Coronavirus and the impact on people with protected characteristics - BMA response to calls for evidence from Women and Equalities Select Committee and Joint Committee on Human Rights

About the BMA

The BMA 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.

Executive Summary

The COVID-19 pandemic and the measures taken to address it are having different impacts on people with different protected characteristics. Scrutiny of the equality impacts of this pandemic is essential and we welcome the opportunity to respond to the Committee's call for evidence.

- Among healthcare workers who have died, there is an over-representation of BAME people. On 22 April, the Health Service Journal reported that 94% of the 19 doctors who had died were BAME.
- Our members are still raising concerns that not all doctors who are at increased risk because they have underlying conditions are being identified by employers and that individual risk assessments are not always being carried out. For groups that have historically faced discrimination or feel like outsiders in UK workplaces[1], it can be particularly hard for them to raise concerns about safety or seek help.
- Our BMA COVID-19 tracker survey of 6,000 doctors (carried out between 14-16 April) found that BAME doctors were much more likely than white doctors to say they felt pressured to see patients without adequate PPE. Among those working in high risk (AGP) areas, 23.2% of BAME doctors said they 'often' felt pressured to see patients without adequate protection compared to 8.5% of white doctors.
- The closure of schools, nurseries and childminding services has had a disproportionate impact on women, who are also more likely to have caring responsibilities for dependent adults. Social distancing measures mean that many cannot rely on informal support from other family members or friends as well.
- The Equality and Human Rights Commission recently announced that it is suspending its compliance work to enforce the specific duties that support the PSED and require public bodies to annually report equality information about their workforce and among service users during the COVID-19 pandemic. We believe this may have caused confusion about the status and priority to be given to equality at present.

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[1] E.g. see GMC Fair to Refer report which identifies overseas-qualified doctors, locums and SAS doctors, all of whom are mainly BAME as being most likely to be 'outsiders' and lacking support at work and the BMA's findings from its survey of disabled doctors and medical students referenced below. Available at: https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

- Public bodies must be clear that the Public Sector Equality Duty remains in force through the current crisis, and must continue to gather data and assess the impact on equality of their policies and practices. Equality monitoring should continue throughout the pandemic and steps taken to identify and mitigate health inequalities and disparities of experiences and outcomes as they arise.
- An immediate priority must be to ensure that better, real-time data is recorded and collated on the impacts of COVID-19 by protected characteristics. This data should be regularly shared and published so that we can learn lessons and take action during this pandemic to prevent excessive and unjustifiable harms for particular groups.
- We welcome the inquiry into the disproportionate effect of COVID-19 on the BAME population and BAME healthcare workers that the government announced on 17 April. Further details of how it will be carried out, the issues and data under consideration, and how organisations representing BAME doctors and healthcare workers will be involved in the review, is urgently needed.
- Steps to protect BAME healthcare workers immediately must be identified too. The BMA is pleased that NHSE/I heeded our calls and instructed all NHS providers to ensure risk assessments are carried out for those who are at increased risk, including BAME healthcare workers.
- As well as improving the supply of PPE to healthcare workers, we must ensure that differing needs are taken into account, including in relation to gender, disability and religion. PPE must be appropriate and properly fitted so it provides adequate protection.
- Extra financial support and a commitment from government to reimburse additional childcare and other caring costs incurred by doctors and other NHS staff is required to prevent the disadvantage, that is most likely to fall on women, from deepening.
- We support the calls for dedicated funding to be made available to study both the short and long-term mental health impacts of the pandemic, to ensure that appropriate mental health support is tailored to the needs of groups who share protected characteristics.
- As the differential impacts of COVID-19 and the response to it have become apparent, we have questioned to what extent due regard was paid to equality and the needs of different groups in pandemic planning. The Government must ensure lessons are learned for the ongoing progress of this pandemic and for similar situations in the future.

Impact of COVID-19

1. How have people been affected by COVID-19 and the response to it?

The impact of the COVID-19 pandemic has been felt across all communities in the UK, as well as globally. The pandemic has placed extraordinary pressure on our NHS and healthcare workers and has dramatically changed the everyday lives of everyone living in the UK. However, it is apparent that the COVID-19 pandemic and the measures taken to address it are having different impacts on people with different protected characteristics. Below we highlight some examples of unequal health, societal and workforce impacts, and potential longer-term inequalities that our members have recently raised concerns about.

