Gender and ethnic diversity management within the Speech and Language Therapy profession in the UK

Mursheda Begum

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School of Business and Management, Queen Mary University of London

Supervisors: Dr Elena Doldor, Professor Tessa Wright and Dr Grant Lewison

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Statement of originality

I, Mursheda Begum, confirm that the research included within this thesis is my own work or that where it has been carried out in collaboration with, or supported by others, that this is duly acknowledged below and my contribution indicated. Previously published material is also acknowledged below.

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Abstract

The UK's Speech and Language Therapy (SLT) workforce is predominantly White and female. Drawing on scholarship about workforce diversity issues and its management, SLT and the UK health sector were explored. SLT workforce diversity is understudied, particularly experiences as professionals, sector-specific insights, and diversity efforts. This study explored gender- and ethnicity-related career experiences and diversity management within the UK's SLT profession.

A tripartite focus was applied: (1) diversity approach; (2) diversity practices and stakeholders; and (3) Speech and Language Therapist's lived experiences. Two data collection methods were used. (1) Semi-structured interviews with therapists and diversity stakeholders explored the tripartite focus. (2) Diversity policy/strategy documents of therapist's employers supplemented the interview data. Both datasets underwent thematic analysis.

Three main themes emerged: (1) entrance to, (2) experiences in, (3) and diversity approaches and stakeholders in, SLT, with seven main theoretical, empirical, and/or methodological contributions. (1) The business case for diversity is problematized through the relatability concept which helps maintain the profession's White, female culture. (2) Intersectionality was a conceptual tool to theorise the fluidity and interlocking patterns of identity-based dis/advantage for therapists. (3) A lack of terminology for SLT and poor understanding of speech disorders emerged as unique minority ethnic community barriers. (3) Context-specific patterns of gender- and ethnicity-based marginalisation and disadvantage were uncovered for therapists. White and male privilege buffered these experiences. (4) Gaps between therapist's experiences and diversity practices were uncovered. (5 and 6) The profession lacks a clear diversity approach, with its agenda, regulatory framework, and stakeholder roles for driving diversity unclear. (7) The tripartite focus comprehensively assessed SLT workforce diversity.

Therapist's gender and ethnicity shapes entrance into, and patterns of marginalisation/disadvantage throughout, their careers. These diversity issues may persist as the profession's diversity approach, agenda, regulatory framework, and stakeholder roles are unclear. Relevant diversity practices have gaps.

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List of key abbreviations

AHP/s: Allied health profession(s)/als
ASLTIP: Association of Speech and Language Therapists in Independent Practice
BLM: Black Lives Matters
CEO: Chief Executive Officer
Covid-19: Coronavirus-19 pandemic
EDI: Equality, diversity, and inclusion
HR/M: Human resources/management
NHS: National Health Service
PSED: Public Sector Equality Duty
RCSLT: Royal College of Speech and Language Therapists

SLT/s: Speech and Language Therapy/ists

WRES: Workforce Race Equality Standard

CHAPTER 1: INTRODUCTION

This thesis explores how gender and ethnic diversity is managed within the Speech and Language Therapy (SLT) profession in the UK. This introductory chapter provides a rationale for this research focus, explains how the research topic was theoretically and empirically explored, sets out how the key concepts of ethnicity and gender are understood, and outlines the thesis structure.

1.1 Research aim and justification

I was inspired to start this doctoral project after working on research demonstrating the importance of ethnically diverse academics in response to the UK's decision to exit the European Union in 2016 (Wallenfeldt, 2023) on UK research and clinical care (Lawler *et al.*, 2018; Begum *et al.*, 2019). I became curious about what gender and ethnic workforce diversity looked like in UK professions. The UK workforce is highly unequal for gender and ethnicity (see chapter two), which is important to tackle for many reasons. For example, the workforce's large socioeconomic impact offers great potential for societal change. Also, dominant theories of occupational segregation say that inequality can be created and maintained in the workforce (e.g., neoclassical and human capital theories (Pratt and Hanson, 1991; Anker, 1997)). Regulated professions, i.e., law/public authority or voluntary bodies allow individuals to practise if they meet certain criteria, are useful targets to address workforce inequality (European Union, 2019; Department for Business Energy and Industrial Strategy, 2020, 2021). They constitute a sizeable portion of the workforce (Office for National Statistics, 2016a), whose knowledge and skills (European Union, 2019; Department for Business Energy and Industrial Strategy, 2020, 2021), and responsibility to protect the public (Barber, 1979) offer them societal power.

Three reasons shaped my choice of Speech and Language Therapy (SLT) as the regulated profession of focus for exploration of its diversity management. First, the UK's SLT workforce lacks gender and ethnic diversity, which is concerning given the relational nature of a

therapist's role (i.e., language and communication focus). There are few male and minority ethnic therapists. From 2006-21, females consistently represented 96-97% of the SLT workforce (Office for National Statistics, 2011; Parity UK, 2013; Health and Care Professions Council, 2018, 2019, 2020b, 2021a, 2021b; Eddison and Leslie, 2022). Minority ethnic therapist representation was just 6% in 2011 (Office for National Statistics, 2011), improving to 7% in 2016 (Office for National Statistics, Social Survey Division Northern Ireland Statistics and Research and Central Survey Unit, 2017), and remained there for 2020 (NHS England, 2020b; Eddison and Leslie, 2022).

Second, the profession's workforce diversity is, arguably, understudied. I found relevant academic literature to be lacking, and some was very outdated (see section 2.3.1). The literature I consulted ranged from 1990-2021, with the more recent being grey literature usually from the Royal College of Speech and Language Therapists (RCSLT). Overall, the literature tends to explore the factors influencing the choice of a SLT profession to understand its poor workforce diversity. For example, lack of awareness and understanding of SLT is a commonly cited reason (Stapleford and Todd, 1998; Greenwood, Wright and Bithell, 2006; Parity UK, 2013; Puhlman and Johnson, 2019; Royal College of Speech and Language Therapists, 2019d, 2019b). There is an emphasis on male perceptions and experiences, in which certain gender-related factors are explored, particularly the profession's feminised image and the role of gender stereotypes (Greenwood, Wright and Bithell, 2006; Byrne, 2007; Bending, 2011, 2012; Litosseliti and Leadbeater, 2013; Matthews and Daniels, 2019; Royal College of Speech and Language Therapists, 2019b, 2019d). Ethnicity, however, has received relatively little research attention. Detailed ethnicity SLT workforce data are lacking. Also, the literature mostly concentrates on why members of minority ethnic communities may be deterred from pursuing a SLT career (e.g., low status and pay) (Stapleford and Todd, 1998; Greenwood, Wright and Bithell, 2006; Royal College of Speech and Language Therapists, 2019d, 2019b), rather than on their workplace experiences. Some literature has considered student experiences, but generally, insight into workplace experiences as qualified professionals, especially related to their ethnicity and in the private sector, is lacking. I could only find two studies (Arnold *et al.*, 2006; Loan-Clarke *et al.*, 2009), and a magazine article (Rossiter, 2006) on SLT experiences in the NHS, and one reference to therapist employment prospects in the private sector (Rossiter, 2000b). Finally, there is insufficient research on practices specifically directed at addressing the profession's diversity concerns. One study mentioned university initiatives for minority ethnic recruitment (Stapleford and Todd, 1998), but most research on diversity practices stems

from reports by SLT's main professional association, the RCSLT (McCormick, Napier and Longhurst, 2019; Royal College of Speech and Language Therapists, 2019d, 2019b, 2021e; Napier and O'Flynn, 2020).

So, I extrapolated research on staff experiences and diversity efforts in the health sector to gain some insight into SLT. SLT is an allied health profession (AHP), i.e., provide healthcare across a person's life course, in the UK (NHS England, 2021a) and the National Health Service (NHS) is a major employer of therapists (Centre For Workforce Intelligence, 2014; Health and Care Professions Council, 2021a). The UK health sector shows evidence of occupational segregation (see chapter four). Despite the NHS being the largest UK and minority ethnic employer (Naqvi and Kline, 2016), with a predominantly female workforce (NHS digital, 2018b; NHS Employers, 2018, 2019), both staff groups face negative experiences throughout their careers. For example, minority ethnic NHS staff face patterns of marginalisation and disadvantage characterised by discrimination, bias, and exclusion. They face discrimination at recruitment and career progression (Henry, 2007; Oikelome, 2007; Santry, 2008; Jaques, 2013; Kline, 2013; Miller, 2019), harassment, bullying and abuse from patients and colleagues (NHS England and NHS Improvement, 2020, 2021). They are also over-represented in disciplinary processes (Sehmi, 2015; Atewologun and Kline, 2019), and poorly represented in senior positions (Harrison, 2003; Oikelome, 2007; Kline, 2014). Male staff in predominantly female professions face prejudice including assumptions about their sexual orientation or safeguarding concerns when working with vulnerable patients (Williams, 1992). Yet, their pay and pace of career progression is better than for women (Williams, 1992; Punshon *et al.*, 2019). So, men are over-represented in senior NHS positions (Esmail, Kalra and Abel, 2005; Kline, 2014). Not all men are privileged (e.g., Black men) (Wingfield, 2009). Motherhood and caring responsibilities are barriers to women's progression (Pratt and Hanson, 1991; McIntosh *et al.*, 2012), but some research suggest this only applies to women who have not always worked full time (Taylor, Lambert and Goldacre, 2009).

Despite the NHS's many efforts to address its gender and ethnic diversity issues, there is mixed evidence of their impact. The NHS states legal, business, and moral reasons for pursuing diversity (Esmail, Kalra and Abel, 2005; NHS Providers, 2014; Warmington J, 2018), but each has its limitations. For example, regulatory compliance varies in the NHS (NHS, 2011). Also, the business case, which mostly stems from the private sector, does not really apply to the NHS because it is not a business despite imitating some market characteristics (Johns, Green and Powell, 2012). There is some evidence that workforce diversity helps to

meet diverse patient needs (Johns, 2006; Gomez and Bernet, 2019), but it is sparse. The NHS has a ten year plan to increase its workforce, and improve working conditions (NHS, 2019c, 2019d), with financial and personnel investment dedicated to improving ethnicity concerns (NHS, 2019b). Yet, critics claim poor ethnicity-related progress in the NHS (West, Randhawa and Dawson, 2015), and it has a narrow view of diversity (e.g., board diversity seen as the final goal) which is fragmented and fails to address core concerns (Randhawa, 2015).

Intersectionality, and Whiteness/critical race theory (CRT) were explored to understand how gender- and ethnicity-based disadvantage or privilege operates. Intersectionality frames people as holding multiple social identities which intersect and interact to shape privilege or oppression systems (see section 4.3.1). Whiteness/CRT theories frame racism as woven across societal structures, privileging White and disadvantaging minority ethnic groups (see section 4.3.2).

I consulted diversity management literature to explore approaches to address gender and ethnic diversity in the UK (see chapter three). Such approaches have evolved from equal opportunities, to diversity management, and then inclusion (Oswick and Noon, 2014). Equal opportunities has traditionally been influenced by anti-discrimination legislation and social justice motivations (Kirton and Greene, 2005b; Tatli *et al.*, 2008), but became increasingly unpopular over time. Some notable reasons underlying its unpopularity included its failure to deliver equal outcomes, and negative connotations or a punitive approach (e.g., social group differences perceived as discrimination) (Maxwell, Blair and Mcdougall, 2001; Kirton and Greene, 2005b; Nkomo and Hoobler, 2014; Oswick and Noon, 2014). Also, there was an increasing emphasis on diversity over equality which had a growing business case influence. As stated earlier, the NHS has business diversity motivations. Diversity management is the dominant approach to addressing inequality in the UK, characterised by increasing individualism, voluntarism, and business motivations for diversity (Dobbs, 1996; Kandola and Fullerton, 1998; Foster and Newell, 2002; Tatli, 2011; Tatli *et al.*, 2012; Jonsen *et al.*, 2013; Cox, 2018). These characteristics can create and maintain inequality rather than improve diversity (Wrench, 2005; Noon, 2007, 2010; Ozbilgin and Tatli, 2011; Tatli, 2011; Johns, Green and Powell, 2012; Tatli and Özbilgin, 2012) Whilst more recent literature emphasises the importance of inclusion on diversity efforts (Miller, 1998; Mor Barak, 2015), diversity management is a necessary first step. The UK has many equality and diversity stakeholders who address workplace diversity issues (Tatli *et al.*, 2012) (see section 3.2). Previous research has explored the roles and agency of various intra- (e.g., diversity officers (Lawrence, 2000;

Kirton and Greene, 2009) and managers (Cornelius, Gooch and Todd, 2000; Kirton, Robertson and Avdelidou-Fischer, 2016)) and extra-organisational ones (e.g., professional organisations (Morris and Washington, 2017)).

Finally, it was practical to study SLT based on access to, and co-operation from members of, the profession. I recruited therapists and relevant diversity stakeholders by securing ethical approval from relevant bodies (e.g., my university and each NHS site), and then using an opportunity sampling method involving gatekeepers, contacts, and online research.

The literature that I explored and research gaps that I identified resulted in the following research question: ***How is gender and ethnic diversity managed within the Speech and Language Therapy profession in the UK?*** Layder's theory of social domains (Layder, 1993) influenced the development of a tripartite focus (see section 5.2.1) to address the research question comprehensively and strategically. The tripartite focus covered: (1) the gender and ethnic diversity approach; (2) diversity practices and stakeholders; and (3) the experiences of Speech and Language Therapists including the impact of these practices on their professional lives. Each focus has its own research question outlined below.

1. Diversity approach: What approaches underlie the gender and ethnicity diversity policies/initiatives in the SLT profession?

2. Diversity stakeholders and practices: What do gender and ethnic diversity policies/initiatives in SLT look like in practice? Who are the key diversity stakeholders and what is their role?

3. Lived experiences: What are the lived experiences of SLTs related to gender and ethnicity? Do diversity practices address the diversity issues that they experience, and if so, how?

My methodology for addressing the research question was aligned towards a Social Constructivist approach (Morgan and Smircich, 1980; Guba and Lincoln, 1994, 2000). Constructivism is a subjective paradigm which says that reality is socially constructed, and so knowledge is created through interactions and communication, making it transactional,

subjective, and fluid. So, a qualitative approach was ideal for many reasons. Qualitative research is user-friendly and explores people's perspectives, experiences, and context to understand the social world in rich and interpreted ways (Denzin and Lincoln, 2011; Ormston *et al.*, 2014). I conducted semi-structured interviews with therapists and diversity stakeholders (i.e., those knowledgeable about, or with vested interest in, driving diversity within SLT or health sector broadly) and collected the organisational diversity documents of therapists' employers. Both datasets were thematically analysed (see section 5.3). I chose thematic analysis because it is appropriate for large qualitative datasets, is a common and accessible method, and can flexibly explore different research questions and study types to create rich and detailed findings (King, 2004; Braun and Clarke, 2006; Nowell *et al.*, 2017).

The thesis findings are expected to extend the knowledgebase of why the profession has consistently comprised of a predominantly White, female workforce. First, the thesis addresses the academic research gaps identified. This includes increasing insight into therapists' gender- and ethnicity-related workplace experiences as qualified professionals across sectors. Previous research has mostly focused on student choices, male perceptions/experiences, with sector-specific insight lacking and mostly about the NHS. Also, there is a unique opportunity to identify the diversity concerns of therapists and relevant stakeholders currently in the profession, and to see if and how diversity practices address them. This presents an opportunity to identify diversity issue-practice discrepancies. Finally, I engaged in reflexivity to see how my positionality potentially shaped the research process (see section 5.4).

1.2 Conceptualisation of gender/sex and race/ethnicity

How gender/sex and ethnicity/race is defined and understood within the diversity management discipline is important for three reasons. First, language is always evolving which means some concepts/terms become outdated or are deemed inappropriate over time. For example, the acronym "BAME" which commonly refers to Black, Asian, and Minority Ethnic groups and individuals became increasingly challenged as reductionist in 2021 (Inc Arts UK, 2021). Critics

rejected a collective reference that blends and so erases different ethnicity, geography, and nationality backgrounds, sometimes reducing them to an acronym.

Second, some concepts/terms can be understood in many ways and lack conceptual clarity, which may cause misunderstanding. The lack of standard definitions aligns with a Social Constructivist world vision which emphasises relativism and subjectivity (Guba and Lincoln, 2000). This means that (a) reality and knowledge about it, including definitions, are deemed subjective and fluid, and (b) there is no absolute way of determining a correct perception of reality. So, every interpretation of these concepts/terms is valid in its own way. Consequently, community consensus is used to achieve shared understandings of any given concept (Guba and Lincoln, 1994, 2000). For clarity, I considered various interpretations of the key thesis terms/concepts to establish my own approach which will be used going forward, although it may change in the future.

Third, defining these concepts is important to understand discrimination, i.e., the treatment of people or groups unfairly or prejudicially based on their protected characteristics (American Psychological Association, 2022). Discrimination links to workforce gender- and ethnicity-related experiences, including sexism and racism (see chapter four).

A Constructivist approach argues that gender and ethnicity is defined and interpreted by people, and shaped by society, culture, and history (Kang, Lessard and Heston, 2017b). The subjective, context-dependent nature of knowledge makes it difficult to establish the content and boundaries of concepts. It contrasts essentialism which views social groups as having "essential characteristics" typically deemed biological, and by extension universal and fixed (Kang, Lessard and Heston, 2017b). Essentialism may encourage over-generalisations and stereotypes about social groups based on those characteristics. For example, biological sex has been used to explain male-female differences in leadership styles/traits, which ignores other potential sources of difference (e.g., unique experiences from within and outside of one's gender category) (Dzubinski and Diehl, 2018).

1.2.1 The conceptualisation of race/ethnicity

It is challenging to define race and ethnicity (Modood, Berthoud and Nazroo, 2002; Smith, 2002; Proudford and Nkomo, 2006) for many reasons. First, both concepts are often inconsistently used, sometimes they are treated as synonyms (Bhopal, 2004), or as completely different. Second, both concepts were distinguished by linking race to biology and physical

traits (e.g., skin colour) which is now discredited, and ethnicity to cultural factors (e.g., nationality) although sometimes also race-related physical characteristics (Bhopal, 2004; Kenny and Briner, 2007; Blakemore, 2019). Third, race/ethnicity is considered a socio-cultural construct, meaning that societal and cultural factors shape how people think, feel, or behave towards them (Hollander and Howard, 2000). Finally, UK legislation labels race as a protected characteristic, but its definition makes reference to cultural factors including colour, nationality, ethnic-/national-origin, and sometimes caste (UK Government, 2010).

The term "racio-ethnicity" can avoid race/ethnicity terminology-associated challenges because it covers membership of biologically and/or culturally different groups, whilst also acknowledging how this membership may translate to differential societal privilege (Cox, 1990, 2004; Atewologun, 2011). Chapter four outlines ethnicity-based advantages and disadvantages in the workplace. However, I favour the term ethnicity to avoid the biological connotations associated with using race. Ethnicity will refer to a person or group based on all or some mixture of the characteristics of both race and ethnicity, including ethnic-origin/lineage/ancestry, geographical origin/national-origin/citizenship, caste, observable race-associated characteristics (both physical – e.g., skin colour, and interaction-based – e.g., accents), religion, and cultural factors (e.g., language and socio-political heritage).

Ethnicity can be used to differentiate between or categorise seemingly different groups of people (Atewologun, 2011; Blakemore, 2019). It is problematic to define ethnic categories because it is complex, controversial, and confusing (Kirton and Greene, 2005b). First, ethnic classifications differ by data source (e.g., formal versus personal classifications) (Kirton and Greene, 2005b) and are reported at different levels of granularity, which makes comparisons difficult. In the UK, standard ethnic categories used by the government and the 2011 Census of England and Wales, include 18 ethnic groups within five broad categories (Kirton and Greene, 2005b; UK Government, 2021c). The division and labelling of ethnic groups is contested because they suggest these groups are homogenous and share common problems (Wrench, 2005). This is not true for employment and discrimination, which is experienced differently between and within different ethnic groups. For example, although both are categorised as "Asian", employment levels in 2019 were lower amongst Pakistani/Bangladeshi (39%) than Indian women (69%) aged 16-64 years in the UK (Office for National Statistics, 2021a).

Second, the race-ethnicity conceptual blur makes their classifications challenging. For example, Rachel Dolezal was accused of cultural appropriation and deception when she was exposed as racially White after long assuming a Black identity, an act termed *reverse passing* (Rivers and Derksen, 2015; Moynihan, 2016; Beydoun and Wilson, 2017; Tuvel, 2017). The debate around Dolezal's race often makes comparisons with transgender experience to reimagine race/ethnic and gender identity formation, showing how both their subcategories are complex and fluid (Rivers and Derksen, 2015; Bey and Sakellarides, 2016; Brubaker, 2016a, 2016b; Beydoun and Wilson, 2017; Tuvel, 2017) rather than as innate, stable, and clear as traditionally thought (Brubaker, 2016b). This is because ethnicity and gender are increasingly seen as something one *does* rather than *has*, and decreasing perceptions of ancestry as shaping identity because it is increasingly thought mixed (Brubaker, 2016b).

Third, what is considered appropriate terminology changes over time (Kirton and Greene, 2005b). In 2020, the use of *"minority ethnic"*, *"BAME"*, and *"BME"* terminology was increasingly discouraged based on arguments that they combine, and so reduce or erase a diverse range of ethnic, geographical, and national identities to an *"other"* group (Inc Arts UK, 2021; UK Government, 2021d). I will not use these acronyms. Similarly, the phrase *"minority ethnic group"* is commonly used to collectively refer to people who are not White within diversity management literature (Kirton and Greene, 2005b) and by the UK government (UK Government, 2021d). It is contested because *"minority"* is not indicative of ethnically and culturally diverse groups as a global majority, and *"ethnic"* views these groups differently (Inc Arts UK, 2021). However, *"minority"* is fitting in the current UK context. Groups which are not White are a minority in the UK population (14% minority ethnic in 2011 and 18% in 2021 in England and Wales (Garlick, 2022)), and workforce (66% versus to 78% White employed in 2019 (UK Government, 2021a)), even if they may not be globally. There is no agreement on collective terminology for different ethnic groups. Instead, more careful consideration of language is encouraged (Inc Arts UK, 2021; Oxfam International, 2023). I will continue using *"minority ethnic group"* to collectively refer to ethnically and culturally diverse groups that are disadvantaged in UK society. Ethnic labels will be specified where possible.

1.2.2 The conceptualisation of sex/gender

Gender and sex are often used as synonyms, but they are different, leading to calls for more linguistic clarity in each term's usage (Unger and Crawford, 1993). Traditionally and legally, sex relates to one's biological identity which is assigned at birth, and is usually considered

dichotomous: male or female (UK Government, 2010; Tolland and Evans, 2019). Binary or dualistic thinking frames the world as having only two mutually exclusive and contrasting realities. This implies that both realities are absolute/fixed, and either completely opposite or have little in common, potentially resulting in simplistic comparisons or inflating differences which mask a complex reality and create stereotypes (Kang, Lessard and Heston, 2017a). Critics of dualistic thinking argue that male-centred oppositions are used (e.g. reason/emotion) to justify women's oppression, with the male-associated term typically deemed superior to the other (Lloyd, 1993; Mikkola, 2019).

Gender is broader than sex. The UK government and feminist scholars relate gender to nurture, and so consider it a social construct, and *"the social product"* associated with ideas of biological sex (Kang, Lessard and Heston, 2017a, page 49) such as personal perceptions about masculine or feminine characteristics or behaviours (Acker, 1992; Tolland and Evans, 2019). So, gender identities extend beyond just male and female with the 2021 Census including transgender and non-binary gender identities (Tolland and Evans, 2019; Roskams, 2023). Feminist scholars popularised the term gender in the mid-1970s to differentiate between the preferences, roles, and behaviours of men and women stemming from social factors instead of biology (Unger and Crawford, 1993; Cislaghi and Heise, 2019). Gender helped reject biological determinism perceptions, the idea of innate and so unchangeable female/male differences, that can implicitly arise when using terms like "sex" or "sexual differences" (Unger, 1979; Unger and Crawford, 1993; Cislaghi and Heise, 2019). For example, Geddes and Thompson (1889, as cited in Mikkola, 2019) alleged biological determinism by linking metabolic state to traits. Women were presented as *"anabolic"* and men *"katabolic"* which apparently made them un/concerned with politics respectively. Gender considers sociocultural influences on people's experiences in ways that sex does not such as gender norms (Cislaghi and Heise, 2019) and socialisation (Stone, 2007) (described in section 4.1). In fact, any theories overlooking gender are deemed deeply flawed (Acker, 1992). Also, diversity literature and practice is criticised for failing to consider diverse gender identities, such as transgender work experiences (Ozturk and Tatli, 2016).

1.3 Thesis outline

Chapter one provides an overview of the project content and importance. It also introduces and explores the conceptualisations of key thesis concepts including gender/sex and race/ethnicity.

Chapter two describes the case for studying gender and ethnic diversity within the UK health sector workforce. This leads to a focus on the SLT profession, including how it was selected, and provides an overview of the profession and its history.

Chapter three reviews diversity management literature which describes the evolving approaches to addressing workforce diversity in the UK, including a critical exploration of its diversity stakeholders and practices.

Chapter four explores previous research on how gender and ethnicity affect the lived experiences of Speech and Language Therapists and other healthcare professionals in the UK. Here, the existing literature on SLT workforce diversity is described, with research gaps identified. Theoretical debates on intersectionality, Whiteness/critical race theory, and social capital are discussed. This, and the prior chapters, culminate in the development of, and justification for, the thesis research questions.

Chapter five outlines my alignment to a Social Constructivist philosophical position because one's worldview shapes how they study it. This stance is applied to the research methodology and method, which is described and justified. Here, I describe a tripartite focus (includes (1) diversity approach, (2) practices and stakeholders and (3) therapists' experiences), and the research process of qualitative semi-structured interviews including an analysis of the organisational diversity documents of SLT employers, and thematic data analysis of both.

The thesis findings are then reported according to three main themes emerging from the thematic analysis process. These themes are (1) entering SLT (chapter six), (2) experiences within SLT (chapter seven), and (3) diversity approach and stakeholders (chapter eight). Diversity issues were matched with relevant diversity practices. For each results chapter, I articulate the theoretical, empirical and/or methodological contributions of the findings to the existing knowledge base about diversity management in SLT.

Finally, chapter nine combines the results chapters to outline and discuss the thesis contributions, and considers their limitations and implications.

CHAPTER 2: GENDER AND ETHNIC DIVERSITY WITHIN THE UK HEALTH SECTOR WORKFORCE

This chapter provides the context and rationale for studying gender and ethnic diversity in the UK health sector workforce, particularly within the Speech and Language Therapy (SLT) profession. I provide an overview of the SLT profession, and justify it as my regulated profession of focus. It is important to position the thesis within its wider context because SLT is a regulated allied health profession (AHP). Also, the UK National Health Service's (NHS) diversity motivations, issues, and practices are explored because it is the largest UK healthcare employer, comprising of a large SLT workforce that are likely impacted by its principles and behaviour (Centre For Workforce Intelligence, 2014; AGCAS, 2020).

2.1 Gender and ethnicity in the UK workforce

The workforce is an important place to tackle UK societal gender and ethnic inequality for three main reasons. Firstly, the UK workforce is highly unequal for gender and ethnicity on many measures (Weekes-Bernard, 2017). Minority ethnic groups historically and currently experience higher economic inactivity and unemployment, representing the unemployed who are actively seeking work and inactive in the labour market respectively, than White people in the UK (Kirton and Greene, 2005b). For example, minority ethnic groups had a 7% unemployment and 29% economic inactivity rate in 2019, compared to 4% and 19% respectively for White people (Office for National Statistics, 2020a, 2021b). Unemployment levels varied by geographical location and ethnicity. For example, Pakistani groups experienced high unemployment levels across the West Midlands (e.g., 18% in Birmingham and Sandwell) and Caribbean groups in certain London boroughs (e.g., 21% in Hackney) in 2011.

Amongst the employed, minority ethnic groups are paid less, over-represented in the lowest paid occupations, and overqualified for their jobs implying a lack of return from educational achievements or skill gains (Weekes-Bernard, 2017). For example, there was a 2.3% ethnicity pay gap in 2019, with a lower median hourly pay for minority ethnic (£12.11) than White

people (£12.40) (Evans, 2020). In 2018, more Bangladeshi/Pakistani (41%), than White (23%) workers were in the three lowest skilled occupations: elementary, sales/consumer services, and process/plants/machine operative jobs (Office for National Statistics, 2020b). Finally, job overqualification is reported higher amongst graduates of Black African (41%) and Bangladeshi heritage (39%) than White people (25%) (Brynin and Longhi, 2015). Gender and ethnicity intersect to shape UK labour market inequality too. For example, Bangladeshi and Pakistani women have higher economic inactivity than men of the same ethnicity (57% vs 20% respectively in 2015) and White women (25% vs. 62% Bangladeshi and 55% Pakistani women in 2017) (Department for Work and Pensions, 2016; Weekes-Bernard, 2017).

Secondly, the workforce has great socioeconomic influence. Regulated professions (defined in section 1.1) are useful targets to address workforce inequality. They typically require specific qualifications, special exams, and/or registration with a professional body to practise and so have specialist knowledge (European Union, 2019; Department for Business Energy and Industrial Strategy, 2020, 2021), which affords them societal power and status, but also social responsibility as their professional activities affect public welfare (Barber, 1979). Regulated professions also represent a sizeable proportion of the UK workforce, accounting for approximately a fifth of the almost 32 million workers in 2016 (Office for National Statistics, 2016a). So, a regulated profession's diversity efforts could have wide-ranging spill-over effects on society.

Thirdly, and perhaps most importantly, some scholars suggest that the workforce may create and maintain inequality, which makes it a key place for tackling it. One influential theory is Joan Acker's *"inequality regimes"*, which says that all organisations have interlocked practices and processes that allow the maintenance of class, gender, and racial inequalities (Acker, 2006). Also, dominant occupational segregation theories such as *neoclassical* and *human capital* theories attribute employers' behaviours to inequality. Both theories assume the labour market to behave rationally and efficiently, where employers make choices to maximise profits and minimise risks (Pratt and Hanson, 1991; Anker, 1997; Kirton and Greene, 2005b; Close the Gap, 2013). Critics argue that employers may rationally prefer some social groups (e.g., men) over others (e.g., women) when offering jobs because one is a riskier or safer option. For example, women may be deemed riskier than men because they are assumed as being more likely to take intermittent and long career breaks for domestic/care duties which affects the time (overall and uninterrupted) invested in their human capital (Becker, 1981; England, 1982;

Kirton and Greene, 2005b). Women also have indirect costs, such as high sickness absence rates recorded in 2018 (Leaker and Nigg, 2019). Similarly, labour segmentation theories, such as the *dual labour theory* link labour market structure with inequality. For example, the labour market is divided into a primary and secondary sector (can be seen as male/White vs female/minority ethnic sectors in the thesis context), where jobs in the former sector have better working conditions, pay, security, advancement opportunities, and less competition than the latter (Doeringer and Piore, 1971; Wachter, 1974; Anker, 1997; Kirton and Greene, 2005b). These theories highlight the importance of addressing labour market inequality despite their core assumptions being limited. For example, the rationality assumption is flawed because employer discrimination is justified if costs are reduced and productivity increased (Close the Gap, no date) which is unethical.

2.2. The UK's health sector workforce

Gender and ethnic inequality persist in the UK's health sector workforce. There is evidence of occupational segregation within it. UK universities are producing more female than male doctors (57% female medical school entrants in 2015-16) (McKinstry, 2008; Tom Moberly, 2018). Yet, men dominate most medical specialties whilst women are concentrated in a few "people-orientated" or family-friendly specialities (McKinstry, 2008; Svirko, Lambert and Goldacre, 2014; Vassar, 2015; Moberly, 2018). For example, surgery was a common first choice, long-term career for male UK medical students during their preregistration years (cohorts 1996, 1999 and 2000) than female graduates (consistently around 30% vs. 11-12%), whilst the opposite was true for paediatrics (males around 3-5% and females 7-10%) (Lambert, Goldacre and Turner, 2003). Gender differences also exist in working practices. Work-life balance is a key concern for women in medicine, who are disproportionately affected by domestic and family responsibilities than their male counterparts, making them more likely to work part-time and defer parenthood for career progression (Dumelow, Littlejohns and Griffiths, 2000; Buddeberg-Fischer and Reed, 2001; Gjerberg, 2003; Jovic, Wallace and Lemaire, 2006; McKinstry, 2008; Elston, 2009; Willett, Lisa L. *et al.*, 2010; Goldacre, Davidson and Lambert, 2012). Gender differences are also apparent in other medical fields. For example, despite women outnumbering men as general practitioners in the UK since 2014 (Bostock, 2018; Michas, 2021), they earn approximately £40,000 less per year on average, and

tend to be salaried/contracted workers than principals/partners of a practice than male counterparts (NHS Information Centre, 2011; Thomas *et al.*, 2020).

The UK health sector is large, as is its expenditure, and its workforce characteristics imply a great capacity to address societal inequality. The health and social sector is estimated to employ 10% of the UK working population, and has highly educated (e.g., 48% hold professional qualifications) and predominantly female staff than the wider workforce (e.g., 80% versus 46% respectively for non-medical health service staff) (The King's Fund, no date). In 2017, the UK spent £2,989 per person (9.6% of GDP) on healthcare (Cooper, 2019).

The UK health sector includes the UK National Health Service (NHS) which is powerful in driving diversity for many reasons. First, as the largest public healthcare provider, the NHS has a large workforce. There are four NHS systems in the UK: one in England (~one million staff), Scotland (~160,000 staff), Wales (~80,000 staff), and Northern Ireland (~63,000 staff), which is run by their respective governments (Full Fact Team, 2017; British Medical Association, 2021). Overall, the NHS is the fifth largest employer in the world, with approximately 1.7 million staff in 2015 (Nuffield Trust, 2017). It is also the biggest UK employer (Naqvi and Kline, 2016). The organisation covers over 350 careers (NHS Health Education England, no date), including SLT (see section 2.3.2) which is my profession of focus. So, NHS diversity motivations, issues, and practices are outlined in chapter four after exploring its staff experiences. Second, the NHS is the largest employer of minority ethnic groups who represent approximately 20% of the workforce (Naqvi and Kline, 2016) and is also predominantly female (~77%) (NHS digital, 2018b; NHS Employers, 2018, 2019). Third, the NHS is a public organisation, which means it is largely government-owned and tax-funded (Full Fact Team, 2017; British Medical Association, 2021). Public organisations are contested areas for diversity issues, perhaps partly because they are usually large (e.g., have departments with several hierarchical levels), and have many specialities (Dobusch, 2017). For example, NHS England has the most complicated structure, with many different organisations and partnerships at national (e.g., Care Quality Commission), regional (e.g., NHS Improvement regional teams), and local levels (e.g., Clinical Commissioning Groups, etc.) (The King's Fund, 2017; British Medical Association, 2021). NHS Scotland covers 14 territories and has seven NHS Boards (British Medical Association, 2021). NHS Wales has three NHS Trusts with an all-Wales focus, and seven local health Boards (Gig Cymru NHS Wales, 2021). Health and Social Care

Northern Ireland (HSCNI) has one regional health Board, and comprises of six Trusts (British Medical Association, 2021).

2.3 The Speech and Language Therapy profession

This section justifies why I focused on the Speech and Language Therapy (SLT) profession in the UK. The choice of profession was broadly informed by its gender and ethnic diversity composition, academic attention levels, and practical issues such as access to healthcare professionals during the Coronavirus-19 (Covid-19) pandemic in the UK. For context, I then provide a brief overview of the profession and its history.

2.3.1 The selection of Speech and Language Therapy: workforce diversity composition, academic attention, and access to therapists

SLT workforce diversity in the UK is important and interesting to study for many reasons. Notably, the SLT workforce is highly unequal for gender and ethnic diversity, but academic attention given to this is lacking. As therapist's roles are relational, with a focus on language and communication, workforce diversity seems uniquely important in meeting the diverse needs of their clients. Also, SLT was practical to study as I had access to therapists, who were very co-operative, during the Covid-19 pandemic in the UK.

It is well documented that the UK SLT workforce is historically, and continues to be, highly White and female (Boyd and Hewlett, 2001). Gender and ethnicity workforce composition data for SLT was sourced from publicly available sources (e.g., websites, Office for National Statistics (ONS) workforce surveys, etc.) and via Freedom of Information requests to relevant stakeholders (e.g., the Health and Care Professions Council (HCPC) in April 2018 and ONS in September 2018). The HCPC provided gender data for the registrants of each of the professions under its regulation. SLT gender data was from 2006-18. They did not collect, and so were unable to provide, registrant ethnicity data at the time (Health and Care Professions Council, 2018). The closest HCPC ethnicity-relevant parameter was religion/belief from its SLT diversity factsheet for 2021 (Health and Care Professions Council, 2021a). I commissioned

2011 Census data from the ONS, which covered all people in England and Wales for four variables: occupation, gender, age, and ethnicity.

Therapists are almost entirely female (see Figure one), consistently representing around 96-97% of the UK workforce from 2006 to 2021 (Office for National Statistics, 2011; Parity UK, 2013; Health and Care Professions Council, 2018, 2019, 2020b, 2021a, 2021b; Eddison and Leslie, 2022). Table one shows that SLT had the highest female workforce in 2020 than other AHPs.

These gender patterns are likely to continue as few men study SLT. Male student levels are consistently reported around or just below 5% over time – e.g., data for 1997, 1999-2000, 2016-18 (Patterson and Woodward, 1996; Sheridan, 1999; Boyd and Hewlett, 2001; Royal College of Speech and Language Therapists, 2019d; Research Works Limited, 2020b, 2020a). These levels are considerably lower than that in other AHP areas such as paramedic science (43%) and physiotherapy (39%) in 2016-18 (Research Works Limited, 2020b). Most male therapists start their degree after the age of 21 or 26 years, with slightly more studying postgraduate than undergraduate courses (e.g., 3-5% and 2-3% respectively from 1999-2000) (Boyd and Hewlett, 2001; Research Works Limited, 2020b; Royal College of Speech and Language Therapists, 2020c). From 2016-18, most male SLT students were concentrated in the East of England (7%) and least in West Midlands (3%) relative to the 5% overall average (Research Works Limited, 2020b).

Table 1. Gender and ethnic compositions of Allied Health Professions (AHP) regulated by the Health and Care Professions Council in the UK in 2020. Note: F=female, M=male, U=gender unknown, and dark grey cells= data unavailable. Gender data from Health and Care Professions Council, and ethnicity data from NHS Digital shared by the RCSLT (Health and Care Professions Council, 2020b; NHS England, 2020b). Data sorted by F(%).

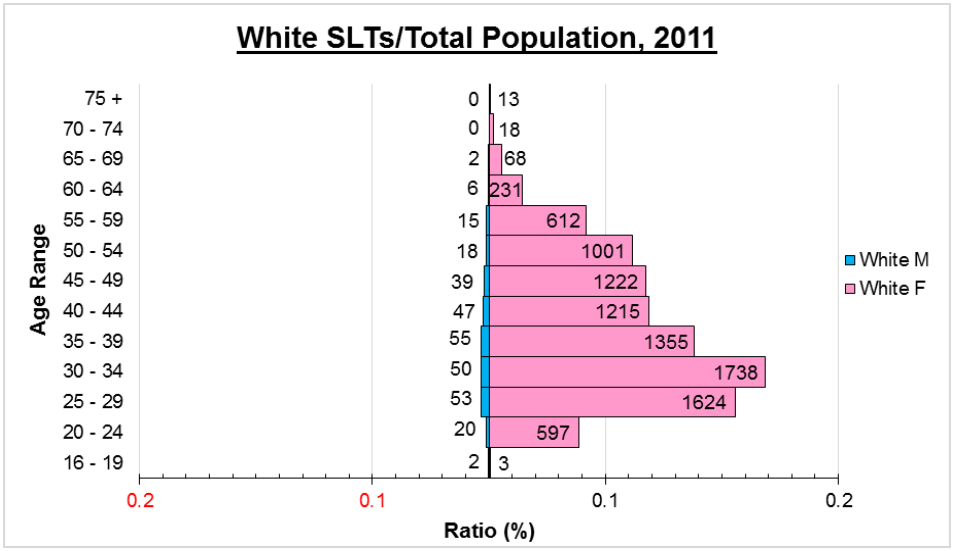
AHP Profession	Gender				Minority ethnic (%)
	F (%)	M (%)	U (%)	Total (N)	
Speech and language therapists	97	3.2	0.0	17,239	7
Dietitians	93	6.5	0.4	10,128	11
Occupational therapists	92	8.0	0.0	41,230	8
Orthoptists	89	11	0.5	1,520	26

Arts therapists	86	14	0.0	4,759	6
Practitioner psychologists	82	18	0.0	25,634	
Chiropodists / podiatrists	75	25	0.1	12,524	14
Radiographers	74	26	0.0	36,923	19-20
Physiotherapists	74	26	0.0	58,097	9
Biomedical scientists	69	31	0.0	23,723	
Operating department practitioners	63	37	0.4	14,824	13
Clinical scientists	61	39	0.0	6,523	
Hearing aid dispensers	55	45	0.0	3,259	
Prosthetists / orthotists	53	45	1.5	1,112	
Paramedics	41	59	0.0	30,422	4

Ethnicity data on therapists were harder to source. AHPs constitute the third largest clinical healthcare workforce, which is stereotyped as being predominantly White, female, and middle-class since the 21st century began (Eddison and Leslie, 2022). So, unsurprisingly, SLT is presented as severely lacking ethnic diversity over time. The 2011 Census reports more therapists in England and Wales to be of White (N=10,004) than minority ethnic background (N= 670) (Office for National Statistics, 2011) (see Figure one). In contrast, the ONS Quarterly Labour Force Survey (April-June) data presents SLT as entirely ethnically White in 2011 (N=14,389), which reduced to 93% (N=12,612) in 2016, stemming from a rise in Black/Black British therapists (N=974) (Office for National Statistics, Social Survey Division Northern Ireland Statistics and Research and Central Survey Unit, 2014, 2017). In 2013, the SLT workforce was reported as 98.5% White European and 1.5% Other (Parity UK, 2013). NHS data shared by the RCSLT, reports only 7% minority ethnic therapists in 2020 (see Table one), which was lower than average level for all AHPs (12%), and the averages in the NHS workforce (20%) and UK population (14%) (NHS England, 2020b; Eddison and Leslie, 2022).

These ethnicity patterns will likely continue as student cohorts lack ethnic diversity. RCSLT data for 2016/17 reported minority ethnic student cohort levels as 13%, which was below the general student population levels of 23% (Royal College of Speech and Language Therapists, 2019b). Male, minority ethnic student levels have been reported at just 2% (Research Works Limited, 2020b). Religion is an indicator of ethnicity (see section 1.2.1). HCPC survey data for 2020 showed that most therapists identified as atheist (44%) and Christian (41%), but relatively

few were of other major faiths such as Muslim, Jewish (each 2%), Hindu, and Buddhist (each 1%) (Health and Care Professions Council, 2021a).



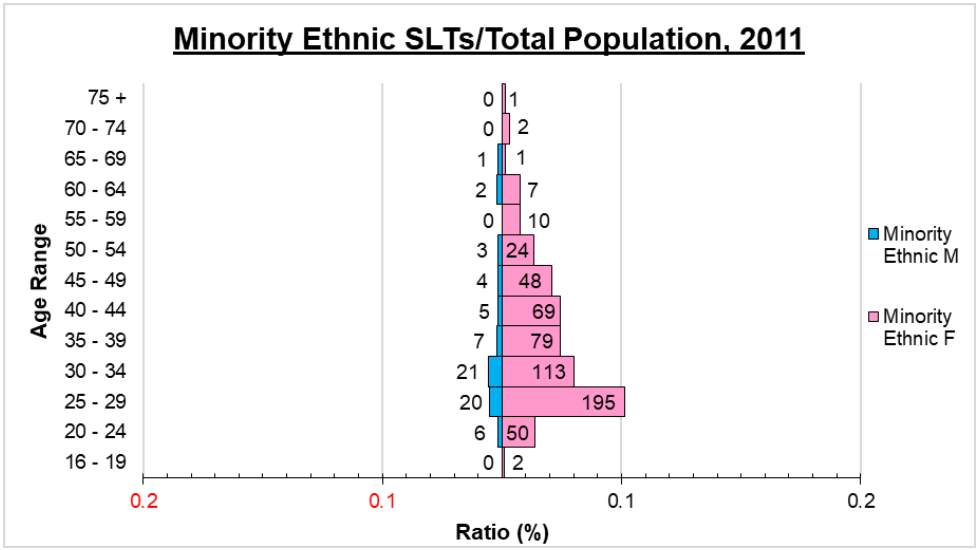


Figure 1. Breakdown of White and minority ethnic Speech and Language Therapists (SLTs) by gender across age ranges compared to in England and Wales White and minority ethnic populations respectively in 2011. For example, in the 25-29 age range, there were 1,624 (or 0.12%) White female therapists out of all White females in the population (N=1,538,064) in England and Wales. *Note: M=male (blue bars), F= female (pink bars), values=numbers of therapists. Adjusted from data commissioned from 2011 Census for England and Wales* (Office for National Statistics, 2011).

SLT's workforce diversity is arguably understudied despite it being very unequal for gender and ethnicity. I searched for relevant academic literature on the Web of Science, OpenGrey, Google Scholar, and websites of professional associations, but found relevant literature to be lacking. The content of this literature and its research gaps are described in section 4.1 which focuses on the lived experiences of healthcare professionals. However, overall, some literature was outdated (e.g., ranged from 1990-21), with the more recent usually grey literature than journal articles. Also, there were some notable research gaps; a lack of focus on ethnicity, workplace experiences as professionals, and sector-specific experiences.

Finally, SLT was selected based on access to, and co-operation from, therapists and relevant stakeholders within the profession during the Covid-19 pandemic. Their willingness to share signalled that our conversations would yield rich and meaningful data.

2.3.2 Overview of Speech and Language Therapy profession in the UK

Speech and language therapy (SLT) is one of 14 AHPs in the UK (NHS England, 2021b). AHPs provide healthcare throughout a person's life-course and are all, except for Osteopaths, regulated by the Health and Care Professions Council (HCPC) (NHS England, 2021a). Regulated professions are a good area of focus within the UK workforce because of their societal power, status, and large representation (see section 2.1). So, the impact of efforts which address profession-level inequality could overflow into society. The HCPC collects diversity data (see section 2.3.1) and has strict rules and codes of practice, mentioned below, which reflects their service's high importance. In 2021, there were 17,240 registered therapists in the UK (Health and Care Professions Council, 2021a). They support, treat, and care for people who have trouble swallowing, eating, drinking, or communicating, but do not help with elocution (Royal College of Speech and Language Therapists, 2020d, 2021c; NHS, 2021).

There are different SLT career routes. Currently, the main route involves either completing an undergraduate or postgraduate HCPC-accredited degree, currently offered in 18 UK universities (Royal College of Speech and Language Therapists, 2019a, 2021b, 2021c; NHS Health Education England, 2020a). Both degree levels require A-Levels or a former relevant degree at a 2:1 grade respectively, in subjects decided by universities which typically includes psychology, biology, sciences, and languages. University routes offer some funding. AHP students in England were eligible from September 2020 onwards for a non-repayable and non-

means tested government grant of at least £5,000 via the NHS Learning Support Fund, in addition to existing student support (NHS, 2021; Royal College of Speech and Language Therapists, 2021a). An apprenticeship degree route is currently being developed which does not offer student grants because the employer and government will cover salary and tuition fees respectively (NHS, 2021). According to a HCPC registrant survey conducted from December 2020 to March 2021, most SLTs received state (83%) rather than private (16%) education (Health and Care Professions Council, 2021a).

All graduates must then register with the HCPC to use the protected title of, and practise as a, Speech and Language Therapist (Royal College of Speech and Language Therapists, 2021d). Regulatory bodies, like the HCPC, are statutory but independent from the government, which means they are funded from registrant fees than the public (Pickett, 2017; Health and Care Professions Council, 2023). The HCPC offers three registration routes: UK (N=16,100), international (N=1,057), and "grandparenting" (N=82) (Health and Care Professions Council, 2020b). The latter allows individuals without approved qualifications to register if they can demonstrate their training and experience to meet certain criteria (Health Professions Council, 2007). Graduates must keep a record of their continued professional development (NHS, 2021). They may choose to become members of professional associations and societies; the main ones are the *Royal College of Speech and Language Therapists* (RCSLT) which has more than 19,000 members (Royal College of Speech and Language Therapists, 2021), and the *Association of Speech and Language Therapists in Independent Practice* (ASLTIP) which has just over 1000 members (Association of Speech and Language Therapists in Independent Practice (ASLTIP), 2015). Some membership benefits include professional insurance (professional indemnity and legal), access to resources (e.g., magazine/newsletters, membership-only areas of their websites, grants, training/networking, etc.), and business support (e.g., advertising/marketing advice) (Association of Speech and Language Therapists in Independent Practice (ASLTIP), 2023; Royal College of Speech and Language Therapists, 2023c).

Therapists' numbers vary by region and sector. Most therapists are employed within social work (N=11,844), health (N=4,368), and education (N=2,483) sectors (Career Smart, 2020). A 2021 survey of 51,170 HCPC registrants across 15 healthcare professions showed that therapists were spread across many settings; community service (28%), the NHS (27%), schools (25%), private sector (7%), other (7%), higher education/research (3%), and adult

social care (1%) (Health and Care Professions Council, 2021a). Similar settings were also reported in the 2014 RCSLT membership census of 2,173 members across England, but some proportions were very different (Centre For Workforce Intelligence, 2014). Notably, most therapists worked in the NHS (66%) and independent practice (10%), but relatively few in all other areas: higher education (5%), local authority (4%), non-profit organisation, social enterprise/public sector mutual, schools, voluntary sector (each 3%), occasional private work, private healthcare (both 1%), and social care and justice (both 0.4%). Therapists spent most of their time working with children (61% of contracted hours), especially primary-school children (12,609 hours/week), but those who worked with adults mostly did so with the 19-64 age group (7,281 hours/week) (Centre For Workforce Intelligence, 2014). In 2020, most UK-based therapists worked in England (84%), then Scotland (7%), Wales and Northern Ireland (both 4%), and finally the crown dependencies (2%) (Health and Care Professions Council, 2020b, 2021a). In England, therapists were mostly based in London (N=3,753) and South-East England (N=2,625) in 2019 (Career Smart, 2020).

Therapist's working hours and salary also vary. In 2020, 53% worked full time, 42% part-time, 3% on a flexible/zero hour basis, and 2% did not work (Health and Care Professions Council, 2021a). The average weekly hours were highest in the East Midlands of England (40 hours) and lowest in Yorkshire and Humberside (31 hours) (Career Smart, 2020). Those within the NHS typically start on Band 5 of the NHS Agenda for Change system at ~£25k-£31k (NHS employers, 2020; NHS, 2021). In 2019, the average annual salary was £31,807, but was highest in the East of England (£41,714) and lowest in Southwest England (£24,507) (Career Smart, 2020).

2.3.3 The history of Speech and Language Therapy

The UK's SLT history can be traced back to the publication of *"The Disorders of Speech"* by John Wyllie in 1894, which amplified the profession's profile (Royal College of Speech and Language Therapists, no date; Wyllie, 1894). Therapists came from two main groups around the start of the 20th Century: elocutionists focused on speech correction, and medical practitioners focused on speech disorders (Royal College of Speech and Language Therapists, no date). Most elocutionists had theatre teaching backgrounds, and some formal training from the Central School of Speech Training and Dramatic Art (Central School) which formed a Department for Speech Therapy in 1925 (Royal College of Speech and Language Therapists,

no date). SLT hospital-based schools were established in London in 1926 and 1932, and SLT education started in 1928 in Glasgow but was formalised in 1935 in the Glasgow School of Speech Therapy (Royal College of Speech and Language Therapists, no date).

Two professional associations were formed in the 1930s to represent these two therapist groups. These were the *Association of Teachers of Speech and Drama* (later the Association of Speech Therapists) formed in 1934, and the *British Society of Speech Therapists* formed in 1935 (Royal College of Speech and Language Therapists, 2005). In 1945, both associations merged to form the *London-based College of Speech Therapists* (CST), a professional organisation and examining body offering qualifications across different UK educational institutions (Royal College of Speech and Language Therapists, 2005, no date). The CST was renamed as the *College of Speech and Language Therapists* (CSLT) in 1991 and subsequently the RCSLT in 1995 (Royal College of Speech and Language Therapists, 2005). Kamini Gadhok has been the acting Chief Executive Officer of the RCSLT since 2000.

The *Council for Professions Supplementary to Medicine* regulated the profession from 2001, but was replaced in 2002 by the *Health Professions Council* (now called HCPC) (Royal College of Speech and Language Therapists, 2005).

2.4 Chapter summary

This chapter outlines and justifies my research focus on the gender and ethnicity workforce diversity of the Speech and Language Therapy profession in the UK. I made a case for each element of this research focus. I chose the UK workforce because it can create and maintain gender and ethnic inequality, and so there is evidence of this inequality within it. For example, I cited research showing that minority ethnic workers face greater disadvantage than White workers in the UK regarding economic inactivity, unemployment, representation in certain occupations, and pay. I argue that one way to address workforce inequality is to target the UK health sector, because it has occupational segregation, but a good capacity to address this given its large size and expenditure, and includes the NHS whose workforce size (e.g., largest UK employer) and characteristics (e.g., largest employer of minority ethnic staff, with a

predominantly female workforce) implies potential to meaningfully reduce workforce inequality. Finally, I provided an overview of Speech and Language Therapy, and justified it as my regulated healthcare profession of focus. Regulated professions have societal power stemming from their workforce's characteristics. SLT's workforce historically and currently lacks gender and ethnic diversity, which I argue is understudied, but I could practically study based on access to, and co-operation from, therapists during the UK's Covid-19 pandemic response. Chapter three reviews diversity management literature to provide insight and context for studying diversity approaches, stakeholders, and practices within the SLT context. Chapter four discusses the lived experiences of gender and ethnicity in health sector workplaces, in which current literature on SLT workforce diversity is discussed, and its research gaps are identified.

CHAPTER 3: DIVERSITY MANAGEMENT LITERATURE

This chapter reviews diversity management literature to explore diversity approaches, stakeholders, and practices in the UK. These research themes represent two parts of my tripartite focus for addressing my research question (see section 5.2.1). So, this chapter provides useful context and insight into potential diversity approaches, stakeholders, and practices within the SLT context, and how they may be shaping the profession's current gender and ethnic workforce diversity. I begin by describing the evolving approaches to managing workforce diversity in the UK, by considering their legislative context and underlying theoretical debates. Then, I discuss how key intra- and extra-organisational stakeholders shape and drive organisational diversity agendas, by considering how they act as agents of change, their diversity motivations, and power. Finally, I explore common diversity practices and policies for addressing workforce diversity, and their criticisms.

3.1 Evolving approaches to diversity in the UK: From equal opportunities to diversity management and inclusion

This section discusses the evolving legal and theoretical approaches to addressing gender and ethnic inequality in the UK. This is because the approaches chosen by SLT employers will affect how inequality is addressed across the profession.

A "fashion lens" can be applied to the popularity of different anti-discrimination approaches over time, whereby the chronological order of their popularity closely echoes scholarly work on management trends and patterns (Oswick and Noon, 2014, page 31). Such approaches have shifted from a focus on equality to diversity, and more recently to inclusion (Oswick and Noon, 2014). Equal opportunities and diversity management are presented as different and transient policy paradigms, with the latter being the current dominant fad. The language of diversity is "almost like a contemporary mantra" popular within academia, policy, and the media (Vacchelli and Mesarič, 2020, page 1). To understand diversity management's current popularity, it is important to consider key debates in its body of management and organisational

studies literature about how to address inequality. These debates include *individualism vs collectivism*, *sameness vs difference*, *voluntarism vs regulation* and the *business vs moral case* (Liff and Wajcman, 1996; Noon, 2007; Ozbilgin and Tatli, 2011; Tatli, 2011; Oswick and Noon, 2014).

3.1.1 The legislative context for diversity approaches

National and legal contexts are important in shaping diversity approaches. For example, European countries use anti-discrimination laws at national and European levels to both understand and define diversity, and as a reference framework for diversity policies in public organisations (Dobusch, 2017). In the UK, legal compliance heavily influences policies aligning towards an equal opportunities approach (Tatli *et al.*, 2008). The UK has a strong history of regulating diversity to protect individuals from discrimination on grounds of gender and ethnicity, which were shaped by its unique history (Tatli *et al.*, 2012). This is clear when exploring the background and development of the UK's most recent anti-discrimination legislation called the Equality Act 2010. The journey to this Act is described below.

The Race Relations Act 1965 was the first legislation to address ethnic/racial discrimination in the UK, supported by a Race Relations Board which addressed complaints under the Act (Equality and Human Rights Commission, 2018a). The Act just covered public domains, but offered a foundation for better future laws. It was replaced by the Race Relations Act 1976 which tried to prevent racial discrimination by outlawing it across society: covered education, training, employment, the provision of goods/services/facilities, and housing (Equality and Human Rights Commission, 2018a). In between both Acts, the UK signed up to the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) in 1969. CERD defined racial discrimination, and offered a framework to ensure rights across society irrespective of one's ethnicity (Equality and Human Rights Commission, 2018a). In 2001, the Race Equality Duty came into force after the Macpherson report recommended reforms on how public sector organisations should tackle racism and discrimination (Tatli *et al.*, 2012; Equality and Human Rights Commission, 2020a). This Duty was the first time that public bodies were required to go beyond preventing discrimination to positively promoting equality (Equality and Human Rights Commission, 2020a). So, there was a responsibility shift from individuals to organisations. Before the Duty, equality legislation focused more on

remedying harassment/discrimination after its occurrence (i.e. reactive) than preventing it (i.e. preventative) (Equality and Human Rights Commission, 2020a).

Gender-related equality regulation can be traced back to a group of female Sewing Machinists at the Ford car manufacturer in Dagenham, Essex who took industrial action in 1968. These women campaigned for recognition of their work as skilled, and against a pay system favouring male workers in similar roles (Trades Union Congress, 2020). This led to the Equal Pay Act in 1970. Shortly afterwards, the Sex Discrimination Act 1975 made gender-based discrimination illegal (Equality and Human Rights Commission, 2018a). The Act influenced the creation of the now dissolved Equal Opportunities Commission, which advised on best practice for promoting equality and removing gender-based discrimination (Kirton and Greene, 2005b). Women's rights were further protected following the UK's formal agreement to the Convention on the Elimination on All Forms of Discrimination Against Women (also called the International Bill of Rights for Women) in 1986 (Equality and Human Rights Commission, 2018a; Women's Resource Centre, 2020). Gender equality duties were introduced later in 2007 (Equality and Human Rights Commission, 2020a).

The Equality Act 2010 combines 116 different pieces of legislation, including those outlined above, and contains the Public Sector Equality Duty which was introduced in 2011 (also called PSED or "equality duty") (Equality and Human Rights Commission, 2019b). The Equality Act extends protections against discrimination and harassment to nine grounds in total: sex, ethnicity, sexuality, age, gender reassignment, pregnancy/maternity, marriage/civil partnership, disability and religion/beliefs (UK Government, 2010). The PSED requires public organisations to consider how their daily business actions can promote equality and good relations, and show compliance (Equality and Human Rights Commission, 2020a, 2020c). All organisations must legally adhere to the Equality Act 2010.

There is widespread support for anti-discrimination legislation for protected characteristics. Such support is demonstrated in a survey exploring the awareness and impact of the Equality Act 2010 amongst 1,811 British organisations from 2011-12 (Perren *et al.*, 2012). Survey respondents were presented with various possible scenarios related to the Act's provisions, and rated their organisation's support for equalities legislation. Respondents strongly supported legislation prohibiting different practices within the scenarios, especially those involving discrimination based on sexual orientation and faith (90% employers agreed), followed by

gender (77%). Organisations of all sizes and sectors were firmly against gender-based discrimination in recruitment (size- large: 93%, medium: 82%, and small: 73%; sector - public: 90%, third sector: 87%, and private: 74%). Also, the UK had three equality organisations until 2007 (Commission for Racial Equality, Disability Rights Commission, and Equal Opportunities Commission), which then merged into the Equality and Human Rights Commission (Equality and Human Rights Commission, 2020b).

3.1.2 From equal opportunities to diversity management approaches

Traditional equal opportunity approaches in the UK are shaped by legislative compliance, and social justice motivations (Kirton and Greene, 2005b). The Sex Discrimination Act 1975 and the Race Relations Act 1976 called attention to unemployment inequalities and put equality issues on employer's agendas (Liff, 1995). Equal opportunity approaches recognise and try to tackle social group-based disadvantage and discrimination in employment (Kirton and Greene, 2005b). Employment inequality is presented as unfair, and employers socially obligated to develop measures addressing it because it works towards a key social goal of achieving socially balanced communities, thus emphasising moral/ethical concerns for social justice (Kirton and Greene, 2005b). Therefore, whether an organisation financially benefits from such an approach is not a priority. Scholars differentiate between liberal and radical equal opportunity approaches (Kirton, Greene and Dean, 2007). Liberal approaches focus on justice in terms of fair procedures, treating people the same, providing equality of opportunity, bureaucratisation (i.e., formal processes), and positive action measures such as training for women to ensure equal access to work. In contrast, the focus of radical approaches extends beyond equality of opportunity to also include equality of outcome for all social groups in workforces (e.g., fair reward distributions). Radicals advocate for the politicisation of decision-making processes, via direct interventions such as positive discrimination/ radical positive action (e.g., imposing quotas).

It is assumed that limited access and discriminatory practices are present where workforces lack equality and diversity (Kelly and Dobbin, 1998; Kirton and Greene, 2005b). Under the liberal approach, the perceived solution involves a commitment to non-discriminatory employment practices offering equal access, entitlement, and treatment to all employees of the same ability and performance, irrespective of their social-group membership (Liff and Wajcman, 1996; Kelly and Dobbin, 1998; Kirton and Greene, 2005b; Equal Opportunities

Commission, 2019). This commitment is translated into practice by implementing formal, standardised rules and processes across recruitment, selection, and appraisal, uniformly to all workers (Jewson and Mason, 1986a; Kelly and Dobbin, 1998; Kirton and Greene, 2005b). Practices include policies, statements, grievance and internal dispute processes (Kelly and Dobbin, 1998). Some employer's policies simply state an intention to become an equal opportunity employer, whilst others have clearer aims and goals (Liff, 1995; Kirton and Greene, 2005b). Policies emphasised being a "good employer" and "good practice" (Dickens, 1999, page 11 and 12), which strongly shaped and became associated with the public sector.

Despite some progress from equal opportunity policies, they did not fully deliver equal outcomes because gender- and ethnicity-based inequality still persists (examples in chapters two and four) (Foster and Newell, 2002; Kirton and Greene, 2005b; Oswick and Noon, 2014). Some parts of working life are hard to bureaucratise, such as informal norms and codes (Jewson and Mason, 1986b). Also, some scholars claim that these formal policies unreliably reflect how organisations actually see and address equality issues (Kirton and Greene, 2005b). These policies are theoretically well-intentioned efforts to address equality issues, but their goals are often ignored across organisations (Kirton and Greene, 2005b). This is demonstrated in equality-implementation (Noon and Ogbonna, 2021) and intention/policy-implementation gaps (Beishon, Virdee and Hagell, 1995; Culley, 2001), representing mismatches between intentions and what is achieved or actually practiced in workplaces for equality, diversity, and inclusion (EDI) and policies respectively (see sections 3.3.5 and 4.2.4.2). Some scholars go further by claiming that many people think certain equal opportunities initiatives do not promote equality because they help, and so unfairly advantage, certain groups. For example, they cite initiatives where rules are tailored for women (e.g., single-gender training schemes), or entrance standards are lowered (e.g., removal of certain qualifications criteria) (Salaman, 1986; Cockburn, 1991; Liff and Wajcman, 1996).

Some scholars argued there was an "equality fatigue" with organisations turning away from equal opportunity initiatives for many reasons (Nkomo and Hoobler, 2014, page 251). They argued that organisations did not take equal opportunities seriously, with organisational leaders believing that they alienated dominant groups, and diversity practitioners deeming them outdated and disillusioned by their inability to enact real social change as inequalities persisted (Foster and Newell, 2002; Ahmed, 2007a; Nkomo and Hoobler, 2014). Some scholars

criticised the negative connotations of equal opportunity approaches, such as associations with inequality and discrimination, as unappealing (Nkomo and Hoobler, 2014). For example, any social group differences are assumed as potential sources of discrimination (Kirton and Greene, 2005b; Oswick and Noon, 2014), which is prevented and addressed punitively (e.g., large fines for breaching anti-discrimination legislation) (Maxwell, Blair and Mcdougall, 2001; Kirton and Greene, 2005b). Also, other approaches to tackling workforce inequality became popular, described below.

The late 1980's and 1990s saw a shift from equal opportunity to diversity management approaches. Equal opportunity policies became increasingly influenced by a business case for diversity (described later) and many organisations began discussing diversity over equality (Kirton and Greene, 2005b; Nkomo and Hoobler, 2014). Social justice arguments for equality were traditionally unpopular in the private-sector given their focus on profit, and public-sector funding constraints resulted in it imitating private-sector management practices (Kirton and Greene, 2005b). Literature advocating diversity management benefits emerged, originating from the "*Workforce 2000"* report in 1980's USA (Johnston and Packer, 1987). This was partly driven by equal opportunity's inadequacy in tackling discrimination, anticipated demographic changes towards multiculturalism in society and the workforce, globalisation, and skills shortages (Johnston and Packer, 1987; Foster and Newell, 2002; Kirton and Greene, 2005b; Tatli *et al.*, 2012). Diversity management was presented as a conceptually different and progressive alternative to equal opportunities, which became increasingly favoured (but also had a lot of critiques) in some public, academic, and political domains (Dick and Cassell, 2002; Oswick and Noon, 2014).

Diversity management is the current dominant approach to addressing inequality in the UK (Tatli, 2011; Tatli *et al.*, 2012; Oswick and Noon, 2014). For example, top UK companies strongly frame diversity, often explicitly linked to gender and ethnicity, as a competitive edge (Jonsen *et al.*, 2021). Kandola and Fullerton (1998) were amongst the first scholars to discuss the approach in the UK. It was framed as way to address the implications of the country's growing multiculturalism (Tatli *et al.*, 2012). The UK has reached *superdiversity*, which means greater and more complex population diversity (levels and types) than has ever existed before (Vertovec, 2007). Organisations were seen as wasting a talent pool they needed to stay competitive. Rhetoric of demanding and justifying the importance of dramatically changing management styles was echoed by management literature (Edelman, Fuller and Mara-Drita,

2001). Diversity management research typically focused on two areas: critical diversity studies documented workplace discrimination and, mainstream studies wanted to prove that diversity benefitted business (Tatli, 2011; Nkomo and Hoobler, 2014).

The diversity management approach assumes that valuing diversity benefits organisations, and so concentrates on how workforce diversity can realise organisational goals (Kirton and Greene, 2005b). These approaches have an implicit principle of respecting difference, and emphasise a business case for diversity with four benefits typically highlighted (Cox and Blake, 1991; Kelly and Dobbin, 1998; Jayne and Dipboye, 2004; Kirton and Greene, 2005b). First, *the best talent is obtained*: organisations can supposedly maximise their workforce's potential by utilising their diverse skills and experiences. This is expected to safeguard employees from low morale and performance linked to discrimination, which improves organisational performance. Second, *diverse customer and labour market concerns are addressed*: organisations can supposedly ease the recruitment issues associated with changing labour and consumer market demographics by capitalising on market diversity. For example, attracting workers from growing and wealthy ethnically diverse communities. Third, *globalisation challenges are addressed:* a need to recruit and retain workers across borders and cultures, especially global organisations, to prosper is seemingly addressed. Finally, it *improves organisation's competitive edge by possessing a better and happier workforce*: the cultural capital from diverse workforces is assumed to boost organisational creativity and business opportunities (e.g., accessing new customer markets). Essentially, diversity management offers organisations a competitive edge by proactively using the different perceptions, skills, and qualities of a diverse workforce.

Diversity management in American corporate companies was practiced in broadly four different ways (Kelly and Dobbin, 1998; Nkomo and Hoobler, 2014). First, there were efforts to recruit workers from minority backgrounds. Second, there was outreach work involving minority backgrounds, such as sponsoring their scholarships/events. Some efforts focused on developing individuals, such as diversity training to foster appreciation of differences. Finally, there were organisational development efforts, such as diversity-related policies, statements, Boards, and action plans.

Whilst mainstream scholars embraced the shift towards diversity management as a positive next step, critical scholars were cautious of possibly going backwards from aims of achieving

workplace fairness and so addressing structural inequalities (Tatli, 2011). The following sections will introduce how diversity management is characterised by the concepts of individualism, voluntarism, and business case for diversity. It appears that UK organisation's increased tendencies to favour these concepts, may be why gender and ethnic inequalities persist. The key debates and criticisms surrounding *individualism versus collectivism, voluntarism versus regulation,* and *business versus moral case for diversity* are discussed below.

3.1.2.1 From collectivist to individualist approaches

The equal opportunities approach is associated with collectivism and regulation, whilst diversity management is characterised as individualistic and voluntarist (Foster and Newell, 2002; Tatli, 2011). The UK's political economy has moved towards deregulation and liberalisation (Lorbiecki and Jack, 2000). Ideas about a free market and individualism influenced social regulation, and in turn what diversity means (e.g., diversity is tailored to policy concerns and excludes taboo areas such as coercive regulation) within the country (Tatli *et al.*, 2012). Individualistic diversity management approaches have also increased in the UK private sector (Ozbilgin and Tatli, 2011). These patterns are perhaps because collectivist diversity approaches are seen as limited, but individualist approaches can also maintain workforce inequality. Both are discussed are below.

Individualism and collectivism represent different diversity approaches. Collectivism treats differences between people on a group-based level. Equal opportunities is a collectivist approach because it offers equal treatment based on social groupings outlined in equalities legislation (Foster and Newell, 2002). Collectivism tries to unify people with shared interests (Triandis and Gelfand, 1998). So, there exist representative bodies (e.g., trades unions) which express the common interests of groups (Purcell, 1987). Organisations are seen as part of society where they must balance their own and society's interests (Jonsen *et al.*, 2013). In contrast, individualism treats difference on an individual level, where each person's unique mixture of traits, skills, and circumstances is considered (Foster and Newell, 2002). Individuals are treated as independent from collectives, implying that management styles should involve direct employer-employee interactions (Storey and Bacon, 1993). For example, organisations using equal opportunities would address all female staff together and equally (e.g., in training

provisions), but those using diversity management would address each female employee differently based on their individual differences (e.g., personality) (Foster and Newell, 2002).

Collectively treating all employees equally can be problematic. This is best understood in an ongoing feminist debate about *sameness versus difference* (also called *equal versus special treatment*). In this debate, both approaches essentially work towards gender equality by exploring how much women are the same or different to men (Bacchi, 1990; Minow, 1990; Capps, 1996; Vogel, 2016). Feminists who emphasise sameness highlight men and women's similarities, pushing for both to be treated similarly (e.g., saying competence should be prioritised over gender) (Capps, 1996). Conversely, feminists highlighting differences between the two genders, push for differential treatment because they say equal treatment is sometimes inappropriate, for example, advocating for gender-related legislation offering women rights and privileges to level their playing field as organisations are thought to favour men (e.g., maternity rights) (Capps, 1996).

Equal opportunities, and by extension collectivism, broadly aligns with the sameness/equal treatment side of the debate. Social group differences are assumed to mean disadvantage, resolved with equal treatment (Kirton and Greene, 2005b; Oswick and Noon, 2014). Feminist critics offer many reasons why equal treatment is problematic (Liff and Wajcman, 1996). First, policies that promote sameness essentially expect women to either reduce or deny their differences to men, which is unfair nor possible for two important reasons. Judgements of sameness/difference are made against male/masculine norms and standards (Liff and Wajcman, 1996), which in the West is mostly hegemonic masculinity ideals (Berdahl *et al.*, 2018). Also, sameness discounts factors that particularly affect women (e.g., domestic duties) (Liff and Wajcman, 1996).

Also, a sameness approach may lead to essentialism and stereotypes. Equal opportunities is accused of seeing diversity in a homogenised and essentialised way (Dobusch, 2017). Seeing and/or treating all members of a group the same (i.e. within-group homogeneity) and those between groups as different (i.e. between-group heterogeneity) can overlook similarities *across*, and differences *within*, group boundaries (Litvin, 1997). This relates to essentialism, which portrays social groups as sharing some "essential" qualities which explains the similarities between group members (Gelman, 2005). For example, gender essentialism assumes that all women share innate characteristics, as do all men. If a person's qualities are assumed to be learned or understood by simply becoming aware of and valuing the qualities of

their associated demographic group, then their personal thoughts and behaviours may be overlooked by attributing those to their group as well (Litvin, 1997). So, essentialist beliefs can endorse stereotypes (Bastian and Haslam, 2006), which disadvantages women (see argument in previous paragraph).

In contrast, diversity management and by extension individualism, aligns with the difference/special treatment side of the *sameness versus difference* debate. Diversity management frames difference positively (Liff, 1997; Kirton and Greene, 2005b; Johns, Green and Powell, 2012; Oswick and Noon, 2014). It assumes that workforces comprise of people differing both visibly and invisibly, and recognising and harnessing these individual differences will mean productivity, meeting organisational goals, and fully utilising workforce talent (Kandola and Fullerton, 1998). Arguably, focusing on individuals means that diversity management is more comprehensive and inclusive of the types of groups that it covers than typical equal opportunities policies (Kandola and Fullerton, 1998). For example, personal/non-physical traits (e.g., working style) are covered by diversity management but not equal opportunities. Equal opportunities policies fail to consider the realistic possibility that not everybody wants equal treatment, but diversity management does. There is evidence that employees want their unique skills recognised, making them almost four times more likely to work in companies where those skills and interests are understood (Bravery *et al.*, 2019). More specifically, this study of global management trends in 2019 found clear differences in why potential employees join an organisation, across gender (males and females), generation (Generations X, Y, and Baby Boomers) and job level (individuals and managers). For example, women reportedly value health benefits and flexible working hours more than men.

However, individualism has its shortfalls. Some Human Resources (HR) leaders do not know their workforce's unique characteristics (Bravery *et al.*, 2019). Employer acknowledgement of individual differences does not necessarily mean that they will change how they recognise or treat their employees at work (Tatli and Özbilgin, 2012). For example, a large UK retail company which offered employee benefits packages using a diversity management approach (i.e., based on individual choices) produced more choice and so value amongst employees, than when using an equal opportunity approach (i.e., standard and group-based) (Foster and Newell, 2002). However, women and minority ethnic employees continue to be valued less than their White male counterparts. For example, there has been little meaningful progress in reducing the UK gender pay gap (Collinson, 2019) which is especially pronounced for certain minority

ethnic women, namely Pakistani, Bangladeshi, and Black African women (Fawcett Society, 2017). Also, people are comfortable around those like themselves, which may conflict with having a diverse workforce and hinder decision-making (Caudron, 1994; Wentling and Palma-Rivas, 1998). For example, 12 experts who were interviewed about workplace diversity initiatives identified negative attitudes and discomfort around people deemed different as a common barrier for diverse groups advancing within organisations. This was attributed partly to most people both un/consciously choosing to associate with people like themselves (Wentling and Palma-Rivas, 1998).

Also, individualistic approaches may overlook historical and systematic factors that create and maintain inequality (Kersten, 2000; DiTomaso, Post and Parks-Yancy, 2007; Tatli, 2011). For example, diversity training programs typically use terminology like multiculturalism and diversity, but rarely mention sexism, racism, and discrimination (Agócs and Burr, 1996). Challenging inequality may be difficult if it is portrayed as fair in individual terms (McVittie, McKinlay and Widdicombe, 2008). So, diversity may be used as a linguistic tool to legitimise existing practices, which sometimes does not reflect a commitment to organisational change, but rather masks systematic inequality (Kirby and Harter, 2003; McVittie, McKinlay and Widdicombe, 2008). For example, unconscious bias training (UBT) is typically a key part of implementing diversity management, but has mixed effectiveness (Atewologun, Cornish and Tresh, 2018). UBT raises awareness of biases but is deemed one of the least effective diversity initiatives (Kalev, Dobbin and Kelly, 2006), partly because it focuses on individual rather than structural biases. UBT does not help those who need it most, nor addresses organisational culture which may include small acts where discriminatory motivations are ambiguous (e.g., frequently ignoring someone's opinion) (Gaertner and Dovidio, 1986; Noon, 2018). One reason why many diversity efforts focus on individuals instead of organisational processes or structures is because the root of management issues is usually attributed to motivation rather than structural factors (Kalev, Dobbin and Kelly, 2006; Dobusch, 2017). Diversity management ignores power and radical ideas about oppression and inequality that are core equal opportunity components (Cockburn, 1989; Wilson and Iles, 1999). Diversity is argued to be a comfort zone. It protects employers against political correctness claims, whilst simultaneously does not require demonstration of discrimination being challenged, so factors creating inequality are ignored which maintains the status quo (Overell, 1996; Wilson and Iles, 1999).

Another criticism of individualist approaches is about practicality. Focusing on differences can make it hard to compare people on jobs, possibly advantaging some groups over others, but can be addressed through an equal value approach (e.g., equal pay for work of equal value) (Liff and Wajcman, 1996; Kirton and Greene, 2005b). Also, framing diversity individualistically may result in trivial differences being considered (Embrick, 2011). Employers may mix sameness and difference approaches because women can be disadvantaged when they are treated the same (e.g., needing time off work for childcare) or differently (e.g., job rejection despite being well-qualified for it) (Liff and Wajcman, 1996). Also, diversity management requires more unconventional and so tricky practicalities (e.g., greater resource demands, and managing individual differences within large workforces) to address ingrained inequality than equal opportunities (Foster and Newell, 2002). Simply communicating what a diversity management approach means to employees is challenging, especially as the term "diversity" lacks a universal definition (Ragins and Gonzalez, 2003; Tatli *et al.*, 2012). "There is diversity even in the way diversity is defined" (Ragins and Gonzalez, 2003, page 133). The term is somewhat "broad and ill-defined" (Noon, 2007, page 780) and is depicted as an "empty container" (Ahmed, 2012, page 80) where all kinds of differences may be inserted, which possibly overlooks group-based inequalities and/or power differences (Linnehan and Konrad, 1999; Ragins and Gonzalez, 2003).

3.1.2.2 Regulatory and moral versus voluntarist and business arguments

The shift from equal opportunities to diversity management signals a shift from regulatory to voluntarist approaches to equality and diversity issues (Tatli, 2011). Regulation and voluntarism are different political ideas. Regulation posits that organisations should be controlled by government laws or institutional rules, whilst voluntarism disagrees with any coercive or restrictive measures for them (Stigler, 1971; Verba, Brady and Schlozman, 1995; Ozbilgin and Tatli, 2011). Voluntarism assumes that organisations should and will voluntarily and proactively promote diversity because it is good for business (Tatli *et al.*, 2012; Jonsen *et al.*, 2013). This is coupled with expectations of organisations facing less regulatory pressure to fulfil legally-based initiatives (Greene and Kirton, 2009; Lucio and Perrett, 2009). This section will explore the regulation versus voluntarism debate, and the reasons why some scholars suggest a movement towards the latter hinders progress towards workforce diversity (Jonsen *et al.*, 2013).

Within the diversity management paradigm, voluntarism has been popular amongst professional bodies, employers, and private sector organisations in the UK (Ozbilgin and Tatli, 2011). The UK public and policy landscape has endorsed and been shaped by a philosophy of opposing state intervention, opting for self-regulation guided by a free market (Tatli *et al.*, 2012) particularly since the Thatcher government (Bolick, 1995). Deregulation and liberalisation have become increasingly popular (Lorbiecki and Jack, 2000), with both trying to free the market from government interference. Liberalisation involves relaxing government control and is usually associated with deregulation, which is about reducing or removing government regulations or restrictions on businesses (Buren, 2021; Smith, 2021). The UK's alignment towards voluntarism and the business case for diversity is reflected in a study of UK investment banks (Barmes and Ashtiany, 2003). Diversity practices in these banks were mainly driven by economic considerations, with moral motivations often branded unexpected side-benefits. Also, diversity vocabulary was favoured over that of equal opportunities, with the latter avoided given its associations with regulatory practices. It was encouraged in the regulations of the New Labour government at the time (1997-2010) (Healy, Kirton and Noon, 2010), and in successive coalition and Conservative governments (Scott and Williams, 2014; Dorey, 2018).

Exploring the problems with regulatory approaches to diversity can explain the appeal of voluntarism. Legislation heavily shapes equal opportunities (see section 3.1.2), with academic literature presenting it as prioritising legally-protected groups using moral/social justice arguments (Kirton and Greene, 2005b; Tatli, 2011). However, equalities legislation is limited. Equal opportunity approaches shaped by the law are also constrained by it. The law decides whether a social group should be a protected characteristic. Scholars argue that those chosen reflect a narrow vision of which characteristics may lead to discrimination; they are usually assumed as being natural and one-dimensional (e.g., gender *or* race), which highlights between-group differences, and makes differences within disadvantaged groups less visible (Litvin, 1997; Zanoni *et al.*, 2010; Dobusch, 2017).

Also, anti-discrimination legislation prohibited discrimination, but did little to actively promote equality before the PSED (Dickens, 1994; Kirton and Greene, 2005b). The law does not specify how to judge equal treatment. Legally based approaches aim for equal opportunities and fairness for all social groups, not diversity. It is assumed workforce diversity may naturally happen by pursuing equal opportunities, but it also may not, which suggests that it is not a priority (Johns, Green and Powell, 2012). There is no guarantee that society will become fairer

if diversity management is widely adopted (Wrench, 2005). Also, the anti-discrimination parts of the Equality Act (but not PSED) have an individualist focus, which mean that discrimination accusations, proof, and compensation are individually assessed (Culley, 2001). So, employers face low risks, although individual cases brought against employers have increased (Culley, 2001) indicating its inadequacy in encouraging them towards better practice. Arguably the UK legal framework is too cautious; there are few voluntary positive discrimination provisions, and sanctions by statutory equality bodies are not tough enough to motivate reluctant employers (Culley, 2001).

Legislation can promote equality by redressing factors that cause disadvantage through positive action. Yet, forceful state-imposed regulatory approaches, such as quotas and positive discrimination, are key taboo areas within UK legislation and diversity management policies (Tatli *et al.*, 2012). There are four main objections against positive discrimination which scholars have convincingly challenged (Noon, 2010). These include an inability to hire the best candidate, undermining meritocracy, negative impacts on those benefitting from it, and reverse discrimination being unjust. Counterarguments include using tie-break systems to choose suitably qualified candidates whilst also helping disadvantaged groups, meritocracy is flawed, preferential treatment accusations can happen without positive discrimination being present, and differential treatment is not morally wrong unless used for exploitation. Unfortunately, uptake of legal, voluntary provisions of positive action is low. Some employers improperly use or are cautious of these provisions, due to potential accusations of reverse racism from those disadvantaged, and discrimination of those advantaged, by the preferential treatment (Davies and Robison, 2016).

Voluntarism offers an alternative approach to diversity, given the limits of regulatory-based approaches. Importantly, voluntarism does not mean a complete absence of state intervention despite its association with labour market deregulation. State intervention allows both regulation and deregulation of the UK labour market and employment relations (Ozbilgin and Tatli, 2011). Legal compliance continues to be the most important motivation for organisational diversity management policies (Tatli *et al.*, 2008).

The assumption that companies will fulfil societal needs and act fairly through voluntarism is flawed (Latané, 1981; Hardin, 1982; Jonsen *et al.*, 2013). Organisational interests sometimes do not match societal needs, which will affect whether and how much an organisation is willing to pursue diversity (Jonsen *et al.,* 2013). Stressing a business case for diversity was thought

one way of motivating organisations to consider diversity management (Dobbs, 1996; Cox, 2018). Diversity became increasingly about business performance/economic arguments and voluntary action, especially in the private sector (Tatli *et al.*, 2012) which was thought to have low uptake of the moral case for diversity (Kirton and Greene, 2005b). So, economic rationality is central to business cases for equality and diversity initiatives (Kirton and Greene, 2005b). Diversity management is thus framed as a strategic organisational issue with pressures to implement it originating from within, whilst equal opportunities has external pressure stemming from compliance to moral and legislative obligations (Thomas, 1991; Foster and Newell, 2002).

However, there are many criticisms of voluntarist/business case diversity management approaches (Wrench, 2005; Noon, 2007, 2010; Ozbilgin and Tatli, 2011; Johns, Green and Powell, 2012). The business case alone is not enough to justify diversity pursuits (Esmail, Kalra and Abel, 2005) and doing so only weakens the case for it (Richards, 1980). First, the moral/ethical case for diversity is ignored, which justifies behaving according to self-interests (Wrench, 2005; Tatli, 2011). Critics claim that ignoring or denying fair opportunities for under-represented groups, and valuing people only by how much they help to achieve a desired outcome is problematic.

Second, some organisations may not pursue diversity if they do not see a business case for it, especially without some coercion such as positive discrimination (Noon, 2007). So moral /social justice motivations are needed for intrinsic motivation, perhaps by framing ethics as benefitting corporate reputation (Kirton and Greene, 2005b). If a business case can be made, it is influenced by two factors (Noon, 2007; Ozbilgin and Tatli, 2011). The first factor is the labour market context, which reinforces a misleading view of a predictable world which may mean that diversity management is rejected during economic hardship (Noon, 2007; Ozbilgin and Tatli, 2011). If organisational diversity benefits are thought too narrow or short-term, diversity policies may lack comprehensiveness by focusing on immediate or obvious business issues (Kirton and Greene, 2005b). For example, organisations adopt flexible working policies to attract older or female workers when young workers are in short supply, but abandon them when the issue is resolved (Kirton and Greene, 2005b). The second factor is organisational competitive strategies, whereby companies may be selective and use mixed methods for addressing diversity issues (Noon, 2007; Ozbilgin and Tatli, 2011). Providing that organisations demonstrate legislative compliance, they may value some forms of diversity over others, or be successful without valuing diversity at all (Kirton and Greene, 2005b). Framing

diversity as an organisational asset might make managers see and treat employees as bottom-line costs or objects to gain a competitive edge globally, without considering their unique needs (Kirby and Harter, 2003). The result is a more fragmented than uniform impact of equality, for example, the business case has not benefitted all women but just those in senior organisational positions, it is argued (Richards, 2001).

Third, diversity benefits are not straightforward. Managers may be good at identifying diversity-related business opportunities and benefits, but choose not to pursue them because they are not as valuable as initially thought (Noon, 2007). Employers are driven by short-term goals whilst the maximum benefits of diversity may appear in the long-term, and some benefits are hard to measure (Noon, 2007). Diversity management may even be rejected for business reasons (e.g., resource demands for managing differences), making organisations opt for equal opportunities instead despite perceptions of less effectiveness in achieving equality (Foster and Newell, 2002).

Finally, most concerning is the little or mixed evidence supporting the business case for diversity. Few studies have systematically measured, monitored, or documented the impact of specific diversity measures (e.g., diversity training) on historically disadvantaged groups (Robinson and Dechant, 1997; Foster and Newell, 2002; Dobusch, 2017). Some research has shown that diversity is good for business in terms of financial/company performance (Dezső and Ross, 2013; Hunt, Layton and Prince, 2015; McGregor-Smith, 2017) and employee retention versus the cost of hiring and training a new employee (Nguyen *et al.*, 2019). Some studies were unable to find an association between diversity and measurable results (Dreachslin, Weech-Maldonado and Dansky, 2004; Esmail, Kalra and Abel, 2005; Wrench, 2005) whilst others reported negative effects (Greenhaus *et al.*, 1990; Sackett, Dubois and Noe, 1991; Kizilos, Pelled and Cummings, 1996; Pelled, Eisenhardt and Xin, 1999; Pitts and Jarry, 2009). Also, there is insufficient empirical research on the link between diversity across individual, group, and organisational level work outcomes (Wise and Tschirhart, 2000).

3.1.2.3 Positions on diversity dimensions are mixed

Diversity represents a broad and jumbled collection of ideas (Lewis, 2000; Jones, 2004). The dimensions discussed (e.g., collectivism vs individualism) are not binary, but quite muddled. For example, a study of diversity discourses in the UK, France, and Germany found that the meaning of, and arguments for, diversity shift across dimensions (e.g., from moral to business case) depending on contextual factors (Tatli *et al.*, 2012). These factors include time and

country, due to national history and regulations at the time (Tatli *et al.*, 2012). People use a mixture of discourses to support diversity practices. For example, both utility (mainly the business case) and justice arguments are used to support applying quotas to get women into Board positions (Seierstad, 2016). Since the UK is currently driven by voluntarism/business case for diversity, these arguments may be more acceptable to those in power. So, some stakeholders may not publicly speak the language of equality or emphasise a moral case for diversity, but may hold these beliefs privately.

Whilst equal opportunities and diversity management may be conceptually different, it is unclear if they also differ in practice. Some critics argue that both approaches have the same management practices, despite the language having changed (Kelly and Dobbin, 1998). The differences between the two approaches become blurred in practice (Foster and Newell, 2002). Some claim that diversity management should be seen as building on equal opportunities rather than as an alternative (McDougall, 1996). Others state that a partial change has occurred. For instance, Tatli (2011) suggests that UK private sector organisations use traditional equal opportunities methods under the label of diversity management. So, she advocates for a shift in language to be accompanied with a shift in people's attitudes, norms, and values towards diversity. This message is echoed in a study of a transnational manufacturing firm (Webb, 1997). The firms' policies portrayed equal treatment, such as recruitment and training access for everyone, but did not address the organisational structure or culture despite claiming a diversity policy. This, the authors argued, allowed managers to translate women's lack of engagement and continued occupational segregation as women's choices without acknowledging the role of organisational culture (Webb, 1997). So Tatli (2011) questions whether private sector organisations are really convinced about the business case for diversity as they are yet to fully shift away from equal opportunities. She argues that organisations may simply use the business case for diversity to support deregulation and voluntarism.

So, it is important to acknowledge both official and unofficial diversity positions and practices, as potential mismatches here may explain why inequality persists.

3.1.3 From diversity management to inclusion

More recent management literature emphasises the importance of inclusion in diversity efforts (Miller, 1998; Mor Barak, 2015). Diversity is about the composition of a group, whilst

inclusion is about group members being able to fully participate in and contribute to the group (Miller, 1998). Feelings of belonging and uniqueness in groups are framed as essential (Shore *et al.*, 2011). So, inclusion is related to how much a group is willing to include individuals (Ellemers and Jetten, 2013). Some research suggests a lack of inclusion of certain demographic groups, for example, women and minority ethnic individuals have fewer opportunities to belong to valued groups (Rosette, Leonardelli and Phillips, 2008).

There are different ways of conceptualising inclusion. Inclusion is presented as an organisational benefit within the "inclusive organisation" discourse, where focus is on identifying and measuring organisational inclusion (Dobusch, 2014). So, inclusion is seen as both a normative and strategic concept (Ozbilgin, 2009). First, inclusion is a normative goal by representing an ideal working condition for a diverse workforce (Ozbilgin, 2009; Dobusch, 2014). Here, diversity is connected to inclusion by determining the success of the latter (Pless and Maak, 2004). Diversity management by itself is presented as inadequate in improving workplace performance, with organisational inclusion of employees necessary (Sabharwal, 2014). For example, how much an individual feels accepted by their organisation is assumed to be directly linked with employee absenteeism and turnover (Mor Barak, 1999).

Second, inclusion is considered an analytical tool for measuring organisational inclusion levels and practices (Ozbilgin, 2009; Dobusch, 2014). Different inclusions measures have been proposed, from an inclusion-exclusion continuum (Mor-Barak and Cherin, 1998) to employee self-evaluations on various inclusion indicators (Janssens and Zanoni, 2008). Growing research presents leadership as key to operationalising inclusion. A study of public managers in Texas agencies found an overreliance on policies and structural changes were insufficient in creating a productive workforce, without leaders who promoted inclusion and empowered individuals (Sabharwal, 2014). Leadership must visibly commit to inclusion (Bourke and Titus, 2020). The words and actions of leaders can make up to a 70% difference in whether a person feels included (Bourke and Titus, 2020). Also, inclusive leaders offer business benefits such as helping organisations adapt to reach diverse talent, customers, and markets (Bourke and Titus, 2020). Inclusive leadership has been positively linked to employee work engagement (Choi, Tran and Park, 2015), and creativity (Carmeli, Reiter-Palmon and Ziv, 2010). Also, the quality of leadership support to employees affects performance, with greater output when leaders work well with diverse employees (Stewart, 2009).

Research has explored what inclusive leadership looks like, namely how it fosters feelings of employee belonging and uniqueness. Leadership may foster belongingness by supporting individuals, ensuring fairness/justice, and offering shared decision-making opportunities (Randel *et al.*, 2018). Uniqueness in this context means maintaining a sense of individuality, and is thought valued when leaders encourage and support group members to contribute using their different perspectives and talents (Randel *et al.*, 2018). Leaders may need certain personal qualities to behave inclusively, which includes pro-diversity beliefs and humility (Homan *et al.*, 2007; Randel *et al.*, 2018) with the latter associated with increased self-awareness and empathy (Nielsen, Marrone and Slay, 2010; Davis *et al.*, 2011; Ou *et al.*, 2014; Bourke and Titus, 2020).

3.2 Diversity stakeholders

The UK has multiple equality and diversity stakeholders who address diversity issues at work (Tatli *et al.*, 2012). Stakeholders are individuals or groups who have strong personal or financial interests in an organisation (Kirton and Greene, 2005b). They can be intra- (e.g., diversity officers) or extra-organisational (e.g., trades unions). Many diversity studies focus on single stakeholders, and who they are depends on the organisation and context studied. For example, some studies explored UK police officers (Dick and Cassell, 2002), employers such as corporate companies and hospitals (Zanoni and Janssens, 2007), and trades unions (Kirton and Greene, 2002, 2006). This section explores key intra- and extra-organisational stakeholders who help to shape and drive organisational diversity agendas. It will discuss how these stakeholders act as agents of change, their motivations for pursuing diversity, and power. These themes can provide some insight into potential diversity stakeholders within the SLT profession.

3.2.1 Intra-organisational diversity stakeholders

An organisation's largest resource of skills and knowledge are employees, which makes them an important intra-organisational stakeholder to study. Employees work under an employment contract (UK Government, 2021b) which has certain characteristics (e.g., requirements to work regularly) and affords them certain rights (e.g., statutory sick pay) (Advisory Conciliation and

Arbitration Service (ACAS), 2021; UK Government, 2021b). This section focuses on diversity specialists and senior managers because the former's role is diversity-specific, and managerial commitment to the diversity agenda can drive its success.

3.2.1.1 Diversity officers

Some employees have roles which directly relate to the management of organisational EDI issues. Their job titles can vary depending on the organisation (e.g., Equalities Officer; Equality, Diversity and Human Rights Officer; Advisors; Co-ordinators, etc.) (National Careers Service, 2021). A diversity officer's specific job title may not accurately reflect the actual content of their work, as some only work in specific areas (e.g., race), whilst others have a more generic remit (Lawrence, 2000). For clarity, I label all such individuals as diversity officers.

To understand who diversity officers are, it is useful to explore how to become one in the UK. There are three main routes, all requiring practical work experience; a college course (e.g., Level 2 Certificate in Equality and Diversity), relevant university degree (e.g., psychology), or direct application for the role subject to relevant experience (e.g., knowledge of equalities legislation and issues) (National Careers Service, 2021). Becoming a diversity officer is often a second career, with many coming from different backgrounds (e.g., personnel management) (Lawrence, 2000). Their UK average annual salaries are £18k-£45k based on experience (National Careers Service, 2021), with higher earning potentials amongst senior positions (e.g., manager or head of department) (£35k to £50k), especially in the public sector (£50k-£70k) (National Careers Service, 2021; Prospects, 2021). Diversity officers can also pursue accreditation with the Institute of Equality and Diversity Professionals (National Careers Service, 2021).

When the equal opportunities approach was dominant, public and some private sector organisations appointed either specialist equality officers or entire equality units (Kirton and Greene, 2009). They were responsible for providing training on equality issues, and evaluating organisational policies and practices (Kirton and Greene, 2009). These were *"a relatively new kind of employee, inserted to be an interface between a particular constituency of interests and the management system"* (Cockburn, 1991b, page 235). These officers were mostly minority ethnic, feminist, progressive, had leftist political and community backgrounds, held

moral/social justice motivations, or were from politicised disadvantaged social groups (Kirton and Greene, 2009). Officers not only brought professional training or qualifications to their role, but also their own personal discrimination experiences which signified a personal commitment to equality issues, affording them credibility, authority, and expertise to lead organisational equality agendas (Cockburn, 1991; Kirton and Greene, 2009). The qualities of such officers are explored further in the following section.

Diversity work usually happens within the human resources (HR) function because they oversee and manage an organisation's workforce, and so employees with diversity-specific roles are likely to be positioned there (Kirton and Greene, 2005a, 2019). Yet some literature presents HR ownership of diversity work as a structural barrier because HR is seen to have little power and status (Shapiro and Allison, 2007; Kirton and Greene, 2009). So, critics claim that diversity officer's HR base means that their work lacks managerial legitimacy, and advise HR members with diversity responsibilities to cautiously talk about their work by advocating soft measures of success and values linked to organisational culture (e.g., job satisfaction measures) (Kirton and Greene, 2019).

3.2.1.1.1 Diversity officers: Their qualities and how they act as change agents

Research on diversity officers has presented them as organisational change agents. These are individuals or groups who initiate and manage change in an organisation, and may be internal (e.g., diversity officers) or external (e.g., consultants) to it (Lunenburg, 2010). Agency has been conceptualised in different ways, but defining it is sometimes considered "slippery" (Hitlin and Elder, 2007, page 170) or a "puzzle" (Fuchs, 2001, page 60). Generally, an agent is an individual with the ability to act, and agency refers to them exercising this ability (Stanford Encyclopedia of Philosophy, 2019). Some insight into how diversity officers are change agents come from frameworks of organisational change management, the tempered radicalism concept, and liberal and radical approaches to equal opportunities.

Tatli and Özbilgin (2009) argue that current models of organisational change management present change agents as independent, unpolitical, and de-contextualised. Instead, they argue the opposite saying that a diversity manager's change agency depends on three concepts, each offering certain resources and constraints: situatedness, relationality, and praxis. Situatedness places diversity managers in their historical, socio-economic, and organisational context. Here, a system of structures (organisational and social) and power relations are thought

to shape their agency. Also, diversity managers are thought to have relational instead of autonomous agency because it is formed through an interplay between three social reality levels: the self (micro-individual), others (meso-organisational), and structures (macro-structural). Thus, they have an interdependent, intersubjective, and interactive relationship with organisations and society. Finally, praxis presents diversity managers as having non-linear and negotiated agency because it consists of reflexive action (where reflection meets actions) and actionable knowledge (where knowledge meets practice). Their agency represents an interdependent relationship between knowing about diversity discourses via reflection, and practising diversity management in organisations.

The concept of tempered radicalism offers another way of conceptualising diversity officers as change agents (Meyerson and Scully, 1995). This research does not specifically refer to diversity professionals, but rather "everyday leaders", but applies to them since their roles include leading organisational diversity-related changes (Meyerson, 2003; Kirton, Greene and Dean, 2007). For example, their duties cover legislative compliance, reviewing existing processes/policies and organisational management (the numbers and range), addressing organisational culture, and offering flexible working practices (Cockburn, 1991; Lawrence, 2000; Kirton, Greene and Dean, 2007). According to Meyerson and Scully, tempered radicals are ambivalent *outsiders-within* (Meyerson and Scully, 1995; Swan and Fox, 2010). They are "radical" for wanting to change and challenge the status quo of their organisations via intentional actions and by being misfits. They are critical like "outsiders" allowing them to identify problems that need addressing, and are "within" given their insider access to knowledge and insights allowing them opportunities to create change. Other scholars see tempered radicals as moving back and forth (i.e. from outside to inside and vice versa) depending on the opportunities and restrictions they face (Swan and Fox, 2010).

When radicals' values/beliefs about social justice mismatch the ones they see being enacted within their organisation, their anger and misfit feelings must be "tempered" to avoid alienating or compromising anyone's personal and professional identities, or careers (Meyerson and Scully, 1995). This is because radical equal opportunity approaches are not received well by some groups of interest, possibly leading to hostility, backlash, and resistance (Cockburn, 1989; Kirton, Greene and Dean, 2007). So, they must balance professionally accepted behaviour with staying true to their identity, which creates ambivalence (Meyerson and Scully, 1995). This ambivalence offers tempered radicals' certain choices and methods (Meyerson and Scully, 1995). They may accept ambivalence which may create dual identities, or find a compromise, which may be received as too radical or conservative for some.

Alternatively, they may pursue co-optation where they assimilate to the point of leaving their outsider-ness and feeling isolated. Research explores their many other resources such as small win discourses to achieve gradual change, and even their bodies and embodiment (e.g., presence of a female body and associated lived experience challenges the status quo/norm of workers as male) (Swan and Fox, 2010).

Sometimes diversity officers combine liberal and radical equal opportunity approaches (described in section 3.1.2) in confusing and contradictory ways to create change (Jewson and Mason, 1986b). For example, radicals may disguise themselves as liberals or use their opponent's arguments, to gain legitimacy or make progress.

More research on organisational employees with diversity-specific roles is needed (Lawrence, 2000; Kirton, Greene and Dean, 2007; Tatli, 2008). Considering how long the equal opportunities paradigm has been established, some researchers claim there has been relatively little interest in its officers. They *"are an occupational group whose work has largely been neglected as a subject for academic research"* (Lawrence, 2000, page 382). A discussion of the existing work on equal opportunity and diversity officers follows. The move from equal opportunities to diversity management resulted in most equalities officers being replaced by diversity officers with backgrounds in business management or mainstream HR in the UK, US, Australia, and New Zealand (Kirton, Greene and Dean, 2007; Kirton and Greene, 2009). There was also a new group of "part-time" diversity officers stemming from middle-senior management (Kirton and Greene, 2009).

Post-2000 diversity work was more legitimatised and respected than 1980's/90's equality work because it was shown as offering more opportunities and lower costs (Kirton and Greene, 2009). This was driven by the business case for diversity becoming dominant, equality becoming depoliticised, and diversity officers' changing background and characteristics (Kirton and Greene, 2009). Studies of equality officers during this era reported negative work experiences. For example, they experienced isolation, exclusion, marginalisation, poor support, hostility/conflict, stress, negative career impact despite good job performance, and suspicion and alienation regardless of whether they came from within or outside the organisation (Cockburn, 1991; Kandola and Fullerton, 1998; Lawrence, 2000). Some work has probed into how these officers navigated their work through these challenges. One such study interviewed 30 equal opportunities officers across UK sectors, reporting use of mainstreaming, work prioritisation, legislation, building alliances, and conflict methods (Lawrence, 2000). Mainstreaming places diversity issues at the core of how an organisation operates and its

culture (Lawrence, 2000). But critics say mainstreaming cannot address multiple discrimination properly because it usually focused on gender at the expense of other protected characteristics (Lawrence, 2000). Sometimes, equalities officers prioritised work to focus on goals or areas where change was achievable, which gave them job satisfaction and feelings of progress towards organisational change (Lawrence, 2000). Two main persuasion tools they used for EDI issues to be taken seriously was the law, and building allies through their intra- and extra-organisational networks (Lawrence, 2000). The latter involved strategically manipulating organisational rules and the power relations between different organisational actors, to negotiate how their equality agenda linked to organisational goals, which presented it as benefitting others (Cockburn, 1989; Lawrence, 2000). Finally, conflict methods, which refers to directly confronting discriminatory behaviour, were unpopular amongst officers because they were thought ineffective and were confident in using alternative methods after feeling properly established within the organisation (Lawrence, 2000).

Organisations are offering more space for diversity officers, especially in the private sector where they may pursue senior roles (Johnstone, 2002; Kirton and Greene, 2009). Managers are the main constituency for diversity management (Johnstone, 2002), and disadvantaged social groups for equal opportunities (Jewson and Mason, 1986b; Cockburn, 1991). Managers are expected to hold certain principles including using their organisation's language and justifications, and linking their work to managerial priorities (Johnstone, 2002). These expectations may be problematic for diversity officers if their personal values and goals do not match those of their organisation (Kirton and Greene, 2009). So, diversity work has costs but also benefits for diversity professionals, which is an important theme in existing work. There are overlaps in the reported costs of diversity and equality work, as found in a study of 31 organisations across different UK sectors (Kirton and Greene, 2009). For example, some officers felt unable to undertake diversity work for long periods of time, expressing concerns of burnout and negative impacts on their reputation and careers. However, career opportunities were available, and they benefitted from having more organisational influence.

The literature on diversity professionals characterise them as holding a tense position in their organisation and diversity discourses (Kirton, Greene and Dean, 2007). Research has explored the qualities that they embody or require to be effective change agents. Government and academic sources expect certain personal and professional skills (Lawrence, 1996, 2000; National Careers Service, 2021). This covers temperament (e.g., patience), knowledge (e.g., of employment laws), professional and political skills (e.g., to introduce and manage

organisational change) and communication (e.g., to deliver/promote training) and comprehension skills (e.g., to understand and manage different perspectives). Some change agents develop the skills needed to oversee organisational change processes through training or experience (Lawrence, 2000; Lunenburg, 2010). Some studies present diversity officers as experts on organisational change, who can identify which practices are working or not (e.g., can identify discrepancies between words and actions of diversity policies and offer recommendations (Ahmed, 2007b)).

3.2.1.1.2 The motivations and power of diversity officers

Diversity officers in the UK balance business and social/ethical motivations for diversity (Lawrence, 2000). Equalities officers use the business case for diversity to support their work as legislative breaches are potentially expensive and bad for business (Lawrence, 2000). Also, there is increasing individualism and voluntarism amongst UK employers and its private sector (Ozbilgin and Tatli, 2011). Yet, equality officer roles reportedly attract progressives with social justice commitments (Cockburn, 1991; Lawrence, 2000). Some researchers have queried whether those with strong commitments to social justice or business, can also pursue or commit to their opposites (Kirton, Greene and Dean, 2007). Some equality officers believe in the co-existence of both diversity motivations, but acknowledge the business case as being more important in certain sectors (e.g. retail) (Lawrence, 2000). Similarly, diversity professionals may use the language of both diversity motivations to further their cause; they are expected to commit to their organisation's diversity business case, but also personally hold organisational change ideas reflecting a passion and commitment to social justice (Kirton, Greene and Dean, 2007).

Whilst EDI is formally within the job remit of diversity officers (Lawrence, 2000; National Careers Service, 2021), some officers and diversity-management literature suggest all organisational members are responsible because diversity management is framed as a business issue (Kossek and Lobel, 1996; Cornelius, Gooch and Todd, 2000; Lawrence, 2000; Kirton, Greene and Dean, 2007). However, this shared responsibility is not considered to make the role of diversity officers as specialists in their domain redundant. Officers may use mainstreaming as it makes EDI issues relevant to everyone, but this has its own challenges. One challenge and tool to create organisational change, is to balance the needs of employees from disadvantaged groups with organisational needs (Kirton, Greene and Dean, 2007). For example, Cockburn

(1989a) said organisations have short and long agendas for change. The short agendas were always present, which focused on recruitment, promotion, and advancing disadvantaged groups to senior positions, whilst long agendas focused on equal pay, sexual harassment, and considering the politics of difference from different protected characteristics (involves changing organisational practices and culture) (Steinberg, 1992; Acker, 1994). The short agenda received support from top management but was often challenged by men (e.g., sometimes ignoring equalities policies), but the long agenda received less support from men and managers (Acker, 1994). Thus, change requires balancing the needs of multiple constituencies (Kirton, Greene and Dean, 2007). This strategy aligns with tempered radicals using small wins to gradually change organisations, and tempering their negative feelings to avoid alienating people as radical equal opportunity approaches are not well received by some groups (Cockburn, 1989; Meyerson and Scully, 1995; Kirton, Greene and Dean, 2007).

There are structural inequalities in access to power and resources (Linnehan and Konrad, 1999; Janssens and Zanoni, 2005; Sinclair, 2006). Actors vary in their power in relation to one another (Ozbilgin and Tatli, 2011). So, their agency and accountability in driving a diversity agenda within their professions also differs. The legitimacy and power of diversity officers is more complex and fluid than what is usually presented in diversity management literature, with leadership commitment thought to drive the success of their work (Thomas, 2004; Kirton and Greene, 2009). British diversity officers use a combination of different power resources stemming from their business knowledge, mandated positions (were mostly senior level roles), and/or having senior leadership support, to create organisational change (Bradley, 1999; Kirton, Greene and Dean, 2007). A culture of organisations undervaluing diversity work limits the change agency of diversity professionals (Greene and Kirton, 2009; Tatli and Özbilgin, 2009). They are apparently on the *"edge of managerial legitimacy"* because their work is marginal to organisations, despite organisations claiming it to be essential and of supporting diversity management (Sinclair, 2006, page 517). Also, work on tempered radicals presents them as having limited access to power, legitimacy, and resources (Meyerson and Scully, 1995). Some UK-based EDI consultants associate economic and business restrictions with the lack of diversity resources in the decade following the global financial crisis (Kirton and Greene, 2019). For example, consultants cited how many clients reduced in-house diversity resources in the past 10 years, and diversity was a low priority since diversity resources were amongst the first to be reduced. This affected consultant's influence and power in selling their diversity services to clients.

So, some researchers argue they need to be professionally empowered to establish their legitimacy, influence, and ability to enact organisational change plans (Tatli, 2011). Senior management can offer them this power by making them senior employees, or by offering opportunities to report progress to committees with Board members present (Tatli, 2011). One study found that equal opportunities officer's work success depends on their seniority level, the amount of clear support from top management, clear aims, and work prioritisation (Lawrence, 2000). Unfortunately, critics argue that diversity officer's ability and authority to make change is stifled because recruitment criteria for them typically lacks rigour, possibly resulting in reduced expertise, professional legitimacy, and influence (Tatli, 2011). Diversity professionals are expected to have business and managerial experience to increase their influence and credibility, than just personal and/or activist experiences in discrimination/disadvantage (Kirton and Greene, 2009). But, they are not given enough development opportunities because academia and policy does not focus enough on their roles (Tatli, 2011). Education and training is needed on areas like leadership skills, legislation, and Human Resource Management (HRM) methods (Lawrence, 2000; Tatli and Özbilgin, 2009).

3.2.1.2 Senior management

Diversity management literature has explored different organisational management levels, and those with diversity-specific managerial positions (Jones *et al.*, 1989; Brimm and Arora, 2001; Todd, 2002). This section discusses the role of senior management in organisational EDI issues, and considers their motivations, power, and agency.

