MAY 2026

BRIEFING FROM HSSIB RHO ROUNDTABLE:

BIAS AND DISCRIMINATION IN PATIENT SAFETY INVESTIGATIONS

When things go wrong in our health and care system – whether because of individual error or inappropriate systems – the cost can be grave. People's lives and quality of life are on the line every day in the NHS, and it's therefore vital that we're learning from these mistakes.

The UK healthcare system has a complex set of mechanisms and processes to enable us to learn lessons when things go wrong. Individual professionals are subject to regulators, as are the organisations that provide care. We have bodies who explicitly investigate patient safety issues, and other umbrella organisations who have ultimate oversight of the functioning of this system.

The complexity of this system, identified in the Dash Review, can mean some things fall through the gaps and, as we've seen elsewhere in the NHS, considerations of equity are often overlooked. It's essential that these investigations are free of bias and discrimination, and any structural racism or inequity is identified and eliminated. To better understand the complexity of these issues, and to identify and scale good practice in this space, the Health Services Safety Investigations Body (HSSIB) and the NHS Race and Health Observatory (NHSRHO) convened a roundtable in late 2025, drawing together experts by lived and learned experience to discuss these issues and look towards solutions.

This briefing outlines that discussion and is intended for national and regional policymakers, NHS senior leaders, regulators, and system partners with responsibility for patient safety, quality, and equity. It sets out why equity must be treated as a core patient safety concern, identifies systemic failures in current investigation approaches, and proposes concrete actions to embed anti-racism and equity into patient safety investigations.

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BACKGROUND

Patient safety investigations are a critical mechanism through which the NHS identifies harm, learns from failure, and prevents recurrence. However, evidence and lived experience consistently show that racially minoritised patients, families, and staff experience investigations differently: their concerns are less likely to be heard, their accounts are more likely to be dismissed, and patterns of harm linked to racism are less likely to be identified or acted upon.

Not only is there evidence that some ethnic minority communities experience higher rates of some adverse patient safety events, but we also know that the process of investigation varies based on a person's race and other characteristics[1]. Structural, institutional, and interpersonal racism shapes what is investigated, how investigations are conducted, and what outcomes they produce. When equity is treated as an optional or downstream consideration, patient safety systems risk reproducing the very harms they are intended to address.

This briefing argues that equity should not be an afterthought to patient safety, but a prerequisite for it. Structural, institutional, and interpersonal racism shapes what is investigated, by whom investigations are conducted, and what outcomes they produce. When equity is treated as an optional or downstream consideration, patient safety systems risk reproducing the very harms they are intended to address. We believe that equity should not be an afterthought to patient safety, but a prerequisite for it.

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[1] Piccardi, C., Detollenaere, J., Vanden Bussche, P. et al. Social disparities in patient safety in primary care: a systematic review. Int J Equity Health 17, 114 (2018). https://doi.org/10.1186/s12939-018-0828-7

ROUNDTABLE

On the 18 November 2025, HSSIB and NHSRHO convened a national roundtable in London. The primary aim of the roundtable was to bring together patient safety investigation stakeholders to identify and address gaps in our understanding of racial bias and discrimination in patient safety investigations. The intention was to raise the profile of this issue and support coordinated system-wise actions to address it.

The roundtable brought together people who have had direct lived experience of bias and discrimination in patient safety investigations, along with academic experts, clinicians, and leaders of the organisations who determine how these same investigations are conducted. The following organisations were represented:

- Several patient advocacy groups
- Individuals with lived experience
- Health Services Safety Investigations Body
- NHS Race and Health Observatory
- Department of Health and Social Care
- NHS England
- NHS Resolution
- Nursing and Midwifery Council
- Maternity and Newborn Safety Investigations (MNSI)
- National Institute for Health and Care Research
- Royal College of Midwives
- Royal College of Psychiatrists
- Health Innovation, Manchester

The group heard from expert speakers and then participated in two breakout roundtable discussions. The conversation was facilitated, with both groups seeking answers to the following questions:

> *How does bias and discrimination manifest in patient safety investigations?*
>
> *What do we know or believe to be effective ways of tackling these issues?*
>
> *How can we ensure that frameworks/approaches aimed at addressing bias and discrimination in patient safety investigations are effectively implemented – i.e. How do we avoid tick-box approach?*

The conversations were wide ranging, reflecting both the complexity of the issue, and the variety of lived and learned experience in the room. The below section of the briefing draws out key themes from the discussion. These are aggregated across several opinions from different contributors, as opposed to representing a final consensus position.

THEMES

Racism and bias are structurally embedded in patient safety investigations — not peripheral failures

Patient safety investigations are not neutral processes; they are shaped by structural, institutional and interpersonal racism, which directly influences what is investigated, whose voice is legitimised, and how harm is interpreted. This means that investigations can add an additional layer of systemic inequity after a patient has already been impacted by an inequitable system.

Across both groups at the roundtable, there was a strong consensus that bias manifests not only in the individual behaviours that can form part of an investigation (e.g. assumptions, dismissal, stereotypes), but in the design and governance of investigations themselves. These biases can manifest in who is appointed to lead the investigation, what data is collected and analysed, how "objectivity" is defined, and how boards and other governance structures are held to account at the outcome of the investigation.

