NHS RACE & HEALTH OBSERVATORY

Improving race equality in your organisation

An evidence based guide for NHS leaders

List of Experts

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Introduction

The NHS Race & Health Observatory works to identify and tackle ethnic inequities in health and care by facilitating research, making policy recommendations, and enabling long-term transformational change. This document is written primarily for NHS leadership, recognising the crucial role that senior decision-makers play in shaping policy. Practice, and organisational culture across the health and care system.

Ethnic health inequities persist across the globe. There are significant commonalities across nations that offer opportunities to reduce disparities, whether in white-majority societies where communities who experience racism – including Black and minority ethnic people, and members of Indigenous communities – face poorer health outcomes, or in societies where non-white populations are numerically in the majority but remain disadvantaged compared with national averages. The Observatory's International Experts Group[1] brings together leading voices on race, ethnicity, and health from Australasia, Africa, North and South America and Europe, to explore solutions to these shared challenges.

In July 2022, the Observatory hosted its inaugural international conference on Race, Racism, and Health[2], which was hosted by the Chairs of its International Race and Health Experts Group, Professor David Williams, Harvard University, and Yvonne Coghill, CBE. The event brought together some of the world's most influential figures on race and health inequities from the UK, USA, Canada, New Zealand, Australia, South Africa, and Guatemala.

The conference focused on global health challenges, effective interventions, and ways to improve health and adapt best clinical practice. Academic researchers, clinicians, and contributors presenting lived-experience case studies examined the impact of entrenched racism on health outcomes and highlighted promising approaches to reducing racial and ethnic health inequities from their respective countries[3-5]. Key areas of focus included: maternal and neonatal health, mental health, COVID-19, sickle cell disease, digital healthcare, genomics and precision medicine, and race equality in the healthcare workforce.

Then in 2024 The RHO International Experts Group met in Windsor to design a practical, action oriented leadership toolkit to address racial health inequalities in the NHS. Led by Yvonne Coghill and Professor David Williams, the group focused on implementation rather than research, drawing on global best practice.

The discussions covered the following topics: Access, Quality of Care, Accountability, Identity and Leadership Models.

The key conclusion from the three day meeting was that transforming racial health equity in the NHS requires:

- Courageous, accountable leadership
- Longterm, system-level strategy and regulatory alignment
- Structural — not individualised — solutions
- True partnership with communities
- A toolkit that is practical, evidence based, emotionally resonant, and explicitly anti-racist

The away days were attended by: Professor Ricci Harris, Professor Raymond Lovett, Professor Sarah Jane Paine, Professor David Williams, Yvonne Coghill CBE, Professor Priscilla Reddy, Professor Anthony Mbewu, Professor Stephani Hatch, Doctor Janet Smylie, Zarah Mowhabuth, Rose Obianwu, and Professor Habib Naqvi.

Message from the Chairs

Change is often challenging, and with all the good intention in the world, it's not always easy or straightforward to address. The global challenge on race equality involves addressing deeply rooted systemic racism, discrimination, and economic disparities that affect Black, Asian, and ethnic minority communities across all regions. While frameworks and models for improvement and change exist, racism remains pervasive, affecting all parts of the social fabric of society, including healthcare. Globally, efforts to promote equality, diversity and inclusion face critical challenges, including a rising backlash, accusations of "tokenism", and in some parts of the world, the total suspension of well-meaning initiatives. Several global organisations, including Amazon[7], Walmart[8], and Facebook[9], have abandoned their EDI programmes, arguing – without evidence – that such initiatives create more race-related challenges than they resolve.

Here in the UK, we have not adopted that stance. The evidence is clear: the change we are working towards, on equity and inclusion, has robust legal, moral, financial and quality cases that underpin it. The National Health Service (NHS) was established in 1948 on the basic principle of equality and built on the efforts of a diverse workforce. This principle is one of the key foundations of the NHS Constitution – ensuring the NHS promotes fairness, social justice and equity in all that it does.

The NHS Race and Health Observatory's International Experts Group, co-chaired by Professor David Williams (Harvard University's Department of Public Health) and Yvonne Coghill (former Director of the NHS Workforce Race Equality Standard), brings together expertise on race, ethnicity, and health from Australasia, South America, North America, Africa and Europe. The Group exists to exchange knowledge and identify responses to shared global challenges related to racism and ethnic inequities in health and healthcare.

The scientific evidence clearly indicates that race inequality is a global challenge. Research shows that across multiple societies, people with darker skin have fewer opportunities and are more likely to face barriers in reaching their potential in education and at work. They are more likely to find that it is more difficult to acquire quality housing and equitable healthcare. These inequities result in poorer overall life chances for people from minoritised ethnic backgrounds.

The NHS in England is one of the largest organisations in the world, employing over 1.4 million people, with more than 25% from minoritised ethnic groups[16]. Yet staff from these groups continue to report poorer experiences of working in the NHS than their White counterparts[17]. This document aims to help organisations understand what they must do to become more equitable. Equity in the NHS is essential: evidence shows that an equitable workforce delivers higher quality patient care, improves patient safety, increases productivity and efficiency, and ultimately saves lives.

In 2015, along with other global academics, we published an article in the British Medical Journal: **Promoting Equality for Ethnic Minority NHS staff—What Works?**, which highlighted evidence-based strategies to improve race equality within organisations. This document builds on that work by providing replicable good practice from across the globe, giving leaders clear, practical, evidence-based guidance on fostering fairness and equity within organisations.

We have gathered examples of initiatives that have been successful in different parts of the world. While every organisation has its own context, and what works in one setting may not transfer directly to another, these examples provide valuable insights. The document is designed to be user-friendly and easy to navigate, enabling colleagues to dip in and out, explore practical guidance, and take meaningful action. We encourage you to study this document, and its accompanying resources, with an open mind and an honest heart, and to apply the learning to your own organisation and context – doing so will help us create an NHS that truly is fit for everyone.

YVONNE COGHILL CBE

PROFESSOR DAVID WILLIAMS

Why we need this document

We know that no single solution from one country will necessarily be relevant to another country. Social, political, historical, and cultural contexts matter, and recognising these differences is essential. At the same time, there are common strategies, and lessons that can support progress across national boundaries. Our goal is to understand what works, share these insights, and help translate experience into meaningful action, because the status quo will no longer suffice.

We cannot ignore the profound human cost of racism and structural injustice. We know that racial and ethnic inequities in health result in preventable deaths every day; inequities driven not by individual characteristics but by entrenched systems, policies, and practices that advantage whiteness and disadvantage those who experience racism.

Similarly, indigenous communities in countries shaped by colonisation continue to face inequities linked to the ongoing impacts of land dispossession, cultural disruption, and systemic exclusion[4]. These inequities restrict opportunities and undermine health and wellbeing, not because illness defines these communities, but because structural conditions continue to limit what should be attainable for all.

There are clear learnings here for the NHS in England, and there is much work to be done. We are committed to sharing learnings with leaders within the NHS and across other healthcare systems internationally, ensuring that evidence and experience inform action.

This is a pivotal moment as we examine and highlight the global impact of race, racism, and the legacies of colonisation on health outcomes. It is essential that this work is prioritised in the NHS and beyond, and that together we identify, and put into practice, replicable, evidence-based approaches that can help address persistent racial and ethnic inequities affecting our diverse communities.

As part of the NHS's ongoing commitment to equity, this document provides healthcare leaders with a clear, practical resource to help them understand and address the challenges associated with racial and ethnic inequities. The aim is to offer an accessible, engaging read that inspires action, grounded in real examples of approaches that have improved patient care and contributed to strengthened working environments for staff.

Our intention is to highlight what works, showcasing evidence-based initiatives and policy changes that have made a positive difference for populations experiencing disadvantage and marginalisation. We aim to support efforts to narrow racism and ethnic health inequities, including the measurable disparities that arise from them, and to outline what has not worked, sharing lessons from initiatives that have failed to produce meaningful or sustained change.

Racial and ethnic inequities are complex, deeply rooted issues shaped by historical and contemporary systems including racism and the legacies of colonisation, that require persistence, courage, and sustained leadership to address. The purpose of this report is not to offer definitive solutions to every challenge that NHS leaders may encounter, but to build on existing efforts and strengthen the foundations for leadership practices that move organisations forward. We emphasise the importance of long-term commitment: the development of sustainable plans, thoughtful implementation processes, and robust evaluation to monitor progress and maintain improvement.

Above all, this document seeks to encourage leaders to act with clarity, conviction, and accountability, helping to shape a fairer and more inclusive NHS for patients and staff alike.

Please note that this document is supplemented by a shorter more UK and NHS focused version, an infographic and animation.

NHS Context

Even though this leadership toolkit was written using some examples that are international, the principles and guideline are still very applicable to the NHS. Leaders should read this guide and consider ways how they can apply this guide in the NHS to address current challenges in line with contemporary initiatives and strategies.

The UK Government's 10-Year Health Plan for England sets out a major reform programme intended to address the NHS's longstanding operational, workforce, productivity, and access challenges. The plan recognises that as the needs of people are changing and demand is increasing there is an urgent need for a fundamental redesign of care delivery.

The plan is underpinned by three transformational shifts:

- From Hospital to Community
- From Analogue to Digital
- From Sickness to Prevention

When implementing the 10-year health plan and other current strategies and initiatives, leaders should do this through an equalities lens with additional focus on race ethnic inequalities.

Taking the move from analogies to digital as an example. The RHO's work has highlighted that in the digital and innovation space, race and ethnic health inequalities exist and require a unique focus. The research on **digital apps** and the rapid review on **pulse oximetry** showed how digital innovations can inadvertently affect people from an ethnic minority background.

Tackling inequalities is a key expectation from NHS leaders. One of the major recommendations from The Messenger Review (2022) was improving equality, diversity and inclusion (EDI). Also, The NHS Leadership Competency Framework for Board Members (2024) sets out the core expectations for leaders across NHS provider and system boards. The framework supports board members to perform effectively by emphasising key competencies including promoting equality, diversity and inclusion, and reducing health and workforce inequalities.

The NHS is currently working on reducing the waiting lists that grew during the Covid-19 pandemic. Research by the RHO and Nuffield Trust found that the pandemic did not impact all ethnic groups equally when it comes to planned hospital care. People from Asian groups experienced a much larger fall in planned hospital care during the pandemic than people from White background, So when working to reduce waiting lists, leaders must be aware of this and account for it on their waiting lists initiatives.

All this is to highlight that tackling race and ethnic inequalities is core to the NHS and not a good to have for leaders at all levels.

A note on language

In this document, we avoid broad acronyms such as 'BAME' (Black, Asian, and Minority Ethnic), or 'BME', as well as the term 'stakeholder'. While these terms are used in some institutional contexts, they can obscure meaningful differences in identity and experience[19]. Such labels can flatten diversity, mask structural inequities, and reinforce a sense of othering by grouping together communities with distinct histories, cultures, and needs. Similarly, the term 'stakeholder' carries hierarchical and, for some, colonial connotations that position groups as external to decision-making rather than as equal partners[20].

Instead, we use specific, descriptive language to name the communities, groups, or populations we are referring to whenever possible.

This approach:

- Recognises diversity within and between groups rather than treating them as homogenous.
- Centres lived experience by focusing on the identities and contexts of the communities involved.
- Supports equity, inclusivity, anti-racist, and decolonial practice by avoiding terminology that can unintentionally marginalise or stereotype.

Where relevant, we refer to communities, partners, or populations by their specific identities, contexts, or experiences. This helps ensure that our work reflects and respects the voices of those we seek to engage and support.

Use of language in case studies

Throughout this document, we draw on published case studies. We mirror the terminology used by the original authors, even where this does not fully align with our preferred language or conceptual frameworks. We do this to avoid misrepresentations and to respect the integrity of the original work.

Understanding Key Concepts: Race, Ethnicity, and Inequity

To support clarity and consistency across this document, we use the following definitions.

Race	A socially constructed system of categorising people based on perceived physical characteristics (such as skin colour). Race has no biological basis, yet it produces real social, political, and economic effects due to racism.
Ethnicity	A category of identity based on shared cultural traits, such as language, ancestry, heritage, or traditions. Ethnicity is often self-defined and can be multiple and fluid.
Indigenous	Refers to peoples with ancestral, cultural, and territorial ties to lands that predate colonisation or settlement by other groups. The term should only be used where communities self-identify as Indigenous.
Identity	An individual's or group's sense of self, shaped by multiple factors (race, ethnicity, gender, culture, lived experience etc). Identity is dynamic and can shift across contexts.
Inequality	A measurable difference between groups (e.g., in education, income, health, or access to services. Inequality describes what is different, not why.
Inequity	Unfair, avoidable, and systemic differences that stem from injustice or structural disadvantage. Inequity focuses on the causes of unequal outcomes.
Disparity	A neutral term meaning 'difference', often used in statistical contexts. A disparity may or may be inequitable; additional analysis is needed to understand whether the difference results from unfair or avoidable conditions.
Racism	A system of power that operates at individual, institutional, and structural levels to produce and maintain racial inequity. Racism is rooted in whiteness as a normative and dominant cultural, political, and social framework that assigns unearned advantages to people racialised as white while disadvantaging and marginalizing those racialised as non-white. It involves beliefs, policies, practices, and cultural norms that shape how societies organise opportunity, distribute resources, and determine outcomes. Racism is not limited to interpersonal prejudice; it is a systemic structure that upholds and reproduces racial hierarchies.

Consistency in language use

The title of this document refers to race and racial equity, while some sections discuss ethnic inequalities. Race and ethnicity are related but distinct constructs, and the concepts of equity, inequity, equality, and inequality carry different analytical meanings, as listed above. To maintain clarity and coherence, we use these terms intentionally and transparently.

- Racial inequity and inequity refer to the differences or injustices associated with processes of racialisation.
- Ethic inequality and inequity refer to differences or injustices linked to cultural, linguistic, or ancestral identity.
- Where both racial and ethnic dimensions are relevant, we identify this explicitly rather than conflate the terms.

We also recognise that in some cases it is not possible to determine whether an observed difference is an inequality (a measurable difference) or an inequity (an unfair, avoidable difference driven by systemic factors). This may be due to limitations in available data, the way case studies are reported, or the complexity of intersecting identities and experiences. Where this uncertainty exists, we avoid making assumptions and describe the difference using the most accurate terminology available (e.g., disparity or difference).

This deliberate and reflective approach supports conceptual precision and ensures that our language remains respectful, transparent, and aligned with the evidence and context available.

Executive Summary

In 2015, Priest and colleagues from the UK, US, and Australia published 'Promoting equality for ethnic minority NHS staff—what works?'[18] Drawing on a broad evidence base, the article identified effective strategies for improving racial equity within organisations and made clear that NHS bodies must fully prioritise on racial and ethnic equity, committing time, energy, and resources to embed equity at every level. Doing so increases staff engagement, which improves patient care, safety, and satisfaction; a relationship first evidenced in the 2009 report NHS Staff Management and Health Service Quality[21].

Building on this foundation, Yvonne Coghill developed an evidence-informed model for addressing racial inequity within NHS organisations[22]. This document extends that work by presenting the evidence on what works to improve racial and ethnic equity not only for staff but also for patients, and by outlining how anti-racist principles can be embedded as a defining feature of high-performing healthcare organisations.

Racism, interpersonal, institutional, and structural, is a fundamental determinant of health, driving illness, premature death, and avoidable healthcare costs. Within the NHS, racial and ethnic inequities harm patients, erode staff wellbeing, and weaken quality and safety. Advancing equity is therefore central to delivering a safe, compassionate, and effective health system. It is not an optional activity or an add-on; it is core to organisational excellence.

What works: Highlights

- **Leadership and vision:** Sustained, visible leadership is the foundation for progress. Racial and ethnic equity must be named, resourced, measured, and integrated into performance management. Leaders must be self-aware, willing to confront racism, and able to demonstrate cultural humility, courage, and accountability.

- **Data to accountability:** Collect accurate and disaggregated ethnicity data, alongside meaningful measures of exposure to racism. Use these data to set clear equity goals, align incentives, and govern transparently so that evidence consistently leads to action.

- **Diversified workforce:** Inclusive recruitment, targeted development, fair progression pathways, and equitable workplace cultures improve representation and engagement. These actions support high-quality patient care and are linked to better system performance.

- **Cultural safety:** Move beyond one-off training toward system-wide approaches that combine provider skill development, organisational reform, and community-defined standards of safe and respectful care.

- **Social determinants:** Integrate social, legal, and community support into care pathways to address inequities in exposures that shape health, access and outcomes.

- **Community voice and authority:** Co-design and co-governance with affected communities increase legitimacy, relevance, and impact. Approaches that share decision-making power are essential for sustainable change.