Managers play an increasing and important role in diversity management (Cornelius, Gooch and Todd, 2000). Those in senior management roles (e.g., CEOs) represent staff at the highest organisational levels, meaning that they appear to offer the highest levels of diversity management support (Gilbert, Stead and Ivancevich, 1999; Kirton and Greene, 2009). Management literature presents senior management as motivating change. Diversity management success is thought related to their input and leadership (Gilbert, Stead and Ivancevich, 1999; Gilbert and Ivancevich, 2000; Thomas, 2004). Literature suggests that top management's commitment to diversity is necessary in encouraging middle managers to follow suit (Thomas and Ely, 1996; Gilbert and Ivancevich, 2000). As discussed earlier, the legitimacy and power of work by equal opportunity and diversity officers depends on their senior management support (Lawrence, 2000; Tatli, 2011). For example, equal opportunity officers

often build alliances with senior White men to make equality initiatives seem more acceptable (Kirton and Greene, 2009). Also, senior level support and input, usually from White males and CEOs, reduces the chance of diversity officers feeling isolated (Kirton and Greene, 2009). In a survey by Russell Reynolds Associates, which polled 2,167 executives of companies across the world, 73% of organisations had a diversity and inclusion strategy set predominantly by leaders, particularly CEOs (49%) (Hechinger *et al.*, 2017). In this survey, more executives felt that that their organisation fostered belonging when leadership was committed to diversity and inclusion (82%) than when it was not (65%).

Unfortunately, senior management commitment may not trickle down to other management levels. Some diversity officers report feeling unpopular within their organisation, typically with middle- or line- than senior- management (Foster and Harris, 2005; Sinclair, 2006; Kirton and Greene, 2009; Tatli, 2011). Some of these officers in this research saw such managers as resistant and unwilling to change their behaviour or practices, and so contributing to a culture of undervaluing diversity. So, there are recommendations to train and support middle management in diversity management because discrimination mostly happens at team level, and so change is likely to be best here (Randhawa, 2018).

Also, senior management commitment may be met with scepticism. Only a half of managers in the UK base of a multinational IT company reported their CEO as being genuinely committed to valuing diversity (Kirton, Robertson and Avdelidou-Fischer, 2016). The other managers were uncertain or mistrusted the integrity of the CEO's diversity rhetoric. The CEO's motivation was associated with being seen as doing the right thing because the valuing diversity agenda was perceived as universal at the time. This study also showed that managers do not always receive diversity practices well (see section 3.3.5). Most managers thought they were fulfilling their roles providing they were not discriminating. Also, critics argue that power holders within organisations adopt an individualist approach which reduces workforce diversity to an individual level, and voluntarism which removes many ethical and legal responsibilities, as tools to reduce their accountability (Tatli, 2011). So, diversity progression is stifled.

The Boards of organisations can influence the success of organisational diversity efforts. Boards are overarchingly responsible for organisational governance, and so their actions affect the entire organisation (Morse, 2002). In public and private sectors, Boards members are typically called Directors, who may be appointed from within or outside the organisation (Cengage, 2021; NHS England, 2023). Literature on corporate and public sector organisational

Board diversity applies to SLT as therapists work in both areas (e.g., SLT companies and the NHS – see section 2.3.2), and so are likely affected by their actions and diversity levels. Board diversity has been linked to organisational reputation because their composition sends a strong message about an organisation's diversity commitment (Mills *et al.*, 2019). They may be role models in driving the diversity agenda within organisations. For example, female presence on Boards is seen favourably, although only in certain situations, such as in sectors working closely with final consumers (Brammer, Millington and Pavelin, 2009). Yet, a report on NHS Board diversity in 2019 stated that just 38% women and 8% minority ethnic individuals were represented across Chair and non-Executive Board roles, despite them comprising 77% and 19% of the NHS workforce respectively (NHS Confederation, 2019). Many corporate Boards, such as UK FTSE company ones, seriously lack gender and ethnic diversity (Davies, 2011; Parker and The Parker Review Committee, 2016), but levels have improved over time (Parker, 2020). So, some critics advocate for positive discrimination/quotas to improve representations (Heidenreich, 2010; Huse, 2011; Seierstad and Opsahl, 2011; Wang and Kelan, 2013; Seierstad, 2016). Others propose targets with a deadline (Davies, 2011). However, a focus on numbers to signify improvement can be problematic (Mulcahy and Linehan, 2014).

Boards can also drive organisational diversity efforts more practically. They can use their governance role to make diversity a priority and embed it into an organisation's strategy (Mills *et al.*, 2019). One study found that non-profit Boards with greater gender and ethnic diversity, had more effective governance practices, and were more likely to have diversity policies and practices (Buse, Bernstein and Bilimoria, 2016). Also, greater gender, ethnic, and age diversity on Boards positively shaped the number of diversity policies and practices. This is echoed in a study of Fortune 500 companies from 2001 to 2010, where Board diversity was strongly associated with equitable practices in organisations (Cook and Glass, 2015). Where Boards lack diversity, individual minority ethnic CEOs have a limited impact on organisational outcomes (Cook and Glass, 2015). So, numerical representation may affect a minority ethnic leader's ability create change. This aligns with research on tokenism, referring to numerical minorities amongst a group of workers (Kanter, 1977). Some research says that minority leaders may distance themselves from diversity issues to avoid highlighting their minority status, or from being perceived as a self-serving diversity activist (Collins, 1997).

3.2.2 Extra-organisational diversity stakeholders

Extra-organisational actors (e.g., consultants) can also shape an organisation's diversity management agenda and practice. External change agents offer different perspectives and can challenge the status quo because they are not bound by the organisations culture, tradition, or politics (Lunenburg, 2010). This also means that they may be unfamiliar with the organisation's history, how it operates, or its workforce (Lunenburg, 2010). Some may be intentional (e.g., government) whilst others may be more "accidental" activists (e.g., head-hunters).

This section explores the role of government and professional associations as external diversity stakeholders. This is because many SLTs in the UK practice within the public sector which is government controlled (e.g., the NHS), and may be members of relevant professional associations (e.g., the RCSLT and ASLTIP).

3.2.2.1 The public sector/government and national legislators

The government's actions impact on the agency of workers and shape organisational diversity agendas and legislation (see section 3.1.1). Organisational agency is bound by legislation because they must and do address diversity issues based on it. For example, many organisations pursue diversity for anti-discrimination legislation compliance (Litvin, 2002; Greene and Kirton, 2009). Also, most organisational policies continue to focus on legally protected characteristics (Van Wanrooy *et al.*, 2014). So, governments are intentional diversity actors.

The government has power to address diversity issues. It can make and enforce laws and regulation, empower other actors (e.g. statutory equality bodies), and has financial resources (Ozbilgin and Tatli, 2011). For example, the UK government used the Equality Act 2006 to establish the Equality and Human Rights Commission; an independent statutory body to challenge discrimination and promote human rights and equality across the country (Equality and Human Rights Commission, 2020b). Government-backed commissions such as the Davies report explored women's under-representation on Boards (Davies, 2011). This triggered head-hunters to consider the impact of, and so change, their behaviour as "accidental activists" (e.g., they contributed to narrow candidate pools) in shaping organisational diversity (Doldor, Sealy and Vinnicombe, 2016).

Many UK equalities bodies (i.e., those focused on specific protected characteristics – e.g., race, or general EDI) and public sector organisations (e.g., those in local government, health, education, business development, employment, science, research, fire and police services, and defence) are aligned towards collectivism and regulation (Ozbilgin and Tatli, 2011). These organisations do not necessarily reflect the UK government, but are government owned. In a study of 66 key UK equality and diversity actors, supporters of regulation framed legal requirements and sanctions as necessary to make organisations prioritise diversity issues over other business issues (Ozbilgin and Tatli, 2011). The absence of state policies could create a void where each company may pursue their own selfish rules, whereby they maximise short-term profits without considering their long-term behavioural impacts (Jonsen *et al.*, 2013). This is an increasing possibility given the rise of voluntarism/business case for diversity management in the UK. To justify their stance, private sector stakeholders voice a business case, whilst public sector stakeholders emphasise social responsibility (Ozbilgin and Tatli, 2011).

Equalities bodies vary their tactics based on government legislation. Some diversity stakeholders suggest that employers highlight the risks of not promoting diversity when strong legislation is present (e.g., tribunals) (Ozbilgin and Tatli, 2011). However, softer approaches (e.g., encouragement) are needed when legislation is weak to avoid making employers feel attacked (Ozbilgin and Tatli, 2011). Thus, equalities bodies exhibit increased voluntarism, using negotiation and caution to engage employers. New Labour and Conservative governments in the UK have had a relaxed approach to regulating diversity issues, rather than strong enforcement (Dickens, 2004). However, the positions of stakeholders across sectors are not uniform. For example, some public sector actors outline voluntarism/business case arguments because of an increased emphasis on value for money within the sector, such as financial concerns being an NHS priority (Ozbilgin and Tatli, 2011).

3.2.2.2 Professional bodies and trade unions

Professional bodies, sometimes called professional associations or societies, are organisations with members from a particular profession or occupation. These bodies represent and promote a profession by overseeing the knowledge, skills, practice and conduct in it (Health and Care Professions Council, 2020a; Science Council, 2020). They differ from, but complement the work of, professional regulatory bodies who outline professional practise standards (Health

and Care Professions Council, 2020a). This section outlines the motivations of, and how, professional bodies may influence organisational diversity agendas within their associated profession.

I only found one study about how professional societies can play a diversity role. It recommended diversity strategies that professional societies for science, technology, engineering, and mathematics professions could use to improve their workforce diversity (Morris and Washington, 2017). Strategies included acting as diversity advocates (e.g., vocalising inclusion or having difficult conversations about organisational culture) and promoting diversity using respected professionals. Also, societies may proactively improve their own practices by considering their Board memberships, reducing membership fees to become more accessible to minority professionals, and supporting the social networks of students from disadvantaged backgrounds. So, societies can indirectly shape organisational diversity within their profession.

Research on external diversity consultants can be extrapolated to provide insight into how professional associations can indirectly influence the diversity agenda within a given area. External diversity consultants convince organisations to buy their diversity services (Mease, 2016; Kirton and Greene, 2019). So, they have the potential to set trends on diversity policy and practice across different organisations, sectors, and industries (Oswick and Noon, 2014). One study found that UK-based external diversity and inclusion consultants commonly used particular discursive methods. This includes pragmatic adaptation (used language to create new discourses aligned with their values that are critical and pragmatic about possibilities), creative appropriation (adjusted language to meet equality goals but sometimes hid practices driven by their values using business language), and principled resistance (only used language aligned with their own diversity values) (Kirton and Greene, 2019).

Professional bodies seem aligned towards voluntarism and individualism, whilst trades unions are aligned towards collectivism and regulation (Ozbilgin and Tatli, 2011). These positions are limited in different ways as discussed earlier. The power of trades unions in the UK private sector has been declining for many reasons such as deliberate government policies, which may have contributed to individualism in the private sector (Ozbilgin and Tatli, 2011). Trades unions are associations which serve the collective interests of workers and have an equality promotion role. However, they still have considerable sway in the UK public sector. There

were approximately 3.9 million trades union members in the public sector, compared to 2.6 million in the private sector in 2021 (Department for Business Energy and Industrial Strategy, 2022).

3.3: Diversity policies, practices, and their criticisms

Current understandings of diversity are translated into certain social practices within organisations in the UK (Vacchelli and Mesarič, 2020). This section explores some common diversity practices including policies, and discusses their benefits and criticisms. SLT employers may use these practices, and so this section provides insight and context for potentially understanding the profession's gender and ethnic diversity profile.

3.3.1 Criticisms of common diversity practices

In their work on why diversity programs fail, Dobbin and Kalev (2016) argue that many organisations try to increase diversity and reduce biases by relying on the same practices used since the 1960s. They explain how some common diversity practices worsen rather than improve diversity, including diversity training, recruitment tests, performance ratings, and grievance systems. These practices target manager's biases by controlling their thoughts and behaviours, which they claim may activate instead of reducing their bias, because people resist rules for autonomy. These are practices discussed below.

Diversity training, such as unconscious bias training (UBT), is a common way organisations target biases (Dobbin and Kalev, 2016; Noon, 2018). There has been growing emphasis on identifying and tackling unconscious biases in the UK, especially following government initiatives such as name-blind curriculum vitae for civil service recruitment, and similar schemes by large graduate recruiters (Noon, 2018). UBT is an individualist form of diversity training which first raises awareness of employee biases, and then ways of managing them to avoid negatively affecting workplace decisions or interactions (Noon, 2018). Dobbin and Kalev (2016) report diversity training to have short-lived positive effects (lasts for a day or two), and can sometimes have negative impacts such as activating bias and causing backlash. They claim

that such training commonly uses negative messages or incentives which presents discrimination as an organisational threat. For example, they emphasise diversity's legal implications which incorporates stories about big settlements. Some critics think UBT is pointless. This is because UBT paints everyone as biased, bias awareness may not cause behaviour change, only aversive racists may change their behaviour if it does work (i.e., non-prejudiced self-perceptions and outwardly support equality, yet hold negative beliefs/emotions about certain ethnic groups (Gaertner *et al.*, 2005)), and it neglects structural factors as barriers to pro-diversity actions (Atewologun, Cornish and Tresh, 2018; Noon, 2018). Dobbin and Kalev (2016) found that mandating diversity training barely impacted, and sometimes even reduced, under-represented group levels in organisational management. Also, trainees often showed anger, resistance, and increased animosity towards other groups after these compulsory courses. This occurred even amongst manager-specific course attendees which implies and differentiates them as the worst offenders. Voluntary training may be an effective alternative. This is demonstrated in a study where White students read a brochure criticising prejudice towards Black people (Legault, Gutsell and Inzlicht, 2011). Reading the brochure strengthened participant's bias against Black people when they felt pressured to agree with it, but reduced their bias when they felt it was their choice.

Scholars offer recommendations to improve diversity training. For example, Gifford *et al.* (2019) proposes that training be embedded within a wider programme of behavioural change activities, so it is not a stand-alone measure. They also say training can align with ongoing learning and development practices, so it is not a one-off measure. Their other recommendations include delivering training using mixed methods (e.g., face-to-face, and online), ensuring relevancy to individuals and roles, and continually evaluating its impact.

Organisations also target biases via mandatory recruitment tests which assess candidate job skills. Some managers may disadvantage minority groups by selectively using these tests or ignoring their results (Dobbin and Kalev, 2016). Companies which administer written job tests for managers have seen 4-10% declines in the levels of White women and minority ethnic groups in management, even those who are highly educated and usually perform well on such tests (e.g., White and Asian American women) (Dobbin and Kalev, 2016). Also, interviewers favour applicants that are competent but also culturally like themselves regarding passions, experiences, and self-presentation (Rivera, 2012). Some organisations train recruitment panel

members or ensure that they are diverse, yet these measures do not meaningfully impact decision-making and so lead to diverse appointments (Kline, 2021, 2022).

Dobbin and Kalev (2016) also outlined that some organisations use performance ratings to ensure managers are fair in their promotion and pay decisions. They acknowledge that performance systems celebrate good employees and protect organisations from discrimination claims, but report that managers may misuse them to review under-represented groups poorly, or strategically review everyone highly to avoid backlash and have more options when assigning promotions. They reported that performance reviews barely impact minority managers five years after its introduction, and can even reduce White women's management representation by 4% on average.

Grievance systems can target managerial bias by giving employees an opportunity to voice and challenge manager's work decisions. Critics argue that managers may react negatively to complainants (e.g., belittle, demote, etc.) rather than be encouraged to change their behaviour (Dobbin and Kalev, 2016). Many employees do not report harassment and discrimination for fear of further punishment or victim marginalisation from their organisation (Zheng, 2020). Dobbin and Kalev (2016) highlight how the lack of complaints may misleadingly signal that organisations are problem-free. They cite evidence which shows a 3-11% decline in under-represented group levels in management five years after organisations adopt formal grievance systems. So, they propose employers use a flexible complaints approach that involves formal investigation and informal mediation, with the latter possibly less threatening to managers but still makes them feel accountable.

3.3.2 Evidence of effective diversity practices

In exploring why diversity programs fail, Dobbin and Kalev (2016) also found out what works. They compiled evidence of effective diversity practices from research analysing more than 30 years of data from over 800 American firms, and interviewing hundreds of managers and executives. Three factors were proposed for why certain diversity practices such as targeted recruitment, mentoring programs, self-managed teams, and task forces successfully boosted organisational diversity. The first factor was engaging managers in diversity work instead of

tightly controlling their behaviours. The research showed that when managers actively and voluntarily contribute to solving their organisation's diversity issues, they take their involvement seriously and consider themselves diversity champions. For example, the authors reported that White women and minority ethnic employee representation in management increased by ~10% five years after a company implemented a college recruitment program targeting female employees.

The second factor was increasing manager's on-the-job contact with under-represented groups. The authors say that this is achievable through self-managed teams (collaborating with people from different jobs and domains), cross training (rotating employees through different departments), and mentoring (mentors teach and sponsor mentees to help them develop within organisations). They report the former two to have increased the representation of disadvantaged groups in management by 3-7%. Similarly for mentoring, one study found that an organisation's formal mentoring program helped triple, from 5% in 2002 to 16% in 2006, minority ethnic representation in Director leadership roles (Olson and Jackson, 2009). Also, minority ethnic employees with the furthest careers progression in three major American corporations, had a strong mentor network and corporate sponsors who helped their professional development (Thomas, 2001). Research suggests that informal rather than formal mentoring programs are better, perhaps because the individuals naturally choose each other based on similar personal characteristics and interests (Underhill, 2006). So, some research recommends improving formal mentoring programs by incorporating a self-selection process (Forret, 1996).

However, mentoring has it challenges. Mentoring and self-managed teams are not typically branded as diversity efforts, nor are they specifically designed to address it. White men tend to find mentors on their own, but some under-represented groups may require help through formal mentoring routes especially since White men feel uncomfortable reaching out to them (Dobbin and Kalev, 2016). Some research suggests that White men may find diversity language and messages threatening (e.g., concerns of unfair treatment, make poorer interview impressions, and experience more cardiovascular distress) (Dover, Major and Kaiser, 2016b) and stress-inducing (Dobbin and Kalev, 2016). Also, mentoring is an individualistic approach as it concentrates on individual employees, rather than on organisation-level change (Song and Pyon, 2008; Davis and Museus, 2019). This aligns with the cultural deficit model (described in section 4.2.2). Mentors may hold negative stereotypes about mentees based on their social

identities or have difficulty identifying with them, and mentor motives may be questioned (Thomas, 2001).

The final factor is encouraging social accountability amongst managers by triggering their need to be seen as fair (Dobbin and Kalev, 2016). The authors cite a study of a large private company's performance-based reward system where accountability was encouraged through transparency (Castilla, 2015). African American employees were consistently given smaller monetary rewards than White employees. This gap almost vanished after each company unit was asked to post its performance rating and pay rises by race and gender. This reduction was attributed to manager's social accountability being triggered whereby they did not want to be seen as acting biased.

3.3.3 Diversity policies and their benefits

Formal diversity methods are more practical to assess than the more intangible elements of diversity management (e.g., organisational culture). An important part of equality work involves writing documents that express a commitment to equality (Ahmed, 2007b). Policies are communication documents conveying a message from management about an organisation's vision, rules, and regulations to various parties (Von Solms and Von Solms, 2004). Policies signpost an organisation's principles, characteristics, qualities, and contain *"fields, frames and networks for action"* (Prior, 2003, page 2; Ahmed, 2007b). These messages may be presented in a written form, which is circulated within organisations (Ahmed, 2007b).

An important debate about diversity policies concerns whether they can effectively facilitate or block diversity progress. Diversity policy benefits were outlined in a study exploring how the Race Relations Amendment Act (2000) led 10 UK universities to write diversity documents (Ahmed, 2007b). First, diversity policies may be a starting point in pushing organisations to consider, and physically outline, their equality-related principles and intentions (Ahmed, 2007b). So, there are consistent standards of acceptable values, organisational goals/commitment, and practice to tackle specific issues (e.g., discrimination). This also adds to an organisation's culture, maturity/integrity, reputation, and helps to attract and retain good staff (European commission, 2003; Equality and Human Rights Commission, 2018b). As standards are outlined, the policies not only act as an reference point to challenge bad behaviour and practices, but are tools to enforce employment laws, which outline minimum standards of

fair access to and treatment at work (e.g. gender pay gap reporting) (Ahmed, 2007b; Government Equalities Office, 2017).

Sometimes broad working groups develop diversity-related policies, which can help set up and facilitate communication networks, potentially resulting in high-quality policies being produced (Ahmed, 2007b). Evidence shows that group decision-making may be better than individuals working alone (Laughlin et al., 2006), but this depends on whether and how responsibility is shared (Ahmed, 2007b), and if "groupthink" occurs. The latter is a psychological phenomenon, where a group's desire to reach an unanimous decision results in poor decision making (e.g., lack of critical thinking) (Kenton, 2019).

3.3.4 The criticisms of diversity policies

Diversity policies also have their critics. Some organisations assign an individual rather than a group with the sole responsibility for writing race equality policies (Ahmed, 2007b). The chosen person may be an appointed diversity officer, or this duty is extended to existing staff members (Ahmed, 2007b). Less-than-ideal policies may be written because of a lack of alternative views and information from others, or possibly because the appointed person may lack necessary expertise. Even if the job of writing a diversity policy is assigned to diversity professionals, who are expected to be knowledgeable in diversity and business (Kirton and Greene, 2009), research discussed previously showed that they may not have the expertise or influence to exercise their role properly (see section 3.2.1.1).

Also, simply having a diversity policy does not mean that diversity will naturally happen. Diversity programs are yet to meaningfully improve the representation of socially disadvantaged groups (Dover, Major and Kaiser, 2016a) including at management level (Dobbin and Kalev, 2016). Critics such as Kaiser *et al.* (2013) point out that the presence of a diversity policy can make people less sensitive to unfair treatment to, and discount claims of this from, under-represented groups. So, they say that policies may maintain the status quo and create an illusion of fairness. CRT argues policies are not neutral and their impact on all workers should be critically evaluated, to identify and expose those discriminating against minority groups (Rocco, Bernier and Bowman, 2014).

Not everyone is aware of, or engages with, organisational diversity policies. Some people dislike being required to read policies (Ahmed, 2007b). A survey of 1,811 British organisations reported low awareness, knowledge, and engagement of the Equality Act 2010 and the practices that it promotes, despite the Act being in play for over a year at the time (Perren et al., 2012). Also, just 74% were aware of one or more of their organisation's diversity programs in a survey of 2000 employees across different UK sectors (Nguyen et al., 2019). Poor knowledge of organisational diversity policies and initiatives was also reported amongst managers in the UK base of a multinational IT company (Kirton, Robertson and Avdelidou-Fischer, 2016).

Poor engagement with diversity policies possibly relates to the criticism that there is too much documentation (Ahmed, 2007b). Diversity management is accused of potentially being used as a tool for control (Lorbiecki and Jack, 2000), and as being too managerialised (e.g., audit cultures) and professionalised (e.g., diversity competencies and equality toolkits) which compromises diversity's political agenda (Swan and Fox, 2010). Critics argue that this benefits those doing the managing, namely organisations and managers, rather than those being managed (Lorbiecki and Jack, 2000; Thanem, 2008). They claim that how managers should create and manage diverse workforces receives more focus than meeting all organisational member's needs. Framing management as being responsible for managing groups deemed diversity relevant has certain implications (Thanem, 2008; Dobusch, 2017). For example, Thanem's (2008) work on disability says that this frames difference as a problem, and management as a solution. This hides manager's differences, but frames those being managed as different, which reinforces a distance between the two. He also says it supports instead of questions how certain dominant groups (e.g., male, able-bodied), values (e.g., working full-time) and norms (e.g., working on weekends) go together. So, he sees diversity management as involving assimilation of individuals deemed different, by those who fit the norm. Management and organisational research has shown that White men tend to manage women and people of diverse ethnic backgrounds in Western society (Collinson and Hearn, 1996; Acker, 2006). Disability, for example, may be neglected in organisations because it conflicts with a business case for diversity (Thanem, 2008).

Critics say that the increasing professionalisation of diversity workers may reduce the potential of diversity practices to be transformative (Swan and Fox, 2010). Scholars acknowledge that HRM knowledge and methods offer tangible ways of tackling diversity by different groups (Kirton and Greene, 2005b). For example, they cite how managers can use these methods to track long-term labour market trends (e.g., participation of minority groups).

Also, diversity activists may use them to prove discrimination or disadvantage, and strengthen or justify their activism. However, professionalisation is accused of domesticating critical or radical thinking or practices (e.g., activist's criticism or dissent), by marginalising any ideas, knowledge, or practices deemed unacceptable to the mainstream (Swan and Fox, 2010). Professionalisation is not always a choice for diversity workers, as they may be forced, co-opted, or recruited into it (Larner and Craig, 2005). Also, professionalisation may mean substantive documentation and so substantive work. Yet, senior managers often do not have the time to consider ways to proactively leverage diversity (Kirton, Robertson and Avdelidou-Fischer, 2016).

According to Ahmed (2007b), diversity policies can misleadingly suggest that an organisation is good at, or doing enough, for diversity. She argues that policies encourage tick-box approaches that become linked to institutional goals and performance. For example, checking if all staff have undergone diversity training may prioritise diversity and drive accountability, but it only indicates whether certain processes/targets were reached, not whether organisational culture changed. She claims this is not helped by organisational personnel being aware of, and good at, audit cultures/ processes. So, some organisations may use diversity policies for image management, where policies become about *"changing perceptions of Whiteness rather than changing the Whiteness of organizations"* (Ahmed, 2007b, page 605). For example, employers concerned about their image to the community, customers, and suppliers, are more likely to value equalities legislation (Perren et al., 2012). Perhaps risk aversion plays a role as larger organisations had greater awareness of the Equality Act (Perren et al., 2012). Also, many people think diversity policies do not drive change, nor that it benefits its target audience, or that their employers have improved them (Bogg and Hussain, 2010; Nguyen et al., 2019). So, policies may simply indicate how good organisations are at writing equality documents, which particularly privilege resource-rich organisations (Ahmed, 2007b).

Finally, there is a debate about whether diversity practices should be mandatory or not. Many types of mandatory diversity practices exist (Collins, 2007; Priest *et al.*, 2015). One method is positive discrimination, where deliberate employment practices are used to favour disadvantaged groups to make workforce distributions more proportional, and so redress past discrimination (Kirton and Greene, 2005b). For example, preferential recruitment based solely on protected characteristics, despite a candidate being ideal for the role. It is illegal in the UK, except in threshold systems for tie-break situations, where the Equality Act 2010 allows UK

employers to choose candidates from disadvantaged backgrounds once they have met a basic standard/benchmark (Noon, 2012). It is different from positive action, which tries to remove labour market obstacles to allow for free and equal competition amongst people (Kirton and Greene, 2005b). Some researchers argue that compulsory diversity policies which have financial and legal penalties, are linked to better outcomes whilst not economically affecting White men, relative to non-mandatory measures (Holzer and Neumark, 2006; Herring, 2009; Herring and Henderson, 2012). For example, the rule that all NHS-university partnerships must hold at least one Athena Swan silver award to achieve grant shortlisting from the National Institute for Health and Care Research, increased the numbers of both Athena Swan applications and women in leadership (Blandford *et al.*, 2011). Also, mandated diversity practices are thought effective across several domains, including recruiting women for competitive environments without compromising on efficiency (Balafoutas and Sutter, 2012), and Norwegian corporate Boards (Ahern and Dittmar, 2011; Mensi-Klarbach and Seierstad, 2020; Seierstad *et al.*, 2020). So, perhaps the absence of mandatory diversity practices, or mandatory elements within diversity polices (e.g., threshold systems), may restrict a diversity policy's impact.

3.3.5 The challenges of implementing diversity policies and practices

Research indicates that the impact of diversity policies and practices is possibly limited by its implementation (see also sections 3.1.2 and 4.2.4.2). For example, policies may act as a substitute for action, because well written ones can hide whether EDI issues outlined in the document are actually being addressed (Ahmed, 2007b). This suggests the presence of a policy-implementation gap, which is a gap between the intention and actual practice of policies. This gap explains why a policy's desired impact may not be realised. Evidence shows that the intentions of HRM practices in many organisations does not match what is implemented. For example, a large gap was reported between the intentions to use certain HRM practices in 12 multinational and local organisations as identified through HR manager interviews, and their implementations as identified by non-HR employees (Khilji and Wang, 2006). These practices covered recruitment, training and development, performance evaluation, rewards/compensation, and job design. Nine of the organisations had low or medium implementation of HRM practices. For example, some employees were not aware of practices being pursued, and some were presented with training opportunities but never sent them.

Research tends to focus on managerial responsibility to address implementation gaps (see sections 3.1.2 and 4.2.4.2), and usually presents HR professionals and line management on opposing sides (Brewster and Holt Larsen, 2000; Noon and Ogbonna, 2021). This applies to diversity management, as diversity professionals are typically positioned within HR, but managerial support is important for their work success, as discussed earlier. Line managers help bring HR policies to life, in terms of whether HR practices achieve their intended impact (Hutchinson and Purcell, 2003). Managerial agency may drive equality-implementation and policy-implementation gaps. They may do this in different ways and for different reasons, which has been applied to formal recruitment processes (Noon *et al.*, 2013). This includes *circumvention by neglect* where managers fail to implement processes. *Circumvention by manipulation* is where managers change or ignore processes to suit their micro-political goals. Also, *circumvention by compliance* is where managers comply with excessively formal organisational processes in robotic (e.g., getting job done), defensive (e.g., fearing mistakes) or malicious (e.g., covering discriminatory decisions) ways. In one case study, three control measures to address the equality-implementation gap were used on Executives in a professional services organisation: mandatory diversity training, diversity targets, and monitoring (Noon and Ogbonna, 2021). These measures had limited success because they depend on managerial agency. For example, diversity training aimed to change attitudes, but managers may not internalise the training messages. Diversity targets and measures aimed to change behaviours, but managers were sceptical of their process and impact. Also, monitoring relies on managerial commitment and monitoring skills. Morover, a case study exploring the policy-implementation gap in the UK base on a multinational IT firm, found that managers did not engage much with their firm's agenda for valuing diversity, nor did they see much value in diversity (Kirton, Robertson and Avdelidou-Fischer, 2016). Diversity training was deemed a superficial, tokenistic, and a tick-box exercise, which managers only undertook because it was mandatory. Female managers were more likely to think diversity training was useful and interesting than male managers, but they had difficulty seeing how it tangibly applied to their roles. Also, the firm's policy expected little practical demonstration of manager's diversity commitment. For example, they were typically just required to approve team member's participation in programmes/events. There are calls for line managers to show ownership of, and accountability for, their diversity strategy as key policy implementors; accountability and incentives signal organisational commitment (Gilbert and Ivancevich, 2000; Noon, 2007; Kirton, 2008; Society for Human Resource Management, 2009). Yet, managers were not incentivised or rewarded for pursuing diversity, and male managers who bid for new projects were unconvinced of

diversity having any impact (Kirton, Robertson and Avdelidou-Fischer, 2016). This aligns with reports that diversity management is seen by managers within retail or healthcare sectors as a challenge, and as a possible source of team conflict (Foster and Harris, 2005; Greene and Kirton, 2009).

Overemphasis on managerial responsibility for implementing HRM practices can present non-managerial employees as passive recipients of these practices (Bos-Nehles and Meijerink, 2015; Budjanovcanin, 2018). There needs to be a focus on non-managerial employees in HR implementation because HR practices directly impact on their experiences (Kirton, Robertson and Avdelidou-Fischer, 2016). Some research presents employees as inactive but "primary evaluators" of HRM implementation, whereby they judge the effectiveness and quality of implementing practices (Budjanovcanin, 2018). Others scholars present employees as being more active, whereby they engage, undermine, delay, or support the HR practice implementation (Janssens and Steyaert, 2009). Employees are likely to actively engage in HRM implementation, called HRM co-production, if they think that genuine motivations underly HR practice (Bos-Nehles and Meijerink, 2015).

3.4 Chapter summary

This chapter used diversity management literature to explore diversity approaches, stakeholders, and practices for addressing workforce diversity. This provides context and insight into elements of these research themes within the SLT profession, and how they may be shaping its gender and ethnic workforce diversity. The next chapter builds on this research by exploring gender and ethnic diversity concerns and practices within the UK health sector context, including the SLT profession.

First, I explored approaches to workforce diversity in the UK, which have shifted from equal opportunities to diversity management, and then inclusion. The underlying theoretical debates of the approaches discussed (e.g., individualism versus collectivism, voluntarism versus regulation, and business versus moral motivations) are limited in different ways when trying to address organisational inequality. As diversity management is the dominant approach for

addressing workforce diversity in the UK, SLT employers will also likely use it, but also be restricted by its limitations.

The discussion of intra- and extra-organisational stakeholders shows the importance of considering multiple actors in diversity research. So, this thesis considers different stakeholders involved in diversity work within SLT. Stakeholders vary in their approach, motivations, and power/agency towards EDI. For example, diversity officer's job remit shapes organisational diversity, and senior management's commitment and support seems necessary for their diversity work success. Extra-organisational stakeholders, such as professional bodies, can indirectly promote diversity within their given profession using various methods (e.g., advocacy). This suggests that the RCSLT or ASLTIP may emerge as important stakeholders when exploring SLT workforce diversity.

Finally, many diversity practices exist, each with benefits and challenges in tackling inequality at work. This section provided context for exploring why diversity practices for addressing SLT gender and ethnic inequality may or may not be working. For example, some diversity practices may be too managerialised and professionalised, and there are challenges to implementing them (e.g., implementation gaps, poor awareness, and engagement of practices).

CHAPTER 4: EXPERIENCES OF HEALTHCARE PROFESSIONALS: THE IMPACT OF GENDER AND ETHNICITY

In this chapter, I discuss existing literature on SLT workforce diversity and identify relevant research gaps which inform my research question. One research gap is the lack of relevant literature on the gender- and ethnicity-related lived experiences of therapists as professionals. Lived experiences reflect a person's views, choices, experiences, and how the latter is shaped by their characteristics (e.g. gender, etc.) (Boylorn, 2008). These experiences are tools for understanding and addressing societal issues because they acknowledge and demonstrate how individual lives may resemble each other using storytelling and interpretation (Boylorn, 2008). So, I use organisational studies literature and published reports to explore the lived experiences of gender and ethnically under-represented and disadvantaged healthcare professionals in the UK. I then explore if and how NHS diversity efforts address the experiences discussed. This will contextualise and provide comparative data for studying SLTs, especially as SLT is an allied health profession (AHP) and many therapists are NHS-based (see section 2.3.2).

4.1 The experiences of Speech and Language Therapists and diversity efforts

Overall, academic literature on therapist's experiences is generally lacking, and some studies are very outdated. For example, the literature cited in this section ranges from 1990 to 2021, with more recent being grey literature mostly from the RCSLT. Most existing relevant literature tends to report poor gender and ethnic diversity among therapists (see section 2.3.1) and to focus on student choices to pursue the profession, especially those who are male. Such literature commonly cites poor awareness and understanding of the profession, and how certain perceptions of it can deter under-represented groups from considering it. SLT's lack of appeal amongst men is associated with the profession's feminised image in which gender stereotypes play a role. Perceptions of SLT holding a low status, which is linked to perceptions of poor income potential and career prospects, is a barrier for both men and minority ethnic individuals

in choosing the profession. Gender barriers for women were only mentioned in relation to maternity/caring responsibilities and flexible work. Limited research attention is given to ethnicity and on qualified professional (i.e., non-student) workplace experiences. To provide some insight into therapist's experiences, I explore the gender- and ethnicity-related lived experiences of other UK healthcare professionals in section 4.2, as therapists are AHPs, and many are NHS-based. The studies discussed cover the UK, USA, and South African samples.

The SLT workforce's poor gender and ethnic diversity is commonly associated with a lack of awareness and/or understanding of the profession. Many people do not know about SLT or its scope of practice when choosing a career (Byrne, 2010). However, SLT is one of the more widely known AHPs amongst students, parents, and teachers, yet understanding of it is limited (Research Works Limited, 2020b). Poor SLT exposure, awareness, and understanding is a common reason given for the profession's inability to attract men (Greenwood, Wright and Bithell, 2006; Parity UK, 2013; Puhlman and Johnson, 2019; Royal College of Speech and Language Therapists, 2019d). Male students are less familiar with, and five times less likely to consider, SLT than women (Greenwood, Wright and Bithell, 2006; Parity UK, 2013). People are likely to consider SLT if they have prior exposure to it from having undergone treatment, through work settings, or having relatives (especially one's mother) within SLT or health-related roles (Boyd and Hewlett, 2001; Stewart, Pool and Winn, 2002; Greenwood, Wright and Bithell, 2006; Byrne, 2007, 2008; Litosseliti and Leadbeater, 2013; Parity UK, 2013; Puhlman and Johnson, 2019). For example, a 2020 RCSLT survey on male therapists reported many being exposed to SLT via someone in their life (e.g., family member) (43%) or their own research (39%) (Royal College of Speech and Language Therapists, 2020c). In contrast, a survey of 31 therapists in South Africa found that many male therapists (87%) chose the profession despite no prior SLT exposure or contact (Du Plessis, 2018). SLT careers advice has been criticised (e.g., high achievers told to consider more academic choices than SLT) (McCormick, Napier and Longhurst, 2019), which for men is reportedly unhelpful, too vague, and discouraging (e.g., instances of being told profession was predominantly female, *"men did not go anywhere"*, and to aim higher) (Fitzmaurice and Coyle, 1995; Boyd and Hewlett, 2001, page 170). In a South African study, SLT was not a first-choice career for many men (Du Plessis, 2018). This means many men have prior careers across diverse occupations or higher education before choosing SLT (Boyd and Hewlett, 2001). Men who pursue SLT cite intellectual interests (e.g., in language/linguistics and psychology, and specific SLT areas/nature of work), altruism (i.e., working with or helping people) and professional reasons

(job security, satisfaction and autonomy) (Boyd and Hewlett, 2001; Stewart, Pool and Winn, 2002; Whitehouse, Hird and Cocks, 2007; Research Works Limited, 2020b). Job satisfaction for men is linked to salary and career progression, whilst for women is linked to working with or helping people (Patterson and Woodward, 1996). Such motivations are not unique as they are reported amongst other AHP students (Miers, Rickaby and Pollard, 2007).

Existing literature does not explore why minority ethnic individuals choose a SLT career, but rather how their poor SLT exposure/awareness and perceptions deter them from it (dicussed latter). SLT exposure and understanding is reported as being particularly low amongst minority ethnic students (Stapleford and Todd, 1998; Greenwood, Wright and Bithell, 2006; Parity UK, 2013; Royal College of Speech and Language Therapists, 2019d, 2019b). Minority ethnic students are less likely to know SLT is a degree course than White students, which is important because they place great importance in studying for a degree (Greenwood, Wright and Bithell, 2006; Parity UK, 2013). Many people and communities never meet therapists, resulting in little knowledge about the profession's scope and practice, which means a need to address individual and community-based SLT perceptions/expectations (McCormick, Napier and Longhurst, 2019). Minority ethnic students interested in SLT face difficulties in attaining work experience (Royal College of Speech and Language Therapists, 2019d), and few are recruited onto master's level SLT courses in the USA (Stewart and Gonzalez, 2002).

Perceptions of SLT as feminised, in which gender stereotypes play a role, are also reported to deter men from choosing the profession. Feminist scholarship studies the societal mechanisms creating female subordination (Acker, 1992) and male domination. Feminism approaches gender as a social system where roles, rights, power, and resources are shared based on whether a person or practice is thought male/masculine or female/feminine (Ridgeway and Correll, 2004). These systems contain gender norms which convey societal rules or expectations (Cislaghi and Heise, 2019), consider socialisation (Stone, 2007), are usually hierarchical, and benefit males/masculinity over females/femininity (Heise *et al.*, 2019). When "doing gender", people perform attitudes and behaviours that are socially acceptable for their sex (West and Zimmerman, 1987, page 126). So, peoples conform to gender stereotypes, which are general preconceptions about the characteristics and/or roles of a given gender (United Nations Human Rights – Office of the High Commissioner, 2018). Stereotypes about male characteristics are presented as being at odds with misconceptions about SLT (Parity UK, 2013; Royal College of Speech and Language Therapists, 2019d, 2019b). For example, such research says that male

stereotypes present men as uncaring/unemotional, unsuited for working with children, direct, solutions-focused, and preferring science, technology, engineering, mathematics, medicine, or manual professions. These stereotypes conflict with perceptions of SLT, such as it being a caring vocational role, involving work mostly with children, comprising only one-to-one work, and using taught rather than science-based practices. Gendered perceptions and discourses of women as carers and good communicators, the high prevalence of women, and job title create perceptions of SLT and AHPs as suited for women (Stapleford and Todd, 1998; Litosseliti and Leadbeater, 2013, 2020; Parity UK, 2013). Media imagery contributes to this narrow portrayal of AHPs. For example, SLT media images are mostly of White female professionals, paediatric clients, or male therapists with select client groups (e.g., young adults) (Byrne, 2017; McCormick, Napier and Longhurst, 2019). So, there are recommendations to reduce the profession's female image to increase the profession's appeal to men. For example, there are calls to rename the professional title to remove any associated female connotations, as the term "*therapist"* may evoke a female therapist image (Litosseliti and Leadbeater, 2013). Also, emphasising SLT's scientific basis and problem-solving is proposed (Greenwood, Wright and Bithell, 2006; Royal College of Speech and Language Therapists, 2020c). However, perceptions of SLT as being gendered differ across countries. For example, in a study of 31 male SLT students in South Africa, 58% did not see SLT as gendered, and 74% said the term therapist did not evoke a woman's image (Du Plessis, 2018).

Poor gender and ethnic representation may also be deterrents for under-represented groups. SLT's feminised image is reinforced by its poor male representation. A lack of male peers/role models is reportedly a barrier for men in SLT courses and the profession overall, which may cause feelings of isolation as reported by male occupational therapists (Parish *et al.*, 1990; Boyd and Hewlett, 2001; Du Plessis, 2018; Royal College of Speech and Language Therapists, 2020c). Also, minority ethnic students on SLT courses are poorly represented, feel unsupported, and have difficulty both sharing personal experiences and having their cultural needs met (Royal College of Speech and Language Therapists, 2019d). The RCSLT plans to create role models by identifying influencers instead of using gatekeepers (McCormick, Napier and Longhurst, 2019). They describe them as people with *"aspirational capital"* (page 19), social media/cultural influence, or reputation with an audience with whom they regularly engage and can motivate or influence their opinions.

Some research claims that both male and minority ethnic individuals are discouraged from choosing SLT because it is thought less prestiguous than other professions (McCormick, Napier and Longhurst, 2019; Royal College of Speech and Language Therapists, 2019d, 2019b). In one study, more than half (55%) of AHP professionals thought that three AHP courses, which included SLT, had a low status amongst minority ethnic groups (Stapleford and Todd, 1998). It also found that middle-class Asian girls who were high achievers would pursue high status careers like law and medicine. The status of SLT may be linked to perceptions about its income potential and progression prospects. A perception of low pay is thought to shape the SLT student population (Royal College of Speech and Language Therapists, 2019d). Careers seen to have low earning potential, such as SLT and dietetics, can deter people from considering them (Lordly, 2012; Litosseliti and Leadbeater, 2013). One study exploring SLT perceptions amongst school and college-level students, found that those of minority ethnic heritage emphasised a high salary and career prestige than White students (Greenwood, Wright and Bithell, 2006). Also, some possible factors affecting the attraction and retention of men within SLT includes the reduced scope for career progression, limited full-time posts, and low salaries, especially if men are sole earners of their household (Parity UK, 2013). In a study exploring why men and women pursue a SLT career, job satisfaction was the primary reason for both group's choices, although for different reasons (Patterson and Woodward, 1996). Men quoted career progression and salary, whilst women cited altruistic reasons (e.g., helping people). Job security is important to male therapists (Boyd and Hewlett, 2001). In 2019, male therapists were advantaged over females in average working hours per week (33 versus 35 hours), hourly pay (£20 versus £17.43), and annual salary (£34,414 versus £31,807) (Career Smart, 2020). They out-earned females across all age bands (Career Smart, 2020). Yet, a NHS progression ceiling at Band seven and perceived low pay/status are barriers for male therapists (Royal College of Speech and Language Therapists, 2020c). A study of career and workplace choices reported that therapists place importance on employment terms, benefits, and conveniences (Katz, Izhaky and Dror, 2013). Perceptions that job shares and part-time work are common in SLT, and motivations to seek flexible working for purposes of raising a family are some reasons women are thought suited for, or choose to, pursue SLT (Litosseliti and Leadbeater, 2013; Parity UK, 2013).

Academic literature on therapist's experiences tends to focus more on students than qualified professionals at work. Where the latter exists, focus is almost exclusively on male experiences. I only found one article on minority ethnic therapist's experiences, which reported that minority

ethnic student attrition on SLT courses was sometimes linked to negative placement experiences (Stapleford and Todd, 1998). No further detail was provided about this finding.

Gender can positively and negatively affect men as students and qualified therapists. Given men's numerical scarcity in SLT, it is noticeable when men miss lectures, and they face integration challenges (e.g., hostility/difficulty being accepted by women or making friends), discrimination or assumptions, isolation feelings, and constantly need to justify their actions or prove that they are nice (Boyd and Hewlett, 2001; Bending, 2011, 2012). Gendered learning and therapy styles are also barriers (e.g., sometimes lecture content biased towards women) (Du Plessis, 2018; Matthews and Daniels, 2019). Men faced gendered assumptions that they have certain demeanours (e.g., relaxed, and rational), preferences (e.g., need complexity), and suitability (e.g., work better with men, should be role models and managers rather than therapists) which affect their training and positions within the profession (Bending, 2012; Litosseliti and Leadbeater, 2013). For example, there is a perception that men have a faster career trajectory than women in SLT, which is associated with their gendered dispositions (e.g., rational not emotional), gendered expectations (e.g., pressures to choose career directions like management or work in certain settings like hospitals), and structural barriers against women (e.g., men as decision makers who promote other men) (Litosseliti and Leadbeater, 2013). However, one particular challenge is negative attitudes towards or differential treatment of men working alone with vulnerable groups, particularly children (e.g., treated with suspicion) (Boyd and Hewlett, 2001; Parity UK, 2013; Du Plessis, 2018; Royal College of Speech and Language Therapists, 2020c). For example, male therapists have been advised to work with clinic doors open, and made aware of child abuse in ways that female colleagues are not (Boyd and Hewlett, 2001). This echoes the challenges men face within early years jobs such as childcare and education (Davies, 2017). Male SLT students use certain strategies to adjust and succeed within their predominantly female educational and work settings (Matthews and Daniels, 2019). Such tactics include acquainting or integrating themselves with female colleagues to navigate social situations, appearing willing and cooperative in group projects, and consciously trying to always attend classes (Matthews and Daniels, 2019).

Some research has explored why male therapists stay in the profession. Reasons cited include the role's diversity/career prospects (e.g., merging of different domains like health, science, and language/communication, and varied specialties), ability to make a difference, and its problem-solving component (Royal College of Speech and Language Therapists, 2020c). Students who cite humanistic or intellectual reasons plan to stay in the profession longer than those who choose professional reasons (Whitehouse, Hird and Cocks, 2007).

Finally, some research has studied therapists within the NHS, but insight into the private sector was almost absent. Therapists are recruited in larger numbers and more easily outside of the NHS. An audit of SLT adverts in the RCSLT Bulletin magazine, from October 1999 to March 2000, reported four applicants on average for non-NHS posts, but just two for NHS posts (Rossiter, 2000b). One study and one report explored why therapists stayed, left, or returned to the NHS (Arnold *et al.*, 2006; Loan-Clarke *et al.*, 2009). Key reasons for staying included employment conditions, professional development opportunities, the work (interesting and enjoyable), and job and pension security including pay. Therapists mainly left the NHS due to excessive and stressful/pressured workloads, childcare responsibilities, poor pay, and an inability/lack of time to deliver patient care. Lack/denial of career opportunities, excessive bureaucracy, and poor management support were less cited reasons for leaving. Some of these reasons were also cited in a RCSLT Bulletin magazine article exploring the reasons for the loss of 1000 RCSLT memberships in 1999 (Rossiter, 2000a). Finally, those who returned to the NHS disliked Agenda for Change (AfC), but cited professional development, pensions, and work location (e.g., close/easy travel), availability, and flexibility (e.g., fit with caring responsibilities). Some therapists who stayed out of SLT after taking career breaks for children, cited lack of local flexible work (e.g., obtaining part-time work), maternity leave issues, and loss of specialist roles because of reduced hours for family commitments (Rossiter, 2000a). These findings suggest two important factors. First, the NHS is perhaps better than other organisations for work flexibility. Second, the findings show that despite SLT being very female and many working part-time (34-42% reported) (Career Smart, 2020; Health and Care Professions Council, 2021a), work flexibility is still an issue.

The profession has experienced a lot of financial difficulty throughout its history. It experienced pay freezes and restrictions in 1972 and 1975 respectively, and was successful in a high-profile equal pay case (Royal College of Speech and Language Therapists, 2005). In the 1997 Enderby case, 351 therapists used the equal pay for equal value legal provision to protest against poor pay compared to other similar professions (Maguire, 2000; Royal College of Speech and Language Therapists, 2005). The case used the Equal Pay Act to argue that predominantly female workforces should be compared to similar professions with predominantly male workforces if their work is of equal value, as therapists earned significantly less than hospital pharmacists and psychologists (Maguire, 2000). The case was successful. However, these efforts seemed undermined by the introduction of the NHS AfC system in 2004. This led many RCSLT members to consider leaving the NHS for the private

sector (Royal College of Speech and Language Therapists, 2005). It was also problematic since the profession suffered from staff shortages and poor retention, with just an approximately 2.5 year average retention for London-based therapists (Royal College of Speech and Language Therapists, 2005). However, one study reported that the AfC pay banding process has, overall, improved (e.g., senior assistants) or maintained (e.g., most newly-qualified therapists) the positions (pay and conditions) of some Trusts or therapist groups working in 85 English NHS Trusts (Rossiter, 2006).

For ethnicity, negative perceptions of the NHS are reported amongst minority ethnic families, where they did not want their children to work for the organisation (Stapleford and Todd, 1998). No reasons were offered for this finding.

Academic literature on efforts to improve SLT workforce diversity is lacking. Most existing literature stems from the RCSLT and is around outreach, and improving SLT education. Diversity has been an RCSLT concern for over 10 years in terms of raising the profession's profile and reflecting the populations being served (McCormick, Napier and Longhurst, 2019). So, in 2019, they outlined broad plans to improve the professions' profile and target current perceptions and stereotypes (McCormick, Napier and Longhurst, 2019; Royal College of Speech and Language Therapists, 2019d, 2019b). These plans focus on attracting potential students which means emphasis on the beginning of the career ladder. For example, plans include collaboration with academic sector stakeholders to review processes (e.g., working with universities to review admissions processes), setting up school outreach programmes/ toolkits for school careers advisers, and shaping a culturally sensitive curriculum (Royal College of Speech and Language Therapists, 2019d, 2019b, 2021e). Academic research has emphasised the importance of cultural competence for therapists (Litosseliti and Leadbeater, 2014; Babatsouli, 2021). So, there is interest in how to improve the SLT curriculum to better consider gender and ethnicity, such as teaching clinical skills on cultural competence/awareness (Daughrity, 2021), and integrating content on sexuality (Mahendra, 2019). There are also efforts to improve the marketing of SLT, which recognises a need to collect stories and diverse photos of therapists for careers promotion, possible development of a student's network, and wider social media use (McCormick, Napier and Longhurst, 2019; Royal College of Speech and Language Therapists, 2019d; Napier and O'Flynn, 2020). SLT students recommend showcasing the different types of patients/problems, and technology used to increase men on SLT courses (Research Works Limited, 2020b). These efforts align with

recommendations for improving SLT recruitment in academic literature. For example, Litosseliti and Leadbeater (2013) suggest improving public education on SLT via the use of media, direct exposure to SLTs, involving men in recruitment processes, use of male therapists as role models, more salary and career prospect information, and changing the profession's title to remove its female connotations. However, these efforts may not improve minority ethnic recruitment (Stapleford and Todd, 1998). I could only source one study which explored diversity practice impact in SLT, which claimed that five types of university initiatives to improve the application and admission rates of minority ethnic students onto SLT courses were unsuccessful. These included positive statements and photographs of minority ethnic people in recruitment, links to access courses in other education institutions, international recruitment fairs, university outreach schemes, contact with local therapists/bilingual teams who had access to the community, academic literature in minority ethnic languages, and the acceptance of lower A-level grades. The authors did not state why these initiatives were unsuccessful.

I could not source information on efforts to improve other parts of the SLT career ladder other than by Stapleford and Todd (1998) and RCSLT plans. The former reported a lack of support for 'home' (i.e., not overseas) minority ethnic students, with SLT course tutorial systems and the encouragement of contact with other minority ethnic students acting as personal support mechanisms. The RCSLT seem focused on building an evidence-base for gender and/or ethnicity issues (e.g., more research on male AHPs and collecting data on therapist's ethnicity) and creating support mechanisms for under-represented groups (Royal College of Speech and Language Therapists, 2019d, 2019b; Napier and O'Flynn, 2020). Examples of the latter include diversity workshops/webinars, creation of male and minority ethnic therapist support networks, and consideration of how racism can be addressed in each of their projects. The RCSLT is also collaborating with the NHS and UK government to promote a business case for investing in the SLT workforce. For example, the RCSLT contributed to the NHS Long Term Plan (see section 4.2.4.2), which specifically mentions SLT twice (Royal College of Speech and Language Therapists, 2019c). The plan acknowledges a need to increase the SLT workforce, and the inclusion of SLT in new and more holistic care models that combine mental and physical services for young people. Collaboration with the NHS offers a potentially effective way to attract diverse applicants as the "We are the NHS" campaign was apparently highly successful in increasing male nursing applicants (NHS England, 2019). A business case for a diverse SLT workforce is also emphasised by the Department of Health for Northern Ireland. The department outlines increasing demands for

SLT services and how the SLT workforce can help deliver the government's "Delivering Together" programme which aims to transform the healthcare system to meet future demands (Speech and Language Therapy Project Group, 2019).

4.1.2 The role of social class

Literature that has considered social class (defined in section 4.3.3) presents it as an important characteristic affecting SLT students (Stapleford and Todd, 1998; Wordsworth, 2013). For example, ethnicity is portrayed as equally important as social class in a pilot study exploring the recruitment of minority ethnic students on three AHP courses (Stapleford and Todd, 1998). High-achieving, middle-class Asian girls would pursue high status careers like law and medicine. However, those who were working-class and less academic, would not find careers requiring long and onerous education prior to qualifying as appealing. So, social class is a SLT diversity issue. Also, a thesis exploring student AHP choices at one university, presented SLT as possessing higher social capital than other AHPs from a Bordieuan perspective (i.e., in group affiliations, social networks, cultural history, etc. - e.g., visible links to the upper class such as King George VI receiving SLT for his stammer) (Wordsworth, 2013). The thesis also cited literature presenting social class as the most important factor in higher education choices because it affects non-participation. For example, middle-class females mostly pursued AHP programmes at the university.

Some research shows that social class and ethnicity influence non-participation in volunteering and higher education choices. Volunteering may be necessary to gain real-life insight into an occupation, or to gain entry onto university courses. People of lower social class are less likely to volunteer than those of higher classes, and people of minority ethnic heritage have less positive volunteering experiences (Donahue *et al.*, 2020). Both groups also report similar barriers in applying to university, which includes wanting to study close to home, financial concerns, and needing to look after family (McCabe, Keast and Kaya, 2022).

At university, one study found that traditional entrants (i.e., A-Levels) outperform non-traditional entrants (i.e., access to higher education routes) on SLT degrees overall, on individual modules, and written exams, but performance is similar for some assessment types (e.g., clinical placements) (Smith and Mahon, 2013). However, non-traditional entrants were generally successful in completing their degrees, and more likely to practise SLT six-months

post-qualification than traditional entrants. So, class shapes academic performance, and may affect many SLT students, as 53% of therapist respondents in a 2020/21 HCPC survey had parents/guardians who did not hold a complete university degree or equivalent, when the respondent was 18 years old (Health and Care Professions Council, 2021a).

Social class did emerge as a subtheme during data collection phase, regarding therapist's experiences in entering the profession in terms of work experience and education (see section 6.1.3). A balanced approach to social class is encouraged when using an intersectional lens, where it is neither ignored as it often is, nor treated as vastly important (Walby, Armstrong and Strid, 2012; Ingram, 2021).

4.2 The experiences of under-represented groups in other healthcare professions and diversity efforts

Organisational studies literature and published reports highlight career barriers amongst gender and ethnically under-represented and disadvantaged healthcare professionals in the UK. Key concepts and theories emerging from this research will likely apply to, and so, inform my understanding of SLT lived experiences as such research is sparse (outlined in section 4.1). Most, but not all, of the studies cited refer to the UK NHS and certain professions like nursing, which receive a lot of research attention, perhaps due to their workforce size and staff shortage concerns. For example, nurses and midwives were the second largest NHS staff group in early 2020, yet had an estimated 8.1% staff shortfall in NHS hospital and community services in 2019 (Rolewicz and Palmer, 2020). The NHS has made efforts to address the career barriers discussed, but their impact is mixed.

4.2.1 Barriers to accessing healthcare professions

Within the literature, there appears a greater focus on ethnicity as a barrier to accessing healthcare professions than gender. This is perhaps because the NHS workforce is predominantly female (77%) (NHS Employers, 2019). However, gender does hinder access to senior roles when career progression is discussed shortly (NHS Employers, 2019).

Many studies present ethnicity as a barrier for minority ethnic groups in accessing healthcare education and NHS recruitment. One's access to wider, particularly educational, opportunities is shaped by social factors including social identity (e.g., ethnicity, class, etc.) (Kline, 2022). Some social groups have greater social capital than others (see section 4.3.3) (Poteyeva, 2018) which privileges them in securing jobs (Kline, 2022), especially those who are culturally similar to employers (Rivera, 2012). So, bias creeps into the design of job specifications and shortlisting processes, which disadvantages minority ethnic individuals and women in recruitment (Kline, 2022). Research shows that the language of, and criteria outlined in, job descriptions may deter women but not men applicants (Gaucher, Friesen and Kay, 2011; Mohr, 2014). Person specifications use flawed ideas of merit, and emphasise past success (e.g., CVs and references are deemed unreliable) over future potential to result in shortlisting bias (Kline, 2022). Evidence shows that minority ethnic groups are disadvantaged in British medical school application processes (McManus, Esmail and Demetriou, 1998). Also, NHS recruitment dispropotionately favours White applicants (Oikelome, 2007; Santry, 2008). Minority ethnic applicants are less likely to be invited to, or chosen after, interviews (Oikelome, 2007). They are 3.5 times less likely to be appointed within NHS England Trusts than White applicants, and 1.8 times less likely to move from shortlist to appointment (Jaques, 2013; Kline, 2013). Medical doctors have reported instances where Consultants openly stated an inability to pronounce *"funny foreign name(s)"*, and clearly removed overseas candidate submissions when sieving through applications (Singh, 2003, page 1418).

Another compounding barrier is poor candidate feedback. Sometimes NHS staff receive biased feedback in their appraisals (e.g., question framing biase-prone) (Kline, 2021). So, it is plausible that such poor feedback extends to NHS job candidates, such as failing to clarify why a job was not secured (Kline, 2022).

4.2.2 Ethnicity-related workplace experiences and marginalisation

Minority ethnic healthcare staff are marginalised in different ways throughout their careers. Discourses on marginalisation conceptualise it in different ways, but essentially it is the exclusion of people or groups from parts of society by denying them equal opportunities, learning, and participation (i.e., linked to capital – see section 4.3.3) (Mowat, 2015). It can happen in different forms, at different levels (in/formal), in a particular context (i.e., time and place), and form part of one's lived experience if internalised (Mowat, 2015). Cohort studies

of medical graduate careers report racism throughout medical training and careers, which is sustained by trainee's reluctance to complain (Singh, 2003). The risk for discrimination and/or harassment in 2019 was highest for women, Black, migrant, nurse, and healthcare assistant staff across many London NHS Trusts (Rhead *et al.*, 2021). It is widely established that NHS minority ethnic staff have poorer experiences than White staff across all Workforce Race Equality Standard (WRES) metrics (Shields and Price, 2002; Carvel, 2003; Healy and Oikelome, 2006). WRES compares minority ethnic and White staff experiences on nine indicators over a 12-month period, with the former performing worse across metrics for 2020 (NHS England, 2021c). Minority ethnic staff represented 21% of all staff in NHS England Trusts, but just 7% of those in the very senior manager pay band and 10% of Trust Board members. White applicants were 1.61 times more likely than minority ethnic applicants to be appointed from shortlisting. Minority ethnic staff were less likely to think that their Trust offered fair progression/promotion (71.2% vs 86.9% White), and 1.16 times more likely to enter the fomal disciplinary process than White staff. They also personally experienced more harrassment, bullying, and abuse from the public, patients/service users and their relatives (30.3% vs 27.9% White). Experiences of the latter from staff were also reported to be higher (28.4% vs 23.6% White) including workplace discrimination (14.5% vs 6.0% White).

Professions requiring patient contact are most likely to be affected, such as SLTs. Unweighted WRES data are provided for different NHS staff groups for 2019 (NHS England and NHS Improvement, 2020). SLTs are not separately outlined, but would be included in the *"Allied Health Professionals, Healthcare Scientists and Scientific & Technical staff"* category. This group faced bullying, harrassment, and abuse from the public, patients/ services users and their relatives (20%), their managers (10%) and other colleagues (15%). But 46% did not report these experiences. Workplace discrimination was also experienced from patients (5%) and managers (10%). Discrimination was mostly based on ethnicity – i.e., racism (35%) and gender – i.e., sexism (24%).

Discrimination against minority ethnic staff can be subtle racial microaggressions (defined in section 4.3.2) at individual, organisational, and societal levels (Van Laer and Janssens, 2011; Ozturk and Berber, 2022). Subtle racism can occur in different ways at the individual level. White colleagues may ascribe minority ethnic professionals with deficit and excess characteristics (e.g., use negative stereotypes) (Ozturk and Berber, 2022). Jokes, questions, compliments, and comments about entire groups can signal and reinforce ideas of individuals

as foreign and of low status (Van Laer and Janssens, 2011). For example, co-workers reactions to religious or cultural practices can make individuals feel like they must justify or defend them. So, sometimes minority ethnic staff may be treated as representatives of their ethnic group whereby their background overshadows their professional competencies, and think that their differences are deemed problematic (Van Laer and Janssens, 2011). Also, White employees may behave in biased ways by being honest liars (i.e., claim to be non-racist, but their actual support is negligible – e.g., lip service) or strategic coverers (i.e., hold racists beliefs, even if not expressed explicitly) (Ozturk and Berber, 2022). When minority ethnic staff witness co-workers being unsupportive during subtle racism incidences, such as failing to intervene, they may question whether the status quo can be challenged (Van Laer and Janssens, 2011). Finally, White employees may act defensively against claims of racism (e.g., emotional reactions) (Ozturk and Berber, 2022). At the organisational level, there may be whitewashing (i.e., organisations focus on creating a non-discriminatory equality-valuing image instead of addressing racism), upstream exclusion (i.e., lack of diversity at senior levels), and management denial (i.e., tendency of middle and senior managers to deny rate and extent of racism) (Ozturk and Berber, 2022). Finally, growing societal racial intolerance can seep into organisations (e.g., government policies can deepen inequalities) (Ozturk and Berber, 2022). The impact is that minority ethnic professionals face patterns of marginalisation including exclusion, rejection, and their work is devalued (Oikelome and Healy, 2007; Van Laer and Janssens, 2011; Health Education England and NHS England and NHS Improvement, 2022; Ozturk and Berber, 2022). So, they have low feelings of organisational belonging. All of this reinforces and hides racial inequality and emboldens perpertrators.

Many examples of microaggressions in the NHS exist. A survey of racial discrimination and harassment in the London primary care workforce reported that subtle or underhand comments or actions (69%) were the most common form faced (Health Education England and NHS England and NHS Improvement, 2022). Minority ethnic staff shared experiences of being undermined, put down, ignored, and disrespected. They were also intentionally (e.g., not favoured for training or promotion) or unintentionally (e.g., social activities were around alcohol) excluded from workplace activities, discussions, or opportunities. Exclusion can be psychologically and physiologically distressing even in the smallest form, such as by a computer or stranger (Zadro, Williams and Richardson, 2004; Böckler, Rennert and Raettig, 2021). Also, overseas-trained doctors and nurses have higher career aspirations and earnings than their UK-trained counterparts, yet are treated as second class. This finding was reported

in a 2004 survey of 1,715 doctors in the *Staff and Associate Specialist Group* (Oikelome and Healy, 2007). Overseas doctors had a higher average total annual salary (£59,106.25 vs. £56,113.54), with fewer plans to stay in their current grade (11% vs. 26%) and greater intentions to reach Consultant grades (54% vs. 18%), than their UK qualified counterparts. However, they faced second class treatment characterised by longer working hours, their skills and experiences unrecognised nor valued, less autonomy, discrimination, and lower morale (Smith *et al.*, 2006; Oikelome, 2007; Oikelome and Healy, 2007). Overseas staff experiences are relevant because many are from minority ethnic backgrounds. For example, of all NHS staff in England whose nationality was known, 14% reported a non-British nationality in January 2020; mostly Indian, Fillipino, and Irish (Baker, 2020). Doctors in hospitals and community health services, where ethnicity was known, were mostly British (71%), followed by Asian (14% - mostly Indian), European (9% - mostly Irish), Black (5% - mostly Egyptian), and other nationalities (mostly Canadian) (Baker, 2020).

Morale is also low across AHPs. The NHS staff survey has a morale theme based on a group of questions which are scored out of ten, with higher scores indicating a more favourable outcome. The morale theme scored 6.2/10 from employees in the *"Allied Health Professionals, Healthcare Scientists and Scientific & Technical staff"* category (NHS England and NHS Improvement, 2020). Also, a 2009 survey reported that more minority ethnic nurses were less satisifed in their current role (57%) and so would leave their profession if possible (33%) or change jobs especially in care homes (51%) than White nurses (62%, 22% and 29% respectively).

Many examples of such minority ethnic disadvantage in the NHS exist. Intersectionality, and Whiteness and critical race theories explain how minority ethnic groups are disadvantaged in organisations and society overall (see section 4.3). Specifically, White ethnicities are socially constructed as the norm, privileged, and have practices (e.g., biased institutional processes) which present minority ethnic groups as culturally deficit, and mean that they frequently face racism across society, with White ethnicities generally unmotivated to address racist practices unless they materially benefit from doing so. For example, minority ethnic staff are overrepresented in NHS Trust disciplinary processes (Sehmi, 2015). Minority ethnic doctors are disproportinately more likely to face General Medical Council 'fitness to practice' referrals by employers and healthcare providers (Atewologun and Kline, 2019). The many interlinked factors underlying this disproportionate representation signal biased institutional processes. For

example, poor inductions, lack of support and feedback, inaccessible leadership, isolated/segregated working patterns/locations, "outsiders" treatment/stereotypes, and blame cultures (Atewologun and Kline, 2019). Also, structural discrimination possibly contributed to the disproportionately high mortality rate of NHS minority ethnic staff during the Covid-19 pandemic (Chaudhry *et al.*, 2020). Despite only comprising approximately 21% of the NHS workforce, 63% of the 119 staff that died and whose ethnicity is known, were of minority ethnic heritage, mostly Black (27%) and Asian (36%) (Cook, Kursumovic and Lennane, 2020). In March 2020, the NHS asked all services including SLTs, to redeploy their clinical staff to deliver critical care for Covid-19 patients (Royal College of Speech and Language Therapists, 2020a; Chadd, Moyse and Enderby, 2021). A survey of the UK minority ethnic healthcare community outlined concerns about unfair ethnicity-based deployment to high-risk areas for Covid-19 exposure (e.g., frontlines) (ITV News, 2020). Some claimed an inability to speak out for fear of losing jobs or being judged.

All of the negative NHS workplace experiences described are concerning for two reasons. First, they affect staff well-being, and job satisfaction (Rhead *et al.*, 2021) and retention, representing the prime negative reasons why nurses (Ball and Pike, 2009), and minority ethnic NHS leaders (NHS Confederation, 2022b) consider leaving their jobs. Staffing has overtaken funding as the biggest risk facing the healthcare sector (The King's Fund, 2018). Staff shortages are estimated to reach 250,000 by 2030 (The King's Fund, 2018) and increasing numbers of nurses and doctors are prematurely leaving their roles (Bailey, 2020). Also, the NHS Long Term Plan (see section 4.2.4.2) explicity acknowledges the SLT workforce as being in short supply (Royal College of Speech and Language Therapists, 2019c). So, second, these trends will likely result in poor healthcare (e.g., longer waiting lists) and staff wellbeing, and secured funding going unspent because of potentially fewer staff to utilise it (The King's Fund, 2018). NHS staff experiences are closely linked to patient outcomes, including patient satisfaction and quality of care (Dawson, 2009; West *et al.*, 2012). Whilst international recruitment is crucial for meeting NHS staffing targets (Buchan and Seccombe, 2006) (e.g., the UK government target of 50,000 nurses by 2024 (Collins, 2021)), nurse inflow from international recruitment has been noticeably dropping (Buchan and Seccombe, 2006). This decline is linked to NHS funding challenges, fewer posts for newly qualified nurses (Buchan and Seccombe, 2006), global Covid-19 pandemic travel restrictions (Collins, 2020), and potential Brexit impacts (Dalingwater, 2019).

4.2.3 Differential career progression and gender-typing of healthcare roles

An occupational segregation lens is useful to study the career progression of under-represented or disadvantaged groups within healthcare. Labour market segregation is often discussed in relation to gender, which can happen horizontally and vertically (Hakim, 1979). Horizontal segregation refers to differences in how many men and women choose or are in different occupations, which feminises or masculinises occupations. Vertical segregation refers to women holding lower-level jobs which have poor pay and progression within an organisation/occupation than men, with leadership typically composed of White men (Hakim, 1979). Differential career progression and gender/ethnic imbalance in management are well documented NHS diversity issues which are oultined below, and reflect both vertical and horizontal segregation. Poor leadership diversity means an NHS failure to fulfil its goal of good representation, which involves making senior teams reflective of the communities that it serves (NHS Leadership academy, 2012). There are debates about what good representation is, and concerns that focusing on numbers to signify improvements may be misleading (Mulcahy and Linehan, 2014). For example, reaching a minimum level of Board diversity may not always translate into more awareness of, or investment in, minority ethnic work prospects (Law, 1997; Culley, 2001).

For ethnicity, the NHS shows clear signs of "snowcapping" (Harrison, 2003). This is the disproportionate concentration of minority ethnic staff in lower grades/occupations of the health service pyramid, whilst many White staff are at the top. This is akin to the "sticky floor" phenomenon which refers to low paying occupations with little promotion scope, which essentially excludes women and minority ethnic individuals from high positions (Harlan and Berheide, 1994). For example, minority ethnic staff are more likely to be in midwifery, nursing, and health visiting (19%) than other occupations (Oikelome, 2007). They are poorly represented across many senior positions relative to their overall workforce levels (19.7% in 2019), including senior manager (6.5%), Medical Director (19.5%), non-Executive Director (11%), Chair (7%), Chief Executive (5%), Nursing and Quality Director, and Director of Operation positions (both 4%) (O'Dwyer-Cunliffe and Russell, 2021). This data only reflects survey respondents in the NHS Provider's annual renumeration survey 2019/20. But other research shows that minority ethnic staff are three times less likely to be senior and very senior managers in the NHS, with reports of 6.5% in 2019, than White staff (Kline, 2014; The WRES Implementation Team, 2020). Such findings support intersectionality and Whiteness/critical

race theories, as the former positions inequality and power dynamics in all social identities, and the latter two present White ethnicities as powerholders, and minority ethnic discrimination as pervasive, in society.

Minority ethnic healthcare professionals see their ethnicity as a career barrier. Minority ethnic doctors report their ethnicity as significantly hindering their medical careers: in medical training, early career opportunities, access to specialties, and progression (Singh, 2003). Many minority ethnic UK-qualified nurses feel inappropriately graded and hold fewer advanced or specialist positions than White nurses (Ball and Pike, 2009). Also, women (55%) and minority ethnic (51%) staff were perceived as generally experiencing career progression barriers in a survey of 120 NHS radiographers (Bogg and Hussain, 2010). One such barrier is slower promotions, with minority ethnic AHP staff significantly disadvantaged, resulting in 4-9% (approximately £40,000) fewer earnings over a whole career (Pudney and Shields, 2000).

Discrimination shapes differential career progression. More minority ethnic (20%) than White British (11%) staff in UK organisations cited discrimination as limiting their career progression (20%) when it mismatched their expectations (Miller, 2019). A study on Ghanaian NHS nurses and midwives showed how informal progression processes can undermine fair formal procedures, which creates space for discrimination within organisations (Henry, 2007). These staff had difficulty reaching senior positions supposedly because of cultural differences and knowledge gaps. These factors became institutionalised and embedded within ward practices, mainly because managerial support was unequally distributed. So, an informal promotions process to management emerged characterised by a lack of transparency, subjectivity, and culturally-specific criteria. Fewer minority ethnic (71%) than White (87%) staff believed that their organisation had fair career progression/promotion irrespective of protected characteristics in the 2019 NHS staff survey (NHS, 2019a).

Social connections (and so social capital) can interact with favouritism to shape informal recruitment practices in ways that favour dominant ethnic groups. The power and influence from employer-employee social relationships are leveraged during recruitment and promotion processes to favour White British, male employees (Hudson *et al.*, 2017). In this study, many minority ethnic and low-paid workers across four UK workforce sectors cited favouritism concerns in organisational progression. For example, in one case study, career opportunity allocations in local government was thought driven by ethnicity-based favouritism. White

British council employees received prior training which seemingly helped achieve higher grade assignments during their organisation's restructuring process, whilst Bangladeshi employees were not offered this training and were assigned to lower grades without explanation. Minority ethnic staff thought it was pointless to challenge these infomal practices because proving discrimination was difficult, informal behaviours were subtle, and only White British manager's views of workplace scenarios were thought accepted. These findings could apply to SLTs given their predominantly White workforce (see section 2.3.1). In the health sector, NHS staff groups vary in the encouragement and stretch opportunities (i.e., tasks that push and so improve one's current skills or knowledge - e.g., secondments) they recieve (Kline, 2022). Such opportunities are important because senior NHS executives report that their key development mostly stemmed from learning through experience/job (70%), from others especially certain people (e.g., mentors/coaches) (20%), and formal training/work (10%) (National Improvement and Leadership Development Board, 2016). Yet, there are anecdotes of managers saying that when they personally encourage individuals from under-represented groups to apply for positions, these individual say they have never received such encouragement before (Kline, 2022). Under-represented groups who do receive mentoring, can face "protective hesitation" which has been reported amongst cross-ethnicity mentoring relationships, where White mentors are defensive or hesitant to provide honest feedback to minority ethnic staff (Thomas, 2001, page 8). Minority ethnic doctorss who do secure senior NHS positions are more likely to land in unpopular, deprived areas with many patients, and in less esteemed/popular institutions and specialties (Gill, 2001; McClenahan and Yardumian, 2001).

Women are disproportionately under-represented in senior positions compared to men, despite constituting most medical entrants (Moberly, 2018), and 77% of the NHS workforce (NHS Employers, 2019). This is likely driven by sexism, i.e., sex-based prejudice and discrimination, which is prevalent in the UK despite being illegal (Miller and Ayling, 2021). NHS leadership is a "snowy white peak", with minority ethnic and female staff absent from top NHS positions (Esmail, Kalra and Abel, 2005; Kline, 2014). Despite London's striking diversity, very few (reports of 8%), if any, Trust Board members are of minority ethnic heritage (Kline, 2014). Women fare better with 40% representation on NHS Trust Boards, and overall, comprise 69% of those in the highest NHS salary bands (8a-9), but this is still below NHS workforce and local population levels (Kline, 2014; NHS Employers, 2019). They are particularly under-represented at Chair and Chief Executive levels, holding just 47% of very senior, 45% of Chief

Executive, and 39% of Non-Executive Director positions in NHS England in 2018 (Kline, 2014; NHS Digital, 2019). This implies a "glass ceiling", which refers to an invisible barrier that prevents certain demographics, typically linked to women, from rising to higher career hierarchy levels (Cotter *et al.*, 2001). Glass ceilings are widely reported for women across healthcare, academia, and business sectors (Kalaitzi *et al.*, 2017). It is particularly pronounced for minority ethnic women in attaining promotion or management (Baldi and Mcbrier, 1997; Maume, 2004). Women who break the glass ceiling face a "glass cliff" (Ryan and Haslam, 2007) referring to how they are more likely to achieve leadership positions when an organisation is going through a precarious period, which means a high chance of failure (Ryan and Haslam, 2005). Glass cliff positions are stressful because risk of failure is high and usually comprises of a lack of support from colleagues and superiors, adeqaute information, and acknowledgement (Ryan *et al.*, 2007). So, women at the top report high levels of stress, exhaustion, and burnout (Lundberg and Frankenhaeuser, 1999; Burke, 2004; McKinsey and Company, 2020). They generally become decreasingly ambitious and committed to their role and organisation, resulting in disidentifying with and leaving their organisation (Ryan *et al.*, 2007). In contrast, men receive more work support than women (e.g., belonging to networks) which means challenging positions offer them opportunities to raise their organisational profile (Ryan *et al.*, 2007).

Women's under-representation in organisational leadership has focused on their ambition and choices. The *"opt-out revolution"*, whereby educated and successful women voluntarily leave their fruitful careers to become stay-at-home mothers, was presented by Belkin (2003) in the New York Times Magazine. The article presents women as exercising their right to choose, but also perpetuates the notion that they are innately less career ambitious/motivated than men. Evidence suggests otherwise. Young professional women start off ambitious but this erodes over time based on their workplace context and experience (Peters, Ryan and Haslam, 2013; Davey, 2015; Harman and Sealy, 2017). For example, young professional women question their organisational fit, facing frustration and uncertainty about reaching and being their authentic selves in senior positions, causing them to lower expectations and want to leave (Harman and Sealy, 2017). Also, senior women do not op-out of work altogether, but instead seek roles with more flexibility and work-life balance (Anderson, Vinnicombe and Singh, 2010). These findings align with case studies of women who are not mothers, opting out of traditionally "successful" careers, in favour of alternative work that redefines success and offers meaning and control over their work (Wilhoit, 2014). So, women do not intrinsically

lack ambition nor do they always opt out of leadership. Rather, they are pushed out and so seek careers where their ambition or success is more likely to manifest (Davey, 2015). These exits are driven by a lack of support and mentors/role models at the top of the career ladder (Davey, 2015). Role models, mentoring, and networking are important career enablers for minority ethnic employees and women (Schipani *et al.*, 2009; Miller, 2019). Unfortunately, many managers typically hire in their own image (Rivera, 2012). Gender imbalances in leadership can manifest into masculine organisational settings, leadership styles, and decision-making processes which disadvantages female staff (Miller, 2007).

In contrast, men are disproportionately privileged in career advancement despite their minority status in the NHS. Women do not progress as far or as fast as men in the NHS (Taylor, Lambert and Goldacre, 2009) which negatively affects their salaries, even if the gender pay gap has narrowed slightly (NHS digital, 2018a). Men are privileged even in female-dominated professions (e.g., men seen as better leadership material) (Williams, 1992). For example, UK male nurses benefit in pay and opportunity despite the profession being predominantly female (Punshon *et al.*, 2019). Men reached higher-grade nursing roles faster post-registration and, were over-represented in senior bands compared to the remaining nursing workforce. This implies a "glass escalator"; a theory claiming that men enjoy better pay and faster career advancement (opportunity and promotions) within predominantly female or "pink collar" professions (Williams, 1992). This differential gender-based career progression can be understood by considering gender stereotypes which shape workplace experiences. Men are accepted as the normative type which affords them *"invisibility"* relative to their opposites (Puwar, 2004), with White men particularly enjoying privilege and power because White is deemed the absence of colour and male is not thought a gendered entity (Puwar, 2004). *Hegemonic masculinity* is most normative and culturally idealised in modern Western society, characterised by physical (tall, athletic and White), personality (stoic, courageous, and confident) and material (rich/professionally successful) traits (Connell, 1987; Connell and Messerschmidt, 2005; Berdahl *et al.*, 2018). Failing to comply with gender stereotypes can be mean facing penalisations. For example, sometimes assertive women are thought less likeable and so hireable (Mayer, 2018).

Male healthcare professionals adapt to contradicting social role expectations and their status in "female" professions in different ways. They specialise in domains or practice approaches considered typically male (Kadushin, 1976). In nursing, men raise their power and position by

distancing themselves from female nurses and nursing's feminine image (Evans, 1997). Men are aware of their privilege in female professions, which they may actively justify by reframing it as personal success or a natural benefit of male bodies (Schwiter, Nentwich and Keller, 2021). However, male experiences within "female" professions are not universal. Black male nurses may not benefit from a "glass escalator". They face stereotypes from patients which impedes their caregiving, biases from supervisors in promotions, and tense colleague relationships (Wingfield, 2009). Also, some men must deal with prejudice outside of their profession which may cause distress. For example, stereotypes about the sexuality of male nurses, and safeguarding against sexual abuse accusations in professions requiring close contact with women and children (Williams, 1992). Literature cites a "revolving door effect" whereby social pressures push men in "female" professions out of them and into more masculine areas (Jacobs, 1993).

Childcare and working patterns represent structural barriers in the UK national context which negatively affect women's career progression. Feminist scholars relate women's poor labour market position to patriarchy, i.e., a "system of social structures and practices in which men dominate, oppress and exploit women" (Walby, 1990, p.20), and their subordinate status in society, and family structures (Hartmann, 1976; Walby, 1986, 1990, 1997; Anker, 1997; Steinmetz, 2012). Women's occupational choices are linked to employers ideas about ideal workers (Reskin, 1993), gender socialisation (Marini and Brinton, 1984; Corcoran and Courant, 1985; Perlman and Pike, 1994), gender-based stereotypes about roles (e.g., breadwinners/homemaker) and abilities (e.g., women's caring nature qualifies them for caring roles) (Kirton and Greene, 2005b; Steinmetz, 2012). For example, women are concentrated in specialties like nursing, and men in others like surgery (i.e., horizontal) (NHS digital, 2018b). Women shoulder the bulk of unpaid domestic and caring labour (Office for National Statistics, 2016b), which indirectly supports the male workforce (Kirton and Greene, 2005b). So, motherhood may negatively affect career progression, even in predominantly female professions. For example, in nursing, progression reduced incrementally as women had more and younger children, career breaks exceeding two years, and working part-time (McIntosh *et al.*, 2012). However, some studies say motherhood does not affect women who have always worked full-time, in the numbers or speed of reaching senior positions (Taylor, Lambert and Goldacre, 2009). Unfortunately, domestic and caring responsibilities means women are limited by time-space constraints (Pratt and Hanson, 1991) pushing them to seek local and flexible part-time work (Carers UK, 2014). A lack of part-time work may act as indirect discrimination

by shaping choice of specialties. For example, female doctors who did not always work full-time in their careers, were over-represented in general practice, but under-represented in surgery (Taylor, Lambert and Goldacre, 2009).

Many of the experiences cited in this section relate to the NHS. The next section outlines the NHS motivations for addressing the gender and ethnicity career barriers discussed, including if and how they have done so.

4.2.4 NHS diversity motivations, practices, and their criticisms

The NHS diversity approach is worthy of detailed exploration because it is a major employer of therapists, but also of women, and minority ethnic individuals. So, NHS diversity efforts could greatly address inequality within SLT and society more broadly. This section explores NHS diversity motivations, and if and how their gender and ethnic diversity issues described in the previous section are addressed.

4.2.4.1. Legal, regulatory, business, and moral diversity motivations and their criticisms

The NHS claims many motivations for pursuing diversity covering legal, moral/ethical, and business stances (Esmail, Kalra and Abel, 2005; NHS Providers, 2014; Warmington J, 2018; Hemmings *et al.*, 2021). Compliance to laws and regulations are key drivers of NHS diversity efforts. The NHS Constitution acknowledges all staff as having rights stemming from work and anti-discrimination legislation which intends to encourage a good, healthy, and safe workplace via various provisions (e.g., grievance processes, flexible working opportunities, etc.) (NHS England, 2009). There are also requirements to deliver on its Public Sector Equality Duty (PSED – described in section 3.1.1), Equality Delivery System, and Workforce Race Equality Standard (WRES – described in section 4.2.2) (Warmington J, 2018). It is questionable how effective regulatory diversity motivations are in the NHS since regulatory compliance levels vary in it. For example, only 88% of Primary Care Trusts were self-assessed as legally complying with regulatory obligations to uphold these rights in 2009 (NHS, 2011). Also, three Trusts were handed race equality compliance notices that had large financial implications; it cost one region about £495,000 in 2009/10 (NHS, 2011).

The business case for diversity which centres on economic rationality (Kirton and Greene, 2005b), whereby organisational workforce diversity is associated with business benefits (e.g., gaining valuable human resources, opportunities to attract diverse clients, etc.) (Noon, 2007), is perhaps more evident in the NHS. For example, a business case is emphasised within NHS WRES reports (NHS Employers, 2020), by NHS Boards (NHS Providers, 2014; Warmington J, 2018) and non-NHS employers (Darling, 2017). WRES reports are mandatory measures of ethnicity-related representation and experience (Naqvi, Razaq and Piper, 2016). These reports present the business case as a tool to convince people who are sceptical or lack buy-in, about the need for effort and resources in diversity initiatives (Darling, 2017). Public sector diversity stakeholders combine social justice and business case arguments for pursuing diversity, because financial concerns are a NHS priority which makes "value for money" a justification (Ozbilgin and Tatli, 2011, page 1241). WRES reports also cite many business-related measures. These include staff performance (e.g., better patient care), recruitment and retention (e.g., competition for talent), and organisational productivity (e.g., better financial returns), reputation (e.g., attracting talent) and risk (e.g., lowering legal challenge risks) (West, Dawson and Mandip, 2012; Darling, 2017; Warmington J, 2018; NHS Employers, 2020).

The business case for diversity has shortfalls (see section 3.1.2.2), but its heavy emphasis in the NHS context is explored here. First, there is little support for the business case (discussed later) which stems from the private sector (Johns, Green and Powell, 2012). Public sector organisations like the NHS are not really businesses even when considering reforms which imitate market characteristics (Johns, Green and Powell, 2012). In 2002, the New Labour government introduced six types of market-like reforms to NHS England to make it more patient-centred and improve its performance (Mays, Dixon and Jones, 2011). Reforms included allowing patients to choose providers, more diverse providers, stronger commissioning, greater publicly-owned hospital autonomy, regulatory framework revisions, and finally introducing Payment by Result; an activity-based payment system for acute healthcare providers (Mays, Dixon and Jones, 2011).

Second, moral cases for diversity should arguably be prioritised over business cases because what is right outranks what is expedient (Johns, Green and Powell, 2012). Each NHS system has core values which imply moral diversity motivations. For example, NHS England has a Constitution comprising six core values and seven principles to bind and serve patients, staff,

and the public (NHS Health Education England, 2020b). The Constitution outlines specific pledges to staff which signal a moral diversity case, covering support and opportunities for personal development and wellbeing, engaging staff in decision-making processes, and empowering them in contexts potentially affecting them or their services (NHS England, 2009). There are also many references to upholding moral principles or responsibilities such as inclusivity, modelling behaviour, fairness/ equity, and diversity as the right thing to do/positive part of organisational culture (Darling, 2017; Warmington J, 2018). Moral motivations are also implied amongst the core principles of NHS Wales (Gig Cymru NHS Wales, 2016), NHS Scotland (NHS Scotland, 2021) and HSCNI (Northern Health and Social Care Trust, 2020).

Alternatively, a quality case for pursuing diversity can be made (Commission for Racial Equality (CRE), 1995) where diverse health providers must address the diverse needs (e.g., cultural and linguistic) of diverse societies. This pulls the NHS diversity management approach back towards a more moral stance which suits the ethos of public service providers (Johns, Green and Powell, 2012). A positive link between workforce diversity and service delivery/performance is needed to support a quality case for NHS diversity. Such evidence exists, but is sparse. For example, the appointment of a Black nurse supposedly increased uptake of a sickle cell service in South England, which was based on that nurse's own testimony (Johns, 2006). Also, patients usually fare better when care is provided by more diverse teams, such as more accurate diagnoses, and patient satisfaction and adherence (Gomez and Bernet, 2019). However, the quality case for diversity may be used to question whether areas lacking ethnic diversity should have a diverse workforce (Swain and Nieli, 2003). Also, increased service uptake may not be considered a positive outcome for the NHS due to associated higher costs and stretching of its finite resources, unlike in the private sector where more customers means greater income (Johns, 2006).

4.2.4.2 Mixed evidence of the impact of NHS diversity efforts on minority groups

A recent report on attracting, supporting, and retaining a diverse NHS workforce found that NHS Trusts participate in many equality, diversity and inclusion (EDI) initiatives and interventions which are tailored to their local needs (Hemmings *et al.*, 2021). The report argued that a single, harmonised library of evidence-based interventions for tackling NHS inequalities is absent. There were, however, examples of Trust initiatives across 12 parameters which

signals a comphrehensive consideration of EDI across the NHS career pipeline. At the beginning of the pipeline, EDI considerations include attracting candidate pools (e.g., social media campaigns), job design, adverts, and applications (e.g., flexible working offers), shortlisting (e.g., monitoring positive action scheme impact), interviews and assessment (e.g., diversity and competence training for recruiting managers), and appointments (e.g., agreeing on working patterns). For the remainder of the career pipeline, EDI was considered in inductions (e.g., support via mentoring/buddying), ongoing support (e.g., staff networks), pay and conditions (e.g., EDI considerations in appraisals), staff development and progression (e.g., talent management schemes), leavers (e.g., return to work schemes), and governance and oversight (e.g., clear roles and responsibilities with links from EDI managers to CEO). According to the report, EDI interventions usually focused on policies, procedures, and training, which were acknowledged as having little material impact in isolation. NHS England published the NHS People's Plan in 2020, which is their workforce strategy (outlines actions for six areas, one of which is belongining in the NHS) for delivering their Long Term Plan (i.e., document outlining healthcare priorities for the next 10 years) (NHS, 2019c; NHS England, 2020c).

There appears few gender-specific initiatives outside of gender pay gap reporting requirements introduced in 2017 which applies to all NHS organisations, and some Trusts ensuring that job applicant shortlists feature more than one woman (Hemmings *et al.*, 2021). However, more general EDI initiatives which could alleviate gender barriers such as caring responsibilities and maternity (see section 4.2.3) do exist. For example, flexible working arrangements, gender-based staff networks (e.g., Health and Care Women Leaders Network), and return to work schemes (Hemmings *et al.*, 2021; NHS Confederation, 2022a).

The NHS has also tried to address racial discrimination. Since 2015, ethnicity data are collected and reported through its mandated WRES programme for all NHS providers (The WRES Implementation Team, 2020). Minority ethnic staff across all NHS Trusts report poorer experiences on all three metrics relative to their White counterparts (The WRES Implementation Team, 2020) (see chapter four). The WRES programme has dedicated resources including WRES expert leads across NHS regions and Model Employer targets for minority ethnic representation amongst senior staff (pay band 8a and above) introduced in 2019 (The WRES Implementation team, 2019). However, what NHS diversity should look like is debated, including how the concept should be measured and operationalised in practice (Johns,

2004). The lack of conceptual clarity between equal opportunities and diversity management (Ragins and Gonzalez, 2003) is problematic for the NHS. Policy goals from, and NHS references to, both management approaches are often mixed, without their nuances outlined (Johns, Green and Powell, 2012). Equality policies are sometimes confused as an outcome measure despite actually being referred to as a tool for improving equal opportunities (Johns, Green and Powell, 2012).

The NHS could use a proportional diversity approach where an organisation's diversity reflects that of the local or regional population (Iganski and Johns, 1998). So, the workforce and local/national populations are benchmarks for assessing the representativeness of minority ethnic groups at different organisational levels (Johns, Green and Powell, 2012). However, applying proportional diversity to employment is problematic when the local population lacks diversity (Johns, 2004). Minority ethnic workforce representation will vary according to UK areas (e.g., approximately 50% in London but may be as low as 1% in southwest England) (Johns, Green and Powell, 2012). So, proportion matching for senior management is controversial (Johns, Green and Powell, 2012). This limitation has been related to a stigma of incompetence and Noah's Ark Syndrome (Nelson, 1990). The former questions the status and abilities of those benefitting from proportional diversity, and the latter superficially links workforce numbers with service quality whereby including two of each minority group somehow implies diversity. Section 4.2 discusses how minority ethnic healthcare professionals are well represented in the NHS workforce, but are usually restricted to lower status/paid jobs. So, some critics use the NHS as a strong example of how increasing minority ethnic staff levels does not necessarily result in organisational change in ways that benefit them (Ward, 1993; Law, 1996).

The "success" of Trust diversity intitatives seemingly depends on three factors; the willingness of initiators to participate in consultations where needs are idenitified, the co-operation of different stakeholders, and clearly linking goals with evaluating outcomes (Oikelome, 2007). The NHS has ambitions to support its organisations to develop their diversity management capacity (NHS Employers, 2021a). Regarding stakeholders, NHS leadership has acknowledged a need to change their culture and style (Kline, 2014) and make diversity an institutional priority (Priest *et al.*, 2015). There has been investment in EDI leadership, with the appointment of Regional Equalities Leads, a Chief People Officer in 2019, and two joint EDI Directors in 2020 (Hemmings *et al.*, 2021; Kituno, 2021). Research on NHS leadership/management advocates for effective leadership and accountability to tackle inequality (Kalev, Dobbin and

Kelly, 2006; Kline, 2015; Equality and Human Rights Commission, 2016; Randhawa, 2018; Hemmings *et al.*, 2021; Business in the community, 2023) using a learning rather than blame culture (Kline, 2021). The NHS Leadership Academy has developed EDI-focused programmes to help leaders build the skills and capacity to create inclusive cultures and systems (e.g., Building leadership for inclusion) (NHS Leadership academy, 2019), with some specifically targetted at minority ethnic applicants to support their progression (e.g., Stepping up) (NHS Leadership academy, 2018). Also, there have been efforts to make Boards accountable such as goals of making its composition reflective the communities that it serves (NHS Leadership Academy Steering Group, 2013). A challenge of 50% women on Boards by 2020 has been embraced (Sealy, 2017). The WRES programme prompts Boards to consider their organisational culture and race equality performance (Randhawa, 2018). Yet, there are reports of inconsistent prioritisation and ownership of EDI by senior NHS leaders (Hemmings *et al.*, 2021). Also, the complexity of (i.e., comprises of many organisations), and anticipated changes to, the NHS organisational structure, makes it hard to place accountability which is unequal across central and national NHS stakeholders, and there are doubts about the collaboration between (e.g., between the seven regional EDI leads), and support for (e.g., WRES leads), some of them (Hemmings *et al.*, 2021).

Some research suggests positive strides for ethnicity, but some critics say progress is not enough (West, Randhawa and Dawson, 2015). For example, around 40,000 race equality schemes were developed across UK organisations, and initiatives featuring minority ethnic networks signal positive outcomes (Kingsley and Pawar, 2002; Breitenbach, 2003; Royal College of Nursing, 2005; Healy and Oikelome, 2006; NHS Employers, 2006). Yet, critics say the NHS falls behind other sectors in broadly embracing the diversity agenda, and grasping the benefits of a diverse workforce (Randhawa, 2015). For example, despite some progress in raising awareness, the NHS continues to talk about difference and run "piecemeal initiatives" that are "tinkering around the edges" without any real impact (Randhawa, 2015). Critics claim that other sectors have gone further to strategically embrace diversity, and accuse the NHS of a narrow diversity vision which typically views improved Board member diversity as the final goal instead of just the start of a sustained diversity journey (Randhawa, 2015). National ethnicity-based efforts have focused on improving the recruitment and retention of minority ethnic staff through intiatives like "positively diverse", but their effectiveness is mixed (Oikelome, 2007). Pessimism surrounds racial equality policies, staff have "initiative fatigue",

and benefits from national level efforts do not always trickle down to minority ethnic staff (Esmail and Everington, 1997; Oikelome, 2007, page 4; Bogg and Hussain, 2010).

Sometimes references to NHS financial challenges is used to encourage sustained diversity efforts (Randhawa, 2015). So, funding is presented as a diversity issue. It is debatable whether the NHS can be considered underfunded (Dixon et al, 1997), but its resources have been negatively affected by austerity and the Covid-19 pandemic (The King's Fund, 2021). There are signs of financial commitment to sustained diversity efforts. The NHS Long Term Plan, published in 2019, proposes to reduce NHS ethnic inequality by investing £1 million annually until at least 2025 and, appointing 42 experts to facilitate the process (NHS, 2019b). One way that this ten-year plan aims to improve patient care relates to its workforce (NHS, 2019c, 2019d), which includes increasing it (e.g., by increasing recruitment and training) and improving workplaces (e.g., greater flexible working and funding for training). This plan implicates SLT workforce diversity (see section 4.2.2). Yet, funding for EDI initiatives varies across the NHS (Hemmings *et al.*, 2021).

The current NHS pay system, Agenda for Change (AfC), poses another financial diversity issue. Prior to AfC was the Whitley Council system which used national bargaining units, involved many stakeholders representing different staff groups (e.g., staff associations, trades unions), and was criticised as too complex and inflexible (Buchan and Evans, 2008). In 1997, the Labour Government outlined NHS modernisation plans in its White Paper on Health, which introduced the AfC as a new pay system with two main features, and was implemented in England in 2004 (Buchan and Evans, 2008). AfC has two national pay spines (healthcare professionals and other NHS employees) with nine pay bands on each as measured by a national job evaluation scheme and a Knowledge and Skills Framework determining staff pay and progression (Buchan and Evans, 2008). Improved equal opportunity and diversity in accessing NHS careers, training, and working patterns was presented as an indicator of AfC success, which was expected to manifest during its implementation and assessed mostly using a staff attitude survey (Buchan and Evans, 2007). Reception of the AfC system has been mixed, with some Trust managers in favour by citing anticipated benefits (e.g., fairness), and capacity for new roles and working practices (Buchan and Evans, 2008). However, some staff groups such as nurses saw AfC as failing to meet its policy goals, such as claiming a lack of rigour in the banding evaluation process (McCafferty and Hill, 2015).

There are many potential reasons for the ongoing challenges discussed. One reason is implementation gaps, such as the equality-implementation and intention/policy-implementation gaps (see section 3.3.5) For example, the intention-implementation gap was reported in a study of minority ethnic nurse experiences, where policies were not translated into specific goals (e.g., checking training opportunity allocations) (Culley, 2001). Also, analysis of monitoring data or policy impact was lacking (e.g., whether policy was being implemented and doing its job). Unfortunately, evaluating NHS diversity initiative outcomes is difficult; it is not routinely done which negatively affects sharing good practice (Hemmings *et al.*, 2021). This is because Trusts implement many initiatives simultaneously, central funding to help them independently monitor and evaluate initiative impact is absent, there is limited data for evaluating smaller initiative impact, and impact can vary based on certain factors (e.g., context/service, by staff group, etc.) (Hemmings *et al.*, 2021). The study also found poor awareness and understanding of equal opportunities policy, and the associated responsibilities amongst middle and line management (e.g., Ward sisters) (Culley, 2001). This supports literature showing poor awareness, and engagement with, formal EDI policies (Ahmed, 2007b; Perren *et al.*, 2012; Nguyen *et al.*, 2019).

Costs and contracting out services/internal markets may be a further reason why NHS equal opportunities policy implementation has been slow and patchy (Culley, 2001). Trusts with improved minority ethnic healthcare and employment coexist with others that are completely inactive on these fronts (Culley, 2001). This is partly because the NHS and Community Care Act (1990) decentralisated NHS management, offering greater autonomy to Ward Managers which allowed space for discriminatory management recruitment decisions (Carter, 2000; Culley, 2001). In 1995, a national survey explored the impact of introducing the NHS internal market in 1991 on 197 NHS SLT managers and their services (May and Pope, 1997). Managers mostly viewed the NHS changes as negatively impacting their work and services, especially causing stress. Managers had greater work demands, administrative work which caused resentment, and responsibility for their service direction as well as showing the value of SLT. Many managers did not hold formal managerial qualifications nor had undertaken sufficient training to support their roles. Insufficient managerial expertise and increased responsibilities may create space for unfair practices. However, some managers embraced the changes as opportunities to make their services more business-like (e.g., directly negotiated contracts involving their services) and increase job satisfaction.

4.3 Theoretical debates on intersectionality, Whiteness/critical race theory, and social capital

I discuss theoretical debates on intersectionality, Whiteness/critical race theory and social capital because they offer insight about the manifestion and study of ethnic inequality.

4.3.1 Intersectionality

Organisation and management scholarship has increasingly recognised intersectionality as important when studying workforce inequality (e.g., see Tatli and Özbilgin, 2012; Rodriguez *et al.*, 2016; Atewologun, 2018). Intersectionality refers to individuals as holding multiple social identities (e.g., gender, ethnicity, and class) which intersect and interact to shape their experiences, including different privilege and oppression levels (Norris, Murphy-Erby and Zajicek, 2007). I describe intersectionality regarding its development, research value, and operationalisation.

4.3.1.1 The development of intersectionality

The work of Crenshaw (1989; 1991), McCall (2005) and Hancock (2007) were pivotal in developing the intersectionality field. Its origins can be traced back to the experiences of Black women who criticised hegemonic White feminism as exclusionary because it mainly focused on White, middle-class, women's lives (Baca Zinn and Dill, 1996; Atewologun, 2018). So, minority voices were silenced. For example, the work of Anna Cooper describes her invisibility as a minority ethnic woman when choosing between using the *"for ladies"* or "*for colored people"* lavatory in a train station, as the former implied use by only White women, and the latter for only Black men (Norris, Murphy-Erby and Zajicek, 2007). Crenshaw coined intersectionality in 1989, arguing that feminist and anti-racist movements only treated gender and ethnicity as dominant respectively, thus failing to consider those at the intersections of both, namely minority ethnic women (Crenshaw, 1989; Crenshaw *et al.*, 1991). Interlocking oppressions (Collins, 1990) and gendered racism (Essed, 1991) are similar ideas around multiple identity impact. So, intersectionality emerged to account for the experiences of people whose identity has two or more disadvantaged social categories (Norris, Murphy-Erby and Zajicek, 2007) and has advanced to consider how they are embedded within power/privilege systems (e.g., racism) (Crenshaw et al., 1991; Carastathis, 2014) requiring consideration of historical and socio-cultural context (Warner, 2008). Intersectionality became popular in legal,

political, and sociological academic scholarship, especially in feminist discourses to understand multiple or compound oppression and interactions between different categories (Atewologun, 2018). It was mainly used as a framework in work and organisational studies to evaluate how gender and ethnicity shape positions and experiences in job hierarchies (Bradley and Healy, 2008), but advanced to consider how inequalities manifest within workplace structures – e.g., see Acker's gendered organisations and inequality regimes (Acker, 1990, 2006; Rodriguez *et al.*, 2016). McCall (2005) outlines three approaches to studying intersectionality. *Anticategorical complexity* rejects fixed social categories because their rigidness cannot capture social life complexity. *Intercategorical complexity* strategically uses existing social categories as a starting point to study inequality amongst social groups and how they change over time across dimensions. Finally, *intracategorical complexity* lies conceptually between these two approaches, focusing on exploring the lived experience of a specific group at the intersection of traditional social categories to uncover their complexity. McCall acknowledges that some intersectionality research cannot be categorised into one of these, or may blend aspects from different, approaches.

Intersectionality was mainly used in business and management studies to understand individual experiences and within-group differences – e.g., see *"content specialization"* (Hancock, 2007) and *"intracategorical"* approach above (McCall, 2005). Adib and Guerrier (2003) exemplify this approach in their study of how women hotel workers navigated their ethnicity, nationality, and class identities within their workplace power dynamics. The women presented these identities as simultaneous but fluid because they emphasised or downplayed different identities at different times, sometimes as resistance.

Other studies, notably from a critical approach, illustrate how structural power dynamics (control, resources, goals), and the impact of structures, ideologies and experiences perpetuate societal inequalities in workplaces (Atewologun, 2018). For example, see *"systemic intersectionality"* (i.e., different inequalities intersect and interact in social structures challenging the notion of one inequality as being more important than others) (Choo and Ferree, 2010), *"intercategorical"* approach (McCall, 2005), and advocacy for focusing on power mechanisms including differentiation processes shaping experiences (e.g., racialisation) and their associated domination system (e.g., racism) (Dhamoon, 2011). Browne and Misra (2003) exemplify this critical approach by showing how ethnicity, nationality, gender, and class intersect in the labour market. Immigrant women, who possibly held good jobs in their home countries, typically undertook low-paid housework and childcare for high-paid US-based

professionals. These professionals usually undervalued immigrant women's experiences and poorly paid them based on assumptions that they were not breadwinners and had better earning potential in the US than in their home country.

The "both/and" logic represents a more comprehensive intersectional approach; it assesses individual identities, makes group level comparisons, and then assesses how different factors intersect to shape different experiences (Warner, Settles and Shields, 2016). Atewologun (2018) details three "both/and" logic methods, one of which I used, which involves exploring cultural stories at different levels, i.e., linking personal career stories to organizational narratives and broader cultural stereotypes.

4.3.1.2 The benefits of embracing intersectionality

Researchers can benefit from considering intersectionality. First, intersectional thinking helps improve scholarship. It offers theoretical insights on how one's multiple social identities are affected by different interacting oppression and privilege systems (Garry, 2011; Atewologun, 2018). Also, it helps understandings of how eurocentrism and colonial legacies affect feminism, and how ingrained gender-, ethnicity- and class-based biases affect methods, issue framing, and preferences for certain Western philosophical positions (Garry, 2011). Intersectional thinking does this by directing researchers where to start identifying issues and what kinds of questions to ask, namely from the perspectives of the marginalised or those outside of Western philosophy (Garry, 2011). It offers diverse perspectives of the same facts, thus enabling fair solutions to inequality issues (e.g., explanations of women's fertility usually considers social class but overlooks ethnicity) (Clarke and McCall, 2013).

Second, intersectionality rejects identities as additive or reductive, but instead explores how oppressions and privileges interact at an individual and structural level (Garry, 2011). Some intersectional research presents privilege and disadvantage as fluid, intertwined and contextual. For example, a study of minority ethnic senior individuals in a UK government department and global professional services firm presented privilege as contextual, conferred, and contested (Atewologun and Sealy, 2014). Privilege was socio-demographically positioned and so *contextual;* individuals recognised entering privileged spaces through self-comparison and self-categorisation against colleagues at the intersection of privilege and disadvantage. For example, one senior minority ethnic woman consciously tried to position herself within the ethnic, gender, and age composition of attendees at a training session for senior government

officials. Privilege was *conferred* in a relational and bestowed manner; shared among in-group members and granted to new arrivals based on sharing similar identities. For example, sharing an Indian ethnicity with a colleague fostered affinity that granted knowledge about and access to exclusive networks holding career progression resources. Finally, privilege cannot be assumed because it is *contested* and asserted at its intersections with other social categories. For example, a Black senior manager faced assumptions about his competence and seniority by clients because of his skin colour. These privilege dimensions are echoed in a study of elite women leaders; their privilege was conferred, contested and defended based on whether their bodies and appearance conformed to or challenged stereotypes about leadership and femininity (Mavin and Grandy, 2016). For example, privilege was *defended* when elite women rejected feminine stereotypes as a part of their credibility or who they are as leaders (e.g., expressing disinterest in fashionable clothing). Research also showcases the fluidity of oppression on the axes of ethnicity, gender and sexuality amongst LGBT mid-level managers in a South African workplace (Luiz and Terziev, 2024).

Third, intersectionality applies to everyone, urging people to recognise the privilege and oppressor in their identity and positionality (Collins, 1993; Garry, 2011). This includes dominant group members acknowledging their ignorance of marginalised people, such as some White people cannot see themselves or their thinking as raced (Garry, 2011). This acknowledgement process shifts focus from White feminists, reduces overgeneralisations, and improves awareness of relationality and hierarchical power amongst women (e.g., how much privileged women depend on other women's childcare and household work) (Garry, 2011).

Finally, practically, intersectional thinking helps people to identify and understand their stakes in specific issues, foster alliances or solidarity despite salient differences, offers methodological standards, and highlights useful analyses, namely those considering intersections and interactions of social identities and oppressions (Garry, 2011).

4.3.1.3 Practising intersectionality

There are debates and limitations to consider when practising intersectionality. First, the term intersectionality is flexible, broad, and complex (Atewologun, 2018). For example, it has been referred to as a metaphor, concept, an ideograph, research paradigm, a consideration when analysing identity and power, and knowledge project (Hulko, 2009; Garry, 2011; Rodriguez *et al.*, 2016). Else-Quest and Hyde (2016) outline three common assumptions underlying most

intersectionality definitions. First, they recognise every person as simultaneously holding multiple social identities (e.g., gender, ethnicity, etc.) which interact (i.e., experiences of different identities are linked). Second, power and inequality dynamics must be considered as they are assumed present in and affect every social identity, whether dominant or disadvantaged. Third, social identities are tied to personal identities and wider processes and practices in organisations and society. So, experiences, and the meaning and value of social identities is potentially fluid and dynamic.

Some scholars frame intersectionality as a perspective; a framework offering methodological standards (Garry, 2011) or paradigm given its broad use (collection of theoretical ideas, belief system, and analysis method) to assess social identities in ways that are not additive nor reductive (i.e., capture the complexity of how identities interact and shape experiences) (Hulko, 2009).

Other scholars have theorised intersectionality. Intersectionality tries to explain and address people's multiple positionality and interlocking oppressions in society (Clarke and McCall, 2013). As a critical theory, intersectionality helps us organise and understand knowledge, recognise power as shaping how we think, experience, and learn, seeks social justice, and aligns well with Social Constructivist and feminist epistemologies (Else-Quest and Hyde, 2016). Both Constructivism (my thesis alignment – see section 5.1) and intersectionality see knowledge as contextually bound (de Vries, 2015).

