Witness Name: Prof. J S Bamrah, CBE
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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. I make this statement in response to the Inquiry's "Request for Evidence under Rule 9 of the Inquiry Rules 2006" issued to FEMHO by the Inquiry and dated 10 March 2023 (the "Rule 9 Request").

3. In this statement I set out: (1) a description of FEMHO as an organisation; (2) an overview of the main concerns and issues which FEMHO has identified in relation to the impact of the Covid-19 pandemic on ethnic minority healthcare workers within the healthcare system; (3) a brief summary of any systemic issues identified by FEMHO relating to the treatment of ethnic minority workers in the healthcare system; and (4) details of any submissions made by FEMHO members to any government department within the United Kingdom and the response, if any, that was received.

4. To the extent possible, the information contained within this statement is based on my own knowledge. Otherwise, it is based on the collective experiences of my colleagues within FEMHO

which I have learned following consultation. I would, of course, be happy to clarify or amplify the points addressed in this statement should that be of assistance to the Inquiry.

I. FEMHO: AN OVERVIEW

5. FEMHO is a multi-disciplinary consortium comprising of over 55,000 individual members belonging to over 40 organisations and networks, the majority of which operate across the nations of the United Kingdom. Please see Annex 1 of this statement for the list of our organisations. The federation brings together existing organisations with shared interests and goals to form a united voice to advocate on behalf of Black, Asian, and Minority Ethnic Black, Asian, and Minority Ethnic Health Care Workers ("HCWs") at all levels within the health and social care sectors.

6. FEMHO was designed to be inclusive and all-encompassing such that its membership would be fully representative across the sector. We represent workers in a huge variety of roles and at all levels of seniority within the UK health and social care system including but not limited to doctors, nurses, midwives, dentists, pharmacists, biomedical scientists, physiotherapists, radiographers, speech and language therapists, healthcare assistants, paramedics, social workers, medical secretaries, public health practitioners, managers, IT staff, chaplains, cleaners, porters, catering and other support staff.

7. FEMHO includes senior medics and other healthcare professionals who, by nature of their profession, also act as pillars of their communities. They are trusted people within Black, Asian, and Minority Ethnic communities and played a critical role in infusing public health messaging with trust, in order that it was embraced and faithfully followed. Our members spoke to community, professional and religious groups, and by virtue of their trusted status were able to successfully amplify public health communications that were, in many cases, instinctively distrusted in our communities due to historic and present-day discrimination in healthcare and by the state generally. Some of these members also used media to increase public health education and fill gaps that existed in government public health education and messaging in Black, Asian, and Minority Ethnic communities. One example of the use of media is the information booklet campaign by the British Islamic Medical Association (BIMA), to raise awareness of, encourage participation in, and "myth bust" regarding the vaccine rollout where Government messaging on

this topic was unsuccessful in reaching the Muslim community.[1] Even now, our members have continued to play a significant role in campaigning, including for example in petitioning for protective action to address the disparate impact on ethnic minority communities and for an independent investigation into them. Furthermore, I was appointed by the Government to assist in the formation of the Black, Asian, and Minority Ethnic Clinical Advisory Group which was tasked with examining Black, Asian and Minority Ethnic covid deaths.

8. Our members were particularly vulnerable and exposed during the Covid-19 pandemic. This assertion is supported up by a plethora of evidence contemporaneous and since, including that which has been aired in Modules 1 and 2 of this Inquiry, which supports the higher risk of infection and mortality amongst minority ethnic HCWs. A significant proportion worked on the frontline of health and social care and were overrepresented in lower levels of the NHS grade hierarchy. This experience is reflected in many publicly available articles and reports [JSB/1 - INQ000215522]. The NHS employs 1.3 million staff, of whom around 74% are white and 26% are Black, Asian, and/or from other minority ethnic groups. Reliance on ethnic staff varies across the healthcare system, for instance almost 50% of the hospital and community doctors come from a Black, Asian, and Minority Ethnic background [JSB/2 – INQ000215499]. Therefore, it is clear that many parts of the NHS would cease to function but for the dedication of many of its minority ethnic staff.

9. It must also be borne in mind that the NHS, the largest employer of Black, Asian and Minority Ethnic people in the country, and providers of health and social care across the UK entered the pandemic already weakened by over a decade of austerity. This too had a significant impact on our capacity to respond to the pandemic and added considerably to the burden placed on HCWs. The British Medical Association (BMA) argues that a *"decade of austerity left the NHS 'extremely fragile' before the onset of the pandemic – with more than four in five English hospitals operating with 'dangerously low' spare capacity. The 'dangerously low' capacity – the product of a decade of underinvestment in the face of increasing demand from increasingly complex patients – combined with poor staffing levels and a lack of crucial equipment like ventilators, provided a deeply concerning backdrop for a pandemic response. […] there can be no question that the austerity politics of the 2010s left the NHS and the wider health and care system deeply hamstrung […]"* [JSB/3 - INQ000360607]. That the public healthcare sector was able to carry on during the pandemic was due to the commitment of front-line workers.

[1] See [JSB/32 – **INQ000215508**

10. FEMHO's members worked tirelessly under brutal pressures and conditions to research, test, treat, care and vaccinate to keep the United Kingdom's public health services going. Many of them lost their own lives, colleagues, friends, family and loved ones along the way, whilst suffering physical and mental burnout because of the conditions they were required to work in. Healthcare professionals were of course more exposed to the virus in their field of work, and minority ethnic groups were over-represented in that field of work [JSB/4 - **INQ000271386**]. It was found that 57% of people reported to have caught Covid-19 at work were from the health and social care sectors [JSB/5 - **INQ000136934** We have closely felt the pain of losing colleagues and loved ones during the pandemic.

11. The starkly disproportionate impact of the Covid-19 pandemic on our members, together with our collective concerns that our voices were not being heard and that our efforts to draw attention to and reduce these disparities were being ignored, provided the impetus to the formation of FEMHO. Our initial focus has been on ensuring that the disproportionate impacts of the Covid-19 pandemic are addressed in the Inquiry, and we have a long-term aim of reducing systemic and underlying inequalities faced by our members and communities.

