research in practice

Frontline Briefing

Delivering person-centred care and support for the UK's culturally diverse communities

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Introduction

A note on terminology (Spillett, 2024). In this briefing the term 'Global Majority' is used. This term includes those people who identify as Black, African, Asian, Brown, Arab and mixed heritage, are indigenous to the global south, and/or have been racialised as 'ethnic minorities'. Globally, these groups currently represent approximately 85% of the world's population (Campbell-Stephens, 2021, p. 7). Where other terminology is used in this briefing (for example 'Black or minority ethnic') this refers to the language used in the research or reports being cited. The term minoritised recognises that people are actively minoritised by others rather than 'naturally' or factually existing as a minority (see Gunaratnum, 2003 in Milner & Jumbe, 2020). Research in Practice capitalises the B in Black to acknowledge a shared historical and cultural identity but does not capitalise white due to associations with white supremacy.

About this briefing

This Frontline Briefing discusses concepts and frameworks for delivering person-centred care and support for the UK's culturally diverse communities. The content will be relevant to practitioners, managers and senior leaders involved in delivering and planning care and support for communities from across all cultural backgrounds. The focus of this briefing is on learning and development to support the delivery of care to culturally diverse communities, by highlighting some of the ways in which culture can influence experiences of social care. It aims to help practitioners to develop 'culturally appropriate care' that is culturally sensitive and responsive. It is not an in-depth study of any specific culture, values or practices, thus further learning is encouraged.

The briefing poses the following questions for reflection, and draws on research and theory to begin to answer them:

- What is culture?
- How does culture relate to inequality and privilege?
- Why is culturally sensitive practice needed?
- What is the importance of intersectionality?
- What are the existing frameworks for developing culturally appropriate care?

What is culture?

Talking about culture is a way of talking about the way people live their lives. Culture encompasses **traditions, beliefs, practices and values that are learnt through living in a social group**. Culture is **dynamic and contextual** - the way people express their culture will always depend on the person, the place and the time.

The concept of culture can be hard to define precisely, and it is difficult to separate it cleanly from other interrelated social structures like religion, socioeconomic status or ethnicity. However, **everybody 'has' culture**, which is to say that everyone belongs to one or many cultural groups. The UK can be called a 'multicultural' society in that it is made up of individuals and communities from many different national, ethnic and social origins, each with various ways of seeing the world and living in it.

Some cultural boundaries are increasingly blurred or have been reshaped, especially in bigger cities where members of many different cultural, national and ethnic groups live side by side and people find new ways to define themselves.

The dictionary definitions of 'culture' describe it generally as "the ideas, customs and traditions, and social behaviour of a particular people or group" - essentially, their way of life.

One example of the impact of culture on everyday behaviour can be illustrated through practices around oral hygiene. In much of Europe and North America, using a toothbrush and toothpaste is the usual and accepted way of cleaning teeth. In parts of Africa and Asia, chewing sticks made from wood such as neem or miswak are used as a natural tooth-cleaning aids. These twigs have antibacterial properties that help fight plaque and bacteria in the mouth. In parts of India and many other cultures, oil pulling with coconut, sesame, or sunflower oil is common practice to improve oral hygiene and promote overall health. Other cultures promote tongue scraping using copper or stainless steel to remove bacteria. All approaches contribute to oral health, but each approach has its own unique cultural history and cultural relevance (Iyer et al, 2024 and Fitch. P, 2004). In settings where personal care and hygiene are delivered in ethnically diverse communities, an awareness of, and responsiveness to, these specific types of cultural beliefs and preferences would likely enhance effective person-centred practice.

Developing practice to explore and respect cultural heritage will help practitioners to meet the needs of people accessing services more holistically and appropriately. Delivering care and support that meets people's cultural needs in this way can be termed 'culturally appropriate care'. The Care Quality Commission defines this as care that is 'sensitive to people's cultural identity or heritage. It means being alert and responsive to beliefs or conventions that might be determined by cultural heritage' (CQC, 2022).

Cultural difference

Culture can also be a way of talking about difference. In a multicultural country like the UK, it is inevitable that social care support is delivered to people from a range of cultural backgrounds, by professionals who all have their own cultural heritage and values. In recognising this plurality, it is important to remember that no culture is inherently more valuable than any other; everyone has the right to cultural expression and to belong to a community. This is outlined in the *Universal Declaration of Human Rights (1948)* and **other human rights charters**.