Second, it is challenging to decide which and how many social identities, oppressions, and intersections to consider. Intersectionality makes identities messy and complex (Garry, 2011). de Vries (2015) study of transgender individuals considered 12 categories (race, gender, sexuality, class, nationality, language, religion, culture, ethnicity, ability, body size, and age) from subjective (i.e., self-perceptions) and objective (i.e., other's perspectives) angles. Anthias (2013) advises against reducing differences to identities and making exhaustive lists of identities or debating which is most important. Tatli and Özbilgin (2012) suggests an emic than predominant etic approach. The former tries to understand identities operating within their specific relationships and settings, whilst the latter uses predefined identities. They present the emic approach as allowing new categories of difference to emerge from data, which involves applying Bourdieu's theory of social capital to identify differences in how people acquire resources. This complements scholarly recommendation to study both potentially overlooked

power/privilege and oppression/marginalised voices (Anthias, 2013; Atewologun, 2018; Atewologun and Mahalingam, 2018). I considered therapists from dominant and marginalised groups for gender and ethnicity (intercategorical approach) although emphasis was on under-represented voices (i.e., male, and minority ethnic therapists), and focused on understanding how different identities operate within specific relationships (e.g., with colleagues) and settings (e.g., NHS) in SLT (emic approach).

Intersectionality is also criticised for not being a methodology, not offering theories of power, oppression, identity, or agency, nor allowing analyses of these factors by itself (Garry, 2011). Some scholars offer practical steps for applying intersectionality to research which I have considered. For example, Rodriguez *et al.* (2016) outlines three steps. First, researchers must decide what data to collect and how. I initially focused on gender and ethnicity as SLT is highly unequal for both, but was open to emerging differences in other social identities via thematic analysis (see section 5.3). Intersectionality emphasises giving voice, and so is often associated with qualitative research methods (Atewologun, 2018), and collecting participant-led audio data (Atewologun and Mahalingam, 2018), both of which I used (see methods chapter). Second, intersectional analyses often use thematic analysis (Atewologun, 2018), which I have done (see section 5.3), to be sensitive to the different categories of diversity studied including their interactions (Rodriguez *et al.*, 2016). Finally, any relevant structural factors should be identified whilst noting intersections as fluid across time and different situations (Rodriguez *et al.*, 2016; Atewologun, 2018). My thesis tripartite focus considers my research question from a macro (context), meso (setting and social activity), and micro (experiences) lens. Also, my thesis Constructivist alignment (see section 5.1), means I explicitly acknowledge the social construction of social identities as fluid, as recommended for qualitative intersectional researchers. Finally, researcher reflexivity is encouraged where researchers articulate how their social identity affects their research, and manage their emotions, knowledge and experiences accordingly (Atewologun, 2014; de Vries, 2015; Atewologun and Mahalingam, 2018).

4.3.2 Whiteness and Critical Race Theory

Considering Whiteness, and subsequently Critical Race Theory (CRT thereafter) helps explain how therapists' ethnicity shapes their privilege and disadvantage. There are different theories about Whiteness but there appears three important characteristics (Frankenberg, 1997a,

1997b). First, Whiteness is an identity and perspective that is normalised compared to other ethnic identities (Hartmann, Gerteis and Croll, 2009) which means it is sometimes unseen (Carr, 1997; Bonilla-Silva, 2003a, 2003b; Lewis, 2004) or an unmarked norm. Second, Whiteness offers automatic structural privilege, and third, Whiteness indicates certain "unmarked and unnamed" cultural practices (Frankenberg, 1997, page 1). For example, some organisational diversity approaches favour White knowledge and experiences (Ward, 2008). This is reflected in educating White individuals about the perplexing behaviours of minority ethnic people, or dismissing the latter's contributions to organisational strategic plans, which then "Whitens" organisations (Ward, 2008). A cultural deficit model emerges, whereby minority ethnic groups are presented as lacking in culturally important ways compared to the dominant group, which means they face and are implicitly responsible for their own issues or inequality (Song and Pyon, 2008; Davis and Museus, 2019). So, the role of institutional structures or practices may be overlooked (Davis and Museus, 2019). Racism is race/ethnicity-based prejudice and discrimination, and when it occurs at an institutional level, is called institutional/systemic/structural racism, defined as:

> *"racial prejudice and discrimination which are generated by the way institutions function, intentionally or otherwise, rather than by the individual personalities of their members."* (Lea, 2000, page 219)

Structural racism harms everyone, but minority ethnic people *"are over-scrutinised, over-sanctioned, under-served and under-valued"* across society (Lingayah, 2021, page 6) relative to their White counterparts. Whiteness grants privilege even when individuals are minorites in their other social identities such as more response options to workplace stigma (Doldor and Atewologun, 2021).

CRT considers how social structures maintain ethnic inequality across various factors beyond just Whiteness. The theory emerged in the mid-1970s within United States' legal scholarship because lawyers, legal scholars, and activists criticised the progress from the 1960s civil rights movement as having stagnated and sometimes regressed (Delgado and Stefancic, 2001). CRT is implicitly activist as its followers want to study dominating/oppressive societal systems (i.e., the link between ethnicity, racism and power) and help people overcome them (Delgado and Stefancic, 2001; Rocco, Bernier and Bowman, 2014). It was inspired by critical legal studies and radical feminism, and is rooted in liberalism seeking gradual progressive changes (Delgado and Stefancic, 2001), continuous evaluation and adjustment of traditions and social practices

to benefit society (Rocco, Bernier and Bowman, 2014), and universal dignity (McGowan, 2007). Over time, CRT has been applied to other countries (e.g., English context – see Chakrabarty, Roberts and Preston (2014) and disciplines (e.g., education) (Delgado and Stefancic, 2001; Rocco, Bernier and Bowman, 2014).

Critical race theorists mostly agree on six principles (Delgado and Stefancic, 2001). First, racism is common and pervasive in society, making it seem normal, often unnoticed, and hard to challenge. So, CRT demands radical approaches to dismantling racism (Peterson, 1999), which dismisses colour-blindness or formal equality (Delgado and Stefancic, 2001), and sees legislation as only bringing temporary progress (Bell, 1992) and insufficient to remove racism by itself (Delgado and Stefancic, 2001). Second, ethnicity is socially constructed (see section 1.2.1), which is either promoted or ignored by powerholders in society to serve their own interests. Third, ethnicity intersects with other oppressions (intersectionality discussed in section 4.3.1) and essentialism is rejected (defined in section 1.2). Fourth, interest convergence presents White skin as holding material and psychological value in society, with most of society rarely motivated to mitigate or eliminate racist practices unless there is a shared interest between White elites and the oppressed to do so, especially if it socially and politically benefits White groups (Bell Jr., 1980; Bell, 1992; Delgado and Stefancic, 2001). Fifth, differential racialisation happens, i.e., society racializes different minority groups at different times based on its changing economic or political needs, which affects how society perceives or stereotypes the group. Racialisation involves devaluing and dehumanising groups using negative stereotypes (e.g., criminality) (Fredrickson, 2002). Sixth, minorities have a unique voice because of their historical and current oppression experiences affording them competence to share stories about ethnicity and racism, that White people may lack awareness of given they lack similar experiences. Minority voices challenge White narratives as a societal normative standard (Delgado and Stefancic, 2000).

CRT has been increasingly discussed in HRM scholarship in the past decade (Bernier and Rocco, 2003; Fenwick, 2004; Lloyd-Jones, 2009; Rocco, Bernier and Bowman, 2014). Some scholars offer guidance for applying CRT to research. Rocco, Bernier and Bowman (2014) outline five steps for practitioners to apply CRT across all HR areas. First, identify social identity categories and consciously think beyond traditional Whiteness and maleness standards. Second, consider how other's social identities affects their decision-making. I consider both by incorporating minority voices and reflexivity. Third, explore how decisions impact everyone,

which involves self-reflections about ethnicity and beliefs, and trying to recognise when microaggressions happen. Microaggressions are:

> *"brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color"* (Sue *et al.*, 2007, page 271).

Fourth, identify microaggressions emerging from stigma or stereotypes. Perpetrators are usually unaware of performing microaggressions when interacting with minority ethnic groups (Sue *et al.*, 2007). There are three microaggression forms: *microassault* (explicit non/verbal attacks via hurtful words, avoidant behaviour, or intentional discriminatory acts), *microinsult* (subtle snubs), and *microinvalidation* (dismissal or negation of an individual's thoughts, feelings and experiences) (Sue *et al.*, 2007). My interviews highlighted different microaggression experiences (see chapter seven). Fifth, evaluate how all policies and practices affect all workers, ensuring assumptions of neutrality or equal impact are avoided. My thesis includes Cook's (2013) proposals: all research designs should include minority voices, treat White as an ethnic group, and explore the link and effect of ethnicity on the studied phenomenon.

Overall, Whiteness and CRT present ethnicity as an essential consideration when studying SLT workforce inequality, offering insights about its manifestation and how to study it.

4.3.3 Social capital

I explored social capital because it shapes ethnic inequality through resource access, political and civic participation, and discrimination.

Modern developments of social capital are credited to Bourdieu, Loury, Coleman, and Putnam (Portes, 1998; Adam and Roncevic, 2003; Hero, 2007; Portes and Vikstrom, 2011). Surfacing in academic and policy debates in the 1990s, social capital's perceived relevance in explaining economic and social phenomena grew over time (Bhandari and Yasunobu, 2009). However, scholars disagree on how to define and use social capital (Adam and Roncevic, 2003). Bourdieu, (1986) defines social capital as:

> *"the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition."* (page 248)

Social capital is multifaceted (Bhandari and Yasunobu, 2009). Four common social capital types include: (1) structural versus cognitive: tangible social networks and their configuration of roles, rules, and processes (e.g., regulations), versus subjective, intangible elements (e.g., trust) (Grootaert and Bastelaer, 2002; Claridge, 2008); (2) strong and weak: close, enduring ties versus causal, temporary and contingent ones (Granovetter, 1985); and (3) horizontal and vertical: ties between people of similar status/power versus across different hierarchy and power dynamics (Woolcock and Narayan, 2000). Finally, (4) bonding (ties within homogenous groups which fosters within-group trust and reciprocity but is likely insular thus potentially exclusionary of other groups), bridging (ties with individuals or groups from different backgrounds which fosters collaboration and inclusivity), and linking (forming and maintaining ties with different organisations and powerful individuals) (Putnam, 2000). Also, social capital lacks common measurement indicators, for example, it can be measured socially at individual- and collective- levels, and geographically at micro-, meso- and macro- levels (Bhandari and Yasunobu, 2009). The difficulty defining and measuring social capital may mean vague interpretations and limited empirical application, potentially undervaluing its importance (Bhandari and Yasunobu, 2009).

Research has explored why individuals or groups differ in social capital. Bourdieu (1986) outlines three social capital forms: economic (money or assets), social (networks, connections, and relationships), and cultural (comprises three states: *embodied*, e.g., knowledge and skills; *objectified,* e.g., cultural goods like books; and *institutionalised,* e.g., education). These capital forms interact with one another (e.g., one capital can be converted to, and help acquire, another), and the amount and composition of each determines an individual's social position. Social positions are deemed relational, with individuals possessing similar amounts and types of capital located closer in a social space, creating the foundation for forming social classes. People often associate or gather with those of similar socioeconomic backgrounds (Lin, 2000). So, social capital is linked to social class. Understandings of social class have evolved over time (Block and Corona, 2014), but is currently dominantly understood as a social category referring to economic and social relationships including lifestyle, educational experiences, and residential arrangements (Bradley, 1996). The role of social class in mediating life experiences is often overlooked (Block, Gray and Holborow, 2012; Block, 2014; Block and Corona, 2014).

Some theories explore why ethnic groups differ in social capital. For example, contact and conflict theories (Putnam, 2007) present opposing claims: the former says that more

contact between ethnic groups improves social relationships, whilst the latter says that increased contact exacerbates divisions and competition for resources, and discomfort over growing diversity in America may cause people to withdraw and isolate from social interactions. Whilst some studies demonstrate diversity as negatively affecting key social capital indicators (e.g., confidence in government, etc.) (Putnam, 2007), others show diversity only weakens social capital among majority White populations in the USA and UK with its impact varied among minority communities (Fieldhouse and Cutts, 2010). Brondolo *et al.* (2012) theorised how different racism forms may individually or together hinder social capital, namely peer relation development (e.g., cultural racism maintains stereotypes restricting social network access). Also, Pichler and Wallace (2009) found that different types of social capital are socially stratified across Europe. Specifically, through formal associations, upper class individuals which includes those holding professional or managerial roles, engage in a wider range of networks which often exposes them to diverse people with varying resources (e.g., skills, connections, etc.) yielding different support options compared to only knowing similar people. Conversely, working class individuals often have fewer social connections, and their social capital is situational; they have more intense informal contacts, but this depends on their workforce participation with those inactive disconnected. Importantly, social capital disparities between social classes were magnified in countries with greater social inequality. Social capital patterns reflected and sometimes reinforced social class in society.

Overall, a therapist's ethnicity and social class shapes their social capital to disadvantage those from minority ethnic and lower-class communities.

4.4 Development of research questions

Chapters one to four provided the context, and outlined the case, for the overall thesis research question: ***how is gender and ethnic diversity managed within the Speech and Language Therapy profession in the UK?*** I made the case for studying regulated professions in the UK's health sector, particularly on the Speech and Language Therapy profession. The SLT workforce is an interesting profession for exploration of its workforce diversity because therapists focus on addressing diverse client/patient language and communication challenges, and so their roles are highly relational in nature. Yet, the profession is highly unequal for gender

and ethnicity. Also, literature on its workforce diversity is sparse, particularly on therapist's experiences as professionals, which for ethnicity and sector-specific insights are almost absent. The diversity management literature review identified three important areas of focus: diversity approach, stakeholders, and practices. The use and limitations of each provide some understanding of why SLT workforce diversity looks as it does. A tripartite focus (described in chapter five) is used to address this question in a comprehensive way. Each focus element is informed by the literature review, and addresses a specific research question, which are as follows:

1. Macro-level: Diversity approaches: What approaches underlie the gender and ethnicity diversity policies/initiatives in the SLT profession?

2. Meso-level: Diversity stakeholders and practices: What do gender and ethnic diversity policies/initiatives in SLT look like in practice? Who are the key diversity stakeholders and what is their role?

3. Micro-level: Lived experiences: What are the lived experiences of SLTs related to gender and ethnicity? Do diversity practices address the diversity issues that they experience, and if so, how?

4.5 Chapter summary

This chapter consulted organisational studies and published reports on the gender- and ethnicity-related lived experiences of Speech and Language Therapists and other UK healthcare professionals. The latter was used because literature on therapist's workplace experiences is sparse, therapists are AHPs, and many are NHS-based. I then explored if and how gender and ethnicity diversity efforts in the profession and NHS, address the experiences discussed. Overall, both horizontal and vertical segregation occurs based on ethnicity and gender in the UK health sector, shaped by experiences of marginalisation characterised by bias, discrimination, and exclusion.

SLT entrance barriers relate to awareness and understanding of the profession, its status linked to income and progression potential, and gender stereotypes reinforced by few male role models in the profession. So, the profession is presented as suitable for women but not men, which means male SLT students or professionals face stereotypes, bias, and exclusion. Yet, men experience career progression privilege within the NHS and predominantly female professions including SLT, despite comprising a numerical scarcity in them (e.g., glass escalator phenomenon). This male privilege may be shaped by factors that disadvantage women including gender stereotypes through gendered roles/expectations (e.g., men as breadwinners), patriarchy (e.g., women unequally burdened with caring responsibilities), and sexism (e.g., glass ceiling and glass cliff phenomena). Male privilege, stemming from Connell's concept of *patriarchal dividend*, says men are generally privileged just because of their gender (Connell, 1995).

Minority ethnic NHS healthcare staff are marginalised through bias, discrimination, and exclusion as job applicants across their careers. Access to jobs is linked to one's social connections based on their social identity (i.e., social capital), which may be problematic for minority ethnic therapists as their profession is mostly White. At work, they face second-class treatment such as harassment and bullying. Their progression is blocked by a "sticky floor", "snowy white cliff", "snowcapping", and poor performance feedback in the NHS. Whiteness and discrimination including microaggressions shape these negative experiences. Critical race and Whiteness theories (see section 4.3.2) posit White ethnicities as socially constructed to be the norm, privileged, and have practices which not only presents minorities as culturally deficit but also means that they frequently face racism across society. Discrimination as microaggressions can reinforce racial inequalities by emboldening perpetrators, and marginalising victims, whilst institutional discrimination means organisational processes are biased against minority ethnic staff (e.g., over-representation in NHS disciplinary processes). CRT's interest convergence asserts that White individuals are unlikely to reform discriminatory practices unless they benefit.

Whilst the NHS has many diversity motivations and practices, I could not find many SLT-specific efforts within the SLT profession. Whilst the NHS and RCSLT seem to focus on ethnicity over gender, NHS ethnicity-related practices have mixed impact. Also, RCSLT efforts seem to mostly concentrate on the beginning of the SLT career pipeline (e.g., targeting

the education sector to attract students), and some are at the very early stages (e.g., scoping member's concerns and building an evidence base of them).

CHAPTER 5: METHODOLOGY

This chapter outlines how the research questions were addressed. My research is positioned within the Social Constructivism paradigm. I then argue the case for using a qualitative approach, semi-structured interviews, and thematic analysis, and these processes are described in detail. Where relevant, theoretical considerations are noted.

5.1 A Social Constructivist approach to research

Researchers should start their work by explicitly articulating their world view for two reasons (Nielsen, 2007; Flick, 2009; Austin and Sutton, 2014). First, it influences the entire research process, such as how a topic can and should be studied. Second, it allows readers to understand the researcher's decisions and findings. Good research practice comes from understanding the background of different methods (Ritchie and Ormston, 2014). Olsen (2003) says that if researchers use methods that align with their philosophical assumptions when starting their research, it is more likely to be internally coherent (Morse, Kuzel and Swanson, 2001). My thesis aligns towards the Social Constructivism paradigm, and its assumptions are described in due course.

5.1.1 Ontology and epistemology

The concepts of ontology and epistemology must be considered when articulating a philosophical paradigm (Ormston *et al.*, 2014). Ontology is about the nature of reality/social world, and so what there is to know about it (Guba and Lincoln, 1994, 2000; Ormston *et al.*, 2014). For example, some key ontological debates are about whether social reality is objective or not, and if people share or have multiple context-dependent social realities (Ormston *et al.*, 2014). Epistemology concerns the nature and scope of knowledge; how social world information can be learned and its limits (Ormston *et al.*, 2014). For example, a key epistemological debate is about the best ways to collect knowledge (e.g., inductive versus deductive reasoning). So, epistemology considers the relationship between the researcher and researched, and so epistemological issues relate to ontology (Letherby, 2003).

There are different paradigms of scientific knowledge, each with its own ontological and epistemological assumptions, which implies the use of certain methodology and methods (Morgan and Smircich, 1980; Nielsen, 2007; Ormston *et al.*, 2014). I do not extensively explore all the competing paradigms, but rather justify an alignment towards Social Constructivism, because its assumptions inform my chosen research approach. I contrast it to Positivism for two reasons (Morgan and Smircich, 1980). First, it is the traditional way of understanding scientific knowledge and so highlights the typical criticisms of social scientific approaches. Second, these criticisms also demonstrate their methodological rigour.

An important ontological debate to consider first is whether reality is objective or not, and by extension whether objective knowledge is obtainable or not, especially since knowledge is experienced or understood through people (Morgan and Smircich, 1980; Ormston *et al.*, 2014). Positivists claim objective knowledge is possible: it is observed through human senses and informed by logic (Nielsen, 2007). Ontologically, they believe the world has an underlying objective structure (Morgan and Smircich, 1980). So, epistemologically, creating knowledge involves mapping and understanding this underlying structure, to uncover the abstract or universal laws governing how it operates. Empirical or objective approaches are typically used where data observation is separated from its interpretation, and only verifiable knowledge is deemed meaningful (Kvale, 1996; Nielsen, 2007). So, strict Positivists see social scientific methods like qualitative interviews as unscientific and irrelevant, especially their interpersonal elements (i.e., interactions and conversation) (Nielsen, 2007). This is because they leave room for interpretation, and interview statements are not replicable between people for they can be ambiguous, contradictory, and unstandardised as everyday language is used (Nielsen, 2007).

However, Positivism is criticised by subjective paradigms (Morgan and Smircich, 1980). First, all sciences use metaphors and analogies to create and communicate knowledge (Schon, 1963; Brown, 1977; Jäkel, Döring and Beger, 2016). Second, conversations are a part of human existence. So, capturing them is important. Third, the relationship between people and the world is mediated linguistically. For example, the concept of the "linguistic turn" says that language exceeds just using labels to describe the world, to also influence how people see themselves and the world (Rorty, 1967). This aligns with the Sapir-Whorf hypothesis which says that the structure of language influences human thought and perception (Sapir, 1947).

5.1.2 Alignment towards Social Constructivism

Subjective paradigms differ in how they see reality as subjective. Social Constructivism is a dominant subjective paradigm in the social sciences. It says that reality is socially constructed as people create their own realities (Guba and Lincoln, 1994, 2000; Nielsen, 2007). The social world is thought inter-subjective because people create and interpret their own realities actively and continuously in everyday new encounters via communication and interaction (Morgan and Smircich, 1980; Guba and Lincoln, 1994, 2000). Similarly, Whiteness and critical race theories frame ethnicity as socially constructed (see section 4.3.2).

Construction is thought a linguistic process (Nielsen, 2007) where language both describes the world and constructs perceptions of it (Burr, 2015). People live symbolically using language, labels, actions, and routines, which has certain implications (Morgan and Smircich, 1980; Guba and Lincoln, 1994, 2000; Nielsen, 2007). First, all knowledge is social because it is constructed through interaction, meaning that social issues are symbolic constructions. Second, people can collaboratively create shared knowledge in their daily interactions. Third, there can be multiple realities because reality is deemed subjective, societally embedded, and fluid. So, constructions are limited to the context where they are actively made, and disappear if people do not sustain them. For example, equal voting rights irrespective of gender is mostly considered common sense today, but has not been historically, which shows how dominant knowledge depends on context. However, construction as a concept is vague and may potentially lead to misunderstandings. For example, the construct of language (e.g., texts) may appear organised in ways that misleadingly imply reality as fixed, stable, and factual (Nielsen, 2007).

Ontologically viewing reality as a construction, means epistemologically viewing knowledge as transactional, subjective, and fluid/relative, which has certain implications (Guba and Lincoln, 1994, 2000; Nielsen, 2007). First, objectivity cannot be claimed. Both researchers and participants actively shape knowledge production via linguistic interaction. So, knowledge is transactional, and so methods involving dialogue are appropriate. Also, both parties share control of research decisions. For example, researcher's interview questions shape knowledge production, but participants can trigger what pathways are explored. So, researcher's values inevitably influence the researched, which makes findings value laden. So, reflexivity is encouraged, echoing intersectionality and CRT (see section 4.3). Second, perceptions of reality cannot be proved as being true, but rather are tested for how relatively educated or complex

they are. This relates to assumptions of fluid/relative knowledge because it can change towards community consensus and is context-specific (i.e., rooted in a particular point in history, place, and culture). So, knowledge just reflects currently accepted world views, which is essentially individual reconstructions of the world moving towards community consensus.

There is no standard or best criteria to accurately capture or present knowledge, which means knowledge is only provisional, partial, fallibilistic, and fluid (Guba and Lincoln, 1994, 2000; Ormston *et al.*, 2014). However, Constructivists can determine the validity of research findings by assessing it trustworthiness and authenticity (Guba and Lincoln, 2000) (see section 5.4).

This thesis flexibly aligns with, but is not determined by, Social Constructivism. There are debates about whether and how much people should adhere to a philosophical paradigm. Some scholars argue that qualitative methodology offers heuristics rather than specific recipes (Hammersley, 2011). So, they recommend pragmatic approaches that are best suited to address research questions (Patton, 2002; Ormston *et al.*, 2014), which acknowledges paradigms but allows researchers flexibility (Hammersley, 2011). Strict adherence to a paradigm-driven approach is not easy nor ideal for novice researchers to conduct good interviews (Roulston, 2010; Hammersley, 2011; Wolgemuth *et al.*, 2015). Social Constructivism was chosen because it aligns with my personal views that reality cannot be truly objective because it is experienced through people. This position was strengthened when reviewing the thesis literature, especially since key thesis terms/concepts are contested, which reflects knowledge as context-specific and fluid. So, reality as being constructed and multiple makes sense.

Constructivism's epistemological assumptions about knowledge implicate my research process. Knowledge is transactional, which means that methods involving dialogue are appropriate. This justifies the use of semi-structured interviews to co-create knowledge relevant to the thesis aim with participants. The subjectivity assumption means that participants will express varying but equally valid understandings of the same concepts explored in the interviews. So, I pursued community consensus by using thematic analysis to find data patterns. Since findings are context-dependent, the thesis conclusions may change in the future. I also demonstrate the trustworthiness and authenticity of findings in different ways. For example, I describe how relevant interview training was undertaken, the inclusion of an ethics process, and how findings are grounded in the data using thematic analysis.

5.2 Methodological approach and method

I begin this chapter by outlining and justifying my methodological approach, which comprises of a tripartite focus and the use of qualitative semi-structured interviews. I then describe how this methodology was operationalised by describing my fieldwork and data analysis.

5.2.1 Tripartite focus informing research design

Layder's (1993) theory of social domains informed the development of a tripartite focus to address the thesis research question (see section 4.4) because it offers a practical map for planning and undertaking social research. The theory has a multi-level approach, which systematically and comprehensively covers the theoretical and empirical aspects of a given research topic (Layder, 1993). It does this by presenting social reality as being shaped by four domains; psychobiography, situated activity, social settings, and context (Layder, 1993, 2006; Knight and Layder, 2016). These domains are presented as interlocking because one can affect the others, but also mutually exclusive because each domain has unique characteristics. The theory has been applied across different research areas from prison settings (Knight and Layder, 2016) to social work (Houston, 2015). Each domain is summarised in Table 2. Note that power, which is linked to an individual's available resources, is considered across domains because it can enable or constrain each (Layder, 1993). Considering power is also emphasised in intersectionality, and Whiteness and critical race theories (see section 4.3). Power is framed as stakeholder agency in this thesis.

Table 2. Thesis tripartite focus as influenced by Layder's (1993, 2006) theory of social domains. Content from Layder (1993, 2006); Ritzer (2004); Green (2010); Sudbery (2010); Houston (2015); and Knight and Layder (2016). SLT/s= Speech and Language Therapy/ists.

Tripartite focus	**Associated social domain by Layder**		**Aim, research question (RQ), and method**	**Examples of fieldwork considerations**
MACRO: Diversity approaches within the SLT	**History and power**	**Context:** The symbolic, economic, and cultural resources in wider society thought to be unequally distributed to groups based on their social identity and status. Includes values, attitudes, beliefs, and political and economic influences. Focus is on resources linked to setting. • Thesis application: UK's diversity management approach is increasingly individualist, voluntarist and business-case driven. Some examples of an equal opportunity approach may be present. **Setting:** The immediate environment where social activity happens. They have unique forms – e.g., modern social settings are thought efficient, predictable, bureaucratic,	**Aim:** Explore diversity approaches in profession and place it within current socio-political and cultural context in wider society. **RQ:** What approaches underlie the gender and ethnicity diversity policies/initiatives in the SLT profession? **Method:** 1. Semi-structured interviews with therapists and diversity stakeholders. 2. Analysis of organisational diversity policy/strategy documents.	Context considerations: • Societal power and resource distribution (e.g., White and male privilege), and how this relates to the researched activity (e.g., profession's workforce diversity). • How the political (e.g., Equality Act 2010), religious, and economic (e.g., NHS financial resources) context relates to the research topic. Setting considerations: • Nature of the setting (e.g., NHS is public sector and so more structured due to Public Sector Equality Duty than private sector settings for therapists). • How setting and its structure is shaped by gender, class, power, ethnicity, and

		and usually use quantitative measures and technology. Focus is on organisation's structure and how they influence experiences. • Thesis application: Profession – approaches to managing diversity in organisations employing therapists.		politics (e.g., NHS has a large female workforce which may mean their greater representation in senior positions).
MESO: Diversity stakeholders and practices within organisations employing SLTs		**Settings:** see above. • Thesis application: Organisations employing therapists. **Situated activity:** The face-to-face interactions (including symbolic communication) between individuals in the above setting and context. These interactions offer people meaning, social support, and belonging, or the opposite if relationships break down. Influences and influenced by all domains. Focus is on emerging meanings, understandings, and definitions of situation.	**Aim:** Explore diversity practices of organisations employing therapists, and consider the key stakeholders involved. **RQ:** What do gender and ethnic diversity policies/initiatives in SLT look like in practice? Who are the key stakeholders and what is their role? **Method:** 1. Semi-structured interviews with therapists and diversity stakeholders. 2. Analysis of organisational diversity policy/strategy documents.	Setting considerations – see above. Situated activity consideration: • People and action involved in interactions (e.g., therapists, diversity practices, etc.) • Communication methods used (e.g., diversity policy use).

		• Thesis application: Organisational diversity practices and the stakeholders involved.		
MICRO: Lived experiences of SLTs		**Self/psychobiography:** The individual's unique biographical experience including psycho-social challenges, critical life events, and identity and/or personality-shaping social positions. Influenced by all domains. Focus is on the life-career. • Thesis application: Therapist's career experiences.	**Aim:** Explore the lived experiences of SLTs related to their gender and ethnicity. **RQ:** What are the lived experiences of SLTs related to gender and ethnicity? Do diversity practices address the diversity issues that they experience, and if so, how? **Method**: Semi-structured interviews with therapists.	• Perceptions related to activity (e.g., value of diversity for profession) • Feelings, motivations, and experiences related to activity (e.g., therapist's gender- and ethnicity-based career experiences).

Layder's four domains seem to examine social reality from three broad perspectives: macro, meso, and micro. At the macro level, wider society is considered through the context and setting domains. At the meso level, organisations are studied through setting and social activity. Finally, at the micro level, individual experiences are explored through the psychobiography domain. The setting domain is covered at both macro and meso levels, to cover the profession overall and organisations respectively, as the resources of the former can shape the latter.

Layder's domains (1993, 2006) were applied to this thesis (see Table two), which alongside literature discussed across chapters two to four, informed the development a tripartite focus to address my main research question (see section 4.4). The tripartite focus led to three sub-questions (see section 4.4 or Table two) and shaped my method (see Figure two).

5.2.2 The case for a qualitative approach

Qualitative research lacks a clear, standard definition because it is broad; it has no specific paradigm or unique set of methods (Denzin and Lincoln, 2011; Ormston *et al.*, 2014). However, qualitative research has common characteristics which demonstrate its benefits (Denzin and Lincoln, 2011; Ormston *et al.*, 2014).

First, qualitative research tries to create in-depth interpreted understandings of the social world by studying people's perspectives, experiences, and context (Denzin and Lincoln, 2011; Ormston *et al.*, 2014). Data are collected in natural settings using different approaches (e.g., observations, interviews, etc.), are flexible by being tailored to participants, and focus on *what*, *why*, and *how* questions to explore emerging issues (Denzin and Lincoln, 2011; Ormston *et al.*, 2014). The importance of understanding people's behaviour by both considering their context (social, material, and historical), and the meanings they attach to their experiences was pivotal in developing qualitative research (Ormston *et al.*, 2014). Qualitative research grew increasingly popular as its focus moved from developing social theory to application so society is better understood (e.g., structures and cultures) (Ormston *et al.*, 2014). Emphasis was increasingly on understanding the nature of the issues that public policies targeted, and having ways to assess policy impact (Rich, 1977; Weiss, 1977; Ritchie and Ormston, 2014). So, qualitative research had increased presence in UK social policy research from the 1980s onwards (Ritchie and Ormston, 2014). A qualitative approach is ideal for this thesis because it offers an opportunity to gain rich and detailed insight into what diversity issues are of concern

to therapists by exploring their gender and ethnicity-related professional experiences. These experiences can be used to uncover if, and how, diversity practices address them.

Second, qualitative research is versatile and user-friendly. Whilst some scholars claim it is easy and common-sensical, others find the reliance on researcher-participant interactions as daunting which possibly stems from poor understanding of how to undertake good qualitative research (Austin and Sutton, 2014). Qualitative research can be contextual, explanatory, evaluative and generative, each offering a detailed perspective of the social world (Ritchie and Ormston, 2014). For example, contextual research identifies and describes existing social phenomena and how it manifests, whilst evaluative research explores how well things work. This versatility is useful for my thesis because it allows different ways of approaching the research topic. For example, a contextual lens offers insight into why the SLT workforce lacks diversity, whilst an evaluative lens can uncover if and how diversity practices address this.

Third, the richness and complexity of qualitative data means its analysis must be complex, nuanced, and capture different themes and participant uniqueness (Ormston *et al.*, 2014). For example, the world is represented in words and/or images, fieldnotes, interviews, etc. Emerging theories or categories are welcomed during data analysis, and findings describe the research topic in detail which is grounded in participant's opinions and accounts (Ormston *et al.*, 2014). So, qualitative research allows multiple social identities, their interactions, including power or inequality dynamics to be captured as expected by intersectionality and CRT (see section 4.3). Also, qualitative data can complement quantitative data. Together they can present a holistic perspective of a phenomenon by inspecting the number and nature of it, qualitative research can build on prior quantitative research, or capture and explain factors that are unknown or too complex for quantitative research alone (Gilbert, 2008; Silverman, 2010; Ritchie and Ormston, 2014). For this thesis, qualitative data can provide context-rich insights about the SLT profession's existing numerical gender and ethnicity data discussed in section 2.3.1.

Finally, qualitative researchers are encouraged to practice reflexivity where they acknowledge their influence in the research process (Ormston *et al.*, 2014) especially those using an intersectionality and/or CRT lens (see section 4.3), and can establish research trustworthiness and authenticity in different ways. Demonstrating both practises is critical for reassuring readers of a rigorous thesis research process and findings. Examples of both are outlined later in this chapter (see section 5.4) and Appendix two.

5.2.3 The case for a Social Constructivist interview approach

This section explores the strengths and criticisms of interviews, and justifies the use of Social Constructivist inspired interviews to address my research questions. Interviews are best defined by Patton, (2002, page 4) who describes them as:

> *"open-ended questions and probes yielding in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge. Data consists of verbatim quotations and sufficient content/context to be interpretable."*

5.2.3.1 Participant interview experiences

Literature on participant experiences of qualitative interviews usually focuses on vulnerable populations (e.g. cancer patients (Carter et al., 2008)) and/or sensitive topics (e.g. rape (Campbell et al., 2010)). This may be emotionally difficult for participants, but can also benefit them (Wolgemuth et al., 2015). Interviews are conversation opportunities with people who are interested and empathetic without judgement, allowing participants time and space for safe self-reflection (Wolgemuth et al., 2015). They can be cathartic/therapeutic experiences encouraging greater insight and acceptance of oneself (Hutchinson, Wilson and Wilson, 1994; Cook and Bosley, 1995; Birch and Miller, 2000; Hiller and DiLuzio, 2004; Campbell et al., 2010). Constructivist approaches stress that inclusivity of all voices is important (Guba and Lincoln, 2000), complementing intersectionality and CRT approaches advocacy for studying both marginalisation and power (where White is treated as an ethnicity), but emphasis is on marginalised voices (see section 4.3). So, empowering interviewees and ensuring ethics is important (see section 5.2.4.1 or Appendix 11 for latter).

Interview participation offers purpose, empowerment (Hutchinson, Wilson and Wilson, 1994), and connection with a wider community based on common experience (Wolgemuth et al., 2015). For example, one therapeutic way of building interview rapport is to validate a person's experiences by normalising it, such as by sharing that other participants had similar experiences (Campbell et al., 2010). So, qualitative interviews give a voice to the invisible and marginalised (Hutchinson, Wilson and Wilson, 1994).

Interviews also help participants learn more about topics that they are personally and/or professionally invested in. Some interview participation is driven by wanting to increase self-

awareness (Hutchinson, Wilson and Wilson, 1994). For example, learning more about one's self and job (Clark, 2010). So, researchers may be considered a knowledge source. Also, participation may be motivated by, and allow advocacy for, something important (Wolgemuth et al., 2015); a specific cause, experience, community, informing change, or developng political empowerment (Clark, 2010). Participants may feel that they are fulling this motivation, even without knowledge about how the research will be shared (Cutcliffe and Ramcharan, 2002; Wolgemuth et al., 2015).

It makes sense that participants favour interviews over other approaches because of the benefits described. For example, rape survivors report gaining more from interview (85%) than survey (<50%) participation (Campbell *et al.*, 2010). Also, Constructivist interviews are thought particularly therapeutic by some (Hiller and DiLuzio, 2004; Carter *et al.*, 2008; Campbell *et al.*, 2010) perhaps because collaborative meaning-making is emphasised (Roulston, 2010). This is akin to therapy being a by-product rather than main purpose of therapeutic interviews (Hiller and DiLuzio, 2004).

However, interviews do not always benefit participants. For example, Wolgemuth *et al.* (2015) outlined four main risks of interview participation. These include participant concerns about being identified, possibly negatively affecting themselves or others (e.g., desires to avoid causing trouble), how they will be represented, and experiencing emotional difficulty. These concerns are addressed via my university ethics procedure (see section 5.2.4.1 or Appendix 11 for latter).

5.2.3.2 Social Constructivist interviews

A researcher's philosophical position influences their data collection process. For example, interviews by Qualitative Positivists focus on scientific rigour, whilst Social Constructivists focus on how researchers and participants negotiate meanings (Wetherell and Potter, 1992; Nielsen, 2007). So, Positivist researchers would try to standardise all interviews, but Constructivists would try to make interviews resemble everyday conversations by questioning assumptions and offering counterexamples. Paradigm-driven interview approaches may help participants, and add to the qualitative knowledgebase by considering its debates and limits (Koro-Ljungberg, 2004; Koro-Ljungberg *et al.*, 2009; Koro-Ljungberg and Bussing, 2013). Paradigms also help novice researchers better understand how theory relates to interviews, by presenting different ways to conceptualise and conduct them, and ensure practice-paradigm

alignment (Roulston, 2010). I am a novice interviewer despite having undergone some university-led training and consultations with experts on conducting interviews. So, I considered Roulston's (2010) Constructivist interview guidance, particularly how its theoretical assumptions shape methodology and research quality assurance. These are discussed below.

Social Constructivists view interviews as a social setting where interviewers and interviewees co-construct data resulting in negotiated and context-specific accounts, and possible ways of discussing or understanding a given topic (Guba and Lincoln, 1994, 2000; Silverman, 2001; Kathryn Roulston, 2010; Ormston *et al.,* 2014). This conceptualisation of interviews has four important implications for practice. First, interviews should be treated as a social interaction (and linguistic performance) in its own right, where people exchange views about the same thing (Kvale, 1996) on specific occasions. For example, diversity as a concept exists because people agree that it exists, and its content is shaped by how people discuss it in their interviews.

Second, interview data must be received as a subjective and contextually-bound reflection of the social world (Roulston, 2010). Such data reflects the shared experience of many interviewees at a particular context, despite bringing their own twists. For example, minority ethnic therapists may describe different career experiences of discrimination during interviews, which will depend on, and reflect, current UK societal attitudes and behaviours towards minority groups.

Third, interviews should be considered a construction process where all parties involved co-construct knowledge using their conversational skills to make interviews resemble everyday conversations (Wetherell and Potter, 1992; Roulston, 2010). For example, interviewers displaying empathy and interest are likely to make interviewees feel comfortable enough to share, and so gain insight into, difficult issues (e.g., workplace discrimination). Co-construction challenges the traditional perspective of interviewers as neutral, uninvolved, and holding power (e.g., researcher owns data) (Wetherell and Potter, 1992; Roulston, 2010). Researchers must consider whether to maintain a relationship with interviewees post-interview because there is no clear end point, and data are jointly created (Cornelius, 2020). Researchers can maintain data ownership due to informed consent and withdrawal procedures (Cornelius, 2020).

Finally, Constructivists focus on sensemaking within interviews (Roulston, 2010), such as how key concepts (e.g., diversity issues) are understood. Interview data are treated as an *account* rather than *report* of the world, allowing analysis of *what* is said and *how* the interview interaction is constructed (Baker, 2002). Doing both together is not easy in research (Silverman, 2001). So, I focus on *what* is said about diversity management within SLT to develop a detailed account of related issues and practices. There is scope for future studies to also explore *how* the topic is discussed because talking involves performing actions (e.g., choosing word sequences) (Roulston, 2010). So, transcriptions of audio and visual interview data must be as accurate and detailed as possible to allow analysis of data co-construction (e.g. laughter, pauses, etc.) (Roulston, 2010). Also, Constructivists emphasise giving voice to marginalised groups, which intersectional research says is achievable by collecting participant-led audio data (Atewologun and Mahalingam, 2018).

5.2.4 Fieldwork and data collection

A cross-sectional, inductive research design was used which was inspired by the tripartite focus, and involved two data sources (see Figure two). The primary data source was semi-structured qualitative interviews with SLTs and diversity stakeholders which covered all tripartite elements. Secondary organisational diversity policy/strategy documents were used to provide a supplementary account of diversity approach/actors and practices. Together, both sources allow a holistic impression of SLT diversity issues and management.

5.2.4.1 The semi-structured interview process

Interviews inform all parts of the thesis tripartite focus (see Figure two). Ethical approval for interviews was sought from relevant bodies for theoretical, pragmatic, and moral reasons. First, Constructivism stresses ethics' importance (see section 5.2.3.1 and 5.4). For example, researchers must empower participants to tell their stories by emphasising confidentiality and anonymity. Second, ethical considerations safeguard participants and researchers. Qualitative methods may appear less invasive and harmful than physical ones (e.g., extracting blood samples), but they also carry risks such as when participants are improperly represented (Austin and Sutton, 2014). So, ethics must prioritise participant's needs and safety, with research ethics boards offering relevant guidance (Austin and Sutton, 2014)

The ethics process was onerous, challenging, and delayed for many reasons (see Appendix 11 for ethics approval timeline and challenges). Two types of ethical approval were attained for the interviews from three different bodies, each requiring the design and completion of many documents. The first approval covered non-NHS staff and was initially obtained by the *King's College London biomedical & health sciences, dentistry, medicine, and natural & mathematical sciences research ethics subcommittees* (KCL BDM REC, reference: HR-19/20-14473). My transfer to Queen Mary University of London (QMUL) in December 2019 invalidated this application, and required review by the *QMUL joint research management office* (QMUL JRMO). This review process was swift, but approval only applied to non-NHS staff (same reference number). So, a new ethics application was required for NHS staff, which involved seeking approval from my university, the Health Research Board (reference for both is IRAS: 281268), and each NHS site. Gatekeepers were only an ethical requirement for recruiting NHS staff.

The Covid-19 pandemic delayed the approval processes. For example, there were health and safety concerns in accessing NHS sites, UK travel restrictions due to lockdowns, and increased staff workloads. So, three changes were proposed which required ethics amendments to be submitted to relevant bodies, and their associated processing time was an additional delay. These changes included conducting virtual rather than face-to-face interviews, extending the project timeline, and including all UK hospitals instead of a select few to increase recruitment chances. The latter removed geographical location as a physical barrier to including distant Trusts. Also, online interviews became normalised during the pandemic with little detriment to interactions beyond minor technical issues (e.g., poor internet connection). Most participants were professionals with technology and internet access. An online platform possibly created a safe space for interviewees to share thoughts and experiences as most interviewed at home during UK lockdowns, granting them convenience, familiarity and so a sense of control. I initially sought local ethics approval from the Trusts of interested participants (e.g., study flyer respondents). However, the pandemic later delayed Trust's ethics response rates and approval timelines. So, recruitment then focused on increasing sample sizes from Trusts that had already granted approval. Overall, the ethics process was helpful in reflecting on and addressing participant and methodological needs (e.g., produced important interview resources - see Table five).

The pandemic also influenced knowledge co-construction during interviews. Suspicions about minority ethnic groups as being disproportionately impacted by Covid-19

happened early, which triggered exposure of, or perhaps heightened attention to, ethnicity-based inequalities across UK society including in healthcare and employment (Platt and Warwick, 2020; Public Health England, 2020). Perhaps there was unique awareness and/or understanding of ethnicity issues among interviewees which shaped their responses. For example, interviewees mentioned how the pandemic prompted people to share and listen to minority ethnic experiences triggering self-reflections and discussions about White privilege and discrimination (see chapter seven) that otherwise may not have occurred.

After securing approval, I focused on recruiting two samples for interviews: currently practising SLTs and diversity stakeholders. Therapists mainly practise in the NHS and private sector (see section 2.3.2), and so participants were mainly recruited from these settings. I tried to recruit therapists across different genders and ethnicities, but they all had to be currently practising in the UK to explore the profession's existing diversity issues and practices within a UK context. Plans to also study Radiographers were abandoned in the early data collection phase because the Covid-19 pandemic in the UK made accessing them difficult.

Diversity stakeholders (see section 3.2) were individuals driving a diversity agenda within the profession, who belonged to one of four different groups:

(a) Internal stakeholders: Typically based in NHS Trusts that employ therapists (e.g., members of EDI teams).
(b) External stakeholders: Individuals with vested interests, knowledge, or actively addressing diversity within the profession (e.g., SLT educators).
(c) NHS stakeholders: Individuals based within NHS bodies (not Trusts) whose roles involve addressing broad NHS diversity issues (e.g., members of NHS arms-length bodies).
(d) Professional body (e.g., association/society) stakeholders: Employees of relevant professional associations or societies who have interest, knowledge, and/or a role in addressing diversity within the profession (e.g., senior staff).

Initially, the plan was to recruit both samples from the same NHS Trusts to achieve organisational perspectives of SLT workforce diversity. However, Covid-19 significantly affected access to NHS staff. So, after consulting with my supervisors, I widened the samples to also include diversity stakeholders from outside the public sector to achieve a broader perspective of diversity management across the profession. Thus, the inclusion criterion of

working in the NHS did not apply to all participants (e.g., private sector therapists) (see Appendix one for sample inclusion and exclusion criteria).

I used an opportunistic participant recruitment method. Relevant participants were located through gatekeepers, contacts, "middlemen" and online research. The latter involved searching Google for organisations or Trusts who employed therapists. Guidance on Trust departments was sought by calling NHS Clinical Commissioning Groups. Gatekeepers were NHS employees (e.g., Trust diversity officers or ethics team staff), relevant professional association/society members, diversity contacts from my supervisory team, or any relevant individuals interested in the research. Covid-19 affected access to participants, especially in NHS sites (e.g., UK lockdowns during the pandemic meant restrictions in free movement).

NHS sites were approached and included based on three main criteria. These were: (1) if they had a SLT team, (2) if the Trust had the capacity/capability to participate as determined by their local ethics approval process, and (3) if a gatekeeper could be established at the site which was an ethics requirement. NHS gatekeepers were identified by searching for key names and contacts in Trust diversity policies, contacting Trust switchboards and HR/ EDI Teams, or asking for recommendations from the Trust staff processing my local ethics applications. Those who were happy to participate needed approval from their Trust and my university ethics team. Data protection rules prohibited gatekeepers from sharing staff details with me. They were also unable to fulfil my request to place study flyers on relevant staff noticeboards due to Covid-19 health and safety concerns.

Non-NHS staff were reached by asking relevant professional associations and NHS bodies (not Trusts) to share my study flyer and information sheet with their members. Private sector therapists were sourced mostly from the Association of Speech and Language Therapists in Independent Practice (ASLTIP), which has an online members directory that lists therapist profiles with their contact details. I randomly picked members, but made some effort to find and contact those who seemed under-represented based on their names (e.g., male names). I also conducted basic internet searches for SLT firms. Most participants were invited via email as cold calling was a less effective recruitment method.

Gatekeepers circulated an email to their relevant contacts (e.g., SLT departments), which briefly described my research, invited potential interviewees, and provided a contact email

address. The study flyer and participant information sheet were added as email attachments. Interested participants emailed me directly for further information. NHS-based therapists who showed interest guided my decisions about which Trusts to seek local ethics approval from. I asked all interviewed participants to share the study with other relevant individuals, who then directly contacted me if interested. All participants agreeing to an interview were emailed the participant information sheet, consent form, some contextual pre-interview questions (described later), were asked for their interview availability, and informed that all interviews would be virtual due to Covid-19.

Sample sizes in qualitative research are typically smaller than quantitative studies. They do not aim to identify statistically significant results, but rather collect enough rich data to form meaningful conclusions about the studied topic (Bloor and Wood, 2006). So, deciding when to stop participant recruitment in qualitative research is hard. Some scholars suggest sampling ranges. For example, Miles and Huberman (2009) say numbers exceeding 15 cases may complicate data analysis. But, Morse (1994) says about 30-50 participants are needed for grounded or ethnographic studies. Other scholars say that sample sizes depend on data richness. This relates to theoretical/thematic saturation, which says participant recruitment should continue until nothing new is being heard about the research topic (Bloor and Wood, 2006; O'Reilly and Parker, 2013; Austin and Sutton, 2014). I used theoretical saturation to determine recruitment termination, but set a minimum limit of 30-40 participants (or 15-20 of each sample) informed by literature and practical factors (e.g., time restrictions and Covid-19 impact including ethics process delays and limited access to participants).

Overall, 51 participants were recruited from September 2020 to October 2021: 29 SLTs, and 22 diversity stakeholders. Tables three and four outlines the sample characteristics. Figure two shows how the tripartite focus guided the sampling strategy. The SLT sample was mostly female and White, but were still more gender (31% male) and ethnically diverse (28% minority ethnic) than the profession overall (3% and 7% respectively) (Health and Care Professions Council, 2020b; NHS England, 2020b).

Table 3. Sample characteristics. Note: Role length covers full years only, and for some stakeholders only reflects their diversity role length where stated.

Characteristic	SLTs (N=29)	Diversity stakeholders (N=22)	Total (N=51)
Gender			
Female	20	14	34
Male	9	8	17
Ethnicity			
White or White British	22	13	35
Asian or Asian British	6	3	9
Black or Black British	0	3	3
Mixed or Multiple Ethnic	1	1	2
Other Ethnic Group	0	2	2
Current role length (years)			
<1	9	7	16
1-6	13	8	21
8-10+	7	7	14
Organisation type			
NHS	18	10	28
Private practice	11	0	11
Professional association/society		6	6
Trades union		2	2
University		4	4
Geographical region			
London	18	12	30
London and South England	1	0	1
Rest of England	10	10	20

Table 4. Participant roles and organisations. Note: AHP= Allied health profession; EDI= Equality, diversity, and inclusion; SLT= Speech and Language Therapy.

Therapists		
Pseudonym	**Position**	**Organisation**
1. Aisha	Therapist	NHS Trust
2. Amy		
3. Ava		
4. Chloe		
5. Hannah		
6. Isabella		
7. Jack		
8. Jamie		
9. Jessica		
10. Kathryn		
11. Lian		
12. Mei		
13. Rahima		
14. Rose		
15. Stella		
16. Tom		
17. William		
18. Adam	Therapist	Sole trader
19. Alice		
20. Danielle		
21. Eileen		
22. George		
23. Graham		
24. Kate		
25. Lauren		
26. Rani		
27. Sanjay		
28. Sophie		
29. Thomas		

Diversity stakeholders		
Pseudonym	**Position**	**Organisation**
1. Gloria	EDI lead	NHS Trust
2. Hazel	AHP lead	NHS Trust
3. Imani	EDI lead	NHS Trust
4. Leah	EDI role	NHS Trust
5. Oliver	Senior manager in HR	NHS Trust
6. Susan	AHP lead	NHS Trust
7. Ajay	Manager	NHS body (not Trust)
8. Joel	EDI lead	NHS body (not Trust)
9. Sunita	EDI lead	NHS body (not Trust)
10. Suresh	EDI lead	NHS body (not Trust)
11. Anita	Senior manager	Leading professional body
12. Anna	Policy role	Leading professional body
13. Fiona	Manager	Leading professional body
14. Matthew	Senior manager	Leading professional body
15. Nathan	Senior manager	Leading professional body
16. Sharon	Senior manager	Leading professional body
17. Amelia	Union representative/ SLT	Trades union
18. Karen	Union representative/ SLT	Trades union
19. Alia	Lecturer in SLT related subject	University
20. Isaac	Research post/ Health sector workforce expert	University
21. Leyla	Lecturer in SLT/ EDI role	University
22. Patrick	Lecturer in SLT	University

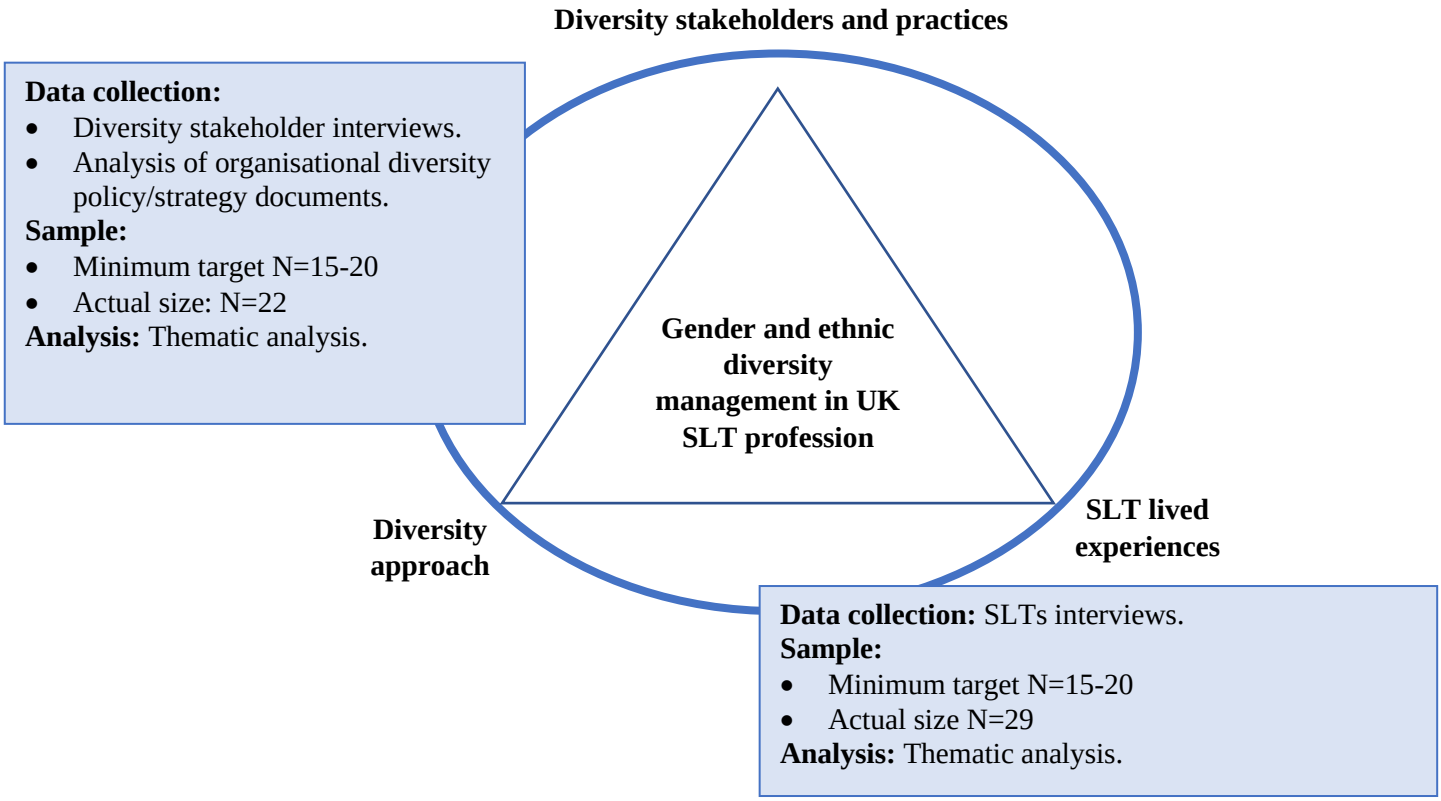


Figure 2. Tripartite focus guiding the sampling strategy.

Interviews were scheduled at the participants convenience given their virtual nature and to maximise potential recruitment. Reminder emails were sent to non-responders after 1-2 weeks. Once participants returned completed consent forms and indicated their interview availability, they were given: (1) a copy of the final consent form which included my signature for their records, (2) their sample's interview protocol for reference or to prepare any responses, (3) a document outlining support organisations for therapists, and (4) a Microsoft Teams/ Zoom interview calendar invite. Initially, the interview protocols shared with participants consisted of probes, but were later removed to avoid overwhelming them or influencing their responses. A list of materials can be found in Table five below, with documents provided in Appendix sections three to nine.

Table 5. List of fieldwork materials.

Item (quantity)	Summary	Appendix no.
Study protocol (x1)	Detailed project outline for review by research ethics boards.	Outlined throughout this chapter.
Gatekeeper email templates (x2)	One for each sample to be used for participant recruitment and tailored in practice as necessary. Briefly outlined project and contact details.	three
Study flyer (x2)	One for each sample which briefly outlined the research aims, use of interview, eligibility criteria, short researcher profile, supervisory team details, and contact details.	four
Participant information sheet (x2)	One for each sample which outlined the research in sufficient detail to make an informed decision about participation.	five
Consent form (x1)	Standard form outlining six points of consent, that required participant's initials and signature. The final copy was signed by the researcher, with a copy shared with the participant.	six
Interview protocol (x5)/ pre-interview questions	One for therapists and four for different diversity stakeholders. The SLT protocol covered their professional experiences related to gender and ethnicity, and opinions/experiences of diversity practices. All protocols for different stakeholder types (external, internal NHS, NHS body, and professional body (e.g., society/association)) covered diversity issues, practices, and impact relevant to SLT. Three/four contextual questions for context which participants could answer via email prior to, or at the beginning of, interviews. This included job title, length in current role, gender and ethnicity, and finally expertise needed for role. The latter was omitted for some because it no longer seemed necessary for SLTs.	seven (protocol content and rationales in eight)
List of support organisations/helplines (x1)	A list of four relevant support organisations were shared with therapists given the topics addressed.	nine

Semi-structured interviews were chosen to balance the pros and cons of structured and unstructured interviews. Structured interviews fail to mimic natural conversation. They are rigid, comprising of a predetermined list of questions and avoidance of improvisation or intuitive adaptation of questioning (e.g., probing responses) (Booth and Booth, 1994; Austin

and Sutton, 2014). Semi-structured interviews balance both characteristics and mimic natural conversation flow (Austin and Sutton, 2014). Unstructured interviews can exhaust researchers because they demand certain interview expertise levels to navigate conversations (Booth and Booth, 1994). However, participants may prefer them because they offer more control over interview content and process (e.g., what is disclosed.) (Cassell, 1980) than structured interviews. Participants undertaking structured interviews may withhold information for different reasons (e.g., relevant question not asked) (Corbin and Morse, 2003). However, semi-structured interviews were ideal as a novice researcher because the predetermined questions helped navigate and maintain the relevancy of conversations, in a natural way that offered participants some freedom. Also, Constructivist interview approaches can counteract participants withholding information because they empower them with a voice and offer a sense of purpose (Hutchinson, Wilson and Wilson, 1994).

The research robustness relied heavily on the interview protocols, and so good time and effort was dedicated to their design and development. The protocol questions emerged from the tripartite focus guided by diversity management literature. Appendix eight outlines the rationale and content of the interview protocols used, including how each question relates to the tripartite focus. Protocol feedback was sought from different sources, including my supervisory team given their qualitative research expertise, and various experts in UK diversity and healthcare domains (e.g., Queen Mary University's Centre for Research in Equality and Diversity colleagues, and individuals involved in the NHS WRES system). Also, the original stakeholder protocol was piloted with two Higher Education diversity officers, who provided feedback on question clarity and relevance.

Both samples were asked three or four pre-interview questions about their job title, current role length, self-described gender and ethnicity, and sometimes the expertise needed for their role. Participants could email their answers prior to, or state them at the beginning of, the interview. All protocols included definitions of gender and ethnicity based on section 1.2, but were later removed to avoid influencing participant responses.

SLT interviews covered four areas: (1) why and how they chose their profession, (2) whether and how their gender and/or ethnicity influenced their professional careers, including barriers and support, (3) perceptions of diversity issues and practices within their organisation and/or profession, (4) and the practice impacts. Therapists were asked to provide relevant examples

of their career experiences. NHS therapists were specifically questioned about the content and impact of their employer's diversity policies/strategies, but this did not apply to sole traders.

Diversity stakeholder interviews covered three areas: (1) perceived gender and ethnic diversity issues within the profession/health sector broadly (2) the diversity agenda of SLT employers/ profession overall, (3) how the agenda was being translated into practice, including their impact. They were first asked about therapist's basic career structure, diversity levels and issues. Then they were questioned about the main strategic priorities and plans of their organisation's/ profession's gender and ethnic diversity agenda, and how they were translated into practice. I inquired about any diversity practices, their implementation, and who the key stakeholders were alongside their associated roles in this process. Sometimes this required asking about the content and implementation of organisational diversity strategy/policy documents. Finally, stakeholders were asked about the impact of the diversity practices they discussed.

All interviews concluded by giving participants an opportunity to ask questions, and add to or clarify their responses. This, and open-ended questions allowed space for new themes or ideas to emerge. Aligned with a Constructivist approach, I was actively involved in the conversation via emotional reactions (e.g., expressing empathy when hearing difficult experiences and surprise or interest at comments made), and allowing participants to ask questions. This involvement helped mimic a natural conversation which encouraged participants to authentically express themselves. Participants who articulated concerns about their interview statements were reminded of data confidentiality and anonymity. All participants were assigned pseudonyms for anonymity which are listed in Table four to help navigate participant quotes in the results chapters. Post-interview, all participants were asked to share the research with relevant contacts to increase recruitment chances.

All interviews were one-off, lasted approximately 1-1.5 hours, and were conducted online mostly using Microsoft Teams because it was deemed more secure than Zoom by QMUL JRMO. Participants who preferred Zoom had to give additional consent for its use. All interviews were in video format as both online platforms have a record function which saves video recordings directly onto devices. The first batch of interviews were also audio-recorded as a safety precaution because of initial technical issues around saving video recordings, but once resolved, was no longer necessary for the remaining interviews. The few participants who

did not want their face video recorded, turned their video function off so that just their audio was recorded. These interviews were sometimes hard to navigate because of the absence of facial expression cues. Also, it was sometimes unclear whether participant's silence was due to thinking or a finished response, which sometimes led to accidental interruptions. Manual notes were taken to help navigate which questions or probes to use. Some participants requested a summary of the results after their interviews, and were told this would be shared in due course.

All video recordings were saved onto my university OneDrive account and an external hard drive, both of which were password-protected. These locations contain a list of site files, one for each organisation/group (e.g., one file for each NHS site, one for all sole traders, etc.). Each site file contained a folder for each participant, labelled with their ID number for easy identification. Participant folders include their consent forms, interview video and/or audio recordings, pre-interview question responses in a Microsoft Word document, any pre/post-interview documents they shared, and their interview transcripts. This archival of all raw data allows for an audit trail and benchmark for future assessment of the data analysis and interpretations (Halpren, 1983; Lincoln and Guba, 1985). See Appendix ten for a flow chart of the interview process.

5.2.4.2 Organisational diversity policies/strategies

Table six outlines brief details of the EDI policy or strategy documents of organisations included in this research which were collected to supplement the interview data. However, these documents are not included in the appendix to ensure participant confidentiality and anonymity. Diversity policies are defined and discussed in section 3.3. Diversity strategy documents outline the action plan of diversity policies (e.g., proposed practices).

Only NHS diversity documentation could be sourced. All private sector therapists interviewed were sole traders, and so they did not have nor abided by a specific diversity document. Diversity documents could not be found for NHS bodies (not Trusts) because their websites only provided guidance and resources from various sources (e.g., the NHS People's Plan). One stakeholder from this sample shared their regional EDI strategy and the NHS People's Plan, which was included in the analysis. The diversity policy of the professional body included in the thesis was requested but not received, and those of the external stakeholder's employers

(i.e., trades unions and universities) were not sought because they do not provide an SLT service. The lack of diversity documents from these organisations is not problematic. First, these stakeholders were recruited as experts in their field who may or may not be practising, or have knowledge about SLT. Whilst this is also true of NHS Trust stakeholders, their policies apply to practising therapists because they employ them. The organisations which I could not or did not collect diversity documents from are unlikely to employ therapists, and even if they do, it is unlikely to be an essential part of their job remit. So, they are unlikely to provide SLT-specific services or research. For example, universities and professional associations may employ individuals with knowledge or experience in SLT as lecturers or policy advisors, whether they are a practising therapist or not.

Each NHS Trust had a dedicated EDI webpage, usually placed in an "about us" section with links to several diversity-related documents. I searched through them to identify those outlining EDI objectives, or their labels had key terms – e.g., "policy", "strategy", or "action plan". Relevant webpages and documents were downloaded as PDF or Microsoft Word documents on Tuesday 6th April 2021. One document per site was selected for analysis for practicality. The final choices were determined based on relevance to the tripartite focus in collaboration with my supervisors. Documents were chosen if they were the most recent version available, focused on both gender and ethnicity together (i.e., not gender pay gap or WRES reports), and had sufficient relevant detail (e.g., some documents only graphically presented diversity data or focused on a diversity event/assessment - e.g., equality impact assessments).

Table 6. List of diversity documents for each site and their characteristics. Note: WDES=Workforce Disability Equality Standard; WRES= Workforce Race Equality Standard.

Site	Source	Details	Brief description	Omitted documents and rationale
NHS Trust (Site 1)	Website	2019, 32 pages, PDF document	Annual equality and diversity report for 2018-19 period. Outlines frameworks for equality and diversity governance and public sector equality duty, equality objectives, and progress update on their previous year's Equality Delivery System.	• No document specific for gender. • WRES plan for 2019 outlining the Trust's race performance, and associated action plan from 2017-20. Omitted because the annual report chosen covered both gender and ethnicity.
Sole traders (Site 2 and 5)	N/A – did not have diversity documents.			
NHS Trust (Site 3)	Website	No date, 21 pages, PDF document	Strategy document for 2020-23 period. Outlines Trust aims and values, and diversity-related practices, resources, and accreditations.	• Older policies (e.g., 2013) and equality reports (e.g., 2016-19) omitted. The latest annual report (2019) outlined inclusion strategy and priorities, gender pay gap performance, WRES and WDES. This content somewhat overlapped those in strategy document.
NHS Body (not Trust) (Site 4)	Participant	No date, 17 pages, PDF document	One strategy document for 2020/21 period – only document sourced from participant. Outlines vision and goals, diversity profile for NHS staff in region, diversity stakeholders, strategy, and associated outcomes.	• One participant showed parts of their strategy during the interview, but did not share the full document afterwards.
Professional body (Site 6)	N/A – documentation sought but not received.			

Site	Source	Details	Brief description	Omitted documents and rationale
NHS Trust (Site 7)	Website	No date, 9 pages, PDF document	Trust annual report for 2019 period. Focus is on equality and diversity successes which relate to the Trust's 2019/20 goals and public sector equality duty. Outlines Trust values and their diversity practices and successes.	• Statement of intent for 2015-20 omitted because title implied it was not a policy or strategy, but it did detail an equality and diversity strategy, stakeholders, and performance measures (e.g., WRES) – some of this content was also covered in the chosen document. • Documents omitted if they just consisted of graphs of Trust diversity levels, were not specific to Trust (e.g., general NHS document on Equality Delivery System) or irrelevant (e.g., focus on diversity event or Equality Impact Assessment). • WRES and gender pay gap reports omitted because some in informal presentation format, and both areas covered in chosen document.
External stakeholders (Site 8)	N/A – documentation not directly related to SLT.			
NHS overall	Participant and website	2020, 52 pages, PDF document	"We are the NHS: People plan 2020/21 – action for us all" (NHS England, 2020c). Policy document outlining NHS challenges and actions for the 2020/21 period. This covers, but is not exclusively about, EDI.	Easy to read versions lacked detail, and so most detailed version was used.

5.3 Data analysis

5.3.1 Thematic analysis of interviews

Data analysis is the most complex qualitative research stage (Thorne, 2000) and may start during data collection. So, researchers should document any initial knowledge, thoughts, interpretations, and questions (Tuckett, 2005). I routinely noted down reflections after participant interviews, or discussions with supervisors, colleagues, or thesis consultants. Researchers can also make sense of interviews by transcribing them. Where possible, video interviews were manually transcribed verbatim using Microsoft Word. VLC Media Player was used to extract the audio from video interviews to conceal participant identities. Then, due to time restrictions, the audio was uploaded onto an online third-party transcription service called Otter.ai. This service was selected because it was economical, and the customer services department stated that all data are kept confidential when contacted prior to service use. Otter.ai provides automatic computer-generated transcriptions, but can be prone to error (e.g., spelling mistakes or wrong words) where audio is unclear (e.g., audio interference, strong accents, and fast speech). The service aligns texts with the audio, and allows manual correction to transcripts. I listened to the full audio for each transcript to check its accuracy, and manually made corrections where necessary. Transcripts were marked where audio was unclear by stating 'audio blip'/ 'audio cut' or three question marks were used. These sections were double-checked by a supervisor to see if they could be clarified. Sometimes, the program failed to save the manual edits made and reverted to the original automated transcript laden with errors. In such cases, this transcription process needed to be repeated, which was time-consuming. It was still faster than just manually transcribing interviews, and the reviewing process improved familiarisation of interview responses. Completed transcripts could be downloaded in Microsoft Word format and saved into relevant participant's files. Interview details (e.g., length, date, and time of interviews) and pre-interview question responses were added to transcripts, and they were then password-protected. Pseudonyms were randomly assigned to each participant using the Forebears website (https://forebears.io/) based on names common for their self-described gender and ethnicity (see Table four).

Interview transcripts were analysed using thematic analysis for several reasons. Thematic analysis identifies, organises/analyses, describes, and reports themes in data resulting in

meaningful and trustworthy findings if conducted rigorously and methodically (Braun and Clarke, 2006; Nowell *et al.*, 2017). First, it is appropriate for studying large qualitative datasets, capable of catering for all the rich interview data collected (Nowell *et al.*, 2017). Second, it is a common and accessible analytical tool for novice researchers potentially unfamiliar with qualitative methods, because it has few rules and does not expect strong theoretical or technological expertise (King, 2004; Braun and Clarke, 2006). Some scholars think thematic analysis should be deemed a method in its own right (Thorne, 2000; King, 2004; Braun and Clarke, 2006; Nowell *et al.*, 2017), whilst others promote it as an analytical tool (Boyatzis, 1998; Ryan and Bernard, 2000; Holloway and Todres, 2003). Third, thematic analysis offers flexibility. It can explore different research questions, study types, and perspectives to create rich and detailed data, such as highlighting overlaps and differences, and discovering unanticipated findings (King, 2004; Braun and Clarke, 2006). The latter allows other protected characteristics and power dynamics relevant to therapist's gender- and ethnicity-based experiences to emerge during data analysis, and so thematic analysis is often used to study intersectionality (Atewologun, 2018). However, flexibility must be balanced by consistently and coherently developing themes from the data. Researchers can do this by explicitly stating their epistemological stance to support their data interpretation (Holloway and Todres, 2003). I outlined an alignment towards Social Constructivism in section 5.1, which guided my data coding process.

Thematic analysis generally involves six main steps described in detail below. Steps include: (1) becoming familiar with the breadth and depth of data until it is understood, (2) generating and allocating a preliminary set of codes to the data to describe its content, (3) looking for patterns/themes across the dataset, (4 and 5) and then developing them by reviewing, defining, and labelling those themes, (6) and finally reporting findings (Braun and Clarke, 2006; Spencer, Ritchie, O'Connor, *et al.*, 2014; Nowell *et al.*, 2017).

Codes are central to thematic analysis and are:

> *"often a word or short phrase that symbolically assigns a summative, salient, essence-capturing and/or evocative attribute for a portion of language-based or visual data"* (Saldana, 2009, page 3).

So, the coding process covers both data management and interpretation. Data judged as looking or feeling alike are grouped together (i.e., classification system), and coding tries to *"fix meaning, constructing a particular vision of the world that excludes other possible viewpoints"* (Seale, 1999, page 154; Saldana, 2009; Spencer *et al.*, 2014). Different software is available for converting raw transcript data into themes more systematically than doing it manually (Austin and Sutton, 2014). I used QSR International's *NVivo 12 Pro* software because it specialises in qualitative data analysis, I have been trained in its use, and my supervisors recommended it.

Stage 1: *Data familiarization* is about immersing oneself in the data to get an overall idea of its content, and actively identifying and noting down relevant parts which makes the later analysis stages rooted and supported by the data (Braun and Clarke, 2006; Spencer, Ritchie, O'Connor, *et al.*, 2014; Nowell *et al.*, 2017). This process promotes awareness of any limitations or overemphasis in the data, and should inspire some theme ideas that can be applied to the dataset (Spencer, Ritchie, O'Connor, *et al.*, 2014). Key concepts from the literature helped shape the choice of codes (e.g., "discrimination" and "career progression"), but coding was also an iterative process. I repeatedly read the interview transcripts, whilst simultaneously identifying and grouping the interesting speech into broad early inductive codes.

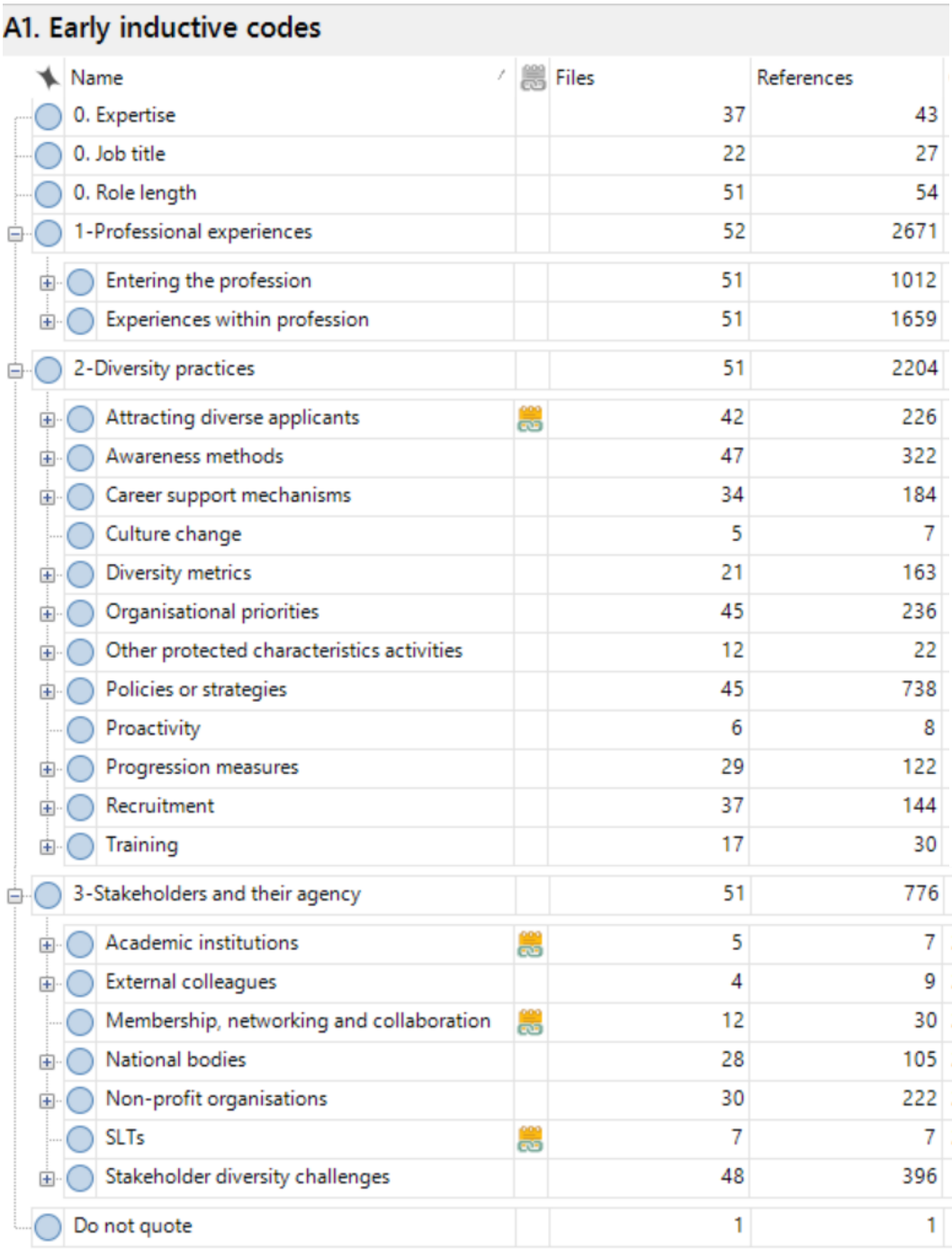
Stage 2: *Generate a preliminary set of codes* from the data and index them. Unstructured data are transformed into ideas about what is happening in the data. This involves looking for important parts of the text and assigning them labels/codes which capture the richness of the topic/issue (Boyatzis, 1998; Morse and Richards, 2002; Spencer, Ritchie, O'Connor, *et al.*, 2014). The same rules must be applied to the entire dataset so that code generation is consistent and systematic (Nowell *et al.*, 2017). Scholars offer different guidelines and recommendations for this process. For example, a provisional coding template to justify why a code was chosen and rules for its use (King, 2004), or using coding manuals (Crabtree and Miller, 1999). I initially used a Microsoft Excel spreadsheet as a provisional coding template. This outlined the thesis research questions, some relevant codes (e.g., ethnicity practices), a brief description of its content (e.g., ethnicity-specific diversity efforts), and some literature concepts to consider (e.g., WRES). Since the spreadsheet required manual updating, I soon chose to use NVivo's coding provisions. NVivo allows codes to be labelled and described in real-time, and is

downloadable as codebooks which lists all codes with their details and has options of including other useful metrics (e.g., number of files with, or references to, a code). The codebook was a working document because new codes were added, or existing codes merged with each interview analysed. The final interview codebook is in Appendix 12. Scholars generally agree that codes should have certain characteristics (Seale, 1999; Attride-Stirling, 2001; Spencer, Ritchie, O'Connor, *et al.*, 2014), such as clear boundaries to ensure their relevancy and not be replicated. This is helped by accompanying notes outlining its definition and rules for use. Also, the early coding stages are about indexing where codes/themes are descriptive instead of abstract, grounded in the data, and are used as signposts (i.e., without fixed meanings). The latter is because starting with advanced thought may distract from important details in the data or *"stultify creative thought"* (Seale, 1999, page 154). An example of an early inductive code was "discrimination and bias". Its content covered all forms of discrimination, stemmed from interview transcripts, was later given subcodes representing its different forms, and moved into an abstract parent code called "belonging and marginalisation/disadvantage".

I initially coded both sample's interviews separately to compare and so uncover code overlaps and differences. However, I was advised during an NVivo training session to code all the interviews together, and use the software's matrix coding function to explore each sample's relative focus on a code. This approach was more pragmatic: it allowed easy code comparisons without duplication as both samples discussed similar topics despite different levels of emphasis. For example, both samples discussed diversity practices, but stakeholders provided more of this content.

The coding structure depends on what the researcher finds useful. Hierarchical coding allows topics or issues to be explored at different specificity levels, where higher levels give an overview and lower levels give specific information (King, 2004). See Figure three for first and second order codes. Parts of the data may be coded several times or be uncoded (Braun and Clarke, 2006). For example, references to the "discrimination and bias" code also featured in the "career progression" (40 references), and "relatability" (21 references) codes. Any unusual findings should be coded (Braun and Clarke, 2006). However, having too many codes can make it difficult to organise and interpret the data (King, 2004). So, researchers aim for five to seven main themes, under which contains more detailed sub-themes (Saldana, 2009). I

had seven final, main NVivo codes (see Figure three), but combined them in ways to report three themes to ensure a clear narrative of findings (see results chapters - e.g., experiences are matched with relevant practices).



A1. Early inductive codes

Name	Files	References
0. Expertise	37	43
0. Job title	22	27
0. Role length	51	54
1-Professional experiences	52	2671
Entering the profession	51	1012
Experiences within profession	51	1659
2-Diversity practices	51	2204
Attracting diverse applicants	42	226
Awareness methods	47	322
Career support mechanisms	34	184
Culture change	5	7
Diversity metrics	21	163
Organisational priorities	45	236
Other protected characteristics activities	12	22
Policies or strategies	45	738
Proactivity	6	8
Progression measures	29	122
Recruitment	37	144
Training	17	30
3-Stakeholders and their agency	51	776
Academic institutions	5	7
External colleagues	4	9
Membership, networking and collaboration	12	30
National bodies	28	105
Non-profit organisations	30	222
SLTs	7	7
Stakeholder diversity challenges	48	396
Do not quote	1	1

Figure 3. NVivo print screen of early inductive first- and second- order codes.

Stage 3: *Index and sort the coded data.* This involves judging which parts of the data are about the same thing, and so belong together to form themes (Braun and Clarke, 2006). Initially, searching for themes helps to organise messy data, but later focuses on meaningfully labelling data to capture, describe, explain, and represent what is being said in the data, and linking different data parts together (i.e., theme development) (DeSantis and Ugarriza, 2000; Spencer, Ritchie, O'Connor, *et al.*, 2014).

The use of semi-structured interviews is helpful in this stage as the predetermined questions offer some order or "neat thematic piles" in the data produced (Spencer, Ritchie, Ormston, *et al.*, 2014, page 282). For example, responses to questions about career experiences and diversity practices were coded into "professional experiences" and "diversity practices" themes/codes respectively (see Figure three). Themes can be produced inductively from the raw data (e.g., theme representing no or uncertain impact of gender/ethnicity on careers), or deductively as informed by theory (e.g., themes of discrimination and career progression from existing literature) (Nowell *et al.*, 2017). A "miscellaneous" theme can temporarily hold codes that do not fit into the main themes (Braun and Clarke, 2006). For example, one code called "unspecified diversity issues" gathered career experiences unclearly linked to gender or ethnicity. There were efforts to assign this code's contents to the relevant main themes where possible by intermittently reviewing them at different analysis stages to gain clarity. Scholars emphasise the need to be consistent and systematic in how codes/ themes are determined, and to document (i.e., audit trail) and communicate this process in clear detail (Attride-Stirling, 2001; Tuckett, 2005). This allows their work to be evaluated for its trustworthiness or credibility (Braun and Clarke, 2006; Nowell *et al.*, 2017). Table seven outlines how I met Constructivist research quality criteria to establish the rigour of this research. There are different tools for ensuring that the research process is described in enough detail to judge if the findings are rooted in and supported by the data (e.g., quotes, tables, coding manuals, diagrams, etc.) (Crabtree and Miller, 1999; Braun and Clarke, 2006; Ryan, Coughlan and Cronin, 2007). This chapter provides a detailed account of the methods and analysis process, with relevant supporting documentation available in the Appendix.

Stage 4: *Review and refine the themes*. The initial thematic framework may be rough. So, themes must be refined by removing and adding codes, or merging and breaking down themes

as needed (Braun and Clarke, 2006; Spencer, Ritchie, O'Connor, *et al.*, 2014). Theme refinement can continue indefinitely, but scholars offer some signposts for stopping (Attride-Stirling, 2001; King, 2004; Nowell *et al.*, 2017). These include reading through all data, including all data relevant to the research question, interrogating codes at least twice, and ensuring that themes are specific enough to be different but broad enough to capture its sub-codes. Eventually, there should be a more manageable set of themes that accurately summarise and tell the story of the data. See Figure four for an example of how the "professional experiences" theme was refined.

Stage 5: *Define and label each theme* in ways that clearly and concisely describe their scope and content (Braun and Clarke, 2006) (see codebook in Appendix 12).

Stage 6: *Tell the story of what the themes say about the research topic*. This involves clearly and convincingly communicating arguments by articulating its underlying logic, including all perspectives even the unexpected, using direct quotes as support, displaying the story's richness and complexity, and referring back to literature (King, 2004; Braun and Clarke, 2006; Nowell *et al.*, 2017). There were three final main themes represented across three results chapters.

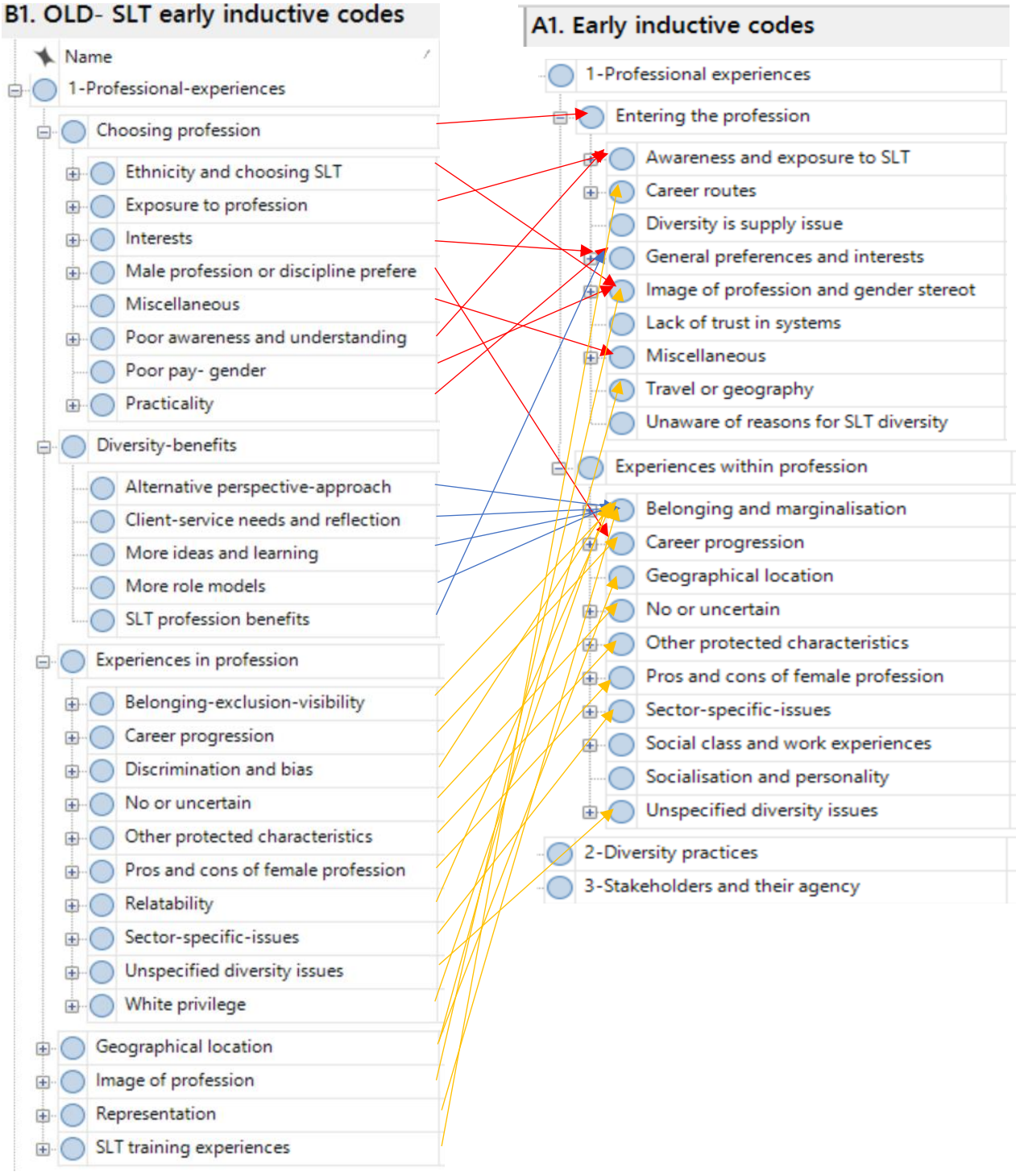


Figure 4. Example of how "professional experiences" codes were refined from left (May 2022) to right (April 2023) following NVivo training and supervisor consultation.

5.3.2 Thematic analysis of diversity policy/strategy documents

Thematic analysis was also applied to diversity policy and strategy documents of therapist's employers for three main reasons.

First, thematic analysis seems the most appropriate method. It allows focus on the *content* of organisational diversity documents, namely approaches to diversity management (e.g., motivations and practices). Discourse analysis was initially considered because diversity documents are exemplary positions *presented in language* that try to attract and convince readers of its exemplary status (Gasper and Apthorpe, 1996). Also, it explores the structure of arguments in spoken or written documents, statements, and practices that act as a tool for making these arguments (Hajer, 2006). However, discourse analysis was inappropriate for this thesis because focuses was on the *content*, rather than the *structure* of language. Also, discourse analysis is not straightforward in practice. For example, some literature mentions problems with the use of computer simulations to try and understand text, which shows that researchers need *"vast amounts of effectively organised knowledge"* to create and understand discourse (van Dijk, 1990, page 6; Gasper and Apthorpe, 1996). In contrast, secondly, thematic analysis has many benefits (see section 5.3.1) including that it is user-friendly for novice researchers (King, 2004; Braun and Clarke, 2006).

Finally, using the same analytic approach throughout the thesis allows for research consistency, and ease in finding the underlying narrative of the data. So, the same thematic analysis steps and quality criteria used for the interviews (see sections 5.3.1 and Table seven) was applied to the diversity documents. Data familiarisation was done by reading through the diversity documents. The diversity documents were analysed separately from the interviews, and resulted in three main codes: content, creation, and stakeholders (see Figure 10 in Appendix 14).

5.4 Research transparency, quality, and reflexivity

This section discusses how my positionality potentially influenced the research process, as reflexivity is advised by Constructivism, intersectionality and CRT (see chapters four and five).

Social Constructivism shaped my interview quality approach. First, an important debate about interview transparency is whether interview data will allow researchers to clearly understand how interviewees make sense of their experiences (Roulston, 2010). Participants can answer questions in problematic ways: *"misinformation, evasion, lies and fronts"* (Walford, 2007, page 147). This may be due to bad memory, inadequate knowledge, holding unique or willingness to share perceptions (Walford, 2007). These are issues from a Positivist rather than a Constructivist lens because in the latter, data are an intersubjective account rather than report of the world. Also, there may be issues around interview conduct, for which scholars offer recommendations (Potter and Hepburn, 2005). This includes studying interviews as an interaction because it is a conversation, and using more naturalistic data (e.g., audio and video interview recordings) in everyday settings (Potter and Hepburn, 2005). I mitigated these potential risks in this thesis. For example, I tried to make interviews mimic informal conversations by probing further on interesting responses, and conducted them virtually allowing participants choice of a convenient time and everyday setting (e.g., home or workplace). Also, all interviews were video recorded.

Second, another key debate about interviews concerns whether they are reliable and valid, and how to assess this (Roulston, 2010). Debates about the quality of qualitative research have queried whether and how quality criteria could be set (Ritchie and Ormston, 2014). For example, quality checklists, frameworks, and guidelines for best practice have been developed (Spencer and Ritchie, 2012; Ritchie and Ormston, 2014). There is no standard term for referring to the "quality" of qualitative research (Roulston, 2010) (e.g., terms include credibility, thoroughness (Rubin and Rubin, 2005), and validity (Kvale, 1996)), nor for determining it, with the latter mostly from descriptions of practice and instructions from theory (Freeman *et al.*, 2007; Roulston, 2010). According to Roulston (2010), quality assessments depend on the researcher's paradigm. So, I use Social Constructivist quality criteria, which are trustworthiness and authenticity (Lincoln and Guba, 1985; Guba and Lincoln, 1994; Robert

Wood Johnson Foundation, 2008; Elo *et al.*, 2014). *Trustworthiness* has four dimensions: credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985; Guba and Lincoln, 1994). *Authenticity* is about how much researchers have fairly and accurately represented different perspectives, and has five dimensions: fairness, and four types of authenticity: ontological, educative, catalytic, and tactical (Lincoln and Guba, 1985; Guba and Lincoln, 1994; Elo *et al.*, 2014). Different techniques can be used to demonstrate each dimension. Table seven outlines each dimension with examples of practices for this thesis.

Third, researcher reflexivity was practised throughout data collection to ensure optimum data. I reflected on question utility, my conduct (e.g., observations that I was interrupting participants), noted down emerging themes, and produced some early interview transcripts for my supervisors to review to improve upcoming interviews. Also, four different interview protocols were produced to cater for the different stakeholder samples, all covering similar questions but tailored in their phrasing or the sequence. For example, the professional association/society and internal NHS protocols both asked about diversity practices but focused on those by the association/society and profession-wide, and Trust-specific and NHS-wide, respectively. Overall, interviews adopted a flexible and reflexive approach where interview questions could be adapted, included, and probed further whilst still fulfilling the main protocol aims. For example, when horizontal segregation of workforce diversity was mentioned (i.e., overall numbers), I probed about vertical segregation (i.e., across career hierarchy levels).

The quality of my interviews improved with my growing interviewing experience and technique. There was an initial reliance on the interview script and probes to push for detailed and relevant interview responses. For example, it was initially difficult to gain rich responses when some interviewees gave short answers. I was able to improve my interview technique by discussing concerns with my supervisors, who offered useful tips and reviewed some of my early interview transcripts. For example, they suggested probes that I could use, which helped achieve deep insight into the reasons for certain perceptions or assertions made. This was important as Constructivists acknowledge that participants have a role in knowledge production, such as triggering pathways to explore, sometimes resulting in emerging findings not properly explored in academic literature.

My positionality possibly affected knowledge co-construction with participants. First, I noticed that my physical appearance positively influenced participant responses. Sometimes participants made direct or indirect references to my social identity based on my appearance (i.e., a visibly Muslim, Asian, female researcher), when sharing gender and/or ethnicity-based experiences. For example, they mentioned my hijab or spoke of female issues in ways that implied that I could understand or relate. This signalled that participants were comfortable and so willing to share their stories with me, which was possibly particularly pronounced for minority ethnic therapists because they were all Asian like myself. This is an asset as Constructivist, intersectionality and CRT approaches all emphasise giving voice to marginalised or under-represented groups. However, my ethnicity does not negate the value of my interactions with White therapists. It is unclear whether awareness of either my minority ethnic status, ethnicity-based inequality triggered by the pandemic, or both, influenced White therapist's responses to ethnicity-related questions. Nonetheless, White therapists reflected on White privilege through comparisons with minority ethnic experiences.

Second, my position as a researcher external to SLT possibly influenced participant interactions. I tried to mitigate any power imbalance perceptions by mimicking natural conversation and granting participants space to speak at length. As an outsider to and unfamiliar with SLT, perhaps participants elaborated on their points to ensure adequate clarity and context. Alternatively, perhaps my minority ethnic researcher status implicitly signalled to participants my investment in, and advocacy for, tackling the profession's diversity issues.

Finally, I practised reflexivity throughout thematic analysis, which was an intellectually challenging, iterative process. It was easy to get lost in the vast data collected, sometimes making it hard to find the core narrative being shared across all the interviews. Interviewees were very generous in their opinions and experiences, but not all information could be included based on direct relevancy and the thesis word limitations. However, my interpretation of the final thesis narrative was guided by discussions with my supervisors, existing literature, research questions, and justified by grounding my claims using direct quotes. NVivo allowed an audit trail, which means themes can be reviewed in the future (e.g., several versions of NVivo files and coding manuals saved). It is important to note that Constructivists posit that findings are context dependent, and so may be inapplicable to future contexts.

Table 7. Application of Constructivist research quality criteria (based on Lincoln and Guba, 1985; Guba and Lincoln, 2000; Patton, 2002; Robert Wood Johnson Foundation, 2008; Ormston *et al.*, 2014; Spencer, Ritchie, Ormston, *et al.*, 2014; Nowell *et al.*, 2017).

Quality criteria	Definition	Application to thesis
Trustworthiness criteria		
Credibility	Confidence in the accuracy of findings.	
Prolonged engagement	Enough field time to learn and understand the studied phenomena.	• Interviews conducted from September 2020 to October 2021. • Interview transcription and analysis required prolonged immersion in data.
Persistent Observation	Focus on the relevant parts of the phenomena of interest/data in detail.	• Not directly applicable, but tried to focus on research-relevant characteristics by shaping the interview protocols using the research questions. Protocols were refined throughout data collection to ensure relevant data collection.
Triangulation	Use of multiple data sources to capture in-depth insights of studied topic. Different types of triangulation exist – e.g., **researcher triangulation** involves the use of more than one researcher (e.g., to review findings/interpretations to uncover research gaps).	• Data collected from two samples (therapists and diversity stakeholders), and organisational diversity documentation to identify diversity issues and practices within the SLT profession. • Thesis supervisors guided research process, and are experts in both diversity and inclusion, and qualitative research.
Peer debriefing	Peers review research to uncover any biases, assumptions, or alternative interpretations possibly overlooked by researcher.	• Thesis supervisors had relevant expertise, and provided feedback throughout the research process (e.g., challenged the content and organisation of my thematic codes).

Quality criteria	Definition	Application to thesis
Negative case/deviant analysis	Identification and discussion of outliers until most data cases are explained.	• I tried to make findings inclusive of all participant experiences. Most interview content placed into relevant themes, ensuring that research findings were inclusive of almost all participants stories. • Unexpected/unusual findings noted and discussed with supervisors (e.g., how to probe therapist's claims that their gender and/or ethnicity did not shape their careers). • Reduced the content of miscellaneous codes by revisiting them throughout analysis to get a refreshed perspective, and discussing them with supervisors. These codes had little content and did not stray from the emerging main narrative. For example, the "unspecified diversity issues" code included some experiences covered in other themes but were not explicitly linked to gender or ethnicity (e.g., career progression and role models).
Referential adequacy	Some data are archived whilst the rest is analysed for preliminary findings, which is then is tested on the archived data.	• Returned to raw interview data to ensure findings are grounded in it – used direct quotes to support interpretations when reporting findings. • Member-checking during the interview process by asking participants to clarify comments made.
Member-checking	Checking of research findings/interpretations with participants to correct any misconceptions, get additional information, etc.	• Asked participants to clarify comments made during interviews.
Transferability:	Applicability or generalisability of the research findings to other settings or groups.	

Quality criteria	Definition	Application to thesis
Thick description	A detailed account of the fieldwork so its applicability to other contexts can be explored. Thin descriptions only provide superficial accounts of the fieldwork.	• Methods and results chapters use text, tables, and figures to describe the entire research process including the findings in rich detail. • Appendix contains additional supporting information.
Dependability:	Replicability of research process by demonstrating it is consistent, logical, traceable, and clearly documented.	
External audit	An external person assesses the research process and findings to check whether it is grounded in the data (i.e., its accuracy). **Inter-rater reliability** often discussed here which says two researchers should be able to draw the same conclusions. Labelling data in qualitative research aims to achieve a meaningful account of the topic in a transparent and systematic way, so readers can see theme development and asses its value, even if others may label things differently. The aim is not to get a perfect set of consistent codes.	• Documentation of entire research process (see thick description above). • There are records of all raw data (interviews, field notes and transcripts), and of interview and analysis materials (e.g., interview protocols and codebooks).
Confirmability	Demonstrating that the researcher's findings and interpretations are grounded in the data and not shaped by researcher biases.	
Audit	As described in *dependability* criteria.	• Audit trails and researcher triangulation discussed above. • Reflexivity examples below and in Appendix two.
Audit trail	Transparent description of the research process recorded from the start to the end which includes certain categories: raw data (e.g., interview recordings), data analysis notes (e.g., coding book), process/instrumental notes (e.g., methods	

Quality criteria	Definition	Application to thesis
	materials), and reflexive notes (e.g., motivations, expectations).	
Triangulation	As described in *credibility* criteria.	
Reflexivity / Emphatic neutrality	Researcher bias must be acknowledged and minimised using emphatic neutrality and reflexivity. **Reflexivity:** researchers reflect on, and transparently report, their biases. This may mean having a reflexive journal outlining beliefs, values, positions, and personal experiences during fieldwork, and having many researchers involved. **Emphatic neutrality:** empathy refers to researcher's showing non-judgemental understanding of participant's beliefs, positions, feelings, and experiences. Neutrality is challenging because researchers are the means of data collection, but there are strategies to help – e.g., addressing biases/errors (by reflecting, dealing with, and reporting them), systematically collecting data, using multiple data	• My social identity as a visibly Muslim, Asian, female researcher encouraged interviewees to make in/direct references to these characteristics (e.g., some mentioned my hijab). • Detailed notes kept of interview reflections, coding process (e.g., initial thoughts on codes), and minutes from all peer debriefings (i.e., thesis supervision/consultation meetings). • Tailored interview protocols to participants. • Supervisors reviewed interview questions during data collection phase to improve upcoming interview quality. • Displayed empathic neutrality in different ways - this included giving participants space to talk without interrupting or imposing my views. I also commented on their experiences to make them feel heard (e.g., congratulating any successes shared).

Quality criteria	Definition	Application to thesis
	sources, and triangulation. Displaying empathy means that neutrality does not mean detachment.	
Authenticity criteria		
Fairness	Fair presentation of different in-depth voices. This requires empowering people to participate and speak up in research. Any omissions may indicate bias or deception.	• Ethics process considered relevant issues of confidentiality, anonymity, and fairness (see section 5.2.4.1, Appendix 11, and Table four).
Ontological authenticity	Increasing participant's awareness of the world's complexity.	• Probed on participant responses which can highlight the complexity of the research topic. • Participants sometimes asked about literature or what other participants had said. They also gave anecdotes of other's experiences as interview examples.
Educative authenticity	Increasing awareness and respect for the different views that exist.	
Catalytic authenticity	Demonstrating that the research inspired participants to act.	• Difficult to assess and generally beyond the strict remit of a thesis. Some participants expressed plans to read or review their organisation's diversity policy.
Tactical authenticity	Redistributing power amongst different stakeholders.	

5.5 Chapter summary

This chapter focused on how I addressed my research question. I began by describing my philosophical alignment towards Social Constructivism, as my ontological and epistemological perceptions shape my research choices. I then described and justified my methodological choices and research process. This included the use of qualitative semi-structured interviews of therapists and diversity stakeholders, collection of the diversity documentation of therapist's employers, and use of thematic analysis to interpret them both. Finally, I reflected on how my positionality potentially shaped the research process including how I ensured research quality according to Constructivist criteria. The following chapters outline and discuss the outcomes of this research process.

CHAPTER 6: FINDINGS: ENTERING THE PROFESSION

The SLT profession in the UK has a predominantly White female workforce, as reported across literature, workforce data, and reaffirmed by the study participants (see sections 2.3.1 and 6.1.2.1). This thesis explores how diversity is managed within the UK's SLT profession to gain insight into why its gender and ethnic workforce demographic persists. So, I interviewed SLTs (N =29) and diversity stakeholders (N=22) about diversity issues and practices. I also analysed relevant diversity strategy/policy documents of therapist's employers. Three broad themes emerged from the data analysis, which are presented over three results chapters: (1) entering the SLT profession; (2) experiences within the profession; and (3) diversity approaches and stakeholders in the profession. Each chapter covers the tripartite focus (see section 5.2.1) in which diversity-related professional experiences and issues are matched with relevant diversity practices. As the stakeholders interviewed represented small numbers from diverse sectors relevant to the SLT profession (e.g., higher education, professional non-profit bodies, etc. – see Tables three and four), their input is embedded throughout chapters where relevant. Participant details in Table four can be used to navigate their quotes across the results chapters.

Entering the SLT profession emerged as a broad theme (see Figure seven in Appendix 14). It included why and how therapists pursued the profession, and the barriers potentially discouraging some groups from doing so, which possibly contributes to the profession's poor gender and ethnic diversity.

Generally, SLT exposure sparked interviewees' interests. This is because they preferred interpersonal work (e.g., wanting to help and build relationships with people, especially children) with practical benefits (e.g., workload variety) that aligned with their areas of interests, particularly in language and communication. Therapists tended to do their own research either online or via academic careers events/materials (e.g., talking to careers advisors). They then sought work experience by shadowing a therapist to gain relevant insight or experience to apply for a SLT degree. SLT career routes are outlined in section 2.3.2.

6.1 Barriers to entering the SLT profession

Some therapists and stakeholders (number of participants who mentioned code (N), N=9) thought that not enough diverse groups were applying to SLT, and so its poor diversity was presented as a supply issue. Several barriers to pursuing a SLT career were identified, but three seemed particularly important. These were: (1) A lack of awareness and understanding of SLT (N=28); (2) the image of the profession as feminised, middle-class, and of low status/poor pay prospects (N=50); and (3) ethnicity and social class, separately and when intersected, shaped networked access to work experience and education, including negatively shaping educational experiences (N=27). Diversity practices grouped under the theme of attracting diverse applicants (N=42) seemed relevant in addressing these barriers. These practices included but were not limited to, raising awareness of, and branding, the profession (e.g., showcasing diversity), and targeting schools/academia (e.g., educational outreach and apprenticeships). The limitations of these practices are discussed accordingly.

6.1.1 Lack of awareness and understanding of the SLT profession

A lack of awareness and understanding about the SLT profession was a predominant reason given for its poor gender and ethnic diversity. Generally, this barrier was linked to the profession being small and insular, and challenges of explaining complex speech disorders and therapist's roles in treating them to the public. So, people did not consider nor value SLT, or misunderstood the role's remit.

> *"…when I wanted to be a Speech Therapist, my dad said 'no, you know, you're not. I don't know what it is'." [Anita: British Indian, female, leading professional body stakeholder]*

People only heard about SLT in specific contexts via direct (e.g., having undergone therapy themselves or knowing someone who had) or indirect contact (e.g., via employment with SLT exposure). For example, men's lack of awareness of speech therapy was linked to exposure being limited to those who worked in predominantly female workforces, such as schools and hospitals. Therapists noted a *"self- perpetuating"* or *"self-fulfilling"* cycle *[Stella and Hannah:*

Both White British, female SLTs] whereby 'female' professions meant women were networking with and recruiting other similar women.

> *"…people only kind of find out about it if they already work in schools, or hospitals, or whatever, and those people are more likely to be female." [Jack: White British, male SLT]*

So, there were perceptions that male students were more likely to be mature because they were mostly exposed to SLT later in life, even in spaces where early exposure should have happened. Also, SLT seemed an unattractive choice to men because of their poor representation in, and inability to identify with, the profession.

> *"…I was even in a health and social care qualification in A-Level and was still not told about Speech and Language Therapy as something that I could go into." [Thomas: White British, male SLT]*

Poor SLT awareness amongst minority ethnic communities was linked to their poor representation within it, lack of terminology for it, and not being aware of special needs nor accessing speech services.

> *"…there is no term in my parent's language for Speech and Language Therapists. So, they had to create something because it doesn't exist… it would be really difficult wouldn't it to promote something, or to talk about something, if you don't even have a word for it?" [Lian: Chinese, female SLT]*

Asian communities sometimes likened therapists to doctors, possibly due to familiarity or to signal respect.

> *"…a lot of times when, for example, when clients come and you know they come from an immigrant background or you know, sometimes parents will ask their children to refer to us as doctor…because that's the closest word that they can think of to describe us… maybe therapist isn't something that you know means anything to them as much as doctor." [Lian: Chinese, female SLT]*

Also, minority ethnic communities were perceived as generally having poor awareness about special educational needs, or therapist's roles in treating them. Special needs were thought misunderstood, negatively shaped by cultural expectations of child development, and taboo stemming from lack of disclosure if something was wrong or there was a blame culture.

> *"I feel this sense of like belonging in the South Asian community where you feel like there is another South Asian family who are experiencing the same thing and then connecting those people... that [i.e., sense of community] doesn't happen. I feel like that's a real struggle." [Rani: British Indian, female SLT]*

Both therapists and stakeholders thought that educational establishments and the media provided some, but insufficient, exposure of the profession, and were concerned about its quality. Some stakeholders thought men and minority ethnic groups were not introduced to SLT in school at all. Many interviewees recommended more careers events and school outreach to improve the profession's diversity levels. There were mixed reviews about the helpfulness of careers advisors ranging from *"gave me that idea [of a SLT career]"* to *"having a conversation with a careers teacher who didn't know very much about Speech and Language Therapy" [Stella and Lauren: Both White British, female SLTs]*. I could not determine if SLT careers advice improved in schools because most therapists did not state their schooling years. Similarly, media and general publicity of the profession was also deemed lacking or inaccurate. For example, therapists thought they could talk more about their profession including explaining career routes, and media representation created misconceptions of SLT roles. For example, TV shows such as Educating Yorkshire *"sensationalise speech therapy on television. We did this to this kid and suddenly he stops stammering" [Sophie: White British, female SLT]*.

6.1.2 Image of the profession

The profession was associated with two images which shaped its poor diversity. First, the profession was widely perceived as having a predominantly White, middle-class, female workforce. Second, the profession was deemed less prestigious than traditional ones, and poorly paid.

6.1.2.1 A White, female, middle-class image, and the role of stereotypes

SLT was widely associated with a female image, shaped by gender stereotypes which created expectations of a stereotypical female therapist. Not all therapists felt that their profession had a gendered image either because they did not see it, or thought people lacked sufficient knowledge about it to hold this image. This was an uncommon view.

The profession's female imagery was reflected in different ways. First, therapists counted the gender and ethnic compositions within the academic (amongst student cohorts and teaching staff) and work contexts (horizontal and vertical) of their career. This highlighted poor male and minority ethnic representation in both.

> *"…because we are more female dominated, most of my clinical supervisors, seniors, and managers have been female." [Kathryn: White other, female SLT]*

> *"…it's pretty rare to see anyone in a leadership role who isn't White…I mean it's also pretty rare to see anyone who isn't White in Speech and Language Therapy per se." [Jessica: White British, female SLT]*

Second, the terminology used to describe the profession implied that interviewees from both samples and/or others thought it comprised mostly of White, middle-class, women. For example, therapists described their workforce as *"feminine"*, *"very twee, female, White, skinny legged, blonde profession"*, and *"middle-aged woman, with a hair like a bobbed haircut"*, or *"middle-class woman who wears statement jewellery or a string of pearls" [Kathryn, Sophie, Lauren, and Danielle: All female SLTs, three White and one Multiracial]*.

Third, both interviewee samples used gender stereotypes about feminine and masculine traits/skills to explain the profession's predominantly female workforce and/or why women were thought ideal for SLT. Therapists associated, and perceived the public to associate, women with having caring demeanours and possessing soft skills which made them ideal for the profession. Women were *"expected to be nice" [Eileen: Anglo-Irish, female SLT]* and seen to be good at *"touchy-feely stuff" [Sophie: White British, female SLT]*, language/communication, and relational work including working with children.

"…if we were to stereotype professions, speech therapy tends to be a very like kind, caring, compassionate and empathetic kind of role… I think that aligns more with femininity I guess, as a caregiving, traditional sort of role. So, it fits well with I guess female identities, and I guess matriarchy." [Kathryn: White Other, female SLT]

So, SLT was compared to other predominantly female (e.g., teaching and nursing) or male (e.g., surgery) professions to illustrate how gender stereotypical characteristics shaped attraction to, and compatibility with, certain professions. The SLT workforce was presented as being traditionally and normatively largely female. There were stereotypes of automatically picturing a female therapist, and jokes about *"the token man" [Lian and Stella: Chinese and White British, female SLTs]* reinforced by images of therapists on Google and careers materials being mostly of women.

