Culture of Care Report

Black Thrive Global's Contribution to the Culture of Care Programme: Enhancing Racial Equity in Inpatient Mental Health Services

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Executive Summary

The Culture of Care (CoC) Programme aimed to improve inpatient mental health services by strengthening safety, relationships, lived experience involvement, and organisational learning. Within this wider programme, Black Thrive Global (BTG) led the race equity and anti-racism component, supporting organisations to apply the Patient and Carer Race Equality Framework (PCREF) at ward, organisational, and executive levels. As a Black-led organisation delivering race equity and anti-racism work at a national level, BTG made a distinctive contribution to the programme.

BTG delivered race equity training, ward-level reviews, organisational support, and executive sessions designed to connect racial equity with culture, safety, and quality of care. Delivery combined in-person and virtual learning, interactive exercises, and feedback tools to support reflection and action.

Overall, participants found the sessions relevant, useful, and thought-provoking. Many reported increased confidence in understanding racism and anti-racism, alongside a clearer understanding of how PCREF related to their role and to the wider CoC programme. Interactive discussions, case studies, and practical examples were particularly well received.

However, the report also found that racism remained difficult to name, discuss, and address in many settings. Participants described fear of saying the wrong thing, uncertainty about language, and limited confidence in challenging racism within teams and organisations. Staff also described racism as a routine part of some inpatient environments, alongside inconsistent reporting, limited follow-up, and a wider culture of silence.

The findings suggest that racially minoritised patients may be particularly affected by mistrust, coercive pathways into care, and the risk that distress is interpreted through a narrow risk lens rather than with understanding and support. Although many staff demonstrated awareness of these issues, race-aware and culturally responsive practice was not always supported by consistent organisational systems.

At leadership level, the report identified continuing gaps in accountability, awareness, and implementation. Participants described fragmented understanding of anti-racism and PCREF, limited visibility of leadership responsibility, and concerns that race equity work could become performative if not supported by clear action and measurable change.

Although all 57 organisations tested at least one change idea with a race equity focus, analysis of programme change idea records showed that racial equity represented a relatively small proportion of overall improvement activity. Of the 3,424 valid change ideas reviewed, 223 explicitly referenced racial equity, representing 6.5% of the total. These ideas most often focused on cultural inclusion, representation, reflective practice, and improving voice and participation for diverse groups.

Overall, the programme demonstrated both the value and the challenge of embedding racial equity within inpatient mental health improvement. It showed that progress depends not only on awareness, but also on stronger accountability, better use of data, safer spaces for honest reflection, and sustained organisational commitment to anti-racism.

Quotes from the Delivery Partners on the Impact of Black Thrive Global's work:

The standout session from me in the Culture of Care Programme was the race equity session with Sheffield Mental Health Trust. Jacqui and Jo were in form. The Disruptive Thinking Exercise impacted people very strongly and there was a lot of deep learning. I felt the day was really special

Harminder Kaur. National Lived Experience Advisor NCCMH

I was really blown away by the training programme that Black Thrive Global delivered as part of the Culture of Care Programme. I remember one of the first standout moments was learning about Carl Linneaus; the Swedish botanist who categorised people into races. It was really the breaking down of the history behind the racialisation of people. That really opened me up!

One of the other training sessions that I remember was just bringing, not just because we're talking about a very difficult topics, but it was about bringing a bit more of the culture, the music and the joy to the training programme. I think these were the two really stand out moments for me

Jason Grant-Rowles. Trauma informed advisor – North London NHS Foundation Trust

My interaction with Black Thrive Global of their race equity contribution has demonstrated the value and importance of lived experiences speaking to racial inequity within the mental health space. Each member of the delivery team always spoke from a place of integrity and authenticity which provided a nuanced perspective on how racism materialises in different spaces and what individuals, systems and organisations can do differently to not just be culturally competent but antiracist"

Antonia Aluko Lived Experience Advisor – Neurodiverse Connection

It has been such a great experience working with BTG on the programme. They've really brought racial equity to the forefront of conversations and it has been such an affirming experience for me to work with people who look like me and live similar lives.

The anti-racism principle has been the most challenging for wards to engage in across the country. Navigating this challenge professionally with my organisations, and the wider delivery team, whilst acknowledging that this is something that directly affects me and my identity has been something I've found challenging as a coach.

So, if we were to do this programme again, I wish there was a space or support network for delivery team members to connect, reflect, and share experiences of delivering on the programme as a Black person outside of a lived experience role.

Delicha Changa. Quality Improvement Coach – NCCMH

I think for me, on a personal level, there has been a lot of learning and insight into what it means to be an antiracist organisation. The training made me think of race equity in a different way; which I did not have an opportunity to do before. It was particularly great to see the impact the training had on the various organisations and how it made them think about the bigger picture, see racism as structural and take more responsibilities for it.

Renata Souza. Senior Quality improvement advisor – NCCMH

Working on Culture of Care as a black person has been eye opening, beautiful and hard. It has been eye opening in the reality that there is still so much work to do for people to understand systemic and structural racism within mental health.

Beautiful in that I have met and worked with the Black thrive team and they are amazing beyond belief and really carry the work of anti-racism

Hard because it has brought up so much negative emotions for me and racial trauma that I had forgotten all about from childhood through to adulthood. During this work it was also when the race riots was rife which was also difficult to navigate.

All in all, being a black woman on CofC has been a mixture of emotions but I am extremely grateful to have been part of such an important programme

Rianna Herbert. Quality Improvement Coach – NCCMH

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Glossary of terms

CoC	Culture of Care **– An NHS England programme focused on improving inpatient mental health care with a specific emphasis on race equity.**
BTG	**Black Thrive Global** – The national backbone organisation coordinating the Black Thrive Collective and leading systems change work across the UK.
RIO	**Research Institute and Observatory** – Black Thrive's research arm focused on race equity, evidence and evaluation.
NCCMH	**National Collaborating Centre for Mental Health** – An organisation supporting evidence-based mental health policy and practice.
NCISH	**National Confidential Inquiry into Suicide and Homicide** – A research programme analysing suicide and homicide data related to mental health services.
NDC	**Neurodiverse Connection** – An Organisation designed to support neurodiverse individuals.
PCREF	**Patient and Carer Race Equality Framework** – An NHS framework aimed at reducing racial inequalities in mental health care.
QI	**Quality Improvement** – A structured approach to improving services and outcomes.
Racism	A structural, dynamic, and historical ideology of oppression embedded in nation states and their institutions. Racism assigns opportunity and values based on produced racialised categories (race) (based in constructed hierarchal stratification of groups of people) and unfairly disadvantages certain racialised groups and communities while advantaging other racialised groups and communities (cf Bonilla-Silva, 2009; Jones, 2000).
Race	A social construct based on differences in somatic characteristics (imagined or real). Race is produced by racism and does not have any biological basis.
Racialisation	The process through which race/racial categories are produced through the stratification of groups of people into groups of sub-and supraordination. Racialisation is the process that gives meaning to racism.
Antiracism	A proactive approach aimed at identifying, challenging, and dismantling systems, structures, and ideologies that perpetuate racial discrimination and inequality (Oxford Review, 2024).
Anti-Black Racism	Racism directed towards people constructed as Black, especially people of African descent. Intrinsically linked with colourism, a form of racism that values Whiteness and proximity to Whiteness, with Blackness being the most devalued on the scale.

Racially minoritised groups	This term refers to a group of people who have been historically racialised as inferior to the dominant White group and which continues to be minoritised.
GDPR	**General Data Protection Regulation** – UK data protection legislation governing the handling of personal information.
Lived Experience	Knowledge gained through personal experience of systems, services, trauma or inequality.

1. Black Thrive Global's Initial Involvement in the Programme

Discussions about the NHS England tender began in mid-October 2023, when the Director of the National Collaborating Centre for Mental Health (NCCMH), Tom Ayers, first contacted Black Thrive Global (BTG). The NCCMH is the leading provider of national QI programmes in mental health in England and has delivered seven national QI collaboratives over the past six years. Jacqui Dyer and Souci Frissa from BTG held their initial meeting with Tom Ayres on the 18th of October 2023. Following that, BTG joined the bid development working group organised by the NCCMH, a collaboration between the Royal College of Psychiatrists and UCL, as part of their Quality Transformation Programme. The group consisted of around 26 members.

