NHS
RACE & HEALTH
OBSERVATORY

STRATEGY | 2025 - 2027

Contents

About Us

The NHS Race and Health Observatory was established in 2021 to identify and proactively tackle ethnic health inequity in English healthcare services, and to work alongside the NHS and the government to embed race equity across the healthcare landscape – from research and policy development to the design and delivery of care on the front lines. We are an independent investigator of race inequity, a repository of evidence and good practice, and a critical friend to leaders, policymakers, and clinicians.

We actively engage with a growing coalition of willing actors who are united in their goal to fight racism in health. By mobilising robust evidence, influencing policy makers, and working with providers to implement tangible approaches to anti-racism in our healthcare institutions, we're moving the system, as a whole, towards race equity. Crucially, we work at the intersection between race and other characteristics, exploring and attending to the complex ways in which our health can be impacted by layers of marginalisation. This includes considerations of women's health, disability, and the impacts of race inequity on children and young people.

We're also a champion of underserved communities - we work alongside grassroots organisations, patients, ethnic minority members of the NHS workforce, and local communities to help shape national policy and practice. We advocate for co-production and community participation in the delivery of healthcare, and work to empower communities to build capacity locally and advocate for their own needs.

In all of our work, we're guided by our organisational values:

OBJECTIVITY
We are independent and objective; our recommendations and actions are guided by high quality research, evidence, and insights from our stakeholders.

IMPACT
We will ensure that our work has tangible and sustained impact on reducing racial and ethnic inequalities in health and healthcare.

COLLABORATION
We will collaborate nationally and internationally to ensure the rigour of our insight and recommendations and will always adopt co-production and community participation in our work.

INTEGRITY
We will not shy away from difficult conversations, and we remain open to challenge and debate. Our processes and decision making will be transparent.

We are an independent investigator of **race inequity**, **a repository of evidence** and **good practice**, and a critical friend to leaders, policymakers, and clinicians.

The context: a shifting landscape

At the time of this strategy's development, the NHS is experiencing a time of unprecedented challenge. Waiting lists remain unacceptably long, the COVID-19 pandemic is still being felt by staff and patients, and the healthcare service is carrying more than 100,000 of vacancies. Our work has shown, time and time again, that these burdens are often felt most acutely by Black, Asian, and ethnic minority communities, who have demonstrably worse health outcomes than the White majority population, from birth to death.

After years of insufficient action on race equity, the government has stated its clear ambition to tackle race inequity, including in health. The government has committed to an Equality (Race and Disability) Act which includes provisions to enshrine equal pay in law and mandate the reporting of ethnicity pay gaps. The government's ambitions mirror the Observatory's own calls for Mental Health Act reform, better quality ethnicity data, and a commitment to close the gap in maternal mortality; and they've set out plans to impose on Integrated Care Boards a duty to develop race equality action plans, and to improve 'cross-cultural' content in clinical training.

These aims will be delivered, in part, though **three shifts** in the way care is delivered- from hospital to community, from analogue to digital, and from treatment to prevention. Their aim is to create a more efficient, agile, and technologically enabled NHS that will deliver care closer to people and further upstream. It is the role of the Observatory to ensure that these shifts benefit ethnic minority patients and communities equitably.

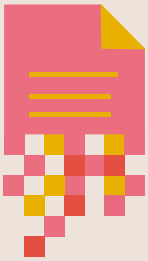
> "These burdens are often felt most acutely by Black, Asian, and ethnic minority communities, who have demonstrably worse health outcomes than the White majority population..."

We will work proactively with the government to achieve this. We'll support the **shift to community care** through a focus on co-production of services, and proper support to the workforce to deliver effective care. We'll support the **shift towards digital** by ensuring that technology and innovation aren't leaving behind ethnic minority communities. And we'll support the **shift towards prevention** by tackling the structural and institutional racism that lies behind so much of the inequity experienced by marginalised communities.