"You get ethnic minorities and women going into particular professions… paediatrics is a good example…the majority of GPs now are women…it may be because those professions offer greater flexibility…you don't find many women in surgery because it's a very high pressure, high demand, and quite ruthless actually area of medicine." [Joel: White, male NHS stakeholder]

Masculine traits were seen to shape men's pursuit of, and discipline choices within, a speech therapy career. Men who sought healthcare professions were thought to pursue practical ones with many male role models (e.g., physiotherapy). Stakeholders thought SLT and its importance was not promoted to men or minority ethnic groups, with more diverse role models needed to challenge the profession's image and attract diverse groups.

"…you look for people who are like you to think could I succeed there? You think can I see myself in them?… I think we all need role models…now there are South Asian therapists. Visibly so... a lot of our students go on placement and they're with someone from those cultures and so there is a role model, and so they feel more validated and maybe they're then telling their friends, and family, and relations, and community, and other people are then applying and it's a known thing." [Leyla: Asian, female, university stakeholder]

Predominant misconceptions about SLT did not help matters. Many therapists thought the public typically misunderstood their role as teaching people how to speak, which was partly blamed on the job title or its acronyms (i.e., SLT or SALT). Titles were seen as too long, did not clarify what the role entails, nor reflect the wide range of communication issues that therapists addressed. 'Therapy' was criticised for lacking clarity (e.g., "*wishy washy" [Thomas: White British, male SLT])* because it was used in unrelated areas (e.g., beauty therapy), and had female connotations. So, the job title, misconceptions about SLT roles, and the lack of medical/scientific focus (discussed below) seemingly deterred men from the profession. The title of 'Speech Pathologists' in America was thought more appealing by therapists because it sounded more medical and scientific.

Men were thought as uninterested in paediatrics. It was thought unnatural for them or more suited to women, and signified a more social than medical model, supported by references to small male workforces within childcare or teaching professions. Male therapists in paediatrics were presented as exceptions, with their presumed masculine traits making them more likely to work with, or suited for, adult and challenging client groups (e.g., children with behavioural problems). Some therapists (N=7) thought men were suited to, and preferred, science, maths, and technology domains because *"it's very black and white, anatomical, pattern based, they can see something" [Kathryn: White Other, female SLT]*. So, men were thought interested in medical-focused specialties or hospital work (e.g., trauma-related adult care) involving procedures or equipment (e.g., X-rays, endoscopies, etc.). But there was a perception that men believed speech therapy was not scientific enough. Therapists attributed this belief to poor awareness about speech therapy's breadth of specialties, non-paediatric client groups, and impact. The latter was somewhat highlighted by Covid-19. Men were also seen to align towards academia/research or high stress/workload roles (e.g., tribunal work or management - see section 7.3.2) which had a perceived higher status than clinical work, and men were associated with higher societal value and success.

Masculine traits were sometimes presented as assets because they contradicted feminine traits. Therapists presented women as emotional (e.g., overly worrying, and afraid of upsetting people), indirect/lacking agency (e.g., unassertive with their recommendations), uncompetitive but collaborative, non-judgemental, and supportive. In contrast, male therapists were seen to offer alternative perspectives, and demanded client respect because they were more rational, direct, confident, assertive and had an authoritative presence afforded by society than women.

For example, one male therapist reflected on how a client directed questions to him when he as a student because he was a man, despite standing next to a qualified female therapist.

> *"I don't know how much this is a female…I think we're all quite sensitive in terms of we'll all stop and ask each other how we are which is quite supportive. But, also by the same token… I think we all worry a bit too much about upsetting other people…I think sometimes certain men can be more direct, and that in some ways might be a plus because they'll be like, 'oh stop all worrying about it'. You know we're gonna get on with it." [Chloe: White, female SLT]*

Gender stereotypes negatively affected both female and male therapists. Feminine traits shaped expectations of, and restricted, female behaviour. Those without feminine traits faced pushback and difficulties within the profession. For example, women who were direct or outspoken were met with criticism, deemed aggressive or pushy, and bullied.

> *"…if you're a little bit more, either with your patients a bit more direct, or a bit more in your face, a bit more a different culture, it does clash a bit with the underlying beliefs of the profession." [Sophie: White British, female SLT]*

> *"…there's a kind of cognitive dissonance between if…you're undertaking a caring role looking after people, to also being bolshy, ambitious, you know wanting to have your voice heard, and in a way sort of being motivated for selfish purposes in a sense of you know because I want my career, and I wanted some recognition, and I wanted da, da, da…. there's a lot of bullying goes on, and a lot of women who don't use their authority and power in… a reasonable way." [Eileen: Anglo-Irish, female SLT]*

In contrast, men's advice and authority was taken more seriously or unquestionably than that of women's, which was related to internalised misogyny and imposter syndrome. For example, one therapist recalled negative reception to a female manager's criticism of an activity:

> *"When she was like 'well we're not doing that because there's no evidence base for it, and it's crap, and so no, we're not doing it'. You could see that people going oooh she's winding people up again, or it's not going down very well. And I've seen male Speech*

Therapists do that at managerial level, and it's just been taken as gospel." [Kate: White British, female SLT].

Also, female sole traders discussed struggles related to being a woman, sometimes causing burnout and decisions to leave the profession. For example, female sole traders expressed discomfort about charging and billing their services. They spoke of waiving travel fees and not costing their services properly to avoid coming across "*a bit hard faced, and quite business-like, and she's not going to have a very nice relationship with the child because she's just money grabbing" [Danielle: Multiracial British, female SLT]*. Danielle spoke of adopting a soft approach when billing services involving *"playfulness and silliness" [Danielle: Multiracial British, female SLT]* as assertiveness or ultimatums were not expected of them and caused guilt. So, female sole traders voiced issues of working long and unsocial hours, and having too many client expectations (e.g., clients discussed things outside of their remit).

"If they don't pay me quick enough…if I do chase them, it's like, 'oh hi. Here's the invoice again. Not sure. Maybe it got stuck in your junk mail, or maybe I didn't send it. Ha ha. How silly.' You know, I can play on that female stereotype of a little bit ditzy. I'm running around after all my own kids. That kind of thing." [Danielle: Multiracial British, female SLT]

This discomfort around women and pay also existed in the public sector. One therapist spoke about negative reception to the profession's prominent equal pay case (see section 4.1) from fellow female therapists.

"*…I remember hearing somebody saying they're selfish... I mean it's that idea that we're sort of money grabbers… that we shouldn't be looking for money. We should be doing it out of love and all of that sort of stuff." [Eileen: Anglo-Irish, female SLT]*

The profession was widely believed to be middle-class, which had two important implications. First, both therapists and stakeholders either assumed, or shared personal experiences of, working-class individuals not feeling belonging at university and work linked to their under-representation. Social class data was not collected, but some White and minority ethnic therapists did explicitly identify as, or implied coming from, working-class families. Being

working-class was associated with feeling uncomfortable in their settings, difficulty relating to their middle-class counterparts, lacking self-confidence, and facing middle-class behavioural expectations from family or university recruiters (e.g., posh accents).

> *"First person in my family ever to go to university and it was a thrill…but I felt a bit like a fraud. I felt like I shouldn't be there because coming from a working-class family, all my friends, and they were lovely don't get me wrong, but they were all extremely…I imagine it still is a very upper middle-class profession. I didn't come from that background. So, I felt a bit like a fish out of water…I had to overcome that insecurity about myself." [Eileen: Anglo-Irish, female SLT]*

Second, social class contributed to networked access to SLT work experience and education (see section 6.1.3).

6.1.2.2 Status of profession and perceptions of poor pay

Both therapists and stakeholders thought that minority ethnic or immigrant communities, particularly South Asians, were commonly exposed to the narrative of, and culturally expected to seek, or personally sought, traditional professions.

> *" I know it's a cliche thing, but it is true. You've got to be an Engineer, a Lawyer, a Doctor, a Dentist, a Pharmacist, an Optometrist." [Sanjay: Indian British, male SLT]*

This was because traditional professions were well known, respected/ deemed high status, and had a high earning potential associated with job stability, security, and status.

> *"Our parents want us to get into a position whereby we are respected for the job that we do…the generation above us want to make sure that we are stable, that we're able to command a salary." [Sanjay: Indian British, male SLT]*

An SLT career was deemed a downgrade because it was a caring profession, with a poor-to-modest salary, and few career opportunities. There was a well-established perception that "*no one goes into speech therapy for the money" [Danielle: Multiracial British, female SLT],*

which was highlighted even in interviews. The salary did not match the educational or financial investment required to become a therapist.

> *"I think considering how hard we have to study, we're definitely not paid nearly enough." [Jack: White British, male SLT]*

Poor income potential, especially in the NHS, was seen to deter men and minority ethnic groups from considering SLT. For example, therapists across genders thought poor pay restricted men's ability to fulfil their breadwinner role.

> *"It's quite you know relatively poorly paid speech therapy. That probably means traditionally it's the area that men might avoid because of expectations you know that a man has to earn XX salary, and be the main provider in a family etc" [Jack: White British, male SLT].*"

A small salary based on men's single income was thought problematic when their female partners became pregnant. However, one therapist disagreed, and pointed out how other AHPs (e.g., physiotherapists) were on similar NHS pay bandings as therapists, but were better at attracting men.

NHS cuts to SLT services had indirect, detrimental impacts on the profession's gender diversity.

> *"…a lot of adults speech therapy services have been cut by the NHS in recent years, and I think that kind of work tends to appeal to guys more I think." [Graham: White British, male SLT]*

Finances seemingly motivated men to seek other career paths or the private sector because a high salary was considered more achievable there than in the public sector. However, boys and the public were unaware of this potential. *"More guys tend to kind of…make a break for it in the independent world" [Graham: White British, male SLT]* because relative to women, they were thought better paid and valued given their *"niche" [Danielle and Tom: Multiracial British female and White male SLT]* status and greater confidence in billing/charging.

6.1.3 Networked access to education and experiences

Ethnicity and social class, both separately and when intersected, shaped homogenous networks of access to work experience and SLT courses, and affected educational experiences, which disadvantaged therapists who did not fit the profession's White, middle-class image.

Therapists emphasised that accessing relevant work experience, which provided insight into SLT or helped entry on its courses, was a barrier. They thought people needed social capital in the form of contacts within the profession to get shadowing opportunities, but this was challenging for those differing from the profession's demographic profile (image outlined in section 6.1.2.1).

> *"If majority people in the profession are often one ethnicity or…it's a predominantly White profession, it might be harder to find work experience, if you had fewer contacts who were White British potentially. I think that's very dependent on people's personal circumstances, and what kind of schools you go to, and what areas you live in, you know kind of jobs your parents do, etc…" [Isabella: White British, female SLT]*

White British and Indian therapist interviewees secured work experience through personal contacts (e.g., cousins, colleagues, etc.), and so ethnicity alone was not a barrier. Perhaps social class was a more important barrier, or that it intersected with ethnicity to become one. Minority ethnic communities were seen by some interviewees to be mostly of lower socio-economic status, which restricted opportunities to volunteer/shadow and study SLT.

> *"…we know that so many people from ethnic backgrounds, except the Jewish community think, maybe have less money. So, for you to get on a course in the first place, you have to have experience…if you can't afford to take time off work to get that experience and exposure, how are you supposed to get on the course? … whereas if you're from a more White, middle-class, upper middle-class, privileged background, you can afford not to work, and go and do lots of these voluntary placements in order to get the experience in order to get on the course. So, there is discrimination embedded into the whole system in the first place." [Sophie: White British, female SLT]*

One working-class therapist thought class similarities buffered or even outweighed ethnicity differences based on having more common experiences.

> *"I think we can get very hung up on the gender stuff and the ethnic stuff which I think is relevant… it's the class that is a big issue, and that's the one that gets so sidestepped all the time…you can get somebody who might be African, or West Indian, or Asian, and if they come from very middle-class families, they've probably got an awful lot more in common than say an African, an Asian, or a White person who comes from a working class [family] who'll probably have more in common than that sect." [Eileen: Anglo-Irish, female SLT]*

This perception aligned with a stakeholder's claim that privileged minority groups lacked awareness of ethnicity issues in the NHS.

> *"…some BAME people, especially Indian BAME people who might have more means than Black BAME people, a lot of them still don't know we have any race issue. Because they go to school. Their parents pay for everything. They become a doctor, and they come in and they go 'well, I just work hard. We don't have an issue'…for some BAME people who will make it the top, they still don't realise we have an issue because they have the means." [Sunita: Indian, female NHS stakeholder]*

Volunteering represented a financial and time commitment, that potentially excluded people from lower social classes. For example, one therapist described balancing volunteering with a:

> *"full-time, quite poorly paid temping work for six months, before I then eventually got a job as a Speech and Language Therapy Assistant. I did that for nearly a year, and did give me enough experience to get onto the speech therapy postgrad course." [Jessica: White British, female SLT]*

The ability to find NHS shadowing opportunities was a barrier that had worsened over time because of increased pressures on therapists' time. Therapists described *"desperately trying to get volunteering opportunities"* by contacting several NHS SLT services, but *"most of them, I didn't get anywhere with" [Jessica: White British, female SLT]*.

> *"Back then it was quite easy…I just emailed the manager of the speech therapy department and asked if I could shadow [a] therapist for a few hours. And they said yes, and here's the number of the therapist and organise it yourself…It's not like that anymore… every month or so get requests from people wanting to shadow a therapist, and it just wasn't possible because of… pressures on therapist time and that kind of thing." [Thomas: White British, male SLT]*

Success in getting relevant work experience in the private sector was associated with individual merit and luck, rather than structural barriers like in the NHS. Sole traders who had the right contacts and had done work experience felt *"lucky" [Rani and Sanjay: Indian British female and male SLT]*, implying some difficulty in securing work experience. However, one Indian sole trader held contradicting views of being lucky and there being ample private sector work experience opportunities. She said her former private employer offered work experience to *"anyone"*, and used her experience of being shadowed by a police officer as evidence that *"there is the capacity to reach people. I think it's just dependent on the individual themselves" [Rani: Indian British, female SLT]*.

Class and ethnicity intersected to influence access to the profession regarding location of, and affordability to, study. Women in deprived areas traditionally did not work, but the next generation of women were entering the profession because they could study close to home.

> *"…whether it's cultural, whether it's socio-economic…in our area, a tendency for people to want to stay closer to home through the training and then…in work… it is such a deprived area…that and ethnicity and culture all combined together... it's only recently that there's been a greater aspiration for girls to go into higher education, and with a view to having a career, and working. And I'm not saying that's true of every community, but that has been the picture in these very poor areas where women have traditionally not worked." [Stella: White British, female SLT]*

But therapists and stakeholders thought class restricted minority ethnic group's ability to afford studying a SLT course.

> *"...you'd need to have the luxury of being able to afford this education, and to do all this studying in order to do a job that…doesn't give you the best pay…it's represented mainly by the majority ethnic group." [Mei: Chinese, female SLT]*

So, working class, minority ethnic families expected their children to complete a university degree in a profession with job prospects and financial stability regardless of their personal passions. For example, an Indian therapist recalled his father's negative reaction to his acting ambitions.

> *"...he said 'oh, that's very good. I just don't think you can do that under this roof'. And it was understandable where my father was coming from. We came from a pretty low socio-economic demographic in that sense…my dad didn't want me to go into a profession whereby more than 90% of people were out of work." [Sanjay: Indian British, male SLT]*

Lack of funding in the profession, especially the removal of government financial support (e.g., bursaries) could strengthen these class-ethnicity interactions. So, interviewees advocated for greater government funding to increase university course spaces and NHS vacancies to better attract diverse SLT applicants.

> *"I'm not saying it's necessarily, but I think families from poorer backgrounds, and I'm not saying that they're automatically of ethnic diversity... if you're making a decision about a job, and you know that going to university is going to incur a really major debt and possibly you need to sort of support your family more quickly…that will influence your decisions. So, taking away things like the bursary from all these professions was a really, really bad call." [Karen: White Irish, female, trades union stakeholder]*

Stakeholders thought minority ethnic, working-class students who pursued SLT education faced challenges during university interviews and courses. For example, prospective students were flustered at interviews. On courses, they lacked a sense of belonging due to poor student diversity, and had poor access to support and resources resulting in differential attainment gaps or poor retention.

> *"…when you do have a kind of relatively White, relatively female, relatively middle-class profession, that can feel quite judgemental sometimes, and the edges can be excluded. So, if you can kind of make the case, and kind of you know cut a deal for some students, and just… try to keep as diverse a group of students as we can." [Patrick: White Irish, male university stakeholder]*

Asian, female, Muslim students were seen to be providing the profession's ethnic diversity, but they were restricted by their vocational educational choices, conservative parents who wanted them to be locally based, and fewer resources (e.g., income).

> *"…when you do the interview days…if there's a student who is going to turn up late and flustered, it will be a Black student from London, because basically they just didn't seem to have as much money and support behind them… I think within the course lots of our BAME students do thrive and do really well. But we tend to lose let's say of a cohort of say 50, we lose between five and 10% in the first year… generally a lot of those students will be Asian Muslim students." [Patrick: White Irish, male university stakeholder]*

6.2 Practices which attract diverse applicants to SLT

Interviewees identified several diversity practices for addressing barriers when entering a SLT career, which were mostly captured under theme of attracting diverse applicants (N=42). Figure eight in Appendix 14 outlines diversity practice themes. This theme mainly focused on raising awareness of, and branding, the profession (N=38) and targeting schools and academia (N=33).

6.2.1 Raising awareness of, and branding, the profession

Media and marketing activities were used to raise awareness of, and brand, SLT (N=37 - SLT=22, stakeholder=15) in ways that attracted diverse applicants to it. The most discussed types of such activities involved creating or sharing media resources (e.g., therapists produced articles highlighting SLT's clinical breadth) and addressing SLT misconceptions mostly by showcasing diversity within it. There was particular emphasis on RCSLT media efforts and

resources which seemingly tried to widen public awareness of the profession, but was criticised for its reach, rationale, and content. For example, there was a perception that RCSLT materials were not disseminated widely enough.

> *"…the Royal College produced a poster about the advantages of bilingualism and sent it to Speech and Language Therapists to share with other people. I'm like don't share it with Speech and Language Therapists…share it with big you know companies…be a bit more forward thinking instead of posting something. Put it on Twitter. Put it on social media. Use almost like public health campaigns. You know go big or go home because you know a drop in the ocean isn't really gonna do that much…I took these posters and I took them around everywhere, and I gave them to families, and I gave them to teachers, and I posted them to GP practices." [Kate: White British, female SLT]*

Also, the appointment of TV presenter Nick Hewer as RCSLT President was perceived to be for his media connections and platform, which represented a missed opportunity to choose an ambassador with an authentic link to the profession.

> *"I just find it interesting that they've appointed this sort of old, male, White man, with no real connection to the profession in this quite important role…He speaks out occasionally in the media now about speech therapy, which I guess is a good thing because you know he's someone, he's a celebrity himself. He's famous on TV. I'm not really sure what his connection is to speech therapy. I just thought it's an interesting thing that they've chosen him of all people to be our ambassador." [Jack: White British, male SLT]*

One branding tactic for appealing to diverse applicants involved embedding diverse images across the profession. The intention was to foster a sense of belonging amongst under-represented groups so that *"whoever looks in can go 'oh, yes, I could become a Speech Therapist. I'm a man or I'm a woman from a BAME community. You know, I feel like I could join this profession'" [Anita: British Indian, female, leading professional body stakeholder]*. Interviewees gave various examples of diverse imagery use across the profession, such as the introduction of black dolls to diversify course materials at university. Again, there was an emphasis on the RCSLT who were seen as:

> *"…noticeably trying more in their professional magazines and emails to spotlight diversity, and to have these conversations about diversity in the profession, and kind of raise people's awareness of it." [Kate: White British, female SLT]*

It was acknowledged that diverse images were *"awkward tick boxy representation stuff…maybe tokenistic but you know, first steps shall we say" [Fiona: White British, female leading professional body stakeholder]*. A focus on imagery was deemed a superficial, late-stage lever.

> *"…kind of PR initiatives. I don't mean that to be derogatory, but I think they are kind of presentational. So, there's been a focus on lots more photographs of the gender mix, an ethnic mix. But I kind of consider those kind of after the fact really…I kind of think it's a relatively kind of limited lever and I think you need to do a lot more than just kind of present things visually." [Patrick: White Irish, male university stakeholder]*

The RCSLT were particularly criticised for their perceived reactionary rather than proactive media response to the Black Lives Matters (BLM) movement regarding their statement and magazine content. For example, their media silence on the movement caused an outcry amongst therapists which motivated them to release an anti-racism statement, and then later revise it because it was deemed weak.

> *"…there was a big Black Lives Matter statement being released from various organisations, charities, service organisations and it was one of the student SLTs wrote a post on twitter and said 'why isn't the Royal College, why haven't they made a statement?'…lots of people were agreeing, and were hurt, and then the College did put out a statement… lots of people were kind of liking it and stuff, but some of us were outraged at the wishy washiness of the statement. We just felt this is saying nothing. It's not addressing the issue." [Leyla: Asian, female, university stakeholder]*

Also, the RCSLT's monthly Bulletin magazine was slated for lacking diverse imagery: *"…somebody said, 'I've counted the Black faces in this first issue after Black Lives Matters. And there's only one, and it's a cartoon'" [Nathan: White, male, leading professional body stakeholder]*. However, efforts to improve the magazine's diverse imagery since BLM were

seen as *"…like 15 years too late at least. I think this should've been happening for a long time… we don't need horrific racism…to spark these kinds of conversations" [Kate: White British, female SLT]*. Whilst interviewees acknowledged that the RCSLT (e.g., initiatives to attract men to SLT) and NHS (e.g., 50:50 campaign for women's leadership representation) had previous and on-going diversity-related events or campaigns, the fleeting nature of campaigns was criticised.

> *"I think there's a bit of a campaign syndrome…there'll be… kind of a flurry of activity… so therefore, there will be kind of initiatives, and there'll be photographs, and there'll be kind of you know nice posters. But then it will die down…I don't really see a kind of sustained policy…" [Patrick: White Irish, male university stakeholder]*

Diverse imagery was just one way of addressing SLT misconceptions to target its exclusionary image. Very few other used practices were mentioned, amongst several recommendations which presented the RCSLT at an early exploration stage. These practices included carefully considering the language used about SLT and adding a decolonisation lens to university SLT curriculums. Recommendations mostly focused on emphasising the lesser-known parts of SLT, such as its science aspects and capacity for progression.

> *"…when I rewrote the wording for the [name of organisation] around the profession, I downplayed references to care, and up-played references to science…Speech and Language Therapists are scientific clinicians. Now, you've also got to have great empathy and people skills and be interested in language. But at the heart of this is scientific rigour. So, let's give the right impression of what the profession is about." [Matthew: White British, male, leading professional body stakeholder]*

6.2.2 Targeting schools and academia

Targeting schools and academia was an important theme for therapists and stakeholders, with the former focused on school outreach, and the latter on university activities. Very few interviewees discussed apprenticeships (N=7). Those who did, thought apprenticeships represented a concentrated effort to tackle social class barriers by improving access for those unable to study a SLT course for financial or caring responsibility reasons. Just one Trust diversity document and the NHS People Plan spoke of apprenticeships, in terms of

collaborating with schools to get students onto health-related apprenticeships, and creating more apprenticeships for clinical, scientific, and management roles.

Student outreach was presented as a way of *"growing the pipeline" [Hazel: White Other, female NHS stakeholder]* because early awareness of the profession shaped career choices. So, therapists and stakeholders thought under-represented groups should be directly targeted at primary or secondary school in ways that presented the profession as inclusive, diverse, and comprising of varied domains presumably to challenge the profession's specific imagery (see section 6.1.2). They recommended focusing on geographical areas that are diverse, incorporating greater male representation in activities, and reintroducing university bursaries. One stakeholder who worked in university admissions stated:

> *"…it really isn't that I'm not making offers to people of colour, or to men. It's just that they don't apply. So, the job almost needs to be done really far back when people are choosing their GCSEs, when they're thinking of aspiring to [a] career. So, it's reaching those teenagers really…" [Nathan: White, male, leading professional body stakeholder]*

But some therapists thought outreach should extend beyond students to members of other professions who were likely to consider SLT once exposed to it (e.g., teachers). According to one stakeholder, 40% of therapists qualified via a master's route which had more mature and male entrants. NHS diversity documentation outlined efforts to create pre-employment pathways to Trust vacancies, employment opportunities for local people, and apprenticeships.

> *"Perhaps go and speak to people who work as carers, speak to different people and approach them about and offer them some kind of experience where… they can see what we do and then they might be more likely to join us. Just going into sixth forms and speaking to A-Level students isn't enough in my opinion." [Chloe: White Other, female SLT]*

Outreach activities mentioned by interviewees mainly involved hosting careers events (e.g., fairs or university open days) and talking to students about SLT (e.g., diverse therapists visiting schools). Both were criticised. For example, physical school talks reduced therapist's clinical time and had limited reach relative to other means (e.g., social media). Also, AHPs were thought as being generally poorly represented in careers events, with NHS workforce provisions (i.e., capacity and demand) sometimes determining which AHPs were included.

> *"…At careers fairs, school careers fairs, or college careers fairs…the NHS Trust isn't [present], or they might be but because they're trying to get more nurses or something like that... you don't tend to see a Speech and Language Therapist department at a careers fair." [Thomas: White British, male SLT]*

After SLT exposure, mostly stakeholders identified universities and Health Education England (HEE) as shaping diversity at the beginning of the SLT career pipeline given their role in attracting students onto courses and training them. HEE was mentioned by just one senior NHS stakeholder as funding and so shaping university recruitment. She argued that their funding capacity was not used to create a positive action strategy for improving university student diversity. However, the NHS People's Plan outlined that HEE was working with universities to create more than 5,000 undergraduate places on nursing, midwifery, and AHPs courses, and supporting clinical placements for these professionals via a £10 million fund. SLT was not specifically mentioned, but would be included under AHPs. Also, it was not stated how these provisions would be distributed across the professions, which means it is unclear if and how they would make a meaningful difference to AHP student diversity.

> *"…in terms of any positive action approach, if you're looking at Speech and Language Therapists, you're looking at how is HE(E) incentivizing the universities to supply a more diverse group of people, students coming in?... Because if you pay the university, for example, a million pounds for a cohort of 20 SALT, they're just going to go out and find students who is interested in this therapy... they are not tackling some of the fundamental issues of how to stratify diversity." [Sunita: Indian, female NHS stakeholder]*

Despite universities expanding SLT courses and comprising many diversity efforts, their recruitment approach, SLT curriculum, and student support were criticised. Stakeholders criticised how universities showcased SLT diversity to recruit students (e.g., using diverse SLT profiles at university open days to signal welcoming diversity and introduce role models), but this was not sustained throughout university. *"You can't just do it once, it's got to be an ongoing thing" [Leyla: Asian, female, university stakeholder]*. Therapists were sometimes absent in university open days. Also, SLT courses were criticised for lacking diversity in terms of lecturers and so role models, curriculum resources (e.g., lack of Black dolls or ethnically diverse families being invited), and content (e.g., single sessions on cultural competence).

> *"…now when I look back, I think wow all of my Lecturers were so homogeneous, and they looked a certain way… I would have really appreciated to see that you know there are other different types of people who go into Speech and Language Therapy...it is a real problem in research and academia. We just don't really have that diversity". [Alia: Multiracial, female university stakeholder]*

Stakeholders and therapists also thought university recruitment strategies resulted in poor candidate selections. For example, one therapist described how students put on reserve lists performed well, but many prime selections did not pursue the profession after university. Stakeholders accused universities of using a free-market recruitment approach that was not values-based. So, universities were recruiting students based on grades without interviewing them, which meant disregarding their values such as *"how are they determining if they're going to be people who might be perpetrating microaggressions on their classmates, or not?" [Sharon: White, female leading professional body stakeholder]*. Also, universities were perceived as aggressively expanding SLT courses which possibly reduced social class as a barrier because A-Level expectations were de-emphasised, but there was inadequate staffing to support students. So, the attrition of students requiring more support was anticipated, namely those of minority ethnic backgrounds.

> *"I think they've created so many problems with the way they've allowed the universities to expand…I don't think they realise because it's very recent. It's only been the last couple of years…aggressive expansion, not supporting students, and the students who'll*

suffer will be BAME... it is blatantly obvious in the university setting." [Patrick: White Irish, male, university stakeholder]

Unfortunately, university support structures were perceived as poor when students faced discriminatory experiences or struggled because courses were challenging. This was partly due to poor resources, and so for example, there was a continued use of placement educators with bad reputations. There were many examples of proactive university-level support. For example, therapists shared their course experiences with students as reassurance. Also, university lecturers encouraged students to report negative placement experiences with plans of non-mandatory training for placement educators. However, stakeholders acknowledged that not all students would be forthcoming about their experiences, which matches some therapists reporting reluctance (see chapter seven).

6.3 Discussion of entering the profession findings

This chapter identified three barriers for men and minority ethnic groups entering the profession. These barriers were: (1) poor awareness and understanding of SLT; (2) its female, middle-class, and low status image; and (3) networked access to work experience and SLT courses, including social class negatively shaping educational experiences. I discuss how my findings represent theoretical and empirical contributions to the knowledgebase on accessing the SLT profession, with reference to existing literature.

Gender stereotypes appear a particularly pervasive mechanism contributing to the resilience of a profession's gendered image. This was emphasised in interviews, and current literature on SLT (Litosseliti and Leadbeater, 2013, 2020), other predominantly female professions (e.g., nursing – e.g., Teresa-Morales *et al.* (2022)), and health sector more broadly (see gender-typing of role in section 4.2.3). Notions of masculinity/femininity shape perceptions of women as suitable for "caring" professions relative to men (e.g., women as good carers and communicators), which is reinforced by women's high prevalence within them. Yet, gender stereotypes operate to subordinate women, as argued by feminists (see section 4.1), even in predominantly female spaces. Feminine expectations restricted women's ability to perform or

advance their roles (e.g., assertive behaviour penalised and difficulty charging and billing their services properly). Conversely, whilst masculinity meant men were deemed less suited to SLT, and so some faced some prejudice (e.g., assumptions about personal characteristics) (see section 7.1.2), they were privileged in acceptance of their authority by colleagues and career progression than women (discussed in next chapter).

The findings on ethnicity addresses an overall lack of research attention on the ethnic diversity of the SLT workforce. Some literature has explored why minority ethnic individuals may find SLT unappealing. This includes awareness of the profession, its salary and status, their academic ability, and the value they give to studying a degree and scientific careers (Stapleford and Todd, 1998; Greenwood, Wright and Bithell, 2006). Such studies are few and outdated. What has not been noted for minority ethnic communities, but is generally discussed in relation to gender or more broadly (Litosseliti and Leadbeater, 2013) (see also section 6.1.21), is the impact of the profession's job title. For minority ethnic communities, the lack of terminology for SLT and poor understanding of speech disorders are unique barriers to SLT awareness. For example, a Chinese therapist noted how her mother tongue lacks a term for SLTs. So, clients sometimes used the closest associated role by referring to her as a doctor. There is a Chinese term for SLTs, "言语治疗师", but the profession is new and rare in China, with less than 1,200 practising today (Haas, 2022). So, the existence or newness of SLT in certain countries can shape awareness of it amongst members of that community. Any targeted outreach for minority ethnic communities needs to also consider poor awareness and understanding about disability aetiology and characteristics (Rohwerder, 2018), as ethnic groups differ in how much disabilities are stigmatised (Saetermoe, Scattone and Kim, 2001). Minority ethnic communities were believed to have low awareness and understanding of special needs or the roles that therapists have in treating them, which was negatively shaped by cultural expectations of child development, resulting in special needs being stigmatised as taboo (e.g., lack of disclosure if something was wrong due to a blame culture). So, minority ethnic families encourage traditional professions for their children because they are more established, which was linked to income potential and stability. This frames traditional professions as possibly holding structural and vertical social capital (definitions in section 4.3.3) (Woolcock and Narayan, 2000; Grootaert and Bastelaer, 2002; Claridge, 2008). Traditional professions are tangible social networks, and their roles, rules, and processes offer esteem, subsequently granting

members access to a high status and income, and economic/job security. Vertical social capital allows members of traditional professions associations with other high-status members or organisations, granting access to influential networks or opportunities. The perception of better income potential in the private than public sector as unknown to the wider public, represents a novel sector-specific insight.

Gaps were documented between the diversity issues when entering SLT and the practices relevant to addressing them, which represents an important empirical contribution as literature on practices is sparse (see section 4.1). Initiatives focused on attracting diverse SLT applicants are limited, which may result in SLT either not reaching or appealing to minority groups. Branding of the profession is one such practice, which was heavily criticised in interviews. Interviewees focused on RCSLT media and marketing activities, perhaps because they are perceived responsible for representing the profession (see chapter eight). The RCSLT were acknowledged as noticeably trying to include diverse images, which they have expressed themselves (McCormick, Napier and Longhurst, 2019). Yet, their media activity and materials were criticised for its reach, rationale, and reactionary approach. SLT campaigns were thought fleeting. Efforts to embed diverse imagery across the profession were deemed a limited, superficial, tick-box exercise which failed to address underlying issues. Advertising diversity messages via print or virtual media offers a cheap way of reaching a wide recruitment pool than physical talks at school, but adverts must consider differential reception by audiences based on certain factors, including one's social identity, openness to ethnic diversity, and perceived value of their ethnicity and being their authentic selves at work (Avery, 2003; Kim and Gelfand, 2003; Myers and Dreachslin, 2007).

Efforts to attract men to the profession are not as simple as emphasising the aspects that appeal to them (e.g., scientific and problem-solving elements), as recommend in interviews and existing literature (Greenwood, Wright and Bithell, 2006; Royal College of Speech and Language Therapists, 2020c). Within literature on teaching, scholars argue that emphasising the masculine aspects of roles is misleading, and may not encourage more men into predominantly female professions since they do not resonate with why some men find them attractive (Carrington, Tymms and Merrell, 2008; Skelton, 2009; Spilt, Koomen and Jak, 2012). Also, attempts to reduce SLT's "female" image implicitly degrades the factors which appeal to women (e.g., "caring" role as unappealing to men), which may reinforce gender stereotypes. Moreover, branding the profession according to why current therapists chose SLT,

such as interests in language and communication, may not be enough. Men are less likely to study language and area studies than female students in the UK (Higher Education Statistics Agency, 2022), or study/work in predominantly female sectors as outlined by interviewees. Arguably, attempts to brand the profession should be framed as creating a balanced perception of SLT, which involves addressing misconceptions, that may inadvertently appeal to men (e.g., framing SLT as more scientific).

Viewing SLT's poor workforce diversity as a supply issue, in terms of not enough people applying to the profession, can overlook structural issues. For example, there were perceptions that male, and minority ethnic individuals did not consider SLT because of their preferences (e.g., desires for high-income potential, traditional professions, etc.). One study highlighted perceptions amongst SLT course teams that minority ethnic individuals lack the academic ability to enter SLT courses (e.g., cannot meet required grades or English language standards) (Stapleford and Todd, 1998). This may frame under-represented groups as the problem for not preferring or being good enough for SLT, which places the onus of change on them. A cultural deficit model emerges (see section 4.2.2) which potentially overlooks or de-emphasises structural barriers. I uncovered structural barriers in diversity efforts targeting education to attract SLT applicants. This included the absence of early educational (i.e., before college) and wide (i.e., extend beyond education to other sectors) outreach. Also, SLT careers advice varied in quality, with AHPs mostly omitted from careers fairs. Interviewee's schooling years were not specified, and so I could not determine if poor SLT careers advice is a former or current issue. However, the delivery and quality of impartial careers advice in UK schools has frequently been criticised (Stephenson, 2017; Eminson, 2018), and there is specific criticism of SLT careers advice (see section 4.1). Some government reforms have tried to improve careers services (Long, Hubble and Loft, 2016), and the RCSLT have plans to address outreach and careers advice (Royal College of Speech and Language Therapists, 2023d, 2023a). Also, an NHS workforce provision case can be made for therapists to be included in careers events as the NHS Long Term Plan 2019 identified the SLT workforce as being in short supply (Royal College of Speech and Language Therapists, 2019c). Inclusion in careers fairs is important because they help attendees choose careers, even if the reasons behind those choices remain unchanged (Waqar and James, 2019).

Universities pose another barrier. Their free-market, non-values-based recruitment practices may not attract the best students. Also, inadequate university staffing likely means

poor student support, potentially worsening the reluctance of under-represented students to report negative university experiences, such as discrimination on placements (see chapter seven). A diverse university workforce is needed to foster a tolerant and inclusive learning environment (Equality and Human Rights Commission, 2019a). Yet, visible diversity, and so role models, are not sustained beyond careers events. For example, universities used diverse therapist profiles to attract students, but SLT course materials, content, and lecturers lacked diversity.

Finally, intersectionality uncovered the fluid and interlocking patterns of dis/advantage based on gender, ethnicity, and social class encountered by therapists in accessing SLT. These findings also extend current understandings about how social class shapes SLT workforce diversity, namely social capital, and networked access to the profession. For example, social class interlocked with ethnicity to shape dis/advantage in accessing work experience and volunteering opportunities, which was linked bridging social capital (defined in section 4.3.3 – e.g., representation and/or connections in the profession). Also, the profession was deemed middle-class which interlocked with gender and ethnicity to shape career choices (e.g., perceptions of pay shaped gender- or ethnicity-based pursuit of traditional professions or SLT career routes offering better status and income/job stability whilst also linked to patriarchal roles, such as men as breadwinners). There is a need to diversify the homogenous networks that gatekeep SLT careers because they can preserve dominant workforce identities. The need for contacts to get work experience for those who mismatch the profession's demographic profile, or cannot volunteer for financial reasons, remains unaddressed. Gatekeepers are important because they have power to shape careers by enabling or denying access to various career opportunities including jobs, promotions, and development (Bosley, Arnold and Cohen, 2009). If networks that gatekeep careers are homogenous, under-represented groups may have fewer opportunities to access career opportunities. For example, accessing and exploiting the social capital from networks of relatives, friends and acquaintances can help people secure jobs, and shape different post-recruitment outcomes (e.g., job satisfaction and promotion) (Trimble and Kmec, 2011; Castilla, Lan and Rissing, 2013a, 2013b). Social capital affects access to UK health sector jobs (see section 4.2.1), and is reported high for SLT than other AHPs (Wordsworth, 2013). However, racism (Brondolo *et al.*, 2012) and low social class (Pichler and Wallace, 2009) negatively affect different social capital forms. Also, using social networks for job acquisition does not benefit everyone, and can maintain gender and ethnic workplace inequality (Elliott, 2001; Stainback, 2008; Trimble and Kmec, 2011). For example,

social networks can be unhelpful for securing jobs when contacts do not possess links to workplaces, or cannot advocate for jobseekers either because they choose not to or lack status (Trimble and Kmec, 2011).

Here, sector-specific nuances to barriers accessing SLT were uncovered, which is almost absent in existing research. Securing work experience was linked to NHS staff workloads in the public sector, and conflictingly linked to luck and meritocracy in the private sector. This contradiction could be for different reasons. First, private companies may have better funding and staffing capacity to offer more work opportunities than the NHS. Therapists did not specifically state this, but did highlight the ability to make more money, and so implied a better financial landscape, in the private than the public sector. Second, the difficulty in securing work experience may differ between ethnic groups. The sole trader who attributed merit to accessing work experience was Indian, and Indian communities tend to have a higher socio-economic status than their fellow South Asians of Bangladeshi or Pakistani heritage (e.g., less likely to have never worked/be in long-term unemployment) (Office for National Statistics, 2018). Third, meritocratic ideas of success can make high-achieving working-class students a third class, where they are distant from their working-class backgrounds and the middle-class, and so their core values lie in meritocracy which may reproduce rather than challenge inequalities (Jin and Ball, 2020).

Interviewees placed very little emphasis on diversity practices addressing social class, even though they and existing literature (see section 4.1.2) emphasised its importance for work experience/volunteering and higher education participation. There were just some references to an SLT apprenticeship route and the RCSLT website suggesting key organisations to approach for volunteering (Royal College of Speech and Language Therapists, 2022b). So, an important diversity issue-practice gap is uncovered. Considering intersectionality revealed that social class intersected with ethnicity to particularly disadvantage minority ethnic groups in the affordability to volunteer and study SLT, because some participants thought that they were likely to be of low social class. This is only partly true, as minority ethnic groups vary in their socioeconomic status (Office for National Statistics, 2018), and social mobility in the UK (Li, 2021). Low social class has been linked to volunteering non-participation (Donahue *et al.*, 2020), and higher education choices such as preferences for, and likelihood to, study or work close to home (Taylor, 1992; Modood and Shiner, 1994; Ball, Reay and David, 2002; McCabe, Keast and Kaya, 2022). High distance sensitivity between parental home and educational

institution is particularly pronounced amongst Bangladeshi and Pakistani females than other ethnic groups, and for poor students (Gibbons and Vignoles, 2012) due to financial and cultural reasons (Taylor, 1992; Bird, 1996; Ball, Reay and David, 2002; Gibbons and Vignoles, 2012; McCabe, Keast and Kaya, 2022). This is perhaps why conservative family attitudes and deprivation were linked to a close training place being perceived as important to female Asian therapists. In the UK, domestic/caring responsibilities hinder women's ability to volunteer, whilst financial costs, limited access to, and experience of exclusion in, volunteering infrastructures are barriers for ethnicity (Southby, South and Bagnall, 2019). Minority ethnic student's difficulty in securing SLT work experience is documented (Royal College of Speech and Language Therapists, 2019d). I did not collect social class data, but future research should do so given its relevance to ethnicity.

Unfortunately, the apprenticeship route is unlikely to improve the ethnic or class diversity of the SLT profession. The low wages of apprenticeships can deter young people from disadvantaged backgrounds (Straw *et al.*, 2022), with its uptake already low amongst minority ethnic groups (Department for Education, 2020). Since 2015, apprenticeships in England have increasingly squeezed out the working class; with fewer apprenticeships available in, and apprentices from, deprived areas (Cavaglia, Mcnally and Ventura, 2022). Apprenticeships are likely to have limited impact on SLT workforce diversity because it is relatively new, with few currently offered (offered by one university in 2022 and by two in 2023) just within England (Royal College of Speech and Language Therapists, 2022a).

Overall, the findings discussed represent theoretical and empirical contributions to existing knowledge about entrance to the SLT profession. Some barriers are noted in existing literature, thus representing ongoing challenges for the profession (e.g., SLT's feminised and low status image in which gender stereotypes play a pervasive role), but they also extend knowledge of ethnic barriers to SLT. The lack of terminology for SLT and poor understandings of speech disorders are unique factors shaping minority ethnic community awareness of SLT. This shows how upbringing in one's ethnic community shapes understandings of SLT and under-representation at entry level. So, a narrative of seeking traditional professions arises linked to income potential and stability. The wider public were thought unaware of better income potential in the private than public sector, which represents a novel sector-specific insight. Also, networked access to the profession via contacts for work experience, excludes those who

do not match the profession's demographic profile, with some groups thought unable to volunteer for financial or caring reasons. Here, an intersectional lens demonstrated fluid and interlocking patterns of gender, ethnicity, and social class based dis/advantage in accessing SLT. A sector-specific nuance was also uncovered here; the perception that getting work experience is easier in the private than public sector. Gaps were documented for diversity practices aiming to attract diverse SLT applicants, comprising of marketing/branding SLT (lack of reach, unclear rationale, reactionary, and focused on superficial image building), and targeting schools/academia (lack of early or wide outreach, exclusion from careers fairs, and lack of support and sustained visible diversity at university). These gaps are empirical contributions given insufficient research on SLT-specific practices.

CHAPTER 7: FINDINGS: EXPERIENCES WITHIN THE PROFESSION

The second theme focuses on whether, and how, SLT's gender and/or ethnicity shaped their career experiences (see Figure nine in Appendix 14). Emphasis is on therapist's stories, but diversity stakeholder's perceptions about SLT career issues are considered. There are different views and contradictions within and between interviewees. Overall, therapists shared many negative career experiences about belonging and marginalisation/disadvantage, and career progression faced by under-represented groups within the profession. Well-represented groups, namely women and White therapists, were also affected in these respects too. Contradicting these experiences, many therapists (N=27) expressed uncertainty about, or felt that their gender and/or ethnicity did not influence their professional careers at all (N=27 – female=19, male=8, White=22, minority ethnic=5). This included positive or negative impact, but emphasis was on the latter. The reasons for these contradictions are explored throughout this chapter. Many different diversity practices relevant to addressing the negative gender and/or ethnicity career experiences were identified (see Figure eight in Appendix 14). Practices were not always linked to the specific diversity issues identified, and so I matched them based on perceived relevance. Discussions about these practices highlighted shortfalls that helps explain why the profession's poor workforce diversity persists.

7.1 Gender- and ethnicity-based belonging and marginalisation/disadvantage

All interviewees discussed gender- and ethnicity-based belonging and marginalisation/disadvantage (N=51), but marginalisation/disadvantage was more pronounced. Belonging is linked to organisational inclusion (see section 3.1.3) and reflected positive feelings of being accepted for one's authentic self and fitting into workplaces and the profession. Belonging experiences were mostly driven by references to the perceived benefit of a diverse workforce in attracting and meeting diverse client needs. Marginalisation/disadvantage represented the opposite (see section 4.2.2), characterised by

bias, discrimination (interpersonal and institutional), social exclusion, and lack of relatability to clients and/or colleagues linked to poor representation in the profession. Ethnicity and gender related experiences within these themes were mostly similar, but are discussed separately for clarity.

7.1.1 Ethnicity-related workplace experiences and patterns of marginalisation

Ethnicity shaped belonging for minority ethnic groups in different ways. First, minority ethnic therapists were perceived as assets from a client perspective. The ability to attract, represent, relate to, and meet the needs of, diverse communities being served, based on gender or ethnicity, was the most highlighted perceived benefit of workforce diversity (N=44). An ethnically diverse workforce was linked to a potential to easily identify things not captured from a standard White, British, middle-class approach, which impacted how people approached and engaged with services. For example, different understandings and expectations of healthcare systems or therapy.

> *"...if you don't even have a word for Speech and Language Therapy, or you have never had experience of Speech and Language Therapy, you might think it is a bit like when you go to the doctor, and maybe, you know they give you something, or they give you a prescription…we have had people who have thought that that is what's going to happen, or that the doctor is going to do everything. Whereas actually…the profession is very different. It's more about facilitating parents for example, or staff to support children…you know there's a different viewpoint in terms of what therapy is…The more experience you have of different cultures and the wider world, the better able you are to serve a wider range of people in the community." [Lian: Chinese, female SLT]*

So, identifying with, and having knowledge of a community's ethnic culture and language was framed as an asset because it facilitated understanding, relatability, and comfort.

> *"Just from having a tiny little bit of knowledge about other people's ethnicities, cultures, you know different rituals and like celebrations and all of that, is so important*

to be able to have a conversation with somebody." [Danielle: Multiracial British, female SLT]

This asset overcame language barriers for clients who did not speak English without needing an interpreter. It also helped both understanding of cultural references and families to engage with services. For example, a Bangladeshi therapist was thought an asset to a team serving a large Bangladeshi community because families appreciated her knowledge of the language and culture. This created instant connections between both parties.

"…when I was first hired for my job, my line manager… she asked me if I speak Bengali. And I was just like, 'yeah a little bit'. And she's just like 'oh that's gonna be really helpful' like in terms of my relationships with families I work with, because they're mostly Bengali families…So, I saw it as a benefit as soon as I went in." [Aisha: British Bangladeshi, female SLT]

There were perceptions that therapists of, or were perceived as being, minority ethnic had an unconscious affinity with other different minority ethnic groups, than White therapists. This affinity attracted clients, possibly because it signalled non-judgemental relatability. For example, a multiracial sole trader described receiving several referrals of Jewish clients because her name was mistaken for being Jewish. She interpreted this as a need for shared understanding of experiences which strengthened therapist-client relationships. However, a shared culture could also raise challenges. One British Indian therapist spoke of how an Indian family expected him to provide additional support outside of his remit.

"…I think people are aware that if you also are not White, then you probably have a slightly different understanding than somebody who comes from a White British background...an unconscious kind of understanding sometimes between people when that happens… sometimes people have said to me things like 'oh, well, you know us Black people'…clearly I am not Black…demonstrates to me that there is a sort of recognition that…I might be more similar to them than perhaps somebody from a different background." [Lian: Chinese, female, SLT]

Second, religious/cultural differences sparked conversations and bonding with colleagues. Visible minorities, mostly those who were Muslim, shared how their visible differences such as wearing religious clothing (e.g., hijab), acted as a conversation topic and opportunity for colleagues to learn about each other's faiths/cultures and highlight similarities. But there was a recognition that an overemphasis on one's ethnicity could make minority groups feel marginalised.

> *"Open up a conversation like 'oh, how come you wear that?'...it was really nice that people don't be like afraid to ask almost…it was nice because then it gives you something to talk about, and it was something different, wasn't it?... when like, an Asian girl walks in with a jumper and a scarf, it's like, 'oh, like, this is something different'."* *[Rahima: Asian, female SLT]*

Also, exposure to culturally different people helped facilitate colleagues' acceptance of their differences as assets within the profession. Supportive teams and practitioners happily accommodated for prayer times and rooms. Also, wearing a hijab was a seen to be a *"really nice change from the usual kind of twinset and pearls kind of thing that you see" [Graham: White British, male SLT]*.

Most of the ethnicity-related career experiences shared were negative and reflected marginalisation and disadvantage. These experiences were mostly about discrimination/racism, bias, exclusion, and a racialised lack of relatability to clients and/or colleagues which was linked to representation in the profession. These experiences had a psychological impact which could, and did, negatively affect the retention of under-represented therapists.

Discrimination and bias were the most discussed marginalisation experience (N=42), particularly ethnicity (N=33) more than gender-based discrimination (N=14) (defined in section 4.3.2). Ethnic discrimination was mentioned by 14 therapists, of which Asian therapists were over-represented relative to their sample size. References to ethnic discrimination were mainly about ethnicity, religion, and White privilege. Therapists focused mainly on interpersonal, and stakeholders on institutional, discrimination.

Stories of ethnicity-based discrimination were usually interpersonal microaggressions against Asian therapists. They faced microassaults (defined in section 4.3.2), mainly racialised comments from colleagues of other professions that they worked with. For example, Sanjay described a casual racist encounter from a secretary and senior staff member.

> *"…a receptionist came up to the room that we were in and said "oh it's awfully quiet in here. It's like 10 little [racist term]"… I went "what? Woah". And for some reason, everyone decided to come to me and say 'look, you know, Sanjay this isn't on, and you've got to take it up with someone'. So, I took it to a higher level and was told 'well, you know, it's okay. There used to be a nursery rhyme called that'." [Sanjay: Indian British, male SLT]*

Sanjay was also bullied in his predominantly White female team, but whilst it was unclear whether ethnicity or gender played a greater role, being a minority in both aspects seemed to have an impact.

> *"You'd walk into a team of five or six female therapists. The majority of them were White, if not all of them, were White…there was definitely some bullying. Absolutely. 110%. You know, the conversations…because you were the only male in the group…you know there was like silent conversations, or accusations, or assumptions made about who you were, how you were." [Sanjay: Indian British, male SLT]*

Being a visible minority ethnic therapist, mostly if they were Asian, meant facing microinsults (defined in section 4.3.2) in the form of assumptions. They faced biased assumptions about their British status by employers, ability to speak English by clients due to being seen as a *"so called foreign" [Mei: Chinese, female SLT]*, and dietary requirements by colleagues (e.g., fussed over at catered meetings). Some therapists shared how clients or non-SLT staff wondered about their names, or where they were from. For some, curiosity was a negative experience; two Asian therapists received comments about their *"unusual"* names *[Rahima: Asian, female SLT]* or accent (laughingly told she *"sounded street" [Aisha: British Bangladeshi, female SLT]*). Aisha linked this experience to being of minority ethnic heritage because a White colleague highlighted that her regional accent would not be mentioned because she was White. For other therapists, curiosity was framed positively; helping build relationships via relatability and fitting in. As almost all minority ethnic therapists interviewed

were Asian, I cannot comment on other under-represented ethnic groups. However, White therapists tended to provide vague anecdotes of discrimination faced by minority ethnic therapists. For example, some White therapists discussed how societal events (e.g., the Black Lives Matters (BLM) movement or Covid-19 pandemic) triggered NHS Trust discussions about ethnicity, where staff shared stories of in/direct workplace racism. These stories described *"actions or very obvious discriminations…that colleagues are faced with in the workplace" [Isabella: White British, female SLT]* to a focus on pronouncing or spelling people's names correctly. None of the White therapists described personal experiences of racism.

Almost all stories about religious discrimination were about Muslim therapists, except one Hindu therapist's experiences, when they were students or in their first roles after qualifying. Their religious beliefs, clothing, and holidays were the subjects of discriminatory remarks, sometimes overtly, by clients, colleagues, and educators. For example, Aisha, a Muslim therapist, recalled an experience where her hijab was mocked by a child client in a placement therapy session. The practice educator present laughed and verbally highlighted a link between the mocking and her hijab.

> *"I just didn't know how to approach it. I was just sort of just shocked. And I was like did someone really just say that to me? And I always remember that quite clearly, and that was like a situation which was made super obvious to me that someone sees me as being different." [Aisha: British Bangladeshi, female SLT]*

A Hindu therapist was told that he would burn in hell by an allied health professional because he did not believe in Jesus Christ. Also, academic and work supervisors were accused of lacking cultural sensitivity by not accommodating minority ethnic religious holidays. For example, a Muslim therapist recalled how a supervisor allowed a meeting to over-run despite knowing it was Eid and she needed to leave early. This resulted in missing her cab, being stranded, and driven to tears.

Therapists subjected to religious discrimination were reluctant to report individuals because they *"didn't want to rock any boats" [Sanjay: Indian British, male SLT]* to avoid associated repercussions, low confidence, and mistrust of university and employer support mechanisms. For example, confidence from professional experience allowed Sanjay to directly confront

colleagues who publicly berated him because *"by that time I just had it for so long. I'd developed a thick skin…I just wasn't standing for it" [Sanjay: Indian British, male SLT]*. However, as a student, Aisha could not connect with university educators who *"seemed like they were also from a very different world from us" [Aisha: British Bangladeshi, female SLT]*. So, complaining was perceived futile because incidents would not be taken seriously, and students experiences would not be emotionally validated. There was evidence of microinvalidation (defined in section 4.3.2). Supervisors were uncaring, as Aisha faced a hostile work environment characterised by constant comments about her hijab "*but my supervisor, she didn't understand. Like she just didn't care. It didn't bother her" [Aisha: British Bangladeshi, female SLT]*. Universities apparently prioritised convenience over student wellbeing as a practice educator with a poor reputation amongst students continued to be used, which was linked to placement shortages. University support was not sustained and seen as unauthentic.

> *"So, one of my placements, I didn't have a very good experience…they say like racially abusive things, and I think I was very naive at the time. So, like I wasn't picking up on all these you know subtle, very subtle things... like when I did it, I did raise it in my uni[versity] and they were really supportive initially. After that…they just never like follow through. Like the people that are reported it to, they just sort of sent me an apology letter, which was not very apologetic should I say." [Rahima: Asian, female SLT]*

Also, dismissal of minority ethnic experiences or values was linked to an inability to relate to them.

> *"I know that from the discussions that we've had in our team, that sometimes people feel like their values aren't reflected by others, or their concerns about how they're being spoken to are dismissed, because that kind of discrimination isn't experienced by the person who they're raising that problem to." [Hannah: White British, female SLT]*

Diversity stakeholders were more likely to apply a CRT lens to stories of ethnic discrimination by understanding them as being part of an institutional problem than therapists. They thought university and NHS processes were biased against minority groups across recruitment (e.g., interview success), working life (e.g., general treatment), and career progression opportunities

(e.g., access to informal opportunities like mentoring). Institutional support mechanisms were deemed poor, with a lack of people with diverse protected characteristics to report to. Also, reporting procedures had negative repercussions for complainants.

> *"…there are whistleblowing policies in all NHS Trusts… people I do know who've gone through whistleblowing for other issues [i.e., not racism] have not been treated favourably, have then been in a position sometimes where they can't be employed anywhere because they're seen as a troublemaker… it's a big deal to go through the process particularly if the people who are being racist towards you are in positions of power. Remember that students are being marked by clinicians. So, it takes a lot of courage to come forward and say, 'oh this clinician is being racist', and sometimes they don't even know whether it's racism or not. They feel something's not quite right…I don't feel comfortable…that was a funny comment she made there. Is it racism? Is it something else? Is it something I've done? So sometimes even unpicking that is really difficult." [Leyla: Asian, female, university stakeholder]*

They also acknowledged wider society as shaping institutional discrimination.

> *"…I am still shocked at hearing about some of the experiences…how much does that reflect our society?...it goes back to some of the narrative of government… people in leadership roles are saying stuff, and they just seem to get away with it…I think with Brexit, that created a lot of hatred didn't it? So, you know if you just think about the narrative within society, I don't think that's helpful…the NHS is the biggest employer in Europe…that's a lot of people in this society who work in the NHS…if there are a significant number who are racist, and or who have right wing leanings…it breaks my heart…how do we change that narrative within society?" [Anita: British Indian, female, leading professional body stakeholder]*

Sometimes marginalisation was more indirect microinsults. There were stories of minority ethnic therapists/NHS staff being made to feel unaccepted or excluded. For example, there were stories of social exclusion at university and workplace events/conversations, being ignored or judged at university, and being perceived to have deficit qualities (e.g., branded as troublemakers or overly sensitive). Minority ethnic therapists faced judgements from colleagues or university staff.

> *"…when you do have a kind of relatively White, relatively female, relatively middle-class profession, that can feel quite judgemental sometimes, and the edges can be excluded." [Patrick: White Irish, male university stakeholder]*

Conversations were exclusionary because of an inability to relate to colleagues from dominant backgrounds (see section 6.1.2.1).

> *"…back then it was weird for me…it was sort of little things. So, I'd sit down for lunch for example, with like the team that I was doing sort of my placement with…I never felt like I could join in on the conversations. As friendly as they were, it was always about things like horse riding, and like just really like absurd things. I'm like, I can't relate to you. I'm sorry... I would just sit there and have my lunch and get all my work, which is fine." [Aisha: British Bangladeshi, female SLT]*

However, Aisha *"felt right at home"* when working in a team comprising of many Bangladeshi colleagues because she could be her authentic self.

> *"I didn't feel like I had to pretend to talk about something I had no clue about to fit in, and especially like with a lot of the socials and things…like people would head down to the pub or things like that, and I wasn't going to be doing that." [Aisha: British Bangladeshi, female SLT]*

Social exclusion from workplace events were mostly about Muslim therapists indirectly being unable to attend because the venues served alcohol. This sometimes happened even when team members were aware of alcohol as a barrier. White therapists were unaffected because they did not have to compromise their principles to fit in.

> *"…it was never done, you know maliciously or intentionally, but the last Christmas team party that we had…there was alcohol for sale and things like that. And I know that one colleague wouldn't go somewhere like that because she wouldn't go to a pub or something like, because she doesn't drink…that's the kind of, you know social exclusion in a way, isn't it? And that wouldn't apply to me because I would, there's nowhere that I wouldn't go." [Tom: White, male SLT]*

However, being outspoken about issues was *"much harder if you're a student, or a newly qualified therapist to do that, because you're seen as a troublemaker maybe. You might seem to be making a mountain after a mole[hill] like I used to be" [Nathan: White, male, leading professional body stakeholder]*.

Lack of relatability with clients and colleagues based on ethnicity emerged as a diversity issue. Therapists described the challenges of working with clients that were of a different ethnicity to them. For example, minority ethnic therapists faced racist clients, and had a burden of educating colleagues about cultural sensitivity and knowledge rather than employers. Therapists in the NHS accessed, and openly sought, culture-related advice, and help with interpretation from, their minority ethnic colleagues.

> *"we're lucky that we have co-workers from the Bangladeshi community who work with us. I often speak to them for advice… like during Ramadan, when might be the best time to call families... little things like that. [Jack: White British, male SLT]*

White therapists highlighted how greater work and effort was needed to relate to clients (e.g., build rapport and overcome distrust) who were ethnically different from them based on differences in appearance and cultural references. Interpreters were valued for bridging communication barriers, but were costly or an anxiety-provoking option (e.g., could insult some families because there was usually a family member who could speak English). So, White therapists had to research cultural practices and norms (e.g., about family dynamics or appropriate communication strategies) to avoid making cultural assumptions. One White therapist described an experience where she let a manager advise a client to stop chewing tobacco, because they shared the same culture/language. This was due to a worry that:

> *"…it might not have come across in a supportive manner necessarily if I either misjudged my place in terms of how familiar to be with the different generations, or I mispronounced the words perhaps because it was already going to be a very difficult conversation without that, you know the cultural difference." [Ava: White British, female SLT]*

There were also challenges with balancing the need to respect client's cultural views and therapist's own values and concerns.

> *"…there's always a fine line between respecting people's different cultural values, but also having my safeguarding hat on and thinking, well where does the line for acceptance of cultural values end and where does neglect begin?" [Lauren: White British, female SLT]*

Representation played an important role in the ability to relate to fellow students or colleagues. Poor ethnic representation, namely being minority ethnic, was associated with an inability to identify with, and feel a sense of belonging within, the profession (see section 6.1.2). Stakeholders and therapists thought gender and ethnically diverse role models were needed across the profession to help under-represented groups envision themselves within it. Therapists described how sharing the same language, cultural references, age ranges, ethnicity, and education meant unconsciously fitting the norms of the culture, team, and profession. Unconscious biases were seen to afford privileges to White therapists (see section 7.5.1) such as instant feelings of affinity, which possibly translated into privileges (e.g., interview success), because they ethnically reflected management.

> *"I think it definitely makes a difference when you can see yourself somewhere. That's really inspiring and really motivating." [Aisha: British Bangladeshi, female SLT]*

Stakeholders presented belonging as a basic need, which required people to feel comfortable in expressing their authentic selves, and being supported when any issues arose.

> *"…As a professional, to feel that you want to stay in the profession, you need to be respected for you…You need to be really comfortable being yourself… And I think we've got a long way to go until that happens, because I think a lot of people still are experiencing microaggressions, maybe some overt racism, maybe some difficulties, and maybe don't feel able to speak out about that because they feel they're making a fuss. …I want people to just say to me, 'do you know I was on placement the other day and this client said this, and the therapist didn't defend me, and I'm furious?' And we go*

'yes, you should be. Let's have a word with that practice educator'." [Nathan: White, male, leading professional body stakeholder]

However, poor ethnic diversity was sometimes ignored at university.

"…people will talk a lot about being the only Black person in the student group and how that felt…you know preaching to the choir, being expected to be the spokesperson for one's religion or ethnicity…or alternatively, it being studiously ignored. So, one of our strongest Black activists said, 'my White, liberal lecturers spent three years ignoring the fact that I was the only Black person in the class'." [Matthew: White British, male, leading professional body stakeholder]

Despite being well-represented, White therapists thought White privilege (see section 7.5.1) sometimes masked their diversity-related concerns and experiences within the profession. Yet, White therapists did not share any personal experiences of racism. Some interviewees thought Whiteness intersected with religion and social class in ways that negated White privilege. For example, being Jewish was supposedly deemed by others *"elevated White privilege"* which concealed antisemitism concerns from employers *[Sophie: White British, female SLT]*. Also, White therapists found talking about ethnicity as challenging. There were concerns about causing unintentional offence or fearing being seen as racist when navigating conversations about ethnicity with clients or colleagues. For example, one White therapist thought positive discrimination was used as a workforce diversification tool, but felt *"strange"* about being *"aware that that means me potentially like giving up the advantage that I don't deserve in any way, but just happened to have" [Hannah: White British, female SLT]*.

"…if a White person is perceived to be racist, then they are a bad person, and that is the fear. So, all the time we have to present as like not a racist person, but when we operate in our societies…we are in a majority White population…we benefit from that, and you know the White privilege side of things." [Leah: White, female NHS stakeholder]

7.1.2 Gender-based workplace experiences and marginalisation

Despite their minority status, being male was not thought a noticeable barrier when integrating within organisations or the profession at large. Rather, there were many perceived benefits to being a male therapist, especially being received as a novelty and easily remembered.

> *"…because they're so niche, if families come across a male therapist…it's like 'yeah this is exciting. It's someone different'…Also their names are about. So, as soon as you hear the name, you're like 'oh yeah I know that person' because there's only four or five of them." [Danielle: Multiracial British, female SLT]*

Male therapist's presence was often met with surprise reactions, usually overt comments, from clients and their families, or colleagues. For example, the *"token man" [Kate: White British, female SLT]*. Some male therapists disliked their gender being emphasised, but others did not mind it.

> *"…there's often been a sort of element of surprise perhaps…I wouldn't describe it as negative. But it is sort of a verbal surprise." [William: White British, male SLT]*

Also, male therapists were welcomed within teams. Like minority ethnic therapists, men were seen to bring the perceived benefits of gender diversity to the profession. They offered a different perspective to women, and attracted or met the needs of male clients. Men did not feel uncomfortable nor pressured to change how they presented themselves because of their gender, especially if they had prior work experience in other predominantly female sectors.

> *"I don't think I've had to change. I felt like I've been like welcomed because of that in a way." [Jack: White British, male SLT]*

Gender-based marginalisation experiences were mostly about sexism and unrelatability to clients or colleagues of the opposite gender. Female therapists faced interpersonal sexism from colleagues and clients. Section 6.1.2.1 outlines how gender stereotypes negatively impacted women, such bullying for unfeminine behaviour, and unrealistic client expectations (e.g., cheaper service costs). Sometimes clients were sexist. For example, one female therapist described facing sexism because of working with families governed by a patriarchal structure:

"I've been in situations where I've visited people at home, and that they've said that the mum, for example, can't speak English. The dad can, and they haven't wanted an interpreter. So, the dad has been sort of conduit for all the information going to the mom. And I have had times where I've felt like I have been condescended to and been patronised by men in that situation, who don't like the fact that this woman is coming into their house and telling them, you know about their child and what they should do… I'm thinking of one family in particular. The dad always used to be quite patronising or…he'd come to see me in clinic, and he'd say 'oh, you know I've tried to tell her', or 'she'... he would, just use pronouns like that in a really derogatory way." [Lauren: White British, female SLT]

Stakeholders thought women in the NHS faced institutional discrimination in recruitment and pay. Therapists emphasised that the profession's predominant female workforce meant women were well represented within the profession's hierarchy.

"So, men with women, the feedback tends to be what's described as benevolent sexism. In other words, you do an interview…the feedback goes like this 'you were very good but on the day somebody else was better'. Absolutely useless feedback because it doesn't tell you what you need to do better. It doesn't help you to get the next job." [Isaac: Jewish, male university stakeholder]

Male therapists were perceived to face assumptions about their personal characteristics. For example, some were assumed to be homosexual and faced homophobic comments. This was not deemed a widespread issue. Also, their communication and working styles were judged at university and work. Sometimes men were mistakenly called by another male therapist's name or mistitled *"miss"* in formal letters.

"…when it comes to like clinical skills, they're usually assessed in person…I've often seen what I feel to be a 'group think' where a group of therapists will criticise and will kind of you know want to fail or want to give a very low mark for a student who really doesn't share their communication style, or doesn't share their kind of worldview…I

think that can affect men, and it can also affect students from more ethnically diverse backgrounds." [Patrick: White Irish, male university stakeholder]

Gender-based exclusion was only spoken about in relation to male therapists being excluded from workplace conversations or social events. Conversations about "female" topics (e.g., menstruation or maternity) did not, or were assumed by female colleagues not to, interest men. Sometimes women did not invite men to social gatherings after work, overlooked or dismissed male issues, and forgot male staff were present.

"…First of all, as the White male, sometimes people have been rather dismissive in that we don't seem to be allowed to have any problems. I've had a number of people say to me a few times, 'oh, it's alright for you. You're a man' or 'it's easy for men. You're different'. Something along those lines which is actually rather dismissive when you think about it." [Adam: White British, male SLT]

Male therapists were thought unsuitable for working with certain groups. A particular issue was safeguarding concerns when working with young or vulnerable clients. This made men hyperconscious of being alone with them. So, they took certain precautions, such as ensured a third person presence during clinical sessions, worked in open spaces/rooms with windowed doors, or made colleagues aware of the session. Male therapists who faced safeguarding accusations were suspended or formally interviewed by authorities, during which they felt vulnerable and unsupported by one or more institutions: their employer, regulatory body, and professional association. Safeguarding concerns were seen to detrimentally affect relationships with clients, especially if interventions were being delivered by non-SLTs (e.g., teaching assistant) who lacked the necessary expertise.

"…you do feel that there can be a very kind of chilling atmosphere for you as a male employee…we all have these procedures to stick to as regards appropriate behaviour with young children. But you kind of feel that you are being particularly scrutinised that and you have to be particularly careful." [Patrick: White Irish, male university stakeholder]

Gender stereotypes shaped therapist's ability to relate to clients and colleagues of the opposite gender.

> *"A man can relate to a man right by virtue of gender. At the same time, the opposite also works." [Sanjay: Indian British, male SLT]*

Some clients preferred female therapists. Reasons included their associated feminine qualities (see section 6.1.2.1), some were mothers which signalled understanding young people's experiences, or some cultures thought it inappropriate to have an unrelated male present. However, some female therapists had caseloads with many male clients with whom there were relatability challenges, but only if they were older, not children. For example, there were concerns of mismatch between female therapists and male clients in clinical priorities, communication styles, or conversation topics.

> *"I'm aware of the fact that a lot my colleagues that work with boys in secondary school…I mean as much as they might try…they do struggle to sort of relate to the issues…that these young boys are going through." [Aisha: British Bangladeshi, female SLT]*

In contrast, male therapists could relate to, and build relationships with, clients who had certain speech conditions (e.g., stammering) because they typically affected males. They did this using stereotypically male conversation topics (e.g., football), and linked boy's preferences for male therapists to seeing male role models. However, male therapists were thought unsuited for working with young, vulnerable, or female clients.

For colleague relatability, being in a predominantly female profession was thought more of an asset for female than for male therapists. Female therapists could relate to each other as women, shaping a comfortable environment to share female issues or health concerns. Conversely, poor male therapist representation was linked to perceptions that men had difficulty identifying with, and integrating within the profession (e.g., reduced possibility of making male friends). Men were thought disadvantaged in networking and workplace conversation topics. Yet, they were privileged in career progression (see section 7.3.2).

"…being a very female dominated profession that you do feel a little bit like a fish out of water. You feel like a square peg in a round hole." [Graham: White British, male SLT]

7.1.3 Psychological impact of marginalisation/disadvantage

The psychological impact of marginalisation and disadvantage was discussed. Both male and minority ethnic therapists experienced negative emotions and practised avoidance coping strategies.

Male therapists experienced negative feelings (e.g., resentment) and integration struggles (e.g., in making friends). Their avoidance was just around conversations for which they used different techniques (e.g., zoned out or initiated different ones). In contrast, minority ethnic therapists displayed wider disengagement. They were seen to lack confidence and fear speaking up or standing out to avoid rejection, unreciprocated feelings, or being misunderstood. So, they kept quiet (e.g., did not raise issues), and disengaged from university (in attendance and social conversations). For example, Rani's inability to relate to fellow course-mates meant *"you then kind of just stay in your own lane I guess, and that's just what I did" [Rani: Indian British, female SLT]*. Minority ethnic therapists also discussed feeling or being seen as different, and doubts about whether merit or tokenism played a role in recruitment success. They felt *"thrown off"* by comments *[Aisha: British Bangladeshi, female SLT]*, and an inability to express their authentic selves. There were pressures to conform to the profession's image, such as "*the need to be able to speak like them in order to be heard" [Sanjay: Indian British, male SLT]*, and be polite rule-followers to start their careers. Those who did not, *"there's a little bit of within the culture of do they accept us as outsiders?" [Sophie: White British, female SLT]*. One therapist highlighted that needing to work to provide for his family whilst knowing that he stood out, had a strong psychological impact on important career choices (e.g., retention and progression), job effort, and the development of feelings towards White counterparts (e.g., bias and hatred). In extreme cases, minority ethnic therapists sometimes left the profession. For example, Aisha's *"horrible"* experience of religious discrimination when working at a school as a newly qualified therapist, comprising of *"always getting comments about my hijab"* by children, feeling like an *"outcast"* by staff, *"super-isolated"*, and witnessing differential treatment for religious observances, pushed her out of the profession for a while *[Aisha: British Bangladeshi, female SLT]*. She became more selective of jobs when she returned to the profession, and

deterred from considering the private sector again. Also, suppressing her thoughts about the experience now made it hard to articulate.

7.2 Management support, diversity documentation, and disciplinary processes

Diversity practices about support mechanisms, diversity documentation, and disciplinary processes seemed the most relevant in addressing therapist's marginalisation/disadvantage experiences within the NHS or more profession-wide. Interviewees highlighted gaps in these practices which I emphasised to provide insight into why they may not have their intended effect. Quotes from Trust policy documents have been shortened throughout the thesis to preserve interviewee's anonymity.

All therapists were specifically asked about any gender and/or ethnicity related support mechanisms during their careers. They identified many types of support (e.g., university, employers, professional associations). Overall, the availability and quality of support throughout a therapist's career was thought poor or non-existent. Organisational management support was the most discussed by therapists. In the NHS, support mechanisms and disciplinary processes were presented by stakeholders as being institutionally biased against minority ethnic staff. For example, one stakeholder criticised staff awareness of available support, and the ethnic and/or gender diversity of support staff.

> *"…the support mechanisms that we sometimes we do have in place don't challenge the system…I as a Black person could have an issue with my White manager, and I go to a support person and the only person there is a senior White male. Am I going to open up and say all my issues? No, I'm not. So, there is a lack of diversity amongst the staff that we to go and report our issues to…There's also a lack of awareness sometimes of those support mechanisms… if I spoke to all staff and said 'are you aware that you can safely go through these channels to report your concerns? Do you know what those*

channels are?' Most of them probably wouldn't be able to name them to me." [Gloria: Black, female NHS stakeholder]

NHS support mostly stemmed from management for interviewees, of which there were mixed experiences. Managerial support was mostly spoken of positively than negatively. Managers provided various support related to career development (e.g., clinical support and progression-related mentorship) and any emerging diversity issues (e.g., emotional, or informational support during discriminatory incidences). However, one therapist thought supportive managers were rare.

"...in 16 years of work, they've been few and far between… I've had more negative experiences with managers than I have had positive, let's put it that way." [Sanjay: Indian British, male SLT]

Therapists criticised NHS management for being too clinically focused, but even then, their clinical expertise and support was thought lacking. For example, there were anecdotes of NHS managers making therapists feel guilty for long waiting lists, or criticising their ability to use complicated computer systems, without offering proper strategies or training.

"…the amount of things I end up telling clinicians: how to manage their caseload, how to manage a waiting list…because they're not getting the support on the job. That stuff really irritates me…I've seen a lot of unhappiness…they become very unhappy in the department; they feel very under supported, undervalued, bullied, all this stuff." [Alice: White British, female, SLT]

There were also stories of managers not understanding, being unapproachable/apathetic, unequipped to deal with discriminatory incidences (e.g., unaware of formal disciplinary processes) or even behaving that way themselves. Opportunities were seen to be *"…very much at…the beck and call of who the manager is, and who gets it sometimes who's liked more…" [Alice: White British, female, SLT].* So, therapists shared experiences or anecdotes of managers behaving in a biased manner. Section 7.1.1 outlines experiences and quotes about managerial discrimination or bias.

Support in the private sector was also thought lacking. This was linked to the profession's small size, competition, perceptions of unregulated managerial behaviour, and engagement with local ASLTIP networks for specific types of support (just to access specialists or supervision). Sole traders tended to seek their own support through networking.

> *"…[support] happened based on who I've networked with. I don't think as an Independent Speech Therapist there's much out there to be honest, unless you've got your little community which I guess ASLTIP does that… it gets harder as you go higher up because especially in the private world…there's a lot more competition in the private sector, and so it's harder to get that support." [Rani: Indian British, female SLT]*

> *"…I knew from that experience [that] I definitely wouldn't want to go into the private sector again. Just because I wanted to be somewhere where I felt…that there are more general rules that I'm aware of, and there's a little bit more of a safety net in a sense working in the NHS." [Aisha: British Bangladeshi, female SLT]*

Organisational diversity documentation also had a perceived role in addressing marginalisation. Overall, the perceived purpose and importance of organisational diversity and other workforce policies was to hold people accountable for bad behaviour. Much of their content was about the NHS because most interviewees were affiliated with the NHS, and sole traders did not have a current diversity policy. Diversity policies were mainly perceived to have two roles. First, to ensure and celebrate workforce diversity to effectively meet patient needs.

> *"…to have a really healthy functioning staff team, people have to feel secure in their own bodies and be able to well be proud of their own identity really. And that then reflects also onto the client group." [Ava: White British, female SLT]*

Second, diversity policies were seen as a legislative-based reference document to regulate employee behaviour by outlining organisational principles, and holding people to account for bad behaviour related to protected characteristics. So, unsurprisingly, diversity policies were mainly perceived as being motivated by legal (N=18), protection/accountability (N=18),

moral/fairness (N=18), and business (N=17) reasons (see Table eight). The diversity documents analysed outlined several specific initiatives and associated stakeholders responsible for them. Relevant support practices mentioned within them were mainly about offering psychological and informational support services. Giving staff a platform to share their experiences was commonly mentioned (e.g., via staff networks - see section 7.5, dedicated EDI personnel called "ambassadors"/"champions"/"guardians", and staff surveys). Toolkits/campaigns to promote acceptable behaviour (e.g., respect/dignity campaigns), policies, and training were also commonly cited. However, in practice, diversity policies were thought insufficient by themselves because *"on their own, they can be a bit of a tick-box exercise" [Susan: White British, female NHS stakeholder]*. Also, there were issues of poor awareness and engagement with diversity policies by therapists, and managers were thought to implement them inconsistently (discussed in section 8.2.4).

> *"There is also the need to have the policy to protect the organisation or to protect individuals. There are cases that have come about whereby by way of us having a policy we're able to draw the attention of the individual to their wrongdoing and call them to order by virtue of yeah whatever may have happened. So, discrimination sadly does take place, harassment we hear of, and without a policy you're not helping yourself as an organisation to correct such wrongdoing." [Imani: Black British, female NHS stakeholder]*

Table 8. Perceived motivations of diversity policy documents from interviews.

Motivation and summary of content	Exemplary quote
Business Staff experience linked to better patient care, attracting, and retaining staff, staff/organisational performance, staff engagement, and diverse thought linked to uncovering unaddressed areas. Also, mentions of using best practice, guiding direction of services/change, and communicating management ideas. Sole traders did not have polices but saw it as recruitment protocol.	*"…diversity means more productivity, you know better patient care, you know better ideas, you know better teamwork, etc."* *[Ajay: Indian, male NHS stakeholder]*
Legal National NHS policy, outlined in NHS People's Plan, holistically covers all nine protected characteristics with sub-policies/strategies on specific areas. Trusts just must show that they meet Equality Act 2010 requirements, either via diversity policies or workforce strategies. Legislation seen as baseline that promotes accountability.	*"…we actually try to create policies and practices which makes sense to people, and which even break through if you like some of the legislation, because legislation can be very dry. You know you can read the Equality Act if you're so minded…you'd fall asleep you know within 10 minutes… but actually, what it's trying to achieve is you know is very real and very practical. So, our policies and procedures and strategies hopefully are an attempt to try and bring the aspirations of the Equality Act to life and to make them meaningful to people." [Joel: White British, male NHS stakeholder]*

Moral/fairness Diversity policies seen as one way of improving organisational processes or culture (e.g., outlining values/principles). Having a policy seen as right thing to do, with its absence sending the wrong message - interviewees outlined personal anti-discrimination and diversity beliefs/experiences. Ensures that organisations have fair equitable processes.	*"I think it's to make sure that everybody who is employed within the Trust is representative of that particular population, and that the best people for the role are included. So, certainly inclusion related. It's simple as do you think about disability as well? Are the right people employed in the right sector? Are they the best candidates? Or is there a pattern where you have too many of one particular ethnicity? Has everything been moderated in the fairest possible way? And so, I think this is probably where they need support from human resources just to make sure everything is completely fair and equitable." [Kathryn: White Other, female SLT]*
Protection/accountability Diversity policies seen as protecting employees (e.g., redressing inequality, fair processes) or organisation (e.g., risk management strategy/safety net by preventing tribunals) namely in cases of poor treatment. Policy seen as clear written codes of conduct that can be used create accountability for non-compliance it (e.g., outline consequences/disciplinary measures).	*"…my reaction is to think that those are really in place so that when somebody starts showing that they aren't automatically following these procedures, then there's something to go back to and be like, well really clearly you need to read this in full to know what it actually entails…I would say, as a reference point… it's not really used until people prove that they don't inherently follow those rules." [Amy: White British, female SLT]*
Socio-political References to under-represented voices now being heard by management, and BLM movement leading to policies being updated to dismantle institutional racism.	*"…non-White people and for people of different genders…and abilities…I imagine…that their voices are being heard, or they're making their voices heard, and that's starting to feed up further up into the Trust." [Lian: Chinese, female SLT]*

Disciplinary/complaints processes were highlighted by stakeholders as a relevant workforce policy for addressing poor staff behaviour, which they framed as being institutionally discriminatory against minority groups. Such processes were thought individualistic and passive/reactive (i.e., waiting for a problem to be reported). Also, complainants faced repercussions regardless of the success of grievance claims (e.g., seen as troublemakers). NHS diversity documents and stakeholders outlined NHS efforts to reduce the likelihood of minority ethnic staff entering disciplinary processes, part of which involved revising HR policies to promote a fair culture. Just one Trust document specified a deadline for this.

> *"…What individuals tend to do is they don't raise the issues. They go somewhere else cos it's not worth doing it. Even if you win, you probably lose. If you win a grievance that you're not being treated fairly and I look like you [referring to interviewer being of minority ethnic heritage], you're a marked person for the rest of your time in that organisation. They'll say 'oh [interviewer name], she's a bit of a troublemaker…she's not really fit for a more senior position because she was the one making all that problem about whatever it was'. So, the best organisations are much more proactive, much more interventionalist…In other words, go out find the problem rather than let the problem find you." [Isaac: Jewish, male university stakeholder]*

7.3 Differential career progression and the role of sector-specific issues

Career progression was discussed by almost all interviewees, with a slightly greater focus on the role of gender than ethnicity.

7.3.1 Ethnicity-based career progression barriers

There were mixed perceptions of whether ethnicity hindered career progression. Some thought it did (N=31 – stakeholders=17, SLTs=14), others disagreed (N=20 – SLTs=17, stakeholders=3). Conflictingly, sometimes the same therapists were on both sides of the argument, which seemed to be driven by two perceptions. First, there was an acknowledgement

of an overall lack of vertical minority ethnic representation and role models within the profession/Trusts. This perception was balanced with an awareness of some successful minority ethnic individuals, who were used as markers of career progression possibility rather than an exception. For example, both minority ethnic and White therapists mentioned seeing token minority ethnic individuals, particularly Asian therapists, who were in senior positions (e.g., the current RCSLT CEO) or successful (e.g., owned prosperous independent practices).

> *"A lady called Kamini Gadhok…she's obviously from a BAME background. So, she's at least flying the flag for diversity. But yeah, generally in the upper echelons, it is very White I'd say." [Graham: White British, male SLT]*

Both samples, either explicitly stated or implied, four reasons why ethnicity impeded minority ethnic therapist's/NHS staff's career progression, which mostly echoed CRT's view of discrimination as pervasive across societal institutions. Stakeholders provided the most detailed content. The first reason was poor vertical representation or role models linked to not envisioning oneself within leadership. However, one stakeholder thought more diverse applicants were entering the profession, but time was needed for this to materialise into proportionate vertical representation in the profession. Second was perceptions of minority ethnic groups as possessing lower social capital: fewer, less access to, or not making use of, in/formal career opportunities or networks (e.g., mentoring).

> *"If you don't have role models, you think is that, could that be for me? If you don't see fair systems for career progression, you might well decide, do you know what? I'm not going to bother to go for that job. The people who get invited to apply for jobs are overwhelmingly going to be White and are more likely to be men. That's what the data shows. So, stretch opportunities, acting up, secondments, involved in major projects are overwhelmingly not filled by open competition, they're filled by whether your face fits." [Isaac: Jewish, male university stakeholder]*

Third was poor minority ethnic career navigation support/talent management in the NHS.

> *" When we're looking for board members, or Directors of nursing, strategy, operations, IT, HR…there is no BAME people that can fill them because we've never navigated any one of those doctors or nurses up the ladder. So we go, we're really interested in race,*

but they're not ready. You know, they don't have the skills. Well, of course they won't, because nobody's been prepping them." [Sunita: Indian, female NHS stakeholder]

Finally, negative experiences such as discrimination and biases (e.g., skills or development not recognised), White privilege (see section 7.5.1 - e.g., face seen to fit role) and structural barriers (e.g., glass ceiling) were linked to minority ethnic groups having less success in securing career opportunities. This, in turn, was associated with reduced confidence in organisational processes, and so the pursuit of career opportunities was gradually deemed futile.

"There's also something about the representations in terms of the organisation, what they want to get from those senior level roles, and a lot of the time, if it's a BAME person sometimes you've got to get the balance if that person is going to be tokenistic to make us look like we're diverse, or if it's going to be someone that's going to challenge the metrics that we have in place. Not a lot of exec teams like challenge…then let's face it, in a world where people do have a lot of biases and you know far more White people, your face doesn't always fit when you're going for those higher-level roles. And then for those reasons, and in terms of BAME people having lack of opportunities to move up, it also means when you put out a role at Band 8d for example, the pool of people to choose from is a lot smaller because you don't have the people at that level to apply for those roles. And a lot of BAME people actually already feel like from the beginning they're not going to be successful. So, what is the point in actually trying?" [Gloria: Black, female NHS stakeholder]

However, there was a perception of fair NHS systems or that Trusts were making genuine efforts to improve them and diversity, amongst therapists who claimed uncertainty or felt that their gender and/or ethnicity did not influence their careers. So, career success was thought to be shaped by personal choices or performance. For example, therapists spoke of merit-based recruitment and progression, managers encouraging them to pursue higher banding roles, and the existence of successful minority ethnic therapists or female leaders.

"…it's just unfortunate that there's just such less Asian people within our team, which is why there aren't any bands seven. So, I know it's not because you know, we're Asian, and that's why they're not going to let us get there. Definitely not that at all. It's

more just so there's such a small number of Asians that they're not getting to that thing." [Rahima: Asian, female SLT]

7.3.2 Gender-based differential career progression

Overall, women were thought disadvantaged, and men privileged, in career progression despite being over- or under- represented in the profession respectively. Representation and role models emerged as an important career progression subtheme (N=31 – SLTs=26, stakeholders=5). Women were well represented in leadership positions, which offered them role models and possible progression-related advantages (e.g., networking), despite a claim that there was a point-based recruitment system.

"[being female] is a bit of a tool in your arsenal…because you can like build relationships with people in leadership…I do just think it's easier to identify and build close relationships sometimes to people that are your gender. And unfortunately, although like the recruitment process of like interviewing and all of this literally, they are done by points, I think it'd be quite silly to assume that like your, the interviewer's own biases never come into play with the marking of these interviews." [Amy: White British, female SLT]

Yet, various barriers to women's progression were identified. Interviewees felt disproportionately fewer female leaders existed given women's overall numbers, with minority ethnic representation particularly lacking. A prominent women's progression barrier was maternity/motherhood. The profession and NHS were thought accepting of maternity/motherhood, and to carefully manage it by making many flexible working arrangements available, because women's high prevalence meant that it was a widespread issue. It was seen as *"part and parcel…and from a service point of view, it's a non-issue for me because you know we employ a lot of women" [Stella: White British, female SLT].* So, female therapists could work flexibly according to their caring responsibilities, without affecting their progression (e.g., losing their banding or working part-time affecting promotions).

"I've known entire teams to be off on maternity leave simultaneously because of the age profiles and gender profile you know and that's just dealt with." [Matthew: White British, male, leading professional body stakeholder]

But there were certain challenges for female therapists and organisations. First, some therapists thought flexible working in the NHS was not flexible enough. NHS managerialisation was linked to a requirement for therapists to work a minimum of approximately three days per week. In healthcare, managerialism is an ideology whereby management symbols and language, rationalisation, and criteria change the nature of healthcare work (Numerato, Salvatore and Fattore, 2012).

"Now that the NHS is very much more a business, there are more pressures from that." [Stella: White British, female SLT]

Planning and facilitating for maternity leave were seen to be in the NHS's best interests to attract and retain experienced staff who had additional experience stemming from parenthood. But maternity leave meant SLT teams had constant movement, unfilled vacancies, and inconsistency. Staff turnover disjointed relationships with organisations with whom SLT teams had long-standing contracts. Also, there was pressure to meet high demands with fewer staff. It was not thought possible for therapists to demonstrate productivity in their work and professional development if they worked less than three days per week. So, women's career efforts were deemed selfish for not prioritising clients. Those who wanted greater work flexibility were pushed to the private sector. Yet, therapists thought there were greater maternity rights and support in the public than private sector. This was because sole traders faced financial instability and some private companies did not offer any maternity packages. So, there were anecdotes of colleagues leaving companies for the NHS before having children to accumulate money, or because they were made to feel bad for being pregnant.

Second, maternity/motherhood was associated with possible deskilling as women were thought more likely to have caring responsibilities. So, women took career breaks or delayed their progression because of flexible working issues or the financial implications of childcare, resulting in missed career opportunities. In contrast, therapists thought men were unaffected by parenthood. For example, there were perceptions that male therapists who were fathers could

continue to work full-time, not have to consider childcare, be more available for the few emerging senior positions, and dedicate time for professional development. This was linked to male privilege.

Male privilege and their discipline choices was a popular topic (N=40 - SLTs=23, stakeholders=17). While female therapists could typically avoid competing with men given their minority status, men were deemed privileged in career progression. More than a half of all therapists observed men within the profession to quickly progress into management within the NHS and academia, and be disproportionately represented there. Stakeholders also echoed the same sentiment.

> *"…even though just a quarter of our workforce are male, on the higher pay quartile we have more men that we do have women." [Imani: Black British, female NHS stakeholder]*

The main reason given was male privilege associated with their perceived qualities and societal expectations shaped by gender stereotypes (e.g., as breadwinners), which afforded men more power than women. Both stakeholders and therapists thought men had personal qualities which steered them towards career advancement. For example, men were thought unaffected by upsetting people, and entitled or confident enough to pursue opportunities even if not the best or sufficiently experienced candidate. They were assumed to dislike or were unable to cope with clinical work, and prefer leadership. So, the erosion of NHS senior positions affected male therapist retention.

> *"…we're kind of on a downward wave at the moment in terms of the grades of the NHS like grade 8a, grade 8, grade 8b. They're kind of disappearing…when that happens, a lot of bright, capable people just think okay this isn't for me. So, maybe there are more men within that group than there should be…" [Patrick: White Irish, male university stakeholder]*

Therapists thought men's novelty within the profession made them memorable, attracted clients, and possibly helped secure jobs in organisations wanting to be representative. They spoke of sexist systems comprising of unconscious bias, in which men were paid more, automatically assumed to be leaders, or were groomed for management. Some male therapists acknowledged male privilege, with one stating that he overcompensated at work to avoid favouritism accusations. Stakeholders thought men were not systematically disadvantaged, yet they received a lot of academic research attention.

> *"…look this isn't like racism, or homophobia, or Islamophobia because men aren't oppressed you know. Men don't suffer discrimination… there have been several PhD theses specifically on men… [the RCSLT] gender working group seems to spend all this time talking about men. You go, hold on. We're a 96% female profession, and the gender group is…spending all this time talking about men." [Matthew: White British, male, leading professional body stakeholder]*

In contrast, female therapists' management potential was linked to their personal qualities (e.g., preferences) or structural factors (e.g., maternity). For example, therapists thought women lacked sufficient knowledge about senior positions, disliked their associated stress and working patterns, or preferred clinical work which was almost absent within them. Women were presented as lacking confidence in ways that hindered progression, such as doubting their knowledge or abilities, despite sometimes exceeding the experience of some men in leadership. Even women in senior positions within SLT faced gendered biases, especially if they were from minority ethnic communities.

> *"I still go to meetings where… I say something. I'm ignored. And then a man says it, and then he's not ignored…And you never know in those situations do you…is it because I'm a woman that you've ignored me, or is it because I'm a Black woman that you've ignored?" [Anita: British Indian, female, leading professional body stakeholder]*

7.3.3 The role of sector specific issues

Recruitment, underfunding, and work intensification emerged as key barriers to the representation and progression of minority groups within the profession, especially in the NHS.

"...it comes down to a government thing where we're understaffed, we're under resourced, and we're certainly underpaid" [Kathryn: White Other, female SLT]

Austerity and government cuts to NHS SLT services caused Trusts to restructure which de-graded therapists, flattened salaries and progression, and unravelled the pay progression afforded by the Pam Enderby case (see section 4.1).

"That's why it was so disheartening and actually kind of devastating when the restructure took place... all of the hard-won things that happened at European Court of Justice were just disintegrated in an instant… for example, my pay which I'd worked so hard to get, my banding was just taken away." [Lauren: White British, female SLT]

The loss of clinical leadership and expertise was an emphasised negative impact. Eileen framed funding as a more urgent priority over promoting diversity in SLT because it was a futile, tokenistic exercise if the profession did not survive.

"We're talking about a profession I think that's trying to survive… the resources are so, so, so thin on the ground… really doing the job…and being trained on job by experienced therapists who've done it as longer than you, they hand their skills down…that kind of legacy of generations has been completely depleted, and so even the trainers who are training therapists…have got very little experience of doing the job...How can they be Speech Therapists if they're not doing the job?" [Eileen: Anglo-Irish, female SLT]

A higher earning potential was associated with the private sector than the NHS, but it also had financial downsides, mainly for female sole traders. For example, they struggled with billing/charging (see section 6.1.2.1), and pregnancy was linked with financial instability because payment relied on having clients. In contrast, men were thought better paid. So, NHS struggles to recruit therapists provided back-up job opportunities for sole traders.

"Really, I'm kind of living month by month…I'm making enough money now, and I also know that I can fall back…I could get a job in the NHS. I mean I get emails from recruiters every day. I know that they're struggling, and I know that I could get a job there now." [Danielle: Multiracial British, female SLT]

However, stakeholders thought that securing an NHS job involved facing unconscious biases and discrimination during shortlisting and interviews processes, which affected under-represented groups. They tended to cite research and statistics to support their claims.

"…if the organisation is run by White men and they happen to sit on interview panels, then there's a likelihood that White men will have an affinity towards White men, and then more White men will get recruited into more senior roles... that's just the way in which we construct interview questions, the qualities that we look for will be designed by the people who run the organisation... that's not consciously bias. It just means that you are operating and behaving in the way in which you've learned to operate and behave based on your background, your training, and your experience." [Oliver: White British, male NHS stakeholder]

Therapist's work in the NHS was perceived as being managed in a business-like manner. Specifically, this involved managing high caseloads and client expectations with little time or having to work extra hours. For example, one therapist recalled having 180 cases on her first day. Also, there was a focus on balancing key performance indicators (KPIs) with service quality and non-clinical administrative tasks (e.g., professional development) with limited resources.

"There's only so much money and there are only so many staff…we have to manage how we can see those children…we're commissioned to provide a certain number of contacts. So, to see a contact is when we see a child... we're monitored monthly on how many contacts we've achieved. We're monitored on waiting lists…lots of different KPIs…that does add pressure, and it absolutely does impact on job satisfaction." [Stella: White British, female SLT]

So, there appeared insufficient time to perform clinical work (i.e., therapy), especially at senior levels, and such work was perceived decreasingly valued. For example, some therapists acted almost like consultants as clinical work was dispensed to others to deliver (e.g., teaching assistants).

> *"…over the last sort of you know 20, 30 years, now it's just a case of the therapist goes in, gives a programme to the learning support system [*school support staff such as teaching assistants*] who gets paid 2p a week and is asked to do the work… if I was a neurosurgeon, and I go right well I'll give you a diagram and I want you to do the surgery. Well, no bloody neurosurgeon…with their right minds would even consider that. But we will." [Eileen: Anglo-Irish, female SLT]*

7.4 Recruitment, progression, and flexible working practices

Diversity practices around recruitment, progression, and flexible working are discussed here as they are directly relevant to career advancement.

Recruitment processes were presented as biased. Therapists had mixed views; some thought recruitment processes were fair and merit-based (see section 7.3.1), but also considered whether positive action/discrimination (e.g., quotas) was being used to redress workforce inequalities. White and minority ethnic therapists considered the impact of positive action/discrimination on their careers. Both were disadvantaged, as the former worried about losing out on opportunities, and the latter doubted why they were recruited. Lian emailed after her interview to state:

> *"There is a push to have more people from diverse backgrounds at higher levels, resulting in, for example, some changes in recruitment. Whilst I appreciate the good intention behind this, it actually adds a layer of difficulty for me. I don't know, for example, if I was appointed to my current role because of my race (and the Trust's attempts to increase diversity) or because I was actually the best person for the job. I*

also don't know if other people are wondering this. I hope my race is not a factor in any decisions about opportunities for me, positive or negative, and that I am judged on my abilities." [Lian: Chinese, female SLT]

Diversity stakeholders were more aware of current recruitment practices than therapists, but focused mainly on shortlisting and interviews. They identified bias as the core issue and thought practices aimed at tackling it (e.g., diverse interview panels and unconscious bias training) lacked an evidence-base or accountability frameworks. Trust diversity documents did not outline repercussions for noncompliance with any diversity-related recruitment practices, although the language by one (e.g., "must have diverse candidate shortlists") implied a sense of obligation. Some stakeholders lacked agency to directly shape recruitment practices and faced resistance from senior leaders. So, they tried to indirectly influence NHS systems. For example, stakeholders targeted managers because recruitment was in their remit, but could not mandate them to adopt their practices (e.g., recruitment toolkits for managers), or collaborated with bodies that recruited therapists (e.g., university).

"...most of the things that people are doing will make no difference…most organisations are doing things and if you say to them 'why are you doing this? Why do you think it's going to work?'. They cannot answer the question…I'd say 'why are you doing that? I'm not against it but where's the research that says that's going to make much difference cos there isn't any'. 'Really?' 'So why did you?'. 'Everybody's doing it... we're doing it because they're doing it'… if you were a doctor, you'd expect to be able to explain why what you've decided to do is the best thing to do in the circumstances. Human Resource Directors have never had that challenge." [Isaac: Jewish, male university stakeholder]

Progression-related practices were a common theme, predominantly discussed by stakeholders. They focused on upskilling under-represented groups, and diversifying and educating leaders. Stakeholders highlighted many NHS and RCSLT positive action initiatives (e.g., mentoring, secondments, etc.) aimed at improving the leadership potential of the under-represented. Managers supported therapists' progression prospects by highlighting and encouraging them to apply to available higher band roles. NHS documents outlined diverse shortlists and interview panels for senior posts, management apprenticeships, and online

leadership/recruitment resources/guidance. However, access to informal opportunities and career navigation support was thought poor in the NHS (see quotes in section 7.3.1). Also, there was little mention by interviewees of practices addressing eroding NHS career structures or the broad devaluing of SLT's clinical work, other than RCSLT plans to build clinical excellence networks. However, NHS diversity documents outlined plans to revise clinical excellence awards processes to make them more inclusive and fairer, and to also increase clinical leadership places. Similarly, the only structural practices mentioned to improve progression were some plans or recommendations by just stakeholders to change therapist's job roles (e.g., advocating to therapist's ability to prescribe), contracts (e.g., adding race metrics), or recruitment strategies (e.g., clarifying career pathways).

Attempts to diversify NHS leadership used targets (e.g., 19% ethnic representation at all NHS levels). Stakeholder references to educating leaders were mostly about raising their awareness of employee experiences by connecting to their staff and teaching cultural sensitivity. Examples included reverse/reciprocal/career mentoring/coaching, and role modelling such as being seen to talk about diversity or listening sessions with staff. The goal was to develop visible "compassionate and inclusive leadership" as outlined in the NHS People's Plan (NHS England, 2020b, page 28). Leadership's decision-making was being addressed because *"the current the sort of the criteria for merit is greatly influenced by those who have succeeded" [Isaac: Jewish, male university stakeholder]*. Reception to these practices was mixed. For example, some thought mentoring encouraged emotional engagement so *"these become real issues, don't they? I mean as opposed to just people and statistics" [Oliver: White British, male NHS stakeholder]*. However, others were more critical. They highlighted how mentoring was limited by numbers (e.g., one Trust document stated plans for 200 senior leader mentors), the benefit to mentees was unclear, and some mentoring initiatives were yet to be launched.

> *"I don't really know what the person who's like the bottom person, the lower Banded person is getting out of it hugely. I can see what the top person might be getting out of it in terms of like information about what's happening on the ground floor." [Amelia: White British, female trades union stakeholder]*

Flexible working policies were mostly discussed in relation to female NHS staff for maternity and caring responsibility purposes. The SLT profession and NHS were seen to be accepting of,

and offered, better work-life balance relative to other organisations or sectors regarding flexible working (e.g., part-time or working from home) and leave options (e.g., carers leave). This NHS policy approach was thought business-driven, particularly for attracting and retaining staff. Yet, some therapists still thought NHS flexible working policies were not flexible enough (see section 7.3.2), and the use of annual leave to manage caring responsibilities as unfair. Both were seen to affect women more. For example, some therapists thought the push to work core hours or a minimum of three days per week was incompatible with the time needed for caring responsibilities or perform enough private work. The scale of the NHS was thought a barrier to the policy's quality and pace of change.

> *"I was fully expecting it to be completely family friendly…and it was terrible… the reason is because it, the NHS is frightened of making changes because once it makes a change for one group, it's going to affect everybody. So, it's going to affect that 1.5 million staff, yeah. So, any change has always got to be quite gradual and quite progressive…and I think in that sense we are, we can get caught up sometimes, and we can be a little bit behind the curve just purely because of the numbers." [Joel: White British, male NHS stakeholder]*

However, NHS diversity documents did state concentrated plans to increase flexibility which could address therapist's concerns. Plans include making flexible working a default and day one consideration with NHS Board support, use of e-rosters, and normalising conversations about flexible working. One Trust mentioned carers passports to increase recognition and support for staff with caring responsibilities.

7.5 Awareness of diversity issues within the profession: Privilege and practices

Some diversity practices raised awareness of diversity issues within the NHS or SLT (N=45). The main methods were using metrics and having discussions which heavily focused on ethnicity than gender. Gender issues were of little or no concern, because whilst gender-related

career barriers were acknowledged, men were thought societally privileged, and women's issues were not thought widespread. The latter was driven by perceptions that women were overrepresented in the NHS workforce, only some professions were feminised, and pay privileges were reduced to medical sector bonuses.

Ethnicity was presented as a greater priority than gender because organisations were seen to reflect wider society's events and issues, which had a perceived emphasis on ethnicity at the time of interviews. The most cited societal events were the BLM movement[1] (stakeholders=17 and SLTs=11) and Covid-19[2] (stakeholders=18 and SLTs=17). NHS culture also prioritised ethnicity due to concerns about differential ethnicity-based staff experiences. Many factors seemed to play a role here, including staff voicing concerns or experiences, leadership prioritising it, more resources (e.g., appointments of race-related roles), workforce data showing systemic barriers, and organisational goals (e.g., reflecting and meeting the needs the diverse community being served).

> *"…the NHS is a mirror of our society…at the moment, race is very much on the agenda…and that is largely driven by the Black Lives Matter campaign …it's also you know driven by a whole host of things that are going on within the NHS culturally… [and]…the disproportionate impact Covid has had on Black, Asian, minority ethnic staff." [Joel: White British, male NHS stakeholder]*

Both BLM and Covid-19 encouraged minority ethnic staff to share their negative career experiences, mostly through team/organisation-level meetings and collaboration in staff networks (e.g., BAME networks). NHS diversity documents also emphasised meaningful conversations. This included the use of toolkits to support conversations, dedicated EDI personnel as a support mechanism (e.g., EDI "champions", "allies", "guardians" and "ambassadors"), emphasis on minority ethnic voices, telling stories, and asking difficult questions. There was an emerging role of social media to share experiences (e.g., podcasts such as SLTea time), connect with other minority members (e.g., male therapists on twitter via #malespeechies) and criticise/feedback organisational responses to ethnicity issues (e.g., RCSLT BLM statement was criticised – see section 6.2.1). There were two main benefits to

[1] BLM movement terms included: BLM, George Floyd, George, Black Lives Matter(s)
[2] Covid-19 terms included: covid, corona, pandemic, lockdown, covid-19

such platforms. First, they were perceived as empowering people to share their experiences, which were mostly negative, and feel heard.

> *"…certainly, students of African Caribbean heritage, particularly through Black Lives Matter, have been going, 'No, I've got stories to tell you about how I was treated'." [Matthew: White British, male, leading professional body stakeholder]*

Second, in doing so, diversity issues were highlighted to their organisation and colleagues who were shocked to hear them, but could learn about them and then encourage action. Subsequent actions were mainly more conversations, self-reflections, and the free exchange of information (e.g., sharing of resources such as newsletters, etc.).

> *"…the network has increased my awareness of what other colleagues face within a workplace…It's increased my perseverance to get sort of names correct… and sort of just constantly learning…I think it's a very small step to continuing to change lots of wider things… that's sort of like on the ground how it changes. But then I think it's really impacted what kind of policy I think needs to be really embedded within the workplace and within the culture." [Isabella: White British, female SLT]*

However, there were three notable challenges associated with raising awareness of diversity issues. First, there was a perception that senior and White organisational members should drive diversity change because their privileged positions afforded power (see section 7.5.1). Yet, they found it difficult to talk about ethnicity because *"it's scary to think that you might be considered racist, or the organisation might be considered racist" [Leah: White, female NHS stakeholder]*. However, the NHS diversity documents analysed seemed to be targeting such groups with plans to host seminars, training, and allyship programmes around ethnicity. Also, senior-level buy in was to be encouraged for ethnicity-related celebrations (e.g., Black History Month, which is the annual one-month remembrance of important African figures and events).

> *"I got into quite a lot of boards, and I'm constantly amazed at how people who are on £200,000 per year almost open the conversation by saying 'we find it really difficult to*

talk about race'…it's been there for years. Nobody's talked about it." [Isaac: Jewish, male university stakeholder]

Second, under-represented groups were expected to lead on diversity issues. For example, there were many anecdotes of minority groups being pressured to talk about their ethnicity-related experiences: *"…I wasn't ready to volunteer like my experiences in front of a bunch of strangers on zoom" [Aisha: British Bangladeshi, female SLT]*. Also, staff networks were used as a source of information, including awareness of diversity issues.

"…let's ask the BAME network what they think, which is dumping the responsibility on them that the HR team should have. So, it's absolutely right that the BAME network lived experience should influence the determination of people to do stuff and is a really good rain check on whether what you're going to do is going to work, but it's not their job to come up with the technical solutions. That's the job of HR." [Isaac: Jewish, male university stakeholder]

Finally, there were barriers to engaging in diversity discussions or staff networks. For example, their voluntary nature affected participation rates, workloads restricted time, there was participation fatigue, and a lack of trust in organisations and their processes. Suggestions to improve engagement highlighted gaps, such as making them more active and demonstrating their impact.

"…involvement in any groups we have drops off and I think some of that is trust in the organisation, some of it is fatigue…there's been a lot of sessions about talking about what's happening and talking about your experiences, talking about what it's like to work here. After the first five or six sessions, you can't be bothered. You're fed up of talking about it…People have just had enough." [Gloria: Black, female NHS stakeholder]

Regarding diversity metrics, the NHS was seen to collect *"mountains of data" [Isaac: Jewish, male university stakeholder]*. This was perceived as a powerful tool by stakeholders to measure diversity issues, inform practices, and promote accountability. There was emphasis on NHS data, with WRES as the most cited ethnicity metric and legislative pay gap reporting most cited

gender metric. However, there were certain challenges. Whilst *"data can be stark, and it can tell a story" [Sharon: White, female leading professional body stakeholder]*, building a consistent narrative was difficult as Trusts could pick and choose metrics outside of their mandatory measures. Also, the NHS was thought to be bad at monitoring and measuring impact, and scrutinising data.

> *"...we don't often have senior managers that look at that data and go 'it doesn't seem right that we've had nobody raise racial discrimination in the past 12 months. Maybe we've got a problem.' You know that data is then not challenged then to make those changes." [Gloria: Black, female NHS stakeholder]*

Some of the NHS diversity documents analysed did not cite the evidence-base they claimed was underlying their diversity practices, nor explain how or why these practices would work. For example, some documents just listed their planned diversity efforts, whilst others provided some more detail (e.g., target deadlines). However, they did mention dedicated EDI resources (e.g., observatories, WRES, etc.) for creating an evidence-base.

7.5.1 The role of privilege

Perceptions of privilege underlay some justifications for claims of unclear or no impact of gender and/or ethnicity on therapist's careers. For gender, there was male privilege (see sections 7.1.2 and 7.3.2). For ethnicity, the term "White privilege" was introduced mostly by White interviewees, but described or implied by ethnically diverse stakeholders and therapists. White privilege, sometimes determined by comparisons with minority ethnic experiences, represented advantages given the perceived absence of negative career experiences for those who fit the professions image. So, White therapists were privileged with the absence of barriers (e.g., discrimination, not having to consider ethnicity, etc.), greater career or social inclusion opportunities, and automatic acceptance unlike their minority ethnic counterparts. For example, one White therapist considered how minority ethnic therapists may have mindsets of doubt about whether their ethnicity influenced careers.

> *"...I guess that's the way I've gone through, you know my career. Not ever thinking about the fact that I'm White because I've never had to, and that of course is the privilege…I can imagine that young women, that women who are not White probably*

do have that thought in their minds, and they're not, are not sure. Because I don't approach an interview panel expecting that they may have a preconceived idea about me. And somebody who approaches my interview panel doesn't need to worry about that, that might well worry about that." [Stella: White British, female SLT]

Also, White therapists could express their authentic self without conformity pressures because being White was the norm across the profession.

"It's really hard...there's nothing that I can think of that, no events that have stood out that made me think it's [i.e., ethnicity] played a part. But then equally, those advantages are invisible too, aren't they?" [Adam: White British, male SLT].

"…this immediate acceptance. This immediate similarity of skin colour. Very intangible…these stereotypes and prejudices run very deep." [Adam: White British, male SLT]

Danielle described the ability to use her ambiguous ethnic look to pass as White, and gain status.

"*I'm able to use myself…because of that chameleon-ism, like no one really knew where I was from…they knew that I had a British accent, and I most probably had a British passport. My name was an English name. So, already there was that. I was able to use my ethnicity as to gain in like status.*" *[Danielle: Multiracial British, female SLT]*

However, White privilege was seen to mask diversity-related concerns emerging from White therapist's ethnicity interacting with their social class and religion (see section 7.1.1).