We believe that scrutiny of the equality impacts of this pandemic is essential and we welcome the Committee's call for evidence at such an early stage. We need prompt, detailed and effective investigation and action to avoid discrimination, mitigate disadvantages and prevent inequalities worsening as a result of COVID-19.

The situation is constantly changing, and we would welcome the opportunity to provide further information and updates as to the situation develops.

2. Specific impacts on people due to them having a protected characteristic

Severity of illness and mortality by protected characteristics

From the early stages of this disease, clinical data was showing that those in older age groups and with certain underlying health conditions were at greatest risk. There were also concerns about women in the late stages of pregnancy. Initial government and public health advice on vulnerable groups and the need for stringent social distancing and shielding to protect them reflected this. Data has also consistently shown that men have a higher incidence of severe illness and mortality than women from COVID-19.

Recent ICNARC data which covers clinical care units in England, Wales and Northern Ireland has shown that BAME people make up 34% of admissions. This is significantly higher than the 14% of BAME people in the England and Wales population. This is partly explained by the initial wave in the UK being focused in London which has a higher BAME population. However, even when matched against the local population for the critical care units that the data comes from, there is still an over-representation of BAME people becoming severely ill.

New NHS England data on daily deaths in hospital from COVID-19 shows that 18% are BAME people (as at 20 April). The age profile of the BAME population in England and Wales, however, is considerably younger than the white population. For example, around half of the hospital deaths recorded from COVID-19 are among the 80+ age group but only around 3% of the over 80s are BAME. This suggests that BAME people are losing their lives to this disease at a younger age.

The increased risk factors for BAME people could be linked to:

- greater representation among healthcare and other frontline key workers (e.g. see NHS workforce figures below) which means they are more exposed to potential COVID infection
- increased likelihood of living in multi-generational households and overcrowded housing (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), which makes social distancing and isolation if a member of the household more difficult.
- living in areas with poorer air quality
- the impact of socio-economic inequality, deprivation and racism on health, which includes increased heart disease and lower life expectancy
- increased incidence of some conditions like type 2 diabetes and hypertension among South Asian and Black African and Caribbean populations.

We need far more data to be recorded, collated and analysed to understand the impact of the COVID-19 disease on different groups and the biological or other factors that may be causing disproportionality. We welcome the review of impacts on BAME communities which the government has announced.

We are calling for better real-time data on infection rates, hospital admissions, critical care admissions, mortality in hospitals and the wider community to be gathered and published by a range of personal and socio-economic characteristics so that intersectional issues can be looked at too.

Women's increased exposure to Covid-19

According to the Resolution Foundation, employed women are twice as likely to be key workers as employed men. They are particularly overrepresented in caring roles - 77% of the NHS workforce are women and 81.7% of adult social service jobs are held by women, and 97% of the early years workforce. This means that women are going to be at significantly greater risk of being exposed to and contracting Covid-19.

Impacts within the medical workforce

BAME and overseas-qualified doctors

Among healthcare workers who have died, there is an over-representation of BAME people. On 22 April, the Health Service Journal reported that 94% of the 19 doctors who had died were BAME. It also reported 71% of nurses and midwives who had died were BAME and 56% of the healthcare support workers.

As already noted, there is a higher proportion of BAME people working in the NHS than in the wider population. However, these deaths show a starkly disproportionate impact within that workforce too. For example, NHS England data shows that 44% of the medical workforce, 20% of nurses and midwives are and 17% of healthcare support workers are BAME

On 10 April, the BMA called for the impact on BAME doctors and other healthcare workers to be urgently investigated. **We welcome the review that the government announced on 17 April. We are pressing for further details of how it will be carried out, the issues and data we believe need to be considered, and the need for involvement of organisations representing BAME doctors and healthcare workers.**

We must also look at immediate steps, including the use of a risk-profiling framework, to ensure BAME doctors are included in those who are at greatest risk are protected. We welcome the NHSE/I letter to all NHS providers on 29 April 2020 calling on them to ensure risk assessments are carried out for those who are at high risk, including BAME healthcare workers in that. This must be supported by implementation of a national framework and guidance.

