Witness Name: Prof. J S Bamrah CBE
Statement No.: 2
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF J S BAMRAH CBE ON BEHALF OF THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

I, Professor J S Bamrah CBE, will say as follows: -

1. I am a senior NHS consultant psychiatrist at the Greater Manchester Mental Health NHS Foundation Trust and former Chairperson of the British Association of Physicians of Indian Origin (BAPIO), a FEMHO member organisation.

2. I am authorised by the membership of FEMHO to make this statement on behalf of the organisation. It has been prepared to comment specifically on issues faced by our members working in the devolved nations and should be considered as an addendum to my previous statement on behalf of FEMHO provided for Module 3 dated 22 December 2023, which comments on UK-wide issues and experiences.

3. FEMHO represents over 55,000 individuals working in the health and social care sector across the nations within the UK. Every one of these individuals will have had unique and differing experiences during the pandemic. In this statement I aim to illustrate, via my own reflections and collective representative experiences of my colleagues within FEMHO, the common issues and disparities faced by Black, Asian and Minority Ethnic healthcare workers (HCWs) working within the healthcare system in Wales, Scotland, and Northern Ireland.

4. I would, of course, be happy to clarify or amplify the points addressed in this statement should that be of assistance to the Inquiry.

Levels of infection and mortality

5. As was the case in England, infection and mortality along with wider impacts resulting from the Covid-19 pandemic felt amongst Black, Asian, and Minority Ethnic HCWs in the devolved nations seemed to be exacerbated by pre-existing health and socioeconomic inequalities.

6. In Wales for example, a June 2020 Report of the First Minister's BAME Covid-19 Socioeconomic Subgroup found: "*race inequalities exist in Wales. In light of Covid-19, the lack of or poor quality of ethnicity data has resulted in poor health decisions, and BAME communities face a higher risk of catching and dying from the disease*" [JSB/1 – INQ000227599]. Other systemic issues are that the Black Asian and Minority Ethnic population in Wales are in generally in lower paid jobs, are more deprived, suffer from more health comorbidities, experience more housing problems, are more likely to live in multigenerational housing and are frontline workers more often, so systemically they are at a disadvantage to begin with. Dr Bnar Talabani MBE, a clinical lecturer in nephrology and founding member of Muslim Doctors' Cymru ("MDC"), knew of deaths of Black and Asian HCW colleagues. Another of our members, Professor Keshav Singhal CBE, an orthopaedic surgeon in Wales and Chair of FEMHO member organisation British Association of Physicians of Indian Origin ("BAPIO") Wales reported that Filipino nurses had a particularly high mortality rate; he described it as *"heart breaking to see them die."*

7. Prof Singhal recognised at an early stage this trend of disproportionately high mortality amongst Black, Asian, and Minority Ethnic HCWs including doctors from South Asian origin and nurses from Black and Filipino communities. On 17 April 2020, Prof Singhal wrote to the Chief Executives of all Health Boards in Wales in his capacity as the Chair of FEMHO member organisation BAPIO Wales, highlighting the issue and asking for an urgent stratified risk assessment to be put in place to protect the lives of healthcare personnel [JSB/2 – **INQ000222868**. This was followed up by a further letter to the Chief Executive of NHS Wales and the Welsh Chief Medical Officer ("CMO") on 24 April 2020 giving further evidence of the disproportionate death rates in Black, Asian, and Minority Ethnic HCWs and communities, and laying out a framework of a simple risk assessment tool [JSB/3 – **INQ000222870** This would become the basis of the final All Wales Covid-19 risk assessment tool which I referred to in my previous statement and which is addressed further later in this statement.

8. Initially, Prof Singhal experienced some scepticism at NHS management level and this continued until a report from Intensive Care National Audit and Research Centre (ICNARC) published data that confirmed the higher death rate of Black, Asian, and Minority Ethnic people [JSB/4 – **INQ000191308**]. From this point, there was a difference in engagement with the issue by the Welsh Government and NHS management. It was apparent that the First Minister and Health Minister considered the issue of higher ethnic minority mortality rates a priority, as is evidenced in the prompt written statement on the impact of Covid-19 on BAME communities of 21 April 2020, from the Welsh Minister for Health and Social Services, Vaughan Gething [JSB/5 – **INQ000227107**]. The Welsh Government formed the "First Minister's BAME Covid-19 Advisory Group" chaired by Judge Ray Singh CBE and Dr Heather Payne. Prof Singhal was asked the same day to Chair the Scientific risk assessment sub group and tasked to come up with a risk assessment tool at pace. All health board managers were in general on board.