7.6 Discussion of experiences within the profession findings

This chapter documented gender- and ethnicity-related professional experiences and diversity practices by corroborating accounts from therapists and diversity stakeholders. The interviews uncovered patterns of gender- and/or ethnicity-based marginalisation/disadvantage and

privilege encountered by under-represented therapists across their professional careers. An intersectional lens helped conceptualise these patterns as fluid and interlocking. Also, the business case for diversity is problematized through the concept of relatability to clients and/or colleagues which helps legitimise and maintain the profession's underlying White, feminised image. Finally, sector-specific nuances to therapist's experiences around maternity/caring responsibility issues and the broad devaluing of clinical work, and gaps between diversity practices relevant to addressing therapist's experiences were found. These findings represent empirical and theoretical contributions which are discussed below.

The thesis interviews uncovered context-specific patterns of marginalisation and disadvantage experienced by under-represented therapists across their careers, characterised by discrimination, bias, exclusion, and a lack of relatability to clients and/or colleagues. Some of these ethnic barriers in healthcare professions were documented before, but have not been studied well for therapists (see chapter four). These patterns were found for minority ethnic therapists in ways that signal the mechanisms of discrimination (interpersonal microaggressions and institutional), White privilege (both concepts are CRT and Whiteness assumptions and are described in section 4.3.2) and the concept of relatability (discussed below) in operation. Prior literature highlights how these processes subordinate minority ethnic individuals, which reinforces and hides racial inequality within organisations (Van Laer and Janssens, 2011; Ozturk and Berber, 2022). Aligned with Ozturk and Berber's (2022) research on subtle racism, there were examples of racialised microaggressions at individual and institutional levels for minority ethnic therapists (see section 7.1.1 and 7.3.1). At the individual level, all forms of microaggressions were reported; microassaults, microinsults, and microinvalidation (defined in section 4.3.2). Ascriptions of deficit or excess qualities by White colleagues were reflected in minority ethnic therapists encounters of racialised comments (e.g., curiosity and assumptions about their identity), bullying (e.g., public criticism), and social exclusion (e.g., alcohol-based venues indirectly excluding Muslim therapists from social events). Some therapists stated that managers displayed religious discrimination (e.g., not accommodating, and differential allowance for observance of, religious holidays) which indicates White employees as strategic coverers. Religious discrimination was mostly faced by Muslim therapists as students or in their early careers. Experiences of, or witnessing, religious discrimination at work are not uncommon in the UK (Savanta ComRes Faith Research Centre, 2017). NHS staff feel unable to bring their religious identity to work (Heliot, 2020), with

Muslim and Hindu groups the most discriminated (West, Dawson and Kaur, 2015) by clients and colleagues, which worsened from 2016-2020 (Limb, 2021). This is relevant as many therapists are NHS-based (see section 2.3.2). Honest lying is somewhat reflected in perceptions of senior NHS leaders as genuinely invested in EDI, yet they and White therapists were perceived as finding it difficult to talk about ethnicity for fears of being deemed racist. The latter may result in defensiveness against racism claims. From a CRT lens, some people may interpret racism accusations against societal systems as personal attacks because they have difficulty separating the two (Ray and Gibbons, 2021). CRT attributes racism to societal systems, not White individuals or groups, assigning them a role in dismantling racism, but they are not blamed for historical events (Ray and Gibbons, 2021).

Institutional discrimination is documented for the NHS (section 4.2.2), and shaped minority ethnic, but not male therapist's, subordination within the profession. There was evidence of whitewashing (e.g., diversity policies partly deemed an organisational risk management tool in discrimination cases – see Table eight) and upstream exclusion (e.g., just token minority ethnic individuals in senior positions or owning successful practices – see section 7.3.1)) (Ozturk and Berber, 2022) in SLT. Management denial of racism is a possibility as senior leaders and White staff were accused of finding ethnicity-related conversations challenging, and leaders did not scrutinise diversity data. Stakeholders also accused various NHS processes including recruitment, progression, and support mechanisms of bias against minority ethnic staff. So, frequently, British workers do not report discrimination based on protected characteristics nor offer support to those affected (Feldblum and Lipnic, 2016; Savanta ComRes Faith Research Centre, 2017; Zheng, 2020). Therapists were reluctant to report discrimination, potentially masking its scale within the profession. The reasons behind such reluctance mirrors those in existing literature including fear of repercussions and lack of confidence in support mechanisms (Pearn Kandola LLP, 2018; Zheng, 2020). My tripartite framework confirmed Whiteness and CRT's claims of Whiteness and racism as embedded across society: at macro (e.g., societal discrimination reflected in BLM and covid-19 pandemic), meso (institutional discrimination) and micro (therapist's microaggression experiences) levels. From both theory perspectives, perhaps White norms become entrenched in SLT employer's processes because Whiteness is not treated as an ethnicity which renders it invisible (e.g., see Puwar (2004)), and they are shaped by the dominant group (e.g., see Oliver's interview panel comment in section 7.4) thus structurally favouring White therapists, including exclusively affording them bonding social capital (defined in section 4.3.3). Conversely, these

processes undermine minority ethnic therapists by silencing their voices (e.g., poor grievance and support mechanisms) rather than uncover and challenge the status quo, and their underrepresentation means exclusion from bonding social capital (defined in section 4.3.3).

The concept of relatability to clients and/or colleagues represents a theoretical contribution which problematizes the business case for diversity as a tool for legitimising and maintaining SLT's underlying White, feminised culture. The value of underrepresented groups was linked to their ability to attract, work with, and meet the needs of, diverse groups (i.e., business and quality case for diversity - see section 4.2.4.1). For example, minority ethnic therapists were valued for using their cultural knowledge and skills to meet the needs of ethnically diverse clients, but also enabling their White colleagues to do so by sharing these assets with them. Similarly, male therapists supposedly offered different perspectives to women, with masculine traits sometimes framed as being better (see section 6.1.2.1 for examples), and attract/meet the needs of male clients. So, underrepresented therapists offer bridging social capital (defined in section 4.3.3). Whilst under-represented groups may benefit from being seen as more capable for a job because of their descent, it can also make them feel that their professional competencies are overshadowed by it (Van Laer and Janssens, 2011). For example, a Chinese therapist questioned if her ethnic diversity influenced her recruitment, rather than just her skills. If minority ethnic acceptance is reduced to what they may offer, they are pigeonholed into a specific racialised function that is used instrumentally by the dominant group, which reinforces their disadvantage (Van Laer and Janssens, 2011) and difference. Also, it exemplifies CRT's interest convergence principle where workforce diversity is embraced to serve the dominant group's interests (defined in section 4.3.2). Both upholds White dominance. This may overlook the possibility that minority ethnic therapists are simply skilled at their job. Also, framing a diverse workforce as a business asset is problematic, especially if a business case cannot be made or is not convincing enough (Noon, 2007).

The lack of gender and/or ethnicity-based relatability to colleagues resulted in the marginalisation of some men and minority ethnic therapists (e.g., inability to participate in some workplace conversations). Whilst curiosity about cultural differences may have sparked conversations and learning, comments about entire groups, questions, and compliments may imply and reinforce discourses of minority ethnic groups as foreign and so low status (Van Laer and Janssens, 2011). This was sometimes linked to their poor representation in the profession. White and male privilege protected against the negative career experiences discussed. Whiteness offered privilege (described in section 4.3.2), as White therapists

acknowledged that they did not face career barriers that minority groups encountered, namely having more career/social inclusion opportunities, and automatic acceptance. A novel finding was how societal events such as the Black Lives Matters movement and coronavirus-19 pandemic raised awareness of career experiences and privilege amongst White staff in the NHS and SLT more widely. An intersectional lens showed White privilege masks disadvantages where Whiteness intersects with gender and social class, and so privilege is fluid, a finding echoed in intersectional research on gender and ethnicity-based privilege (Atewologun and Sealy, 2014; Mavin and Grandy, 2016).

Similarly, SLT is feminised by the business case for diversity through its use and reinforcement of patriarchal and essentialised ideas of femininity and masculinity. Men were disadvantaged in entry to SLT (see chapter six) but were thought privileged in being welcomed and progression in SLT (i.e., glass escalator phenomenon (Williams, 1992)) despite their numerical scarcity, corroborating with literature of male experiences within predominantly female professions (Williams, 1992; Evans, 1997; Torre, 2018, 2019; Punshon *et al.*, 2019) (see section 4.2.3). This is likely a combination of men's minority representation in SLT allowing them to be easily remembered and considered niche, and Western society awarding men with greater status and power stemming from patriarchy and gender stereotypes (see section 4.2.3). Women welcome men in predominantly female professions because they are thought to raise its status and pay, but male expectations (e.g., ambitiousness) pressure men to seek masculine roles within them or leave (Evans, 1997; Torre, 2018, 2019). Conversely, despite SLT and the NHS comprising a predominantly female workforce, maternity/motherhood was a challenge for women. Gendered expectations burden women with the bulk of caring responsibilities, pushing them to seek roles with work-life balance (see section 4.2.3). Here, a sector-specific barrier emerged highlighting how gender intersects with maternity/pregnancy to structurally disadvantage women. Flexible working in the NHS was deemed not flexible enough. Whilst the private sector offered more flexibility with working hours and greater income potential, it lacked financial stability and maternity packages when women became pregnant unlike in the NHS.

The sector-specific nuances identified for therapist's experiences represents an empirical contribution given that they have largely been unaddressed in academic literature. These sectoral insights were around maternity issues (outlined above) and there was a broad devaluing

of clinical work (i.e., delivering therapy). The latter was implied via perceptions of other work as being of greater status (e.g., management and academia/research), and clinical work being dispensed to support staff in other occupations (e.g., teaching assistants). Also, in the NHS, workloads and eroding career structures at senior levels affected the value of, and opportunity to develop or access, clinical expertise. Increasing financial pressures on NHS England (Roberts, Marshall and Charlesworth, 2012; Robertson *et al.*, 2017) have negatively affected SLT services (RCSLT, no date). A 2014 RCSLT survey reported an average 10% budget/income cut across SLT services in the NHS, schools, and local authorities, with many posts cut, abolished, reduced, downgraded, or frozen (RCSLT, no date; Harlow, 2014). These cuts were expected to recur annually and detrimentally affect services, resulting in losing or downgrading clinical leadership, expertise/experienced therapists, and specialism. So, therapist's concerns about the gradual demise of clinical work will likely worsen. Therapists emphasised the value of clinical work which made some avoid seeking management because it lacked it.

Finally, comparisons of therapist's experiences with relevant diversity practices for the first time, exposed gaps between the two, representing an important empirical contribution. Some of these gaps echo the criticisms of common diversity practices including biased organisational processes (see section 3.3.1) supporting Whiteness and CRT claims that institutional discrimination reinforces and maintains minority ethnic subordination (see section 4.3.2), and highlight policy-implementation gaps in EDI work (see section 3.3.5), but are novel because they apply specifically to the SLT context. NHS and university shortlisting and interviewing processes were thought biased. Therapists reported a lack of support mechanisms across the profession. Some stories were shared about managers who behaved discriminatively, and there were perceptions of bias in, poor awareness of, and lack of diversity amongst staff in, NHS support mechanisms. Whilst diversity policies were a tool to address bad staff or organisational behaviour on an as-and-when-needed basis, they were thought insufficient by themselves, and there was poor awareness, engagement, and implementation of them. Also, progression activities focused on upskilling minority staff and educating/ diversifying leaders. "Fixing" minority groups by upskilling them frames them as being culturally deficit in important ways compared to the dominant group, signalling that they are to blame for their own challenges (Song and Pyon, 2008; Davis and Museus, 2019). Diversifying leaders may not equate to better experiences for minority ethnic staff. For example, the CEO of the RCSLT was an Asian woman, yet the Association was criticised by therapists for its BLM response.

Little or no emphasis was given to addressing structural barriers, such as institutional discrimination claims by stakeholders and the erosion of senior NHS positions. Challenging inequality is hard if it is seen as fair on an individual basis (McVittie, McKinlay and Widdicombe, 2008). Simply focusing on individual biases neglects organisational culture (Gaertner and Dovidio, 1986; Noon, 2018).

Practices around raising awareness of diversity issues across the NHS and profession were at the very early stages of conversations and so are unlikely to improve issues until there is a transition to action. Discussion platforms allowed therapists to share their negative experiences from which colleagues could learn about them, but this places a burden of educating colleagues and being the spokesperson for diversity issues, on minority ethnic staff. Treating minority ethnic individuals as representatives of their ethnic group is subtle discrimination, which may make them feel that their professional competencies, and broader personal identity or individuality are overshadowed by their descent (Van Laer and Janssens, 2011). Also, these discussions focused on ethnicity, which potentially overlooks gender issues (e.g., issue of NHS flexible working policies as not flexible enough). Whilst diversity metrics may be used to uncover and monitor diversity issues and diversity practice impact, the profession lacks data on ethnicity, and the NHS was accused of not properly monitoring or scrutinising their abundant data resources. For example, stakeholders accused NHS senior leaders' of blindly following diversity efforts, and not questioning available data. The NHS and RCSLT are invested in building an evidence-base for diversity issues (see section 4.1 and 7.5). Unfortunately, evidence-based management *"is underdeveloped, misunderstood, misapplied, and implemented inconsistently"* (Briner, Denyer and Rousseau, 2009, page 19).

Overall, this chapter offered unique insight into how therapist's gender and/or ethnicity shapes their professional experiences, with emphasis on how under-represented groups are negatively affected. Various diversity practices seemed relevant to addressing the issues identified by therapists, but each has limitations which may maintain the profession's diversity concerns. These findings were discussed in relation to their empirical and theoretical contributions to the extant literature on gender and ethnicity-related experiences in SLT and the UK health sector more broadly.

CHAPTER 8: FINDINGS: DIVERSITY APPROACHES AND STAKEHOLDERS IN THE PROFESSION

The first two results chapters explored the experiences of therapists related to their gender and/or ethnicity across their career (*research question 3*), and relevant diversity practices for addressing the issues were identified (*research question 2*). This chapter draws on the SLT and stakeholder interviews, supplemented by NHS diversity documentation, to build on these two results sections by addressing the theoretical aspects of the thesis research questions. First, it examines the evidence of both diversity management and equal opportunity approaches underlying the diversity practices in the SLT profession (*research question 1*), and discusses its negative implications for the profession's diversity efforts. Second, it explores the impact of diversity practices on therapists' careers (*research questions 3*). The awareness, engagement, and implementation of diversity practices, particularly of diversity policies, emerged as key barriers to impact. Here, the dispersed accountability of key stakeholders within the profession, and lack of accountability frameworks within diversity practices, made it unclear who was responsible for driving the profession's diversity agenda (*research question 2*).

8.1 A hybrid diversity approach to managing SLT workforce diversity

There were examples of both diversity management and equal opportunity approaches to addressing SLT workforce diversity. I must note that my judgements of the overall approach of practices depended on how much detail interviewees provided about them. The RCSLT and NHS diversity efforts were discussed the most in interviews overall. However, there was some insight into diversity activities in other sectors (e.g., academia) because the stakeholders interviewed were from varying backgrounds.

Many of the diversity practices discussed across the first two results chapters align with a diversity management approach, in that they are individualist, voluntarist, and business based (see section 3.1.2). First, diversity management is individualist because it focuses on recognising and valuing individual differences, with the expectation that this will translate into productivity, meeting organisational goals, and maximising workforce talent (Kelly and Dobbin, 1998; Kirton and Greene, 2005b). The perceived benefits of diversity emerged as an important theme during interviews (N=45), which heavily focused on how a diverse SLT workforce can meet the diverse needs of the populations being served (see section 7.1). Also, some of the diversity practices in the profession can be considered individualist (see chapter seven). There were examples of NHS diversity practices trying to 'fix' under-represented therapists or placing the onus of driving diversity change on them rather than the organisation. For example, references to career progression measures focused on upskilling minority ethnic staff or using such staff to educate leaders about their lived experiences (e.g., reciprocal mentoring). Also, whilst NHS diversity policies, disciplinary processes, and team/organisation-wide ethnicity-related discussions applied to all staff, they relied on individuals voicing concerns and/or treated issues on a case-by-case basis (see sections 7.2 and 7.5). So, some stakeholders advocated for proactive approaches to identifying and resolving diversity issues.

> *"You need to be proactive to triangulate a range of data, find out where the issues are. So, for example, if it's the case Speech and Language Therapists is very obviously overwhelmingly female and White, go find out why. Don't wait for the one BME speech and language therapist in the Trust to say 'I feel very uncomfortable here. I don't think I'm being treated fairly'. That is not going to solve the problem." [Isaac: Jewish, male university stakeholder]*

An individualist focus may de-emphasise or overlook structural issues. Interviewees criticised, and in doing highlighted the gaps in, the different organisational processes across a therapist's career. The first two results chapters outlined the barriers that under-represented therapists faced in education (e.g., lack of diversity across SLT curriculum content and staff), recruitment (e.g., bias in shortlisting and interviews), and their daily working lives (e.g., institutional discrimination and poor support mechanisms). A lack of awareness, engagement, and implementation of diversity policies is discussed in section 8.2.4.

Second, a diversity management approach is voluntarist and so diversity efforts are typically based on whether there is a business case for it. Only three gender and/or ethnicity related practices were stated to be mandatory, and they were all in the NHS: the collection of certain diversity metrics (e.g., WRES), ethnic representation targets by the CEO at the time of interviews, and induction/statutory training which did not always cover EDI. Staff participation across all other specific initiatives mentioned in interviews were explicitly stated, or implied, as being voluntary. For example, uptake of materials (e.g., a Trust recruitment toolkit and RCSLT guidance), participation in discussions about ethnicity/staff networks (e.g., staff engagement identified as a barrier – see section 8.2.4), and various training programmes were stated as being voluntary. Stakeholders outlined how the voluntary nature of diversity activities could restrict their engagement.

> *"…not all clinicians come to training. It's usually the ones that are taking students for the first time who'll come to training...It's not mandatory… so there will always been some that you don't reach and we're talking about well what do we do?" [Leyla: Asian, female, university stakeholder]*

However, mandating activities outside of legislative compliance was not easy.

> *"The legal side of it is mandatory…However, the certain toolkits that we've put in place to really enforce some of that, they are not yet mandatory. But they're not always mandatory because the Trust isn't invested. There's also something about how do we make things mandatory necessarily in such a widespread, diverse organisation in terms of the services we offer, how our clinics run, community services, inpatient services? It's not just as straightforward as making something mandatory straight away because we have to see how we need to adjust those practices based on the communities that some of our services are in." [Gloria: Black, female NHS stakeholder]*

Also, NHS and RCSLT diversity efforts were thought business driven by interviewees, which was also signalled in NHS diversity policy documents. For example, in the NHS, staff experiences were linked to quality of patient care and attracting/retaining staff. Also, diversity policies comprised of protection/accountability motivations linked to legal compliance (e.g., the Equality Act 2010). They were deemed a risk management strategy to protect the NHS from tribunals (see Table eight).

> *"…diversity means more productivity, you know better patient care, you know better ideas, you know better teamwork, etc." [Ajay: Indian, male NHS stakeholder]*

The RCSLT were presented as using business arguments to advocate for their profession in the NHS. They highlighted a short supply of therapists in the NHS workforce, and the importance of recognising and meeting patient SLT needs. The latter involved demonstrating therapy impact to get financial investment.

> *"…unless you can prove your worth and your value, you know, to those who fund services, that it's very hard just to say 'Yes, I think I'm great. I think I do a really good job'…we're not in a medical model profession, you know, like a hip replacement that you can count. 'Yes, I've done this many hips'. It's a bio-psychosocial model of care. So, what we have to do is support the profession to measure their impact in an area which is more nebulous, you know, because it's around communication…How do we measure that impact of early intervention for children? For adults?...we're not going to bring them back to where they were, post-stroke, but how are we supporting them in terms of their wellbeing? How are we supporting them in terms of their quality of life, if they've had a stroke, or a head injury, or have got MS? So, it's all about the patient and how we support our profession to be the best they can be in delivering that care." [Anita: British Indian, female, leading professional body stakeholder]*

However, some diversity practices aligned with an equal opportunity approach. First, some diversity practices collectively applied to all staff or specific groups based on their protected

characteristics. Collectively treating all employees equally (i.e., collectivism aligns with a sameness approach - see section 3.1.2.1) was problematic in some instances. For example, NHS policies and processes that applied to all staff seemed to disadvantage specific staff groups. Their policy of a minimum three-day per week work commitment disadvantaged women who needed greater flexibility (see section 7.4). Also, disciplinary and recruitment processes were thought biased against minority ethnic staff. Some diversity practices targeted under-represented groups, such as positive action programmes to upskill and so improve the progression prospects of minority ethnic staff. However, one NHS stakeholder noted how the differential experiences between minority ethnic groups needed to be considered.

> *"…some BAME people, especially Indian BAME people who might have more means than Black BAME people, a lot of them still don't know we have any race issue. Because they go to school. Their parents pay for everything. They become a doctor, and they come in and they go 'well, I just work hard. We don't have an issue'. Right. So, for even for some BAME people who will make it the top, they still don't realise we have an issue because they have the means." [Sunita: Indian, female NHS stakeholder]*

Second, NHS diversity policies were shaped by legislative compliance and social justice/fairness motivations, although there were aspirations to go beyond the former. Such motivations are a characteristic of traditional equal opportunity approaches in the UK and were signalled in interviews and the NHS diversity documents analysed (see Figure 10 in Appendix 14).

> *"…[as] the well the fifth largest employer in the world, and certainly the largest employer in Europe, and certainly the largest employer within the UK, you know we know that the NHS has got responsibility to be an exemplar…we're always pushing organisations to go beyond the legislation and to make sure that they aspire to a much higher level... we talk about creating you know a good place to work and being a good employer..." [Joel: White British, male NHS stakeholder]*

Also, legislative compliance underpinned NHS diversity efforts. Some interviewees mentioned the Equality Act 2010 in general, whilst others specifically referenced the PSED within it. The

latter involves proactive actions and not just a sameness/anti-discrimination approach.

> *"...each individual organisation is also responsible for ensuring the Equality Act is properly implemented… influence is interesting. It's an interesting word, but we talk a lot more about accountability and governance because ultimately that's what it's about…there is an element of you know making sure that you are doing the right thing and that you are not breaching legislation." [Joel: White British, male NHS stakeholder]*

Also, equal opportunity approaches are commonly criticised for framing diversity in a negative way (see section 3.1.2), which was highlighted by interviewees. For example, diversity policies were thought motivated by legislative compliance and protection/accountability concerns (i.e., protecting employees and organisations from negative outcomes - e.g., tribunals). One therapist thought such policies should promote positive guidance.

> *"…it's kind of a shame that it's only used in that sort of negative way for holding people accountable when something goes wrong. Whereas, actually it would be better to have it in a sort of more positive way…where it's kind of guiding things that are done actively to make a difference, and that's what I think doesn't really happen." [Jessica: White British, female SLT]*

However, the terminology used to describe EDI personnel within Trust diversity documents and the NHS People Plan signalled a more pro-active EDI stance that went beyond compliance. For example, they were called "fairness champions", "inclusion allies", "well-being guardians" and "freedom to speak up guardian".

8.2 Poor practice impact and the dispersed accountability of stakeholders

Interviews and organisational diversity documents identified several stakeholders as shaping the diversity agenda within the NHS and/or profession (see Figure 11 in Appendix 14). However, it was unclear which stakeholder was responsible for driving the agenda, and there was no shared perspective on what the solutions ought to be. Some stakeholders were thought important based on their power to mandate using funding, legislative, and regulatory measures (e.g., the government, Health and Care Professions Council, etc.). The UK NHS and RCSLT were the most cited stakeholders. They were presented as directly shaping the profession's diversity agenda, based on their mandating powers and job remit. Leaders were deemed the most influential intra-organisational stakeholders within them because they endorsed diversity, offered relevant support, and were role models. However, there were also perceptions that diversity was everyone's responsibility. Both organisation's agency, in terms of their capacity to act, was challenged by capacity/scale issues and lack of awareness, engagement, and implementation of diversity practices. Also, societal issues seeped into organisations (e.g., see BLM and Covid-19 references in section 7.1.1 and 7.5). Embedding accountability within organisational diversity practices was seen as an important way to address these challenges.

8.2.1 Organisations with mandating powers

The government was identified as a broad and direct driver of diversity within SLT based on their power to mandate legislation and allocate funding for public services. For example, legislative compliance underpinned important NHS diversity efforts, such as diversity policies, and reporting of certain diversity metrics (e.g., gender pay gaps). Also, their funding allocations were linked to access and progression barriers for under-represented therapists (e.g., removal of SLT bursaries and NHS service funding cuts criticised – see sections 6.1.3 and 7.3.3). Other stakeholders were thought to have the capacity to, but did not currently mandate practices, as regulators (e.g., Health and Care Professions Council regulates professional standards) or funders (e.g., Health Education England funds university recruitment) in the profession.

8.2.2 The Royal College of Speech and Language Therapy (RCSLT)

The RCSLT was deemed an influential stakeholder directly shaping the profession's diversity agenda because they represented the profession. They were expected to meet therapist needs as membership was paid, and had access to sources of influence (e.g., government and media attention).

8.2.2.1 The role of the RCSLT CEO

There are limits to how much one individual can shape an organisation. Section 3.2 discussed how diversity actors vary in their power in relation to one another. For example, the impact of diversity officer's work depends on senior management support. The manifestation of the latter's EDI commitment requires middle-management implementation. Yet, there was a focus on RCSLT governance, with particular emphasis on the current CEO being a minority ethnic woman. Some interviewees thought that the RCSLT CEO was a symbol of diversity, but others felt she masked the profession's diversity issues. The CEO was perceived as genuinely interested, and actively involved, in addressing the diversity issues facing the SLT profession. For example, there were many stories of the CEO directly speaking to therapists to listen to their experiences and offer help.

> *"I wrote an email to the Chief Exec… and someone wrote straight back to me and said the Chief Exec wants to phone you. Are you available? Straight on the phone. I had an hour-long meeting with her… she was great. She really listened. She's from an ethnic minority herself. She had faced discrimination herself. So, I think she felt that she understood, but she hadn't understood that the College's position wasn't standing up and saying 'look we're not standing for any racism within our profession'… by the end of the next day, they had created this brilliant statement which they released…finally felt 'oh I'm in a profession I belong in. I finally feel like yeah, I'm in a profession that shares my values'…It was a clear statement of anti-racism" [Leyla: Asian, female, university stakeholder]*

The CEO position meant action over the RCSLT's operational matters, regarding shaping priorities, restructuring the Association, and lobbying external stakeholders, in ways that addressed SLT diversity concerns. For example, she was mentioned as restructuring the organisation to create new job roles (e.g., investment in public relations/communication roles),

and have fewer committees which meant faster responsiveness to issues. She also lobbied external bodies in the education (e.g., working with universities to review recruitment) and healthcare sector (e.g., sat on top NHS strategic Boards). However, some interviewees thought she was institutionalised, politically swayed, and distant from their clinical work concerns.

> *"I think the problem is that our professional bodies have become too in lockstep with the politics of the day…they need to stand by the clinical work… they need to go back to the clients…I think she [RCSLT CEO] understands that but…I think the problem is when you're in that role for so long, and you're so connected, and so in lockstep with the policies, and the documents, and the groups, and the this, and the that, it's like another world." [Eileen: Anglo-Irish, female SLT]*

8.2.2.2 EDI expectations conflict with agency

Overall, the RCSLT's influence on the profession's diversity agenda was presented as indirect and loose. Their agency was restricted by lack of control over societal issues (e.g., UK austerity), inability to mandate actions (e.g., guidance was voluntary), and limited reach or capacity due to their small size (52 staff representing ~18,000 members). The latter was an asset for facilitating quick changes and engaging closely with members, but this also limited their ability to get public attention. Their small organisational size was thought to restrict how much presence they had across sectors employing therapists and the media, including insufficient funding for large media campaigns. Tactics to overcome capacity restrictions included changes to the RCSLT's governance structures to be more responsive (see section above) and suggestions to collaborate with other smaller AHPs for a greater voice.

> *…It's okay for me to do a few talks in school where people, where there might be more Asian people or Black people, or more working-class people, or any combination of those things…that's one school, and it's very difficult…So, I need all Therapists in my area to do this stuff and that's again taking away from their clinical practice. So, again you kind of faced with pragmatics of how do we raise awareness?" [Nathan: White, male, leading professional body stakeholder]*

Their main tactic comprised of lobbying and collaborating with various stakeholders to discuss and consider SLT diversity issues. For example, they worked with trades unions for pay issues,

universities to address recruitment issues, and the government to influence policy (e.g., highlighting speech therapy provisions in, or need for funding of, local services). Sometimes the RCSLT indirectly influenced organisations through their members and networks (e.g., targeted members with NHS managerial positions to consider their recruitment concerns) or used their organisational priorities as a lever.

> *"You do not have the power as a single organisation to make anything stick…It's how do we then work within the system. So, it goes back to the importance of this letter from Simon Stevens, and the importance of the NHS itself responding and waking up to what it needs to do if it really wants to be representative of the populations it serves. So, you know how do you use this as a lever?" [Anita: British Indian, female, leading professional body stakeholder]*

The NHS CEO, Simon Stevens, wrote a letter to NHS leaders in England about implementing the third phase of their Covid-19 response (NHS England, 2020a; Royal College of Speech and Language Therapists, 2020b). The letter outlined diversity commitments, particularly around addressing ethnicity-based inequalities for staff and patients.

As an Association, the RCSLT was presented as having a responsibility to meet the needs of its members. They scoped members' diversity-related concerns using various platforms (e.g., webinars, networks, and surveys) and offered associated support. For example, guidance, creation of clinical upskilling opportunities like clinical excellence networks or helping therapists on advanced cases. However, RCSLT diversity efforts and support were heavily slated by some interviewees. Their Bulletin magazine was accused of being heavily shaped by the work of therapists without properly acknowledging them, and lacking content on or framing diversity negatively (e.g., articles on pronouncing names incorrectly). Some therapists said that they were unaware of, or were not invited to, RCSLT diversity activities. They were accused of being disconnected from therapists, and failing to extend support to members working abroad.

> *"… I've noticed that sometimes before, I've written something…And two days later, this, the College came out with another policy about you know [what article is about]…they're influenced a lot by what clinicians write, but it's not very acknowledged. But I can just see the pattern of how close it comes after I've written*

something usually quite assertive you know...[Interviewer: Sounds like they're listening, which is good.]… yeah, but not in a very invited way." [Alice: White British, female, SLT]

Also, the RCSLT was thought to lack proper data on diversity issues facing their profession. For example, they relied on anecdotes or external data sources (e.g., NHS data). There were intentions to address data gaps using post-anti-racism event surveys to establish baseline diversity data, and to introduce ethnicity data collection on their internal membership system. However, many therapists felt they were over-surveyed and wanted more direct contact. There were also concerns of potentially offending members when creating ethnicity classifications for the membership system.

"…wouldn't be lovely if they just stopped sending us these bloody surveys and just kept saying you know is there something that you think would make a direct, a good impact in the profession…? I think they should invite members and have regular brainstorms…the other idea I had was to ask that the lead of the Royal College to go on the road more. To go and spend time in departments… I'd like to stay really connected to the therapists doing the work." [Alice: White British, female, SLT]

8.2.3 The NHS

Overall, the NHS was thought a powerful employer because of its size, comprising of a large workforce with several organisations and services organised hierarchically. Trust HR departments and senior leaders were perceived as responsible for driving a diversity agenda within the NHS. However, their agency was limited because of capacity/scale issues and difficulties talking about ethnicity.

8.2.3.1 EDI governance challenges

Interviewees generally acknowledged that *"leadership is everything" [Suresh: Black, male NHS stakeholder]* to driving the NHS diversity agenda, especially the most senior members, namely the CEO and Boards of Trusts. Leaders were perceived to shape organisational priorities or policies which meant they were also the most accountable to them, signed off plans (e.g., policies), and allocated support (e.g., time and resources/funding) to addressing issues.

They also represented the highest levels of career progression, and so were deemed role models. For example, interviewees thought leaders should be visibly seen talking about diversity (e.g., sharing their thoughts or experiences on ethnicity), and demonstrating action to signify going beyond rhetoric to create space for conversation. Senior NHS leaders were generally perceived as being genuinely interested in, and were taking seriously, the establishment of a diverse and inclusive workforce.

> *"…when a senior woman says, 'hang on, my mother just developed breast cancer and I looked at the study, and I saw nothing for BAME women or Pakistani woman, or anything. Do we have NIHR? Do we have any data?' And they go 'no, never studied it'. Then people with power go, 'well study it. Here's a million pounds'. But if everybody in the room does not signify anything to do with diversity, then nobody has those stories, and don't underestimate the power of Boards. And when a board member says, 'oh well my son is disabled, and they're epileptic, and I checked all the services, and it's shocking that we don't have a whatever'. Everybody else goes, 'no way. We should do it'. It's done. Several times, when you have powerful people that are diverse, you then start having the power which equals money, and time and resources into those things that matter." [Sunita: Indian, female NHS stakeholder]*

However, senior leadership was accused of not knowing how to talk about ethnicity, looking for silver bullets, and failing to scrutinise the evidence-base of advice from hired consultants. Also, NHS Board diversity was generally acknowledged as poor, but there were concentrated efforts to support the career progression of under-represented groups to reach leadership positions (see section 7.4).

> *"If the Chief Executive doesn't know how to have a difficult conversation, how do they have the authority to tell managers they have to have them? So, the whole organisation is tiptoeing, everybody knows there's a problem, everybody is tiptoeing around it… I would say a lot of senior leaders think this is important and want to do something better, but they haven't been shown how to do it, except on discipline where they have been shown how to do it and they've done it." [Isaac: Jewish, male university stakeholder]*

Trust HR departments were identified as an important intra-organisational stakeholder for two reasons. They had overall responsibility for addressing workforce diversity issues, and delivering the organisation's EDI policy/strategy. So, individuals or teams with EDI responsibilities were usually based in HR. However, the capacity for HR to meaningfully fulfil their EDI responsibilities were thought limited for many reasons. Staff were seen as overworked, and those in EDI were junior with their roles restricted to compliance motivated by risk management rather than improvement. Also, Trust HR departments were accused of delegating their EDI responsibility to staff networks, and using a model accused of being outdated, reactive, individualistic, and which failed to address the root causes of diversity issues.

> *"…the HR model, paradigm on everything is policies, procedures, and training. So, bullying, we have a policy on bullying - we're against it. We have a procedure where individuals can raise concerns. We have training for people…so they learn. Managers know how to handle it. But that doesn't address the problem… individuals raising concerns rarely addresses issues of organisational climate. You need to be proactive to triangulate a range of data…go out find the problem rather than let the problem find you. Because in the health service we have lots of data. We have mountains of data." [Isaac: Jewish, male university stakeholder]*

8.2.3.2 Organisational scale/capacity challenges

Finally, the NHS's large size was considered a challenge to their diversity efforts. The NHS workforce size meant any changes had to be introduced slowly, and why it reflected societal issues. Structurally, the NHS was presented as comprising of several bodies and services (e.g., NHS England and Improvement, NHS Employers, NHS Providers/Confederation, NHS career/jobs, and NHS digital mentioned). They operated in different ways (e.g., some were autonomous) and places. However, they collectively worked to realise the diversity agenda outlined in the NHS People's Plan 2020/21 (see section 4.2.4.2). The NHS seemed to address capacity issues through the recent appointment of new regional-level EDI lead positions (see section 4.2.4.2). This was described as *"revolutionary" [Sunita: Indian, female NHS stakeholder]* because it offered diversity-related support infrastructure for Trusts that had previously not existed. Their strategies tended to focus on ethnicity because it was thought

neglected, but their structural approach covered organisational processes (e.g., recruitment) to culture (e.g., having compassionate leaders), which was expected to have wider impact on other protected characteristic areas.

> *"…if you tend to get it right for race, you improve things for everybody. So, it's a way for organisations to concentrate their attentions on one area but still make overall improvements that improve things for all." [Gloria: Black, female NHS stakeholder]*

However, regional leads had restricted capacity to drive change. Some leads had to cover large geographical areas by themselves. This was being offset by creating EDI subgroups to manage the workload. Also, they did not have the power to mandate actions or assign accountability. So, they used other forms of influence to mobilise their diversity strategies, for example, existing NHS mandates (e.g., WRES), leadership priorities (e.g., CEO targets), the role's credibility, organisational reputation levers (e.g., telling organisations that poor WRES metrics make their Trust look bad), and seeking support from other stakeholders (e.g., Care Quality Commission). Working as a singular person or in small teams that covered large regions, encouraging senior buy-in and accountability for strategies with limited funding or resources, were identified as limiting their agency.

> *"We can't fine you. We can't do anything if you don't do it. We can just tell you 'oh it looks bad'…There is no consequence." [Sunita: Indian, female NHS stakeholder]*

8.2.4 Diversity practices: uneven implementation and dispersed accountability

Diversity practices were not well known amongst interviewees, and some thought they had no impact on their professional lives. Poor engagement with, and implementation of, diversity practices emerged as an important barrier to practice awareness.

Many interviewees expressed limited or absent awareness of diversity efforts within the profession (N=19 – SLTs=12, stakeholders=7). Whilst diversity stakeholders had knowledge or vested interest in driving diversity within SLT or the health sector broadly, this did not

necessarily mean awareness of efforts outside of their own specific areas or efforts. Some interviewees provided vague guesses about the diversity work of the NHS or RCSLT, but the titles of specific initiatives were hardly mentioned. This was despite specific efforts by Trusts, as outlined in their diversity documents, to encourage staff engagement with EDI (e.g., arranging EDI governance to give staff a "stronger voice" and a "share" in decision-making). NHS stakeholders had a better idea of NHS diversity efforts, which aligned with those outlined in the NHS diversity documentation analysed. For example, for ethnicity, both sources focused on minority ethnic staff experiences, emphasised diversity metrics (e.g., many references to WRES), mentioned the same diversity stakeholders, and focused on similar diversity efforts (i.e., recruitment, progression, support mechanisms, and tackling diversity work engagement and implementation).

> *"I have to be honest and say that I don't exactly know what Royal College is doing to improve it [i.e., diversity]... I don't know whether that's because I haven't read enough about it or whether they haven't told us enough about what they're doing...I know there was an e-newsletter that arrived recently, and there was something on it about diversity. But I don't remember it kind of informing me how. I think they're just taking more and more surveys." [Alice: White British, female, SLT]*

Also, several therapists (N=17) thought their Trust's diversity policy had no impact on their professional lives. This was partly because many therapists were unfamiliar, or had limited to no engagement, with Trust diversity policies. For example, they did not read it or know of its contents (N=14). This was because they thought diversity policies were inaccessible (e.g., too long, and boring) (N=21), their content obvious or could be sourced elsewhere (N=11), and was not mandatory to read (N=21) except for managers. So, staff used them as and when needed (N=20) due to limited time or workload capacity (N=11), because there were too many organisational policies (N=5). Analysis of organisational diversity documents did show that they varied in length, from 9-52 pages, although more accessible versions were available (e.g., "easy read" version of NHS People's Plan).

"…there are literally hundreds of policies for everything you can possibly think of. So, I tend to go to a policy when I need it." [Stella: White British, female SLT]

Many efforts to encourage staff engagement with diversity policies existed. These were mostly around increasing awareness of the policy's existence by signposting it across organisational processes (e.g., inductions) (N=13). There appeared opportunities to engage staff during the policy making process, which stakeholders presented as being systematically collaborative in that there were many stages of various stakeholder consultations. However, frontline staff were thought to have the least influence in shaping policies.

"…does your average frontline health care workers see this [policy] before it gets signed off? Probably not. Not you know unless they're maybe in a specific role." [Hazel: White Other, female NHS stakeholder]

In contrast, senior members of healthcare governance in the government and NHS (i.e., the Department of Health and Social Care and NHS Boards), and the policy author were branded the most influential stakeholders because they were most accountable to them. So, diversity policy implementation responsibilities were mostly attributed to senior management, although ownership by all NHS staff was planned by embedding policies/strategies into all organisational processes. Despite some consequences (e.g., sanctions) and rewards (e.g., acknowledgement) to encourage policy implementation, it was deemed a challenge.

Managers were the most cited implementation barrier because it was done at their discretion. Some managers were deemed unfamiliar with, or inconsistently applied, workforce policies because they were high-level and therefore open to interpretation and human error. So, translating policy to practice was problematic, with some managers worried about getting it wrong, or had other important priorities.

"I think it's just people are people…so they're either in the day-to-day busyness of life... the detail of the policy isn't foremost in their mind or practices slip…It might be not being familiar with it, not committing it to memory, not having it forefront of your mind every day, every decision…But often when things go wrong, sometimes it's because the policy isn't followed, or sometimes it's how it's been implemented…so you know it hasn't been implemented properly…or the way people have communicated it, or the way

people just resorted to policy. You know the sort of the mantra of 'oh but the policy says' is actually sometimes not a very helpful tool. It's a fairly crude tool to use…often there'll be grey areas in policy, and it's how you balance all that to get the right outcome." [Hazel: White Other, female NHS stakeholder]

Other managers displayed poor behaviour (see section 7.2), or had qualities that apparently made them prone to bias (e.g., authoritative, and task-orientated). Some lacked knowledge about their staff which resulted in the development of wellbeing and recruitment measures to facilitate manager's conversations with staff. Also, the lack of clear qualification paths for individuals with diversity management responsibilities was deemed a potential barrier to how effectively they could push a diversity agenda. There were just requirements to understand legislation, and so some organisations were developing qualifications to give such positions *"kudos" [Joel: White British, male NHS stakeholder]*.

"…what we're seeing unfortunately in the NHS, is a lot of our managers are task oriented. And that's where the bias comes in a lot more actually. Because there's this, you know kind of the blind vision around not seeing diversity, and actually associating themselves with people who looks like them, and who they think is more, you know got more competency around what they're trying to achieve…we need to equip managers to become hopefully leaders. But then some managers might never be leaders, and this is where we need to have this accountability." [Suresh: Black, male NHS stakeholder]

Other barriers to engagement and/or implementation of diversity efforts included lack of impetus due to time/workloads and the positive image of therapists. Two trades unionists claimed that many therapists in the NHS did not engage with trades unions, who were responsible for creating collective responses to workforce issues. They associated this lack of engagement to therapists' relaxed and well-behaved dispositions, and being unaffected by their organisation's diversity issues.

"…it [i.e., trades union] was kind of a security blanket for them in case they had an issue. Overall, they didn't engage…because they were okay…If people aren't directly affected, there aren't many people who will, you know sort of get up and do something… everyone's very comfortable…that sounds brutal…lots of people need to sort of be made

to come out of their ivory tower, and actually engage with things that they think they don't need to." [Karen: White Irish, female, trades unionist]

Poorly designed practices/processes were also outlined as barriers. For example, poor evidence-bases of practices and poor monitoring of compliance or impact, despite designated provisions for this (e.g., inclusion teams, centres, and observatories mentioned in Trust documents). Communication was also a challenge for promoting wide awareness because *"…if we produce something, and we put it out there... The chance of all staff knowing about it, slim to nil" [Leah: White, female NHS stakeholder]*. Also, careful communication was needed to encourage buy-in of diversity efforts. For example, many therapists (N=13) advocated for active policy learning to improve engagement with them (e.g., application to real life scenarios). Also, staff needed positive motivation.

"…making people feel guilty about it doesn't necessarily motivate them and doesn't help them understand what needs to be done, and I think that there I can see is now a risk of some pushback… that's why it's really important I think to be able to explain that what you're doing is worth doing, and is likely to work, and if it's done properly will actually benefit other people as well." [Isaac: Jewish, male university stakeholder]

Sole traders thought that the private sector offered more flexibility to participate in diversity efforts, but they prioritised their businesses for earning capacity.

"…being self-employed and a private practitioner, I have to prioritise my work, day-to-day work, and then planning for the next month, and so even just having enough time to sit down and really think about how best to support. Like I just don't really have the time for it. I don't have the time to sit down and think calmly enough to articulate my views." [Danielle: Multiracial British, female SLT]

8.2.4.1. A need for accountability frameworks

A common underlying theme across interviews was a perceived need to embed accountability frameworks within diversity practices to improve engagement, implementation, and ultimately their impact.

Some stakeholders thought EDI work should be everybody's responsibility. So, they advocated for a centralised approach where EDI considerations were embedded (one Trust document used the term "weave") across organisational processes. For example, NHS diversity documents outlined equality and diversity charters, governance, and competency frameworks across organisational processes (e.g., embedding diversity considerations in recruitment, appraisal, and progression). There was a perceived need for mandates to achieve this, which was thought lacking in the NHS.

> *"It's like climate change. Is it my job, or is it your job? Do you recycle more than me? Do you care about this agenda? Is it just values? Are we both going to save the world together? Who is accountable? Nobody. Well, we all are, or nobody is right?…So for this topic, nobody's accountable because there is not a target." [Sunita: Indian, female NHS stakeholder]*

Other stakeholders focused on managerial accountability. For example, Isaac, a healthcare sector expert, accused NHS management of failing to scrutinise diversity data or advice, and of using disciplinary processes to evade the responsibility of having difficult conversations with staff. Diversity metrics and policies were presented as flawed accountability tools. NHS diversity documents signalled accountability by emphasising diversity data collection and monitoring methods (e.g., NHS staff survey, equality delivery systems), and reporting/publishing of diversity outcomes (e.g., progress on goals such as representation levels). Mandatory diversity metrics, such as WRES, promoted accountability by targeting organisational reputation. Yet, metrics were accused of lacking tangible consequences to motivate improvement. Also, some diversity data was collected annually, including WRES, which meant that their real-time progress could not be monitored, which negatively impacted staff motivation.

> *"WRES is saying I'm holding you to account by you sharing your data…WRES doesn't hold them to account for making it 100% good. There's no accountability framework there. WRES just say, 'well here's what your data says. You're not looking that good'. There's nothing I can do about it. I can ask you, please can you do better? That's all WRES does….it would have been easier if every year they to have to say, 'also the 10 pounds I give you, if you don't get White staff and BAME staff equal in terms of these*

indicators, I take away 50 pence'…I have no levers to pull except, you know you don't particularly look great as a Trust." [Sunita: Indian, female NHS stakeholder]

Diversity policies were presented as a necessary tool to hold organisational and staff behaviour to account, but by themselves were thought an insufficient *"tick-box exercise"* because *"it has to be made real" [Susan: White British, female NHS stakeholder]*. Some stakeholders highlighted how policy implementation accountability was fostered using rewards (e.g., acknowledgement through appraisals or awards), consequences (e.g., informal criticism and formal grievance/disciplinary process), and emphasis on legislative compliance.

Also, efforts to address staff biases through UBT and diverse interview panels were thought ineffective without accountability.

"…Lots of BME people were entering disciplinary processes when for the same thing if they'd been White, it would have been a slap on the wrist, an arm around the shoulder, or a bit of extra training. But if you're Black, not in every case, but in this occasion, we need to investigate. Actually, part of the reason for that is cos if I'm the manager and I think you need investigating, I don't have to have the difficult conversation with you. Somebody else investigates you. So, I can phew, I no longer have to." [Isaac: Jewish, male university stakeholder]

So, Isaac recommended a bias interrupter via an 'explain or comply' approach where decisions needed to be justified, and diversity treated as a key performance indicator (KPI).

"…introduce a complaint system so that within Speech and Language Therapy if you keep appointing White women, you better be able to explain why, or it has to change. Depends obviously on men and BME people applying. But on the assumption that they will start to apply, if it looks more likely they're going to get the jobs, you'd have to explain. If you shortlist people, why do you keep not appointing them? If it becomes part of your KPIs, part of your own performance management, it will change things as it does on everything else." [Isaac: Jewish, male university stakeholder]

Some stakeholders discussed the importance of getting the right narrative about diversity in a transparent and blunt way, with an acknowledgement that people need support to be

accountable. This involved raising awareness of diversity issues, using evidence to support claims and practices, and highlighting best practice (e.g., *"You know why don't you talk to this Trust? They're doing it much better" [Isaac: Jewish, male university stakeholder]*). In line with these recommendations, NHS diversity documents mentioned celebrating achievements, and developing support for EDI infrastructure (e.g., supporting EDI leads and having in-house WRES experts).

> *"…it hasn't been addressed before because there was no mandate. There's no holding to account... without any strategic steer, or programmes, or people talking about it, you know it's like history: if nobody talks about it, it never existed…so only now that we're talking about it, we're writing about it, we're on campaigns, then people go 'oh I didn't know there was a race issue. Oh wow, we have a race issue in the NHS'…" [Sunita: Indian, female NHS stakeholder]*

8.3 Discussion of diversity approach and stakeholder findings

Overall, this chapter identified two key challenges to diversity management in the SLT profession. First, a coherent approach to EDI was found to be lacking, with equal opportunities and diversity management approaches or arguments, and practices used in hybrid ways. Second, an overarching agenda, regulatory framework, and stakeholder roles for driving diversity within the profession was unclear. Key stakeholders and their agency to act was limited by different barriers. These two empirical contributions are discussed in relation to organisational and management literature on diversity approaches, practices, and stakeholders that were explored in chapters three and four.

Whilst there is abundant literature on the theoretical underpinnings of diversity approaches (see section 3.1), its application to the UK SLT context is absent. So, the finding of both diversity management and equal opportunity approaches across the diversity efforts identified within the SLT profession, represents a new empirical insight. Each approach can impede the ability to address diversity issues, and so maintain the status quo (see section 3.1.2). Examples of an equal opportunity approach were only identified for the NHS because it was one of the two

most discussed stakeholders. Whilst the RCSLT was also a highly referenced stakeholder, they were unable to mandate actions on therapists. They did, however, offer voluntary-level support for therapist's careers (e.g., helped therapists with advanced cases which could add to their accomplishments profile). Conversely, the NHS employed, and so their rules applied to, therapists. NHS workforce policies and processes aligned with a liberal equal opportunities approach. Equal opportunity approaches present employers as socially obligated (i.e., emphasis on social justice/moral motivations) to identify and address social group-based employment disadvantage (Kirton and Greene, 2005b). Liberal versions typically practice commitments to non-discriminatory employment via fair processes, equal treatment and opportunity, bureaucratisation, and positive action measures (Kirton, Greene and Dean, 2007). NHS employment policies and processes reflected bureaucratisation as they formally applied to all staff uniformly, or specific social groupings based on protected characteristics (e.g., see sections 7.2 and 7.4 for examples). They also shared the criticism of equal opportunities that diversity is framed negatively (see section 8.1). Diversity policies comprised of legislative and social justice arguments (see Table eight).

However, equal opportunities can give a false sense of fairness because gender- and ethnicity-based inequalities persist (see chapter four). Whilst NHS policies and processes applied to all staff, they were perceived to disadvantage the careers of some social groups. Chapters four and seven outline group-based disadvantages for therapists and NHS staff. For example, flexible working was thought not flexible enough for some women, which supports reports of NHS therapist attrition linked to childcare, maternity, and lack of flexible working (Loan-Clarke *et al.*, 2009). Also, recruitment was thought biased against minority ethnic staff, and so the NHS has been described as a "snowy white peak" (Esmail, Kalra and Abel, 2005; Kline, 2014). Both disadvantages occurred despite the presence of NHS diversity policies. So, the equal opportunity commitment to non-discriminatory practices through formal and standardised rules and procedures (Kelly and Dobbin, 1998), does not solve inequality in the NHS and SLT profession more widely. The scholarly criticisms of diversity policies discussed previously (see section 3.3.4) corroborate with the thesis findings. For example, policies do not always lead to diversity, people are not always aware of them nor engage with them, and there are challenges implementing them. So, CRT, Whiteness theory, and intersectionality say that organisational policies and processes should not be assumed as fair and neutral (see section 4.3).

A diversity management approach was emphasised across the profession more widely as both the NHS and RCSLT emphasised individual differences, and voluntarism which aligns with a business case for diversity. The thesis findings provide a novel insight into how the criticisms of diversity management in academic literature (see section 3.1.2) apply to the SLT profession. A focus on individual differences can overlook structural issues and place the onus of change on under-represented groups, rather than on organisations or those in privileged positions. For example, stakeholders outlined the importance of HR, White, and senior staff in driving organisational diversity change. Similarly, intersectionality and CRT approaches recognise that powerholders have must help dismantle inequality. Also, managers were framed as responsible for diversity management as implementers of diversity practices. They were accused of shaping a policy-implementation gap (Khilji and Wang, 2006) (defined in section 3.3.5) because implementation was at their discretion, and some lacked knowledge of their staff and diversity policies, or behaved in unsupportive and biased ways. Whilst such managerial issues need addressing, framing differences as a problem for managers to solve, focuses on making people deemed different assimilate to the dominant group's values and norms (Thanem, 2008). For example, marginalisation experiences led therapists to feel conformity pressures (see section 7.1.3). At work, minorities feel pressured to create *"facades of conformity"* which involves pretending to embrace their organisation's values by masking their true selves (Hewlin, 2003, page 633, 2009). For example, in a study of women of colour in UK workplaces, 61% claimed to have changed themselves to fit in at work including the language or words they used (37%), accent (24%), conversation topics (37%), their names (22%) and appearance (e.g., hairstyles: 26%, clothes: 40%) (Gyimah *et al.*, 2022).

Also, the expectation that voluntarism which aligns towards a business case for diversity, will encourage the pursuit of diversity efforts (discussed in section 3.1.2) did not materialise for therapists. First, the perceived benefits of diversity emerged as a popular theme across interviews, yet some therapists lacked awareness of, and engagement with, diversity practices in their organisation and profession more widely. Lack or low awareness of diversity practices was expressed mostly by White male therapists (N=7) than other groups (White female=3, minority ethnic female =2). But poor engagement was cited more evenly (White female=7, White male=3, and minority ethnic female=4). So, unsurprisingly, some therapists did not think that existing diversity efforts impacted on their professional lives (White female=8, White male=3, minority ethnic female=3). The voluntary nature of diversity practices negatively affected engagement in diversity discussions or staff networks, and the

reading of Trust diversity polices. However, making practices mandatory may not promote engagement. One stakeholder outlined the need to scope out potential issues before mandating an organisational activity. Also, compulsory diversity practices (e.g., mandatory diversity training) can cause negative feelings amongst trainees (e.g., anger and resistance) (Dobbin and Kalev, 2016) and mandatory policy reading is disliked (Ahmed, 2007b).

Second, the emphasis on the business case for diversity is problematic (Noon, 2007). Many diversity motivations were thought to underlie NHS diversity policies (see Table eight), which echoes those cited for the NHS in existing literature (see section 4.2.4). However, framing diversity as an organisational asset may result in employees being treated as bottom-line costs or objects to gain a competitive edge (Kirby and Harter, 2003). This aligns with the perceived need to prove the value of SLT to get funding (see section 8.1), and criticism of the broad devaluing of clinical work in SLT linked to the erosion of SLT services and career progression in the NHS (see section 7.3.3). The relatability concept shows how the business case for diversity can maintain the SLT profession's White, feminised culture (see section 7.6).

There appeared no overarchingly clear agenda nor regulatory framework (i.e., clear body of stakeholders or practices, and accountability frameworks in the latter) for driving diversity within the profession. The dispersed accountability of the many stakeholders identified as driving a diversity agenda within the NHS or SLT more widely, made the issue of responsibility unclear. Society seemed to shape diversity priorities. For example, the BLM movement triggered NHS and RCSLT focus on the ethnicity-based experiences of their staff/members. Organisations shaped workforce diversity through their practices and processes. The RCSLT and NHS were emphasised in interviews, which means that only a partial view of diversity concerns and practices within the profession was collected. It is likely that both organisations were the most cited stakeholders because many interviewees had prior or current affiliations with them. After all, the NHS is a large employer of therapists, and the RCSLT is one of the main relevant professional associations (see section 2.3.2). So, interviewees were perhaps more knowledgeable of their diversity issues and efforts. Yet, many therapists expressed a lack of awareness and engagement with diversity efforts in the profession. This could mean that there was no overarchingly clear diversity agenda for SLT, and/or that therapists were not aware of its content. Many therapists expected the RCSLT to behave as the main regulator of diversity work within the profession, which conflicted with their actual agency to do so. Whilst the

Association represents its members concerns, its agency to drive a diversity agenda was restricted by their small organisational scale, and inability to mandate change. So, they relied on lobbying and influencing tactics. For example, the RCSLT could only influence organisations employing therapists by collaborating with them (e.g., with universities on recruitment), targeting their members who worked in them (e.g., NHS managers), or using their organisation's priorities as levers for considering SLT concerns (e.g., Simon Stevens letter – described in section 8.2.2.2). In this way, they appeared the only organisation to have a clear EDI link between employers of therapists. They also have links to independent therapists as ASLTIP members are required to have RCSLT membership (Association of Speech and Language Therapists in Independent Practice (ASLTIP), 2023). This represents an important empirical finding as I could source little research on the role of professional associations in shaping the diversity of a profession (see section 3.2.2.2).

This discrepancy between therapist's expectation of, and the RCSLT's agency to enact, a diversity role resulted in criticism of RCSLT governance, mainly targeted at the CEO. This focus was partly because the CEO was identified as having power over the Association's operational matters and had access to powerful stakeholders (e.g., negotiated access to NHS Board meetings for SLT advocacy). But there was also emphasis on the symbolic status of her minority ethnic heritage for SLT diversity. Treating individuals as representatives of all or just their own minority ethnic group is subtle discrimination potentially overshadowing their professional competencies (Van Laer and Janssens, 2011). The RCSLT CEO's minority status also demonstrates that token diversity at senior levels does not mean the absence or addressing of diversity concerns. Also, there is a limit to how much one person can influence a profession. Focusing on individuals may overlook structural barriers to workforce diversity (see section 3.1.21 on individualism).

The complexity of the NHS, due to its scale and intricate governance structure, is a challenge for diversity roles and practices within SLT. The organisation's EDI efforts apply to patient care and all of its many professions, in which SLT is trying to navigate and address its specific concerns (e.g., via the RCSLT – see section 8.2.2). Prior literature has acknowledged how the complexity and anticipated changes to the NHS structure makes it hard to assign accountability for addressing EDI concerns, with unequal accountability across different NHS stakeholders (Hemmings *et al.*, 2021). Issues of voluntarism versus regulation have generally been theorised

in relation to clearer organisational boundaries, supported by studying private sector organisations which arguably have simpler and more coherent govenance structures than the NHS (see chapter three). Diversity management in the NHS was presented in interviews and Trust diversity documentation as the responsibility of different stakeholders including HR/EDI personnel, senior leaders, managers, and all staff (i.e., everybody's responsibility). The capacity of each to fulfil this role was restricted in different ways. Diversity stakeholders provided more content about NHS stakeholders and practices, as therapist's interviews centred around their personal experiences within SLT. For example, stakeholders thought that HR was overworked and orientated towards legislative compliance than improvement. EDI personnel were thought junior, underfunded, and under-supported. So, senior level buy-in for EDI was thought necessary to enact their roles. Yet, there is inconsistent EDI prioritisation and ownership amongst senior NHS leaders (Hemmings *et al.*, 2021). Also, translating leadership EDI commitment into practice requires middle management implementation of diversity practices, with abundant literature on the latter (e.g., - see Noon *et al.*, 2013; Kirton, Robertson and Avdelidou-Fischer, 2016; Noon and Ogbonna, 2021). Interviews highlighted why managers may shape an implementation gap, including bias, high workloads, an operational focus, and human error. Finally, diversity management was framed as the responsibility of all staff, as Trusts attempted to embed EDI considerations across NHS proccesses. Ahmed (2007a) argues that diversity as everyone's responsibility quickly means no-one, unless accountability for it is assigned to someone. Embedding accountability frameworks across NHS practices and processes has been advocated (Kline, 2022). It may offer one way to improve the awareness, engagement, implementation, and so perceived impact of diversity practices across the NHS and thus profession-wide. Based on findings, such a process would involve clearly communicating the rationale for a diversity practice with evidence, having targets, monitoring their progress using metrics, and justifying actions or outcomes. Yet, interviews highlighted how a lack of EDI mandates in the NHS meant that accountability frameworks within diversity practices were lacking (see section 8.2.4.1). For example, there were no tangible consequences linked to WRES metrics. Instead, diversity metrics can be used to trigger social accountability, i.e., the need to be seen positively by others (Castilla, 2016).

Overall, the findings revealed two important challenges to diversity management within SLT. First, a coherent EDI approach is absent, with diversity management and equal opportunities arguments and practices used in hybrid ways. Each approach is limited in its ability to address

diversity issues within SLT. Second, it is unclear what the profession's overall diversity agenda is because many stakeholders are involved in driving diversity within it, and it is unclear who is ultimately responsible. The RCSLT and NHS were the most cited in interviews. Then, there is a question of which staff group or whether all staff within them has a diversity responsibility. Also, the capacity of both organisations to drive change is negatively affected by their scale, as well as lack of awareness, engagement, implementation, and accountability frameworks of diversity practices.

CHAPTER 9: CONCLUDING DISCUSSION

This thesis explored gender and ethnicity career experiences and diversity management within the SLT profession in the UK. Thematic analysis of interviews and organisational diversity documents generated three main themes: (1) entering the profession (chapter six); (2) experiences in the profession (chapter seven); (3) and diversity approaches and stakeholders within the profession (chapter eight). Diversity issues that emerged within each theme were matched, where appropriate, with relevant diversity practices, and discussed in relation to existing literature and theory. In this chapter, I discuss the seven main thesis findings as theoretical, empirical, and methodological contributions, consider my research limitations, and share my conclusions.

9.1 Thesis contributions

This section discusses the two theoretical, four empirical, and one methodological contribution(s) across the three thesis themes.

9.1.1 Theoretical contributions

My findings theoretically contribute to diversity management and intersectionality literature. First, the business case for diversity is problematized through the concept of relatability which legitimises and maintains the SLT profession's underlying White, feminised culture. Consistent with Whiteness and critical race theories (see section 4.3), Whiteness was constructed as the norm, privileging White therapist's careers but marking all else as deviant and culturally deficit with their value needing to be justified. Relatability shows how gender- and ethnicity-based dis/advantage are subtly intertwined. Therapist's minority status was deemed an asset in relating to other minority clients, but was also a disadvantage by making them less easily relatable to client groups, colleagues, and fellow students from the dominant social group. The further therapists strayed from Whiteness and its associated practices, the harder it was for them to enter and progress in the profession. For example, just minority ethnic therapists, mostly those who were Muslim, faced religious discrimination which presented them as foreign (e.g., comments about their religious clothing) and disadvantaged them (e.g., social exclusion from work events because they were in venues that served alcohol). Racism

can hinder peer relation development (Brondolo *et al.*, 2012). White therapists acknowledged their privilege as they did not face the career barriers that minority groups encountered; they had more career/social inclusion opportunities, and automatic acceptance. So, minority ethnic therapists shared conformity pressures and experiences such as the need to speak like the dominant group, not raise concerns, and politely follow rules. Belonging in the profession was linked to minority ethnic and male therapist's contributions around attracting and meeting diverse client needs (i.e., social/cultural capital). The burden of educating colleagues about cultural sensitivity and knowledge to help interact with ethnically diverse clients fell on minority ethnic therapists rather than employers. So, visible minority therapists can be considered ambivalent outsiders-within (Meyerson and Scully, 1995) (defined in section 3.2.1.1.1). Their disruptive self-expression, i.e., simply behaving according to their own values and styles (e.g., language and clothing), sparked conversation and exchange of cultural information. For example, the hijab was a topic of interest. These expectations of under-represented therapists reflect a business case for diversity (see section 3.1.2.2). For the NHS, this means making their workforce representative of the community served to improve patient care and experience (NHS England, 2020c). Given the relational and communicative nature of therapist's work, it makes sense that the skills and knowledge stemming from their workforce diversity, are perceived as assets. However, scholars are critical of framing workforce diversity as business assets (Noon, 2007). It is reductionist by potentially pigeonholing under-represented groups with a specific racialised function (or gendered for male therapists) which reinforces their disadvantage (Van Laer and Janssens, 2011), and overlooks the fact that they may simply be good at their job. Thus, the business case for diversity legitimises Whiteness as the norm.

Similarly, the business case for diversity feminises the profession by drawing on and reinforcing patriarchal and essentialised ideas about femininity. Feminine attributes and dispositions are presented as making women better suited to SLT than men (e.g., better communicators and carers). Also, paradoxically, clinical work and its associated attributes are highly feminised and deemed essential (e.g., soft skills), whilst simultaneously broadly devalued, such as clinical work being perceived as low status than other work (e.g., management), its delivery dispensed to other professionals (e.g., teaching assistants), and links to high workloads and eroding career structures in the NHS. Also, there was a perceived need to prove the value of SLT to secure funding for services which was challenging as the impact of therapy may be unclear. The financial difficulties of the SLT profession (e.g., pay freezes and its renowned equal pay case) and NHS have been previously reported (see sections 4.1 and

4.2.4.2 respectively), but this thesis extends insight into its impact on the value of their work and career progression prospects. This may also explain why men experienced a glass escalator despite their numerical scarcity, as clinical skills are deemed necessary for being a therapist but less so for career progression. Thus, the gendered and racialised 'added value' has limited business worth within the UK SLT context.

Second, intersectionality served as a conceptual tool to theorise the fluidity and interlocking patterns of identity-based dis/advantage in SLT. Using gender and ethnicity as a starting point (i.e., intercategorical intersectional approach (McCall, 2005)), and focusing on understanding identities within specific relationships and settings (i.e., an emic approach (Tatli and Özbilgin, 2012)) uncovered context-dependent patterns of marginalisation/disadvantage and privilege encountered by therapists across their careers based on three axes of difference: gender, ethnicity, and social class. Dis/advantage on these axes was fluid and interacting, supporting intersectional research presenting gender- and ethnicity-based privilege (Atewologun and Sealy, 2014; Mavin and Grandy, 2016) and oppression (Luiz and Terziev, 2024) as fluid, and the rejection of identities as additive or reductive (Garry, 2011). Also, social capital varied based on these identities. For example, ethnicity interlocked with social class dynamics to shape networked access to SLT for work experience and volunteering opportunities disadvantaging those who did not fit the profession's image (i.e., minority ethnic, male, and low social class individuals) linked to bridging social capital (e.g., lack of connections in SLT). The profession's middle-class characteristic linked to ethnicity and gender for career choices and clinical work. For career choices, for example, SLT was thought poorly paid and so its choice was not monetary based, hence underrepresented individuals sought careers offering high pay and status (e.g., traditional professions) and private sector/management SLT routes, with the latter linked to men's patriarchal role as breadwinners. For clinical work, for example, gender stereotypes/roles influenced perceptions of suitability for clinical work and client discomfort with male versus female therapists. Across these intersections, therapists who fit the profession's specific image benefitted in bonding, bridging, and linking social capital (defined in section 4.3.3) than therapists who did not (see Whiteness discussed above for examples) which supports privilege as conferred (Atewologun and Sealy, 2014).

White and male privilege protected against ethnicity and gender career barriers to an extent. White privilege is discussed for the relatability concept above, and minority ethnic discrimination is outlined in empirical contributions below. The findings on privilege supports research presenting it as contextual, conferred and contested (Atewologun and Sealy, 2014).

Privilege was contextual as the BLM and Covid-19 pandemic were macro level contextual factors that triggered self-awareness of White privilege involving socio-demographic self-comparison and self-categorisation against others. Yet, White privilege (discussed above) was also contested as it masked disadvantages for White therapists who were underrepresented in social class (e.g., low social class), religion (e.g., Judaism) and gender (e.g., see dismissal of White men's issues in section 7.1.2). For gender, a pattern of (dis)advantage across the SLT career was uncovered, whereby men were disadvantaged at entry to the profession, but privileged in progression, and vice versa for women. For example, relative to men, women had better exposure to SLT, with its feminised image presenting them as more suited to it, and so they were more prevalent in it (see chapter six). Also, gender intersected with sexual orientation to disadvantage male therapists (e.g., homophobia). Yet, gender stereotypes made billing/charging services difficult for female sole traders, and maternity/motherhood were barriers to women's progression (see empirical contributions). So, a feminised profession does not mean it is unaffected by patriarchal assumptions and structures.

White and male privilege may also explain why some therapists expressed contradictory views between and within themselves. Despite the emphasis on negative issues and experiences, both personal or anecdotes heard from others, some therapists claimed that their gender and/or ethnicity did not affect their careers, or were uncertain of the impact. This was mostly expressed by White female therapists (N=14). Yet, male (N=8) and minority ethnic female (N=5, no males) therapists were over-represented here relative to their overall sample size. A false sense of meritocracy, i.e., assuming that merit determines job opportunities and success and any discrimination is anomalous (Lawton, 2000), potentially contributed to this finding. For example, some therapists gave token examples of gender and/or ethnically diverse senior leaders or successful entrepreneurs including themselves, and colleagues who were working parents, as evidence that gender and/or ethnicity was not a progression barrier. So, minority groups are presented as having agency over their success, possibly masking institutional or structural barriers. Meritocratic beliefs are prevalent value amongst Britons (Brown, 2021; Duffy *et al.*, 2021) and can make members of disadvantaged communities feel they deserve success less and underestimate how much they face discrimination (McCoy and Major, 2007).

9.1.2 Empirical contributions

The findings represent four empirical contributions. First, while the findings reaffirmed already documented gender- and ethnicity-related barriers to entering SLT, they also extend knowledge of ethnic barriers to SLT. All three barriers to entering SLT found in this thesis have been reported before and so these findings demonstrate that they remain ongoing challenges for the profession. Prior literature has reported the following barriers to entering SLT for under-represented groups: poor awareness and understanding of SLT (Stapleford and Todd, 1998; Greenwood, Wright and Bithell, 2006; Puhlman and Johnson, 2019; Royal College of Speech and Language Therapists, 2019d, 2019b), and its feminised and low status image shaped by gender stereotypes, narrow media imagery, and poor profession-wide gender and ethnic representation (Parish *et al.*, 1990; Stapleford and Todd, 1998; Boyd and Hewlett, 2001; Litosseliti and Leadbeater, 2013, 2020; Byrne, 2017; Du Plessis, 2018; McCormick, Napier and Longhurst, 2019; Royal College of Speech and Language Therapists, 2020c). Gender stereotypes were emphasised in interviews as a particularly resilient factor shaping the profession's "female" image. Networked access to work experience and SLT courses has also been documented as a barrier. Social class negatively affects minority ethnic and low-income individual's participation in volunteering and higher education (Donahue *et al.*, 2020; McCabe, Keast and Kaya, 2022), and shapes choices to pursue an SLT course (Stapleford and Todd, 1998; Wordsworth, 2013). So, diversifying gatekeepers to SLT is important, as access was linked to social capital, excluding those who did not fit the profession's profile. A novel sector-specific empirical contribution here was finding that therapists thought that securing work experience was easier and income potential greater in the private sector than NHS, which was unknown to the public. Difficulty securing work experience in the NHS was linked to therapist's high workloads, and such opportunities were thought greater in the private sector.

Also, the thesis addresses an overall lack of research attention on why minority ethnic individuals may not pursue SLT, and extends knowledge on the nature of ethnic barriers to this specific profession. Just a few journal articles and grey literature have explored this. They cited the low awareness of the profession, its perceived low prestige, preferences for a high salary, the pursuit of traditional professions for high achieving students, negative perceptions of the NHS, lack of representation and support, and difficulty getting work experience (Stapleford and Todd, 1998; Greenwood, Wright and Bithell, 2006; Parity UK, 2013; Royal College of Speech and Language Therapists, 2019d, 2019b). The thesis findings extend this knowledge and are novel by also revealing that a lack of terminology for SLT, and poor understanding of speech disorders are unique barriers to SLT awareness for minority ethnic communities.

Minority ethnic communities were thought to have poor awareness and understanding of special needs and the role that therapists have in treating them. Special needs were thought misunderstood and stigmatised in these communities because they were shaped by cultural expectations of child development, and people did not access speech services. So, special needs were not disclosed in these communities because it was deemed taboo or there was a blame culture. These two barriers precede or go beyond the educational system per se and call for more systemic understanding of how upbringing in particular ethnic communities' shapes perceptions about the SLT profession, and creates under-representation at entry level, beyond the broad societal perceptions of the profession.

Second, patterns of context-specific gender- and/or ethnicity-based marginalisation and disadvantage encountered by under-represented therapists across their careers were uncovered. This pattern was characterised by perceptions of discrimination, bias, exclusion, and unrelatability to clients and/or colleagues. Prior literature focused on male experiences in SLT, and so this finding extends scholarship into therapist's employment experiences by bringing unique insights into female and minority ethnic therapist's experiences. Ethnic barriers in healthcare professions were documented before (see chapter four) (Pudney and Shields, 2000; Shields and Price, 2002; Carvel, 2003; Harrison, 2003; Healy and Oikelome, 2006; Henry, 2007; Sehmi, 2015; Atewologun and Kline, 2019; O'Dwyer-Cunliffe and Russell, 2021). However, my findings show how minority ethnic disadvantage manifests within the SLT profession specifically, through discrimination, White privilege, and the concept of relatability. The tripartite framework confirmed Whiteness and CRT claims of pervasive discrimination as it was uncovered at the macro level as societal discrimination (e.g., BLM and covid-19 pandemic as disproportionately affecting minority ethnic individuals), at the meso level as institutional discrimination (e.g., perceptions of recruitment and disciplinary processes as biased against them), and at the micro level as microaggressions (e.g., racialised comments about their identity). White privilege protected against ethnicity-based career barriers (see theoretical contributions). See section 4.3.2 for definitions and literature of these mechanisms, and relatability is discussed under theoretical contributions.

Novel sector-specific nuances were uncovered for gender-based dis/advantage. Flexible working policies in the NHS were not thought flexible enough for female therapists given requirements to work core hours/minimum of three days per week. Whilst therapists thought that the private sector offered more flexibility, it lacked maternity packages and financial stability when women were pregnant. However, I was unable to assess maternity or

flexible working provisions within the policies of private SLT companies as only sole traders were interviewed from the private sector. Nonetheless, these findings provide sector-specific insights into therapist's experiences which is limited for the NHS (Royal College of Speech and Language Therapists, 2005; Arnold *et al.*, 2006; Loan-Clarke *et al.*, 2009) and almost absent for the private sector. Patriarchal systems shaped by gender stereotypes are likely to be shaping maternity/motherhood as a career barrier. Domestic and caring responsibilities hinder women's careers, but indirectly benefit that of men's (Kirton and Greene, 2005b; Office for National Statistics, 2016b), pushing women to seek work-life balance/flexibility (Anderson, Vinnicombe and Singh, 2010). Conversely, consistent with studies of other predominantly female professions, despite some men experiencing prejudice due to contradicting gendered expectations (e.g., assumptions around working with vulnerable clients), men were welcomed, accepted and experienced a "glass escalator" in progression despite their numerical scarcity (Williams, 1992; Punshon *et al.*, 2019) in SLT. Male privilege was partly because men were unaffected by women's career barriers (e.g., maternity/childcare). Extant literature shows that women face a glass ceiling within organisations (Kalaitzi *et al.*, 2017) and are disproportionately under-represented within senior NHS leadership (Esmail, Kalra and Abel, 2005; Kline, 2014).

Third, by juxtaposing therapist's experiences with relevant diversity practices for the first time, the thesis exposed gaps. These gaps demonstrate that EDI practices are partially deficient in addressing the challenges faced by minoritized therapists, signifying an equality-, and/or intention/policy-implementation gap (Beishon, Virdee and Hagell, 1995; Culley, 2001; Kirton, Robertson and Avdelidou-Fischer, 2016; Noon and Ogbonna, 2021) (see sections 3.3.5 and 4.2.4.2 for definitions). Specifically, regarding entry to SLT, current initiatives focused on raising awareness of and branding the profession, and targeting education or academia. However, the tactic of increasing images of diversity, was deemed as superficial image-building that does not address more structural issues of under-representation. For example, a lack of sustained, visible diversity across the profession (e.g., amongst university or workplace personnel) was quoted as an ongoing challenge. Also, RCSLT marketing efforts were accused of having limited reach (e.g., their resources thought not disseminated widely enough), unclear rationale (e.g., Nick Hewer as the profession's spokesperson but his link to SLT was unclear) and a reactionary approach (e.g., criticism of their delay in making, and quality of, BLM movement statement). Whilst the RCSLT's "Giving Voice" campaign, which raises awareness and appreciation of SLT roles within communities, did engage key stakeholders such as the

UK government (UK Parliament, 2010), speech therapy services are still the main audience (Royal College of Speech and Language Therapists, 2023e, 2023b). Most thesis interviewees did not name specific RCSLT practices, and so their impact is restricted by awareness of, or engagement with, them. Moreover, initiatives targeting education/academia were limited because school outreach was thought not early or wide enough, with the profession sometimes absent from careers events, and SLT careers advice varied in quality. Also, important academic stakeholders were perceived as failing to consider diversity despite a capacity to make a difference (e.g., funding capacity of Health Education England), or maintaining inequality through their processes (e.g., universities offering SLT courses were criticised for their recruitment approach, SLT curriculum and student support). Just one study on SLT has reported initiatives around targeting education/academia (included outreach schemes, international recruitment, links to access courses, and acceptance of lower grades), and awareness/branding (included minority ethnic images in recruitment, contact with therapists, and academic literature in different languages) by universities to improve minority ethnic student's entrance onto SLT courses (Stapleford and Todd, 1998). The authors claimed that such practices were unsuccessful, but did not say why. The criticisms of both types of practices in the interviews provide insight into how their efficacy may be limited. The RCSLT should consider these limitations as they plan to use both types of initiatives (McCormick, Napier and Longhurst, 2019; Royal College of Speech and Language Therapists, 2019d, 2019b, 2021e, 2023d, 2023a; Napier and O'Flynn, 2020).

There was little discussion of efforts to improve social class barriers to the profession, either reflecting a lack of such practices, or limited knowledge about or perceived importance of them amongst interviewees. The latter two reasons seem likely as there are practices with the potential to address social class barriers including SLT apprenticeships (Royal College of Speech and Language Therapists, 2022a), and various RCSLT efforts. The latter includes guidance on organisations to approach for work experience on the RCSLT website (Royal College of Speech and Language Therapists, 2022b) and proposed projects exploring socio-economic diversity (Royal College of Speech and Language Therapists, 2023f).

Many key problems were identified for interventions regarding therapist's experiences. These included insufficient awareness of EDI issues and policies/support mechanisms, a lack of implementation of EDI policies by managers, perceptions of biased recruitment and grievance/support processes, a focus on upskilling minoritized staff, and efforts to raise awareness of diversity issues were at early conversations stages and focused on ethnicity which

may mean overlooking gendered career barriers (e.g., NHS flexible working policies were thought not flexible enough). Whilst there has been prior criticism of common diversity practices (e.g., biased organisational processes) (Dobbin and Kalev, 2016), their application to the SLT context is new. Uncovering these diversity practice gaps requires addressing a wider issue of monitoring and measuring diversity issues and practice impact. Despite their perceived abundance of workforce data, the interviewees saw the NHS as unskilled at both scrutinising it to identify problem areas and measuring impact. Previous literature suggests that White men may find diversity language and messages as threatening (Dover, Major and Kaiser, 2016b) or stress-inducing (Dobbin and Kalev, 2016). My interviews highlight how senior and White individuals found it difficult to talk about ethnicity. Based on CRT's interest convergence (defined in section 4.3.2), perhaps such individuals acknowledging or discussing inequality challenges existing power structures that benefit them resulting in resistance to change (e.g., fear of racism accusations or potentially losing White privilege noted in interviews). Also, many organisations struggle to measure EDI (Romansky *et al.*, 2021). The NHS may find it challenging to follow evidence-based diversity practices outside of their own data as few studies have systematically measured or monitored the impact of specific practices on disadvantaged groups (Robinson and Dechant, 1997; Foster and Newell, 2002; Dobusch, 2017). Whilst the NHS had dedicated resources to address EDI issues (e.g., EDI roles and teams), the impact of their EDI initiatives are not routinely evaluated, which affects the ability to share good practice (NHS Employers, 2021b). Here, the large scale of the NHS was a challenge, as interviews highlighted a need for greater financial and personnel investment for EDI. For example, one NHS stakeholder expressed how organisational scale meant an inability to narrowly focus on specific departments unless there was vested interest in them. So, diversity concerns for SLT teams may go unnoticed. Diversity practices were described in varying levels of detail, and so future research should explore each in sufficient detail to better understand why many therapists thought they had little or no impact on their professional lives.

Fourth, two key challenges to diversity management in SLT were identified, namely, (a) the lack of a coherent EDI approach, and (b) an unclear overarching agenda, regulatory framework, and stakeholder roles for driving diversity, within the profession. While organisational studies literature suggests that equal opportunities and diversity management approaches are distinct, my findings evidence a more hybrid approach in the SLT profession context. It is unclear what the dominant diversity approach was in SLT because only a partial insight was collected given the overemphasis on the NHS and RCSLT in interviews. However, there were examples of

both equal opportunity and diversity management approaches to tackling diversity issues within the profession, likely to be because the thesis covered public and private sectors. Key diversity actors in the UK vary in their positioning in relation to equal opportunities and diversity management paradigms, with public sector organisations (e.g., NHS) closer to collectivism and regulation, and private sector, professional bodies, and employers closer to individualism and voluntarism (Ozbilgin and Tatli, 2011). However, positions on paradigm elements are not always straightforward, for example, the NHS heavily uses a business case for diversity (see section 4.2.4.1). A unique business case for SLT workforce diversity can be made by emphasising how SLT workforce diversity would mean meeting the language and communication needs of a diverse client group, as stressed by interviewees, but may not be realised since therapists are currently in short supply (Royal College of Speech and Language Therapists, 2019c). However, approaching workforce diversity from a business lens is problematic (see theoretical contributions). Each diversity approach can maintain rather than address workforce inequality (see section 3.1.2) in SLT. For example, diversity management's focus on individuals can overlook structural issues within SLT, of which many were identified (described across results chapters). For SLT, experiences of marginalisation led therapists to feel conformity pressures (see section 7.1.3). Also, the expectation that voluntarism/business case for diversity will result in the pursuit of diversity efforts (see section 3.1.2), did not materialise for therapists. Whilst a diverse workforce was widely acknowledged as an asset for SLT, many therapists lacked awareness and engagement with diversity practices across the NHS and SLT.

An overarchingly clear agenda and regulatory framework (i.e., clear body of stakeholders or practices, and accountability frameworks in the latter) for diversity is absent, or at least very vague, in the profession. A range of stakeholders were identified as driving a diversity agenda within SLT, but assigning responsibility was difficult. There was particular emphasis on the NHS and RCSLT which may reflect interviewee's knowledge or perceived importance of them. Therapists expected the RCSLT to act as the main regulator for diversity work, which conflicted with their agency being limited to lobbying and influencing. For example, the RCSLT targeted members who were managers to influence recruitment, and collaborated with universities to address SLT course issues. Managers were branded as key barriers to the implementation of diversity practices, but targeting them can sometimes be an ineffective strategy (e.g., resistance and unwillingness to change their behaviours or practices (Foster and Harris, 2005; Sinclair, 2006; Kirton and Greene, 2009; Tatli, 2011)). Whilst

different stakeholder's agency has been studied, this finding adds academic insight into the diversity roles and tactics of professional bodies which is lacking (see section 3.2).

The complexity of the NHS, and the SLT position within it, means that diversity strategies identified as effective in literature may be hard to put into practice. Several intra-organisational actors within the NHS were thought influential (e.g., leaders, managers, HR, privileged groups, etc.), yet conflictingly, sometimes the burden was placed on minority ethnic staff, and there were efforts to make diversity everyone's responsibility. The issues within the *voluntarism versus regulation* debate has mostly been understood in relation to the clearer organisational boundaries of private sector companies, but the NHS governance structure is arguably more complex. So, whilst the broad business case for diversity (i.e., benefits of recruiting a diverse workforce) (Kirton and Greene, 2005b; Noon, 2007) makes sense for the NHS (see section 4.2.4.1), its specific economic arguments does not, as the NHS is not a business despite imitating some market characteristics (Johns, Green and Powell, 2012). Also, societal issues were seen to seep into and shape the priorities of organisations within the profession which may discount organisational responsibility to an extent. The BLM movement and Covid-19 pandemic both occurred during this thesis, which exposed minority ethnic staff discrimination and White privilege within the NHS and profession by triggering related discussions and reflections (see section 7.5). This is a novel insight into how new external influences shaped understandings of ethnicity-based experiences and the development of diversity practices within the NHS and SLT.

Diversity stakeholders advocated for proactivity and accountability frameworks to be embedded across organisational processes, to promote engagement with, and the efficacy of, diversity practices. Proactivity is important because managers can misinterpret a lack of complaints as the absence of problems (Dobbin and Kalev, 2016), and formal organisational processes can display the very biases that they target (e.g., introducing formal grievance process reduced managerial diversity) (Dobbin and Kalev, 2016). Interviewees thought that diversity practices lacked accountability frameworks, which support calls for greater accountability within organisational processes (Kalev, Dobbin and Kelly, 2006). Also, NHS disciplinary processes were accused of passively waiting for concerns to be raised, and senior leaders of failing to scrutinise NHS workforce data to identify diversity issues, or consultant advice on how to address them. The latter is unsurprising since senior leaders and White staff (most senior staff were White) were unable to even talk about ethnicity, driven by fears of making mistakes or racism accusations. This signals White defensiveness maintaining racial

inequality (Van Laer and Janssens, 2011), and represents a missed opportunity to use privilege to address ethnicity barriers.

9.1.3 Methodological contributions

The tripartite focus represents a methodological contribution that future research should consider. No research to date has explored SLT workforce diversity from a macro (diversity approach), meso (diversity practices, therapists, and stakeholders relevant to SLT), and micro (therapist's experiences) lens. CRT claims of pervasive racism could be demonstrated for SLT across these three levels (see empirical contributions). Also, therapist's experiences could be compared with relevant diversity practices, which revealed gaps between the two (discussed as empirical contributions). Finally, for therapist's experiences, applying an intercategorical (McCall, 2005) and emic (Tatli and Özbilgin, 2012) intersectional approach allowed identification and analysis of multiple relevant social identities without assuming dis/advantage in advance which uncovered their fluidity of dis/advantage (see theoretical contributions).

9.2 Thesis limitations

On reflection, the thesis method had some limitations which affects the generalisability of findings to an extent. First, interviewees were asked to self-classify their gender and ethnicity to authentically reflect, rather than potentially impose, identity categories. However, the lack of a standard ethnicity classification system made it difficult to establish whether some interviewees could be considered minority ethnic or not. For example, one interviewee stated their ethnicity as Jewish, whilst others stated a standard ethnic category (e.g., White British) and Jewish together. There are differing views of whether being Jewish is a religious and/or an ethnic identity (e.g., see Lugo *et al.*, 2013). So, Jewish interviewees were classified according to their stated standard ethnic category. Where an interviewee stated their ethnicity as just Jewish, they were classified as minority ethnic because the UK's Jewish population is very small (reported <1% in the 2021 Census) (Graham and Boyd, 2022).

Second, minority ethnic therapists were mostly Asian, and male therapists were mostly White. So, the voices of other under-represented groups are not reflected well or at all (e.g., Black

therapists), but there were concentrated efforts to recruit and reflect their voices. For example, I contacted therapists with seemingly male or a non-White-British names in the ASLTIP directory, and asked all interviewees to share my study with their contacts (see section 5.2.4.1). Also, achieving an ethnically or gender diverse sample via an opportunity sampling technique was difficult because the SLT profession significantly lacks diversity in both respects. Future research should consider a more stratified sampling approach to collate a sample more diverse across relevant demographic variables that emerged during interviews, including sexuality, age, disability, religion, social class, SLT course years, careers advice quality, and length of time as a therapist (which is not properly captured by length of time in current role which I collected). Collecting this information for all therapists would allow for comparisons and so highlight changes between therapists and over time.

Third, the diversity of participant's workplaces was either too broad or narrow, and all were England-based. Diversity stakeholders came from varying professional backgrounds, and so an in-depth commentary on their sectors could not be established. Also, private sector insight stemmed just from sole traders. Some private companies provide SLT amongst other healthcare services, or focus exclusively on SLT. So, the diversity issues discussed are possibly being addressed better elsewhere. However, the diversity of stakeholder roles allowed a profession-wide insight into diversity issues and practices across sectors, including perspectives from non-profit, education, and health sectors. Future research should increase and diversify the sample from each sector, and consider organisational level studies to gauge whether they have a clearer diversity management approach than the profession overall.

Fourth, the diversity practices of private sector companies were not collected. Sole traders did not have diversity documentation, and so just those from the NHS were discussed and analysed. The NHS does not fully capture diversity practices relevant to SLT in the public sector, just as sole traders do not for the private sector. Nonetheless, this thesis identifies diversity practices relevant to SLT that future research can explore in more detail. Also, just one diversity document was collected per NHS site, excluding the NHS Long Term Plan 2019 which applies to the NHS overall. Each document differed in the level of detailed content provided. They supplemented the interview data; the aim was not to provide a comprehensive account of formal NHS diversity rhetoric. Future research should consider including more diversity

documentation, such as WRES and gender pay gap reports, for a more holistic and detailed idea of each site's approach to gender and ethnicity diversity management.

Fifth, all interviews were conducted online, and for some, there were technical issues. For example, sometimes poor internet connection resulted in poor audio or led to the Microsoft Teams/ Zoom calls shutting down. The latter was resolved by restarting the interview platforms or calling the interviewees again. In all cases, interview content prior to loss of internet connection was recovered. However, the internet quality affected the audio or video quality, which affected the ability to accurately transcribe interviews. Overall, though, the unclear audio did not affect the ability to understand interviewee's points, which could be deciphered using the wider context of their question responses. Also, online interviews were beneficial for wide reach of, and convenience for, participants. The thesis timing allowed novel insight into how Covid-19 and BLM shaped professional experiences and diversity practices across SLT.

Finally, the qualitative approach focused on *what* diversity discourses and issues exist within the profession, which future research could develop by exploring *how* such diversity discourses are created, and applying a quantitative lens to gauge the scale of diversity issues to help to prioritise concerns.

9.3 Conclusion and implications of findings

Three broad themes emerged: (1) entrance into SLT; (2) experiences within SLT, and (3) diversity approaches and stakeholders in SLT. Based on these themes, the thesis offers seven main theoretical, empirical and/or methodological contributions to the current knowledgebase of SLT workforce diversity.

Theoretically, my findings contribute to diversity management and intersectionality literature. First, the business case for diversity is problematized through the relatability concept which legitimises and thus maintains SLT's White, feminised culture. Whiteness was constructed as the norm with under-represented therapists valued by their ability to attract,

work with, and meet the needs of diverse groups, and allow their colleagues to do so by sharing these assets with them. However, they had difficulty in relating to clients and colleagues of the dominant group. For gender, men were disadvantaged in entry to SLT as gender stereotypes presented women as better suited and so more prevalent in SLT than men. Yet, men were privileged in being welcomed, accepted, and progression within SLT, whilst gender stereotypes made billing/charging services difficult for women and maternity/motherhood negatively affected women's career progression.

Second, intersectionality served as tool to theorise the fluidity and interlocking patterns of gender, ethnicity, and social class dis/advantage across therapist's careers. For example, class intersected with gender and ethnicity to shape career choices and suitability for clinical work.

There were four empirical contributions. First, I uncovered a lack of terminology for SLT, and poor understanding of speech disorders as unique barriers to SLT awareness for minority ethnic communities.

Second, I uncovered patterns of context-specific gender- and/or ethnicity-based marginalisation and disadvantage for therapists across their careers. This pattern was characterised by discrimination/bias, exclusion, and lack of relatability to clients and/or colleagues. For ethnicity-based patterns of marginalisation/disadvantage, I found evidence of microaggressions (e.g., racialised comments), institutional discrimination (e.g., bias within processes), White privilege (i.e., Whiteness as the norm and privileged, which signals minority ethnic therapists as foreign and disadvantages them) and concept of relatability at work (discussed as theoretical contribution). Also, I found sector-specific nuances about SLT issues, with private sector insight almost absent until now. Whilst securing work experience, income potential, and flexible working was thought better in the private sector of SLT than the NHS, it lacked support mechanisms, maternity packages, and there was financial instability for pregnant women. Also, there was a broad devaluing of clinical work across the profession.

Third, I exposed gaps between the experiences of minoritized groups and the practices meant to address them. At entrance to SLT, initiatives focused on raising awareness of or branding SLT, and targeting education or academia. However, embedding diverse imagery was thought a superficial act, not sustained, and failed to address core diversity concerns, across the profession. Also, the RCSLT's media efforts were accused of being reactionary, having

limited reach, and unclear rationale. Efforts to target education to attract diverse applicants were not early or wide enough, SLT was absent from careers fairs, and SLT careers advice varied in quality. Universities offering SLT courses had a free-market, non-values-based recruitment approach which may disadvantage minoritized students via inadequate staffing, there was poor student support when reporting discrimination at placements, and poor visible diversity across university materials, content, and lecturers. Despite social class and networked access to the profession outlined as barriers to entering SLT, interviewees placed little emphasis on diversity practices to address them. Moreover, patterns of marginalisation and disadvantage experienced by under-represented therapists are unlikely to be addressed given a focus on upskilling minority ethnic groups for career progression which can ignore structural issues such as perceptions of biased NHS recruitment processes, and a lack of/poor support mechanisms across SLT (e.g., stories of unsupportive managers). Whilst NHS Trust diversity policies may be used to hold poor behaviour to account, there was a lack of awareness of, engagement with, and implementation of, them. Raising awareness of diversity issues was at early discussion stages and focused on ethnicity, which may mean gender issues are unaddressed, and burden minority ethnic staff with educating others on diversity issues (e.g., expectations to share career experiences). The profession lacks diversity metrics, particularly on ethnicity, and whilst the NHS has a lot of such data, they were thought unskilled at monitoring diversity, scrutinising data to identify diversity issues, and measuring diversity practice impact.

Finally, two key challenges to diversity management within the profession were identified. First, the profession lacked a coherent EDI approach, with examples of equal opportunity and diversity management positions used in hybrid ways. This finding is novel as diversity approaches and their limitations have not been studied within the UK SLT context. Also, an overarching agenda, regulatory framework, and stakeholder roles for driving diversity within SLT was unclear. Therapists expected the RCSLT to act as a regulator of diversity work within SLT, but their small scale and inability to mandate actions meant that they relied on lobbying and influence tactics. The RCSLT should be clearer to therapists about the remit of their role. The diversity role and expectations of professional associations has not been studied well, and so this finding represents an empirical contribution. The NHS was found to be a complex context for diversity, and SLT is not understood well within it. So, unsurprisingly, many therapists lacked awareness of, and engagement with, diversity practices within the profession, and its impact on their professional lives was negligible or absent.

The thesis contributions have practical, policy, and theoretical implications for EDI management in the SLT profession. Practically, they suggest areas of focus to improve the profession's workforce diversity. When entering the SLT career pipeline, gender stereotypes need addressing by creating a balanced perception of the profession by addressing misconceptions which may inadvertently achieve appeal to men. For example, branding efforts should clarify the job title and role by highlighting its breadth of specialties and clients and their impact. Outreach should be early and wide, with SLT included in career fairs and its careers advice regulated. Also, there needs to be dialogue with different ethnic communities to develop a more systemic understanding of how upbringing in these communities shape the pursuit of SLT. Additionally, facilitating SLT entry involves financial considerations like ensuring paid work experience, reinstating SLT course bursaries, and increasing apprenticeship wages. Knowledge of therapist's professional experiences around ethnicity- and gender-based marginalisation and disadvantage, sector-specific nuances, and diversity practice gaps in addressing them, highlight how they can all be improved. For example, the profession should consider sustaining visible gender and ethnic representation across the SLT career pipeline, and better collect or analyse diversity data.

Regarding policy, career path, pay, and pastoral support structures need improvement at employer and profession level. Awareness and engagement with diversity practices and policies can be improved by making them routine rather than additional work activities, active learning, and sharing their rationale and impact. Also, there is a need for a clearer agenda and co-ordination of stakeholders for diversity within the NHS and SLT more broadly, but this is difficult as the NHS is a complex context for diversity. Empowering the stakeholders discussed can improve their diversity efforts, such as supporting senior leaders to talk about ethnicity and granting more resources and agency to HR and/or EDI leads including adding accountability structures in existing practices. The criticisms of the RCSLT's diversity efforts signal how their role could be enhanced. For example, they should be more proactive in tackling the profession's diversity concerns, have clearer objectives for their diversity work accompanied with rationales, and actively communicate their work in ways that reach therapists because most interviewees did not name their specific practices.

Theoretically, the business case for diversity and intersectionality should be considered as tools for understanding identity-based workforce dis/advantage.

Overall, three main themes emerged which resulted in seven main theoretical, empirical, and methodological insights about how gender and ethnicity shapes therapist's careers and how diversity is managed within the profession in the UK. I hope that these insights help to better understand why the profession's workforce lacks gender and ethnic diversity, and how to address it.

References

Acker, J. (1990) ‘Hierarchies, jobs, bodies: A theory of gendered organizations’, *Gender and Society*, 4(2), pp. 139–158. doi: https://doi.org/10.1177/089124390004002002.

Acker, J. (1992) ‘From Sex Roles to Gendered Institutions’, *Contemporary Sociology*, 21(5), pp. 565–569.

Acker, J. (1994) ‘Reviewed Work(s): In the Way of Women: Men’s Resistance to Sex Equality in Organizations by Cynthia Cockburn: The Promise and the Price: The Struggle for Equal Opportunity in Women’s Employment by Clare Burton’, *Signs*. The University of Chicago Press, 19(2), pp. 504–506. Available at: https://www.jstor.org/stable/3174811%0AJSTOR.

Acker, J. (2006) ‘Inequality regimes: Gender, class, and race in organizations’, *Gender and Society*, 20(4), pp. 441–464. doi: 10.1177/0891243206289499.

Adam, F. and Roncevic, B. (2003) ‘Social capital: Recent debates and research trends’, *Social Science Information*, 42(2), pp. 155–183. doi: doi:10.1.1.198.7340.

Adib, A. and Guerrier, Y. (2003) ‘The interlocking of gender with nationality, race, ethnicity and class: The narratives of women in hotel work’, *Gender, Work and Organization*, 10(4), pp. 413–432. doi: 10.1111/1468-0432.00204.

Advisory Conciliation and Arbitration Service (ACAS) (2021) *Checking your employment rights*. Available at: https://www.acas.org.uk/checking-your-employment-rights (Accessed: 12 January 2021).

AGCAS (2020) *Job profile: speech and language therapist*. Available at: https://www.prospects.ac.uk/job-profiles/speech-and-language-therapist (Accessed: 12 February 2021).

Agócs, C. and Burr, C. (1996) ‘Employment equity, affirmative action and managing diversity: Assessing the differences’, *International Journal of Manpower*, 17(4–5), pp. 30–45. doi: 10.1108/01437729610127668.

Ahern, K. R. and Dittmar, A. K. (2011) ‘The Changing of the Boards: The Impact on Firm Valuation of Mandated Female Board Representation’, *Quarterly Journal of Economics*, Forthcomin, pp. 137–197. doi: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1364470.

Ahmed, S. (2007a) ‘The language of diversity’, *Ethnic and Racial Studies*, 30(2), pp. 235–256. doi: 10.1080/01419870601143927.

Ahmed, S. (2007b) ‘“You end up doing the document rather than doing”: Diversity race

equality and the politics of documentation', *Ethnic and Racial Studies*, 30(4), pp. 590–609. doi: 10.1080/01419870701356015.

Ahmed, S. (2012) *On Being Included: Racism and Diversity in Institutional Life*. Durham: Duke University Press. doi: https://doi.org/10.1215/9780822395324.

American Psychological Association (2022) *Discrimination: What it is and how to cope*, *Psychology topics*. Available at: https://www.apa.org/topics/racism-bias-discrimination/types-stress (Accessed: 29 March 2023).

Anderson, D., Vinnicombe, S. and Singh, V. (2010) 'Women partners leaving the firm: Choice, what choice?', *Gender in Management*, 25(3), pp. 170–183. doi: 10.1108/17542411011036383.

Anker, R. (1997) 'Theories of occupational segregation by sex: An overview', *International Labour Review*, 136(3), pp. 315–340.

Anthias, F. (2013) 'Intersectional what? Social divisions, intersectionality and levels of analysis', *Ethnicities*, 13(1), pp. 3–19. doi: 10.1177/1468796812463547.

Arnold, J. *et al.* (2006) *Push and pull: why allied health professionals stay in, leave or return to the NHS - views of professionals inside and outside the NHS*. Loughborough. Available at: https://repository.lboro.ac.uk/articles/report/Push_and_pull_why_allied_health_professionals_stay_in_leave_or_return_to_the_NHS_-_views_of_professionals_inside_and_outside_the_NHS/9494612?file=17120876.

Association of Speech and Language Therapists in Independent Practice (ASLTIP) (2015) *ASLTIP members*. Available at: https://asltip.com/news/asltip-members/ (Accessed: 3 February 2021).

Association of Speech and Language Therapists in Independent Practice (ASLTIP) (2023) *Member benefits*. Available at: https://asltip.com/member-benefits/ (Accessed: 27 March 2023).

Atewologun, A. O. (2011) *An examination of senior Black, Asian and Minority Ethnic women and men's identity work following episodes of identity salience at work*. Cranfield University.

Atewologun, D. (2014) 'Sites of intersectional identity salience', *Gender in Management: An International Journal*, 29(5), pp. 277–290.

Atewologun, D. (2018) 'Intersectionality theory and practice', *Oxford Research Encyclopedia of Business and Management*. Oxford University Press. doi: 10.1093/acrefore/9780190224851.013.48.

Atewologun, D., Cornish, T. and Tresh, F. (2018) *Unconscious bias training: An assessment of the evidence for effectiveness. Equality anf Human rights commission research report 113.* Equality and human rights commission. Available at: https://www.equalityhumanrights.com/sites/default/files/research-report-113-unconcious-bais-training-an-assessment-of-the-evidence-for-effectiveness-pdf.pdf.

Atewologun, D. and Kline, R. (2019) 'Fair to refer? Reducing disproportionality in fitness to practise concerns reported to the GMC', *General Medical Council*, pp. 1–77. Available at: https://www.gmc-uk.org/-/media/documents/fair-to-refer-report-pdf-79011677_pdf-79021583.pdf.

Atewologun, D. and Mahalingam, R. (2018) 'Intersectional reflexivity: Methodological challenges and possibilities for qualitative equality, diversity, and inclusion research', in Bendl, R., Booysen, L., and Pringle, J. (eds) *Handbook of research methods on diversity management, equality, and inclusion at work.* Cheltenham, UK: Edward Elgar.

Atewologun, D. and Sealy, R. (2014) 'Experiencing privilege at ethnic, gender and senior intersections', *Journal of Managerial Psychology*, 29(4), pp. 423–439. doi: 10.1108/JMP-02-2013-0038.

Attride-Stirling, J. (2001) 'Thematic networks: An analytic tool for qualitative research', *Qualitative Research*, 1(3), pp. 385–405. doi: doi:10.1177/ 146879410100100307.

Austin, Z. and Sutton, J. (2014) 'Qualitative research: Getting started', *Canadian Journal of Hospital Pharmacy*, 67(6), pp. 436–440. doi: 10.4212/cjhp.v67i6.1406.

Avery, D. R. (2003) 'Reactions to diversity in recruitment advertising - Are differences Black and White?', *Journal of Applied Psychology*, 88(4), pp. 672–679. doi: 10.1037/0021-9010.88.4.672.

Babatsouli, E. (2021) 'Diversity considerations in speech and language disorders', in Jack S. Damico, Nicole Müller, M. J. B. (ed.) *The Handbook of Language and Speech Disorders*. Second. John Wiley & Sons Ltd, pp. 33–52. doi: https://doi.org/10.1002/9781119606987.ch2.

Baca Zinn, M. and Dill, B. T. (1996) 'Theorizing difference from multiracial feminism', *Feminist Studies*, 22(2), pp. 321–331. Available at: https://www.jstor.org/stable/3178416.

Bacchi, C. (1990) *Same Difference: Feminism and Sexual Difference*. Sydney: Men & Unwin.

Bailey, S. (2020) 'Editorials: The NHS people plan', *BMJ*, 370, p. m3398. doi: https://doi.org/10.1136/bmj.m3398.

Baker, C. (2020) *NHS staff from overseas: statistics, Briefing paper No.7783*. Available at: https://commonslibrary.parliament.uk/research-briefings/cbp-7783/ (Accessed: 4 June

2021).

Baker, C. D. (2002) ‘Ethnomethodological Analyses of Interviews’, in Gubrium, J. and Holstein, J. (eds) *Handbook of Interviewing: Context and Method*. Thousand Oaks, CA: Sage.

Balafoutas, L. and Sutter, M. (2012) ‘Affirmative action policies promote women and do not harm efficiency in the laboratory’, *Science*, 335(6068), pp. 579–582. doi: 10.1126/science.1211180.

Baldi, S. and Mcbrier, D. B. (1997) ‘Do the Determinants of Promotion Differ for Blacks and Whites? Evidence from the U.S. labor market’, *Work & Occupations*, 24(2), pp. 478–497.

Ball, J. and Pike, G. (2009) *Past imperfect, future tense: Nurses’ employment and morale in 2009*. London. doi: 003 545.

Ball, S. J., Reay, D. and David, M. (2002) ‘“Ethnic choosing”: Minority ethnic students, social class and higher education choice’, *Race ethnicity and education*, 5(4), pp. 333–357. doi: 10.1080/1361332022000030879.

Barber, B. (1979) ‘Control and responsibility in the powerful professions’, *Political Science Quarterly*, 93(4), pp. 599–615. doi: 10.2307/2150105.

Barmes, L. and Ashtiany, W. S. (2003) ‘The diversity approach to achieving equality: Potential and pitfalls’, *Industrial Law Journal*, 32(4), pp. 274–296. doi: 10.1093/ilj/32.4.274.

Bastian, B. and Haslam, N. (2006) ‘Psychological essentialism and stereotype endorsement’, *Journal of Experimental Social Psychology*, 42(2), pp. 228–235. doi: 10.1016/j.jesp.2005.03.003.

Becker, G. (1981) *A treatise on the family*. Cambridge, MA: Harvard University Press.

Begum, M. *et al.* (2019) ‘The value of European immigration for high-level UK research and clinical care: cross-sectional study’, *Journal of the Royal Society of Medicine*, 112(1), pp. 29–35. doi: 10.1177/0141076818803427.

Beishon, S., Virdee, S. and Hagell, A. (1995) *Nursing in a Multi-Ethnic NHS, PSI research report*. London.

Belkin, L. (2003) ‘The Opt-Out Revolution’, *The New York Times Magazine*, 26 October. Available at: https://www.nytimes.com/2003/10/26/magazine/the-opt-out-revolution.html (Accessed: 22 June 2021).

Bell, D. (1992) *Faces at the bottom of the well: The permanence of racism*. New York, NY: Basic.

Bell Jr., D. A. (1980) ‘Brown v . Board of Education and the interest-convergence dilemma’, *Harward Law Review*, 93(3), pp. 518–533.

Bending, H. (2011) ‘Becoming a male speech and language therapist’, in *International Conference of Education, Research, and Innovation 2011 Proceedings*, pp. 3254–3259. Available at: https://library.iated.org/view/BENDING2011BEC (Accessed: 29 December 2022).

Bending, H. (2012) *Becoming a speech and language therapist: A qualitative exploration of the experiences of male speech and language therapy students and early career professionals*. University of Exeter.

Berdahl, J. L. *et al.* (2018) ‘Work as a Masculinity Contest’, *Journal of Social Issues*, 74(3), pp. 422–448. doi: 10.1111/josi.12289.

Bernier, J. D. and Rocco, T. S. (2003) ‘Working in the margins of critical race theory and human resource development’, in Ferro, T. and Dean, G. (eds) *Proceedings of the Midwest research-to-practice conference in adult, continuing, and community education*. Columbus: The Ohio State University, pp. 13–18.

Bey, M. and Sakellarides, T. (2016) ‘When we enter: the blackness of Rachel Dolezal’, *Black Scholar*. Taylor & Francis, 46(4), pp. 33–48. doi: 10.1080/00064246.2016.1227197.

Beydoun, K. A. and Wilson, E. K. (2017) ‘Reverse passing’, *UCLA L. Rev.*, 64, pp. 282–354. doi: 10.3868/s050-004-015-0003-8.

Bhandari, H. and Yasunobu, K. (2009) ‘What is social capital? A comprehensive review of the concept’, *Asian Journal of Social Science*, 37(3), pp. 480–510. doi: 10.1163/156853109X436847.

Bhopal, R. (2004) ‘Glossary of terms relating to ethnicity and race: For reflection and debate’, *Journal of Epidemiology & Community Health*, 58(6), pp. 441–445. doi: 10.1136/jech.2003.013466.

Birch, M. and Miller, T. (2000) ‘Inviting intimacy: The interview as therapeutic opportunity’, *International Journal of Social Research Methodology*, 3(3), pp. 189–202. doi: 10.1080/13645570050083689.

Bird, J. A. (1996) *Black Students and Higher Education*. Buckingham: Open University Press; Society for Research into Higher Education.

Blakemore, E. (2019) *Race and ethnicity, explained*. Available at: https://www.nationalgeographic.co.uk/history/2019/02/race-and-ethnicity-explained (Accessed: 4 February 2021).

Blandford, E. *et al.* (2011) *Equality in higher education: statistical report 2011. Part 2: students.* London. Available at: https://www.ecu.ac.uk/wp-content/uploads/2011/12/equality-in-he-stats-11-part-2-students.pdf.

Block, D. (2014) *Social class in applied linguistics*. London: Routledge.

Block, D. and Corona, V. (2014) 'Exploring class-based intersectionality', *Language, Culture and Curriculum*. Taylor & Francis, 27(1), pp. 27–42. doi: 10.1080/07908318.2014.894053.

Block, D., Gray, J. and Holborow, M. (2012) *Neoliberalism and applied linguistics*. London: Routledge.

Bloor, M. and Wood, F. (2006) 'Sampling', *Keywords in qualitative methods*. SAGE Publications Ltd, pp. 154–157. doi: https://www.doi.org/10.4135/9781849209403.

Böckler, A., Rennert, A. and Raettig, T. (2021) 'Stranger, Lover, Friend: The Pain of Rejection Does Not Depend', *Social Psychology*, 52(3), pp. 173–184. doi: 10.1027/1864-9335/a000446.

Bogg, J. and Hussain, Z. (2010) 'Equality, diversity and career progression: Perceptions of radiographers working in the National Health Service', *Radiography*. Elsevier Ltd, 16(4), pp. 262–267. doi: 10.1016/j.radi.2010.02.001.

Bolick, C. (1995) 'Thatcher's revolution : Deregulation and political transformation', *The Yale Journal of Regulation*, 12, pp. 527–548. Available at: https://core.ac.uk/download/pdf/72838789.pdf.

Bonilla-Silva, E. (2003a) ''New Racism,' Color-Blind Racism, and the Future of Whiteness in America', in Doane, A. W. and Silva, E. B.- (eds) *White Out: The Continuing Significance of Racism*. New York: Routledge, pp. 271–284.