Doctors at increased risk from COVID-19

For our members, the deaths of healthcare workers has also raised concerns over how well those who may be at increased risk from COVID-19 are being protected in the workplace .The majority of doctors who have died are BAME, overseas-qualified, over 50 and about half are over 60, and the majority are men; we do not have information on underlying health conditions.

The BMA has written to NHS England to ask that it urgently revises its approach to those healthcare workers at greatest risk from this illness. **Specifically, we ask that the age at which frontline staff are categorised as 'at-risk' be reduced to 60 (from the current threshold of 70) which is in line with the WHO recommendation. We also ask that NHS England develops a risk profiling framework to assist**

employers in conducting risk assessments that take into account not only age, but other factors such as ethnicity, sex and comorbidities.

Up until now, there has been encouragement for NHS employers to consider the needs of those who are most at risk in their workforce and to consider the need to make adjustments, including possible redeployment to lower risk roles or remote working. However, our members have raised concerns that not all doctors who are at increased risk are being identified by employers and that individual risk assessments are not being carried out.

It can be particularly hard for groups that have historically faced discrimination or feel like outsiders in UK workplaces[2] to raise concerns about safety or seek help. For example, a BMA survey in 2018 found that BAME doctors were twice as likely as white doctors to say they would not feel confident about raising safety concerns (also see 'PPE and diversity section' below on differences by ethnicity on concerns about PPE). This is why we want to see stronger guidance requiring greater organisational action and better support for individuals who are most at risk or vulnerable, such as BAME doctors.

Disabled doctors and those with long-term health conditions

There is some evidence to suggest that some NHS workers who are disabled or have long-term health conditions could be reluctant to disclose them in the workplace – around 19% of respondents to anonymous NHS staff surveys disclose disability but only around 3% do so on the electronic staff record (ESR). The recently published NHS England Workforce Disability Equality Standard showed that only around 2% of the clinical workforce disclosed a disability, and that disclosure rates decreased at later career stages. A BMA survey (not yet published) of disabled doctors and medical students at the end of 2019/early 2020 before the COVID-19 pandemic, found that the majority (77%) had disclosed to their current place of work or study, however, 77% said they had been worried about being treated unfavourably as a result. **The BMA has encouraged members who have not previously disclosed a disability or health condition that may require consideration or adjustments because of COVID-19 to inform their employer. However, we believe more needs to be done by employers to encourage and help identify who may need additional support or protection at work.**

We are concerned that the current demands on occupational health services are making it difficult for disabled doctors and those with long-term health conditions to access the support and adjustments needed to keep them safe and well. **The BMA has long called for a comprehensive occupational health service to be made available to all doctors, in all settings, including primary care. Our survey of disabled doctors and medical students found that only 54% had been satisfied with occupational health support before the current crisis, and there are now intense pressures on OH services in the NHS.**

PPE and diversity

The BMA has continually raised concerns about the lack of adequate PPE supply to frontline workers throughout this crisis. Our BMA COVID-19 tracker survey of 6,000 doctors (carried out between 14-16 April) shows that half of those working in high-risk areas are facing shortages or no supply of key PPE

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[2] E.g. see GMC Fair to Refer report which identifies overseas-qualified doctors, locums and SAS doctors, all of whom are mainly BAME as being most likely to be 'outsiders' and lacking support at work. Available at: https://www.gmc-uk.org/-/media/documents/fair-to-refer-report_pdf-79011677.pdf

items. The survey also found a significant disparity between BAME doctors and white doctors in whether they felt pressured to see patients without adequate PPE:

- Among those working in high risk (AGP) areas, 23.2% of BAME doctors said they 'often' felt pressured to see patients without adequate protection compared to 8.5% of white doctors. Two-thirds (66.5%) of white doctors in high-risk areas said they 'never' felt pressured compared to 37.5% of BAME doctors.
- Among those working in lower risk non-AGP areas, 22.9% of BAME doctors said they 'often' felt pressured to see patients without adequate PPE compared to 9.5% of white doctors. 62.9% of white doctors said they 'never' felt pressured to see patients without adequate protection compared to 39.4% of BAME doctors.
- In general practice, 26.6% of BAME doctors said they 'never' and 26.7% said they 'rarely' had sufficient PPE to see patients. This compares to 10.1% of white doctors who said 'never' and 13.1% who said 'rarely'. By contrast, 69.5% of white doctors said they 'always' or 'usually' had sufficient PPE compared to just 40% of BAME doctors in general practice.