However, some cultural groups have held, and still hold, power over others. The recent history of British imperialism, among other historical and contemporary factors, means that cultural and ethnic groups in the UK often have unequal recognition, status and opportunities for their members. Tensions exist across cultural divides, for example in Islamophobic attitudes towards Muslims or in negative stereotypes about Traveller communities.

In the UK, white British culture is dominant across the health and social care system. Cultural difference may just be the tip of the iceberg when it comes to structural differences between communities, as discrimination, histories of oppression and barriers to access also play a part in systemic inequalities in health and wellbeing. This idea will be explored further in the section 'reflecting on culture within the social care workforce' on page 10.

Cultural difference can be acknowledged without excluding or 'othering' people. Othering involves excluding people from membership in a group or from equitable access to services on the basis of difference. Excluding people on the basis of cultural difference, or viewing difference through a lens of deficit, can be hurtful and is discriminatory.

Further reading

Othering and being othered in the context of health care services (Johnson et al., 2004)

Acknowledging difference in a positive way will involve respecting personal preferences, acknowledging unequal power dynamics and fostering conversations about the ways somebody wants to live their life in the context of these factors.

How does culture relate to inequality and privilege?

Culture is one dimension of the unequal power dynamics ever-present in social care practice and within the workforce. Structural and systemic factors such as poverty, insecure housing, discrimination and language barriers are also important in understanding the inequalities between different cultural and ethnic groups in the UK (Edmiston et al, 2022).

Inequalities between or within communities, and histories of discrimination, mean that cultural behaviours may be expressed very differently. For example, stigma around people experiencing mental health difficulties may not be a feature of a person's cultural heritage, but may stem from previous trauma when seeking care or support (Golpakrishnan, 2018).

Having some level of familiarity with public services can help you to navigate them more effectively. Being white and not experiencing outright racism and discrimination when seeking care or support means you are likely to be more satisfied with services, and will potentially have better outcomes for your health and wellbeing. These benefits may seem minimal on their own, but they accumulate over time to make some people's lives significantly easier than others.

Continually reflecting on these barriers and on personal experiences of culture and social status is a step towards redressing inequalities within adult social care. It is important to evaluate the services provided in terms of ease of access and engagement for people of all cultural, ethnic and national backgrounds.

Video resource

Exploring power and difference in adult social care

Being able to easily fit in with the people, organisations and services around you can often be taken for granted, which can sometimes make people close to the cultural norm blind to other people's struggles (Ferber, 2012).

Another way of describing this is **privilege** or **white privilege** – the experience of rarely having to navigate your own distance from the norm (see Bhopal, 2018, p.18). If you don't have to think about this often, it can be hard to discern your own cultural beliefs or practices and to recognise the **implicit** or **unconscious bias** they may produce. Implicit/unconscious bias means holding unfair assumptions about other groups or individuals based on stereotypes or prejudiced beliefs rather than valuing people for their individuality and inherent worth as a human being (Sabin, 2022).

The 'unconscious' part of the term indicates that people can be unaware that these biases exist or that they are harmful, but their impact can be substantial. Recalling that everyone has their own cultural heritage, and that no culture is more valuable or 'correct' than any other, it is important to reflect on how one's own perspective is culturally biased and take steps to redress any undue impact of that.

Video resource

This video resource with Shabnam Ahmed (clip 7) presents several reflective exercises for supervisors to explore questions of bias, self-reflection and cross-cultural relationships within the supervisory relationship.

Unequal privilege

White privilege is a term that has been defined as:

> "the privilege of not having to be concerned that the way in which you are racialized will be the specific cause or motive for unequal treatment, in majority-white societies"
>
> (Decolonising De Montfort University, 2023)

or

> "White privilege denotes both obvious and less obvious passive advantages that white people may not recognize they have, which distinguishes it from overt bias or prejudice. These include cultural affirmations of one's own worth; presumed greater social status; and freedom to move, buy, work, play, and speak freely."
>
> (Martin-McDonald et al., 2008)

In the same way, we might talk of 'cultural privilege'. An example of this here in the UK might be where if you are culturally Christian, your religious holidays are likely automatically bank holidays, enabling you to spend important rest time with your friends and family, without having to take additional leave from work, hence the social and economic benefits of being culturally Christian.

