Health Innovation East

A rapid evidence review of how anti-racism interventions impact healthcare staff outcomes and experiences.

EVIDENCE REVIEW COMMISSIONED BY CAMBRIDGESHIRE AND PETERBOROUGH INTEGRATED CARE SYSTEM (ICS).

COMPLETED ON BEHALF OF HEALTH INNOVATION EAST
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Contents

Glossary of terms

Citation – *a reference to a document or publication.*
Covidence – *software used to manage systematic review processes.*
Cultural competency – *whilst this definition varies across studies included in this report, it broadly relates to the ability of people to function effectively in the context of cultural differences or any diversities.*
Cultural safety – *acknowledges the power imbalance between patient and clinician and encourages clinicians to critically examine themselves and their own biases and assumptions.*
Document analysis – *a systematic approach to reviewing and/or evaluating documents.*
Folk illness – *Beliefs or behaviours which may not align with the traditional biomedical paradigm of healthcare.*
Grey literature – *literature or documents which are published outside of traditional commercial publishing, e.g. policies, published reports, blogs.*
Implicit bias – *a negative attitude, for which the person may not be consciously aware of, towards a social group.*
Longitudinal – *following something up over a set time period.*
Racism – *discrimination or prejudice based on someone's race or ethnicity.*
Scoping review – *evidence synthesis approach to identify and map available evidence.*
Social-ecological model – *a framework which can illustrate the dynamic interrelations of influences on an individual across different system levels.*
Systematic review – *evidence synthesise approach which uses systematic and explicit methods to minimise bias, which can inform policy and decision making.*
Umbrella review – *a systematic collection and assessment of multiple systematic reviews.*

Abbreviations

ICS - *Integrated care system*
JBI – *Joanna Briggs Institute*
NHS - *National Health System*
PICO – *Population, Intervention, Comparator, Outcome(s)*
PRESS Checklist – *Peer Review of Electronic Search Strategies*
PRIOR – *Preferred Reporting Items for Overviews of Reviews*
PRISMA – *Preferred Reporting Items for Systematic Reviews and Meta-Analyses*
XML – *Extensive Markup Language*

Executive Summary

1 Cambridgeshire and Peterborough ICS commissioned Health Innovation East to conduct a review of anti-racism interventions in healthcare and examine the impact of these interventions on staff outcomes and experiences.

2 The review comprised two stages: a document analysis of grey literature providing context for anti-racism in healthcare settings and in the Eastern region, and an umbrella review which explored the impact of anti-racism interventions implemented into healthcare settings on staff outcomes and experiences.

2.1 The document analysis included forty documents comprising strategy documents, policies, population profiles, staff surveys, demographic data and commissioned reports. The analysis identified four key themes within the documents: policy, process, culture and structure.

2.2 The umbrella review included 10 scoping reviews and systematic reviews, comprising a total of 105 primary studies. Review papers were published between 2003-2024 and interventions had been implemented across Australia, Canada, Unites States of America and South Africa.

3 All reviews reported staff outcomes at the individual-level (E.g. staff skills, attitudes, knowledge), rather than at organisational-level (E.g. HR processes, recruitment, retention, organisational culture). Four of the reviews reported improved staff outcomes after receiving cultural competency interventions. Six of the reviews reported mixed findings relating to staff outcomes. One review reported no improvement in staff outcomes resulting from the anti-racism interventions.

4 We proposed using a social-ecological model to frame the findings from both stages of the review. The model can be used to identify and address systemic racism across all system levels in healthcare. The framework will be helpful to inform a future anti-racism toolkit.

5 Interventions which led to more positive outcomes for staff knowledge, skills and attitudes focussed on cultural competency.

5.1 Interventions varied in duration and frequency of delivery, but those which were more effective included staff education, engagement with people with lived experience of racial injustice, and practical learning which included challenging prejudices and stereotypical thinking about minoritised groups and discussing scenarios and case studies.

6 This review identified improvements in staff knowledge, attitudes and beliefs around anti-racism. However, there was no evidence to suggest that these improvements impacted on the experiences or outcomes for racially minoritised staff on a long-term basis. We would need longitudinal data to establish this.

Background and context of this review

Why was this review needed?

Health Innovation East were commissioned to conduct a review of relevant and available literature relating to anti-racism in healthcare. The findings of the review will inform a wider project to develop an anti-racism toolkit for Cambridgeshire and Peterborough Integrated Care System (ICS). The evidence-based anti-racism toolkit will aim to reduce racism amongst staff, consequently improving staff outcomes, such as wellbeing and staff retention.

Review question

What impact do anti-racism interventions delivered to staff working in healthcare settings have on staff outcomes and experiences?

Review aim

This review aimed to scope the evidence for how anti-racism interventions delivered to the workforce in healthcare settings impact staff outcomes and experiences.

Review outcomes

The review was concerned with collecting information relating to the following:

- Types of anti-racism interventions which most effectively improve outcomes for the workforce in healthcare settings.
- Types of anti-racism interventions which did not improve outcomes for the workforce in healthcare settings.
- The impact of anti-racism initiatives/programmes/projects on the workforce in healthcare settings.

How we conducted this review

We received a briefing document from Cadence Partners in March 2024 which detailed the specification for the review. The briefing document requested that we, at Health Innovation East, collate and summarise information published by, and within Cambridgeshire and Peterborough ICS, relating to addressing or understanding racism in the region. The briefing document also requested that we collate and summarise existing research evidence relating to racism in healthcare settings. We met with colleagues from Cadence Partners and Professor Nicola Rollock throughout the review process, ensuring understanding and agreement of the review scope.

After discussions with partners in March 2024, it was agreed that we would proceed with the review in two stages: a document analysis, followed by an umbrella review. We would then combine findings from the umbrella review with the themes identified from the document analysis to inform the development of an evidence-based anti-racism toolkit. We proposed to use a social ecological model (1) to frame the review findings within, because it is a useful framework for considering and addressing systemic racism within healthcare systems.

