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BMA

Sir Simon Stevens
Chief Executive
NHS England
NHSE Skipton House
80 London Road
London, SE1 6LH

9 April 2020

Dear Simon,

Re. Impact of COVID-19 on BAME communities and the doctor workforce

We are writing to express our concerns about two issues. Firstly, the impact of COVID-19 on the Black, Asian and Minority Ethnic (BAME) population, and second, the high number of deaths among BAME doctors. We note that our colleagues at BAPIO have also raised these concerns with you. We seek your assurances that you will investigate the issues raised below and take every necessary action to ensure that the experiences and needs of BAME people are properly considered and addressed.

As you will be aware, the recently published ICNARC report found that, despite making up 13% of the population, 35% of people critically ill with COVID-19 are BAME. Given the higher rates of death among those admitted to critical care, it is likely that there will be higher mortality rates too. However, there is currently no data on ethnicity, infection and mortality rates from COVID-19 and we believe NHS England should work with PHE to look into whether this can be collected as a matter of urgency.

Factors that may be contributing to increased burden of disease and severity of illness for BAME people include existing and significant structural health and socio-economic inequalities and higher rates of long-term conditions for some BAME groups.

For example, BAME people have higher rates of poverty and are more likely to live in multi-generational or overcrowded households. It has been reported that 80% of Asian people over the age of 70 live in multi-generational households. The 2020 Marmot report found that 30% of Bangladeshi households and 15% of Black African households were overcrowded, compared to

only 2% of White British households. These factors should be considered when developing guidance and measures to reduce transmission. It is also essential that public health communications are tailored, where necessary, to reach different groups. For example, we note that it appears to be only recently that the government has produced leaflets in a range of languages other than English.

We know that people of South Asian or Black African origin are two to four times more likely to develop Type 2 diabetes than people of White European origin. Similarly, people of South Asian ethnicity are more likely to develop coronary heart disease than white Europeans. Both underlying conditions are key risk factors for COVID-19. There may also be relevant genotypic or underlying biological mechanisms in different ethnic groups, the understanding of which may help planning for future pandemics.

With regard to potential exposure to COVID-19, we note that BAME people are more likely to be in insecure work or self-employment or working in essential public services, including public transport, cleaning, social care and health care. BAME people make up two-fifths of the NHS medical workforce in England, for example.

To date, the doctors who have tragically died from COVID-19, are disproportionately from BAME backgrounds and the majority with primary medical qualifications gained overseas. We ask that NHS England urgently investigates whether any patterns are emerging in the deaths of healthcare workers, as well as the admission of healthcare workers to hospital, and what factors may be causing this, including differences by protected characteristics. We would be grateful if you could involve us, as well as other healthcare worker organisations, in any research that you conduct.

It is vital that data is collected and shared on the infection rate, hospital admission and mortality of healthcare workers with COVID-19, so that we can understand how to better protect them. As well as looking at individual characteristics, we suggest that you look at collecting and sharing data on work settings, roles, shift frequency and shift duration, PPE used, and duration of exposure for different groups of doctors. Structural inequalities in the workforce may be placing some BAME doctors at greater risk. There may also be issues related to workplace culture. We know, for example, from our own research that BAME doctors are more likely to say they do not feel confident in raising safety concerns than white doctors.

We remain concerned about the deployment of older, retired doctors into direct patient-facing or high-risk roles too. As well as coming from mainly BAME backgrounds, the majority of doctors who have so far died in this pandemic are over the age of 60.

As we have raised with you multiple times, it is essential that adequate and effective PPE is provided to the NHS workforce, in line with WHO recommendations at a minimum. We also need to ensure that there is sufficient supply of effective PPE to meet different needs. For example, some doctors, such as Sikh and Muslim doctors, wear beards for religious reasons and

we have heard they are facing difficulties in getting alternative respirators like PAPR hoods when FFP3 masks cannot be fitted.

We would appreciate an opportunity to discuss these concerns further.

Yours sincerely,

Personal Data

Dr Chaand Nagpaul CBE
BMA Council Chair

CC: Professor Chris Whitty, Chief Medical Officer
Duncan Selbie, Chief Executive, Public Health England
Yvonne Coghill OBE, Director, WRES Implementation Team, NHS England
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