Exacerbating this, the routine failure to name racism in the terms of reference or rationale for investigation explicitly allows investigations to miss patterns of harm, particularly where families themselves may not feel able or safe to articulate racism as a cause. Too often, these investigations are considered "one size fits all" and are not meaningfully tailored to minoritised communities, if at all.

Implications:

Treating racism as an "external context" rather than a core determinant of patient safety outcomes risks systematically flawed investigations and perpetuates inequity.

National policymakers should mandate explicit consideration of racism and discrimination within all patient safety investigation standards, methodologies and guidance.

The current model of "family involvement" is inadequate and sometimes tokenistic

The groups at the roundtable expressed concerns that existing approaches to patient and family involvement in investigations routinely fail to deliver meaningful participation for racially minoritised communities. Participants repeatedly highlighted that families often:

- Are unaware that an investigation is underway in the first place
- Do not understand their right to be involved
- Don't have sufficient understanding to know what "good" looks like
- Fear negative repercussions on ongoing care if they speak up
- Experience poor communication, delayed feedback, or tokenistic engagement

Furthermore, consent processes are frequently managed by the very organisations under investigation, raising serious questions about informed consent, power imbalances, and trust. Where families lack confidence, cultural familiarity, or advocacy support, involvement becomes procedural rather than substantive, leaving many in doubt as to whether their involvement has had any impact either on the process of investigation, or on its outcomes. This has the serious implication of further eroding trust between marginalised people and the organisations designed to care for them.

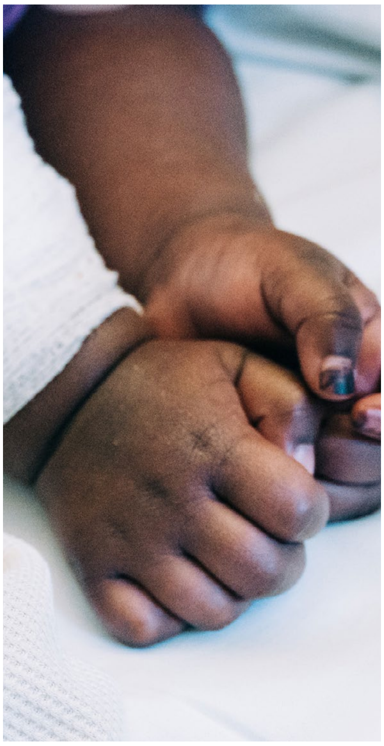
Implications:

Without proactive, supported, and independent mechanisms for family voice, investigations risk reinforcing existing inequitable power dynamics rather than correcting them.

Training and expertise around 'good' family engagement is critical; we know that some providers are being asked to reduce in-house engagement services as part of the cuts to staffing, with serious implications for patients.

Policymakers should set clear national expectations for equitable family involvement, including minimum standards for communication, feedback, and informed consent.

The culture of investigation often prioritises "process compliance" over equity, learning, and accountability



A proliferation of frameworks, tools, and reporting requirements over the past few years has not translated into equitable practice; instead, it has increased the risk of "tick-box" compliance that obscures lived experience and ultimately weakens accountability rather than enhancing it. Both groups raised concerns that:

- Equality Impact Assessments, Duty of Candour, and equity frameworks are often applied retrospectively or superficially as opposed to being used as 'live tools' that can help to embed accountability.
- Recommendations default to generic actions (training, policies, posters) with little enforcement or follow-up.
- There is no shared articulation or understanding of "what good looks like" for anti-racist investigations.
- Boards and senior leaders are insufficiently equipped to interrogate findings through an equity lens and/or are not being challenged to do so.

This process-heavy approach risks reframing racism as a technical issue rather than a leadership and governance failure. Even where racism is considered as part of an investigation, it is acknowledged but not targeted for action. This builds a sense that organisations are good at itemising shortcomings in patient safety, but bad at tackling culture.

Implications:

Without clear accountability levers, professional standards, and consequences for inaction, equity frameworks risk becoming performative rather than transformative. Leaders, especially those at board level, should consider how they're reviewing the findings of investigations, and how they're holding one another to account for applying an equity lens to such considerations.

Regulators should use their levers to challenge superficial or tick-box approaches to Equality Impact Assessments and Duty of Candour and require boards to evidence how learning from racially patterned harm has informed improvement action.

Workforce conditions and power dynamics stand in the way of speaking up – for both staff and families

Unsafe cultures for staff and unsafe conditions for care are mutually reinforcing, particularly for racially minoritised staff and patients. Roundtable participants consistently highlighted:

- Burnout, vacancy pressures, and time scarcity are all increasing pressure on staff.
- There's a fear of repercussions for staff who raise concerns, especially where there is a pre-existing sense of inequitable treatment or discrimination.
- There can be a culture of gatekeeping of information about complaints, investigations, and escalation routes, meaning staff are not always aware of their rights or how to raise concerns.

These dynamics discourage challenge and narrow the scope of investigations. They can also limit the candour of the individuals engaged as part of the investigation. The shift towards "system-focused" approaches was seen by some as unintentionally diluting responsibility and making racism harder to name.

