GOV•UK

Department of Health & Social Care

Independent report

Lord Mann review of antisemitism and other forms of racism in the NHS and healthcare regulatory system

Published 4 June 2026

Contents

This publication is available at https://www.gov.uk/government/publications/lord-mann-review-on-antisemitism-and-other-forms-of-racism-in-the-nhs/lord-mann-review-of-antisemitism-and-other-forms-of-racism-in-the-nhs-and-healthcare-regulatory-system

Foreword

The levels of anti-Jewish racism in the UK constitute a national emergency. The Heaton Park Synagogue attack of 2 October 2025, the abhorrent terrorist, arson and other attacks on members of the Jewish community that took place in April 2026 in Golders Green, and across London all point to a worsening of the situation. No sector is untouched by it. The criminal cases, taken together with the data drawn from the Home Office, from the NHS and from various community organisations, and the cases reported to the General Medical Council and other health and care professional regulators, have highlighted allegations of antisemitic behaviour perpetrated by UK doctors and other healthcare professionals. It is within this context that I was asked to undertake a review into tackling antisemitism in the NHS. My view is that addressing antisemitism cannot happen in isolation; it is part of how we tackle racism in all forms in the NHS and the recommendations from this review set out actions that the health service can take that will benefit those who experience such discrimination or abuse.

The NHS was built on the principle that everyone should be treated equally and with respect. Discrimination undermines everything the NHS stands for and its ability to provide safe, world class care. The NHS should be for everyone and there is an urgent need to look closely at how to protect patients and staff and hold perpetrators to account.

There are those that balked at this review, who without knowledge of its remit or terms, reduced it to ‘anti-Palestinian discrimination’. This is a symptom of the wider problem. The fact that a review of anti-Jewish racism should be reduced to something connected to the Middle East conflict, or be immediately condemned as discriminatory, belies a bias and bad faith approach. This simply would not be the same for other forms of racism and is frankly disgusting. Commenting or condemning the actions of any government is of course acceptable, if done within the law, but what is unacceptable is using racist or antisemitic slurs or tropes or inciting hatred against any one group.

In my role as the government’s independent advisor on antisemitism, and in leading this review, I have heard evidence of routine ostracism of Jewish people, continuous negativity to people because of their identity, extreme behaviours including serious race hate incidents, and related consequences, for example, patients not wishing to present for treatment and staff no longer wishing to work within the NHS. Clear leadership across the NHS and the health sector as a whole will rebuild confidence and trust across communities, including the Jewish community, that the NHS is equally for them. The experience must be the same across all sectors of the NHS - at present, experience varies across settings and the country. The Jewish community that I have met is proud of Britain and its NHS - we must ensure that continues.

Lord Mann of Holbeck Moor

UK government advisor on antisemitism

> “The need to re-establish trust between minority ethnic communities and the police is paramount… seeking to achieve trust and confidence through a demonstration of fairness will not in itself be sufficient. It must be accompanied by a vigorous pursuit of openness and accountability.”

Sir William Macpherson, Macpherson Report

Introduction: the case for action

In October 2025, the previous Secretary of State for Health and Social Care asked Lord Mann to lead a rapid review in response to antisemitism - or anti-Jewish racism - and other forms of racism across healthcare regulation and the NHS.

One of the most significant reviews of systemic and institutional racism is the Macpherson report (https://www.gov.uk/government/publications/the-stephen-lawrence-inquiry) (1999) into the racism that led to “failures, mistakes, mis-judgements, and a lack of direction and control” that plagued the

investigation into the murder of Stephen Lawrence. Macpherson defined institutional racism (https://publications.parliament.uk/pa/cm5802/cmselect/cmhaff/139/13911.htm) in the police as “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin”. He found this in processes, attitudes and behaviour “…which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people”. Features of these same failures are true of the NHS and health sector more broadly today, including for the Jewish community.

It is well-evidenced that racism is persistent in the NHS. Recent Kings Fund analysis of the NHS staff survey (https://www.kingsfund.org.uk/insight-and-analysis/press-releases/NHS-staff-survey-racism-disturbingly-normalised) shows racism is deeply pervasive and has reached the stage where it has become normalised in the NHS. This includes interactions between NHS staff and with patients, their relatives and members of the public. The Commission on Antisemitism report (https://bod.org.uk/wp-content/uploads/2025/07/commissiononantisemitismreport-web.pdf) (PDF, 308 KB) (July 2025), co-chaired by Lord Mann and the Right Hon Dame Penny Mordaunt DBE, found a specific unaddressed issue of antisemitism within the NHS that is making Jewish patients uneasy about accessing care and Jewish NHS staff feeling that discrimination against them is not being addressed. This means a real fear in seeking care, considering removing religious symbols before seeking treatment, or being uneasy about asking for kosher meals. An environment that allows this fear to persist is never acceptable, and needs real, demonstrable and visible action to address this. The commission for this review predates the October 2025 terrorist attack in Heaton Park, and more recently the appalling escalation in attacks on the Jewish community in the UK. Tolerating the existence of a culture within the NHS that fails to address persistent racism is never acceptable. However, these attacks on our communities have highlighted why we must act to ensure our most important institutions are taking all necessary steps to combat racism.

While there is a focus throughout this review on antisemitism and the experiences of Jewish people working within and seeking care from the NHS, it does not address antisemitism in isolation. Race and religious discrimination and hatred should be addressed more broadly. Many of the recommendations of this review set out how in particular antisemitism must be recognised, acknowledged, and addressed but the majority speak to the need to address racism at every level, no matter its form.

The latest NHS staff survey (2025) results show that 11% of Jewish staff and 16% of Muslim staff have faced discriminatory behaviour from patients or the public in the last 12 months, and 13% of both Jewish and Muslim staff report experiencing discrimination from managers or colleagues at work over the last 12 months. Over 20% of Black and minority ethnic staff report facing discrimination from patients or the public in the last 12 months,

compared with just 5% of white staff, while double the number of Black and minority ethnic staff have faced discriminatory behaviour from their colleagues or managers compared to white staff. It is profoundly troubling that NHS staff of all religions, and black and minority ethnic NHS staff, are more likely to experience discriminatory behaviour at work from patients or the public than they were 5 years ago. Jews in the UK have protections as both a religious and an ethnic group. For data collection purposes, at present, in the NHS, only religion is captured, in line with Office for National Statistics (ONS) standards. This is something considered in this review.

This reflects a wider and worrying prevalence of incidents of racism and religious hatred in broader UK society. As set out in the UK government's social cohesion plan Protecting What Matters (https://www.gov.uk/government/publications/protecting-what-matters-towards-a-more-confident-cohesive-and-resilient-united-kingdom) (2026), antisemitism and anti-Muslim hate crimes have now reached record highs. According to Home Office (2025) statistics (https://www.gov.uk/government/statistics/hate-crime-england-and-wales-year-ending-march-2025), 7 out of every 10 recorded hate crimes are racially motivated and religious hate crimes have increased 25% in the last year alone, including a 19% rise over the last year in recorded hate crimes against Muslims. Taking religious hate crime statistics into consideration, which does not include incidents of anti-Jewish discrimination based on ethnicity, Jewish people proportionately face the highest level of reported hate crime of any religious group. Information on reported religious hate crimes (https://www.gov.uk/government/statistics/hate-crime-england-and-wales-year-ending-march-2025) based on rates per population using estimates from the 2021 Census, indicate that last year there were 106 recorded religious hate crimes per 10,000 of population targeted at Jewish people, which far exceeds that of other religious groups. Similarly, the Community Security Trust (https://cst.org.uk/research/cst-publications/antisemitic-incidents-report-2025) (CST) recorded 3,700 antisemitic incidents across the UK in 2025, the second highest total ever reported to CST in any year. Reports from Tell MAMA (https://tellmamauk.org/tell-mama-records-the-highest-number-of-anti-muslim-hate-cases-in-2024-since-its-founding/) in 2025, an organisation which measures anti-Muslim attacks, similarly recorded across the previous year, the highest number of anti-Muslim hate cases since its founding.

Reflecting on the entrenched problem of racism in the NHS, the 2024 Brap report Too Hot to Handle (https://www.brap.org.uk/post/toohottohandle), examines a number of employment tribunal cases and responses from over 1,000 NHS staff. It finds deeply concerning experiences of NHS staff facing racism and discrimination, and a sorely lacking response to concerns raised about racism from the NHS as an employer. NHS England's equality, diversity and inclusion (EDI) improvement plan (https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/), published in 2023, set out 6 high impact actions for board leaders to create an inclusive environment where staff feel psychologically

safe, are supported to speak up to raise concerns, and in turn deliver efficient, productive safe care to patients. The EDI improvement plan is currently under review by NHS England, however, the results of the NHS staff survey and Brap report demonstrate there is a critical need to go further to stamp out racism in the NHS.

Racism in the NHS does not just affect staff but the public too. As demonstrated in ongoing research by the NHS Race and Health Observatory (https://nhsrho.org/research/the-cost-of-racism-how-ethnic-health-inequalities-are-standing-in-the-way-of-growth/) (NHSRHO), racism does not only have a devastating human impact, but also a profound impact on health equalities and economic sustainability for the NHS. Where health professionals demonstrate racist or discriminatory behaviour towards others, it can affect access to care. There have been a number of high-profile investigations in the last year involving registered health professionals sharing offensive, racist and antisemitic views. This behaviour is unacceptable and can deter patients from seeking medical care, leaving them feeling as though they risk discrimination and less favourable treatment should they access NHS services. The Care Quality Commission (CQC) adult inpatient survey (2025) (https://nhssurveys.org/surveys/survey/02-adults-inpatients/year/2025/), demonstrates that certain ethnic and religious patient groups, including those recording their religion as Judaism, have a much lower than average level of trust and confidence in the doctors and staff treating them in hospital. Similarly, the 2025 NHSRHO survey of primary care providers (https://nhsrho.org/news/patients-report-alarming-lack-of-trust-in-nhs-primary-care-providers/) highlighted that more than half of all Black, Asian and ethnic minority patients surveyed experienced some form of discrimination from a member of NHS staff, leading to low levels of trust in the health service (only 55% of patients surveyed trusted their primary care provider to meet their care needs).

In order to spread knowledge and regain trust and confidence, a reset is needed, which requires homing back in on the NHS's foundational principles and those of the health service in general, including the fundamental responsibilities of healthcare professionals, dating back to the Hippocratic Oath. It requires the re-prioritisation of the patient and inculcating a sense of pride for - and protection of - the NHS, focusing on creating an environment where anyone can feel safe to work and seek treatment and care.

The review

This rapid review has sought to examine how the regulatory system for healthcare professionals, from employment through to national oversight and professional regulatory bodies, supports recognition and reporting of

antisemitism and other forms of racism, and tackles racism at every stage and level. In particular, the review has sought to answer 2 principal questions:

1. How do we make sure in the NHS in England that perpetrators of antisemitism and other forms of racism are held to account with effective action taken to tackle their behaviour?
2. How do we make sure that patients and staff are protected from racism within the NHS in England and across the UK health and care professional regulation system?

This review proposes that the NHS establishes a clear organisation-wide priority to increase trust and confidence in NHS services among Jewish, and other minority ethnic patients and staff through actively promoting an anti-racist workplace culture and putting in place systems to tackle incidents of all forms of racism thoroughly, fairly and transparently. The NHS must work to embed anti-racism principles at its very core, eliminate racist prejudice and disadvantage, and demonstrate fairness in all aspects of NHS employment and care. That must include efforts to tackle anti-Jewish racism.

