The Principles for anti-racism

Last Updated: 29/10/2026

The principles recognise that racism is embedded in structures, policies, processes, power, and culture, not only in individual behaviour. Effective anti-racism should therefore address professional conduct, organisational design, leadership decisions, and regulatory influence.

This includes recognising and addressing all forms of racism and discrimination, including anti-Jewish hate and anti-Muslim hate, and other forms of prejudice based on identity, culture, ethnicity, and faith, as they manifest within healthcare systems.

While these principles address racism explicitly, the evidence is clear that tackling racial injustice improves safety, equity, and inclusion for all marginalised groups, recognising intersectionality and local context.

1. Culture, equity and inclusion

Individuals and organisations should recognise anti-racist as fundamental to patient safety and public protection and as a legal requirement. Midwifery and nursing practice must actively address racism, religious hate, and other forms of discrimination, alongside racialised inequalities, as core components of safe, effective, and compassionate care.

This requires embedding anti-racist practice, bias awareness, cultural safety, curiosity and respect and having professional curiosity and equity as core expectations across education, practice learning, assessment, and continuing professional development (CPD).

Cultural humility, respect, and responsiveness are essential elements of professional conduct, and include self-reflective practice, valuing lived experience, and recognising and addressing both conscious and implicit bias.

Action should be taken at individual, organisational and sector level. All have a responsibility to raise concerns in line with our Raising Concerns guidance, to challenge racist behaviour and practice, and interrupt bias where these are seen, to ensure that the care provided does not further entrench structural inequalities. This also includes individuals consciously monitoring their own biases.

Individuals and organisations should ensure that care, education, and supervision are culturally safe, as defined by those receiving them. This includes actively preventing harm, humiliation, exclusion, and power-based inequities.

Registrants must always uphold anti-racist values, recognising that conduct outside professional settings, including on social media and in public or political activity can affect public trust in the profession. They must not engage in or endorse racist or discriminatory behaviour in any context.

Providers and AEIs should address structural inequities, remove barriers to equitable care, and ensure curricula reflect diverse perspectives to prepare learners to address health inequalities and structural injustice.

2. Learning, education and workforce diversity developments

Workforce development should prioritise patient safety, wellbeing, inclusion and belonging, ensuring learning environments model culturally safe, curious, and respectful, anti-racist, bias aware practice and explicitly respond to intersectional challenges.

Educators, practice supervisors, and assessors should be equipped to deliver inclusive, evidence-based teaching, ensure fair and unbiased assessment processes, and support and embed reflective and reflexive practice, including the ability to recognise and respond to intersectional bias, awarding gaps and differential attainment. This includes measuring, publishing, and acting on award and attainment gaps.

AEIs should develop proactive interventions to interrupt and challenge race discrimination and bias, for instance by using evidence-based learning resources.

One example of how AEIs can disrupt bias would be to share the film 22+1 with student midwives. 22+1 is a short film that outlines a woman's journey following a late miscarriage. It explores the story of an interracial couple navigating the

grief of pregnancy loss, while confronted with the underlaying layer of racism in the health and care sector.

AEIs should also ensure education around privilege and intersectionality to embed understanding of anti-racism and equality principles more widely.

Organisations should foster and embed psychological safety, enabling meaningful feedback, promoting allyship and advocacy for all, safe speaking up and raising concerns processes. This should include support for those who do raise concerns, enabling supportive team cultures that value diversity and promote patient safety.

AEIs should ensure students are exposed to diverse communities, cultures and lived experiences throughout education and practice learning, recognising that local populations may not reflect the diversity of the wider population. Programmes should proactively develop cultural awareness, curiosity and understanding to reduce the risk of future bias arising from limited exposure or experience.

3. Community and person-centred practice

Practice should be grounded in co-production with service users, their families, and communities, ensuring engagement is trauma informed, ethical, and respectful – particularly for those experiencing inequalities and inequities.

Practice must recognise and respond to the cultural and faith-based needs of individuals and communities, including those of Jewish and Muslim service users and other minority communities, ensuring care is respectful, informed, and free from discrimination.

Lived experience should clearly feed into assurance, evaluation and improvement cycles, including through case studies, service user engagement and feedback loops in implementation.

Registrants should proactively challenge racist stereotypes such as 'Black women don't feel pain' or 'Black women have a higher pain threshold', or sickle cell sufferers' pain being classed as drug seeking behaviour. These stereotypes can lead to service users receiving care that is not culturally sensitive nor individualised or person-centred, resulting in inferior care.

Registrants should always be aware of intersectional factors that can exacerbate inequitable outcomes of care, such as, but not limited to, social determinants such as low socio-economic status, being subject to domestic abuse or being LGBTQ+.

Registrants and students should prioritise respect, collaboration with individuals in their care, autonomy, and continuity of care, building trusting relationships that improve outcomes for all.

Develop, strengthen, and embed a sector that understands and considers at all stages of education and practice both the macro and micro context of lived experiences and how that impacts on care delivery.

4. Assurance, accountability and sector improvement

The sector should demonstrate inclusive, accountable leadership and team cultures and translate principles into clear implementation pathways.

Leaders at all levels should contribute to shared learning and should demonstrate accountability for anti-racist practice and outcomes.

Chief Nursing Officers, Chief Midwifery Officers, or other executive sponsors, should consider providing regular, confidential opportunities – such as biannual meetings – for students to share experiences, raise concerns, and be heard in a psychologically safe environment.

Organisations should embed anti-racism within governance, decision-making, and performance frameworks, ensuring sustained and measurable change.

Accountability for equitable, anti-racist practice applies to individuals, providers and AEIs, requiring documentation, active responses to discrimination, support, and reflective learning, recognising that diversity is complex and multidimensional.

Anti-racism should be visible and reinforced through the Code, standards, proficiencies, education requirements, and quality assurance processes. It should be seen as core professional practice, not an additional or optional expectation.

Ongoing monitoring, evaluation, and data use are essential to identify inequalities, and target areas of intervention, with practical steps taken to address inequalities identified and act as a vehicle to drive continuous improvement and support sector wide collaboration. Impact of interventions on patient safety should be measured and regularly reported through properly owned assurance mechanisms.