II. IMPACTS AND ISSUES FACED BY ETHNIC MINORITY WORKERS WITHIN THE HEALTHCARE SYSTEM DURING THE PANDEMIC.

Levels of infection and mortality

12. An early and striking feature of the Covid-19 pandemic was that HCWs from Black, Asian, and Minority Ethnic communities were becoming infected and dying at alarmingly disproportionate rates. This is reflected in a report from the Equality and Human Rights Commission of 9 June 2020, which found that 6 in 10 healthcare workers who died in the early stages of the pandemic were from a minority ethic group.[2]

13. This was apparent to us at a very early stage in the pandemic. The first ten doctors to die from contracting coronavirus were from Black, Asian, and Minority Ethnic backgrounds [JSB/6 – **INQ000116819**]. The British Medical Association found that 44% of all medical staff are Black,

[2] See [JSB/5 – **INQ000136934**

Asian, and Minority Ethnic and yet 95% of the NHS doctors that had died from Covid 19 during the first wave were from a Black, Asian, and Minority Ethnic background. It also found 64% of nurses who died were Black, Asian, and Minority Ethnic.[3] Further, 21% of all NHS staff are from Black, Asian, and Minority Ethnic backgrounds yet by June 2020 it was known that they had made up 63% of healthcare workers who had died after contracting the virus [JSB/7 – INQ000215513]. This statistic was also advanced in the oral evidence of the Chair of the British Medical Association, Dr. Chaand Nagpaul, to the Women and Equalities Committee, on the unequal impact of the virus of minority ethnic people [JSB/8 - **INQ000176357** The disproportionalities laid bare by the statistics are truly stark.

14. However, despite the risks being obvious to many of us, there were delays around the collecting, collating and analysis of data in real time. This reduced the ability to accurately predict and identify effective responses. As an example, one of our member organisations the Filipino Nurses Association UK ('FNA UK') began collating data from different sources on Filipino nurses who had died and began submitting them to the Chief Nursing Officer because no Government body was doing it. An Independent SAGE report published in July 2020 called for action to address this as one of the most urgent issues in the pandemic in the UK [JSB/9 – INQ000215514].

15. Infection and mortality among Black, Asian, and Minority Ethnic HCWs seemed to be exacerbated by pre-existing health and socioeconomic inequalities. Many of our members had to perform their professional duties with comparatively more burdens from covid disruption in their personal lives. By way of example, many did not have the option of working from home as their roles were, by and large, patient facing. Similarly, using public transportation to and from work, where there was no personal means to do so, carried heightened risks of infection.

16. This all placed significant additional physical and mental strain and had a profoundly negative effect on our members, who felt overstretched, unsafe and unsupported during the pandemic. Significantly, many felt forced to take action to protect themselves and their families by investing in their own PPE (see below) and/or in many instances moving into temporary accommodation to protect against the risk of carrying Covid back to their family homes. It is common amongst many Black, Asian, and Minority Ethnic communities for the older generations to co-habit with the

[3] See: [JSB/7 – **INQ000215513** referring to data taken from "Covid-19 – The Risk to BAME doctors", British Medical Association, 2021 (this report cannot be accessed).

younger members of the family. Consequently, it is more likely that Black, Asian, and Minority Ethnic households would have clinically vulnerable people co-habiting with keyworkers with increased exposure risk.

17. FEMHO members were at the forefront in bringing this to the public attention and advocating for government intervention. One of our member organisations, the British Association of Physicians of Indian Origin (BAPIO) raised "serious concerns" to NHS England and Public Health England (PHE) about mortality rates in Black, Asian, and Minority Ethnic HCWs in early April 2020. We stressed the need for a comprehensive risk assessment to facilitate a safe working environment and emphasised the importance of detailed statistical analyses to understand the disproportionate death rates in the Black, Asian, and Minority Ethnic group of NHS workers, not just for this pandemic but so that we are better prepared for the future [JSB/10 – **INQ000148476**. PHE responded on 30 April, stating it is "critical that we find out which groups are most at risk, so we can help to protect them," citing the various purported efforts being made [JSB/11 INQ000215504].

18. In April 2020, BAPIO wrote to Caroline Nokes MP of the UK Parliament Women and Equalities Committee with concerns about the disproportionate impact on Black, Asian and Minority Ethnic workers dying in NHS and care home sector as well as in the general population, a lack or inappropriate provision of PPE, the inability to adhere to social distancing and self-isolation guidelines, and a degradation of psychological wellbeing [JSB/12 – INQ000215517]. No response was received.

19. Francis Fernando, Founding Director of FNA UK wrote to Yvonne Coghill, the Vice President of the Royal College of Nursing and NHS Workforce Race Equality Standard national director on 25 April 2020 regarding the plight of Filipino nurses working in the UK during the early days in the pandemic. The Women and Equalities Committee and the Chief Nursing Officer, Ruth May, were also copied into the correspondence. His email [JSB/13 - INQ000371586] cites a number of urgent *immediate actions* to be taken to address the increasingly obvious disproportionate impact felt by Filipino nurses and HCWs. These include but are not limited to a plea for financial assistance for and bereavement counselling to families of Filipino nurses and HCWs who died in service; assistance with repatriation of bodies; an investigation into the high number of Black, Asian and Minority Ethnic staff deaths in the NHS; urgent implementation of risk and equality impact

assessments; clarification of guidance; access to testing; and concerns around deployment without PPE. Many of these matters are dealt with in succeeding sections of this statement. This correspondence was requested by Ms Coghill after a teleconference with Mr Fernando and other leading Filipino nurses. No response was received from the Women and Equalities Committee, however, Mr Fernando attributes much support to Ms Coghill and Ms May.

20. During the first wave, the Chief Medical Officer commissioned PHE to investigate the extent to which ethnicity impacts upon risks and outcomes arising from Covid-19. We were alarmed at the initial approach taken by PHE to this exercise in their appointment of an inappropriate choice of individual to lead the work, Sir Trevor Phillips. BIMA, along with several ethnic minority healthcare organisations appealed against the appointment to PHE. It was stated in a letter of 27 April 2020 that given the then impact of the pandemic on our communities, any experts supporting the review must have a distinguished track record in engaging our communities in order to enjoy their trust, and must have academic and other credentials appropriate for the task including in medicine, epidemiology, culture and discrimination: Sir Trevor had none of these essential characteristics and would have been unable to carry out such an essential exercise with the rigour it demanded [JSB/14 – INQ000371587]. PHE replaced Sir Trevor with Dr Kevin Fenton shortly afterwards. Had the intervention by BIMA and others been unsuccessful, it is our view that the resulting undoubtedly inadequate report would have minimised the impact on our HCWs and communities. The appointment of Sir Trevor exemplifies a cavalier approach by Government to investigating and addressing disproportionate impact, and is typical of the ignorance with which our needs are approached.