The scope of this review considers actions that can be taken to address racism from all quarters, including:

- NHS staff
- patients and their relatives
- members of the public

Building on the existing large body of evidence on the impact of racism in healthcare, and on the extensive experience of Lord Mann, the review undertook:

- a period of targeted engagement with relevant stakeholders, including the UK health and care system and professional regulatory bodies
- thorough examination of existing mechanisms, guidance, and processes for addressing incidents of racism in the NHS

A note on terminology used in this report: for the purposes of this report, this review recognises that collective terms for ethnic minority communities do not represent a single, homogenous group. Considering the principles set out in the NHSRHO's Power of Language report (https://nhsrho.org/research/the-power-of-language-a-consultation-report-on-the-use-of-collective-terminology-at-the-nhs-race-health-observatory/), we avoid acronyms or initialisms where possible. However, this report will use acronyms or initialisms where they are part of established data reporting, to avoid confusion when interpreting data sets. Where possible within the data,

the report aims to reflect specific experiences, including those relating to antisemitism and other forms of racism.

Openness, accountability and the restoration of confidence

Principles for tackling racism

The NHSRHO establishes 7 principles of anti-racism specifically for the NHS workforce. Staff should:

- name racism
- demonstrate leadership
- focus on data and evidence
- value lived experience of staff
- [use] evidence based interventions
- foster transparency and accountability
- [support] wellbeing and cultural safety

Simple, evidence-based models of anti-racism are a good start for healthcare organisations and systems to begin to think about the steps needed to help shift the dial on racial inequalities for our communities. The NHSRHO principles should be the starting point for NHS organisations seeking to better address racism. Research, including the Brap Too Hot to Handle report, highlights a persistent reluctance to acknowledge racism as a systemic issue. It identifies a tendency to minimise harm where discrimination is not seen as deliberate, overlooking the role of unconscious bias and the cumulative impact of repeated behaviours. This contributes to underreporting, as ethnic minority staff may lack confidence that concerns will be recognised or addressed. The findings underline the importance of addressing everyday behaviours, including challenging microaggressions, rather than focusing solely on overt or intentional acts of discrimination.

In line with the Macpherson principles, the central tenets of the approach to tackling racism across health and social care should be:

- calling out racism, including antisemitism, wherever it occurs
- supporting its victims

- treating with kindness those that report having suffered it

Racism presents in different forms and understanding this is important. Some have raised objections to undertaking a review that has a focus on a particular form of racism, but this fails to acknowledge our starting point that racism in all its forms must be addressed and that anti-Jewish racism is a significant problem in health settings.

In healthcare the Jewish experience is in some ways unique compared to other ethnic groups. Drawing on the NHS staff survey data (which captures data based only on Jewish as religion, and not ethnicity), Jewish staff are the only religious group where discrimination from managers and colleagues exceeds discrimination from patients. Jewish staff report levels of staff engagement and morale in line with the national average. They report feeling free to speak up and are confident that bullying would be addressed, but their willingness to recommend their organisation has fallen since 2021 compared to the national average Judaism is captured as a religion, not ethnicity, so we cannot directly compare to specific ethnic groups, but indicatively we can place them side by side. When we do that, we see Jewish staff have identical levels of reported discrimination from managers and/or colleagues as Black African and Indian staff, 2 of the largest ethnic minority groups in the NHS .

Naming racism is one of the major elements within the NHSRHO principles and seeking to devalue or level allegations of a smear in response to concerns about antisemitism not only runs contrary to the Macpherson principles, it provides cover for racism to continue unimpeded. Antisemitism should be named as racism by senior leadership to set an example at all levels of healthcare organisations.

In line with NHSRHO's principles, working with ethnic minority communities, including Jewish communities, is vital. Through partnerships with the voluntary, community and social enterprise (VCSE) sector and wider NHS system partners, NHS organisations can identify key priorities for improving the experience of patients. For example, the NHSRHO has created resources together with the Jewish community, including its review of NHS health communications with (and for) the Jewish community (https://nhsrho.org/research/health-communications-report-and-resources-to-improve-access-to-nhs-services-for-jewish-communities/), which sets out excellent examples of joint working. In particular, the Manchester University Foundation Trust has worked closely with its local Jewish community and developed a model of collaborative working and problem solving. Community-based initiatives that promote inclusion and address racism should be actively supported.

The Nursing and Midwifery Council (NMC) has similarly engaged with related community organisations that attend its Diaspora Registrants Forum and the General Medical Council (GMC) has engaged with members of its Strategic EDI Advisory Forum and its Race Equality Forum. In the last year,

both NMC and GMC have worked with organisations such as the Antisemitism Policy Trust to develop bespoke training offers, and with the CST to embed awareness and learning amongst their regulatory workforce. While these examples focus on the Jewish community, parallel learning offers have also been delivered that cover awareness of other forms of racism and discrimination, and it is vital these examples and others like it are amplified by the Department of Health and Social Care (DHSC) and NHS England.

Adoption of the NHSHRO's 7 principles can support the NHS in meaningfully informing tangible actions to promote anti-racism and tackle racism.

> Recommendation 1: the Department of Health and Social Care and the NHS should adopt the 7 NHS Race and Health Observatory workforce principles and encourage wider NHS organisations to do so.

Essential to this recommendation's impact, especially for the Jewish community, will include embedding an understanding that antisemitism is a form of racism.

Reporting, data and evidence

There is a paucity of ethnicity data impacting recognition and service provision for Jewish people and other religious and ethnic minority groups, including Sikhs. The Government Statistical Service (GSS) sets the parameters for harmonised data collection and at present Jewish and Sikhs people are recognised as a religion but not an ethnic group. The matter has already been a focus of debate in Parliament, and a Private Members' Bill was brought forward to secure change in this area. The number of Jewish people defining themselves as ethnically Jewish in the census has risen from 12,000 in 2001 to 68,198 in 2021. In Scotland, in 2020, there was a 15% rise in those identifying as ethnically Jewish when given the opportunity to do so. The Board of Deputies of British Jews argues that in the absence of 'Jewish' as an ethnicity in ONS data collection categories, British Jews are invisible to government departments and public bodies for purposes of research and data collection that can ensure proper evaluation of service delivery and outcomes. This review agrees with this assessment, and it is one echoed in the inquiry led by Lord Mann and Dame Penny Mordaunt for the Board of Deputies of British Jews.

For the health sector, on registering with a GP, ethnicity is captured, but religion is not. This may result in a negative impact on service delivery or

health screening for conditions Jewish people might be more vulnerable to, for example Tay-Sachs disease, or breast cancer (https://www.england.nhs.uk/2025/01/hundreds-of-people-at-increased-cancer-risk-identified-by-new-nhs-brca-testing-programme/). There is therefore a case to go further and suggest that Jewish health outcomes might be improved if the NHS acts to ensure it has the right data to understand the community it is serving. There needs to be an overhaul of NHS data collection principles, with disparity between trusts addressed, some using models that are over 20 years out of date.

While it may be desirable, there is no requirement to wait for GSS to update its standard. The National Statistician informed the Board of Deputies of British Jews that public bodies 'may consider alternative approaches to data collection, where these are justified by specific contexts, legislation across UK nations, or user needs'.

Appropriate data collection is essential. Screening based on Jewish - and indeed other - ethnicity criteria could save lives and give improved health-related outcomes, including patient access to healthcare services. This is particularly urgent in women's health and maternity services.

> Recommendation 2: the Secretary of State for Health and Social Care should consider including Jewish and Sikh as ethnicities in data collection. This could include consulting on this question for the health service as part of a wider update and equalisation of data capture across the NHS, as part of the update of the Unified Information Standard for Protected Characteristics (UISPC).

Under the public sector equality duty (PSED), NHS organisations must:

- demonstrate due regard to the need to eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity for people who share a protected characteristic and those who do not
- foster good relations between people who share a protected characteristic and those who do not

To fulfil these duties, NHS organisations must publish equality information at least once a year to show how they have complied with the equality duty and prepare and publish equality objectives at least every 4 years. The workforce race equality standard (WRES) also provides measurable data to help NHS organisations monitor and manage race inequalities through 9 workforce indicators (https://www.england.nhs.uk/about/equality/equality-hub/workforce-equality-data-standards/equality-standard/). Trusts must collect WRES data in accordance with the standard NHS contract and publish action plans that respond to that data.

WRES measures NHS organisations against 9 indicators covering areas such as workplace discrimination, career progression, bullying and harassment, and entry into disciplinary processes. Organisations are expected to use this data to develop and implement actions to address identified workforce race inequalities. The Care Quality Commission (CQC) considers WRES evidence as part of its assessment of workforce equity and culture within the 'well-led' domain.

This statutory activity provides a solid foundation but needs to be strengthened. At a national level, strong leadership of the WRES agenda is required. The quality and consistency of patient and workforce ethnicity data captured by NHS services locally is variable and can undermine efforts to identify and eliminate inequalities. Greater onus could also be placed on NHS organisations to develop robust WRES action plans and take local accountability and ownership of them as part of their duty under PSED to help rebuild public confidence in the NHS. Local trusts also need to be properly supported to implement actions to address areas of focus identified in their WRES outcomes.

In line with the NHSRO's 7 principles, NHS organisations can and should be using data and evidence to help them tackle racism, including by:

- drawing on evidence gathered through reviews of the economic impact of racism on the NHS, such as that from the NHSRHO, to focus and inform impactful action on anti-racism. Further evidence-based research should also be supported to determine what actions can make the most impact in NHS settings
- learning from data insights captured from existing information systems (for example, from the friends and family test (FTT), patient participation groups, and partnerships with the VCSE sector) to identify relevant priorities for improving the experience of patients from minority communities
- improving the collection, quality and use of patient and staff ethnicity data, to understand where discrimination is occurring within organisations and drive targeted action and improvement. This will involve fostering a culture of psychological safety where patients, in particular, feel comfortable sharing their ethnicity data with NHS services

Recommendation 3: in considering their work to develop robust, evidence-based workforce race equality standard (WRES) action plans, with specific, measurable targets, trusts should ensure they monitor progress against WRES action, applying the 'explain or reform' principles for any persistent inequalities. They should ensure any WRES plans are easily accessible to the public and should discuss their WRES planning at least annually at a public board meeting to help facilitate this. In the absence of Jewish ethnicity data trusts must also look at staff survey data in relation to Jewish staff alongside WRES

indicators to understand how they are performing and addressing the experience of Jewish staff.

Recommendation 3 will be supported by the introduction of a suite of staff standards to be published in 2026 which will set minimum standards of employment and raise the profile of staff experience following the commitment set out in the 10 Year Health Plan. All standards, including a specific standard on tackling racism, will be measured through a new composite score within the NHS Oversight Framework (https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26) (NOF) and wider accountability and assurance processes to ensure clear consequences for a lack of action. This will help increase accountability in relation to tackling racism, along with other relevant NHS metrics.

Recommendation 4: NHS boards and leaders should be held accountable for race equality and staff experience metrics, as part of the recently added score in the NHS Oversight Framework (NOF) that will support compliance with the new NHS Staff Standards. The metrics supporting this new NOF score, and trusts' performance on these, should be made publicly visible.