The following sections summarise the stages of the review. The detailed review methodology can be found in Appendix 1.

Document analysis

We conducted a document analysis in April 2024. The aim of the document analysis was to identify grey literature which related to addressing or understanding racism, either published by Cambridgeshire and Peterborough ICS, or relating to the Eastern region. We searched relevant organisations' websites within the ICS and NHS England (NHSE) for eligible literature. We purposively selected published grey literature which either described anti-racism, discrimination and racism, and/or workforce and population data reports. We included any document type within our search. We excluded any documents which were not published online and therefore not publicly available. We reviewed all of the documents included in the document analysis, and identified key themes from each, based on principles from Braun and Clarke's guidance on conducting reflexive thematic analysis (2).

Umbrella review

In May 2024, we conducted an umbrella review. After an initial search of the racism in healthcare literature, we became aware of the large extent of literature in this field. We therefore decided that an umbrella review was an appropriate approach following Joanna Briggs Institute (JBI) methodology to conduct this review (3). Umbrella reviews are considered useful for providing

decision makers with a clear understanding of a broad topic area, resulting from the highest level of evidence relating to the review question (3). The umbrella review identified literature pertaining to the impact of anti-racism initiatives on staff outcomes and experiences working in healthcare settings.

Inclusion criteria

We included English-language peer-reviewed scoping reviews and systematic reviews which provided details of how anti-racism interventions delivered to staff working within healthcare settings impacted on staff outcomes and experiences. We did not restrict by publication date.

We used a broad approach to define racism in this review, to ensure that we did not exclude any potentially eligible interventions defined by other terms. We therefore included terms used to describe anti-racism interventions such as "cultural safety", "addressing difference in power and reallocating resources to people from minoritised ethnic groups", "Diversity, Equity and Inclusion".

Findings

Findings from the document analysis and umbrella review are presented separately below. We then combined the findings to present a synthesis using a social-ecological framework (1) (Figure 1).

Document analysis

What types of documents did we include?

We included 40 published documents that were publicly available online. These can be found in Supplementary File 3. Documents were published between 2009-2024, though 12 documents were undated. Whilst the majority of the documents were published by NHS organisations (n=23), documents were also published by Higher Education Institutions (n=4), trade unions (n=4), professional bodies (n=2), media (n=2), local councils (n=2), journals (n=2) and third-sector organisations (n=1).

Eighteen of the documents reported population reports, NHS staff survey results, anti-racism charters, strategy or guidance relating to racism and anti-racism in the Eastern region. We included 22 national documents relating to anti-racism, racism strategies and racism awareness, because they reported instructive and useful learnings, relevant to informing the Cambridgeshire and Peterborough ICS anti-racism toolkit.

How we synthesised the findings

We condensed the contents of the forty documents and identified commonly occurring themes. We identified four higher-level themes and 14 subthemes: Policy (*strategy, policies, auditing, code of conduct*), Process (*recruitment, pay, discipline, training, training, progression*), Structure (*workforce makeup/groups, leadership make-up/groups, board make-up*), Culture (*allyship, bullying/harassment by staff and patients, discrimination*), as shown in Table 1.

Table 1: Themes identified in the document analysis

Theme	Sub-theme
Policy	Strategy
	Policies
	Auditing
	Code of conduct
Process	Recruitment
	Pay
	Discipline
	Training

	Progression
Structure	Workforce make-up / groups
	Leadership make-up / groups
	Board make-up
Culture	Allyship
	Bullying / harassment by staff and patients
	Discrimination

Umbrella review

What types of reviews did we include?

We imported 4808 citations into Covidence software (4) which we used to manage this review. We imported an additional 17 citations from searching the reference lists of three umbrella reviews. Covidence removed 543 duplicated citations. We screened 4265 title and abstracts and excluded 4234 citations which did not meet our inclusion criteria. We screened 30 full texts for eligibility into the review. We excluded 20 papers at this stage for reasons such as not reporting staff outcomes, not systematic or scoping reviews, wrong setting and wrong type of intervention. We included 10 systematic and scoping reviews within this review. See Figure 2 (Appendix 1).

How we synthesised the findings

What types of reviews did we include?

We included 10 reviews, of which included 105 primary studies relevant to the present review question. Five of the reviews reported on interventions delivered in the United States of America (5-9), three reported on interventions delivered in Australia (9-11), one reported on interventions delivered in Canada (12), one reported on interventions delivered in South Africa (13) and one reported on interventions delivered globally (14).

It should be noted that the Lie (2010) (5) review was an update of the Anderson (2003) review (7). Both these reviews only included the same one paper relevant to this review (15).

Included reviews were published between 2003-2024. Six of the reviews reported on cultural competency interventions (5-7, 10, 13, 14), whilst others reported on implicit bias interventions (8), cultural safety interventions (11) and anti-racism interventions (9, 12) delivered to staff working in healthcare settings.

All of the reviews reported on anti-racism interventions delivered to staff working in healthcare settings, with the primary aim of improving patient outcomes. Four reviews only reported improved staff outcomes post-intervention, all of which were cultural competency interventions (5-7, 10). Six of the reviews reported mixed findings relating to staff outcomes, though these were still largely positive outcomes overall (8, 9, 11, 13, 14). Hassen *et al.,* (2021) was the only review which reported no improvement in staff outcomes resulting from the anti-racism interventions (12). Authors reported that the small convenience sample of 13 White occupational therapists in this study held significantly negative attitudes towards African Americans prior to the intervention, and believed that health disparities did not result from racial discrimination (16).

The umbrella review aimed to identify how anti-racism interventions delivered to staff working in healthcare settings impacted staff outcomes and experiences. Table 2 includes an overview of the interventions reported on, within each of the 10 reviews included in this umbrella review. Table 2 also reports the staff outcomes and experiences resulting from the interventions.