21. Dr Kevin Fenton, following his appointment to lead the PHE investigation into the impact of Covid-19 on Black, Asian and Minority Ethnic people, invited BIMA to a 5 May 2020 roundtable discussion on the impact of Covid-19 on minority ethnic groups. BIMA was asked at the meeting to follow up with representations, which they did in May 2020, expressing “alarm” at the disproportionate mortality rate of Black, Asian, and Minority Ethnic HCWs during this pandemic. BIMA urged PHE to collect data and propose solutions to mitigate the impact of inequalities on the mortality of Black, Asian, and Minority Ethnic HCWs [JSB/15 – INQ000215516]. No direct follow up response was received.

22. At later stages in the pandemic, BIMA (among other of our members) wrote to the Health Secretary, Matt Hancock, and the Minister for Covid Vaccine Deployment, Nadhim Zahawi, copying in the then Prime Minister, criticising the lack of prioritisation of ethnic minority communities by the Joint Committee on Vaccination and Immunisation (JCVI) [JSB/16 – INQ000215518]. Minister Zahawi wrote back to BIMA in a letter of 17 February 2021 [JSB/17 INQ000360604]. In it, our request for prioritisation of ethnic minority communities was declined, citing a lack of evidence that ethnicity by itself or genetics as the sole explanation for observed differences in rates of severe illness and death, while stating that certain health conditions associated with increased risk of serious disease are overrepresented in certain ethnic minority groups. However, our letter did not suggest ethnicity was the sole reason for the increased risk of severe disease. Indeed, as the response points out, certain health conditions overrepresented in certain ethnic minorities are associated with increased risk of severe disease in those communities – as is social deprivation, occupational risk, and living with high risk relatives, all additional factors in the increased risk for ethnic minorities – and as such forms a reason for prioritisation of ethnic minority communities.

23. There was a lack of meaningful and timely engagement or action on the issues raised by our members. It seemed that senior leaders within the public health sector were incredulous to our problems. In subsequent correspondence addressed to senior management of NHS Trusts, BAPIO expressed "palpable worry, upset and at times anger amongst [Black, Asian, and Minority Ethnic HCWs] that the matter was not being addressed with sufficient urgency" [JSB/18 - **INQ000120826**]. No direct response to this letter was received.

PPE: access to and suitability

24. Black, Asian, and Minority Ethnic HCW's suffered disproportionately from the failures to facilitate adequate personal protective equipment (PPE), not least because as stated previously, our members are overrepresented on the frontlines of NHS care and in patient facing roles and therefore were in urgent need of the protection afforded by suitable PPE. The consistent picture from across our members was one of discrimination through unavailability or inadequate PPE and fit testing rejection. Black, Asian, and Minority Ethnic HCWs were more likely to find themselves in hazardous work situations (i.e., treating COVID patients on the front lines, in intensive care, in

A&E, and so on) without adequate PPE compared to white colleagues.[4] And yet, they were the least empowered to speak up about it.[5] Many of our members belong to cultural communities where challenging authority is not the norm, and those from minority ethnic backgrounds are less likely to be in trade unions but more likely to be in precarious employment which can further limit confidence and ability to raise concerns about hazardous working conditions. Further, distrust of authority and healthcare leaders (even when working in the sector) due to historic and present-day discrimination has been found to provide a barrier to Black, Asian and Minority Ethnic HCWs speaking out against hazardous working conditions.

25. We are appalled but sadly not surprised by the very recent evidence of Sir Christopher Wormald, permanent secretary to the Department of Health and Social Care ('DHSC'), in Module 1 to this Inquiry. He confirmed the department had stocked lower levels of PPE (specifically, respirators) suitable for Black staff working in healthcare, and that little planning had been done to consider the equality of PPE provisions. To quote from Sir Christopher's evidence: *"Q: Did your own departmental briefing paper for oversight and assurance in July 2020 report that the respirators which had been provided for frequently fitted white faces but the ones which were better off for black staff were purchased in much smaller quantity and there had been no provision for that in the post Exercise Cygnus pre-pandemic planning? A: Yes, that is a finding that the department found during the pandemic and acted on during the pandemic, that is correct."* [JSB/19 – PHT000000005]

26. This goes some way to explaining why our members were disproportionality affected by PPE shortages. PPE that was eventually provided was often poorly fitting and therefore of limited value due to the lack of adequate consideration for variation of facial anthropometrics between ethnicities. Across studies, lower pass rates were seen in cohorts of Black, Asian and Minority Ethnic HCWs who were fit tested for respirators due to the anthropometric variations not currently accounted for in the development of respirators, which have conventionally been developed for the white male population [JSB/20 - INQ000215526].Felicia Kwaku OBE, Chair of the Chief Nursing and Chief Midwifery Officers' Black & Minority Ethnic Strategic Advisory Group, ran a number of online webinars in collaboration with the groups regional leads to engage NHS staff to share their experiences of working conditions during the pandemic. During these webinars, NHS

[4] See [JSB/5 – INQ0001 36934 p.32
[5] See [JSB/5 – INQ0001 36934 p.11

staff of Black, Asian and Minority Ethnic backgrounds described their experiences of PPE provision: *"One of the issues was that the FFP3 masks didn't fit. If you're Asian, it doesn't fit properly, as it is designed for white males."*

27. It is also consistent with the BMA findings that only four out of ten Black, Asian, and Minority Ethnic doctors in general practice said they had sufficient PPE for safe contact with patients with possible or confirmed COVID-19 compared to seven out of ten doctors who identified as white. Further, 64% of Black, Asian, and Minority Ethnic doctors felt pressured to work in settings with inadequate PPE compared with 33% of doctors who identified as white.[6]

28. The shortage of PPE was by no means limited to our doctors. A survey revealed, for example, that only 43% of minority ethnic nurses received eye and face protection equipment, compared to 66% of white British nurses [JSB/21 – INQ000215500] and 49% of minority ethnic nurses had been asked to reuse single use equipment, compared with just over a third of white British respondents.[7] Others were not provided with PPE that was compatible with religious and/or cultural dress [JSB/22 – INQ000215527].