The NCCMH led the application process, and the tender went live on 23 October 2023, with a submission deadline of 21 November 2023. The bid was strong due to our collective approach, which was emphasised and came across clearly, notwithstanding the immense competition.

We were energised by the process of developing the bid together. Regardless of the outcome, it was hard to imagine a group better suited to the challenging task of transforming the culture within inpatient services. The opportunity to do this work would be a genuine privilege.

On 15 December 2023, we were informed that our response to the QTP Culture of Care tender had been successful. Once we returned from the Christmas break (9 January 2024), we began discussions around roles and recruitment, aiming to have people in post by March/April. By April, we had completed recruitment for our Lived Experience Advisors.

BTG's involvement from the outset helped ensure that the programme's approach to culture change was informed by race equity, lived experience, and a wider systems perspective. This early positioning shaped BTG's later role in training, ward reviews, organisational support, executive engagement, and programme reflection.

2. Description of the Culture of Care Programme

The Culture of Care (CoC) Programme was designed to support improvements in inpatient mental health care by strengthening the conditions that shape care experience, staff practice, and organisational culture. At its core, the programme focused on creating safer, more supportive, and more relational environments for patients and staff.

The programme aimed to move beyond narrow service improvement by looking more broadly at the cultures, relationships, and systems that influence how care is experienced and delivered. This included attention to safety, lived experience, staff support, trust, and organisational learning.

The programme was delivered through a combination of ward-level, organisational-level, and leadership-focused activity. It brought together several strands of improvement work, including

quality improvement, co-production, personalised approaches to risk, autism-informed practice, trauma-informed practice, and racial equity and anti-racism.

Across the two-year programme, the CoC offer reached 213 wards across 60 mental health providers in England. Delivery included ward coaching, executive coaching, organisational support sessions, national learning events, and training sessions (see Figure 1 for an illustration of the Trusts, organisations and demographics.

Within this broader programme, BTG led the race equity and anti-racism strand, helping organisations apply the Patient and Carer Race Equality Framework (PCREF) in practical ways across ward practice, organisational change, and leadership accountability.

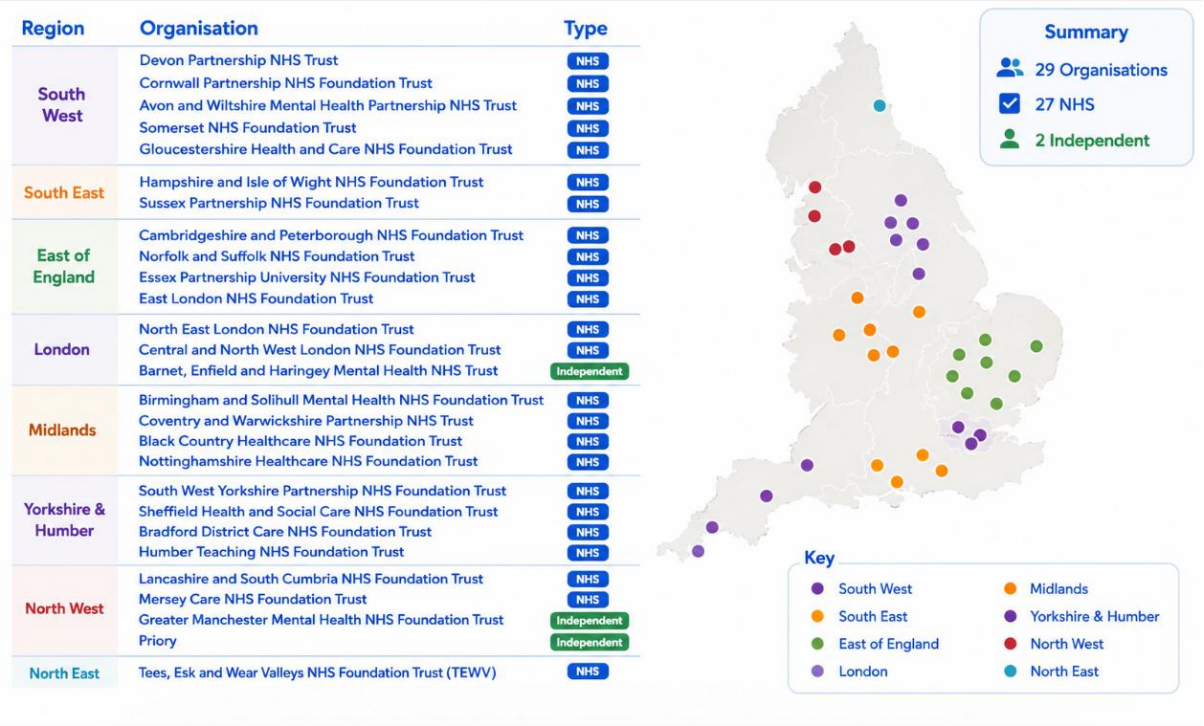

Figure 1. Trusts and demographics
Illustrative participating geographies (as evidenced): Nottinghamshire; Northamptonshire; Norfolk & Suffolk; Cambridgeshire & Peterborough; Essex/EPUT; CNWL; Sheffield; South West Yorkshire & Bradford; Hampshire & Isle of Wight; Devon & Cornwall; Black Country; Herefordshire & Worcestershire; Coventry & Warwickshire; Birmingham; Greater Manchester; AWP/Somerset; Lancashire & Merseyside; TEWV & Humber; Dorset; NELFT; Gloucestershire & Priory.

2.1 Key Aspects of Culture of Care

- ***Definition***: The CoC encompasses the values, beliefs, and practices that shape how care is delivered in healthcare environments. It aims to create a supportive atmosphere where both patients and staff feel valued and safe.
- ***Core Commitments***: The CoC standards developed by NHS England include twelve core commitments that guide the implementation of care practices. These commitments focus on aspects such as:

- *Lived Experience:* Valuing the insights of those with lived experience in shaping care practices.
- *Safety*: Ensuring that patients feel safe and cared for in all settings.
- *Relationships*: Building trusting relationships between staff and patients to foster a supportive environment.
- *Staff Support*: Providing necessary support to staff to enable them to deliver high-quality care.

- ***Implementation Programs***: Various programs, such as the CoC Programme by the Royal College of Psychiatrists and NHS England, aim to improve care standards in mental health and other healthcare settings. These programs focus on:

  - *Quality Improvement:* Engaging staff and patients in initiatives to enhance care quality.
  - *Training and Development*: Offering training for staff to improve their interactions with patients and enhance their well-being.
  - Impact on Care: A strong CoC is linked to better patient outcomes, increased staff satisfaction, and reduced turnover. By fostering an environment where care is prioritised, organisations can improve the overall experience for both patients and healthcare providers.

The programme focused on four key interventions:

1. Ward-level Quality Improvement
2. Organisation-level Support
3. Leadership Support
4. A personalised approach to risk

These four interventions used the following five approaches:

1. Co-production and lived experience
2. Autism-informed approaches
3. Personalised approaches to risk
4. Racial equity and anti-racism
5. Trauma-informed practice

The programme comprised 213 wards across 60 mental health providers in England. Over the two-year period, the CoC Programme delivered more than 3,000 ward coaching sessions, 250 executive coaching sessions, 80 organisational support sessions, 70 national and regional events, and 40 training sessions.

In summary, the CoC Programme is a vital component of effective healthcare delivery, focusing on creating environments that prioritise safety, support, and positive relationships. Through various programs and standards, healthcare organisations aimed to implement these principles to enhance the quality of care provided.

2.2 Key Players in the Culture of Care Programme

The CoC programme involved a wide range of key players across national organisations, programme delivery partners, participating provider organisations, and people with lived experience. These key players fulfilled different roles in shaping, delivering, and implementing the programme and are described below.