Further reading

The Adults Supervisor Development Programme by Research in Practice contains tools to use in peer-to-peer reflection and supervision to reflect on aspects of lived experience and identity, including a **tool to think about experiences of privilege** (Tool 3).

The Research in Practice **Practice Supervisor Development Programme resource *Exploring unconscious bias & racial microaggression in the workplace*** goes into further detail about recognising and acting upon implicit forms of racism and discrimination.

Questions to reflect on

- How would you describe the dominant culture in your area of work? How might this impact on the people you deliver services to?
- Where have you noticed patterns of cultural privilege in your practice?
- Where have you noticed patterns of cultural inequality or disadvantage in your practice?
- How comfortable do you feel talking about points of cultural difference?
- How can you help to improve levels of awareness of cultural difference, and implement more culturally sensitive responses?

Why is culturally sensitive practice needed?

In a recent Research in Practice event, practitioners told us why culturally sensitive practice is important:

> *Easy to relate to someone who has a similar cultural heritage, similar interests. Easier to make conversation e.g. football.*

> *The diversity [in my area] is growing but the majority of my clients are from similar cultural background as myself - white British. I do find it much easier to engage with these families but I think this is down to my own anxiety and feeling comfortable and not worried about offending or coming across as ignorant etc.*

> *I work on a voluntary basis [abroad] so I'm used to working with people, especially women, from another culture and speaking another language. I find that if you have common ground or interest, it opens up conversation and enables us to work more effectively as there are so many common issues - and new ones associated with other cultures we may not understand.*

> *Very important to ask specifics to make support plans person centered around diet, prayer and clothing.*

> *I sometimes lack confidence to ask questions. I find it difficult to ask what is your ethnicity? I do not wish to offend. In my job I need to ask alot of questions and can feel like I'm being nosey.*

> *Capacity and language barriers are so very important and the use of a linguist has no links with the family.*

> *We often have issues from our clients not understanding the culture or identity of their carers, [who may be from] another culture to their own...*

Culturally sensitive practice is required to help address the patterns of bias and disadvantage that exist.

Since culture is dynamic and multifaceted, it is not always straightforward to collect statistical data on health and wellbeing experiences and outcomes for different cultural groups (Kleinman & Benson, 2006).

Statistics on ethnicity are often routinely collected, because ethnic groupings tend to be static (they do not change over time) whereas culture is recognised as being fluid and can evolve over time (Loue, S. 2013).

However, culture is intrinsically tied to ethnicity, and where ethnicity statistics are available, they tend to point to patterns of disadvantage, discrimination and adverse outcomes. Various examples from adult social care illustrate this.

> In mental health services:
  - Some cultural groups are overrepresented in inpatient facilities, while research in the field often overlooks the differential impact of culture on individual experience of mental illness (Gopalkrishnan, 2018, p.2).

    One example of this is shown in the CQC's **Monitoring Mental Health Act 2020-21**, which found that African and Black Caribbean people were ten times more likely than other ethnic groups to be subjected to Community Treatment Orders, and Black people are 'disproportionately likely to be detained under the Mental Health Act... have longer periods of detention and more repeated admissions' (CQC 2021, p.5).

- The NHS Race and Health Observatory Rapid Evidence Review in Ethnic Inequalities in Healthcare, 2022) identified 'clear barriers to seeking help for mental health problems rooted in a distrust of both primary care and mental health care providers, as well as a fear of being discriminated against in healthcare' (NHS RHO, 2022, p. 88) for ethnically minoritised individuals.

> The *First Analysis of Safeguarding Adult Reviews* identified a widespread lack of consideration of race, ethnicity and culture in the cases analysed, that contributed to missed opportunities for safeguarding (2020, p.102).

  The *Second National Analysis of Safeguarding Adult Reviews April 2019 - March 2023* (2024) reported: "As in the first national analysis, beyond gender and age other characteristics protected in the *Equality Act 2010* were only rarely reported. Ethnicity was not recorded in 67 per cent of cases, nationality in 76 per cent, sexual orientation in 90 per cent and religion in 96 per cent, raising concern that this may reflect an absence of attention to these features of people's lives in practice."