29. To make matters worse, instructions were sometimes not in English and so people didn't know how to use the PPE.

30. Salman Waqar of BIMA has described how agency workers and locum staff were more likely to be allocated to more high-risk patients. This could take shape in, for example, provision of shifts to treat "hot patients" who could only receive treatment at home or patients displaying certain Covid symptoms who were treated at separate "hot sites" set up for that purpose. Francis Fernando of FNA UK has also described that agency nurses were being allocated to high-risk patients over non-agency staff, and yet had poorer access to PPE. During the webinars run by Felicia Kwaku OBE, it became clear that the working conditions of agency nurses were particularly alarming. The webinars were told how agency nurses were being excluded from access to PPE, and even how some managers were hiding PPE. I myself have learned, through the BAPIO membership, that HCWs were often bullied when they asked for PPE. Another of our members has mentioned HCWs having to resort to using bin bags instead of clinical gowns. These are, of

[6] See [JSB/7 – INQ000215513]
[7] See: [JSB/9 – INQ000215514] p.6.

course, anecdotal accounts, but are repeated throughout our membership indicating a pattern of discrimination.

31. Many of our male Muslim members were asked to remove their beards to be eligible for the 'fit test' which had negative implications on their psychological and emotional wellbeing.[8] Similar requests were made to our Sikh and Jewish members. Many did so under duress and out of fear for their job security. Female Muslim members were sometimes told they couldn't be 'fit-tested' to ensure PPE fit to the face of the wearer because of a hijab. Some female Muslim members who were in non-clinical or non-patient facing roles wishing to cover their forearms were threatened with referral to professional regulators for 'breaching' duties in expressing their views and religious positions. Changes to multi faith dress codes policy for PPE was sought by some of our members because of these sorts of problems.

32. Our members were routinely expected to go onto high risk clinical areas without adequate PPE, if any at all, notwithstanding no risk assessments having been conducted on pre-existing medical conditions (addressed further below). Many of our members felt they were pressured into this and did not have the discretion to refuse. Even some pregnant nurses were threatened with disciplinaries if they refused. The power imbalances between Black, Asian, and Minority Ethnic HCW's and managers were especially heightened for those on working permits. Studies conducted by the BMA showed that Black, Asian, and Minority Ethnic HCWs are the least empowered to speak up about voicing concerns about PPE [JSB/23 – **INQ000118384**

33. In March 2020, BAPIO wrote a letter to the Health Secretary, Matt Hancock, expressing our grave concerns about the disbursement of PPE for frontline workers. The delay in procuring PPE was said to put our members at risk unnecessarily and that NHS Trusts were reluctant to give them masks and protective clothing even on request [JSB/24 - **INQ000148474**]. No response was received from Mr Hancock's office. In the same month, BAPIO followed up these concerns with NHS England warning of the dangers due to the lack of PPE [JSB/25 - **INQ000148475** BAPIO again raised the provision of PPE in a letter to the Chief Medical Officer, NHS Medical Director and the CEOs of PHE the NHS in April 2020 [JSB/26 – **INQ000148477**

[8]See: [JSB/15 – **INQ000215516**

34. Our membership had a lot to say about PPE but there was no public statement at the top level within Government addressing it. They were not being transparent about the problems with sourcing adequate PPE. The country's leaders were saying there were no issues with PPE, but this did not resonate with what our members were experiencing on the ground.

35. On 30 April 2020, PHE responded to BAPIO's letters of 7 April (referred to at paragraphs 17 and 30) stating they are not responsible for PPE supply and advised that NHS England had set up a supply distribution helpline[9]. This had no meaningful impact. NHS England responded in June 2020 to assert that the UK Government updated the PPE guidance for health and social care staff to clarify which PPE staff should be wearing in different settings [JSB/27 - **INQ000148467**

36. In contradistinction to the preceding accounts, an apparently rare example of good practice surrounding the accommodation of minority ethnic needs in PPE provision was seen in the Leeds Teaching Hospitals Trust. Dr Babatunde Gbolade, a gynaecologist, tells of how after it became clear in the later part of 2020 that not everybody could use the same masks, provision was successfully made for different masks for those who needed them: *"We all went for fitting tests to make sure they fit your face. Everybody did that. Those of us who needed different to the mainstream, it was decided we needed it. This was in […] July/August 2020. […] It was a slightly different shape, it really fitted well. Measurements were taken, tests were done to check whether gas was seeping through the sides. It was made to fit as close as possible with the shape of your face. I use glasses, and at times you need to operate with the mask on. They paid for us to have goggles in line with our prescriptions. This was very good of the Trust."* This, however, is not a commonplace account and we have not heard it echoed elsewhere. This is not to say that other similar examples do not exist, but if all Trusts and healthcare providers paid this kind of attention to the safety and unique needs of their minority ethnic staff, the overall picture could have been very different. We consider it an inexcusable missed opportunity.

Availability of testing

37. We learned from our members that access to testing at the beginning of the pandemic was generally poor. This is despite the development of the first test being announced by PHE on 10 January 2020.

[9] See [JSB/11 **INQ000215504**

38. We have been told that in the early days of the pandemic, healthcare organisations had individual policies as to who should be tested. There was no consistent policy across the NHS in relation to who should be tested and in what circumstances, and the staff in charge of testing allowed variable access to testing. We have learned from a nurse who wishes to remain anonymous that she felt pressured to take a test without fully understanding what it was, or its consequences. While she reasonably took some time to understand the test more fully, and to ensure that she was informed around and comfortable in taking the test, she felt threatened by her managers who sent aggressive WhatsApp messages demanding that she perform the test. She never refused to take the test and did in fact take it.

39. Francis Fernando of FNA UK spoke of confusion over whether to take PCR or LTF tests, and that the guidance from PHE on testing seemed to change daily. He heard from some of his membership that some Filipino nurses had issues accessing testing kits when they needed them and felt they did not have priority access to testing kits, unlike other staff on more stable employment contracts. This was especially true for agency nurses and bank nurses. Many Filipino nurses work for several employers at once, or through agencies, and as a result found they were not granted equal access to testing. Poor access for testing was not limited to nurses of Filipino heritage – it was consistent across other minority ethic HCW groups also.

Capacity and staffing

40. Our frontline staff members faced increasing pressure amid surges in COVID-19 cases as this combined with staffing shortages. Across the NHS, staffing ratios varied between organisations and departments, but nurse to patient ratios in the heart of the pandemic mostly rested between 1:2 and 1:6, where the ratios should have been 1:1. For example, one of our members has told us that the ratio of bedside trained critical care nurses to patients requiring advanced monitoring and support was 1:2; that of senior clinicians to patients was 1:15; and middle grade staff to patients was 1:8.

41. The second wave in the pandemic was worse for staffing levels because more was being understood about the impact of vulnerabilities, comorbidities, health inequalities, and other wider

determinants of health. As such, many members of staff were excluded from clinical practice on account of their being assessed as vulnerable, which stretched the capacity of our staff.