2.2.1 National Programme Leadership and Oversight

The programme was led nationally through the National Collaborating Centre for Mental Health (NCCMH), which held responsibility for overall programme design, coordination, and oversight. NHS England also played an important role through its wider policy leadership in relation to mental health improvement and the PCREF.

2.2.2 Programme Delivery Partners

Delivery partners contributed to different strands of the wider programme and supported organisations to embed key CoC principles. These included:

- BTG, which led the race equity and anti-racism component of the programme
- Neurodiverse Connection, which contributed autism-informed learning
- North London Mental Health Partnership / Trauma-Informed Collaborative / NCISH team, which contributed trauma-informed approaches

Each delivery partner brought a distinct area of expertise, while the wider programme aimed to create links across these themes within organisational practice and improvement work.

2.2.3 Participating Provider Organisations

Participating organisations included NHS mental health and community trusts, alongside a small number of independent providers. These organisations engaged with different parts of the Culture of Care offer, including ward-level activity, organisational-level sessions, executive engagement, and learning events.

Their role was not only to attend sessions, but also to test, adapt, and implement change ideas within inpatient care settings.

2.2.4 Leadership and Governance

Within participating organisations, several leadership and governance roles were important to the programme's implementation. These included:

- Executive leadership teams
- Trust board members
- Equality, diversity and inclusion leads
- PCREF leads
- Quality improvement and organisational development teams

These groups were particularly important in linking the programme to governance structures, organisational priorities, and leadership accountability.

2.2.5 Operational and Clinical Staff

The programme also engaged staff working more directly in inpatient services and related support functions. These included:

- Ward managers
- Inpatient clinical staff
- Nursing teams and allied health professionals

- Operational managers
- Corporate and support service staff involved in organisational-level activity

These groups played a key role in translating learning into changes within day-to-day care, team practice, and local service environments.

2.2.6 Lived Experience Contributors

Lived experience was a core part of the programme's design and delivery. Key lived experience contributors included:

- Lived Experience Advisors involved in programme delivery and reflection
- Patients with current or previous experience of inpatient mental health care
- Carers and family members
- Peer support workers and lived experience leadership roles within participating organisations

These perspectives were important in ensuring that programme activity remained grounded in the realities of care experience, particularly where racial inequity and organisational culture were concerned.

Overall, the programme depended on a broad network of contributors, partners, and participating organisations. Its effectiveness relied not only on participation, but on how well these different roles could connect lived experience, frontline practice, organisational learning, and leadership responsibility.

2.3 Embedding PCREF as an Antiracism Framework Across the CoC Programme

Across the CoC programme, PCREF was used as a practical framework for applying a racial equity lens to culture change. Rather than being treated as a separate or parallel initiative, PCREF was embedded across the programme to connect race equity with the wider aims of Culture of Care, including safety, lived experience, organisational learning, leadership, and quality improvement.

This meant that BTG's contribution did not focus only on raising awareness of racism. It also supported organisations to consider how racial inequities are produced, sustained, and challenged within everyday inpatient practice, organisational processes, and leadership decision-making.

PCREF was embedded in several ways across the programme. First, it supported training and shared understanding. BTG introduced PCREF within race equity sessions to help participants understand how national expectations on race equality related to their own roles, teams, and services. This helped move discussion beyond general statements about fairness or inclusion towards a clearer understanding of accountability, data, co-production, workforce culture, and culturally responsive care.

Second, PCREF shaped ward-level and organisational discussions. In ward reviews and organisational sessions, it provided a structure for exploring how racism and inequity might

appear in practice. This included discussion of issues such as differential experiences of care, mistrust, racialised pathways into services, the use of restrictive interventions, staff experiences of racism, and the visibility of race equity within local systems and processes.

Third, PCREF informed executive engagement and leadership reflection. Executive sessions highlighted the role of senior leaders in setting expectations, reviewing data, supporting implementation, and ensuring that race equity was not left to individual champions or isolated teams. This helped frame racial equity as a matter of governance and organisational responsibility, not only personal awareness.

Fourth, PCREF supported change-idea development and action planning. Participants were encouraged to consider how race equity could be built into practical improvement activity, rather than remaining at the level of discussion alone. These included ideas linked to cultural inclusion, patient voice, reflective practice, staff confidence, community connection, and more visible responses to racism.

Using PCREF in this way reinforced several key messages across the programme: racial equity is part of quality and safety; lived experience must shape improvement, particularly where racialised harm is present; data matters, but must be used alongside insight from staff, patients, and communities; leadership accountability is essential if anti-racism is to move beyond aspiration; and culture change requires practical action, not only awareness or policy language.

At the same time, the programme also showed that embedding PCREF is not straightforward. Many participants had limited awareness of the framework, were unsure how it applied locally, or did not know who their PCREF lead was. In some settings, PCREF appeared more visible in policy language than in everyday practice. This reinforced the importance of ongoing support to translate the framework into action that is understood, owned, and measurable across different parts of an organisation.

Overall, embedding PCREF across the programme helped create a clearer link between race equity, organisational culture, and improvement practice. It grounded anti-racism within the wider Culture of Care agenda while also exposing the gaps that still need to be addressed if racial equity is to become a consistent and visible part of inpatient mental health care.

2.3.1 Applying PCREF Across the Culture of Care Standards

Using PCREF as a racialised lens has enabled organisations participating in the programme to critically examine each of the 12 Culture of Care standards and consider how they are experienced differently by racialised communities.

1. Leadership, Accountability and Governance

PCREF has supported organisations to strengthen accountability for racial equity within leadership structures. This includes embedding equity into governance processes, monitoring disparities in outcomes (such as use of restrictive interventions), and ensuring that senior leaders are responsible for driving measurable change.

2. Co-Production and Lived Experience

A central feature of the programme has been the meaningful integration of lived experience, particularly from racially minoritised communities. PCREF has guided the expectation that lived experience is embedded at all levels—from programme leadership to ward-level decision-making—ensuring that care is co-produced rather than designed in isolation.

3. Workforce Development and Culture

PCREF has informed the development of a workforce that is better equipped to understand and respond to racism and inequity. Across the programme, this has included creating reflective spaces, building confidence in discussing racism, and embedding anti-racism within supervision, training, and day-to-day practice.

4. Data, Insight and Continuous Improvement

The CoC programme has utilised PCREF to emphasise the importance of data in identifying and addressing inequities. Organisations are encouraged to disaggregate data by race and ethnicity; use lived experience insight alongside quantitative data and establish feedback loops that inform continuous improvement.

5. Culturally Responsive and Trauma-Informed Care

PCREF has strengthened the programme's focus on delivering care that is responsive to the cultural, social, and emotional needs of racially minoritised patients. This includes recognising the impact of systemic and racial trauma, adapting therapeutic approaches, and ensuring that inpatient environments reflect the diversity and dignity of the populations they serve.

6. Impact on the 12 CoC Standards

Through this integrated approach, all 12 CoC standards are reframed to explicitly address racial equity. This includes:

- Ensuring lived experience is valued at all levels through equitable co-production
- Redefining safety and care to include freedom from racial harm and bias
- Building trust through culturally competent and relational approaches
- Delivering equitable access, treatment, and outcomes through data and accountability
- Supporting staff to provide care that promotes anti-racism and is culturally informed
- Reducing restrictive interventions through an understanding of bias and systemic inequities
- Respecting diverse understandings of distress
- Embedding shared decision-making and patient voice
- Providing hopeful, culturally relevant therapeutic support
- Creating spaces for open and honest conversations about racism
- Designing inclusive inpatient environments
- Ensuring activities reflect the cultural needs and interests of all patients.

BTG has played a key role in embedding this approach across the programme by:

- Grounding PCREF in lived experience and community insight
- Supporting organisations to translate national competencies into practical, ward-level change

- Creating spaces for honest reflection and learning around racism and inequity
- Bridging the gap between policy, practice, and experience

Embedding PCREF across the CoC programme ensures that culture change is not only about improving general standards of care, but about actively addressing the systemic inequities that shape the experiences and outcomes of racially minoritised communities. This approach enables organisations to move beyond awareness and towards sustained, measurable change where racial equity is understood as central to delivering safe, therapeutic, and person-centred care.

