IN THE MATTER OF THE UK COVID-19 PUBLIC INQUIRY BEFORE

BARONESS HALLETT

THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

MODULE 3 CLOSING STATEMENT

"There was a lot of fear that they dare not tell them that the rules were being broken and they are being partial in some ways or even racist in some ways… that word that, you know, is often just in the background but not used in the NHS."[1]

Dr JS Bamrah, FEMHO.

1. EXECUTIVE SUMMARY

1.1. The pandemic was not only a public health crisis but also a profound moral test of equity, inclusion and justice. The NHS constitution states: "*it [the NHS] is available to all irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy, and maternity or marital or civil partnership status*". The evidence presented to this Inquiry, however, has demonstrated an undeniable pattern of institutional neglect and structural inequality. While the pandemic's unprecedented challenges stretched healthcare systems worldwide, its response in the UK revealed entrenched disparities that left ethnic minority healthcare workers and their communities disproportionately vulnerable to harm. These workers are the backbone of the NHS[2], yet historically have felt, and continue to feel, like second class citizens. Overrepresented and under-protected on the frontlines, they bore the brunt of systemic failures in planning, implementation and accountability. The UK government and public health bodies' failure to take proactive measures to address these entirely foreseeable vulnerabilities underpins it all. This Inquiry must hold those responsible to account for the systemic failures that allowed these preventable harms to occur.

1.2. The evidence presented in Module 3 has uncovered interconnected systemic issues, which by now are irrefutable. They are each underpinned by prevailing structural inequalities. Healthcare workers from ethnic minority groups faced heightened risks due to structural and institutional racism, pre-existing health inequities, systemic neglect of inclusive medical technologies such as pulse oximeters, and overrepresentation in frontline roles. Delayed interventions and inadequate risk assessments exacerbated these vulnerabilities, resulting in preventable harm. From this position of instability and vulnerability, the evidence has established glaring critical failures in protecting Black and Asian Minority Ethnic healthcare workers:

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[1] Hearing Transcript, 17/61/7-22

[2] Ethnic minorities account for nearly half of the hospital doctor workforce, for example, and GMC data has recently revealed that in the past two years nearly 2/3 of doctors joining the medical register in the UK qualified overseas.

1.2.1. **Failures in Personal Protective Equipment (PPE):** Witness testimony revealed significant deficiencies in the procurement, distribution and access to appropriate PPE for ethnic minority healthcare workers, including inadequate fit-testing for those with religiously significant facial hair and attire. These failures starkly highlighted the absence of inclusive planning in pandemic preparedness.

1.2.2. **Inadequate Risk Assessments and Staffing Redeployment**: The lack of standardised, ethnicity-aware workplace risk assessments exacerbated health disparities, particularly for ethnic minority workers in high-risk roles. The evidence also points to widespread inconsistencies in redeployment practices, further exposing vulnerable groups to heightened risks.

1.2.3. **Engagement, Consultation and Trust:** Public health responses failed to engage meaningfully with ethnic minority communities, eroding trust and reducing the uptake of critical health interventions such as vaccination. Within healthcare settings ethnic minority staff felt marginalised, undervalued and unheard. The absence of culturally competent communication strategies deepened the disconnect between healthcare authorities and marginalised populations.

1.2.4. **Data Failures:** The absence of robust ethnicity-disaggregated data capturing systems and processes severely undermined the ability to identify, assess and mitigate disparities in outcomes, leaving policymakers blind to critical vulnerabilities and delaying remedial action.

1.2.5. **Accountability, Inclusion and Leadership:** A lack of clear accountability structures and the underrepresentation of ethnic minorities in leadership roles weakened responses to health disparities.

1.3. The evidence makes it clear that systemic failures were not inevitable consequences of the pandemic but preventable outcomes of long-standing inequities. These failures reflect a broader culture of institutional neglect and inertia, wherein the needs of ethnic minority groups are systematically deprioritised.

1.4. In the sections that follow, we will delve deeper into each of these themes, drawing on witness testimony and documentary evidence to underscore the urgent need for systemic reform. We will start by outlining the most significant overriding layers of structural issues and inequalities uncovered and then explore how they intersected and interlinked to result in the specific disparate outcomes, suffering and harm experienced by ethnic minority healthcare workers during the pandemic.

1.5. We finish by looking forward at Recommendations. This Inquiry must not only acknowledge and document these disparities but also lay the groundwork for meaningful reform. The disproportionate impact of COVID-19 on Black, Asian, Minority Ethnic healthcare workers uncovered in this Inquiry reinforces the urgent need for systemic change. The COVID-19 pandemic must serve as a wakeup call and a turning point. The time for reflection is over; the time for action is now. The goal must be to achieve parity of esteem, promotion, and access to training for ethnic minority healthcare workers. This is not a matter of charity—it is a matter of justice. FEMHO calls on this Inquiry to ensure that the lessons learned here are not consigned to history but are translated into tangible policies that protect and empower ethnic minority healthcare workers in the years to come a moment for the UK's healthcare system to confront its failures and commit to meaningful change.

PREVAILING STRUCTURAL INEQUALITIES

"Well, it would be a combination of structural inequalities, the inequalities and structural racism that we see within society, how that plays out, for example, within the education system or the legal system, or within healthcare, as well as the interpersonal racism that we see on an everyday basis, the trauma, the bullying and harassment, what we call micro and macro aggressions, and how those two interact in terms of institutional racism, how that plays out within policies and processes within organisations, including, of course, our healthcare system."[3]

Dr Habib Naqvi (NHS Race and Health Observatory)

2. SYSTEMIC RACISM IN THE UK HEALTH SECTOR

2.1. The pandemic did not create the inequalities faced by Black, Asian, Minority Ethnic healthcare workers—it exposed and deepened them. This Inquiry has laid bare the stark and undeniable truth: the COVID-19 pandemic did not impact all people, or all healthcare workers, equally. It magnified and exploited pre-existing inequalities, exposing systemic failures that disproportionately endangered Black, Asian, and Minority Ethnic healthcare workers. FEMHO represents a significant number of these workers, and as their voice brings to this Inquiry's attention the fact that despite being at the frontline of the pandemic, these workers were too often left behind, under-protected, and unheard. Ethnic minority healthcare workers felt invisible, dispensable, and not valued.[4]

2.2. The underlying theme to all of the core issues in Module 3, we say, is systemic racism. The evidence heard over these weeks of Module 3 has painted a disturbing picture of disparity and neglect. From the outset, Black, Asian Minority Ethnic healthcare workers were at a disadvantage; overrepresented in high-risk roles and yet met with inadequate protections and systemic indifference. Simply put, surely it comes to this: namely that without acknowledging

[3] Hearing Transcript, 19/112/24-19/114/2
[4] INQ000475581, Witness Statement of Patricia Cullen.

that racism exists, we will not be able to move from the base. This Inquiry has provided ample evidence of that base, and it is our collective duty to ensure that lessons are not only learned but acted upon.