42. We have heard anecdotal evidence from the frontlines as to a disproportionate amount of Black, Asian, and Minority Ethnic HCWs being redeployed into "red zones" to cover overstretched and under supported departments. Many of our members complained about unfair allocation to high-risk areas such as covid wards compared to their white counterparts, however many others felt unable to voice their concerns due to fears of negative repercussions.

43. This perception is supported by a recent survey from Black, Asian, and Minority Ethnic HCWs where the most common opinion provided on the disproportionately high mortality in NHS workers belonging to non-white ethnicities was deployment of Black, Asian, and Minority Ethnic staff in areas with higher potential for exposure to virus [JSB/28 – INQ000215505]. The report states: *"One respondent described treatment as 'very unfair' adding: 'All BAME nurses [have been allocated] to red wards and my white colleagues [are] constantly in green wards.' Another said: 'Only BAME doctors from the department have been put forward for deployment.'"* The report sets out further examples of this shocking and demoralising experience. Dr Hina Shahid, Chairperson of the Muslim Doctors' Association (MDA), tells of how Black, Asian and Minority Ethnic HCWs were frequently placed into patient facing, frontline roles while many of their white colleagues were able to perform administrative, desk-based roles behind the scenes, avoiding face-to-face contact with patients: *"what that did was create a heightened level of anxiety and stress among minority ethnic colleagues, who were treated unfairly on the coal face."*

44. Retired Black, Asian, and Minority Ethnic doctors and nurses continued to be called to come back and help with the pandemic despite the known disparities in infection and mortality for Black, Asian, and Minority Ethnic HCWs. Many unfortunately contracted covid and died. This exercise was ethnically blind. There was no consideration of those added vulnerabilities at all when redeploying former staff back into the NHS workforce. FEMHO considers that attention should have been paid to how to risk assess retired Black, Asian and Minority Ethnic doctors and nurses who were being considered for redeployment. If an individual was assessed as high risk, then of course they should not have been redeployed high risk areas and consideration should have been had to whether such individuals were recalled at all.

45. One further matter that impacted on staffing was border closures and the lack of attention given to the fact the NHS relies on the hard work of those from overseas. Some of our members speak of the arrival of overseas nurses, who would ordinarily be able to come and work in the NHS, coming to a halt. We have heard of how nurses who had already made arrangements to come over to the UK to begin work were no longer able to come and suffered financially in their home countries as a result. Some nurses who were on holiday or who were visiting family in their home countries were unable to return to the UK to continue in their roles when they were desperately needed. We are not aware of any exemptions to the border rules for nurses or midwives from abroad.

Risk assessments

46. Under the Management of Health and Safety at Work Regulations 1999, employers must assess the workplace for what could cause injury or illness and take action to eliminate or control the risk. A significant failing in preparedness, emergency planning, and response for our members was that risk assessments, designed to address risks for those working in high-risk settings, were delayed and when they were conducted failed to take account of ethnicity as a relevant factor. FEMHO does not consider that there was any justification for this delay, nor the failure to take account of ethnicity as a risk factor. The impact of both was undoubtedly that more Black, Asian and Minority Ethnic HCWs were deployed into high risk areas of work while being at increased risk of serious illness and death.

47. FEMHO members number highly in roles with more frontline exposure to patients and the wider public. This problem was particularly acute for our frontline workers who were at increased risk due to the absence of adequate PPE. Most of our members did not have any risk assessment carried out until much later in the pandemic and were not assessed for risks arising from the known disparities in infection and mortality for Black, Asian, and Minority Ethnic HCWs. Outsourced workers in the NHS were often not given a risk assessment. This created anxiety and uncertainty for many of our members.

48. One nurse was 27 weeks pregnant yet had to challenge the allocation decision of her manager via the Chief Midwifery Officer for England at the time, Jacqueline Dunkley-Bent who intervened. However, many others did not have the courage to speak up.

49. Our members' experience is consistent with a study in June 2020 into risk assessments for Black, Asian, and Minority Ethnic doctors which found that 65% of doctors said they had not yet had a risk assessment [JSB/29 – INQ000215506].

50. FEMHO member organisation BAPIO challenged NHS England and PHE in respect of the lack of risk assessments in a letter of 22 April 2020.[10] The correspondence made clear the *"palpable worry, upset and at times anger"* among NHS Black, Asian and Minority Ethnic staff at the lack of urgency in addressing the unabated mortality rates among their ranks. With reference to compelling statistics reflecting ethnic disparities, BAPIO urged the recipients to provide risk assessments for staff given the danger of Covid-19: *"… we are recommending that employers urgently carry out a stratified risk assessment so that those HCWs on the frontline of tackling the pandemic are not unnecessarily put at risk."* BAPIO then sets out the risk assessment they propose in detail. For example, it is proposed that frontline staff are risk assessed for, among other things, ethnicity, and if found to be a high risk are redeployed in non-Covid clinical areas or to work remotely, with retired returning doctors and nurses given priority. It is further proposed that all frontline staff dealing with confirmed and suspected Covid cases are given suitable PPE including FFP3 masks. As referred to in paragraph 20 of this statement, no direct response was received to this letter. A letter from NHS England to BAPIO of 12 June 2020, albeit apparently in response to separate correspondence, refers to the new risk assessment framework.[11] BAPIO devised its own risk assessment model to address these failings which met with some success as it was rolled out in Wales as well as parts of England [JSB/30 - **INQ000147870**

51. When risk assessments began to be implemented more routinely in or around June 2020, there remained a lack of consistency between NHS Trusts as to whether ethnicity was identified and included as a risk factor. For a long time, there were rarely any positive outcomes or decisions arising from risk assessment. One FEMHO member who wishes to remain anonymous has said that when risk assessments were eventually carried out at their Trust, they weren't done so appropriately, and they had no consequence. At this particular Trust, they were carried out at peer level: minority ethnic staff members were told to carry out risk assessments on other minority ethnic staff members, as opposed to the risk assessments being carried out by managers with

[10] See also: [JSB/18 - INQ000120826].
[11] See [JSB/27 **INQ000148467**

the power to make the changes required by the assessment result. Assessments therefore often had no consequences and amounted to a "tick box" exercise, with the responsibility for assessing minority ethnic staff delegated to those *"who look like [them]"*. The same member was not aware of any redeployments to non-Covid clinical areas after an assessment concluded somebody was at high risk. Further, no data was shared with our member organisations on how many risk assessments were being carried out, how many people were found to be high risk, and how many decisions were made as a result and what those decisions were. FEMHO is keen to understand what evidence exists to suggest that the NHS were rolling out risk assessments to minority ethnic HCWs, and whether recommendations arising from risk assessments were put in place for those HCWs.

