Wales Centre for Public Policy
Canolfan Polisi Cyhoeddus Cymru

Improving Race Equality in Health and Social Care

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Summary

- This report is one of a series of six that provides independent evidence to inform the development of the Welsh Government's Race Equality Action Plan.
- It analyses the evidence about strategies to reduce racial disparities in the health and social care system for both the workforce and service users.
- Experts advocate **de-biasing recruitment and career progression** processes as a way to achieve equitable staff representation and progression. This requires inclusive recruitment, promotion, and development opportunities, as well as positive action and targets.
- These initiatives are insufficient alone. They require a concurrent emphasis on **promoting inclusive and psychologically safe workplaces**.
- This includes bolstering mandatory training for all staff which goes further than existing 'cultural competency' or unconscious bias training to prioritise anti-racist approaches, experiential learning, active reflection, and perspective-taking.
- Importantly, **training alone will not be effective in changing behaviour**. Other strategies include improving discrimination reporting procedures, promoting open discussion about race, empowering staff to raise concerns and share ideas, de-biasing disciplinary processes, and parity of physical safety.
- Strategies to support racial equality for service users include the provision of **culturally sensitive and non-discriminatory services**, including explicitly **anti-racist service delivery and training** curricula supported by mandated organisational frameworks and certification schemes.
- To effectively reach racial and ethnic minority communities, public health promotion and prevention must be **grounded in and involve partnership working with the third sector, sustained community engagement, use of multiple channels, and tailored messaging**.
- **Intersectional approaches** to policy, research, and practice; collection of **quality, meaningful data** to target and continuously evaluate change; **visible senior leadership support**; and the implementation **of multiple, multi-level and sustained strategies** are important to success.
- N**o one strategy will be effective in the long-term unless health and social care sectors systematically unpick underlying racist institutional policies, processes, procedures, norms, and attitudes which maintain the status quo**.

Background

The Welsh Government has made a commitment to publish a Race Equality Action Plan designed to tackle structural racial inequalities in Wales (Welsh Government, 2020a). This report is one of six that has been produced by the Wales Centre for Public Policy to provide independent evidence to inform the development of the Action Plan (see Annex 1). It focuses on evidence and recommendations for action related to race equality in health and social care.

Introduction

This report presents the evidence relating to what works in reducing race disparities within the health and social care sector. The first section focuses on ways to improve the experiences and outcomes of health and social care staff by:

- Supporting racial and ethnic diversity among the health and social care workforce;
- Debiasing recruitment, development and secondment opportunities; and
- Promoting inclusive, psychologically and physically safe workplaces.

The second section focuses on strategies to improve the experiences and outcomes of racial and ethnic minority service users through:

- Non-discriminatory and culturally sensitive mental health provision;
- Data collection, monitoring and reporting to support equitable health and social care services; and
- Equitable public health approaches.

These actions were identified through four phases of analysis:

- First, we analysed the best available evidence, policy reports and reviews which make recommendations for reducing race inequality in Wales and the UK to identify recurring recommendations or ‘types’ of interventions (see Annex 2).
- We then tested and refined these with academic experts.
- Next, we conducted a further review of academic and grey literature evidence related to each of these interventions with the aim of establishing which of

these recommendations are likely to have the greatest impact if they are included in the Race Equality Action Plan.

- Finally, the report was peer reviewed by three experts in the field: Dr Victoria Showunmi (University College London), Dr Ada Hui (Nottingham University) and Professor Keshav Singhal (University of South Wales).

The causes, consequences and solutions to race inequality are interconnected and require change across a range of policy areas and public services. So this report should be read in conjunction with five related reports that focus on **leadership and representation, education, employment and income, crime and justice** and **housing and accommodation** (see Annex 1), and an overarching report (forthcoming) which pulls together cross-cutting findings and recommendations.

The Welsh context

Racial and ethnic minority communities in Wales have a history which long pre-dates the Windrush era, exemplified by one the UK's oldest multi-ethnic communities, in Tiger Bay (Butetown), as well as a centuries-long history of Gypsy, Roma and Traveller migration to Wales (Marsh, 2020). From the 1919 Race Riots to ongoing racialised miscarriages of justice[1], Welsh history and experiences of racism are distinct from elsewhere in the UK, although some UK Government policies, such as the 'hostile environment', have inevitably had an impact in Wales, adversely disadvantaging migrants in accessing healthcare, education and accommodation despite a devolved focus on integration[2] (Parker 2017).

This report provides a synthesis of research, policy recommendations and examples from practice relevant to reducing racial disparities in health and social care. While much of the available data and research evidence comes from UK-wide studies, studies covering both England and Wales, as well as international studies, we recognise the importance of situating this within the Welsh policy context. This includes the broader legal context of the Equality Act 2010, the Public Sector Equality duty in the Act and the specific duties for Wales as well as the Welsh Government's Strategic Equality Plan (2020-2024)[3] and the 2018 Equality and Human Rights Commission (EHRC) report 'Is Wales Fairer?' (EHRC 2018), which underpin an

[1] **https://www.theguardian.com/uk/2012/sep/17/cardiff-three-five-wait-justice**

[2] **http://www.docsnotcops.co.uk/newresearch-hostileenvironment-wales/**

[3] **https://gov.wales/equality-plan-and-objectives-2020-2024**

ongoing commitment to tackling racial inequalities in Wales exemplified by the development of the forthcoming Race Equality Action Plan.

In Wales, 5.9% of the population identify as Black, Asian, 'Mixed/Multiple' or 'Other' ethnic groups, but there are wide variations between local authority areas ranging from 1.7% to 19.8% (Welsh Government, 2020b). There are persistent racial inequalities in health and access to health and social care, and in levels of loneliness, among other social and economic disparities (EHRC, 2018).

The Coronavirus pandemic has increased the urgency of actions to eliminate racial disparities in Wales and highlighted the importance of health and social care as one of several key policy areas through which inequalities can be addressed. For example, in Wales the COVID-19 mortality rate (2nd March to 15th May 2020) was two times higher for Black males than White males, and nearly one and a half times higher among Black than White females, even after accounting for differences in population density, household and socio-economic factors (Office for National Statistics 2020).

In response to evidence of inequalities faced by racial and ethnic minority groups at risk of COVID-19 related morbidity and mortality, the First Minister convened the Black, Asian and Minority Ethnic group COVID-19 Advisory Group. The Socio-economic Sub-Group was set up specifically to identify socioeconomic factors contributing to racial inequalities in health and social care outcomes, as well as immediate and longer-term actions to reduce such disparities, for which Professor Ogbonna's report was commissioned (Ogbonna, 2020). The findings of this report align closely with health and social care recommendations outlined in the Equality, Local Government and Communities Committee's (ELGC) response to the EHRC's 'Rebuilding a more equal and fairer Wales' report (ELGC 2020), the Ogbonna report recommendations, and the Welsh Government's recent response to those recommendations.[4]

Key concepts and review scope

It is important to acknowledge that **both race and ethnicity are social constructs not biological distinctions**, and to **recognise differences in needs and experiences within and between different racial and ethnic groups**. We actively avoid using the terms 'BAME' or 'BME' except where this describes the name of an organisation or network. These terms can be experienced as stigmatising,

[4] **https://gov.wales/now-time-action-racial-inequality-welsh-government-lays-out-route-systemic-and-sustainable-change**

depersonalising and 'othering', as well as reflecting an unwillingness and discomfort among White people to discuss specific experiences of racial and ethnic minority groups (e.g. Bunglawala, 2019).