- **Communication:** Transparent, consistent communication and visible feedback loops build trust, reinforce accountability, and maintain momentum.

Delivering racial and ethnic equity within the NHS requires more than policy statements; it demands a sustained, system-wide commitment to action and accountability. Equity must be embedded into governance, leadership, strategy, and everyday decision-making so that it becomes a core measure of quality and organisational effectiveness. This means aligning data, incentives, and accountability with meaningful improvements in both exposures and outcomes for staff and patients.

By fostering inclusive leadership, listening to and partnering with communities, and addressing structural barriers, NHS organisations can create workplaces that value all people equally and deliver safer, fairer, and more effective care. Advancing racial and ethnic equity is not a peripheral task, it is central to the NHS's purpose, values, and long-term success.

Background: Racial and Ethnic Inequity and Health

Racism is not simply a matter of individual prejudice. It is a system sustained by power, norms, and the ideology of superiority and inferiority; an ideology historically rooted in whiteness as a dominant social, political, and cultural framework. Racism is woven through culture, institutions, and policies, and it operates at multiple interconnected levels[23]:

- **Internalised racism:** shaping how people understand themselves, others, and their place within racial hierarchies.
- **Interpersonal racism:** expressed in everyday interactions, including biased assumptions, discriminatory behaviour, and microaggressions.
- **Institutional racism:** embedded in policies, practices, and organisational cultures that systematically advantage those racialised as white and disadvantage those racialised as non-white.
- **Structural racism:** the cumulative impact of historical, cultural, economic, and political systems reinforce inequity across generations.

These levels reinforce one another, producing patterns of inequitable exposure and outcomes, and collectively contributing to inequitable health outcomes. The harms of racism are cumulative across the life course and can begin before birth[24-27].

Evidence shows that:

- Racism-related stress and disadvantage can affect preconception health, influencing fertility, parental wellbeing, and access to care.

- Pregnant people exposed to racism experience higher risks of complications, with consequences for foetal growth and development.

- Infants, children, and adolescents can be affected through differential access to resources, discriminatory treatment, and chronic exposure to racialised stressors.

- These exposures accumulate across adulthood, contributing to long-term conditions, unequal ageing, and earlier mortality.

Racism is a fundamental determinant of health, shaping who is exposed to harm, who can access care, and the quality and safety of the care received. Chronic exposure to racism is associated with cardiovascular disease[28-30], adverse maternal outcomes[27], mental ill-health[31], and other long-term conditions linked to physiological dysregulation caused by sustained stress[32].

Why this matters for health systems

Racism is a driver of illness and premature death. It shapes who becomes sick, who receives timely and effective care, and whose suffering is overlooked. The consequences are profound:

- **For patients:** poorer outcomes, delayed diagnoses, reduced trust[33], and preventable deaths.

- **For health systems:** higher costs from avoidable emergency care and late-stage treatments. Studies show that inequitable systems generate inefficiencies, increasing demand for expensive interventions that could have been prevented.

- **For staff and society:** a culture of discrimination in the workforce limits opportunity, wastes talent, and erodes trust. Inequities experienced by staff often mirror and reinforce those experienced by patients.

Racism does not exist in isolation, it interacts with housing, education, employment, and other determinants of health to compound disadvantage. When health systems fail to act, they not only perpetuate injustice but also undermine their own effectiveness.

The imperative to act is not because equity is ‘good for everyone’, but because health systems must uphold justice, deliver safe and effective care, and stop perpetuating harm.

How change happens

Addressing racism and advancing health equity requires sustained, multi-level action:

- **Early detection and prevention:** reducing reliance on costly, crisis-driven care.
- **Building transferable skills:** equipping staff and leaders to recognise and dismantle racism in multiple contexts.
- **Embedding accountability:** aligning governance, incentives, and resources with equity goals.
- **Learning from evidence:** implementing strategies proven to work and rigorously evaluating impact.

The task before us is clear; to name racism, to confront it at every level, and to re-shape health systems so they no longer reproduce injustice but instead advance dignity and fairness for all.

Chapter 1: The Foundational Importance of Vision and Leadership

1.1 Why it matters

A clear and compelling vision from leadership is a critical determinant of progress. For NHS organisations, this means setting out not only why things must change, but also how the organisation will do things differently to achieve meaningful and sustained improvement. When leaders articulate this vision with conviction and integrity, they inspire staff, build trust, and create the direction and conditions needed to realign the organisation towards fairer and more equitable outcomes.

The NHS Race & Health Observatory's Seven Principles of Anti-Racism[34] provide a strong foundation for this work. The very first principle, naming racism, reminds leaders that change begins with honesty, clarity, and a willingness to confront the systems that perpetuate racial and ethnic inequities. By openly acknowledging how racism affects patient care, staff experiences, and organisational culture, leaders lay the groundwork for genuine action and lasting transformation.

However, effective leadership in this space requires more than articulating a vision. Leaders, and indeed all staff, must be self-aware, able to locate themselves within systems of power and privilege, and capable of recognising and managing their emotional responses when engaging with issues of racism. This includes being willing to demonstrate humility, accept discomfort, make mistakes, and remain committed to ongoing learning. These capabilities are essential for leaders to be ready to engage meaningfully in naming and addressing racism in their organisations.

Evidence from the literature, including work cited in the BMJ article, Beyond shame, sorrow, and apologies—action to address indigenous health inequities[4], shows that such reflective

capacity does not emerge automatically. Many leaders will not be fully prepared for this work until they have participated in focused, sustained anti-racism training that builds understanding, competence, and confidence. This training is an enabler, not an optional supplement, and helps ensure that leaders are equipped to act responsibly, thoughtfully, and effectively.

INSET BOX 1.1.1

The NHS Race & Health Observatory's Seven Anti-Racism Principles

1	Demonstrate leadership by naming racism, engaging seriously and continuously with the ways in which racism impacts the lives of patients and the public, and actively working to dismantle it.
2	Understand and acknowledge that structural, institutional and interpersonal racism all impact on health and be clear about where accountability lies for improvement and progress. Create transparent pathways for raising concerns and tangible steps for addressing them.
3	Meaningfully involve racially minoritised communities in the early stages of developing a service or intervention, including ensuring that teams and decision-making structures themselves are racially diverse and fundamentally inclusive.
4	Collect and publish data on race inequity in that captures the diversity of Racial/ethnic populations, and that ensures that the diversity of Racial/ethnic populations is acknowledged in informing policy, strategy, and improvement. 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.
7	Evaluate and reflect on interventions using metrics that recognise the role of racism as a determinant of health. These evaluations should seek to understand the extent to which interventions mitigate the impacts of racism.

Without strong leadership and a clear vision, efforts risk becoming fragmented or tokenistic, resulting in well-intentioned initiatives that fail to address the underlying drivers of inequity. Even more concerning, the absence of decisive and accountable action can reinforce existing racial and ethnic inequities, further eroding trust among staff, patients, and communities. Visionary leadership is therefore not optional; it is the essential foundation for building a more equitable, inclusive, and high-performing NHS.

1.2 What works

Evidence shows that leadership vision alone is not enough; it must be supported by concrete systems of accountability and sustained institutional investment. Research by Priest and colleagues demonstrates that efforts to advance racial and ethnic equity succeed only when they are embedded across all levels of an organisation[18]; driven by visible leadership, reinforced through mandated policies, and sustained through long-term, coordinated strategies. Their findings provide a clear evidence base for how the NHS can translate leadership intent into measurable, meaningful, and lasting change, ensuring that equity becomes part of the organisation's structures, cultures, and everyday practice.

However, evidence from Indigenous cultural safety frameworks and wider anti-racism scholarship shows that many leaders are initially hesitant, unprepared, or uncertain about how to engage in this work. Successful leadership therefore requires not only expectations and accountability, but also support, training, and coaching. Studies highlight that cultural safety training is most effective when it is sustained, reflective, experiential, and grounded in the voices and authority of communities affected by racism. One-off sessions that focus solely on cultural awareness or information transfer have limited impact; meaningful change comes from approaches that build self-reflection, positionality, humility, and an ability to recognise and respond to racism in everyday practice. Embedding these elements into leadership development ensures that leaders have the skills, confidence, and emotional readiness to enact the behaviours associated with successful equity-focused leadership.

INSET BOX 1.2.1

Evidence summary: Leadership, accountability, and systemic change
Priest N, Esmail A, Kline R, Rao M, Coghill Y, Williams DR. *Promoting equality for ethnic minority NHS staff—what works?* BMJ. 2015;351:h3297. https://doi.org/10.1136/bmj.h3297

KEY INSIGHTS

Vision from the top determines success. Progress depends on leaders who understand that advancing racial and ethnic equity is not a compliance requirement, but a core component of organisational excellence. When leadership articulates a clear, values-driven vision that explicitly names racism and inequity, it creates shared purpose and moral direction across the system.

Visible commitment inspires confidence. Leaders who consistently communicate, invest in, and model equity as a strategic priority build credibility and trust. This visible commitment signals that anti-racism and fairness are integral to how the organisation defines quality, safety and effectiveness.

Leadership must link values to action. A compelling vision needs practical translation; clear goals, aligned resources, and accountability structures that make equity everyone's business. Staff at every level must understand how their work contributes to addressing inequities in both exposures and outcomes.

Mandate and motivation must coexist. Policy requirements and performance metrics help maintain focus, but transformational change occurs when they are combined with authentic motivation, a shared ethical responsibility to challenge racism and advance fairness.

Sustained leadership attention keeps momentum. Equity work loses traction when priorities shift or leadership changes. Long-term commitment, reinforced through continuous communication, measurement, and accountability, keeps the vision alive and evolving.

Equity strengthens the organisation's moral and operational core. A vision grounded in justice and inclusion improves the experiences of racialised and minoritised staff, strengthens teams, and enhances patient care. Embedding equity into leadership and governance contributes to a safer, fairer, and higher-performing NHS.

Visionary leadership turns equity from an aspiration into an organisational reality. When leaders clearly articulate what fairness and racial and ethnic equity look like and commit to achieving them through concrete action and accountability, they transform culture as well as policy. A compelling vision provide staff with direction, purpose, and confidence that meaningful change is both possible and expected. It signals that equity is not a peripheral goal but a fundamental standard for how the organisation operates and delivers care.

CASE STUDY 1.2.1

Addressing anti-Indigenous racism through leadership and collaboration

BACKGROUND

Dr. Janet Smylie and the Well Living House research centre partnered with a mid-sized hospital serving urban and rural Indigenous and non-Indigenous populations to address anti-Indigenous racism at the hospital. Well Living House was contracted to provide independent research and recommendations regarding Indigenous patient and staff experiences at the hospital. The project was guided by an Indigenous advisory council comprised of community representatives and hospital staff, including senior leaders.

KEY FINDINGS

- Indigenous patients and staff reported persistent experiences of racism negatively impacting both patient care and workplace culture.
- Policy review revealed systemic barriers that hindered equity and inclusion.
- Existing practices were beneficial but inconsistently applied.
- Leadership engagement facilitated alignment between recommendations and organisational priorities.

KEY OUTCOME

Two years after completion of the report and recommendations, 100% of the substantive list of recommendations have been implemented with 98% completed in the first year..

LESSONS LEARNED

Independent, staff and community-guided research paired with committed leadership can drive rapid, meaningful change. Visible support from senior leaders ensures recommendations are implemented effectively. Coordinated action across policy, practice, and interpersonal levels, combined with genuine collaboration with communities, is essential to transform organisational culture and make equity initiatives sustainable.

Case study 1.2.1 illustrates how a clear, actionable vision, when combined with strong leadership commitment and structured accountability, can transform organisational culture. It demonstrates Priest et al.'s findings in practice: embedding equity across multiple levels, aligning leadership with measurable action, and sustaining initiatives over time are critical to turning vision into reality. By pairing independent, community-guided insights with executive support, organisations can move beyond aspiration to achieve tangible, lasting change in equity and inclusion.

1.3 Recommendations

Inspire a clear, equity-focused vision

Position racial and ethnic equity as a visible organisational priority. Articulate a shared vision that names racism as a determinant of health and culture, and encourage staff to think differently about their roles, responsibilities, and impact in advancing equity.

Equip managers and leaders to drive change

Provide managers and supervisors with the training, tools, coaching, and authority required to lead anti-racist practice, respond to inequities in both exposures and outcomes, and foster accountability within their teams. This includes sustained, reflective anti=racism and cultural safety development, not one-off sessions.

Reward innovation and reinforce progress

Recognise and celebrate early successes, creative practices, and staff who are driving meaningful improvement. Visible reinforcement signals that equity work is integral to organisational excellence, not peripheral or optional.

Mandate and enable accountability

Implement clear organisational policies with measurable equity outcomes, regular monitoring, transparent reporting, and consequences for lack of progress. Accountability systems should focus on structural change rather than individual blame.

Commit to sustained, multi-level action

Coordinate efforts across organisational, team, interpersonal, and individual levels. Monitor progress over time, adapt strategies based on evidence and community feedback, and embed equity into everyday governance and decision-making so cultural change becomes lasting and self-sustaining.

1.4 Implementation for impact

Translate vision into strategy

Develop a clear, organisation-wide plan that sets out how the leadership vision for racial and ethnic equity will be operationalised. Define responsibilities, timelines, required resources, and measurable outcomes that address both inequities in exposure and inequities in outcomes. Ensure the strategy is embedded in formal governance structured so it persists beyond individual leaders.

Empower managers and teams

Equip supervisory staff with the authority, resources, coaching, and sustained anti-racism and cultural safety training needed to lead change. Managers must be able to model inclusive and anti-racist behaviours, identify inequities in their own areas, and hold teams accountable for progress.

Embed equity into everyday systems and processes

Integrate anti-racist principles into recruitment, progression, performance evaluations, decision-making, and organisational communications. This shifts equity from a standalone initiative to a routine, structural expectation that shapes everyday practice and organisational culture.

Set measurable targets and monitor progress

Establish concrete, time-bound goals related to workforce equity, staff experience, organisational culture, and patient outcomes. Track progress using robust metrics, publish updates transparently, and adjust strategies based on evidence and community feedback. Monitoring should identify both gaps and the systems that create them.

Celebrate and learn from successes

Publicly recognise early wins, innovations, and staff contributions to reinforce commitment and sustain momentum. Highlighting meaningful progress builds confidence and encourages wider adoption of effective practices.

Coordinate multi-level action

Align efforts across organisational, team, interpersonal, and individual levels to ensure that interventions are coherent. Systemic, and mutually reinforcing. Avoid fragmented or isolated initiatives; cultural and structural change requires consistent, multi-level action over time.

Engage staff and communities frequently

Work directly with staff, local communities, and collaborative partners to co-create and co-govern equity initiatives. Use community expertise to validate priorities, shape strategies, and ensure interventions are relevant, trusted, and accountable. Invest in long-term relationships that honour community authority and lived experience.

Review, adapt, and evolve

Use ongoing evaluation, feedback, and emerging evidence to refine approaches. Address unintended consequences, respond to new challenges, and ensure the leadership vision remains actionable, relevant, and effective. Organisations should treat equity as a continuous practice, not a time-limited programme.

1.5 Conclusion

Strong leadership and a clear, equity-focused vision are essential for achieving lasting change. Vision alone is insufficient; it must be paired with structured accountability, multi-level strategies, and sustained institutional investment. Leaders who define what racial and ethnic equity looks like, model anti-racist behaviours, and embed equity into everyday systems and decisions help align organisational priorities and inspire staff to act.

The case study on addressing anti-Indigenous racism (1.2.1) illustrates how visible leadership commitment, community-guided insights, and coordinated, system-wide action can drive rapid and meaningful cultural transformation. This approach demonstrates that equitable outcomes are achievable when organisations pair leadership intent with evidence-driven practice and community partnership.

By tracking inequities in exposures and outcomes, evaluating progress, and continuously refining strategies, NHS organisations can translate leadership vision into tangible, measurable impact. Doing so builds a healthcare system that is fair, accountable, culturally safe, and trusted by the communities it serves.

Chapter 2: The Basics - Data, Accountability, Responsibility, Targets, Governance, Resource and Incentives

2.1 Why it matters

High quality ethnicity data, alongside meaningful measures of racialisation and racism, is fundamental to addressing racial and ethnic inequities in health. Being counted is more than a bureaucratic exercise, it signals that every individual and community is recognised and valued. Collecting detailed data, including identifiers for racialised, ethnic, and Indigenous groups, as well as valid measures of exposures to racism, enables organisations to identify differences and inequities in both exposures and outcomes, target interventions appropriately, and monitor progress over time.

