physical/mental health, finds Naqvi (2019: 9) in a recent review of race equality in UK workplaces. Others scholars find similar (e.g. Williams and Mohammed, 2013; Wallace et al., 2016; Williams, 2000; Meyers, 2001; Fuller, 2004, cited in Myers and Dreachslin, 2007: 294). Physiological impacts of discrimination include increased blood pressure, heart rates, cortisol secretions and unhealthy behaviours. However, awareness of this appears vastly lacking in practice (West, 2021a; Larsen, 2007). Further, 'little' things accumulate and matter profoundly when it comes to discrimination and employee health (e.g. Ross et al., 2020: 68), such as pronouncing names correctly. Poor retention and promotion prospects are a logical extension of employee ill-health. It is suggested here that the number of negative health impacts increases the more dimensions of discrimination faced.

A well-cited paper on the mental health impacts of discrimination found that an individual's sense of self is undermined such that it becomes a form of 'symbolic violence' (Bourdieu, 1991, cited in Larsen, 2007: 2187). Institutional experiences of powerlessness tend to accompany discrimination, exacerbating mental health impacts (Larsen, 2007; Alexis et al., 2007; Likupe, 2015) such as diminished confidence (Larsen, 2007) and fear or anxiety (e.g. Esmail et al., 2007; Alexis et al., 2007; Likupe, 2015; Flores and Combs, 2013). Accumulated experiences of discrimination are widely understood as 'trauma' (e.g. Combs and Milosevic, 2016; Kinouani, 2020). In sum, 'highly competent and experienced healthcare professionals are broken down by these [discriminatory] experiences and the United Kingdom is deprived of the specialized contribution these workers could make' (Larsen, 2007: 2194).

Systemic discrimination requires a systemic approach (Myers and Dreachslin, 2007), leading to another fundamental (macro) factor affecting career progression for racially minoritised women: leadership and organisational cultures.

Leadership and Organisational Cultures

Evidence from the literature indicates that attention to leadership and organisational cultures was vital for the promotion and retention of racially minoritised women and other marginalised staff groups (e.g. Naqvi, 2019; Miller, 2007; Kline, 2014; Bolden et al., 2019; Esmail et al., 2009). Since it is agreed that 'culture and leadership are interdependent and synergistic' (de Zulueta, 2015: 1), discussion of the two are interwoven.

AQ: References 'de Zulueta, 2015; Do... and Ga... 1996; Ha... 2011; He... 2006; Hannes ... 2020; W... 2000' cited in text but not provided in list. Please check and provide the reference list entry or delete the reference citation.

Leadership that supports the career progression of marginalised groups has been characterised in various ways: West (2021a) in the United Kingdom has long written about compassionate leadership; others have espoused this approach (Bolden et al., 2019; Naqvi, 2019). Such leadership has also been framed as 'transformational' (Alimo-Metcalfe, 2010; Esmail et al., 2007). 'Diversity management' (Dreachslin et al., 2001; Esmail et al., 2007) is another advocated in healthcare, originating in the United States. Each of these shall now be examined, notwithstanding overlap.

Compassionate Leadership

Compassionate leadership is understood here as a conduit for culture change. Compassionate leadership is 'empathy in action', according to Bailey and Burhouse (2019: 108). West (2021a) asserts 'if it's not inclusive, it's not compassionate leadership'. He deconstructs compassionate leadership thus (West, 2021a: 129):

1. Listening with fascination
2. Understanding
3. Empathising
4. Helping

Imperatives related to compassionate leadership – and cultures of inclusion – are shown in Table 37.9. There is more on this topic in Chapter 3 of this volume written by Suzie Bailey and Michael West on healthcare leadership: cultures, climates and compassion.

This literature indicates that racially minoritised women staff in the NHS will progress quicker if they experience inclusive cultures, achieved via compassionate leadership.