> In occupational therapy, qualitative research has highlighted the difficulty of translating key ideas about person-centred and empowering care to people who don't speak English fluently, making it challenging to deliver consistent levels of support (Willis et al., 2017).

> In the context of services supporting people with learning disabilities, disabled people from minoritised ethnic or cultural groups may face a 'double jeopardy' of experiencing systemic discrimination based on their disability and their ethnicity (O'Hara, 2003).

Further reading

The NHS Race & Health Observatory produced **an infographic showing research evidence of health inequalities between ethnic groups in the UK (2021)**.

The British Medical Journal produced a **heatmap of ethnic disparities in healthcare and outcomes across the life course (2023)**.

These examples from research highlight the ongoing need for sensitive and person-centred care that takes into account the nuances of an individual's life and identity. Research also highlights that differences in experience cannot be solely attributed to cultural differences, but have roots in systemic disadvantages such as structural racism, discrimination and other barriers to access (Blake et al., 2017).

Reflecting on culture within the social care workforce

The term 'culture' can also be applied to the practices, values and traditions within a professional organisation. A healthy, open and respectful workplace culture is an important part of establishing an inclusive and welcoming atmosphere for everyone who accesses or provides care and support services, from any cultural background (Cross, 1989).

Colleagues will have many cultural similarities and differences between one another and may feel more or less close to the cultural norms expressed within a workplace. On a structural level, practices and values differ greatly between organisations and these produce different experiences for professionals and the people they work with (**Manley et al., 2011**).

Regarding ethnicity specifically, the social care workforce is more ethnically diverse and has a higher proportion of employees born outside of the UK than the population as a whole, which indicates a high degree of cultural diversity. Skills for Care publishes information on the demographic profile of the Adult Social Care workforce in England. The latest reports breaks down the following:

> *"Staff with a white ethnic background made up 74% of the adult social care workforce compared to 83% of the population of England. People with an Asian / Asian British ethnicity made up 9% of the workforce, and the population. People with a Black / African / Caribbean / Black British ethnicity made up 14% of the adult social care workforce compared to 4% of the population.*
>
> *There were large variations by region, with London having the most diverse workforce (29% with a white ethnic background) and the North East the least diverse workforce (93% with a white ethnic background).*
>
> *The majority of the adult social care workforce had a British nationality (81%), 6% had an EU nationality and 13% had a non-EU nationality."*
>
> (Skills for Care, 2022/23)

These statistics indicate a number of different communities being represented in the adult social care workforce, which suggests a high degree of cultural diversity.

It is important to note that professionals of minoritised ethnicity are underrepresented at the leadership level (Spillett, 2024), cementing the need for practical and organisational strategies that take into account internal power dynamics and barriers to qualification and progression. The Supervisors' Development Programme resource **Addressing barriers to the progression of black and minority ethnic social workers to senior leadership roles** contains more information on this topic.

Opportunities for learning and development

There will be many nuanced cultural similarities and differences between, and within, all of these broad social groups. What these statistics do show, however, is a general trend of diversity within the adult social care workforce and in the population they serve, making it certain that social care professionals across all roles will be working alongside colleagues and with members of the public from different ethnic, national and cultural backgrounds.

Research has noted that some social care staff report feeling uncertain of their ability to deliver consistent levels of care and support with people from different cultural groups (Willis et al., 2016), making it an important area for learning and development.

Action for leaders

The Department for Health and Social Care has developed a **Social Care Workforce Race Equality Standard** that can be used to understand the experience of ethnically minoritised staff within an organisation. Tracking these metrics and acting upon them can help to ensure that all professionals feel they are given equal and fair treatment.

The diversity of the workforce and the population they serve means that developing cross-cultural practice will always be more complex than teaching white, British staff how to provide care and support for people from many different ethnicities, nationalities and cultures. This is why learning and development should focus on developing principles, systems and attitudes rather on than reiterating prescriptive ideas of 'us' and 'them'.

Questions to reflect on

- How aware are you about the extent of evidence showing ethnic inequality in the health and social care outcomes?
- What is the level of alignment between your personal culture and the culture of your work environment? Does this feel comfortable to you? Why or why not?
- What can you do to feel more informed or empowered to act, when you come across examples of cultural bias?

What is the importance of intersectionality?