TABLE 2: INCLUDED REVIEWS AT A GLANCE

StudyID (ref)	Intervention - components	Reported outcome(s)
Anderson (2003) (7)	**Cultural competency:** 4hr cultural sensitivity training incl. skills training component.	- Positive impact on counselling skills and staff's cultural sensitivity.
Beach (2005) (14)	**Cultural competency:** General cultural concepts, specific cultural content, language, racism, access issues, doctor-patient interactions, socioeconomic status and gender/sexuality. Targeted the knowledge, attitudes, and skills of health professionals.	- Positive impact on staff attitudes, knowledge and skills relating to cultural competency. - Some mixed findings relating to change in staff attitudes.
Bhui (2007) (6)	**Cultural competency:** Educational and training, improved cultural knowledge and improved skills through encounters.	- Positive impact on staff knowledge and attitudes towards diverse groups, and improved clinical and therapeutic skills.
Chipps (2008) (13)	**Cultural competency:** Education and training [Ranged from single sessions to 3-days] focussing on the following competencies: (1) language issues; (2) understanding the values and needs of people with disabilities; (3) folk illness and treatments; (4) provider practice; and (5) normative cultural values.	- Positive impact on staff's cultural knowledge, attitudes, awareness and understanding of multiculturalism. - **One study reported no change post-intervention**.
Gonzalez (2023) (8)	**Implicit bias:** Guided by four major components of Transformative Learning Theory: 1.A 'disorienting dilemma' that challenges learner assumptions, 2.Critical reflection on the meaning of the dilemma, 3. Guided discourse to expand on learners' experiences, 4. Action/behaviour change related to implicit bias recognition and management.	- Positive impact on staff relating to their assessment of implicit bias post-intervention. - **Three studies reported no change in staff's implicit bias post-intervention.**
Lie (2010) (5)	**Cultural competency:** 4 hour cultural sensitivity training including skills training component.	- Positive impact on counselling skills and staff's cultural sensitivity.
Hamed (2022) (9)	**Anti-racism:** Training varied across all studies, ranging from conferences to narrative.	- Positive impact on staff knowledge,

StudyID (ref)	Intervention - components	Reported outcome(s)
	photography, discussion series and full curriculums.	understanding and awareness of racism. - **One study reported staff's implicit racial bias remained unchanged**.
Hassen (2021) (12)	**Anti-racism:** Education and Training to staff. Other studies included policy-level, organisation-level, community-level, interpersonal-level and individual-level strategies as part of anti-racism interventions.	- No positive impacts. - **Staff maintained negative attitudes toward African American post-intervention**.
Marchand (2024) (11)	**Cultural safety:** Education intervention studies highlighted key themes and action areas: culturally safe care practices, staff cultural competency, relationships, education, and communication.	- Positive impact on staff interest in raising awareness of inequity, and staff awareness. - Limited effectiveness data due to early nature of interventions.[*pilot studies/interventions had not yet formally assessed outcomes*].
Pearson (2007) (10)	**Cultural competency:** Education and training, organisational commitment, equity in workforces.	- Positive impact on staff knowledge and understanding of cultural competency.

*Negative outcomes highlighted in bold.

Components linked to more impactful interventions

The duration and frequency of interventions did not seem to impact the success of an intervention, but authors of one study which reported an unsuccessful one-off 6-hour intervention recommended that the delivery of an intervention should be prolonged and should consider how developed staff's cultural competence is prior to receiving any intervention(12). The intervention did however improve staff awareness of racism (16). Many effective interventions were standalone sessions without follow up (5, 7, 8, 13-15). One review recommended that cultural competency training should be delivered at staff inductions and then embedded within organisational processes for continued professional development (10). Anti-racism programmes should be

delivered to all staff (9). All of the interventions included in-person training and/or education, and some included additional online learning components.

Cultural competency interventions appear to be promising for improving staff awareness, attitudes, knowledge and beliefs, whilst there is less convincing evidence for implicit bias interventions having the same effect (9, 13, 14). Whilst it should be noted that there is little consensus amongst the included studies for principles of cultural competency most effective at improving staff outcomes and experiences, interventions which applied the 'Campinha Bacote cultural competency model' (17) were more successful than those that employed the 'culture brokering model' (18) of cultural competency. 'Cultural brokering' is a type of person-centred communication whereby people's diverse worldviews are brought together in order to share meaning and understanding (19).The 'Campinha Bacote' model assumes that cultural competency is a process and includes five principles (17): 1. cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire, awareness of intra-ethnic variation. Interventions which had positive impacts on staff skills, knowledge and attitudes were mostly delivered in-person, and designed to increase staff awareness of cultural competency and sensitivity, and then provided experiential and active learning to staff. This active learning involved engaging with and learning from people from racially minoritised communities, reflecting on and discussing provocative scenarios, and challenging conscious and subconscious prejudices and stereotypical thinking about minoritised groups (8-10).

Interventions which were not as impactful used the cultural brokering model of cultural competency and/or were delivered in one-off sessions. A one-off 6-hour in-person workshop using multiple modes of delivery, including PowerPoint, DVD, small group discussion, problem-based learning and reflections, improved staff awareness of racism, but did not change staff's negative attitudes towards African Americans, nor did it change their beliefs that healthcare disparities could be due to racial discrimination (12). The authors attributed the lack of success of the intervention to the significantly negative attitudes towards African Americans, held by the White recipients of the intervention, rather than flaws of the intervention design (16). The authors recommend that staff level of cultural competency should be considered prior to intervention delivery, inferring that recipients with more negative attitudes, and/or lower levels of cultural competence may require a prolonged intervention (16). See Table 3 below for a summary of components more and less impactful on staff outcomes.