Bonilla-Silva, E. (2003b) *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States*. Lanham, MD: Rowman and Littlefield.

Booth, T. and Booth, W. (1994) 'The use of depth interviewing with vulnerable subjects: Lessons from a research study of parents with learning difficulties', *Social Science and Medicine*, 39(3), pp. 415–424. doi: 10.1016/0277-9536(94)90139-2.

Bos-Nehles, A. C. and Meijerink, J. (2015) 'Implementing HRM Systems: The Role of Employees' Co-Production Behavior and HRM Attributions', *Academy of Management Proceedings*, (1), pp. 1–42. doi: 10.5465/ambpp.2015.11291abstract.

Bosley, S. L. c., Arnold, J. and Cohen, L. (2009) 'How other people shape our careers: A typology drawn from career narratives', *Human Relations*, 62(10), pp. 1487–1520. doi: 10.1177/0018726709334492.

Bostock, N. (2018) *The rise of women in general practice, GP Online*. Available at: https://www.gponline.com/rise-women-general-practice/article/1458988 (Accessed: 31 August 2021).

Bourdieu, P. (1986) 'The forms of capital', in Richardson, J. G. (ed.) *Handbook of theory and*

research for the sociology of education. New York, NY, USA: Greenwood press, pp. 241–258. doi: 10.4324/9780429494338.

Bourke, J. and Titus, A. (2020) *The Key to Inclusive Leadership*, *Harvard Business Review*. Available at: https://hbr.org/2020/03/the-key-to-inclusive-leadership (Accessed: 1 July 2021).

Boyatzis, R. (1998) *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Boyd, S. and Hewlett, N. (2001) 'The gender imbalance among speech and language therapists and students', *International Journal of Language and Communication Disorders*, 36(1995), pp. 167–172. doi: 10.3109/13682820109177878.

Boylorn, R. M. (2008) 'Lived experience.', in Given, L. M. (ed.) *The SAGE Encyclopedia of Qualitative Research Methods*. Sage. doi: https://dx.doi.org/10.4135/9781412963909.n250.

Bradley, H. (1996) *Fractured identities: Changing patterns of inequality*. Cambridge: Polity press.

Bradley, H. (1999) *Gender and Power in the Workplace*. Basingstoke: Macmillan.

Bradley, H. and Healy, G. (2008) *Ethnicity and gender at work: Inequalities, careers, and employment relations., The Future of Work Series.* London, UK: Palgrave Macmillan.

Brammer, S., Millington, A. and Pavelin, S. (2009) 'Corporate reputation and women on the board', *British Journal of Management*, 20(1), pp. 17–29. doi: 10.1111/j.1467-8551.2008.00600.x.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3(2), pp. 77–101. doi: 10.1191/1478088706qp063oa.

Bravery, K. *et al.* (2019) *Global talent trends 2019: Connectivity in the human age*. Available at: http://www.mmc.com/content/dam/mmc-web/insights/publications/2019/feb/gl-2019-global-talent-trends-study.pdf.

Breitenbach, E. (2003) *Statutory Duties to Promote Equal Opportunities and Evidence of their Impact, BRIEFING NOTE FOR THE STRATEGIC GROUP ON WOMEN*. Available at: https://www.webarchive.org.uk/wayback/archive/20170701074158/http://www.gov.scot/Publications/2003/11/18591/29800 (Accessed: 4 June 2020).

Brewster, C. and Holt Larsen, H. (2000) 'Responsibility in human resource management: The role of the line', in Brewster, C. and Holt Larsen, H. (eds) *Human Resource Management in Northern Europe*. Oxford, UK: Blackwell.

Brimm, L. and Arora, M. (2001) 'Diversity Management at Hewlett-Packard, Europe', in Albrecht, M. A. (ed.) *International HRM- Managing Diversity in the Workplace*. Oxford:

Blackwell, pp. 108–124.

Briner, R. B., Denyer, D. and Rousseau, D. M. (2009) 'Evidence-based management: Concept cleanup time?', *Academy of Management Perspectives*, 23(4), pp. 19–32. doi: 10.5465/AMP.2009.45590138.

British Medical Association (2021) *Toolkit for doctors new to the UK: How the NHS works*. Available at: https://www.bma.org.uk/advice-and-support/international-doctors/life-and-work-in-the-uk/toolkit-for-doctors-new-to-the-uk/how-the-nhs-works (Accessed: 31 August 2021).

Brondolo, E. *et al.* (2012) 'Racism and Social Capital: The Implications for Social and Physical Well-Being', *Journal of Social Issues*, 68(2), pp. 358–384. doi: 10.1111/j.1540-4560.2012.01752.x.

Brown, J. (2021) *Is the UK a meritocracy?* Available at: https://www.economicsobservatory.com/is-the-uk-a-meritocracy (Accessed: 4 May 2022).

Brown, R. . (1977) *A poetic for sociology*. Cambridge: Cambridge University Press.

Browne, I. and Misra, J. (2003) 'The intersection of gender and race in the labor market', *Annual Review of Sociology*, 29(1), pp. 487–513. doi: 10.1146/annurev.soc.29.010202.100016.

Brubaker, R. (2016a) 'The Dolezal affair: Race, gender, and the micropolitics of identity', *Ethnic and Racial Studies*. Taylor & Francis, 39(3), pp. 414–448. doi: 10.1080/01419870.2015.1084430.

Brubaker, R. (2016b) *Trans: Gender and race in an age of unsettled identities*. Princeton, New Jersey: Princeton University Press. Available at: https://press.princeton.edu/books/hardcover/9780691172354/trans.

Brynin, M. and Longhi, S. (2015) *The effect of occupation on poverty among ethnic minority groups*. York. Available at: https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/occupation-poverty-ethnic-minority-full.pdf.

Buchan, J. and Evans, D. (2007) *Realising the Benefits? Assessing the implementation of Agenda for Change*. London. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/realising-benefits-assessing-implementation-agenda-change-james-buchan-david-evans-kings-fund-30-july-2007_0.pdf.

Buchan, J. and Evans, D. (2008) 'Assessing the impact of a new health sector pay system upon NHS staff in England', *Human Resources for Health*, 6(12), pp. 1–7. doi: 10.1186/1478-

4491-6-12.

Buchan, J. and Seccombe, I. A. N. (2006) *From Boom to Bust? The UK nursing labour market review 2005/6*. London. Available at: http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.467.5626&rep=rep1&type=pdf.

Buddeberg-Fischer, B. and Reed, V. (2001) 'Career obstacles for women in medicine: an overview', *Medical Education*, 35, pp. 139–147. doi: 10.1046/j.1365-2923.2001.00860.x.

Budjanovcanin, A. (2018) 'Actions speak louder than words: how employees mind the implementation gap', *International Journal of Human Resource Management*. Routledge, 29(22), pp. 3136–3155. doi: 10.1080/09585192.2018.1443959.

Buren, H. J. Van (2021) 'Deregulation', *Britannica*. Available at: https://www.britannica.com/topic/deregulation (Accessed: 5 January 2021).

Burke, R. J. (2004) 'Work experiences, stress and health among managerial women: Research and practice', in Schabracq, M. J., Winnubst, J. A. M., and Cooper, C. L. (eds) *The Handbook of Work and Health Psychology*. Second edi. Chichester, UK: John Wiley & Sons, pp. 259–278.

Burr, V. (2015) 'The Role of Language in Social Constructionism', in *Social Constructionism*. Third. London: Routledge. doi: https://doi.org/10.4324/9781315715421.

Buse, K., Bernstein, R. S. and Bilimoria, D. (2016) 'The Influence of Board Diversity, Board Diversity Policies and Practices, and Board Inclusion Behaviors on Nonprofit Governance Practices', *Journal of Business Ethics*, 133(1), pp. 179–191. doi: 10.1007/s10551-014-2352-z.

Business in the community (2023) *Race: capability not ethnicity*. Available at: https://www.bitc.org.uk/race/ (Accessed: 24 March 2023).

Byrne, N. (2007) 'Factors influencing the selection of speech pathology as a career: A qualitative analysis utilising the systems theory framework', *Australian Journal of Career Development*, 16(3), pp. 11–18. doi: 10.1177/103841620701600304.

Byrne, N. (2008) 'Current and prospective speech-language pathology students' reports of exposure to speech-language pathology', *International Journal of Speech-Language Pathology*, 10(5), pp. 297–304. doi: 10.1080/17549500802147018.

Byrne, N. (2010) 'Why do students from related professions choose not to enter speech-language pathology?', *International Journal of Speech Language Pathology*, 12(4), pp. 344–351. Available at: https://doi.org/10.3109/17549500903464346.

Byrne, N. (2017) 'Internet images of the speech pathology profession', *Australian Health Review*, 42(4), pp. 420–428. doi: https://doi.org/10.1071/AH17033.

Campbell, R. *et al.* (2010) '"What has it been like for you to talk with me today?": The impact of participating in interview research on rape survivors', *Violence Against Women*, 16(1), pp. 60–83. doi: 10.1177/1077801209353576.

Capps, J. (1996) 'Pragmatism, Feminism, and the Sameness-Difference Debate', *Transactions of the Charles S. Peirce Society*, 32(1), pp. 65–105.

Carastathis, A. (2014) 'The concept of intersectionality in feminist theory', *Philosophy Compass*, 9(5), pp. 304–314. doi: 10.1111/phc3.12129.

Career Smart (2020) *Speech and language therapists*. Available at: https://careersmart.org.uk/occupations/speech-and-language-therapists (Accessed: 15 February 2021).

Carers UK (2014) *Caring and family finances inquiry: Executive summary*. Available at: https://www.carersuk.org/for-professionals/policy/policy-library/caring-family-finances-inquiry (Accessed: 26 March 2018).

Carmeli, A., Reiter-Palmon, R. and Ziv, E. (2010) 'Inclusive leadership and employee involvement in creative tasks in the workplace: The mediating role of psychological safety', *Creativity Research Journal*, 22(3), pp. 250–260. doi: 10.1080/10400419.2010.504654.

Carr, L. G. (1997) *Color-Blind Racism*. Thousand Oaks, CA: Sage Publications.

Carrington, B., Tymms, P. and Merrell, C. (2008) 'Role models, school improvement and the "gender gap" - Do men bring out the best in boys and women the best in girls?', *British Educational Research Journal*, 34(3), pp. 315–327. doi: 10.1080/01411920701532202.

Carter, J. (2000) 'New public management and equal opportunities in the NHS', *Critical Social Policy*, 20(1), pp. 61–83. doi: 10.1177/026101830002000101.

Carter, S. M. *et al.* (2008) 'You have to make something of all that rubbish, do you? An empirical investigation of the social process of qualitative research', *Qualitative Health Research*, 18(9), pp. 1264–1276. doi: 10.1177/1049732308321753.

Carvel, J. (2003) *NHS is race biased says Phillips*. Available at: https://www.theguardian.com/society/2003/apr/30/equality.raceequality (Accessed: 24 December 2020).

Cassell, J. (1980) 'Ethical Principles for Conducting Fieldwork', *American Anthropologist*, 82(1), pp. 28–41. doi: 10.1525/aa.1980.82.1.02a00020.

Castilla, E. J. (2015) 'Accounting for the gap: A firm study manipulating organizational accountability and transparency in pay decisions', *Organization Science*, 26(2), pp. 311–333. doi: 10.1287/orsc.2014.0950.

Castilla, E. J. (2016) 'Achieving meritocracy in the workplace', *MIT Sloan Management*

Review, (Reprint #57421), pp. 35–41.

Castilla, E. J., Lan, G. J. and Rissing, B. A. (2013a) 'Social Networks and Employment: Outcomes (Part 1)', *Sociology Compass*, 7(12), pp. 999–1012. doi: 10.1111/soc4.12095.

Castilla, E. J., Lan, G. J. and Rissing, B. A. (2013b) 'Social Networks and Employment: Outcomes (Part 2)', *Sociology Compass*, 7(12), pp. 1013–1026. doi: 10.1111/soc4.12095.

Caudron, S. (1994) 'Diversity ignites effective work teams', *Personnel Journal*, 73(9), pp. 54–63. Available at: https://www.workforce.com/uk/news/diversity-ignites-effective-work-teams.

Cavaglia, C., Mcnally, S. and Ventura, G. (2022) *The recent evolution of apprenticeships: Apprenticeship pathways and participation since 2015*. London, UK. doi: 10.1007/978-94-015-9946-7_4.

Cengage (2021) 'Board of directors', *Encylcopedia.com*. Available at: https://www.encyclopedia.com/social-sciences-and-law/economics-business-and-labor/businesses-and-occupations/board-directors (Accessed: 3 February 2021).

Centre For Workforce Intelligence (2014) *Securing the future workforce supply: Speech and language therapy stocktake*. London. Available at: https://recipeforworkforceplanning.hee.nhs.uk/Portals/0/HEWM_LinksAndResources/Speech and language therapy stocktake - Dec 2014.pdf?ver=2016-04-18-112016-557.

Chadd, K., Moyse, K. and Enderby, P. (2021) 'Impact of COVID-19 on the Speech and Language Therapy Profession and Their Patients', *Frontiers in Neurology*, 12, pp. 1–11. doi: 10.3389/fneur.2021.629190.

Chakrabarty, N., Roberts, L. and Preston, J. (2014) *Critical race theory in England*. London, England: Routledge.

Chaudhry, F. B. *et al.* (2020) 'Covid 19 and BAME health care staff: Wrong place at the wrong time', *Journal of Global Health*, 10(2), pp. 1–4. doi: 10.7189/jogh.10.020358.

Choi, S. B., Tran, T. B. H. and Park, B. Il (2015) 'Inclusive Leadership and Work Engagement: Mediating Roles of Affective Organizational Commitment and Creativity', *Social Behavior and Personality: an international journal*, 43(6), pp. 931–943. doi: https://doi.org/10.2224/sbp.2015.43.6.931.

Choo, H. Y. and Ferree, M. M. (2010) 'Practicing Intersectionality in Sociological Research: A Critical Analysis of Inclusions, Interactions, and Institutions in the Study of Inequalities', *Sociological Theory*, 28(2), pp. 129–149. doi: 10.1111/j.1467-9558.2010.01370.x.

Cislaghi, B. and Heise, L. (2019) 'Gender norms and social norms: differences, similarities and why they matter in prevention science', *Sociology of Health and Illness*, 42(2), pp. 407–

422. doi: 10.1111/1467-9566.13008.

Claridge, T. (2008) *What is Structural Social Capital?* Available at: https://www.socialcapitalresearch.com/structural-social-capital/ (Accessed: 30 December 2023).

Clark, T. (2010) 'On "being researched": Why do people engage with qualitative research?', *Qualitative Research*, 10(4), pp. 399–419. doi: 10.1177/1468794110366796.

Clarke, A. Y. and McCall, L. (2013) 'Intersectionality and social explanation in social science research', *Du Bois Review*, 10(2), pp. 349–363. doi: 10.1017/S1742058X13000325.

Close the Gap (2013) *Shifting the balance? Exploring the trade union responses to tackling gendered occupational segregation. Working paper 8.* Available at: https://www.closethegap.org.uk/content/resources/CTG-Working-Paper-8---Shifting-the-Balance.pdf (Accessed: 18 November 2019).

Close the Gap (no date) *Handout 2: Recap: Occupational Segregation*. Available at: https://www.closethegap.org.uk/content/resources/HANDOUT2.pdf (Accessed: 18 February 2020).

Cockburn, C. (1989) 'Equal opportunities: the short and long agenda', *Industrial Relations Journal*, 20(3), pp. 213–225. doi: https://doi.org/10.1111/j.1468-2338.1989.tb00068.x.

Cockburn, C. (1991) *In the Way of Women: Men's Resistance to Sex Equality in Organizations*. Basingstoke: Macmillan.

Collins, A. (2020) *NHS workforce plan at risk as covid scuppers overseas recruitment, Health service journal*. Available at: https://www.hsj.co.uk/workforce/nhs-workforce-plan-at-risk-as-covid-scuppers-overseas-recruitment/7027683.article (Accessed: 9 February 2021).

Collins, A. (2021) 'The Ward Round: Ramping up international recruitment in a pandemic', *Health Service Journal*. Available at: https://www.hsj.co.uk/workforce/the-ward-round-ramping-up-international-recruitment-in-a-pandemic/7029615.article (Accessed: 4 June 2021).

Collins, B. W. (2007) 'Tackling unconscious bias in hiring practices: The plight of the Rooney Rule', *New York University Law Review*, 82(3), pp. 870–912. Available at: https://www.nyulawreview.org/issues/volume-82-number-3/tackling-unconscious-bias-in-hiring-practices-the-plight-of-the-rooney-rule/.

Collins, P. H. (1990) *Black feminist thought: Knowledge, consciousness, and the politics of empowerment.* New York: Routledge.

Collins, P. H. (1993) 'Toward a new vision: Race, class, and gender as categories of analysis and connection', *Race, Sex & Class*, 1(1), pp. 25–45. Available at:

https://www.jstor.org/stable/41680038.

Collins, S. M. (1997) 'Black mobility in white corporations: Up the corporate ladder but out on a limb', *Social Problems*, 44(1), pp. 55–67. doi: 10.2307/3096873.

Collinson, D. and Hearn, J. (1996) 'Breaking the silence: on men, masculinities and managements', in Collinson, D. and Hearn, J. (eds) *Men as Managers, Managers as Men: Critical Perspectives on Men, Masculinities and Managements*. London: Sage, pp. 1–24.

Collinson, P. (2019) 'UK gender pay gap for full-time workers increases', *The Guardian*. Available at: https://www.theguardian.com/money/2019/oct/29/uk-gender-pay-gap-full-time-workers (Accessed: 6 November 2019).

Commission for Racial Equality (CRE) (1995) *Racial Equality Means Quality' a Standard for Racial Equality for Local Government in England and Wales*. London.

Connell, R. (1987) *Gender and Power: Society, the Person and Sexual Politics*. Palo Alta: University of California Press.

Connell, R. W. (1995) *Masculinities*. University of California Press.

Connell, R. W. and Messerschmidt, J. W. (2005) 'Hegemonic masculinity rethinking the concept', *Gender and Society*, 19(6), pp. 829–859. doi: 10.1177/0891243205278639.

Cook, A. and Glass, C. (2015) 'The Power of One or Power in Numbers?: Analyzing the Effect of Minority Leaders on Diversity Policy and Practice', *Work and Occupations*, 42(2), pp. 183–215. doi: 10.1177/0730888414557292.

Cook, A. S. and Bosley, G. (1995) 'The experience of participating in bereavement research: Stressful or therapeutic?', *Death Studies*, 19(2), pp. 157–170. doi: 10.1080/07481189508252722.

Cook, D. (2013) 'Blurring the boundaries: The mechanics of creating composite characters', in Lynn, M. and Dixson, A. (eds) *The handbook of critical race theory in education*. New York, NY: Routledge, pp. 181–194.

Cook, T., Kursumovic, E. and Lennane, S. (2020) 'Exclusive: deaths of NHS staff from covid-19 analysed', *Health Service Journal*. Available at: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article (Accessed: 4 June 2021).

Cooper, J. (2019) *How does UK healthcare spending compare with other countries? An analysis of UK healthcare spending relative to comparable countries, using data produced to the international definitions of the System of Health Accounts (SHA 2011).* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/articles/howdoesukhealthcarespendingcomparewithothercountries/2019-08-29#main-points (Accessed: 16 April 2020).

Corbin, J. and Morse, J. M. (2003) 'The Unstructured Interactive Interview: Issues of Reciprocity and Risks when Dealing with Sensitive Topics', *Qualitative Inquiry*, 9(3), pp. 335–354. doi: 10.1177/1077800403009003001.

Corcoran, B. M. E. and Courant, P. N. (1985) 'Sex Role Socialization and Labor Market Outcomes', *The American Economic Review*, 75(2), pp. 275–278. Available at: https://www.jstor.org/stable/1805610 Accessed:

Cornelius, N. (2020) 'Writing a Literature Review. Part 1: Academic content and reasoning. Theoretical/ Conceptual Framework.' London: Queen Mary University of London, pp. 1–32.

Cornelius, N., Gooch, L. and Todd, S. (2000) 'Managers Leading Diversity for Business Excellence', *Journal of General Management*, 25(3), pp. 67–78.

Cotter, D. A. *et al.* (2001) 'The Glass Ceiling Effect', *Social Forces*, 80(2), pp. 655–681. doi: 10.1353/sof.2001.0091.

Cox, T. (2004) 'Problems with Research by Organizational Scholars on Issues of Race and Ethnicity', *The Journal of Applied Behavioral Science*, 40(2), pp. 124–145. doi: 10.1177/0021886304263851.

Cox, T. H. and Blake, S. (1991) 'Managing cultural diversity: implications for organizational competitiveness.', *The Executive*, 5(3), pp. 45–56. doi: 10.5465/ame.1991.4274465.

Cox, T. J. (1990) 'Problems with research by organizational scholars on issues of race and ethnicity', *The Journal of Applied Behavioral Science*, 26(1), pp. 5–23.

Cox, T. J. (2018) 'The multicultural organization', *The Executive*, 5(2), pp. 34–47. Available at: https://www.jstor.org/stable/4165006.

Crabtree, B. and Miller, W. (1999) 'Using codes and code manuals: A template for organizing style of interpretation', in Crabtree, B. and Miller, W. (eds) *Doing qualitative research*. Second. Newbury Park, CA: Sage, pp. 163–178.

Crenshaw, K. (1989) '"Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics', *University of Chicago Legal Forum*, (1), pp. 139–167. doi: 10.4324/9781315631011-38.

Crenshaw, K. *et al.* (1991) 'Mapping the margins : Intersectionality, identity politics , and violence against women of color', *Stanford Law Review*, 43(6), pp. 1241–1299. Available at: https://www.scopus.com/record/display.uri?eid=2-s2.0-84926443235&origin=inward&txGid=FE9082C8BF76CA5D0B9B1AAD235670AA.wsnAw8kcdt7IPYLO0V48gA:1.

Culley, L. (2001) 'Equal opportunities policies and nursing employment within the British

National Health Service', *Journal of Advanced Nursing*, 33(1), pp. 130–137. doi: 10.1046/j.1365-2648.2001.01646.x.

Cutcliffe, J. R. and Ramcharan, P. (2002) 'Leveling the playing field? Exploring the merits of the ethics-as-process approach for judging qualitative research proposals', *Qualitative Health Research*, 12(7), pp. 1000–1010. doi: 10.1177/104973202129120313.

Dalingwater, L. (2019) 'NHS staffing shortages and the Brexit effect', *Observatoire de la société britannique*, 24, pp. 67–86. doi: https://doi.org/10.4000/osb.3216.

Darling, C. (2017) *Case studies of good practice from non-NHS employers*. Available at: https://www.england.nhs.uk/wp-content/uploads/2017/08/wres-case-studies-1.pdf (Accessed: 27 January 2020).

Daughrity, B. (2021) 'Exploring outcomes of an asynchronous learning module on increasing cultural competence for speech-language pathology graduate students', *American Journal of Speech-Language Pathology*, 30(5), pp. 1940–1948.

Davey, M. (2015) 'Women start out as ambitious as men but it erodes over time, says researcher', *The Guardian*, 19 November. Available at: https://www.theguardian.com/australia-news/2015/nov/19/women-start-out-as-ambitious-as-men-but-it-erodes-over-time-says-researcher.

Davies, C. M. and Robison, M. (2016) 'Bridging the gap', *International Journal of Discrimination and the Law*, 16(2–3), pp. 83–101. doi: 10.1177/1358229116655647.

Davies, E. (2011) *Women on Boards*.

Davies, J. (2017) *How can we attract more men into London's Early Years workforce?* Available at: http://www.fatherhoodinstitute.org/wp-content/uploads/2017/05/MITEY-2017-London-report.pdf (Accessed: 11 February 2021).

Davis, D. E. *et al.* (2011) 'Relational humility: Conceptualizing and measuring humility as a personality judgment', *Journal of Personality Assessment*, 93(3), pp. 225–234. doi: 10.1080/00223891.2011.558871.

Davis, L. P. and Museus, S. D. (2019) 'What Is Deficit Thinking? An Analysis of Conceptualizations of Deficit Thinking and Implications for Scholarly Research', *Currents*, 1(1), pp. 117–130. doi: http://dx.doi.org/10.3998/currents.17387731.0001.110.

Dawson, J. (2009) *Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys.* Birmingham.

Delgado, R. and Stefancic, J. (2000) 'Introduction', in Delgado, R. and Stefancic, J. (eds) *Critical race theory: The cutting edge*. Philadelphia, PA: Temple University Press, pp. xv–

xix.

Delgado, R. and Stefancic, J. (2001) ‘Introduction’, in *Critical race theory: An introduction*. New York and London: New York University Press, pp. 1–35. Available at: https://static1.squarespace.com/static/5441df7ee4b02f59465d2869/t/5d8e9fdec6720c0557cf55fa/1569628126531/DELGADO++Critical+Race+Theory.pdf.

Denzin, N. and Lincoln, Y. (2011) *The sage handbook of qualitative research*. Fourth. London: Sage.

Department for Business Energy and Industrial Strategy (2020) *The recognition of professional qualifications and regulation of professions: Call for evidence*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/911936/recognition-professional-qualifications-professions-cfe.pdf.

Department for Business Energy and Industrial Strategy (2021) *The recognition of professional qualifications and regulation of professions: Call for evidence: Summary of responses*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1005090/recognition-professional-qualifications-regulation-professions-cfe-summary-responses.pdf.

Department for Business Energy and Industrial Strategy (2022) *Trade union membership, UK 1995-2020: Statistical bulletin, Department for Business, Energy & Industrial Strategy*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1077904/Trade_Union_Membership_UK_1995-2021_statistical_bulletin.pdf.

Department for Education (2020) *Apprenticeship starts*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/a-levels-apprenticeships-further-education/apprenticeship-starts/latest#:~:text=The data shows that in the year ending July 2019,8.4%25 of the overall population (Accessed: 7 September 2022).

Department for Work and Pensions (2016) *Labour market status by ethnic group*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/515622/labour-market-status-by-ethnic-group-april-2016.pdf (Accessed: 2 June 2021).

DeSantis, L. and Ugarriza, D. N. (2000) ‘The concept of theme as used in qualitative nursing research’, *Western Journal of Nursing Research*, 22(3), pp. 351–372. doi: 10.1177/019394590002200308.

Dezső, C. L. and Ross, D. G. (2013) 'Does Female Representation in Top Management Improve Firm Performance? A Panel Data Investigation.', *Strategic management journal*, 33(9), pp. 1072–1089.

Dhamoon, R. K. (2011) 'Considerations on mainstreaming intersectionality', *Political Research Quarterly*, 64(1), pp. 230–243. doi: 10.1177/1065912910379227.

Dick, P. and Cassell, C. (2002) 'Barriers to managing diversity in a UK constabulary: The role of discourse', *Journal of Management Studies*, 39(7), pp. 953–976. doi: 10.1111/1467-6486.00319.

Dickens, L. (1994) 'Wasted resources? Equal opportunities in employment', in Sisson, K. (ed.) *Personnel Management*. Oxford: Blackwell, pp. 253–296.

Dickens, L. (1999) 'Beyond the business case: a three-pronged approach to equality action', *Human Resource Management Journal*, 9(1), pp. 9–19.

Dickens, L. (2004) 'Problems of fit: Changing employment and labour regulation', *British Journal of Industrial Relations*, 42(4), pp. 595–616. doi: 10.1111/j.1467-8543.2004.00332.x.

van Dijk, T. (1990) 'Discourse and Society: a new journal for a new research focus', *Discourse and Society*, 1(1), pp. 5–16.

DiTomaso, N., Post, C. and Parks-Yancy, R. (2007) 'Workforce diversity and inequality: Power, status, and numbers', *Annual Review of Sociology*, 33, pp. 473–501. doi: 10.1146/annurev.soc.33.040406.131805.

Dobbin, F. and Kalev, A. (2016) 'Why diversity programs fail', *Harvard Business Review*, 2016(July-August).

Dobbs, M. F. (1996) 'Managing diversity: Lessons from the private sector', *Public Personnel Management*, 25(3), pp. 351–367. Available at: https://doi.org/10.1177/009102609602500308.

Dobusch, L. (2014) 'How exclusive are inclusive organisations?', *Equality, diversity and inclusion: An international journalDiversity and Inclusion*, 33(3), pp. 220–234. doi: 10.1108/EDI-08-2012-0066.

Dobusch, L. (2017) 'Diversity discourses and the articulation of discrimination: the case of public organisations', *Journal of Ethnic and Migration Studies*. Taylor & Francis, 43(10), pp. 1644–1661. doi: 10.1080/1369183X.2017.1293590.

Doeringer, P. B. and Piore, M. J. (1971) *Internal Labor Markets and Manpower Analysis*. Lexington, Mass.: Heath.

Doldor, E. and Atewologun, D. (2021) 'Why work it when you can dodge it? Identity responses

to ethnic stigma among professionals', *Human Relations*, 74(6), pp. 892–921. doi: 10.1177/0018726719895552.

Doldor, E., Sealy, R. and Vinnicombe, S. (2016) 'Accidental activists: headhunters as marginal diversity actors in institutional change towards more women on boards', *Human Resource Management Journal*, 26(3), pp. 285–303. doi: 10.1111/1748-8583.12107.

Donahue, K. *et al.* (2020) *Time well spent: Diversity and volunteering*. London, UK. Available at: https://www.ncvo.org.uk/news-and-insights/news-index/time-well-spent-diversity-and-volunteering/#/payload-wrapper.

Dorey, P. (2018) '"Don't intervene, don't get involved": the Conservative Party's voluntarist approach to industrial relations and trade unionism, 1951–1964', *Contemporary British History*. Routledge, 32(3), pp. 408–436. doi: 10.1080/13619462.2018.1503957.

Dover, T. L., Major, B. and Kaiser, C. R. (2016a) 'Diversity Policies Rarely Make Companies Fairer, and They Feel Threatening to White Men', *Harvard Business Review*. Available at: https://hbr.org/2016/01/diversity-policies-dont-help-women-or-minorities-and-they-make-white-men-feel-threatened?cm_sp=Article-_-Links-_-Top of Page Recirculation.

Dover, T. L., Major, B. and Kaiser, C. R. (2016b) 'Members of high-status groups are threatened by pro-diversity organizational messages', *Journal of Experimental Social Psychology*. Elsevier Inc., 62, pp. 58–67. doi: 10.1016/j.jesp.2015.10.006.

Dreachslin, J. L., Weech-Maldonado, R. and Dansky, K. H. (2004) 'Racial and ethnic diversity and organizational behavior: A focused research agenda for health services management', *Social Science and Medicine*, 59(5), pp. 961–971. doi: 10.1016/j.socscimed.2003.12.007.

Duffy, B. *et al.* (2021) *Unequal Britain: Attitudes to inequalities after covid-19*. London, UK. Available at: https://www.kcl.ac.uk/policy-institute/assets/unequal-britain.pdf.

Dumelow, C., Littlejohns, P. and Griffiths, S. (2000) 'Relation between a career and family life for English hospital consultants: Qualitative, semistructured interview study', *British Medical Journal*, 320(7247), pp. 1437–1440. doi: 10.1136/bmj.320.7247.1437.

Dzubinski, L. M. and Diehl, A. B. (2018) 'The Problem of gender essentialism and its implications for women in leadership', *Journal of Leadership Studies*, 12(1), pp. 56–61. doi: 10.1002/jls.21565.

Eddison, N. and Leslie, R. (2022) *The challenge of diversity in the allied health professions*. Available at: https://ihm.org.uk/2022/06/08/the-challenge-of-diversity-in-the-allied-health-professions-by-dr-nicky-eddison-and-dr-ros-leslie/ (Accessed: 29 December 2022).

Edelman, L. B., Fuller, S. R. and Mara-Drita, I. (2001) 'Diversity Rhetoric and the Managerialization of Law', *American Journal of Sociology*, 106(6), pp. 1589–1641. doi:

10.1086/321303.

Ellemers, N. and Jetten, J. (2013) 'The Many Ways to Be Marginal in a Group', *Personality and Social Psychology Review*, 17(1), pp. 3–21. doi: 10.1177/1088868312453086.

Elliott, J. R. (2001) 'Referral hiring and ethnically homogeneous jobs: How prevalent is the connection and for whom?', *Social Science Research*, 30(3), pp. 401–425. doi: 10.1006/ssre.2001.0704.

Elo, S. *et al.* (2014) 'Qualitative Content Analysis', *SAGE Open*, 4(1), pp. 1–10. doi: 10.1177/2158244014522633.

Else-Quest, N. M. and Hyde, J. S. (2016) 'Intersectionality in quantitative psychological research: I. Theoretical and epistemological issues', *Psychology of Women Quarterly*, 40(2), pp. 155–170. doi: 10.1177/0361684316629797.

Elston, M. A. (2009) *Women and Medicine: The Future*. London.

Embrick, D. G. (2011) 'The diversity ideology in the business world: A new oppression for a new age', *Critical Sociology*, 37(5), pp. 541–556. doi: 10.1177/0896920510380076.

Eminson, S. (2018) 'Careers advice still missing the mark', *Children & young people now*, 2017(15). Available at: https://www.magonlinelibrary.com/doi/abs/10.12968/cypn.2017.15.14.

England, P. (1982) 'The Failure of Human Capital Theory to Explain Occupational Sex Segregation', *The Journal of Human Resources*, 17(3), pp. 358–370.

Equal Opportunities Commission (2019) *What Does Equal Opportunities Mean?* Available at: https://www.eoc.org.uk/ (Accessed: 24 July 2019).

Equality and Human Rights Commission (2016) *Healing a divided Britain: the need for a comprehensive race equality strategy*. Available at: https://www.equalityhumanrights.com/sites/default/files/healing_a_divided_britain_-_the_need_for_a_comprehensive_race_equality_strategy_final.pdf.

Equality and Human Rights Commission (2018a) *A history of human rights in Britain*. Available at: https://www.equalityhumanrights.com/en/what-are-human-rights/history-human-rights-britain#:~:text=1965%3A Race Relations Act,foundations for more effective legislation (Accessed: 15 December 2020).

Equality and Human Rights Commission (2018b) *Guidance for small businesses and human rights*. Available at: https://www.equalityhumanrights.com/en/advice-and-guidance/guidance-small-businesses-and-human-rights (Accessed: 29 March 2018).

Equality and Human Rights Commission (2019a) *Tackling racial harassment: Universities challenged Thank you*. Available at:

https://www.equalityhumanrights.com/sites/default/files/tackling-racial-harassment-universities-challenged.pdf.

Equality and Human Rights Commission (2019b) *What is the Equality Act?* Available at: https://www.equalityhumanrights.com/en/equality-act-2010/what-equality-act.

Equality and Human Rights Commission (2020a) *Public Sector Equality Duty*. Available at: https://www.equalityhumanrights.com/en/advice-and-guidance/public-sector-equality-duty.

Equality and Human Rights Commission (2020b) *Who we are*. Available at: https://www.equalityhumanrights.com/en/about-us/who-we-are.

Equality and Human Rights Commission (2020c) *Your rights under the Equality Act 2010*. Available at: https://www.equalityhumanrights.com/en/advice-and-guidance/your-rights-under-equality-act-2010#psed (Accessed: 10 December 2020).

Esmail, A. and Everington, S. (1997) 'Asian doctors are still being discriminated against', *BMJ*, 314, p. 1619. doi: https://doi.org/10.1136/bmj.314.7094.1619.

Esmail, A., Kalra, V. and Abel, P. (2005) *A critical review of leadership interventions aimed at people from black and minority ethnic groups, A Report for the Health Foundation*. Manchester. Available at: http://www.aneezesmail.co.uk/PDF files/HealthFoundReport.pdf.

Essed, P. (1991) *Understanding everyday racism: An interdisciplinary theory*. Thousand Oaks, CA: SAGE Publications, Inc. doi: https://doi.org/10.4135/9781483345239.

European commission (2003) *The costs and benefits of diversity: A study on methods and indicators to measure the cost-effectiveness of diversity policies in enterprises*. Available at: https://www.coe.int/t/dg4/cultureheritage/mars/source/resources/references/others/17 - Costs and Benefits of Diversity - EU 2003 ExSum.pdf (Accessed: 29 March 2018).

European Union (2019) *What is a regulated profession*. Available at: https://europa.eu/youreurope/citizens/work/professional-qualifications/regulated-professions/index_en.htm (Accessed: 2 August 2019).

Evans, J. (1997) 'Men in nursing: Issues of gender segregation and hidden advantage', *Journal of Advanced Nursing*, 26(2), pp. 226–231. doi: 10.1046/j.1365-2648.1997.1997026226.x.

Evans, T. (2020) *Ethnicity pay gaps: 2019*. Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/ethnicitypaygapsingreatbritain/2019#analysis-of-ethnicity-pay-gaps (Accessed: 3 June 2021).

Fawcett Society (2017) *Press Release: MANY MINORITY ETHNIC WOMEN 'LEFT BEHIND'*

BY PAY GAP PROGRESS. Available at: https://www.fawcettsociety.org.uk/news/minority-ethnic-women-left-behind-pay-gap-progress (Accessed: 6 November 2019).

Feldblum, C. R. and Lipnic, V. A. (2016) *Select Task Force on the Study of Harassment in the Workplace*. Available at: https://www.eeoc.gov/select-task-force-study-harassment-workplace (Accessed: 17 May 2022).

Fenwick, T. J. (2004) 'Toward a critical HRD in theory and practice', *Adult Education Quarterly*, 54(3), pp. 193–209. doi: 10.1177/0741713604263051.

Fieldhouse, E. and Cutts, D. (2010) 'Does diversity damage social capital? A comparative study of neighbourhood diversity and social capital in the US and Britain', *Canadian Journal of Political Science*, 43(2), pp. 289–318. doi: 10.1017/S0008423910000065.

Fitzmaurice, R. and Coyle, L. (1995) 'Careers advice', *Bulletin of the Royal College of Speech & Language Therapists*, p. 14.

Flick, U. (2009) *An introduction to qualitative research*. Thousand Oaks (CA): Sage Publications Ltd.

Forret, M. L. (1996) 'Issues facing organizations when implementing formal mentoring programmes', *Leadership & Organization Development Journal*, 17(3), pp. 27–30. doi: 10.1108/01437739610116966.

Foster, C. and Harris, L. (2005) 'Easy to say, difficult to do: diversity Management in Retail', *Human Resource Management*, 15(3), pp. 4–17. Available at: http://repository.uwa.edu.au/dtl_publish/INS01/37/14920.html.

Foster, C. and Newell, S. (2002) 'Managing diversity and equal opportunities - some practical implications', *Business and Professional Ethics Journal*, 21(2), pp. 11–26. doi: 10.5840/bpej200221211.

Frankenberg, R. (1997a) *Displacing Whiteness: Essays in social and cultural criticism*. Durham, NC: Duke University Press.

Frankenberg, R. (1997b) *The social construction of Whiteness: White women, race matters.* Minneapolis, Minnesota: University of Minnesota Press.

Fredrickson, G. M. (2002) *Racism: A short history*. Princeton, New Jersey: Princeton University Press.

Freeman, M. *et al.* (2007) 'Standards of Evidence in Qualitative Research: An Incitement to Discourse', *Educational Researcher*, 36(1), pp. 25–32. doi: 10.3102/0013189X06298009.

Fuchs, S. (2001) 'Beyond Agency', *Sociological Theory*, 19(1), pp. 24–40. Available at: https://www.jstor.org/stable/223290.

Full Fact Team (2017) *What is the NHS?*, *Full Fact*. Available at:

https://fullfact.org/health/what-is-the-nhs/ (Accessed: 31 August 2021).

Gaertner, S. and Dovidio, J. (1986) 'The aversive form of racism', in *Prejudice, Discrimination, and Racism*. Orlando, FL: Academic Press, pp. 61–90.

Gaertner, S. L. *et al.* (2005) 'Aversive racism: Bias without intention', in Nielsen, L. B. and Nelson, R. L. (eds) *Handbook of Employment Discrimination Research*. New York: Springer, pp. 377–393. doi: https://doi.org/10.1007/978-0-387-09467-0_19.

Garlick, S. (2022) *Ethnic group, England and Wales: Census 2021, Data and analysis from Census 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/bulletins/ethnicgroupenglandandwales/census2021 (Accessed: 27 March 2023).

Garry, A. (2011) 'Intersectionality, metaphors, and the multiplicity of gender', *Hypatia*, 26(4), pp. 826–850. doi: 10.1111/j.1527-2001.2011.01194.x.

Gasper, D. and Apthorpe, R. (1996) 'Introduction: Discourse analysis and policy discourse', *European Journal of Development Research*, 8(1), pp. 1–15. doi: 10.1080/09578819608426650.

Gaucher, D., Friesen, J. and Kay, A. C. (2011) 'Evidence That Gendered Wording in Job Advertisements Exists and Sustains Gender Inequality', *Journal of Personality and Social Psychology*, 101(1), pp. 109–128. doi: 10.1037/a0022530.

Gelman, S. A. (2005) *Science briefs: Essentialism in everyday thought, Psychological Science Agenda*. Available at: https://www.apa.org/science/about/psa/2005/05/gelman#:~:text=Essentialism is the view that,that one cannot observe directly (Accessed: 30 December 2020).

Gibbons, S. and Vignoles, A. (2012) 'Geography, choice and participation in higher education in England', *Regional science and urban economics*. Elsevier B.V., 42, pp. 98–113. doi: 10.1016/j.regsciurbeco.2011.07.004.

Gifford, J. *et al.* (2019) *Diversity management that works: An evidence-based view*. London, UK. Available at: https://www.cipd.co.uk/Images/7926-diversity-and-inclusion-report-revised_tcm18-65334.pdf.

Gig Cymru NHS Wales (2016) *The core principles of NHS Wales*. Available at: https://www.wales.nhs.uk/nhswalesaboutus/thecoreprinciplesofnhswales (Accessed: 2 September 2021).

Gig Cymru NHS Wales (2021) *Health in Wales*. Available at: http://www.wales.nhs.uk/nhswalesaboutus/structure (Accessed: 31 August 2021).

Gilbert, J. A. and Ivancevich, J. M. (2000) 'Valuing diversity: A tale of two organizations',

Academy of Management Executive, 14(1), pp. 93–105. doi: 10.5465/ame.2000.2909842.

Gilbert, J. A., Stead, B. A. and Ivancevich, J. M. (1999) 'Diversity management: a new organizational paradigm', *Journal of Business Ethics*, 21, pp. 61–76.

Gilbert, N. (2008) *Researching social life*. Third. London: Sage.

Gill, P. (2001) 'General practitioners, ethnic diversity and racism', in Coker, N. (ed.) *Racism in medicine: An agenda for change*. London: King's Fund, pp. 99–120.

Gjerberg, E. (2003) 'Women doctors in Norway: The challenging balance between career and family life', *Social Science and Medicine*, 57(7), pp. 1327–1341. doi: 10.1016/S0277-9536(02)00513-0.

Goldacre, M. j., Davidson, J. m. and Lambert, T. w. (2012) 'Doctors' age at domestic partnership and parenthood: Cohort studies', *Journal of the Royal Society of Medicine*, 105(9), pp. 390–399. doi: 10.1258/jrsm.2012.120016.

Gomez, L. E. and Bernet, P. (2019) 'Diversity improves performance and outcomes', *Journal of the National Medical Association*. Elsevier Inc, 111(4), pp. 383–392. doi: 10.1016/j.jnma.2019.01.006.

Government Equalities Office (2017) *Gender pay gap reporting: guidance for employers published*. Available at: https://www.gov.uk/government/news/gender-pay-gap-reporting (Accessed: 16 April 2018).

Graham, D. and Boyd, J. (2022) *Jews in Britain in 2021: First results from the Census of England and Wales*. Available at: https://www.jpr.org.uk/reports/jews-britain-2021-first-results-census-england-and-wales (Accessed: 1 November 2023).

Granovetter, M. S. (1985) 'Economic action and social structure: The problem of embeddedness', *American Journal of Sociology*, 91, pp. 481–510.

Green, L. (2010) *Understanding the life course*. Cambridge: Polity Press.

Greene, A.-M. and Kirton, G. (2009) *Diversity Management in the UK: Organizational and Stake¬holder Experiences*. London: Routledge.

Greenhaus, J. H. *et al.* (1990) 'Effects of race on organisational experiences, job performance evaluations and career outcomes', *Academy of Management Journal*, 33(1), pp. 64–86.

Greenwood, N., Wright, J. A. and Bithell, C. (2006) 'Perceptions of speech and language therapy amongst UK school and college students: Implications for recruitment', *International Journal of Language and Communication Disorders*, 41(1), pp. 83–94. doi: 10.1080/13682820500177604.

Grootaert, C. and Bastelaer, T. V. (2002) *Understanding and measuring social captial: A multidiciplinary tool for practitioners*. Washington D.C: The World Bank.

Guba, E. G. and Lincoln, Y. S. (1994) 'Competing paradigms in qualitative research', in Denzin, N. and Lincoln, Y. (eds) *Handbook of qualitative research*. Thousand Oaks, California: Sage, pp. 105–117.

Guba, E. G. and Lincoln, Y. S. (2000) 'Paradigmatic controversies, contradictions & emerging confluences', in Denzin, N. and Lincoln, Y. S. (eds) *Handbook of qualitative research*. 2nd edn. Thousand Oaks, California: Sage, pp. 163–188.

Gyimah, M. *et al.* (2022) *Broken ladders: The myth of meritocracy for women of colour in the workplace*. London, UK. Available at: https://www.fawcettsociety.org.uk/Handlers/Download.ashx?IDMF=72040c36-8cd6-4ae3-93f3-e2ad63a4b4b0.

Haas, C. (2022) *Communication science & disorders in China*. Available at: https://alliedhealth.llu.edu/current-students/communication-science-disorders-china#:~:text=The field of Speech Language,for every 1.3 million people.

Hajer, M. (2006) 'Doing discourse analysis: coalitions, practices and meanings', in Brink, M. van den and Metze, T. (eds) *Words matter in policy and planning: discourse theory and method in the social sciences*. Netherlands: Labor Grafimedia b.v., pp. 65–74. doi: 10.1007/978-1-137-28562-1_11.

Hakim, C. (1979) *Occupational Segregation: A Comparative Study of the Degree and Pattern of the Differentiation between Men and Women's Work in Britain, the United States and Other Countries*. London.

Halpren, E. S. (1983) *Auditing naturalistic inquiries: The development and application of a model*. Indiana University.

Hammersley, M. (2011) *Methodology: Who Needs It?* Thousand Oaks, CA: Sage.

Hancock, A.-M. (2007) 'When multiplication doesn't equal quick addition: Examining intersectionality as a research paradigm', *Perspectives on Politics*, 5(1), pp. 63–79. doi: https://doi.org/10.1017/S1537592707070065.

Hardin, R. (1982) *Collective Action*. Baltimore, MD: The Johns Hopkins University Press.

Harlan, S. and Berheide, C. W. (1994) *Barriers to workplace advancement experienced by women in low-paying occupations.* Available at: https://ecommons.cornell.edu/xmlui/bitstream/handle/1813/79400/GlassCeilingBackground7WomenInLowPayingOccupations.pdf?sequence=1.

Harlow, S. (2014) 'Cuts 2014: You tell us about the effects on your services', *RCSLT Bulletin*, pp. 13–15. doi: 10.4324/9780203453117-14.

Harman, C. and Sealy, R. (2017) 'Opt-in or opt-out: exploring how women construe their

ambition at early career stages', *Career Development International*, 22(4), pp. 372–398. doi: 10.1108/CDI-08-2016-0137.

Harrison, S. (2003) 'White staff do better in the NHS, says CRE chief', *Nursing Standard*, 17(34), pp. 6–6. doi: 10.7748/ns.17.34.6.s9.

Hartmann, D., Gerteis, J. and Croll, P. R. (2009) 'An empirical assessment of whiteness theory: Hidden from how many?', *Social Problems*, 56(3), pp. 403–424. doi: 10.1525/sp.2009.56.3.403.

Hartmann, H. (1976) 'Capitalism, Patriarchy, and Job Segregation by Sex', *Signs*, 1(3, Women and the Workplace: The Implications of Occupational Segregation), pp. 137–169.

Health and Care Professions Council (2018) *Speech and language therapists gender breadown (FR05569), via Freedom of Information Request*.

Health and Care Professions Council (2019) *Registrant snapshot - 2 December 2019, Registrant data and statistics*. Available at: https://www.hcpc-uk.org/about-us/insights-and-data/the-register/registrant-snapshot-2019/registrant-snapshot-2-dec-2019/ (Accessed: 29 December 2022).

Health and Care Professions Council (2020a) *Professional bodies*. Available at: https://www.hcpc-uk.org/about-us/who-we-work-with/professional-bodies/ (Accessed: 2 July 2021).

Health and Care Professions Council (2020b) *Registrant snapshot - 3 November 2020*. Health and Care Professions Council. Available at: https://www.hcpc-uk.org/about-us/insights-and-data/the-register/registrant-snapshot---2020/registrant-snapshot---3-november-2020/ (Accessed: 3 September 2021).

Health and Care Professions Council (2021a) *HCPC Diversity Data Report 2021: Speech and language therapists, HCPC Diversity Data 2021 factsheets by profession*. Available at: https://www.hcpc-uk.org/globalassets/resources/factsheets/hcpc-diversity-data-2021-factsheet--speech-and-language-therapists.pdf.

Health and Care Professions Council (2021b) *Registrants snapshot – 1 December 2021, Registrant data and statistics*. Available at: https://www.hcpc-uk.org/about-us/insights-and-data/the-register/registrant-snapshot-2021/registrant-snapshot-dec-2021/%0A (Accessed: 29 December 2022).

Health and Care Professions Council (2023) *Why we charge fees, Fees and tax*. Available at: https://www.hcpc-uk.org/registration/your-registration/fees-and-tax/why-we-charge-fees/ (Accessed: 7 May 2023).

Health Education England and NHS England and NHS Improvement (2022) *Experiences of*

racial discrimination and harassment in London primary care. Available at: https://www.hee.nhs.uk/sites/default/files/documents/Pan-LondonDiscrimination%26RacismPrimaryCareSurvey_Final.pdf.

Health Professions Council (2007) *Review of the grandparenting process: 9 July 2003 to 8 July 2005*. London. Available at: https://www.hcpc-uk.org/globalassets/resources/reports/review-of-the-grandparenting-process.pdf?v=636785062220000000 (Accessed: 11 February 2020).

Healy, G., Kirton, G. and Noon, M. (2010) 'Inequalities, intersectionality and equality and diversity initiatives', in Healy, G., Kirton, G., and Noon, M. (eds) *Equality, Inequalities and Diversity*. Basingstoke: Palgrave, pp. 1–17.

Healy, G. and Oikelome, F. (2006) *Ethnicity, Career, Work and the Health Services*. London.

Hechinger, J. *et al.* (2017) *Diversity and Inclusion Pulse: 2017 Leader's Guide*. Available at: https://www.russellreynolds.com/en/Insights/thought-leadership/Documents/Diversity and Inclusion Pulse.pdf (Accessed: 1 July 2021).

Heidenreich, V. (2010) 'Rekruttering til ASA-styrer etter innføring av kvoteringsregelen', *Magma*, 7, pp. 56–57. Available at: https://www.magma.no/rekruttering-til-asa-styrer-etter-innfoering-av-kvoteringsregelen.

Heise, L. *et al.* (2019) 'Gender inequality and restrictive gender norms: framing the challenges to health', *The Lancet*, 393(10189), pp. 2440–2454. doi: 10.1016/S0140-6736(19)30652-X.

Heliot, Y. (2020) *Religious identity and working in the NHS*. Surrey, UK. Available at: https://s3.eu-central-1.amazonaws.com/eu-st01.ext.exlibrisgroup.com/44SUR_INST/storage/alma/24/E7/B5/36/E4/0F/8D/FF/25/94/6A/EE/A1/B9/68/C4/Héliot Y.F._NHS research report_2020.pdf?response-content-type=application%2Fpdf&X-Amz-Algorithm=AWS4-H (Accessed: 17 May 2022).

Hemmings, N. *et al.* (2021) *Attracting, supporting and retaining a diverse NHS workforce Commissioned and supported by*. Available at: https://www.nuffieldtrust.org.uk/research/attracting-supporting-and-retaining-a-diverse-nhs-workforce.

Henry, L. (2007) 'Institutionalized disadvantage: Older Ghanaian nurses' and midwives' reflections on career progression and stagnation in the NHS', *Journal of Clinical Nursing*, 16(12), pp. 2196–2203. doi: 10.1111/j.1365-2702.2007.02094.x.

Hero, R. E. (2007) *Racial diversity and social capital*. New York: Cambridge University Press.

Herring, C. (2009) 'Does Diversity Pay?: Race, Gender, and the Business Case for Diversity', *American Sociological Review*, 74(2), pp. 208–224. doi:

https://doi.org/10.1177/000312240907400203.

Herring, C. and Henderson, L. (2012) 'From Affirmative Action to Diversity: Toward a Critical Diversity Perspective', *Critical Sociology*, 38(5), pp. 629–643. doi: 10.1177/0896920511402701.

Hewlin, P. F. (2003) 'And the award for best actor goes to...: Facades of conformity in organizational settings', *Academy of Management Review*, 28(4), pp. 633–642. doi: 10.5465/AMR.2003.10899442.

Hewlin, P. F. (2009) 'Wearing the cloak: antecedents and consequences of creating facades of conformity', *The Journal of Applied Psychology*, 94(3), pp. 727–741. doi: doi: 10.1037/a0015228.

Higher Education Statistics Agency (2022) *What do HE students study?* Available at: https://www.hesa.ac.uk/data-and-analysis/students/what-study (Accessed: 11 May 2022).

Hiller, H. and DiLuzio, L. (2004) 'The interviewee and the research interview: analysing a neglected dimension in research', *Canadian Review of Sociology*, 41, pp. 1–26.

Hitlin, S. and Elder, G. H. (2007) 'Time, self, and the curiously abstract concept of agency*', *Sociological Theory*, 25(2), pp. 170–191. doi: 10.1111/j.1467-9558.2007.00303.x.

Hollander, J. A. and Howard, J. A. (2000) 'Social psychological theories on social inequalities', *Social Psychology Quarterly*, 63(4), pp. 338–351. doi: https://www.jstor.org/stable/2695844.

Holloway, I. and Todres, L. (2003) 'The status of method: Flexibility, consistency and coherence', *Qualitative Research*, 3, pp. 345–357. doi: doi:10.1177/1468794103033004.

Holzer, H. J. and Neumark, D. (2006) 'Affirmative action: What do we KNOW?', *Journal of Policy Analysis and Management*, 25(2), pp. 463–490. doi: 10.1002/pam.20181.

Homan, A. C. *et al.* (2007) 'Bridging Faultlines by Valuing Diversity: Diversity Beliefs, Information Elaboration, and Performance in Diverse Work Groups', *Journal of Applied Psychology*, 92(5), pp. 1189–1199. doi: 10.1037/0021-9010.92.5.1189.

Houston, S. (2015) 'Enabling others in social work: reflexivity and the theory of social domains', *Critical and Radical Social Work*, 3(2), pp. 245–260. doi: 10.1332/204986015x14302240420229.

Hudson, M. *et al.* (2017) 'Ethnicity and low wage traps: favouritism, homosocial reproduction and economic marginalization', *Work, Employment and Society*, 31(6), pp. 992–1009. doi: 10.1177/0950017016674898.

Hulko, W. (2009) 'The time- and context-contingent nature of intersectionality and interlocking oppressions', *Journal of Women and Social Work*, 24(1), pp. 44–55.

Hunt, V., Layton, D. and Prince, S. (2015) *Why diversity matters*. Available at: https://www.mckinsey.com/~/media/McKinsey/Business Functions/Organization/Our Insights/Why diversity matters/Why diversity matters.ashx (Accessed: 7 November 2019).

Huse, M. (2011) *The " Golden Skirts ": Changes in board composition following gender quotas on corporate boards, Australian and New Zealand Academy Meeting*. Wellington. Available at: https://www.anzam.org/wp-content/uploads/pdf-manager/473_ANZAM2011-148.PDF.

Hutchinson, S. A., Wilson, M. E. and Wilson, H. S. (1994) 'Benefits of Participating in Research Interviews', *Journal of Nursing Scholarship*, 26(2), pp. 161–166. doi: 10.1111/j.1547-5069.1994.tb00937.x.

Hutchinson, S. and Purcell, J. (2003) *Bringing Policies to Life: The vital role of front line managers in people management*.

Iganski, P. and Johns, N. R. (1998) 'The problem of "diversity" and health care provision for minority ethnic communities', *Journal of Contemporary Health*, 7, pp. 87–89.

Inc Arts UK (2021) *A statement for the UK*. Available at: https://docs.google.com/document/d/e/2PACX-1vQkg5IIoeAqMjMF6VW-eIEtEUEgK3GLudW1meE2DILbJPZYPiP0dO3Qwx6YVxBFxOhI1KEp5swpok80/pub (Accessed: 3 June 2021).

Ingram, P. (2021) *The forgotten dimension of diversity, Harvard Business Review*. Available at: https://hbr.org/2021/01/the-forgotten-dimension-of-diversity (Accessed: 26 August 2021).

ITV News (2020) '"Discrimination" on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff', 13 May. Available at: https://www.itv.com/news/2020-05-13/discrimination-frontline-coronavirus-covid19-black-minority-ethnic-bame-deaths-nhs-racism/.

Jacobs, J. A. (1993) 'Men in female-dominated fields: Trends and turnover', in Williams, C. L. (ed.) *Doing 'women's work': Men in nontraditional occupations*. Newbury Park, CA: Sage Publications, Inc, pp. 49–63. doi: https://doi.org/10.4135/9781483326559.n4.

Jäkel, O., Döring, M. and Beger, A. (2016) 'Science and Metaphor: A truly interdisciplinary perspective. The third international metaphorik.de workshop.', *Metaphorik.de – online journal on metaphor and metonymy*, pp. 7–14. Available at: http://www.metaphorik.de/fr/journal/26/science-and-metaphor-truly-interdisciplinary-perspective-third-international-metaphorikde-workshop.html.

Janssens, M. and Steyaert, C. (2009) 'HRM and performance: A plea for reflexivity in HRM

studies: Point-counterpoint', *Journal of Management Studies*, 46(1), pp. 143–155. doi: 10.1111/j.1467-6486.2008.00812.x.

Janssens, M. and Zanoni, P. (2005) 'Many diversities for many services: Theorizing diversity (management) in service companies', *Human Relations*, 58(3), pp. 311–340. doi: 10.1177/0018726705053424.

Janssens, M. and Zanoni, P. (2008) 'What Makes an Organization Inclusive? Organizational Practices Favoring the Relational Inclusion of Ethnic Minorities in Operative Jobs', in *IACM 21st Annual Conference Paper*. Chicago, IL. doi: http://dx.doi.org/10.2139/ssrn.1298591.

Jaques, H. (2013) 'White applicants are more likely to get NHS jobs than those from ethnic minorities', *Bmj*, 346, p. f3673. doi: 10.1136/bmj.f3673.

Jayne, M. E. A. and Dipboye, R. L. (2004) 'Leveraging diversity to improve business performance: Research findings and recommendations for organizations', *Human Resource Management*, 43(4), pp. 409–424. doi: 10.1002/hrm.20033.

Jewson, N. and Mason, D. (1986a) 'Modes of discrimination in the recruitment process: formalisation, fairness and efficiency', *Sociology*, 20(1), pp. 43–63.

Jewson, N. and Mason, D. (1986b) 'The Theory and Practice of Equal Opportunities Policies: Liberal and Radical Approaches', *The Sociological Review*, 34(2), pp. 307–334. doi: https://doi.org/10.1111/j.1467-954X.1986.tb02704.x.

Jin, J. and Ball, S. J. (2020) 'Meritocracy, social mobility and a new form of class domination', *British journal of sociology of education*. Routledge, 41(1), pp. 64–79. doi: 10.1080/01425692.2019.1665496.

Johns, N. (2004) 'Ethnic diversity policy: Perceptions within the NHS', *Social Policy and Administration*, 38(1), pp. 73–88. doi: 10.1111/j.1467-9515.2004.00377.x.

Johns, N., Green, A. and Powell, M. (2012) 'Diversity in the British NHS: The business versus the moral case', *Equality, Diversity and Inclusion*, 31(8), pp. 768–783. doi: 10.1108/02610151211277626.

Johns, N. R. (2006) *How the British National Health Service Deals with Ethnic Diversity: Professional Problems, Patient Problems*. New York: Edwin Mellen.

Johnston, W. B. and Packer, A. E. (1987) *Workforce 2000: Work and Workers for the Twenty-First Century*. Indianapolis, IN. Available at: https://files.eric.ed.gov/fulltext/ED290887.pdf.

Johnstone, S. (2002) *Managing Diversity in the Workplace*. London: Eclipse/IRS.

Jones, D. (2004) 'Screwing diversity out of the workers? Reading diversity', *Journal of*

Organisational Change Management, 17(3), pp. 281–91.

Jones, R. T. *et al.* (1989) 'Four by four: how do you manage a diverse workforce', *Training and Development Journal*, 43(2), pp. 13–21.

Jonsen, K. *et al.* (2013) 'The tragedy of the uncommons : Reframing workforce diversity', *Human Relations*, 66(2), pp. 271–294. doi: 10.1177/0018726712466575.

Jonsen, K. *et al.* (2021) 'Diversity and inclusion branding: a five-country comparison of corporate websites', *International Journal of Human Resource Management*. Routledge, 32(3), pp. 616–649. doi: 10.1080/09585192.2018.1496125.

Jovic, E., Wallace, J. E. and Lemaire, J. (2006) 'The generation and gender shifts in medicine: An exploratory survey of internal medicine physicians', *BMC Health Services Research*, 6, p. 55. doi: 10.1186/1472-6963-6-55.

Kadushin, A. (1976) 'Men in a woman's profession', *Social Work*, 21(6), pp. 440–447.

Kaiser, C. R. *et al.* (2013) 'Presumed fair: ironic effects of organizational diversity structures', *Journal of Personality and Social Psychology*, 104(3), pp. 504–19. doi: doi: 10.1037/a0030838.

Kalaitzi, S. *et al.* (2017) 'Women leadership barriers in healthcare, academia and business', *Equality, diversity and inclusion: An international journal*, 36(5), pp. 457–474. doi: 10.1108/EDI-03-2017-0058.

Kalev, A., Dobbin, F. and Kelly, E. (2006) 'Best practices or best guesses? Assessing the efficacy of corporate affirmative action and diversity policies.', *American Sociological Review*, 71(4), pp. 589–617. Available at: https://www.cfa.harvard.edu/cfawis/Dobbin_best_practices.pdf.

Kandola, R. and Fullerton, J. (1998) *Managing the mosaic: Diversity in Action*. Second. Instutute of Personnel and Development.

Kang, M., Lessard, D. and Heston, L. (2017a) 'Introduction: Binary systems', in *Introduction to Women, Gender, Sexuality Studies*. Amherst, Massachusets, p. 48.

Kang, M., Lessard, D. and Heston, L. (2017b) 'Social Constructionism', in *Introduction to Women, Gender, Sexuality Studies*. Amherst, Massachusets: University of Massachusets Amherst Libraries, pp. 35–37. Available at: https://openbooks.library.umass.edu/introwgss/open/download?type=mpdf (Accessed: 20 August 2021).

Kanter, R. M. (1977) *Men and women of the corporation*. New York, NY: Basic Books.

Katz, N., Izhaky, S. G. and Dror, Y. F. (2013) 'Reasons for choosing a career and workplace among occupational therapists and speech language pathologists', *Work*, 45(3), pp. 343–

348. doi: 10.3233/WOR-121532.

Kelly, E. and Dobbin, F. (1998) 'How Affirmative Action Became Diversity Management: Employer Response to Antidiscrimination Law, 1961-1996', *American Behavioral Scientist*, 41(7), pp. 960–984. Available at: https://scholar.harvard.edu/files/dobbin/files/1998_abs_kelly.pdf.

Kenny, E. J. and Briner, R. B. (2007) 'Ethnicity and behaviour in organizations: A review of British research', *Journal of Occupational and Organizational Psychology*, 80(3), pp. 437–457. doi: 10.1348/096317906X156313.

Kenton, W. (2019) *Groupthink*. Available at: https://www.investopedia.com/terms/g/groupthink.asp (Accessed: 30 October 2019).

Kersten, A. (2000) 'Diversity management, dialogue, dialects and diversion', *Journal of Organisational Change Management*, 13, pp. 235–248.

Khilji, S. E. and Wang, X. (2006) '"Intended" and "implemented" HRM: The missing linchpin in strategic human resource management research', *International Journal of Human Resource Management*, 17(7), pp. 1171–1189. doi: 10.1080/09585190600756384.

Kim, S. S. and Gelfand, M. J. (2003) 'The influence of ethnic identity on perceptions of organizational recruitment', *Journal of Vocational Behavior*, 63(3), pp. 396–416. doi: 10.1016/S0001-8791(02)00043-X.

King, N. (2004) 'Using templates in the thematic analysis of text', in Cassell, C. and Symon, G. (eds) *Essential guide to qualitative methods in organizational research*. London, UK: Sage, pp. 257–270.

Kingsley, S. and Pawar, A. (2002) *Putting Race Equality to Work in the NHS: A resource for action*. London.

Kirby, E. L. and Harter, L. M. (2003) 'Speaking the Language of the " Managing Diversity "', *The Journal of Business Communication*, 40(1), pp. 28–49.

Kirton, G. (2008) 'Managing multi-culturally in organisations in a diverse society', in Clegg, S. and Cooper, C. (eds) *The Sage Handbook of Organisational Behavior*. London: Sage.

Kirton, G. and Greene, A. M. (2002) 'The dynamics of positive action in UK trade unions: the case of women and black members', *Industrial Relations Journal*, 33(2), pp. 157–173. doi: 10.1111/1468-2338.00226.

Kirton, G. and Greene, A. M. (2005a) 'Human resource management and diversity', in *The dynamics of managing diversity: A critical approach*. Second. Oxford: Elsevier Butterworth-Heinemann, pp. 225–250.

Kirton, G. and Greene, A. M. (2005b) *The dynamics of managing diversity: A critical*

approach. Second. Oxford: Elsevier Butterworth-Heinemann.

Kirton, G. and Greene, A. M. (2006) 'The discourse of diversity in unionised contexts: Views from trade union equality officers', *Personnel Review*, 35(4), pp. 431–448.

Kirton, G. and Greene, A. M. (2009) 'The costs and opportunities of doing diversity work in mainstream organisations', *Human Resource Management Journal,* 19(2), pp. 159–175. doi: 10.1111/j.1748-8583.2009.00091.x.

Kirton, G. and Greene, A. M. (2019) 'Telling and selling the value of diversity and inclusion—External consultants' discursive strategies and practices', *Human Resource Management Journal*, 29(4), pp. 676–691. doi: 10.1111/1748-8583.12253.

Kirton, G., Greene, A. M. and Dean, D. (2007) 'British diversity professionals as change agents - Radicals, tempered radicals or liberal reformers?', *International Journal of Human Resource Management,* 18(11), pp. 1979–1994. doi: 10.1080/09585190701638226.

Kirton, G., Robertson, M. and Avdelidou-Fischer, N. (2016) 'Valuing and value in diversity: the policy-implementation gap in an IT firm', *Human Resource Management Journal*, 26(3), pp. 321–336. doi: 10.1111/1748-8583.12110.

Kituno, N. (2021) 'NHS England "reboots" race work to "focus down hard" on laggard trusts', *Health Service Journal*. Available at: https://www.hsj.co.uk/workforce/nhs-england-reboots-race-work-to-focus-down-hard-on-laggard-trusts/7029631.article.

Kizilos, M., Pelled, L. and Cummings, T. (1996) *Organisational demography and prosocial organisational behaviour*. Columbia, SC.

Kline, R. (2013) *Discrimination by appointment: how black and minority ethnic applicants are disadvantaged in NHS staff recruitment*. Available at: http://www.publicworld.org/files/Discrimination_by_appointment.pdf.

Kline, R. (2014) *The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England., Middlesex University Research Repository*. Middlesex. Available at: www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf.

Kline, R. (2015) *Beyond the snowy white peaks of the NHS?, A Race Equality Foundation Briefing Paper*. London. Available at: http://www.better-health.org.uk/sites/default/files/briefings/downloads/Health Briefing 39 _Final.pdf.

Kline, R. (2021) *No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer*. Available at: https://www.england.nhs.uk/east-of-england/wp-content/uploads/sites/47/2021/10/NHSE-Recruitment-Research-Document-FINAL-2.2.pdf.

Kline, R. (2022) ‘Interviews: Asking the wrong questions by Roger Kline’, *BMJ Leader*. Available at: https://blogs.bmj.com/bmjleader/2022/06/01/interviews-asking-the-wrong-questions-by-roger-kline/.

Knight, V. and Layder, D. (2016) ‘Concept-formation, complexity and social domains: Investigating emotion(s) in a prison setting’, *Sociological Research Online,* 21(4), pp. 107–120. doi: 10.5153/sro.4119.

Koro-Ljungberg, M. (2004) ‘Impossibilities of reconciliation: Validity in mixed theory projects’, *Qualitative Inquiry,* 10(4), pp. 601–621. doi: 10.1177/1077800403261860.

Koro-Ljungberg, M. *et al.* (2009) ‘(E)pistemological awareness, instantiation of methods, and uninformed methodological ambiguity in qualitative research projects’, *Educational Researcher,* 38(9), pp. 687–699. doi: 10.3102/0013189X09351980.

Koro-Ljungberg, M. and Bussing, R. (2013) ‘Methodological Modifications in a Longitudinal Qualitative Research Design’, *Field Methods,* 25(4), pp. 423–440. doi: 10.1177/1525822X12472877.

Kossek, E. and Lobel, S. (1996) ‘Introduction: Transforming Human Resource Systems to Manage Diversity – An Introduction and Orienting Framework’, in Kossek, E. and Lobel, S. (eds) *Managing Diversity. Human Resource Strategies for Transforming the Workplace*. Oxford: Blackwell.

Kvale, S. (1996) *InterViews. An Introduction to Qualitative Research Interviewing*. Thousand Oaks: Sage.

Van Laer, K. and Janssens, M. (2011) ‘Ethnic minority professionals’ experiences with subtle discrimination in the workplace’, *Human Relations,* 64(9), pp. 1203–1227. doi: https://doi.org/10.1177/0018726711409263.

Lambert, T. W., Goldacre, M. J. and Turner, G. (2003) ‘Career choices of United Kingdom medical graduates of 1999 and 2000: Questionnaire surveys’, *British Medical Journal,* 326(7382), pp. 194–195. doi: 10.1136/bmj.326.7382.194.

Larner, W. and Craig, D. (2005) ‘After neoliberalism? Community activism and local partnerships in Aotearoa New Zealand’, in Laurie, N. and Bondi, L. (eds) *Working the Spaces of Neoliberalism*. Oxford: Blackwell, pp. 9–31.

Latané, B. (1981) ‘The psychology of social impact’, *American Psychologist,* 36(4), pp. 343–356. doi: https://doi.org/10.1037/0003-066X.36.4.343.

Laughlin, P. R. *et al.* (2006) ‘Groups perform better than the best individuals on letters-to-numbers problems: Effects of group size’, *Journal of Personality and Social Psychology,* 90(4), pp. 644–651. doi: 10.1037/0022-3514.90.4.644.

Law, I. (1996) *Racism, Ethnicity and Social Policy*. London: Harvester Wheatsheaf.

Law, I. (1997) 'Modernity, anti-racism and ethnic managerialism', *Policy Studies*, 18(3–4), pp. 189–205. doi: 10.1080/01442879708423732.

Lawler, M. *et al.* (2018) 'The impact of Brexit on UK cancer research', *The Lancet Oncology*, 19(10), pp. 1276–1278. doi: 10.1016/S1470-2045(18)30518-7.

Lawrence, E. (1996) 'Working for equal opportunities: an exploratory study of equal opportunities officers as a professional group', in *14th Annual International Labour Process Conference, 27-29 March*. Birmingham: Aston University.

Lawrence, E. (2000) 'Equal opportunities officers and managing equality changes', *Personnel Review*, 29(3), pp. 381–401. doi: 10.1108/00483480010324733.

Lawton, A. (2000) 'The meritocracy myth and the illusion of equal employment opportunity', *Minnesota Law Review*, 85(2), pp. 587–661.

Layder, D. (1993) *New strategies in social research: An introduction and guide*. Cambridge: Polity Press.

Layder, D. (2006) *Understanding social theory*. Second edi. London: Sage Publications.

Lea, J. (2000) 'The Macpherson report and the question of institutional racism', *The Howard Journal of Criminal Justice*, 39(3), pp. 219–233. doi: 10.1111/1468-2311.00165.

Leaker, D. and Nigg, W. (2019) *Sickness absence in the UK labour market: 2018.* Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2018 (Accessed: 22 February 2020).

Legault, L., Gutsell, J. N. and Inzlicht, M. (2011) 'Ironic effects of antiprejudice messages: How motivational interventions can reduce (but also increase) prejudice', *Psychological Science*, 22(12), pp. 1472–1477. doi: 10.1177/0956797611427918.

Letherby, G. (2003) *Feminist research in theory and practice*. Buckingham: Open University Press.

Lewis, A. E. (2004) '"What group?" studying whites and whiteness in the era of "color-blindness"', *Sociological Theory*, 22(4), pp. 623–646. doi: 10.1111/j.0735-2751.2004.00237.x.

Lewis, G. (2000) 'Discursive histories, the pursuit of multiculturalism and social policy', in *Rethinking Social Policy*. London: Sage, pp. 257–75.

Li, Y. (2021) *The social mobility of ethnic minorities in Britain in the last 50 years (1972-2019), Research and analysis: The report of the Commission on Race and Ethnic Disparities: supporting research*. Available at:

https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities-supporting-research/the-social-mobility-of-ethnic-minorities-in-britain-in-the-last-50-years-1972-2019-by-professor-yaojun-li#contents (Accessed: 25 January 2023).

Liff, S. (1995) 'Equal opportunities: continuing discrimination in a context of formal equality', in Edwards, P. (ed.) *Industrial relations: Theory and practice in Britain*. Oxford: Blackwell Publishers.

Liff, S. (1997) 'Two routes to managing diversity: Individual differences or social group characteristics', *Employee Relations,* 19(1), pp. 11–26. doi: 10.1108/01425459710163552.

Liff, S. and Wajcman, J. (1996) '"Sameness" and "difference" revisited: Which way forward for equal opportunity initiatives?', *Journal of Management Studies,* 33(1), pp. 79–94. doi: 10.1111/j.1467-6486.1996.tb00799.x.

Limb, M. (2021) 'NHS lacks the fundamental tools required to tackle discrimination, report warns', *BMJ,* 375, p. n2714. doi: 10.1136/bmj.n2714.

Lin, N. (2000) 'Inequality in social capital', *Contemporary Sociology,* 29(6), pp. 785–795.

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic inquiry*. Beverly Hills, CA: Sage Publications.

Lingayah, S. (2021) *It takes a system: The systemic nature of racism and pathways to systems change, IPPR Progressive Review*. doi: 10.1111/newe.12236.

Linnehan, F. and Konrad, A. M. (1999) 'Diluting diversity: implications for intergroup inequality in organizations', *Journal of Management Inquiry*, 8(4), pp. 399–414.

Litosseliti, L. and Leadbeater, C. (2013) 'Speech and language therapy/pathology: Perspectives on a gendered profession', *International Journal of Language and Communication Disorders,* 48(1), pp. 90–101. doi: 10.1111/j.1460-6984.2012.00188.x.

Litosseliti, L. and Leadbeater, C. (2014) 'The importance of cultural competence for speech and language therapists', *Journal of Interactional Research in Communication Disorders,* 5(1), pp. 1–26. Available at: https://doi.org/10.1558/jircd.v5i1.1.

Litosseliti, L. and Leadbeater, C. (2020) '"Nice, Threat-Free, and Child-Friendly": Gendered Discourses in the Speech and Language Therapy Profession.', in McDowell, J. (ed.) *De-Gendering Gendered Occupations: Analysing Professional Discourse*. New York: Routledge Taylor and Francis Group, pp. 140–157. doi: 10.4324/9780429031434.

Litvin, D. R. (1997) 'The Discourse of Diversity: From Biology to Management', *Organization,* 4(2), pp. 187–209. doi: https://doi.org/10.1177/135050849742003.

Litvin, D. R. (2002) 'The business case for diversity and the "Iron Cage"', in Czarniawska, B.

and Hopfl, H. (eds) *Casting the other:The production and maintenance of inequalities in work organizations*. London: Routledge, pp. 160–184.

Lloyd-Jones, B. (2009) 'Implications of race and gender in higher education administration: An African American woman's perspective', *Advances in Developing Human Resources*, 11(5), pp. 606–618. doi: 10.1177/1523422309351820.

Lloyd, G. (1993) *The Man of Reason: 'Male' and 'Female' in Western Philosophy*. Second edi. Edited by Routledge. London.

Loan-Clarke, J. *et al.* (2009) 'Why do speech and language therapists stay in, leave and sometimes return to the National Health Service NHS?', *International Journal of Language and Communication Disorders*, 44(6), pp. 883–900. doi: 10.3109/13682820802381334.

Long, R., Hubble, S. and Loft, P. (2016) *Careers guidance in schools, colleges and universities*, *House of Commons Library*. Available at: https://dera.ioe.ac.uk/26579/2/CBP-7236_Redacted.pdf.

Lorbiecki, A. and Jack, G. (2000) 'Critical Turns in the Evolution of Diversity Management', *British Journal of Management*, 11, pp. 17–31.

Lordly, D. (2012) 'Students' perceptions of males entering the dietetic profession', *Canadian Journal of Dietetic Practice & Research*, 73(3), pp. 111–6. doi: 10.3148/73.3.2012.111.

Lucio, M. M. and Perrett, R. (2009) 'The Diversity and Politics of Trade Unions' Responses to Minority Ethnic and Migrant Workers: The Context of the UK', *Economic and Industrial Democracy*, 30(3), pp. 324–347. doi: 10.1177/0143831X09336562.

Lugo, L. *et al.* (2013) *A Portrait of Jewish Americans: Findings from a Pew Research Center Survey of U.S. Jews*. Washington, D.C.

Luiz, J. M. and Terziev, V. (2024) 'Axes and fluidity of oppression in the workplace: Intersectionality of race, gender, and sexuality', *Organization*, 31(2), pp. 295–315. doi: 10.1177/13505084221098252.

Lundberg, U. and Frankenhaeuser, M. (1999) 'Stress and workload of men and women in high-ranking positions.', *Journal of occupational health psychology*, 4(2), pp. 142–151. doi: 10.1037/1076-8998.4.2.142.

Lunenburg, F. C. (2010) 'Managing change: The role of the change agent', *International Journal of Management, Business and Administration*, 13(1), pp. 1–6.

Maguire, K. (2000) 'Therapists share £12m in landmark equal pay victory', *The Guardian*, 8 May. Available at: https://www.theguardian.com/uk/2000/may/08/kevinmaguire (Accessed: 11 February 2021).

Mahendra, N. (2019) 'Integrating lesbian, gay, bisexual, transgender, and queer issues into the

multicultural curriculum in speech-language pathology: Instructional strategies and learner perceptions', *Perspectives of the Asha special interests groups*, 4(2), pp. 384–394. doi: https://doi.org/10.1044/2019_PERS-SIG14-2018-0007.

Marini, M. M. and Brinton, M. C. (1984) 'Sex typing in occupational socialization', in *Sex Segregation in the Workplace: Trends, Explanations, Remedies*. Washington, DC: National Academy Press, pp. 191–232.

Matthews, J.-J. R. and Daniels, D. E. (2019) 'The Gendered Experiences of Male Students in a Speech-Language Pathology Graduate Program: A Multi-Case Study', *Teaching and Learning in Communication Sciences & Disorders*, 3(2). doi: 10.30707/tlcsd3.2matthews.

Maume, D. J. (2004) 'Is the Glass Ceiling a Unique form of Inequality? Evidence from a Random-Effects Model of Managerial Attainment', *Work and Occupations*, 31(2), pp. 250–274. doi: 10.1177/0730888404263908.

Mavin, S. and Grandy, G. (2016) 'Women elite leaders doing respectable business femininity: How privilege is conferred, contested and defended through the body', *Gender, Work and Organization*, 23(4), pp. 379–396. doi: 10.1111/gwao.12130.

Maxwell, G. A., Blair, S. and Mcdougall, M. (2001) 'Edging towards managing diversity in practice', *Employee Relations*, 23(5), pp. 468–482. doi: 10.1108/01425450110405161.

May, N. and Pope, C. (1997) 'Summary', in *Speech and language therapy services and management in the internal market: A national survey*. London, UK: The King's Fund, pp. IX–XI. Available at: https://archive.kingsfund.org.uk/concern/published_works/000017996?locale=en (Accessed: 6 September 2021).

Mayer, D. M. (2018) *How Men Get Penalized for Straying from Masculine Norms, Harvard Business Review*. Available at: https://hbr.org/2018/10/how-men-get-penalized-for-straying-from-masculine-norm (Accessed: 17 November 2020).

Mays, N., Dixon, A. and Jones, L. (2011) 'Return to the market: Objectives and evolution of New Labour's market reforms', in Mays, N., Dixon, A., and Jones, L. (eds) *Understanding New Labour's market reforms of the English NHS*. London: The King's Fund, pp. 1–15. Available at: https://www.kingsfund.org.uk/publications/understanding-new-labours-market-reforms-english-nhs.

McCabe, C., Keast, K. and Kaya, M. S. (2022) 'Barriers and facilitators to university access in disadvantaged UK adolescents by ethnicity: a qualitative study', *Journal of Further and Higher Education*. Routledge, 46(10), pp. 1434–1446. doi: 10.1080/0309877X.2022.2086037.

McCafferty, S. and Hill, H. (2015) ‘Another change agenda: Reflections on “Agenda for Change”’, *Public Policy and Administration*, 30(2), pp. 165–181. doi: 10.1177/0952076714561345.

McCall, L. (2005) ‘The complexity of intersectionality’, *Signs: Journal of Women in Culture and Society*, 30(3), pp. 1771–1800. doi: 10.4324/9780203890882.

McClenahan, J. and Yardumian, A. (2001) ‘Recruiting doctors: Fair selection’, in Coker, N. (ed.) *Racism in medicine: An agenda for change*. London: King’s Fund, pp. 211–226.

McCormick, M., Napier, B. and Longhurst, L. (2019) ‘Special report: careers and diversity’, *Bulletin of the Royal College of Speech & Language Therapists*, September, pp. 18–20. Available at: https://www.rcslt.org/wp-content/uploads/media/Project/Bulletins/bulletin-2019/bulletin-september-2019.pdf.

McCoy, S. K. and Major, B. (2007) ‘Priming meritocracy and the psychological justification of inequality’, *Journal of Experimental Social Psychology*, 43(3), pp. 341–351. doi: 10.1016/j.jesp.2006.04.009.

McDougall, M. (1996) ‘Equal opportunities versus managing diversity: Another challenge for public sector management?’, *International Journal of Public Sector Management*, 9(5–6), pp. 62–72. doi: 10.1108/09513559610146357.

McGowan, J. (2007) *American liberalism: An interpretation for our time*. Chapel Hill: North Carolina University Press.

McGregor-Smith, R. (2017) *The time for talking is over. Now is the time to act. Race in the workplace: The McGregor-Smith Review*. Available at: https://www.gov.uk/government/publications/race-in-the-workplace-the-mcgregor-smith-review (Accessed: 12 April 2018).

McIntosh, B. *et al.* (2012) ‘Motherhood and its impact on career progression’, *Gender in Management*, 27(5), pp. 342–360. doi: 10.1108/17542411211252651.

McKinsey and Company (2020) *Women in the Workplace 2020: Corporate America is at a critical crossroads*. doi: 10.1049/et.2009.0920.

McKinstry, B. (2008) ‘Are there too many female medical graduates?’, *BMJ*, 336(7647), p. 748. doi: doi: 10.1136/bmj.39505.491065.94.

McManus, I. C., Esmail, A. and Demetriou, M. (1998) ‘Factors affecting likelihood of applicants being offered a place in medical schools in the United Kingdom in 1996 and 1997: Retrospective study’, *British Medical Journal*, 317(7166), pp. 1111–1117. doi: 10.1136/bmj.317.7166.1111.

McVittie, C., McKinlay, A. and Widdicombe, S. (2008) ‘Organizational knowledge and

discourse of diversity in employment', *Journal of Organizational Change Management*, 21(3), pp. 348–366. doi: 10.1108/09534810810874822.

Mease, J. J. (2016) 'Embracing Discursive Paradox: Consultants Navigating the Constitutive Tensions of Diversity Work', *Management Communication Quarterly*, 30(1), pp. 59–83. doi: 10.1177/0893318915604239.

Mensi-Klarbach, H. and Seierstad, C. (2020) 'Gender Quotas on Corporate Boards: Similarities and Differences in Quota Scenarios', *European Management Review*, 17(3), pp. 615–631. doi: 10.1111/emre.12374.

Meyerson, D. E. (2003) *Tempered Radicals: How Everyday Leaders Inspire Change at Work*. Boston, MA: Harvard Business School Press.

Meyerson, D. E. and Scully, M. A. (1995) 'Tempered radicalism and politics of ambivalence and change', *Organization Science*, 6(5), pp. 585–600. Available at: http://dx.doi.org/10.1287/orsc.6.5.585.

Michas, F. (2021) *Registered doctors in the United Kingdom in 2020, by gender and specialty, Statista*. Available at: https://www.statista.com/statistics/698260/registered-doctors-united-kingdom-uk-by-gender-and-specialty/ (Accessed: 31 August 2021).

Miers, M. E., Rickaby, C. E. and Pollard, K. C. (2007) 'Career choices in health care: Is nursing a special case? A content analysis of survey data', *International Journal of Nursing Studies*, 44(7), pp. 1196–1209. doi: 10.1016/j.ijnurstu.2006.04.010.

Mikkola, M. (2019) 'Feminist Perspectives on Sex and Gender', *The Stanford Encyclopedia of Philosophy*. Fall 2019. Edited by E. N. Zalta. Available at: https://plato.stanford.edu/archives/fall2019/entries/feminism-gender/.

Miles, B. and Huberman, A. (2009) *Qualitative data analysis*. Thousand Oaks (CA): Sage Publications Ltd.

Miller, F. A. (1998) 'Strategic culture change: The door to achieving high performance and inclusion', *Public Personnel Management*, 27(2), pp. 151–160. doi: 10.1177/009102609802700203.

Miller, J. (2019) 'Tackling race inequalities in career progression in UK organisations', in Nachmias, S. and Caven, V. (eds) *Inequality and Organizational Practice. Palgrave Explorations in Workplace Stigma.* Palgrave Macmillan, Cham, pp. 265–285. doi: https://doi.org/10.1007/978-3-030-11644-6_12.

Miller, J. and Ayling, L. (2021) *Sex discrimination and employment*. Available at: https://www.cipd.co.uk/knowledge/fundamentals/emp-law/sex-discrimination/factsheet#gref (Accessed: 20 May 2021).

Miller, K. (2007) ‘Policy and organizational implications of gender imbalance in the NHS’, *Journal of Health, Organisation and Management*, 21(4–5), pp. 432–447. doi: 10.1108/14777260710778952.

Mills, D. *et al.* (2019) *Diversity and Inclusion—the Role for Chairs and CEOs*. Available at: https://corpgov.law.harvard.edu/2019/04/03/driving-diversity-and-inclusion-the-role-for-chairs-and-ceos/#3b (Accessed: 1 July 2021).

Minow, M. (1990) ‘Adjudicating differences: conflicts among feminist lawyers’, in M., H. and Keller, E. F. (eds) *Conflicts in Feminism*. New York: Routledge, pp. 149–63.

Moberly, T. (2018) ‘Men outnumber women three to one in some specialties’, *BMJ*, 363, p. k4098. doi: https://doi.org/10.1136/bmj.k4098.

Modood, T., Berthoud, R. and Nazroo, J. (2002) ‘“Race”, racism and ethnicity: A response to Ken Smith’, *Sociology*, 36(2), pp. 419–427. doi: 10.1177/0038038502036002010.

Modood, T. and Shiner, M. (1994) *Ethnic minorities and higher education: why are there differential rates of entry?*, *PSI research report*. London, UK: Policy Studies Institute; Universities and Colleges Admissions Service.

Mohr, T. S. (2014) ‘Why women don’t apply for jobs unless they’re 100% qualified’, *Harvard Business Review*. Available at: https://hbr.org/2014/08/why-women-dont-apply-for-jobs-unless-theyre-100-qualified.

Mor-Barak, M. E. and Cherin, D. A. (1998) ‘A tool to expand organizational understanding of workforce diversity: Exploring a measure of inclusion-exclusion’, *Administration in Social Work*, 22(1), pp. 47–64. doi: 10.1300/J147v22n01_04.

Mor Barak, M. E. (1999) ‘Beyond affirmative action: Toward a model of diversity and organizational inclusion’, *Administration in Social Work*, 23(3–4), pp. 47–68. doi: 10.4324/9780203725191_4.

Mor Barak, M. E. (2015) ‘Inclusion is the Key to Diversity Management, but What is Inclusion?’, *Human Service Organizations Management, Leadership and Governance*. Routledge, 39(2), pp. 83–88. doi: 10.1080/23303131.2015.1035599.

Morgan, G. and Smircich, L. (1980) ‘The case for qualitative research’, *The Academy of Management Review*, 5(4), pp. 491–500. doi: 10.1111/j.2042-7174.1992.tb00564.x.

Morris, V. R. and Washington, T. M. (2017) ‘The Role of Professional Societies in STEM Diversity’, *Journal of the National Technical Association*, 87(1), pp. 22–31.

Morse, G. (2002) *Imbalance of Power, Harvard Business Review*. Available at: https://hbr.org/2002/07/imbalance-of-power (Accessed: 1 July 2021).

Morse, J., Kuzel, A. and Swanson, J. (2001) *The nature of qualitative evidence*. Thousand Oaks

(CA): Sage.

Morse, J. M. (1994) ‘Designing funded qualitative research’, in Denzin, N. and Lincoln, Y. (eds) *Handbook of Qualitative Research*. Thousand Oaks, CA: Sage, pp. 220–235.

Morse, J. and Richards, L. (2002) ‘Coding’, in *Read me first for a user’s guide to qualitative methods*. Thousand Oaks, CA: Sage, pp. 111–128.

Mowat, J. G. (2015) ‘Towards a new conceptualisation of marginalisation’, *European Educational Research Journal*, 14(5), pp. 454–476. doi: 10.1177/1474904115589864.

Moynihan, S. (2016) ‘“Lying about a lie”: Racial passing in US history, literature and popular culture’, *Journal of American Studies*, 50, p. e18. doi: 10.1017/S0021875816000219.

Mulcahy, M. and Linehan, C. (2014) ‘Females and Precarious Board Positions: Further Evidence of the Glass Cliff’, *British Journal of Management*, 25(3), pp. 425–438. doi: 10.1111/1467-8551.12046.

Myers, V. L. and Dreachslin, J. L. (2007) ‘Recruitment and retention of a diverse workforce: Challenges and opportunities’, *Journal of Healthcare Management*, 52(5), pp. 290–298. doi: 10.1097/00115514-200709000-00004.

Napier, B. and O’Flynn, P. (2020) ‘Towards a diverse profession: One year on’, *Bulletin: The official magazine of the Royal College of Speech and Language Therapists*, July, pp. 13–15. Available at: https://www.rcslt.org/wp-content/uploads/media/Project/Bulletins/bulletin-july-2020.pdf.

Naqvi, H. and Kline, R. (2016) *Equality Analysis on the NHS Workforce Race Equality Standard*. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/equality-analysis-wres-april-16.pdf (Accessed: 26 November 2019).

Naqvi, H., Razaq, S. A. and Piper, J. (2016) *Workforce Race Equality Standard Report: 2015 Data Analysis Report for NHS Trusts.* Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf (Accessed: 27 January 2020).

National Careers Service (2021) *Equalities officer*. Available at: https://nationalcareers.service.gov.uk/job-profiles/equalities-officer (Accessed: 18 January 2021).

National Improvement and Leadership Development Board (2016) *Developing People – Improving Care*. Available at: https://www.nwacademy.nhs.uk/sites/default/files/resource_files/Developing People - Improving Care.pdf (Accessed: 3 April 2023).

Nelson, A. (1990) ‘Equal opportunities: dilemmas, contradictions, white men and class’, *Critical Social Policy*, 28, pp. 25–42.

Nguyen, A. *et al.* (2019) *Why Your Diversity Strategy Needs to Be More Diverse*. Available at: http://image-src.bcg.com/Images/Why Your Diversity Strategy Needs To Be More Diverse_17Jan_tcm9-211941.pdf (Accessed: 22 May 2019).

NHS (2011) *The equality delivery system for the NHS: Equality analysis 29 July 2011*. Available at: https://www.england.nhs.uk/wp-content/uploads/2013/08/6eds-equal-anal2011.pdf (Accessed: 31 January 2020).

NHS (2019a) *National workforce equality data: National NHS Staff Survey - WRES metrics. National NHS Staff Survey - WDES metrics, NHS Staff Survey Results*. Available at: https://www.nhsstaffsurveyresults.com/homepage/local-results-2019/workforce-equality-standards-wres-2019/ (Accessed: 16 February 2021).

NHS (2019b) *News: NHS commits to long term support for race equality*. Available at: https://www.england.nhs.uk/2019/01/race-equality/ (Accessed: 15 June 2021).

NHS (2019c) *NHS Long Term Plan - a summary*. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/the-nhs-long-term-plan-summary.pdf.

NHS (2019d) *The NHS Long Term Plan – easy read*. Available at: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/easy-read-long-term-plan-v2.pdf (Accessed: 2 September 2021).

NHS (2021) *Speech and language therapist*. Available at: https://www.healthcareers.nhs.uk/explore-roles/allied-health-professionals/roles-allied-health-professions/speech-and-language-therapist (Accessed: 11 February 2021).

NHS Confederation (2019) *Chairs and non-executives in the NHS: The need for diverse leadership*. London. Available at: https://www.nhsconfed.org/system/files/media/Chairs-and-non-executives-NHS-diverse-leadership.pdf.

NHS Confederation (2022a) *Health and care network of women's networks*. Available at: https://www.nhsconfed.org/articles/health-and-care-network-womens-networks (Accessed: 23 March 2023).

NHS Confederation (2022b) *Shattered hopes: black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS.* London, UK. Available at: https://www.nhsconfed.org/system/files/2022-06/Shattered-hopes-BME-leaders-glass-ceiling-NHS.pdf.

NHS digital (2018a) *Narrowing of NHS gender divide but men still the majority in senior roles: The proportion of NHS doctors who are women has grown every year since 2009, analysis of NHS workforce statistics by NHS Digital for International Women's Day shows.*, *News*

and events. Available at: https://digital.nhs.uk/news-and-events/latest-news/narrowing-of-nhs-gender-divide-but-men-still-the-majority-in-senior-roles (Accessed: 24 December 2019).

NHS digital (2018b) *News: Narrowing of NHS gender divide but men still the majority in senior roles, News and events*. Available at: https://digital.nhs.uk/news-and-events/latest-news/narrowing-of-nhs-gender-divide-but-men-still-the-majority-in-senior-roles# (Accessed: 16 April 2020).

NHS Digital (2019) 'The number of women in very senior manager, chief executive or non-executive director roles in the NHS'. NHS Digital. Available at: https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2019-supplementary-information-files/staff-numbers/non-clinical-and-support/the-number-of-women-in-very-senior-manager-chief-executive-or-non-executive-direct (Accessed: 4 June 2021).

NHS employers (2020) *Annex 2: Pay bands and pay points on the second pay spine in England*. Available at: https://www.nhsemployers.org/tchandbook/annex-1-to-3/annex-2-pay-bands-and-pay-points-on-the-second-pay-spine-in-england (Accessed: 11 February 2020).

NHS Employers (2006) *Equity in Implementing Organisational Change*. London. Available at: https://www.nhsemployers.org/~/media/Employers/Publications/equity_guidance0406.pdf.

NHS Employers (2018) 'Gender in the NHS', p. 1. Available at: https://www.nhsemployers.org/-/media/Employers/Images/2018-D-and-I-infographics/Gender-in-the-NHS-2018.pdf.

NHS Employers (2019) 'Gender in the NHS'. Available at: https://www.nhsemployers.org/-/media/Employers/Documents/Plan/DIVERSITY-AND-INCLUSION/EQW19/Gender-in-the-NHS-infographic.pdf.

NHS Employers (2020) *Research: Business case for diversity*. Available at: https://www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion/tools-and-resources/research (Accessed: 27 January 2020).

NHS Employers (2021a) *Diversity and Inclusion*. Available at: https://www.nhsemployers.org/retention-and-staff-experience/diversity-and-inclusion (Accessed: 15 June 2021).

NHS Employers (2021b) *Improving diversity in recruitment practices in the NHS*. Available at: https://www.nhsemployers.org/articles/improving-diversity-recruitment-practices-nhs (Accessed: 20 April 2023).

NHS England (2009) *The NHS constitution: The NHS belongs to us all*. Available at: https://www.nhs.uk/NHSEngland/aboutnhs/Documents/NHS_Constitution_interactive_9Mar09.pdf (Accessed: 27 January 2020).

NHS England (2019) *Young male nursing applicants surge after 'We are the NHS' recruitment campaign, News*. Available at: https://www.england.nhs.uk/2019/02/young-male-nursing-applicants-surge-after-we-are-the-nhs-recruitment-campaign/#:~:text=News-,Young male nursing applicants surge after,are the NHS' recruitment campaign&text=A record breaking number of,Are The NHS" recru (Accessed: 29 December 2022).

NHS England (2020a) *Implementing phase 3, Coronavirus documents*. Available at: https://www.england.nhs.uk/coronavirus/documents/c0716_implementing-phase-3/#:~:text=Strengthen leadership and accountability%2C with,the diversity of senior leaders. (Accessed: 16 April 2023).

NHS England (2020b) 'NHS England webinar on EDI: Allied Health Professionals: BME representation'. NHS, p. Slide 2.

NHS England (2020c) *We are the NHS: People plan for 2020/21 - action for us all*. Available at: www.england.nhs.uk/ournhspeople.

NHS England (2021a) *Allied health professions: About AHPs*. Available at: https://www.england.nhs.uk/ahp/about/ (Accessed: 11 February 2021).

NHS England (2021b) *Allied health professions: The 14 allied health professions*. Available at: https://www.england.nhs.uk/ahp/role/#speech (Accessed: 11 February 2021).

NHS England (2021c) *Workforce Race Equality Standard 2020: Data Analysis Report for NHS Trusts and Clinical Commissioning Groups*. Available at: https://www.england.nhs.uk/wp-content/uploads/2021/02/Workforce-Race-Equality-Standard-2020-report.pdf.

NHS England (2023) *Board members*. Available at: https://www.england.nhs.uk/about/nhs-england-board/board-members/ (Accessed: 4 April 2023).

NHS England and NHS Improvement (2020) *ST19: National NHS staff survey 2019 - detailed spreadsheets, NHS Staff Survey*. NHS Staff Survey Coordination Centre. Available at: https://www.nhsstaffsurveys.com/static/52b25ae389b6b31f69c642ea45f35939/ST19-Detailed-Spreadsheets_FINAL-1.xlsx (Accessed: 8 September 2021).

NHS England and NHS Improvement (2021) 'National results: National WDES and WRES metrics data 2020'. NHS Staff Survey Coordination Centre. Available at: https://www.nhsstaffsurveys.com/static/52cd823a2002538cc2f65f125bc578e2/NHS-Staff-Survey-2020-National-WRES-WDES-data_v2.xlsx (Accessed: 8 September 2021).

NHS Health Education England (2020a) *Entry requirements and training (speech and*

language therapist). Available at: https://www.healthcareers.nhs.uk/explore-roles/allied-health-professionals/roles-allied-health-professions/speech-and-language-therapist/entry-requirements-and-training-speech-and (Accessed: 12 February 2020).

NHS Health Education England (2020b) *The NHS constitutional values hub*. Available at: https://www.hee.nhs.uk/about/our-values/nhs-constitutional-values-hub-0 (Accessed: 27 January 2020).

NHS Health Education England (no date) *Explore roles.* Available at: https://www.healthcareers.nhs.uk/explore-roles (Accessed: 7 November 2019).

NHS Information Centre (2011) *NHS Staff 2000–2010 (General Practice)*. London.

NHS Leadership academy (2012) *Building equality, diversity and inclusion into the NHS board selection process : for chief executives and executive directors.* Available at: http://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-CEORecruitmentEXEC.pdf.

NHS Leadership academy (2018) *Stepping up: Line manager guide*. doi: 10.12968/denn.2021.17.6.292.

NHS Leadership academy (2019) *Building leadership for inclusion: Narrative 2019, Leadership for Inclusion*. doi: 10.1163/9789460911378.

NHS Leadership Academy Steering Group (2013) *The Healthy NHS Board 2013: Principles for good governance*. doi: 10.1136/oem.60.5.322.

NHS Providers (2014) *Leading by example: the race equality opportunity for nhs provider boards*. Available at: https://nhsproviders.org/media/1199/nhsp_race_equality_report.pdf (Accessed: 3 February 2020).

NHS Scotland (2021) *Principles and values, Workforce Policies*. Available at: https://workforce.nhs.scot/about/principles-and-values/ (Accessed: 2 September 2020).

Nielsen, K. (2007) 'The qualitative research interview and issues of knowledge', *Nordic Psychology*, 59(3), pp. 210–222. doi: 10.1027/1901-2276.59.3.210.

Nielsen, R., Marrone, J. A. and Slay, H. S. (2010) 'A new look at humility: Exploring the humility concept and its role in socialized charismatic leadership', *Journal of Leadership and Organizational Studies*, 17(1), pp. 33–43. doi: 10.1177/1548051809350892.

Nkomo, S. and Hoobler, J. M. (2014) 'A historical perspective on diversity ideologies in the United States: Reflections on human resource management research and practice', *Human Resource Management Review*. Elsevier Inc., 24(3), pp. 245–257. doi: 10.1016/j.hrmr.2014.03.006.

Noon, M. (2007) 'The fatal flaws of diversity and the business case for ethnic minorities',

Work, Employment and Society, 21(4), pp. 773–784. doi: 10.1177/0950017007082886.

Noon, M. (2010) 'The shackled runner: Time to rethink positive discrimination?', *Work, Employment and Society*, 24(4), pp. 728–739. doi: 10.1177/0950017010380648.

Noon, M. (2012) 'Simply the best? The case for using "threshold selection" in hiring decisions', *Human Resource Management Journal*, 22(1), pp. 76–88. doi: 10.1111/j.1748-8583.2011.00168.x.

Noon, M. *et al.* (2013) 'The Equality Effects of the "Hyper-formalization" of Selection', *British Journal of Management*, 24(3), pp. 333–346. doi: 10.1111/j.1467-8551.2011.00807.x.

Noon, M. (2018) 'Pointless Diversity Training: Unconscious Bias, New Racism and Agency', *Work, Employment and Society*, 32(1), pp. 198–209. doi: 10.1177/0950017017719841.

Noon, M. and Ogbonna, E. (2021) 'Controlling management to deliver diversity and inclusion: Prospects and limits', *Human Resource Management Journal*, 31(3), pp. 619–638. doi: 10.1111/1748-8583.12332.

Norris, A., Murphy-Erby, Y. and Zajicek, A. (2007) 'An intersectional perspective in introductory sociology textbooks and the sociological imagination: A case study', *Race, Gender & Class*, 14(1/2), pp. 333–344. Available at: https://www.jstor.org/stable/41675213?seq=1&cid=pdf-reference#references_tab_contents.

Northern Health and Social Care Trust (2020) *What we do*. Available at: http://www.northerntrust.hscni.net/about-the-trust/trust-overview-2/ (Accessed: 2 September 2021).

Nowell, L. S. *et al.* (2017) 'Thematic Analysis: Striving to Meet the Trustworthiness Criteria', *International Journal of Qualitative Methods*, 16(1), pp. 1–13. doi: 10.1177/1609406917733847.

Nuffield Trust (2017) *The NHS is the world's fifth largest employer.* Available at: https://www.nuffieldtrust.org.uk/chart/the-nhs-is-the-world-s-fifth-largest-employer (Accessed: 7 November 2019).

Numerato, D., Salvatore, D. and Fattore, G. (2012) 'The impact of management on medical professionalism: A review', *Sociology of Health and Illness*, 34(4), pp. 626–644. doi: 10.1111/j.1467-9566.2011.01393.x.

O'Dwyer-Cunliffe, F. and Russell, J. (2021) *BAME representation and the experience in the NHS*. Available at: https://nhsproviders.org/inclusive-leadership/bame-representation-and-experience-in-the-nhs (Accessed: 18 June 2021).

O'Reilly, M. and Parker, N. (2013) '"Unsatisfactory Saturation": A critical exploration of the

notion of saturated sample sizes in qualitative research', *Qualitative Research*, 13(2), pp. 190–197. doi: 10.1177/1468794112446106.

Office for National Statistics (2011) *Dataset population: DC2101EW - Ethnic group by sex by age. All usual residents in England and Wales)., Nomis*. Office for National Statistics. Available at: https://www.nomisweb.co.uk/census/2011/DC2101EW/view/2092957703?rows=c_age&cols=c_ethpuk11 (Accessed: 19 November 2018).

Office for National Statistics (2016a) *Dataset: EMP04: Employment by occupation. April-June 2016.* Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/datasets/employmentbyoccupationemp04 (Accessed: 9 May 2018).

Office for National Statistics (2016b) *Women shoulder the responsibility of 'unpaid work'.* Available at: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/articles/womenshouldertheresponsibilityofunpaidwork/2016-11-10 (Accessed: 18 November 2019).

Office for National Statistics (2018) *Socioeconomic status*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/socioeconomic-status/latest (Accessed: 20 May 2022).

Office for National Statistics (2020a) *Economic Inactivity Rate by Broad Ethnic Group (working-age)*. Available at: https://data.london.gov.uk/dataset/economic-inactivity-rate-broad-ethnic-group-working-age (Accessed: 3 June 2021).

Office for National Statistics (2020b) *Employment by occupation*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment-by-occupation/latest (Accessed: 3 June 2021).

Office for National Statistics (2021a) *Employment*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment/latest#by-ethnicity-and-gender (Accessed: 3 June 2021).

Office for National Statistics (2021b) *Unemployment*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/unemployment-and-economic-inactivity/unemployment/latest#by-ethnicity (Accessed: 3 June 2021).

Office for National Statistics, Social Survey Division Northern Ireland Statistics and Research and Central Survey Unit (2014) *Dataset: Quarterly labour force survey, April - June, 2011*. 2nd edn. Colchester, Essex: UK Data Service. doi: SN: 6851: 10.5255/UKDA-SN-6851-2.

Office for National Statistics, Social Survey Division Northern Ireland Statistics and Research and Central Survey Unit (2017) *Dataset: Quarterly labour force survey, April - June, 2016*. 2nd edn. UK Data Service. doi: SN: 8039: 10.5255/UKDA-SN-8039-2.

Oikelome, F. (2007) *The recruitment and retention of black and minority ethnic staff in the National Health Service*. London. Available at: http://www.scie-socialcareonline.org.uk/the-recruitment-and-retention-of-black-and-minority-ethnic-staff-in-the-national-health-service/r/a11G00000017wMnIAI.

Oikelome, F. and Healy, G. (2007) 'Second-class doctors? The impact of a professional career structure on the employment conditions of overseas- and UK-qualified doctors', *Human Resource Management Journal*, 17(2), pp. 134–154. doi: 10.1111/j.1748-8583.2007.00033.x.

Olsen, H. (2003) 'Veje til kvalitativ kvalitet. Om kvalitetssikring af kvalitativ interviewforskning. (Roads to qualitative quality? On securing quality of qualitative interview)', *Nordic Educational Research*, 23, pp. 1–20.

Olson, D. A. and Jackson, D. (2009) 'Expanding leadership diversity through formal mentoring programs', *Journal of Leadership Studies*, 3(1), pp. 47–60. doi: 10.1002/jls.20095 47.

Ormston, R. *et al.* (2014) 'The foundations of qualitative research', in *Qualitative research practice: a guide for social science students and researchers*. Second. London: Sage, pp. 1–25.

Oswick, C. and Noon, M. (2014) 'Discourses of diversity, equality and inclusion: Trenchant formulations or transient fashions?', *British Journal of Management*, 25(1), pp. 23–39. doi: 10.1111/j.1467-8551.2012.00830.x.

Ou, A. Y. *et al.* (2014) 'Humble Chief Executive Officers' Connections to Top Management Team Integration and Middle Managers' Responses', *Administrative Science Quarterly*, 59(1), pp. 34–72. doi: 10.1177/0001839213520131.

Overell, S. (1996) 'Ouseley in assault on diversity', *People Management*, 2(9), pp. 7–8.

Oxfam International (2023) 'Inclusive language guide'. Oxford, UK, pp. 1–92. doi: 10.21201/2021.7611.

Ozbilgin, M. F. (2009) 'Equality, diversity and inclusion at work: yesterday, today and tomorrow', in Ozbilgin, M. F. (ed.) *Equality, Diversity and Inclusion at Work. A Research Companion*. Cheltenham: Edward Elgar Publishing, pp. 1–13.

Ozbilgin, M. F. and Tatli, A. (2011) 'Mapping out the field of equality and diversity: Rise of individualism and voluntarism', *Human Relations*, 64(9), pp. 1229–1253. doi: 10.1177/0018726711413620.

Ozturk, M. B. and Berber, A. (2022) 'Racialised professionals' experiences of selective incivility in organisations: A multi-level analysis of subtle racism', *Human Relations*, 75(2), pp. 213–239. doi: 10.1177/0018726720957727.

Ozturk, M. B. and Tatli, A. (2016) 'Gender identity inclusion in the workplace: broadening diversity management research and practice through the case of transgender employees in the UK', *International Journal of Human Resource Management*. Routledge, 27(8), pp. 781–802. doi: 10.1080/09585192.2015.1042902.

Parish, J. *et al.* (1990) 'Undressing the facts: the problems encountered by male occupational therapists', *The British Journal of Occupational Therapy*, 53(2), pp. 67–70. doi: https://doi.org/10.1177/030802269005300208.

Parity UK (2013) *Gender balance in public sector occupations: Speech and Language Therapists., Parity briefing paper*. doi: 10.1201/9781315264974-10.

Parker, J. (2020) *Ethnic Diversity: Enriching business leadership. An update from The Parker Review*. Available at: https://assets.ey.com/content/dam/ey-sites/ey-com/en_uk/news/2020/02/ey-parker-review-2020-report-final.pdf.