2.3. The pandemic exposed two interlinked yet distinct forms of entrenched racism—structural racism and institutional racism—that collectively perpetuated the inequities faced by Black, Asian, and Minority Ethnic healthcare workers and patients. These concepts are not theoretical abstractions; they are lived realities that operated visibly and invisibly throughout the healthcare system during COVID-19, as eloquently described by Dr Habib Naqvi.[5]

3. STRUCTURAL RACISM

3.1. Structural racism reflects how the overarching societal systems and structures that cumulatively create and maintain inequality across society, including healthcare, disadvantage ethnic minorities. Structural racism operated as a backdrop, amplifying the vulnerabilities of ethnic minority healthcare workers and placing them at heightened risk. These outcomes were not inevitable; they were the predictable result of this systemic neglect and racism.

3.2. These structural disparities manifested in a myriad of ways, including inequitable access to resources, discriminatory workplace practices, and a lack of representation in decision-making processes. It was evident in socioeconomic disparities that placed many ethnic minority workers in overcrowded, multigenerational housing, intensifying their risk of infection. Pre-existing health inequalities, such as higher rates of diabetes and cardiovascular disease among ethnic minorities, compounded these vulnerabilities. These inequities were exacerbated during the pandemic due to delays in accessing care, lack of targeted interventions, and mistrust rooted in a long history of discriminatory practices.

3.3. The former Secretary of State for Health and Social Care, Matt Hancock, acknowledged structural racism as a contributing factor to the disproportionate impact on ethnic minority workers. When asked whether *"Structural racism is likely to have been a contributing factor to the disproportionate impact on ethnic minority workers and patients. Can we agree on that?"* Hancock responded: *"Yes, we can. Yes."* This is a critical concession from the highest levels of government—a stark admission that the impact of the pandemic was not simply biological or coincidental but rather structural racism, embedded in the broader fabric of society, was a causative factor.

3.4. Witnesses such as Professor Keshav Singhal MBE (Chair of British Association of Physicians of Indian Origin, Wales)[6] and Dr Habib Naqvi underscored how socioeconomic deprivation, overcrowded housing, and occupational clustering exposed ethnic minority communities to

[5] Hearing Transcript, 19/112/24–19/114/2
[6] INQ000251934, Witness statement of Professor Keshav Singhal CBE

greater risks. As Dr Habib Naqvi stated: *"Structural racism isn't about a single institution; it is about interconnected systems—housing, education, employment—that have disadvantaged minority communities for decades. COVID-19 was simply the latest, most visible manifestation of these inequities."*[7] All these factors, stemming not from individual failings but from systemic inequities rooted in social and economic policies, increased exposure to COVID-19 and exacerbated its impact.

3.5. FEMHO submits that the evidence unequivocally shows that structural racism was a driving factor behind the disproportionate impact on ethnic minority healthcare workers. This Inquiry must confront these realities and ensure that the structural barriers exposed by the pandemic are dismantled to prevent future injustices

4. INSTITUTIONAL RACISM

4.1. Institutional racism by contrast, operates within organisations. It manifests in the discriminatory policies, processes, decisions, attitudes and workplace cultures that—intentionally or unintentionally—create inequitable outcomes. Witnesses across the hearings provided damning evidence of institutional racism at play in the UK health sector:

4.2. **Disparity in deployment:** Black, Asian, and Minority Ethnic healthcare workers were disproportionately deployed to high-risk frontline roles without appropriate risk assessments or protections, leaving them dangerously exposed. Decisions made without proper consideration for ethnicity-specific risks resulted in predictable harm. Risk assessments were either absent, inadequate, or 'tick-box exercises"' that failed to result in meaningful protections.

4.3. **Access to PPE and Medical Equipment**: PPE stockpiles failed to account for diverse facial features, relying on the 'Sheffield man face'—a design that excluded ethnic minority workers. This wasn't just a logistical failure; it was a moral failure, a stark example of institutional racism that cost lives.

4.4. **Exclusion from Decision-Making.** Ethnic minority workers were excluded from pandemic planning, depriving decision-makers of critical insight and creating a power imbalance that left ethnic minority workers voiceless in decisions affecting their safety. As FEMHO argues, a one-size-fits-all approach ignored the unique challenges ethnic minorities faced.

5. FORESEEABILITY

5.1. The COVID-19 pandemic cast a harsh light on the systemic inequalities embedded within the healthcare system for Black, Asian, and Minority Ethnic healthcare workers and patients. From the earliest stages of the pandemic, the evidence revealed an alarming pattern: minority ethnic

[7] Hearing Transcript, 19/112/24–19/114/2

people – particularly healthcare workers – were disproportionately affected, both in terms of infection rates and mortality. Professor Philip Banfield, Chair of the BMA, recounted: *"It was obvious very, very early on, the first ten deaths of doctors were all Black or … South Asian.*[8]

5.2. These disparities became evident as early as March 2020, when stories were being told about clusters of infections and deaths disproportionately involving ethnic minority groups. This reality was further emphasised by Professor Keshav Singhal, Chair of the BAPIO Wales, who confirmed: *"Towards the end of February 2020 and through March 2020, I and my colleagues became aware of disproportionately high mortality amongst BAME healthcare workers, including doctors from South Asian origin and nurses from Black and Filipino communities."*[9]Alarm was raised by the numbers of minority ethnic patients being admitted to ICU experiencing severe Covid symptoms.

5.3. So too the pandemic revealed profound structural inequalities, manifesting in issues as fundamental as access to safe PPE and disproportionate redeployment to high-risk zones. These failures were compounded by cultural insensitivity and a lack of tailored guidance. Ethnic minority workers were effectively pressured to work in unsafe environments, particularly where they lacked the power to advocate for their safety without fear of reprisal.[10] As a consequence, ethnic minority healthcare workers were not only disproportionately exposed to the virus but also silenced in raising concerns about their safety. The cumulative impact was a tragic reflection of systemic neglect that cost lives and eroded trust.

5.4. The effects have persisted long after the initial waves of the pandemic. Ethnic minority healthcare workers despite bearing the brunt of the pandemic have been left under-supported in its aftermath, reporting higher rates of attrition, burnout and mental health challenges, driven by the cumulative toll of their experiences during the crisis.[11] These systemic failings highlight the pervasive impact of structural racism on healthcare workers.

5.5. The disparate impact of the COVID-19 pandemic on ethnic minority healthcare workers was not an unforeseeable consequence but a predictable outcome of well-documented and deep-rooted systemic inequities. These are not new challenges; rather, the pandemic merely amplified longstanding structural issues that have been permitted to persist. Professor Kamlesh Khunti, Chair of the SAGE Ethnicity subgroup, stated: "*Inequalities in health outcomes and access to care by ethnic group were well evidenced prior to the pandemic, as were wider social inequalities. This made the likelihood of disparities in risks and outcomes as a consequence of Covid-19 infection somewhat foreseeable*"[12] Professor Banfield, Chair of the BMA, powerfully

[8] Hearing Transcript 20/166/10–20/168/8
[9] INQ000251934, Witness statement of Professor Keshav Singhal CBE
[10] INQ000215615/11, Report from UNISON Scotland, titled Underlying Inequalities & Infection Risk, Black Workers and Covid-19
[11] INQ000176038/6-8, Report from Royal College of Nursing, titled Building a Better Future for Nursing
[12] INQ000252609/5, paras 2.10-2.11, Witness Statement of Professor Kamlesh Khunti

articulated: "*Before the pandemic, we already knew that there was a disparity... And we went into the pandemic, you know, in that state —born of systemic neglect—compromised the ability of Black, Asian, and Minority Ethnic healthcare workers to perform their roles effectively and safely. These workers found themselves disproportionately deployed to high-risk wards, yet the lack of adequate induction, training, and risk assessments left them uniquely vulnerable.*"[13]

5.6. When asked what could have practically been done for ethnic minorities to reduce the obvious disparity (and what could be done in the future), Chris Whitty, former CMO, responded, "*I think you are obviously precisely right, that some bits of this are (a) predictable and (b) unremediable, in the immediate crisis of a pandemic. So if you want to do something about it, you should have done it over many years previously, and that's just a practical reality.*"[14] This response in one sense is correct in that it highlights the total lack of preplanning by Government and within public health on this issue. On the other hand, it is a profound abdication of responsibility, deflecting accountability for a failure to act both before and during the pandemic. While systemic disparities are predictable, they are not 'unremediable' in a crisis. Effective interventions such as ethnicity-specific risk assessments, equitable PPE distribution, and targeted support for vulnerable groups were demonstrably possible. Whitty's framing minimises the urgency of addressing foreseeable inequities and perpetuates the cycle of inaction, failing to meet the state's legal and moral obligations to protect life and advance equality.