Our review focuses on race and ethnicity, but it is important not to examine these aspects of people's social identities in isolation. People's health and social care experiences and needs differ according to gender, class, socio-economic and employment status, sexual orientation, disability, and migration status – among other things. While it is not possible (because of both a lack of available data and space) to disaggregate our review by all relevant aspects of people's intersectional[5] experience, work focusing on the intersections with migration status is particularly essential for this policy area, given the considerable reliance on migration within both the health and care sectors (Moriarty, 2018). The Welsh Government's Action Plan also needs to acknowledge that approaches to increasing racial and ethnic equity cannot just rely on 'top down' policy and strategic initiatives but must also incorporate 'bottom up' approaches. Alongside visible senior leadership commitment, sustained action is needed to tackle three levels of racism – institutionalised, personally mediated, and internalised racism (Jones, 2000). It also means that racial and ethnic minority individuals and organisations must be actively engaged and involved in all decisions about race equity, while acknowledging that it is everybody's responsibility to address it.

Health and social care staff

Supporting racial and ethnic diversity and inclusion among the health and social care workforce

The health and social care sectors tend to be more racially and ethnically diverse than the Welsh population as a whole. There is limited data available to disaggregate health and social care workforce data by ethnicity in Wales (Stats Wales, 2020; Social Care Wales, 2020) but experimental statistics indicate that 15% of General

[5] Intersectionality refers to the fact that people from racial and ethnic minority groups also hold other social statuses (e.g. gender, sexual orientation, migration status, religion/faith, disability) which influence their experience, needs and outcomes. For instance, the experience of belonging to a racial or ethnic minority in a particular domain is likely to differ for men and women, or for new migrants compared to second or third generation individuals. Intersectional perspectives encourage consideration of the whole person.

Practitioners are from a minority ethnic group, predominantly Asian or Asian British (Welsh Government, 2020c). In 2018, 82% of regulated social care workers identified as White, while 15% preferred not to state their ethnicity (Social Care Wales, 2018). UK-wide data indicates that health and social care workers are disproportionately more likely to be from Black, Asian and other minority ethnic groups (Autonomy, 2020; GOV.UK, 2020). Hostile environment and new immigration UK policies have and will disproportionately affect the eligibility of non-UK born social care workers in Wales, with many jobs excluded from the proposed Health and Care Visa (Portes et al., 2020).

Racial and ethnic minority health and social care staff are over-represented in lower paid and lower status health and social care jobs in the UK. We were unable to identify Wales-specific information on the progression of health and social care staff by ethnicity. Therefore, it is unclear to what extent it mirrors the trend of decreasing representation as seniority increases, and very low representation at the highest levels of management seen elsewhere in the UK (Kline, 2015; Race Disparity Unit, 2019; GOV.UK, 2020). While racial and ethnic disparities in progression have been found to be similar for men and women in the healthcare sector (Milner et al., 2020), equivalent data were not found for social care.

Such inequalities are underpinned by implicit and explicit racism[6] in recruitment, promotions, and career progression opportunities (e.g. Royal College of Physicians, 2020). Importantly, and more difficult to tackle, these inequalities are also the more insidious result of everyday micro-aggressions[7] (Sue, 2008) both in and outside of work, and of internalised racism that reflects the broader societal context (The King's Fund, 2020; Ross et al., 2020). The Ogbonna report (2020) highlights evidence from stakeholder engagement that racial and ethnic minority healthcare staff in Wales similarly experience both covert and overt racism and are disproportionately affected by disciplinary procedures.

Evidence specifically in health and social care contexts about what works to improve workforce diversity is limited (Priest et al., 2015), although sharing learning across sectors is important. For example, Manthorpe et al. (2018) argue that employment sectors, including health, could learn much from the experience of social care in workplace diversity but that this is an underused resource. In the context of the

[6] Implicit racism refers to unconscious and automatic processes, explicit racism refers to conscious and controlled processes.

[7] Described as 'brief, commonplace, and daily verbal, behavioral, and environmental slights and indignities' (Sue, 2008; p.329) directed towards racial and ethnic minorities, often involving undermining, insulting, and excluding behaviours.

Workforce Race Equality Standard (WRES)[8] requirements implemented in the NHS in England, Priest et al. (2015) distilled key features of effective diversity initiatives from a review of international evidence covering a variety of organisation types and contexts. They outlined key strategies which, as overarching principles for promoting diversity and equality of opportunity, are also applicable to social care and vice versa, and to equivalent institutions in Wales (we discuss the relevance of WRES to Wales further below). These include:

- Mandated targets or actions;
- Leadership support; and
- The implementation of multiple sustained initiatives acting at multiple levels (in terms of both seniority and organisational scale).

Efforts to increase workplace racial and ethnic diversity in terms of employee progression and senior level representation are only likely to have a sustained positive impact when employees perceive that the climate is both psychologically safe[9] (Edmondson and Lei, 2014) and genuinely inclusive[10] (Kline, 2020). This in turn relies on visible employer promotion and commitment, as well as on the behaviour of colleagues (van Knippenberg and Schippers, 2007).

The need to improve data collection and monitoring disaggregated by ethnicity has been identified as a notable gap in Wales (Ogbonna, 2020) and is also important to increasing equality of representation and reducing discrimination.

We therefore structure the following sections relevant to the health and social care workforce in relation to evidence, practice examples and recommendations for debiasing recruitment and career progression, as well as promoting inclusive and psychologically safe workplace environments. We then describe how leadership support and accountability; multiple, multi-level and sustained initiatives; as well as enhanced data collection underpins these processes.

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[8] The Workforce Race Equality Standard (WRES) was mandated in England in 2015. It requires NHS organisations to demonstrate progress against nine indicators of workforce race equality, e.g. in relation to access to training opportunities, disproportionality of disciplinary actions, and prevalence of racial discrimination, bullying and harassment. WRES also supports improvement action planning to address the underlying causes of discrimination. **https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/**

[9] Psychological safety refers to the perceived risk of speaking up, voicing concerns and making mistakes at work (Edmondson and Lei, 2014).

[10] Inclusion refers to feeling valued at work, being treated equitably, and the extent to which people feel that they are contributing and are encouraged to contribute to a team or group's effectiveness (Shore et al., 2018).

Debiasing recruitment, development and secondment opportunities

Recommendations

- Utilise a combination of recruitment and progression practices (such as anonymised job applications, (reverse) mentoring, role modelling, succession planning, and leadership programmes) at individual, workplace and institutional levels and ensure they are sustained and visibly supported by management. At their forefront needs to be a commitment to unpicking structures, policies and procedures (both formal and informal) which maintain the status quo (e.g. practices around access to promotion opportunities and migration-related policies).
- Publish locally meaningful targets for representation and sector-specific targets for progression for racial and ethnic minorities which are underpinned by sustained positive action, and for which leaders are held to account.
- Provide specific support and guidance for health and social care employers to implement positive action and to collect data to support targeted action.
- Consider making funding dependent on particular initiatives or practices, such as implementation of the Race Equality Charter.
- Take a systems approach and intersectional perspective to avoid unintentionally creating new, or exacerbating existing, inequalities.

While data are not available from Wales, evidence from stakeholder engagement (Ogbonna, 2020) and data from NHS trusts in England over the past five years illustrate that White healthcare staff are more likely to be appointed from shortlists to all posts and are more likely to access non-mandatory training and professional development than racial and ethnic minority applicants (WRES Implementation Team, 2020). Debiasing recruitment, development and progression opportunities is therefore key to reducing workforce racial and ethnic inequalities.

We describe approaches to doing this in more detail in the report on increasing racial equality in ‘Improving Race Equality in Employment and Income’. Here, we focus on offering evidence and examples from health and social care practice. Such approaches include inclusive recruitment, promotion, and development processes, as well as positive action and targets.