Table 37.9 Enacting compassionate leadership and cultures of inclusion

- 'Embodying' inclusivity by being psychologically and emotionally present (de Zulueta, 2015; Bailey and Burhouse, 2019; West, 2021a).
- Awareness of leader biases to see those more similar to them as more competent; and consciously seeking more contact with those seen as 'other' or more 'difficult' (West, 2021a: 134).
- Ability to lean into areas of conflict, given that diversity creates the potential for conflict as well as creativity and better decision-making (Dreachslin et al., 2001; Guillaume et al., 2017; De Dreu, 1997; Pelled et al., 1999, cited in West, 2021a: 135).
- Patience: leaders should expect benefits such as the 'cross-fertilization of different approaches' to take time to emerge (Watson et al., 1993, cited in West, 2021a: 137).
- Assessment of performance as inclusive leaders, 'ensuring all they lead feel included by their leadership' (West, 2021a: 142; Bailey and Burhouse, 2019).
- Mentoring and providing stretching opportunities for staff from disadvantaged groups; and create opportunities for reverse mentoring, whereby staff from majority groups are mentored from typically more junior staff from minority groups (West, 2021a).
- Collective leadership (De Zu[illegible], 2015; Bailey and Burhouse, 2019; West, 2021a).
- Robust knowledge of the hea[illegible]mpacts of discrimination, also affecting life chances (Williams et al., 2019).

Transformational Leadership

The transformational leader 'inspires, intellectually stimulates and is individually considerate' of followers (Bass, 1999: 9). Attentiveness and communal/collective mentalities are characteristic of transformational and compassionate approaches, as are relationships based on respect and trust (Miller, 2007). Indeed, transformational leadership may be considered a culture itself.

Despite being wary of binaries, it is noted that transformational leadership styles associated with women contrast with the more 'transactional' leadership style – or cultures – of men, often marked by monitoring, assertiveness and dominance (Bass, 1998; Bass and R[illegible]io, 2006; Eagly and Johannesen-Schmidt, 2001, cited in Miller, 2007: 441). The claim that w[illegible]en have superior leadership skills has been widely evidenced, including by meta-analysis (Eagly et al., 2003). The persistence of underrepresentation of racially minoritised women at leadership levels points to the extent of prejudice, says Eagly (2007). Further, communal qualities, applicable to all women, are sometimes perceived – consciously or unconsciously – as incompatible with leadership success (Eagly et al., 2003). This paradox, potentially resulting in women being overlooked for promotions, underscores the need to address underlying cultures of discrimination.

Little is written on the applicability of the largely American literature on transformational leadership to other settings (Sinclair, 2007). Further, transformational leadership literature is (also) ahistorical and individualistic, and divorced from structural forces present in organisational life (Sinclair, 2007: 151). Sinclair (2007) asks 'what or whose interests are really being served when transformational leadership is exhorted?' Similar caution may apply to compassionate leadership given the potentially moral undertones and commodification of leadership types. Put another way, awareness is needed to lessen the colonisation of leadership approaches (Narayan, 1995).

What does this mean for the career progression of racially minoritised women leaders in healthcare? Transformational leadership – and cultures – could be both a driver of, and a benefit to, women's career progression if adopted with critical awareness.

Diversity Management/Leadership

Diversity management (used here interchangeably with 'diversity leadership') involves strategic attention to organisational culture as well as recruitment and retention (Myers and Dreachslin, 2007; Bolden et al., 2019). Insufficient movement has been made towards diversity management in the NHS say Esmail et al. (2007). Many diversity management recommendations are similar to those based on compassionate or transformational leadership. In addition, Esmail et al. (2007) demand greater recognition of unconscious sociopsychological processes (e.g. biases) key to organisational cultures. Another difference is the recommendation for all managers to pursue their own 'racial identity development' (Helms, 1990, cited in Dreachslin et al., 2001: 406).

In sum, it is argued here that critically minded leadership and cultures, drawing on all three approaches, are needed to counter cultures of discrimination. All of the above supports the finding that an individual's fit within an organisation is more important than 'role fit' in predicting intentions to quit (Cooper-Thomas and Poutasi, 2011).

Given the vastness and complexity of healthcare systems, a systemic, committed and long-term approach is required for healthcare cultures (plural) to change (Myers and Dreachslin, 2007). Yet, leadership development and culture change are in nascent stages, taking the NHS as an example; as is the study and workplace practice of both inclusion (Oswick and Noon, 2014) and intersectionality (Rodriguez et al., 2016).

Having discussed some fundamental drivers and barriers to career progression at a macro level, meso and micro factors affecting the promotion and retention of racially minoritised women leaders are now considered.