Data alone, however, does not create change. Leaders must ensure that data inform action by creating strategies that motivate and enable staff to respond to findings. This may include incentive structures, performance-linked metrics, and results-focused improvement programmes. By defining what equitable outcomes look like for staff, patients, and communities, and by clearly identifying which tools will be used to measure progress, organisations can turn information into meaningful and accountable action. Systems of accountability, transparent governance, clear targets, and aligned resourcing ensure that efforts are directed effectively toward closing gaps and reducing inequities.

2.2 What works

Addressing racial and ethnic inequities in health, social outcomes, and governance requires a combination of high-quality measurement, targeted interventions, systemic programs, and culturally grounded, community-led approaches. Evidence from the United States, Australia and Aotearoa New Zealand shows that meaningful change emerges when policies:

- are informed by robust and disaggregated data,
- are co-designed with the communities most affected, and
- are implemented in ways that respect cultural values, histories, and local contexts.

The following case studies illustrate how these principles have been applied in practice and highlight lessons for designing effective, equitable, and sustainable interventions.

CASE STUDY 2.2.1

Collecting baseline data about discrimination can reveal disparities in care

BACKGROUND

The Commonwealth Fund and the Afro-American Research Collective surveyed over 3,000 US healthcare workers to capture front-line observations of racial and ethnic discrimination in care settings spanning hospitals, outpatient clinics, long-term care, and community health centres.

KEY FINDINGS

- Almost half (47%) of respondents reported witnessing discrimination against a patient based on race or ethnicity.
- In facilities serving predominantly Black patients, 79% of workers described discrimination as a crisis or major problem, compared with 52% in majority-white settings.
- Almost three-quarters of respondents said incidents of discrimination had occurred within the past three years.

LESSONS LEARNED

Systematic data collection from staff can expose patterns of inequity that would otherwise remain hidden. However, measurement must be followed by action; organisations should build reporting systems, train staff to recognise and address racism, and ensure findings directly inform governance, resource allocation, and accountability frameworks. Only then can data drive meaningful and sustained change.

Once differences of disparities are identified, targeted interventions can be implemented to address the underlying inequities that produce them.

CASE STUDY 2.2.2

The impact of affirmative action on Indigenous healthcare access in Australia

BACKGROUND

In 2010, Australia introduced the Indigenous Practice Incentives Program (IPIP), a targeted reform aimed at reducing healthcare disparities between Indigenous and non-Indigenous populations. The program provided financial incentive to general practitioners (GPs) to improve chronic disease management and reduced or abolished co-payments for prescription medicines for Indigenous patients. This initiative was designed to address the differential access to primary healthcare services by Indigenous communities, particularly those with cardiovascular disease.

KEY FINDINGS

The study of 75,826 Australians, including 1,896 Indigenous patients with cardiovascular disease, found that the program:

- Increased prescription medicine use by 12.9% and GP visits by 6.6%.
- Boosted use of chronic disease services by 34%, but also reduced specialist attendances by 11.8%, mainly among lower-income patients.
- Had the strongest impact on those receiving the largest co-payment relief and living in metropolitan areas.

LESSONS LEARNED

Well-designed financial incentives can effectively increase healthcare usage among underserved populations. However, impact is not uniform; geographic location and socioeconomic status play a significant role in determining who benefits most. While the program successfully increased access to primary care, it also highlighted that such interventions must be carefully balanced to avoid unintended reductions in specialist care.

While targeted interventions can improve specific outcomes, broader systemic strategies are needed to address the underlying inequities and achieve change at scale.

CASE STUDY 2.2.3

Lessons from Australia's Closing the Gap initiative to reduce disparities for Indigenous communities

BACKGROUND

Since 2008, Australia's 'Closing the Gap' initiative has set national targets to reduce disparities in health, education, and employment for Aboriginal and Torres Strait Islander communities. These targets were designed and monitored primarily by government agencies, without formal input from Indigenous communities.

KEY FINDINGS

- The 2020 Closing the Gap report showed that most targets were not on track.
- Mortality gaps between Indigenous and non-Indigenous Australians widened, and the Coalition of Peaks, a representative body of more than 80 Aboriginal and Torres Strait Islander community-controlled peak organisations and members, described infant mortality trends as "very worrying".
- Only early childhood education and Year 12 equivalence targets were partially on track, and only in some states.
- Lack of Indigenous voice in design, implementation, and evaluation, contributed to repeated cycles of unmet targets.

LESSONS LEARNED

Targets alone do not drive meaningful change. Without active involvement of the communities affected, actionable strategies, and mechanisms for accountability, progress is limited. The Coalition of Peaks' partnership with government, co-designing priorities and structural reforms, demonstrates that inclusive governance, community engagement, and clearly resourced actions are essential to break cycles of failure. This case study highlights that data and goals must be paired with actionable plans, accountability, and leadership commitment to achieve real improvements.

Beyond national strategies, approaches to data sovereignty and governance that enable communities to manage, control, and determine the use of their own data are critical.

CASE STUDY 2.2.4

Co-designing Māori data governance in Aotearoa, New Zealand

BACKGROUND

In Aotearoa New Zealand, Māori data is considered a taonga (treasure) that requires culturally grounded models of protection and care. The Māori Data Governance Model was designed by Māori data experts for use across the New Zealand public service. This model provides guidance for the system-wide governance of Māori data, consistent with the Government's responsibilities under te Tiriti o Waitangi (the Treaty of Waitangi). The model is intended to assist all agencies in undertaking Māori data governance in a way that is values-led, centred on Māori needs and priorities, and informed by research.

KEY FINDINGS

The co-design process involved Māori data experts and representatives from 16 Crown agencies, facilitated by Stats NZ. The outcome was a Māori Data Governance Model that emphasizes:

- Te Waka Hourua (The Double-Hulled Canoe): A metaphor representing the partnership between Māori and the Crown, where each group is represented by one hull, working together towards a common goal.
- Māori Data Governance Values: These include whanaungatanga (relationships), whakapapa (genealogy), manaakitanga (care and hospitality), kaitiakitanga (guardianship), kotahitanga (unity), and rangatiratanga (self-determination).
- Māori Data Security Considerations: The model outlines best practices to inform ethical advice for the treatment of all data, including Māori data.

LESSONS LEARNED

Genuine partnership and shared decision-making are essential. Māori data governance must be values-led, culturally grounded, and aligned with Māori needs and priorities. The model serves as a foundational reference for public service agencies to support Treaty-aligned approaches to Māori data governance.

While these international examples demonstrate how high-quality data, governance, and culturally grounded approaches can drive change, the NHS has also developed its own national model of data-driven accountability. The Workforce Race Equality Standard (WRES)[35] illustrates both the power and the limitations of mandatory measurement in tackling inequities.

INSET BOX 2.2.1

The Workforce Race Equality Standard (WRES): A national model for data-driven accountability

The Workforce Race Equality Standard (WRES), introduced in 2015, established the first national, mandatory framework for understanding and addressing inequities experienced by racialised and minoritised ethnic staff within the NHS. Prior to its introduction, data on workforce inequities were inconsistent, incomplete, and often invisible. WRES created a unified, transparent system that enables organisations to identify inequities, monitor trends, and hold themselves accountable for change.

WHY WRES WAS NEEDED

Research across the NHS demonstrated that racialised and minoritised ethnic staff often faced poorer treatment, fewer opportunities, and greater exposure to bullying, harassment, and discrimination than white staff. These inequities damaged staff wellbeing, undermined organisational effectiveness, and contributed to variations in care quality and safety for patients. The principle underpinning WRES was clear: you cannot change what you do not measure.

All NHS trusts were therefore required to submit baseline WRES data from July 2015 onwards. This made racial workforce inequity a visible, measurable, system-wide priority rather than a localised or optional concern.

WHAT WRES MEASURES

The WRES consists of nine indicators that highlight racial and ethnic inequities across three domains:

Workforce representation and processes

1. Representation across Agenda for Change bands and Very Senior Management
2. Relative likelihood of appointment from shortlisting
3. Relative likelihood of entering the formal disciplinary process
4. Access to non-mandatory training and CPD

Workplace culture and experience

5. Bullying, harassment, or abuse from patients or the public
6. Bullying, harassment, or abuse from other staff
7. Belief that the organisation provides equal opportunities for progression
8. Experiences of discrimination from managers or senior staff

Leadership diversity

9. Voting Board membership compared with overall workforce composition

These indicators expose points of systemic disadvantage, across recruitment, progression, treatment, culture, and leadership, enabling organisations to identify where change is needed most.

IMPACT AND CONTINUING CHALLENGES

After a decade, WRES can be considered a success in establishing robust, standardised data collection and embedding accountability into the NHS Standard Contract. Annual national and organisational reports make inequities impossible to ignore, offering transparency at local, regional, and national levels.

However, the data also show that persistent and, in some cases, widening inequities remain, particularly in staff experience indicators. This gap between measurement and meaningful change underscores a critical lesson for all equity work: data without action does not close inequities.

WRES illustrates the importance of coupling high-quality data with mandated action, organisational accountability, targeted interventions, and sustained leadership commitment. It remains a foundational model for how the NHS can use data to reveal inequity, and why stronger governance, consistent implementation, and system-wide responsibility are required to eliminate it.

The experience of WRES reinforces a central lesson: measurement is essential but only leads to change when paired with clear expectations, accountability, leadership commitment, and sustained action. These principles underpin the recommendations that follow.

2.3 Recommendations

Prioritise evidence-based action

Collect and analyse data on disparities in both exposures and outcomes, including access to care, treatment pathways, and health outcomes. Combine quantitative data with staff insights and community-reported experiences to inform decision-making, resource allocation, and policy development. Use this evidence to identify where inequities exist, determine their likely drivers, and tailor responses accordingly.

Implement targeted interventions

Design programs that respond directly to documented racial and ethnic inequities, such as tailored service models, financial incentives, or supportive pathways that increase access and engagement. Ensure interventions are informed by local context, including geography, socioeconomic conditions, and service capacity, and monitor for unintended consequences or the risk of widening disparities.

Develop systemic and coordinated strategies

Embed interventions within broader organisational frameworks that align policies, services, and resources to equity goals. Set clear, measurable objectives, establish benchmarks and reporting mechanisms, and incorporate evaluation, accountability, and iterative improvement. System-wide alignment strengthens the ability to deliver sustainable change at scale.

Engage communities in governance and co-design

Involve affected communities in the design, implementation, and evaluation of interventions. Establish co-governance structures and decision-making processes that provide communities meaningful authority and influence. This ensures that strategies reflect cultural values, align with legal and ethical standards, and are responsive to local priorities and lived experience.

Foster cultural safety and inclusive practices

Provide training for staff and leaders to recognise and address racism, racialisation, and bias within clinical and organisational contexts. Implement robust reporting systems and feedback loops to support participation in equity initiatives. Promote organisational cultures that value cultural safety, transparency, inclusion, and the principles of racial and ethnic equity.

2.4 Implementation for impact

Collect and act on evidence

Systematically gather data on disparities in both exposures and outcomes, including access to care, service use, treatment pathways, and staff and patient experience. Use both quantitative measures and qualitative insights from staff and communities to understand the drivers of inequity. Critically, ensure that findings directly inform policy, governance, and resource allocation so that measurement leads to meaningful and sustained action, not simply documentation.

Design targeted interventions

Develop programmes and incentives that respond directly to specific racial and ethnic inequities identified through data and community insight. For example, financial incentives may help increase access to timely primary care, but interventions must be carefully tailored

to local context and assessed for potential unintended consequences, including the risk of shifting pressures onto other parts of the system. Targeted interventions are most effective when embedded within broader systemic strategies.

Embed inclusive governance and co-design

Engage affected communities in the design, implementation and monitoring of policies and interventions. Co-governance structures and shared decision-making ensure that initiatives are culturally grounded, aligned with community values, and responsive to lived experience. Models such as the Māori Data Governance Model and the Coalition of Peaks partnership demonstrate the effectiveness of approaches that uphold authority and data sovereignty.

Set actionable goals and accountability mechanisms

Translate insights from data and community engagement into clear, measurable, and time-bound goals. Pair these goals with accountability frameworks, transparent reporting systems, and leadership oversight to ensure they drive action rather than remain symbolic. Accountability should be embedded across all levels of the organisation and linked to performance and governance processes.

Address systemic inequities and structural barriers

Tackle the procedural, institutional, and structural barriers that uphold inequities. This may include reviewing policies, redesigning pathways, revising governance structures, and ensuring equitable distribution of resources. Sustainable impact requires attending not only to immediate service gaps, but to the broader systems that perpetuate racial and ethnic inequity.

Monitor, evaluate, and adapt continuously

Track progress using robust metrics and evaluation methods and gather regular feedback from staff and communities. Use these insights to refine interventions and adjust strategies as needed. Continuous evaluation ensures programmes remain effective, culturally relevant, and capable of reducing inequities over time.

Communicate progress and celebrate successes

Share achievements with staff, patients, and communities to reinforce organisational commitment to equity. Highlighting measurable improvements, acknowledging challenges, and recognising contributions helps build trust, foster engagement, and maintain momentum for long-term change.

2.5 Conclusion

Meaningful equity in health requires more than targets or data, it requires sustained, evidence-informed action. The case studies included in this chapter demonstrate that combining systematic measurement, targeted interventions, and culturally grounded, community-led governance, alongside strong mechanisms for engagement and accountability, can drive real and lasting impact.

Continuous monitoring, adaptation, and transparent communication help maintain momentum and reinforce trust, while tackling structural and institutional barriers ensures that interventions are both effective and sustainable.

By linking evidence to action and embedding racial and ethnic equity into governance, policy, and everyday practice, organisations can achieve measurable improvements in exposure to risk, access to care, health outcomes, and trust among communities that have historically been underserved or marginalised.

Chapter 3: Diversifying the Leadership and Staff of the Healthcare Workforce

3.1 Why it matters

Research consistently shows that people from minoritised racial and ethnic backgrounds often receive lower-quality care and experience poorer health outcomes than their white counterparts[24-32]. A contributing factor is the lack of representation within the healthcare workforce, particularly in leadership roles where key decisions about strategy, culture, and resource allocation are made[36]. Increasing representation is therefore an important step toward ensuring that the NHS is better equipped to understand and respond to the needs of all communities it serves.

However, as emphasised by Priest et al.[18], increasing diversity alone is necessary but insufficient. Representation improves organisational insight and strengthens teams, but it cannot, on its own, dismantle the structural, cultural, and procedural forms of racism that shape staff and patient experience. Progress requires systemic change, creating environments where minoritised staff are psychologically safe[37], treated fairly, supported to progress, and not expected to shoulder the emotional labour of educating colleagues or leading equity work simply because they experience racism[38].

For representation to have real impact, organisations must:

- Ensure psychological safety, where racialised staff can speak up without fear of reprisal or further marginalisation.

- Avoid tokenism by building a critical mass of racialised staff across roles and levels, rather than isolated appointments.

- Distribute responsibility for anti-racism so the burden does not fall on those who bear its arms; equity is a leadership responsibility, not an additional expectation placed on minoritised staff.

- Invest in organisational capability, including training, coaching, and specialist expertise in anti-racism, cultural safety, and organisational change.

- Align structures and processes (recruitment, promotion, talent development, governance) to ensure equitable progression and sustained representation at senior levels.

When diverse leadership is supported by meaningful structural change, organisations are better positioned to deliver culturally safe care, drive innovation, and implement targeted solutions that reduce health inequities and improve outcomes for all patients.

The following case study illustrates one dimension of this principle in practice: how increased representation of Black primary care physicians contributed to improved outcomes for Black patients. Representation matters, but its greatest impact occurs when it is part of a broader, systemic commitment to racial and ethnic equity.

CASE STUDY 3.1.1

Greater representation of Black primary care doctors improves health outcomes for Black patients

BACKGROUND

A cohort study in the US evaluated the association between Black representation in the primary care physician (PCP) workforce and survival outcomes at three timepoints: 2009, 2014, and 2019.

KEY FINDINGS

Out of 3,142 counties, only 1,619 had at least one Black primary care physician. The study found that higher numbers of Black PCPs were associated with increased life expectancy for Black residents, and lower all-cause Black mortality. Greater Black PCP representation was also linked to reduced disparities between Black and white individuals. On average, a 10% increase in Black PCPs corresponded to a 31-day increase in life expectancy for Black residents.

LESSONS LEARNED

Increasing the representation of Black primary care physicians is associated with improve survival outcomes and reduced racial disparities in health. This underscores the importance of workforce diversity in delivery equitable healthcare.

This case study provides a practical example of the broader principle outlined in Section 3.1: when healthcare teams are more representative, including in leadership and frontline roles, they are often better positioned to deliver equitable, culturally safe care and can contribute to reducing health inequities.