6. DELAYED RESPONSE

6.1. The evidence paints a clear and devastating picture: the disproportionate impact on ethnic minority healthcare workers was known early but not acted upon with urgency. The failure to protect these frontline workers in a timely and targeted manner remains a profound injustice.

6.2. Despite early data showing disproportionate infection and mortality rates among ethnic minority healthcare workers, the response was inexcusably delayed. As Professor Philip Banfield, Chair of the BMA, reflected: "*It would have been eminently preferable to have taken a precautionary approach. And at that point to have made sure that we were absolute in our support and making sure that people from ethnic minority backgrounds were protected... and that they were not being pressurised to work in unsafe environments.*"[15] Yet, this precautionary approach was not taken. It was not until significant pressure from organisations like FEMHO that the government began to acknowledge and address these disparities. A letter from FEMHO member organisation BAPIO as early as April 2020 urged the government to implement stratified risk

[13] Hearing Transcript, 20/166/10–20/168/8
[14] Hearing Transcript, 12/163/9-12/166/6
[15] Hearing Transcript, 20/165/19–20/166/8

assessments and protections for ethnic minority staff, warning of "*palpable worry, upset, and anger*" among Black, Asian Minority Ethnic healthcare workers.[16]

6.3. The evidence reveals a pattern of delayed responses and missed opportunities to mitigate the risks faced by ethnic minority healthcare workers. It was not until June 2020—several months into the pandemic—that NHS England began urging trusts to conduct ethnicity-specific risk assessments. Even then, these efforts were patchy, and as noted by UNISON, 60% of Black workers had not been offered an individual risk assessment, and of those who had, a significant minority (35%) felt it did not adequately address the risks they faced.[17] This accords with FEMHO members' generally poor experiences of the process; of those who had risk assessments and where risks had been identified there was more often than not no mitigating action and no follow up.[18]

6.4. By the time these issues began to be addressed, the damage was done—trust was broken and many lives had already been lost due to systemic inertia, institutional failures, and an unforgivable delay in responding to a crisis that disproportionately claimed ethnic minority lives.

7. ACCOUNTABILITY AND RESPONSIBILITY

7.1. Accountability must lie at the heart of this Inquiry's findings. The NHS and public health systems across the four nations as employers must fulfil their duty of care to their employees, and yet, as the evidence shows, this duty was too often neglected. The disproportionate impact on these workers, their overrepresentation in high-risk roles, and the structural inequalities exacerbated by the crisis demand urgent attention. This Inquiry must confront these realities head-on to ensure meaningful reform

7.2. The evidence heard during this Inquiry has made it abundantly clear that addressing these disparities requires more than surface-level interventions. FEMHO would argue that the ethical principle of reciprocity is relevant and pertinent, namely that if you have a healthcare worker who is putting themselves in harm's way, that greater risk should inform decisions about how they work, where they work, and that should be a priority. However, as became clear as the evidence unfolded, no mechanisms were in place to ensure this principle was upheld during the pandemic.

7.3. Similarly, Professor Habib Naqvi made clear that it is important to "*focus on the causes of the causes if we are to have permanent solutions to these challenges.*",[19] Advocating for a deeper examination of the systemic factors that place Black, Asian, Minority Ethnic workers in high-risk

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[16] INQ000120826, Letter from BAPIO to Chief of Executives of NHS Trusts and other health boards regarding COVID-19: Disproportionate high mortality rates in BAME health and social care workers (HSCW), dated 22/04/2020.
[17] INQ000471985/41-42; paras 135-137, *Witness Statement provided by Sara Gorton on behalf of the Trades Union Congress*
[18] See for example the experiences of M3/W3 at INQ000494256/8
[19] Hearing Transcript, 19/121/25–19/123/11

roles, such as lower pay, limited career advancement opportunities, and unsafe living conditions. Without tackling these root causes, any measures implemented will be, at best, temporary fixes.

7.4. FEMHO stresses the need for a cultural shift within the NHS to prioritise equity and inclusion. Structural and institutional racism within the NHS have long compromised the safety, opportunities, and outcomes of ethnic minority healthcare workers. The pandemic exposed these issues in stark detail, underscoring the urgent need for reform. FEMHO submits that addressing these forms of racism and underlying structural inequalities requires both immediate and long-term action.

THE OUTCOME: CRITICAL FAILURES IN PROTECTING BLACK ASIAN MINORITY ETHNIC HEALTHCARE WORKERS

8. PERSONAL PROTECTIVE EQUIPMENT (PPE)

8.1. The provision and use of PPE became one of the most visible symbols of institutionalised racism pervasive across the health sector during the COVID-19 pandemic. For healthcare workers on the frontline, PPE was not just a precaution—it was a lifeline. Yet, for many Black, Asian, and Minority Ethnic healthcare workers, this lifeline was flawed, inconsistent, and at times, inaccessible. The inadequate fit testing of PPE for ethnic minorities, coupled with disparities in access and data deficiencies, amounted to systemic failures that jeopardised the health and safety of these workers.

8.2. **Disparities in Access to PPE:** Witnesses consistently highlighted the inadequacy of PPE fit-testing processes, particularly for staff with facial hair due to religious or cultural practices. Standard mask designs often excluded such workers, forcing them to choose between their faith and their safety. This exclusion was entirely preventable but persisted throughout the pandemic due to a lack of foresight and inclusive planning.

