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NHS must tackle racism and sexism for the benefit of patients, staff, and society

The evidence and policy options for eliminating inequity are clear; what is needed now is political and institutional commitment and action, say J S Bamrah and colleagues

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Despite the NHS being founded on the principle of equitable treatment for all,[1] discrimination remains rife.[2] Inequities related to protected characteristics such as race, sex, gender reassignment, age, disability, sexual orientation, marriage and civil partnership, pregnancy and maternity, and religion and belief contribute directly to increased risk of physical and mental health conditions, limit access to care, shape negative experiences of illness and encounters with services, and lead to worse overall health outcomes, including mortality.[3] "Proportionate universalism"—adjusting the intensity of universal services to combat discrimination—has not gained widespread acceptance.[4]

Extensive evidence of bias and mistreatment of patients and staff is unequivocal, and recurring discrimination worsens lifelong health.[5-8] Health inequalities lead annually to productivity losses of £31-£33bn, lost taxes and increased welfare payments of £20-£32bn, and direct healthcare costs of at least £5.5bn.[9] As one senior NHS leader puts it, an investment in equality and inclusion is a "strategic investment that pays dividends in the form of better patient care, a more inclusive work environment that supports retention of valued staff, and the eradication of health disparities."[10]

Adversity and harm are magnified when protected characteristics intersect.[11,12] A black woman living in poverty who is also disabled on average experiences worse health than a white woman with those characteristics, with the effect on health worse than the additive impact of each characteristic considered in turn. It is not possible here to consider all dimensions of inequity in detail, particularly as the intersectional forces of disadvantage in the NHS are so poorly quantified. Elsewhere, research has shown clearly that the intersectionality of ethnicity and gender has a profound and enduring adverse influence on careers in the corporate sector, making it imperative for more work to be done in this area in the health sector.[13]

Because of the scale of injustice in the NHS caused by race, ethnicity, sex, and gender bias (box 1), this work focuses on inequity related to these forms of discrimination and their interaction. Discussion of racism, sexism, and gender bias and recommendations for action to tackle them have wider relevance to other inequities in the NHS; however, different forms of inequity require radically different approaches. One major confounding factor in establishing inequitable health outcomes is the lack of consistency, completion, and accuracy of coding of ethnicity in health records. It is difficult to comprehend how NHS bodies will fulfil their commitment to equality and equity in the current climate without tackling this fundamental challenge.[61]

Box 1: Racism, sexism, and gender bias: impact on NHS patients and staff

Black, Asian, and other ethnic minority patients face worse health outcomes than their white counterparts across many conditions.[14] These include covid-19 morbidity and mortality,[15,16] obstetric adverse events, maternal and infant mortality,[5,17,18] incidence of mental illness, and rates of detention under the Mental Health Act.[6,19-21]

Ethnic inequities were starkly shown during the covid-19 pandemic: black, Asian, and other minority ethnic people in England and Wales, who constitute only 14% of the population, accounted for 34.5% of 4873 patients who were critically ill up to 16 April 2020, much higher than the 11.5% seen for viral pneumonia between 2017 and 2019. Several longitudinal studies have shown racial discrimination to be a major cause of poor health and ethnic inequalities in health.[22] These inequities are not unique to the NHS; evidence from several countries shows similar patterns.[23]

The Race and Health Observatory (RHO) was established in 2021 to standardise ethnicity related inequity assessments and study intersectional effects in the NHS. It has collected evidence for understanding ethnic inequalities in health, which shows that socioeconomic inequality and damaging prejudicial attitudes affecting health seeking experience and treatment drive these inequities, instead of inherent underlying poor health of particular groups.[6]

The observatory has shown how devices and instruments that are calibrated on white Europeans, or fair skinned people, might cause hazards for people with darker skins. A rapid review of the use of pulse oximetry, a device that determines the level of oxygen in blood, cast doubt on reliability of the standard safe levels of 92% saturation, when comparing white with black patients.[24] The observatory also found that the Apgar score method of detecting cyanosis and jaundice from skin colour of neonates is fraught with false positive and false negative results in babies with dark skin tones.[25]

Racism can affect the health of people from ethnic minorities in myriad ways, including reduced access to employment, housing, and education and increased exposure to risk factors (eg, avoidable contact with police); adverse cognitive and emotional processes and associated psychopathology; chronic stress; lower life

satisfaction, diminished participation in healthy behaviours (eg, diet, sleep, and exercise) and increased unhealthy behaviours (eg, alcohol and other drug taking); and racially motivated violence.[22 26]