9. Similarly, in Scotland the disparity in deaths of HCWs amongst Black, Asian, and Minority Ethnic communities became clear early in the pandemic. In early April, FEMHO member Dr Shahzad Hanif, a GP under NHS Lanarkshire, and NHS Greater Glasgow and Clyde, co-ordinated an open letter signed by more than 100 medics to the Scottish Government to express concerns over personal protective equipment (PPE) [JSB/6 – INQ000409269]. Dr Hanif also made media appearances where he made mention about the concern he had over Black, Asian, and Minority Ethnic colleagues and the disproportionality in terms of morbidity and mortality [JSB/7 – INQ000409585]. This was picked up by media and brought to the attention of Nicola Sturgeon who was First Minister at the time. It led to a meeting with Gregor Smith, the Scottish CMO, to highlight these issues.

PPE: access to and suitability

10. The consistent picture from across our membership in the devolved nations was one of discrimination through unavailability or inadequate PPE and fit testing rejection.

11. One hospital social worker in Northern Ireland who wishes to remain anonymous did not recall there being any FFP3 masks at all in her hospital and says that she was never fit tested for PPE despite her asking for this. She stated: "*it was kind of left to us. If you felt at risk, you make sure you have your mask and visor and the plastic apron.*"

12. As I mentioned in my first statement dated 22 December 2023, it is the experience of our members that Black, Asian, and Minority Ethnic HCWs were more likely to find themselves treating Covid patients on the frontline rows, such as in intensive care or in A&E, without adequate PPE compared to White colleagues and yet they were the least empowered to speak up about it. A frontline social worker in Northern Ireland recalls that a lot of her nursing colleagues were Indian and that they had anxieties that they couldn't really communicate to others. Some had newly arrived in Northern Ireland, and they didn't want to be seen to be making a fuss by raising concerns.

13. A FEMHO member and GP based in Scotland describes a catalogue of failings regarding the provision of PPE. Provision of PPE in hospitals is centrally directed and it is protocol for hospitals to have better access to PPE, FFP3/2 masks, full gowning, and decontamination, but none of this was provided in primary care. Our member states: "*we were given surgical masks that were not sufficient to prevent airborne spread of viruses. We never received FFP3 or FFP2 masks.*" They recall that doctors had to order their own masks from China themselves, and also that on at least one occasion, a batch of surgical masks that had been supplied were obviously out of date, but there had been an attempt to cover up the date by hand with a sticker. The situation was farcical. When the issue was raised with the Scottish Government including at a meeting with the Scottish CMO, Gregor Smith, no answer was given as to why that had occurred, other than that they "*have reassessed*" it, and that their position was that the masks were reusable. Mr Smith went as far as to refuse to accept that coughing is an aerosol generating event despite worldwide experts and common sense confirming that coughing is of course an aerosol generating act and spreads viruses.

14. The experience was similarly poor for our members in Wales. Dr Talabani, a clinical lecturer in nephrology, says the workforce in Wales were one of the last to get FFP3 masks. There was a delay in proper PPE provision in Wales compared to England, with the delay with masks probably worse than England. She recalls colleagues explaining that levels of PPE availability were not good, and that this never really changed. Filipino nurses had difficulties accessing PPE too. A staff nurse member of the Filipino Nurses Association UK ("FNA UK") in Wales describes hospitals implementing procedures and directives that would limit the amount of PPE somebody could access and use to ration supplies.

15. However, experience in relation to PPE amongst our members in the devolved nations did differ and it would not be accurate to suggest it was all negative. An advanced nurse practitioner and Executive Lead of the British Indian Nurses Association ("BINA") in Wales, Kokila Swamynathan, considers that PPE was well organised at her hospital in Wales. There were issues with fit testing for ethnic minority staff (for example, most of the Indians failed their fit tests and indeed she herself failed), however everybody who had failed their fit test for the FFP3 mask automatically got air purifier respirators (APRs). Similarly, Daisy Sandeman, a clinical nurse manager at the Edinburgh Royal Infirmary, takes the view that as Scotland has a smaller population when compared to England the challenges faced there were not the same. In Scotland, she says benefit was had from being at the tail end of the wave in England: "*we were ahead of the curve in organising PPE, allocation PPE, organisation, forming working groups with infection control team to make sure people were adequately protected*." She did not find that there was any significant delay in supply or availability of PPE, and felt the team at her hospital were able to react to what was going on in England before the same hurdles arose in Scotland: *"everything happened there first and we got our learning points from [England] and [saw] what not to do."*