Inclusive recruitment, promotion and development processes

Building on learning from the implementation of WRES since 2015, the recently published NHS England strategy recommends the use of anonymised job applications (Krause et al., 2012) and encourages managers to consider 'the ability and expertise of the individual to demonstrate and encourage an inclusive culture when in role' (NHS England and Improvement, 2020a; p.52). Such an approach is also recommended by Race Alliance Wales (2020). A focus on inclusion is outlined for each stage of the recruitment process from job design (e.g. skills to match the role rather than those of the person previously in post) through to interview (e.g. ensuring Black, Asian and minority ethnic staff representation on the panel with equal scoring weight and that work-related tasks do not inadvertently discriminate against racial and ethnic minority applicants), and role orientation.

Mentoring (including reverse-mentoring[11]) can positively impact career progression and recruitment, for example, by helping to counteract and confront biases and stereotypes; developing professional skills; sharing knowledge about workplace practices; facilitating access to role-models; and increasing social capital (Robinson, 2018; Clarke et al., 2019). When the junior counterpart is from a racial or ethnic minority (as in reverse-mentoring), there may be potential for positively impacting career progression and recruitment (Robinson, 2018). An example of a reverse mentoring initiative in the healthcare sector is the 'Reverse Mentoring for Equality, Diversity and Inclusion (ReMEDI) programme'. Here, senior staff or staff from majority racial/ethnic groups are mentored by more junior or racial/ethnic minority staff (Raza and Onyesoh, 2020). Similarly, role modelling forms part of the key recommendations based on learning from the implementation of WRES. They suggest that, while avoiding tokenism, this would be supported by actively showcasing racial and ethnic diversity in senior management levels.

Other inclusive recruitment and progression strategies include:

- Succession planning to support the 'talent pipeline';
- Reviewing equity of access to secondments; and

[11] When a more junior employee is paired with and mentors a more senior colleague, e.g. to share knowledge about generational perspectives or updated expertise. Reverse mentoring can also refer to specific situations in which a racial or ethnic minority employee is paired with and mentors a colleague who is more senior or from the majority racial and ethnic group.

- Leadership programmes to support Black, Asian and minority ethnic staff to enter non-executive posts and to prepare them for their first board appointment (e.g. the Seacole Group[12]).

'Moving Forward' is a leadership programme for racial and ethnic minority healthcare staff in Bradford, showcased as a case study in Ross et al. (2020). It targets band 5 and 6 staff and offers training in leadership skills and learning experiences to support them to apply and be successful in obtaining more senior positions.

Positive action and targets

Positive action[13] is encouraged to recruit to roles where racial and ethnic minority staff are underrepresented and is supported by Race Alliance Wales (2020). Under the 2010 UK Equality Act, positive action policies focusing on promoting workforce diversity are voluntary but can be supported by aspirational target-setting. They have long been advocated in the health sector (Iganski et al., 2001), though we were unable to find evidence of this in social care. The tie-break system is most commonly used in the UK, whereby a person's protected characteristic can be used to decide between two equally qualified candidates to benefit the more disadvantaged candidate. However, there is little evidence about whether positive action produces more racially and ethnically equal workforces (Davies, 2019), and barriers to implementing positive action may limit its effectiveness. These include a lack of clarity among recruitment decision-makers about what it is, and fears of tokenism, 'reverse discrimination'[14] and positive discrimination, which is illegal (EHRC, 2019).

Both the McGregor-Smith review (2017) and Race Alliance Wales manifesto (2020) recommend that organisations ensure that the diversity of staff is representative of local communities as well as regional and national labour markets. Diversity targets for which management are accountable are key to this requirement (Gifford et al., 2019). Targets can be used to focus on diversifying particular organisational levels (e.g. NHS Boards) and to ensure progression rates for racial and ethnic minority staff

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[12] **https://www.seacolegroup.com/**

[13] Positive action refers to specific actions taken to increase workplace equality for people with protected characteristics under the 2010 Equality Act. For example, addressing the under-representation of racial and ethnic minority personnel in more senior roles by encouraging applicants from those backgrounds and/or more favourably recruiting a racial and ethnic minority candidate over a White candidate but only **where the two are equally qualified**. Positive action is voluntary but may support organisations to meet their Public Sector Equality Duties. **Positive action is distinguished from positive discrimination** which is illegal and involves treating a disadvantaged group more favourably than an advantaged group when the conditions for positive action are not met. See section 159 of the Equality Act 2020 **https://www.legislation.gov.uk/ukpga/2010/15/section/159**. Accessed 23rd October 2020.

[14] Reverse discrimination is a contested term used to refer to when a majority group is discriminated against in favour of a traditionally disadvantaged or minority group.

are proportionate to their representation in health and social care services (Byrne et al., 2020).

Initiatives from other sectors could be adapted for the health and social care sectors. In higher education, the Athena Swan Charter is an evidence-based example of success in increasing representation of women, which recognises initiatives to enhance gender equality using financial and reputational incentives (Rosser et al., 2019). Similarly, universities can apply for different levels of award against the newer Race Equality Charter (REC) which supports institutions to identify and reflect on barriers faced by Black, Asian and minority ethnic staff and students (Bhopal and Pitkin, 2018). Uptake of the REC has been lower than for Athena Swan, partly due to perceived greater difficulty in attaining Charter mark status and partly because it is not incentivised in the same way (demonstration of Athena Swan award attainment is a requirement of certain funders).

These schemes can be seen as tokenistic (Patel, 2020) and may be used for 'gaming' purposes where a competitive advantage is possible (Bhopal and Pitkin, 2018). However, available (qualitative) evidence suggests universities have benefited from applying and obtaining REC awards, for example, in terms of increased communication about race, using it to support positive action initiatives for recruitment, retention and progression (Bhopal and Pitkin, 2018). It is however essential that initiatives do not replicate or generate new inequalities. For instance, the Athena Swan was criticised for mainly benefitting White women (Bhopal and Henderson, 2019) and so explicit incorporation of intersectional approaches has since been included in both Athena Swan and REC award criteria. Systems thinking is also key to identifying unintended or unanticipated consequences of actions to address racial disparities (Came and Griffith, 2017).

Promoting inclusive, psychologically and physically safe workplaces

Recommendations

- Scrutinise and transform existing approaches to diversity training, mindful of and actively pre-empting unintended effects, such as the risk of focusing on individual behaviours rather than systemic issues.
- Actively involve racial and ethnic minority staff in training development but ensure it is mandatory for all staff at all levels. Training should be on-going and incorporate experiential, perspective-taking, and reflective approaches with a priority focus on action and behaviour change. Importantly, it should have an

explicitly anti-racist lens, incorporating a focus on acknowledging the role of – and challenging – whiteness as the institutional norm, white privilege, and white fragility.

- Combine training with a broader institutional and workplace commitment to psychological safety and inclusivity, with a clear focus on covert, everyday microaggressions; encourage allyship and bystander intervention which is visibly supported by senior leadership.
- Outline expectations for and support all staff at all levels to have open discussions about race and racism in the workplace and beyond.
- Create specific forums (e.g. Schwartz rounds, staff networks, Freedom to Speak Up Guardians) for staff to share experiences, raise concerns, and have their opinions heard with clear and transparent channels of communication and accountability to middle and senior management.
- Enhance access to culturally sensitive psychological interventions for staff such as counselling and bereavement support, alongside broader health, and wellbeing support.
- Actively unpick and de-bias disciplinary procedures as part of a more collaborative and person-centred approach to human resources processes.
- Provide sufficient and adequately fitting Personal Protective Equipment (PPE) tailored to fit racial and ethnic minority communities.
- Support research and evaluation (including collection of appropriate data) to identify what works in what contexts to change behaviour in a sustained way.
- Promote risk assessments that specifically and sufficiently consider the physical and mental health of all Black, Asian and minority ethnic staff.