People from ethnic minorities have unequal health outcomes compared with white people as well as within the groups,[27] while for mental health services, black people are more likely to present through the crisis or custodial pathways.[21] Access and delay in seeking care results in part from language and cultural barriers, exacerbated by NHS budget cuts that have drastically reduced interpreting and translation services for people who may struggle to communicate their needs and preferences without an interpreter.[6]

Effects on staff

As well as the impact of racism in their ordinary lives, ethnic minority healthcare staff experience additional compounding stresses: NHS staff experience racial inequities on a daily basis.[28 29] The ethnic diversity of nearly 1.3 million NHS employees exceeds the diversity of the UK population. Minority ethnic staff make up almost 25% of the workforce overall (compared with around 20% of working adults in England); more than two fifths of doctors, dentists, and consultants; and almost a third of nurses, midwives, and health visitors.[30]

Despite these statistics, people from ethnic minorities have poorer experiences working in the NHS than their white counterparts as a result of mistreatment by employers, other employees, regulators, and the public.[28-35] Bullying and harassment in the NHS is conservatively estimated to cost the taxpayer £2.28bn.[36]

Some of these employees have migrated to the UK, with the NHS owing its continued existence to staff recruited from abroad. Yet many of them report feeling unwelcomed and undervalued.[37-39] Migrant health workers, who are largely black, Asian, or other ethnic minority, feel greatly unappreciated despite constituting a significant proportion of the NHS workforce.[30] In many ways, their challenges are unique; they face discrimination because of ethnicity, language, and cultural differences, as well as pressures adapting to new healthcare systems, family issues, adjusting to diets, visa and immigration matters, finding adequate housing, and managing finances.[40] They are often in the media's eyes when things go wrong, fuelling anti-migrant rhetoric within the public amid sensationalist claims.[41 42] Explicit or implicit criticism of foreign doctors by politicians or medical bodies, such as the BMA, simply feeds into the inherent bias in the media and with the public.[43-45]

Sexism

Similarly, sex and gender bias are major drivers for death and disease, but this is underacknowledged within UK healthcare.[46] British women live four years longer on average than men,[47] but they do so in poorer health from life limiting illnesses, with life expectancy among women in socioeconomically deprived areas in decline since 2010.[48] The UK has the largest female health gap among G20 countries and the 12th largest globally.[49] Conditions that affect women specifically—such as endometriosis and some reproductive cancers—as well as conditions that affect women differently or disproportionately—such as many autoimmune diseases, anxiety, depression, and musculoskeletal conditions—are under-researched and underfunded.[50-52] This is despite clear evidence for the economic value of improving women's health,[53 54] and that research that does not acknowledge diversity, drives greater inequalities.[55]

Sexism plays out in the NHS workforce through inequities in pay, promotion, and wellbeing.[56 57] Over 75% of NHS staff are women,[58] yet women experience far higher rates of offensive, discriminatory behaviour and sexual harassment than men, with surgical environments proving particularly unsafe because of the behaviours of other colleagues.[56 59 60]

Racism, sexism, and gender bias have been alarmingly normalised[62 63] and are pervasive and pernicious within the structures as well as in interpersonal interactions throughout the NHS. Most patients and staff are at risk of one or both. Institutional racism—racially discriminatory processes, policies, attitudes, and behaviours arising from systems and norms embedded within an organisation—is clear in the NHS's history and current practice, as is ongoing sexism. The NHS continues to delay acknowledging past and present accusations of racist and gender biased practices. Learning lessons from the past and acknowledging those historical injustices requires a high level inquiry by the government, to ensure that people who were wronged in the past can start the process of reconciliation and healing, and to ensure that wrongdoing is not perpetuated.

Equality in healthcare means offering everyone in society the same choices, opportunities, and treatment. Equity, however, acknowledges that people have different needs, necessitating responses to those circumstances with varying resources. Policies committed to equitable outcomes must adjust for the people who experience discrimination, especially those who experience multiple inequities simultaneously.