8.3. Their testimonies provide clear and harrowing evidence of inadequate PPE, leading healthcare workers to reuse disposable equipment or purchase their own protective gear. Sara Gorton of the Trades Union Congress summarised the problem: *"There was a scramble for PPE... Even when PPE was available, it was often out of date or was not shaped to fit the gender and ethnicity profile of the NHS workforce."*[20]

8.4. The lack of sufficient PPE, combined with the systemic failure to address these concerns equitably across trusts, resulted in both physical and psychological harm to frontline staff. Witness statement of M3/W2, Member of Frontline Migrant Health Workers' Group, highlighted

[20] INQ000471985/5; para 15, Witness Statement provided by Sara Gorton on behalf of the Trades Union Congress

stark inequities in PPE distribution, stating, "*In-house staff were given a better quality of PPE… and many of our workers were given sort of disposable masks that they were told to reuse.*" They further revealed that staff who questioned inadequate protections faced "*punitive measures*," being labelled as "*troublemakers*," silenced, or moved to more dangerous roles. This testimony underscores systemic failures in safeguarding and supporting healthcare workers, particularly those already vulnerable.[21]

8.5. Professor JS Bamrah said of the inconsistent supply and response: *"Many of them [healthcare workers] actually had to purchase their own PPE because the hospitals would not provide them… we were not adequately equipped to look after patients. We are putting our own lives and our families' lives at risk.*[22] Ms Gillian Tierney said in her statement *"Some members reported being advised to use a single facemask and apron for an entire ward round due to lack of supplies, and others purchased their own supplies from industrial supply companies."*[23]

8.6. Additionally, powered air-purifying respirators (PAPRs), which could have resolved fit-testing issues for staff with religiously significant facial hair, were largely unavailable. Professor McKay said, "*we had access to power respirators… But it transpired that there wasn't an approved method of filter cleaning or availability of filters to change for these masks. But for whatever reason, we were never allowed to deploy these masks into the workplace at that time and it was a source of ongoing frustration that it took many months for a supply of powered respirators to be made available to staff.*"[24] Ethnic minority healthcare workers were more likely to fail fit tests due to the reliance on standard-sized masks. Despite repeated warnings, alternatives like PAPRs were not adequately supplied. Instead, these workers were often redeployed to lower-risk roles, further stigmatising them and exacerbating staffing shortages in critical areas.[25]

8.7. **Disparities in PPE Distribution:** This inequity was not only a matter of inadequate stock but also of flawed distribution. Ethnic minority healthcare workers, overrepresented in frontline roles, reported experiencing delays and shortages in accessing suitable PPE. These delays placed them at heightened risk of exposure to the virus. The guidance around PPE was often written before the pandemic failed to anticipate the unique needs of diverse healthcare workers. As a result, ethnic minority staff found themselves working without the protections they desperately needed. Further, the lack of tailored guidance exacerbated the problem. A precautionary approach to ensure that ethnic minority workers were adequately protected should have been taken, but this approach was not implemented. Instead, these workers were

[21]Hearing Transcript, 19/51/2-8
[22]Hearing Transcript, 17/33/9–17
[23] INQ000252912/7 §21 onwards, Witness Statement provided by Gillian Tierney
[24]Hearing Transcript, 31/15/1-16
[25] INQ000412904/26 Witness Statement provided by Dr Katherine Henderson

left to navigate a system that prioritised standard practices over specific needs, often at the expense of their safety.

8.8. Witnesses described a postcode lottery in PPE availability, with some Trusts taking proactive steps to address disparities while others lagged behind. This inconsistency, coupled with a lack of centralised accountability, left many healthcare workers feeling abandoned. For example, Dr. Tilna Tilakkumar (GP/BMA): *"We — so a lot of us used our own scrubs. I borrowed some scrubs from the neighbouring trust, an acute trust. We bought visors and goggles off the internet... That was something that we asked for. That wasn't included in the original PPE that we had, but we needed that specifically for our cohort of patients.*[26]

8.9. **Cultural and Religious Barriers:** One of the most troubling aspects of the PPE crisis was the failure to accommodate cultural and religious diversity. Facial hair, which is often worn for religious reasons, presented a well-documented challenge to achieving an adequate fit for FFP masks. Guidance merely suggesting 'suitable facial hair' was insufficient. The absence of proactive measures to address these issues was stark. FEMHO submits that simple, yet impactful steps, such as stockpiling alternative PPE designs and engaging with community leaders to develop inclusive solutions, could have mitigated these risks. This approach highlights the importance of building trust and ensuring representation in decision-making processes, a recommendation that remains critical for future planning.

8.10. **Inadequate Fit Testing**: Proper fit testing of respiratory protective equipment is essential to ensure effective protection. For FEMHO's healthcare workers, however, this fundamental safety measure was often overlooked or improperly conducted. As Professor Fong acknowledged: minority ethnic staff faced higher failure rates in fit testing due to "*facial features and characteristics*," including cultural factors such as facial hair. This was not merely a technical oversight but a reflection of a system ill-prepared to accommodate diversity. A mid-2020 survey of Black healthcare and social care workers revealed a systemic failure to address these disparities. The survey found that 60% had not been offered an individual risk assessment, and only 6% had been redeployed to lower-risk roles. Alarmingly, over a third (35%) felt pressured to work in unsafe conditions, and only half reported receiving appropriate PPE, with 58% lacking training in its safe use.[27]

8.11. The impact of these failures was devastating. Although employers were ultimately responsible for ensuring the safety of their workers, this duty was left unfulfilled for Black, Asian, Minority Ethnic healthcare staff. In her witness statement, Dr. Tilna Tilakkumar of the British Medical Association testified, "*A lack of PPE meant staff (who were predominantly from Black and ethnic*

[26]Hearing Transcript, 14/117/9-21

[27] INQ000471985/41-42; paras 135-137

minority backgrounds) had to source their own PPE … We brought goggles off Amazon. This resulted in a feeling amongst staff on the ground that we were not being heard and we did not feel safe." [28] This stark account highlights the systemic neglect faced by ethnic minority healthcare workers, leaving them unprotected and eroding trust in their safety and value within the NHS. These systemic lapses left many ethnic minority workers exposed to higher risks, a reality that should never have been tolerated.

8.12. **Broader Implications of PPE Failures:** The persistent inadequacies in PPE provision had a profound impact on trust among healthcare workers, particularly those from ethnic minority backgrounds. Lord Bethell, in his witness statement, acknowledged this erosion of trust: *"The failure to ensure consistent access to PPE undermined morale and confidence, particularly among ethnic minority healthcare workers who were disproportionately affected."*[29] This erosion of trust extended beyond the workforce, with many ethnic minority communities viewing the failures as further evidence of systemic disregard for their safety and well-being. The emotional toll of inadequate PPE provision was starkly evident in the testimony of ethnic minority healthcare workers. Some described feeling undervalued and invisible.[30]

9. ASSESSMENT OF RISK

9.1. Risk assessments, a cornerstone of workplace safety, were often said to have been carried out as a tick-box exercise and conducted without sufficient consideration for the heightened vulnerabilities of Black, Asian and Minority Ethnic workers. Lisa Ritchie, Chair of the NHS England IPC Cell, admitted that risk assessments were only conducted as general measures and not tailored specifically to the heightened vulnerabilities of ethnic minority healthcare workers, despite a stark disparity in infection rates being evident at the time: *"There was a clear and stark disparity evident in the disproportionate infection rates for ethnic minority healthcare workers which was public at the time... Counsel to the Inquiry asked whether there was any particular risk assessment specific to ethnic minority healthcare workers, and your response was that it was only a general risk assessment."*[31]

9.2. The risk assessments and redeployment protocols implemented during the pandemic represented a critical failure to protect ethnic minority healthcare workers, who faced disproportionate risks of infection and mortality. Evidence presented to the Inquiry has revealed that these failures were rooted in a lack of centralised accountability, inconsistent implementation across Trusts, and insufficient consideration of the unique vulnerabilities faced by these workers. This section examines these failings and their broader implications.