Debiasing recruitment and progression practices and implementing targets will have only limited effectiveness if the workplace environment remains hostile to racial and ethnic minority staff (Kline, 2020). Ensuring psychological safety means fostering a work climate which instils in all staff a sense that they are able to, and should, speak up about issues at work, to question decisions, raise concerns and any mistakes they make (Edmondson and Lei, 2014). Tackling staff discrimination is essential to the health and social care sectors because it is associated with poorer psychological health and well-being, lower job satisfaction and increased intention to leave (Rhead et al. 2020) – in short, an environment free of all forms of discrimination is essential for staff psychological safety.

Training and skills development to tackle race inequalities

Equality and diversity training initiatives predominantly consist of 'cultural competency' and 'unconscious bias' training.[15]

Cultural competence has been defined as 'a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or professions to work effectively in cross-cultural situations' (Cross et al., 1989; p. iv).The term 'cultural competence' describes the ability of professionals to provide services and to interact with other staff in ways which effectively take into account people's cultural beliefs, needs and behaviours. It comprises cultural awareness, knowledge, and sensitivity, in addition to promoting anti-racist policies and practice (Collins, 2007).

It should be noted that the term has been criticised for conflating 'culture' with race and ethnicity, assuming culture is fixed and something that can be learned, individualising cultural 'competence' rather than addressing fundamental systemic inequalities, and for leading to unhelpful cultural stereotyping (e.g. Kleinman and Benson, 2006; Kirmayer, 2012; Beagan, 2018). Training in 'cultural competency' should take account of this critique and ensure that providers are aware of the ways in which race and ethnicity intersect with other characteristics in different ways to influence an individual's needs and experiences (Powell Sears, 2012).

Our analysis of the evidence base identified three systematic reviews of cultural competency training[16] for health professionals (Beach et al., 2005; Truong et al., 2014; Jongen et al., 2018). Each review identified a wide variety in approaches to and content of such training. They all found good evidence for effectiveness in short-term improvements in skills, attitudes, and knowledge, as well as improvements to patient satisfaction. However, they highlight a lack of evidence to allow comparison of different approaches to cultural competency training, or to assess longer term and behaviour-change outcomes (e.g. discrimination, patient or service user adherence and outcomes).

Importantly, both Truong et al. (2014) and Jongen et al. (2018) conclude that such initiatives are unlikely to be effective in isolation. As outlined for workforce diversity

[15] Evidence on unconscious bias training is considered by Hatch et. al. (2020), in 'Improving Race Equality in Employment and Income' report in this series (see Annex 1).

[16] Such training often aims to develop understanding of the role of culture in people's lives and its impact on behaviour; developing respect and acceptance of different cultures; being able to adapt practices that are culturally specific; and, encouraging awareness of one's own cultural influences, prejudices or biases (Jongen et al., 2018).

more generally, strong leadership support demonstrating organisational commitment to cultural competence is key. For instance, by embedding commitment and accountability to competency targets within policy and strategic documentation, and within professional development initiatives. Such support can have trickle-down effects on the cultural competence of health and social care professionals (Truong et al. 2014).

Mentoring (including reverse-mentoring) can also be effective in increasing cultural competence within the workforce alongside initiatives which increase contact between racially and ethnically diverse staff members. There is some evidence that 'cross-cultural mentoring', where a racial majority staff member is responsible for mentoring a racial minority, can increase cultural competency but further research is needed to assess its efficacy and impact on behaviours (Jongen et al., 2018).

There is also learning and recommendations from practice in relation to cultural competency within the workforce (with examples for communities and service users outlined below). King et al. (2012) reviewed the impact of diversity training (which focuses on increasing awareness of diversity issues and cultural sensitivity) on racial discrimination that was delivered across multiple providers of NHS healthcare to a total of 155,922 employees, typically lasted four to ten hours, and involving up to two trainers and up to 30 trainees. Their findings indicated some (although not uniform) evidence of positive outcomes for both individuals and organisations, increasing job satisfaction and reducing discrimination of racial and ethnic minority employees.

Based on learning from the implementation of WRES, the London Workforce Race Equality Strategy (LWRES) advocates training to increase cultural awareness and sensitivity which incorporates 'perspective taking' or 'walking in the shoes of' minority groups. Such experiential approaches have been found to be effective in reducing implicit bias in the short term (Lai et al., 2014; Banakou et al., 2016). However, it is unclear whether such effects are sustained over time (Lai et al., 2016). More research is needed to identify the features of interventions which may predict longer term change. The LWRES also recommends increasing contact between healthcare staff from different racial and ethnic backgrounds by providing opportunities for them to work together (NHS England and NHS Improvement, 2020a), in line with suggestions made to organisations more widely within the literature (Dobbin and Kalev, 2016).

Incorporating anti-racist approaches to training

Racial and ethnic minority staff in both the health and social care sectors have consistently reported experiencing racial discrimination at work (Brockmann et al., 2001; WRES Implementation Team, 2020). Anti-racism, which moves beyond

reducing bias and increasing cultural competence to explicitly encompass action taken to resist and tackle racism, is a recently revitalised concept in health (Came and Griffith, 2017; Cénat, 2020; Crear-Perry et al., 2020) and social care (Reid, 2020). In Wales, there have been specific recommendations to reduce racism experienced by health staff, particularly in light of the Coronavirus pandemic (Ogbonna, 2020; Race Alliance Wales, 2020).

Although rigorous evidence on 'what works' is lacking (Came and Griffith, 2017), there is salient learning and recommendations from practice about what works (Unite, 2016; Cénat, 2020; Crear-Perry et al., 2020; Reid, 2020), which may be incorporated into existing training and organisational approaches. These include the need for:

- Initiatives which have an explicit focus on and develop shared understanding about whiteness, white fragility[17] (DiAngelo, 2011; 2015) and white privilege[18] (McIntosh, 1998) as the norm in institutions.
- Explicit acknowledgement of racism as an underlying driver of inequalities in health and social circumstances within health and social care educational curricula, institutional strategy, and policy, including increasing awareness of and action against more covert acts of racism.
- Decolonising the health, mental health and social care curricula, for example, as described by Gishen and Lokugamage (2018) in relation to medical school training[19] and in the Social Justice and Health Equity curriculum for trainee psychiatrists at Yale University (Belli, 2020).
- Taking reports of racism seriously and acting on them as well as enacting, incentivising, monitoring, and holding to account targets to reduce racism.

Open communication about race and intersectionality

Encouraging open communication about race between health and social care staff members can increase confidence in raising issues about racism without fear of negative consequences (Taffel, 2020). An example of good practice is the 'Race

[17] White fragility, or defensiveness refers to when discomfort is experienced by White people when confronted with racialised challenges which leads to them minimising, ignoring, defending against, withdrawing from engaging with racial issues in a way that preserves the status quo or seeks to protect them from discomfort.

[18] Systemic and systematic advantage associated with being White, or the systematic disadvantages afforded to other racial groups which is embedded within some societies which Peggy McIntosh describes as 'an invisible package of unearned assets' (McIntosh, 1988, p.31).

[19] **https://decolonisingthemedicalcurriculum.wordpress.com/**

Discussion Toolkit' co-developed by staff and students with external diversity and inclusion practitioners for faculty-level culture, and diversity and inclusion initiatives at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN), King's College London. This toolkit provides staff and students at all levels of employment, across all departments and directives, and from all racial and ethnic groups with the skills and knowledge to feel confident to engage in race discussions.

Open communication should extend to discussions about intersectionality which help to demystify the term, increase awareness of how people's experiences differ at the intersections of different social statuses (e.g. race/ethnicity and gender), and encourage consideration of the 'whole person' (Equality Challenge Unit, 2018). As with other approaches relevant to workforce diversity (Priest, 2015; Dobbin and Kalev, 2016), open communication is most effective when it is visibly supported by senior management and forms part of a sustained and fundamental organisational approach.