The social determinants of health drive inequity beyond the workings of the NHS and tackling these inequities is the greatest opportunity to further an equitable health agenda[4] (health inequity related to socioeconomic groups, education, housing, and work are considered elsewhere in this BMJ commission[64]). Social and economic inequalities have worsened health inequities in the past 15 years,[65] but these factors do not sufficiently account for inequity related to race and sex.[66 67]

The NHS cannot maintain legitimacy as a publicly funded healthcare system rooted in principles of fairness while perpetuating discrimination. Multilevel interventions are required to tackle racism and sexism, including committed leadership scaffolded by governance mechanisms, targeted clinical research, employment improvements, and staff education. Such changes are eminently achievable: the evidence and policy options already exist but will only be realised with political and institutional commitment. Although health is a devolved matter across the four nations, efforts should incentivise collaborative, UK-wide action. Implementation of the following recommendations would transform organisational performance, care quality, and staff wellbeing and save costs in all NHS organisations.

Representative leadership that prioritises equity

The composition of NHS leadership and governance groups should be representative of the diversity of the population, with people facing race, sex, and other disadvantages actively supported to reach senior positions, an aspiration in the NHS equality, diversity, and inclusion improvement plan.[68] Representation of black, Asian, and other ethnic minority people among the most senior NHS leadership increased by a small margin, from 10.3% to 11.2% between 2022 and 2023.[30] Detecting room for improvement in 2021, the then secretary of state for health and social care, Sajid Javid, commissioned an independent report from Gordon Messenger which resulted in seven recommendations (box 2).[69]

Box 2: Actions to improve diversity and inclusion from Messenger report[69]

Targeted interventions on collaborative leadership and organisational values

- A new, national, entry level induction for all who join health and social care
- A new, national, mid-career programme for managers across health and social care

Positive equality, diversity, and inclusion (EDI) action

- Embed inclusive leadership practice as the responsibility of all leaders
- Commit to promoting equal opportunity and fairness standards
- More stringently enforce existing measures to improve equal opportunities and fairness
- Enhance CQC role in ensuring improvement in EDI outcomes

Consistent management standards delivered through accredited training

- Single set of unified, core leadership and management standards for managers
- Training and development bundles to meet these standards

A simplified, standard appraisal system for the NHS

- A more effective, consistent, and behaviour based appraisal system, of value to both the individual and the system

New career and talent management function for managers

- Creation of a new career and talent management function at regional level that oversees and provides structure to NHS management careers

More effective recruitment and development of non-executive directors and encouraging top talent into challenged parts of the system

- Establishment of an expanded, specialist non-executive talent and appointments team

Government must commit fully to these laudable objectives; any dilution will only demoralise staff further

- Improve the package of support and incentives in place to enable the best leaders and managers to take on some of the most difficult roles

There has been a persistent failure to implement these recommendations with any consistency or commitment, in a system where NHS leaders are rule makers and rule breakers, especially when it comes to racism and sexism. For a start, government and NHS leaders must publicly acknowledge the pervasiveness of racism and sexism in the health service. They must then be held accountable for evidence informed action to deliver health equity. Four NHS national directors of health inequity, appointed to each of the UK nations and reporting to its chief medical officer, would be well placed to oversee progress.

In an NHS increasingly run as a business, sustained, determined senior leadership championing anti-racism and anti-sexism is vital not only to maximise quality of care but also financial performance.[70 71] In a large study, the management consultant company McKinsey showed that companies in the top quarter for gender diversity on executive teams were 25% more likely to have above average profitability than companies in the bottom quarter, and the likelihood of outperformance continues to be higher for diversity in ethnicity than for gender.[72]

Role modelling needs to be cascaded from the highest level across all NHS services, with a strategy that recognises the moral and economic value of equity in the NHS. This would bring benefits in terms of health outcomes and productivity. Leaders who model anti-bias behaviour can reduce the bystander effect, empowering employees to act against racism and sexism in the workplace.

At a local level of service planning and service delivery, all leaders should be responsible for equity impact assessments, and progress towards equity should be a standing item on every board meeting agenda.

Statutory regulation and accountability

Independent regulation of NHS services in the four nations should be increased to monitor, and hold accountable, organisations for healthcare equity. In England, this would fall to the CQC, which assesses services against five criteria—safe, caring, effective, responsive to need, and well led—related to patient experience and organisational leadership.

The CQC (and equivalent organisations in the devolved nations such as Healthcare Improvement Scotland) should add a sixth criterion of "staff wellbeing," which should explicitly include questions on racism and sexism experienced by employees and patients, with regulator accountability to ensure concerns are responded to quickly and effectively.