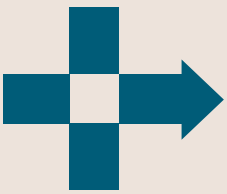
We know that our healthcare system can work in a way that eliminates race inequity, and this strategy will support the system to get there.

These aims will be delivered, in part, though **three shifts:**

SHIFT TOWARDS
COMMUNITY CARE



SHIFT TOWARDS
DIGITAL



SHIFT TOWARDS
PREVENTION

Our model

We've spent the past three years developing an organisation and model with the skill mix, governance, and networks to best achieve our aims of embedding anti-racism in the NHS and reducing racial and ethnic health inequity.

The Observatory has three main aims:

EVIDENCE

Synthesise, signal-boost, and validate existing evidence, making it more accessible to a broader audience. We fulfil a bridging role by making evidence relevant to changemakers and decision-makers. We also fill evidence gaps by strategically commissioning original research.

INFLUENCE

We use evidence and intelligence to support and influence policymakers and decision-makers through thought leadership, strategic engagement with leaders, and the championing of new approaches to community participation, working internationally to develop and spread good practice.

IMPLEMENT

We implement - and support the implementation of - anti-racism practice by demonstrating what effective interventions look like and how they can be replicated, working in partnership with providers, patients, and the public.

Across all of the above ambitions, we are supported by a strong strategic communications function, using traditional and social media channels to build awareness of our work and of racial health inequity more generally; to empower racialised communities; to find and cultivate new audiences for our work; and to build a coalition of actors to help drive race equity in health.

Racism & Anti-Racism

At the NHS Race and Health Observatory, and in the context of healthcare, we understand racism to be the process by which members of a racial or ethnic group have unequal access to services and resources, differential experiences within the healthcare system, and diverging health outcomes when compared with the White majority group. As such, racism harms individuals and undermines the full potential of the whole of society.

In this model, racism can take the form of **interpersonal racism**, where a person experiences direct discrimination, bullying, harassment, or sitgmatisation based on their race or ethnicity. It may take the form of **structural racism**, where a person's access to vital resources, and their experiences with housing, education, employment, and the justice system are impacted by their race and ethnicity, often because discriminatory practices are deeply embedded in legislation, or historical policies of colonisation and segregation continuing to have damaging legacies.

It can also take the form of **institutional racism**, where these above forms of racism combine and are enshrined in policies and practice, limiting an individuals ability to access fair treatment, to get ahead in their careers, or to access the vital services they're entitled to. Finally, we must not ignore the impacts of **internalised racism**, where minoritised individuals start to believe the negative stereotypes about their abilities and self-worth.

While factors such as deprivation and geography are vitally important to understanding health inequity in the NHS, we recognise the ways in which racism causes many of these inequities in the first place, and how any solutions to health inequity must address the existence and impacts of racism. Similarly, we take an intersectional view of racism – especially where race interacts with characteristics such as migration status, sex, gender, disability, sexual orientation, religion or belief, and age – and will always approach these areas through a lens of racism and race equity.

INTERPERSONAL RACISM:
Where a person experiences direct discrimination, bullying, harassment, or sitgmatisation based on their race or ethnicity.

STRUCTURAL RACISM:
Where a person's access to vital resources, and their experiences with housing, education, employment, and the justice system are impacted by their race and ethnicity.

INSTITUTIONAL RACISM:
Where these above forms of racism combine and are enshrined in policies and practice, limiting an individual.

INTERNALISED RACISM:
Where minoritised individuals start to believe the negative stereotypes about their abilities and self-worth.

ANTI-RACISM PRINCIPLES

Over the past three years, we've sought to demonstrate that anti-racism must entail more than pledges and vague ambition. In healthcare, anti-racism is a vital practice, a set of actions and approaches which, if taken forward, can have a major impact on the lives of minority communities. In advancing our work, we've developed a set of anti-racism principles copied below that any organisation should be embedding in their ways of working if they're serious about tackling racism:

1. Demonstrate leadership by naming racism, engaging seriously and continuously with the ways in which racism impacts the lives of the patients and service users who are your focus. If leaders can't use the word, they won't solve the problem.