TABLE 3: COMPONENTS OF MORE AND LESS EFFECTIVE INTERVENTIONS ON STAFF OUTCOMES

More impactful	Less impactful
Cultural competency interventions	Implicit bias interventions
Cultural competency interventions using principles of the 'Campinha Bacote' model (17)	Cultural competency interventions using the 'Cultural brokering' model (20)
Practical skills	Small group of staff received intervention
Active learning	
Multiple modes of training delivery, e.g. PowerPoint, video, small group work, audiovisual aids, discussion, reflections.	
Provocative triggers to allow for experiential learning	
Involves all staff roles	
Develop case studies about communities to learn from	
Engagement with communities (e.g. lecture, or interviews)	
Cultural competency training delivered at staff inductions and throughout refresher trainings	

Conceptual framework to frame the review findings

Bronfenbrenner's social ecological model (1) suggests that human behaviour is impacted by the interconnected systems that we exist within. Each of the circles represent a system level. The model is useful for understanding behaviour within complex systems such as healthcare settings. The model may therefore provide useful framework for developing an anti-racism toolkit, ensuring that all system levels are targeted to address racism within healthcare.

We present the combined review findings from the document analysis and umbrella review within the social-ecological model (1) in Figure 1 below. Figure one shows numerous ways in which racist beliefs, attitudes, culture and actions may exist and be perpetuated within a healthcare system. An anti-racism toolkit should address systemic racism, by considering behaviour change at each of these system levels.

The four themes identified in the document analysis can be considered at the organisational level. The umbrella review highlights the positive impact on staff knowledge, awareness, and attitudes towards diverse groups and cultural sensitivity, which relates to the individual level. The umbrella review also

showed improved clinical and communication skills for staff, which can be attributed to the interpersonal level.

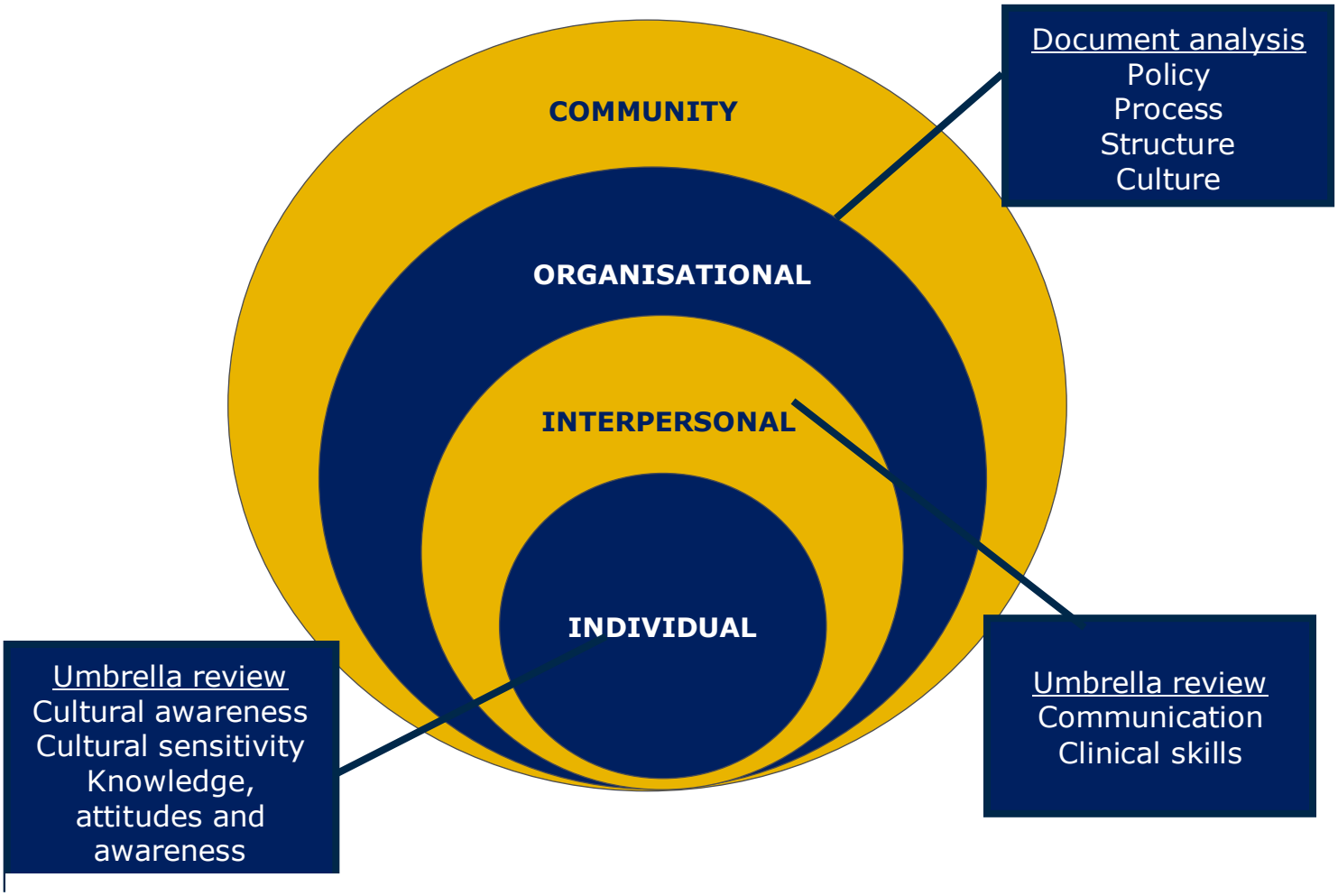

FIGURE 1: CONCEPTUAL FRAMEWORK FOR THE INTEGRATED FINDINGS

Recommendations from the umbrella review

Many of the included reviews reported recommendations for healthcare providers to consider when designing and implementing interventions to address and reduce racism. We collated these recommendations and have reported them within each of the system levels in Table 4 to link to the model provided in Figure 1. Although we have organised recommendations within particular system levels, as shown below, it is more likely that these mechanisms for addressing racism fluidly span across system levels, e.g. although tailored mandatory staff training happens at an individual-level, it will need to be embedded into staff inductions or annual trainings at an organisational-level.