Capacity and staffing

16. As mentioned above, some of our members in the devolved nations experienced unfair allocation and deployment of Black Asian and Ethnic Minority HCWs to high-risk areas such as Covid wards compared to their White counterparts. Prof Singhal, Chair of BAPIO Wales, tells of a *"small, minority concern"* of Black, Asian and Minority Ethnic HCWs being disproportionately placed into patient facing, frontline roles. He recalls staff members approaching him to raise this concern in the early stages of the pandemic and that he felt moved to intervene with managers. A staff nurse member of the FNA UK in Wales bluntly tells of how staff allocations were responsible for disproportionate Filipino HCW deaths. This again touched on cultural sensitives and vulnerabilities, including that Filipino nurses tend not to stand up for themselves and are more disinclined to challenge authority: "*We normally follow orders of senior leaders. When we came here to the UK, we learned that you can say no. You can actually turn down work. But for us, if you refuse to do a task, it means that you are ineffective. It is cultural – many people just do the work and don't question it, this is our work ethic and how we are trained. The Filipino way is to do it first, before you complain*."

17. The same nurse continued: "*when we were being allocated in greater numbers to high risk areas we were asking in the back of our minds: "why us, why not them?" But what follows is that more of us died because there were more of us on the frontline. This isn't just in Wales, it is all over the world. When new Filipinos come to the UK, they are asked to be on the frontlines, especially in A&E. We find it difficult to turn this down. They were put there, first to be deployed in these areas, but many are afraid of the situation and they can't turn it down. They felt very scared. Not only in pandemics, but generally, we find it hard to stand up for ourselves and cannot turn down*."

18. The deleterious impact of staff shortages due to Covid sickness were felt across the full spectrum of staff across the devolved nations. However, our members were often disproportionately impacted by staff shortages and illness. For example, in Northern Ireland, a larger proportion of nurses working for agencies (and so not directly employed by healthcare trusts) were from minority ethnic backgrounds. Unlike permanent staff, they didn't benefit from sick pay when they contracted Covid. Not working because of illness could mean those staff couldn't pay their outgoings, or provide for themselves or their families, and so often they had to continue to work. Additionally, while permanent staff did feel able to take time off to return to full health and ability to work, agency staff had to bear the increased burden of the workload during times of high staff shortages. The effect of this was that staff were not only being extremely overworked and burning out more frequently, but it follows that agency staff working longer hours in frontline roles suffered increased exposure to the virus.

Risk assessments

19. As I explained in my first statement dated 22 December 2023 and above, it became obvious early in the pandemic that Black, Asian and Minority Ethnic populations were disproportionately affected by higher mortality. Various organisations including FEMHO member BAPIO and the Race Council Cymru (RCC) brought this to the attention of the Welsh Government, referring to the data in reports from the King's Fund, Office of National Statistics (ONS), Intensive Care National Audit & Research Centre (ICNARC), the Institute of Fiscal studies and the Nuffield Foundation [JSB/8 – INQ000401078].

20. In response to these concerns the Welsh Government proactively set up a Black, Asian and Minority Ethnic Covid-19 Advisory Group under the Chairmanship of Judge Ray Singh CBE and Dr Heather Payne. Two subgroups of this group were set up. A socio-economic subgroup chaired

by Prof Emmanuel Ogbonna and a Scientific Risk Assessment subgroup chaired by FEMHO member and BAPIO Chair Prof Singhal CBE (set up on 29th April 2020). The Risk Assessment (RA) subgroup was tasked with developing a risk assessment tool for use by NHS and Social care staff. The RA subgroup decided to take a pragmatic approach developing a simple, easy to use and self-administered Covid-19 risk assessment tool (RA tool). The first version of the RA Tool was prepared within 2 weeks of the group's constitution [JSB/9 – INQ000409272] and within one month the RA tool was launched by the Welsh Government for use by all NHS/Social care staff on 27th May 2020 [JSB/10 – INQ000409576]. BAPIO was instrumental in the development of the RA tool through the leadership of Prof Singhal and others, including myself with NHS England. The RA tool has kept pace with emerging evidence over the last year with only minor modifications and has proven to be robust and fit for purpose. The RA tool has been said to provide confidence to public sector workers to manage their risks and continue working, helping to sustain the NHS and public services during the second wave of the pandemic. By 2021, more than 71,000 NHS and Social care employees and over 74,000 public sector employees had used the online version of the tool, with an estimated 45,000 additional paper versions downloaded and used [JSB/11 – INQ000082919].