Equitable data and governance

Collecting accurate data is critical for progressing research and practice to correct health inequities, and yet it is political whim rather than clinical will that determines what data are included, and what are left out.[73] NHS trusts must collect and report transparent, accurate, disaggregated data on ethnicity, sex, and gender, obtained with consent from patients, clinical records, and NHS employees where appropriate. Demographic questions should be asked according to uniform, validated, and sensitive methods (such as the diversity and inclusion survey (DAISY) guidelines[74]), consistent with categories in the UK census. Standardised questions for NHS records would ensure data compatibility among NHS trusts. It should be possible to link data to other health registers, but data must be anonymised, and legal firewalls should secure the single purpose use of these data for health equity purposes, preventing repurposing or sharing data with government departments, such as the Home Office for immigration control.

National equity metrics would improve the NHS if all organisations were required to collect and contribute to a centralised database for identifying improvements and guiding equitable research across the life course. These metrics could then feed into health information systems, such as the Race and Health Observatory (RHO).

The RHO, funded largely by NHS England, currently has no powers to design and implement NHS policy. Its role should be strengthened to provide the basis on which NHS leaders are held accountable for their performance on equity. It should have statutory responsibility for producing equity impact assessments of new NHS policies and programmes. Government and NHS leaders at all levels should act decisively on RHO recommendations.

NHS England and the NHS Equality and Diversity Council developed the Workforce Race Equality Standard (WRES)[30] in 2014 to improve equality in career opportunities and fair treatment for black, Asian, and other minority ethnic staff. WRES began collecting data on workforce inequalities in 2015, from which it produces reports and recommendations, but WRES cannot change outcomes purely by publishing data. NHS leaders at all levels should implement change in light of these data and hold employers accountable for doing so.

Responsibility for WRES lies within NHS England, and it has therefore lacked the independence of the RHO and CQC. The abolition of NHS England presents an opportunity to consolidate the role of WRES. Given that the principles of the RHO and WRES overlap, bringing WRES within the structures of the RHO would provide WRES with greater independence.

The RHO's influence should be present throughout the UK (beyond just England, as at present) with national hubs to highlight areas of excellence and poor practice. Funding and support from within RHO should be directed to specialist academic centres researching race and ethnicity, as well as intersectionality with sex and gender, which can feed their data and expertise into the RHO's reports, creating a new "Network for NHS Equity."

Mandating equitable research

Equitable care begins with equitable research. Inequity is embedded in scientific evidence, however, with disproportionately fewer women and ethnic minority participants recruited to clinical trials and research studies, reducing knowledge generation about, and therefore optimal care for, people other than white men.[14 75] Reforms are vital, not only for fairness, but also to advance scientific rigour and reproducibility.

The NHS must prioritise equitable research, financially supported by government research funders (National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI)) collaborating with charitable research funders. This would require bold action, such as giving primacy to projects that ensure ethnicity and gender are given due consideration wherever relevant and withholding funding where this is not the case.

NIHR should lead a national research agenda co-designed with patients to share a 10 year plan for equitable research funding and implementation across the UK to inform policy questions and public priorities beyond the political lifecycles of individual health ministers and partisan governments. All research grants and studies should be required to show that diversity and inclusivity issues have been considered, and the National Institute for Health and Care Excellence must assess new drugs, medical devices, and technology against equality impact standards, particularly in relation to ethnicity and sex. The thematic approach devised by the World Health Organization might be a useful method of achieving this.[76]

Accounting for demographic differences in research after equitable recruitment would improve if analyses disaggregated by sex and ethnicity became normalised in medical research and were essential criteria for funding and ethical approval.

Research cohorts should be representative of society in their composition regarding sex and ethnicity as well as other protected characteristics as far as possible, and funding should be conditional on a robust equity strategy. The UK should follow the leads of Canada, the US, and other European countries in supporting policies that reward equitable research designs and representation of society's diversity.[77-81] Currently, there are no unified polices in place to encourage or mandate researchers to consider race and ethnicity in studies and trials in the UK, even though achieving this is imperative. The INCLUDE (Innovations in Clinical Trial Design and Delivery for the Under-served) guidance is an example of a best practice co-designed resource for inclusion of ethnicity in research, which has been adopted by NIHR and should be mandated by all other funders.[82] The MESSAGE (Medical Science Sex and Gender Equity) policy framework encourages researchers to consider sex throughout their research projects. MESSAGE policies are currently being rolled out across UK research funders, including the NIHR and members of the Association of Medical Research Charities.[57]