Recommendation 5: there should be board-level oversight of all investigations related to racism through annual reporting on volume, themes, outcomes and timelines, deep-dives into hotspots or repeated patterns, and assurance that recommendations are implemented and monitored. Existing governance systems can also be strengthened.

Leadership and best practice

Trusts exhibiting good practice in relation to EDI and anti-racism, for example the Northeast London NHS Foundation Trust, Mersey Care and Manchester NHS Trust, should be upheld as positive examples for other trusts and regulatory bodies and used to inform models for other organisations. They have recognised, as others will have to, that change will require consideration and time and will not be immediate or easy.

Recommendation 6: NHS England should work with system partners, such as the NHS Race and Health Observatory, to strengthen how it supports and celebrates organisations that make positive progress in

the anti-racism agenda. The NHS should further build on existing recognition initiatives, and the development of an accreditation mark should be considered.

The national EDI repository on the NHS Futures platform and the NHSRHO ‘Harp’ platform provide collaborative spaces and useful resources where staff and patients from across the NHS can share and learn from best practice and NHS organisations should promote and make use of these platforms. The NHSRHO’s principles highlight that leadership is essential to supporting delivery against an anti-racism agenda and it is well evidenced that effective leadership plays a vital role in fostering an inclusive and compassionate workplace culture. NHS leaders should therefore have a responsibility to drive performance improvement against EDI measures and support the 7 principles, and the systems of governance that hold managers and leaders accountable for improving outcomes should be further developed. But some of the actions the NHS has already set out for itself need to be delivered. Specifically, high impact action 1 from the NHS EDI improvement plan should be delivered in full.

Recommendation 7: all NHS board members and senior leaders should have explicit, measurable equality, diversity and inclusion objectives embedded within their performance goals. Assessment against these objectives should reference the themes in the NHS Race and Health Observatory’s 7 anti-racism principles as a framework for evidencing delivery.

There is work in progress to introduce statutory regulation for senior NHS leaders within this Parliament. This will help to increase accountability for NHS leaders, meaning that there is a mechanism in place to disbar those whose conduct falls short of that expected, for example leaders who silence whistleblowers. Regulation is not expected to be in place until 2028, however, it will provide another mechanism to ensure that leaders are held accountable for their actions and are accountable for meeting the standards expected of them, which will contribute to increasing public trust in the profession.

Freedom of expression

With the aim of restoring confidence in the NHS, this review must specifically address concerns relating to freedom of expression, political opinion and racism. These concerns have been raised by stakeholders

repeatedly with Lord Mann, specifically with regard to uniform policy or social media, but in other contexts too.

To be clear, individuals in the UK have the right to offend, the right to hold strong political views and the right to express themselves freely within the law, but protecting those rights must not undermine the purpose of the health service and must not infringe on other people's rights. The role of the employer here is critical. Employers must set policies that strike the right balance between protecting the rights of other people and the freedom of expression of their employees. For the NHS in particular, it must seriously consider its brand. In referring to the NHS brand here, we are speaking about use of the NHS logo, often referred to as the NHS 'lozenge', and more widely about the NHS brand identity and reputation as a whole. Employers have the right to expect that staff will not bring their employer into disrepute, which could include unprofessional conduct or undermining the effectiveness of the organisation to carry out its functions. What is acceptable or allowable by employers for staff in other settings is not automatically transferable to the NHS. The risk factor is both higher and more critical. A patient failing to present for or seek care because of their avoidable perception of an NHS service, of a perceived bias of a medical practitioner or other employee, is not acceptable.

Individual patients must be confident in the NHS, whatever service they are accessing, for whatever reason, regardless of geographic location The NHS looks after those often at the most significant and vulnerable moments of life, and in every case, patients should not fear that they will be discriminated against within the NHS services they need to access. The position of a current or potential patient is unique, and therefore NHS staff ought to be held to a high standard by their employers (and regulators). As well as being subject to the public sector equality duty as set out in Section 149 of the Equality Act (2010), the NHS, as an employer and service provider, has a legal duty not to discriminate against a person on the basis of their protected characteristics. The NHS should at all times seek to create an environment where people feel safe to receive care. This must be the uniformly accepted starting point and end point for how the NHS deals with perceived racism. It is the intersection of the Macpherson principles within the NHS and underscores the responsibility of the employer, and the importance of appropriate systems and guidance. For example, the employer (NHS or other) will have rules on the right (or not) to be active in politics. However, taking into account the context set out above, and the caveats about freedom of expression, the firm position of this review is that political identifiers do not have a place in the NHS, that is to say there should be a restriction on NHS staff from displaying political identifiers while at work.

To be more specific, saying 'Free Palestine' or 'I love Israel' are reasonable beliefs and expressions but the identification of such views or beliefs on public facing NHS owned profiles might, in of themselves, be a barrier to patients presenting. NHS guidance in relation to this must be precise, on

what is acceptable, not vague or open to interpretation. Whether it be uniform, official social media, meeting rooms, digital backgrounds or equipment such as laptops or iPads, guidance on use of the NHS brand issued by the NHS must be national and unambiguous. DHSC strictly controls the NHS identity and takes unauthorised use of the NHS mark very seriously and action is taken against cases of potential misuse. This must be made clear to NHS staff within published NHS guidance.

Uniform and workwear have been a particular concern in recent years and both the Prime Minister and the previous Secretary of State for Health and Social Care (in 2025) have committed to a review of national uniform guidance. Examples such as the brandishing of badges, the display of uniforms on political marches or the co-branding of the NHS by staff or others with third parties has made it unclear what patients can expect from the NHS. The current arrangements mean the likelihood of inconsistency is significant as guidance from NHS England supports the development of local policies but there is no requirement to follow it. Although NHS England may be updating this guidance there is no certainty it will be adhered to, indeed guidance about uniform being worn outside the workplace has clearly, in some cases, been ignored.

Essential to developing uniform guidance were important principles including freedom of religious expression, ensuring patients feel safe and respected at all times, and that the political views of staff do not impact on patients' care or comfort. These were principles the leadership of NHS England committed to maintaining following the Prime Minister's announcement that uniform policy would be reviewed. It is the view of this review that uniform policy, however reformed, should not inhibit freedom of religious belief. The current guidance is outdated, not focused or sufficiently specific on these issues and has not been reviewed for a number of years.

There are examples where local uniform policy has been developed with the above principles in mind. Manchester University Foundation NHS Trust and University College London Hospitals NHS Foundation Trust have been cited as examples of good practice. There are a number of trusts that do not permit the wearing of political badges (Shrewsbury and Telford), the wearing of any item of clothing with a political message (Wolverhampton, Sheffield Partnership), or wearing a uniform to political rallies (Sherwood Forest, Doncaster and Bassetlaw). This means that such an approach is not unheard of.

Ultimately, patients must feel safe and respected at all times. As above, the clear view of this review is that political identifiers are not acceptable in the NHS.

> Recommendation 8: some political identifiers can and do cause distress to patients, and employers should develop local policies to be clear about what is acceptable. In order to create an inclusive NHS, upholding

the aim of everyone feeling safe to seek and receive care, NHS England should update national uniform guidance, in line with reviewing broader guidelines for those in the NHS using its name, logo or branding, including in relation to social media accounts.

Even with new national guidance in place, successful implementation will require the investment of senior managers locally, sensitivity, and a patient focused approach, as well as reassurance to relevant communities and regular reminders. Employers should also ensure they are considering relevant Equality and Human Rights Commission (EHRC) guidance in developing and implementing their policies.

The responsibilities of health care professionals

Philosopher Jean Paul Sartre theorised that we all have prejudices within us, the issue is whether we challenge them, and it can be argued that the NHS is no different in this. NHS employees face hidden, unconscious, visible and audible racism at their place of work. Sometimes there will be mutual animosity and at other times mutual unconscious bias.

However, healthcare professionals have particular responsibilities to challenge their biases and ensure their conduct justifies patients' trust in them and the public's trust in the profession. They, of course, also have a legal duty not to discriminate against others as set out in the Equality Act 2010. There is no legal requirement for health workers to take an oath in the UK, although GMC's Good Medical Practice (https://www.gmc-uk.org/professional-standards/the-professional-standards/good-medical-practice/domain-2-patients-partnership-and-communication) guidance, which details the professional standards all registrants are required to meet, builds on the principles of the Hippocratic Oath. This includes a requirement to "treat patients fairly", setting out that "you [the registrant] must not discriminate against them [the patient] or allow your personal views to affect your relationship with them or the treatment you provide or arrange". Good Medical Practice also counsels against the refusal or delay of treatment, warns about bias and demands respect and sensitivity for others' "…life experience, cultures and beliefs". Similar guidance such as the Health and Care Professions Council's (HCPC) standards of conduct, performance and ethics (https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/) and the General Dental Council's (GDC) standards for the dental team (https://www.gdc-uk.org/standards-guidance/standards-and-guidance/standards-for-the-dental-team) exists across the health and care professional regulators. NMC's professional standards of practice and behaviour (https://www.nmc.org.uk/standards/code/) for nurses, midwives, and nursing associates, known as 'the Code', sets out that "[in order to uphold

the standards of the profession, you must] act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment", and "[make sure] that any discriminatory attitudes and behaviours towards those receiving care are challenged".

Drawing directly on the Equality Act 2010, the NHS constitution and staff rights and pledges handbook (https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england) - which applies to all staff - states unequivocally that NHS staff have a right to healthy and safe working conditions and an environment free from harassment, bullying or violence and to be treated fairly equally and free from discrimination. Likewise, the constitution handbook sets out a patient's right not to be unlawfully discriminated against in the provision of NHS services including on grounds of sex, race, disability, age, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity or marital or civil partnership.

This is not to say that healthcare professionals should be discouraged from or cannot express political beliefs in their personal life, but they must be particularly mindful of doing so lawfully and in a way that does not undermine public confidence.

Despite these clear standards set by health and care regulators for registered professionals, and the rights and pledges set out in the NHS constitution, it is evident that people, including Jewish patients, in recent years have not always experienced the behaviour expected of medical professionals. Refocusing on the principles of beneficence, non-maleficence, confidentiality and professional and ethical conduct, as well as providing clear support for staff impacted by racism, will benefit minority communities and all patients, staff and connected individuals, not just Jewish patients and those suffering antisemitism.

The responsibilities of all staff and volunteers

There needs to be enhanced confidence that the system is working, and NHS organisations should ensure relevant standards and codes apply appropriately across these groups. This should cover all staff and volunteers, including sub-contracted staff, from cleaning teams in a hospital to volunteers in a hospital shop.

> Recommendation 9: all staff, including volunteers and sub-contracted staff, should be made fully aware of and have easy access to the documents, contracts and agreements that contain details of the expectations on them with respect to anti-racism, discrimination and fostering an inclusive NHS culture, including the NHS

constitution, leadership and management standards (once published), and any volunteer agreements or codes of conduct.

Definitions, reporting and investigation of racist incidents

Definitions

In order to report racism, one must be able to define it. The International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism (https://holocaustremembrance.com/resources/working-definition-antisemitism) is the most prominent international standard of anti-Jewish racism. The IHRA definition is not legally binding, but a point of reference which when applied must take account of the overall context of the incidents. It is a helpful guide and gives confidence to Jewish communities and others that antisemitism is well understood.

The Jewish staff and patients Lord Mann has engaged with have said they might reference the IHRA definition when having encountered antisemitism or having had it directed towards them.