TABLE 4: RECOMMENDATIONS FOR ANTI-RACIST INTERVENTIONS IN HEALTHCARE SETTINGS

Individual	Interpersonal	Organisational	Community
- Tailored mandatory staff education and training informed by critical theories (12)	- Sensitively, yet directly, addressing racism (11).	- Leadership investment and buy-in (11, 12).	- Long-term meaningful relationships with people from diverse backgrounds (8, 11, 12).
- Cultural competency should be a component of education and training (10, 13, 14).	- Regular meetings to enable relationship-building amongst staff (11).	- Policy and organisational-level interventions (11, 12).	
		- Continuous dialogue within the organisation about racism (11).	
		- Cultural competency should be embedded within infrastructure and ethics of service providers (6).	

Discussion

There is vast amount of literature relating to racism in healthcare, yet the literature predominantly focuses on the impact on patient outcomes, instead of staff outcomes. Most healthcare interventions designed to address anti-racism intend to improve patient outcomes. The majority of anti-racism interventions included within this review, which reported staff outcomes, related to cultural competency initiatives. There was wide variation in the composition of interventions reported. None of the reviews reported long-term outcomes or experiences of staff working in healthcare settings because they did not measure such outcomes. Staff outcomes were mostly self-report assessments based on any change in staff skills, attitudes and knowledge of anti-racism, after completing the intervention. No studies reported staff outcome data measured at the organisational-level, nor on a longitudinal basis, which limits the potential impact of the anti-racism interventions reported in this review.

Recommendations for an anti-racism toolkit

Much of the racial justice literature acknowledges that racism is systemic and thus a system-approach would be beneficial for an anti-racism toolkit. We propose Bronfenbrenner's social ecological model (1) as a useful framework to support the development of an anti-racism toolkit. It could be argued that an intervention which addresses racism at all system levels may be a more sustainable and effective intervention. Over the past five years, the social-ecological model has increasingly been used to examine racism and anti-racism (20-22). The model identifies how influences on racism can be identified and addressed at each system level and how factors at each level may influence others, which is key to our understanding for developing an anti-racism toolkit. Many interventions reported in the literature address racism across system levels in healthcare settings, but the impact of this specifically on staff outcomes have not been evaluated (12).

There were strong recommendations captured from the umbrella review that cultural competency should be a component of staff education and should be embedded within the infrastructure and ethos of the service provider. The 'Campinha Bacote' model appears to be the most impactful cultural competence model for anti-racism interventions in healthcare settings.

Whilst the umbrella review identified effective interventions to reduce racism and improve cultural sensitivity at the individual-level, it may be useful to draw upon learnings from government reviews, the corporate sector and other sectors in developing an anti-racism toolkit which addresses racism at all system levels. Anti-racism interventions retrieved in this review have mostly addressed and measured influences on racism at the individual level. There may be useful and effective intervention models which are implemented

outside of the healthcare sector, which could be instructive in addressing racism in the workplace.

Health Innovation Network South London

For example, the Health Innovation Network South London conducted a rapid review of workplace anti-racism initiatives, including those within healthcare, to develop their own anti-racism strategy (23). They recommended the importance of co-design in designing an anti-racism strategy, developing an action plan with clear goals, sustaining the impact of the intervention over time, and linking goals to metrics to enable measurement of change over time (23). The Health Innovation Network South London recommend that organisations implement an advisory group, deliver staff training, review recruitment processes, develop educational resources and implement mechanisms for staff to raise concerns about racism (23).

McGregor-Smith Review

Baroness McGregor-Smith conducted an independent review in 2017 of issues affecting minoritised ethnic groups in the workplace (24). The review recommended that organisations should publish data pertaining to diversity and inclusion and publish aspirational targets of what they expect their organisation to look like in five years' time, to increase diversity and inclusion (24). The report highlighted the importance of leadership in addressing racism in the workplace (24). The report identified the need to address racism throughout all system levels, and the need to talk about race (24). The report recommended that all UK staff receive mandatory unconscious bias training and for staff who work in recruitment roles, to receive more detailed training (24). However, our review found no evidence that unconscious bias training had a positive impact on staff outcomes or experiences (8).

Parker Review

There is a strong focus on leadership in addressing racism in a number of corporate sector and government publications. An independent review into the ethnic diversity of UK boards, updated in 2023 by Sir John Parker, highlighted the need to improve ethnic diversity on UK boards and within leadership positions (25).

Other reviews and initiatives

An article written for Harvard Business Review in 2020 reported that leaders and organisations need to firstly admit and acknowledge there is a problem with racial equity, and then implement a strategy to address it by changing personal attitudes, addressing informal cultural norms, and changing formal institutional policies (26). A McKinsey and Partners report showed how the organisation had made 10 commitments to anti-racism and racial justice (27). The organisation focuses on building Black leadership and offers a firmwide 'anti-racism learning journey' which is an anti-racism and inclusion programme in addition to the organisation's unconscious bias training, delivered to all staff

(27). They also focus on recruitment and leadership processes to improve diversity in their workforce (27). It is clear from looking at this small number of reports from other sectors, that they also advocate a system-wide approach to addressing racism.

Practical applications of the review findings

An anti-racism toolkit may consider a cultural competency framework, modelled using principles from Campinha Bacote (17). An anti-racism toolkit may consider a prolonged delivery of training and should be embedded within an organisation for all staff to complete on a routine basis. Training should begin with making staff aware of racial inequalities and disparities, and staff should be encouraged reflect on this. In-person training appears to be most effective and should involve multiple modes of delivery including learning from people with lived experience and communities affected by racial injustice.

Strengths and limitations of this review

Strengths

This review has many strengths. We combined data from the document analysis of grey literature, with peer-reviewed umbrella review findings. This provided a comprehensive search of relevant literature. We included a broad definition of anti-racism to ensure that we scoped any available evidence on this topic. We conceptualised the findings of this review within a useful systems framework, which can be used to inform an evidence-based toolkit. We have reported on recommendations from our examined included reviews and also considered a select number of reports from other sectors.

Limitations

We conducted the review applying systematic methodology following formal guidance wherever possible. However, there is a chance that we have not included all potentially eligible studies due to the scope of the search strategy and/or human error. We were unable to source the full text of one review paper. We did not conduct critical appraisal of included studies and therefore cannot provide information about the risk of bias of each review. Much of the peer-reviewed literature focused on patient outcomes and only reported on short-term outcomes for staff.

