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# Exploring aspects of mentoring for black and minoritised healthcare professionals in the UK: a nominal group technique study

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## ABSTRACT

**Objective** Mentoring plays a crucial role in career development, particularly for black and minoritised ethnic (BME) professionals. However, existing literature lacks clarity on the impact of mentoring and how best to deliver for career success. This study aimed to ascertain perceptions and build consensus on what is important in mentoring for BME healthcare professionals.

**Design** Nominal group technique: The participants in the group followed a structured stepwise process of introduction, silent idea generation, each participant presenting ideas in turn, open discussion and priority voting based on common themes generated during the discussion. This was followed by the creation of a model covering the important aspects of mentoring for BME healthcare professionals.

**Setting** UK.

**Participants** A nominal group technique workshop with 12 participants briefed on this technique.

**Results** There was strong agreement about the most highly rated attributes. Participants emphasised the significance of psychosocial mentoring, highlighting trust, intimacy and clear communication of expectations between mentor and mentee. Discussions on race and racism in mentoring were considered essential. Mentoring circles were proposed as complementary to one-to-one mentoring, offering peer support. Participants stressed the importance of allies in the mentoring process, highlighting the need for authenticity, humility and courage in challenging established norms.

**Conclusion** This study helped create a mentoring model tailored to the needs of BME health and care professionals. This model highlights the importance of sponsorship, allyship, surface characteristics and peer support in fostering career progression for BME mentees. Key elements include mentor honesty, humility and awareness of bias and race issues, alongside skills for effective mentoring relationships. This model provides a mechanism for supporting and mentoring BME workers in healthcare for career advancement.

## STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This study recruited participants from across the UK with diverse age groups and ethnicities.
⇒ Nominal group technique typically involves small groups of participants, which may not represent the views of a larger population.
⇒ This study allowed for triangulation of findings from different perspectives, providing stronger evidence and more confidence in our findings.

## INTRODUCTION

The National Health Service (NHS) workforce in England is more diverse than at any other point in its history, according to The NHS Workforce Race Equality Standard.[1] Black and minoritised (BME) allied healthcare professionals (AHPs) are underrepresented in all 14 professions at 12.2% which is below the NHS workforce average of 19.9%.[2] We use the term BME as defined by the Law Society[3] to include persons from Black, South Asian and East Asian ethnicities. AHPs are the third-largest clinical workforce in England[4] and occupational therapists (OTs), the focus of this study, the second largest profession among them.[2] While positive changes are occurring to promote fair access to AHP career progression, there is concern that career progression is hindered by indirect discrimination, for example, managerial gatekeeping in physiotherapy.[5] BME AHPs need strategies to manage additional barriers (such as lack of networking opportunities, visible leadership from other BME colleagues, discriminating practices at work) for their career progression. One mechanism to facilitate career advancement is mentorship, which has been found to have a positive outcome on career progression.[6] A 'mentor' describes a more senior person, with expertise and knowledge, who takes an interest in the sponsorship of a junior staff member to support the mentees achieve career success.[7] Career advancement is important to retain and recruit OTs. It is important, as it has a positive impact on how a person engages with an organisation and

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their commitment to their own role. It also has a positive effect on affective commitment which in turn influences engagement.[8]

This paper principally details the nominal group technique (NGT) study on mentorship for career progression for BME health and care professionals, which is part of a larger study on mentoring for career progression for BME OTs. The study comprised a scoping review,[9] a survey[10] and focus groups.[11] The components of this research are described in detail previously, a summary of the research is provided here to provide context. The scoping review highlighted that—existing literature did not identify if mentoring enabled career success in BME OTs; there is a necessity to understand how mentoring programmes needed to operate, including the concept of mentoring circles (participant groups providing peer support for mentees).[12] The survey (responses from 54 BME OTs) identified—mentoring is important for OTs; there is a need for further research on mentoring and its effect on career outcomes for BME OTs; allyship (how advantaged individuals seek to support those who are disadvantaged),[13] needs to be authentic and the importance of creating safe spaces as part of psychosocial mentorship (enhance an individual's sense of competence, identity and effectiveness in a professional role).[14] The results from the survey identified themes for additional probing questions as part of the focus group topic guide. The four focus groups (involving 19 participants) identified—importance of providing opportunities for networking; acknowledging good work and giving permission were all seen as outcomes from good mentoring; a paucity of BME role models and ingroup bias as issues that need to be addressed; cross-race mentoring is likely to continue; the need for supporting mechanisms to be put in place to manage racial and cultural differences during mentoring; the necessity for creating a charter for supporting and mentoring BME workers for career progression in healthcare.