Building on this, the next case study explores how racial concordance between patients and physicians can influence engagement with health services. While concordance is not a universal solution and cannot replace the need for systemic anti-racist practice, it illustrates one pathway through which representation and relational trust can shape patient experience and outcomes.

CASE STUDY 3.1.2

Engagement of Black patients with health services increases when their physician is of the same race

BACKGROUND

A randomised controlled trial in the US studied outcomes of 1,300 Black men attending a free health screening at a Saturday clinic. Participants were randomly assigned to see either a Black physician, or a physician of a different race.

KEY FINDINGS

Black men who saw a Black physician were more engaged with their healthcare.

Specifically:

- 29% more likely to discuss other health issues
- 47% more likely to undergo diabetes screening
- 56% more likely to receive a flu vaccine
- 72% more likely to complete cholesterol screening.

LESSONS LEARNED

Patient-provider racial concordance can significantly increase engagement with preventative health services. This highlights the importance of workforce diversity in improving patient participation, uptake of preventative care, and overall health outcomes.

Together, these case studies show that increasing representation within the healthcare workforce can contribute to improved patient experience and outcomes, while also supporting broader organisational efforts to advance racial and ethnic equity. Although representation alone is not sufficient, when combined with structural change and culturally safe practice, a more diverse workforce can enhance engagement, strengthen trust, and help address inequities at both system and individual levels.

3.2 What works

Most evidence on promoting workforce diversity comes from sectors outside healthcare, yet the consistency of findings across organisations and national contexts demonstrates that many lessons are directly relevant to the NHS. Progress is most likely when action is intentional, sustained, and visibly supported by leadership, with racial and ethnic equity articulated as an institutional priority, reinforced through consistent communication, and backed by meaningful organisational investment.

Sustainable change requires multi-level strategies that combine interventions at organisational, workplace, interpersonal, and individual levels. Voluntary measures alone are rarely sufficient; mandated targets and meaningful accountability are often necessary to drive lasting improvements in representation, progression, and workplace culture.

When these elements come together, organisations are better able to recruit, retain, and advance staff from a broad range of racialised and ethnic backgrounds. However, as outlined in Section 3.1, diversifying the workforce is necessary but not sufficient. Representation must be supported by culturally safe environments and sustained structural change. The diagram below summarises how these three components interact and why all are required for meaningful, long-term workforce equity.

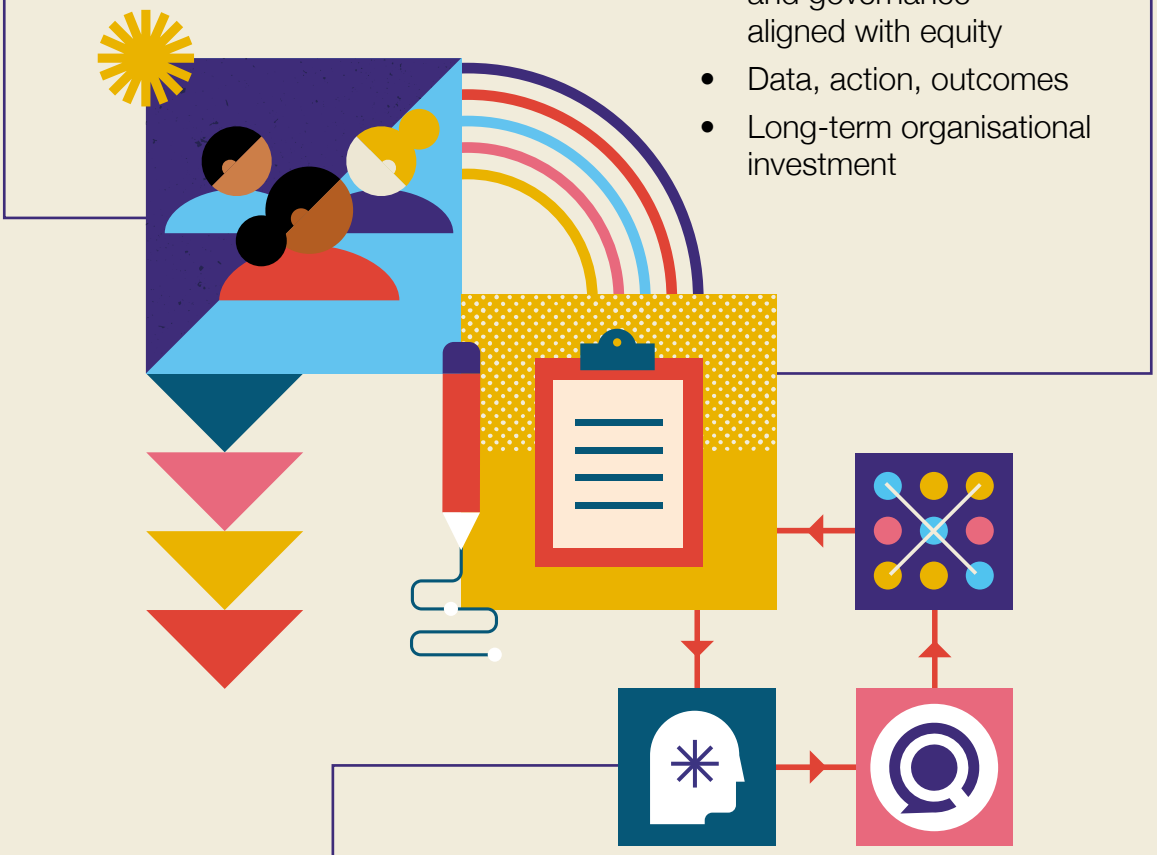
HOW WORKFORCE EQUITY IS ACHIEVED
THREE INTERDEPENDENT COMPONENTS

REPRESENTATION

- Diverse workforce at all levels, including leadership
- Critical mass, not tokenism
- Fair recruitment and progression systems

STRUCTURAL CHANGE

- Mandated accountability
- Policies, processes, and governance aligned with equity
- Data, action, outcomes
- Long-term organisational investment



CULTURALLY SAFE ENVIRONMENTS

- Address implicit and explicit racism
- Psychological safety
- Anti-racism skills, training and leadership
- Protection from emotional labour burdens

The relationship depicted above reinforces the central principle of this chapter: workforce diversity is most effective when it exists within culturally safe environments and is supported by structural reform. Without these conditions, representation risks becoming tokenistic, racialised staff may lack psychological safety, and the burden of change may fall unfairly on those who already experience racism.

A critical component of supporting a diverse workforce is addressing implicit and explicit racial bias within the healthcare organisations. Bias and racism shape staff experience, affect clinical decision-making, and undermine cultural safety. Anti-bias and anti-racism interventions are therefore essential, not as substitutes for structural change, but as complementary strategies that enable diverse teams to thrive and deliver equitable care.

The following case study illustrates the measurable physiological basis of implicit bias and its potential for modification. Yet, as the diagram underscores, such interventions produce lasting benefit only embedded within wider organisational efforts to address structural and cultural barriers. Evidence from initiatives such as the TIDES study (Tackling Inequalities and Discrimination Experiences in health Services)[39-42], shows how racism impacts racialised staff and patients, and why comprehensive, system-level approaches are needed to create psychologically and culturally safe workplaces.

Together, these strategies: equitable recruitment and progression, anti-racism practice, bias reduction, and structural accountability, are mutually reinforcing. Meaningful and sustained progress arises when they are implemented collectively and guided by the experiences of those most affected.

CASE STUDY 3.2.2

Workplace diversity training programmes are ubiquitous but do not improve diversity in isolation

BACKGROUND

NHS senior leadership does not reflect the diversity of either the wider NHS workforce or the UK population. A 2009 review examined the effectiveness of various management interventions available to organisations like the NHS to drive change in this area.

KEY FINDINGS

Individual-focused programmes, while effective at raising awareness of bias and supporting development of self-awareness, have limited impact on actual behaviour change and reducing bias in practice. Persistent institutional challenges, such as limited mentorship, unequal access to career development, and entrenched workplace culture, continue to hinder the progression of staff from minority ethnic backgrounds. Sustainable change requires organisational-level strategies that actively promote diversity and inclusion.

LESSONS LEARNED

Awareness-raising alone is insufficient to reduce bias or its effects. Mandatory, tailored programmes combined with organisational strategies, multi-level interventions, and accountability mechanisms are necessary to create lasting change in workplace culture and decision-making.

Effective interventions to reduce bias and advance workforce diversity combine individual-level learning with system-level organisational change. Addressing racial bias – implicit and explicit – is essential for creating culturally safe environments in which diverse staff can thrive, while recruitment, progression, and leadership initiatives ensure representation is strengthened and sustained.

The following case studies demonstrate these complementary approaches in practice: one examining long-term, structured interventions to reduce racial bias, and the next illustrating how inclusive recruitment and staff development programmes can support equitable representation and progression across the workforce.

CASE STUDY 3.2.3

Long-term reduction in implicit racial bias through a prejudice habit-breaking intervention

BACKGROUND

A 12-week longitudinal study developed a multi-faceted intervention aimed at reducing implicit racial bias. The intervention combined awareness of implicit bias, concern about its effects, and the application of strategies to reduce bias.

KEY FINDINGS

Participants who received the intervention showed a dramatic reduction in implicit racial bias. Those who reported greater concern about discrimination and actively used the strategies demonstrated the most significant reductions. The intervention also led to increased awareness of bias and concern about discrimination over the study period. In stark contrast, the control group showed no such effects.

LESSONS LEARNED

Addressing implicit bias requires more than awareness; it requires sustained engagement. Interventions that combine awareness, concern, and actionable strategies can lead to long-term reductions in implicit racial bias.

CASE STUDY 3.2.4

Inclusive recruitment and staff development at North East London NHS Foundation Trust

BACKGROUND

North East London NHS Foundation Trust (NELFT) recognised that staff from minoritised backgrounds were underrepresented and often faced barriers in recruitment and progression. To address this, the trust prioritised inclusive recruitment practices as part of its broader strategy to create a diverse and equitable workforce.

KEY FINDINGS

NELFT reviewed and revised its recruitment processes to attract a broader range of candidates. Measures included:

- Widening advertising channels to reach diverse communities
- Standardising selection criteria to reduce subjective bias
- Training recruitment panels to reduce bias
- Actively monitoring recruitment data to identify gaps in representation.

In addition to recruitment, the Trust implemented staff development programmes aimed at preparing minoritised staff for leadership positions, including mentoring, coaching, and leadership training. As a result, staffing from minority ethnic backgrounds increased at all bands, particularly bands 8a and above. For example, in 2019, band 8d representation increased from 17.6% to 37.5%, and very senior managers from 7.7% to 23.5%.

LESSONS LEARNED

Inclusive recruitment, coupled with targeted and accessible staff development processes, can contribute to a culture where diverse talent is not only recruited, but also supported to progress into leadership roles. Embedding these practices strengthens workforce diversity and creates more equitable and representative leadership structures.

Together, these case studies show that effective workforce diversity strategies must address both individual and organisational drivers of inequity. This includes reducing racial bias, strengthening culturally safe practice, ensuring equitable recruitment and progression pathways, providing meaningful mentorship and career development, and removing the structural barriers that limit opportunity. Sustainable change arises when these elements work together to support representation, improve staff experience, and advance racial and ethnic equity across the healthcare system.

3.3 Recommendations

Prioritise representation and tackle segregation across all levels of the workforce

Racialised and minoritised ethnic staff are disproportionately concentrated in the lowest paid, least prestigious roles across the NHS, and underrepresented in senior and decision-making positions. Addressing this entrenched pattern requires proactive strategies to ensure equitable representation at every level, including at the top.

Leadership should make its commitment to racial and ethnic equity visible and central to organisational strategy, embedding representation goals into decision-making, resource allocation, performance frameworks, and accountability structures. This includes investing in the full workforce pipeline, widening access to healthcare education, ensuring anti-racist training and support for early-career professionals, to providing equitable opportunities for progression, leadership development, mentorship, and sponsorship.

Increasing representation must be understood as a system-wide responsibility, achieved through structural investment rather than individual effort, and without placing the emotional or educational burden on racialised staff.

Recruit inclusively

Design recruitment processes that attract a broad range of candidates and minimise bias at each stage. This includes widening recruitment channels, standardising selection criteria, training recruitment panels, and monitoring real-time recruitment data to identify and address inequities in shortlisting, appointment, and starting grade.

Develop diverse talent

Provide mentoring, coaching, and structured leadership pathways that support progression. Targeted staff development programmes can help address historical disparities in access to opportunity, enabling underrepresented staff to build the skills, experience, and visibility needed for advancement into senior roles.

Measure and hold accountable

Set clear, time-bound targets for representation, progression, and staff experience. Track progress transparently and link outcomes to organisational accountability and leadership performance. Measurable goals ensure that equity commitment translate into meaningful change.

Actively address racism

Implement intervention that reduce explicit and implicit racial bias in decision-making, workplace interactions, and organisational processes. Effective approaches combine individual learning with systemic change to address cultural and structural barriers. Anti-racism capability, cultural safety, and protected psychological safety are essential foundations for supporting a diverse workforce.

3.4 Implementation for impact

Plan with purpose

Develop a clear strategy for racial and ethnic equity in the workforce, with defined responsibilities, executive sponsorship, and Board oversight. Leadership must model anti-racist behaviours, allocate resources, and embed equity into core organisational priorities.

Use data to drive change

Collect and analyse disaggregated workforce metrics to identify inequities in recruitment, pay, progression, disciplinary action, and staff experience. Transparent reporting enhances accountability and supports evidence-based decision-making.

Embed equitable practices into everyday systems

Integrate inclusive recruitment, mentoring, and staff development into standard HR and managerial processes. Bias-aware selection panels, standardised decision-making criteria, and targeted development programmes help ensure equitable access to opportunities across the NHS workforce.

Set measurable goals and monitor progress

Translate strategic commitments into specific, time-bound objectives for recruitment, retention, leadership representation, and staff experience. Link goals to organisational accountability mechanisms to ensure that progress is monitored and sustained.

Address racism actively and systematically

Implement multi-level interventions that tackle both individual behaviour and organisational culture. Anti-bias and anti-racism approaches must be embedded within broader structural reforms that protect psychological safety, prevent discrimination, and promote equitable opportunities for all staff.

Communicate progress and celebrate achievements

Regularly update staff on progress, highlight measurable improvements, and recognise contributions that advance racial and ethnic equity. Celebrating milestones reinforces commitment and fosters collective engagement.

Learn, adapt, evolve

Use evaluation findings, staff feedback, and ongoing research to refine strategies over time. Continuous learning ensures that initiatives remain relevant, responsive, and effective in advancing equity across the workforce.

3.5 Conclusion

Diversifying the healthcare workforce is both a moral and practical imperative. Evidence shows that intentional, multi-level strategies, from increasing representation and tackling occupational segregation, to reducing racism and bias, to embedding equitable recruitment and progression systems, improve organisational culture, strengthen leadership, and enhance both staff experience and patient outcomes.

Sustainable progress requires purposeful planning, data-driven decision-making, measurable goals, and sustained leadership commitment. By embedding equity into everyday systems, building culturally and psychologically safe environments, and investing in the full workforce pipeline, NHS organisations can create meaningful and lasting change.

When workforce structures reflect the communities they serve, and when all staff are supported to thrive, healthcare organisations become more equitable, innovative, and effective. Advancing racial and ethnic equity within the NHS is not only a measure of fairness; it is central to improving quality, safety, and outcomes for patients.

Chapter 4: Creating Culturally Safe Care and Work Environments

4.1 Why it matters

Creating cultural safety within healthcare is fundamental to delivering high-quality, equitable care. Cultural safety is not only about interpersonal respect; it is about ensuring that health systems and services do not reproduce racism, discrimination, or harm. When cultural safety is absent, the consequences for patients and staff are profound.

Impacts on patients

For patients from racialised and minoritised ethnic communities, including Indigenous peoples internationally, the absence of cultural safety can lead to:

- Avoidance of care, delayed presentation, or self-discharge due to anticipated or experienced racism.
- Misdiagnosis or poor-quality care when clinical signs are interpreted through biased assumptions or non-inclusive clinical guidelines.
- Non-adherence to treatment when communication is unsafe, dismissive, or invalidating.
- Preventable morbidity and mortality, as documented in inquiries and studies across the UK, Canada, Aotearoa New Zealand, and the US.

UK and international evidence highlight recurrent patterns, for example, inequities in pain management[43], maternal mortality[44], mental health pathways[31], and emergency department experiences[45], where racism and lack of cultural safety contribute directly to harm. These

human costs are immeasurable, and the financial costs, through increased emergency care, late-stage treatment, and avoidable complications, are substantial.