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Appendix 1

Umbrella review quality processes

The review team were trained to conduct the umbrella review, familiarised with the review protocol, and are trained in using Covidence. This umbrella review is reported in line with the Preferred Reporting Items for Overviews of Reviews (PRIOR) statement, which is published guidance for reporting overviews of reviews/umbrella reviews (28).

Eligibility Criteria

For the umbrella review, we included peer-reviewed scoping reviews and systematic reviews which provided details of how anti-racism interventions delivered to staff working within healthcare settings impacted on staff outcomes. The inclusion criteria was framed using JBI's PICO mnemonic (3) (See Table 5). We only included English-language studies and did not restrict by publication date.
We included umbrella reviews for the purpose of citation searching reference lists, to identify relevant and eligible systematic and scoping reviews.

We used a broad approach to define racism in this review, to ensure that we did not exclude any potentially eligible interventions defined by other terms. We therefore included terms used to describe anti-racism interventions such as "cultural safety", "addressing difference in power and reallocating resources to people from minoritised ethnic groups", "Diversity, Equity and Inclusion".

TABLE 5: INCLUSION CRITERIA FOR UMBRELLA REVIEW

PICO	Inclusion
Population	Staff working in healthcare settings
Intervention	Anti-racism interventions delivered to staff
Comparator	Any
Outcomes	Staff outcomes Staff experiences
Document type	Systematic and scoping reviews Umbrella reviews/reviews of reviews *(For citation searching purposes only)*

We excluded any primary studies and reviews that were not defined as being scoping or systematic reviews. For the purpose of this review, we agreed with Cadence Partners and Professor Rollock that we would apply the UK definition of healthcare to screening decisions, and thus excluded studies that included interventions within social care settings, or those which would have been classified as social care settings within the UK context, e.g. Nursing homes.

Search strategy

We iteratively developed the search strategy, informed by the PRESS Checklist (29) based on the PICO framework relevant to the review question: [anti-racism intervention] AND [staff outcomes] AND [healthcare]. We searched from database inception to 3rd May 2024.

We ensured comprehension and precision of our search strategy by ensuring inclusion of key papers identified from the Yip *et al.* (2024) umbrella review of anti-racism interventions in healthcare settings (30), and by conducting a brief search of NHS England anti-racism interventions and initiatives. The full search strategy for MEDLINE (Ultimate) can be found in Appendix 2.

Selection of sources and evidence

We searched two online databases: MEDLINE Ultimate (EBSCO) and CINAHL Ultimate (EBSCO). We then exported citations from each database into EndNote and exported the XML file into Covidence. We citation searched reference lists from included umbrella reviews to identify additional eligible systematic or scoping reviews.

We used Covidence, a web-based collaboration software platform that streamlines the production of systematic and other literature reviews, to manage all stages of the review (4). Three reviewers were involved in this review. Two reviewers completed title, abstract and full text screening. The lead reviewer duplicated screening for 20% of all included and excluded studies, to ensure accuracy and minimise bias.

Data charting/Extraction

We conducted data extraction in Covidence. The lead reviewer developed the data extraction template in Covidence, enabling the team to extract details relating to the PICO framework: document details, characteristics of the interventions, setting, reason for implementing the intervention, staff outcomes, any recommendations from the review paper and any gaps to inform future research. Reviewers extracted details from each included study independently and referred back to primary studies for details of outcome data wherever necessary. The lead reviewer checked each data extraction for accuracy and completeness.

Synthesis of results

We tabulated outcome data items in a brief 'characteristics of included studies' table (*Table 6*) which can be found in Appendix 3 at the end of this report. We have provided the full data extraction table in Supplementary File 1. We provide the excluded studies within Supplementary File 2. We conducted a narrative synthesis of the review findings relating to the key outcomes.