Intersectionality (Crenshaw, 1989) is a way of thinking about how the different dimensions of a person's life and identity can come together to produce unique experiences of discrimination and oppression. These dimensions may include class, race, gender, sexuality, disability or cultural heritage, along with other factors.

The **Equity Change Project** brings together academics, practitioners in adult social care, and people with lived experience to explore how intersectionality can help achieve equitable experiences and outcomes in adult social care. Project resources explore intersectionality and aim to look at how different forms of oppression interact and intersect to influence lived experiences. In turn this can help to identify the practices, attitudes and actions needed to overcome barriers, challenge oppression and increase equity in adult social care.

Further reading

Research in Practice | **Promoting anti-racist practice blog** which highlights resources that aim to understand how we talk about the impact of racism and promote anti-racist practice.

Research in Practice | **Racism, intersectionality, privilege, power, fragility and allyship podcast** discussing key issues on promoting anti-racism in social work

Research in Practice | **Intersectionality and why it is important for social care practice with older people**

Video resource

Kimberlé Crenshaw coined the term intersectionality in response to a US court case where a judge failed to acknowledge the complex discrimination faced by a Black woman. Crenshaw concluded that neither 'sexism' nor 'racism' alone adequately explained her experience. **Watch this video** to hear Crenshaw talk about how intersectionality can allow us to consider people's experiences holistically and in context.

Reflecting on structural barriers and disadvantages can inform a holistic assessment of individuals accessing care and support services. The Social Graces model (see **Social Grace Tool** for an online resource based on Burnham 2012) can help professionals to make sense of relative privilege and intersecting factors of oppression. Exploring a person's cultural background while considering the structural forces that shape their lives can be achieved through asking open-ended questions.

Some questions to help understand structural barriers and disadvantages in a person centred context

- How can we support you to feel like you are living the life you want to lead?
- What brings you to this service today? How would you describe the problem if you were talking to someone you are close to?'
- Can you tell us about any issues or stresses that make your situation worse?
- What would the best outcome look like for you?
- Is there anything that prevents you from making the changes you want to see?

(Adapted from *Cultural Formulation* interview in DSM-5, APA, 2013)

In the context of services providing care and support to adults, there is a minimum of two cultures meeting - that of the person drawing on care and support, and that of the person providing it . This is the case even if both people are from the same cultural group. Taking this as a starting point for conversations can allow for more sensitive exploration of an individual's preferences for care and support.