Impacts on staff

Cultural safety also matters profoundly for the workforce. Staff who experience racism, bullying, harassment, or exclusion are less able to provide safe and compassionate care. Research by West at al.[46] shows that disrespectful or unsafe environments for staff lead to:

- Lower morale
- Increased sickness absence
- Poorer patient satisfaction
- Reduced care quality

Bullying and harassment alone cost NHS England an estimated £2 billion per year in turnover, sickness absence, and lost productivity[47]. Cultural safety for staff is therefore not simply a wellbeing issue; it is central to organisational effectiveness, patient safety, and quality of care.

Why cultural safety must address both patients and staff

The experiences of patients and staff are interconnected. When staff, particularly those from racialised groups, work in environments marked by racism or exclusion, this can mirror and reinforce the inequities experienced by patients. Likewise, when staff feel culturally unsafe, they may be less able to challenge injustice or provide culturally safe care to others.

This chapter addresses both dimensions of cultural safety, recognising that they require linked but distinct interventions:

1. Cultural safety for staff: ensuring racialised and minoritised ethnic staff can work without racism, discrimination, or exclusion, and can progress equitably.
2. Cultural safety for patients: ensuring that clinical care, communication, policies, and organisational cultures do not perpetuate racism or cause harm.

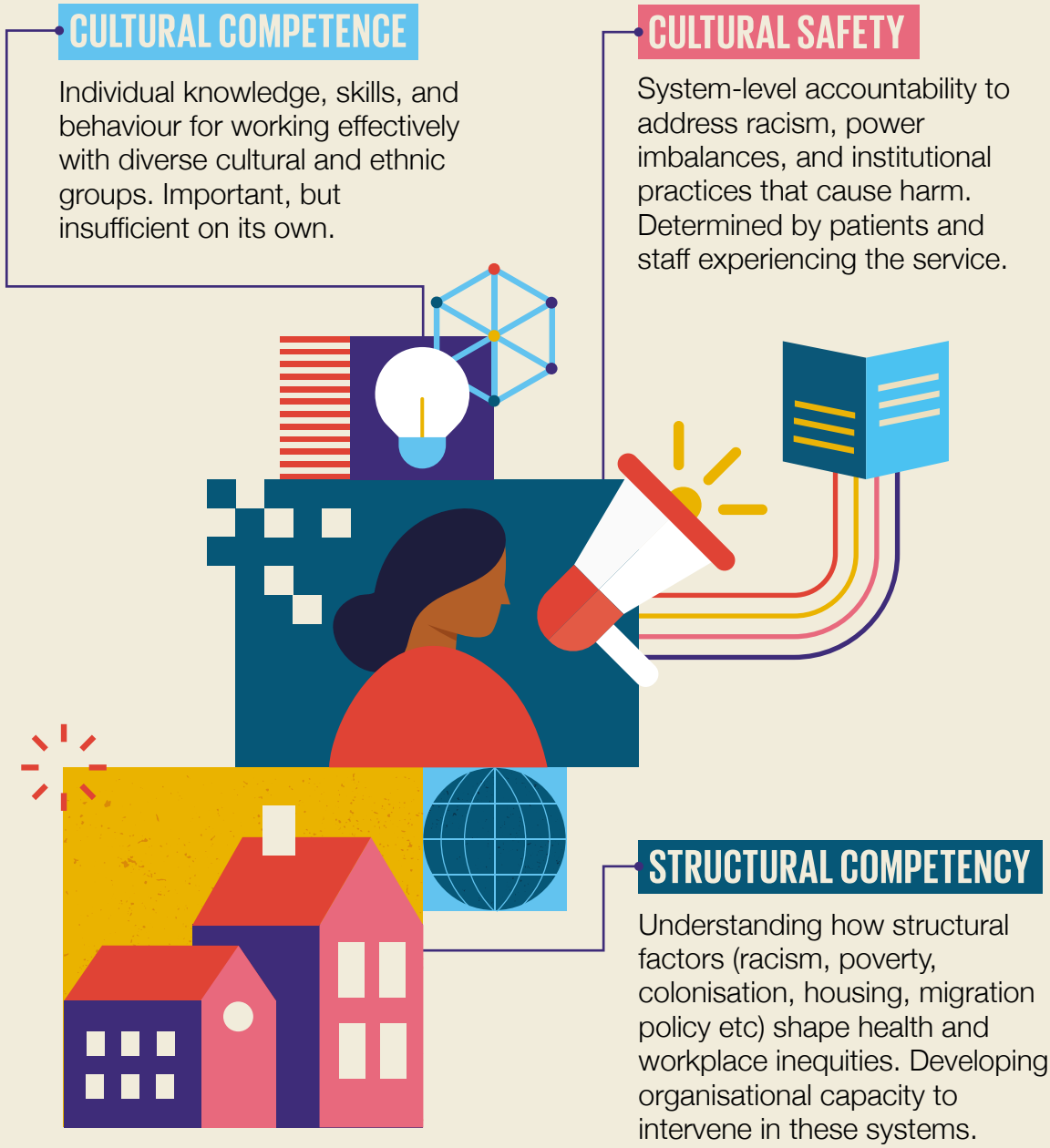
This dual focus aligns with international evidence showing that safe, equitable care depends on safe, equitable workplaces.

Introducing cultural competence, structural competency, and cultural safety

Different but overlapping terms are used to describe this work. Cultural competence, structural competency, and cultural safety form a developmental pathway, rather than interchangeable terms.

- Cultural competence strengthens individual capability.
- Structural competency builds institutional understanding of how systems create inequity.
- Cultural safety requires organisational accountability to address racism, redistribute power, and ensure that patients and staff, particularly those from racialised and minoritised ethnic groups, experience care and workplace environments as safe.

Cultural safety is the goal, and the standard against which organisations should assess their progress.



CASE STUDY 4.1.1

Enhancing provider cultural competence improves equity in HIV/AIDS care

BACKGROUND

A study conducted in California, USA, examined racial disparities in HIV.AIDS care among 437 patients receiving treatment from 45 medical providers. Each provider completed a 20-item self-assessment scale measuring their level of cultural competence. The study explored whether differences in provider cultural competence were associated with disparities in treatment access, adherence, and outcomes among minoritised racial and ethnic patients.

KEY FINDINGS

Racial disparities were evident among patients treated by providers with low cultural competence, but these disparities were substantially reduced when providers demonstrated high competence.

Specifically:

- Patients of low-competence providers were less likely to receive appropriate antiretroviral therapy (ARVs).
- They reported lower confidence in managing their treatment.
- They were less likely to achieve viral suppression.

By contrast, racial minority patients treated by providers with high cultural competence were more likely to receive ARVs, adhere to treatment, and achieve viral suppression, regardless of the provider's own race or ethnicity.

LESSONS LEARNED

Cultural competence among healthcare providers is a measurable determinant of equitable care and clinical outcomes. Structured education, reflection, and self-assessment can strengthen providers' ability to deliver responsive, patient-centred care across diverse populations. Enhancing cultural competence not only enhances trust and communication but also reduces disparities in treatment access and adherence. Sustained investment in provider training, organisational support, and accountability mechanisms is essential to embed cultural competence as a core component of quality care.

INSET BOX 4.1.1

WHAT DOES IT LOOK LIKE TO BE HIGH ON CULTURAL COMPETENCE?

Providers who score highly on cultural competence agree with the following six statements, reflecting relational awareness, cultural humility, and partnership with patients.

Family and friends are as important to health as doctors

Social history contributes to how I care for my patients

I am familiar with the lay beliefs my patients have

I ask my patients about alternative therapies they use

I find out what my patients think is the cause of their illness

I involve patients in decisions about their health care

Together, these behaviours demonstrate that culturally competent care is not just about knowledge of different cultures, it is about empathy, respect, and collaboration; understanding the whole person in their social and cultural context. Even though this study did not provide a strategy of how to effectively train providers to share these cultural competence values, it did indicate the values and orientations of providers that make a big difference.

4.2 What works

Addressing inequities in healthcare and creating safe environments requires interventions that operate at multiple, interconnected levels: individual capability, organisational systems, and community-governed structures. International evidence consistently shows that meaningful and sustained change emerges when:

- Policies and practices are grounded in robust data that identify inequities and monitor progress,
- Interventions explicitly address structural drivers of inequity, including racism, colonisation, and discriminatory organisational norms,

- Workforces are trained and supported to develop cultural competence and structural competency,
- Organisations commit to cultural safety through accountability, resourcing, and continuous improvement, and
- Communities most affected by inequities are meaningfully involved in design, governance, and evaluation.

Effective approaches therefore do not rely solely on individual behaviour change or isolated training sessions. Instead, they combine individual learning, system redesign, and community partnership, ensuring that environments become safer for both patients and staff.

The following case studies illustrate these principles in practice, showing how different health systems have implemented:

- Interventions that reduce harmful bias and improve communication,
- Organisational reforms that build culturally safe practices and environments, and
- Community-led and co-governed processes that reshape policy, accountability, and service design.

Together, these examples demonstrate that cultural safety is achievable when organisations take an integrated, multi-level approach that centres the experiences of racialised and minoritised communities and embeds anti-racist practice across the whole system.

CASE STUDY 4.2.1

Understanding workplace cultural competence among healthcare providers

BACKGROUND

A 2019 study in the US surveyed 56 healthcare providers to explore their perceptions of cultural competence and organisational support in multi-cultural workplace settings. The study assessed providers' confidence in cross-cultural care, prior training, and how their organisations addressed cultural challenges.

KEY FINDINGS

Providers reported confidence in serving diverse populations despite gaps in formal training:

- Almost half of the participants had not received structured cross-cultural training.
- Most defined cultural competence as awareness of norms, customs, or use of interpreters.
- Critical reflection on power, majority-culture bias, and institutional barriers was rarely acknowledged.
- Organisational support for cultural competence lagged behind power confidence.

LESSONS LEARNED

Cultural competence must be reinforced by organisational structures. Training alone is insufficient; health systems need policies, governance frameworks, and supportive workplace cultures that enable providers to deliver culturally competent care effectively.

While establishing baseline cultural competence is important, evidence shows that this alone does not change outcomes. Targeted, process-oriented approaches are needed to translate awareness into practical, relational, and context-specific skills that improve the safety and quality of care. These approaches help staff move beyond knowledge to enact behaviours and practices that meaningfully address bias, support cultural safety, and respond to the structural factors shaping patients' experiences.

CASE STUDY 4.2.2

Developing provider cultural competence through process-oriented approaches

BACKGROUND

Research shows that content-focused cultural competence training can inadvertently reinforce stereotypes, while process-oriented approaches emphasise understanding and responding to each patient's unique needs. Effective strategies include structured reflection, patient engagement, and interactive learning that prioritises relational and ethical responsiveness.

KEY FINDINGS

Evidence shows that process-oriented approaches to cultural competence are more effective and ethically sound. Rather than memorising cultural facts, providers are trained to engage with each patient as an individual with unique values, beliefs, and experiences. Key aspects of culturally appropriate care include:

- Providers learn to devote adequate time and attention to understanding the patient's needs and perspectives.
- They develop skills to provide individual, or group support tailored to patient needs.
- Emphasis on high-quality care ensures treatment is clinical effective and culturally appropriate.

LESSONS LEARNED

Cultural competence is not about learning how to treat certain groups; it is about learning how to listen and respond respectfully to difference. Process-oriented training builds practical skills while avoiding reinforcement of negative stereotypes. Embedding these principles into provider education and clinical practice fosters a culture of equitable, person-centred care that meets patients where they are.

Although improving individual skills is important, inequities persist when structural and organisational barriers remain unaddressed. Structural competency shifts the focus from individual behaviour to the systems, policies, and power dynamics that shape healthcare delivery, enabling organisations to recognise and intervene in the structural drivers of cultural unsafety and unequal outcomes.

CASE STUDY 4.2.3

Advancing structural competence to address racism in healthcare

BACKGROUND

Structural competence expands the focus beyond individual clinicians to the organisational and systemic factors that perpetuate inequity. Racism is embedded in policies, procedures, and institutional culture, affecting health outcomes regardless of individual provider behaviour.

KEY FINDINGS

Addressing systemic inequities requires recognising and acting on structural determinants:

- Institutional policies and practices can maintain inequities even when individual providers are well-intentioned.
- Organisations must actively identify and dismantle discriminatory structures.
- Multi-domain policy changes are often necessary to create inclusive, affirming healthcare environments.

LESSONS LEARNED

Equitable care demands organisational transformation. Structural competence involves embedding equity into governance, policy, resource allocation, and service delivery, ensuring the healthcare system itself does not perpetuate disparities.

INSET BOX 4.2.1

WHAT DOES STRUCTURAL COMPETENCE LOOK LIKE IN PRACTICE?

Healthcare organisations and providers demonstrating structural competence:

Recognise how policies, resources, and institutional practices shape patient outcomes.

Identify and address systemic barriers to care, such a housing, transport, or access to healthy food.

Integrate social, economic, environmental context into clinical decision-making.

Partner with community, legal, and social services to address upstream determinants of health.

Embed equity into governance, service pathways, and organisational culture.

Continuously evaluate and adapt policies and practices to reduce disparities.

Structural competence moves beyond individual bias, equipping providers and systems to act on the social and institutional determinants that drive health inequities.

Building on structural competency, cultural safety provides a comprehensive framework that brings together provider capability, organisational accountability, and community-defined standards of safe and equitable care. It shifts responsibility from individual patients or staff to the health system itself, requiring organisations to address racism, power imbalances, and institutional practices that create harm.

CASE STUDY 4.2.4

Moving from cultural competency to cultural safety to achieve health equity

BACKGROUND

Curtis and colleagues (2019) reviewed 59 international articles to examine how health systems can achieve equity. They argue that cultural safety goes beyond knowledge of other cultures to include critical reflection on power, structure, and institutionalised racism within health systems. However, there are mixed definitions and understandings of cultural competency and cultural safety, and how best to achieve them.

KEY FINDINGS

Healthcare disparities persist because inequities operate at both individual and systemic levels.

Specifically:

- Many cultural competence initiatives focus on learning about other cultures rather than critiquing dominant culture, power, and privilege.
- Health practitioners and organisations need to engage in self-reflexivity, challenge entrenches systems, and question institutional norms.
- Organisations much be accountable to patients and communities for providing culturally safe care as defined by those communities.
- Without addressing structural determinants and institutionalised racism, health systems cannot achieve equity.

LESSONS LEARNED

Achieving equitable care requires more than training clinicians; it demands organisational transformation. Health services must adopt cultural safety frameworks that:

- Centre the voices of affected communities
- Embed accountability mechanisms into policy and governance
- Systemically dismantle structural barriers to care

Leadership, continuous evaluation, and meaningful community partnerships are essential to sustain this change.

4.3 Recommendations

Prioritise workforce cultural competence

Embed cultural competence as a core expectation for all healthcare staff. Training should focus on relational, process-oriented skills, such as active listening, culturally responsive communication, and reflective practice, while avoiding approaches that essentialise or stereotype communities. Leadership should champion this work and allocate resources for ongoing professional development.

Develop structural competency across organisations

Review and reform policies, procedures, governance structures, and organisational culture to address the structural drivers of inequity. This includes identifying barriers created or reinforced by institutional norms, embedding equity goals into decision-making and accountability frameworks, and creating environments where staff and patients can raise concerns safely.

Adopt culturally safe frameworks

Move beyond cultural competence to embed cultural safety as an organisational responsibility. Cultural safety requires healthcare systems to centre patient and community definitions of what constitutes safe, respectful, and affirming care. Engage communities in co-design, governance, and evaluation, and establish accountability mechanisms to ensure organisations meet these standards.

Measure, monitor, and act on inequities

Collect and analyse data on staff experiences, patient outcomes, and organisational practices to identify inequities and gaps in cultural safety. Use provider self-assessment tools, organisational audits, and patient feedback, especially from racialised and minoritised communities, to inform interventions and guide iterative improvement.

Integrate learning and reflection

Support ongoing individual and organisational reflection to sustain progress. Combine cultural competence training with structural reforms that address racism and systemic inequities. Ensure learning is continuous, context-specific, and embedded in everyday practice rather than delivered as one-off sessions.

Ensure leadership accountability

Hold senior leaders responsible for embedding cultural competence, structural competency, and cultural safety across the organisation. Link progress to measurable targets, performance management, and governance structures. Communicate successes visibly to reinforce commitment, maintain momentum, and build trust with staff and communities.

4.4 Implementation for impact

Plan with purpose

Develop a clear organisational strategy for equity and cultural safety, with defined responsibilities, executive sponsorship, and appropriate resource allocation. Leaders must model inclusive behaviours, integrate cultural safety into strategic priorities, and communicate consistently about its importance.

