

Equality and Human Rights Commission  
Sent via email: [RI@equalityhumanrights.com](mailto:RI@equalityhumanrights.com)

26 February 2021

## Racial inequality in health and social care workplaces

### About the BMA

The BMA (British Medical Association) is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

### Summary

We welcome the Equality and Human Rights Commission's inquiry into racial inequality in health and social care workplaces.

We acknowledge that the inquiry's focus on workers in lower-paid roles does not apply to our members. We are responding to share our concerns and recommendations as we believe that structural inequalities and racism in the NHS affect workers from ethnic minority backgrounds in all roles. Whilst some of our evidence is doctor-specific, we hope that it may be helpful in identifying areas of concern.

We believe that urgent action is needed to tackle racial inequalities and ensure that the NHS fosters a diverse and inclusive environment. This will not only benefit staff. An inclusive NHS where all staff, including privately contracted staff, are valued and treated fairly will allow the NHS to function as best as it can and benefit patient care.

We are deeply concerned by the tragically high, and disproportionate Covid-19 death rate for healthcare workers from ethnic minority backgrounds. We believe that PPE shortages, unequal distribution of PPE, and delays in undertaking risk assessments likely played a part in this tragedy. We are also concerned that workplace culture issues, such as staff not feeling comfortable to raise safety concerns, may have placed some ethnic minority healthcare workers at greater risk.

**Chief executive officer:** Tom Grinyer

Registered as a Company limited by Guarantee. Registered No. 8848 England.  
Registered office: BMA House, Tavistock Square, London, WC1H 9JP.  
Listed as a Trade Union under the Trade Union and Labour Relations Act 1974.



## Evidence of structural inequalities

Despite the numbers of ethnic minority doctors growing in the medical profession – currently around 2 in 5 doctors currently record their ethnicity as Black, Asian or minority ethnic – inequalities persist about how they are treated.

A BMA survey in 2018 found that only 55% of black and minority ethnic doctors said there was respect for diversity and a culture of inclusion in their main place of work compared to 75% of white doctors. <sup>1</sup>Black and minority ethnic doctors were also more than twice as likely as white doctors to agree that bullying and harassment is often a problem.<sup>2</sup>

Data from the NHS England Workforce Race Equality Standard (the WRES) evidences disparities in treatment and experience across the whole workforce. The 2019 WRES found that white applicants were 1.46 times more likely to be appointed from shortlisting compared to ethnic minority applicants. <sup>3</sup> It also found that white applicants were 1.15 times more likely to access non-mandatory training and continuous professional development than ethnic minority staff. We anticipate that 2020 NHS WRES data will be published soon.

Despite the fact that 19.7% of staff working for NHS trusts and CCGs in England are from an ethnic minority background, only 6.5% of staff at very senior manager level are from ethnic minority backgrounds.

Whilst there has been progress at board level but there is still a lot to be done. As recently as 2014, two-fifths of all London NHS trusts had no ethnic minority members. As at December 2019, every London trust had at least one ethnic minority board member. Across England, just 8.4% of board members of NHS trusts are from ethnic minority backgrounds.

We believe that the collection and publication of analysis of similar data on workforce demographics and experiences, broken down by protected characteristics for Scotland, Wales, and Northern Ireland is needed.

### Health of the healthcare workforce

Within the healthcare workforce, as at April 2020, a shocking 61% of 200 healthcare workers who had died from Covid-19 have come from ethnic minority backgrounds. <sup>4</sup> Among doctors, over 85% of those who have died from COVID-19 have been from ethnic minority backgrounds. <sup>5</sup> This is more than double the proportion of ethnic minority doctors in the medical workforce as a whole.

The BMA wrote to Sir Simon Stevens in April 2020 asking that NHS England collect and share data on the mortality of healthcare workers with Covid-19 with consideration of work settings, roles, shift frequency and shift duration, PPE used, and duration of exposure for different groups of doctors. We are not aware that these data has been collected or analysed and we are disappointed to still be reliant on April 2020 data for information about the mortality of all healthcare workers. We were also disappointed that the PHE review into inequalities in the impact of COVID-19<sup>6</sup> did not

---

<sup>1</sup> BMA Future vision for the NHS: All member survey (2018) <https://www.bma.org.uk/collective-voice/policy-andresearch/nhs-structure-and-delivery/future-vision-for-the-nhs/future-vision-for-the-nhs-survey>

<sup>2</sup> Ibid.

<sup>3</sup> NHS Workforce Race Equality Standard 2019

<sup>4</sup> Health Service Journal Deaths of NHS staff from COVID-19 analysed (April 2020)

<sup>5</sup> This is based on information the BMA has been collecting based on media reports and our records.

<sup>6</sup> Public Health England [Covid-19: Review of disparities in risks and outcomes](#) (June 2020)

investigate or make any recommendations to address the disproportionate deaths of ethnic minority healthcare workers, despite the overwhelming number of deaths among these groups.