Evidence shows that composition of research teams influences the quality and equity of the science that they produce.[83] Diverse teams tend to consider equity with greater rigour in their work. Clinical academics from black, Asian, and other minority ethnic backgrounds as well as women researchers are under-represented at principal investigator level within the NHS. People in these groups should be pro-actively mentored, enabling them to develop personally and professionally, and ensuring that the mentor is an important component of their strategy, plans, and ideas, with people encouraged to actively seek out their mentors and establish good communication channels with them. Laudable though the aims are of the Athena Swan awards,[84] by themselves they will not achieve sex equality. Institutes such as HRA, UKRI, NICE, and relevant employing organisations should be statutorily obliged to promote diversity and gender equality and have their funding withheld if they fail in their duty to do so.

Autonomous systems tend to reinforce racist and sexist assumptions that can influence medical practice, research shows. As we progress rapidly into an era of advanced technology and artificial intelligence is introduced throughout the NHS, it is essential that biases are identified and tackled, and new biases are not introduced into diagnostics and treatment algorithms for patients.[85 86]

Eradicating inequitable harms in clinical care

Services and treatment may need to be tailored for people from different ethnic groups and for women. Harmful and inequitable care has been evident in some areas and medical specialties across the UK. Clinical failings in maternity care and worsening maternal mortality inequalities, with black women almost three times more likely to die in childbirth than white women,[87] are of particular concern.[88] The NHS should prioritise the reduction of preventable maternal and neonatal deaths, and differential adverse outcomes for black, Asian, and other ethnic minority women, as specified in the MBBRACE report.[87] Over 42% of black women surveyed about their experiences of maternity care in the UK felt discriminated against, partly because of their ethnicity. The positive practices of maternity centres performing well need to be shared and scaled, as well as action to reduce barriers when accessing maternity services and correct negative experiences (including stereotyping, disrespect, and cultural insensitivity) of those services for ethnic minority women.

There are stark ethnic inequities in common mental disorders with higher prevalence for women than for men in all ethnic groups in England.[89] Severe mental illness is particularly pronounced among black patients, who are detained more often than white patients under the Mental Health Act.[89] However, treatment rates are higher among white people. Higher rates of detention of non-white groups may in part be addressed by forthcoming reform of the Mental Health Act, but accompanying redesign of services is also required.

Psychological therapies fare no better; ethnic inequalities exist in access and outcomes.[90] Overcoming barriers to make mental health services more accessible by reducing often justifiable patient fears of racist treatment, discrimination, and stigma; distrust of healthcare professionals; and inadequate provision of interpreting services requires an evidence based, coordinated approach, as proposed in the NHS advancing mental health equalities strategy.[91] However, the reality is that prolificacy in rolling out such policies is not matched by determination or conviction to enact them.

Addressing knowledge gaps among clinical staff about the ways in which patient presentations are related to (or unchanged by) race, ethnicity, sex, and gender would improve quality of care, clinical outcomes, and reduce the spread of racist and gender biased stereotypes within health services.[63 92-94] Clinical guidelines that insist on different pathways of care depending on a person's ethnicity, such as for asthma, kidney function, and hypertension, have been shown to increase ethnic inequalities.[95] Consideration of ethnicity in clinical pathways requires nuance and careful evaluation, and differences in care should be evidence based.[96 97] For sex and gender, however, evidence is increasingly showing that existing clinical guidelines do not give sufficient weight to how biological and social differences between women and men affect health. The NHS, NICE, SIGN, medical and surgical royal colleges, and other bodies should review their clinical guidelines through sex, gender, race, and ethnicity lenses.

Recent efforts to improve the quality of healthcare for women in the UK have been encouraging, through the Women's health plan in Scotland (2021)[98] and women's health strategy in England (2022).[48] However, ongoing funding and institutional support from the UK government is overdue.

Ringfenced funding for existing initiatives, such as women's health hubs for holistic medical care, is small; a more ambitious scope is needed to include specialties beyond obstetrics, gynaecology, cardiology, and sexual and reproductive health. The next iteration of UK based women's health policies must recognise that women's health includes conditions affecting women's lifelong health, not simply their reproductive functions, and should attend to the ways in which conditions and their treatments might differentially affect women and men. Sex and gender related differences should also be included in the long promised men's health strategy[99] to underscore that sex and gender disaggregated approaches in research lead to more accurate understandings about specific health risks and targeted treatments for everybody in society.