Questions to reflect on

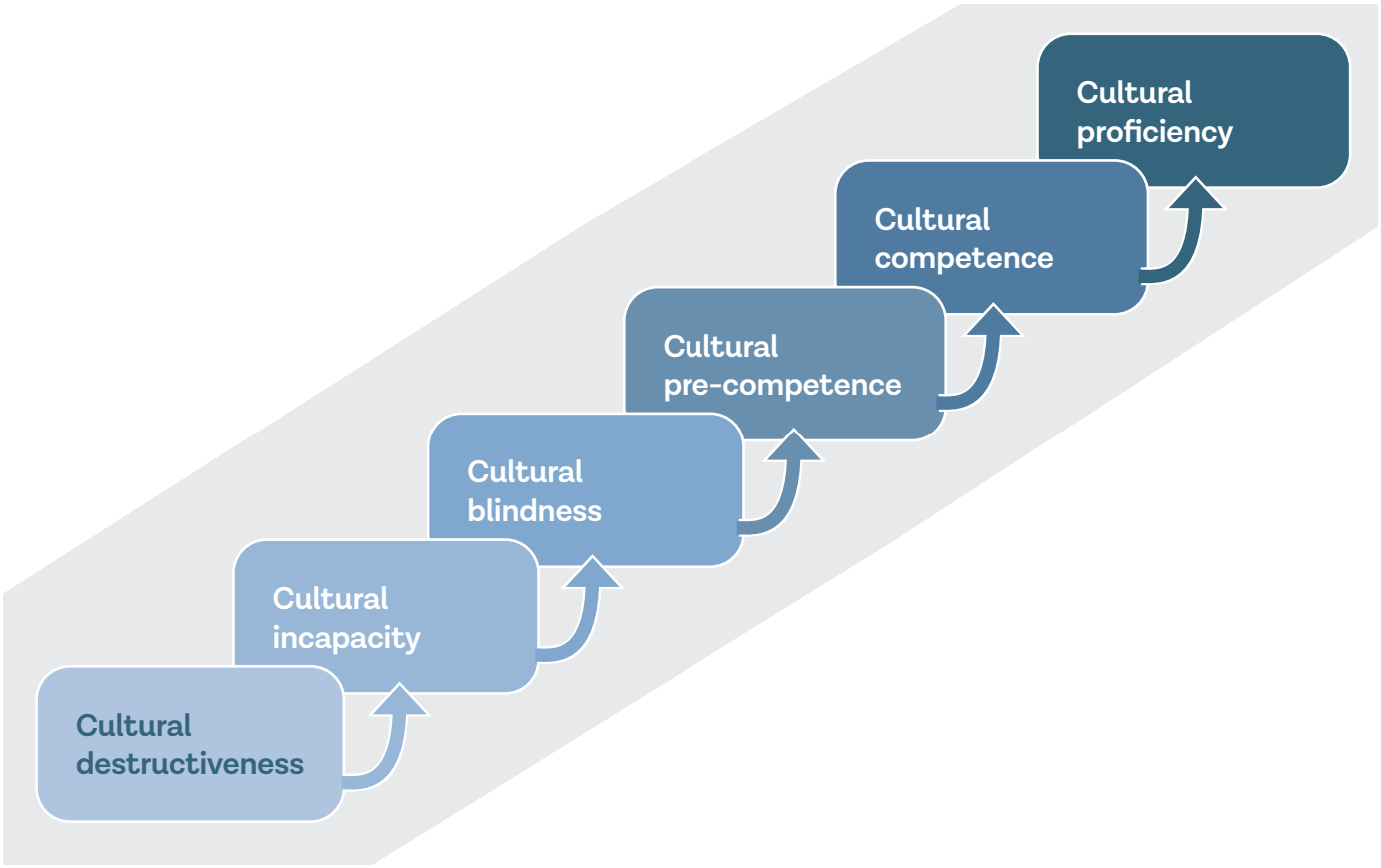
- How often do you reflect on how the impact of intersectionality affects the people you deliver services to?
- Are there organisational blind spots, where intersectionality should be considered, but isn't? (think about your policies and procedures, or strategic responses)
- How can you ensure that you are using an intersectional lens to inform your understanding of the people you deliver services to?

What are the existing frameworks for developing culturally appropriate care?

Cultural competence is a commonly-used framework for developing culturally sensitive practice in health and social care and other sectors. The concept was developed by Native American social worker Terry Cross and colleagues in the 1980s, with the following widely accepted definition:

> ***...a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross-cultural situations.***
>
> **(Cross et al., 1989, p. 13)**

It is both 'a goal towards which agencies can strive' and 'a developmental process' (1989, p.13) - along a **spectrum** from '**cultural destructiveness**', meaning a workplace where policies, attitudes and practices are harmful to culture, to '**cultural proficiency**', where a workplace actively holds cultural diversity and cultural heritage in high regard and develops practice in line with these principles.



Some researchers have identified flaws with this approach and how it has been interpreted in practice. Common criticisms include:

- Cultural competence frameworks that emphasise cultural knowledge suggest that culture is a static set of attributes, implying that all practitioners need to do is learn a checklist of cultural traits in order to be competent (Curtis et al., 2019).

- Learning and development materials on cultural competence have often assumed that the practitioner is white and belongs to the dominant local cultural group, while the person being supported is culturally 'othered'. This doesn't reflect the diversity of the health and social care workforce and the population served, or the fact that everyone has their own cultural perspectives and biases which they bring to the care relationship (Kleinman & Benson, 2006).