Parker, J. and The Parker Review Committee (2016) *A Report into the ethnic diversity of UK boards*. Available at: http://www.ey.com/Publication/vwLUAssets/A_Report_into_the_Ethnic_Diversity_of_UK_Boards/$FILE/Beyond One by 21 PDF Report.pdf (Accessed: 13 January 2017).

Patterson, A. and Woodward, R. J. (1996) 'Choice of speech and language therapy as a career', in *Caring to Communicate (Proceedings of the Golden Jubilee Conference)*. London: Royal College of Speech and Language Therapists.

Patton, MQ (2002) *Qualitative research and evaluation methods*. Third. Thousand Oaks (CA): Sage.

Patton, M (2002) 'The nature of qualitative inquiry', in *Qualitative research and evaluation methods*. Thousand Oaks (CA): Sage Publications Ltd, pp. 1–35.

Patton, M. Q. (2002) 'Strategic themes in qualitative Inquiry', in *Qualitative research & evaluation methods*. 3rd edn. Thousand Oaks, California: Sage Publications, pp. 34–73. Available at: https://aulasvirtuales.files.wordpress.com/2014/02/qualitative-research-evaluation-methods-by-michael-patton.pdf.

Pearn Kandola LLP (2018) *Racism at Work Survey Results*. Kidlington.

Pelled, L. H., Eisenhardt, K. M. and Xin, K. R. (1999) 'Exploring the black box: an analysis of work group diversity, conflict and performance', *Administrative Science Quarterly*, 44(1), pp. 1–28.

Perlman, R. and Pike, M. (1994) *Sex Discrimination in the Labour Market: The Case for Comparable Worth*. Manchester University Press.

Perren, K. *et al.* (2012) *Evaluation of the Implementation of the Equality Act 2010: Report 2 - Awareness and impact of the Equality Act. CRSP 620*. London. doi: 978-1-78246-023-7.

Peters, K., Ryan, M. K. and Haslam, S. A. (2013) 'Women's occupational motivation: the impact of being a woman in a man's world', in Vinnicombe, S. et al. (eds) *Handbook of Research Promoting Women's Careers*. Cheltenham: Edward Elgar, pp. 162–177.

Peterson, E. A. (1999) 'Creating a culturally relevant dialogue for African American adult educators', *New Directions for Adult and Continuing Education*, 1999(82), pp. 79–91. doi: 10.1002/ace.8206.

Pichler, F. and Wallace, C. (2009) 'Social capital and social class in Europe: The role of social networks in social stratification', *European Sociological Review*, 25(3), pp. 319–332. doi: 10.1093/esr/jcn050.

Pickett, L. (2017) *Professional regulation in health and social care, House of Commons Library*. London. Available at: http://researchbriefings.files.parliament.uk/documents/CBP-8094/CBP-8094.pdf.

Pitts, D. W. and Jarry, E. M. (2009) 'Getting to know you: Ethnic diversity, time and performance in public organization', *Public Administration*, 87(3), pp. 503–518. doi: 10.1111/j.1467-9299.2009.01776.x.

Platt, R. and Warwick, L. (2020) *Are some ethnic groups more vulnerable to COVID-19 than others?, The Institute for Fiscal Studies Deaton Review*. Available at: https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/.

Pless, N. M. and Maak, T. (2004) 'Building an Inclusive Diversity Culture : Principles', *Journal of Business Ethics*, 54(2), pp. 129–147.

Du Plessis, S. (2018) 'Male students' perceptions about gender imbalances in a speech language pathology and audiology training programme of a South African institution of higher education', *South African Journal of Communication Disorders*, 65(1), pp. 1–9. doi: 10.4102/sajcd.v65i1.570.

Portes, A. (1998) 'Social capital: Its origins and applications in modern sociology', *Annual Review of Sociology*, 24, pp. 1–24. doi: 10.1016/b978-0-7506-7222-1.50006-4.

Portes, A. and Vikstrom, E. (2011) 'Diversity, social capital, and cohesion', *Annual Review of Sociology*, 37, pp. 461–479. doi: doi:10.1146/annurev-soc-081309-150022.

Poteyeva, M. (2018) 'Social capital', *Britannica*. Available at:

https://www.britannica.com/topic/social-capital (Accessed: 28 March 2023).

Potter, J. and Hepburn, A. (2005) 'Qualitative interviews in psychology: Problems and possibilities', *Qualitative Research in Psychology*, 2(4), pp. 281–307. doi: 10.1191/1478088705qp045oa.

Pratt, G. and Hanson, S. (1991) 'Time, space, and the occupational segregation of women: a critique of human capital theory', *Geoforum*, 22(2), pp. 149–157. doi: 10.1016/0016-7185(91)90004-A.

Priest, N. *et al.* (2015) 'Promoting equality for ethnic minority NHS staff-what works?', *BMJ*, 351(July), p. h3297. doi: 10.1136/bmj.h3297.

Prior, L. (2003) *Using Documents in Social Research: Introducing Qualitative Methods*. London: Sage.

Prospects (2021) *Job profile: Equality, diversity and inclusion officer*. Available at: https://www.prospects.ac.uk/job-profiles/equality-diversity-and-inclusion-officer#salary (Accessed: 7 September 2021).

Proudford, K. L. and Nkomo, S. (2006) 'Race and Ethnicity in Organizations.', in Konrad, A. M., Prasad, P., and Pringle, J. K. (eds) *Handbook of workplace diversity*. Sage Publications, Inc., pp. 323–344. Available at: https://doi.org/10.4135/9781848608092.n14.

Public Health England (2020) *Beyond the data : Understanding the impact of COVID-19 on BAME groups*. London, England. Available at: www.facebook.com/PublicHealthEngland%0Ahttps://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf.

Pudney, S. and Shields, M. (2000) 'Gender, race, pay and promotion in the British nursing profession: Estimation of a generalized ordered probit model', *Journal of Applied Econometrics*, 15(4), pp. 367–399. doi: 10.1002/1099-1255(200007/08)15:4<367::AID-JAE563>3.0.CO;2-Z.

Puhlman, J. and Johnson, R. K. (2019) 'Survey of male college students' perceptions and knowledge of speech-language pathology', *Journal of Communication Disorders*. Elsevier, 82, p. 105936. doi: 10.1016/j.jcomdis.2019.105936.

Punshon, G. *et al.* (2019) 'Nursing pay by gender distribution in the UK - does the Glass Escalator still exist?', *International Journal of Nursing Studies*. Elsevier Ltd, 93, pp. 21–29. doi: 10.1016/j.ijnurstu.2019.02.008.

Purcell, J. (1987) 'Mapping management styles in employee relations', *Journal of Management Studies*, 24(5), pp. 533–548. doi: https://doi.org/10.1111/j.1467-6486.1987.tb00462.x.

Putnam, R. D. (2000) *Bowling alone: The collapse and revival of American community*. New York: Simon & Shuster.

Putnam, R. D. (2007) 'E pluribus unum: Diversity and community in the twenty-first century the 2006 Johan Skytte prize lecture', *Scandinavian Political Studies*, 30(2), pp. 137–174. doi: 10.1111/j.1467-9477.2007.00176.x.

Puwar, N. (2004) *Space Invaders. Race, Gender and Bodies Out of Place*. New York: Berg.

Ragins, B. R. and Gonzalez, J. A. (2003) 'Understanding diversity in organizations: Getting a grip on a slippery construct', in Greenberg, J. (ed.) *Organizational behavior: The state of the science*. 2nd edn. Mahwah: Lawrence Erlbaum Associates Publishers, pp. 125–163.

Randel, A. E. *et al.* (2018) 'Inclusive leadership: Realizing positive outcomes through belongingness and being valued for uniqueness', *Human Resource Management Review*. Elsevier, 28(2), pp. 190–203. doi: 10.1016/j.hrmr.2017.07.002.

Randhawa, M. (2015) *Inclusion and diversity in the NHS: let's be bigger and bolder*. Available at: https://www.kingsfund.org.uk/blog/2015/05/inclusion-and-diversity-nhs-lets-be-bigger-and-bolder (Accessed: 15 June 2021).

Randhawa, M. (2018) *Closing the gap on BME representation in NHS leadership: not rocket science*. Available at: https://www.kingsfund.org.uk/blog/2018/03/bme-representation-nhs-leadership (Accessed: 3 February 2020).

Ray, R. and Gibbons, A. (2021) *Commentary: Why are states banning critical race theory?* Available at: https://www.brookings.edu/articles/why-are-states-banning-critical-race-theory/ (Accessed: 4 January 2024).

RCSLT (no date) *Cuts to speech and language therapy services, Giving voice factsheet*. RCSLT. Available at: https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/rcslt-cuts-to-speech-and-language-therapy-factsheet.pdf (Accessed: 11 January 2023).

Research Works Limited (2020a) *Male participation in nursing and allied health higher education courses: Appendix 4: Quantitative analysis data tables: OfS analysis of 2016-17 and 2017-18 HESA data.*

Research Works Limited (2020b) *Male participation in nursing and allied health higher education courses: Final report prepared by Research Works Limited for the Office for Students, January 2020*. doi: 10.3143/geriatrics.57.contents2.

Reskin, B. (1993) 'Sex segregation in the workplace', *Annual review of sociology*, 19, pp. 241–270. doi: 10.1146/annurev.soc.19.1.241.

Rhead, R. D. *et al.* (2021) 'Impact of workplace discrimination and harassment among National

Health Service staff working in London trusts: results from the TIDES study', *BJPsych Open*, 7(1), pp. 1–8. doi: 10.1192/bjo.2020.137.

Rich, R. (1977) 'Uses of social science information by federal bureaucrats: knowledge for action versus knowledge for understanding', in Weiss, C. (ed.) *Uses of social research in public policy*. Lexington MA: DC Heath, pp. 199–212.

Richards, J. R. (1980) *The Sceptical Feminist: A Philosophical Enquiry*. London: Routledge.

Richards, W. (2001) 'Evaluating equal opportunity initiatives: The case for a "transformative" agenda', in Noon, M. and Ogbonna, E. (eds) *Equality, Diversity and Disadvantage in Employment*. Basingstoke: Palgrave, pp. 15–31.

Ridgeway, C. L. and Correll, S. J. (2004) 'Unpacking the gender system a theoretical perspective on gender beliefs and social relations', *Gender and Society*, 18(4), pp. 510–531. doi: 10.1177/0891243204265269.

Ritchie, J. and Ormston, R. (2014) 'The applications of qualitative methods to social research', in *Qualitative research practice: a guide for social science students & researchers*. Second. London: Sage Publications Ltd, pp. 27–46.

Ritzer, G. (2004) *The McDonaldization of society*. London: Sage.

Rivera, L. A. (2012) 'Hiring as Cultural Matching: The Case of Elite Professional Service Firms', *American Sociological Review*, 77(6), pp. 999–1022. doi: 10.1177/0003122412463213.

Rivers, N. A. and Derksen, M. (2015) 'Ecologies of deception in psychology and rhetoric', *Quarterly Journal of Speech*. Taylor & Francis, 101(4), pp. 633–654. doi: 10.1080/00335630.2015.1127404.

Robert Wood Johnson Foundation (2008) *Lincoln and Guba's Evaluative Criteria*. Available at: http://www.qualres.org/HomeLinc-3684.html (Accessed: 30 March 2021).

Roberts, A., Marshall, L. and Charlesworth, A. (2012) *The funding pressures facing the NHS from 2010/11 to 2021/22: A decade of austerity?* London, UK. Available at: http://www.nuffieldtrust.org.uk/publications/decade-austerity-funding-pressures-facing-nhs.

Robertson, R. *et al.* (2017) *Understanding NHS financial pressures: How are they affecting patient care?* London, UK. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Understanding NHS financial pressures - full report.pdf%0Ahttps://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Understanding NHS financial pressures - full r.

Robinson, G. and Dechant, K. (1997) ‘Building a Business Case for Diversity’, *The Academy of Management Executive (1993-2005)*, 11(3), pp. 21–31. doi: https://www.jstor.org/stable/4165408.

Rocco, T. S., Bernier, J. D. and Bowman, L. (2014) ‘Critical race theory and HRD: Moving race front and center’, *Advances in Developing Human Resources*, 16(4), pp. 457–470. doi: 10.1177/1523422314544294.

Rodriguez, J. K. *et al.* (2016) ‘The Theory and Praxis of Intersectionality in Work and Organisations: Where Do We Go From Here?’, *Gender, Work and Organization*, 23(3), pp. 201–222. doi: 10.1111/gwao.12131.

Rohwerder, B. (2018) *Disability stigma in developing countries, K4D Helpdesk Report*. Brighton, UK. Available at: https://assets.publishing.service.gov.uk/media/5b18fe3240f0b634aec30791/Disability_stigma_in_developing_countries.pdf.

Rolewicz, L. and Palmer, B. (2020) *The NHS workforce in numbers: Facts on staffing and staff shortages in England.* Available at: https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers (Accessed: 12 February 2021).

Romansky, L. *et al.* (2021) ‘How to measure inclusion in the workplace’, *Harvard Business Review*. Available at: https://hbr.org/2021/05/how-to-measure-inclusion-in-the-workplace (Accessed: 11 January 2023).

Rorty, R. (1967) *The Linguistic Turn*. Chicago: Chicago University Press.

Rosette, A. S., Leonardelli, G. J. and Phillips, K. W. (2008) ‘The White Standard: Racial Bias in Leader Categorization’, *Journal of Applied Psychology*, 93(4), pp. 758–777. doi: 10.1037/0021-9010.93.4.758.

Roskams, M. (2023) *Gender identity, England and Wales: Census 2021, Census 2021: Data and analysis from Census 2021*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/genderidentity/bulletins/genderidentityenglandandwales/census2021#glossary (Accessed: 21 March 2023).

Rossiter, D. (2000a) ‘Leaving the profession.’, *Bulletin of the Royal College of Speech & Language Therapists*, April.

Rossiter, D. (2000b) ‘Recruitment and retention: the black and white picture’, *Bulletin of the Royal College of Speech & Language Therapists*, July.

Rossiter, D. (2006) ‘AfC: a level playing field or a slippery slope’, in *Bulletin of the Royal College of Speech & Language Therapists*. RCSLT, p. 10. Available at: https://www.rcslt.org/-/media/Project/Bulletins/bulletin-april-2006.pdf.

Roulston, Kathryn (2010) 'Considering quality in qualitative interviewing', *Qualitative Research*, 10(2), pp. 199–228. doi: 10.1177/1468794109356739.

Roulston, K (2010) *Reflective Interviewing: Guide to Theory and Practice*. Los Angeles, CA: Sage.

Royal College of Nursing (2005) *Releasing the Potential within BME Networks: BME networks report*. London.

Royal College of Speech and Language Therapists (2005) 'Celebrating the RCSLT's diamond jubilee', *Bulletin of the Royal College of Speech & Language Therapists*, October, pp. 1–27. Available at: https://www.rcslt.org/wp-content/uploads/media/docs/75th-files/bulletin-october-20051/bulletin-october-2005.pdf?la=en&hash=95284861EBD00D592A6EB2718DB296024AAFD324.

Royal College of Speech and Language Therapists (2019a) 'HEI List 2019: Universities offering accredited speech and language therapy programmes', pp. 1–3. Available at: https://www.rcslt.org/wp-content/uploads/media/hei-list-2019.pdf (Accessed: 12 February 2021).

Royal College of Speech and Language Therapists (2019b) 'RCSLT workshop: Towards a diverse profession'. Royal College of Speech and Language Therapists, pp. 1–15. Available at: https://www.rcslt.org/wp-content/uploads/media/docs/events/towards-a-diverse-profession-careers-and-diversity-slides-pdf-v2.pdf?la=en&hash=8ED8E52686F8350A0A1EB6AC58E7CEDC3FD2F5B2.

Royal College of Speech and Language Therapists (2019c) *The NHS England Long Term Plan February 2019: What it means for speech & language therapy*. Available at: https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/note-on-the-nhs-long-term-plan.pdf (Accessed: 3 September 2021).

Royal College of Speech and Language Therapists (2019d) 'Welcome to the webinar: Towards a diverse profession'. Royal College of Speech and Language Therapists, pp. 1–28.

Royal College of Speech and Language Therapists (2020a) *COVID-19 : Maximising the contribution of the speech and language therapy workforce*. London, UK. Available at: https://www.rcslt.org/wp-content/uploads/media/docs/Covid/RCSLTCOVID19-Maximising-the-contribution-of-SLT-workforce240420.pdf?la=en&hash=FB5E49E11B2FC628FCAFF07EBD3A4E90DA24BF22 (Accessed: 8 September 2021).

Royal College of Speech and Language Therapists (2020b) *RCSLT welcomes diversity commitments in Simon Stevens letter*. Available at: https://www.rcslt.org/news/rcslt-

welcomes-diversity-commitments-in-simon-stevens-letter/ (Accessed: 16 April 2023).

Royal College of Speech and Language Therapists (2020c) 'Survey of male SLTs'. London, UK: Royal College of Speech and Language Therapists, p. 1. Available at: https://www.rcslt.org/wp-content/uploads/2020/06/RCSLT-Gender-Survey-2020-infographic.pdf.

Royal College of Speech and Language Therapists (2020d) *What is speech and language therapy?* Available at: https://www.rcslt.org/-/media/Project/RCSLT/rcslt-what-is-slt-factsheet.pdf (Accessed: 12 February 2020).

Royal College of Speech and Language Therapists (2021a) *How to become a speech and language therapist: Financial information for students*. Available at: https://www.rcslt.org/speech-and-language-therapy/become-a-speech-and-language-therapist/#section-4 (Accessed: 11 February 2021).

Royal College of Speech and Language Therapists (2021b) *How to become a speech and language therapist: Speech and language therapy courses*. Available at: https://www.rcslt.org/speech-and-language-therapy/become-a-speech-and-language-therapist/#section-2 (Accessed: 12 February 2021).

Royal College of Speech and Language Therapists (2021c) *How to become a speech and language therapist: What do speech and language therapists do?* Available at: https://www.rcslt.org/speech-and-language-therapy/become-a-speech-and-language-therapist (Accessed: 12 February 2020).

Royal College of Speech and Language Therapists (2021d) *Speech and language therapy regulation: Registering with the HCPC*. Available at: https://www.rcslt.org/speech-and-language-therapy/regulation/#section-2 (Accessed: 11 February 2021).

Royal College of Speech and Language Therapists (2021e) *Supporting equality, diversity and inclusion in speech and language therapy pre-registration degrees*. Available at: https://www.rcslt.org/news/supporting-equality-diversity-and-inclusion-in-speech-and-language-therapy-degrees/ (Accessed: 29 December 2022).

Royal College of Speech and Language Therapists (2021f) *We are the Royal College of Speech and Language Therapists*. Available at: https://www.rcslt.org/ (Accessed: 3 February 2021).

Royal College of Speech and Language Therapists (2022a) *Apprenticeships (England only): About apprenticeships*. Available at: https://www.rcslt.org/speech-and-language-therapy/become-a-speech-and-language-therapist/apprenticeships/ (Accessed: 7 September 2022).

Royal College of Speech and Language Therapists (2022b) *Students: Volunteer opportunities*.

Available at: https://www.rcslt.org/learning/students/#section-3 (Accessed: 7 September 2022).

Royal College of Speech and Language Therapists (2023a) *Careers promotion working group, Projects*. Available at: https://www.rcslt.org/members/speech-and-language-therapy/careers-promotion-and-diversity/careers-projects/#section-1 (Accessed: 11 January 2023).

Royal College of Speech and Language Therapists (2023b) *Giving voice factsheets, Factsheets on speech and language therapy*. Available at: https://www.rcslt.org/policy/uk-wide/fact-sheets-on-speech-and-language-therapy/#section-1 (Accessed: 11 January 2023).

Royal College of Speech and Language Therapists (2023c) *RCSLT member benefits, Membership overview*. Available at: https://www.rcslt.org/about-us/membership-overview/ (Accessed: 27 March 2023).

Royal College of Speech and Language Therapists (2023d) *Schools outreach project, Projects*. Available at: https://www.rcslt.org/members/speech-and-language-therapy/careers-promotion-and-diversity/careers-projects/#section-2 (Accessed: 11 January 2023).

Royal College of Speech and Language Therapists (2023e) *What is the giving voice campaign?, Giving voice: campaigning and influencing*. Available at: https://www.rcslt.org/get-involved/giving-voice/#section-1 (Accessed: 1 November 2023).

Royal College of Speech and Language Therapists (2023f) *Wider aspects of diversity, Projects*. Available at: https://www.rcslt.org/members/speech-and-language-therapy/careers-promotion-and-diversity/careers-projects/#section-5 (Accessed: 11 January 2023).

Royal College of Speech and Language Therapists (no date) *A brief history of speech and language therapy in the UK*. Royal College of Speech and Language Therapists. Available at: https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/a-brief-history-of-speech-and-language-therapy-in-the-uk.pdf?la=en&hash=E7A926C218C1DFB292D9146F332CED2E96ACF1D7 (Accessed: 11 February 2021).

Rubin, H. J. and Rubin, I. S. (2005) *Qualitative Interviewing: The Art of Hearing Data*. Edited by Second. Thousand Oaks, CA: Sage.

Ryan, F., Coughlan, M. and Cronin, P. (2007) 'Step-by-step guide to critiquing research. Part 2: Qualitative research.', *British journal of nursing*, 16(12), pp. 738–744. doi: 10.12968/bjon.2007.16.12.23726.

Ryan, G. and Bernard, H. (2000) 'Data management and analysis methods', in Denzin, N. and Lincoln, Y. (eds) *Handbook of qualitative research*. Thousand Oaks, CA: Sage, pp. 769–

802.

Ryan, M. K. *et al.* (2007) 'Opting out or Pushed off the Edge? The Glass Cliff and the Precariousness of Women's Leadership Positions', *Social and Personality Psychology Compass*, 1(1), pp. 266–279. doi: 10.1111/j.1751-9004.2007.00007.x.

Ryan, M. K. and Haslam, S. A. (2005) 'The glass cliff: Evidence that women are over-represented in precarious leadership positions', *British Journal of Management*, 16(2), pp. 81–90. doi: 10.1111/j.1467-8551.2005.00433.x.

Ryan, M. K. and Haslam, S. A. (2007) 'The glass cliff: Exploring the dynamics surrounding the appointment of women to precarious leadership positions', *Academy of Management Review*, 32(2), pp. 549–572. doi: 10.5465/AMR.2007.24351856.

Sabharwal, M. (2014) 'Is diversity management sufficient? Organizational inclusion to further performance', *Public Personnel Management*, 43(2), pp. 197–217. doi: 10.1177/0091026014522202.

Sackett, P., Dubois, C. and Noe, A. (1991) 'Tokenism in performance evaluation: the effects of work representation on male-female and black-white differences in performance ratings', *Journal of Applied Psychology*, 76(3), pp. 263–7.

Saetermoe, C. L., Scattone, D. and Kim, K. H. (2001) 'Ethnicity and the stigma of disabilities', *Psychology and Health*, 16(6), pp. 699–713. doi: 10.1080/08870440108405868.

Salaman, G. (1986) *Working*. London: Tavistock.

Saldana, J. (2009) *The coding manual for qualitative researchers*. London: Sage.

Santry, C. (2008) *HSJ survey shows 'racism alive in NHS'*, *Health Service Journal*. Available at: https://www.hsj.co.uk/news/hsj-survey-shows-racism-alive-in-nhs/1915075.article (Accessed: 30 March 2020).

Sapir, E. (1947) *Selected Writings in Language, Culture and Personality*. Los Angeles: University of California Press.

Savanta ComRes Faith Research Centre (2017) *Faith research centre - survey of British workers - belief at work, Belief at work: Faith in the workplace 2017 survey*. Available at: https://comresglobal.com/polls/belief-at-work-faith-in-the-workplace-study-2017/ (Accessed: 17 May 2022).

Schipani, C. A. *et al.* (2009) 'Pathways for women to obtain positions of organisational leadership: The significance of mentoring and networking.', *Duke journal of gender law and policy*, 3, pp. 89–136.

Schon, D. (1963) *The displacement of concepts*. London: Tavistock.

Schwiter, K., Nentwich, J. and Keller, M. (2021) 'Male privilege revisited: How men in female-

dominated occupations notice and actively reframe privilege', *Special Issue: On and Off Screen: Women's Work in the Screen Industries*, 28(6), pp. 2199–2215.

Science Council (2020) *Our definition of a Professional Body*. Available at: https://sciencecouncil.org/about-science/our-definition-of-a-professional-body/ (Accessed: 2 July 2021).

Scott, P. and Williams, S. (2014) 'The Coalition Government and employment relations: accelerated neo-liberalism and the rise of employer-dominated voluntarism', *Observatoire de la société britannique*, 15, pp. 145–164. Available at: https://doi.org/10.4000/osb.1636.

Seale, C. (1999) *The quality of qualitative research*. Oxford: Blackwell.

Sealy, R. (2017) *NHS Women on Boards by 2020*. Available at: https://www.nhsemployers.org/-/media/Employers/Publications/NHS-Women-on-Boards-report.pdf (Accessed: 21 February 2020).

Sehmi, H. S. (2015) *An ethnographic study exploring the over-representation of black and minority ethnic (BME) employees in the disciplinary process in a National Health Service (NHS) Trust*. University of Surrey. Available at: http://epubs.surrey.ac.uk/808709/.

Seierstad, C. (2016) 'Beyond the Business Case: The Need for Both Utility and Justice Rationales for Increasing the Share of Women on Boards', *Corporate Governance: An International Review*, 24(4), pp. 390–405. doi: 10.1111/corg.12117.

Seierstad, C. *et al.* (2020) 'A "quota silo" or positive equality reach? The equality impact of gender quotas on corporate boards in Norway', *Human Resource Management Journal*, 31, pp. 165–186. doi: 10.1111/1748-8583.12288.

Seierstad, C. and Opsahl, T. (2011) 'For the few not the many? The effects of affirmative action on presence, prominence, and social capital of women directors in Norway', *Scandinavian Journal of Management*. Elsevier Ltd, 27(1), pp. 44–54. doi: 10.1016/j.scaman.2010.10.002.

Shapiro, G. and Allison, M. (2007) *Reframing Diversity*. London.

Sheridan, J. (1999) 'A career in speech and language therapy: For white women only?', *Bulletin of the Royal College of Speech & Language Therapists*, 562(3).

Shields, M. A. and Price, S. W. (2002) 'The determinants of racial harassment at the workplace: Evidence from the British nursing profession', *British Journal of Industrial Relations*, 40(1), pp. 1–21. doi: 10.1111/1467-8543.00220.

Shore, L. M. *et al.* (2011) 'Inclusion and Diversity in Work Groups : A Review and Model for Future Research', *Journal of Management*, 37(4), pp. 1262–1289. doi: 10.1177/0149206310385943.

Silverman, D. (2001) *Interpreting qualitative data: methods for analysis, talk, text and interaction*. Fourth. London: Sage.

Silverman, D. (2010) *Doing qualitative research*. Third. London: Sage.

Sinclair, A. (2006) 'Critical diversity management practice in Australia: romanced or co-opted?', in Konrad, A. M., Prasad, P., and Pringle, J. K. (eds) *Handbook of Workplace Diversity*. London: Sage, pp. 511–530. doi: http://dx.doi.org/10.4135/9781848608092.n22.

Singh, D. (2003) 'Racism rife in the medical profession, BMA report says', *Bmj*, 326(7404), p. 1418. doi: 10.1136/bmj.326.7404.1418.

Skelton, C. (2009) 'Failing to get men into primary teaching: A feminist critique', *Journal of Education Policy*, 24(1), pp. 39–54. doi: 10.1080/02680930802412677.

Smith, C. and Mahon, M. (2013) 'Speech and Language Therapy Students: how do those with "non traditional" university entry qualifications perform?', *International Journal of Language and Communication Disorders*, 48(4), pp. 394–401. doi: doi: 10.1111/1460-6984.12016.

Smith, K. (2002) 'Some critical observations on the use of the concept of "ethnicity" in Modood et al., Ethnic minorities in Britain', *Sociology*, 36(2), pp. 399–417. doi: 10.1177/0038038502036002009.

Smith, N. (2021) 'Liberalization', *Britannica*. Available at: https://www.britannica.com/topic/liberalization (Accessed: 5 January 2021).

Smith, P. *et al.* (2006) *Valuing and Recognising the Talents of a Diverse Workforce*. United Kingdom.

Society for Human Resource Management (SHRM) (2009) *Global Diversity and Inclusion*. Alexandria, VA.

Von Solms, R. and Von Solms, B. (2004) 'From policies to culture', *Computers and Security*, 23(4), pp. 275–279. doi: 10.1016/j.cose.2004.01.013.

Song, S. Y. and Pyon, S. M. (2008) 'Cultural Deficit Model', *Encyclopedia of Educational Psychology*. Edited by N. J. Salkind. Sage Publications, Inc. Available at: https://www.doi.org/10.4135/9781412963848.n60.

Southby, K., South, J. and Bagnall, A. M. (2019) 'A Rapid Review of Barriers to Volunteering for Potentially Disadvantaged Groups and Implications for Health Inequalities', *Voluntas*. Springer US, 30(5), pp. 907–920. doi: 10.1007/s11266-019-00119-2.

Speech and Language Therapy Project Group (2019) *Department of Health workforce review report: Speech and language therapy, 2019-2029*.

Spencer, L., Ritchie, J., Ormston, R., *et al.* (2014) 'Analysis: principles and processes', in

Ritchie, J. et al. (eds) *Qualitative research practice: a guide for social science students and researchers*. Second. London: Sage Publications, pp. 269–293.

Spencer, L., Ritchie, J., O'Connor, W., *et al.* (2014) 'Analysis in practice', in Ritchie, J. et al. (eds) *Qualitative research practice: a guide for social science students and researchers*. Second. London: Sage Publications, pp. 295–346.

Spencer, L. and Ritchie, J. (2012) 'In pursuit of quality', in Harper, D. and Thompson, A. (eds) *Qualitative research methods in mental health and psychotherapy*. Chichester: Wiley-Blackwell, pp. 227–242.

Spilt, J. L., Koomen, H. M. Y. and Jak, S. (2012) 'Are boys better off with male and girls with female teachers? A multilevel investigation of measurement invariance and gender match in teacher-student relationship quality', *Journal of School Psychology*. Society for the Study of School Psychology, 50(3), pp. 363–378. doi: 10.1016/j.jsp.2011.12.002.

Stainback, K. (2008) 'Social contacts and race/ethnic job matching', *Social Forces*, 87(2), pp. 857–886. doi: 10.1353/sof.0.0123.

Stanford Encyclopedia of Philosophy (2019) 'Agency', *Stanford Encyclopedia of Philosophy*. Available at: https://plato.stanford.edu/entries/agency/ (Accessed: 2 February 2021).

Stapleford, J. and Todd, C. (1998) 'Why are there so few Ethnic Minority Speech and Language Therapists?', *International Journal of Language & Communication Disorders*, 33(S1), pp. 261–266. doi: 10.3109/13682829809179433.

Steinberg, R. J. (1992) 'Review: Gender on the Agenda: Male Advantage in Organizations. Reviewed Work(s): The Promise and the Price: The Struggle for Equal Opportunity in Women's Employment. by Clare Burton: In the Way of Women: Men's Resistance to Sex Equality in Organizations.', *Contemporary Sociology*. American Sociological Association, 21(5), pp. 576–581. Available at: https://www.jstor.org/stable/2075532%0AJSTOR.

Steinmetz, S. (2012) 'Explaining occupational sex segregation', in *The Contextual Challenges of Occupational Sex Segregation: Deciphering Cross-National Differences in Europe*. VS Verlag für Sozialwissenschaften: Springer VS. doi: 10.1007/978-3-531-93056-5.

Stephenson, J. (2017) 'Careers guidance and advice', *Children & young people now*, 2016(24). Available at: https://www.magonlinelibrary.com/doi/epub/10.12968/cypn.2016.24.24.

Stewart, M. M. (2009) 'Leader – Member Exchange and Team Performance', *Group & Organization Management*, 34(5), pp. 507–535.

Stewart, S. R. and Gonzalez, L. S. (2002) 'Serving a diverse population: the role of speech language pathology professional preparation programs', *Journal of Allied Health*, 31(4), pp. 204–216.

Stewart, S. R., Pool, J. B. and Winn, J. (2002) 'Factors in recruitment and employment of allied health students: preliminary findings', *Journal of Allied Health2*, 31(2), pp. 111–116.

Stigler, G. J. (1971) 'The Theory of Economic Regulation Published by : RAND Corporation Stable URL : http://www.jstor.org/stable/3003160', *The Bell Journal of Economics and Management Science*, 2(1), pp. 3–21.

Stone, A. (2007) *An Introduction to Feminist Philosophy*. Wiley.

Storey, J. and Bacon, N. (1993) 'Individualism and collectivism: into the 1990s', *International Journal of Human Resource Management*, 4(3), pp. 665–684. doi: https://doi.org/10.1080/09585199300000042.

Straw, S. *et al.* (2022) *Equalising access to apprenticeships: Investigating the barriers to young people accessing apprenticeship opportunities*. Berkshire, UK. Available at: https://www.nfer.ac.uk/media/4954/investigating_the_barriers_to_young_people_accessing.pdf.

Sudbery, J. (2010) *Human growth and development: An introduction for social workers.* London: Routledge.

Sue, D. W. *et al.* (2007) 'Racial microaggressions in everyday life: Implications for clinical practice', *American Psychologist*, 62(4), pp. 271–286. doi: 10.1037/0003-066X.62.4.271.

Svirko, E., Lambert, T. W. and Goldacre, M. J. (2014) 'Career progression of men and women doctors in the UK NHS: a questionnaire study of the UK medical qualifiers of 1993 in 2010/2011', *Journal of the Royal Society of Medicine Open*, 5(11), pp. 1–9. doi: 10.1177/2054270414554050.

Swain, C. M. and Nieli, R. (2003) *Contemporary Voices of White Nationalism in America*. Cambridge: Cambridge University Press.

Swan, E. and Fox, S. (2010) 'Playing the game: Strategies of resistance and co-optation in diversity work', *Gender, Work and Organization*, 17(5), pp. 567–589. doi: 10.1111/j.1468-0432.2010.00524.x.

Tatli, A. *et al.* (2008) *State of the Nation, Diversity in Business: A Focus for Progress*. London: CIPD.

Tatli, A. (2008) *Understanding the agency of diversity managers : A relational and multilevel investigation*. Queen Mary University of London.

Tatli, A. (2011) 'A Multi-layered Exploration of the Diversity Management Field : Diversity Discourses , Practices and Practitioners in the UK', *British Journal of Management*, 22, pp. 238–253. doi: 10.1111/j.1467-8551.2010.00730.x.

Tatli, A. *et al.* (2012) 'The role of regulatory and temporal context in the construction of

diversity discourses: The case of the UK, France and Germany', *European Journal of Industrial Relations*, 18(4), pp. 293–308. doi: 10.1177/0959680112461092.

Tatli, A. and Özbilgin, M. F. (2009) 'Understanding diversity managers' role in organizational change: Towards a conceptual framework', *Canadian Journal of Administrative Sciences*, 26(3), pp. 244–258. doi: 10.1002/cjas.107.

Tatli, A. and Özbilgin, M. F. (2012) 'An Emic Approach to Intersectional Study of Diversity at Work: A Bourdieuan Framing', *International Journal of Management Reviews*, 14(2), pp. 180–200. doi: 10.1111/j.1468-2370.2011.00326.x.

Taylor, K. S., Lambert, T. W. and Goldacre, M. J. (2009) 'Career progression and destinations, comparing men and women in the NHS: Postal questionnaire surveys', *BMJ (Online)*, 338(7708), p. 1429. doi: 10.1136/bmj.b1735.

Taylor, P. (1992) 'Ethnic Group Data and Applications to Higher Education', *Higher Education Quarterly*, 46(4), pp. 359–374. doi: 10.1111/j.1468-2273.1992.tb01608.x.

Teresa-Morales, C. *et al.* (2022) 'Current Stereotypes Associated with Nursing and Nursing Professionals: An Integrative Review', *International Journal of Environmental Research and Public Health*, 19(13). doi: 10.3390/ijerph19137640.

Thanem, T. (2008) 'Embodying disability in diversity management research', *Equal Opportunities International*, 27(7), pp. 581–595. doi: 10.1108/02610150810904292.

The King's Fund (2017) *How does the NHS in England work? An alternative guide*. Available at: https://www.kingsfund.org.uk/audio-video/how-does-nhs-in-england-work (Accessed: 31 August 2021).

The King's Fund (2018) *The health care workforce in England: Make or break?* London. Available at: https://www.kingsfund.org.uk/publications/health-care-workforce-england.

The King's Fund (2021) *The NHS budget and how it has changed*. Available at: https://www.kingsfund.org.uk/projects/nhs-in-a-nutshell/nhs-budget (Accessed: 15 June 2021).

The King's Fund (no date) *Overview of the health and social care workforce, Time to Think Differently*. Available at: https://www.kingsfund.org.uk/projects/time-think-differently/trends-workforce-overview (Accessed: 16 April 2020).

The WRES Implementation team (2019) *A Model Employer: Increasing black and minority ethnic representation at senior levels across the NHS*.

The WRES Implementation Team (2020) *NHS Workforce Race Equality Standard: 2019 Data Analysis Report for NHS Trusts*. Available at: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf (Accessed: 3 June 2021).

Thomas, C. *et al.* (2020) *Revealed: GP gender pay gap as high as 35 per cent*, *The Progressive Policy Think Tank*. Available at: https://www.ippr.org/news-and-media/press-releases/revealed-gp-gender-pay-gap-as-high-as-35-per-cent (Accessed: 31 August 2021).

Thomas, D. (2004) 'Diversity as strategy', *Harvard Business Review*, 82(9), pp. 98–108.

Thomas, D. A. (2001) 'Race Matters', *Harvard Business Review*. Available at: https://hbr.org/2001/04/race-matters.

Thomas, D. and Ely, R. (1996) 'Making differences matter: A new paradigm for managing diversity', *Harvard Business Review*, 74(5), pp. 79–90. doi: 10.1225/96510.

Thomas, R. (1991) *Beyond Race and Gender*. New York: AMACOM.

Thorne, S. (2000) 'Data analysis in qualitative research', *Evidence Based Nursing*, 3, pp. 68–70. doi: doi:10.1136/ebn.3.3.68.

Todd, S. (2002) 'Stakeholder perspectives: a personal account of an equality and diversity practitioner's intervention experience', in Cornelius, N. (ed.) *Building Workplace Equality: Ethics, Diversity and Inclusion*. London: Thomson, pp. 265–295.

Tolland, L. and Evans, J. (2019) *What is the difference between sex and gender?, Census 2021: Data and analysis from Census 2021*. Available at: https://www.ons.gov.uk/economy/environmentalaccounts/articles/whatisthedifferencebetweensexandgender/2019-02-21 (Accessed: 21 March 2023).

Tom Moberly (2018) 'Data chart: Number of women entering medical school rises after a decade of decline', *BMJ*, 360(k202), pp. 167–168. doi: https://doi.org/10.1136/bmj.k254.

Torre, M. (2018) 'Stopgappers? The Occupational Trajectories of Men in Female-Dominated Occupations', *Work and Occupations*, 45(3), pp. 283–312. doi: 10.1177/0730888418780433.

Torre, M. (2019) *The flip side of segregation: men in typically female jobs*. Available at: https://blogs.lse.ac.uk/businessreview/2019/01/29/the-flip-side-of-segregation-men-in-typically-female-jobs/ (Accessed: 18 May 2022).

Trades Union Congress (2020) *How Ford's striking women drove the Equal Pay Act*. Available at: https://www.tuc.org.uk/workplace-guidance/case-studies/how-fords-striking-women-drove-equal-pay-act (Accessed: 15 December 2020).

Triandis, H. C. and Gelfand, M. J. (1998) 'Converging measurement of horizontal and vertical individualism and collectivism', *Journal of Personality and Social Psychology*, 74(1), pp. 118–128.

Trimble, L. B. and Kmec, J. A. (2011) 'The role of social networks in getting a job', *Sociology Compass*, 5(2), pp. 165–178. doi: https://doi.org/10.1111/j.1751-9020.2010.00353.x.

Tuckett, A. G. (2005) 'Applying thematic analysis theory to practice: a researcher's experience.', *Contemporary nurse : a journal for the Australian nursing profession*, 19(1–2), pp. 75–87. doi: 10.5172/conu.19.1-2.75.

Tuvel, R. (2017) 'In defense of transracialism', *Hypatia*, 32(2), pp. 263–278. doi: 10.1111/hypa.12327.

UK Government (2010) *Equality Act 2010: Chapter 1 protected characteristics. Part 2, Chapter 1, Section 4., The National Archives*. United Kingdom. Available at: https://www.legislation.gov.uk/ukpga/2010/15/part/2/chapter/1 (Accessed: 21 December 2017).

UK Government (2021a) *Employment*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/employment/employment/latest#by-ethnicity-and-gender (Accessed: 4 February 2021).

UK Government (2021b) *Employment status*. Available at: https://www.gov.uk/employment-status/employee (Accessed: 2 February 2021).

UK Government (2021c) *List of ethnic groups*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/style-guide/ethnic-groups (Accessed: 9 June 2021).

UK Government (2021d) *Writing about ethnicity*. Available at: https://www.ethnicity-facts-figures.service.gov.uk/style-guide/writing-about-ethnicity (Accessed: 9 June 2021).

UK Parliament (2010) *Royal College of Speech and Language Therapists' giving voice campaign., Early Day Motion*. Available at: https://edm.parliament.uk/early-day-motion/42111/royal-college-of-speech-and-language-therapists-giving-voice-campaign#tab-supporters (Accessed: 11 January 2023).

Underhill, C. M. (2006) 'The effectiveness of mentoring programs in corporate settings: A meta-analytical review of the literature', *Journal of Vocational Behavior*, 68, pp. 292–307. doi: 10.1016/j.jvb.2005.05.003.

Unger, R. K. (1979) 'Toward a redefinition of sex and gender', *American Psychologist*, 34, pp. 1085–1094. Available at: https://eric.ed.gov/?id=EJ218805.

Unger, R. K. and Crawford, M. (1993) 'Sex and Gender—The Troubled Relationship Between Terms and Concepts', *Psychological Science*, 4(2), pp. 122–124. doi: 10.1111/j.1467-9280.1993.tb00473.x.

United Nations Human Rights – Office of the High Commissioner (2018) *Gender stereotyping*. Available at: https://www.ohchr.org/en/issues/women/wrgs/pages/genderstereotypes.aspx (Accessed: 1 December 2020).

Vacchelli, E. and Mesarič, A. (2020) 'Diversity as discourse and diversity as practice: critical

reflections on migrant women's experiences of accessing mental health support in London', *Identities: Global studies in culture and power*, pp. 1–18. doi: 10.1080/1070289X.2020.1785181.

Vassar, L. (2015) *Specialty profiles: How medical specialties vary by gender*, *American Medical Association*. Available at: https://www.ama-assn.org/residents-students/specialty-profiles/how-medical-specialties-vary-gender (Accessed: 16 April 2020).

Verba, S., Brady, H. and Schlozman, K. (1995) *Voice and Equality: Civic Voluntarism in American Politics*. Boston, MA: Harvard University Press.

Vertovec, S. (2007) 'Super-diversity and its implications', *Ethnic and Racial Studies*, 30(6), pp. 1024–1054. doi: 10.1080/01419870701599465.

Vogel, L. (2016) 'Debating difference: feminism, pregnancy and the workplace', *Feminist Studies*, 16(1), pp. 9–32.

de Vries, K. M. (2015) 'Transgender people of color at the center: Conceptualizing a new intersectional model', *Ethnicities*, 15(1), pp. 3–27. doi: 10.1177/1468796814547058.

Wachter, M. L. (1974) 'Primary and Secondary Labor Markets: A Critique of the Dual Approach', *Brookings Papers on Economic Activity*, 3, pp. 637–693. doi: 10.2307/2534250.

Walby, S. (1986) *Patriarchy at work: patriarchal and capitalist relations in employment*. Minneapolis, Minnesota: University of Minnesota Press.

Walby, S. (1990) *Theorizing patriarchy*. First. Oxford, UK: Wiley-Blackwell. Available at: https://libcom.org/files/Theorizing Patriarchy - Sylvia Walby.pdf.

Walby, S. (1997) *Gender transformations*. London New York: Routledge.

Walby, S., Armstrong, J. and Strid, S. (2012) 'Intersectionality: Multiple inequalities in social theory', *Sociology*, 46(2), pp. 224–240. doi: 10.1177/0038038511416164.

Walford, G. (2007) 'Classification and framing of interviews in ethnographic interviewing', *Ethnography and Education*, 2(2), pp. 145–157. doi: 10.1080/17457820701350491.

Wallenfeldt, J. (2023) 'Brexit: United Kingdom referendum proposal', *Britannica*. Available at: https://www.britannica.com/topic/Brexit (Accessed: 22 March 2023).

Wang, M. and Kelan, E. (2013) 'The Gender Quota and Female Leadership: Effects of the Norwegian Gender Quota on Board Chairs and CEOs', *Journal of Business Ethics*, 117(3), pp. 449–466. doi: 10.1007/s10551-012-1546-5.

Van Wanrooy, B. *et al.* (2014) *The 2011 Workplace Employment Relations Study*. London: Department for Business, Innovation and Skills.

Waqar, H. and James, P. (2019) 'The Impact of Medical Careers Fairs on the Career Aspirations of Medical Students', *MedEdPublish*, 8(41), pp. 1–19. doi:

10.15694/mep.2019.000041.1.

Ward, J. (2008) 'White normativity: The cultural dimensions of whiteness in a racially diverse LGBT organization', *Sociological Perspectives*, 51(3), pp. 563–586. doi: 10.1525/sop.2008.51.3.563.

Ward, L. (1993) 'Race equality and employment in the National Health Service', in Ahmad, W. I. U. (ed.) *"Race" and Health in Contemporary Britain*. Buckingham: Open University Press.

Warmington J (2018) *NHS workforce race equality: A case for diverse boards*. Available at: https://www.england.nhs.uk/wp-content/uploads/2018/03/nhs-workforce-race-equality-a-case-for-diverse-boards.pdf (Accessed: 27 January 2020).

Warner, L. R. (2008) 'A best practices guide to intersectional approaches in psychological research', *Sex Roles*, 59(5–6), pp. 454–463. doi: 10.1007/s11199-008-9504-5.

Warner, L. R., Settles, I. H. and Shields, S. A. (2016) 'Invited Reflection: Intersectionality as an Epistemological Challenge to Psychology', *Psychology of Women Quarterly*, 40(2), pp. 171–176. doi: 10.1177/0361684316641384.

Webb, J. (1997) 'The politics of equal opportunity', *Gender, Work and Organization*, 4(3), pp. 159–169. doi: 10.1111/1468-0432.00032.

Weekes-Bernard, D. (2017) *Poverty and ethnicity in the labour market*. York. Available at: https://www.jrf.org.uk/report/poverty-ethnicity-labour-market (Accessed: 2 June 2021).

Weiss, C. (1977) *Uses of social research in public policy*. Lexington MA: DC Heath.

Wentling, R. M. and Palma-Rivas, N. (1998) 'Current status and future trends of diversity initiatives in the workplace: Diversity experts' perspective', *Human Resource Development Quarterly*, 9(3), pp. 235–253. doi: 10.1002/hrdq.3920090304.

West, C. and Zimmerman, D. H. (1987) 'Doing Gender', *Gender and Society*, 1(2), pp. 125–151.

West, M. *et al.* (2012) *NHS Staff Management and Health Service Quality Results from the NHS Staff Survey and Related Data*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215455/dh_129656.pdf.

West, M., Dawson, J. and Kaur, M. (2015) *Making the difference Diversity and Authors*. Available at: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Making-the-difference-summary-Kings-Fund-Dec-2015.pdf.

West, M., Dawson, J. and Mandip, K. (2012) *Making the difference: diversity and inclusion in*

the NHS. Available at: https://www.england.nhs.uk/wp-content/uploads/2014/10/WRES-Data-Analysis-Report.pdf.

West, M., Randhawa, M. and Dawson, J. (2015) *Making the difference: Diversity and inclusion in the NHS*. Available at: https://www.kingsfund.org.uk/publications/making-difference-diversity-inclusion-nhs (Accessed: 15 June 2021).

Wetherell, M. and Potter, J. (1992) *Mapping the Language of Racism. Discourse and the Legitimation of Exploitation*. New York: Columbia University Press.

Whitehouse, A. J. O., Hird, K. and Cocks, N. (2007) 'The recruitment and retention of speech and language therapists: what do university students find important?', *Journal of Allied Health*, 36(3), pp. 131–136.

Wilhoit, E. D. (2014) 'Opting Out (Without Kids): Understanding Non-Mothers' Workplace Exit in Popular Autobiographies', *Gender, Work and Organization*, 21(3), pp. 260–272. doi: 10.1111/gwao.12034.

Willett, Lisa L. *et al.* (2010) 'Do Women Residents Delay Childbearing Due to Perceived Career Threats?', *Academic Medicine*, 85(4), pp. 640–646.

Williams, C. L. (1992) 'The Glass Escalator: Hidden Advantages for Men in the "Female" Professions', *Social Problems*, 39(3), pp. 253–267. doi: 10.2307/3096961.

Wilson, E. M. and Iles, P. A. (1999) 'Managing diversity - An employment and service delivery challenge', *International Journal of Public Sector Management*, 12(1), pp. 27–48. doi: 10.1108/09513559910262661.

Wingfield, A. H. (2009) 'Racializing the glass escalator: Reconsidering men's experiences with women's work', *Gender and Society*, 23(1), pp. 5–26. Available at: https://www.jstor.org/stable/20676747.

Wise, L. R. and Tschirhart, M. (2000) 'Examining empirical evidence on diversity effects: How useful is diversity research for public-sector managers?', *Public Administration Review*, 60(5), pp. 386–394. doi: 10.1111/0033-3352.00102.

Wolgemuth, J. R. *et al.* (2015) 'Participants' experiences of the qualitative interview: considering the importance of research paradigms', *Qualitative Research*, 15(3), pp. 351–372. doi: 10.1177/1468794114524222.

Women's Resource Centre (2020) *CEDAW*. Available at: https://www.wrc.org.uk/cedaw (Accessed: 15 December 2020).

Woolcock, M. and Narayan, D. (2000) 'Social capital: Implications for development theory, research, and policy', *The World Bank Research Observer*, 15(2), pp. 225–249.

Wordsworth, S. (2013) *Thesis A Career in the Allied Health Professions: borrowing from*

Bourdieu to navigate student choice, class and policy. University of Sheffield. Available at: https://etheses.whiterose.ac.uk/7665/1/finalEdD_thesis.pdf.

Wrench, J. (2005) 'Diversity management can be bad for you', *Race and Class*, 46(3), pp. 73–84. doi: 10.1177/0306396805050019.

Wyllie, J. (1894) 'The disorders of speech.', *Edinburgh Medical Journal*, 39(7), pp. 577–595. doi: 10.1037/14028-000.

Zadro, L., Williams, K. D. and Richardson, R. (2004) 'How low can you go? Ostracism by a computer is sufficient to lower self-reported levels of belonging, control, self-esteem, and meaningful existence', *Journal of Experimental Social Psychology*, 40(4), pp. 560–567. doi: 10.1016/j.jesp.2003.11.006.

Zanoni, P. *et al.* (2010) 'Unpacking diversity, grasping inequality: Rethinking difference through critical perspectives', *Organization*, 17(1), pp. 9–29. doi: 10.1177/1350508409350344.

Zanoni, P. and Janssens, M. (2007) 'Minority employees engaging with (diversity) management: An analysis of control, agency, and micro-emancipation', *Journal of Management Studies*, 44(8), pp. 1371–1397. doi: 10.1111/j.1467-6486.2007.00700.x.

Zheng, L. (2020) 'Do Your Employees Feel Safe Reporting Abuse and Discrimination?', *Harvard Business Review*. Available at: https://hbr.org/2020/10/do-your-employees-feel-safe-reporting-abuse-and-discrimination (Accessed: 17 May 2022).

Appendices

1: Sample inclusion and exclusion criteria.

	Inclusion criteria	**Exclusion criteria**
Diversity stakeholders	• Must be working for an organisation that employs SLTs. • Organisation has an existing diversity policy. • Role practically involves or requires knowledge about the creation, practice, or implementation of employer's equality, diversity, and inclusion policies. • Employed by a hospital that is part of the UK NHS. *(Note: this did not apply to external or professional body stakeholders).*	• Role does not practically involve, or require knowledge about, the organisation's diversity practices and so they are likely unaware of its content, practice, or implementation. • Very new to the post - they possibly may not have knowledge about diversity issues and practices. • Not employed by a hospital that is part of the UK NHS. *(Note: this did not apply to external or professional body stakeholders).*
SLTs	• Must be working for an organisation that employs SLTs. • Must be registered and currently practising SLTs. • Based in the UK. • Employed by a hospital that is part of the UK NHS. (*Note: this did not apply to those based in the private sector*).	• Not currently practicing or registered. • Not working in the UK. • Not employed by a hospital that is part of the UK NHS. (*Note: this did not apply to those based in the private sector*).
Both samples	• Able and willing to give informed consent. • Can be any gender, ethnicity, and from any socio-economic group. • Aged 18+ (i.e., legal adults).	• Unable or unwilling to give informed consent. • Aged below 18 years of age (i.e., a minor). • Inability to speak understand written and/or verbal English.

2: Example of reflexive notes for SLT interviews

Note: Most notes across thesis were handwritten in notebooks, but some translated onto Microsoft Office Word documents to be shared with supervisors. This table combines examples from both.

Beliefs/value and position(s)	Alignment towards Social Constructivism, student, female, minority ethnic, Muslim.
Fieldwork experiences	• Internet connection can be problematic for some – some communication can be unclear – questions/responses are repeated for clarification. Use wider speech context for clarity on meaning. • Difficult to respond to reactions for those who chose to switch their video function off. • Over time, have learned not to speak so much to fill in silences – allows participant to elaborate. • Probing necessary when asking about obstacles and support. • Ask for examples when participants make assertions about issues. • Lots of people asked about my findings and literature – example of participants also learning from interviews. • Participants interested in my background/interest – mentions of my hijab and ethnicity. • Difficult to hear about bad experiences.
Interview - emerging ideas	<u>Choice of/entering profession:</u> • SLT exposure: child/ family member. • Language/communication interests. • Funding: social class, poor salary, work experience. • Degree profession: time, financial resources, and interest for studying. <u>Issues:</u>

	• Poor awareness and understanding of SLT career: medical/technical aspects unknown, minority ethnic understanding based on comparisons to medicine/being a doctor. • Poor diversity on SLT courses and profession: mostly White, female, middle-class. ○ Reasons: caring stereotypes, work flexibility, women in leadership, male privilege, poor pay, social exclusion, how profession is promoted (do not hear about it, unaware of technical aspects), seek traditional careers, lack of role models. • Poor SLT course experiences: teaching style, low diversity on course so under-represented stick out in class, males more vocal in class, sexism, religious discrimination on placements. • White privilege mentioned. • Discrimination: religious minority, minority ethnic, men, unconscious bias. • Relatability/belonging: gender more important for older clients than younger ones? (e.g., periods, puberty); placement alienation; relating to other peers; refraining from complaining about placements because of lack of emotional support/building relationships with tutors; valuing contributions based on individuality (a sign of diversity management?); Relatability to clients based on cultural differences; concerns about rocking the boat/troublemaker. • Progression barriers: lack of clinical work in management; maternity/children; unconscious bias; stereotypes; too much paperwork; lack of senior posts. • Multi-disciplinary teams: need to address diversity issues in other AHPs as well. • Societal influences: BLM; Covid-19 impact. • Money: pay; renumeration packages/commissions. • Large caseloads. • Undervalued profession. <u>Benefits</u> • Largely female profession: comfort talking about female issues - helps building relationships/networks/support?

	• Diversity benefits: for business reasons (client's needs); cannot assume minority ethnic SLTs provide better service to diverse populations just because they're minority ethnic (can still make assumptions so hides problem of social class). <u>Stakeholders</u>: Government; managers/supervisors; peers/ teams; professional body; academics; placement educators. <u>Diversity practices:</u> • Support: staff networks (minority ethnic, carers), family, friends, SLT teams, line management is key, weekly meetings. • Policies: o Comments on content lacking – most did not read it but had idea of what it would entail. Reasons: workload, very long, not easy to read. Most knew where to find it & noted it as being part of induction and statutory mandatory training. o All thought important but poor impact & insufficient alone – need to integrate into working lives instead of an additional job. o Ethical and legal reasons emphasised. o Reference point tool. o Recommendations: active learning – make it relatable with real life experiences. o Gives space for small grassroots initiatives. • Targeting universities/schools. • Coaching. • Need consistent and frequent effort. • Conversations about ethnicity: issues of safe space to share. • Mandatory training seen as diversity effort.
Transcriptions reflections	<u>Practical issues:</u> • Unclear audio. • Mistakes in transcription by Otter ai (some picked up when reviewing them, others when conducting thematic analysis).

	• Version control for edited transcripts. • Emerging ideas for codes from interview reflections and transcription process need to be grouped together and condensed. <u>Examples of possible codes:</u> <u>Experiences</u> • Second career; areas of interests; autonomy. • Profession's image: misconceptions/stereotypes; masculinity/femininity - gender roles; value/respect of profession; media. • Representation: education/training, organisation, profession, pace of change; role models. • Discrimination; unconscious bias; surprise reactions; social exclusion. • Visible minority. • Belonging/comfort. • Social class/confidence. • No/uncertain (impact of gender/ethnicity). • Stability (financial, career). • Geographical location. • Caring responsibilities. • Progression; Privilege (male and White). <u>Practices/stakeholders/approach</u> • Policies: Active learning; characteristics; motivations; challenges (e.g., accessibility, implementation); impact. • Diversity benefits: alternative approach; community (needs and reflection); more ideas/learning; role models. • Stakeholders: management; RCSLT; ASLTIP. • Private vs public sector: pitfalls of self-employment. • Work-life balance; timing (for diversity efforts). • Implementation. • SLT training. • Management vs clinical: Managerialisation; devaluing clinical work. • Intergenerational change? • Culture. • Accountability. • Staffing. • School outreach. • Gendered workplace implications. • Conversations about race; meetings. • BLM; Covid-19. • Priorities.

3: Gatekeeper email template

The final versions (version 3) of both gatekeeper email templates are below.

3.1 Email template for healthcare professionals

Subject: Request for participant recruitment assistance for PhD project at Queen Mary University of London

Dear XXXX,

I am a doctoral student based at Queen Mary University of London. I am writing to you to ask for your assistance on my project which is exploring sex and ethnic diversity within two specific professions: Speech and Language Therapy and Medical Radiography.

Why you are being contacted

You are being contacted for two main reasons:

- your organisation is employs medical radiographers and/or speech and language therapists and you may be able to get me into contact with them, and
- your organisation is UK-based and has an existing diversity policy.

Would you kindly be able help in getting me into contact with potential participants within your organisation? I have briefly outlined my study below, but please feel free to contact me should you want any more clarification. I have also attached a copy of my project's recruitment flyer for more information.

Aim

My project aims to gain an insight into how diversity policy is practiced in organisations within these two professions, the discourses that underlie them, the actors that shape them and importantly, the extent to which they impact on the lived experiences of practising professionals within them.

Method

To do this, I would like to interview speech and language therapists and medical radiographers about their career experiences related to sex and ethnicity (e.g., in terms of reasons for career choices, sources

of support/barriers faced, etc.). Interviews are expected to be just over an hour long and entirely confidential. An anonymised summary of project findings will be shared with interested participants.

Thank you in advance for your interest. I look forward to hearing from you.

Yours sincerely,
Mursheda

3.2 Email template for diversity stakeholders

Subject: Request for participant recruitment assistance for PhD project at Queen Mary University of London

Dear XXXX,

I am a doctoral student based at Queen Mary University of London. I am writing to you to ask for your assistance on my project which is exploring sex and ethnic diversity within two specific professions: Speech and Language Therapy and Medical Radiography.

Why you are being contacted

You are being contacted for three main reasons:

- your organisation employs medical radiographers and/or speech and language therapists,
- your organisation has an existing diversity policy, and
- you may be able to get me into contact with diversity practitioners within your organisation

Would you kindly be able help in getting me into contact with potential participants within your organisation? I have briefly outlined my study below, but please feel free to contact me should you want any more clarification. I have also attached a copy of my project's recruitment flyer for more information.

Aim

My project aims to gain an insight into how diversity policy is practiced in organisations within these two professions, the discourses that underlie them, the actors that shape them and importantly, the extent

to which they impact on the lived experiences of practising professionals within them. I am hopeful that the findings will provide rich insight into how diversity policies are practiced within these professions.

Method

To do this, I would like to interview individuals within your organisations whose role practically involves or requires knowledge about the creation, practice, or implementation of your organisation's diversity policies. Interviews are expected to be just over an hour long and entirely confidential. An anonymised summary of project findings will be shared with interested participants.

Thank you in advance for your interest. I look forward to hearing from you.

Yours sincerely,
Mursheda

4: Study flyers

The final versions (version 4) of both study flyers are below.

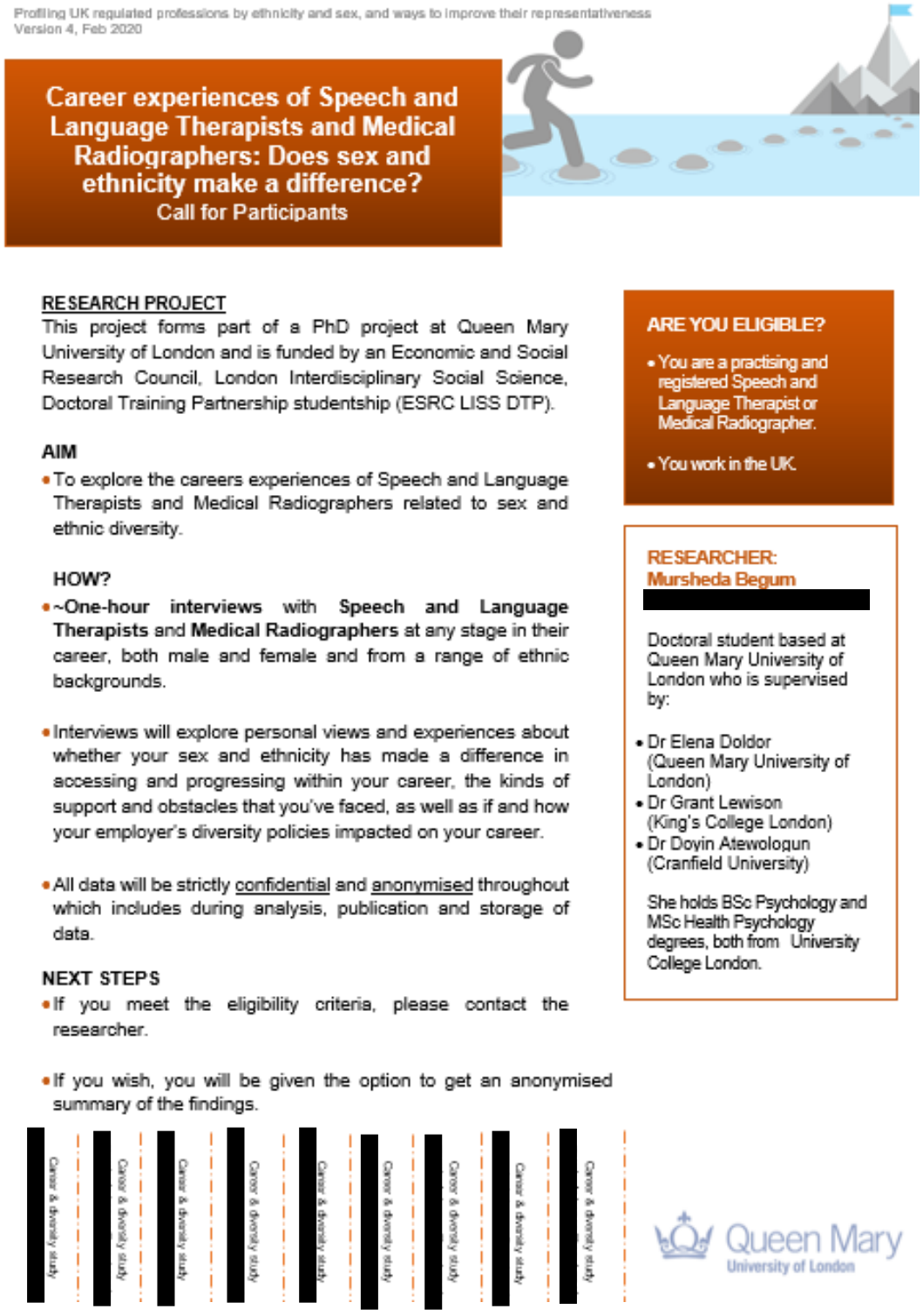


Figure 5. Flyer for healthcare professionals

Profiling UK regulated professions by ethnicity and sex, and ways to improve their representativeness
Version 4, Feb 2020

How are sex and ethnicity diversity policies practised within the Speech and Language Therapy and Medical Radiography professions?

Call for Participants

RESEARCH PROJECT

This project forms part of a PhD project at Queen Mary University of London and is funded by an Economic and Social Research Council, London Interdisciplinary Social Science, Doctoral Training Partnership studentship (ESRC LISS DTP) .

AIM

- To learn about how sex and ethnicity diversity policies are practised within Speech and Language Therapy and Medical Radiography professions.

HOW?

- ~**One-hour interview** with **diversity practitioners** with expertise and knowledge of the organisation's diversity policies and practices. Interviews will explore the practice of diversity policies in your organisation, such as why your organisation has created a diversity policy, what it includes, who is involved and how they're implemented.

- All data will be strictly confidential and anonymised throughout which includes during analysis, publication and storage of data.

NEXT STEPS

- If you meet the eligibility criteria, please contact the researcher.

- If you wish, you will be given the option to get an anonymised summary of the findings.

ARE YOU ELIGIBLE?

- You work for an organisation that employs Speech and Language Therapists or Medical Radiographers.
- Your organisation has an existing diversity policy.
- Your role practically involves or requires knowledge about the creation, practice or implementation of your employer's equality, diversity and inclusion policies

RESEARCHER:

Mursheda Begum
[redacted]

Doctoral student based at Queen Mary University of London who is supervised by:

- Dr Elena Doldor (Queen Mary University of London)
- Dr Grant Lewison (King's College London)
- Dr Doyin Atewologun (Cranfield University)

She holds BSc Psychology and MSc Health Psychology degrees, both from University College London.

Diversity policy study

Queen Mary University of London

Figure 6. Flyer for diversity stakeholders

5: Participant information sheet

5.1 Information sheet for healthcare professionals

Version 5, IRAS ID: 281268, Date: 06/07/2020

PARTICIPANT INFORMATION SHEET

Study title

Profiling UK regulated professions by ethnicity and sex, and ways to improve their representativeness.

Invitation and brief summary

I would like to invite you to participate in this research project which forms part of my PhD. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

The purpose of the project is to explore sex and ethnic diversity within two professions in the UK: Speech and Language Therapy (SLT) and Medical Radiography professions. In particular, the research will look at how diversity policy is practiced, the discourses that underlie them, the actors that shape them and importantly, the extent to which they impact on the lived experiences of practising professionals (i.e., therapists and radiographers) within them.

Why have I been invited to take part?

You are being invited to participate in this project because:

- You are a practising and registered Speech and Language Therapist or Medical Radiographer.
- You are based in the UK.
- You are employed by a hospital that's part of the UK National Health Service.

What will happen if I take part?

If you choose to take part in the project you will be asked to take part in an interview, and will be emailed some pre-interview questions about your background (e.g., your job role, how long you've been in the role, etc.) which will help to contextualise the interview conversation. Participation in the

interview will take place for around an hour, and may be conducted face-to-face or virtually for practical reasons (e.g., health and safety due to Covid-19, distance, etc.). Face-to-face interviews will be conducted when it is safe to do so in a quiet and private space that is most convenient for you. As part of participation, you will be asked about your personal views and career experiences related to sex and ethnicity. For example, you'll be asked about why you chose your profession, whether your sex and ethnicity has made a difference in accessing and progressing within your career, the kinds of support and obstacles that you've faced, as well as if and how your employer's diversity policies impacted on your career. As this research is focused on sex and ethnic diversity, you will also be asked about your sex and ethnicity to contextualise the findings. Only after getting your consent, the interviews will be audio- or video-recorded and notes will also be taken by the interviewer. Video recordings will only happen for virtual interviews, however, if you are not comfortable with this, you can request to switch your camera off so only a blank screen with the interview audio is recorded.

Do I have to take part?

Participation is completely voluntary and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

You may feel uncomfortable when talking about any negative experiences you've had or are currently facing in your career (e.g., any obstacles or negative impact of your employer's diversity policies). If you feel uncomfortable with answering any question, please notify the researcher to indicate that they should move on to the next question - you do not have to give or complete your response, and if you feel too distressed, you can withdraw from the interview altogether or continue at a later date. If you choose to, you may redact any information that you provided so long as it within two weeks of the interview. The researcher will offer a list of support organisations if deemed necessary or it can be provided on request.

What are the possible benefits of taking part?

The findings are expected to give rich insight into the sex and ethnicity diversity within the Speech and Language Therapy and Medical Radiography professions in the UK.

How will we use information about you?

We will need to use information from you for this research project. This information will include:

- Your name and contact details
- Your responses to the pre-interview questions
- Your responses from the interview

Your data will be processed in accordance with the General Data Protection Regulation 2018 (GDPR).

- Every effort will be made to ensure your anonymity and confidentiality. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number/pseudonym instead.
- Audio files of your interview may be sent to a third-party transcription service to produce scripts of the interview. If you took part in a video recording, an audio recording of it will be created using an audio-recording device, which will then be sent to transcription services (not the video recording), so your identity is kept confidential. Where a transcription service is used, files will be passed on via a password-protected flash drive and if needed, the use of Royal Mail first class tracked delivery. They must follow our rules about keeping your information safe.
- We will keep all information about you safe and secure. Data will be stored in an anonymised format in password protected areas (e.g., on the researcher's password-secure OneDrive account and on external flash drives that will be locked away – these will be encrypted with a password). This will be done according to Queen Mary University of London's policies.
- Once we have finished the study, we will keep some of the data so we can check the results. We will write our results in a way that no-one can work out that you took part in the study. For example, any direct quotes used will not be indicative of names, contact details and other personal identifiers.

What if I change my mind about taking part?

You can stop being part of the study at any time, without giving a reason. However, we will keep information about you that we already have from two weeks onwards after your interview has been completed. This is because data analysis may possibly commence at this point and will so data will be anonymised and committed to the final project.

You can find out more about how we use your information by asking one of the research team using the contact details listed at the end of this information sheet. Please also see: www.hra.nhs.uk/patientdataandresearch

How is the project being funded?

This project is being funded by a studentship from the Economic and Social Research Council, London Interdisciplinary Social Science Doctoral Training Partnership (ESRC LISS DTP: ES/P000703/1, https://liss-dtp.ac.uk/).

What will happen to the results of the project?

The results of the project will be summarised in the researcher's PhD thesis and may be presented in conferences, seminars or published in relevant journals.

Who should I contact for further information?

If you have any questions or require more information about this project, please contact:

Murshed Begum

Queen Mary University of London, School of Business and Management,

[redacted]

[redacted]

What if I have further questions, or if something goes wrong?

If this project has harmed you in any way or if you wish to make a complaint about the conduct of the project you can contact Queen Mary University of London using the details below for further advice and information:

Dr Elena Doldor

Queen Mary University of London, School of Business and Management,

[redacted]

Tel: [redacted]

@: [redacted]

Thank you for reading this information sheet and for considering taking part in this research.

5.2 Information sheet for diversity stakeholders

Version 5, IRAS ID: 281268, Date: 06/07/2020

PARTICIPANT INFORMATION SHEET

Study title

Profiling UK regulated professions by ethnicity and sex, and ways to improve their representativeness.

Invitation and brief summary

I would like to invite you to participate in this research project which forms part of my PhD. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

The purpose of the project is to explore sex and ethnic diversity within two professions in the UK: Speech and Language Therapy (SLT) and Medical Radiography. In particular, the research will look at how diversity policy is practiced, the discourses that underlie them, the actors that shape them and importantly, the extent to which they impact on the lived experiences of practising professionals (i.e., therapists and radiographers) within them.

Why have I been invited to take part?

You are being invited to participate in this project because:

- You work for an organisation that employs Speech and Language Therapists or Medical Radiographers.
- Your role practically involves or requires knowledge about the creation, practice, or implementation of your employer's diversity policy.
- Your organisation has an existing diversity policy.
- You are employed by a hospital that's part of the UK National Health Service.

What will happen if I take part?

If you choose to take part in the project you will be asked to take part in an interview, and will be emailed some pre-interview questions about your background (e.g., your job role, how long you've been in the role, etc.) which will help to contextualise the interview conversation. Participation in the interview will take place for around an hour, and may be conducted face-to-face or virtually for practical reasons (e.g., health and safety due to Covid-19, distance, etc.). Face-to-face interviews will be conducted when it is safe to do so in a quiet and private space that is most convenient for you. As part of participation, you will be asked to provide information on why your organisation has a diversity policy, what it includes, who is involved, how they're implemented/enforced and its impact. As this research is focused on sex and ethnic diversity, you will also be asked about your sex and ethnicity to contextualise the findings. Only after getting your consent, the interviews will be audio- or video-recorded and notes will be also be taken by the interviewer. Video recordings will only happen for virtual interviews, however, if you are not comfortable with this, you can request to switch your camera off so only a blank screen with the interview audio is only recorded.

Do I have to take part?

Participation is completely voluntary and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you make a decision about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

There are no anticipated risks associated with participation.

What are the possible benefits of taking part?

It is expected that the results of the interviews will give a rich insight into how diversity is practiced within SLT and Medical Radiography professions.

How will we use information about you?

We will need to use information from you for this research project. This information will include:

- Your name and contact details
- Your responses to the pre-interview questions
- Your responses from the interview

Your data will be processed in accordance with the General Data Protection Regulation 2018 (GDPR).

- Every effort will be made to ensure your anonymity and confidentiality. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number/pseudonym instead.
- Audio files of your interview may be sent to a third-party transcription service to produce scripts of the interview. If you took part in a video recording, an audio recording of it will be created using an audio-recording device, which will then be sent to transcription services (not the video recording), so your identity is kept confidential. Where a transcription service is used, files will be passed on via a password-protected flash drive and if needed, the use of Royal Mail first class tracked delivery. They must follow our rules about keeping your information safe.
- We will keep all information about you safe and secure. Data will be stored in an anonymised format in password protected areas (e.g., on the researcher's password-secure OneDrive account and on external flash drives that will be locked away – these will be encrypted with a password). This will be done according to Queen Mary University of London's policies.
- Once we have finished the study, we will keep some of the data so we can check the results. We will write our results in a way that no-one can work out that you took part in the study. For example, any direct quotes used will not be indicative of names, contact details and other personal identifiers.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason. However, we will keep information about you that we already have from two weeks onwards after your interview has been completed. This is because data analysis may possibly commence at this point and will so data will be anonymised and committed to the final project.

You can find out more about how we use your information by asking one of the research team using the contact details listed at the end of this information sheet. Please also see: www.hra.nhs.uk/patientdataandresearch

How is the project being funded?

This project is being funded by a studentship from the Economic and Social Research Council, London Interdisciplinary Social Science Doctoral Training Partnership (ESRC LISS DTP: ES/P000703/1, https://liss-dtp.ac.uk/).

What will happen to the results of the project?

The results of the project will be summarised in the researcher's PhD thesis and may be presented in conferences, seminars or published in relevant journals.

Who should I contact for further information?

If you have any questions or require more information about this project, please contact:

Mursheda Begum

Queen Mary University of London, School of Business and Management,

[redacted]

[redacted]

What if I have further questions, or if something goes wrong?

If this project has harmed you in any way or if you wish to make a complaint about the conduct of the project you can contact Queen Mary University of London using the details below for further advice and information:

Dr Elena Doldor

Queen Mary University of London, School of Business and Management,

[redacted]

Tel: [redacted]

@: [redacted]

Thank you for reading this information sheet and for considering taking part in this research.

6: Consent form

Version 5, Date: 06/07/2020, IRAS ID: 281268

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Profiling UK regulated professions by ethnicity and sex, and ways to improve their representativeness.

Name of Researcher: Mursheda Begum

	Please initial box
1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.	☐
3. I understand that data collected during the study (notes will be taken, face-to-face interviews will be audio-recorded and virtual interviews video-recorded - you may request to switch your camera off for virtual interviews so only a blank screen and interview audio is recorded), may be looked at by individuals from Queen Mary University of London, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4. I consent to my data being shared with third-party transcription services to produce interview scripts.	☐
5. I understand that the information collected about me will be used to support other research in the future, and may be shared anonymously with other researchers.	☐
6. I understand that all data will be safely stored according to Queen Mary University of London's policies.	☐
7. I agree to take part in the above study.	☐

Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

7: Interview protocols

Note, the final versions of the protocols for each sample were as follows: healthcare professionals - v4, internal stakeholders - v4, NHS body stakeholders - v3, external stakeholders - v2, and professional association - v3.1. The probes were removed when sharing protocols with participants. SLT=Speech and Language Therapy; MR= Medical Radiography.

7.1 Healthcare professional protocol

**NOTE – KEY AIMS:*

- *Gender/ethnicity issues & experiences (with examples) within organisation/profession.*
- *Perceptions of diversity efforts within organisation/profession.*

SHARE COPY OF HELPLINE LIST

I understand that talking about some of your experiences may not have been easy. I have a set of helpline/support organisations that may be of interest to you.

PRE-INTERVIEW QUESTIONS

**Note: If not answered prior to interview, ask as first set of questions*

a) What is your job title?

Tell me about your role – how would you describe it?

b) How long have you been in your current role?

c) What expertise is needed for your role?

d) How would you best describe your ethnicity and gender?

MAIN QUESTIONS

1) Why did you pursue a career in SLT/MR?

PROBES

- Motivations, expectations & influences
- How did you come across SLT/radiography?
    - How well known is the profession – if not, why?

2) Has your gender and/or ethnicity impacted upon your career in any way and how?

**Note: Ask for professional experiences that made them aware of gender/ ethnicity – say can be positive/negative.*

PROBES

**Note: start with gender & then ethnicity.*

- If not - Why?
    - How do/would you know it has (not) had an impact?? Which doors would otherwise be closed?
- What does your profession look like in terms of gender – why?
    - Horizontal: numbers? Should there be more (wo)men – why(not)?
    - Vertical: Who makes it to the top of the profession/workforce? Pay/banding? Are women progressing in senior roles? Why (not)? What is considered being successful?
- What does the profession look like for ethnicity? *(repeat probes above)*
- What are the main issues for gender/ethnicity in your profession/career?
    - What career obstacles exist?
    - Why are these seen as issues by yourself/your organisation?
    - Does gender & ethnicity get same attention or not?
    - What is like to work in a very female and White profession/workplace?

3) What were the main obstacles in your career so far?

PROBES

- Do you anticipate any obstacles – what & why? How did they impact in your career?
- If none, why do you think this is? How do you know?
- Negative attitudes (stereotypes/prejudice)/ behaviours (discrimination, bullying/harassment)
    - How did it make you feel? How did you know if was do with your gender/ethnicity?
    - Did it affect how you practise – how?
    - What kinds of support were available?
- What does career progression look like for you/ your profession?
    - What are your plans? How do you intend to get there?
    - Do you see yourself in senior leadership – why(not)?

4) What were your main sources of support in your career so far?

PROBES

- What kinds of support are available within and outside of your organisation for?
    - Working patterns/ caring responsibilities/ funding
    - Networks, guidance - within/outside of org/career? How accessible are they?
- How did they impact on your career?

5) What can you tell me what you know about your employer's gender and ethnicity diversity policies/strategies?

PROBES

- Awareness/engagement:
  - Seen/read them? – why(not)?
  - What do they look like?
  - How accessible are they?
- What is your organisation's motivation for the policy? Should they have one?
- Does gender and ethnicity get the same attention – why(not)? How do you know?

If sole trader:

- How are diversity issues being addressed in the profession? How do you know?
- What policies/strategies are currently addressing diversity issues within the profession?
  - What are they? Motivations? Are they (not) working? How can they be improved?

6) Has your employer's diversity policy/strategy impacted upon your professional life and how?

PROBES

- If not sure – why hasn't it?
- Have you taken part in any diversity initiatives?
- Are these diversity policies/strategies good/effective in addressing inequality – why(not)?
  - How can they be improved?
  - What would make you the policies more meaningful/increase engagement for you?

If sole trader:

- Are diversity efforts working? What do you take part in? How can they be made more meaningful for you?

7) We have a few moments left, is there anything else you want to add about what we've discussed?

PROBE

- Do you see yourself with your current employer in the next five years – why/why not?
  - Best/worst parts of job – what would make you consider staying/leaving?

8) Do you know anyone relevant that might want to also take part in the study?

NOTE: refer to eligibility criteria

7.2 Internal stakeholder protocol

**NOTE - KEY AIMS:*

- *What is their diversity agenda? (Perceived diversity issues, priorities, EDI strategies)?*
- *How is it translated into practice? (Examples of practices, what's worked/not worked, role of stakeholders in driving agenda).*

PRE-INTERVIEW QUESTIONS:

Note: If not answered prior to interview, ask as first set of questions

a) What is your job title?
    - Tell me about your role and responsibilities within the org
    - How do diversity issues feature in your role?

b) How long have you been in your current role?

c) What expertise is needed for your role?

d) How would you best describe your ethnicity and gender?

MAIN QUESTIONS:

1) In your view, what are the key issues related to gender and ethnic diversity for SLT/MR?

**Notes:*

- *Ask about health sector broadly (e.g., EDI issues in NHS) & then professions OR focus on former if no insight on professions**
- *Start with gender and then ethnicity; State it can be positive or negative**

- What does the profession look like for gender?
    - Horizontally: numbers?
    - Vertically: who makes it to the top of the profession/workforce? Are women progressing in senior roles? Why (not)?
    - How do you know? Why do you think these patterns exist? – Changing/will change?
    - What are the issues for gender? (e.g., what career obstacles exist?)
        - Why are these seen as issues by yourself/your organisation?
- What does the profession look like for ethnicity? *(Repeat probes above)*

2) What are the strategic priorities for gender and ethnicity in your organisation, and why?

PROBES

Note: Talk about gender and ethnicity separately/ Ask for examples

- What do these priorities tackle and why?
    - Does gender & ethnicity get same attention or not?
- Could you give examples of specific initiatives or D&I practices that tackle the issues discussed?

- How do they tackle them? (What is being done, what is mandatory/voluntary, etc)

3) How are these strategic diversity priorities implemented or tackled in practice? (e.g., key diversity practices and initiatives) Who are the key people involved?

PROBES

**Note:*

- *If mentioned in Q2 – just review the stakeholders here**
- *Expect people to say "I don't know" – if so, who would you approach for diversity issues ?**

o Who are the main people involved in these strategic diversity priorities and what are their roles?
  - Who sets the priorities? How do they decide on them?
  - Who implements them- and how?
  - Are they enforced in any way – if so, who does this and how? How is awareness of it promoted?
  - Is anyone accountable if the priorities are not addressed? Any rewards/consequences?
  - Are there any other stakeholders driving the diversity agenda?
    - Within/outside of organisation or both?
    - How does the diversity agenda fit into their role? What are their roles? Why are they involved? What kinds of expertise do they bring?
    - Who has the most and least power/influence – in what ways? why?

4) How do you know if these policies/strategies are working?

PROBES

o Can you give examples of which initiatives worked/ did not work?
  - How did they address the issues discussed?
  - Why did they work/not work?
    - How do you know they worked? Any measurement tools used? What's done with data collected?
  - What could be improved?

o How do employees engage with these strategies?
  - Are they aware of them? How do they see/understand them?
  - Do employees think they're effective – why/why not? How do you know? (e.g., initiatives engagement/feedback)

5) We have a few moments left, is there anything else you want to add about what we've discussed?

6) Do you know anyone relevant that might want to also take part in the study?

NOTE: refer to eligibility criteria

7.3 NHS body (not Trust) stakeholder protocol

**NOTE - KEY AIMS:*

- *What is their diversity agenda? (Perceived diversity issues, priorities, EDI strategies)?*
- *How is it translated into practice? (Examples of practices, what's worked/not worked, role of stakeholders in driving agenda).*

PRE-INTERVIEW QUESTIONS

Note: If not answered prior to interview, ask as first set of questions

a) What is your job title and organisation?
    - Tell me about your role and responsibilities within the organisation

b) How long have you been in your current role?

c) What expertise is needed for your role?

d) How would you best describe your gender and ethnicity?

MAIN QUESTIONS:

1) In your view, what are the key issues related to gender and ethnic diversity in SLT/MR?

**Notes:*

- *Ask about health sector broadly (e.g., EDI issues in NHS) & then professions OR focus on former if no insight on professions**
- *Start with gender and then ethnicity; State it can be positive or negative**

- What the main priorities for gender and ethnicity in the profession?
    - Which issues on the radar? How do you know?
- What does the profession look like for gender?
    - Horizontally: numbers?
    - Vertically: who makes it to the top of the profession/workforce? Are women progressing in senior roles? Why (not)?
    - How do you know? Why do you think these patterns exist? – Changing/will change?
    - What are the issues for gender? (e.g., what career obstacles exist?)
        - Why are these seen as issues by yourself/your organisation?
- What does the profession look like for ethnicity? *(Repeat probes above)*
- Does gender & ethnicity get same attention or not?

2) What are the strategic priorities for gender and ethnicity in your organisation, and why?

PROBES

Note: Talk about gender and ethnicity separately/ Ask for examples

- What do these priorities tackle and why?
    - Does gender & ethnicity get same attention or not?
- Could you give examples of specific initiatives or D&I practices that tackle the issues discussed?
    - How do they tackle them? (What is being done, what is mandatory/voluntary, etc)

3) How are these strategic diversity priorities implemented or tackled in practice? (e.g., key diversity practices and initiatives) Who are the key people involved?

PROBES

**Note:*

- *If mentioned in Q2 – just review the stakeholders here**
- *Expect people to say "I don't know" – if so, who would you approach for diversity issues ?**

- How are the priorities you mentioned translated into practice/on the ground?
- Who are the main people involved in these strategic diversity priorities and what are their roles?
    - Who sets the priorities? How do they decide on them?
    - Who implements them- and how?
    - Are they enforced in any way – if so, who does this and how? How is awareness of it promoted?
    - Is anyone accountable if the priorities are not addressed? Any rewards/consequences?
    - Are there any other stakeholders driving the diversity agenda?
        - Within/outside of organisation or both?
        - How does the diversity agenda fit into their role? What are their roles? Why are they involved? What kinds of expertise do they bring?
        - Who has the most and least power/influence – in what ways? why?

4) How do you know if these policies/strategies are working?

PROBES

- Can you give examples of which initiatives worked/ did not work?
    - How did they address the issues discussed?
    - Why did they work/not work?
        - How do you know they worked? Any measurement tools used? What's done with data collected?
    - What could be improved? What other ways could gender/ethnic inequality be addressed?
- How do employees engage with these strategies?
    - Are they aware of them? How do they see/understand them?
    - Do employees think they're effective – why/why not? How do you know? (e.g., initiatives engagement/feedback)

5) We have a few moments left, is there anything else you want to add about what we've discussed?

6) Do you know anyone relevant that might want to also take part in the study?
Note: refer to eligibility criteria

7.4 External stakeholder protocol

**NOTE - KEY AIMS:*

- *What is their diversity agenda? (Perceived diversity issues, priorities, EDI strategies)?*
- *How is it translated into practice? (Examples of practices, what's worked/not worked, role of stakeholders in driving agenda).*

PRE-INTERVIEW QUESTIONS:

Note: If not answered prior to interview, ask as first set of questions

a) What is your job title and organisation?
    - Tell me about your role and responsibilities within the organisation.

b) How long have you been in your current role?

c) How would you best describe your gender and ethnicity?

MAIN QUESTIONS:

1) In your view, what are the key issues related to gender and ethnic diversity in SLT/MR?

**Notes:*

- *Ask about health sector broadly (e.g., EDI issues in NHS) & then professions OR focus on former if no insight on professions**
- *Start with gender and then ethnicity; State it can be positive or negative**

- What the main priorities for gender and ethnicity in the profession?
    - Which issues on the radar? How do you know?
- What does the profession look like for gender?
    - Horizontally: numbers?
    - Vertically: who makes it to the top of the profession/workforce? Are women progressing in senior roles? Why (not)?
    - How do you know? Why do you think these patterns exist? – Changing/will change?
    - What are the issues for gender? (e.g., what career obstacles exist?)
        - Why are these seen as issues by yourself/your organisation?
- What does the profession look like for ethnicity? *(Repeat probes above)*
- Does gender & ethnicity get same attention or not?

2) Can you tell me about your role in driving the diversity agenda within SLT/MR?

Note: Ask about health sector more broadly, then narrow down to professions

- How do diversity issues feature in your role?
    - What are you doing and how?

- What are your motivations/ influences for addressing diversity issues within SLT/MR?
- Are your efforts working? How do you know?

3) To your knowledge, what is being done to address gender and ethnic diversity issues within SLT/MR?

Note: Talk about gender and ethnicity separately/ Ask for examples

PROBES

- How are these issues you mentioned before (Q1) being tackled? Can you give examples of key D&I policies and practices/initiatives/programmes?

  Focus on specific EDI initiatives/ interventions/programmes (not too much on policies) – what, when, who, why & how?

  - What do you think are the most important ones? Why?
    - How do they tackle the issues discussed?

      (what is mandatory/voluntary? How are they implemented? Who does this? How is it promoted/enforced?)

4) Who are the main stakeholders driving the diversity agenda within the profession, and what are their roles?

Note: Expect people to say "I don't know" – if so, who would do people approach for diversity issues?

PROBES

- Who are the stakeholders driving the diversity agenda and how do you know?
  - What is their role?
  - How are they addressing these diversity issues we talk about?
    - What issues are on their radar?
    - What are their key challenges?
    - How can they be improved?
  - Is anyone accountable? - rewards/consequences
  - Who has the most and least power/influence – in what ways? Why?

5) Are these policies/initiatives/practices to address diversity issues working and how do you know?

PROBES

- Can you give examples of which what has worked /not worked?
  - How did they address the issues discussed?
  - Why did they work/not work? How do you know?
  - What could be improved? – any measurement tools? What's done with this data?
- How do SLTs/MRs engage with these strategies?

- Are they aware of them?
- How do they see/understand them?
- Do they think they're effective – why/why not? How do you know?

6) We have a few moments left, is there anything else you want to add about what we've discussed?

7) Do you know anyone relevant that might want to also take part in the study?
NOTE: refer to eligibility criteria

7.5 Professional body protocol

**NOTE - KEY AIMS:*

- *What is their diversity agenda? (Perceived diversity issues, priorities, EDI strategies)?*
- *How is it translated into practice? (Examples of practices, what's worked/not worked, role of stakeholders in driving agenda).*

PRE-INTERVIEW QUESTIONS:

Note: If not answered prior to interview, ask as first set of questions

a) What is your job title and organisation?
    - Tell me about your role and responsibilities within the organisation
    - How do diversity issues feature in your role?

b) How long have you been in your current role?

c) How would you best describe your gender and ethnicity?

MAIN QUESTIONS:

1) What is the basic career structure of a SLT?

PROBE

- Education/training
- What are the different career routes? Who are the gatekeepers of career progression (i.e., who decides if an SLT progresses upward) – e.g.?
    - Are they line managed within Trusts?
    - If they freelance, what does career progression look like?
- What does it mean to be "successful" or make it to the top of the profession? highest senior position; salary; which specialties/management?
- Recent Bulletin stated limited routes/getting work experience as barriers to profession – why? How do you know this?

2) In your view, what are the key issues related to gender and ethnic diversity in the profession?

- Lack of representation – mostly White & female? How do you know?
    - Horizontally: numbers?
    - Vertically: female-dominated but who makes it to the top of the profession? What does the workforce at the top look like?
    - What are the trends for minority ethnic SLTs?
- Why do these patterns exist for gender? What about for ethnicity?
    - [redacted] materials ([redacted]) flagged three main themes – how did you learn about them?

1. [redacted],
2. [redacted] &
3. [redacted]

- Why is a diverse workforce important (e.g., client base/bilingualism)?

3) Do you think a SLT's gender and/or ethnicity impacts their career in any way and how?
**Note: state it can be positive or negative*
PROBES

- What career obstacles exist in the field? What issues are on the radar?
  - Recruitment/career progression:
    - are women/minority ethnic progressing in senior roles? Why (not)?
    - Going back to the gatekeepers of career progression in the field – how do they shape access to career opportunities?
  - Structural factors - working patterns, childcare/caring responsibilities
  - Funding?
- What sources of support might there be? Networks?

4) ORG ROLE: Can you tell me about the role of the *name of professional body* in setting the diversity agenda within the profession?
PROBES

- Who in the *name of professional body* has a role in the D&I agenda? What is their role?
- Guidance/policies/practices
  - What kind?
  - How do you come up with it – who designs it? How do they know what key diversity issues are?
  - Once guidance published – how do you engage org to follow it? What works well and what are the main challenges in cascading D&I guidance to employers and in the profession more broadly?
  - If no direct oversight on engagement – are there feedback channels to understand how guidance is taken up in the profession? Do you collect any data?
- How has guidance addressed specific career obstacles mentioned?
- Developing diversity resources – what are they? Who made them? Why have them?
- [redacted] – influencing professional culture identified as workstream – what does this mean? How do you plan to achieve this?

5) BEYOND THE ORG: To your knowledge, what is being done to address gender and ethnic inequality within the profession?

PROBES

- Ways of addressing inequality
  ([redacted] identified workstreams – included one for gender and one for ethnicity) – what does this mean? How do you know it will have an impact? Do you collect data?
- What do employers do to address these issues? What do you see as key challenges when it comes to employers addressing D&I issues?
- Does sex & ethnicity get same attention or not?
- Thoughts on diversity policies – motivations? Should org have one? How can they be improved?

6) Are there issues you see as important to this topic, that I haven't asked about?

PROBES

- Add to anything?

Final: ask to share study with others in org who are driving diversity agenda within profession.

NOTE: refer to D&I practitioner eligibility criteria

8: Interview protocol rationales

Table 9. Rationale for diversity stakeholder interview protocols. Note: similar questions from the four stakeholder protocols are grouped together.

Rationale for diversity stakeholder questions	**Framework element, literature themes covered, and questions asked**
Situate the data, and can be used as an indicator of how much participant will know about the organisation.	**Framework element:** Actors and practices – length and expertise of role asked because literature suggests lack of expertise a barrier for diversity practitioners to drive diversity agenda, but the expertise question was not always asked if answered describing their role. **Key literature themes covered:** N/A **Questions:** a) What is your job title and organisation? b) How long have you been in your current role? c) What expertise is needed for your role? d) How would you best describe your gender and ethnicity?
Define key terms to avoid misunderstanding.	**Framework element:** Diversity approaches **Key literature themes covered:** lack of standard definition of key concepts **Questions:** N/A – definitions later removed to avoid influencing responses.
Explore diversity levels and issues within profession overall and in organisation.	**Framework element:** Diversity approaches and lived experiences. **Key literature themes covered:** motivations, voluntarism, possible lack of familiarity with policies. **Questions:** • What is the basic career structure of a SLT? • In your view, what are the key issues related to gender and ethnic diversity in SLT/MR/ your profession? • Do you think a SLT's gender and/or ethnicity impacts their career in any way and how?
Explore diversity agenda/priorities and how it is translated into efforts/practices within the	**Framework element:** Actors & practices **Key literature themes covered:** diversity efforts, professionalisation/managerialisation of diversity, un/official ways of shaping organisational diversity.

profession/organisation, and the ways it addresses the diversity issues discussed.	**Questions:** • To your knowledge, what is being done to address gender and ethnic diversity issues within SLT/MR? • What are the strategic priorities for gender and ethnicity in your organisation, and why? • How are these strategic diversity priorities implemented or tackled in practice? (e.g., key diversity practices and initiatives) • BEYOND THE ORG: To your knowledge, what is being done to address gender and ethnic inequality within the profession? • What do you think are your employer's most important policies/strategies on gender and ethnicity, and why? • How are these policies/strategies implemented?
Explore the main stakeholders in diversity and their roles in shaping the agenda/practices.	**Framework element:** Actors & practices **Key literature themes covered:** accountability, key diversity actors - intra- and extra-organisational, possible lack of expertise of diversity actors, influence/power. **Questions** • Who are the main people involved in the policy/strategy and what are their roles? • Who are the key people involved? • Who are the main stakeholders driving the diversity agenda within the profession, and what are their roles? • Can you tell me about your role in driving the diversity agenda within SLT/MR? • ORG ROLE: Can you tell me about the role of the [ORG NAME] in setting the diversity agenda within the profession?
Explore the perceived impact of diversity practices and how they could be improved.	**Framework element:** Actors & practices; diversity approaches **Key literature themes covered:** perceptions of diversity management (DM) policy effectiveness/impact, perspectives of other DM approaches, some indirect evaluation of diversity policies, policy awareness/engagement. **Questions:** • Are these policies/initiatives/practices to address diversity issues working and how do you know? • How do you know if these policies/strategies are working?

	• Other than policies, in what other ways could your employer address gender and ethnic inequality?
Allow new themes, concepts, or ideas to emerge.	**Framework element:** N/A **Key literature themes covered:** aligns with Social Constructivism to make space for emerging themes, interviewee constructing knowledge. **Questions:** • We have a few moments left, is there anything else you want to add about what we've discussed? • Are there issues you see as important to this topic, that I haven't asked about?
Increase participant recruitment through opportunity sampling technique.	**Framework element:** N/A **Key literature themes covered:** N/A **Question:** • Do you know anyone relevant that might want to also take part in the study?

Table 10. Rationale for SLT interview protocol.

Rationale for diversity stakeholder questions	**Framework element, literature themes covered, and questions asked**
Situate the data.	**Framework element:** N/A **Key literature themes covered:** N/A **Questions:** a) What is your job title? b) How long have you been in your current role? c) What expertise is needed for your role? d) How would you best describe your ethnicity and gender?
Define key terms to avoid misunderstanding.	**Framework element:** Diversity approaches **Key literature themes covered:** lack of standard definition of key concepts. **Questions:** N/A – definitions later removed to avoid influencing responses.
Explore reasons for choosing profession.	**Framework element:** lived experiences **Key literature themes covered:** motivations/expectations, influences **Question:** Why did you pursue a career in speech therapy/radiography?
Explore gender and ethnicity diversity issues and experiences within profession.	**Framework element:** lived experiences **Key literature themes covered:** access to professions/role, working life, career progression, structural factors, lack of diversity within profession. **Question:** Has your gender and/or ethnicity impacted upon your career in any way and how?
Explore gender and ethnicity diversity issues and experiences within profession – focus on obstacles.	**Framework element:** lived experiences **Key literature themes covered:** access to professions/role, working life, career progression, negative attitudes/behaviours, femininity as possibly less valued, lack of role models/poor representation in leadership. **Question:** What were the main obstacles in your career so far?
Explore gender and ethnicity diversity issues and experiences within SLT – focus on support/diversity efforts available.	**Framework element:** lived experiences **Key literature themes covered:** access to professions/role, working life, career progression, minority ethnic/women's networks. **Questions:** What were your main sources of support in your career so far?

Explore diversity efforts within SLT, as well professional's knowledge and engagement with them.	**Framework element:** diversity approaches; actors and practices **Key literature themes covered:** awareness/engagement with diversity efforts/ practices, perceptions of motivations for diversity management (DM) efforts/practices. **Questions:** • Can you tell me what you know about your employer's gender and ethnicity diversity policies/strategies? • If sole trader - How are diversity issues being addressed in the profession? How do you know?/ What policies/strategies are currently addressing diversity issues within the profession?
Explore impact of diversity efforts within SLT.	**Framework element:** lived experiences; actors and practices **Key literature themes covered:** pros/cons, engagement with DM efforts/practices, perceptions of DM practice's impact. **Questions:** Has your employer's diversity policy/strategy impacted upon your professional life and how?
Allow new themes, concepts, or ideas to emerge.	**Framework element:** N/A **Key literature themes covered:** aligns with Social Constructivism to make space for emerging themes, interviewee constructing knowledge. **Questions:** • We have a few moments left, is there anything else you want to add about what we've discussed? • Are there issues you see as important to this topic, that I haven't asked about?
Increase participant recruitment through opportunity sampling technique.	**Framework element:** N/A **Key literature themes covered:** N/A **Question:** Do you know anyone relevant that might want to also take part in the study?

9: List of support organisations

The final version of the list of support organisations was version 2.

Mind

Information and support on mental health issues, including how to get help.

Website: https://www.mind.org.uk/

Infoline

Covers information and signposting service (e.g., mental health problems, where to get help near you, treatment options and advocacy services).

- Telephone: 0300 123 3393
- Email: info@mind.org.uk
- Text: 86463
- Post: Mind Infoline, PO Box 75225, London, E15 9FS

Legal line

Covers legal information and general advice on mental health related law (e.g., discrimination and equality).

- Telephone: 0300 466 6463
- Email: legal@mind.org.uk
- Post: Mind Legal line, PO Box 75225, London, E15 9FS

Equality Advisory Support Service (EASS)

The Helpline advises and assists individuals on issues relating to equality and human rights, across England, Scotland, and Wales.

Website: www.equalityadvisoryservice.com

- Advice line telephone: 0808 800 0082
- Textphone: 0808 800 0084
- Fax: 0800 090 2305
- Post: FREEPOST EASS HELPLINE FPN6521

Advisory, Conciliation and Arbitration Service (ACAS)

Free and impartial information and advice to employers and employees on all aspects of workplace relations and employment law.

Website: https://www.acas.org.uk/about-us

- Helpline: 0300 123 1100

- Post: Head Office - ACAS National - Euston Tower, 286 Euston Road, London NW1 3DP

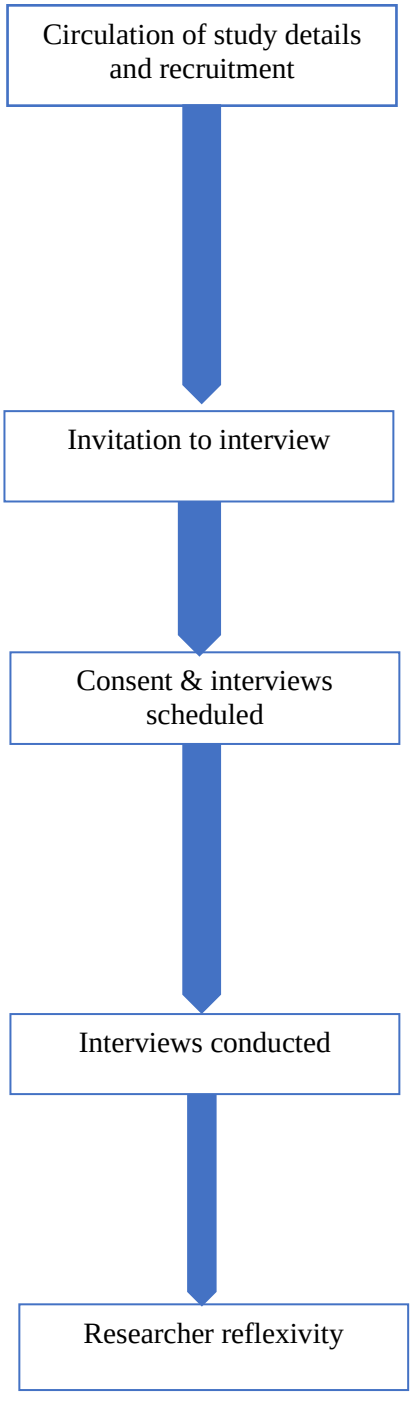
Citizens Advice Bureau

Give people the knowledge and the confidence they need to find their way forward - whoever they are, and whatever their problem.

Website: https://www.citizensadvice.org.uk/work/discrimination-at-work/

- Adviceline (England): 0800 144 8848
- Advicelink (Wales): 03444 77 20 20
- Textphone: 18001 0800 144 8884
- More contact info: https://www.citizensadvice.org.uk/about-us/contact-us/contact-us/contact-us/

10: Flow chart of interview process



- Study details circulated to potential participants by gatekeepers, relevant professional associations/societies, NHS bodies, and through direct contact. The latter involved identifying participants using public sources such as NHS Trust diversity documents, and online directories of healthcare professionals. Contact was mainly through email which briefly described the research, contact details, and attached the study flyer and participant information sheet.

- Interested participants emailed about study, eligibility was determined, and any queries answered.
- Participants emailed a participant information sheet, consent form and pre-interview questions, and asked to indicate interview availability.

- Participants returned completed consent forms which were signed by researcher and a final copy was kept by both parties for their records.
- A copy of interview protocol shared with participants, and a list of support organisations for therapists.
- Interviews scheduled according to participant availability, and Microsoft Teams or Zoom calendar invites shared.

- Interviews conducted online for about an hour, which were initially both audio and video-recorded, but then just the latter. Written notes also taken during interview.
- Interview recordings saved onto university OneDrive and external hard-drive, both of which are password-protected.

- Interview reflections noted after some interviews.
- Some interview transcripts produced and shared with supervisory team to assess the quality of data collected, and amendments made accordingly.

11: Thesis ethics approval timeline and challenges

Note: CRED= Centre for Research on Equality and Diversity; HRA= Health Research Authority; JRMO= Joint Research Management Office; KCL= King's College London; NHS= National Health Service; OID= organisation information sheet; QMUL= Queen Mary University of London; R&D= research and development; SBM= School of Business and Management.

Oct '17 - Dec '20 **KCL ethics process and move to QMUL**

- **Oct '17- Dec '19:** Full-time PhD commences at KCL cancer Studies department. Focus of first year was producing a literature review, with preparation for fieldwork starting in second year. KCL BDM research ethics committee deemed interview aspect of research as high risk because they would explore career experiences. Form was comprehensive, and required producing many supporting documents. These included a cover letter, consent form, gatekeeper email templates, data protection statement, participant information sheets, study flyers, and list of support organisations. Challenges caused by position within irrelevant cancer studies department at KCL emerged in second year. For example, there was a lack of exposure to relevant academic research staff and opportunities.
- **Dec '19:** Moved to SBM in QMUL and went part-time**,** but still had access to KCL via a visiting position**.** Interviews approved by KCL pending clarifications/amendments.
- **Jan '20:** KCL ethical approval for interviews was granted, but no longer applicable because KCL was no longer my main institution. Discussed ethics needs and process with QMUL JRMO.

Feb '20 **QMUL ethics for non-NHS sample**

- Completed QMUL JRMO's fast track ethics form for non-NHS organisations. This form did not have to be detailed as copies of the KCL ethics application and relevant supporting documents were submitted with it. Approval granted on 14th Feb 2020, and only allowed recruitment of non-NHS staff.

Mar '20 **QMUL and HRA ethics for NHS sample**

- A new ethics application was required for NHS staff, to be submitted to the QMUL JRMO and HRA via IRAS system (see list below). This application process was time-consuming and had long waiting periods. Tasks included:
  - Updating all supporting documents. For example, including QMUL logos to all documents.

- Including two types of additional documents. One document type was evidence. For example, departmental approval of research, proof that data collection tools were peer reviewed, and primary supervisors CV. The other document type was involved producing or completing many existing forms. This included a document checklist, protocol template, sponsorship conditions, consent form template, participant information sheet guidance, no cost form, OID form, and HRA schedule of events.
- Undertaking good clinical practice training before fieldwork commenced. This was completed online due to Covid-19, and certification was received on 1st June 2020.
- Completing a HRA application via their IRAS system. The application was submitted on 26th March 2020, and then required addressing six points by a HRA reviewer. HRA and HCRW approval received on 5th May 2020.
- Applying for local review and approval for research from each NHS site being pursued for participant recruitment.
- Locating gatekeepers at each NHS site which proved difficult during the UK's Covid-19 lockdown.

o QMUL sponsorship of study and clinical insurance documents was received on 24th March 2020. However, sourcing gatekeepers at NHS sites proved difficult, and final approval to include a site could not be done until then.

Jun '20 - Jul '20 **Covid-19 impact and non-substantial amendments**

o Covid-19 caused many research challenges, which included:
- QMUL JRMO and many NHS R&D departments paused approval of non-NHS studies, and said HRA approval process likely delayed by pandemic too.
- Lack of physical access to workplaces for interviews due to health and safety concerns and UK lockdowns.
- Locating and accessing gatekeepers at NHS sites was difficult as many of the target departments were busy. For example, they had higher workloads, were adjusting to working from home, and being redeployed to the NHS frontlines. This ethics requirement had to be fulfilled prior to commencing fieldwork.
- Lack of available Good Clinical Practice training due to lockdown, which was also a pre-fieldwork requirement.
- Research timeline needed to be reconsidered.

o **Jun '20:** Three non-substantial amendments to thesis submitted to QMUL JRMO and HRA. These included adding all UK hospitals, virtual interviews, and extension to project timeline. This required completion of a HRA amendment tool, and updating relevant documents. HRA submission was on 23rd June 2020, and updated tools sent to QMUL JRMO on 6th July 2020.

- **Jul '20:** HRA requested a few additional information/clarification, and HRA amendment approval received 6th July 2020. Updated confirmation of QMUL sponsorship or project received 9th July 2020.

Jun '20 - Aug'20	Site approvals

- Overall, local approval was sought from three NHS sites. A formal approval process was not needed for non-NHS sites, which grouped similar participants or those from the same organisation together. The sites are as follows:
  - **Site 1 (NHS Trust)**: R&D department contacted on 9th June 2020, and documentation submitted on 20th July 2020. Confirmation of capacity and capability was received on 27th and 28th July 2020 via OID form (minor mistake updated by Site). QMUL JRMO were notified of approval on 28th July 2020, but there was some confusion in demonstrating formal HRA amendment approval because the HRA does not provide any documentation for minor amendments. This delayed recruitment until recruitment permission was granted on 3rd August 2020. Principal Investigator was assigned by R&D department.
  - **Sites 2 and 5 (independent SLTs):** Formal approval process not necessary for each site as QMUL JRMO approval for non-NHS was received on 14th February 2020. Initially each independent SLT was ascribed their own site, but later grouped together for practicality.
  - **Site 3 (NHS Trust):** R&D department did not require separate site approval due to university affiliation. So, a gatekeeper just needed to be recruited which occurred in August 2020. After completing a short admin process, confirmation of capacity and capability for site given by QMUL JRMO on 3rd September 2020. The first participant was interviewed in September 2020.
  - **Site 4 (NHS body, not a Trust)**: Organisation heard about thesis and contacted me directly in May 2020. The first participant agreed to participation on 20th August 2020.
  - **Site 6 (professional body):** CEO of professional body introduced to study in July 2020, and collaboration which involved sharing the research and permission to interview members, was agreed in a meeting in September 2020.
  - **Site 7 (NHS Trust):** Trust heard about research via a circulated email from an NHS body, and SLT employee contacted me directly. Local ethics application submitted in October 2020, which required some additional documentation/clarification. Permission to recruit participants was received in November 2020. An SLT employee acted as a gatekeeper and circulated the study to the relevant team.
  - **Site 8 (external stakeholders):** These stakeholders were grouped together and had either contacted me directly because the study was circulated by professional body, or were recommended by supervisors.