3. Black Thrive Global's Role in the Programme

BTG played a central role in the design, facilitation, and evaluation of the programme. The organisation convened a multidisciplinary team including Strategic Leads, Colleagues from the Research Institute and Observatory (RIO), Lived Experience Advisors, a Programme Coordinator, and colleagues from the Culturally Appropriate Peer Support and Advocacy (CAPSA) team.

BTG delivered numerous training sessions both virtually and in person. In addition to leading training delivery, the team supported a range of programme activities, including national learning sessions, Quality Improvement (QI) coaching sessions, and Personalised Approach to Risk (PAR) events. This support included coordinating logistics, developing live polling and evaluation templates, facilitating breakout discussions, and integrating PCREF literacy and application into Culture of Care change-idea coaching.

Key contributors from BTG included: Jacqui Dyer, Souci Frissa, Sarah Hamed, Nathan Stanley, Jo Green, Tanya-Louise Graham, Shantae Loftus, Gabrielle Duberry and Robert Horton, with earlier contributions from Erica Deti, Grace Fairweather and Gillian Marshall.

Lived Experience Advisors were grouped into regional learning networks across the country. Each network brought together advisors, Quality Improvement coaches, leadership coaches, executive representatives from participating trusts, and other programme partners. These networks worked collaboratively to support NHS trusts in embedding race equity principles and practices within their organisations.

Within BTG, CAPSA and RIO teams formed part of an internal working group that provided ongoing support to the Lived Experience Advisors and programme coordination. The working group met weekly to review programme progress, respond to emerging needs and conduct reflexive discussions. Discussions often focused on identifying appropriate data to collect, ensuring approaches to care were culturally appropriate, and supporting the development and delivery of training sessions.

Through this collaborative structure, the teams worked closely together to co-produce materials, contribute to programme delivery, and support the wider CoC through a range of additional tasks as required.

3.1 Description of the programme (including partnerships, meetings etc.)

- Training: Virtual and in-person Race Equity Training using flipped learning, Camara Jones videos, case studies, Mentimeter polls, and small-group activities (break-out rooms).
- Ward Race Equity Reviews: In-person reviews (e.g., Black Country – Friar Ward; Livewell Southwest – Syrena House; Leeds and York Partnership; Berkshire – Sorrel Ward; GMMH; CNWL) with scheduled follow-ups.
- Executive Training: Online sessions with national PCREF leads, focusing on governance, metrics, and aligning PCREF Part 1–3 with CoC

3.2 Description of Data collection

A range of data sources were used across the programme to understand how participants engaged with the race equity strand and what themes emerged from delivery. These sources supported both immediate feedback and broader reflection on the programme's impact.

Data collection methods included:

- Mentimeter polling, used during sessions to gather live reflections, test confidence, and explore attitudes and understanding
- Post-session evaluation forms, used to collect participant feedback on relevance, learning, and delivery
- Chat data from virtual sessions, which captured questions, tensions, comments, and reflections raised during live delivery
- Ward race equity reviews, which generated qualitative insight into staff experience, patient care, and organisational culture
- Panel and discussion questions, including material used in executive and organisational sessions
- Attendance records and participant information, which helped track participation across different audience groups
- Cross-audience feedback collected between October 2025 and March 2026, which enabled broader analysis across roles, organisations, and session types
- Change idea records, used to analyse how often racial equity appeared in practical improvement activity and what themes were most common

These sources were used to identify recurring themes rather than to produce a formal comparative evaluation of all programme activity. The focus of the report is therefore on the main patterns emerging from delivery, discussion, and feedback, particularly in relation to racism, racial equity, confidence, organisational culture, and the conditions for change. Taken together, the data provided both quantitative and qualitative insight into how the programme was experienced, what participants took from it, and where the main barriers and opportunities to advance anti-racism appeared to lie.

3.3 How the programme evolved

The programme evolved continuously over its two-year lifespan, shaped by learning, feedback, and expanding scope. This section highlights the key stages of that evolution and related organisational developments.

- **Early period (2024):**
  The programme began with an in-person foundation day in London. This was followed by virtual sessions focused on establishing CoC principles and building PCREF literacy. Interactive elements, including polls and case study activities, were introduced and refined during this phase.
- **Scale-up (2025):**
  Delivery expanded to include organisation-level, in-person support. Executive training was introduced to strengthen Board-level accountability and align PCREF Part 1 governance with improvements at ward level.
- **Integration and feedback (Late 2025 – Early 2026):**
  A cross-audience Anti-racism Session Feedback instrument was launched. This enabled mixed-methods evaluation and supported analysis of trends across different roles, cohorts, and time periods.

3.3.1 Programme Development and Delivery Adaptations

The race equity strand of the CoC evolved over time in response to participant feedback, delivery experience, organisational need, and internal capacity. This evolution reflected both the wider development of the programme and changes within BTG's own role and delivery model.

During the early phase of delivery in 2024, the programme focused on establishing a shared foundation. This included an in-person foundation day, followed by virtual sessions introducing key ideas around racism, anti-racism, and the role of PCREF within the wider CoC agenda.

These early sessions helped build shared language and confidence, while also making clear that many participants still found racism difficult to discuss. Feedback indicated that the content was relevant and useful, but also that participants needed more support in moving from awareness to practice.

3.3.2 Scale-up Phase

During 2025, the programme expanded to include more direct organisational-level engagement. This reflected a growing recognition that race equity work could not rely only on ward-level activity or individual learning. Broader staff engagement and stronger organisational ownership were needed if change was to become more visible and sustained.

Executive-level sessions were also introduced or strengthened during this phase, helping to connect ward-level experience with leadership accountability, governance responsibilities, and PCREF implementation. This marked an important shift from awareness-focused delivery towards wider organisational and leadership engagement.

3.3.3 Integration and Evaluation Phase

During late 2025 and early 2026, the programme introduced a more consistent cross-audience feedback approach, enabling broader analysis across session types, organisations, and participant roles. This helped strengthen evaluation and allowed for clearer identification of recurring themes across the race equity strand.

By this stage, the programme had developed a more integrated understanding of the relationship between training, organisational culture, leadership accountability, and practical improvement activity. This made it possible to reflect not only on what participants learned, but also on the organisational conditions that supported or limited change.

3.3.4 Internal Development Within BTG

Alongside these wider programme changes, BTG's own contribution also evolved. Early delivery focused more heavily on naming racism, introducing PCREF, and creating shared language. Over time, the work placed greater emphasis on application, organisational systems, leadership responsibility, and the translation of race equity into action planning and change ideas.

This evolution reflected learning from delivery: participants were often willing to engage, but many still lacked confidence, clarity, or practical routes into action. BTG's approach therefore became more explicitly focused on bridging awareness and implementation.

Overall, the programme evolved from an early emphasis on shared understanding towards a more developed focus on organisational embedding, accountability, and practical application. This shift was important in helping the race equity strand move beyond introductory learning and towards a more system-aware approach to change.

3.3.5 Pre-Session Learning Approach

During the second year of delivery, the programme introduced a flipped learning approach to make better use of live session time and encourage participants to engage with key material in advance.

Participants were sent a learning document before their session, usually around a week in advance. This document was intended to provide a shared baseline of understanding before the live training, so that sessions could focus more on discussion, reflection, and application.

The pre-session material included:

- An overview of the history of racism and its impact on healthcare systems
- Key definitions, including race, racism, anti-racism, and anti-Black racism
- An introduction to intersectionality and overlapping experiences of discrimination
- Examples of how racism can appear within mental health services
- An overview of the PCREF
- The PCREF Easy Read Guide
- A visual tool linking PCREF national competencies with the CoC standards
- A link to Camara Jones' presentation on the levels of racism

The intention behind this approach was to reduce the amount of foundational material that needed to be covered in the live session and to support participants to arrive with a clearer understanding of the key concepts.

In practice, uptake was mixed. Many participants reported that they had not received, opened, or reviewed the material before the session. As a result, facilitators often still needed to introduce core ideas during live delivery to ensure that participants could fully engage with the discussion.