We have raised with PHE that it is not just quantity of PPE items but ensuring diversity of PPE so that differing needs are taken into account. For example, we have heard from women doctors who have struggled to access smaller sizes for the most highly protective and correctly-fitting FFP3 masks; Sikh, Muslim and Jewish doctors who wear beards for religious reasons and would like HSE-recommended alternatives (like PAPR hoods) to be made available so that they do not have to abandon their religious practice; and deaf doctors and medical students who have called for transparent face masks so they can lip-read and communicate easily with colleagues (we believe only prototypes of transparent masks are available which have not been approved for safe use in the COVID-19 pandemic).

PHE must make sure that, as well as improving the supply of PPE to healthcare workers, they take differing needs into account, including gender, disability and religion.

Lack of childcare support

The closure of schools, nurseries and childminding services has had a disproportionate impact on women, as has the social distancing measures which mean many cannot rely on informal support from other family members or friends as well. This is because women are likely to take on more childcare responsibilities and 90% of single parents are women. This is true within the medical profession too as research for the (not yet published) review of the gender pay gap in medicine highlights.

About half the medical profession is female and 77% of the NHS workforce is female. While the government has sought to keep provision open for children of key workers, some of our members with dependent children have faced significant challenges in managing the demands of work and childcare at this time as they have lost wraparound care and informal support. Many may also be caring for vulnerable dependent adult relatives too.

Nurseries and other childcare services are hugely dependent on parental fees. The government commitment to continue to fund councils for free childcare entitlements has not been enough to keep many of these businesses running, the Department for Education reported on 17 April, that at least 46% of childcare settings had closed. The BMA has heard from many doctors who overnight have found out that their nursery has been closed and they have had to take unpaid carers leave or annual leave to find a new care arrangement. These new care arrangements are likely to come with a significant impact in cost, with many childcare settings now charging more and many closed nurseries still asking parents to pay part of their fees.

Informal care (commonly provided by grandparents) is more likely to be used by key workers due to the hours they work. Social-distancing measures have left doctors and other key workers without the wraparound care they rely on. Losing this has led to them needing to stay home during this crucial time and unable to cover shift work with unsociable hours, despite wanting to do this work. An option for some has been to pay for nannies. This is incredibly costly and will have left many financially disadvantaged. The inability to access wraparound care has led to some NHS workers leaving their children with relatives during the entirety of the pandemic period.

The government appears to have delegated all responsibility for finding childcare to local authorities. There is significant variability in how supportive different local authorities are and we have found little consistency in policies across them.

We have heard from multiple doctors that the uncertainty around childcare has caused them anxiety and emotional distress. Sudden changes to childcare are also likely to have a negative impact on children too. Some doctors have highlighted significant increases in their childcare costs as a result of the pandemic and additional hours they are working. **Extra financial support is needed for early years childcare and a commitment from government to reimburse additional costs that NHS staff have incurred, would prevent the disadvantage that is most likely to fall on women, from deepening. The government should also consider offering childcare providers the financial support to allow them to open for longer hours and supplying them with adequate PPE and testing to prevent staff absences – another factor that has led to nursery closures**.

Disproportionate impact on clinical academic women

Many clinical academics have had their time re-allocated to clinical roles to support the NHS effort, with significant detrimental impact on their academic work and productivity compared to other academics. Clinical academic women with caring responsibilities are doubly disadvantaged, in many cases being unable to devote any time at all to their academic work. This could have a major impact on their future career prospects, particularly with universities facing significant financial disruption. Universities should give assurance that these circumstances will be taken into account for clinical academics with caring responsibilities, among whom women are disproportionately represented.

Widening participation in medicine

BMA medical student members have raised concerns about the impact of government plans to calculate grades for A-level students following the decision to cancel exams. This could potentially impact on the important objective of widening participation in the medical profession. Evidence shows that high-achieving students from low-income backgrounds are more likely to have their grades under-predicted than students from high-income backgrounds. There is also evidence to suggest that BAME students may be more likely to have their grades under-predicted.