MESO LEVEL STATE CHANGE: BARRIERS AND DRIVERS OF PROMOTION AND RETENTION

Recruitment and Talent Management

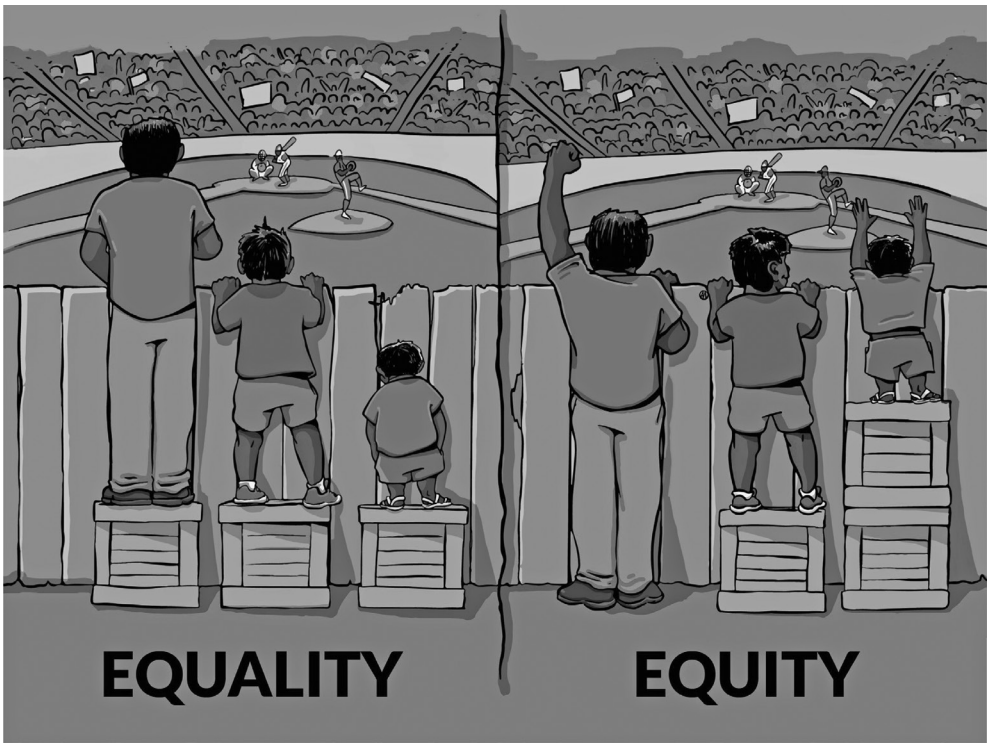
Recruitment is a 'first step' to inclusive organisational cultures say Flores and Combs (2013: 34). Despite equality legislation covering much of the domain of recruitment, practices of discrimination are not uncommon (Esmail et al., 2007): e.g. In 2020, 'White applicants were 1.61 times more likely to be appointed from shortlisting compared to minority ethnic applicants' in the NHS (Kituno, 2021: para. 2). So what can be done? The literature reviewed, as well as case studies of NHS Trusts, point to several strategies for gender parity (Sealy, 2020: 34); research on ethnic parity often indicates similar. See Table 37.10.

The first in the list, intentional or targeted recruitment (an example of positive action) was not much contested in the literature. Affirmative action, however, i.e. targeted recruitment beyond shortlisting stages, is illegal in the United Kingdom. Contrastingly, affirmative action is legal in New Zealand, and its gender pay gap is one of the lowest worldwide (New Zealand Government, 2020). Targeted recruitment was found to raise some concerns over 'reverse' discrimination, prioritising equality over equity (Sealy, 2020: 39). In agreement with West (2021a), Naqvi (2019) and Flores and Combs (2013), however, equity rather than equality is considered the goal of inclusive practices as illustrated in Figure 37.3.