2. Acknowledge that structural, institutional and interpersonal racism all impact on health and be **clear about where accountability** lies for improvement and progress.

3. Involve racially minoritised individuals in every part of your work, whether designing and delivering health interventions for patients, or making decisions that impact staff. This includes ensuring that teams themselves are racially diverse.

4. Collect and publish data on race inequity in its entirety. Where data is not available, change policies to ensure that data is collected.

5. Identify racial bias in policies, decision making processes, and other areas within your organisation.

6. Apply a race-critical lens to the adoption of any interventions or improvements to be tested, and to the design and delivery of services. Did underlying research involve community participation? Who were the researchers?

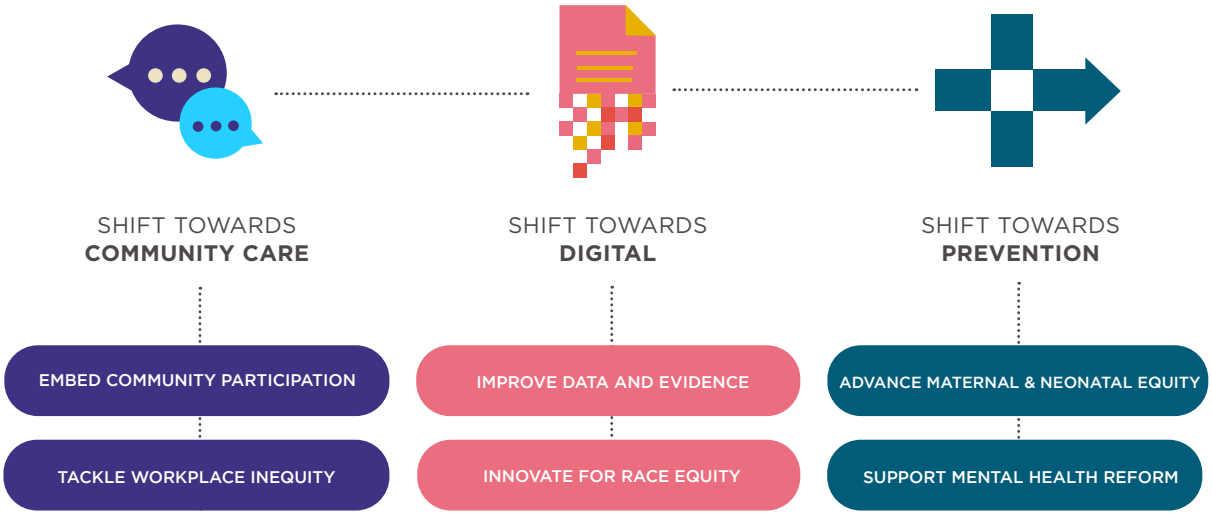
7. Evaluate based on measures that recognise the role of racism as determinant of health.

Our ambitions for the next three years

Over the past three years, we've not just been acting, but also listening. We engage with community intelligence through our Stakeholder Engagement Group, with subject matter experts through our Maternity and Neonatal and Mental Health advisory groups, and with academics, internationally and domestically, through our Academic Reference Group and International Experts Group.

We've also worked with the Race Equality Foundation to undertake an extended engagement exercise with stakeholders including members of the health and care workforce, patient voice organisations, and the voluntary sector. This exercise culminated in a large face to face event in November 2024, where we released our ambitions in draft form and worked with attendees to refine them.

All of the people we've engaged – hundreds overall – have helped to steer us towards a set of ambitions which, over the next few years, will be the focus of our collective efforts. These are the result of years of work and we believe delivering them would make the greatest possible impact in tackling racial and ethnic inequity.