To be clear, freedom of expression, which is legally protected by the Human Rights Act (1998) allows people to say things that others find offensive. It crosses an ethical line when someone is denied the right to define their own identify and ethnicity and is met with hostility for doing so. The right to freedom of expression is a qualified right. It must be balanced against other human rights, including the right of each person to be protected from discrimination and violence. Attacking the actions or policies of the Israeli government or state, including in ways that some will see as offensive, or support for a Palestinian state or the plight of Palestinians, does not in of itself constitute antisemitism or contradict IHRA. Every action must be taken within its overall context.

The UK government adopted the IHRA definition a decade ago, and last year the Health Secretary reaffirmed DHSC's commitment to it. The government recently also published a non-statutory definition of anti-Muslim hostility (https://www.gov.uk/guidance/a-definition-of-anti-muslim-hostility). NHS England has formally adopted the IHRA definition and written to trusts asking they also consider adopting it. In 2025, the previous Secretary of

State asked that other DHSC executive agencies and arm's length bodies also adopt it, which they too have done.

Its adoption is important because antisemitism can appear in many pervasive forms, some of which people can fail to identify due to lack of understanding, or wilfully or nefariously misinterpret. The definition helps organisations to identify antisemitism and patterns of speech or behaviour that may amount to antisemitism. It also helps individuals who have been subjected to antisemitism, giving them a clear definition to point to. Helpful guides exist which set out further detailed examples, such as the Antisemitism Policy Trust's A Guide to the International Holocaust Remembrance Alliance Working Definition of Antisemitism (https://antisemitism.org.uk/wp-content/uploads/2020/06/IHRA-Explainer-Web-Pages.pdf) (PDF, 1.99 MB).

Adopting clear definitions of racism and religious hatred helps to validate lived experiences of discrimination. It provides clarity and consistency, which can help organisations and individuals know how to respond more effectively to incidents of discrimination. Adopting clear definitions for forms of discrimination is about protecting individuals from targeted criminal acts, prejudicial stereotyping and unlawful discrimination. These definitions are not legally binding and do not override the laws in place concerning matters such as freedom of expression or hate crimes, however, they are useful tools to support organisations and individuals in increasing understanding, better acknowledging and more successfully addressing discrimination.

It is important that the IHRA definition should sit alongside NHS-wide codes of practice, other definitions that the NHS chooses to adopt, and guidance for reporting and investigating incidents of racism and religious hatred.

The UK health and care system and professional regulators currently use multiple definitions of racism. This is not a sustainable or acceptable approach, and this inconsistency should be addressed.

> Recommendation 10: the Department of Health and Social Care should work across the health and care regulators, including the Care Quality Commission, to secure an agreed approach on definitions of racism and religious hatred.

GMC, CQC and NMC, with 6 other health and care professional regulators, have endorsed joint principles on Advancing Workforce Race Equity in Health and Social Care (https://nhsrho.org/news/uk-regulators-sign-new-principles-to-tackle-racism/) and jointly released statements alongside this (see recommendation 22). This should be continued and strengthened, and the other health and care professional regulators should consider their position on these matters. Such a statement should provide clarity and consistency on how regulators will work together to consider workforce race equality and

issues of discrimination in regulation. This work should specifically address antisemitism.

In relation to the reporting of racist incidents, the NHS has a number of statutory functions and duties relating to the data it captures, the insights it generates, and the priorities it sets for improving the experience of patients and staff from minority communities. For instance, NHS commissioners and trusts are legally required to involve current and potential service users in the planning and delivery of NHS services. NHS England therefore contractually requires service providers across primary and secondary care to capture relevant information to meet this duty through mechanisms such as the FTT and patient participation groups. The NHS Standard Contract also requires all NHS trusts to run the annual NHS staff survey and to collect WRES data. However, the impact of these activities will always be determined by the relevance of the metrics underpinning them and the knowledge and capability of the individuals who capture, handle and determine the response to datasets. While WRES captures data on representation, career progression, discrimination and bullying and harassment experienced by Black and ethnic minority staff in the NHS, the indicators have not been updated since WRES was first introduced in 2015. It is therefore worth considering whether these indicators still accurately and intentionally capture staff experiences of racism, including antisemitism, in the NHS.

Similarly, NHS complaint systems provide mechanisms by which concerns can be raised about racial harassment or discrimination. Patients can report concerns about NHS staff through the Patient Advice and Liaison Service (PALS) and the NHS complaints system. NHS organisations provide training for staff to raise awareness on the importance of raising concerns and Freedom to Speak up Guardians are there to support and guide staff who wish to speak up and raise concerns about other members of staff. NHS staff are also encouraged to follow NHS trust guidelines to report incidents of racial harassment or discrimination by patients. However, the quality and consistency of the response and the insights generated through this process are, in part, dependent on the capabilities of complaints handlers such as PALS staff.

To strengthen these mechanisms for reporting on incidents of racism this review recommends:

Recommendation 11: as part of the ongoing development of the NHS staff standards and the accountability processes around them, the staff experience questions in the annual NHS staff survey should be reviewed, with input from a wide range of staff representatives and networks, to ensure they continue to be relevant in capturing ethnic

minority staff's experience of racism and discrimination in the NHS, including those of Jewish NHS staff.

Recommendation 12: training for Patient Advice and Liaison Services and/or complaints handlers should be rolled out to better identify and handle complaints about racism and support their organisations in responding to racism. Complaints handlers in all settings should have clear process set out for sharing information and insights with other internal NHS functions and leadership, including taking advantage of tools like artificial intelligence to better understand their complaints data, supporting identifying trends.

The investigation of racist incidents must be rooted in safeguarding principles, should be in line with the Macpherson principles and must satisfy the requirements of the Equality Act 2010. NHS services often lack the capability to effectively investigate cases of race discrimination. Discrimination can occur in the form of multiple microaggressions that collectively amount to exclusion or ostracism. Investigators may not traditionally understand how to identify, investigate, hold individuals to account and report well. NHS England is currently in the process of developing a national investigatory framework to address this issue, and training has a role to play in this too.

Recommendation 13: a single national set of policy frameworks should be developed and clearly signposted to support more effective handling and investigation of racial harassment and discrimination. Work should be undertaken to develop the skills and cultural capability to deal with these issues better in trusts, including how they are investigated and staff supported.

These policies and codes must include detail on how support should be offered and delivered for victims and witnesses of racism, with a focus on sensitivity and confidentiality. It must also set out what support services are in place. Access to counselling and support should be available for affected staff and patients.

This work should be informed by statutory guidance and codes of practice and build on existing racism investigatory and disciplinary procedures across the NHS, working with staff and patient representatives. In line with this guidance, trust leadership along with other NHS organisations should ensure that their procedures are clear and proportionate, and that accurate and transparent recording (identification and categorisation of incidents), reporting, governance and accountability is in place.

Recommendation 14: trusts should take into account the relevant Advisory, Conciliation and Arbitration Service (ACAS) code in developing their processes and strongly consider routes for early intervention and resolution. The forthcoming review of the ACAS disciplinary and grievance code (https://www.acas.org.uk/acas-code-of-practice-on-disciplinary-and-grievance-procedures) should support this.

To ensure policies for reporting and investigating incidents of racism are enacted correctly, staff require basic anti-racism knowledge and cultural competency training, and when issues of racism are reported should have confidence in their employer's disciplinary and grievance processes. In line with the NHSRHO and Macpherson principles, issues of racism should be recognised and named as such. They should then be appropriately triaged and escalated. This will require appropriate levels of knowledge at different levels of seniority, including understanding of appropriate processes and the related timelines, monitoring for bias and an understanding of when to contract external expertise. WRES captures the relative likelihood of Black and ethnic minority staff entering formal disciplinary procedures compared to White staff, however, the NHS does not routinely monitor for bias in how race discrimination and harassment is investigated. Employers should consider how they could do so.

Regulation

Strategic leadership and oversight is imperative to the improvement of handling the reporting and investigation of racist incidents and, to this end, NHS England, DHSC, CQC and others have an important role in monitoring, ensuring transparency and holding organisations to account for performance against this. CQC is the independent regulator of health and adult social care in England. Healthcare services are primarily held to account on tackling racism by CQC, largely within the 'well-led' domain of the CQC assessment framework. Regulated services must demonstrate an inclusive and fair culture that improves equality and equity, based on the needs of people who use their services and the needs of wider communities. However, during the engagement of this review, Lord Mann was made aware of service providers rated as 'good' under the well-led domain, while having poor indicators for minority ethnic staff experience, as well as development and career progression. CQC oversight should ensure that investigations are reviewed to ensure they are timely, credible and trusted, and transparent feedback should be provided to staff on outcomes and organisational learning to ensure the rebuilding of trust.

Recommendation 15: the Care Quality Commission (CQC), working with the Department of Health and Social Care (DHSC), should make greater use of powers to inspect NHS organisations on their equality, diversity and inclusion (EDI) performance, against patient inequalities and for staff workforce, under the ‘well-led’ domain. In doing so, it should ensure that NHS boards and leaders are held accountable for delivering the staff standards as reflected in the NOF, including how organisations handle racist incidents and the effectiveness of reporting systems. More broadly, DHSC should consider how CQC might enhance its assessment of all NHS organisations for EDI performance and the role of the organisation’s leadership in addressing racism. As referenced in the section of this report on reporting and investigation of racist incidents, this should include the handling of racist incidents.

The Parliamentary Health and Social Care Select Committee has the ability, as part of its regular scrutiny, to probe CQC on these matters, and we trust it will do so.

There is a need for all health and care system and professional regulators to go further in sharing learning, including data and examples, and to build on existing constructive dialogue to ensure clarity and consistency of approach to investigating racist incidents. There are a number of forums and processes already in place to support this, including the emerging concerns protocol and the inter-regulatory EDI working group. The Professional Standards Authority for Health and Social Care (PSA) also has a central role to play in stewarding the health and care professional regulators to enhance information sharing and dissemination of good practice across the health and care sectors.

Recommendation 16: health and care system and professional regulators should establish a taskforce to clarify and reinforce the appropriate mechanisms, including the emerging concerns protocol, for sharing information about local areas of concern, racist incidents, thematic issues related to antisemitism and other forms of racism, and best practice for employers and regulators to address them. Health and care system and professional regulators should co-ordinate actions where more than one regulator has a role to play in responding to issues or incidents and the Department of Health and Social Care should work closely with the devolved nations.

Recommendation 17: the existing inter-regulatory equality, diversity and inclusion working group should be strengthened to provide a dedicated forum for sharing good practice, and the Secretary of State for Health

and Social Care should convene a dedicated session or roundtable for regulatory bodies on addressing antisemitism, and other forms of racism.

Wider governance, regulation and oversight

Transparency and best practice in regulation

It is the view of this review that the current arrangements between GMC and the Medical Practitioners Tribunal Service (MPTS) are not working as they should. The MPTS has failed to evaluate where it does not have sufficient expertise to determine cases concerning allegations of antisemitism and has failed to consult appropriately, or taken too long to do so, and in doing so has lost the confidence of many in the Jewish community. Concerns have been raised to this review about the decision-making process and outcomes in cases that were brought to MPTS regarding allegations of antisemitic rhetoric and support for proscribed terrorist organisations. There is significant media attention on such cases, which can also undermine public trust in the ability of the MPTS process to fairly adjudicate matters of antisemitism and other forms of racism. GMC is unique among the healthcare professional regulators in having a tribunal service that operates separately to the regulator making independent decisions on whether registrants are fit to practise in the UK. However, the same concerns apply across the regulatory system.