Whilst there will be an option to sit exams in the next academic year, this could still pose a barrier for students from low-income backgrounds who may have lesser access to learning opportunities and resources while schools are shut and who may struggle to stay in school or maintain their studies for a further year.

The BMA Medical Students Committee has written to both Ofqual and the Office for Students to raise our concerns about the process and ask that further equality and diversity guidance is provided for teachers calculating grades.

Impacts on patients and social care service users

Triage decisions on prioritisation and access to intensive care

The BMA published ethical guidance on 1 April for doctors who may face difficult decisions on the frontline at the peak of the COVID-19 pandemic about resource allocation. Revised guidance was issued on 24 April. We recognised that the pandemic was progressing rapidly and unpredictably, and we could reach a stage where intensive care resources were overwhelmed. Doctors should not have to make decisions about who to give access to limited resources without clear, authoritative and ethically sound support and guidance. We also believed there was an urgent need for a public debate to encourage transparency and a wider understanding of the rationale behind decisions if the health service reached that stage.

A key principle of the guidance is that, if there is a situation of excess demand and insufficient ICU capacity (which we thankfully have not had to face in this pandemic so far due to the increase in capacity and success of social distancing measures), decisions should be made on the basis of clinical evidence on the likelihood to benefit from intensive care treatment. We recognised that this would disproportionately disadvantage older people and some disabled people but we believe that it would be objectively justified by the obligation to make the best use of public resource and the need to save as many lives as possible in such circumstances of acute shortages.

We have emphasised in a clarifying statement that decisions on the likelihood to benefit must be based on clinically relevant factors only. A blanket approach to disability or an age cut-off for access to treatment would not be morally or legally justifiable.

Since the guidance was first published, we have continued to listen to concerns raised by elderly and disabled people about decision-making on access to intensive care if the pandemic overwhelms capacity (which so far it has not) and we are keeping our ethics guidance under review. We will also continue to review the emerging clinical evidence.

As well as publishing a clarifying statement on our website, we have also responded to and support the principles set out by Disability Rights UK on the rights of disabled people during COVID-19 and we link to it from our own web resources for doctors.

The BMA was deeply concerned by reports about blanket requests being sent to people with learning disabilities asking them to sign Do Not Attempt to Resuscitate (DNAR) or Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) notices. The BMA, together with CQC, the RCGP and the Care Provider Alliance, issued a statement that made clear the benefits of advance care planning, particularly for those who are frail, elderly or who have serious conditions at the time of COVID-19. However, it makes clear that “it is unacceptable for advance care plans, with or without DNAR form completion to be applied to groups of people of any description. These decisions must continue to be made on an individual basis according to need”.

Access to healthcare during COVID-19

We recognise that there are significant challenges in ensuring health and care services remain accessible to all vulnerable patients and service users during and after the COVID-19 pandemic. For example, we recognise that for people with learning disabilities and autism it will be particularly frightening to go to hospital at this time without the support of a familiar carer or family member. **Our updated ethics guidance for doctors informs them of the importance of making reasonable adjustments for people with learning disabilities and autism, enabling them to have someone who can support and help them to be part of decisions about their treatment. We have also written to the government to encourage them to make information accessible and jargon-free during COVID-19.**

Access to digital/online services

At a time when vital public health communications and access to health services are moving online ONS data shows that around one in ten people in the UK are digitally excluded. The NHS recognises that particular groups may be more likely to be digitally excluded, including older people, disabled people, those in low income groups, and people whose first language is not English. These are also some of the groups who may be particularly vulnerable to COVID-19. It should also be noted that switches to telephone-only based services, for example for booking GP appointments, can also exclude some groups, for example, D/deaf people. **Government and NHS services should ensure alternative methods of communication remain available to these groups, especially if the switch towards digital or online services persists in the longer term, to avoid widening existing health inequalities.**

Producing BSL and inclusive public health messages

It is vital that everyone is able to readily access up-to-date public health advice and government guidance. **The BMA supports the British Deaf Association and others in calling for government updates on coronavirus to be broadcast concurrently in British Sign Language (BSL). Sign language interpretation is available in many other countries for government and public health broadcasts. We urge the government to prominently highlight plain English guidance on the main gov.uk/coronavirus page and ensure that its online content on COVID-19 is fully compatible with assistive technology**. The Government must make information available in a range of community languages to support people for whom English is not their first language.