This paper provides details of consensus building on what is important in mentoring for career progression of BME health and care professionals using a NGT. This study aimed to explore aspects of mentoring that were important for BME OTs and to create a model for mentoring for BME health and care professionals.

## METHOD

### Patient and public involvement

Patients were not directly involved in this research; however, we carried out four coproduction workshops with BME OTs and established a research steering group to identify and articulate the research questions. This steering group provided overall supervision and guidance for the research project and received information on progress of the study, ensured the safety and wellbeing of participants and reflected and provided advice on ethical issues.

### Study design

The larger study used a sequential explanatory mixed-method study design. The use of quantitative and qualitative approaches provided a better understanding of perceptions and experiences of mentoring for career progression from the perspectives of BME OTs. Collection of quantitative data and analysis of the results followed by collection of qualitative data and analysis of the results and 'mixing' the analysis of the qualitative data to explain the findings is called the sequential explanatory mixed-method design.[15–17] Integration of the quantitative and qualitative phases of the study was made at recruitment (by recruiting those who completed the survey to join focus group discussions and later for the NGT workshop), data collection and data analysis stages. Data collection took place in separate and sequential stages.[18] The quantitative survey data were collected between May and July 2022, the qualitative focus group data were collected between Augus and October 2022. An NGT prioritisation meeting was held in November 2022. At the analysis and interpretation stage, integration was achieved through discussion of how the focus group findings explain and elaborate on the findings from the survey, and what were the priority areas of focus for mentoring for career progression for BME OTs. The methods of recruitment, data collection and analysis for the survey and focus groups have been described elsewhere[10 11] and only details of the NGT workshop are presented here.

The NGT was employed as a structured and systematic method to gather and prioritise input from participants in this study. NGT is a group decision-making process that allows for the generation and ranking of ideas in a collaborative manner.[19 20] This method was chosen for its ability to enable consensus and inclusivity by facilitating equal participation by all group members despite power imbalances and minimise the potential influence of dominant personalities (from different backgrounds) within the group. The overall study design is visually represented in figure 1.

### Participant selection

A purposive sampling method was used to select a diverse group of OTs who possessed relevant expertise or experience on mentoring for career progression. Some of the participants at the NGT workshop were those who had completed the survey and/or participated in the focus group discussions as well as representatives from the steering group, consisting of BME affinity group members, OT allies in senior positions in health and social care and BME OTs in senior leadership positions in health and social care in the UK.

### Pre-NGT workshop preparation

Prior to the NGT workshop, the authors met to discuss and prepare a summarised version of the findings from the literature review, survey and focus groups. Participants were provided with written background information about the study, including a short description of what