Even so, the flipped learning approach remained useful. It provided a structured resource that participants could return to after the session and helped clarify the programme's intention to combine preparation, reflection, and practical application rather than relying solely on one-off live teaching.

Overall, the approach showed promise but also highlighted the limits of pre-session learning where participants are working under pressure or where organisational systems do not actively support preparation.

3.3.6 Internal Programme Adaptations

Over the course of the programme, several internal changes within BTG affected delivery capacity and programme operations. These adaptations were important in sustaining the work, but they also exposed some of the pressures involved in delivering anti-racism activity at scale.

A major challenge was the reduction in Lived Experience Advisor capacity over time. Three Lived Experience Advisors left the team at different points in the programme lifecycle. By the final stage of the programme, delivery responsibilities had narrowed significantly, with a smaller number of colleagues carrying a larger share of the work across multiple learning networks.

As a result, the Programme Coordinator role expanded beyond its original scope. What had initially been designed primarily as a coordination and operations role became a more hybrid function that also included practical support for delivery, facilitation, and participant engagement. This adaptation helped maintain continuity, but it also reflected the need for roles to flex in response to reduced staffing capacity.

The wider BTG team also provided additional support at different stages of the programme, particularly during periods of high delivery demand. This included colleagues contributing to organisational-level sessions, supporting facilitation, and helping to maintain programme momentum where staffing pressures were most acute.

Another important adaptation related to travel and delivery format. The organisational-level element of the programme initially involved significant travel, with an ambition to provide in-person activity across multiple organisations and programme themes. As delivery developed, this proved demanding, particularly for part-time staff and in the context of wider workload pressures.

In response, some sessions were delivered in shared or combined formats alongside other Culture of Care strands, such as autism-informed and trauma-informed sessions. This helped reduce travel and enabled organisations to engage with multiple themes in a more streamlined way.

However, this adaptation also had limitations. In some cases, combined sessions divided attention across several priorities, and anti-racism activity risked receiving less focus than other programme strands. This highlighted a recurring challenge within the programme: ensuring that racial equity remained central rather than becoming diluted within broader culture improvement activity.

Overall, these internal adaptations helped sustain delivery under pressure, but they also highlighted the importance of capacity, role clarity, and maintaining a dedicated focus on anti-racism throughout programme delivery.

4. Participants' Views on Racism from Training Outputs

Across training sessions, ward reviews, and organisational discussions, participants generally described the race equity strand as relevant, useful, and thought-provoking. Many reported increased confidence in understanding racism and anti-racism, and a clearer sense of how PCREF connected to their role and to the wider CoC agenda.

At the same time, participants also made clear that racism remained difficult to discuss in practice. Common barriers included fear of saying the wrong thing, uncertainty about language, discomfort in challenging colleagues or systems, and limited confidence in how to act on learning within organisational settings.

Participants discussed racism at multiple levels. This included direct interpersonal racism, such as racist incidents involving patients and staff, as well as wider organisational patterns of silence, minimisation, fragmentation, and weak accountability. There was often a sense that leadership narratives about inclusion or equity did not always match the realities experienced within ward environments or organisational culture.

Across the different outputs, a recurring theme was that participants valued opportunities for interactive reflection. Case studies, breakout discussion, live polling, and practical exercises helped move the conversation beyond abstract statements and into more honest engagement with everyday practice. Participants often responded positively to the chance to reflect on difficult issues in a structured setting.

However, the data also suggested that increased awareness did not necessarily translate into confidence or action. In many cases, participants could recognise inequity more clearly after the sessions, but still described uncertainty about how to challenge racism, raise concerns safely, or influence wider organisational change.

Overall, participants' perceptions suggest that the programme was effective in opening discussion and strengthening understanding, but that efforts to embed anti-racism remained constrained by organisational culture, leadership visibility, and the absence of clear systems for sustained action.

4.1 Experience of Staff

Across ward reviews and training spaces, staff described inpatient care as both demanding and deeply relational. Many spoke with commitment about providing compassionate care in high-pressure environments. At the same time, staff also described regular exposure to racism in their day-to-day roles.

This included direct racist abuse from patients, as well as more subtle forms of racism linked to accent, nationality, professional status, or assumptions about competence. Staff accounts suggested that these experiences were not rare or exceptional. In some settings, they were described as a routine part of working life.

A consistent theme was that organisational responses to racism were often inconsistent or reactive. Staff described racist incidents being ignored, minimised, or handled informally rather than through clear and trusted systems. Some also felt that racism was treated as an individualised issue rather than recognised as part of a wider organisational and structural problem.

This had serious consequences. Staff described a lack of safe space to speak openly about racism, fear of repercussions, and anxiety about saying the wrong thing. For racially minoritised staff in particular, this created an additional layer of emotional labour, as they were expected to manage both the experience of racism and the pressure to remain professional within a Culture of Care that did not always acknowledge or respond adequately to what they were facing.

There was also concern that reporting systems were not always experienced as credible or effective. Some staff felt that incidents disappeared into informal processes, while others described a lack of visible action after concerns had been raised. This weakened confidence and contributed to a sense that racism was something to be endured rather than meaningfully addressed.

Overall, staff experience points to the need for more than awareness-raising. Staff need clear reporting routes, visible follow-up, emotional and psychological support, and stronger organisational acknowledgement of racism as both a workplace and care issue. There was also interest in peer support, advocacy-based approaches, and stronger links to structures such as Freedom to Speak Up Guardians, so that staff feel safer raising concerns.

4.2 Experience of Patients (Staff and Advocacy Perspectives)

Direct patient input was limited in some parts of the programme, but staff and advocacy perspectives pointed to consistent concerns about the experience of racialised patients in inpatient care.

Participants reflected that many racially minoritised patients enter services through crisis-driven or coercive routes, sometimes involving police, restraint, or other forms of intervention that can deepen mistrust. There was also concern that distress shown by racially minoritised patients may be interpreted too quickly through a lens of aggression, threat, or risk, rather than understood in context.

This matters because it shapes what kinds of care become possible. When distress is read primarily as risk, opportunities for therapeutic engagement, trust-building, and culturally informed support may be reduced. Participants recognised that racially minoritised patients may therefore experience services as frightening, disproportionate, or difficult to trust, particularly where they already carry histories of racial harm or wider mistrust of statutory services.

Staff often showed strong awareness of these dynamics and a clear commitment to improving care. Many spoke about the need for race-aware, trauma-informed, and culturally responsive approaches, including more personalised care planning, better understanding of patient context, and greater attention to how services are experienced by different communities.

At the same time, staff and advocacy perspectives suggested that these approaches were not always supported by consistent organisational systems. In practice, good care often depended on the confidence, skill, or commitment of individual staff rather than on reliable structures embedded across services.

There was also concern that opportunities for service users and carers to shape discussions about race equity were not always present in a meaningful way. Where those voices were absent, discussions about patient experience risked becoming filtered through staff interpretation rather than grounded in direct testimony.

Overall, these perspectives suggest that improving patient experience requires organisations to move beyond general commitments to person-centred care and pay closer attention to how racially minoritised patients experience safety, voice, trust, and interpretation within inpatient settings.

4.3 Issues at Leadership and Organisational Level

A major theme across the programme was the gap between stated commitment and lived organisational reality. Participants described continuing difficulty at leadership and organisational level in naming racism clearly and treating it as a real factor in inequity within mental health care.

This took several forms. In some settings, racism was denied or minimised. In others, it was acknowledged in principle but not translated into clear structures, confident language, or visible action. Participants also highlighted confusion around terminology, including concepts such as racism, racialisation, and minoritisation. This mattered because uncertainty about language often fed broader uncertainty about responsibility.

Participants described anti-racism policy and PCREF as present in some organisations, but unevenly understood and inconsistently implemented. Some were aware of PCREF and could link it to change work; others did not know what it involved, how it applied locally, or who held responsibility for it. This suggested that race equity frameworks were not yet fully embedded in everyday organisational thinking or practice.