The Jewish Medical Association (JMA) and the British Islamic Medical Association (BIMA) have both submitted evidence to the review and have expressed concern about the way that cases of antisemitism and other forms of racism and religious discrimination are handled by system and professional regulators. Lord Mann has engaged and has been provided with evidence from stakeholders, including the NHSRHO and EDI leads in NHS England. Major themes of the evidence include:

- equality - stakeholders stressed the importance of ensuring parity of protection, representation and procedural fairness across all racial groups. It is essential that there is no real or perceived ‘hierarchy of discrimination’. BIMA also raised concerns regarding disproportionality within existing systems, including the unequal outcomes faced by under-represented groups in disciplinary and regulatory processes

- transparency - the need for transparency, particularly when cases are closed at an early stage and do not progress to tribunal
- accountability - accountability mechanisms should be strengthened to ensure regulators are handling cases of antisemitism and other forms of racism fairly and consistently
- education and understanding - stakeholders called for regulators and NHS organisations to adopt appropriate definitions of antisemitism and anti-Muslim hostility to improve understanding and to aid in consistent decision making. JMA also suggested that regulators receive advice in cases of alleged antisemitism from respected independent Jewish organisations

This review has sought evidence from all the health and care system and professional regulators and had in-depth discussions with the chief executives and senior leaders of these regulators, including PSA, CQC, GMC, NMC, HCPC and GDC.

There are 10 healthcare professional regulators, overseen by PSA. PSA, and the majority of regulators, are directly accountable to Parliament and the Privy Council. The Privy Council can direct some of the 10 professional regulators where they have failed to carry out their statutory functions, but only rarely has it used these powers. A list of the 10 UK health and care professional regulators and the professions they regulate is at annex B.

The health and care professional regulatory landscape is cumbersome and complex and is not working as it should. Many regulators are facing sustained increases in the number of concerns being raised with them. This has contributed in some part to the higher fitness to practise caseload being experienced by regulators. Higher caseloads may result in delays in cases being heard, increased pressure on regulators and a growing lack of confidence in the regulatory system and the decision making of tribunals.

Far too often, and increasingly, cases of suspected racist conduct are being referred to regulators - including by third party organisations, rather than staff or patients directly impacted by the actions of a healthcare professional - raising concerns which would be best investigated at the local level in the first instance.

The government has publicly committed to reforming the legislative frameworks for regulated health and care professionals across the UK, beginning with GMC. The government is currently consulting on a draft legislative framework for the GMC (https://www.gov.uk/government/consultations/reforming-the-general-medical-council-legislative-framework) (the draft ‘GMC Order 2026’). The draft GMC Order 2026 will provide a blueprint legislative framework for other regulators, introducing as much consistency across the regulators as possible. The consultation closes on 23 June 2026. Following this statutory consultation, the GMC Order 2026 will be laid in both the Westminster and

Scottish Parliaments and will be subject to the affirmative Parliamentary process. The consultation includes a small number of questions related to the recommendations of this review which will be discussed later in this chapter.

As part of its regulatory reform programme, the government has proposed in the draft GMC Order 2026 consultation that GMC case examiner powers should be extended. Case examiners are decision makers in GMC fitness to practise procedures. The role of the case examiner at the GMC was introduced in the 'General Medical Council (Fitness to Practise) Rules Order of Council 2004', which came into force on 1 November 2004. Under current legislation, case examiners have limited powers. For example, at the end of an investigation into a doctor's fitness to practise, a case examiner can only refer the case to a fitness to practise panel, agree undertakings (these set out the limits within which a doctor may practise), issue a warning to a registrant, close a case with no further action or issue advice to a registrant. As part of the regulatory reform programme, the government is proposing that case examiners should have broadly similar powers to a fitness to practise panel. Case examiners will be able to conclude cases and impose final measures through an accepted outcomes process, meaning that they will be able to find that a registrant's fitness to practise is impaired and propose a final measure to the registrant. A case examiner could propose that conditions of practise, or a suspension, are placed on a registrant's registration, or they could propose that the registrant is removed from the GMC's register. Where a registrant does not agree that their fitness to practise is impaired and/or with the proposed final measure, the case will be referred to a fitness to practise panel to make a determination on the case. The government aims to deliver a fitness to practise process that is swifter, fairer and less adversarial for GMC and other regulators. Its fitness to practise reforms should benefit all parties involved in fitness to practise proceedings and, most importantly, ensure swift public protection where needed.

When a concern is raised to a regulatory body, the regulator has a duty to consider the allegation. In accordance with published decision-making frameworks (https://www.gmc-uk.org/concerns/information-for-doctors-under-investigation/how-we-make-decisions), the regulator will usually make an initial assessment of whether the information received about a professional would, if proven evidentially, be serious enough to give rise to a question of impaired fitness to practise and whether the professional may pose any current and ongoing risk to public protection. There are a number of serious concerns that will usually give rise to a question of impaired fitness to practise such as sexual misconduct, dishonest behaviour, clinical failings and criminal convictions. Where the regulator considers that the threshold for referral has been met, the regulator is under a legal duty to refer the allegation to the relevant decision maker.

However, the role of the regulator is not limited to fitness to practise investigations, and regulators should also work jointly to support employers

to have the best clinical governance arrangements, including mechanisms to root out racism and all forms of discrimination.

Where there is a concern that an individual has broken the law - including support for a proscribed terrorist organisation - this should, of course, be referred to the police in the first instance, and then to a regulator. Attacks on work colleagues are also particularly egregious. Where an individual persistently threatens, undermines or publicly abuses colleagues including in relation to any protected characteristic this should be referred to the relevant regulator in line with their established guidance.

While it is absolutely the case that some concerns require investigation and involvement from both employers and regulators, especially as the facts of a case may evolve or change, it is the view of this review that patients, service users or staff should consider registering complaints with the employer or franchisor in the first instance. Employers should be the first line of defense and best understand the context in which patients and professionals are operating. Where behaviour is concerning but may not reach the level of concern that might warrant regulatory action, the employer can and should take appropriate action, which may range from informal interventions to serious disciplinary action. Where an employer or NHS contractor fails to act, or where the complainant remains dissatisfied with the outcome, a referral to the regulator will always remain an option. Where incidents occur in a healthcare setting outside of the NHS, or the professional is not employed in the NHS, private healthcare companies are responsible for taking action and concerns can be raised directly with the regulator. No employer or contactor should use possible pending regulatory action as an excuse for inaction.

If, having considered the issue, an employer believes there to be a case for regulator involvement, they should, and in many cases do, refer the case to the relevant regulator. Strong relationships between regulators and employers are essential to both protecting the public and ensuring consistent approaches and action.

Regulatory reform provides opportunity for regulators to work with employers and PSA to develop better and more consistent guidelines to support patients and family members and those who engage with the regulatory system where different organisations and agencies have overlapping responsibility. This review actively encourages the government and GMC to use regulatory reform to make clearer where action should take place. No single organisation can address this in isolation. However, this provides an opportunity to improve how organisations in the regulatory system work together and work with registrants, patients and employers.

Looking specifically at the regulation of doctors, there are existing mechanisms for updating GMC on relevant employment matters (which are planned to continue under the new GMC reformed order). It is the responsibility of ‘responsible officers’ to, where appropriate, refer concerns

about doctors with a prescribed connection to the organisation for which they are the responsible officer, to GMC. (The Medical Profession (Responsible Officers) Regulations 2010 (https://www.legislation.gov.uk/uksi/2010/2841/contents/made) set out a duty for organisations designated under the regulations ('designated bodies') to appoint a responsible officer. The regulations prescribe connections between medical practitioners and designated bodies. One of the duties of a responsible officer is to make recommendations to GMC about the fitness to practise of medical practitioners who are connected to them). They can be supported by GMC's outreach teams, who can advise employers when they are considering a referral. Again, the emphasis should be on employers as the first point of call for action against racism before regulatory involvement. There is a duty on the responsible officers not to withhold information. There is also a legal requirement to pass information to CQC. In this way, the regulators should be able to better adjudicate cases in which there are repeat offenders.

For any cases that do reach the threshold for regulatory investigation, there should be an expectation that the approach - while taking into account relevant context - should be consistently applied across all regulators and apply equally in respect of any and all protected characteristics.

Recommendation 18: the review recommends that:

- the Department of Health and Social Care, NHS England and the Care Quality Commission should work with the health and care professional regulators to develop a clear, single set of national guidance for employers (in England), clearly defining employers' responsibilities in tackling discrimination incidents and providing guidance and examples of the types of incidents that may require a regulatory referral, to build consistency. This guidance should complement and build on work that regulators already do to support employers to determine when incidents might also be referred to a regulator alongside the employer taking action or referring matters to the police. This should also be publicly available
- health and care professional regulators should work together to develop communications for patients and the public to raise awareness of what is being done to tackle antisemitism and other forms of racism more widely and who they contact if they have a concern
- health and care professional regulators should work with patient representative groups to develop material that is clear, brief, and helpful for navigating the system
- this work is urgent and must be a priority. The Professional Standards Authority for Health and Social Care should oversee and report back

on this work within 6 months and include an assessment of progress on implementation within their annual report to Parliament

Further to the above, this review recommends:

Recommendation 19: the Professional Standards Authority for Health and Social Care should further use its powers to set guidance for all health and care professional regulators on equality, diversity and inclusion matters.

Recommendation 20: the Professional Standards Authority for Health and Social Care should more regularly convene and issue joint communications to health and care professional regulators regarding their responsibilities.

Recommendation 21: health and care professional regulators, including the General Medical Council and the Medical Practitioners Tribunal Service should work with the Professional Standards Authority for Health and Social Care to develop a clear process for securing expert advice on relevant fitness to practise decisions, particularly where they involve matters relevant to those with protected characteristics, to support cultural awareness and learning among relevant decision makers.

Recommendation 22: on 13 May 2026 the national UK health and care professional regulators signed up to the NHS Race and Health Observatory principles of antiracism (https://nhsrho.org/news/uk-regulators-sign-new-principles-to-tackle-racism/) to help tackle racism. Each regulator should report back within 6 months of the publication of this report on how they propose applying and embedding these principles.

Recommendation 23: the Professional Standards Authority for Health and Social Care should convene fitness to practise staff across health and care professional regulators to probe their approach to cases involving racism, including antisemitism and discrimination. With complaints potentially arising from staff, patients, volunteers,

contractors, students and members of the public, consistency is required.

Recommendation 24: on all of the above, the Professional Standards Authority for Health and Social Care should formally report to the Health and Social Care Committee on its progress following this review within 6 months and include updates specifically on this area in its annual reports to Parliament.

Recommendations responded to in the consultation on the GMC Order 2026

The programme to reform the regulation of healthcare professionals in the UK, including the draft GMC Order 2026 consultation referred to at the start of this chapter, provides a timely opportunity to consider whether regulators' fitness to practise processes are sufficiently transparent to enable effective scrutiny at every stage. The consultation seeks views on proposals to ensure that there is sufficient oversight of fitness to practise decisions made by regulators and their fitness to practise panels, including appropriate appeal routes, particularly to improve transparency, efficiency and consistency in handling allegations of racism. The proposals are as follows:

- PSA and GMC should have a right of appeal to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court in Northern Ireland against interim registration measure decisions made by a fitness to practise panel
- GMC and PSA should retain their right of appeal to the High Court of Justice in England and Wales, the Court of Session in Scotland or the High Court in Northern Ireland against a fitness to practise panel's final registration measure decisions
- PSA should have the power to compel information from GMC in order to fulfil its statutory duties with respect to its rights of appeal, and to ensure an agile approach can be taken to monitoring regulator performance

The review understands that the processes by which regulators investigate complaints about healthcare professionals can feel complex and impenetrable, and this can be further confused if there are ongoing employer or criminal investigations. GMC's fitness to practise guide for doctors sets out the many steps and possible outcomes in the GMC process currently.