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[28] INQ000492278/9; para 31, Witness Statement of Dr Tilna Tilakkumar
[29] INQ000486334/19
[30] INQ000475581/55, Witness Statement of Patricia Cullen, RCN
[31] Hearing Transcript, 5/173/21-5/175/8

9.3. Despite evidence of their increased susceptibility to severe outcomes from COVID-19, these assessments were not prioritised until months into the pandemic. This was a critical failing that exposed ethnic minority workers to unnecessary risks. The NHS Race and Health Observatory reported that risk assessments often relied on generic templates, failing to incorporate specific adjustments for ethnic minority staff. This approach effectively ignored the disproportionate impact of COVID-19 on these groups and the urgent need for tailored interventions. As Sara Gorton of the Trades Union Congress testified: *"Risk assessments for staff from Black, Asian, and minority ethnic (BAME) backgrounds have clearly been inadequate, threatening their safety."*[32]

9.4. A survey by the Royal College of Emergency Medicine highlighted "*significant racialised patterns of occupational risk for staff working in Emergency Departments during the first wave of the pandemic*." Almost half of BAME respondents reported failing fit testing for PPE "*very often, often, or sometimes*," compared to just over one-third of white respondents. Risk assessments for BAME staff were described as "*clearly inadequate,*" leaving them more likely to lack access to adequate PPE while in contact with suspected or confirmed COVID-19 cases. The survey further emphasised that ethnic minority staff faced disproportionate mortality risks and often felt unable to voice their concerns, reflecting deep systemic issues. As the report states, "*It is essential that the PPE guidelines are revisited to ensure they are adequate to keep all staff safe,*" particularly in recognising and addressing the heightened vulnerabilities of minority staff.[33]

9.5. **Exclusion of Ethnicity as a Key Risk Factor:** The lack of systematic inclusion of ethnicity as a factor in risk assessments was a glaring oversight. Despite early data indicating the disproportionate impact of COVID-19 on ethnic minorities, many assessments relied on generic templates. This omission left ethnic minority healthcare workers unprotected despite their overrepresentation in frontline roles. As described by Professor Kamlesh Khunti, ethnic disparities in health outcomes were well evidenced before the pandemic, and yet the scale of the disparities witnessed during COVID-19 should have made ethnicity a clear factor in risk assessments. This oversight was a missed opportunity to prevent harm.[34]

9.6. **Inconsistent Implementation Across Trusts:** Risk assessment protocols varied widely between Trusts, creating disparities in worker protection. Some Trusts conducted comprehensive assessments and implemented redeployment strategies to safeguard

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[32] INQ000376187/1-2, Article from The Royal College of Emergency Medicine titled RCEM survey finds one in five BAME EM clinicians have not been risk-assessed by their Trust, dated 21/01/2021.
[33] INQ000376184/9 Guidance from The Royal College of Emergency Medicine titled Emergency Department Infection Prevention and Control (IPC) during the Coronavirus Pandemic, dated February 2021.
[34] INQ000252609/2-3, Witness Statement of Professor Kamlesh Khunti

vulnerable workers. Others treated risk assessments as a procedural formality, with little regard for the actual risks involved.

9.7. **Unequal Redeployment Practices:** Redeployment policies often placed ethnic minority healthcare workers in high-risk roles without adequate consideration of their vulnerabilities. Witnesses testified to being disproportionately assigned to COVID-19 wards, even when they expressed valid safety concerns. Professor JS Bamrah of FEMHO gave evidence on the disproportionate risks faced due to being "*more likely to turn up right at the coalface of Covid*," often assigned to high-risk patients and areas without adequate consideration for their safety. This was particularly evident when substantive staff were shielded, leaving agency staff (disproportionally from ethnic minorities) to fill the gaps. Professor Bamrah highlighted the vulnerability of these precariously employed workers, noting that they often felt unable to refuse unsafe assignments for fear of losing future work opportunities, despite the evident risks. He emphasised, "*They don't have the kind of protection that substantive people have in employment*,". FEMHO also raised concerns about the inadequate risk assessment for these workers, particularly those with pre-existing vulnerabilities such as asthma or diabetes, underscoring the urgent need for systemic protections to prevent such inequities in future crises. When redeployment was necessary, support mechanisms such as training and psychological resources were frequently absent, compounding the challenges faced by healthcare workers.

9.8. The BMA survey revealed that 64% of Black, Asian and Minority Ethnic doctors felt pressured to work in "*hot wards*" with COVID-19 patients, compared to 33% of their white colleagues.[35] Additionally, workers from ethnic minority backgrounds were far less likely to have access to adequate PPE or be fit-tested for critical respiratory protection. Despite this, systemic data systemic data documenting redeployments was glaringly absent. As Professor Summers, ICU expert, acknowledged the anecdotal evidence suggesting racial disparities in redeployment practices, but found there was no *"systemic data that outlined the problem"*.[36] He conceded the "data gap" issue —a gap that underscores the broader failure to monitor and address disparities.

10. FAILURES IN MEDICAL EQUIPMENT DESIGN: THE CASE OF PULSE OXIMETERS

10.1. **A Cataclysm of Inequality and Structural Racism:** The failure of pulse oximeters to accurately measure oxygen saturation in individuals with darker skin tones stands as a stark symbol of structural racism and inequality embedded within healthcare. This issue is not merely a technical flaw but a manifestation of systemic neglect that has perpetuated health disparities and undermined trust in medical systems.

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[35] INQ000339466 Report titled Never Again, COVID from the frontlines, a joint report of the experiences of UK doctors from HCSA and EveryDoctor, dated March 2022.
[36] Hearing Transcript, 18/86/16-87/9

10.2. Pulse oximeters, a critical diagnostic tool during the pandemic, were found to provide less accurate readings for individuals with darker skin tones. This flaw delayed treatment and contributed to worse health outcomes for ethnic minority patients. Research dating back to 1990 highlights systemic issues with these devices. A 2020 study found that among patients with oxygen saturation readings of 92% to 96% on pulse oximeters, Black patients were three times more likely than White patients to have arterial oxygen saturation below 88% when measured by arterial blood gas sampling, a significant disparity linked to delayed or inadequate care. [37] Another analysis from the NHS Race and Health Observatory revealed, "*Pulse oximeters consistently overestimated oxygen saturation during hypoxia in individuals with darker skin tones*"[38]

10.3. The mechanism by which skin pigmentation affects pulse oximetry remains unclear, but experts agree on the urgent need for corrective action. Recommendations included the immediate review of pulse oximetry products and international standards to ensure calibration for diverse populations.[39]

10.4. A consensus statement from NHS England emphasised that pulse oximetry should remain part of clinical assessments but cautioned that reliance on these devices could exacerbate health disparities if inaccuracies for darker skin tones are not addressed. "*The potential harm from undetected deterioration is far greater than the risks of inaccuracies in the devices,*".[40] The consensus statement appropriately acknowledges both the critical role of pulse oximetry and its limitations, particularly for patients with darker skin tones. However, it strikes a tone of minimisation by stating that the harm from undetected deterioration outweighs device inaccuracies, without sufficiently addressing accountability or immediate mitigation strategies. The emphasis on "*further research and vigilance*" is vague, given the long-standing evidence of these disparities. This phrasing risks shifting urgency away from actionable reforms in testing, calibration, and procurement processes that could address systemic biases now, rather than later.