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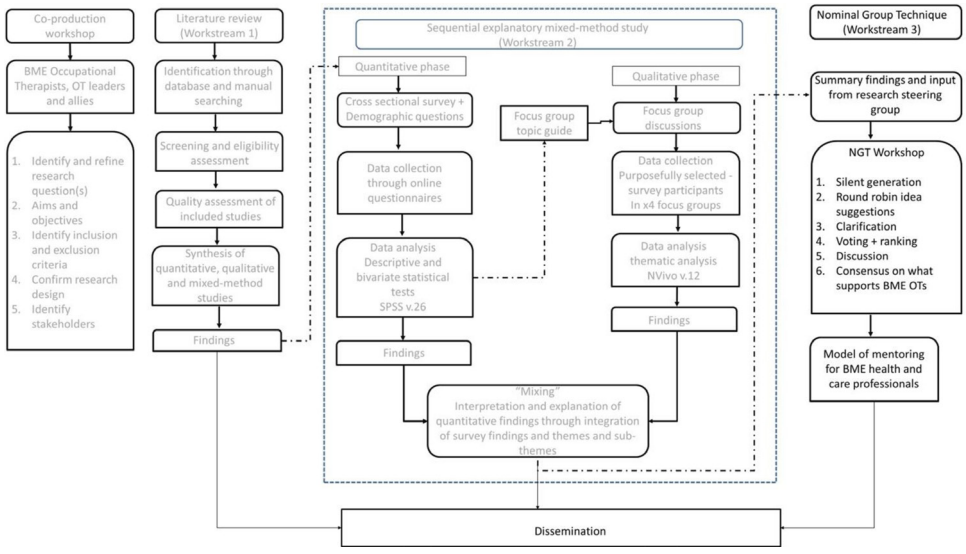


**Figure 1** Study design of the larger mixed-method study. Greyed areas refer to the workstreams including a literature review, survey and focus groups, which provided context and discussion questions for the nominal group technique workshop, highlighted in black. BME, black and minoritised ethnic; NGT, nominal group technique; OTs, occupational therapists.

to expect during the NGT workshop and a consent form, which was completed and returned electronically prior to the workshop. The NGT workshop was conducted online using MS Teams, to allow participants from across the UK to attend. The workshop lasted 150 min (2.5 hours) in total. Informed written consent was obtained from all participants prior to their involvement in the NGT workshop. All participant identification information has been pseudonymised for reporting of results.

### NGT workshop structure

The NGT session started with an introduction and explanation. Authors VS and AA acted as facilitators. EAM took notes and ensured that the participants were included in turn during the discussions. VS captured the ideas as they were generated in PowerPoint slides through the 'shared screen' feature on MS Teams. VS and AA introduced the NGT process, its purpose and the specific topic of discussion. Participants were encouraged to ask questions to ensure a clear understanding of the task at hand.

The participants were then given 5 min for silent idea generation related to the topic without discussion with other group members. This phase allowed for the unbiased expression of individual thoughts. After this, in a structured and cyclical manner (round-robin), participants took turns sharing their ideas with the group. No discussion or critique occurred during this phase, ensuring that all ideas were heard and documented. Following this, participants engaged in open discussion to clarify and elaborate on the ideas presented. This phase aimed to enhance the understanding of each idea and identify common themes. Participants were then asked to independently vote on the ideas generated during the session and these were immediately tallied and ranked. This was followed by a final discussion to review the participants' results and see if they had 'face validity' with the group.

### Data analysis

The votes collected were tallied to identify the most highly prioritised ideas. Additionally, qualitative data from the discussion phase were reviewed to gain a deeper understanding of the nuances and rationales behind participant choices and to create a model for BME OTs and other healthcare professions to use for career progression. The model was developed following the process outlined in the work of Naeem *et al*[21] and used an inductive approach, whereby the model is based on themes emerging from the data and allows for new understanding of mentoring for BME health and care professionals. The structured nature of NGT contributed to the rigour and reliability of the data collected for this study.

### Reflexivity

The project was conceived and designed by VS, AA and EAM. AA and VS are authors from a BME heritage. All authors are OTs and have experience in research using multiple methods and have mentored other health and care professionals. All authors were aware of their own feelings and debriefed after the session. It is acknowledged that authors' previous experience may have influenced the coding and interpretation of some of the discussions. The steering group members consisted of BME affinity group members, OT allies in senior positions in health and social care, and BME OTs in senior leadership positions in health and social care in the UK and provided advice and steer throughout the research study.