Professional regulation reform aims to simplify fitness to practise processes, deliver greater consistency within and across regulators, and enable greater transparency. It also ensures due consideration of the impact on those who raise concerns, alongside appropriate oversight and clearly understood routes for challenging decisions at each stage.

This is also why transparency, appropriate oversight and possible appeals routes were looked at as part of this review.

GMC's Our fitness to practise processes: a guide for doctors (https://www.gmc-uk.org/cdn/documents/dc4524-a-guide-for-doctors-reported-to-the-gmc_pdf-3799410.pdf) (PDF, 420 KB) flowchart details the process of the fitness to practice process. At any stage in a GMC investigation, GMC can refer a registrant to the MPTS for an interim orders tribunal hearing. They can make the referral where it is necessary for the protection of members of the public or is otherwise in the public interest, or is in the interests of the registered professional.

Interim orders are used by regulators to place restrictions on a registrant's registration, on an interim basis, while an investigation takes place ahead of a decision around impairment. These orders can place conditions on registration, or, in the most serious cases, suspend registration. A GMC interim order can last for a period of up to 18 months until it is revoked or extended following an application to the High Court of Justice in England and Wales, the Court of Session in Scotland and the High Court of Justice in Northern Ireland.

Where there are concerns regarding a fitness to practise panel's decision making, this review is supportive of GMC and/or PSA having rights to challenge interim registration measure decisions to the High Court of Justice in England and Wales, the Court of Session and the High Court in Northern Ireland. This is a proportionate additional route to ensuring protection of the public.

Allowing interim decisions to be challenged by PSA could ensure that PSA is able to exercise their responsibility to provide oversight of GMC more quickly and effectively, where PSA deems interim registration decisions made are not sufficient to protect the public and would support in ensuring oversight at all the main points in the regulatory decision making process. It is likely to have a cost implication for PSA.

This recommendation is intended to address the need to improve oversight of regulator decision making and ensure appropriate accountability at every stage of the fitness to practise process. It seems sensible to also consider if this power should be extended to GMC.

Therefore, this review recommends that the government should consult on the following proposal:

PSA and GMC should have a right of appeal against a fitness to practise panel's interim registration measure decision to the High Court of Justice in England and Wales, Court of Session in Scotland or High Court of Justice in Northern Ireland.

PSA and GMC should have a right of appeal against a fitness to practise panel's interim registration measure decision to the High Court of Justice in England and Wales, Court of Session in Scotland or High Court of Justice in Northern Ireland. The review also looked at the appeal arrangements regarding final MPTS hearings. Currently, if evidence suggests that such a serious failure to meet standards that, if proven, a doctor's fitness to practise would be impaired and the safety of the public, or the public's confidence in doctors, may be at risk GMC will refer a case to an MPTS hearing. If GMC has concerns regarding the outcome of that hearing it can currently appeal that decision to the High Court of Justice in England and Wales, the Court of Session in Scotland and the High Court of Justice in Northern Ireland.

When deciding whether to lodge an appeal GMC considers a number of grounds:

- protecting the health, safety and wellbeing of the public
- maintaining public confidence in the medical profession
- maintaining proper professional standards and conduct for members of that profession

PSA can also join a GMC appeal or take over the conduct of an appeal with which GMC decides not to proceed. PSA has the power to bring its own appeal against an MPTS hearing decision where GMC does not bring an appeal. PSA appeals have 2 respondents, the regulator and the registrant - whereas the registrant is the only respondent in a GMC appeal. In addition, the MPTS cannot oppose a GMC or PSA appeal. As a respondent to a PSA appeal, GMC is able to respond to, and take part in, an appeal by PSA. Sir Norman Williams' rapid policy review on gross negligence manslaughter in healthcare (https://www.gov.uk/government/publications/williams-review-into-gross-negligence-manslaughter-in-healthcare), published in June 2018, recommended that the GMC right of appeal be removed from legislation to ensure a consistent approach to appeals across the regulated health professions, and to address increasing levels of registrant mistrust in GMC. This recommendation was accepted by the previous government.

The Williams review found that the principle of a right of appeal against fitness to practise decisions that are considered insufficient to protect the public was universally accepted. It also noted that:

> "The panel's view was that GMC's use of appeals is not excessive. Taken together with the high rate of successful appeals there can be no suggestion that the GMC has used its appeal power inappropriately.

> Indeed it can be argued that these successful appeals have improved patient safety."

This review's position, based on concerns that have been raised regarding the decision-making process and outcomes in a number of high-profile cases that were brought to MPTS, is that these have underlined the importance of having appropriate, timely and proportionate appeals routes at every stage of the fitness to practise process.

As the Williams review noted, GMC has a record of success on the decisions it chooses to appeal. Since GMC right of appeal came into force in January 2016, GMC has issued section 40A appeals in respect of a total of 60 doctors. Of the cases that have completed the GMC are successful in around 70% of cases. Maintaining GMC's appeal right would ensure a route to challenge MPTS decisions which GMC deems insufficient to protect the public, thereby ensuring opportunities for decisions that improve patient safety. However, PSA also has a right of appeal, though it is used less frequently. This gives an appearance that GMC or PSA are applying different criteria when considering appeals. However, the true picture is nuanced. PSA does not join a GMC appeal of an MPTS decision unless it has additional points or grounds of concern that it thinks should be considered. This is to avoid unnecessary duplication and help keep resources focused on appealing cases where no other body is doing so. If retaining the GMC right to appeal was not adopted there would remain a need for a clear, transparent process by which GMC could raise concerns regarding certain MPTS decisions with PSA and transparency on when PSA subsequently decides to use its powers. This is especially true where GMC's expert knowledge may play a role in decision making on taking appeals.

Table 1: PSA appeal numbers

Type of appeal	Number
PSA appeals of GMC cases since 2012 (excluding joined appeals)	26
GMC appeals of MPTS decisions PSA has joined since 2016	11

Addressing some of the other concerns raised by the Williams Review, GMC has taken forward work to set out more clearly the process followed when they use their appeal powers, setting this process out publicly, which includes the convening of an internal panel to make the decision. Work has also been done to address bias in fitness to practice (https://www.gmc-uk.org/about/how-we-work/our-equality-diversity-and-inclusion-programme) by GMC, including commissioning the Fair to Refer report. While bias in the fitness to practise process must be addressed by regulators it is also

influenced by what happens at the employer level (addressed elsewhere in this review); it is crucial that regulators are addressing bias in their own processes, at every stage. The 2024 NMC independent culture review (https://www.nmc.org.uk/about-us/nmc-culture/shaping-our-culture/independent-reviews/) clearly sets out the issues that arise when regulators fail to address racism and bias internally. GMC has made significant progress against its target to eliminate disproportionate fitness to practise referrals by 2026 and become a more inclusive organisation with higher representation of people from ethnic minority backgrounds, and progression for people of ethnic minority backgrounds within its own workforce. This also includes work to develop fairer and more consistent fitness to practise processes and further diversify its investigations teams.

Concerns and mistrust from doctors in this should be balanced with ensuring the right mechanisms exist to challenge decision making. The view of this review is that the approach to appeals should ensure at every stage there are proportionate routes to challenge decision making.

Therefore, this review recommended the government consult on the following proposal, which it has done:

GMC and PSA should retain its right of appeal to the High Court of Justice in England and Wales, the Court of Session in Scotland and the High Court of Justice in Northern Ireland against a fitness to practise panel's final registration measure decision.

Both organisations should continue to publish comparable, detailed information on the use of appeals powers. This must include transparency on how it determines if an appeal is made, how it draws on expertise and regularly published, clearly set out detailed data, including appeal outcomes.

In the previous 2021 regulating healthcare professionals consultation, it was proposed that any legislative restrictions on regulators from being able to consider fitness to practise concerns more than 5 years after they came to light should be removed from legislation. Section 35CC, subsection (5), of the Medical Act 1983, permits GMC to make rules preventing allegations that are more than 5 years old from being investigated unless it is deemed it is in the public interest to investigate these allegations. Rule 4(5) of The General Medical Council (Fitness to Practise) Rules Order of Council 2004 (https://www.legislation.gov.uk/uksi/2004/2608/made), commonly known as the 5-year rule, makes rules to this effect.

The draft GMC order 2026 does not include a rule-making power which would allow GMC to replicate its current 5-year rule. The removal of the 5-year rule will help to ensure robust and continued means to challenge concerns about unfitness to practise so that patients can be kept safe. The review supports the removal of the 5-year rule applied by GMC. Its inclusion

does not seem to support either holding registrants to account or protection of the public when concerns emerge at a later date.

Throughout the function of its statutory duties GMC, like all other healthcare regulators should be able to be held to account for their decision making. This review's position is that the PSA should be given greater powers to compel the professional regulators it oversees to provide information to this end. As the GMC Order consultation provides an opportunity to address this in relation to the GMC this review recommended that the government consult on this proposal, which it has done:

The PSA should have the power to compel information from the GMC in order to fulfil its statutory duties and with respect to its rights of appeal, and to ensure an agile approach can be taken to monitoring regulator performance.

> Recommendation 25: the government should carefully consider the results of the General Medical Council (GMC) reform consultation, which contains the proposals set out in this sub-chapter, to ensure GMC reform includes efficient and proportionate regulatory oversight and decision making.

Primary care and the performers lists

In addition to the role of the responsible officer for doctors, further clinical governance arrangements apply in primary care. As well as being included on the register of their respective professional regulator, practitioners working in primary care in England must be included on the relevant performers list.

The National Health Service (Performers Lists) England Regulations 2013 (https://www.legislation.gov.uk/uksi/2013/335/contents) ('The Performers Lists Regulations'), give assurance that performers included in the list are suitable ('fit for purpose') to work independently to deliver NHS primary care services in England. The Performers Lists Regulations provide an important legal framework for ensuring that medical, dental and ophthalmic practitioners who contract with NHS England are qualified and competent to provide safe and effective services in primary care settings, where many practitioners are independent contractors practising without the oversight of an employer. A practitioner wishing to work in NHS primary care must satisfy checks, equivalent to employment checks, to be accepted on a Performers List. The Performers List Regulations then give NHS England powers to manage practitioners where necessary through imposing

conditions on their practice, suspending or removing them from a performers list. The Performers List Regulations allow NHS England to manage concerns about performers when their fitness for purpose is called into question and, if the concern raises a question about the individual's fitness to practise, to also refer the matter to the appropriate professional regulator. This review considered the role of the performers list in protecting the public.

Recommendation 26: the Secretary of State should consider making amendments to the Performers List Regulations to enable conditions to apply on 'suitability' grounds, not only on 'efficiency' grounds. This may give more options to impose conditions in cases of practitioners expressing racist or extremist views where concerns relate to the conduct of the practitioner but not necessarily their clinical performance or the efficiency of the service.