Fostering a culture of learning not blaming

A study published by the King's Fund think tank emphasises that the human costs of discrimination are huge and the effect on patient care is substantial.[100] The authors conclude that the NHS must set national standards around developing cultures of diversity and inclusion in order to bring about change; where staff are overworked, stressed, marginalised by their leaders, and blamed, engagement levels are likely to be low and discrimination and stereotyping high.

NHS England's workforce plan[101] fails to mention the importance of whistleblowing or "freedom to speak up" guardians and the safeguards that are needed to protect staff who come forward to improve the service.[102] Legal reform is needed to protect whistleblowers, to prevent employers using disciplinary measures unfairly to punish people who raise genuine concerns,[103] particularly for employees who continue working with employers where the abuse took place in the first place. A culture that defaults to trusting testimony from people affected by prejudice will increase if greater diversity is visible at the top of the NHS. The current secretary of state for health and social care, Wes Streeting, has promised to overhaul the whistleblowing policy to herald a much needed improvement in the forthcoming NHS 10 year plan.[104]

Training and education co-designed with staff and patients

Undergraduate and graduate training for NHS professionals should be co-designed with patients and staff to combat negative attitudes and assumptions and to fully reflect the varying health needs of people of different sex, gender, race, and ethnicity, including the needs of migrants.[105] Medical practice needs to continually evolve, incorporating not just the best clinical guidance but also knowledge of culture and ethnicity that might help deliver the best holistic care to the patient. For instance, healthcare professionals need to be confident in diagnosing dermatological conditions and signs, the use of pulse oximeters,[24] and applying algorithms such as the Apgar score[25] in people with different skin tones, as well as the sensitivities around performing physical examinations on women from different ethnic groups.

To fix the underlying biases and discrimination affecting healthcare structures, processes, and knowledge, NHS reform must improve training to reflect prevailing discrimination and increase awareness of persisting biases. Employees who receive training on bias reduction are more likely to have improved interactions with colleagues from diverse backgrounds.[106] Continuing education of the NHS workforce at all staff levels, including executive and board members, should be required to embed the knowledge and skills for equitable hiring approaches, working practices, and values.

All staff must be given protected time for mandatory in-person training, co-designed by service users, at induction and annually, on culturally competent care as well as race, ethnicity, sex, and gender bias. E-learning modules from NHS England's Core20PLUS5[107] training, which aims to narrow health inequalities in hypertension, early cancer diagnosis, chronic respiratory disease, maternity, and severe mental illness, are a good start but are not well publicised. Cultural safety and cultural competency training would encourage professionals to develop awareness about how ethnicity and power shape clinical interactions and to reflect on personal and systemic bias.[108]

Decolonisation of UK medical and healthcare education has been led by activism from patients and healthcare professionals to raise staff and students' awareness of the effects of imperialism on today's inequities, but this work is just beginning.[109 110] Medical and healthcare education should embed an appreciation of the literature, knowledge, and achievements of subjugated countries and cultures, and acknowledge the gendered, patriarchal roots of many of modern medicine's values and practices that continue to affect service provision and outcomes for non-white populations and women. In effect, an important aim of decolonisation is to educate the white majority about how racialised people have felt mistreated through years of training and service.

NHS organisations have long tried to support and encourage professional development of ethnic minority staff through training, mentoring, and development programmes. The issue of differential attainment is a vexed one for many overseas graduates,[35 111] and several medical royal colleges have recently made attempts to understand and tackle it. While promising initiatives exist, it is difficult to know how effective they are: data about outcomes should be routinely collected and published. Learning should be taken from successful equity schemes, and newly piloted efforts should have clear data collecting practices along with evaluation criteria for transparency and shared learning across all royal colleges.

Supportive management and flexible working

All NHS organisations are responsible for fostering an inclusive culture and safe workplace. Managers should be responsible for monitoring the diversity of their staff and transparently tracking inequity across roles and career trajectories.