Guidance and communication

52. The UK Government has been rightly criticised for its poor communication during this pandemic. While this affects everyone, it was particularly acute for some of our members. Difficulties experienced by of the public in accessing the Government guidance and information on coronavirus and prevention strategies were mirrored by those working within the healthcare system, in terms of both internal NHS guidance and public communications.

53. One nurse at a large city hospital who wishes to remain anonymous gave an account of their experience of the guidance being provided during the pandemic. They told of how it was "not easy to have clarity from [their] managers" because the guidance from central government was "neither here nor there", and so they chose to rely on social media for information on infection control and management. One of our senior members, the Founder and Chairman of the British Indian Nurses Association (BINA), Marimouttou Coumarrassamy, speaks of how the guidance coming from the top down relating to infection control was "very unclear […] the Government was changing the guidance very often. One week [the guidance was] saying wear the mask and the next it would be different, [it was] very confusing. The Department of Health was changing the guidance all the time. The guidance on PPE was changing […] [one] week I am telling the staff to wear the mask and wear the shield, the next week it's wear the mask but don't wear the shield. It was very difficult from this perspective." This capriciousness was not the fault of his Trust: it was very difficult for the Trust to stay on top of the guidance because of the changing nature of the communications from central government. Another member of FEMHO, who wishes to remain anonymised,

describes the guidance as "chaotic", with, for example, the guidance instructing at once the wearing of masks in certain circumstances, for example around patients who had a cough, but then having to be removed while in corridors. Francis Fernando of FNA UK also describes the guidance as "confusing […] you had to spend at least thirty minutes looking at the website to find out what they want you to do." He takes the view that had the guidance been clearer, more nurses would have felt protected. The adequacy of guidance was poor all around.

54. Our members recall the guidance being confusing, ever-changing, and lacking in clarity, in many cases creating additional stress in already extremely challenging circumstances. For example, guidance notes were issued by the DHSC on the use of alternative medications when stockpiles ran low of specific products. Not only did staff have to adapt to using unfamiliar products but the guidance notes at times unhelpfully caused stress and concern for some as they emphasised the professional accountability of the prescribers. It was the responsibility of the DHSC to ensure staff were given information and appropriate guidance about the use of alternative medicines and contingency process in a responsible, clear and tactful manner – instead, it appeared efforts were put into transferring responsibility onto prescribers which caused unnecessary fear at a time when HCWs were already under huge pressures.

55. It is vital that Government guidance is accessible to everyone so that individuals can stay informed and prevent contraction or transmission of the disease. Government guidance was not culturally competent and inadequately catered to the needs of Black, Asian, and Minority Ethnic HCWs. This was expressed in the PHE led review of the impact of Covid-19 on minority ethnic communities of June 2020 [JSB/31 - **INQ000106482**]ome of our member organisations attempted to engage state bodies to improve their communications with Black, Asian and Ethnic Minority communities so that they were better protected. For example, in anticipation of the PHE review referred to above, BIMA wrote to the review lead, Professor Kevin Fenton, to set out their alarm at the disproportionate deaths rates of minority ethnic healthcare staff and "[in the absence of minority ethnic voices in leadership roles] *the need for credible community voices to work with PHE to amplify messages. These often require cultural nuance, let alone translation, to activate behavioural change and engagement with staff. Sadly, this has been overlooked in the response to Covid-19 in the public communications to society and internally in how NHS staff, BAME professional groups, and community-based organisations are involved and mobilised."*.. There

were few community-specific awareness raising campaigns or materials distributed by local and central government.

56. Throughout the pandemic, our members stepped in together with community organisations and faith groups to support communities and plug the gaps left by Government. In the absence of meaningful intervention from the top, our member organisations sought to mitigate some of the impacts. For example, BIMA produced several statements and pieces of guidance that reflected the concern about COVID-19's impact on Muslim communities such as 'Covid-19 Answering the Myths' [JSB/32 – INQ000215508]. They advocated for the suspension of Muslim congregational activities at an early stage and well in advance of the UK Government's announcement of the first lockdown, writing to Muslim community leaders about their safety concerns. Our members delivered talks on Covid-19 to community and faith groups, issued their own guidance, raised money to bereaved families, produced risk assessment tools, and provided counselling.

57. There are myriad examples of work done by our members to promote culturally sensitive, understandable information and community specific awareness raising campaigns and would be too numerous to list in this statement. However, illustrations of our members' focus on webinars can be seen in FEMHO's response of 9 December 2022 to the Rule 9 response provided to Module 2 of the Inquiry [JSB/33 - **INQ000099685**]. For example, "Going Beyond Statistics: Impact of COVID-19 on BAME lives" which included speakers from Better Health 4 Africa, a FEMHO member organisation. This webinar focused on "enhancing a better understanding of the risks of COVID-19 amongst the UK BAME community". Also, the Medical Association of Nigerians Across Great Britain (MANSAG) hosted a webinar series arranged for all its members, Black, Asian and Minority Ethnic communities and the general public to raise awareness about the mechanics of the virus and the impact on those communities.

58. Some FEMHO members, along with other voluntary and community sector organisations and faith leaders were needed to provide the necessary leadership on guidance to engage with those from Black, Asian, and Minority Ethnic groups and ensure that important public health messaging and information was communicated in culturally sensitive and language appropriate ways. This voluntary effort was pursued on top of our already high workloads and with little to no formal support from the system. Our communities were often referred to, both in policy and the press, as "*hard to reach"*, implying that Black, Asian and Minority Ethnic communities were the problem

rather than the ineffectiveness of public communications. This label was advanced throughout the pandemic and is still used now. Listing each time this unhelpful term was used would not be possible, but one key example from the heart of government efforts to communicate more effectively with our communities, would be the use of the term in Minister Badenoch's "Third quarterly report on progress to address health inequalities". It is stated that social media "outputs" have been published in an array of languages *"including for those harder-to-reach communities such as Akan, Mirpuri and Yiddish"* as part of Minister Badenoch's "Community Champions" scheme, which had the aim of reducing the impact of the virus on all communities beyond just the target areas, including promoting vaccine uptake and tackling misinformation [JSB/34 – **INQ000089776**]. The problem was of course not speakers of Akan, Mirpuri and Yiddish refusing to let important information reach them before that point, but rather that this was the first time the government had performed such an exercise. The report was published in May 2021, well over one year since the pandemic struck the United Kingdom.