The BMA believes PPE shortages, unequal distribution of PPE, and delays in undertaking risk assessments likely played a part in this tragedy.

We are continuing to call on the government to ensure the design and supply of PPE considers diversity of need, particularly by ethnicity, faith, and gender. We have heard from our members about issues with the fit of facial PPE. This includes the lack of smaller-sized PPE, and that all PPE sizes, including small, have been designed to fit a male face shape. Our Covid-19 tracker surveys have also found that ethnic minority doctors are less likely to pass the fit test first time.

Without properly fitting face protection, the health of workers is being put at risk. Respiratory protective equipment must be properly fitting, in line with [HSE guidance](#), and readily available.

Throughout last year, we continued to hear instances of doctors experiencing difficulties in accessing PPE that is consistent with religious dress practices. It is essential that the provision of alternative PPE such as hoods, which allow workers to keep up their religious dress practices (such as wearing a beard or hijab), are readily provided and the provision of alternative PPE (such as hoods), should be made available, as necessary.

We are concerned too that workplace culture issues have placed some ethnic minority doctors at greater risk. These are groups who have historically faced discrimination or feel like outsiders in UK workplaces and it can be particularly hard for them to raise concerns about safety or seek help. <sup>7</sup>A BMA all-member survey in 2018 found that ethnic minority doctors were twice as likely as white doctors to say they would not feel confident raising concerns.

The BMA's COVID-19 tracker surveys also consistently found that ethnic minority doctors were much more likely than white doctors to say they felt pressured to see patients without adequate PPE. For example, our April survey found 64% of ethnic minority doctors in high risk settings feeling pressured compared to 33% of White staff. <sup>8</sup> We note that whilst our evidence on this is doctor-specific, we would welcome the inquiry looking into this issue for all healthcare workers.

We welcome the [UK-REACH study](#) investigating the risk of Covid-19 to healthcare workers from ethnic minority backgrounds, for which we sit on the stakeholder advisory group. We have urged the government to act swiftly on the findings when published.

---

<sup>7</sup> See GMC Fair to Refer (2019)

<sup>8</sup> BMA (April 2020) BAME doctors hit worse by lack of PPE

## BMA recommendations

### More diverse ethnic representation in NHS leadership and management

To truly tackle ethnic disparities within the workforce, a more representative ethnic diversity of medical and organisational leadership is necessary, alongside more transparent recruitment and promotion systems in the all organisations employing doctors and culture change within all organisations. We welcome goals to increase diversity in leadership within the NHS People Plan for 2020-2021.<sup>9</sup>

Although the ethnic minority medical workforce has grown over the last few years, representation of ethnic minority healthcare professionals at board level is still far too low. Ensuring that NHS Trust and organisation boards reflect the ethnic make-up of the workforce they manage would help ensure a more inclusive culture from the top-down and ensure there are ethnic minority role models visible to healthcare staff, students and patients.

This recommendation was also made by the Parker review in 2016.<sup>10</sup>

### Addressing bullying and harassment within the NHS workforce

The BMA's survey of all members in 2018 found that the most common answer given for why bullying and harassment is a problem was that people are under pressure.<sup>11</sup> The BMA believes that alleviating system pressures will, amongst other benefits, help to develop positive working relationships across the NHS.

### Developing more inclusive cultures

To address creating a culture in which everyone feels included, where diversity is celebrated and there is equality of opportunity and reward, the BMA has recommended:

- making inclusivity a core competency for NHS leaders, something they are expected to demonstrate and be held accountable for, and<sup>12</sup>
- developing effective training for all doctors, medical students and non-medical managers on the value of diverse teams and the importance of inclusion<sup>13</sup>

### NHS Race and Health Observatory

The BMA supports the newly established [NHS Race and Health Observatory](#). It should help ensure that there is a more systematic approach to collecting data on race and health, better engagement with ethnic minority healthcare workers and communities, and better assimilation of academic research, enabling the NHS and public health system to learn and respond more effectively to trends.

---

<sup>9</sup> NHSE (July 2020) We are the NHS: People Plan for 2020-21

<sup>10</sup> Sir John Parker (November 2016) Ethnic diversity of UK boards: the Parker review.

<sup>11</sup> BMA Future vision for the NHS: All member survey (2018) <https://www.bma.org.uk/collective-voice/policy-andresearch/nhs-structure-and-delivery/future-vision-for-the-nhs/future-vision-for-the-nhs-survey>

<sup>12</sup> Ibid.

<sup>13</sup> Ibid.

### **Improved data reporting**

There also needs to be better recognition of diversity of the identities, experiences and needs of different ethnic groups. We encourage the government to improve the granularity of its data collection, analysis and reporting on the experiences of NHS staff to better recognise the variety of ethnicities in the UK. This is preferable to relying on the categories BAME and white as 'BAME' is a collective term, not an identity.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

A handwritten signature in black ink, consisting of a series of loops and a long horizontal stroke at the end.

**Stella Dunn**

Acting director of policy

Professional Policy and Activities