## RESULTS

12 participants with previous experience of mentoring, took part in the NGT workshop with a mix of self-identified ethnicities (black African, black Caribbean, Asian, white British, white Irish), age ranges (from 30 to 65) and work settings (NHS, social care, voluntary sector,



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retired and independent sector). There were 10 female and 2 male participants. To preserve anonymity, we have referred to them by participant number.

During the NGT session, after providing a summary of findings from the scoping review, survey and focus groups participants were asked:

'What do you consider is important in/for …'

1. Mentoring.
2. Mentoring discussions on race and racism.
3. Mentoring circles.
4. Allyship in the mentoring process.

1: Mentoring—For the first question, ideas and discussion around psychosocial mentoring came up.

Participants discussed the need for building a mentoring relationship. Having open frank conversations between mentor and mentee and making expectations clear.

> *Psychosocial mentoring is more about Trust and intimacy in those interpersonal aspects of mentoring. It's about relationship building between a mentor and mentee and helps you grow and have an identity through that process.* [Participant 4]

They felt that the process improves tolerance when different ideas are proposed, and an initial open and frank discussion of what mentoring can offer/expected helps avoid future clashes and understand what the other person meant. Participants also felt that this built hope and commitment to the mentorship process and provides accountability and psychological safety.

> *Being able to have that psychosocial mentoring would support that development and you know to start to address the low self-esteem issue and build confidence as a basis for moving forward.* [Participant 2]

Additional discussions centred around the timing and duration of the mentoring, OTs benefiting from mentoring early on in their career, mentors supporting networking opportunities and providing a sense of direction for career progression, and if the mentoring even needed to be provided by another OT. Members ranked the priorities for psychosocial mentoring with least votes for the duration of the psychosocial mentoring, professional background (stage in their career) and the need for similarity of values and/or interest.

2: Mentoring process to involve discussions on issues on race and racism—participants' ideas and discussions centred around: how it effects world views and insight.

> *…race and racism is [sic] prevalent in workplace and needs to be acknowledged.* [Participant 11]

Participants accepted that for BME mentoring, issues around discrimination should be added into the conversation. There were also discussions around who brings up racism issues (mentor or mentee) and if it was not raised by them who should? and that there should be an expectation from non-ethnically matched duos that this is an issue that will come up and that addressing these issues would be mutually beneficial.

> *Establish those expectations [discussion on race and racism issues] from both parties [mentors and mentees] and also [it will] give both parties [an] opportunity to identify any potential barriers … If I approach someone to mentor me, there must be something that they feel they can contribute, but also get out of the process as well.* [Participant 1]

The group acknowledged that mentees and mentors should not be forced to discuss race and related issues if they do not want to. However, participants did voice that as allies and for a mentor or mentee from a non-BME background they wanted to support and help discuss these issues.

> *I want that challenge, I want someone who's different, who's going to point out the things for me, so I wouldn't want to be matched with somebody who's got the same interest or background as me because I want to be exposed to something different. Get out of my comfort zone.* [Participant 5]

Members ranked who brings up race and racism issues (mentee) and who manages discussion if it comes up (mentor) as important skills in mentoring.

3: Mentoring circles—Participants felt that groups which provide peer support for mentees should run in parallel to one-to-one mentoring sessions with a mentor. These groups are referred to as mentoring circles. Participants felt that the mentees should approach the situation openly, give a structure and help set goals and expectations from others in the mentoring circle while continuing to get structured guidance from a mentor.

> *I was gonna [sic] say you could add it to open frank conversation, including expectations. I think it's a really important point, isn't it? About what? What do we want from this?* [Participant 6]

Participants also acknowledged that while clinical skills were important in mentoring, the mentor did not necessarily have to be from the same professional background.

> *Mentoring—does not have to come from an OT* [Participant 11]

> *I think people should have the choice either way because you know it's good to always have the choice whether you want to have an OT or someone from another profession.* [Participant 7]

What was important was that the mentor facilitated and encouraged career progression and was honest and showed humility.