Recruiting staff – especially leaders – who are dedicated to inclusive practice should be prioritised as much as recruiting diversely say Bolden et al. (2020: 39) and Sealy (2020: 43). The perception of fairness is also paramount when it comes to recruitment (Naqvi, 2019; Isaac,

Table 37.10 Strategies to support gender and ethnic parity in recruitment

- Intentional or targeted recruitment. E.g. flexible application of criteria and processes (Flores and Combs, 2013; Kline, 2014; Myers and Dreachslin, 2007; Bolden et al., 2019)
- Managing a talent pipeline – and identifying talent through various means (e.g. Magee and Penfold, 2021; Flores and Combs, 2013; Sealy, 2020; Sait et al., 2020; Kline, 2014; Esmail et al., 2007)
- Gender (Sealy, 2020) and racial awareness in recruitment practices – including checking for bias
- More diverse panels – also as a counter to individuals' unconscious bias (Naqvi, 2019)
- Empowering Black or minority ethnic panel members to overturn interview panel results and escalate for review (NHS England and NHS Improvement, 2019)
- Name-blind recruitment (Sealy, 2020; Bolden et al., 2019; Naqvi, 2019)
- Using the 'tie-breaker' (Sealy, 2020: 34) or 'Rooney' rules (Priest et al., 2015)



Source: Image from Interaction Institute for Social Change, www.interactioninstitute.org. Permission to reproduce granted. Artist: Angus Maguire, www.madewithAngus.com.

Figure 37.3 Equality and Equity

2020; Henry, 2007). Increased transparency, and other pipeline development activities such as networks and reverse mentoring – and accountability for these – led the North East London Foundation Trust (NELFT) to halve the recorded racial discrimination during shortlisting between 2016 and 2018 (NHS England and NHS Improvement, 2019: 10), amongst other tangible shifts towards equity.

Finally, the use and success of leadership development programmes in relation to managing a talent pipeline was scarcely discussed in the reviewed literature. And, research tended to be siloed rather than holistic: the question remains, 'how does gender come into play when recruiting racial and ethnic minorities?' (Flores and Combs, 2013: 34).

Policies

Policies supporting the career progression of racially minoritised women are important because they may disrupt the status quo on an institutional or structural level (Rodriguez et al., 2016: 14). Four key policy areas were identified as particularly impacting promotion and retention: recruitment, work–life balance, training, and pay. The issues related to each also tend to converge, hence their simultaneous consideration.

On a structural level, 'the implications of a masculine organisational context and macro policy network … are that policy decisions are not inclusive of the greater proportion of employees in the NHS, that is women' (Miller, 2007: 444). Informal practices, underpinned by prevailing assumptions such as part-time workers being uncommitted (e.g. Lane, 2000; Brown and Jones, 2004; Likupe, 2015), undermine inclusive policies (Henry, 2007). Tending toward the operational, policies are necessarily limited, say Brown and Jones (2004), advising more attention to organisational culture and challenges to the construction of gender. Policies – like other individual drivers – are necessary but not sufficient to foster the career progression of marginalised staff.

Another necessity is for organisational policies to be based on multiple axes to capture intersectional experiences (Verloo et al., 2012; Isaac, 2020; Sait et al., 2020; Opara et al., 2020). The 'continual homogenising of ethnic minority nurses [with respect to metrics] is unhelpful to address their lag in senior Bands' argues Isaac (2020: 107). Similarly, Sait et al. (2020: 4) found no data on the 'BAME women' pay gap. And efforts to close the gender pay gap for one group of women are likely to look very different to efforts required for another group, assert Opara et al. (2020: 1195). No mention of the ethnicity pay gap was found within the included papers, possibly connected to a lack of policy in this area. Further, correlation between unfair pay and intention to leave is apparent from recent media interviews with NHS nurses (Mistlin, 2021).

Finally, it is worth noting that 'one reason it may be challenging to bring about institutional change through policy is because policy implementation is likely to be subject to the very processes and structures it is designed to disrupt' (Rodriguez et al., 2016: 15). Conscientious flexibility within policy processes and structures may therefore be appropriate.

Training

As a tool to dismantle discrimination, there is much support for various training (e.g. Naqvi, 2019; Priest et al., 2015; Ross et al., 2020; Sait et al., 2020; West, 2021a; Guillaume et al., 2013). Cultural competence training has, for example, been linked to lower turnover (Cheng and Liou, 2011). Unconscious bias, anti-discriminatory, diversity management and recruitment training are all commonly discussed in the literature. Though approach, content and target audiences differ, analysis is deemed richer by their simultaneous consideration given

their commonality: the aim of changing attitudes, as well as skills development. Such training presents several conceptual and empirical challenges, elaborated below.