Mental health and wellbeing impacts

The pandemic is likely to have profound psychological impacts throughout the population. Research published in the Lancet has set out the urgent need for research into the psychological impacts of the pandemic. It is critical that this research considers the potential impacts on vulnerable groups, including disabled people, and NHS and other front line-workers.

It notes that:

- Older adults and those with multiple morbidities might be particularly affected by issues including isolation, loneliness, end of life care, and bereavement, which may be exacerbated by the so-called digital divide.
- People with existing mental health issues, including those with severe mental illnesses, might be particularly affected by relapse, disruptions to services, isolation, the possible exacerbation of symptoms in response to pandemic-related information and behaviours, and changes in mental health law.

- Front-line health-care workers might be affected by fears of contamination, moral injury, disruption of normal supportive structures, work stress, and retention issues.
- People with learning difficulties and neurodevelopmental disorders might be affected by changes and disruption to support and routines, isolation, and loneliness.

We support the calls set out in the Lancet paper for dedicated funding to be made available to study both the short and long-term mental health impacts of the pandemic, to ensure that appropriate mental health support is tailored to the needs of groups who share protected characteristics.

Additionally, we highlight the potential impact of extended lockdown on LGBT+ people, who may struggle to access support. LGBT+ people, particularly LGBT+ youth, may be living in households where other people may be hostile to their LGBT+ identity. This may be a period during which LGBT+ people are forced back into the closet, or unable to access support (both formal and informal) for others. This may pose risk to the mental and physical health of these groups.

Access to abortion services

There are tight controls on where abortion services can be delivered in all four nations under the Abortion Act 1967 (England, Wales and Scotland) and Abortion (Northern Ireland) Regulations 2020. Prior to the COVID-19 pandemic, women were required to attend physical locations. Some aspects of abortion services can, however, be delivered remotely, both safely and effectively.

In England, Scotland and Wales the governments have all now temporarily approved some remote provision of abortion services under their individual powers to extend 'the class of place' where abortion can be provided and administered - to allow for telephone and video consultations and remote prescribing in some circumstances.

The Northern Ireland Department of Health now also has powers to allow for some remote provision under section 8(3) of the Abortion (Northern Ireland) Regulations 2020, which came into force at the end of March. **We believe the Department should use these powers – a move that is supported by clinical bodies – before more women suffer unnecessary and inappropriate delays to accessing services that they are lawfully entitled to, increasing the risk of the procedure and potentially taking some women over the legal time-limits; and to help decrease the possibility of COVID-19 transmission and infection, and protect women and girls, healthcare professionals and the wider population.**

Domestic abuse

The BMA has previously produced research and guidance on the role of health professionals in identifying and reducing the harm caused by domestic abuse and, in the past year, we have highlighted the support needed for health professionals who may themselves experience domestic abuse.

We are deeply concerned that incidences of domestic abuse have increased significantly during lockdown. For example, Refuge, reported a 120% increase in calls to its helpline, and a 700% increase in website traffic, in a single day. Many victims of domestic abuse will be living with their abuser during the lockdown and will have restricted access to support networks.

It is important that the Government recognises that particular groups of women are more likely to need specialist support if they become victims of domestic abuse. Women from BAME communities may face additional barriers in accessing support, due to language barriers or cultural pressures and expectations. It is important that culturally sensitive services are available. Disabled women are also more likely to be victims of abuse. There will also be partners in LGBT+ relationships who may be at risk during lockdown. According to figures from the Association of LGBT Doctors and Dentists (GLADD), 11% of LGBT+ people have faced domestic abuse from a partner in the last year, increasing to 17% of BAME LGBT people. These figures rise further in the trans and non-binary communities, with 19% of people in each community facing domestic abuse from a partner in the last year, including 21% of trans men and 16% of trans women.

The COVID-19 outbreak has had a significant impact on the homeless population. LGBT+ people are more likely to suffer homelessness. 18% of LGBT+ people have experienced homelessness at some point in their lives. This number increases to 28% of LGBT+ disabled people compared to 11% of LGBT+ non-disabled people. 25% of trans people have experienced homelessness at some point in their lives, compared to 16% of LGB people who aren't trans.