Empowering racial and ethnic minority staff to raise concerns and to share ideas

Research and engagement with health and social care professionals by the King's Fund (2020), which was conducted as part of the Tackling Inequalities and Discrimination Experiences among health and social care professionals (TIDES study)[20], indicates that racial and ethnic minority staff feel disempowered to raise concerns at work and that their ideas and opinions are not valued.

While we could not identify research evidence on approaches to addressing this issue, learning from the implementation of WRES has informed several recommendations for relevant interventions which would particularly promote psychological safety (NHS England and NHS Improvement, 2020a). These include the importance of:

- Forums and 'safe spaces' where staff can share lived experience (e.g. 'Schwartz rounds'[21]). Schwartz rounds have traditionally focused on sharing experiences about the emotional and social impact of caring for patients and have been found to be effective for increasing understanding and appreciation of colleagues, improved well-being, and reduced stress and perceived isolation (Flanagan et al.,

[20] **http://www.tidesstudy.com/**

[21] Schwartz rounds are (usually) monthly facilitated forums for staff which are safe environments to come together to discuss the emotional and social challenges of patient care, to share stories and to offer each other support. **https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/**

2020). Such an approach may therefore be an effective mode of sharing workplace experiences and offer a route to support perspective-taking to reduce bias and discrimination.

- Freedom to Speak Up Guardians which aim to reduce barriers to speaking up by providing independent support and advice to staff who want to raise concerns. Greater representation of Black, Asian and minority ethnic Guardians would further promote psychological safety.
- Encouragement of open discussions through an open door to CEO and Board members for Black, Asian and minority ethnic staff network Chairs; and, facilitated interactive events (e.g. webinars) involving a panel of executives, at which staff can ask questions, discuss opinions and share experiences.
- Reverse mentoring (see section above and also the 'Improving Race Equality in Employment and Income' report (noted in Annex 1).
- Staff networks for Black, Asian and minority ethnic group staff which are appropriately resourced and supported. Aspects of effective networks are outlined in the 'Improving Race Equality in Employment and Income' and in 'Supporting staff networks for Black and ethnic minority staff in the NHS' (NHS England, 2017). To encourage intersectional approaches to promoting equity, we highlight an example described by Advance HE in which, in addition to existing staff networks which focus on 'single issues' (e.g. LGBTQ+, race/ethnicity etc.), organisations encourage communication and action across networks through a 'cross-strand' network. This has overlapping representation and co-leads, cross-network mentoring schemes, and clear lines of influence on institutional diversity and inclusion policies and procedures (Equality Challenge Unit, 2018).

Reduce fear of taking responsibility for mistakes

Psychological safety is also impaired by fears of speaking out and taking responsibility for mistakes due to disproportionate representation of racial and ethnic minority groups in formal disciplinary action. This affects staff psychological wellbeing, sickness absence and intentions to leave, and is a key concern for Wales (Ogbonna, 2020).

More collaborative and person-centred learning approaches to human resources processes are recommended to prevent punitive disciplinary actions, except where these are strictly necessary for, among other things, patient safety, theft, and violence. These could build on the Just Culture Guide[22] as well as recommendations

[22] **https://improvement.nhs.uk/resources/just-culture-guide/**

made in the 2019 Fair to Refer report (Atewologun, Kline and Ochieng, 2019) and 2019 WRES Implementation report on reducing ethnic disparities in disciplinary action in the NHS (Archibong and Darr 2010; Atewologun et al. 2019; WRES Implementation Team 2019).

The Coronavirus pandemic has further highlighted the need to enhance access to culturally sensitive psychological interventions for staff such as counselling and bereavement support (Royal College of Psychiatrists, 2020).

Physical safety

The disproportionate number of COVID-19 related deaths among Black, Asian and minority ethnic health and social care staff (Autonomy, 2020; Health Service Journal, 2020) is evidence of inequities in the physical safety of racial and ethnic minority staff. This has brought to light particular areas where the physical safety of racial and ethnic minority staff could be improved. The Ogbonna (2020) report highlighted physical safety for social care staff as a key issue, and equity of physical safety forms part of the Welsh Government's response to that report[23]. Synthesising recommendations made in blogs, discussion pieces (e.g. Care Home Professional, 2020; Kline, 2020; NHS England and NHS Improvement, 2020b), and research and engagement work for the TIDES study,[24] as well as Ogbonna's recommendations, areas for improvement include:

- Risk assessments that specifically consider the physical and mental health of Black, Asian and ethnic minority staff, including the circumstances of bank and agency staff. To note, the Welsh Government in May 2020 released an 'All Wales COVID-19 Workforce Risk Assessment Tool'[25] to support staff in the health and social care (and other) sectors who are more vulnerable to COVID-19, including racial and ethnic minority staff.
- Ensuring that all staff feel able and empowered to raise concerns about their physical safety.
- Offering a bespoke health and wellbeing offer (including rehabilitation and recovery) for racial and ethnic minority staff (Public Health England, 2020b).

[23] **https://gov.wales/COVID-19-bame-socio-economic-subgroup-report-welsh-government-response-html#section-50745**

[24] **https://tidesstudy.com/**

[25] **https://gov.wales/covid-19-workforce-risk-assessment-tool**

- Providing adequately fitting Personal Protective Equipment (PPE) tailored to fit racial and ethnic communities; e.g. with variation in facial and bone structures and allowances for head coverings. While the Welsh Government has committed to ensuring adequate supply of PPE, it is not clear whether the issue of tailoring has been addressed.
- Involving staff in decision-making about redeployment; and awareness of bias and pressures which may inhibit racial and ethnic minority staff from questioning decisions.
- Protecting staff from verbal and physical assault from patients, e.g. through zero tolerance policies.

Overarching principles

Recommendations

- Visible, sustained, senior management support which includes clear lines of social accountability and adequately resources initiatives to reduce racial disparities is essential.
- Leaders need to implement multiple, multi-level approaches that target institutions and not just individuals. These approaches need to actively unpick underlying structures which maintain and perpetuate inequality and focus on action. They would usefully be informed by systems-thinking that considers wider influences on desired change and to identify and pre-empt any unintended consequences.
- Collection of locally relevant and contextually meaningful workforce data, which is informed by active engagement with racial and ethnic minority communities in Wales.
- This includes collection of data on workforce, career progression, job satisfaction, experiences of discrimination and disciplinary proceedings which is disaggregated appropriately by ethnicity (e.g. including Black Welsh and Asian Welsh categories); and by other key social statuses (in particular gender and migration status).

Senior leadership support and resource allocation

Priest et al.'s (2015) evidence review highlighted the importance of senior leadership support which clearly and openly identifies workforce diversity as a high institutional and organisational priority and which invests and appropriately allocates resources for the psychological safety of racial and ethnic minority staff.

Evidence from existing literature reviews and engagement with diversity and inclusion professionals also highlights the importance of middle and lower-level management in reinforcing senior leader commitments to racial and ethnic diversity (West et al., 2015; Gifford et al., 2019). Evidence from the social care literature suggests that increasing the experience and skills of managers and employees at all levels, so they can work with racially and culturally diverse colleagues, would help promote representation in the workforce (Butt, 2006; Manthorpe et al., 2018).

Finally, the importance of leadership support is supported by international research about what works to promote gender inclusivity (Devine et al., 2002; Foschi, 1996; McCracken, 2000) and from learning from the implementation of WRES. This indicates that accountability and holding personnel decision-makers to account for their commitment to diversity is essential (Naqvi et al., 2018).

An example of good practice that helps to make senior leadership visible is outlined in the London Workforce Race Equality Strategy (NHS England and NHS Improvement, 2020a). The 'white allies programme' involves white allies in power with capacity to change decision-making being trained in issues affecting racial and ethnic minority staff, and being encouraged to take up the responsibility for change.