> *Because you know someone who I thought was super [a good mentor] and then turns out to make my life even difficult than what it is. Right? How do we move away from not causing conflict in the future? This could be very delicate. They should be transparent, and you know… be humble.* [Participant 8]



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Members ranked that there might be a risk of not being able to participate in both a one-to-one mentoring relationship as well as being part of a mentoring circle; followed by skills required for mentoring and building an open and transparent mentoring relationship.

4: Allyship in the mentoring process—Participants felt that allies played an important role and needed to understand their role in the mentoring process. They felt that allies as mentors should not expect the mentee to constantly justify or validate their experiences. They acknowledged that there was no expectation for the Ally to be perfect.

> *I think the background for any working relationship would be if the personalities you know matched. If people have similar approaches to things and if they kind of understood what the other person meant by things that they said* [Participant 7]

Participants also contributed that allies should, in their position as a mentor and role model be able to lead with authenticity and integrity.

> *We are looking for someone who has similar values or similar interests, but these not necessarily always have to relate to personal interest, but professional interest in somebody who can help you.* [Participant 1]

Participants also felt that allies should be able to challenge and disrupt established status quo and bring about change for the benefit of their mentees, as well as the healthcare professions. Participants ranked that for allyship, allies needed to be bold and combine kindness with courage, have humility to acknowledge what they do not know while understanding racism and related issues.

The votes from participants, as presented in online supplemental table 1, were tallied to identify prioritised ideas.

### A model for mentoring for career progression for BME health and care professionals

Based on the discussion from the NGT workshop, we created a model for what would benefit and support mentees from a BME background (figure 2) and a representation of what good allyship in mentoring should be like (figure 3). The mentoring model shows a Venn diagram of intersecting areas, with the mentee at the centre. The questions—What I need? (essential for basic function); What can help me? (provides or makes things easier, but not absolutely necessary); What can support me? (offers guidance or assistance over time, enhancing outcomes but not mandatory) and What I require? (a formal or necessary condition for proceeding)—are answered by domains of sponsorship from the mentor, allyship from mentors and others. Additionally, how surface characteristics can play a role in supporting mentees and the use of peer support through mentoring circles are included. Each of these domains in turn is defined by themes of a mentor being able to provide direction for career progression, bringing their clinical skills to support the mentee, the mentor being honest and showing humility, with an understanding of bias and race issues affecting health and care professionals, possessing