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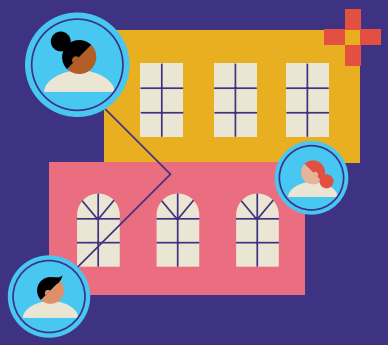


1. Embed community participation in the design and delivery of healthcare services by building and maintaining trust.

Paving the way for an NHS that is responsive to the genuine needs of diverse communities.

In every piece of work we've commissioned to date, we've involved communities from the point of inception to completion, guided by a set of co-produced community participation principles. In this strategic period, as well as enhancing our own ability to engage with communities, we will also work with NHS leaders to enhance community engagement across the system, demonstrating the value of true participation in improving health outcomes. We will also work with grassroots organisations to increase the capacity and resilience of vulnerable community-led organisations and create a platform to spread and scale their successes.

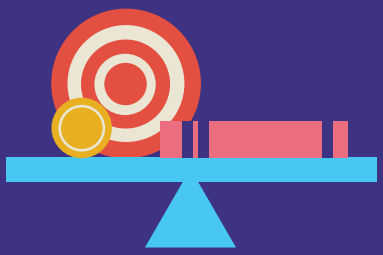
Our work has also shown, countless times, that a lack of trust is a structural determinant of health inequity in this country. We want to build on this learning to enhance these relationships, and to help create a healthcare service that is built on a foundation not just of trust, but of cultural safety, a Māori practice through which we must acknowledge how quality of care and clinical effectiveness are affected by power imbalances between patients and clinicians, and between policymakers and communities.[1]

ACTIONS TO SUPPORT THIS AMBITION

- We'll work in partnership with grassroots organisations to co-produce a set of resources aimed at embedding effective co-production with Black, Asian and minority ethnic communities across the NHS.
- We'll establish an online resource centre to host and highlight evaluated good practice to be picked up and replicated by providers.
- We'll establish new infrastructure to engage directly with underserved communities.
- We'll initiate a programme of work exploring how trust can be built between primary care providers and communities.

[1] Curtis, Elana, et al. "Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition." International journal for equity in health 18 (2019): 1-17 https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3

2. Empower Black, Asian, and minority ethnic members of the healthcare workforce by tackling disparities.



ACTIONS TO SUPPORT THIS AMBITION

- Conduct a thorough independent review of the ethnicity pay and progression gap in the NHS, highlighting not just disparity in pay grades, but also in lifetime earnings, pension accrual, and extra-clinical income such as clinical awards.
- Work with the NHS to establish targets for reducing the ethnicity gap in workplace bullying and harassment, and to reduce the overall levels across the NHS.
- Scope existing approaches to decolonising clinical curricula, identifying examples of effective practice, and working with educational institutions to replicate beneficial changes.
- Work with the Faculty for Public Health to generate anti-racism educational materials that contribute to continuing professional development.

Ensuring equitable experience for more than a quarter of the workforce and improving the quality of education.

With more than 25% of the NHS workforce coming from Black, Asian, and ethnic minority backgrounds, it's essential that the system comes together to tackle racism and improve the experiences for our staff – not least because we know of the evidence-based link between fully engaged, supported staff, and better outcomes for all patients. To do this, we'll need to work to ensure equity in pay and progression, and to reduce experiences of bullying and harassment. Furthermore, changing the structures of our healthcare system will not have any effect if clinical and non-clinical staff are not sufficiently equipped to push forward practices that have their foundations in anti-racism. This will mean embedding cultural safety – the ability to meet the needs of diverse patients – into clinical education. We will also need to remove often historical biases from clinical curricula, including the tendency for skin conditions to be described as they appear on white skin - to ensure that future generations of clinicians have a deep appreciation of race equity.