Incorporation of multiple, multi-level and sustained diversity strategies

Priest et al. (2015) warn that mandated policies alone are insufficient to create a workplace climate which is open to and welcomes racial and ethnic diversity. Similarly, an evidence review about what works to improve diversity in the NHS (West et al., 2015) concluded that diversity training alone is insufficient to change organisational climate.

As is also borne out by findings from successive WRES data analysis reports (Kline et al., 2017; Naqvi et al., 2018; WRES Implementation Team, 2020) and West et al.'s (2015) review, strategies must be sustained and simultaneously target multiple levels (organisational, workplace, between-staff interactions and individuals). It is important to emphasise that 'culture change' (which would influence experience of discrimination, bullying, harassment or abuse), is more difficult to implement than procedural change (Scott et al., 2003) and initiatives targeting multiple levels would usefully incorporate systems thinking (NIHR, 2019) to identify and pre-empt unintended consequences of change.

Workforce data

Workforce data (including on representation, career progression and staff experience) is essential for research, monitoring and for identifying where targeted

action is needed (Priest et al., 2015). As noted above, workforce data broken down by ethnicity is lacking in Wales, and Ogbonna's (2020) report highlights improvements to data recording as key recommendations for the Welsh health and social care sectors.

Building in mandated and/or incentivised collection of data on ethnicity would help to reduce the amount of missing and incomplete data (Butt et al., 1994). At minimum, organisations should standardise recording of ethnicity data using the census categories to allow comparison across datasets, and to incorporate 'Black Welsh' and 'Asian Welsh' in new census categories (Race Alliance Wales, 2020). Where possible, finer, more disaggregated categories relevant to local circumstances should be used (Toleikyte and Salway, 2018). This is relevant to health and social care but also to local authorities and other public sectors.

Concurrent mandatory collection of workforce, experience and progression data on migration status (as well as sexual orientation, religion/belief and other protected characteristics) is needed to more effectively identify inequalities and target interventions (Byrne, 2020; Moriarty, 2020 [personal communication]). This is because, as outlined at the start of this review, the experiences and needs of health and social care staff at the intersections of race, ethnicity, gender, migration status are likely to vary. Moreover, workforce monitoring that includes both ethnicity and migration data is key to establish which groups are over and under-represented in both the health and the social care workforce (Butt, 2006). For instance, in England more social care workers are recent migrants rather than from Black British background (Hussein et al., 2014).

The WRES[26] was mandated in England in 2015. It requires NHS organisations to demonstrate progress against nine indicators of workforce race equality, e.g. in relation to access to training opportunities, disproportionality of disciplinary actions, and prevalence of racial discrimination, bullying and harassment. The WRES also supports improvement action planning to address the underlying causes of discrimination. Using a data collection framework such as the WRES is one way to monitor underrepresentation of racial and ethnic minority staff and to develop targeted quality improvement methods to address this (Naqvi et al., 2018). While racial and ethnic inequalities remain, there is evidence for improvements in several indicators since the implementation of WRES (WRES Implementation Team, 2020). Such an initiative is not yet in place in Wales and we recommend the development and implementation of an equivalent framework and addressing some of the current limitations of WRES in England from the outset by also collecting data on bank,

[26] **https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/**

agency and locum staff, and employers outside of NHS Wales who provide NHS services in Wales (NHS England and NHS Improvement, 2020a).

It is important that **any such standard be adapted to the Welsh context and to consider the distribution of racial and ethnic minority staff across Wales**; the WRES as-is may not be valid in the Welsh context. Due to low numbers of racial and ethnic minority staff in some areas, a one-sized fits all approach may not be optimal and may lead to 'gaming'. The development of any such standard should be **grounded in engagement with the lived experiences and opinions of racial and ethnic minority health and social care staff in Wales**, building on the Welsh tradition of community-based approaches (W. Farah, co-ordinator NHS Confederation BME Leadership Network [BLN], personal communication 27th October 2020).

Racial and ethnic minority service users

Non-discriminatory and culturally sensitive mental health provision

Recommendations

- Engage racial and ethnic minority service users and their carers in the design and development of a Wales-specific organisational competency framework. This should develop a set of local and national competencies to enable mental health providers to understand and meet the needs of their local population and reduce racial disparities in care and outcomes for service users and their carers.
- Support and extend accreditation schemes such as Diverse Cymru's 'BME Mental Health Workplace Good Practice Certification Scheme', which engages with practitioners so that they are able to deliver culturally competent services.
- Support culturally competent models of care provision on the basis of engagement with service users and carers, evaluation and ongoing quality improvement.

- Incorporate explicitly anti-racist approaches to service delivery into training curricula and professional development of all staff at all levels within mental health services.
- Create structures to support research, evaluation and quality improvement to assess and enhance the impact of provision on racial and ethnic minority service users and their carers. Engage with service users and carers to inform how and which data are collected.

Racial and ethnic minorities in Wales experience disparities in mental health and wellbeing (e.g. greater levels of loneliness) and access to mental health care, particularly among refugees and asylum seekers (EHRC, 2018). Research also indicates that the Coronavirus pandemic and associated social distancing measures are disproportionately affecting the mental health and wellbeing (including anxiety and feelings of isolation) of Black, Asian and minority ethnic groups in Wales (Public Health Wales, 2020). The Ogbonna report (2020) outlined several recommendations relevant to delivering culturally appropriate mental health and social care services. Based on our research, prior engagement work and review of the literature, we outline three examples of approaches which specifically aim to meet the needs of racial and ethnic minority communities in mental health services. These include:

- Organisational competency frameworks;
- Culturally competent mental healthcare; and
- Explicitly anti-racist mental healthcare delivered by all staff from all racial and ethnic backgrounds.

Organisational competency frameworks

Organisational competency frameworks or standards are developed to define what needs to be achieved by organisations to attain a particular level of accreditation or licensing, to outline standards of practice and/or to act as a development framework for improvement.

The NHS England Patient and Carer Race Equality Framework (PCREF) is an example of a national intervention endorsed by the recent NHS England and NHS Improvement **'**Advancing Mental Health Equalities Strategy' (Dyer, Murdoch and Farmer, 2020). It was refined by NHS Trusts in collaboration with their local communities, to reduce racial inequalities in access, experience, and health outcomes. PCREF was adopted by NHS England and NHS Improvement as

Recommendation 1 of the Mental Health Act Review African and Caribbean Group,[27] with the aim of developing an organisational competence framework (the PCREF) to address inequalities in mental health services amongst different racial groups (Dyer, 2020). This builds on recommendations from the Crisp Commission's 'Old Problems, New Solutions' report (Crisp, Smith and Nicholson, 2016) and the 2016 'Five Year Forward View for Mental Health' (Mental Health Taskforce, 2016).

The PCREF aims to develop a set of local and national competencies that will enable NHS Trusts to better understand and meet the needs of the local population and reduce racial and health inequalities within and across systems. The framework holds local systems to account more robustly, bringing the perspective of patients and carers to the centre of service-led quality improvement agendas. It is a long-term, strategic response to build (currently lacking) trust and confidence among racial and ethnic minority communities (Craig et al., 2020) by utilising co-production methods. This ensures it has integrity and co-ownership across staff, service users, carers, and communities. While it is currently being be applied to Mental Health Trusts, the PCREF is applicable across acute and other types of trusts and health service providers. However, as yet, the initiative is still under development and we are not aware of any available evidence or user feedback to comment on its effectiveness.

As with the WRES, in recommending such an approach in Wales, **we emphasise the importance of involving racial and ethnic minority communities living in Wales in the development and tailoring of such initiatives**.