A meta-analysis integrating 40 years of research on overall 'diversity training' found only small effects for attitudinal, compared with cognitive learning (Bezrukova et al., 2016), indicating limited practical benefit for marginalised staff. Moreover, even where attitudinal shifts were reported, these tended to erode over time (Bezrukova et al., 2016). Table 37.11 outlines possible explanations.

Conceptual and empirical challenges have led some, e.g. the UK Civil Service, to discard implicit bias training. Such training is intensely debated (Robson, 2021; Noon, 2018; Tetlock and Mitchell, 2009), though empirical conditions conducive to successful outcomes deserve attention. At NELFT, training for minority ethnic staff to participate in interview panels was instated. Between 2013 and 2017 the number of minority ethnic staff in senior leadership increased from 2 to 32 (NHS England and NHS Improvement, 2019: 11). Concurrent initiatives were important: recruitment policy changes preceded this; all interviews above a certain band needed a Black or minority ethnic member on the panel. If well-conceptualised and enacted, all forms of training have the potential to reduce barriers to promotion and retention for all marginalised staff.

Who should the training target? Everyone, given the ultimate aim of transforming cultures. However, leaders have a particular responsibility to model inclusive values (Guillaume et al., 2017). And, leaders from majority groups can be particularly effective at dismantling discrimination (West, 2021a). Training for trainers is also advocated (Esmail et al., 2007). Though training should target everyone, literature guards against emphasising the development of racially minoritised employees, arguing that many are already well-qualified for promotion (Iheduru-Anderson, 2020; Larsen, 2007; Esmail et al., 2007). Equal access to training is a different matter, discussed below.

Table 37.11 Conceptual challenges of equality, diversity and inclusion training

- Inadvertent negative consequences of training: e.g. highlighting the ubiquity of unconscious bias may demotivate participants to discover their own prejudices (Noon, 2018; West, 2021a).
- Tokenistic offering and undertaking of training (Lane and Piercy, 2003); an issue that may affect other themes too e.g. work–life balance and recruitment. This issue may be exacerbated by mandatory training, though this approach is endorsed (Esmail et al., 2007; Naqvi, 2019; Priest et al., 2015; West, 2021a), and has been successful (NHS England and NHS Improvement, 2019). Context-dependent experimentation with mandatory or elective training may therefore be apt.
- Responsibility being placed on individuals rather than organisations, despite problems being ultimately institutional (Bolden et al., 2019).
- Lack of connection between the conceptual aspects of training and the practical: management 'still don't have a "clue" how to enact diversity management' argue Esmail et al. (2007: 34) and West (2021a).
- Conscious or unconscious resistance to sharing power may undermine the potential of any training according to postcolonial theory (Prasad, 2005: 139).
- Neglect of intersectionality. And how to teach intersectionality; as well as how to teach intersectionally (Naples, 2009; Davis, 2010, cited in Rodriguez et al., 2016: 19). I.e. a lack of reflexive and experience-based learning to engage with 'live' identity and power dynamics (Naples, 2009; Davis, 2010, cited in Rodriguez et al., 2016: 19).

Monitoring and Accountability

Rigorous monitoring and accountability systems are necessary architecture to sustain other drivers (at macro, meso and micro levels) of career progression. Monitoring and accountability – of processes and outcomes (Tetlock and Mitchell, 2009) – are inextricably connected, hence discussed in tandem. In recruitment, training, and promotion practices, monitoring and accountability are imperative to uphold UK legal obligations (Esmail et al., 2007). Further, the 'almost complete lack of good data' is argued to have sustained systemic discrimination in recruitment (Kline, 2013, 2014) and organisational culture (Esmail et al., 2007). Of the eight themes, this was the second from least cited, potentially contributing to poor outcomes given that data highlights inequalities.

However, it is not that simple: since 2015, there is better data with the emergence of the Workforce Race Equality Standard (WRES) but it is not translating to better outcomes. For example, indicators related to culture have stalled over the last five years (Kituno, 2021). And, as with other themes, tokenistic compliance may thwart efforts (Bolden et al., 2019; Ross et al., 2020; Sealy, 2020) A related question is raised: who should managers be accountable to? Employees? (Tetlock and Mitchell, 2009: 17).