Whilst we welcome the government's commitment to provide an additional £2m to domestic abuse services, we support calls from domestic abuse charities that more funding is needed. It is also essential that the government ensures alternative housing is readily available for people living with an abuser.

Reviewing the measures

1. What needs to change or improve, which could be acted on in three weeks' time

Data recording

An immediate priority must be to ensure that sufficient data is being recorded and collated on the impacts of COVID-19 by protected characteristics. We need this data to be regularly shared and published so that we can learn lessons and take action during this pandemic to prevent excessive and unjustifiable harm for particular groups. Equality monitoring should continue throughout the pandemic, to identify and mitigate health inequalities and disparities of experiences and outcome.

For example, when data was first published on critical care admissions by ethnicity on 10 April, it revealed that about a third of those in hospital and critically ill with COVID-19 were BAME. Most of the deaths we were seeing among doctors were among BAME and overseas-qualified doctors. This caused great concern and led us to call for further investigation and more data to be published by ethnicity. We are pleased the government announced a review on the impacts of COVID-19 on BAME communities on 17 April. The daily hospital deaths dataset from NHS England also started to include ethnicity data from 17 April. However, we are still lacking sufficient data and evidence to monitor this disproportionate impact and to understand the causes and what action could be taken to address it.

Role of the Public Sector Equality Duty

We believe that it should be made clear to public bodies that the PSED remains in force through the current crisis. There is still a requirement to pay due regard to equality of opportunity, avoid unlawful discrimination and foster good relations between different groups. To demonstrate compliance, public bodies still need to be gathering data and assessing the impact on equality of their policies and practices and be considering and taking action to avoid or mitigate disproportionate impacts, where appropriate.

The EHRC recently announced that it is suspending its compliance work to enforce the specific duties that support the PSED and require public bodies to annually report equality information about their workforce and among service users during the COVID-19 pandemic. We believe this may have caused confusion about the status and priority to be given to equality at present and it would be helpful if EHRC or the government clarified the importance of continuing to gather data, consider impacts and take mitigating or preventative action, throughout this crisis.

Other recommendations that could be acted on quickly include:

- Ensuing the supply of PPE to healthcare workers takes differing needs into account, including gender, disability and religion.
- Extra financial support or a commitment from government to reimburse additional childcare costs facing doctors
- Improving the availability of accessible and jargon-free information during the COVID-19 pandemic. This should include updates on coronavirus to be broadcast concurrently in British Sign Language (BSL) and provision of materials in community languages

2. What needs to change or improve, which could be acted on in 6 months' time.

As the differential impacts of COVID-19 and the response to it have become apparent, we have questioned to what extent due regard was paid to equality and the needs of different groups in pandemic planning. For example, when considering public health advice on social distancing to prevent transmission, particularly to vulnerable 'at risk' groups, it is not apparent that the circumstances of those who live in overcrowded or multigenerational households was properly considered. PHE's campaign materials were not initially made available in a variety of languages and formats (some resources were published on the PHE website in April), and there was a lack of British Sign Language interpretation in England for major national government and public health announcements.

We are also unclear to what extent diversity in the healthcare workforce was considered in prior planning exercises. Examples include but are not limited to:

- the need for a variety of PPE to meet different needs linked to protected characteristics, and
- limitations on the healthcare workforce that would be available in a pandemic because of the need to protect workers who themselves are vulnerable because of underlying conditions or who are unable to work because of childcare or other caring responsibilities).

Lessons must be learned for the ongoing progress of this pandemic and for similar situations in the future.

Government should also be mindful of the lasting knock-on effects of the pandemic on the health care system as a whole, including issues relating to delay in diagnosis and treatment for non-Covid conditions. Additionally, it is probable that there will be lasting psychological and physical effects for people who have recovered from Covid-19, which may increase the number of people seeking specific support for disability and long-term health conditions. It is important that the Government looks to build capacity for this group to be effectively supported.

We also support the calls for dedicated funding to be made available to study both the short and long-term mental health impacts of the pandemic, to ensure that appropriate mental health support is tailored to the needs of groups who share protected characteristics.

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