PRISMA flow diagram of the reviews included within the umbrella review

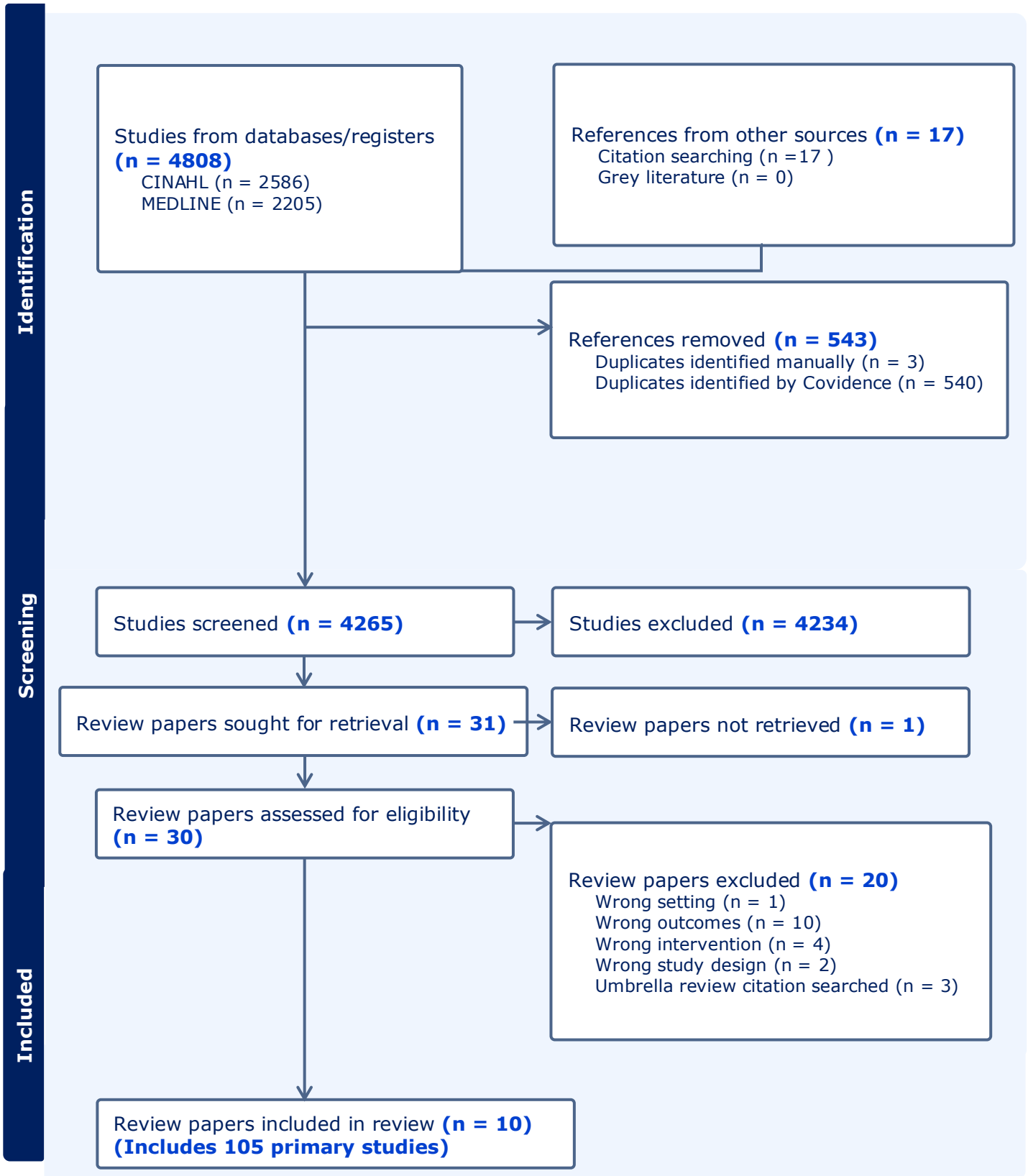

FIGURE 2: PRISMA FLOW DIAGRAM FOR UMBRELLA REVIEW

Bronfenbrenner's social ecological model to frame the review findings

We framed the combined findings within an ecological systems framework because racism is widely considered to be systemic. Although Bronfenbrenner's social ecological model (1) stems from the field of child psychology it is often used as a model for understanding human behaviour within complex systems, such as healthcare. Bronfenbrenner's ecological systems theory (1) proposes that humans are influenced by multiple levels of interconnected environmental systems surrounding them. In the context of racism, this means that racism is likely to exist at all system levels (individual, interpersonal, organisational, community) and therefore anti-racism should be addressed at all levels.

Appendix 2

	Friday, May 03, 2024 10:04:27 AM		
#	**Query**	**Last Run Via**	**Results**
S64	S38 AND S48 AND S63	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	2,219
S63	S49 OR S50 OR S51 OR S52 OR S53 OR S54 OR S55 OR S56 OR S57 OR S58 OR S59 OR S60 OR S61 OR S62	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	16,053,338
S62	TX "tertiary healthcare"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	5,766
S61	TX "secondary healthcare"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	2,968
S60	TX "primary healthcare"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	41,837
S59	TX "primary care"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	611,540
S58	TX "tertiary care"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	195,836
S57	TX "community health"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	439,519
S56	TX "health service"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	374,542
S55	TX "acute care"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	157,303
S54	TX "national health service"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	88,564
S53	TX NHS	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	403,512
S52	TX ward*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	872,116
S51	TX hospital*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	9,199,551
S50	TX health*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	11,354,788
S49	TX healthcare	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	1,694,781
S48	S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45 OR S46 OR S47	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	9,908,810
S47	TX professional*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	1,558,546
S46	TX "healthcare staff"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	14,304
S45	TX "NHS staff"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	3,147
S44	TX employee*	Interface – EBSCOhost Research Databases	395,695

		Database – MEDLINE Ultimate	
S43	TX person*	Interface – EBSCOhost Research Databases	4,005,917
		Database – MEDLINE Ultimate	
S42	TX team*	Interface – EBSCOhost Research Databases	1,401,482
		Database – MEDLINE Ultimate	
S41	TX staff*	Interface – EBSCOhost Research Databases	1,294,529
		Database – MEDLINE Ultimate	
S40	TX work*	Interface – EBSCOhost Research Databases	7,482,376
		Database – MEDLINE Ultimate	
S39	TX workforce	Interface – EBSCOhost Research Databases	219,039
		Database – MEDLINE Ultimate	
S38	(S33 OR S34 OR S35 OR S36 OR S37)	Interface – EBSCOhost Research Databases	2,539
		Database – MEDLINE Ultimate	
S37	TX "racis* educat*"	Interface – EBSCOhost Research Databases	176
		Database – MEDLINE Ultimate	
S36	TX "racis* program*"	Interface – EBSCOhost Research Databases	73
		Database – MEDLINE Ultimate	
S35	TX "racis* interven*"	Interface – EBSCOhost Research Databases	112
		Database – MEDLINE Ultimate	
S34	TX "anti-racism"	Interface – EBSCOhost Research Databases	1,592
		Database – MEDLINE Ultimate	
S33	TX anti-racis*	Interface – EBSCOhost Research Databases	2,021
		Database – MEDLINE Ultimate	
S32	S6 AND S16 AND S31	Interface – EBSCOhost Research Databases	2,219
		Database – MEDLINE Ultimate	
S31	S17 OR S18 OR S19 OR S20 OR S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30	Interface – EBSCOhost Research Databases	16,053,338
		Database – MEDLINE Ultimate	
S30	TX "tertiary healthcare"	Interface – EBSCOhost Research Databases	5,766
		Database – MEDLINE Ultimate	
S29	TX "secondary healthcare"	Interface – EBSCOhost Research Databases	2,968
		Database – MEDLINE Ultimate	
S28	TX "primary healthcare"	Interface – EBSCOhost Research Databases	41,837
		Database – MEDLINE Ultimate	
S27	TX "primary care"	Interface – EBSCOhost Research Databases	611,540
		Database – MEDLINE Ultimate	
S26	TX "tertiary care"	Interface – EBSCOhost Research Databases	195,836
		Database – MEDLINE Ultimate	
S25	TX "community health"	Interface – EBSCOhost Research Databases	439,519
		Database – MEDLINE Ultimate	
S24	TX "health service"	Interface – EBSCOhost Research Databases	374,542
		Database – MEDLINE Ultimate	
S23	TX "acute care"	Interface – EBSCOhost Research Databases	157,303
		Database – MEDLINE Ultimate	
S22	TX "national health service"	Interface – EBSCOhost Research Databases	88,564
		Database – MEDLINE Ultimate	
S21	TX NHS	Interface – EBSCOhost Research Databases	403,512
		Database – MEDLINE Ultimate	