ACTIONS TO SUPPORT THIS AMBITION

- We'll support the NHS to produce and disseminate new guidance on the collection and use of patient ethnicity information in England, thereby increasing the overall quality and representativeness of data, and the accuracy of insights.
- We'll work with the funding sector and the government to mandate and promote ethnic and racial representation in clinical trials and other healthcare research.
- We'll work alongside the Genomic Medicine Service and others to ensure that genomic databases and biobanks are sufficiently representative of the population so that advances in precision medicine serve all.
- We'll work with the National Institute of Healthcare Research to support the funding sector to make health and care research more inclusive of ethnic minority groups so that data can be disaggregated by ethnicity. This includes setting clear rules on accounting for ethnicity and making it a requirement for funding.

3. Advocate for better quality ethnicity data across healthcare and greater representation in research and evidence.

Ensuring that decisions about healthcare are based on truly accurate and equitable evidence.

Good quality evidence ought to be the bedrock of service design and delivery, but we know that too often the evidence we have is skewed by low quality and unrepresentative samples. If healthcare services and national leaders are making decisions about healthcare based on incomplete and unrepresentative evidence, health interventions will inevitably leave some of our most marginalised communities under-supported and poorly cared for. Improving the quality of evidence is a systemic change that would benefit ethnic minority communities for generations to come.

The collection and quality of ethnicity data needs to be consistent between different health services and electronic patient record systems and, crucially, these datasets need to be linked together to avoid multiple points of collection and contradictions. These changes can help to rectify age-old patterns of inequity. Clinicians and professionals must understand why and how they should be collecting this information, and patients should be told why it's being collected and what it will be used for.

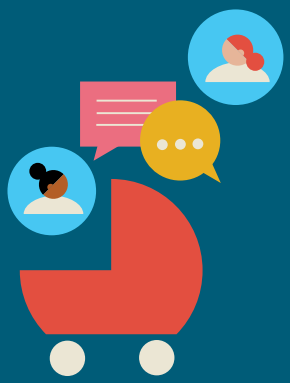
4. Promote the effective spread of technology and innovation to reduce inequity and eliminate bias.

ACTIONS TO SUPPORT THIS AMBITION

- We'll promote and pilot the use of digitised personal care plans for Sickle Cell patients and beyond, ensuring that user-focused digital design is at the heart of health tech development.
- We'll conduct an in-depth study of the Genomic Medicine Service, working with GMSAs to understand and reduce biases from the service.
- We'll identify innovative practice in race equity taking place at a community level and boost the profile of effective interventions, working with the NHS to explore new approaches to scale and spread, and promoting best practice through our online resource centre.

Ensuring that advances in areas such as sickle cell and genomics are mobilised to serve ethnic minority people across their lifespan.

With the increasing availability of genomic medicine and AI-assisted diagnostics, the NHS is likely to transform over the coming decades. If key strategic actions are not taken now, the promise of this innovation and practice will only be realised for some parts of our society. In some cases, "innovations" that have been in use in the NHS for decades are still not being deployed equitably. If genomic medicine is to work for ethnic minority groups, we must ensure that screening and treatments are not just based on the sequencing of White European genomes. If we want technology to modernise the way patients interact with the NHS, we must ensure that nobody is left behind. More than this, we need to expand the way we think about innovation, looking not just to tech entrepreneurs, but listening to communities and identifying true grassroots innovation.



ACTIONS TO SUPPORT THIS AMBITION

- We will scale up anti-racism practice through our Learning and Action Network programme, working with integrated care systems, and holding the government to account with its commitment to close the maternal mortality gap.
- We'll promote the use of testing and assessment of neonates that takes account of their skin colour, pushing for more robust jaundice testing in the community, and creating a national database of open access images of minority ethnic neonates to aid in more inclusive assessment and diagnosis.
- We'll work in partnership with the NHS to launch a communications campaign to raise awareness of childhood mortality, and to embed cultural intelligence in the delivery of care to Black, Asian, and minority ethnic communities.

5. Addressing structural disparities in maternal and neonatal mortality for Black, Asian, and minority ethnic women and babies.