NHS staff from abroad, including healthcare assistants, nurses, midwives, allied professionals, and medics, must be supported and welcomed when starting employment in the NHS through fair assessment processes, induction and mentorship programmes, and opportunities for professional development.[112] Ethical recruitment practices should acknowledge challenges faced by staff coming to work for the NHS from abroad,[113] including employees who bring dependents with potential healthcare needs themselves. At the same time, the government and the NHS must acknowledge and celebrate the contributions that migrant doctors and nurses (most of whom are black or Asian) make to the NHS, without creating a climate of fear or dislike for them.[41 43]

The NHS faces one of its worst workforce crises that we have witnessed in its 77 year history. Without concerted action, the NHS will lose the skills, experience, and knowledge of staff who could have been retained on a part time or ad hoc basis with adjustments to working.[114] Flexible working in the NHS should be supported for

anyone, without requiring a reason.[115] Mentorship schemes, standardised across the UK, are needed for returning to work after a period of absence, particularly for parental leave, which is still mainly taken by women. Progression and promotion must be compatible with responsibilities outside the workplace, shouldered most often by women, as well as accommodating employees' life stages and health needs. NHS England's recent commitment to offer leave after a miscarriage is a step in the right direction towards acknowledging the psychological and physical implications of pregnancy loss, and its positive public reception suggests an appetite for similar initiatives.

Commitment and action must start now

Establishing a core NHS ethic of anti-racism and anti-sexism is long overdue. A deeper understanding of intersectionality is crucial because inequity affects multiple characteristics in many people, and services should be codesigned with those who struggle the most to access care, have the poorest outcomes, and are representative of the target population.

NHS leaders and the public must recognise that prioritising health equity is a proved strategic investment that leads to good patient outcomes, and better retention and recruitment rates of staff. It is also an ethical and legal imperative. NHS leaders must recognise the avoidable and unacceptable effect on mental and physical health caused by discrimination in the health service. They must focus on measuring this impact and taking steps to mitigate it by implementing enduring changes and ensuring accountability in the system. For the migrant healthcare worker, the challenges are considerable; better efforts must be made to ensure longevity of employment and satisfaction in work.

Inaction represents an unacceptable choice that increases harms to patients and costs in terms of increased staff absences, sickness, resignations, and reduced productivity. The evidence and policy options are abundantly clear. Political and institutional leaders must urgently choose to prioritise the elimination of these avoidable, unhealthy, and costly injustices, or face the consequences of a disaffected NHS workforce, and widening inequalities in health outcomes in the general population. The recommendations we make, if implemented, will go a long way to make the NHS a happier and healthier place.

Summary recommendations

For the UK government

- Hold NHS leaders responsible for achieving the ambitions outlined in the NHS equality, diversity, and inclusion improvement plan
- Implement the independent Messenger report on inclusive leadership in full
- Give the NHS Race and Health Observatory (RHO) statutory responsibility for producing equity based impact assessments of new NHS policies and programmes and make it the main repository for all matters related to race and ethnicity in the NHS, including the Workforce Race Equality Standards
- Mandate national research and health bodies to establish equality standards (especially concerning race, ethnicity, sex, and gender) in all research grants, studies, and approvals of drugs, medical devices, and technologies.
- Ensure that biases in existing advanced technology and artificial intelligence are identified and corrected, preventing the introduction of new biases that discriminate against patients

For the Care Quality Commission (CQC) and equivalent regulators

- Add an explicit inspection criterion for staff wellbeing to identify and tackle racism, sexism, and other forms of discrimination
- Hold leaders and organisations accountable for failures in addressing discrimination

For the NHS

- Collect and report transparent, accurate, disaggregated data on race, ethnicity, sex, and gender in all organisations
- Prioritise equitable research, with financial support from government research funders such as the National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI), and collaboration with charitable research funders. Withhold funding where these principles are not met
- Implement the starkest findings of research on inequitable clinical care and ringfence funding to support improvements
- Set national standards for diversity and inclusion to produce culture change
- Provide statutory protection for whistleblowers and update the NHS England long term workforce plan to include the role of freedom to speak up guardians
- Make evidence based training focused on reducing bias and discrimination (including intersectionality training) readily available, emphasising improved interactions with diverse colleagues, cultural safety, and cultural competency. Encourage professionals to develop awareness of clinical interactions and reflect on personal and systemic bias

For leaders

- Improve working conditions by facilitating flexible and remote working and reducing reduce bullying, harassment, and discrimination
- Model anti-racist and anti-sexist behaviour to encourage similar conduct in employees
- Monitor staff diversity and track inequity across roles and career trajectories

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