S20	TX ward*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	872,116
S19	TX hospital*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	9,199,551
S18	TX health*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	11,354,788
S17	TX healthcare	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	1,694,781
S16	S7 OR S8 OR S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	9,908,810
S15	TX professional*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	1,558,546
S14	TX "healthcare staff"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	14,304
S13	TX "NHS staff"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	3,147
S12	TX employee*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	395,695
S11	TX person*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	4,005,917
S10	TX team*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	1,401,482
S9	TX staff*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	1,294,529
S8	TX work*	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	7,482,376
S7	TX workforce	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	219,039
S6	(S1 OR S2 OR S3 OR S4 OR S5)	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	2,539
S5	TX "racis* educat*"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	176
S4	TX "racis* program*"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	73
S3	TX "racis* interven*"	Interface – EBSCOhost Research Databases Database – MEDLINE Ultimate	112
S2	TX "anti-racism"	Interface - EBSCOhost Research Databases Database - MEDLINE Ultimate	1,592
S1	TX anti-racis*	Interface - EBSCOhost Research Databases Database - MEDLINE Ultimate	2,021

Appendix 3

TABLE 6: CHARACTERISTICS OF INCLUDED STUDIES

Study ID (ref)	Review type	Studies relevant to this review	Setting	Type of Intervention	Improved Staff Outcomes	No improvement in staff outcomes
Anderson (2003) (7)	Systematic review	1	Outpatients (USA)	Cultural competency	1. Patients considered clinicians to have superior counselling skills (p<0.001). 2. Patients considered clinicians to show increased cultural sensitivity (p<0.001).	N/A
Beach (2005) (14)	Systematic review	34	Healthcare (Global)	Cultural competency	1. Most studies (17/19) demonstrated a beneficial effect on provider knowledge. 2. Most studies (21/25) demonstrated a beneficial effect on provider attitudes. 3. All studies (14/14) demonstrated a beneficial effect on provider skills.	1. One study showed no effect. 2. Three studies showed a partial/mixed effect for provider attitudes.
Bhui (2007) (6)	Systematic review	5	Mental healthcare (USA)	Cultural competency	1. 30% of staff intended to modify practice. 2. 20% of staff self-reported actual change in behaviour. 3. 86% of staff satisfied with new consultation model. 4. 48% self-reported providing better treatment. 5. 31% self-reported improved communication, empathy, understanding and therapeutic alliance. 6. Improved self-awareness and skill	N/A

Study ID (ref)	Review type	Studies relevant to this review	Setting	Type of Intervention	Improved Staff Outcomes	No improvement in staff outcomes
					refinement. 7. Increased cultural (including social and religious) knowledge.	
Chipps2008(13)	Systematic review	4	Community-based rehabilitation (South Africa)	Cultural competency	1. Two studies reported significant improvement in cultural understanding of multiculturalism (p = .0001), cultural awareness (p = .0001), understanding of cultural differences (p = .001), and cultural beliefs (p = .004). 2. One study reported that 'cultural school' participants showed significantly more cultural knowledge and attitudes (p < .001). 3. One study showed increased Cultural Knowledge Score (p < .01). 4. One study showed statistically significant ratings for cultural competence at post-test and 3 months.	1. One study did not show any statistically significant changes in knowledge or attitude.
Gonzalez (2023) (8)	Scoping review	37	Healthcare (USA)	Implicit bias	1. 29 studies reported improvement in their assessments related to implicit bias.	1. Three studies reported negative data including no change in objective knowledge assessments or self-reported changes in attitudes.

Study ID (ref)	Review type	Studies relevant to this review	Setting	Type of Intervention	Improved Staff Outcomes	No improvement in staff outcomes
Hamed (2022)(9)	Scoping review	15	Healthcare (Australia and USA)	Anti-racism	1. Better understanding of racism in healthcare. 2. Increased confidence and comfort in discussing and addressing racism. 3. Interest in anti-racism training. 4. Increased knowledge and awareness of racism.	1. One study shows that implicit racial bias remained significantly unchanged.
Hassen (2021) (12)	Scoping review	1	Outpatients and community (Canada)	Anti-racism	N/A	1. Staff's negative attitudes towards African Americans were not ameliorated by the intervention, when assessed using the Racial Argument Scale and Racial Attitude Implicit Association Test
Lie (2010) (5)	Systematic review	1	Outpatients (USA)	Cultural competency	1. Patients considered clinicians to have superior counselling skills ($p<0.001$). 2. Patients considered clinicians to show increased cultural sensitivity ($p<0.001$).	N/A
Marchand (2024) (11)	Systematic review	3	Healthcare (Australia)	Cultural safety	1. One study noted achievements, such as raising awareness of inequity and sparking passion and interest.	1. Due to the early nature of the interventions, effectiveness data was limited. Pilot study ongoing and

Study ID (ref)	Review type	Studies relevant to this review	Setting	Type of Intervention	Improved Staff Outcomes	No improvement in staff outcomes
						outcome data had not yet been assessed and/or published.
Pearson (2007) (10)	Systematic review	4	Healthcare (Australia)	Cultural competency	1. Understanding/ knowledge of ethnicity and race concepts. 2. Increased confidence in engaging with diverse groups. 3. Awareness of resources available to diverse groups. 4. Increased consciousness of practice effect on cultural competence.	N/A