Protection and support for staff

Our NHS workforce is diverse, as are the communities it serves. Workforce data shows nearly 500,000 Black and minority ethnic staff are working in NHS trusts and integrated care boards in England. The staff who are the backbone of our national health system should not be subject to racism or religious hatred at their place of work. The NHS Constitution (https://www.gov.uk/government/publications/the-nhs-constitution-for-england) in England, to which all NHS bodies and all providers of NHS care (including primary care providers and sub-contractors) operating in England have a statutory duty to have regard, is clear that access to NHS treatment is contingent on patients and the public acting in a respectful way. The NHS constitution sets out the responsibilities and rights of both patients and staff. In detailing the responsibilities of patients, it is clear in stating to 'treat NHS staff and other patients with respect and recognise that violence, or the causing of nuisance or disturbance on NHS premises, could result in prosecution. You should recognise that abusive and violent behaviour could result in you being refused access to NHS services.'

This is reinforced by the NHS standard contract 7.2.3, which confirms that a provider is not required to provide or continue to provide a service to a patient '…who displays abusive, violent or threatening behaviour unacceptable to the Provider, or behaviour which the Provider determines constitutes discrimination or harassment towards any Staff or other Service User', with the provider "in each case acting reasonably and taking into account that Service User's mental health and clinical presentation and any other health conditions which may influence their behaviour". Through the

civility and respect programme (https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/civility-and-respect/), NHS England also provides national guidance, training and resources to help organisations build positive workplace cultures, tackle bullying and harassment, and ensure staff and volunteers feel safe and supported in all work environments.

However, it is clear that racism towards staff continues to be a significant problem in the NHS. Recently published data by the Royal College of Nursing (2025) showed a 55% increase in the number of calls to its helpline about incidents of racism at work over the past 3 years. The latest available NHS staff survey data shows that across the NHS, a higher proportion of Black and minority ethnic staff, and staff from most religious groups, including Jewish, compared to White staff and non-religious staff, experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This is twinned with trusts reporting a higher percentage of Black and minority ethnic staff than White staff (https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/), and a higher percentage of staff of almost all religious groups (compared to non-religious), including Jewish staff, experiencing discrimination from a manager or team leader or other colleagues.

As has been made clear, a patient failing to present because of their avoidable perception of an NHS employee, or the perceived bias of a medical practitioner or other employee, does not always have the option to seek alternatives. However, there is a fundamental different between perceived and presumed bias or racism. An NHS employee has an obligation to consider the impact of their behaviour and actions on an actual or a potential patient. They also have the right to protection against racism, or bias from presenting patients and those that accompany them. This is also true for NHS staff who might work alone out in community settings or other non-hospital settings. It is not clear all trusts have policies that are consistently applied to address incidents of racism towards staff, or that make clear that all staff, from senior leaders to all those that witness harm, have a responsibility to speak up and act. There is need for clear guidance, for both trusts and the public on what action or models trusts can take to address racism. There is also an equal and precise requirement to be inclusive of all work colleagues, whether immediate or at a distance. It is right that the public harassment of other identifiable persons or named NHS colleagues because of their race and religion, and because of presumptions and prejudices about that race or religion, is considered a disciplinary offence in itself.

Recommendation 27: establish national guidance, building on and updating the guidance issued following the 2024 riots, to support organisations when staff face violence or discrimination from patients or the public. This should include clear, context-specific guidance on how, in non-life threatening situations, trusts

support staff to refuse access to services (to protect their safety and dignity). It is recommended that the NHS, the Department of Health and Social Care and others work closely with the UK healthcare professional regulators and patient and staff representatives to update this guidance, ensuring alignment with existing regulator guidance on this matter, and relevant legal duties. This should include real life examples of how NHS employers can protect staff. NHS employers should be held to account for implementing this guidance consistently and for taking firm action to protect staff.

Performance on the NHS staff survey questions regarding staff experience of violence will be part of the new staff standards score in the NOF.

Staff networks are incredibly important for supporting staff and helping foster a fair and inclusive work environment. They are invaluable in providing safe spaces for staff to make connections, collaborate with colleagues with similar experiences, be open about challenges people may be facing and share expertise that can help inform colleagues, senior leaders and boards. The NHS England Jewish Staff Network (JSN) has been a vital support for Jewish employees and an advisory group for culturally competent policy implementation. With the government's plan to merge NHS England into DHSC by 2027, there is concern about the continuity of this network.

Recommendation 28: the Secretary of State should confirm that NHS England faith and ethnicity-based networks will be supported during and after the transition into the Department of Health and Social Care with a structure agreed with its members. This includes supporting smaller networks, like NHS England Jewish Staff Network (JSN).

Education, training and development

There is more work to be done to ensure that the existing NHS workforce has the capabilities needed to foster an inclusive and safe culture. This means providing access to appropriate training and development and, as this report has already set out, setting clear expectations on behaviour, across all levels and parts of the workforce, with specific input from experts and subject matter representative groups. It is equally important for the NHS to retain the existing workforce, and to do this, employers must improve staff experience and fully support staff to feel safe and instil confidence that their organisations will take EDI matters seriously and properly address concerns about racism. Preventative action in this space should focus on

partnership working with education providers to promote cultural diversity and prevent racism, including within clinical placements and training environments.

We will shortly see the publication of a series of staff standards for the NHS. Announced in the 10 Year Health Plan, these will outline minimum standards for employment across a range of areas in order to improve staff experience. This will include a standard focused on tackling racism in the NHS which will set out how NHS organisations must prioritise, prevent, respond to, and ultimately learn from, incidents of racism in the NHS workplace. The standard will set the expectation that their organisation will take the sustained and significant action to prevent and tackle racism. A new composite score in the NOF for the new standards will ensure clearer accountability and consequences for organisations. Building on NHS England's 2023 EDI improvement plan, WRES is clear that organisations should be developing clear and transparent plans for how they intend to improve the recruitment and retention of minority ethnic staff at all levels and structured career pathways to enable staff progression into senior roles. (We anticipate that the College of Leadership and Management will also play an important role here by supporting greater diversity across all levels of leadership and in supporting the development of diverse talent pipelines towards board level roles). During periods of organisational change, including restructures and redundancies, there should be a clear expectation - underpinned by robust data - that progress on diversity is maintained and not eroded. This requirement will be further reinforced through the new NHS staff standards and the CQC inspection regime through their 'well led' domain.

Pre-registration training

In order for the NHS and the health sector more broadly to be a safe and welcoming space for Jewish and other people, the culture and expectations must be set at the earliest possible stage. Lord Mann has been shocked at some of the examples shared regarding conduct in medical schools. The way in which these schools appear to have been considered as separate to the wider higher education sector is regrettable and the position and conduct of Medical Royal Colleges also needs addressing.

Students who aspire to work as regulated healthcare professionals in the UK should be aware that they are expected to maintain certain standards and these can extend to their time as students. Many health and care professional regulators provide guidance to students (https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/student-professionalism-and-ftp/achieving-good-medical-practice) and universities should ensure students are made aware of this.

All universities, including their medical schools, should be reviewing as a matter of urgency, the recommendations of the All-Party report on best practice in higher education (https://antisemitism.org.uk/publication/parliamentary-taskforce-on-antisemitism-in-higher-education-good-practice-guide/), the report from the Union of Jewish Students 'Time for Change (https://www.ujs.org.uk/publications)' and the Universities UK guidance on tackling antisemitism (https://www.universitiesuk.ac.uk/what-we-do/policy-and-research/publications/features/tackling-harassment/tackling-antisemitism-practical-guidance). In the same way that antisemitism in the NHS should be an employment matter, Lord Mann recommends that:

> Recommendation 29: medical schools council leadership should undertake anti-racism training, specifically including antisemitism, and work with Lord Mann's offices on a communication to all medical schools about tackling racism including antisemitism, to be updated as required.

> Recommendation 30: medical schools should consider the full range of disciplinary sanctions and processes at their disposal to address anti-Jewish hatred and abuse in educational settings. They should also ensure they comply with the relevant Office for Students (OfS) requirements around data collection and reporting on incidents of harassment. OfS should consider where they can add value through communications, engagement and reporting on anti-Jewish harassment, and the health and care professional regulators must review their student professionalism standards in line with the recommendations in this report.

Considerations of professionalism extend to those that hold positions in important institutions in the healthcare system, including in Medical Royal Colleges. While most positions are voluntary and they provide an integral part of the health landscape, their level of visibility and position of responsibility means upholding professional standards is of even greater importance.

> Recommendation 31: the Academy of Medical Royal Colleges should work with its members, potentially using their equality, diversity and inclusion network to ensure each organisation has the training needed to fully understand anti-Jewish hatred and abuse, and other forms of racism.

The Academy of Medical Royal Colleges (AoMRC) and Medical Royal Colleges should ensure, when issues arise that they are using the full range of disciplinary sanctions and processes at their disposal to address anti-Jewish hatred and abuse, and other forms of racism among their members.

Training for all NHS staff

For the NHS and other healthcare services, anti-racism (and cultural competence) training should be mandatory as this will support understanding that underpins locally agreed grievance or disciplinary policies, for example. Such training already is mandatory in many cases, including development for boards or those in management or leadership positions. Evidence indicates that the development of a holistic approach to training, including continued sessions over time building on initial content to develop expertise, will ensure higher retention and enhanced knowledge, allowing organisations to work towards embedding understanding of racism, including antisemitism into workplace culture and practices. The following recommendation will support in providing NHS staff with the knowledge and competencies they will need to help address racism within their organisations.

Recommendation 32: the NHS mandatory training module on equality, diversity and human rights - which is accessed by 1.5 million people - requires urgent updating and the specific inclusion of quality assured content on antisemitism and anti-Muslim hostility. Subject matter experts should be consulted as part of the content review and update. Staff should be required to undertake this training, once updated, without delay and not wait until the 3-year cycle renews. This training will be replaced in 2026 with another training framework which must include the aforementioned quality-assured materials.

Training for health professionals outside the NHS

NHS anti-racism training is not available to some professions - for example, osteopaths and chiropractors - who mostly work in independent practice. This review is aware that both the General Osteopathic Council and General Chiropractic Council would welcome discussion about how to make training available to all regulated practitioners and not just those within the NHS. This would serve to up-skill the UK workforce to a consistent level.

Recommendation 33: this review recommends that the Department of Health and Social Care convene a meeting specifically on training, with all of those bodies representing individuals not captured by NHS training, to discuss and find a path to delivering training.

NMC has worked with expert providers to develop bespoke sessions that run like case clinics, considering scenarios and case studies to enhance expertise, build capacity for identifying and unpacking nuances and complexities in referrals, and to develop the right skills to ensure cases are not closed prematurely. This should be used as a model across other regulatory bodies and the NHS and information shared through the forums noted in recommendation 17. The use of independent, expert reviewers for complex or high-risk cases should be considered to prevent bias or minimisation. DHSC should support by providing recommendations of appropriate expert providers to ensure a consistent approach to specialist training across NHS trusts, health and care professional regulators and arm's length bodies.

Development for NHS leaders

This report has already highlighted the leading role that strong and effective leadership plays in tackling racism and therefore it is particularly important that anti-racism and cultural competency training is mandated for those at board level or in leadership or management positions. The forthcoming NHS College of Leadership and Management can play a role in providing access to this. For senior leaders there should be sustained, reflective development to build awareness of personal bias and support behavioural change. As board executives are required to have oversight of locally agreed grievance and disciplinary policies, they must have sufficient understanding of racism, including antisemitism, to ensure such policies are robust.