Accountability to employees may lie in feedback from those subjugated. Jolliff (2018) argues that such feedback is a resource not to be overlooked. She urges leaders to admit that unwittingly they may have contributed to the maintenance of systems that harm others (Jolliff, 2018: para. 5) – especially given social conditioning to do so (Jolliff, 2018; DiAngelo, 2018). Jolliff (2018, para. 14) encourages self-scrutiny, pressing leaders to ask themselves, 'how is it that our intentions and efforts to make race equality happen often lead to the opposite outcomes?' It is suggested that lack of admission – or even apology – undermines the foundations of drivers. Further, though Jolliff (2018) writes in relation to one axis of disadvantage (racism), it is argued that this applies to others, and upholds the persistence of inequity for marginalised staff. Taking a macro example, the New Zealand Prime Minister genuinely offering an 'institutional' apology for institutional racism (Australian Associated Press, 2021) appears not unconnected to New Zealand's low gender pay gap relative to the rest of the world (OECD, 2020).

Finally, monitoring and accountability via goal-setting and subscribing to benchmarks is advocated by several (e.g. Ashraf, 2013; Sait, 2020; Esmail, 2007), despite the complexities mentioned above, e.g. tokenism. A positive impact on gender issues is reported by 90% of Athena Swan champions, a global gender equality charter in higher education (Sait et al., 2020: 4). The WRES is the closest equivalent in the healthcare sector in the United Kingdom; and tends not to engage intersectional experiences. There is no known intersectional benchmarking for equality in any sector (or for that matter, country). More data on intersections of staff is urged also by Isaac (2020).

Work–Life Balance (a Meso and Micro Factor Affecting Promotion and Retention)

Acker (1990: 139), in a landmark paper, articulates that the ordinary worker is assumed to be a disembodied man with few obligations outside work. This assumption may explain this theme being the least cited of all eight. Evidence of systemic gender discrimination in healthcare are plentiful: e.g. Miller (2007); Brown and Jones (2004); Lane (2000). A large-scale survey conducted in Australia found that promotion chances were best explained by whether or not an

individual had worked full-time continuously (Brown and Jones, 2004); invariably the remit of men. This is consistent with the theory that men accumulate higher stores of human capital to facilitate their promotion (Brown and Jones, 2004). Similarly, cultures of presenteeism frame recruitment decisions in healthcare, says Lane (2000).

Britton and Logan (2008: 110) extend Acker's thinking, stating that the 'ideal worker' is not only male but also White. What then of those racially minoritised women who also work part-time, and/or have dependents? More exposure to discrimination seems inevitable (Brown and Jones, 2004), e.g. judgement for being 'uncommitted'. 'Flight risk' may be a consequence according to studies of nurses (Lane, 2000: 278; Rambur et al., 2003: 186), though one study found that part-time status was viewed as a privilege (Lane, 2000: 278; Rambur et al., 2003: 186). One thing is clear: discrimination pertaining to part-time working mainly affects women (Miller, 2007).

Recommendations to address gendered discrimination from part-time working include line-manager flexibility (Sealy, 2020; McKinsey & Company, 2020; Rambur et al., 2003) and non-judgemental support of men and women having different work patterns (Lane, 2000).

MICRO LEVEL STATE CHANGE: BARRIERS AND DRIVERS TO PROMOTION AND RETENTION

Support

The amount of support required by marginalised staff is potentially proportionate to the multiplicity of disadvantages faced. 'Support' was the second most widely discussed theme found in the literature, appearing vital to retention and promotion chances (e.g. Alexis, 2015; Iheduru-Anderson, 2020; Henry, 2007). However, colonisation will likely be at play within support systems (Rodriguez, 2021, personal communication), i.e. the organisation itself, and relationships with line managers/supervisors, are likely to be colonised e.g. colourblind, and/or missing awareness of power dynamics. The following individual and organisational supports for career progression (Table 37.12), discussed in turn, thus require awareness of 'everyday colonisation'.