'Culturally competent' services

Notwithstanding the critiques of the term 'cultural competency' described above, there is evidence that services which are more culturally sensitive and appropriate are likely to increase patient satisfaction (Truong et al., 2014; Jongen et al., 2018). However, there is limited research and evaluation evidence that can attribute improvements to cultural competence to improved patient adherence, outcomes and reduced racial and ethnic minority inequalities (Beach et al., 2005; Truong et al., 2014; Benuto et al., 2018; Jongen et al., 2018). Cultural competence training has been recommended to better support service users specifically relating to certain health issues, roles, or specialisms (e.g. for Black, Asian and minority ethnic dementia patients) (Truong et al., 2014; Jongen et al., 2018). This may be particularly important in rural areas or areas with lower ethnic density, where skills or experience

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27 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/703475/mental_health_act_review_african_and_caribbean_group_terms_of_reference.pdf

in relating to racial and ethnic minorities may be lower (Manthorpe et al., 2010; 2012).

There are examples of good practice in this area in Wales and elsewhere in the UK that could be expanded on. In 2018, the equalities charity Diverse Cymru launched the 'BME Mental Health Workplace Good Practice Certification Scheme'[28] which aims to improve the quality and accessibility of mental health (and social care) services for Black, Asian and ethnic minority service users. The certification scheme is supported by the Welsh Government and is endorsed by the Royal College of Psychologists Wales. It aims to help staff to deliver culturally appropriate services (through training, tools and resources), and to annually assess and measure the competency of services, requiring organisations to submit evidence in order to achieve their target certification level. The scheme is verified by an independent accredited body, the United Kingdom Investor in Equality and Diversity (UKIED), who assess the work and provide the certification to the participants. It builds on the 'Cultural Competency Toolkit' that was designed for mental health and other professionals working with Black, Asian and minority ethnic communities in Wales (Duval, 2016). While a promising future initiative for Wales, we were unable to find any evaluation evidence for the certification scheme's impact on service users e.g. in relation to accessibility, adherence, satisfaction, or outcomes.

An example of good practice from social care is Meri Yaadain CiC[29], which works with services to help them develop culturally competent dementia care for Black, Asian and minority ethnic communities. For example, adapting outreach based on the recognition that certain racial and ethnic communities do not have a name for dementia, which may restrict access to support. It is important that such initiatives enable the provision of care which is grounded in an understanding of the specific barriers to the delivery and take-up of dementia services for Black, Asian and minority ethnic groups (Kenning et al., 2017; Baghirathan et al., 2020). However, the necessary research and evaluation evidence is not available to establish the effectiveness of such initiatives.

Importantly, 'culturally competent' service development should consider alternatives to Western approaches to mental health provision, and seek to increase awareness

[28] **https://www.diversecymru.org.uk/bme-mental-health-good-practice-certification-scheme/?doing_wp_cron=1603635147.0817689895629882812500#:~:text=The%20BME%20Mental%20Health%20Workplace,quality%20of%20social%20care%20and**

[29] **http://www.meriyaadain.co.uk/working-with-services/**

of how such a lens influences the experience and outcomes for racial and ethnic minority service users and their families (Jacobs et al., 2015).

Explicitly anti-racist mental health care

To address the discrimination experienced by mental health and social care service users, there is a need to move beyond culturally competent services to explicitly anti-racist ones (Cénat, 2020; Reid, 2020). Approaches to anti-racist services are similar to those identified above in relation to anti-racist workplace practices for staff, though the literature goes further in specifying guidelines for anti-racist delivery of services. Based on three decades of research on Black communities' experiences of mental health care, and on different approaches to treatment and care for various psychiatric disorders, Cénat (2020) proposes a set of guidelines for ant-racist mental health care. The guidelines are designed to be cross-cultural, to reflect the complexity of issues around race, as well as consider variation in experience within and between Black, Asian and minority ethnic group communities.

These care approaches for Black communities specifically take into account individual, institutional, and systemic racism. Four main elements of the guidelines are:

> **"an awareness of racial issues, an assessment adapted to the real needs of Black individuals, a humanistic approach to medication, and a treatment approach that addresses the real needs and issues related to the racism experienced by Black individuals."** (Cénat, 2020, p.931)

Another example is an initiative from Yale University which targets training of mental health professionals. The social justice and health equity curriculum[30] incorporates social justice and health equity into psychiatry residency training, though again we were unable to identify any evaluation evidence to assess effectiveness.

Data collection, monitoring and reporting to support equitable health and social care services

As outlined in Ogbonna's (2020) report, improvements to data collection on race and ethnicity are essential to understand and reduce racial and ethnic inequalities

[30] **https://guides.library.yale.edu/SocialJusticeHealthEquity**

experienced by service users in health, mental health, and social care. Improved data collection is also essential to disaggregating information within and between racial and ethnic groups to better reflect the diversity of experience and needs. Missing and incomplete ethnicity data can lead to inaccurate interpretations; and prevents the evaluation and monitoring of initiatives which disproportionately affect, or which are targeted at racial and ethnic minority groups. In addition, under-representation of Black, Asian and minority ethnic participants in research, as well as a lack of specific evaluation evidence focusing on the impact of diversity initiatives on racial and ethnic minority service users, further limits the capacity of policy and practice improvements (Hui et al., 2020).

We therefore make the following recommendations for changes to data collection and monitoring based on our evidence review. Relevant to all these points is that to avoid replicating existing structural inequalities, it is important to ensure that data are transparent and accessible (Butt, 2006).

Recommendations

- Building in mandated and/or incentivised collection of standardised data on ethnicity to reduce missing and incomplete data (Butt et al., 1994). At minimum, standardise ethnicity data recording using the census categories to allow comparison across datasets. Where possible, use finer-grain, more disaggregated categories relevant to local circumstances (Toleikyte and Salway, 2018) and collect data at both national and local levels to reflect the diversity of health and social care experience and needs among racial and ethnic minority groups.
- Incorporate mandatory data collection to support intersectional analysis and research. This includes data on migration status (whether or not UK born and length of stay), sexual orientation and religion/belief alongside data on race and ethnicity in health and social care datasets to better understand patterns of health and social outcomes (Byrne, 2020; Moriarty, 2020 [personal communication]).
- Use over-sampling to increase the numbers of racial and ethnic minority groups represented in research, national population datasets and evaluation, with inclusion of data on migration status (Berthoud et al., 2009; Lynn et al., 2018).
- Engage with racial and ethnic minority groups locally to improve the relevance, appropriateness and acceptability of questions asked and data collected.
- Improve data sharing and data linkages across partner organisations, including between health and social care, with local authorities and with voluntary and

community sector organisations supporting racial and ethnic minority communities (Toleikyte and Salway, 2018).

- Collect data on local service outcomes, their effectiveness, quality, safety, and service user/carer satisfaction by ethnicity. This includes publicly accessible yearly audits of local mental health services focusing on service experience and outcomes by ethnicity (Joint Commissioning Panel for Mental Health, 2014).
- Record ethnicity at death registration to improve data on racial and ethnic inequalities in life expectancy and mortality (Public Health England, 2017; 2020; Ogbonna, 2020).
- Create a national dataset for the work of approved mental health professionals who carry out a number of functions under the Mental Health Act (MHA) to inform planning and improvement, to understand and better support those disproportionately affected by the MHA (Mental Health Act Review Team, 2018).
- Develop a national baseline of use of the MHA in Wales in line with recommendations set out for NHS England in the Mental Health Act Review (Mental Health Act Review Team, 2018).
- Publish timely policing data on use of detention powers under the MHA broken down by ethnicity (Mental Health Act Review Team, 2018).

Equitable public health approaches

Effective disease prevention and health promotion campaigns

Recommendations

- Engage racial and ethnic minority community members and representatives from voluntary, community and social enterprise sectors, faith organisations, and other stakeholders in designing and implementing communications and prevention strategies which are relevant to the local population.
- Based on this engagement work, identify and tailor appropriate multiple channels of communication to local communities, while also acknowledging and addressing any community concerns about specific strategies.
- Adequately resource Black, Asian and minority ethnic community organisations to enable them to be involved in engagement work and to take an active role in public health promotion and messaging.
- Address barriers to digital inclusion which disproportionately affect racial and ethnic minorities including resource-based, motivational, and skills-based barriers.