Work has commenced to redesign the NHS staff appraisal system as part of the delivery of the Messenger Review recommendations (https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future). The revised appraisal system is intended to strengthen the link between performance, professional standards, behaviours, and career development, with implementation expected to take between 1 and 2 years. For senior leaders, this presents a significant opportunity to set explicit, measurable EDI objectives and to strengthen accountability for delivery through appraisal and performance management processes. The intention is that standards will evolve over time but updates to the standards could include more explicit references to anti-racism, EDI, and dealing effectively with racist incidents as part of

expected management behaviours. The NOF, the forthcoming staff standards, management and leadership framework including a code of practice, standards and competencies, and the NHS College of Leadership and Management provide important tools for embedding these expectations consistently across the NHS.

> Recommendation 34: there must be mandatory training for the approximately 400 chairs and chief executives of NHS provider trusts on antisemitism, anti-racism and building on the Macpherson principles, within the next 6 months.

This training should support leaders to understand how they can take evidence-based actions to address discrimination and effect change in their organisations, building on NOF and the staff standards. Consideration should also be given to how this might be extended to integrated care boards and primary care networks leadership.

> Recommendation 35: the leaders of the UK health and care system and professional regulators should ensure they undertake similar training, if they have not already done so.

> Recommendation 36: the proposed NHS College of Leadership and Management must reinforce the importance of the training elements on antisemitism and other forms of racism and play a major role in embedding expectations and providing access to further, comprehensive training for leaders and managers. The training should be monitored and reported on publicly with input from relevant stakeholders to ensure it is having the desired impact.

The recent training developed by the BBC for all its staff may provide a model for this.

Conclusion

The case for taking action to combat antisemitism and other forms of racism in the NHS is clear. The NHS is the largest employer in the country and should play a leading role in addressing such discrimination. NHS staff deserve a place of work free from discrimination where they feel safe and supported, and NHS patients - across all communities - deserve to access

high quality health care in the knowledge they will be treated fairly and equally.

This review has examined how employers and professional regulators are currently dealing with incidents of racism and has set clear, actionable steps that are needed in every part and at every level of the health system to tackle antisemitism and other forms of racism.

Everybody across the health and care system must take responsibility for going further to progress a culture concerned with opposing and preventing antisemitism and other forms of racism and ensuring they are well equipped to address concerns about racism where and when they do arise.

The actions recommended by this review should be the minimum of changes made to ensure the problem of racism, including antisemitism, in the NHS is improved and will require hard work and accountability for outcomes for both NHS employers and health and care system and professional regulators. The government should report back to Parliament on progress made against the recommendations in this report, providing an initial update by October 2026 and a detailed report within 12 months of this review being made public.

Acknowledgements

Lord Mann and the review team would like to extend thanks to everyone involved in contributing to this report, through providing evidence, expert subject matter views and lived experience, through to reflection and valuable discussion during the development of the review. Particular thanks to the Antisemitism Policy Trust, who provided the secretariat for Lord Mann in his role as an independent government advisor on antisemitism, and for its support throughout this review. The review received input from Jewish representative organisations including the Jewish Medical Association and members of the cross-government antisemitism working group. System partners including NHS England, NHS Chief People Officers groups, the NHS Race and Health Observatory, NHS Providers, NHS Employers, and the UK health and care professional and system regulators. Other professional, representative groups and staff bodies, including the British Islamic Medical Association, the British Medical Association, the Academy of Medical Royal Colleges, and union representatives via the Social Partnership Forum, Leaders of NHS EDI networks, and independent subject matter experts provided input and expertise. A number of government departments have taken the time to engage with us, as well as officials from the devolved administrations. Your individual and collective contributions to this review have been hugely valuable and we look forward to continuing conversations with stakeholders following publication of this report. Lord

Mann would also like to extend his thanks to the Department of Health and Social Care team who supported his work in delivering this review.

Annex A: terms of reference for the review of antisemitism, other forms of racism and the oversight and regulation of healthcare professionals

1. Purpose

This review will examine how the regulatory system for health and care professionals, from employment through to national oversight and system and professional regulatory bodies, supports recognition and reporting of antisemitism and other forms of racism, and tackles it at every stage. In particular, the review will seek to answer 2 principal questions:

1. How do we make sure in the NHS that perpetrators of antisemitism and other forms of racism are held to account with effective action taken to tackle their behaviour?
2. How do we make sure that patients and staff are safe from racism within the NHS and professional healthcare regulation system?

The review will make recommendations for the Department of Health and Social Care and NHS England on how to root out antisemitism and other forms of racism across the healthcare system.

2. Objectives and scope

This review will consider employer actions, regulator powers and responsibilities, and the role of the performers lists in primary care. It will consider their effectiveness and any deficiencies in addressing antisemitism and other forms of racism. This will include considering:

- how regulators address complaints of antisemitism and other forms of racism throughout, from a complaint being raised, to investigation and fitness to practise proceedings

- how greater transparency can be brought to regulatory processes, including GMC investigations and MPTS decision making on antisemitism and other racism complaints
- how the whole systems can adopt clearer, confidential reporting mechanisms
- how the NHS and the regulatory system can root out racism, including antisemitism, more effectively. This includes:
  - how zero tolerance policies, with consequences for violations can be effectively adopted across the NHS
  - the role that training can play, including in reducing incidences of antisemitism and other forms of racism and improving responses when it occurs
  - how standards for NHS staff conduct inside and outside of work can be adopted, shared and enforced
  - any legislative constraints affecting the health and care regulatory system's ability to address antisemitism and other forms of racism

The review will not touch on those aspects of delivering healthcare that are devolved to Scotland, Wales and Northern Ireland.

3. Governance and reporting

This review will make practical recommendations to the Secretary of State on how to address antisemitism and other forms of racism within the NHS and health and care regulatory system.

4. Deliverables and outputs

This review will report to the Secretary of State within 6 weeks of starting, with the option for a final report to follow as determined by the reviewer.

5. Context and supplementary

The department and ministers will need to consider the findings of the report on its receipt and may request Lord Mann's additional assistance post-receipt, as necessary.

Annex B: UK health and care professional regulators and the professions they regulate

The UK's health and care professional regulators are:

- the General Medical Council (GMC)
- the Nursing and Midwifery Council (NMC)
- the General Dental Council (GDC)
- the General Pharmaceutical Council (GPhC)
- the Pharmaceutical Society of Northern Ireland (PSNI)
- the General Optical Council (GOC)
- the General Osteopathic Council (GOsC)
- the General Chiropractic Council (GCC)
- Social Work England (SWE)
- the Health and Care Professions Council (HCPC)

GMC regulates:

- medical practitioners (doctors)
- physician associates
- anaesthesia associates

NMC regulates:

- registered nurses
- midwives
- nursing associates (England only)

GDC regulates:

- dentists
- dental nurses
- dental hygienists
- dental therapists
- dental technicians

- clinical dental technicians
- orthodontic therapists

GPhC regulates:

- pharmacists (England, Scotland and Wales only)
- pharmacy technicians (England, Scotland and Wales only)

PSNI regulates pharmacists in Northern Ireland only.

GOC regulates:

- optometrists
- dispensing opticians
- student optometrists and dispensing opticians

GOsC regulates osteopaths.

GCC regulates chiropractors.

SWE regulates social workers (England only).

HCPC regulates:

- arts therapists
- biomedical scientists
- chiropodists and podiatrists
- clinical scientists
- dietitians
- hearing aid dispensers
- occupational therapists
- operating department practitioners
- orthoptists
- paramedics
- physiotherapists
- practitioner psychologists
- prosthetists and orthotists
- radiographers

Note that PSNI and SWE were not contacted to provide evidence during the development stages of the review.

Annex C: professional regulatory guidance on student conduct and professionalism

Across all regulators, students are expected to:

- maintain high standards of professional behaviour at all times, including outside formal training environments
- prioritise patient safety, including raising concerns where appropriate
- work within the limits of their competence and supervision
- demonstrate honesty, integrity, confidentiality and respect
- recognise that fitness to practise applies from the outset of training

Role of education providers

Universities and training providers are responsible for monitoring and assessing student professionalism and fitness to practise.

Providers must have procedures to identify and manage concerns about conduct.

Students who fail to meet required standards may face disciplinary action or removal from programmes, preventing progression to registration.

Guidance on student conduct and professionalism by regulator

Where a regulator does not publish separate guidance, students and education providers are expected to refer to the regulator's core professional standards for education and training and fitness to practise.

General Medical Council (GMC)
For students: Achieving good medical practice: guidance for medical students (https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/student-professionalism-and-ftp/achieving-good-medical-practice) and Achieving good medical practice: guidance for PA and AA students

(https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/student-professionalism-and-ftp/achieving-good-medical-practice-for-pa-and-aa-students)

For education providers: Professional behaviour and fitness to practise (https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/student-professionalism-and-ftp/professional-behaviour-and-fitness-to-practise) (medical students) and Professional behaviour and fitness to practise - guidance for course providers (https://www.gmc-uk.org/education/standards-guidance-and-curricula/guidance/student-professionalism-and-ftp/professional-behaviour-and-fitness-to-practise---guidance-for-course-providers) (PA and AA students)

Nursing and Midwifery Council (NMC)
For students: The Code: Professional standards of practice and behaviour (https://www.nmc.org.uk/standards/code/)

For education providers: Health and character guidance for AEIs (https://www.nmc.org.uk/registration/joining-the-register/health-and-character/good-health-and-good-character-for-aeis/)

General Dental Council (GDC)
For students: Student professionalism and fitness to practise - an introduction for students (https://www.gdc-uk.org/education-cpd/students-and-trainees/becoming-a-member-of-the-dental-team/guidance-for-students)

For education providers: Student professionalism and fitness to practise - guidance for training providers (https://www.gdc-uk.org/education-cpd/students-and-trainees/becoming-a-member-of-the-dental-team/guidance-for-students)

Health and Care Professions Council (HCPC)
For students and education providers: Guidance on conduct and ethics for students (https://www.hcpc-uk.org/resources/guidance/guidance-on-conduct-and-ethics-for-students/)

General Pharmaceutical Council (GPhC)
For students and education providers: Guidance on managing fitness to practise concerns in education and training (https://www.pharmacyregulation.org/students-and-trainees/education-and-training-providers/fitness-practise-concerns-pharmacy-education-and-training)

General Optical Council (GOC)
For students and education providers: Standards for Optical Students (https://optical.org/standards-and-guidance/standards/standards-for-optical-students.html)

General Osteopathic Council (GOsC)
For students and education providers: Guidance on Professional Behaviours and Student Fitness to Practise in Osteopathic Education

(https://www.osteopathy.org.uk/training-and-registering/becoming-an-osteopath/student-fitness-to-practise/)

General Chiropractic Council (GCC)
For education providers: Code of Professional Practice (https://www.gcc-uk.org/i-am-a-chiropractor/the-code-of-professional-practice)

Social Work England (SWE)
For students and education providers: Guidance on Professional standards (https://www.socialworkengland.org.uk/standards/professional-standards-guidance/)

Pharmaceutical Society of Northern Ireland (PSNI)
For students and education providers: Standards for the initial education and training of pharmacists (https://psni.org.uk/training/)