Robson and Robson (2016) emphasise the role of line managers in mediating UK nurses' intentions to leave, given their impact on an individual's 'affective commitment', i.e. their 'emotional attachment' to an organisation (Allen and Meyer, 1990, cited by Robson and Robson, 2016). Such 'sponsorship' from managers and colleagues early in their careers is found to be vital to later progression (Magee and Penfold, 2021). Indirectly, supervisors and

Table 37.12 Individual supports important to career progression

1. Line managers or supervisors (Robson and Robson, 2016; Iheduru-Anderson, 2020; Alexis, 2015; McKinsey & Company, 2020; Magee and Penfold, 2021; West, 2021a; Henry, 2007) and colleagues or teams (Guillaume et al., 2013; Edmondson, 1999; West, 2021b)
2. Mentors (Magee and Penfold, 2021; Sait et al., 2020; Esmail et al., 2007) and networks (Sait et al., 2020; Ashraf, 2013; Bolden et al., 2019; Ross et al., 2020; Opara et al., 2020; Esmail et al., 2009)
3. Access to all training (NHS Employers, 2021; Bolden et al., 2019: 12; Iheduru-Anderson, 2020; WRES Implementation Team, 2020; Henry, 2007)

colleagues are 'crucial in reducing and preventing stress' (Melchior et al., 1997, cited in Alexis, 2015: 242) and may support promotion and retention this way, too.

Most discrimination occurs within teams, observes West (2021a: 141). This is based on research (e.g. Coomber and Barriball, 2007) and related thinking that 'people's work experience is primarily located in and emergent from the teams [including immediate supervisors] they are a part of rather than from policies, practices or broader culture' (West, 2021b). An antidote to discrimination in teams may be 'psychological safety' (Edmondson, 1999), integral to inclusion (for example, Priest et al., 2015; Ross et al., 2020; Bolden et al., 2019). Synergies across sub-themes are also noted here: psychologically safe teams are said to have compassionate leaders (West, 2021a).

The relevance of mentoring and networks to inclusivity and career advancement, the second item in Table 37.10, is well established in literature and practice (Dreachslin et al., 2001; Esmail et al., 2007; Iheduru-Anderson, 2020; Magee and Penfold, 2021; Naqvi, 2019; Sait et al., 2020). However, the reported effectiveness is mixed (Ross et al., 2020; Bolden et al., 2019). In the United Kingdom, the mixed success of mentoring may be due to its direction (Sait et al., 2020): reverse mentoring is not well established in the NHS (Esmail et al., 2009: 39), and where it exists, tends not to take account of being 'free labour' (Kapadia et al., 2022, personal communication) despite its potential to address root issues of organisational cultures. This also calls into question lines of responsibility for inequalities.

Turning to networks (formal and informal), an oft-cited reason for mixed success in supporting marginalised groups is their potential to exclude as much as accelerate progression (Miller, 2007; Kamenou and Fearfull, 2006; Esmail et al., 2007). Moreover, powerful networks in organisations are typically White and male, potentially rendering racially minoritised women less able to realise their human capital into social capital (Miller, 2007). Exclusion from networks may also enhance feelings of 'unbelonging' and increase 'flight risk'. However, networks also create psychologically safe spaces for marginalised staff (Bolden et al., 2019; Dreachslin et al., 2001; Sait et al., 2020) if sustained with awareness and alongside other initiatives. In one study, networks of Māori women accountants were not only psychologically safe spaces but vehicles to interrupt colonisation and practices that inhibit progression (McNicholas and Humphries, 2005: 38).

The third aspect of support, equal access to training, has been correlated to retention (Iheduru-Anderson, 2020). However, inequality reigns despite some improvement over time (WRES Implementation Team, 2020).

The theme of support is intrinsically linked to other themes: a systemic approach is needed in order to overcome 'the social role that discrimination had pushed her into', as one woman put it (Larsen, 2007: 1294).

STRENGTHS AND LIMITATIONS

This review has led to a framework (Figure 27.2) for thinking and practice that supports the promotion and retention of racially minoritised women leaders in healthcare – and all marginalised staff. Referring to Hannes' (2011) quality assessment criteria, several standards of reliability and validity have been met. Furthermore, attempt has been made to embed a decolonial lens, supporting the integrity of the review.