21. The Welsh model can be considered in comparison to England where there was more of a focus on a data intensive approach preparing a RA tool which would be linked to the patient's medical records and had to be administered by a health care professional. As described in my statement dated 22 December 2023, this approach presented issues because there were delays around the collection, collation and analysis of data in real time. The Scottish approach was to assign an age score to each comorbidity thereby calculating the Covid age which would guide the degree of risk. The Covid-19 RA subgroup in Wales however decided following consultations that their own pragmatic approach which would allow everyone, including members of the public, to risk assess themselves would be best suited to Wales and allow greatest penetration and almost universal use of the tool.

22. There was a roll out of the RA tool to other public sectors. Our member Prof. Singhal recalls getting enquiries from various other public sector bodies like the Police, education and higher education and Government departments including the NHS Employers, to whom also the tool was made available and they were given advice on how to modify it as per their specific requirements. By August 2020, the tool had been expanded to include a generic version for use in education, childcare, play work, youth work and further education.

23. Initially the tool was released as a pdf version and cascaded to all NHS Wales employees and health boards through staff bulletins and emails. However, the need to cascade the information widely on an electronic platform led to the later development of an animation for the public published on YouTube. The final report of the subgroup was submitted to the Welsh Government in October 2021 by which time the pandemic was waning and the tool was well established in identifying the vulnerable population.[1]

24. In Scotland, however, the quality and timeliness of risk assessments appeared to our members to differ. We have heard from one of our HCW members that there was no push from the Scottish Government to pursue an ethnicity specific HCW risk assessment for primary care staff, despite the disproportionate vulnerability of our communities being plain. There was a generalised risk assessment performed, but similar to the case in England, this began much too late into the pandemic: our member recalls this started around six months after the pandemic struck. With regards to secondary care, we have heard from Daisy Sandeman, a clinical nurse manager at Edinburgh Royal Infirmary, that risk assessments were mandated for all staff from the beginning of the pandemic. From at least September 2020, the assessments took ethnicity into account in the risk score [JSB/12 – INQ000401082]. Staff at higher risk were then redeployed as appropriate. Vipin Zamvar, a cardiothoracic surgeon at the same hospital, feels there was a proactive and understanding approach towards staff: *"nobody was forced to do anything they were not comfortable with. If you were anxious, then you could leave, so be it. A colleague's wife was very worried about him getting Covid – he had two children – he was granted leave for three weeks […] no special risk assessment for BAME doctors was provided, nothing special for them, but at the same time we didn't feel that this was required and so we were not pushing for it – if we had a problem, we would get it sorted without the need for a special risk assessment. […] We never felt the problems that took place in England."* He recalls that some doctors, all from minority ethnic backgrounds, requested not to be made to work in high risk Covid areas, and all to his knowledge had those requests granted.

25. As for Northern Ireland, the situation was different still. We have heard that in one health trust, absent a mandated risk assessment policy for staff, one concerned minority ethnic staff member searched for and found a risk assessment document online that was being used in another part of the UK. They brought the assessment to the attention of their line manager, who was unaware

[1] See [JSB/11 – INQ000082919]

that it existed at all. The fact that this staff member found the risk assessment online was the sole reason that risk assessments were then carried out at her hospital: the line manager was encouraged to mandate the assessment, and did. There was no prior plan to risk assess staff.

26. Following these assessments, some staff with underlying health conditions were redeployed. However, whether this was possible depended on the needs of the healthcare system: sometimes, staff were simply required to work in spite of the risk. The same staff member further comments on the plight of agency workers, who, again, are overwhelmingly from minority ethnic communities in Northern Ireland: *"If you are agency, they won't ever move you anyway. I don't know if agency staff were risk assessed at all. I worked in an agency before, and you didn't want to kick up a fuss about anything because you need the job […] I wouldn't have spoken up about risk assessments if I wasn't a permanent member of staff."* It may therefore be the case that the full consequences of a lack of risk assessments for agency staff in at least this region will never be fully known.