59. The approach to public health guidance often felt paternalistic to Black, Asian, and Minority Ethnic HCWs, *let me help you* – as opposed to just giving us the resources and working with us. It was more a case of just than telling us what to do. In one example, a member of a Clinical Commissioning Group in a high Muslim population area expressed concerns regarding Muslims fasting during Ramadan in response to a rapid review evidence-based document produced by BIMA. BIMA was asked to withdraw its guidance. This document had been peer-reviewed by 60 experts and had been signposted or endorsed by the Association of British Clinical Diabetologists, the British Society of Gastroenterology, the Renal Association, the Royal College of General Practitioners, the British Thoracic Society, South Asian Health Foundation, and others. Furthermore, it had received positive feedback from frontline clinicians who have found it a practicable document to facilitate patient-centred consultations and shared decision-making. These concerns were very quickly escalated to the Chair of the BMA and the CEO of the Royal College of Nurses (RCN) without any prior consultation with BIMA. This showed a lack of engagement and understanding. Following the escalation to the Chair of the BMA, the BMA got in touch with BIMA via email on 17 April 2020 and sought their advice on fasting. A representative from BIMA and the Muslim Doctors' Association (MDA), another FEMHO organisation, then met with the BMA representatives who were supportive. BIMA and the MDA were assured that no further action would be taken.

60. In another example of the paternalism referred to above, PPE guidance or lack thereof for staff with beards and head coverings meant that employers had to come up with their own solutions or continue to be exposed unnecessarily to risk.[12] As mentioned earlier in this statement, there were further suggestions and instances within healthcare organisations of people being asked to or feeling they had to change their religious or cultural observance to accommodate PPE.

61. The NHS has historically had problems with engaging with Black, Asian, and Minority Ethnic publications, such as Asian Star as an example. They don't have appropriate knowledge of our communities. Whenever there were press releases, it wasn't to communities directly, it was to mainstream outlets. For some FEMHO members, they were not given public health information in languages other than English, which created difficulties and barriers in accessing the guidance that impacted on their lives. There was the ever-present danger of slogans in public health communications translating poorly across languages, in that linguistic nuances could be missed. For example, there is no word for 'virus' in some South Asian languages. Further, when messaging was translated into other languages, this was slow to occur.

62. Consultancy firms like Deloitte and McKinsey, and other bodies like the Royal Navy were involved in the management of the healthcare system during the pandemic. It became obvious early in the pandemic that there was no diversity amongst them or any meaningful representation from Black, Asian, and Minority Ethnic HCWs participating in the discussions and decisions behind the exercises performed by these organisations, despite there being a wealth of evidence that increased diversity in leadership and decision-making exponentially improves outcomes. McKinsey itself published a paper in May 2020 discussing the benefits of diversity and inclusion [JSB/35 - INQ000215530]. This made it hard for frontline HCWs in the FEMHO community to engage with the leadership.

Impact on mental health

63. The poor treatment and lack of care for our needs, combined with the disproportionate and excessive levels of suffering and death experienced by our members and their families and communities during the pandemic had a deleterious impact on our members' mental health. This cannot be understated.

[12] See [JSB/22 – **INQ000215527**

64. Dr Hina Shahid of the MDA wishes to emphasise the matter, stating that the level of anxiety and burnout experienced by Black, Asian and Minority Ethnic HCWs was high during the pandemic. She states that given many minority ethnic HCWs lived in larger households, widespread guilt was felt about bringing the virus home from work and passing it on to vulnerable family members. This was only bolstered by the fact that at the start of the pandemic, there was poor access to testing which meant that HCWs with symptoms didn't know whether it was covid or not and therefore didn't know whether they were putting their families at risk. This was a strong and constant fear.

III. SYSTEMIC INEQUALITIES

Structural Racism

65. The Cambridge Definition of Structural Racism is as follows: the laws, rules, or official policies in a society that result in and support a continued unfair advantage to some people and unfair or harmful treatment of others based on race. It is the macro level systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups. Such inequalities include the disproportionate rates of death and unequal health outcomes amongst Black, Asian, and Minority Ethnic groups arising from the pandemic and the government's response to it.

66. The impact of the pandemic was not colour blind, and this must be considered against a whole host of pre-existing inequalities, especially regarding health, housing, education, and employment exacerbated the impacts of the pandemic for Black, Asian, and Minority Ethnic HCWs. Structural racism and discrimination are the underlying causes and we urge the Inquiry to fully explore these issues. If it does not, it risks not only perpetuating the structural inequalities that have plagued our members but also failing to identify and address the underlying causes of the pandemic's disproportionate impact.

67. Our members report that there was very little specific guidance on the needs of Covid-19 patients from Black, Asian, and Minority Ethnic backgrounds and poor communication on the issues with negative impacts including confusion, reduced understanding, stigmatisation and

consequent higher risks. So too, there was a lack of representation of Black, Asian, and Minority Ethnic individuals in clinical trials for Covid-19 treatments.

68. As mentioned above, the lack of consideration for ethnic differentials was also apparent in the provision of healthcare equipment. In addition to the PPE fit issues raised above, for example, in April 2021 concerns were raised about the functionality of oximeters, an important covid response tool used to test oxygen levels in a person's blood by sending a beam of light through the body via a clip like device. Research found that the accuracy of pulse oximeter readings from black and minority ethnic people could be "seriously misleading" and needed further assessment [JSB/36 – **INQ000191136**]. The majority of oximeters have been developed based on studies measuring oxygen levels in Caucasian and light-skinned individuals, but research revealed inaccurate and ambiguous readings for those with darker pigmentation and skin tones. Another major risk was that treatment could be delayed by individuals over-relying on physical descriptions within the product guidance of pulse oximeters, which were found to inappropriately use terms such as 'pale', 'blotchy skin' or skin or lips 'going 'blue' which do not typically apply to Black, Asian, and Minority Ethnic people.

69. One further and particularly cruel example of how the issue of structural racism played out for some of our members was advanced by Francis Fernando of FNA UK. He was approached by the husband of a nurse of Filipino heritage who had died from Covid-19 in London after experiencing problems following his wife's death. There was no doubt as to where she had contracted the virus, working in a busy London NHS hospital and in patients' homes as a community specialist nurse. After an ambulance had declined to take her to Accident and Emergency, she was driven by her husband. She was assessed by the consultant there as being severely ill and in need of immediate intensive care, where she died the following day. Her family tried to access the death benefit (the NHS and Social Care Coronavirus Life Assurance Scheme) announced by the Government in 2020, but were told their claim had been rejected on the basis that they could not prove that the deceased had contracted the virus at work. The money was needed to repatriate the body back to the Philippines. Mr Fernando attests to these bureaucratic barriers erected by the Government which worked against those from our communities.