There was also concern that anti-racism could become performative if it remained at the level of statements, training, or policy without being backed by accountability, data, follow-through, and visible leadership ownership. In this context, organisations were still often relying on individual

judgement, isolated champions, or informal coping strategies rather than structured systems of response and learning.

Participants also raised concerns about limited access to meaningful data, fragmented communication about anti-racism policies, and weak organisational follow-through after difficult issues had been surfaced. This created a risk that racial harm would remain visible to staff and patients but insufficiently visible to leadership systems.

The wider consequence is that racial harm can become normalised while responsibility remains diffuse. This affects both staff wellbeing and patient care, and it limits an organisation's ability to learn from what is happening in practice.

Overall, the findings point to the need for stronger leadership accountability, clearer organisational ownership of race equity, better communication about PCREF, improved access to meaningful data, and more consistent systems for acting on concerns and learning from them.

5. Summary of Racial Equity Change Ideas

An analysis was carried out on all CoC change ideas recorded across participating wards and organisations. A total of **3,424** valid change ideas were reviewed to understand how many explicitly incorporated racial equity as part of their design, implementation, or intended impact.

5.1 Key Findings

- **223 change ideas** were directly involved in racial equity. This represents **6.5%** of all recorded change ideas and **93.5%** of change ideas did **not** reference racial equity within the dataset.
- All 57 organisations tested at least one change idea with a race equity focus.
- Some of the themes from these ideas include:
    - Pre-ward round sheets to help all patients prepare effectively. Ward round prompt sheets designed to support communication.
    - Introducing multicultural games in communal areas.
    - Integrating chaplain/imam in community meetings.
    - Adding cultural/diversity sections to wellbeing plans.
    - Creating personal boxes tailored to cultural or individual needs.
    - Displaying flags representing patients' countries of origin.

Across the programme, a total of 1,077 change ideas were tested and implemented, of which 185 (17%) focused on race equity. This was the lowest proportion among the equity principles considered, compared with trauma-informed change ideas (42%) and autism-informed change ideas (37%).

These results highlight that while racial equity focused work is present, it is proportionally limited across the broader improvement activity captured within the CoC programme.

5.1.1 Common Themes Identified in Racial-Equity-Related Ideas

Analysis of the 223 ideas suggests they generally fall into a few recurring themes:

- **Improving cultural inclusion** e.g., multicultural games, flags of the world, cultural sections in wellbeing plans.
- **Enhancing representation and spiritual inclusion** e.g., integrating chaplain/imam in community meetings.
- **Embedding anti-racism principles into routine practice** e.g., anti-racism added to handovers or reflective spaces following racist incidents.
- **Improving patient voice for diverse groups** e.g., lived-experience involvement forms and feedback tools aimed at widening participation.

5.1.2 Action Plans from the Org Level Sessions

A range of action plans emerged from the organisational-level sessions, reflecting consistent themes around improving race equity, strengthening cultural awareness, and enhancing staff confidence in addressing racism across clinical and non-clinical areas. The actions identified include the importance of continuously naming and acknowledging racism. This would include for instance having continuous discussions around racism in ward meetings but also various ways of mainstreaming racism in healthcare culture including incorporating racially minoritised and community voices within healthcare. An emphasis on committing to creating safer and more inclusive ward environments was discussed to ensure that staff found support to discuss experiences of racism as well as racism against staff. Safe space would entail the need for organisational support and the ability to challenge, speak against and report racism and racial incidence.

The need to incorporate reflexive spaces was also discussed, not only to address and challenge racism, but also to encourage reflection, share ideas, and reduce the emotional labour associated with racism. In line with this, accountability was emphasised as an important strategy for advancing anti-racism, alongside the inclusion and promotion of anti-racism champions and dedicated units within wards to counteract the silencing of racism. Participants also highlighted the need to increase diversity within digital and clinical teams, rethink career progression for racially minoritised staff, improve staff education on racism and cultural competence, and ensure clearer communication of anti-racism policies and expectations. Several departments also emphasised the need for ongoing reflective practice, improved interpreting services, and greater visibility of zero-tolerance messaging within patient settings. Additionally, better communication between supervisors and staff was identified as essential to strengthening anti-racism, accountability, and the reporting of racial incidents.

It should be noted that the actions included in this report represent only those sessions for which information had been submitted at the time of writing. Not all organisational-level sessions had completed their action plan entries by that stage, and therefore this summary does not reflect all actions that will ultimately be included. Additional updates will be incorporated in future iterations of the report as remaining sessions submit their information.

6. Evaluation of the various outputs

This section brings together feedback on the main outputs delivered by BTG across the programme. Overall, the evidence suggests that the race equity strand was experienced as

relevant, challenging, and practically useful, while also revealing the limits of one-off learning where wider organisational conditions were not yet in place to support sustained change.

6.1 Feedback on the Individual Sessions

Feedback from training and learning sessions was broadly positive. Participants generally rated the sessions as relevant, useful, and well delivered, and many described increased confidence in understanding racism and anti-racism within healthcare settings.

A consistent strength of the sessions was their interactive format. Participants responded well to case studies, discussion, reflective activities, breakout groups, and live polling. These methods appeared to support more active engagement than presentation-led delivery alone and helped participants connect the material to their own roles and settings.

Participants also valued the effort to link race equity work to the wider aims of the CoC programme. This was particularly important in helping people see that anti-racism is not separate from care quality, but connected to safety, trust, lived experience, and outcomes.

At the same time, feedback showed that discussing racism remained difficult for many participants. Common barriers included fear of saying the wrong thing, lack of confidence in language, discomfort in challenging others, and uncertainty about how to act on learning within organisational settings. This suggests that the sessions were effective in opening discussion, but that many participants still needed ongoing support to translate insight into practice.

Different audiences also engaged differently. Ward-based sessions were often more interactive, while executive or senior-level spaces sometimes required more active facilitation to move beyond general agreement and into clearer reflection on leadership responsibility, governance, and accountability.

Overall, the training and learning sessions appear to have been effective in increasing awareness, confidence, and engagement. However, they also showed that learning alone is not enough. Where organisations lacked clear processes, visible leadership ownership, or psychologically safer cultures, the impact of the sessions was likely to be more limited.

6.2 Reflections on the Disruptive Thinking Exercise

One of the more distinctive elements of the organisational-level work was the Disruptive Thinking exercise. This was designed to help participants move beyond conventional action planning by first asking what behaviours, decisions, and organisational habits would produce the worst possible outcomes for anti-racism.

This approach encouraged participants to identify the everyday patterns that can quietly undermine equity work, such as ignoring feedback, failing to act on data, avoiding difficult conversations, or treating anti-racism as a one-off task rather than an ongoing organisational responsibility.

The exercise appears to have been effective because it created a structured route into honest reflection. Rather than asking participants to state what good practice looks like in the abstract, it encouraged them to recognise how harmful patterns may already exist within their own organisations, even when unintentional.

Although some concern was raised by parts of the wider delivery team about whether the exercise might create discomfort, participant feedback suggested that this discomfort was often productive rather than harmful. Reflections described the exercise as thought-provoking, confronting, and useful in helping people identify both organisational barriers and practical actions.

The exercise also generated concrete outputs. Participants used it to identify areas where accountability needed strengthening, where data and feedback were not being used effectively, where staff confidence needed support, and where anti-racism needed to be made more visible in everyday organisational practice.

Overall, the Disruptive Thinking exercise appears to have been a valuable part of the programme. It demonstrated that discomfort, when well facilitated, can support deeper reflection and more honest organisational learning. It also reinforced the wider finding that meaningful culture change requires organisations to look not only at what they say they value, but at the patterns that continue to weaken those values in practice.

6.3 Participant Feedback and Reflections

Participant feedback on BTG's contribution was limited in number but strong in consistency. Responses suggested that BTG played a significant role in shaping the depth, focus, and credibility of the race equity strand across the programme.

A key theme in the feedback was transformational learning. Some respondents described a noticeable shift in their own confidence and understanding, particularly in relation to naming racism, recognising its different forms, and speaking more openly in professional settings. This suggests that BTG's contribution was not experienced only as technical input, but as something that shifted how people thought and worked.