Preventing avoidable deaths by tackling racism at all levels of maternal and neonatal care.

The fact that Black and Asian women are more likely to die during or after childbirth than White women is a shocking illustration of the human cost of race inequity. In a modern and progressive society, it is unacceptable that a person's race could have such a profound impact on whether they live or die. And yet these trends are visible across maternal and neonatal health. Our landmark programme of work – the Learning and Action Network – seeks to identify and amplify anti-racist practice in this space in partnership with integrated care systems across the country. By scaling this practice, bolstering our understanding through research, and working with policymakers to embed these changes, we want to see a meaningful reduction in the mortality gap.

6. Support equitable reform to mental health legislation, practice, and culture.

Ensuring that mental health services are serving ethnic minority communities, and that people are entering the system before they are in crisis.

The 2018 review of the Mental Health Act found that deeply entrenched racism led to inequitable outcomes for ethnic minority communities. Even then it was clear that the Mental Health Act, designed to protect the rights of individuals, was failing to serve all groups equally, with Black people especially more likely to be sectioned under the Act, and subject to community treatment orders. The application of this legislation, however, is only part of the picture, and our research has shown race inequity across access, experience, and outcomes across the mental health service for a number of different marginalised communities. With the government committed to reforming the Mental Health Act, the Observatory has an important role in ensuring that this legal process does not lose sight of anti-racism principles, and that broader cross-government reform is enacted to address the structural causes of mental health inequity.

ACTIONS TO SUPPORT THIS AMBITION

- We will work with the government to properly embed anti-racism measures into the new Mental Health Act and the supporting Code of Practice, with a focus on Advance Choice Documents and effective implementation of the Patient and Carers Race Equality Framework.
- We'll produce original research and briefings on trauma-informed care, race equity in dementia screening, and perinatal mental health to ensure that the mental health service works for everyone.
- We will work with the NHS to produce public-facing communications campaigns to draw attention to, and destigmatise conversations about, mental health among minority communities.

Evolving how we work

Over the past three years, we've been listening and learning, making refinements to our approach in order to ensure we're having the greatest possible impact. This section explores those refinements in more detail.

In research, we will do more work on synthesis and bridging. We will work with large research funders to identify opportunities for research, using our influence to leverage greater investment in race equity work nationally. Our work will also involve looking at the research sector itself, seeking to increase representation not only in terms of research participation, but also looking at the diversity of researchers themselves and building more diverse capacity in the research sector by promoting and supporting early-career researchers from Black, Asian, and other ethnic minority backgrounds.

In policy, we will do more responsive policy briefings that draw attention to key policy developments in race and health; we'll produce thought leadership publications advancing the discourse in this area; and lead more targeted engagement focused on achieving the tangible achievements in this document. We will also focus on the process of policymaking, as opposed to just advocating for specific policy changes, meaning we will work with policymakers to demonstrate where different approaches to policymaking achieve more impactful results. At the heart of this will be an exploration of progressive community participation models and the ways in which they can be better embedded in policymaking and delivery structures.

In implementation, we will be facilitating and capturing practical changes in the system (and across systems), with a focus on identifying and scaling existing practice; incubating and supporting promising experimental interventions; and partnering with providers, ICBs, and others to evaluate work and disseminate learning, providing a blueprint for others to follow. Practically, this will lead to the generation of good practice case studies and the development of communities of practice.