A breadth of literature was reviewed. This also meant analysis was not comparing 'like with like', though heterogeneity across methods harnessed some benefits of triangulation. The manual coding of themes by a single researcher may have undermined the validity of results despite close consultation; and the themes generated were comprehensive but not exhaustive. The decision to consider the explanatory value of themes, not just frequency, added value as well as subjectivity; and inevitably some selection and publication bias. There was also a leaning towards studies in nursing. Further, reliance on the UK context, the exclusion of unpublished studies and those not in English will have added to bias and to a colonial lens. The researcher aimed to be 'consciously subjective' in reporting decisions (Klein, 1993, cited in Essed, 1991: 11), particularly given the shared ethnic background and gender with the study population. This also links to the 'big' questions of decolonising research: who decides what is legitimate knowledge?

CONCLUSION

This review is intended to form part of future empirical research leading to an analysis of implications for policy and practice. It is however possible to elicit some preliminary implications from this review: see Table 37.13. These may be especially pertinent for line managers and supervisors, well-positioned to be uniquely influential in abating discriminatory experiences and fostering career progression.

The recommendation from Crenshaw's (1989: 166) seminal paper was to 'address the needs of those who are most disadvantaged; then others who are singularly disadvantaged would also benefit'. This review is pertinent not just for racially minoritised women but for all marginalised staff. The aims were to establish and integrate what is already known on the career progression of racially minoritised women leaders in healthcare, and to identify the sub-areas and gap(s) in knowledge. The first two of these aims have been addressed through the identification of macro, meso and micro themes (drivers and barriers) relating to a 'gear shift' or 'state change' needed to address systemic discrimination. Sub-themes are also pinpointed. Each theme alone may be thought of as necessary but not sufficient to improve promotion and retention. Taken together, there is the potential for a different story, as indicated by the North East London Foundation Trust (UK) case example. The long-term engagement of drivers systemically and systematically is considered a meta-theme.

Table 37.13 Preliminary implications for line managers and supervisors

- Deep knowledge of the mental, social and physical health impacts of discrimination; and of covert discrimination
- Flexibility and non-judgemental acceptance of different work patterns and behaviours, usually between men and women
- Targeted recruitment; and applying criteria flexibly in recruitment and wider policy processes when appropriate
- Awareness of 'everyday colonisation', especially in relationships with subordinates
- Being accountable to employees; and self-scrutiny

Given that there is little clarity on intersectional research it is hoped that this chapter is a useful resource for advancing intersectional writing. Regarding future research, no data was found relating specifically to the career progression of racially minoritised women leaders in healthcare; only in nursing. Instead, healthcare leadership research focussed on either ethnicity or gender, neglecting intersectional experiences. Back in 1998, a call was made for 'deeper analyses' to address this very gap (De Anda et al.: 33). An in-depth empirical study of the career progression experiences of racially minoritised managers in the NHS, conducted by the present author and complementing this review, is therefore forthcoming and addresses the key research question, 'what drives this population to leave, remain in, or pursue leadership roles in the NHS?'. The urgency for such research seems well-articulated by Calás and Smircich (1991: 568): 'the more things change, the more they remain the same'.

NOTES

1. **Acknowledgements:** Thank you to Professor Ann Mahon and Dr Dharmi Kapadia for their guidance and insight throughout the writing of this chapter. Appreciation also for the reviewers' comments.
2. The term 'racially minoritised' (rather than 'Black and minority ethnic') is adopted to confer minoritisation as a social rather than biological process, shaped by power (Milner and Jumbe, 2020). It is also preferred because it refers to those with some shared experience of exposure to systemic and individual racism.
3. Twenty-two per cent of the NHS workforce are from racially minoritised backgrounds, and 'non-medical staff' are referred to since they comprise 90% of the NHS workforce (UK Government, 2021).
4. UK *Equality Act 2010* and *Race Relations (Amendment) Act 2000.*
5. New Zealand and Australia were originally included due to the similarity of their healthcare models to the United Kingdom; and their potential to offer insight into the shared problems of compounded discrimination given their indigenous populations. However, in the end, the inclusion of Māori, Aboriginal and Torres Strait Islanders was deemed unsuitable due to their unique histories and circumstances.
6. This table displays the terms originally searched. New Zealand and Australia were subsequently excluded as discussed above.
7. Other study populations included physiotherapists, pharmacists, surgeons, child health workforce, primary healthcare workers.

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