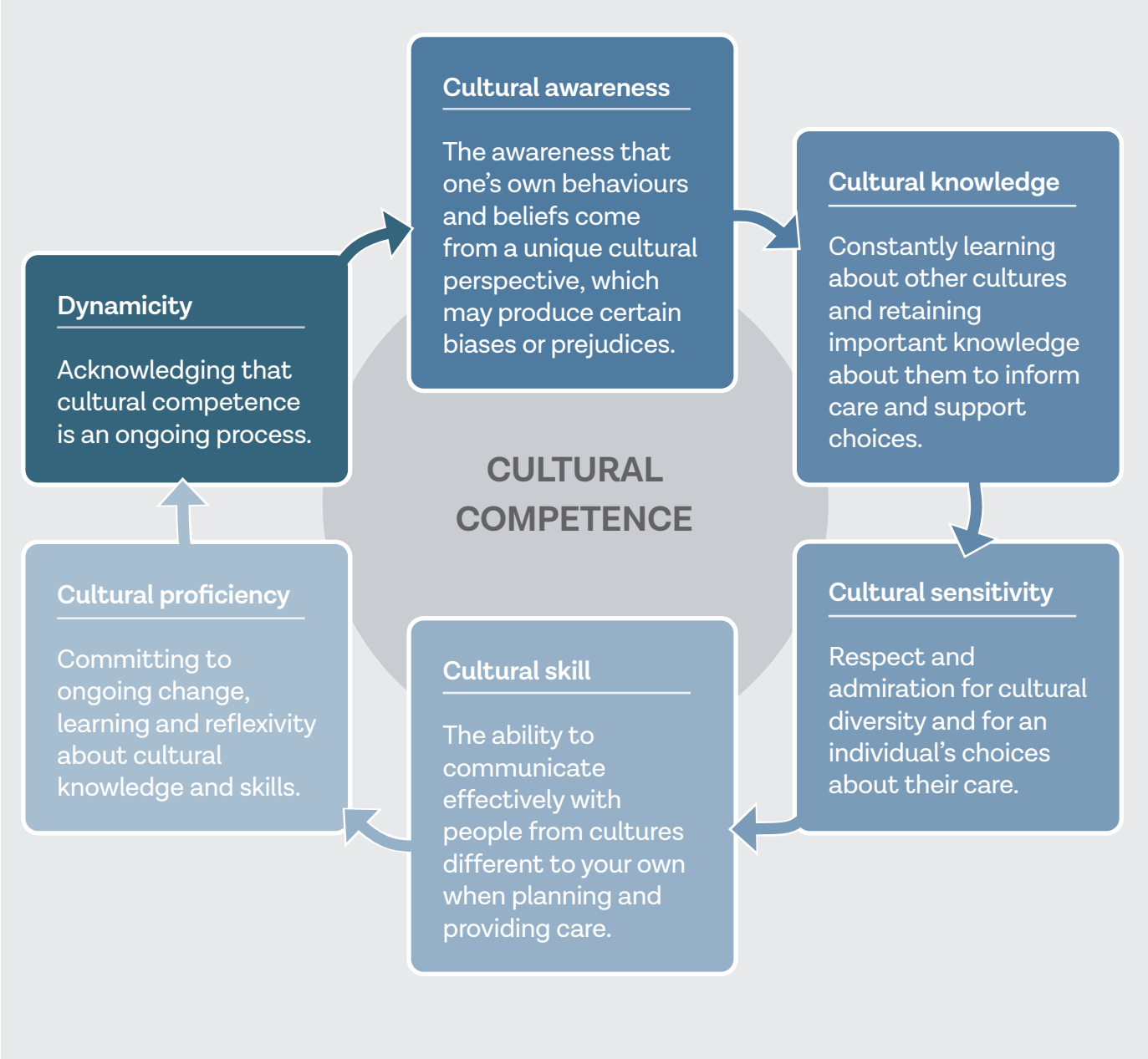
- The framework doesn't account for the wider structural forces which shape individuals' lives, choices and their care-seeking behaviours (FisherBorne et al., 2015) or the nuanced power dynamics at play between practitioners, their colleagues and the people they serve.

- The idea of 'competence' can imply culturally sensitive practice is a finite goal to be reached rather than an ongoing process of negotiation and reflection.

Some cultural competence strategies focus on cultural differences between groups, which may include offering options to cater for different traditions, practices and food, hygiene and religious preferences. These tend to have positive outcomes for satisfaction with care (see Handtke et al., 2019) but not necessarily on structural inequalities.

Other strategies focus on addressing barriers to access and engagement, which may differ between cultural groups but are not themselves a feature of culture (Hoens et al., 2022). The latter kind of strategy has been found to have a deeper impact on care inequalities (Hoens et al., 2022).