Another recurring theme was the creation of spaces that were both supportive and challenging. Participants highlighted the value of sessions that allowed difficult conversations to take place in ways that were honest without being dismissive or defensive. This balance between care and challenge was seen as a particular strength of BTG's approach.

Feedback also indicated that BTG's contribution had a wider impact on the programme itself. Respondents linked BTG's involvement to stronger race equity conversations, more critical reflection, more grounded action planning, and a greater sense that lived experience and cultural awareness were being taken seriously within delivery.

At the same time, the limited response rate should be acknowledged. It means the participant feedback cannot be taken as a full picture of all views across the programme. However, the depth and consistency of the responses received still provide useful insight into how BTG's role was experienced by those who engaged.

Overall, the feedback suggests that BTG's contribution was seen as substantive, credible, and necessary to the programme's ability to engage meaningfully with race equity. It also reinforces the wider finding that this kind of work depends not only on content, but on the quality of facilitation, the authority of lived experience, and the ability to hold difficult organisational realities without retreating into abstraction.

7. Discussion and reflection

The findings from this report suggest that the CoC Programme created valuable space for organisations to engage more directly with racism, racial inequity, and the realities of inpatient care. Participants generally responded positively to the work and many described increased confidence, stronger understanding, and greater willingness to reflect on issues that are often avoided in organisational settings.

At the same time, the report shows that awareness does not automatically lead to change. Across the programme, there was a recurring gap between learning in the room and the wider organisational conditions needed to sustain action. Participants could often identify the issues clearly, but still faced uncertainty about how to raise concerns, how to challenge racism safely, and how to turn discussion into measurable improvement.

This points to a central tension within the programme. On one hand, there was a clear appetite for honest and practical engagement with race equity. On the other, many of the systems in which staff were working still appeared shaped by silence, fragmentation, and inconsistent accountability. In this context, progress in advancing anti-racism can too easily depend on individual commitment rather than being supported by clear organisational structures.

The report also highlights the importance of understanding racial equity as part of core care quality, not as a separate or competing agenda. The findings show that racism affects staff wellbeing, patient trust, therapeutic relationships, and the way distress is interpreted and responded to. This means that racial equity is directly linked to safety, experience, and outcomes within inpatient care.

A further reflection is that the programme's most useful moments often came when it created space for participants to move beyond abstract language and engage with real practice, discomfort, and responsibility. Interactive formats, case-based discussion, lived experience input, and reflective exercises helped participants think more honestly about what racism looks like in everyday care. This suggests that practical, relational, and discussion-led approaches may be more effective than information-heavy delivery on its own.

The findings also reinforce the importance of leadership visibility and follow-through. Without clear leadership ownership, race equity risks remaining unevenly understood, weakly implemented, or treated as the responsibility of a small number of committed individuals. For culture change to be sustained, organisations need clearer routes from insight to action, supported by governance, data, reflective spaces, and visible accountability.

Overall, the programme shows that meaningful progress is possible, but that it depends on more than willingness. It requires structures that support honest discussion, protect those who raise concerns, translate learning into action, and make racial equity visible within everyday organisational practice.

7.1 Summary of Lived Experience Advisor's Reflections

One Lived Experience Advisor joined the programme at a late stage (18 months into a 24-month project), which shaped both the challenges and opportunities they experienced. Entering an already established system meant navigating pre-existing relationships, cliques, and ways of

working that at times limited effective communication and inclusion. However, they also brought fresh perspectives, challenged existing approaches, and positively disrupted established ways of thinking, particularly in relation to event planning and delivery.

Across the programme, inconsistencies in structure, communication, and clarity of purpose were a recurring challenge. Several spaces—particularly wellbeing and introductory sessions—lacked clear agendas, defined outcomes, or alignment with Culture of Care principles. This sometimes led to unproductive discussions, feelings of disengagement, and confusion about expectations. In response, they demonstrated critical reflection and autonomy, choosing to disengage from spaces that did not feel purposeful or psychologically safe, while advocating for more inclusive and racially conscious environments.

A key theme throughout their reflections was the variable quality of partnership working. While some colleagues and delivery partners were welcoming, inclusive, and collaborative, others displayed disengagement, a lack of preparation, or an unclear commitment to advancing anti-racism. They highlighted the importance of stronger co-production, clearer onboarding processes (e.g. structured introductions and glossaries), and better alignment across teams to support meaningful collaboration.

In facilitating and observing race equity sessions and ward reviews, they noted both examples of impactful practice and significant gaps. Positive experiences included spaces where staff engaged emotionally and authentically with lived experiences of racism, leading to deeper reflection and meaningful dialogue. However, they also identified several challenges, including:

- Limited diversity among participants and service users, which affected the depth of conversations about racism
- A lack of organisational preparedness, requiring facilitators to improvise
- The absence of service user and carer voices in some reviews, reducing authenticity and accountability
- Leadership styles and organisational cultures that may hinder progress in advancing anti-racism

They also reflected critically on how racism and microaggressions were addressed within programme spaces. They observed that responsibility for responding to challenging or microaggressive comments often fell disproportionately on delivery leads, rather than being shared across the wider team. This raised concerns about allyship, collective accountability, and the extent to which the programme's commitment to anti-racism was reflected in practice.

They also noted experiences of both overt and covert racism, particularly in organisational dynamics, representation, and staff experiences. Their reflections demonstrated a strong critical awareness of how racism operates at multiple levels, including tokenism, power dynamics, and unspoken cultural norms within teams.

Overall, their reflections highlighted:

- The importance of structure, clarity, and intentional design in programme spaces
- The need for stronger collective responsibility in addressing racism
- The value of lived experience in challenging systems and fostering deeper reflection
- The ongoing gap between the stated Culture of Care principles and their implementation in practice

Despite these challenges, they identified moments of meaningful impact, particularly where honest conversations about racism were enabled and where staff connected their personal and professional experiences to the work. These moments demonstrated the programme's potential when lived experience is centred and meaningfully supported.

8. Conclusion

This report shows that BTG made a substantial contribution to the CoC programme by helping to place race equity and anti-racism at the centre of discussions about inpatient mental health improvement. Through training, ward reviews, organisational support, executive engagement, and lived experience leadership, BTG helped create space for more direct and practical engagement with issues that are too often avoided or softened in organisational settings.

The programme demonstrated that there is clear value in this work. Participants generally found the sessions relevant and useful, reported stronger understanding of racism and anti-racism, and showed willingness to engage with the relationship between race equity, care culture, safety, and quality. The programme also generated practical change ideas and opened important conversations across ward, organisational, and leadership settings.

At the same time, the report highlights the limits of awareness without wider organisational change. Racism remained difficult to name, discuss, and act on. Staff described silencing, inconsistency, and emotional labour. Concerns were raised about patient mistrust, coercive pathways into care, and the absence of sufficiently embedded race-aware and culturally responsive systems. At leadership level, gaps in accountability, ownership, and implementation remained clear.

The silencing and individualisation of racism at the organisational level, as well as the ad hoc and fragmented implementation of anti-racism strategies, is not new and has been documented in other settings, including education (Ahmed, 2006). Institutions may resist implementing change that advances anti-racism, either consciously or unconsciously, in order to maintain existing racialised power structures. They may also co-opt the language of anti-racism without enacting the policies or practices needed to disrupt racial inequities. In doing so, institutions may claim a commitment to anti-racism without meaningfully advancing it in practice.

Similar trends have been seen in healthcare where an over-emphasis on the idea of evidence-based medicine and medical neutrality as the core ethos of healthcare coupled with a colourblind mentality results in a reluctance in viewing healthcare as a racialised institution, evidence of racism notwithstanding (Hamed, 2022).

As articulated by the LED, even within the CoC programme (see section 7.1.1) issues related to how racialised talk was dealt with (or not dealt with), a lack of awareness on how racism operates at multiple levels within team existed. Not only did these issues exist, but there was also at times an unwillingness to deal with these issues. Therefore, the non-performativity of antiracism is present at multiple levels within racialised institutions in Western nation-states which entails that racism continues to be marginally dealt with.