Sep '20 – Jun '21 **Interviews scheduled and conducted**

- Study flyers and information sheets were shared to potential participants through gatekeepers or directly via email/online contact forms.
- Interviews scheduled and conducted online via Microsoft Teams or Zoom.

Jun ’21 – Oct ‘21 **Interviews concluded, transcriptions and preliminary analysis began**.

- Interviews concluded after consideration of saturation, meeting minimum sample targets, thesis time restrictions, and difficulty accessing further participants.

12: Final copy of NVivo coding template for interviews and organisational diversity documentation

Note: Created on 12th April 2023. Interviews based on 51 SLT interviews (29 Speech and Language Therapists and 22 diversity stakeholders). Coding of diversity documentation based on five NHS policy/strategy documents. Some code descriptions were very detailed and so their complete content was added in linked NVivo memos due to lack of space.

12.1 Inductive codes for interviews

Early inductive codes - combines both SLT and stakeholder responses.

Name	Description	Files	References
0. Expertise	Self-described expertise needed to practise as a SLT.	37	43
0. Job title	Job title of diversity stakeholder - use to show array of backgrounds.	22	27
0. Role length	Length of time in role - possibly used to differentiate between new and old SLTs.	51	54
1-Professional experiences	Gender and ethnicity issues within a SLT career. Focus: What the professional experiences are Interview questions covered: 1) Why did you pursue a career	52	2671

Name	Description	Files	References
	in SLT/MR? 2) Has your gender and/or ethnicity impacted upon your career in any way and how? 3) What were the main obstacles in your career so far?		
Entering the profession	Experiences and issues related to choosing SLT as a profession.	51	1012
Awareness and exposure to SLT	Participants speak about awareness and exposure to the SLT profession.	38	178
Exposure to profession	How SLTs heard or learned about the SLT profession.	34	124
Education	Exposed to SLT through an educational establishment.	18	27
Family or friend or contact	Exposed to SLT via family or friends.	21	37
Had SLT treatment	Exposed to SLT through getting therapy themselves.	7	7
Media	Exposed to SLT through media.	2	4
Other	Other exposure to SLT that do not fit the other categories.	3	3
Own research	Exposure to SLT through own research.	7	9
Professional association	Exposure to SLT through a professional association, namely the RCSLT.	2	3

Name	Description	Files	References
Work experience	Exposure to profession through work experiences including shadowing and coming across SLT in job.	22	34
Difficulty getting shadowing	Experiences of getting shadowing difficult or may be difficult (e.g., having to know someone in the profession, NHS shadowing opportunities influenced by workload).	9	13
Poor awareness and understanding of SLT	Generic statements about how people do not know what SLT is nor are aware of it as a profession. The reasons for the lack of awareness and lack of diversity in the profession are covered in the child codes.	28	54
Awareness and diversity reasons	Reasons suggested for the low/lack of awareness of the SLT profession as well as its diversity levels.	39	155
Educational orgs poor awareness	Educational establishments are poor at raising awareness about the profession.	22	28
Family friend influences	Family or friends influenced choices in terms of joining profession or other decisions about it - e.g., no one in family knew about or had misunderstandings about the profession, or not respected.	16	24

Name	Description	Files	References
Poor SLT media and marketing	Perception that SLT is poorly marketed, and SLTs not good at talking about their profession but is improving. Media representation of the profession is lacking or inaccurate. Also, challenges with media such as engagement, and some SLTs talk about the media work they are currently doing such as social media and writing articles, and the need to talk about the profession more.	26	54
SLT service use	SLT service use may affect awareness of it.	1	2
Small profession	Lack of awareness of profession linked to its small size.	2	2
Specific to ethnicity	Ethnicity specific issues related to awareness/exposure to profession.	13	21
Specific to gender	Gender specific issues related to awareness/exposure to profession. One reason is people in predominantly female professions tend to hear about it, so not reaching other groups.	12	24
Career routes	Current SLT career routes and issues related to it.	42	226
Degree routes for SLT	The types of degree routes to become a SLT, and the academic experiences of SLT students.	42	181
Academic experiences	University may deter people from profession - e.g., negative placement or university experiences (e.g., discrimination, lack of belonging, poor	39	123

Name		Description	Files	References
		representation of underrepresented groups, lack of role models, etc), course structure or teaching styles, poor retention of minority ethnic students, problems of needing a degree, competitiveness of courses, etc.		
	Course structure, teaching style, and staff	References to course structure/content, staff, and teaching styles as barriers - mostly negative - e.g., course was challenging, course content or teaching style was confusing, and private sector routes not promoted, inability to form relationships with staff.	10	15
	Discrimination and lack of belonging from fellow students	Discrimination and lack of belonging (related to representation) from fellow students (not related to class or staff).	5	7
	Placement experiences	Experiences on placement can shape choice of profession- most experience seem to be negative and may be a possible deterrent.	4	8
	Positive experiences	Positive experiences at school or university.	4	6
	Social class and on academic access and experiences	Low social class as a barrier - includes affording to access and study SLT education, travel restrictions, experiences of not belonging/exclusion, needing to work whilst studying, etc.	27	55

Name	Description	Files	References
Student recruitment issues	Issues related to the recruitment of students - covers entry requirements, recruitment biases, there being one route to becoming an SLT.	18	32
Types of degree routes	Most participants speak about needing to study an undergraduate or postgraduate degree to become a SLT. Postgrad routes are usually done after a second relevant degree - very few choose an undergrad after already holding a degree. Degree route seen as potential barrier in terms of access (e.g., just one way to get into profession).	34	58
NHS or private sector route	Focus is on career route - an NHS role is common after qualifying as an SLT. A private sector route seems to occur after having worked in the NHS for a while. Some cases of SLTs having gone straight into the private sector after qualifying. Some work in NHS and private together.	26	45
Diversity is supply issue	Perceptions that lack of diversity is because not enough gender and/or ethnically diverse people apply for profession or higher job positions.	9	12
General preferences and interests	Choice of SLT career shaped by certain preferences and interests - not specific to gender or ethnicity.	29	177
Practicality	Other practical factors influencing career choices - e.g., practicality, job availability.	18	53

Name	Description	Files	References
Autonomy	Preferences for autonomy at work.	7	12
Learning	Interests in learning development.	7	14
Variety	The profession has a large variety of domains.	9	17
SLT interests	The different interests influencing choice of profession	28	113
Arts-creativity interests	Interests in arts or creative work influencing SLT career choice.	4	7
Building relationships interests	Interests in building relationships influencing SLT career choice.	11	14
Children interests	Interests in working with children influencing SLT career choice.	11	14
Health sector interests	Interests in working within the health sector influencing SLT career choice.	6	10
Helping interests	Interests/motivations to help people influencing SLT career choice.	17	34
Language-communication interests	Interests in language/communication influencing SLT career choice.	18	29
Science interests	Interests in science influencing SLT career choice.	3	4

Name	Description	Files	References
SLT profession benefits	Perceived benefits of SLT profession.	7	11
Image of profession and gender stereotypes	How the image of the profession and gender stereotypes shapes choices of jobs/professions.	50	400
Image of profession	Perceptions of profession related to gender and ethnicity.	48	299
Gender stereotypes	Preferences or capability for certain professions or roles seen to be shaped by gender (e.g., women as good communicators and better suited to working with children, men as valuing practical/STEMM areas). The child codes outline popular stereotypes about what the profession involves.	31	72
Caring profession	Perceptions of SLT as a caring profession and its implications.	29	49
Children	Stereotype of working with children a barrier to men choosing the SLT profession or choice of paediatrics route.	18	28
Gender socialisation	How socialisation influences diversity within profession - e.g., gender role socialisation.	12	16
STEMM or practical choices	Men prefer to choose routes that are practical/hands on or involve a focus on medicine, science, and technology.	20	32

Name	Description	Files	References
Misconceptions about SLT	Stereotypes or misconceptions of profession or more widely in society.	31	84
Adult clients	Lack of awareness that SLTs work with adults.	1	1
Job role and valuing medicine or science	References to how participants think people are not aware of what a SLT job entails and that they value professions that are scientific, medical, or evidence-based, but are not aware of that this aspect exists within SLT. For example, they are not aware of the role of SLTs in rehab or interventions.	20	37
Job title	Impact of SLT job title on diversity of profession.	8	11
Teaching how to speak	Misconceptions that SLTs teach people how to speak - pronunciation, elocution, etc.	22	35
Well spoken	Perceptions of SLTs needing to be well spoken.	4	4
Poor or modestly paid profession	SLT seen as a poorly or modestly paid profession. This is problematic because money is seen as important for stability, but potential for making money better in private sector than NHS. Also, maternity seen to be a barrier for income, and is seen as worse in private than public sector.	20	39

Name	Description	Files	References
Feminised image and pay	Perceptions of how being a predominantly female profession influences the pay (and value) within SLT. References to famous SLT equal pay case included.	8	11
Money stability	Importance of money for stability.	4	5
NHS vs private sector pay	Potential to make money seen as higher in private sector although NHS pay is seen to be decent.	15	34
Maternity pay	References to how maternity can negatively affect income, and how maternity pay is worse in private sector than NHS.	7	8
Pay scales	Perception of capacity for pay progression within the profession.	6	6
SLT history and culture	References made about the history of SLT in terms of its origins and how that relates to the current diversity of the profession.	10	16
White female middle class image	Profession has image of a White, female, middle class workforce which has certain implications such as deterring male and minority ethnic SLTs from considering it.	40	87
Class representation	Lack of diversity in terms of social class within the profession - mostly middle-class.	8	11

Name	Description	Files	References
Gender and ethnic vertical and horizontal representation	Representation of gender and ethnic diversity within the profession or health sector and its impact.	0	0
Academic diversity	Academic staff or students when undertaking SLT training generally have poor representation of people from minority ethnic backgrounds and men.	24	44
Workforce - ethnicity representation	Ethnicity representation of workforce mostly poor both vertically and horizontally. Private practice seen to be better ate representation than public sector. Ethnicity seen to be improving slowly, but better than gender.	28	77
Workforce - gender representation	Gender-specific representations and associated implications/issues.	30	112
Role models and representation	References to how representation shapes image of profession in terms of presence of role models and belonging. NOTE - this code covers gender stereotypes and ethnicity.	17	25

Name	Description	Files	References
Traditional, or status of, professions	Perceptions of certain cultures being more accepting of traditional professions, and the reasons why. Make sure to link to low awareness of SLT code as a reason too.	39	101
Pay	Perceptions of pay influence choice of SLT career of underrepresented groups.	14	16
Progression and job security prospects	Perception of poor career progression prospects deterring people from considering SLT.	11	15
Status of professions	Perception that there is a hierarchy of professions with traditional ones the highest status, and SLT occupies a relative low status position. There's a role of ethnicity because minority ethnic communities are seen to prefer traditional professions because of status. There's a role of gender as perceptions of a feminised profession reduces the status of the profession.	34	52
Type of work	Perceptions of the type of work SLTs do shaping whether people choose the profession - links to professions that involve STEMM seen as more valuable.	12	18
Lack of trust in systems	Lack of trust in system and organisations as barriers to choosing SLT for minority ethnic people.	3	4

Name	Description	Files	References
Miscellaneous	Miscellaneous reasons not covered by other codes - include perception that it is reflection of society, personal issues, feeling connected to what they read about profession.	3	3
Clothing not a barrier	Clothing not a barrier for minority ethnic women in SLT unlike in other AHPs such as physiotherapy.	2	5
Travel or geography	Travel as a barrier to accessing the profession.	4	10
Unaware of reasons for SLT diversity	Unaware of reasons for diversity of the profession.	2	2
Experiences within profession	SLT experiences once they've entered the profession.	51	1659
Belonging and marginalisation/disadvantage	Gender and ethnic experiences related to feeling a sense of belonging and marginalisation/disadvantage, and how this relates to visibility.	51	673
Authentic self - ethnicity only	References to being/not being able to be one's authentic self, based on ethnicity.	5	7
Career support and belonging	How career support can foster feelings of belonging based on gender or ethnicity.	9	16

Name	Description	Files	References
Ethnicity	Ways that career support mechanisms can foster feelings of belonging - e.g., being able to share about experiences.	8	15
Gender	How career support can foster feelings of belonging.	1	1
Discrimination and bias	Gender and ethnic experiences or anecdotes about discrimination.	42	185
Ethnic discrimination, racism, or bias	Experiences of racism or discrimination.	33	134
Institutional racism or discrimination	References to systemic discrimination within institutions and their processes (e.g., in recruitment, disciplinary processes) - mostly in reference to ethnicity, but also covers generic statements about bias based on protected characteristics more generally.	19	55
Interpersonal discrimination for EM status or other	Experiences or anecdotes of interpersonal discrimination linked to being of minority ethnic status or general talk about discrimination (includes lack of support mechanisms - also covered in institutional discrimination code) - assumptions, bias, comments, questioning their abilities.	21	54
Religious discrimination	References made to the protected characteristics of religion.	13	25

Name	Description	Files	References
Gender discrimination	Gender based discrimination experiences such as bullying or sexism.	14	21
Female discrimination	References to women being discriminated against because of their gender.	4	6
Male discrimination	Discrimination based on being male.	21	44
Safeguarding concerns	How gender, specifically being male, is related to concerns about safeguarding clients.	8	11
Surprise reactions or novelty of being male	Experiences of clients or colleagues being surprised by gender/ethnicity of SLT.	14	25
Comments	People making comments about being a male minority within the profession.	9	12
Sexual orientation	References to sexual orientation of SLTs.	4	6
Other discrimination	References to discrimination that are not specific to gender or ethnicity alone.	2	2
Unconscious bias	Perceptions of unconscious bias within profession, the issues related to it, its impact, and any other relevant comments related to bias.	16	27

Name	Description	Files	References
Exclusion	References to exclusion/not being accepted based on gender or ethnicity.	20	37
Ethnicity	References to ethnicity-based exclusion. Feeling excluded based on personality, recruitment exclusion (adverts), being ignored by university staff, not welcomed/accepted in teams which impacts opportunities, feel judged at school, microaggressions, seen as troublemaker/overly sensitive, not referred patients, social exclusion from work events or conversations, ethnicity-based microaggressions.	14	18
Gender	Experiences or feelings of being socially excluded based on being male.	12	19
Horizontal and vertical representation and belonging	How ethnic or gender representation within the profession/organisation sends a message about belonging.	18	32
Ethnicity	How ethnic representation within the profession/organisation sends a message about belonging.	16	26
Gender	How representation sends a message about belonging.	5	6
Non-specific	Statements about belonging that are not specific to gender or ethnicity.	4	4
Positive belonging	Positive experiences of belonging based on gender or ethnicity.	46	175

Name	Description	Files	References
Ethnicity	Experiences related to feeling a sense of belonging based on ethnicity - e.g., sparking conversations/learning, bonding with colleagues, ethnic ambiguity means fitting in.	2	6
Gender	Experiences related to feeling a sense of belonging based on gender.	15	23
Perceived diversity benefits	Perceptions of the benefits of diversity and the profession.	45	146
Client relatability and needs	The ability to relate to and meet the needs of clients based on gender or ethnicity. Issues related to meeting the needs of clients and services. Diverse workforces benefit community in terms of reflecting it, relating to its which includes addressing cultural needs, and speaking more than one language is an advantage.	44	109
Learning and alternative perspectives	A diverse workforce allows (1) opportunities for learning/professional development & (2) different perspectives/more ideas - different perspectives/attitudes and approaches seen as refreshing & create a less serious atmosphere (e.g., not getting bogged down by details, more efficiency, etc.).	17	27

Name	Description	Files	References
More role models	Diversity is good because there will be more spokespeople/role models within the profession.	2	2
Staffing business benefits	Business benefits identified for staff diversity.	6	7
Psychological impact - ethnicity	Psychological impact of being a visible minority ethnic SLT - confidence, comfort, doubt, feeling silenced.	14	26
Relatability	Gender and ethnic experiences about relatability.	29	131
Ethnic relatability or sensitivity	Ability or inability to relate to clients or colleagues based on culture or ethnicity.	24	82
Female relatability	Relatability to clients and colleagues based on being a female SLT.	11	20
General relatability on characteristics	General comments about relatability on protected characteristics.	1	1
Male relatability	Relatability to clients and colleagues related to being a male SLT.	14	28
White privilege	References specific to White privilege.	28	60

Name	Description	Files	References
Masked issues/concerns	Concerns related to being White, and how they can sometimes be masked by perceptions of White privilege.	6	11
No ethnicity impact and they how know	SLTs implied White privilege because their ethnicity did not have an impact. When asked how they would know if it did - rationales involved comparing minority ethnic groups negative experiences.	12	17
Privilege	General comments about White privilege that don't fit into other two codes.	20	31
Career progression	Gender and ethnic experiences related to career progression.	50	408
Both	Issues related to career progression - relating to gender or ethnicity.	14	38
Discrimination or bias	The ways discrimination hinders career progression.	3	3
Progression and funding	Perception of a lack of opportunities within SLT - placed within financial context of austerity.	11	19
Service funding	Issues of poor funding for services.	4	11
Progression routes	References on career progression routes and the type of work it entails.	5	13

Name	Description	Files	References
Representation and role models	References to how role models and representation shape career progression for SLTs - not specific to gender and/or ethnicity.	2	3
Ethnicity progression	Issues related to career progression specifically relating to ethnicity.	40	118
Barriers	Ethnicity seen as barrier to career progression barriers. Reasons include lack of leadership opportunities, role models/representation, support mechanisms, and presence of stereotypes and bias.	31	72
Ethnicity leadership and role models	Ethnicity leadership/role models used as an argument for and against ethnicity being a barrier to career progression. Barrier= comments on lack of role models/diverse leadership. Not barrier = knowing of minority ethnic leaders (e.g., CEO of RCSLT being Asian female).	10	15
Ethnicity NOT progression barrier	Ethnicity not seen as barrier to career progression.	20	31
Gender progression	Career progression issues specifically relating to gender.	48	252
Confidence	Men seen to have confidence and women seen to lack it - seen to affect career progression or women who are confident are not kindly received by others.	8	17

Name	Description	Files	References
Female interview barriers	Perceptions that women are less likely to invited to interview, face stereotypes/bias in interviews and receive poor feedback after interviews.	1	3
Male privilege and discipline choices	References specific to male privilege in terms of fast career progression which is related to choosing specific specialties/career routes such as management.	40	110
Academic or research choices	Men have preferences for academic or research routes.	6	8
Gender stereotypes and progression	How gender stereotypes shape career progression.	10	13
Male barriers	References to male barriers.	4	5
Management preferences	Men seem to choose management routes over clinical ones.	9	11
Maternity-caring responsibilities and career progression	The impact of maternity on career progression - e.g., missing out on opportunities, having to quit role, etc.	27	44
No impact of gender on career progression	Perceptions that gender does not impact on career progression.	12	16

Name	Description	Files	References
Pay	Women seen as disadvantaged in pay but men as privileged.	11	17
Men and pay	Perceptions that men are privileged in pay.	3	5
Women and pay	Reference to how women are disadvantaged in pay - includes references to famous equal pay case led by Pam Enderby.	9	12
Role models and representation	Male and female role models in profession.	31	45
Female leadership-role models	Comments about profession being mostly female and so leadership is also mostly female - includes comments about female representation in leadership which sometimes is related to having female role models, and not having to compete with men. Also, includes comments about women facing promotion barriers, disproportionately fewer women in leadership given their overall numbers, and very few minority ethnic women in leadership.	29	42
Male role models	References to there being successful male sole traders, a male SLT benefiting from having a male manager, and the need for male role models for young male clients.	3	3

Name	Description	Files	References
Geographical location	Geography affecting diversity levels of workforce, and likelihood of facing barriers.	11	13
No or uncertain	Impact of gender or ethnicity on careers is non-existent or unclear.	32	116
Reason - fairness	Gender and ethnicity not seen to impact because processes in SLT are seen to be fair.	15	21
Reason - female or White dominated	Gender or ethnicity not seen to impact because it's a predominantly White female profession.	10	12
Reason - lack of awareness of profession	Gender or ethnicity does not have an impact because people do not know enough about profession to have any expectations about it.	1	1
Reason - other or miscellaneous	Miscellaneous reasons why gender or ethnicity does not have an impact like choosing their own path- e.g., focus is on availability of jobs, personal characteristics, unsure of motives behind people's decisions, being able to reach goals.	7	9
Reason - poor treatment or no discrimination	Gender or ethnicity not seen to impact because they are not discriminated against based on these characteristics, or not had to think about its impact.	21	38

Name	Description	Files	References
Reason - representation exists	Gender or ethnicity not seen to impact because there is representation in the profession. NOTE also includes tokenism/merit discussion.	9	10
SLT-No or unsure of impact - reason unspecified	Gender and ethnicity not seen to have an impact on therapist's career, but the reasoning for thinking this is not specified or because it's too early in their career to be able to tell.	14	19
Stakeholders-No impact	Stakeholder's perception of no impact of gender and/or ethnicity on careers of SLTs.	4	6
Other protected characteristics	References made to other protected characteristics.	20	31
Age	References made to the protected characteristics of age.	13	18
Disability	References made about disability experiences.	5	7
Sexual orientation	References made to the protected characteristics of sexual orientation.	5	6
Pros and cons of female profession	Perception of SLT as a female profession, and the pros and cons of this.	19	48
Cons of female profession	Disadvantages of being a female in a female profession.	1	1

Name	Description	Files	References
Female privilege	Advantages of being in a mostly female profession outlined - note that this code should be discussed with female relatability code which was a commonly cited advantage.	7	10
Maternity - not on progression	Issues related to maternity or childcare - NOTE impact on career progression is in gender career progression code.	17	37
No maternity support	Lack of support for maternity.	2	3
Other	Other maternity related comments.	1	1
Relatability as mother	Motherhood influencing relatability to colleagues or clients.	4	4
Team impact	Maternity affecting the workload and stress of team.	5	8
Working hours-flexibility-childcare	The relationship between maternity and working hours/flexibility.	12	21
Sector-specific-issues	Issues related to being in the public or private sector.	47	326
Managerialisation of work	Perceptions that work is very managerialised in terms of high workloads with few resources, lack of clinical work especially in senior management roles, and issues relating to the availability of progression opportunities.	24	88

Name	Description	Files	References
Availability of opportunities	Perceptions about the availability of job and progression opportunities.	13	25
Side passions	Experiences of having other passions on side of SLT career - this may relate to benefits of working part-time or men having more space to explore other passions.	2	4
Clinical vs non-clinical work	Possibility and time for clinical work reduced in senior positions, and it is seen as lower value. Focus is on performance and non-admin tasks.	14	30
High workloads-stress	SLT work involving high caseloads/workloads, high stress, and long working patterns.	15	23
Low or poor resources	Lack of resources, funding, and support of SLT work - includes need for more staff.	6	10
NHS	Issues relating to structure and processes of NHS.	17	48
Private sector	Any references to the private sector - to be used when comparing to the public sector.	19	78
Recruitment issues	Issues related to the recruitment of SLTs or healthcare staff.	22	62

Name	Description	Files	References
Interviews and shortlisting	Issues during the interview and shortlisting process that affect the diversity of the profession.	17	31
Senior role recruitment	References to senior role recruitment and their diversity.	2	2
Tokenism	References to tokenism when recruiting or offering posts.	9	9
Other	General statements about recruitment, senior role recruitment, and vacancies.	2	2
Supply and demand	Lack of diversity stemming right from beginning of the SLT career pipeline with diverse people simply not applying (i.e., same people applying) or workforce shortages/demand for SLTs not being addressed through international recruitment.	15	29
Work life balance	Issues related to work-life balance.	17	44
Social class and work experiences	How social class can affect work experiences - main message is that being working class negative affects experiences at work. However, some working-class qualities identified as advantages in career such as not being intimidated by senior members.	12	20

Name	Description	Files	References
Client relatability and sensitivity	Ability to relate to clients and be sensitive to their needs based on class identified as important.	6	10
Colleague relatability	Colleague relatability affected by social class.	1	1
Socialisation and personality	The ways that an SLT's culture and associated socialisation has given them personal qualities which they use to practice as a SLT.	3	5
Unspecified diversity issues	Diversity issues not specific to gender or ethnicity.	13	19
Generic comment	Generic comment about how gender and ethnicity play a role in everything.	1	1
Unspecified bullying	Experiences of bullying and harassment in career where it's not explicitly linked to gender or ethnicity.	3	3
Unspecified career progression	Experiences of career progression given where it's not explicitly linked to gender or ethnicity.	3	5
Unspecified confidence	Confidence/imposter syndrome account that is not explicitly linked to gender or ethnicity.	2	2
Unspecified representation	Representation within organisation or profession, both vertically and horizontally, where it's not explicitly linked to gender or ethnicity.	6	6

Name	Description	Files	References
Unspecified role models	Comments about role models not explicitly linked to gender or ethnicity.	1	2
2-Diversity practices	Diversity practises used to address gender and ethnic diversity issues within profession. Includes stakeholder's awareness of diversity practices and their understanding of how it addresses the diversity issues identified in the profession.	51	2204
Attracting diverse applicants	Practices try to attract a diverse workforce through various methods including improving access to the profession outlining ways to get work experience, targeting education (apprenticeships - covers mainly financial barriers, university activities (focus on student experiences) and addressing the profession's/NHS image (addressing misconceptions, events and campaigns & media/marketing of the profession and its issues.)).	42	226
Awareness and branding activities	Activities addressing issues related to the image of the profession. Includes addressing misconceptions, events and campaigns, and media and marketing of the profession.	38	129
Media and marketing	The role of media in diversity activities - e.g., TV, radio, social media, magazines, etc.	38	129

Name	Description	Files	References
Addressing misconceptions	Activities focused on addressing misconceptions about the profession's role - e.g., highlighting the science aspects of the profession, showing there is capacity for progression.	19	58
Other methods	Other ways of addressing misconceptions about the profession other than showing diversity - e.g., highlighting the science aspects of the profession, showing there is capacity for progression.	10	12
Showing diversity	Activities essentially aimed at showing diversity in SLT in image, the workforce, and careers materials.	17	46
Careers materials and events	References to improving content of careers materials - virtual talks by diverse SLTS, diversity in panels in careers days, diverse SLT profiles on open days, careers video on SLT, show diversity in careers booklets, talking in university recruitment days.	9	11
Direct marketing	Targeting men through more direct almost aggressive marketing.	1	1
Diverse images	Activities where diverse workforce images are being used.	14	26

Name	Description	Files	References
Organisational representation	Activities involving representation within different organisations and their levels.	3	5
Statements	Make statements about diversity.	3	3
Celebrate SLT history	SLT marketing should celebrate the women who helped the profession get more recognition - reference to equal pay case.	2	2
Community outreach efforts	RCSLT essentially exploring how to reach out to the community to raise awareness of SLT and encourage people to join.	4	4
Events and campaigns	Mostly related to NHS, but some to RCSLT - Number of events & other opportunities to raise awareness of profession & diversity issues – includes NHS 50:50 women's campaign; male nurse campaign; outlining RCSLT standards; webinars on ethnicity; diversity events to voice issues and experiences; annual conference. ISSUES: too many campaigns but not sustained. PROs: virtual events are recorded.	12	16

Name	Description	Files	References
More media presence	SLT and diversity seen to have more media presence - reference to Kings Speech, Tiny happy people, stammering campaign in train stations, Nick Hewer as spokesperson.	5	5
Sharing or producing media resources	Addressing diversity issues within profession by producing or sharing media resources - e.g., articles, books, Bulletins/magazines, emails, posters, WhatsApp groups.	25	41
Visits	Profession can be marketed by visiting schools and SLT to raise awareness and learn about issues.	3	3
Targeting schools and academia	Attracting diverse students through apprenticeship scheme, school outreach activities, university activities and widening participation methods.	33	95
Apprenticeship	There's an upcoming SLT apprenticeship route- includes studying part-time at university and employer provides on the job training. Tuition fee covered by government, and apprentice paid by employer. Seen as way of increasing socioeconomic diversity (people who cannot be full-time student because need to earn money for debts/caring responsibilities, mortgages, have fees paid). Government & private sector interested in this route. University of Essex offering first one in Sept 2021.	7	9

Name	Description	Files	References
	Issue: some minority ethnic groups do not access them because more emphasis on traditional route.		
Student or school outreach	School outreach to diversify students. Essentially about promoting profession as inclusive & diverse to young groups, namely those in secondary school. Some efforts to highlight AHP careers & that they have career progression – some presence in careers events & others scoping issues (e.g., community outreach methods). Offer work experience & support & improve placement experiences (e.g., place minorities with minority therapists). ISSUES: Careers promotion based on workforce provision; curriculum needs change.	23	36
Careers events	Promoting SLT career awareness at student level – have working group looking at school career promotion; some learnt about SLT through university open days; targeting careers days/ rep in careers fairs; SLTs go into SLT courses and share their course experiences to help student retention.	8	9
Widening participation	Widening participation in higher education is a major component of government education policy in the United Kingdom and Europe. It consists of an attempt to increase not only the numbers of young people entering higher education, but also the proportion from under-represented groups.	2	3

Name	Description	Files	References
University	Academics have many diversity activities driven by strong beliefs- addressing lack of diverse career materials (e.g. no Black dolls); redesigning curriculum (e.g., more sessions on cultural competence, decolonising curriculum); talking to students about experiences; training placement educators (problem=not mandatory); display diverse SLT profiles on open days/show diversity; lecturers as role models; universities doing community outreach; promoting values-based recruitment; mentor students for SLT course.	18	50
Work experience access	RCSLT outlining the different ways to getting work experience on their website.	2	2
Awareness methods	Awareness of EDI issues within SLT/NHS primarily done through conversations and meetings (and some training). Conversations mostly cover ethnicity due to BLM and overall, this includes consultation with staff groups and networks.	47	322
Conversation and meetings	Practices involving listening to staff/SLTs about their experiences – includes having conversations through different platforms. Conversations mostly focused on ethnicity driven by BLM. Essentially seen as way for under-represented staff to vocalise & raise awareness of issues, organisation to learn about issues, and then encourage action. Variety of platforms used (team or	45	224

Name	Description	Files	References
	organisation level meetings, minority ethnic /women's staff networks, online meetings, RCSLT events). See memo for pros and cons.		
Meetings-networks-working groups	Diversity practices involving meetings, networks, working groups, etc.	41	155
Diversity overall	Conversations about diversity overall (not specific for gender or ethnicity) and the platforms for this.	23	38
Ethnicity	Platforms for and discussions about ethnicity within organisations - includes networks, meetings, webinars, and forums - e.g., minority ethnic networks, RCSLT anti-racism event and their working groups.	32	100
Gender	Platforms for and discussions about gender based within organisations - includes networks, meetings, webinars, and forums - e.g., women's networks.	12	17
Staff-groups	Staff used as an information base – variety of staff networks exist for each protected characteristic – lots of reference to minority ethnic and women's network. They contribute in many ways, but there are issues – see attached memo.	19	69

Name	Description	Files	References
Diversity working panel	One SLT mentioned diversity working panels - seems like a forum to share, learn about or challenge different opinions. Focus seems to be on the panel being voluntary and only engaged by people who are interested in it.	1	2
Producing and sharing information	The RCSLT have a role in producing and sharing information. Some materials slightly cover diversity (e.g., clinical guidance on cultural sensitivity/bilingualism) whilst other are more focused (e.g., antiracism resources). Information shared through various communication routes, but some issues identified - see memo.	22	41
Bulletin	References to the RCSLT Bulletin – monthly magazine shared to members. PRO: perceptions that it reaches many SLTs & outlines ways of contacting RCSLT. CONS: Criticised for lack of diversity - Images included are now more diverse & more articles on diversity; Perception getting less relevant; Don't have time to read it; Articles focus is mostly negative – e.g., not getting names pronounced correctly – diversity should be presented in more positive light; Increased diversity focus too late.	17	20

Name	Description	Files	References
Guidance	RCSLT produce guidance for members which is co-produced with them, or they consult on it - mostly clinical guidance but some cover diversity in indirect ways (e.g., bilingualism and need for cultural competence/sensitivity).	6	11
Media communication of resources	Digital expertise/roles being brought into to share resources and information with members. Information shared through various media including website; emails; networks; e-newsletter; Bulletin articles; social media; online forums; webinars. ISSUE: Difficult to monitor reach of communications; Used to be bad at responding to emails but better now.	10	20
Social media use	Social media seems to have emerging role in addressing diversity within SLT profession - covers LinkedIn, Twitter, FB, blogs, websites, and YouTube. Gives voice to SLTs (e.g., podcasts to share experiences), ways to feedback/criticise to RCSLT (e.g., BLM statement criticised), way of displaying profession diversity, blog for exposure, can connect to other (male SLTs on twitter #malespeechies, LinkedIn for private, FB support group). ISSUE: trolling, unwelcoming; minority ethnic people pressured to show diversity; just conversations.	18	45
Podcasts	References to use of podcasts to address diversity issues - SLTea time.	4	6

Name	Description	Files	References
Training	EDI awareness promoted through EDI training.	8	10
Career support mechanisms	Various forms of career support identified - include family and friends, organisational (managers, peers, other services - NOTE also refer to staff networks), professional associations and statutory bodies. However, some participants thought support was poor, especially in the private sector where sole traders often seek own support. The limitations of each support mechanism are also identified.	34	184
Family and friend support	Includes cousins, siblings, parents, school friends, friends in other professional roles. Types of support include learning from one another; discussions; informal support – tell you things; enabled to take risks; venting; share social experiences at university – e.g., drinking/going out; encouragement & instilling confidence; different insights; childcare or domestic support. ISSUES: Family not understanding role or valuing it when started, but now do.	11	12
Information Commissioners Office	Information Commissioner's Office provides sole traders with informational support - e.g., about legal requirements.	1	1
Organisational-level support	Two main stakeholders that provide support within organisations - managers and peers (NOTE: make sure to refer staff networks code). Some positive and	29	113

Name	Description	Files	References
	negative experiences outlined for both, but overall, they appear to be positive. Diversity/workforce policies also form of support (use when needed) for staff and organisations. Other support includes allyship, positive provisions, and others.		
Management support	Organisational management is mostly seen as supportive, although there are (fewer) contrasting experiences too. NOTE: Examples of support include supervision, guidance, resolving issues, etc. Management refers individuals responsible for managing other employees - e.g., team leads, supervisors, managers, etc.	22	55
Supportive management	Many SLTs described current and former managers positively. Managerial support important because SLTs mostly interact with managers than other SLTs because they're focused on their caseloads. Different forms of managerial support identified by SLTs - main ones are clinical/Personal Development Review supervision; approach for problem solving; mentorship/career progression guidance; foster belonging and relatability. However, there are certain issues - see attached memo for details.	19	41
Unsupportive management	Some SLTs outlined experiences of where managers were unsupportive and the impact - this included quitting job/profession, negatively affecting progression, feeling a lack of belonging, and negative emotions.	9	14

Name	Description	Files	References
Other organisational support services	SLTs identified several other sources of support in organisation – includes counselling service – free; clinical excellence networks – info, education, collaboration with other professionals; staff networks (see meetings-networks code for more info); policies that cover maternity and carers leave; designated area on Trust websites for wellbeing support; would stay in organisation if career progression was encouraged; social media groups for male SLTs. But there are also issues - see memo.	17	21
Allyship activities	White staff seen to have position of privilege and should use that to push change because they have more power than minority ethnic staff & responsibility of perpetrators. One Trust is exploring how to be a White ally in the ethnicity agenda to target unconscious biases/promote reflection on privilege– they did a focus group exploring white staff experiences – found poor understanding & White fragility.	4	5
Positive provisions for disadvantaged groups	Includes proactively identifying the needs of certain disadvantaged groups, namely women and disabled staff, and putting positive measures in place to address them	1	1
Peer support	Most SLTs speak positively about peer support. Many SLTs highlight a strong supportive culture within their team and outline various types of support peers	20	37

Name	Description	Files	References
	provide (see attached memo). However, there are issues of being mostly female workforce, and lack of skilled/qualified staff to learn from.		
Poor support	Perceptions of poor or no support by SLTs. This includes lack of support mechanisms (e.g., lack of diverse people to report to); no external support available or used; lack of tutor support at university; and many comments about no/unclear support in the private sector - see attached memo. Can also refer to unsupportive management code.	15	35
Academic support	More academic support needed for students.	4	4
Sought own support	Private practitioner's sought supervision by themselves.	8	13
Professional association support networks	SLTs seek guidance from professional associations, namely RCSLT & ASLTIP. Support includes guidance and reassurance on standards, professionalism, insurance, problem solving; encourage to start own businesses, create & learn from networks; share & learn about best practices; not emotional support. ISSUES: RCSLT not useful – not assertive enough, don't get enough as member other than occasional webinars or clinical excellence networks; ASLTIP limited support – join for register so people find them.	14	22

Name	Description	Files	References
Unspecified support	Unspecified support outlined by participants - e.g., general statements that initiatives have support mechanisms within them.	1	1
Culture change	References to culture change in three different ways: (1) Societal: More Asian girls pursuing education; (2) Policies: Culture and working practices filter down from leaders through policies- slowly creates culture shift which allows grassroots activities to be created; policies must be dynamic by relating to daily working culture, (3) Work culture: Have supportive work cultures and need to create culture of openly speaking about discrimination at work.	5	7
Diversity metrics	Different data are collected to measure diversity levels and issues within SLT and the NHS. Essentially data used as a tool to identify issues, inform practices, and promote accountability.	21	163
Care Quality Commission data	A single statement about how CQC have data as well.	1	1
General recruitment data	Data clearly shows recruitment unfair; plans to introduce a complaint system where staff performance management should include justifications of recruitment decisions.	2	3

Name	Description	Files	References
Health Care and Professions Council registrant data	HCPC has most full and rounded data on registrants - apparently collecting more diversity data from registrants including on ethnicity, and their gender data shows small male SLT workforce.	3	3
Legislation - Gender pay gap	Gender pay gap reporting is a legislative requirement if have over 250+ staff – report numerical data annually & have action plans on how to close the gap. There are some plans to look at pay gaps from intersectional lens. Impact: Law improved focus on gender. Helps identify problem areas (NHS has large gap); helps inform action plans in equality strategies; Women's network is critical friend in criticising & raising awareness of pay gaps; Issue: Share Trust gap data but not enough resources to go specific.	8	18
Meeting minutes	One sole trader stated not collecting any staff data except for meeting minutes.	1	1
National Health Service data	NHS collects a lot of data from a variety of sources, although the four main ones are WRES, WDES, gender pay gap and staff survey. Data seen as way of identifying issues, informing action plans, and promoting accountability. However, there are issues to consider - e.g., mostly collected annually.	16	78
BAME network data	Single comment about how the minority ethnic network (called BAME network) look at Trust data and comment on it which is seen as powerful.	1	1

Name	Description	Files	References
EDS or ESR	NHS uses Equality Delivery System (EDS2) & Electronic Staff Record (ESR) to explore EDI issues. ERS shows representation of workforce & staff experience– references to it not being reflective of workforce nationally/locally. EDS is self-assessment tool –grade how each organisation is meeting EDI requirements –sets strategic direction but individual NHS organisations must make sense of it (e.g., some say data shows gender not a problem relative to ethnicity). Some efforts to identify baseline diversity for SLT services & drawing action plan.	7	12
Disability - WDES	References to the NHS Workforce Disability Equality Standard - mandatory to report on and outlines staff experiences based on disability.	6	12
Ethnicity/race - WRES	Workforce Race Equality Standard is most cited NHS metric - participants commented on its history, content/how it works, benefits and issues - see attached memo.	14	58
Sexuality	Single statement how there are measurement tools for LGBTQA+ area.	1	1
Friends and family test	One stakeholder mentioned the friends and family tests which essentially asks staff whether they would recommend their organisation as a good place to work and receive treatment - used as indicator of staff experience - can be broken down by demographic area.	1	1

Name	Description	Files	References
NHS data analysis and outputs	NHS has many measurement tools to collect EDI-related data. Used to identify, monitor, and report on issues - includes supporting claims about staff experiences & measuring impact. Many stakeholders involved in analysing data. Also, several issues/limitations to consider with how data are collected and analysed - see attached memo.	10	28
Targets	NHS has targets for diversity representation overall and at senior levels. Also, includes reference to how HEE would get diverse students if given a target.	3	4
NHS staff survey	NHS staff survey explores staff experiences, engagement, and their opinions on practices – conducted & reported annually. Covers 350,000 staff – can get breakdown by occupation. There's also a survey when leaving the organisation. Used to inform practices (e.g., where more funds are needed), make comparisons to other organisations/ between demographics staff groups, can see size & scale of discrimination. ISSUE: Done annually but need live data for accountability/keeping people motivated.	9	18
Other data	Variety of other NHS data collected – first batch relates to staff experiences (grievances/complaints/disciplinaries, sickness, absenteeism, retention, progression data on diversity, engagement with events). Second batch related	12	18

Name	Description	Files	References
	to NHS acting like a business in terms of service performance & need for data to see if career progression/senior positions available.		
Other data Issues	Data are impactful because it can be stark/powerful & tell a story of problem areas & create the evidence-based for practices. Issues: Data not used properly. Consultants advising organisations lack understanding of organisational development & Human Resources do not read (or it's not practice-focused reading) – must consider implications; Boards don't question consultant advice; organisations looking for silver bullets to fix problems; need built-in accountability; difficult to talk about ethnicity & have not addressed area rigorously; need proactivity.	3	5
Research data	Research used as a tool to support initiatives – SLT must prove worth and value to get funding for their services so use data to support case; EDI stakeholders have job of keeping up to date with research for their jobs; research used to make case for WRES; lots of Trusts bring in consultants without questioning their evidence; note that research says three things must be combined (bias in decision-making, change processes not biases, build accountability). ISSUE: research mostly done by White people.	7	11

Name	Description	Files	References
Royal College of Speech and Language Therapists data	RCSLT lacks diversity data about SLT & relies on external data (especially from NHS/HESA) to highlight issues in their events – seen as stark way of seeing problems. Covers RCSLT data efforts – includes doing surveys pre- and post-events to get baseline data on experiences so can be monitored; supporting organisations to collect diversity data; working on building member's profiles on their customer relationship management (CRM) system to include more diversity data (jobs, sexuality, ethnicity) – but issues with creating/self-identifying ethnicity.	8	33
Student data	Student data shows poor diversity for SLT, and Health Education England can diversify student populations for courses if given a target.	3	5
Voluntary resources	NHS Trusts can use a variety of voluntary benchmarking tools and resources to measure their performance on different diversity measures - includes disability confident scheme, green park resources, Stonewall schemes, TIDE benchmarking, etc.	2	5
Organisational priorities	Overall national policies and legislation address all protected characteristics equally. However, in NHS and SLT ethnicity seems to get more focus and is prioritised over gender. The former is influenced by societal events, CEO priorities, data, and other factors, whilst gender seen as unproblematic systematically and women well represented.	45	236

Name	Description	Files	References
Equal priority	Perception of equal priority given to protected characteristics (e.g., a focus on diversity overall & under umbrella of inclusion; usually have single policy that covers all of them broadly- policies are extension of Equality Act which lists all characteristics together so rarely have gender/ethnicity referred to separately (but can have separate sub-policies or strategies on them). All seen as equally important to address with focus. Intersectionality and inclusion emerging areas of importance.	13	16
Prioritising ethnicity	Perception ethnicity prioritised because of BLM; Covid-19; media focus on ethnicity; driven by NHS culture (CEO prioritised staff experience gaps /leadership focus, aim to reflect community served, more ethnicity roles); racism seen seriously; data says ethnicity is bigger problem than gender (WRES mandatory); more systematic barriers/bigger issues for ethnicity than for men; embracing multiculturalism/service needs; driven by SLT/staff concerns/feedback/sharing experiences.	23	45
Prioritising gender	Not focus: Gender issues hidden because men are vocal; professions feminised but not bad outcomes; data say not important, not on political/any agenda nor seen as cultural issue; little change/ sustained effort to address gender; women well represented in NHS workforce so can progress; seen more as societal issue; ethnicity just higher on agenda.	20	35

Name	Description	Files	References
	Focus: Gender issues focus influenced by gender pay gap reporting, women's networks outlining issues, more progress on gender due to workforce numbers/more gender evidence.		
Societal influences	Diversity agenda seems to be shaped by societal events and issues - many references made to BLM movement, Covid-19, media/society in general, the media, diversity as a buzzword, American societal events (e.g., footballers kneeling), Brexit.	40	140
BLM	Black Lives Matters (BLM) mentioned a lot – mostly in: (1) Raising awareness of minority ethnic people's experiences; (2) triggering lot of ethnicity-related activities (discussions, minority ethnic networks, webinars, podcasts, organisational statements, anti-racism events, etc); (3) seen as another opportunity to deal with ethnicity properly since murder of Stephen Lawrence; (4) helping shape ethnicity as a priority for organisation (amplifying it); (5) some references to societal/institutional racism.	29	59
Covid-19	Many references to Coronoavirus-19 (Covid-19) pandemic across different topics. Important ones seems to be: (1) Show value of SLTs by linking their role to UK Covid response; (2) Contributed to ethnicity agendas - highlighted minority ethnic experiences, triggered reviews of policies/exploration of staff needs, caused grief to senior leaders so they're addressing it, triggered	23	42

Name	Description	Files	References
	webinars; (3) Broke barriers of staff wanting to share learning; (4) Covid-19 as barrier to engagement in networks/events (e.g. workloads) & getting work experience.		
Society and media	Societal narrative and events seen as high-level and negatively impact on organisations: (1) NHS issues reflect societal issues; (2) White privilege is societal thing; (3) References to murder of Stephen Lawrence, Brexit, racism in general society, Royal family racism, Daily mail articles/media, Palestine, criminal justice system; (4) Diversity issues need government leadership; (5) Media attention helps to get funding; (6) Society shapes power dynamics – gender roles/identities, student choices - see memo.	24	39
Other protected characteristics activities	Many activities across four protected characteristics mentioned - mostly on ethnicity, with little details about gender and passing comments about disability and sexuality. Each child code outlines details of specific activities - mostly references to a diversity workshop in 2019 where SLT experiences were shared and discussions on diversity issues, as well as an anti-racism event where surveys will collect date pre and post event.	12	22
Disability	Disability seems to be a RCSLT focus, and they have a working group on it.	3	4

Name	Description	Files	References
Diversity - general	References to diversity that don't specifically mention gender/ethnicity. RCSLT working through diversity issues now - has acknowledged it in past, but more concerted efforts now. Has been diversity initiatives in past – CEO personally upset because of her equalities background & lack of diversity & hearing about these experiences. There is continuation of initiatives but more energy going into it - see memo for examples.	10	14
Sexuality	References to having working groups for LGBTQ+.	3	3
Policies or strategies	References to different types of policies or strategy documents related to diversity and inclusion.	45	738
Diversity policies	Details about organisational diversity policies - its creation, review, awareness, engagement, implementation, and impact. Issues at each stage are explored. Note issues of engagement, implementation, awareness, and impact duplicated in challenges theme under stakeholder code.	39	631
Policy impact	Some SLTs unaware of impact because did not read diversity policy. Stakeholders outlined many impact measures. Policies seen to have high level impact (e.g., guides service direction), and are seen as necessary but insufficient by themselves and need consideration of other factors for impact (listed as child nodes).	29	74

Name	Description	Files	References
Active policy learning	SLTs think policy engagement would be better by actively learning about them. (1) Explain why policy is useful/important/what the outcomes are – use practical approach (e.g., use problem scenarios to signpost help routes); (2) Privately gather & share real and relatable stories; (3) Educate in entertaining way; (4) Share resources; (5) Training; (6) Coaching; (7) Use different forums; (8) Consistent engagement - see attached memo for detail.	13	25
High level impact	Policies seen to high level impact - e.g., direction of services.	1	1
Measuring impact	Methods of measuring policy impact include - regulatory bodies reviewing them, collecting, and monitoring staff experience data (e.g., staff surveys, staff network responses, focus groups, WRES indicators, grievance data), diverse recruitment data. Some stakeholders unable to comment on impact because new to position.	5	6
Necessary but insufficient	Perception that diversity policies are necessary but at the same time insufficient by themselves in having an impact because other seems like a tick box exercise. Policies require the following for impact: accountability and ownership via embedding across organisation, addressing organisational culture, communicating policy information and its importance (e.g., show leadership buy-in), considering practical barriers (e.g., wording makes it open to interpretation)	16	23

Name	Description	Files	References
Accountability and ownership	Accountability and ownership of EDI needed alongside policies for impact - one way to do this is to embed EDI goals across organisational processes, measuring impact, train and educate staff so they are well informed.	6	8
Address culture	Need for cultural change. Recommendation include encouraging inclusivity/improving staff experiences, challenging inequality/having difficult conversations, self-reflection on biases, managers listening to employees, role modelling good behaviour/leadership influence trickles down, promoting just culture based on learning rather than discipline, addressing culture locally, having comprehensive action plans, by educating and training staff.	9	16
Address unconscious biases	Perception that policies need activities that people engage in to change their behaviour and biases.	2	2
Communication strategies	Making the diversity policy meaningful through communication important - includes storytelling, highlight why it's important, show commitment to agenda/showing leadership is on board, using data to show inequalities and improvements, teach policy to managers in accessible way, make it dynamic and applicable to daily life, need sustained activity.	9	9

Name	Description	Files	References
Practical application issues	Diversity policies difficult to apply in practice because content is not specific/detailed/targeted enough - open to interpretation, need to monitor adherence, not frequently used.	3	5
Tick box exercise	Perception of diversity policies by themselves as tick box exercises.	7	7
Unsure or no impact	Unsure if policy has had an impact (e.g., cannot tell if or have not been discriminated)) or no impact at all (most common reason seems to be because have not read the policy, organisational processes are fair, yet to see changes, and recently started job).	14	19
Policy in practice	References made to the awareness, engagement, and implementation of diversity policies - essentially there are barriers at each level.	35	288
Policy awareness and engagement	Engagement with diversity policies is poor, and some insight into why through several engagement barriers that were identified. A few strategies for promoting engagement also identified.	33	244
Engagement - none or poor	Lack of familiarity or engagement with the diversity policy seems common. Many participants (mostly SLTs) state they have not read the diversity policy and/or do not know of its contents (reasons why covered in engagement issues code).	18	36

Name	Description	Files	References
Engagement Issues	Several issues outlined as barriers to engaging with diversity policies. Overall, policies seen as inaccessible, it’s not mandatory, their content is obvious or can be sourced elsewhere, and there's too many of them but people do not have time to engage and so they use them when needed. Also, people lack confidence in challenging issues or are unconvinced of EDI. Managers must engage with diversity policies.	31	168
Accessibility of policies	Accessibility of diversity policies - shared by communications/emailed/Bulletins, signposted in mandatory EDI training or inductions or not at all, usually on Trust intranet. CONS: long, too complicated content/formal language/rhetoric reduces desired impact/cannot understand, intranet difficult to navigate for some but others think they can find it if needed, not detailed/specific enough when applying, long, dry reading, cannot relate to it, manageable to read, not memorable, would be hard for learning difficulties.	21	48
Alternative policy info access	Participants access diversity policy info through alternative means - e.g., training, presentations, specific individuals who signpost channels, learning on the job.	5	6

Name		Description	Files	References
	Confidence	Lack of confidence as barrier to engaging with EDI issues and challenging issues.	2	2
	Content obvious	Lack of engagement with diversity policy because the content seems obvious.	6	8
	Managerial responsibility	Managers expected to be familiar with the diversity policy because it is part of their job. Important for senior management to talk visibly about diversity to show people that equality and equity are genuine aspirations.	4	5
	Role of mandatory quality	Varying views whether diversity policies are mandatory - is for managers to read it but engagement unchecked for everyone. No mandating means just encouraging certain actions, but people would read policy/do actions if management said so. Nothing ethnicity mandated except WRES. Current mandating effort= including ethnicity metrics in performance contracts - linked to accountability (e.g., poor minority ethnic career progression not addressed because of no strategic steer so no awareness). Some say mandating unhelpful.	21	35
	Timing or workload	Important to engage staff to get their lived experiences but barriers include workload/demands, lack of time, do not spend much time on computers, and	11	16

Name	Description	Files	References
	employers focus on whether they can do their job more, inundated with information from other sources (e.g., emails, newsletters, training, etc.).		
Too many policies	Lack of engagement with diversity policy because there are far too many policies and so pragmatically it's important to know where they are, and people use as and when needed.	5	7
Unconvinced	Challenge of some staff who are unconvinced and so disengaged with EDI (e.g., they stay quiet to avoid being seen badly).	1	2
Use when needed	Diversity policies approached practically – used as-and-when-needed, predominantly when something goes wrong, but in some instances, it is in response to events in an employee's life cycle (e.g., maternity, retirement, etc.).	20	39
Engagement strategies	Strategies outlined for engaging people with diversity policy documents - includes learning about best practice/org, making it meaningful to them, link to personal interests in EDI, consult staff in their development.	18	40
Learning	Diversity engagement related to learning about organisation or best practices.	2	2

Name	Description	Files	References
Meaningful	Diversity policy engagement linked to making it meaningful in people's working lives.	1	1
Personal interest	Engagement depends on personal interest.	3	4
Policy awareness strategies	Various methods of raising the awareness of diversity policies.	13	23
Other awareness methods	Other ways of raising the awareness of policies includes during the policy review process, appraisals, webinars, setting up focus groups, awareness weeks, and see use when needed code where trades unions can signpost policy.	5	7
Training	Information about organisational diversity policy usually delivered through training.	12	16
Staff consultation	Consulting staff when developing diversity policy seen to help their engagement with it.	6	9
Volunteers	Employees with voluntary EDI roles.	1	1

Name	Description	Files	References
Policy implementation	The responsibility for implementation seems to be on senior management although local ownership is encouraged. There are some consequences (e.g., sanctions) and rewards (e.g., acknowledgement) for implementing Trust diversity policies. Some barriers that implementation is based on manager's discretion (e.g., inconsistently apply rules), implementation not always monitored and sometimes does not happen. Also, staff are not always engaged and so do not see it as relatable (and therefore may not implement them?).	20	44
Consequences and rewards for implementation	Consequences and rewards for lack of implementation. Consequences includes informally calling out non-compliance, performance management/grievance/disciplinary route, appraisal process, sanctions. Rewards for implementation include incentives and acknowledgement through appraisal process and awards.	6	8
Governance and accountability	Main stakeholders accountable for implementation are Department of Health (DoH) and senior management (e.g., NHS inclusion boards chaired by the CEO, HR director) but aim is to get local ownership of implementation/everyone's responsibility by embedding strategy/policies into all organisational processes. People will do things if head office tell them to, and policies only worthy if applied.	6	8

Name	Description	Files	References
Managers discretion	Seen to apply more to managers but they are unfamiliar with and inconsistently implement policies which can lead to perceptions of unfairness - high-level so can be interpreted (so translating policy to practice is a barrier), worried about getting it wrong, not collaborating with clinical staff in designing policies, focus is on whether employees can do job not on monitoring policy engagement, managers need to role model and monitor implementation.	14	18
Monitoring issues	Need to monitor implementation compliance - various ways to do this e.g., in appraisals process. Refer to "role of mandatory" code here as no one seems to check/monitor if staff have engaged with diversity policies.	6	7
No implementation	Policies only worthy if applied when it comes to the crunch but there is a perceived lack of implementation of policies because inequalities persist.	3	3
Policy making - what, why and how	References to the why diversity policies are made, how and what content is included.	36	269
Content	Participant perceptions of the content of diversity policies.	33	126
Diversity management	Perception that diversity policies are about ensuring and celebrating differences based on protected characteristics and being inclusive (varying views about which characteristics are prioritised). So, policies ensure and	18	24

Name	Description	Files	References
	allow questioning of whether workforce is representative of the population being served in a fair way to meet diverse client, needs, ensure voices/concerns of underrepresented groups are heard, and allow people to be their authentic self. Some criticisms.		
Reference and regulation	Diversity policy seen as document which outlines the principles of employers and is used as an information/guidance reference document to educate (e.g., outline expectations) and regulate employee behaviour (e.g., used when conflict arise and as a tool to hold people to account). Also, about regulating employer's behaviours (e.g., ensure fair processes, using best practice, manager accountability). Spoken mostly in reference to preventing and addressing discrimination related to protected characteristics.	31	94
Specific initiatives	Overall, not much comment on initiatives. One view that policy does not contain initiatives but inspires them, and some initiatives mentioned related to policy include addressing recruitment biases (e.g., diverse interview panels, name blind approaches, bias training), evaluation (e.g., reviewing employee behaviour), diversity training (which covers bullying and prejudice), and meetings (e.g., team or organisation-level meetings where diversity issues are discussed).	7	8

Name	Description	Files	References
Motivations	A variety of motivations outlined for diversity policies (mainly for the NHS) - includes business, legal, moral, socio-political and for protection/accountability. Similar numbers of people mentioning them all, except socio-political (N=2 only), but most references for legal.	35	118
Business	Diversity policies for business reasons. Reasons include - staff experience linked to better patient care, attracting & retaining staff, staff/organisational performance, more diverse thinking uncovers unaddressed areas (e.g., Black women have worse maternity outcomes), more staff engagement. Also, helps organisation in best practice, guides direct of services/change, communicate management ideas. Sole traders do not have polices but see it as protocol when recruiting employees- would follow other policies as guidance for their own.	17	25
Legal	Nationally there's an NHS policy which holistically covers all nine protected characteristics (NHS People's Plan) but no specific gender/ethnicity focus- but there are sub-policies/strategies on it. So, Trusts just must show meeting legal requirements from Equality Act 2010 (e.g., reporting) - can be done through diversity policies or workforce strategies. Legislation seen as baseline but is inaccessible (e.g., dry) and limited (inequality still exists despite changes) but promotes accountability.	18	36

Name	Description	Files	References
NHS People's Plan	References to the NHS People's Plan - launched in Aug 2021, authored by NHSE&I, NHS workforce strategy for next 5-10 years to meet legislative requirements (e.g., reporting on WRES, WDES, pay gaps etc.), outlines aspirations and EDI goals (ethnicity made urgent), is overarching so Trusts need to make sense of it and demonstrate compliance in any way - e.g., diversity policy or workforce strategy.	6	9
Moral/fairness	Moral or ethical reasons for diversity policy: One way of changing or creating fair & inclusive culture/ organisational processes (bias awareness, equal opportunities, creating positive employee experience, outlining organisational values/principles (e.g., dignity and respect) - organisations as role model employers), wrong message if do not have one/right thing to do, personal anti-discrimination and diversity beliefs/experiences. Overlaps with protection/accountability code in terms of ensuring organisations have fair equitable processes.	18	28
Protection or accountability	Diversity policies are for protecting employees (e.g., redressing inequality, fair processes - no bias) or organisation (risk management strategy or safety net - e.g., prevent tribunals) namely in cases of poor treatment. Policies = clear written codes of conduct and so can be used to hold people and oneself to	18	26

Name	Description	Files	References
	account for non-compliance it (e.g., outline consequences/disciplinary measures and details about accountability governance). Criticism = negative framing instead of positive guidance.		
Socio-political	Social or political reasons for diversity policy or its changes - includes underrepresented voices now being heard by management, and political movement after BLM led to policies being updated to dismantle institutional racism.	2	2
Unspecified yes	Think employers should have diversity policy but reasons unspecified.	1	1
Policy creation and review	NHS policy process has ~5 stages with many stakeholder input throughout (1-DoH must deliver gov social policy so assigns job to NHSE&I, 2-NHSE&I write overall policy, 3-consult senior members of Trusts, 4- organisation's consultation process based on Trust needs (author, policy working group which includes senior members, HR, union/staff networks, external bodies), 5-revision and sign off). So, policies collaborative with non/experts. Policies are reviewed ~3 years/earlier - by Trust, regulatory bodies & staff survey.	12	25

Name	Description	Files	References
Other workforce policies	References made to number of workforce policies as way of addressing diversity issues - common was disciplinary and flexible working. Policy opinions highlights general criticisms of a policy approach.	35	85
Disciplinary or complaints process	Variety of practices to improve disciplinary/complaints process - aims to target managers, improve accountability, make people feel supported to report racism. However, lots of issues with current practices - e.g., individualistic, reactive, not evidence based, CEO/managers avoidance of difficult conversations, and poor support mechanisms.	19	43
EIA policies	References to use of equality impact assessments on policies.	1	2
Flexible working	Flexible working (FW) mostly linked to caring responsibilities & maternity. Motivations: for staff experience for their retention, working longer, bring whole self to work. Practices: FW variety available, menopause focus, making training & job designs gender friendly. CONS: NHS scared to make changes because of its scale, depends on Trust implementation, push for core hours/3 days min, childcare money, carers leave. PROS: NHS >other orgs for maternity & FW- accepting, does not affect progress, childcare available.	15	27

Name	Description	Files	References
Policy opinions	Opinions about policies. CONS: HR model of policies, procedures & training do not address root EDI issues - individualistic, not proactive, staff overworked, conversations but no planning, merit criteria influenced by successful people, constantly changing policies. Responsibility of CEO, leadership culture filters down. PROS: policies help educate and empower staff.	3	6
Safeguarding policy	References to safeguarding policies - seems these are standard policies that are imagined to be consistently & professional applied rather than slanted against men today than in the 90s.	2	2
Workforce policy overall	Complying with Equality Act may mean creating a workforce policy, involves collaborating with other bodies (e.g., HEE, NHS careers, NHS jobs). Trades unions help with advice on workforce policies & try to build staff needs into policies (e.g., religious observance needs).	3	5
Strategy or guidance	Stakeholders spoke about creation/governance of strategies, their content and how they engage and influence buy-in. Essentially strategy making process is like diversity policies. Content essentially targets leadership and EDI leaders use different ways of getting accountability because they cannot make people/organisation do something (cannot mandate).	7	22

Name	Description	Files	References
Content and issues	Content of diversity strategies - Issues: ethnicity is a focus- no existing strategy, organisational priority & improves others; Poor international AHPs support. Aims: Address structural factors, compassionate leaders, bullying/harassment, recruitment, support, engagement, inclusive culture (fair progression & disciplinaries, senior diverse representation), intent statement/values. Target: Leaders. Practices: diverse panels, 2-week job advert time, informal development (e.g., shadowing, stretch projects, acting up, training).	6	9
Creation and governance	Business motivations. Process: (1) Conversations, (2) bringing region-level evidence (e.g. WRES), (3) draft with author's vision & CEO priorities (some in People's Plan), (4) consult staff (staff surveys, minority ethnic network) (5) draft strategy, (6) review it (7) Board review & sign off strategy (8) Organisations develop action plan for strategy (9) Progress monitored by EDI regional subgroup with EDI rep from each org. RCSLT guidance authors are SLTs & have one person on EDI parts.	4	9
Engagement and influence	Engaging and influencing people on the strategy done by promoting accountability in different ways - use credibility from post, leadership endorsement, organisational performance data, make organisation sign up to strategy, offer support, cause discomfort feeling (e.g., question them),	2	13

Name	Description	Files	References
	manager accountability by leadership training & their PDRs, call for leadership sanctions. Issues - not implementing actions, managers bias, unsure of leadership support.		
Proactivity	Perceptions of a need to be more proactive when addressing diversity issues. When writing about this, include content from organisations scoping needs (e.g., RCSLT), proactivity in disciplinary issues (find out issues do not wait for individual grievances), etc.	6	8
Progression measures	Variety of progression measures exist - common ones are creating leadership opportunities, mentoring, and coaching under-rep staff, and role modelling. others are changing job roles, scoping needs, and training staff.	29	122
Adapting job roles and recruitment	Activities involving changing the job roles, contracts, or recruitment strategies to allow for career progression - e.g., campaigning for the ability to prescribe, adding ethnicity metrics to contracts.	7	10
Addressing clinical work	Broad devaluing of clinical work is linked to the demise of the profession and should be a core priority- addressing gender/ethnicity seen as plasters. RCSLT	8	17

Name	Description	Files	References
	seem to be looking at developing clinical excellence networks and helping SLTs in advanced cases to address this issue.		
Fair progression and equality strategy	Expectations that progression will be fair & merit based. Equality strategy used to ensure fairness in progression.	5	6
Leadership opportunities	Activities involving creating more leadership opportunities for under-represented groups- includes positive action programmes, representation targets, monitoring diversity levels, offering informal opportunities & RCSLT influencing career structures.	16	32
Mentoring or training	Focus on upskilling minority ethnic staff and educating leaders (reciprocal/reverse mentorship, buddying, coaching, clinical academic mentors, access to CPD, cultural intelligence training, general career support). Expectation: support into leadership/navigational skills, demystify & provide more access to opportunities, educate leaders about their staff experiences, and teach them how to work with diverse staff.	23	37
Role modelling	Important to have role models – show how to behave, show ok to learn from mistakes (people scared to be seen as racist) or challenge bad behaviour, foster feelings of belonging in profession/not being alone, reference to using privilege to be demanding about what needs to be done to address issues.	5	6

Name	Description	Files	References
Scoping needs	Activities involving scoping the needs of groups to see what adjustments are needed - e.g., reasonable adjustments, developing groups to identify issues.	9	13
Unsure	Unsure of diversity practices or what should be done to address current diversity issues within the profession.	1	1
Recruitment	Practices related to the recruitment of staff. Some see processes as fair, whilst others see bias creeping in at different stages. Positive discrimination to redress diversity imbalances but some concerns about it. There are different methods for attracting diverse students, and many recruitment practices do not work because need built in accountability.	37	144
Fair and good recruitment efforts	Perceptions that recruitment processes are fair. Job success linked to experience, interview performance, skills, diversity/additional lang being verbally outlined as asset, seeing other under-rep members get jobs/promotions. Notion of fair score-based system, well trained interviewers, references to blind recruitment practices & diverse interview panels.	10	17
Recruitment challenges	Recruitment issues that refer to the recruitment process in general. Examples include need more accountability, current practices are limited (are not evidence-based, no activities, not tackling fundamental issues, too many recruitment changes), and need a holistic approach.	11	31

Name	Description	Files	References
Accountability and agency	The role of accountability and agency in the recruitment process.	5	10
Holistic approach	References to holistic approach to recruitment.	4	4
Poor effectiveness	Generally, recruitment efforts lack impact - current practices are limited (are not evidence-based, no activities, not tackling fundamental issues, too many recruitment changes. One stated that WRES indicators improved a bit	9	16
Recruitment policy	Perception that recruitment policies need changing - includes diverse interview panels, opening work experience, increasing SLT presence in community.	1	1
Recruitment practices	Various forms of recruitment practices discussed and their limits. Note - attracting diverse applicants code can represent recruitment as well.	33	96
Positive action or discrimination	References to positive action recruitment which involves targeting specific groups - e.g., underrepresented groups or managers. ISSUES: managers may not use recruitment toolkits, perception of quotas for men and minority groups - can cause feelings of tokenism by minority groups and resentment for not using merit, and feelings of uncomfortable disadvantage for white women.	12	16
Scoping	Scoping out issues and needs, as well as best practice by learning from others.	10	15

Name	Description	Files	References
Shortlisting and interviews	Bias in shortlisting & interviews - policy cannot address this. Practices: diverse interview panels & Unconscious Bias Training (representation but evidence says they don't work, no one challenges it & lots of financial investment); panels should score first & then discuss; blind recruitment (e.g., remove school and candidate names); values-based recruitment (look at grades & their values/cultural insights/lang skills they bring); increase informal opportunities; target managers; effectiveness needs built-in accountability.	16	34
Unspecified recruitment activity	Recruitment efforts outlined but unspecified.	2	2
Various recruitment methods	Recruitment methods mentioned. Includes have job evaluation system & scheme (covers standard job descriptions & accepted career paths); monitoring types of applicants & their success; tackle bias in job advertising & recruitment & build accountability (e.g., number of essential criteria & blind recruitment); advertise jobs externally for minimum of two weeks & more internal recruitment; explore how profession advertised; use different recruitment methods/outreach; target local authorities & understand their service demands, target managers; international recruitment.	14	24
Training	Training was referred to as a diversity practice - covered various forms including it being a forum for sharing best practice/reflecting on behaviours,	17	30

Name	Description	Files	References
	teaching cultural competence, or addressing unconscious biases. Mixed opinions of whether EDI was included in mandatory training and some adjustment efforts so people can attend training. However, many limitations identified.		
Best practice and reflection	Training as forum to reflect on good and bad behaviour, to share resources - videos, articles, or statistics, to have discussion/debates about ethnicity.	3	6
Cultural competence	Training to teach cultural competence.	1	1
Mandatory statutory or induction training	References to mandatory statutory training (some say EDI not included but others say EDI training is mandatory - could be two different types - signpost help but seen as unhelpful because unfocused discussions, did not refer to diversity policy & people did not feel comfortable to share experiences) and preceptorships (signpost support but not EDI focused).	10	14
Training adjustments	Adjustments to training based on needs - e.g., flexibility to access training.	4	4
Training limitations	Limitations of training identified - includes lack of funding for training opportunities in NHS - have to self-fund which is seen as wrong; lack of male engagement in training; for diversity policies - need training to be consistent & frequent & timely shared.	4	4

Name	Description	Files	References
UBT or diversity	References to a need for unconscious bias or diversity training to help minorities with career progression.	1	1
3-Stakeholders and their agency	A variety of stakeholders identified in shaping the diversity of the SLT profession - who they are, roles, practices, and support. Some of these stakeholders are covered in the practices code (e.g., universities & everyone's responsibility).	51	776
Academic institutions	-Universities seen to offer support in returning to work post maternity/childcare -Have role in educating public about positively talking about bilingualism. Mostly spoken about negatively.	5	7
Influence or lobbying	University stakeholders lobby or influence for their diversity activities by educating self on anti-discrimination to have intelligent debates; practically make students confident – encourage to be representatives or advocates; role model and share beliefs/ideas (using privilege).	5	5
Stakeholder job descriptions	The details of the academic stakeholder jobs.	2	3
University stakeholder challenges	University stakeholder challenges include seen as crazy/making a fuss/troublemaker; difficulty sharing support on social media so support	3	9

Name	Description	Files	References
	advocated behind the scenes; don't always get it right; using student voices; change is slow/cannot see it for some areas (e.g., gender); cannot monitor implementation; staff engagement mixed; cannot shape university recruitment practices; pick battles. Motivations – strong drive/values.		
External colleagues	References to consultants, doctors, and Special Educational Needs Co-ordinators (SENCos) CONSULTANT: One stakeholder commented on his EDI consultancy across sectors mostly focusing on poor EDI work in the area (and of consultant's quality of work). DOCTOR: One sole trader point: Doctors seen as having a role in referring patients to sole traders – ambiguous point about ethnicity/religion of doctor affecting lack of referrals. SENCO: SLTs outlining working with SENCOs as being challenging.	4	9
Consultants	References made to consultants and their role in diversity within the profession.	2	6

Name	Description	Files	References
Doctors	One sole trader point: Doctors seen as having a role in referring patients to sole traders – ambiguous point about ethnicity/religion of doctor affecting lack of referrals.	1	1
Special educational needs co-ordinators (SENCos)	SLTs outlining working with SENCOs as being challenging – aligning demands & expectations of both parties (also a story of SENCO making discriminatory remark about a minority SLT's accent in professional experiences code).	1	2
Membership, networking, and collaboration	How diversity stakeholder sits on or collaborate with various groups as way of influencing diversity activity in the profession. Most content about RCSLT networking with various stakeholders including their members.	12	30
National bodies	References to national bodies and their roles in diversity - e.g., government, HCPC, HEE, etc.	28	105
Advisory, conciliation and arbitration service (ACAS)	One point of ACAS being signposted in a Trust diversity policy as a source of support.	1	1
Care quality commission (CQC)	References to the Care Quality Commission= arms-length NHS body. Offers tools to assess how well an NHS organisation is doing on EDI. Seen as important stakeholder to get on board because role in giving incentives/sanctions to make organisations deal with ethnicity – doing badly	4	7

Name	Description	Files	References
	for ethnicity because organisation will not financially invest in minorities if data are not telling them to & will not make their life easier – but will do it if must. Perception that CQC ratings of Trusts should be linked to minority ethnic metrics for accountability, but CQC rejected.		
Equality and human rights commission (EHRC)	Stakeholder stated that Equality and Human Rights Commission can have role in checking policies and getting staff feedback on its impact.	1	1
Government	Government identified as stakeholder in addressing EDI structurally through legislation, funding, and power to mandate - see attached memo for details.	11	18
Health and care professions council (HCPC)	Health and Care Professions Council are regulators. Mostly indirect/loose EDI influence (e.g., source of full diversity data, have resources that promote certain values/standards), some direct EDI influence (BLM statement, pushing quotas perception). Seen as powerful because can mandate EDI consideration as part of registration or revoke licenses. Two male sole traders had negative experiences with them - offering extra help and poor safeguarding support - see attached memo.	13	18
Health education England (HEE)	•Health Education England (HEE) have role in education/training SLTs •One NHS stakeholder thinks HEE have not done very little to mitigate gender/ethnicity gaps – how?	3	7

Name	Description	Files	References
	o Have national widening participation lead; Have careers promotion for AHPs; Receiving NHS EDI regional support. o Can do foundational work – includes incentivise universities through funding/contracts to supply more diverse students; outreach work. o Have hired EDI leads for different regions – ISSUE: not senior enough to be on Boards.		
Higher education statistics agency (HESA)	One reference to Higher Education Statistical Authority as source of data.	1	1
National health service (NHS)	References to several NHS organisations that are not Trusts in shaping diversity within profession or NHS more broadly. Has a hierarchical system which covers NHS overall as a body, NHS England and Improvement, NHS Employers, NHS England, NHS providers/confederations, NHS careers, NHS jobs, and NHS digital. See attached memo for roles and challenges.	19	52
HR	HR seen as important organisational level stakeholder – spoken mostly in relation to NHS: Governance: Usually sit within employee relations team in Trusts; Senior HR leader is HR Director – driving force for diversity agenda & has overall responsibility of delivering EDI policy/strategy/action plan & paid a lot so need to deliver; have data analysis and EDI teams. ROLE: Have	20	85

Name	Description	Files	References
	role in addressing workforce issues/finding solutions, diversity policy, fair recruitment. Some criticism outlined - see memo.		
EDI roles or panels	References to EDI positions across the SLT profession or NHS and their roles - seems to be lots of local roles in the NHS Trusts and national ones too but they are limited in their own respects (see attached memo), the RCSLT sometimes include sub-authors of guidance that focus on diversity elements.	18	56
Leaders	References made to senior and middle management in organisations - mostly the NHS but also the RCSLT. Leadership seen as important on EDI issues in terms of endorsement, support, and role modelling. But there are some challenges which are discussed.	30	149
Middle management	Mostly references to local service manager and team leaders - seen as important for career progression, as role models, in shaping policies/resources, & many stakeholders target them. However, not all D&I qualified, don't behave like leaders, and references to poor management (includes avoiding responsibility, do not implement policies at all or properly, do not know staff well, sometimes source of discrimination, and lack diversity) - see memo for detail.	16	33

Name	Description	Files	References
Senior leadership	Senior leaders in Trusts seen as genuinely interested and take seriously having an inclusive & diverse workforce (some queries about whether it is tokenistic as previously been in position). Seen as most powerful - influence & inspire, EDI sponsorship is key & their job, reference to power of boards, shaping priorities, key to culture change but some limitations - see memo.	28	116
Policy working group or committee	Policy working group or committee are an important stakeholder in the diversity policy making process. Administered by employee relations team. Have top-level involvement (e.g., final sign off policies). Includes senior NHS Trust members, employee relations team/HR, union/staff side, inclusion team, relevant stakeholders (e.g., member of a specific diversity network).	2	6
Non-profit organisations	References to non-profit organisations and their roles in diversity - mainly covers RCSLT, ASLTIP, AHP groups, charities, and trades unions. Their roles, and helpfulness is discussed.	30	222
Allied health profession groups	References to RCSLT having meeting with AHP Federation to share activities, and a Chief AHP Officer setting up a national level minority ethnic strategic advisory forum - not much detail about their roles.	1	2
Charities	References to charities and their roles in diversity within the profession/NHS.	2	2

Name	Description	Files	References
	- Provide accreditation/diversity measures– includes Stonewall for LGBTQ+, invested in diversity, disability confident. - Signposted in diversity policies as sources of information & support – includes ACAS, chaplaincy, voluntary guardians, Stonewall, OD, trades union. - Consult on diversity policies – includes stonewall and inclusive employers.		
Professional associations	References to professional associations and their roles. RCSLT mentioned most by SLTs and by stakeholders, followed by ASLTIP, and mentions of equivalents in other countries. Their roles seem to be supporting their members in terms of sharing/producing materials, advocacy and general support based on member feedback. However, a lot of criticism of RCSLT considering BLM, and lack of support from ASLTIP.	26	171
Association of speech and language therapists in independent practice (ASLTIP)	References made about the Association of Speech and Language Therapists in Independent Practice. Paid membership professional body that covers SLTs in private practice. Role seems to be providing a network of other independent SLTs as support framework; upholding professional standards, professionalism - insurance, resolution of difficulties and conflict, etc; o providing guidelines on legal requirements. Some positive & negative perceptions of their value - see memo.	11	17

Name	Description	Files	References
Other associations	Just three main points made. (1) Passing references to the Royal College of Nursing as comparator of another organisation dealing with a large female workforce. (2) Professions clustering together because small. (3) References or equivalent of RCSLT in other countries which provide resources to SLTs- Speech Pathology Australia (not mandatory to join), American Speech and Hearing Association, mention there being one in New Zealand and Canada, but name not stated.	4	7
Royal college of speech and language therapists (RCSLT)	References to the RCSLT governance, agency, and criticism - RCSLT activities included in the “diversity practices” theme.	24	147
Criticism of RCSLT	SLT criticisms of RCSLT - see memo for full list.	10	16
Governance	How the RCSLT is organised, what their strategic plan includes, their motivations and references to their CEO.	21	71
Other RSCLT roles and governance details	Organisation details: charity (funded by member contributions); ~50 staff, Asian female CEO (does operational matters); have Board of trustees (have prioritised diversity in 2018, looked at workforce makeup, looking at career progression measures, take feedback from SLTs); restructured ~3-4 times to be for purpose; have different teams; fewer committees now so	7	19

Name	Description	Files	References
	decisions/responses are quicker; main union is Unite; staff role model; work with small AHPs to get bigger NHS voice; have strategic plan.		
RCSLT CEO	Many references made about RCSLT CEO by SLTs and stakeholders. Being Asian female seen as positive symbol of diversity. Seen to be genuinely interested in diversity issues facing profession. Seems to be actively involved - e.g., personally calling SLTs, asking for accountability, sitting on top strategic boards (see influence and lobbying code).	11	18
Strategic plan and motivations	High level plan being updated – become more action based in last two years Focus areas include: (1) Priorities shaped by member feedback, by Board & CEO; (2) Values-based recruitment; (3) Widening participation; (4) Raising profession's profile; (5) Anti-racism/ethnicity high on agenda – expectations of members to respond specifically to challenges of BLM – CEO wants active not passive; (6) Fair recruitment; (7) Diversity on agenda for long time but more focus on it now. See memo for rest.	15	34
Influence, lobbying & engagement	The role of RCSLT in influencing and engaging different stakeholders and how that relates to diversity of the profession - idea of making incremental changes. NOTE - make note of all the stakeholders they collaborate with - namely government (for lobbying) and trades union (for pay).	12	60

Name	Description	Files	References
Challenges	Several challenges identified for RCSLT. Includes perception that they're driven by societal changes; can only lobby/influence but not direct impact; small profession so cannot fund big TV campaigns/hard to get attention of public; difficult to monitor which attraction method is working; PR initiatives seen as limited lever that don't address earlier core issues – need more than visual presentation; and lack of time.	14	44
Unaware or vague	Comments related to being vaguely aware or unaware of RCSLT activities or role.	13	21
Meet population needs	RCSLT address diversity when trying to meet the needs of the population being served. (1) Talking to members to see how to build business case for resources & plan actions; (2) Encourage sharing of learning & best practice (NHS competitive culture barrier here) – helping profession develop evidence base because not reinventing wheels; (3) Top down and bottom-up approach (talk to members about needs); (4) Helping SLTs develop professionally so can deliver best care - see memo for rest of the points.	3	8
Role modelling	The RCSLT as role models of good behaviour and best practice.	1	3
Trades unions	Trades unionists motivated by fairness, equality, parents being labourers or socio-political climate they grew up in. Unite seems to be main union for	13	47

Name	Description	Files	References
	SLTs. Their role tends to cover addressing employer-employee workforce issues, shaping policy, collaborating with different bodies, exploring organisational issues. Unionists did not see SLTs having many diversity issues although equal pay case was mentioned & that they lack engagement with the union because don't have issues - see memo for issues.		
SLTs	SLTs seen as having a role in and have been involved in addressing diversity issues within their profession.	7	7
Stakeholder diversity challenges	Some challenges faced by stakeholders includes the scale of the organisation, access/control over funding (see also service cuts & lack of RCSLT control over it), and societal influences permeating into organisations.	48	396
Capacity-scale and agency	The scale of the NHS, RCSLT and the SLT profession seen as barriers to diversity work.	13	23
NHS	NHS capacity/scale issues as barrier to diversity activities. Scared to make changes because affects so many staff; reflects societal issues because of workforce size; HR directors finding it hard due to workload and number of NHS organisations (some autonomous & spread out); covers many professions; difficult to monitor implementation; EDI leads cover large areas	10	12

Name	Description	Files	References
	by self/small teams with little funding. However, some efforts put in place to address this - see memo.		
RCSLT	RCSLT is a small organisation which limits their diversity activities in terms of reaching the public, but also seen as an asset in making changes quickly and being close to members.	4	8
Small professions	Stakeholder recommends small professions cluster together to drive diversity agenda.	2	3
Engagement-Implementation	Engagement and implementation are barriers to diversity efforts & ways of improving them - see memo for detail.	48	373
Poor engagement and implementation	Perceptions of poor implementation & engagement- reference to data showing lack of fairness, fragmented practices have not become embedded into daily practice, people not doing practices, not paying attention to ethnicity/using evidence-based research, feeling broken by years of getting people to regard & apply policy, issue of how people apply policies, lack of time/impetus to apply RCSLT diversity guidance, implementation at managers discretion/bad managers, fatigue/same people engaged, nice people image prevents action.	32	68
Issues	Several issues outlined as barriers to engaging with diversity policies. Overall, policies seen as inaccessible, it's not mandatory, their content is obvious or	38	210

Name	Description	Files	References
	can be sourced elsewhere, and there's too many of them but people don’t have time to engage and so they use them when needed. Also, people lack confidence in challenging issues or are unconvinced of EDI. Managers must engage with diversity policies.		
Funding	EDI regional leader strategy does not have funding support - waiting for approval.	1	1
Policies - accessibility	Accessibility of diversity policies - shared by comms/emailed/bulletins, signposted in mandatory EDI training or inductions or not at all, usually on Trust intranet. CONS: long, too complicated content/formal language/rhetoric reduces desired impact/cannot understand, intranet difficult to navigate for some but others think they can find it if needed, not detailed/specific enough when applying, long, dry reading, cannot relate to it, manageable to read, not memorable, and would be hard for learning difficulties.	21	48
Policies - alternative info access	Participants access diversity policy info through alternative means - e.g., training, presentations, specific individuals who signpost channels, learning on the job.	5	6

Name	Description	Files	References
Policies - confidence	Lack of confidence as barrier to engaging with EDI issues and challenging issues.	2	2
Policies - content obvious	Lack of engagement with diversity policy because the content seems obvious.	6	8
Policies - managers discretion	Policies seen to apply more to managers but they are unfamiliar with and inconsistently implement policies which can lead to perceptions of unfairness - high-level so can be interpreted (so translating policy to practice is a barrier), worried about getting it wrong, not collaborating with clinical staff in designing policies, focus is on whether employees can do job not on monitoring policy engagement, managers need to role model and monitor implementation.	15	22
Policies - too many policies	Lack of engagement with diversity policy because there are far too many policies and so pragmatically it's important to know where they are, and people use as and when needed.	5	7
Policies - unconvinced	Challenge of some staff who are unconvinced and so disengaged with EDI (e.g., they stay quiet to avoid being seen badly).	1	2

Name		Description	Files	References
	Policies - use when needed	Diversity policies approached practically – used as-and-when-needed, predominantly when something goes wrong, but in some instances, it is in response to events in an employee's life cycle (e.g., maternity, retirement, etc.).	20	39
	Practical application issues	Diversity policies difficult to apply in practice because content is not specific/detailed/targeted enough - open to interpretation, need to monitor adherence, not frequently used, communication challenges.	4	6
	Role of mandatory quality	Varying views whether diversity policies are mandatory - is for managers to read it but engagement unchecked for everyone. No mandating means just encouraging certain actions, but people would read policy/do actions if management said so. Nothing ethnicity mandated except WRES. Current mandating effort= including ethnicity metrics in performance contracts - linked to accountability (e.g., poor minority ethnic career progression not addressed because of no strategic steer so no awareness). Some say mandating unhelpful.	21	35
	Timing-workload	Timing and workload identified as barriers for SLTs and stakeholders. Stakeholders – not enough time to learn about diversity efforts in profession, or to write a comprehensive diversity policy. SLTs teams under pressure due to high caseloads/ and workloads, understaffed, under-resourced, underpaid,	22	34

Name	Description	Files	References
	inundated with lots of different information so need summaries – affects ability to engage with policies & activities - so prioritise clinical work activities. Sole traders must focus on business to earn.		
Poor diversity policy engagement	SLTs who said they did not, or were usure if, read their organisation's diversity policy. Also, includes SLTs who had limited engagement with it and so were unsure of its contents.	14	14
Poor practice awareness and impact	Some participants expressed a low or lack of awareness of diversity efforts within the profession. For some, diversity efforts had no impact (see also diversity policy impact in which many SLTs state the policies had not impact on their careers). Some SLTs state changes have happened over time but the pace has been slow with a lot of work left to do.	40	91
Changes over time	Profession is diversifying, but pace of change is slow, minimal, at early stages and activity is not sustained. See attached memo for details.	12	24
Diversity policies - necessary but insufficient	Perception that diversity policies are necessary but at the same time insufficient by themselves in having an impact because other seems like a tick box exercise. Policies require the following for impact: accountability and ownership via embedding across organisation, addressing organisational culture, communicating policy information and its importance (e.g., show	16	23

Name	Description	Files	References
	leadership buy-in), considering practical barriers (e.g., wording makes it open to interpretation).		
No impact	Perceptions that diversity policies have not had an impact on the professional lives of participants – reasons include overcame challenges by self, issues not being addressed just plasters on real issue of profession dying, and initiatives not having an impact in current organisation.	17	22
Lack or low awareness of activities	Participants express a lack of or limited awareness of diversity efforts within the profession. Some explained why – includes lack of time, ignorance, fear of being up lack of representation topics due to lack of confidence, possible rejection or being misunderstood. Other provided guesses of efforts which covers recruitment, employment policies being in place, senior members being aware of issues, managers making concentrated efforts on diversity levels, aware of some activity in 2014.	19	31
Monitoring and measuring issues	Monitoring implementation and measuring impact issues - see attached memo.	11	13
Recommendations	Recommendations to improve engagement and implementation.	40	213
Accountability and bias	Bias needs to be better understood and addressed by creating a culture of accountability (people look for silver bullets). For policies, accountability and	20	63

Name	Description	Files	References
	ownership of EDI needed alongside policies for impact - one way to do this is to embed EDI goals across organisational processes, measuring impact, train and educate staff so they are well informed.		
Centralised approach	Centralised approach is the idea that EDI work should routinely be considered/embedded across organisational processes/strategies because - Many SLTs work in multidisciplinary teams; people in system own the aims of strategies/policies; Culture change requires consideration of many factors; - Popular idea that if you get it right for ethnicity you get it right for other characteristics; RCSLT addressing diversity issues through NHS centrally; EDI work is everyone's responsibility.	10	17
Everyone's responsibility	Perception that being inclusive, equalities, implementing diversity policies & addressing diversity issues is everyone's responsibility. Seen as hard to do but involves number of activities (see attached memo). Emphasis on diversity work not minority group's responsibility – reference to dominant group (e.g., White allies) being on board.	13	22
Embedding accountability	Ways of embedding accountability into practices - includes incentivising/promoting ownership (see memo for examples), make a narrative, give support with accountability, and collaborate. A variety of issues also identified - see attached memo.	14	34

Name	Description	Files	References
Legislation or regulators as lever	Legislation or regulators used to get people to think about their practices or implementation.	2	4
Collaboration and outreach	Reaching out to and collaborating with other stakeholders in the community/society and students to address diversity issues- includes running events/producing materials to explain why diversity matters, hosting anti-racism group/events, proactive communication through webinars, encouraging students to be leaders/representatives, have shared priorities, celebrate people doing well, engage emotionally and intellectually, social media helps accessibility.	9	13
Frame practices positively	Perceptions that diversity practices are framed negatively which can deter people from engaging with them. Positive framing ideas are shared - see attached memo.	5	5
Leadership endorsement and engagement	Leadership as role models and their endorsement seen to as way of diversity effort being taken seriously. But shouldn't make leaders feel guilty but explain the business case of why an activity should be done. Get CQC to not rate organisation as outstanding if have poor WRES metrics. Leadership aware of issues but hasn’t fully cascaded down organisation.	6	9

Name	Description	Files	References
Monitoring	Various ways to monitor identified - includes focus groups, staff engagement events, regulators, statutory bodies, getting managers to tell people about policy/strategy and monitor implementation, inclusion board, monitoring team, policies include EDI monitoring measures, audit of recruitment toolkit, comms hard, awareness/engagement not consistent, use data.	8	18
Policy engagement strategies	Strategies outlined for engaging people with diversity policy documents - includes learning about best practice/org, making it meaningful to them, link to personal interests in EDI, consult staff in their development.	27	98
Active learning	SLTs think policy engagement would be better by actively learning about them. Explain why policy is useful/important/what the outcomes are – use practical approach (e.g., use problem scenarios to signpost help routes); privately gather & share real and relatable stories; educate in entertaining way; share resources; training; coaching; use different forums; consistent engagement - see attached memo for detail	13	25
Address culture and biases	Need for cultural change by encouraging inclusivity/improving staff experiences, challenging inequality/having difficult conversations, self-reflection on biases, managers listening to employees, role modelling good behaviour/leadership influence trickles down, promoting just culture based on learning rather than discipline, addressing culture locally, having	10	17

Name	Description	Files	References
	comprehensive action plans, by educating and training staff. Policies need activities that people engage in to change their behaviour and biases.		
Best practice learning	Diversity engagement related to learning about organisation or best practices.	2	2
Communication strategies	Making the diversity policy meaningful through communication important - includes storytelling, highlight why it's important, show commitment to agenda/showing leadership is on board, using data to show inequalities and improvements, teach policy to managers in accessible way, make it dynamic and applicable to daily life, need sustained activity.	9	9
Meaningful	Diversity policy engagement linked to making it meaningful in people's working lives.	1	1
Personal interest	Engagement dependent on personal interest.	3	4
Policy awareness strategies	Various methods of raising the awareness of diversity policies.	13	23

Name	Description	Files	References
Other awareness methods	Other ways of raising the awareness of policies includes during the policy review process, appraisals, webinars, setting up focus groups, awareness weeks, and see use-when-needed code where trades unions can signpost policy.	5	7
Training	Information about organisational diversity policy usually delivered through training.	12	16
Staff consultation	Consulting staff when developing diversity policy seen to help their engagement with it.	6	9
Tick box exercise	Perception of diversity policies by themselves as tick box exercises.	7	7
Volunteers	Employees with voluntary EDI roles.	1	1
Positive engagement	Perceptions that SLTs are engaging with diversity activities - but focus is more on clinical implications, engagement with RCSLT activities seen as good.	3	3
Sustainability	Perceptions that diversity efforts need to be sustained to have impact - they are currently seen as short-lived. One way is to have accountability by perpetrators.	4	4

Name	Description	Files	References
Do not quote	Interview responses that participants specifically asked not to directly quote/mention.	1	1

12.2 Inductive codes for diversity policy/strategy documentation

Analysis of organisational diversity policy or strategy documents.

Name	Description	Files	References
Policy content	The content of diversity policy or strategy documents.	5	277
Content	References to content of policy or strategy.	5	235
Ethnicity issues	Focus based on WRES with minority ethnic staff discrimination experiences and progression.	3	4
Gender issues identified	Focus on gender seems to be about pay and legislative requirements to report on it.	2	3
Motivations	Motivations for diversity.	5	20

Name	Description	Files	References
Business	Diversity seen as business asset for patient care and organisational performance.	3	5
Legal	Legal motivations, mostly references to fulfilling PSED.	4	10
Moral	References to social justice, compassion, equity/fairness and belonging.	3	5
Other protected characteristics	Two other protected characteristics seem to be of focus in policies of strategies - these are disability and sexual orientation.	5	11
Specific initiatives	Specific initiatives mentioned.	5	142
Disciplinary processes	References to disciplinary processes.	1	1
Diversity training	References to diversity training.	1	2
Engagement and implementation	References to implementation of policy or strategy.	5	19
Accountability	Ways of encouraging accountability. Includes making diversity sound like everyone's responsibility, using monitoring systems, and making pledges.	4	12
Rewards and appraisals	References to rewards or appraisal process.	3	6

Name	Description	Files	References
Staff survey	References to NHS staff survey.	1	1
Gender pay gap reporting	References to pay gap reporting.	1	2
Outreach	Community outreach as method of attracting applicants.	2	4
Progression	Progression activities cover mentoring where leaders are identified as playing a key role.	5	34
Target leadership	References to targeting leadership.	5	16
Recruitment	Recruitment practices - Goal of workforce representative of local population; diverse panels, diverse shortlisting, managerial feedback to unsuccessful candidates, inclusive recruitment/interviewing, EDI considerations for entire recruitment process, recruitment toolkits, emphasising importance of roles, apprenticeships, building local hubs, and redesigning roles.	5	11
Support mechanisms	Support mechanisms for staff that may impact on diversity.	5	69
Diversity resources and collaboration	References to supporting diversity work by creating resources and through collaboration.	5	31

Name	Description	Files	References
Flexible working	References to flexible working.	2	4
Staff networks or voices	References to platforms in which staff can express their voice – includes staff networks.	5	17
Wellbeing and protection mechanisms	References to mechanisms for supporting staff wellbeing and ensuring their protection.	5	17
The role of evidence	Data and evidence play a role in identifying gender or ethnicity issues and shaping focus on them. For gender it is gender pay gap reporting, and for ethnicity it is WRES and staff experiences. Other forms of monitoring impact are also mentioned.	5	33
Values or goals outlined	Organisational values/principles or goals outlined. Outlines focus areas: creating workforces that are representative of local populations, workforce development and wellbeing, service commissioning, fair access to services outlines number of EDI principles – dignity, respect, no discrimination, inclusive culture, welcoming, engaging, collaborative, accountable, respectable, equitable, belonging.	4	22
Creation	References to how policy or strategy is created.	2	2

Name	Description	Files	References
Stakeholders	Stakeholders mentioned – includes: patient experience; Boards (sponsorship, signing off action plans); senior leaders (mentoring); strategy implementation groups; NHS commissioning organisations; people committees; EDI support roles (e.g., EDI guardians, champions, etc. for advice, celebrate achievements, signposting support, voicing staff concerns); staff networks (hold organisation to account, get things done); EDI observatories/ centres (intelligence, creating programmes); NHS England,/confederation (expert policy recommendations) - see memo for detail.	4	40

13: Societal influences mentioned by participants

• Black Lives Matters.	• Coronavirus-19 pandemic.	• Kneeling in football games.
• Mood of society.	• Police stopping people.	• Healthcare awareness.
• Stephen Lawrence murder.	• Policeman abducted woman in Croydon.	• UK Royal family racism.
• Boris Johnson speech.	• Diversity as a buzzword.	• Palestine.
• Reduction of manual employment as affecting men.	• Media in general, newspapers (namely the Daily Mail and The Guardian), Sainsbury's Christmas advert.	• Ethnic representation in criminal justice system and mental health services.
• Societal gender roles/ women's empowerment.	• Hate speech or crimes.	• Reports on minority ethnic populations.
• Brexit.	• Refugees.	

14: NVivo coding maps

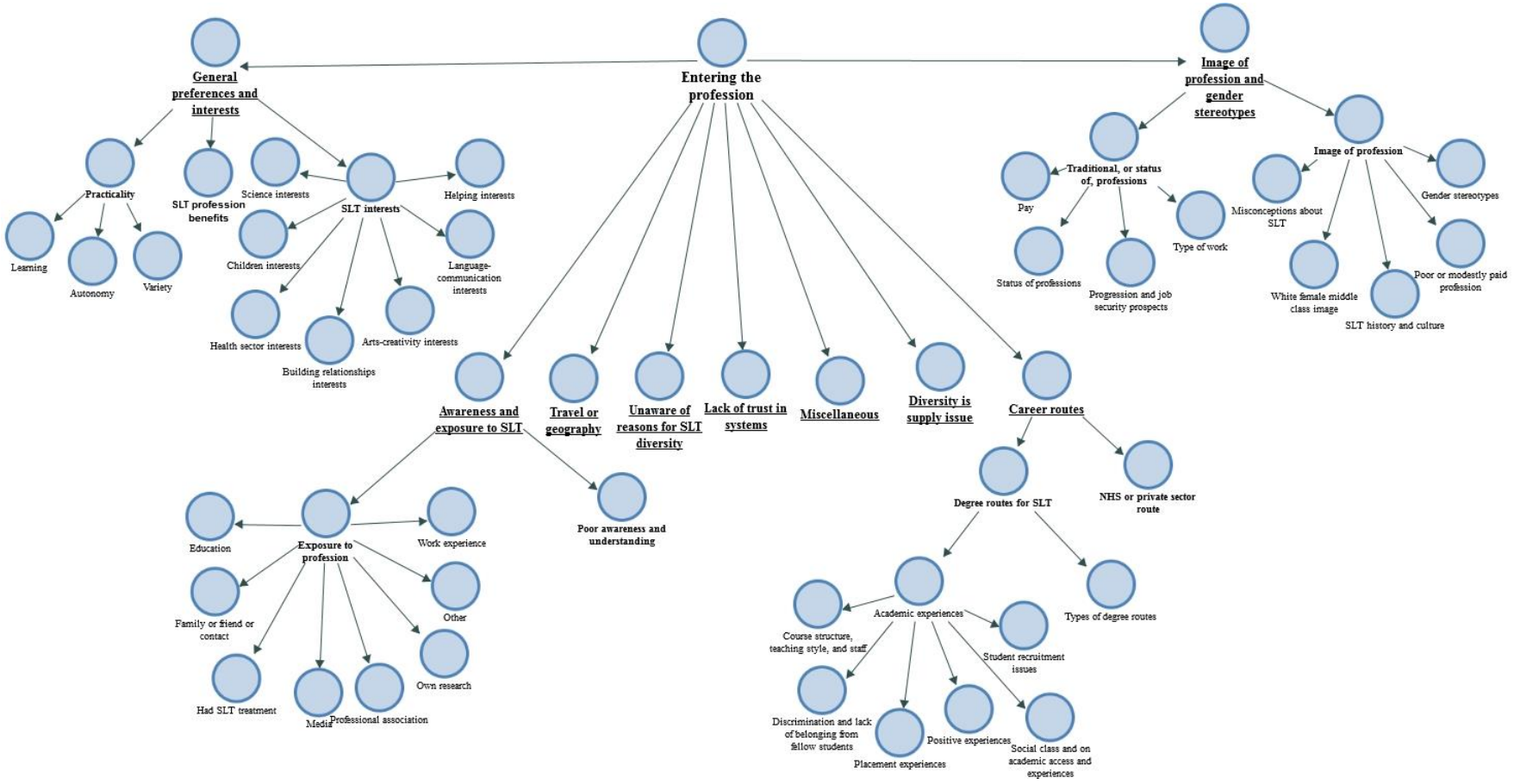


Figure 7. NVivo coding map of entering the SLT profession theme.

Figure 8. **NVivo coding map outlining diversity practices within profession.**

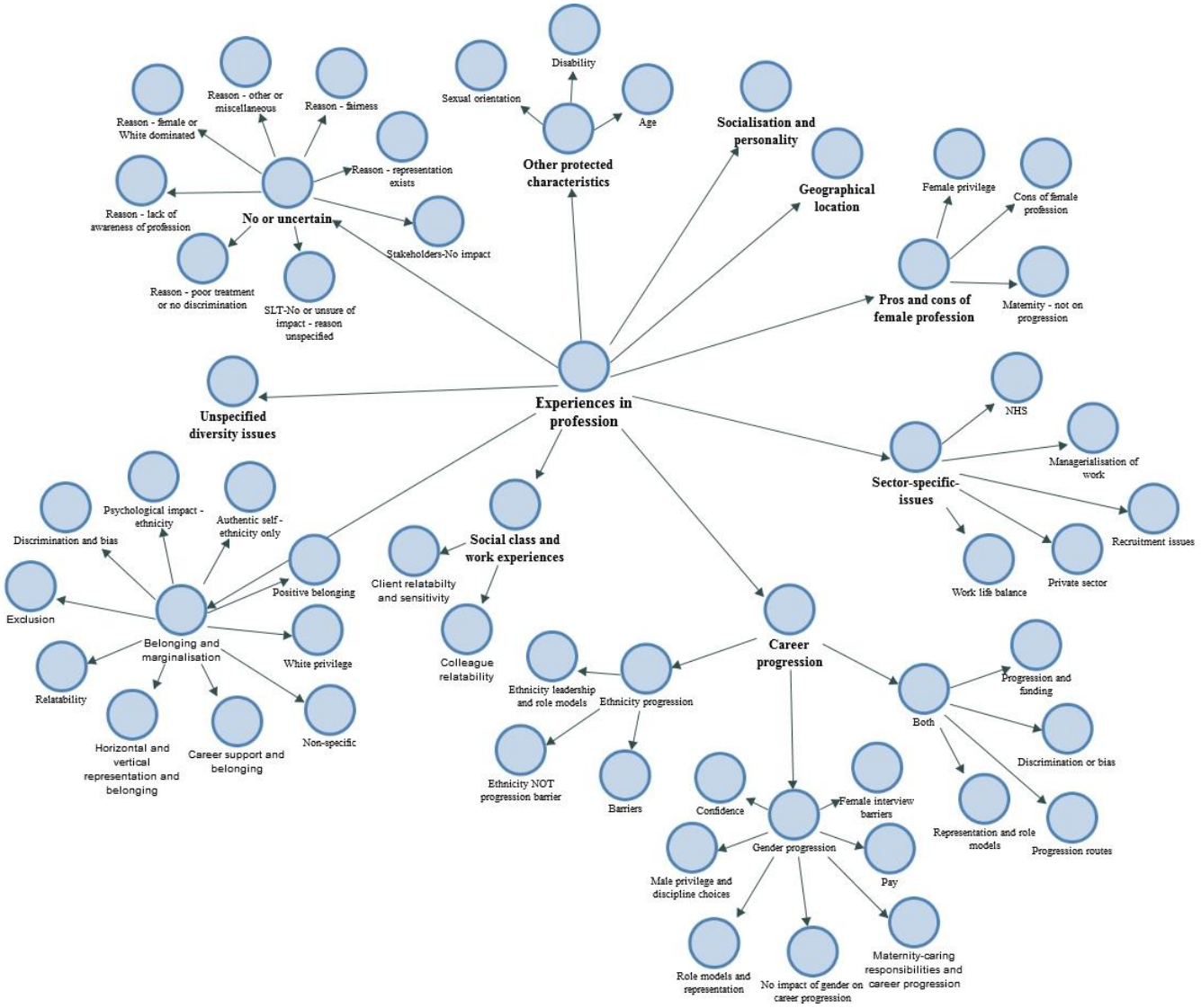


Figure 9. Experiences of therapists in the Speech and Language Therapy profession.

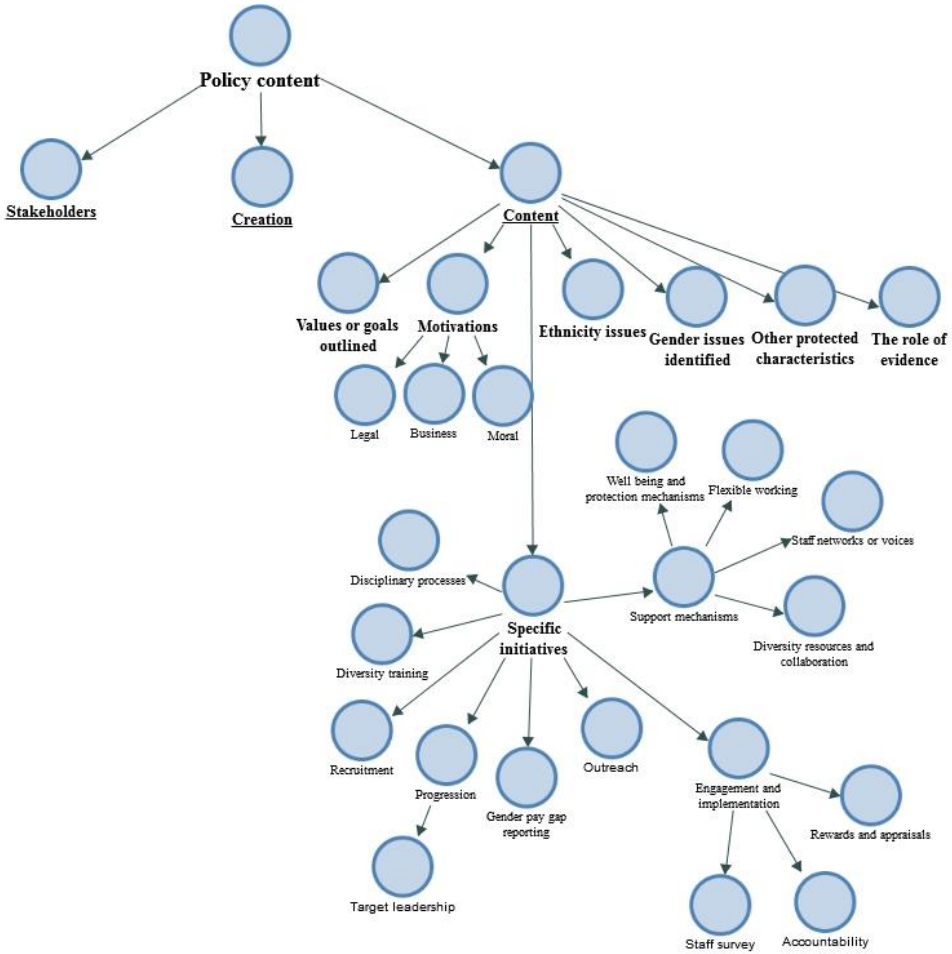


Figure 10. NVivo coding map of themes from organisational diversity documents.

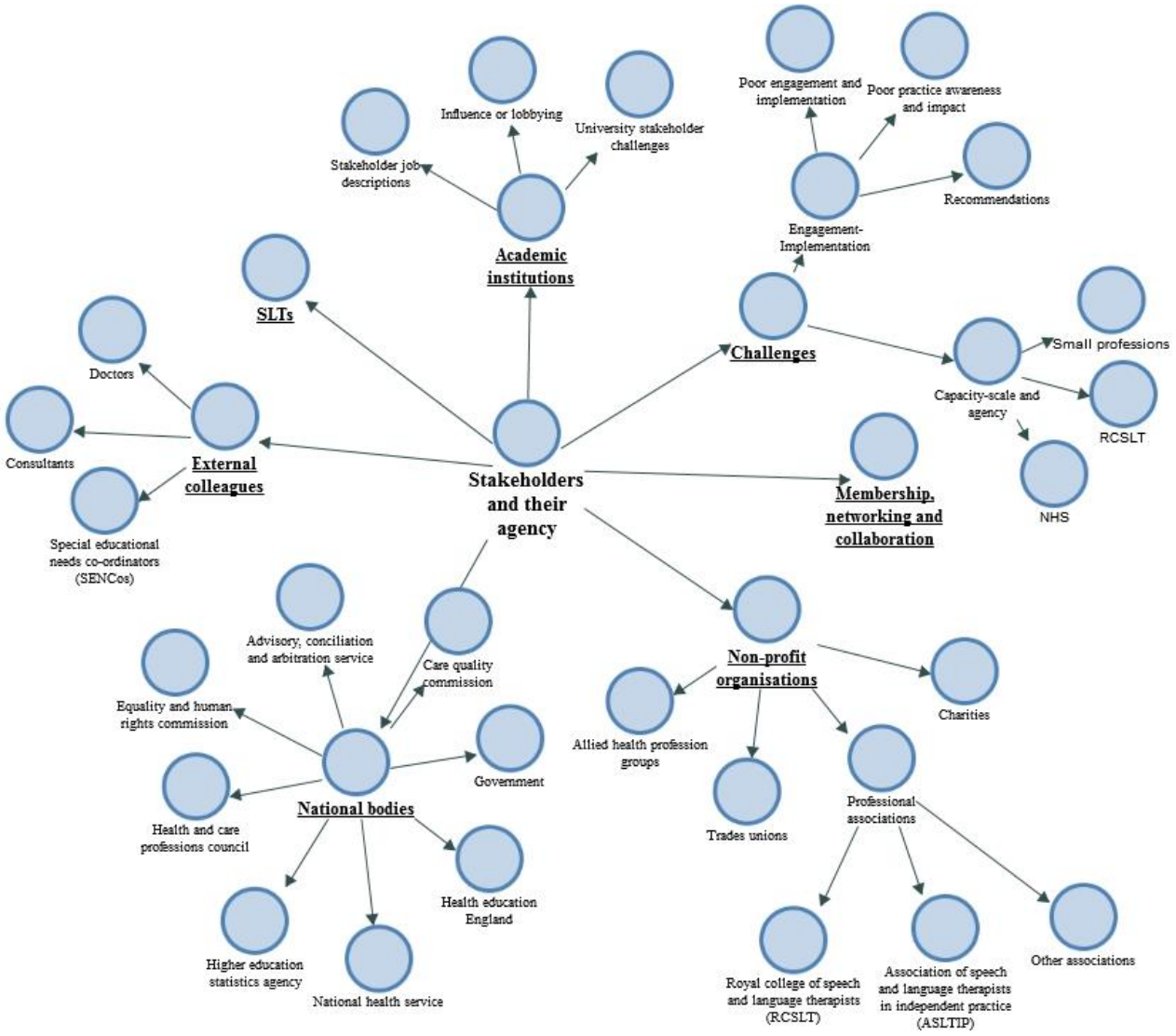


Figure 11. NVivo coding map of stakeholders identified in interviews and their agency.