10.5. The Department of Health and Social Care's 2024 report, Equity in Medical Devices: Independent Review, was more forthcoming in acknowledging the impact as it noted: "*There is extensive evidence of poorer performance of pulse oximeters for patients with darker skin tones. This bias has been linked to delayed recognition of disease, worse organ function, and even*

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[37] INQ000249826/2 Report from the NHS Race and Health Observatory, titled Pulse oximetry and racial bias: Recommendations for national healthcare, regulatory and research bodies, dated March 2021. .
[38] INQ000249826/3 Ibid
[39] INQ000315604/4 Witness Statement provided by Habib Naqvi on behalf of NHS Race and Observatory.
[40] INQ000283537, pp. 1–3 Consensus Statement between DHSC, NHS England, and other UK Health System partners on the use of pulse oximeters on patients from different ethnic groups, final draft [file name indicates date of 04/02/2022].

death in Black patients compared to White patients in other healthcare systems. While causation is complex, the association underscores the potential for harm in the NHS."[41]

10.6. **Accountability in Medical Device Procurement:** Despite long-standing awareness of these disparities, healthcare systems continued to procure and deploy flawed devices. The Witness Statement of Matthew Style, Jonathan Marron and Professor Lucy Chappell, dated 22/12/2023, discusses issues with pulse oximeters for those with darker skin pigmentation. Notes MHRA guidance published 26 March 2021 which: "*suggested that it is possible that patients with lighter skin may have small differences in the result reported when compared to those with darker skin. Skin colour was identified as just one of the factors that can alter the result produced, amongst other factors such as low perfusion, movement, and tattoos*." The guidance goes on at [126-127] to refer to the NHS Race and Health Observatory rapid review on this which identified: "*a growing body of evidence ...that pulse oximetry is less accurate in darker skinned patients. Given the increased mortality amongst ethnic minority patients during the Covid-19 pandemic, it is possible that the differential accuracy of pulse oximetry is a contributing factor to this health inequality*".[42]

10.7. These ongoing failures shall continue to erode trust among ethnic minority communities, many of whom already perceived systemic bias within healthcare systems. That the devices' flaws were known but not addressed is astonishing and reinforces perceptions of neglect. As one clinician noted, "*The colour of your skin should not determine your chances of survival,*"[43] The NHS Race and Health Observatory highlighted this as a failure in regulation and procurement practices, stating systemic biases in device design and testing perpetuate inequities, requiring immediate regulatory reform.[44] The inaccuracy of pulse oximeters compounded broader health inequalities. Black and Asian patients faced disproportionate mortality rates during the pandemic, with equipment failures identified as a contributing factor. It is trite that devices designed without diversity considerations are more likely to lead to adverse outcomes in vulnerable groups, which was underscored the NHS Race and Health Observatory. [45]

10.8. The systemic failures in PPE and medical equipment provision during the pandemic were avoidable and highlight a broader lack of inclusivity in healthcare planning and procurement. The pandemic has underscored the urgent need for reforms in medical device testing, regulation, and procurement processes to ensure equitable health outcomes for all populations.

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[41] INQ000438237/23, Report from DHSC titled Equity in Medical Devices: Independent Review, dated 14/03/2024.
[42] INQ000389241/38, Witness Statement of Matthew Style, Jonathan Marron and Professor Lucy Chappell
[43] Hearing Transcript 27/130/22–27/137/21.
[44] INQ000315604/5 Witness Statement provided by Habib Naqvi on behalf of NHS Race and Observatory
[45] INQ000315604/4 Witness Statement provided by Habib Naqvi.

As emphasised by multiple inquiries, "*The NHS must lead by example in ensuring its procurement standards prioritise equity and inclusivity.*"[46]

11. DATA QUALITY AND MONITORING: THE MISSING FOUNDATION

11.1. Underlying many of the failures was a lack of reliable data to guide decision-making. Tools like Onomap, which were relied upon to infer ethnicity data, were limited and imprecise. While such tools provided some insight, they were insufficient for capturing the full scope of disparities. Without comprehensive data, the system was unable to adequately understand or address the factors driving disparities.

11.2. Professor Fu-Meng Khaw's evidence was particularly illuminating in this regard. He described the limitations of the Onomap tool used to analyse ethnic disparities, admitting that it provided only a partial picture and lacked the robust data necessary to drive informed action. Professor Khaw explained: *"The system that we had access to where information around ethnicity on individuals is stored didn't have a very good completion rate... I understand it's about 40%. So for 60% of individuals across Wales, we didn't have information around ethnicity."*[47]

11.3. This deficiency was compounded by the absence of meaningful ethnicity data in PPE fit testing and distribution. This Inquiry should rightly criticised the lack of targeted data collection, and should note that without accurate information, it was impossible to fully understand or address the disparities in infection risks faced by ethnic minority healthcare workers.

11.4. The failure to collect and analyse comprehensive data not only hindered immediate responses but also undermined efforts to learn from the pandemic. FEMHO submits that this represents a critical gap that must be addressed. Inclusive data collection and analysis are essential for understanding and mitigating health inequities.

11.5. **Limitations in Ethnicity Data Collection: A Flawed Foundation**: The pandemic exposed significant gaps in the collection and use of ethnicity data, undermining the ability to measure and address its impact on Black, Asian, and minority ethnic groups. The collection and analysis of ethnicity data were critical to understanding how COVID-19 affected different groups. Yet, the evidence presented to this Inquiry reveals systemic failings in this area. A lack of robust ethnicity data meant that patterns of disparity were not identified quickly enough thereby delaying targeted interventions. This failure reflected broader deficiencies in how ethnicity data is integrated into public health systems.

11.6. Further, the absence of a unified approach to data collection led to inconsistencies across healthcare providers. This patchwork system resulted in delays in identifying clusters of

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[46] INQ000438237/307 Report from DHSC titled Equity in Medical Devices: Independent Review, dated 14/03/2024.
[47] Hearing Transcript, 25/73/17–25/75/2

infections and deaths among ethnic minority healthcare workers, leaving many vulnerable to preventable harm.

11.7. **Long Covid Data Gap**: The absence of robust data on Long Covid has severely limited understanding of its prevalence and impact, particularly among ethnic minority communities. Professor Rachel Evans highlighted the data gaps, explaining: "*One of the major, if not the limitation, is data, and that data being from routine clinical healthcare records. We rely on that a great deal to understand how healthcare is delivered, but it absolutely relies on people having correct coding in their healthcare record... The difficulty is that 20% of people seem to be missing their ethnicity data, and therefore we really can't comment whether that data is representative*"[48] It is unclear whether Long Covid disproportionately affects ethnic minority groups. While it is known that ethnic minority healthcare workers were at a higher risk of contracting COVID-19, Professor Evans noted that underreporting and cultural barriers may mean affected individuals remain invisible to the healthcare system: "*There are definite people that we're missing, and they are people that we miss in all healthcare.*"[49]

11.8. **The Impact of Data Gaps on Public Health Responses**: The lack of reliable ethnicity data had profound implications for public health responses. This deficiency FEMHO submits hindered efforts to allocate resources equitably, prioritise high-risk populations, and tailor interventions to meet specific needs. The gaps in ethnicity data collection were not merely administrative oversights but systemic failures that disproportionately affected Black, Asian, Minority Ethnic healthcare workers and communities. These failings reinforced pre-existing health inequalities and undermined trust in public health institutions.