Use data to drive change

Collect and analyse meaningful metrics to identify inequities in staff experience, organisational culture, patient care, and outcomes. Use self-assessment tools, organisational audits, and patient-reported experience measures, disaggregated by race and ethnicity, to target interventions and drive continuous improvement.

Embed inclusive and culturally safe practices

Integrate cultural competence and cultural safety into recruitment, induction, mentorship, professional development, clinical pathways, and service delivery. Process-oriented training should cultivate listening, humility, and responsiveness, while organisational reforms should address structural barriers and discriminatory policies.

Set measurable goals and strengthen accountability

Translate recommendations into specific, time-bound objectives for workforce capability, organisational readiness, and patient outcomes. Link these goals to governance, reporting structures, and leadership performance metrics to ensure sustained focus and tangible change.

Address bias and structural inequities actively

Implement interventions that combine awareness with practical tools to reduce implicit and explicit bias in decision-making. Support organisational self-reflexivity, policy review, redesign of discriminatory processes, and resourcing of equity initiatives across departments.

Centre community voices

Engage patients, staff networks, and communities most affected by inequities in co-designing policies, services, training, and evaluation frameworks. Cultural safety must reflect the standards defined by those who receive and experience care, not solely those who provide it.

Learn, adapt, and sustain

Monitor outcomes, gather feedback from staff and communities, and refine strategies based on evidence and lived experience. Continuous evaluation ensures interventions remain relevant, effective, and embedded in organisational culture rather than isolated or time limited.

4.5 Conclusion

Creating culturally safe care and work environments is essential for both equitable patient outcomes and staff wellbeing. Evidence from provider-level initiatives, process-oriented training, structural reforms, and community-governed models demonstrates that cultural competence alone is insufficient; meaningful progress requires organisations to confront and change the structures, policies, and practices that reproduce inequity.

Achieving cultural safety demands a combination of individual skill development, organisational transformation, and authentic partnership with communities who experience racism. Leadership commitment, rigorous evaluation, and strong accountability mechanisms are critical to sustaining this work. By embedding cultural competence, structural competency, and cultural safety across the workforce and throughout organisational systems, healthcare providers can reduce disparities, strengthen trust, and deliver care that is respectful, responsive, and equitable for all.

Chapter 5: Health Systems Addressing the Social Determinants of Health

5.1 Why it matters

Sir Michael Marmot opened The Health Gap[48] with a powerful question: **"Why treat people and send them back to the conditions that made them sick?"** This highlights a fundamental truth; healthcare cannot succeed in isolation from the social and structural systems that shape people's opportunities to live healthy lives. Psychosocial stress, insecure housing, economic hardship, discrimination, and exposure to violence or abuse all accumulate across the life course, and for many, across generations, to influence health outcomes long before a person enters a clinic.

These social determinants are not distributed equally. In the UK and globally, racialised and minoritised ethnic communities, including Indigenous peoples internationally, are more likely to be exposed to adverse social conditions due to longstanding histories of racism, colonisation, exclusion from resources, and discriminatory policy.

Racism itself is a powerful social determinant of health, shaping who has access to opportunity, safety, and care. It interacts with other determinants: housing, education, employment, policing, environmental harm, to compound disadvantage.

LESSONS FROM SOUTH AFRICA
RACISM AS A STRUCTURAL DETERMINANT OF HEALTH

South Africa provides a striking illustration of how deeply racism can structure health outcomes long after the end of formal segregation. Despite the end of apartheid in the early 1990s, the country remains profoundly racially and economically segregated. South Africa spends approximately 8.9% of its GDP on healthcare, similar to the UK, but this headline figure hides extreme inequity. Half of total health spending goes to the private sector, which serves only 16% of the population, while the remaining 84% depend on an under-resourced public system[49].

Evidence shows that racial inequities in health remain "striking," even after adjusting for socioeconomic status[50]. These findings demonstrate that structural racism, not just socioeconomic disadvantage, is a fundamental determinant of health. Mbewu and colleagues argue that acknowledging the systemic racism woven into institutions, policy, and governance is essential for reducing inequities. Addressing social determinants without confronting underlying racism will not close gaps. The same lesson applies to the UK and the NHS.

A UK EXAMPLE
BLACK THRIVE AND ANTI-RACIST SYSTEM CHANGE

Examples within the UK also demonstrate how racism operates as a social determinant, and how community-led action can help address it. Black Thrive[51], established in Lambeth, is a partnership that brings together Black communities, local government, health services, and voluntary organisations to tackle the structural factors driving poor mental health outcomes for Black people.

Rather than focusing only on individual behaviour or clinical access, Black Thrive addresses:

- Systemic discrimination in education, employment, and policing,
- Barriers to timely and culturally safe mental healthcare,
- Lack of trust arising from historical and ongoing racism, and
- Fragmented local systems that fail to respond to community needs.

Their co-production approach ensures that Black communities define priorities and shape solutions, demonstrating how anti-racist, community-governed, and structurally focused

interventions can shift local systems toward equity. Black Thrive illustrates the importance of addressing racism explicitly when tackling the wider determinants of health, not treating it as an ancillary or optional issue.

WHY THIS MATTERS FOR THE NHS

This international and UK evidence makes clear that:

- Clinical care alone cannot close racial and ethnic health gaps.
- Interventions must address the material, social, and structural factors that shape people's lives.
- Racism, and its legacies in housing, education, employment, policing, and healthcare, must be named and actively dismantled.

Addressing social determinants is therefore not only a moral imperative but a practical one. When social needs go unmet, patients return sicker and more stressed, emergency service use increases, long-term conditions worsen, and inequities deepen. Conversely, when health systems integrate support for social needs into care pathways, patients experience fewer crises, greater stability, and improved outcomes.

Breaking cycles of disadvantage requires multisector collaboration, cross-government commitment, and healthcare organisations that recognise their role as anchor institutions. By embedding a focus on social determinants into planning and service design, health systems can create sustainable, equitable, and community-grounded care.

The case studies in the next section illustrate how integrating social, legal, and economic support into healthcare can reduce inequity and strengthen the foundations of health for entire communities.

5.2 What works

Health interventions that address social determinants are most effective when they recognise that many of the challenges patients face; housing instability, financial insecurity, discrimination, immigration issues, and exposure to violence or chronic stress, are shaped by structural conditions, including racism. Clinical care alone cannot mitigate these forces; effective approaches must integrate medical support with responses to social, structural, and legal factors that shape people's health.

Successful models share several factors. They:

- Combine healthcare with social and legal support, enabling clinicians to identify underlying drivers of poor health and connect patients with practical solutions.
- Partner with communities to design interventions that reflect local priorities, cultural contexts, and lived experience.
- Address racism directly by recognising its role in creating unequal exposures to harmful conditions and unequal access to resources.
- Work across sectors, using coordinated approaches that involve healthcare, housing, welfare, legal services, community organisations, and local government.
- Build trust and continuity, ensuring that support is relational, not transactional, and tailored to the complex realities of patients' lives.

The following case studies illustrate how these principles have been implemented in different contexts, including integrated health–legal partnerships in the United States and community-led approaches in the UK. Together, they demonstrate the impact of interventions that respond not only to illness, but to the conditions that make people unwell in the first place.

CASE STUDY 5.2.1

Outreach intervention reduces hypertension among low-income Black patients

BACKGROUND

A 1978 study in the US assessed interventions for 244 hypertensive patients (80% of whom were Black), that were living on low incomes. Participants were randomised into three groups:

1. Routine medical care
2. Routine care plus 12 weekly clinic-based health education sessions
3. Routine care plus home visits by locally recruited, trained lay health workers providing both health guidance and broader social support.

KEY FINDINGS

After 7 months, patients in the outreach group:

- Knew twice as much about blood pressure as those in the other two groups
- Were more adherent to medication than those in the health education group
- Achieved twice the success in blood pressure control compared with similarly compliant patients in the education group.

Overall, the outreach group was significantly more likely to have controlled blood pressure than patients in the other groups.

LESSONS LEARNED

Health interventions that integrate medical care with social support, addressing patients' finances, family difficulties, and employment, are more effective than education or clinical care alone. Embedding health management into daily life, through trusted, locally trained workers improves knowledge, adherence, and health outcomes for marginalised communities.

While outreach programmes can respond to patients' immediate social and medical needs, many of the barriers that shape health are structural and legal, including issues related to housing, immigration status, employment rights, welfare access, and discrimination. These

challenges often disproportionately affect racialised and minoritised ethnic communities due to systemic inequities and racism embedded within wider social systems.

Embedding legal expertise directly within healthcare teams, as demonstrated by Medical-Legal Partnerships, enables patients to address these structural obstacles alongside their clinical care. This integrated approach helps resolve the underlying conditions that contribute to ill health and ensures that routine healthcare is not undermined by unaddressed social and legal determinants.

CASE STUDY 5.2.2

Medical-legal partnerships in the US support care for vulnerable children

BACKGROUND

Medical-Legal Partnerships (MLPs) embed legal professionals within healthcare teams to tackle social and legal issues affecting health, including unsafe housing, income insecurity, access to food and education, immigration challenges, disability, and family law matters.

KEY FINDINGS

Research shows that patients using MLP services experience:

- Fewer emergency department visits
- Shorter hospital stays
- Reduced stress and better coping mechanisms.

As of July 2023, MLPs operated in approximately 450 hospitals and health centers, 170 legal aid agencies, and 58 law schools across 49 states and the District of Columbia.

LESSONS LEARNED

Standard clinical care cannot fully address the social and legal determinants of health. Integrating legal services into healthcare allows patients to resolve systemic barriers more effectively, improving well-being and the efficiency of healthcare delivery.

Beyond legal and financial support, health systems can improve outcomes by connecting patients to wider community resources that address the social and structural conditions influencing their health. The integration of social prescribers into GP practices in Tower Hamlets demonstrates how coordinated support for housing, employment, and social connection, alongside clinical care, can reduce avoidable pressure on healthcare services and enable patients to navigate challenges more effectively.

CASE STUDY 5.2.3

Integrating social prescribers in Tower Hamlets GP practices

BACKGROUND

Tower Hamlets, one of the most deprived and ethnically diverse boroughs in the UK, introduced social prescribers (link workers) based in GP practices to support patients with non-medical needs such as housing, debt, employment, benefits, parenting, and physical activity.

KEY FINDINGS

After seeing a social prescriber, a cohort of 890 patients made 418 fewer GP appointments over six months: a reduction of approximately 47%. Additional evidence indicates that social prescribing services contribute to:

- A 24% reduction in emergency department attendances on average
- A 55% reduction in secondary care referrals within a year.

LESSONS LEARNED

Embedding link workers within GP practices allows holistic support that addresses social determinants alongside clinical needs. This model reduces pressure on primary and secondary care, enables patients to manage their health more effectively, and highlights the value of integrating community-based support into routine healthcare.

In addition to patient-level interventions, healthcare systems can leverage their considerable economic and operational influence to improve health at a population level. As anchor institutions, they shape local employment, procurement, environmental conditions, and investment, factors that are deeply intertwined with the inequitable distribution of social determinants and life chances. The Rush University Medical Center initiative illustrates how a health system can mobilise its resources to reduce life-expectancy gaps and promote population health across entire communities.

CASE STUDY 5.2.4

Addressing social and economic determinants to reduce life expectancy gaps

BACKGROUND

Leaders at Rush University Medical Center in Chicago identified 14-16-year life expectancy gaps between neighbourhoods in their service area. Low life expectancy neighbourhoods were racially segregated and affected by poverty, unsafe streets, poor housing, and limited educational opportunities. In response, Rush expanded its mission from healthcare delivery to improving the overall health of the community, setting a goal to reduce the life expectancy gap by 50% over ten years and engaging five other local health systems to collaborate.

KEY FINDINGS

- Established strong community partnerships through listening sessions and shared decision-making.
- Directed all business units toward promoting economic activity in disadvantaged neighbourhoods, including local hiring, career development, apprenticeship programs, impact investing, and sourcing supplies locally.
- Provided financial education and volunteering opportunities to support community economic and social well-being.

LESSONS LEARNED

Addressing social determinants at a system-wide level, including economic, housing, and education factors, can complement clinical care and community-level interventions. Health systems that leverage their economic and operational influence as 'anchor institutions' can create meaningful, long-term improvements in population health and equity.

The Rush Equity Framework illustrates the principles guiding their anchor mission strategy, highlighting a structured, actionable approach to tackling structural inequities and social determinants of health.

INSET BOX 5.2.1

The 5 Pillars of the Rush Equity Framework

1	**Name and eliminate racism** Recognise and address structural and interpersonal racism within the health system and community.
2	**Adopt an anchor mission** Leverage the health system's economic and operational influence to benefit local communities.
3	**Create wealth-building opportunities for employees** Provide career development, local hiring, and economic empowerment programs.
4	**Eliminate health care inequities** Ensure equitable access, quality, and outcomes for all patients.
5	**Address social and structural determinants of health** Target housing, education, employment, and broader community factors that influence health.

5.3 Recommendations

Recognise racism as a key social determinant of health

Acknowledge that racism, structural, institutional, interpersonal, and internalised, shapes the unequal distribution of all other social determinants. Health systems should explicitly identify racism as a driver of inequity and integrate anti-racist action into social determinant strategies, ensuring interventions address both material conditions and the structures that produce them.

Prioritise social determinants in strategy

Embed social, economic, and structural determinants into organisational planning. Leadership should champion initiatives that integrate health, social, and legal support to address root causes of illness and reduce inequities in exposures and outcomes.

Integrate health, legal, and community services

Develop sustained partnerships between healthcare, legal, social, and community organisations. Linking patients to housing, education, employment, welfare, and legal support addresses structural barriers to health, improving engagement, outcomes, and equity.

Implement community-based interventions

Use outreach workers, social prescribers, navigators, and community partners to connect patients with services, provide culturally and contextually grounded guidance, and support continuity of care.

Leverage health systems as anchor institutions

Direct organisational resources, including hiring, procurement, capital investment, and partnership activities, towards addressing inequities in disadvantaged communities. The Rush Equity Framework offers a model for how health systems can use their institutional power to promote economic opportunity, neighbourhood stability, and population health.

Collect and use data

Monitor the impact of interventions on health outcomes, service utilisation, and social indicators. Use disaggregated data to identify inequities, guide iterative improvement, and demonstrate the value of integrated, cross-sectoral approaches.

Train staff on social determinants and equity

Equip healthcare workers with the skills to identify non-medical needs, understand systemic inequities – including racism – and collaborate effectively across sectors. Training should support culturally safe practice and reduce structural and interpersonal barriers to care.

Ensure accountability and sustainability

Set clear targets, allocate appropriate resources, and maintain Board-level oversight. Continuous evaluation, community feedback, and iterative adaptation ensure initiatives remain effective, scalable, and sustainable.

5.4 Implementation for impact

Leadership engagement

Effective action on social determinants requires visible, sustained commitment from senior leaders. Executives must champion the integration of social, economic, and structural determinants, including racism, into organisational priorities, resource allocation, and operational planning.

Organisational readiness

Assess existing systems, policies, and organisational culture to identify structural barriers that prevent integrated models of care. This includes reviewing referral pathways, workforce capacity, data infrastructure, and commissioning arrangements. Adapt workflows and resource distribution to support cross-sector collaboration and meaningful community engagement.

Multi-level interventions

Combine patient-level, community-level, and system-level strategies. The greatest impact comes from models that integrate clinical care with social and legal support, economic initiatives, and community-led solutions. Multi-level design ensures health systems address both the conditions that make people unwell and the structures that maintain unequal exposures to those conditions.

Monitoring and evaluation

Collect and analyse disaggregated data on outcomes, service utilisation, and community impact. Include measures that capture structural inequities and experiences of racism where possible. Use findings to refine interventions, ensure accountability, and demonstrate the value of integrated, equity-focused approaches.

Sustainability

Embed social determinant strategies within core organisational functions rather than treating them as short-term projects or pilots. Secure long-term investment, staffing, leadership oversight, and community partnerships to ensure continuity and scalability.

Community partnership and co-governance

Engage communities in planning, decision-making, and evaluation through co-design and co-governance structures. Regular listening sessions, shared governance panels, and community-led evaluation ensure interventions reflect local realities, build trust, and enhance social accountability.

5.5 Conclusion

Addressing social determinants of health is essential for reducing inequities and improving outcomes. Evidence from patient-level interventions, social prescribing initiatives, medical-legal partnerships, and system-level anchor strategies demonstrates that integrating social, legal, and economic support with clinical care yields measurable benefits for individuals and communities. Crucially, these strategies must also confront racism as a determinant of health, recognising its role in shaping unequal access to housing, employment, safety, and opportunity.