Guidance, engagement and communication

27. My previous statement of 22 December 2023 describes the lack of consultation at higher decision-making levels, and the tokenistic and paternalist nature of engagement with Black Asian and Minority Ethnic communities from the top down. Public health communication from the Government and senior leaders within healthcare settings and ethnic minority communities in the devolved nations was a mixed picture.

28. In Northern Ireland, a frontline care worker who wishes to remain anonymous reported that nothing was done at the hospital where she worked to support ethnic minority HCWs, and that she was having to read data and issues coming out of England herself and disseminate this amongst her ethnic minority staff network. She commented that there is zero engagement with Black and Ethnic Minority HCWs from senior Trust figures or Government, saying: "*it really felt like nobody was looking at was what happening in England and engaging with us and learning. Even with the ethnic minority network – what little engagement they did do with us has now fizzled out. It was lip service – they just wanted to look like they were doing something*".

29. A staff nurse and FNA UK member in Wales reports similar experiences: "*I think they don't want to get involved, because if they did, they have to act on it. So they left it. If you ask Filipinos how*

it is in covid for them, and then they tell you problems, then as a manager you have to act on it. Less communication means you won't hear the problems and so you won't be responsible for them […] With the Filipinos it is just about getting to know them. Compared to other Asians, who can have stronger personalities, Filipinos are less likely to speak up."

30. In Wales, our member organisation BAPIO was obtaining good evidence early in the pandemic that Vitamin D was helpful to the population at large in protecting against Covid because it boosted immunity generally, improved overall health, and could reduce the severity of Covid. It was critical to Black Asian and Ethnic Minorities who are often severely Vitamin D deficient. They were constantly highlighting this to Public Health Wales ("PHW") in meetings but it took them quite a long time to pick it up. When they did, BAPIO recommended a specific level of daily intake of Vitamin D during various discussions, but PHW felt it appropriate to limit the recommendation to only 400 micrograms and reflected this in their public advice. This was less than the level of dosage that we, as clinicians, had recommended. There was a difference of opinion on this issue, though there was good collaboration overall between BAPIO and the Welsh government.

31. Some of our other members in Wales also considered that they had good support. Our member Kokila Swamynathan, Executive Lead of BINA in Wales, is one of the founding members of the 'BAME' Network at her health board which put together programmes such online workshops with Black, Asian and Minority Ethnic staff covering an array of issues and which had a positive impact. Similar positive experiences were reported from Wales, including from Dr Talabani, who stated that in her view: "*Wales is very different to England. Geographically big, but culturally and community wise it is a lot smaller and less diverse. So our work gained traction quickly with the authorities, unlike the work of similar organisations in England.*"

32. PHW reached out to MDC, Dr Talabani's network, because they wanted access to a survey regarding minority ethnic vaccination uptake that her network had carried out. PHW used it to guide their policy about vaccine engagement and getting the message out quickly. Within a few weeks of MDC being formed, Dr Talabani and representatives from MDC had a seat at a monthly government meeting, with their communications team, about Covid messaging and Covid vaccination. In her view: "*Communication was successful here because a collaborative approach was adopted between us, Government, and health bodies. Our links with BAME communities put us in a good position to relay public health messaging to these communities. It would have been*

easier for us to achieve that if the resources were already available, such as tailored information regarding evidence and stats, but it wasn't. If it were, we would have been quicker."

33. Dr Talabani considered that the Welsh Government was much better at communication and guidance than the English Government. She described "*lots happening in Wales to address racism and this work is ongoing as part of the anti-racist Wales initiative*", and how the First Minister, Mark Drakeford, visited a mosque where vaccines were being given to show his face and his support, and he also then mentioned what they were doing in a debate.