11.9. **Improved Data Collection and Inclusive Tools**: To address these deficiencies, witnesses emphasised the need for comprehensive, inclusive, and standardised data collection practices. Professor Ann John underscored the importance of co-production with ethnic minority communities to ensure the relevance and accuracy of data collection processes. She explained: *"It really highlighted how important it was to have co-production, be going to groups of people from, you know, ethnic minorities, from more deprived communities, to really understand how they felt about interventions being discussed... that co-production and co-development of interventions is really important."*[50] Such measures are essential for identifying and addressing disparities. Moreover, the design of data collection tools must reflect the diversity of the population they serve. Co-production with ethnic minority communities could enhance the accuracy and relevance of data collection processes. FEMHO endorses this proposal and calls for the establishment of robust systems to monitor and address disparities in real time.

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[48] Hearing Transcript, 21/117/21–21/118/35
[49] Hearing Transcript, 21/117/21–21/118/35.
[50] PHT000000074/29-30, Hearing Transcript from Module 2B

12. FAILURE TO ENGAGE ETHNIC MINORITY COMMUNITIES

12.1. **Lack of Targeted Communication:** The pandemic exposed significant gaps in the government's engagement with ethnic minority communities in disseminating information about COVID-19 measures and vaccines. Witnesses highlighted that public health messaging often failed to consider cultural, linguistic, and socioeconomic factors, limiting its reach and impact. Dr. Habib Naqvi, said: *"The message is important, but so is the messenger."*[51] JS Bamrah remarked on the lack of understanding from leadership in regards to the particular issues of culture race and ethnicity and referred to the "*abject failure*" to actually understand the related sensitivities.[52]

12.2. Public health campaigns were often generic, failing to account for cultural and linguistic diversity. Key public health messages were not always accessible to non-English-speaking communities, resulting in confusion and reduced compliance with safety measures. This failure was particularly evident in the dissemination of information about vaccination and infection prevention, where mistrust and misinformation flourished in the absence of tailored communication. This lack of culturally tailored engagement also contributed to disproportionately lower vaccination uptake among certain groups, particularly Black Caribbean and Black African communities.

12.3. **Barriers to Accessing Healthcare**: Cultural and linguistic challenges further exacerbated the difficulties faced by ethnic minority communities in accessing healthcare during the pandemic. Language barriers can prevent ethnic minority patients from seeking timely medical advice, increasing the severity of illness by the time care was. These barriers were not limited to language. Cultural stigma around certain medical conditions, coupled with a lack of understanding among healthcare providers, can created additional obstacles for ethnic minority patients. This combination of factors contributes to poorer health outcomes and reinforced health inequalities. Structural barriers such as digital exclusion, socioeconomic disparities, and historical mistrust limited the effectiveness of public health messaging.

12.4. The Inquiry heard that where efforts were made to collaborate with trusted community leaders, there was value in proactive partnerships. Vaughan Gething, Former Health Minister for Wales, provided an example: *"We were able to work with organisations like the British Islamic Medical Association. They created a video with ethnic minority doctors and clinicians who were able to explain and answer concerns... Feedback was really important and helped us nuance our response"*[53]

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[51] Hearing Transcript, 19/126/11–19/127/3
[52] Hearing Transcript, 17/44/1-10
[53] Hearing Transcript, 34/102/13–34/103/18

12.5. **The Digital Divide and Accessibility:** The shift to digital and remote healthcare services during the COVID-19 pandemic exposed significant inequities in access, disproportionately affecting ethnic minority communities. These disparities were rooted in systemic barriers, including the digital divide, socio-economic inequalities, and a lack of culturally sensitive design in healthcare delivery. These challenges hindered equitable access to care and worsened health outcomes for ethnic minority groups. As Michael Mullholland accepted on Day 9 "*We recognise that there was -- some populations didn't have the same digital access as others. And I think some of our work within the health and equalities group has shown that some of the black, Asian and minority ethnic groups fall into some of those places where digital access was less available. And so that would've impacted them adversely.*"[54]

12.6. The reliance on digital platforms for healthcare services during the pandemic presented unique challenges for ethnic minority communities. Many individuals lacked the necessary infrastructure, such as reliable internet connections or access to suitable devices, to engage with remote healthcare services effectively. This digital divide was particularly pronounced in lower-income households, where affordability further limited access to technology.

12.7. Ethnic minority communities also faced additional obstacles related to digital literacy. Many patients struggled to navigate online healthcare platforms or utilise remote consultation technologies effectively, creating barriers to accessing timely and essential care. The absence of adequate support to bridge this digital literacy gap exacerbated inequalities in healthcare access during a critical time.

12.8. **Language and Cultural Barriers in Remote Healthcare**: Remote healthcare services often failed to account for the linguistic and cultural diversity of ethnic minority communities. Many platforms and systems were designed with limited language options, leaving non-English-speaking patients unable to communicate effectively with healthcare providers. This lack of accessibility further excluded individuals from accessing vital medical advice and treatment.

12.9. Cultural factors also played a significant role in deterring ethnic minority communities from engaging with remote healthcare services. Traditional face-to-face consultations often allowed for greater trust and understanding between patients and providers, which was difficult to replicate in a digital format. The absence of culturally tailored communication strategies in remote settings amplified feelings of alienation and mistrust, further discouraging engagement with these services.

12.10. **'Hard-to-Reach':** Several witnesses challenged the term 'hard-to-reach' as stigmatising and counterproductive. Professor JS Bamrah argued: *"The hardness is with us, not with [the communities] ...It sends the wrong signal because it implies that 'The problem is with you and*

[54] Hearing Transcript, 9/186/9-9/187/12

not with us'"[55] Faith leaders, grassroots organisations, and community networks were crucial in countering vaccine hesitancy when they were engaged effectively.

12.11. **Challenges to Community Engagement and Trust Building**: While the importance of community engagement and trust is well recognised, significant barriers remain. One challenge is the lack of representation of minority ethnic voices in public health leadership and policy design. Decisions made without input from affected communities often fail to address their specific needs, further alienating these populations. The reliance on top-down approaches that do not prioritise co-production with communities is a problem. This disconnect undermines the effectiveness of public health interventions and perpetuates a cycle of mistrust. FEMHO highlights that community engagement must be a collaborative process, grounded in mutual respect and shared responsibility.

12.12. The underrepresentation of ethnic minorities in decision-making processes was another significant issue raised during this Inquiry. The lack of diverse perspectives at the highest levels of public health policy contributed to the systemic failings observed during the pandemic. Decisions were often made without input from those most affected, resulting in policies that were ill-suited to the needs of ethnic minority communities. This lack of representation also perpetuated mistrust, as many communities felt excluded from the decision-making processes that directly impacted their lives.

12.13. Community engagement and trust building are fundamental to addressing healthcare inequities and creating a more inclusive public health system. FEMHO submits that involving community leaders, fostering collaboration, and prioritising trust must become standard practices for public health bodies. By adopting the strategies and recommendations outlined above, public health systems can overcome barriers, improve healthcare access, and promote equity for ethnic minority communities. This Inquiry has the opportunity to highlight the importance of these efforts and ensure that they are embedded in future public health policy.