The report therefore points to a central conclusion: racial equity cannot sit at the margins of culture change work. If organisations are serious about improving inpatient mental health care, they must transform the very idea that healthcare is inherently neutral to acknowledge racism in

order to treat racial equity as part of core quality, safety, experience, and governance. The non-performativity of antiracism needs to be taken seriously, and institutions need to be held accountable for implementing antiracism. This requires more than training or policy language. It requires visible, ongoing reflexive leadership commitment, stronger accountability, better use of data, meaningful co-production, and systems that support honest reflection and sustained action.

Overall, the CoC showed both the importance and the difficulty of this work. It created valuable learning and momentum, but it also exposed how much remains to be done if anti-racism is to become a consistent and measurable part of inpatient mental health care.

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Appendix 1

Evaluation of race equity training

Black Thrive Global (BTG) delivered a comprehensive programme of race equity training across multiple formats and audiences, including in-person workshops, virtual learning sessions, executive-level training, organisational support sessions, and bespoke adaptations. The training offer evolved throughout the Culture of Care programme in response to participant feedback, emerging learning, and the needs of participating organisations.

Training Design and Preparation

All training sessions were developed through a collaborative planning process involving the BTG Culture of Care team and colleagues from the wider programme partnership. Weekly working group meetings provided a structured space to review previous delivery, plan upcoming sessions, refine content, and respond to emerging learning and participant feedback.

Miro was used to support collaborative planning and co-production, while detailed training plans and session agendas ensured clarity of purpose, consistency of delivery, and clear allocation of responsibilities across the team. Content was initially developed in Canva before being finalised in PowerPoint for delivery.

All sessions were recorded for quality improvement and reflective learning purposes. Following delivery, the team conducted debrief sessions to identify strengths, capture learning, and inform future adaptations. This approach enabled continuous improvement while maintaining consistency across a large volume of programme activity.

In-Person Race Equity Training (August 2024)

The in-person training was designed as an interactive and reflective learning experience, enabling participants to explore racism, anti-racism, and their relevance within mental health services and the wider Culture of Care programme. Sessions combined presentations, facilitated discussion, case studies, and live polling through Mentimeter to encourage active participation and critical reflection.

A central feature of the training was its grounding in lived experience. Participants were encouraged to explore both personal and systemic dimensions of racism, reflect on the experiences of racially minoritised communities, and consider how these insights applied within their professional roles and responsibilities.

The training created space for open dialogue, enabling participants to ask questions, challenge assumptions, and build confidence in discussing complex and sensitive issues. Structured activities supported participants to move beyond awareness and consider practical applications within healthcare settings.

Feedback from participants indicated a positive impact on understanding and confidence. Most participants reported an increased understanding of racism and anti-racism, alongside greater confidence in discussing these issues within professional settings.

Despite this progress, many participants identified ongoing challenges in discussing racism. Common barriers included fear of saying the wrong thing, concerns about causing offence, the emotional impact of the subject matter, and uncertainty about how to challenge racism effectively. These findings highlighted the need for continued support and opportunities for reflective learning.

Participants particularly valued the interactive nature of the sessions, the use of case studies, and the opportunity to engage in honest discussion. Feedback suggested that participants left with a stronger understanding of racism as a systemic issue and a greater appreciation of the shared responsibility required to address racial inequities in healthcare.

Virtual Race Equity Training (December 2024)

Following the initial in-person training, BTG delivered a three-hour virtual Race Equity Training session on 13 December 2024 for participants who were unable to attend in person.

The session was structured around three key themes:

Part One: Naming Racism

Improving understanding of racism, its historical roots, and its impact within healthcare systems and inpatient mental health services.

Part Two: Aligning with PCREF

Exploring how the Culture of Care Programme aligns with the Patient and Carer Race Equality Framework (PCREF) and identifying barriers to equitable care and outcomes.

Part Three: Moving to Action

Supporting participants to identify practical approaches for improving experiences and outcomes for racially minoritised and culturally diverse communities.

The session was delivered collaboratively by Race Equity Lived Experience Advisors, Research Institute and Observatory colleagues, CAPSA representatives, the Race Equity Lead, and the Programme Coordinator.

This marked BTG's first full virtual delivery as a team and established a strong foundation for future online training.

Adaptation for Ward Staff

The virtual training was subsequently adapted for ward-based staff and delivered on 7 March 2025. The content was tailored to reflect the realities of frontline mental health care and focused on supporting practical application within inpatient settings.

Guest speakers, including PCREF Leads from NHS Trusts, contributed to three of the four ward-based sessions delivered during 2025. Their contributions strengthened the connection between policy requirements and operational practice, providing participants with practical examples of implementation within healthcare settings.

Executive-Level Training

BTG delivered two tailored race equity training sessions for executive audiences on 6 May 2025 and 4 September 2025.

These sessions included contributions from senior leaders and PCREF Leads and focused on leadership accountability, organisational responsibility, governance, and implementation. A key feature was a facilitated panel discussion informed by questions developed by Lived Experience Advisors, highlighting systemic issues identified through learning network engagement and programme delivery.

The sessions created space for strategic reflection and reinforced the role of leadership in embedding racial equity within organisational culture and practice.

Wider Programme Contributions

In addition to formal training delivery, Lived Experience Advisors made significant contributions across the wider Culture of Care Programme. This included participation in:

- Lived Experience Network events
- Personalised Approach to Risk (PAR) events
- National Learning Sessions

Across these activities, Advisors co-facilitated alongside programme partners and contributed lived experience perspectives that helped ensure race equity remained central to programme delivery and organisational learning.

National Learning Session: Black History Month

On 30 October 2025, BTG delivered a national Race Equity learning session to mark Black History Month.

The session incorporated creative approaches, including a Black history quiz and music from Black artists across the world. These elements contributed to a more engaging and reflective learning environment and were positively received by participants.

Feedback highlighted the value of incorporating cultural and creative approaches into training delivery and demonstrated their potential to increase engagement and participation.

Organisational-Level Virtual Sessions

BTG delivered two large-scale organisational-level virtual sessions on 26 September 2025 and 20 January 2026.

These sessions supported participating organisations to embed race equity within organisational systems, leadership structures, and improvement activity. They built on earlier programme learning and encouraged organisations to translate discussion into practical action.

Continuous Improvement and Delivery Approach

Training content and delivery methods were continuously refined throughout the programme in response to participant feedback and team reflection.

Over time, the programme moved from a more presentation-led approach towards a highly interactive learning model that incorporated:

- Breakout room discussions
- Mentimeter polling
- Case study-based learning
- Reflective discussion spaces
- Active use of chat functions and real-time facilitation

Different audiences engaged in different ways. Ward-based sessions were generally highly interactive, while executive-level sessions often required more facilitation to encourage deeper reflection and discussion. Mixed-audience sessions frequently produced the most balanced levels of engagement and exchange.

Evaluation and Data Collection

Evaluation forms were distributed following training sessions to capture participant feedback and learning. While responses provided valuable insights, completion rates varied across sessions, highlighting opportunities to strengthen evaluation processes in future programme delivery.

Feedback data informed ongoing adaptation of content, delivery methods, and facilitation approaches throughout the programme.

Inclusive and Bespoke Delivery

As part of its commitment to inclusive practice, BTG developed a bespoke version of the ward-based training for Deaf audiences. This included a pre-recorded four-hour Race Equity training session delivered alongside interpreters.

This adaptation helped ensure that Deaf staff and service users could access the training in a format that met their communication needs and reflected the programme's wider commitment to equity and inclusion.

Overall Impact

Despite periods of reduced staffing capacity and high delivery demands, BTG successfully delivered an extensive programme of race equity training across multiple settings and audiences.

The programme increased awareness and understanding of racism and anti-racism, strengthened confidence in discussing race equity, and supported participants to connect these issues to care quality, safety, leadership, and organisational culture.

The experience also demonstrated the value of lived experience-led and co-produced approaches to learning. Through continuous adaptation, collaborative delivery, and a sustained commitment to race equity, BTG made a significant contribution to the Culture of Care Programme and its wider objectives.