Pathway to Impact

AIM	OUTPUT	OUTCOME
• Enable effective community involvement • Increase trust in primary care • Enhance experience and progression of ethnic minority workforce	**RESEARCH & EVIDENCE** • Evidence on trust in primary care • Practice-based evidence for decolonising curricula • Independent review into ethnicity pay and progression gap • Comprehensive representation in biobanks and databases • Trauma-informed care • Race-equity in dementia screening • Perinatal mental health access	• Mandate for greater NHS accountability to racialised communities • Enhanced racialised community involvement and agency in the NHS • Greater cultural safety • Decolonised clinical curricula • Embedded anti-racism practice
• Increase inclusivity of evidence-based healthcare • Facilitate equitable innovation	**ADVOCACY & CAMPAIGNS** • Promoting decolonisation of education • Diversity in research: design, funding, practitioners, and practice • Health promotion in maternal and neonatal and mental health	• Ethnically representative health service data, databases, biobanks and research • Equity in digital services
• Decrease mental and maternal health risk factors • Enable early detection and prompt, appropriate intervention for mental, maternal and neonatal health	**RESOURCES** • Co-production toolkit • Good practice repository • Jewish communications toolkit • Targets for ethnicity gap in bullying and harassment • Educational materials for anti-racism • Ethnicity data collection guidance • Digital care pathway for Sickle Cell • Anti-racism Quality Improvement change package • Open access national image database	• Equitable improvement practice • Improved secondary and tertiary prevention for minoritised communities • Raised awareness of ethnic health inequalities • Equitable care

SHIFT TOWARDS **COMMUNITY CARE**

SHIFT TOWARDS **DIGITAL**

SHIFT TOWARDS **PREVENTION**

PARTNERSHIP WORKING

The Observatory, though impactful, is just one organisation in a large and complex system. Tackling racism – a centuries old and deeply entrenched force – will take a huge number of actors from across the system working together to fearlessly challenge and fight racism in all its forms. We work in close partnership with the NHS and with the Department of Health and Social Care, and beyond that we are continuing to build an influential network of other organisations.

In our first three years, we signed landmark partnership agreements and memoranda of understanding with the National Institute for Healthcare Research, the Faculty of Public Health, and the Alzheimer's Society. We have international agreements with the US Centers of Disease Control and health departments in Australia and Brazil. We've worked closely with the CQC (Care Quality Commission), the MHRA - Medical and Healthcare Products Regulatory Authority, the NMC - Nursing and Midwifery Council and others. We have close ties to community-led initiatives and race equity specialists such as the Race Equality Foundation; the Caribbean and African Health Network; Friends Families and Travellers and more.

Only by forming and maintaining these strong partnerships have we been able to have the impact we have in such a short time – we'll continue this work, building both meaningful relationships with our partner organisations, and continuing to build a progressive consensus on race equity in health, as well as growing our network to ensure we're working with the right people to deliver on our strategic aims.

OUR GOVERNANCE STRUCTURES

At the Observatory, we've brought together a team of experts in research, policy, implementation, communications, community engagement, and business management to drive forward our work on race equity. As well as being supported by an influential board, we also work through a dispersed network of experts across several advisory groups:

- Academic Reference Group
- Stakeholder Engagement Group
- Maternal and Neonatal Health Advisory Group
- Mental Health Advisory Group
- International Experts Group

This network of passionate experts is the reason we've been able to have such

considerable reach in such a short space of time. As well as steering us towards areas of potential impact, we also rely on these groups to check and challenge the work we do, ensuring that every project or initiative we launch is based on the best possible academic and community intelligence; is informed by up-to-date clinical insights; and represents the best interests of diverse racialised communities in England and beyond. As we move forward, we'll ensure we have the right groups of advisors to reflect our work and strategic ambitions.

LOOKING TO THE FUTURE

By 2027, the Observatory will have grown in influence and impact well beyond roots established in 2021. We will continue to implement the important lessons learned from the pandemic years - placing patients, communities and the NHS workforce at the heart of our work to tackle inequalities in health and healthcare.

We will continue to be driven by data and insight, focussing on the root causes of deep-seated and long-standing inequities as well as being agile and reactive to issues of the day. It is important that we continue to focus on race and its intersectionality with other characteristics and determinants of health.

While remaining a strategic partner and important resource to the NHS, it's also vital that the Observatory is sustainable in the long term – race equity will not happen overnight, and the Observatory needs to persist in its role as a steward for the system.

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