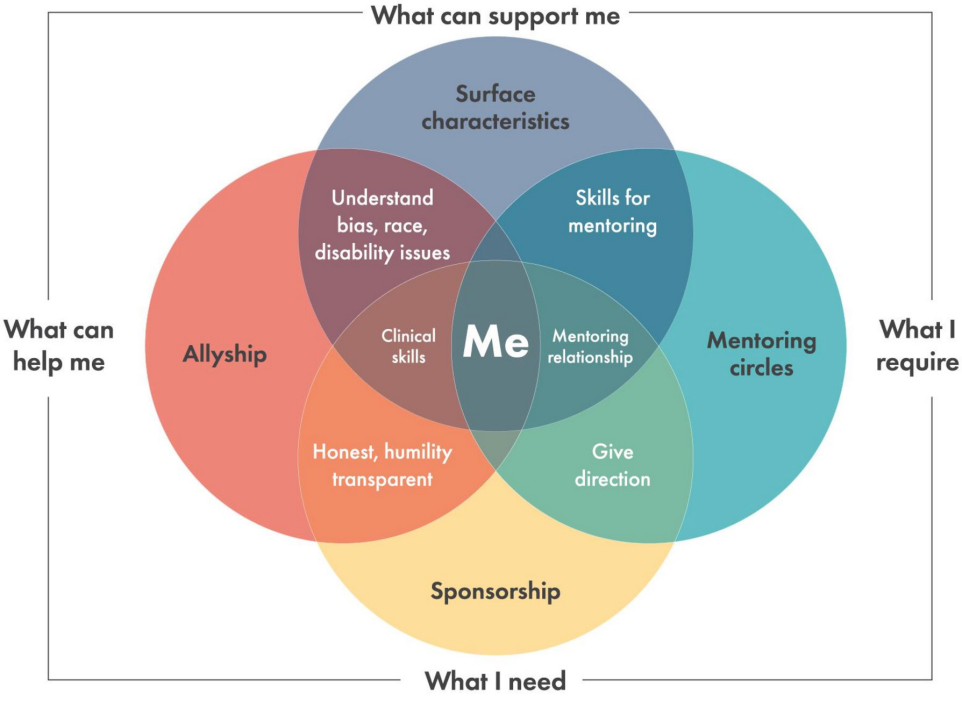


**Figure 2** This figure presents a model for mentoring, with the mentee at the centre. The mentee is surrounded by key intersecting support systems: allyship, mentoring circles, surface characteristics and Sponsorship. The figure highlights what is needed, can help, support and be required in a BME mentoring relationship. BME, black and minoritised ethnic.



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**Figure 3** This figure emphasises the importance of allyship in mentoring, highlighting qualities valued in BME mentoring and what allies are advocated to do. BME, black and minoritised ethnic.

skills for mentoring and being able to build an effective mentoring relationship.

## DISCUSSION

We intended through this study to explore aspects of mentoring that were important from the perspective of BME OTs and create a model for mentoring for BME health and care professionals. Our model is not just relevant for OTs but can be used as a mechanism to support multiprofessional mentorship by offering practical guidance in supervision sessions and mentoring conversations.[22] It aims to improve the experience of mentoring and career outcomes for minoritised healthcare workers, particularly as there is emerging evidence of poor mentoring practice linked to a person's ethnicity.[23] The mentoring model presented here highlights the need for additional reflection into the mentoring process that involves people of different ethnicities. There is a need to acknowledge that minoritised persons require different models of mentorship. While we acknowledge the importance of social learning theory[24] on mentoring, critical race theory was a major influence in our study, using it as a lens through which to understand mentoring in contexts where systemic racism is present or unaddressed.[25] This



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was further influenced by Todic *et al*,[26] who suggest that we should view ourselves as change agents and recognise that our actions can contribute to organisational and social change, which is drawn out in our representation of what good allyship in mentoring (figure 3) should be like. In addition, we used social capital theory to inform our model, particularly regarding the quality of social relationships within mentoring.[27] While four forms of capital have been outlined by Bourdieu,[28] our model emphasises the importance of social connections. This perspective focuses on mentors facilitating equitable access to resources, support, and opportunities that mentees might not otherwise have. Our model requires mentors and mentees to ask and reflect on four distinct questions to enable the function and impact of mentoring to be achieved and need to be embedded within mentor training programmes.

What I need? Effective mentoring between persons of different ethnicities requires careful management of relationships that need to acknowledge differences and similarities since mentoring requires trusting and close didactic exchanges between mentors and mentees.[29 30] Trust has not been explored sufficiently in the mentoring literature.[31] Acknowledging and accepting differences are important, particularly as mentees who perceived themselves to more alike their mentors reported positive mentoring outcomes.[32 33] Our research found that mentees wanted a mentor who had achieved integrative awareness which included internalising a non-racist identity.[34]

What can help me? In our research, we found that allyship is important and expectations of allyship can help shape the mentoring relation at the start of the mentoring process. Our findings agreed that allyship is an integral part of mentorship.[35] Skills needed to be an ally complement findings from Melaku and Beeman[36] and are all important aspects of psychosocial mentoring. Allies needed to be bold and combine kindness with courage, as well as be authentic. Our research highlighted the individual-level factors for mentors to be an ally, mentors needed to have humility to acknowledge what they do not know while understanding racism and related issues. In our research, minoritised OTs did not expect mentors to be perfect. Our findings are reflected in a Swiss study which found that matching mentors with mentees on two specific personality traits—openness to experience and conscientiousness, enhanced the outcomes of mentoring relationships for mentees.[37]