Diversity at senior level

70. Our members identify the lack of diversity in senior levels of the NHS is one of the most damaging systemic issues which contributed to the loss. The NHS is the largest employer of Black, Asian, and Minority Ethnic people in the country [JSB/37 – **INQ000113273** hat the public healthcare sector was able to carry on during the pandemic was due to the commitment of front-line workers [JSB/38 – INQ000215521], with Black, Asian, and Minority Ethnic HCWs overrepresented in lower levels of NHS grade hierarchy.[13] Senior management within the NHS is almost exclusively white despite the huge diversity and large portion of Black, Asian, and Minority Ethnic staff within the workforce.

71. 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. They make up around 20 per cent of the overall NHS workforce but just 6.5 per cent of senior managers [JSB/39 – INQ000215511][14]. In London, almost half of NHS employees are Black, Asian, and Minority Ethnic, but 80 per cent of NHS Trust Board members are white [JSB/40 – INQ000215512].[15]

72. NHS does not serve all its staff equally and that the culture often casts doubt of Black, Asian, and Minority Ethnic staff experiences of inequality and racism. As such, Black, Asian, and Minority Ethnic staff are more reluctant to report concerns.[16]

Consultation and engagement

73. In addition to lack of representation, there is also a lack of consultation at higher decision-making levels. The approach to equality is largely performative and tokenistic rather than from a culture, ethos or curiosity about connecting to people from different cultures or experiences. One example of how this manifests in healthcare settings has been described in paragraph 42 of this statement, where risk assessments were found by one of our members to be performed at peer level and without leading to any consequence, therefore amounting to a "tick box" exercise. Decisions are routinely made about a group of people without understanding their behaviours or needs, or even seeking advice as to what is needed.

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[13] See [JSB/1 – **INQ00021 5522** p.2
[14] See p.13.
[15] See p.3.
[16] See: [JSB/7 – **INQ000215513**

74. The ability of our communities to call on senior leaders to engage with us is otherwise generally absent. This is structural, because in majority white medical bodies, informal relationships exist and our facilitated within those institutions. It is easy for them to call on NHS leaders to address issues or speak to their communities. For Black, Asian, and Minority Ethnic groups those relationships rarely exist. We are lucky if somebody just happens to have a relationship with somebody in a leadership position. For example, the Chief Medical Officer for the DHSC attended a couple of our member organisations' meetings but that was only because a FEMHO member had a relationship that facilitated that attendance.

75. In that sense, the system unfairly wagers on the resilience of Black, Asian, and Minority Ethnic HCWs to self-organise, mobilise and address our own needs at a distance. During the pandemic, FEMHO members set up and hosted webinars in their own time, and had to then get back to their day jobs there was an over reliance on the willingness of these healthcare workers to perform this work, to try and improve their conditions, in their own time.

76. The system does not recognise the extra work many Black, Asian, and Minority Ethnic HCWs and their organisations do. All the Black, Asian, and Minority Ethnic HCW networks are voluntary. Many organisations at the forefront of information campaigns were being asked to provide services and expertise in a voluntary capacity by media companies contracted and paid for by the government. and there is no protected time to do that work. This can lead to falling behind at work or as a result and now we are seeing, post-pandemic, career progression is being affected for ethnic minority healthcare workers. Our white colleagues don't necessarily need to join such networks and because they don't need to protect their time they are free to do other things.

77. The pandemic exposed the systemic problem that senior leaders within Central Government, and public health didn't understand the workforce they controlled. A critical piece for developing this understanding is consultation and engagement with communities of Black, Asian, and Minority Ethnic HCWs. Only then could any targeted policies or guidelines be developed to address the vulnerabilities within our communities, conduct emergency planning and build pandemic resilience. It seems obvious to our members that building pandemic resilience and proper emergency planning required an appreciation of health inequality, structural racism and institutional racism.

78. An example of a region where some of our members felt things were done well was Blackburn and Darwen – the directors of public health were very active in the communities and wanted to work with communities and wanted to counter the government messages coming out which were saying that the spread was due to ethnic minority congregations. It was good to have them as positive voices in those spaces and using their privilege to speak out against those messages.

IV. RECOMMENDATIONS

79. FEMHO are keen to share our expertise and experiences to the Inquiry in Module 3 to ensure that lessons are learned, and the disproportionate impacts of the Covid-19 pandemic are addressed and not repeated in future emergencies. We look forward to having the opportunity in due course to contribute to the Chair's recommendations in reducing systemic and underlying inequalities faced by our members and communities. At this early juncture, we invite the Inquiry to begin to consider the following areas:

(a) Improving data collation to ensure that race and ethnicity are relevant factors imbedded into data collation going forwards.

(b) Ensuring there is appropriate and cohesive guidance, plans and protocols for effective infection control across healthcare settings nationwide (including for situations involving airborne transmission).

(c) The need for review and investment where necessary into culturally competent and sensitive healthcare equipment (including appropriate PPE) and devices (e.g. oximeters).

(d) Specific and actionable plans to redress the gap in racial equality in senior management roles.

(e) Proper engagement with Black, Asian, and Minority Ethnic interests at senior levels, including in decision-making contexts to minimise future disparities. Consultation and formal recognition of Black, Asian, and Minority Ethnic staff networks are considered integral to improvement. Ensure that communications are improved and made accessible and relevant to ethnic minority communities. There should be a named team responsible and accountable for

delivering this action and leading on translation activities and other actions to make content accessible for ethnic minorities.

(f) Effective risk assessments and protection for vulnerable staff, including consideration of risk factors such as race and ethnicity.

(g) Afford Black, Asian, and Minority Ethnic network leaders across the NHS protected time to devote to network activities and improvements along with economic safety and professional protection.

(h) Tackle the underlying social determinants of health which have exposed many Black, Asian, and Minority Ethnic communities to the ill-effects of the pandemic. Steps must be taken to ensure that where recommendations are made in reports they are implemented. There should be a designated and named check and balance team accountable for monitoring progress. Recommendations already made should be implemented and tied to measurable goals and strategic roadmaps designed in close consultation with Black, Asian, and Minority Ethnic groups. Independent bodies reporting to parliament should be established and well-resourced to effectively track timely progress and ensure accountability.

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: 22 December 2023

ANNEX 1

List of FEMHO member organisations

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)

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 therapy 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	Speech and language therapy assistants
Maternity support workers	Switchboard operators
Medical secretaries	Theatre support staff