Health systems that prioritise racial and ethnic equity, build sustained partnerships with communities, and leverage their institutional resources holistically can help break cycles of disadvantage and strengthen population health. By embedding multi-level, equity-focused approaches into routine practice, and by committing to long-term leadership, accountability, and community co-governance, the NHS can create more sustainable, responsive, and equitable care for all.

Chapter 6: The Importance of Community Voice

6.1 Why it matters

Lasting progress on racial and ethnic equity in healthcare cannot be achieved without actively engaging with, learning from, and supporting the authority of the communities most affected by inequities. Patients, families, staff, and the broader communities that shape the ecosystem of an organisation hold vital knowledge about how racism and structural barrier operate in practice, as well as what meaningful, culturally grounded solutions look like.

When community voices are not only heard but valued, engaged, and embedded in decision-making, trust is strengthened, accountability is reinforced, and policies become more responsive to the diverse needs, priorities, and contexts of the populations served[52]. Crucially, long-term relationships building, rather than episodic consultation, enables health systems to develop social accountability, which is recognised in many Indigenous health frameworks as one of the most important indicators of service quality and success[53].

Conversely, overlooking or marginalising community perspectives risks widening inequities, producing services that are misaligned with community needs, and deepening mistrust between the NHS and the people it serves. Embedding community partnership at every stage, from defining problems to designing policy, delivering services, interpreting data, and evaluating impact, ensures healthcare systems are trusted, relevant, and capable of delivering equitable outcomes for all.

6.2 What works

Listening to and acting on community voice is most effective when it is structured, sustained, and grounded in long-term relationships built on trust and reciprocity. Evidence from NHS initiatives, community-led research, and patient experiences demonstrates that health systems achieve better outcomes when interventions are co-designed and co-governed with the people they serve. Strategies that combine formal engagement mechanisms, participatory research, and culturally informed approaches help identify hidden barriers, strengthen trust, and ensure that services are relevant, culturally safe, and equitable.

Crucially, successful community engagement is relational, not transactional. It is built through ongoing dialogue, shared decision-making, and investment in community partnerships over time. Only through these relationships can organisations understand lived experience, honour community expertise, and build social accountability that is central to many Indigenous health frameworks and recognised internationally as a marker of high-quality services.

The following case studies illustrate practical examples of how community voice and community authority can be integrated into healthcare delivery, from monitoring and technology use to vaccination campaigns and structured governance panels. Each highlights lessons for designing interventions that are both inclusive, impactful, and rooted in strong, enduring relationships. The second case study demonstrates a shift from listening to active engagement through co-design and partnership, showing how deeper collaboration can transform both practice and outcomes.

CASE STUDY 6.2.1

Updating medical device guidance to protect equity in patient monitoring

BACKGROUND

In July 2021, the NHS Race and Health Observatory reported that the widely used pulse oximeter can produce misleading oxygen saturation readings in people with darker skin pigmentation, potentially delaying critical care. NHS England and NHS Improvement responded by issuing updated guidance clarifying these risks and urging clinicians and patients to interpret readings with caution.

KEY FINDINGS

Misleading device readings create disproportionate risks for minority groups, and new guidance aims to mitigate that. Specifically:

- The RHO's rapid review found that pulse oximeters may overestimate oxygen saturation in people with darker skin, obscuring early signs of deterioration.
- The updated NHS guidance publicly acknowledges this limitation and provides FAQs and advice for home monitoring.
- Patients with dark or Black skin reported confusion and concern when readings appeared 'normal' despite feeling unwell, underscoring the importance of contextual understanding.
- There is a critical need for device manufacturers, regulators and health services to address algorithmic bias and ensure equitable accuracy across skin tones.

LESSONS LEARNED

Ensuring equity in healthcare extends beyond access, training, and individual provider behaviour; technology itself must be scrutinised for racial bias, and its limitations acknowledged in practice. Healthcare leaders and systems should actively involve communities in assessing device safety, accuracy, and usability, particularly for populations at heightened risk. Listening to patients when they report feeling unwell, even if device readings appear 'normal', is critical. Co-producing guidance, educational materials, and awareness campaigns with community input ensures that people understand potential device limitations and are empowered to act on their symptoms. Embedding equity checks into procurement, regulatory review, and patient information strengthens accountability and safeguards care outcomes.

INSET BOX 6.2.1

PERSONAL EXPERIENCES
PULSE OXIMETERS AND EQUITY

Director of the NHS Race and Health Observatory, Dr Habib Naqvi, said:

> *"We need to ensure there is common knowledge on potential limitations in healthcare equipment and devices, particularly for populations at heightened risk of life-changing illness, this includes black, Asian diverse communities using pulse oximeters to monitor their oxygen levels at home."*

Ranjit Senghera-Marwaha and her husband Harjeet Marwaha, both of whom contracted the COVID-19 virus in 2020 have welcomed the updated guidance.

Harjeet Marwaha recalled calling for an ambulance on Boxing Day and being told by paramedics Ranjit's oxygen levels were borderline, Ranjit was admitted to hospital the following day after they fell even further. He added:

> *"These oximeters are simple machines that can really help but people need to know how to use them properly and take into account that the readings may not be 100 percent accurate due to skin tone.*
>
> *"The risk is that people are sat at home relying on the display and not being aware their oxygen levels could actually be slightly lower than shown. It's important the community is made aware of these risks."*

The couple have since made sure that relatives and friends, who have purchased oximeter devices, know about the risk of variations in readings.

While technology can support health monitoring, these experiences show that community insight and partnership are essential to ensure that digital tools are used in ways that are safe, culturally appropriate, and equitable. Likewise, understanding barriers to preventive care, such as vaccination, requires structured, ongoing collaboration with community organisations, whose knowledge of local context, lived experience, and structural barriers is critical to designing effective and trusted interventions.

CASE STUDY 6.2.2

Improving COVID-19 vaccine uptake through community-led evidence and co-design

BACKGROUND

Collaboration for Change, a partnership between two UK universities, nine community organisations, and two SMEs, co produced research to understand and improve COVID 19 vaccine uptake in ethnic minority communities in the UK. Their approach combined a systematic review of the evidence on vaccine uptake with deep engagement of community organisations and lived-experience partners, using the GRADE Evidence to Decision (EtD) framework to guide structured, equitable decision-making.

KEY FINDINGS

Despite the availability of vaccines, uptake among some ethnic minority groups remained lower due to multiple overlapping factors:

- **Trust:** Low trust in health systems and government, influenced by past discrimination and limited engagement.
- **Information:** Generic public health messaging often failed to address specific cultural, linguistic, or community concerns.
- **Accessibility:** Even when willing, individuals faced barriers in convenient access, appointment systems, or location of services.
- **Community voice:** Community organisations emphasised that interventions must reflect lived experience and genuine co-design, rather than tokenistic engagement.

LESSONS LEARNED

Increasing vaccine uptake requires more than broad campaigns. Meaningful involvement of community organisations from the outset ensures interventions are culturally relevant, trusted, and accessible. Embedding community voice into research, strategy, and implementation helps identify and address barriers around trust, language, and access. Health systems should institutionalise partnerships with local community groups, co-develop tailored messaging, and monitor uptake using disaggregated data to drive equity.

From monitoring devices to vaccine campaigns, these case studies highlight the practical impact of working in partnership with communities to shape services that are safe, trusted, and effective. Community involvement can also be embedded more systematically through formal governance and co-design structures, which provide sustained mechanisms for communities to influence service design, resource allocation, and strategic decision-making. Such approaches move beyond episodic engagement, ensuring that community expertise helps guide the system continuously rather than only when issues arise.

CASE STUDY 6.2.3

Embedding patient and public voice through NHS Citizen' Panels

BACKGROUND

NHS Citizens' Panels, such as the Northwest London panel, provide structured mechanisms for patient and public input into service design, strategy, and governance. Panels include thousands of members broadly representative of the local population.

KEY FINDINGS

Effective Citizens' Panels demonstrate several key features that make community input meaningful and actionable:

- **Representation:** Broad demographic diversity improves relevant of feedback.
- **Two-way engagement:** Members see how their input influences decisions.
- **Structured influence:** Insights feed directly into service redesign and resource allocation.
- **Sustained involvement:** Ongoing participation builds trust and reduces tokenistic consultation.

LESSONS LEARNED

Citizen panels demonstrate that systematic engagement amplifies community voice in governance. Feedback loops, resourcing, and integration into decision-making structures are key to moving from consultation to co-creation.

6.3 Recommendations

Embed community voice through structured and sustained mechanisms

Establish formal mechanisms, such as Citizens' Panels, advisory boards, or co-design groups, that enables communities to hold ongoing influence over strategy, service design, research, and policy decision. Ensure participation is meaningful, adequately resourced, and supported, avoiding tokenistic or one-off consultation.

Co-design interventions with lived experience and community authority

Partner with community organisations and individuals from the outset when developing services, communications, digital tools, or public health interventions. Tailor approaches to cultural, linguistic, and contextual needs to build trust, relevance, and cultural safety.

Monitor equity, accessibility, and experience

Use disaggregated data to identify disparities in exposure, access, service quality, and outcomes. Combine quantitative measures with qualitative insights from communities to understand drivers of inequity and guide targeted, culturally grounded action.

Communicate transparently and close feedback loops

Provide clear updates to communities on how their input has shaped decisions. Transparency builds trust, reinforces accountability, and supports long-term relationship building.

Balance technology with human insight and cultural context

Avoid over-reliance on digital devices or algorithms, particularly where technology may have limitations or biases for racialised or minority ethnic groups. Ensure community experience, cultural context, and self-reported symptoms guide decisions and monitoring and care.

Invest in capacity, infrastructure, and support

Provide training, facilitation, and resources to community members and organisations so they can participate confidently and effectively in decision-making. Sustained engagement requires investment, not expectation of unpaid or unsupported labour.

6.4 Implementation for impact

Map and prioritise community partners

Identify key communities, lived-experience partners, and local organisations. Understand their histories, interests, cultural contexts, and priorities to targeted and respectful engagement.

Embed co-design and co-governance processes

Create workshops, joint taskforces, or governance panels where community members actively shape priorities, service models, and communications from the beginning, not merely after decisions are drafted.

Create structured, transparent feedback loops

Develop formal mechanisms to demonstrate how community input is used, with regular updates on actions taken, decisions made, and outcomes achieved. This builds credibility and supports social accountability.

Integrate engagement into core governance

Ensure that community partnership is embedded within existing governance and accountability structures, such as decision-making committees, quality improvement processes, and resource allocation, so that community influence is sustained over time.

Build capacity for meaningful participation

Provide training, accessible materials, translation, facilitation, and financial support so that community members can contribute on equal footing. Capacity-building strengthens both engagement quality and long-term partnership.

Monitor, evaluate, and adapt continuously

Track the effectiveness of engagement approaches, assess their impact on equity in exposures and outcomes, and adapt strategies based on feedback and evolving community needs. Engagement must evolve to remain relevant, respectful, and impactful.

6.5 Conclusion

Meaningful community partnership is central to achieving racial and ethnic equity in healthcare. The case studies show that when organisations work alongside communities, from digital monitoring and vaccine campaigns to structures Citizens' Panels, they uncover hidden barriers, design culturally relevant solutions, and builds trust that strengthens engagement and outcomes.

Delivering this in practice requires structured, long-term engagement, co-design, approaches that value lived experience as expertise, and feedback mechanisms that demonstrate accountability. By embedding community perspectives and community authority into governance, service design, and evaluation, healthcare organisations move beyond tokenistic consultation towards, equitable, culturally grounded, and effective practice.

Prioritising community partnership strengthens outcomes for patients, builds trust, and enhances the accountability, responsiveness, and resilience of the NHS.

Chapter 7: The Centrality of Effective Communication Strategies

7.1 Why it matters

Even the most compelling recommendations risk fading into the background if they are not communicated clearly, consistently, and with an understanding of power. For race and ethnic equity work to take root, NHS leaders, who are often positioned within dominant groups that benefit from existing structures, must be able to communicate why change is needed, what the evidence shows, and how action will be taken, in ways that resonate with different audiences across the system.

Effective communication must be tailored to the realities of those receiving it.

- For those in positions of power, including senior leaders, Boards, and managers (often predominantly white), communication needs to confront inequity honestly, build understanding of racism as a structural determinant, and establish clear expectations for action and accountability.

- For staff and communities who experience racism, communication must acknowledge lived experience, demonstrate organisational commitment, and build trust through transparency, partnership, and follow-through.

- For the wider NHS workforce, messages must translate equity principles into everyday practice, showing how individual roles contribute to collective progress.

Communication is therefore not a neutral activity, it is a strategic tool that shapes culture, influences behaviour, and determines whether equity commitments become reality.

Transparent, engaging, and audience-specific communication builds confidence, reduces resistance, and fosters collective ownership of change.

Conversely, poor or inconsistent communication creates confusion, erodes trust, and allows momentum to dissipate. Placing communication at the centre of race and ethnic equity efforts ensures that recommendations do not 'wilt on the vine', and instead grow into sustained, system-wide action that delivers real impact across the NHS.

7.2 What works

The Frameworks Institute in the United States has conducted extensive research on how to communicate about racial inequities in ways that build public understanding and support for structural change[54]. Their work shows that simply presenting data on racial disparities can inadvertently activate dominant cultural frames such as individualism, blame, or deficit thinking, that reduce support for systemic solutions. This highlights that communication is not only about conveying information; it shapes how people interpret inequities and where they believe responsibility lies.

Crucially, effective framing does not require softening messages to protect the comfort of those in dominant groups. Instead, it helps create space for people to recognise the realities faced by communities experiencing racism, to understand the structural causes of inequity, and to support action that addresses those causes. The goal is to foster empathy for racialised and minoritised groups, whose experiences are too often dismissed or misunderstood, and to build shared commitment to addressing the systems that perpetuate harm.

Although the Frameworks Institute's findings reflect a specific cultural and political context, they underscore the importance of undertaking ongoing, context-specific communication research in every region. Understanding local narratives, values, histories, and audience perspectives is essential for crafting messages that resonate, build support for structural solutions, and sustain the political and organisational will needed to address racial and ethnic inequities in health.

These dominant frames can manifest in multiple ways; Inset box 7.2.1 outlines three of the most common examples and illustrates why careful, evidence-informed communication is essential to advancing equity.

INSET BOX 7.2.1

The Dominant Racial Discourse.

These cultural frames shape how many people interpret racial inequity. When activated, often unintentionally, they make it harder to recognise racism as structural, and they weaken support for systemic solutions.

1 Historical progress and personalised racism

Many people assume that racial progress has largely been achieved through civil rights legislation or equity policies. From perspective, racism is seen as primarily an individual attitude or personal behaviour, rather than a structural and institutional force.

This frame also normalises the belief that discrimination as something that exists on both sides, which obscures power, historical context, and the ongoing impact of structural racism. As a result, systemic interventions appear unnecessary, excessive, or unfair.

2 The self-making person

This frame reflects the belief that success is achieved through individual effort, character, and personal responsibility. Within this worldview, racialised and minoritised groups are often judged as failing to meet these standards, while white people are presumed to have earned their advantage solely through merit.

When this individualistic lens dominates, people struggle to understand how racism, unequal access to opportunities, and structural disadvantage shape health, education, employment, and wellbeing. Structural explanations are replaced with deficit narratives about communities.

3 Separate fates

This frame assumes that the wellbeing of racialised groups is unrelated to the wellbeing of wider society. Inequities are viewed as issues affecting "other people," rather than reflecting shared systems and collective consequences.

The separate fates frame obscures how white advantage, structural racism, and unequal distribution of social determinants shape different outcomes for different groups. It makes it harder for people to recognise racism as a systemic issue that affects the whole population, weakens social solidarity, and reduces support for equity-focused policies.

Understanding these dominant narratives helps communicators identify where public thinking becomes constrained and where strategic reframing is needed to shift focus toward structural causes of inequity. Effective reframing opens space for empathy with communities experiencing racism, strengthens recognition of systemic drivers, and builds support for collective action.

The next example summarises research on how different ways of framing messages can either open or close pathways to understanding and meaningful engagement.

INSET BOX 7.2.2

Framing of messaging about racial and ethnic inequities; what supports understanding, and what requires careful use?

Communication research shows that different ways of framing messages can either support public understanding of structural racism and equity, or unintentionally close pathways for engagement. Effectiveness varies across audiences, so the examples below highlight approaches shown to open or constrain understanding, rather than 'good' versus 'bad' messaging.