What I require? Our model reinforces the need for mentors to sponsor their mentees, particularly in relation to providing opportunities (networking, resource building, etc) and or signposting for career progression. This has been cited as one of the key roles of a mentor particularly as minoritised persons have been found to have less access to social support than white persons.[38 39] We need a better understanding and evidence, to determine strategies and/or interventions that promote careers, particularly as cross-ethnic mentoring is dependent on, connected identities which relates to who mentors are and who they (as mentees) should be.[40] In our research, we found building a relationship was important, as well as strategies to build hope and commitment into the relationship. Both the mentor and mentee need to agree on how the relationship will work and an initial open and frank discussion of what mentoring can offer or can be expected, helps avoid future clashes.[41] Mentoring circles were perceived to be an important mechanism for peer support which run parallel with one-to-one mentoring. One of the identified strengths of mentoring circles is the exposure of different opinions and experiences to a group of mentees.[42] However, there is currently little evidence within healthcare to support use of mentoring circles[12 43] adjacent to one-to-one mentoring.

What can support me? Our findings agree with a key recommendation by Deng *et al*[44] that it was important to ask both mentors and mentees preferences for matching in relation to surface-level characteristics. In contrast Ghosh,[33] suggests that demographic similarity may not always ensure that the mentee receives the best mentoring support. There is a view that mentorship can act as a buffer to help navigate effects of racism in professional practice.[45] Our findings support this, but it is important to add that, within a cross-ethnic mentoring relationship, both the mentor and mentee need to have similar perspectives on race. This study noted that issues related to ethnicity were not discussed if either the mentor or mentee felt uncomfortable with the subject area.[46]

### Strengths and Limitations

This is the first study to identify mentoring relationships from the perspective of BME OTs and create a model for what good mentoring for career progression for this group might look like and is transferable to other health and care professional groups. We captured views from diverse group of OTs in the UK from different health and care settings, but the narratives from those in independent sector employment are less, despite our continuous efforts to identify and invite them to participate in the nominal group workshop. The use of NGT helped generate a large number of ideas in a short span of time and also ensured that each participant's perspective was noted and ideas were discussed and ranked based on priorities.

## CONCLUSION

This study examines how mentorship can aid career growth for OTs from BME backgrounds. The findings suggest the need for considering issues around allyship, sponsorship and surface characteristics as part of a mentoring relationship and how mentoring circles could offer peer support for mentees. These recommendations could also be applied to other health and care professionals and can be used as reflective questions prior to or when engaging in mentoring involving BME health and care professionals. The study further underscores



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the importance of addressing racial and cultural differences in mentoring relationships and the importance of adequate role modelling and approaching mentoring with honesty and humility. Building trust and allyship are essential for successful mentoring outcomes to promote career progression. The next phase of this project is to implement the model in practice to determine its feasibility and acceptability. It will also require the training of mentors to reflect on their own biases as well as mentors' commitment to allyship. We anticipate that many of the principles of the model could be transferable to clinical supervision.

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**Competing interests** The authors have read the journal's policy and have the following competing interests: AA works as an Associate Professor of Interprofessional Working for London Southbank University. EM is a Professor of Occupational Therapy in Edinburgh Napier University. VS is a paid employee of University Hospitals Bristol and Weston NHS Foundation Trust and the NIHR Applied Research Collaboration in northwest London. The author declares that this article presents independent research facilitated by the National Institute for Health and Care Research (NIHR) under the Applied Health Research (ARC) programme for Northwest London. The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health.

**Patient and public involvement** Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

**Patient consent for publication** Not applicable.

**Ethics approval** This study involves human participants and was granted ethical approval by the London Southbank University Research Ethics Committee (ETH2122-0206). All participants gave informed consent for the nominal group technique workshop. All methods used were performed in accordance with the relevant guidelines and regulations. Participants gave informed written consent to participate in the study before taking part.

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