Implications:

We cannot expect equitable investigations in organisations where staff themselves do not feel psychologically safe or supported to challenge harm. Leaders must consider how they're making the workplace safe for staff to make care safe for patients.

Data gaps, poor use of evidence, and fear of disclosure obscure patterns of inequality

The absence of robust, complete, and granular data on race and ethnicity fundamentally limits the NHS's ability to identify, evidence, and act on inequities in patient safety. This can be exacerbated by an unwillingness or discomfort among professionals around proactively collecting or correcting ethnicity data. Key issues raised during the roundtables include:

- Inconsistent or missing ethnicity data in investigations and reporting (and a lack of consequence for incomplete data).
- Limited consideration or cross-referencing of investigation data with existing national data sets (e.g. Workforce Race Equality Standard).
- Fear among communities that disclosing ethnicity may worsen care or that their data may be used in a way they don't want.
- Failure to integrate qualitative lived-experience evidence with quantitative data, leading to a lack of nuance in investigation outcomes.

Participants stressed that lack of data is not a "neutral gap"; it actively protects the status quo by making inequity harder to prove and easier to ignore, and the decision not to prioritise solutions is an active decision not to tackle racism.

Implications:

Data collection must be paired with trust-building, transparency, and clear purpose, otherwise it risks deepening disengagement rather than enabling accountability.

We must also think carefully about what data needs to be collected and when.

Policymakers should require the routine collection, analysis and publication of disaggregated ethnicity data linked to patient safety incidents and investigations.

Investigator capability and diversity are central to equitable outcomes

Who conducts investigations, and how they are trained and supported, materially shapes whether racism and bias are identified or missed. This means not just hiring a more diverse workforce to conduct investigations but also ensuring the training is available to embed cultural competency, and that individuals are systematically prompted to engage with unconscious bias.

During the roundtable, both groups highlighted:

- A lack of racial and experiential diversity among investigators and investigation leaders.
- Insufficient training on racism, bias, and intersectionality.
- Discomfort or lack of appropriate language/understanding when asking about race and ethnicity.
- Political and organisational pressures that constrain what investigators feel able to name.

There was strong support for professionalising patient safety investigation roles, embedding anti-racism as a core competency, and using innovative, reflective training models rather than compliance-based modules. Without these actions, not only could the conclusions of the investigations be biased, but the trust in the process and outcomes may be further eroded.

Implications:

Equity cannot be bolted onto investigations; it must be embedded in investigator identity, capability, and professional standards. The professionalisation of patient safety investigators must embed anti-racism as a competency.

Communities must be partners in designing patient safety investigations and systems, not just subjects of them

Sustainable progress on equity in patient safety requires systematic co-production with communities, not episodic consultation after harm has occurred. This means not just more meaningful engagement throughout the investigation process, but also involvement in the design and functioning of the bodies that oversee these processes.

Participants pointed to effective practice where:

- Community and VCSE organisations are involved early to shape methods.
- Investigations draw on existing evidence of lived experience rather than repeatedly asking communities to “prove” harm.
- Communication about risk, rights, and escalation routes happens before deterioration or crisis, meaning patients can feel empowered where they identify patient safety risks.
- Learning from communities with strong advocacy models is actively applied on a continuous or cyclical basis, and all co-design is underpinned by trauma-informed approaches.

The above were framed not merely as an engagement exercise, but as a redistribution of power towards marginalised communities and deeper consideration of what we mean by ‘expertise’.

Implications:

Without co-production, even well-intentioned safety initiatives risk benefiting those already most able to navigate the system. Communities should be embedded in patient safety systems long before the need for investigation arises.

Implementation, as well as policy design, is a key area of focus to improve patient safety investigations.

A major threat to equity-focused patient safety reforms is just not lack of policy intent, but weak and uneven implementation. There needs to not only be greater attention to implementation science and practice, but also a robust system to monitor impact and effectiveness.

Across both groups at the roundtable, participants emphasised:

- The need for enforcement mechanisms, accreditation, KPIs and regulatory alignment (e.g. CQC, ICBs).
- The value of implementation science to understand what works, for whom, and in what contexts.
- The danger of leadership churn and short-term initiatives undermining sustained cultural change.
- The importance of feedback loops so learning from investigations drives system improvement.

There was broad agreement that equity must be assessed across the entire investigation pathway, not confined to after-action reviews or final reports.

Implications:

Without deliberate system stewardship, equity-focused frameworks will degrade into symbolic compliance rather than meaningful change.

CONCLUSION

Without deliberate system leadership, patient safety investigations risk reinforcing inequity rather than preventing harm. Embedding equity and anti-racism into investigation practice is therefore not only a moral imperative, but a patient safety necessity.

The issues highlighted in this roundtable cover a huge range of different areas – from incomplete data and flawed mechanisms to investigator capability and leadership culture. Taken together, they present a stark challenge to the sector and to healthcare leaders, but they also present us with several timely and potentially deeply impactful opportunities. If leaders grasp these opportunities now, we can build a system of patient safety investigations that is not only more equitable for the most marginalised people in our society but improves health and care for all.