The Coronavirus pandemic has highlighted the essential and urgent need for disease prevention and health promotion campaigns that more effectively reach racial and ethnic minority groups (Baggaley et al., 2020; Public Health England, 2020; Ogbonna, 2020; Public Health Wales, 2020; Saltus, 2020). Ogbonna specifically recommends developing ‘a clear multi-channel communications strategy for health and social care’ for Wales (Ogbonna, 2020, p.12).

Evidence suggests effective strategies include adapting messages to specific audiences. This includes translation as well as utilising culturally relevant channels of communication. For instance, engaging faith and community leaders (Netto et al., 2010; Toleikyte and Salway, 2018) and involving racial and ethnic minority groups in emergency preparedness planning (Andrulis et al., 2007). Similarly, findings from a rapid evidence synthesis (Gilmore et al., 2020) suggest that community engagement is an effective ‘bottom-up’ strategy for disease prevention and control which better reaches racial and ethnic minority groups. This includes engagement with local leaders, faith organisations, voluntary and community groups and organisations, local health facilities, influential individuals, and other key stakeholders. This supports

Ogbonna's recommendation for the Welsh Government to fund Black, Asian and minority ethnic group organisations with strong grassroots connections to support the dissemination of public health messages (Ogbonna, 2020).

A review focusing on public health approaches more generally also emphasised the importance of community engagement, particularly engagement which involves and empowers racial and ethnic minority people in health promotion campaign development and messaging (O'Mara-Eves et al., 2015). Specific channels of engagement identified in the review include involving communities in designing and planning interventions/messaging; building trust; communication about social and behavioural change, risk and contact tracing; as well as activities supporting the logistical and administrative aspects of disease control (e.g. testing and contact tracing, implementation of handwashing facilities) (Gilmore et al., 2020).

Awareness of the impact of receiving a diagnosis is also essential to understanding take up of prevention and early intervention support among racial and ethnic minority communities. For example, stigma associated with mental health diagnoses, and fear of diagnosis and death from COVID-19 have both been found to inhibit timely help-seeking (Public Health England, 2020). Similarly, lack of trust in health and mental health services can feed reluctance to seek help (Craig et al., 2020). Thus, concerted efforts to build trust are important (Public Health England, 2020).

Finally, supporting digital inclusion is important. Black, Asian and minority ethnic groups are more likely to be digitally excluded in Wales (Ogbonna, 2020) and elsewhere in the UK, which also inhibits access to public health messaging. A review by Borg et al. (2019) highlighted the need to develop strategies which do not just address material access, but which also address motivational, physical, and skills-based barriers to inclusion. Factors promoting digital inclusion include material support, social support, educational training, and the more inclusive design of digital materials.

Third sector organisations have a key role in public health promotion and messaging (Local Government Association, 2017). As recommended by Ogbonna (2020), these approaches would be supported by sustained backing of and communication with third sector organisations in Wales, working with different ethnic and racial minority groups. Such organisations were at increased risk of closure before the pandemic (Craig, 2011) and are disproportionately facing closure as a result of it (Murray, 2020).

Conclusion

This report considers the evidence for what works to reduce racial disparities experienced by health and social care staff, mental health, and social care service users, and increasing the reach of public health campaigns. The imperative to eliminate racial and ethnic disparities in health and social circumstances could not be clearer. In the context of the death of George Floyd and the Black Lives Matter movement, the Coronavirus pandemic has laid bare the impact of such disparities in Wales as well as the UK more widely. Welsh people from Black, Asian and minority ethnic groups are more likely to die from Coronavirus, including health and social care workers. Anxiety about the impact of Coronavirus is highest amongst racial and ethnic minority healthcare professionals, and the adverse economic and social impacts of Coronavirus-related social distancing measures is and will be disproportionately felt among racial and ethnic minority groups. These disparities are not new. Rather they reflect and exacerbate existing entrenched inequalities which emerge from structural and institutional racism across generations.

The Welsh Government has demonstrated a clear commitment to reducing racial disparities, both prior to and in response to the pandemic, and has started to act upon the recommendations outlined in the Ogbonna report (Welsh Government, 2020a; 2020d). Relevant to health and social care, this includes (among other initiatives):

- Bringing forward the development of a Race Equality Action Plan underpinned by a Race Equality Strategy;
- Release of an ‘All Wales COVID-19 Workforce Risk Assessment Toolkit’;
- Work to ensure sufficient provision of PPE;
- Improvements to mandatory equality training delivered by Health Education and Improvement Wales (HEIW);
- Translation of Coronavirus public health messaging; and
- The scoping of a Welsh Race Disparity Unit as part of efforts to improve the quality of ethnicity data recording and reporting.

Our review indicates that these are all key proximal actions to help address extant disparities faced by racial and ethnic minorities in Wales. However, each action will be insufficient in isolation unless they form part of a sustained effort (over years and decades) that consistently receives high level and visible support from Welsh Government and from senior management in the health and social care sectors. Learning from existing diversity initiatives indicates that such action must embed

accountability and transparency as standard and be informed by robust, standardised recording and sharing of data. These data are essential for research, evaluation, and quality improvement initiatives, which is lacking in this area.

Underpinning all of these factors is the need to **systematically unpick the policies, processes, procedures, norms, and attitudes operating within and across institutions that systematically disadvantage people from Black, Asian and minority ethnic backgrounds**. This is essential for building trust and to avoid returning to the status quo.

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Annex 1: References to the report series

This is one report of six, each focusing on a particular policy area to inform the Race Equality Action Plan. The series of report includes:

Arday, J. (2020). **Improving Race Equality in Education**. Cardiff: Wales Centre for Public Policy.

Hatch, S., Woodhead, C., Moriarty, J., Rhead, R., and Connor, L. (2020). **Improving Race Equality in Health and Social Care.** Cardiff: Wales Centre for Public Policy.

Hatch, S., Woodhead, C., Rhead, R., and Connor, L. (2020). **Improving Race Equality in Employment and Income.** Cardiff: Wales Centre for Public Policy.

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Annex 2: Recurring recommendations

Recurring recommendation	Area of focus
Health and social care workforce recruitment to ensure greater levels of diversity and representation	What works to improve diversity among the health and social care workforce?
Professional/workforce training	What works to train health and social care professionals in cultural competence and anti-racism?
Ensuring parity of safety for Black, Asian and minority ethnic healthcare and social care professionals	What works to ensure parity of safety for Black, Asian and minority ethnic healthcare and social care professionals (e.g. the role of procurement, confidential support, Black, Asian and minority ethnic staff networks/ groups)?
Prevention and health promotion campaigns	What works in producing effective culturally competent disease prevention and health promotion campaigns/ messaging? How can this information best be disseminated to the relevant stakeholders?
Ensuring mental health provision is sufficient, culturally appropriate and/or tailored for Black, Asian and minority ethnic service users	What factors are required to ensure mental health provision adequately serves, is non-discriminatory and culturally sensitive, meeting the needs of Black, Asian and minority ethnic communities?
Collecting, using and monitoring data to improve health outcomes for Black, Asian and minority ethnic communities	What key changes to health and social care data collection, monitoring and reporting regarding race and ethnicity would be most impactful?

Recurring recommendation	Area of focus
Collecting, using and monitoring data to improve health outcomes for Black, Asian and minority ethnic communities	How could data collection and monitoring be improved to monitor the needs of Black, Asian and minority ethnic service users (within both social care and healthcare), ensure parity of care, and prevent future disproportionate health outcomes?

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