Theme	Framing that supports understanding and action	Framing that can create barriers or requires careful use
Solutions and action	**Lead with solutions:** Begin by showing that practical, achievable interventions exist. This fosters a sense of efficacy and positions inequities as solvable.	**Problem-first framing:** Leading solely with disparities can produce overwhelm, compassion fatigue, or resignation, particularly among audiences accustomed to deficit-focused narratives about racialised groups.
Opportunity and access	**Opportunity for all:** Show how expanding access to resources, rights, and institutions benefits everyone while addressing inequities created by racism. Prosperity grid: Use metaphors that show how communities rely on shared systems (schools, transport, healthcare) and how gaps in the grid create unequal outcomes.	**"Diversity as a strength" rhetoric (on its own):** Can be heard as emphasising individual traits or symbolic gestures rather than addressing structural barriers.

Theme	Framing that supports understanding and action	Framing that can create barriers or requires careful use
Systemic thinking and structural awareness	**Prevention framing:** Emphasise early, systemic action to stop inequities from arising or worsening. Focus on changing conditions, not communities.	**Metaphors that locate the problem within minoritised communities (e.g., "canary in the coal mine"):** These metaphors risk reinforcing stereotypes or implying that communities themselves are the source of the problem rather than the structures harming them.
Community and shared benefit	**Interdependence and shared fate:** Stress that communities are connected, that structural inequities affect society as a whole, and that advancing racial equity strengthens collective wellbeing. **Fairness between places:** Comparing outcomes across neighbourhoods or regions helps people see how systems, not individual choices, shape opportunity.	**Highly individualistic framing:** Focusing on personal beliefs, behaviour, or effort can obscure structural causes of inequity, activating deficit narratives and weakening support for systemic solutions.

These insights demonstrate how careful framing can shift thinking away from individual responsibility and deficit narratives toward a clearer understanding of structural causes and shared solutions. When communication centres the experiences of communities affected by racism and uses narratives that engage audiences emotionally and constructively, it can build support for meaningful action. The following case study illustrates how emotionally resonant communication can apply these principles in practice.

CASE STUDY 7.2.1

Reshaping racial empathy bias through emotionally engaging communication

BACKGROUND

Empathy underpins emotional understanding, coordination, and effective communication. Neuroimaging studies in Africa, Asia, Europe, and the US, show that people exhibit stronger neural responses when observing pain in same-race compared to other-race individuals. This racial empathy bias can unconsciously reduce emotional resonance and compassion across racial lines, shaping interpersonal and societal interactions.

KEY FINDINGS

Empathetic neural responses to others' pain occur rapidly and automatically. In contrast, self-reported empathy often shows weaker bias, suggesting that individuals consciously suppress or deny bias due to social norms. This gap underscores the need for communication strategies that address both unconscious and deliberate dimensions of bias.

LESSONS LEARNED

Empathy engages multiple neural systems that can be retrained through emotionally resonant communication. Techniques such as empathetic listening, mutual self-disclosure, and shared emotional reflection stimulate affective sharing and perspective-taking; processes shown to reduce racial empathy bias. Communication that authentically conveys the lived experiences and challenges of disadvantaged racial or ethnic groups, in ways that evoke emotional connection among dominant groups, can foster greater cross-racial empathy and inclusivity.

The strategies in this case study align with neuroscientific and behavioural evidence showing that empathy, perception, and bias are not fixed traits. They can be influenced by communication that builds emotional connection, highlights shared identity and collective wellbeing, and reframes inequities as the result of structural conditions rather than individual failings. Such approaches help shift audiences toward greater understanding of racism's impacts and stronger support for systemic solutions.

INSET BOX 7.2.3

What reduces the racial gap in empathy?

1	**Individuation:** focus on a person's suffering, not their race.
2	**Shared goals:** see yourself on the same team as people from other racial groups.
3	**Interracial socialisation:** more interactions with people from different racial backgrounds.

7.3 Recommendations

Diversify leadership of communications teams

Prioritise racial and ethnic diversity within senior communications roles so that strategic decisions reflect the perspectives, insights, and lived experiences of the communities being served. Diverse leadership strengthens credibility, relevance, and cultural safety.

Build capacity for inclusive and equitable engagement

Provide training for communications staff to engage effectively with diverse audiences, publications, and platforms. Strengthen cultural safety, active listening, anti-racist practice, and the ability to tell stories in ways that respect context and avoid reinforcing stereotypes.

Develop emotionally resonant campaigns that support structural understanding

Design campaigns that illustrate the challenges and complexities of communicating about racial and ethnic inequities in health. Use emotionally engaging framing to connect with shared values such as fairness, dignity, and justice, motivating broad audiences, including those unfamiliar with or resistant to equity work.

Frame for empathy with those experiencing racism and for shared responsibility

Use accessible language that connects across political and cultural perspectives while being explicit about the structural nature of racism. Effective framing evokes empathy for communities affected by racism, builds understanding of structural causes, and reinforces shared responsibility for change.

Tell human stories with accuracy, dignity, and care

Share stories that humanise inequities and illustrate the real impacts of racism on health, while avoiding narratives that sanitise, trivialise, or oversimplify trauma, violence, or harm.

Storytelling should honour lived experience, support agency, and motivate structural action; not reduce people to their suffering or present inequities as individual misfortunes.

Invest in evidence-based communication science

Build a research base to identify which frames, narratives, and linguistic approaches most effectively increase understanding of structural racism, reduce bias, and strengthen support for policies that address racial and ethnic inequities in health. Use this evidence to inform local and national campaigns.

INSET BOX 7.3.1

What you can do to influence change.

Audience	Actions that influence change
Health professionals	• Speak out about inequities in treatment and access to care. • Use patient stories to advocate for inclusive care practices. • Mentor practitioners from underrepresented groups.
Community organisations	• Share local success stories that highlight change. • Host dialogues linking community experience to policy change. • Partner with researchers and communicators to co-create messages.
Policymakers and leaders	• Champion inclusive health policies grounded in empathy and evidence. • Fund communication initiatives that build cross-community understanding. • Publicly recognise and amplify strategies that work.
Members of the public	• Engage with stories that humanise inequities. • Share verified information on social platforms. • Support organisations advancing health equity.

7.4 Implementation for impact

Plan with purpose

Develop a clear communication strategy aligned with the organisation's racial and ethnic equity goals. Ensure executive sponsorship, senior leadership support, and dedicated resources. Communication must be positioned as a strategic driver of culture change, not a peripheral activity.

Use data and evidence to guide messaging

Collect and analyse data on audience perceptions, engagement, and responses to different framings. Draw on neuroscience, behavioural science, and social psychology to design messaging that fosters understanding of structural inequities and empathy for communities experiencing racism.

Embed inclusive and anti-racist communication practices

Integrate principles of cultural safety, inclusivity, dignity, and anti-racism into every stage of communication; from message development and audience testing to partnerships, delivery channels, and content review. Ensure materials avoid stereotypes, deficit narratives, or sanitised accounts of racism.

Set measurable outcomes

Define specific, time-bound goals for reach, engagement, shifts in perception, and changes in organisational behaviour. Track progress, evaluate impact, and report findings transparently to foster accountability and ongoing learning.

Highlight success and share learnings

Regularly communicate stories of progress, evidence-informed strategies, and lessons learned, without trivialising or overshadowing lived experiences of harm. Celebrate achievements to maintain momentum and reinforce credibility, while continuing to acknowledge ongoing challenges.

Engage with communities as partners

Co-create messages with community organisations, staff networks, and trusted local voices to ensure authenticity, accuracy, and resonance. Prioritise two-way communication that builds trust, accountability, and long-term relationships, not one-off consultation.

Learn and adapt continuously

Monitor outcomes, gather feedback from diverse audiences, and refine messaging, framing, and storytelling techniques based on emerging evidence and lived experience. Treat communication as an ongoing practice of reflection, iteration, and improvement.

7.5 Conclusion

Effective communication is central to transforming equity commitments into meaningful action. As this chapter demonstrates, the way messages are framed, whether they highlight shared responsibility, evoke empathy for communities experiencing racism, or foreground practical solutions, profoundly shapes understanding, engagement, and support for change.

By combining evidence-based communication strategies, emotionally resonant and dignifying storytelling, and inclusive, anti-racist practices, health systems can bridge the gap between knowledge and action. Thoughtful communication helps build trust with diverse audiences, strengthens organisational accountability, and motivates collective responsibility for reducing racial and ethnic inequities in health.

Embedding communication at the heart of equity work, supported by diverse leadership, rigorous research, and sustained community partnership, ensures that messages do more than inform. They inspire, they mobilise, and they contribute to the long-term, systemic change required to improve health outcomes and experiences for racialised and ethnically marginalised communities.

Conclusion

Achieving racial and ethnic equity within the NHS is both a moral and operational imperative. The evidence is clear: organisations that identify and address inequities, challenge racism within their systems, and embed equity into everyday practice deliver better outcomes for patients and create healthier, more motivated workforces. Equity is not a supplementary priority; it is fundamental to the NHS's ability to provide safe, high-quality, and person-centred care.

Over the past decade, research has demonstrated that racism is not confined to individual interactions but is embedded within structures, cultures, and processes. Addressing these patterns requires sustained, visible leadership and a willingness to confront uncomfortable truths about how racism shapes exposures, access, experience, and outcomes. Meaningful change demands a shift from awareness to accountability, where leaders, teams, and systems take collective responsibility for progress.

Data must be transformed into action. High-quality ethnicity data, measures of exposure to racism, robust analysis, and transparent reporting should drive measurable improvement in recruitment, progression, service design, care quality, and outcomes. Policies and governance systems must ensure that equity is built into every layer of decision-making, from Board strategy to frontline operations.

Progress depends on partnership. Real improvement happens when staff and the communities most affected by inequity are not only consulted but empowered to shape and lead change. Co-designing solutions, sharing power, and recognising lived experience as a form of expertise are essential to creating services that are trusted, culturally grounded, and effective.

Embedding racial and ethnic equity also demands cultural transformation. NHS organisations must foster environments where people feel psychologically safe, valued, and able to challenge injustice. This includes strengthening inclusive and anti-racist leadership capability, embedding cultural safety into education and appraisal, and integrating equity into quality improvement, safety, and governance processes.

The journey toward equity will not be linear, but progress is both possible and necessary. By integrating evidence-based practice, holding themselves accountable for outcomes, and maintaining open dialogue with staff and communities, NHS organisations can move from statements of intent to demonstrable, measurable change.

Racial and ethnic equity is not only a measure of fairness; it is a marker of quality, compassion, effectiveness, and trust. When the NHS fully reflects the communities it serves – within its workforce, culture, governance, and care – the entire system benefits. The work begins and continues with leadership, data, and courage, sustained by a shared commitment that equity is central to health.

Next Steps

The insights in this report must now be translated into visible, sustained change across the NHS. The next phase should focus on dissemination, implementation, and shared learning at scale.

1. COMMUNICATE THE VISION WIDELY

- Develop clear, accessible communications that highlight the report's key findings, practical actions, and the evidence underpinning them – adopt the NHS Race and Health Observatory's **'7 Principles of Anti-racism'**.
- Present the core messages, why equity matters, what works, and how to act, through concise visuals, infographics, and summaries tailored for different audiences.
- Use NHS England, ICSs, Trust channels, and staff networks, and professional bodies to ensure broad and consistent dissemination.

2. ENGAGE LEADERSHIP AT EVERY LEVEL

- Convene briefings and workshops with Boards, executive teams, and clinical leaders to align equity goals with organisational priorities, including quality, safety, and workforce wellbeing.
- Encourage Boards to formally adopt the report's recommendations, and embed them within strategic plans, risk frameworks, and performance frameworks.
- Identify executive sponsors and senior responsible officers to oversee implementation and accountability.

3. ENABLE SYSTEM-WIDE LEARNING AND COLLABORATION

- Create a structured learning network or community of practice to support shared learning, problem-solving, and innovation.
- Use data, early adopter case studies, and evaluation findings to demonstrate impact and accelerate adoption across the system.
- Partner with academic institutions, staff networks, community organisations, and patient groups to build and continually update the evidence base.

4. INTEGRATE EQUITY INTO EXISTING NHS IMPROVEMENT FRAMEWORKS

- Embed the report's principles into existing programmes such as the Workforce Race Equality Standard (WRES), Patient Safety Improvement, and Quality Improvement (QI) initiatives – adopt the NHS Race and Health Observatory's **'Anti-racism Model Improvement'**.
- Ensure equity metrics are visible in performance dashboards, Board reports, and regulatory reviews.
- Link implementation to mechanisms of assurance and accountability, including CQC regulatory frameworks and the NHS People Promise.

5. BUILD CAPACITY AND CAPABILITY ACROSS THE SYSTEM

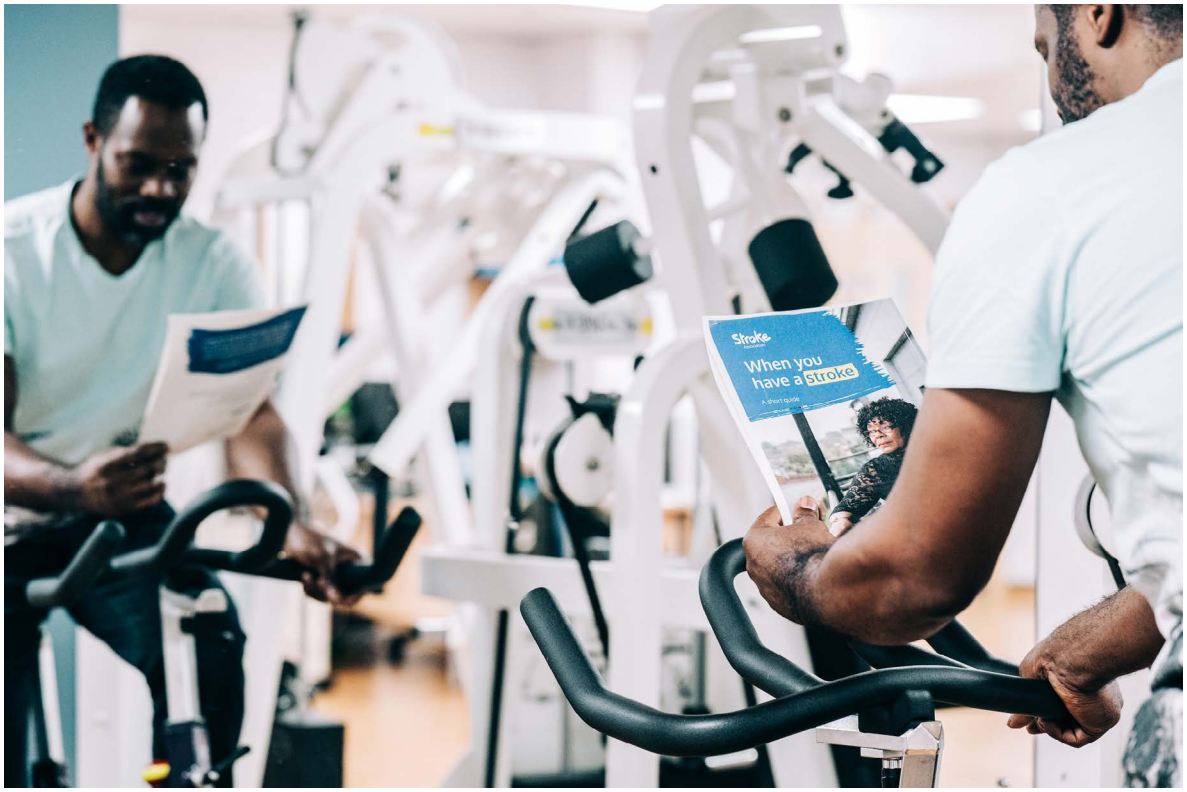
- Provide targeted development for leaders and managers on inclusive leadership, cultural safety, and anti-racist practice.
- Support equity leads, staff networks, and frontline champions with practical tools and resources to translate the report into local action.
- Develop open-access tools, e-learning modules, and training resources aligned with this report's recommendations to promote consistent practice across organisations.

6. MONITOR, EVALUATE, AND ADAPT

- Establish a national monitoring framework to track adoption, outcomes, and impact using standardised data and regular reporting.
- Share results transparently to reinforce accountability, promote learning, and highlight effective interventions.
- Use evaluation findings to refine guidance, address persistent gaps, and ensure the work remains responsive to evolving needs.

The challenge ahead is ensuring that the messages of this report are not confined to discussion but are embedded in the everyday reality of NHS organisations. Dissemination, leadership, learning, and accountability must work in concert to drive practical, measurable change.

The evidence is clear, the moral case is unequivocal, and the tools exist. What remains is collective will and sustained action; turning knowledge into practice, and commitment into equity.



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