Sharifi et al. (2019) produced a model of cultural competence that is a recent example of a multi-faceted strategy that seeks to go beyond the surface-level of culturally appropriate care provision:



Cultural humility

Cultural humility is a framework for multicultural care provision that was developed by two nurses, Tervalon and Murray-Garcia (1998) in response to some of the issues identified with cultural competence training. They drew on their own experiences in cross cultural care provision to produce an alternative model.

The authors noted that, while it is important to have some knowledge of culturally specific practices and values, the 'false sense of security' (1998, p.118) that competence framings provide may lead to adverse care outcomes. These may arise from stereotyping populations and from valuing the expertise of the practitioner over the lived experience of the person they are supporting. They propose a relational and situational approach that places value on the perspective of the person accessing care and support services:

> ***...cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.***
>
> **(Tervalon & Murray-Garcia, 1998, p.125)**

Their explanation of cultural humility in health care sits well with the idea in social care practice that people are experts in their own lives:

> ***...only the patient is uniquely qualified to... understand the intersection of race, ethnicity, religion, class, and so on in forming [their] identity and to clarify the relevance and impact of this intersection on the present illness or wellness experience.***
>
> **(Tervalon & Murray-Garcia, 1998, p.121)**

Learning and development

Research in Practice |
The **Cultural humility and anti-racist practice workshop**

Cultural humility is closely aligned with concerns for social justice. It promotes an accountability model for practitioners that requires individual action to continually 'challenge the barriers that impact marginalised communities' (FisherBorne et al., 2015: p. 166).

Accountability means individual professionals and institutions need to make concrete steps to listen to, reflect upon and respond to the perspectives of a wide variety of stakeholders that includes people with lived experience, their families and communities, and the workforce.

Tervalon and Murray-Garcia (1998) recommend that organisational leaders and managers reflect and act upon the following items in order to consider how organisations are serving diverse local communities while remaining accountable to their policies:

- Are the workforce and leadership team representative of the diversity in the local community?
- Are leaders required to undergo the same training on multicultural skills and knowledge as junior staff members? If not, why not?
- How are professionals supported to discuss the implications of cultural, racial and ethnic differences that arise in their work? Does this happen in practice?
- Are there institutional processes that contradict lessons taught in training? (i.e. if it is taught that practitioners should not use children or other family members as translators, does the institution provide an accessible alternative)?
- How has the relationship between the organisation and the local community been in the past? What does it look like now?

(Adapted from Tervalon & Murray Garcia, 1998, p.122)

Cultural humility has overlap with the concept of **cultural safety**. Cultural safety is a model for culturally appropriate care developed by Maori scholars and nurses in the 1990s and made a requirement for nursing education in Aotearoa (New Zealand) in 1992 (Curtis et al., 2019).

> ***Cultural safety seeks to achieve better care through being aware of difference, decolonising, considering power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe.***
>
> **(Curtis et al., 2019, p.13)**

While the frameworks for pursuing and evaluating culturally appropriate care have diverged over the decades, there are some themes that arise from research in the area that can inform social care practice and organisational strategy.

Key messages from research into cross-cultural training frameworks highlight:

- Multi-dimensional cultural competence training and development for social care professionals has a **positive impact on their confidence and skills** (Hoens et al., 2022).
- **Strengths-based approaches** can harness the skills of a multicultural workforce (Hoens et al., 2022).
- **Whole-system strategies** are needed to address surface-level and structural barriers to equitable care across different cultural groups (Handtke et al., 2019; Hoens et al., 2022).
- **Professional reflexivity** is a crucial component in delivering continuously high quality care and support to members of different cultural groups (Willis et al., 2016).
- Building partnerships with communities served can promote integrated and holistic care and support (Golpalkrishnan, 2018).

Conclusion

Developing culturally sensitive practice and systems is an important and ongoing task for professionals and organisations providing care and support to adults. The UK's increasingly diverse population is reflected in both the social care workforce and the people they work with, making knowledge of, and respect for, cultural differences a significant aspect of care provision.

This approach requires professionals to listen, be reflective and to understand people's lives through an intersectional and person-centred lens. System leaders should note the importance of multi-level strategies that involve professional development, broadened service provision and cultural shifts within the workplace.

Keeping the individual at the centre of decisions about their care and support will be the underlying principle across all efforts to provide culturally appropriate care.

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