Diversity at senior level and in Government

34. Across the devolved nations, Black, Asian and Minority Ethnic HCWs are overrepresented in frontline roles and underrepresented at the level of senior management, both within the NHS and across other spaces in health and social care and Government. The well-known lack of diversity was acknowledged by Prof Emmanuel Ogbonna in his *BAME Covid-19 Advisory Group Report of the Socioeconomic Subgroup in June 2020.*[2] Whilst the NHS Workforce Race Equality Standard in England was at least devised to seek equal access to career opportunities for employees from Black, Asian, and Minority Ethnic backgrounds, in Wales there appears to be much less capacity or initiative for this kind of diversity. We have heard similar positions reflected in Northern Ireland and Scotland, where the upper echelons of healthcare leadership and Government are almost exclusively White. Decisions are made that effect minority ethnic HCWs, often negatively due to a lack of understanding about the effect of those decisions paired with a lack of willingness and effort to engage with us, which could mitigate this problem.

Conclusion

35. In conclusion, as will be evident from this statement when read with my previous statement dated 22 December 2023, the issues faced by Black, Asian and Minority Ethnic HCWs in the devolved nations, whilst variable and individual, revealed strong common thematic links to the experiences felt across the entire UK. It is vital that joint action be taken across the UK to tackle the underlying inequalities at the heart of the disparate impacts felt by our members and communities.

[2] See [JSB/1 - INQ000227599]

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 28 February 2024

Annex 1

The Federation of Ethnic Minority Healthcare Organisations ("FEMHO")

1. African Caribbean Medical Mentors (ACMM)
2. Asian Professionals National Alliance NHS (APNA NHS)
3. AskDoc
4. Association of Afghan Healthcare Professionals-UK (AAHPUK)
5. Association of Pakistani Physicians and Surgeons UK (APPS UK)
6. Association of Pakistani Physicians of Northern Europe (APPNE)
7. Bangladesh Medical Association UK (BMAUK)
8. Bangladeshi Doctors in the UK (BD Doc UK)
9. Better Health 4 Africa (BH4A)
10. Black Women in Health (BWIH)
11. British Association for Physicians of Indian Origin (BAPIO)
12. British Caribbean Doctors and Dentists (BCDD)
13. British Egyptian Medical Association (BEMA)
14. British Indian Nursing Association (BINA)
15. British Indian Psychiatrists Association (BIPA)
16. British International Doctors Association (BIDA)
17. British Islamic Medical Association (BIMA)
18. British Pakistani Psychiatrists Association (BPPA)
19. British Sikh Doctors Organisation (BSDO)
20. British Sikh Nurses (BSN)

21. British Somali Medical Association (BSMA)
22. Cameroon Doctors UK (CamDocUK)
23. Filipino Nurses Association UK (FNA UK)
24. Ghanian Doctors and Dentists Association UK (GDDA-UK)
25. Medical Association of Nigerians Across Great Britain (MANSAG)
26. Melanin Medics
27. Midlands Egyptian Society (MES (Medical))
28. Muslim Doctors Association (MDA)
29. Nepalese Doctors Association (NDA UK)
30. Nigerian Nurses Charity Association UK (NNCAUK)
31. PalMed UK
32. Seacole Group
33. Sikh Doctors and Dentists Association UK (SDDA(UK))
34. Sri Lankan Psychiatrists Association UK (SLPA(UK))
35. Sudan Doctors Union UK (SDU-UK)
36. Syrian British Medical Society (SBMS)
37. Uganda Nurses and Midwives Association UK (UNMA-UK)
38. UK Black Pharmacists Association (UKBPA)
39. UK Ugandan Medical Doctors Association (UK UMDA)
40. United Iraqi Medical Association (UIMA)
41. Zimbabwe Doctors Association UK (ZDA-UK)
42. Zimbabwean Allied Medical Professional Association (ZAMPA UK)
43. Society of African Caribbean midwives UK (SoAC)
44. Pamoja Network
45. Muslim Doctors Cymru (MDC)

Individual members cover roles and specialisms including:

Administrative staff	Mental health nurses
Biomedical scientists	Midwives
Chaplains	Nurses
Chefs and catering staff	Nutritionists
Cleaners/domestic services staff	Occupational therapists and support workers
Clinical managers	Operational managers
Communications/public relations staff	Paediatricians
Dentists	Paramedics
Dieticians	Pharmacy staff
Doctors	Phlebotomists
Education trainers	Physiotherapists
Estates managers	Podiatrists
Finance managers	Porters
GPs	Project managers
Healthcare assistants	Public health practitioners
HR professionals	Radiographers
Information analysts	School nurses
IT help desk advisors	Social workers
IT support officers	Social care workers
Maternity support workers	Care workers
Medical secretaries	Theatre support staff
Speech and language therapy assistants	Switchboard operators