13. VACCINATION AS A CONDITION OF DEPLOYMENT:

13.1. The Vaccination as a Condition of Deployment ("VCOD") policy brought to light the entrenched systemic racism within the NHS and its impact on trust among ethnic minority healthcare workers. Former Health Secretary Sajid Javid acknowledged the policy's disproportionate effect on Black, Asian, and Minority Ethnic staff, stating, "*I was aware of the... disproportionality before, you know, I became health secretary, just from what I'd read and heard... [and] these social factors I think were important.*" [56] However, despite this awareness, he defended the policy when questioned by FEMHO, emphasising, *"I think all workers in the NHS should be treated*

[55] Hearing Transcript, 19/126/11–19/127/3
[56] Hearing Transcript, 37/77/25-37/79/2

equally regardless of their race". This approach failed to account for the historical mistrust fostered by institutional racism. As outlined in a Healthwatch meeting[57], participants felt that targeted messaging during vaccine rollouts "*had created a sense of blame... [making] them feel as though they were being seen as 'problem groups' for having lower uptake*" Such experiences underscored the disconnect between government policies and the lived realities of ethnic minority staff.

13.2. This policy not only heightened mistrust but also risked creating a climate of exclusion. NHS Providers highlighted that VCOD could "*likely exacerbate the impact of existing health inequalities*,"[58] especially as it might lead to redeployment or job losses for ethnic minority staff, further undermining long-term efforts to build trust and improve inclusion within the NHS. Additionally, a culture of fear and silence often pervaded workplaces, where ethnic minority staff hesitated to raise safety concerns. The NHS failed to foster an environment where ethnic minority workers felt safe to speak out without fear of reprisal.

BREACH OF DUTIES

14. SYSTEMIC OBLIGATION UNDER ARTICLE 2 ECHR

14.1. The state's failure to adequately protect Black, Asian, and Minority Ethnic healthcare workers during the COVID-19 pandemic represents a fundamental breach of Article 2 of the European Convention on Human Rights (ECHR). Under Article 2, state bodies are required to implement a systemic framework of laws, procedures, and safeguards to protect life to the greatest extent practicable. This includes addressing known risks to vulnerable groups. As evidenced throughout Module 3 and discussed above, the disproportionate impact of the pandemic on ethnic minority healthcare workers was totally foreseeable.

14.2. The Expert Report by Professors Clare Bambra and Sir Michael Marmot highlights significant failures in the UK's and devolved administrations' pandemic planning to account for pre-existing health inequalities.[59] It finds that there was minimal consideration of inequalities. Pandemic planning focused largely on age and clinical risk factors, with only minimal attention paid to pre-existing health inequalities. Structural racism and its potential impacts were entirely omitted from planning documents, which the experts describe as a missed opportunity to effectively mitigate hospitalisations, deaths, and morbidity. The report stresses that addressing the most vulnerable groups requires anticipating and proactively addressing structural inequalities systematically. The planning and risk management structures did not systematically or comprehensively assess

[57] INQ000366259/24 Joint Report from Healthwatch England and Traverse titled VacciNation: Exploring vaccine confidence with people from African, Bangladeshi, Carribean and Pakistani backgrounds living in England, dated June 2021
[58] INQ000371138/10 Questions and answers from NHS Providers, titled Mandatory staff vaccinations in health and care
[59] INQ000195843 Expert Report by Professor Bambra and Professor Marmot

societal, economic, and health impacts arising from existing inequalities, leaving groups such as ethnic minorities disproportionately vulnerable to the pandemic's effects.

14.3. This failure to act proactively and meaningfully falls far short of the state's Article 2 obligation to safeguard life by addressing systemic risks. As Chris Wormald conceded, the pandemic magnified long-standing systemic biases,[60] particularly in PPE distribution and risk mitigation

15. PUBLIC SECTOR EQUALITY DUTY (PSED)

15.1. The Public Sector Equality Duty (PSED), as enshrined in the Equality Act 2010, obligates public authorities to proactively have due regard to eliminate discrimination, advance equality of opportunity, and foster good relations between people with differing protected characteristics. This duty must be exercised with substance, rigour, and an open mind, ensuring that equality considerations inform every aspect of policy and decision-making. The PSED traces its roots to the Stephen Lawrence Inquiry and its findings on institutional racism. The duty was intended to create a strong, enforceable legal framework requiring public authorities to proactively address structural inequalities. However, the evidence presented to this Inquiry reveals that these principles have not been effectively embedded within public health governance. Witnesses repeatedly testified to the lack of targeted protections for ethnic minority healthcare workers, including delayed risk assessments and unsuitable PPE. The evidence reveals a stark failure to give effect to the PSED within the pandemic response, particularly concerning Black, Asian, and Minority Ethnic healthcare workers.

15.2. The systemic neglect of the PSED is evident in the lack of Equality Impact Assessments (EIAs) conducted for key pandemic policies. For example, Caroline Lamb, CEO of NHS Scotland, admitted that no Equality Impact Assessment was carried out on the PPE action plan despite known disparities in access and fit for Black, Asian and Minority Ethnic healthcare workers.[61] This omission reflects an institutional disregard for the duty's purpose: to ensure that public policies proactively address and mitigate inequalities. Moreover, as the expert report by Professors Clare Bambra and Sir Michael Marmot noted, pre-existing health inequalities and structural racism were entirely absent from pandemic planning documents.[62] Such neglect not only concerningly undermines the PSED but also breaches the principle that lies at the heart of public authority obligations.

16. HEALTH AND SAFETY AT WORK ACT 1974: SYSTEMIC FAILURES TO SAFEGUARD ETHNIC MINORITY HEALTHCARE WORKERS

[60] Hearing Transcript, 29/120/11-29/121/25
[61] Hearing Transcript, 31/83/20 - 31/85/7
[62] INQ000195843, Expert Report by Professor Bambra and Professor Marmot

16.1. The Health and Safety at Work Act 1974 ("HAS") imposes a statutory duty on employers to ensure, as far as reasonably practicable, the health, safety, and welfare of employees at work. Its protections extend beyond employees to any person affected by work activities, encapsulating a dual obligation under Sections 2 and 3 of the Act. The Act's obligations are further operationalised by the Management of Health and Safety at Work Regulations 1999, which require employers to conduct rigorous risk assessments (Reg. 3), plan and implement effective control measures (Reg. 5), and ensure comprehensive training and communication (Regs. 10 and 13).

16.2. **Failure to Risk Assess and Protect**: Consequently, the systemic failure to conduct meaningful, ethnicity-specific risk assessments represents a clear breach of these statutory duties. Witnesses to this Inquiry have confirmed that risk assessments were often generic and inadequately tailored to address the heightened vulnerabilities of Black, Asian, and Minority Ethnic healthcare workers. This oversight contravenes Regulation 3, which mandates employers to identify and mitigate workplace risks systematically; suitably and sufficiently. Regulation 6(b) refers to recording any group of employees identified as being especially at risk, as was the case for Black, Asian and Minority Ethnic healthcare workers. Moreover, the inconsistent provision of suitable PPE for Black, Asian, and Minority Ethnic healthcare staff underscores a failure to effectively implement and monitor preventive measures as required under Regulation 5. Ethnic minority workers were disproportionately likely to fail fit-testing for standard PPE due to structural biases in design. This disparity not only heightened exposure risks but also eroded trust in workplace safety protocols.

16.3. **Inadequate Communication and Training**: Effective health and safety management relies on clear communication and adequate training, as prescribed by Regulations 10 and 13 of the 1999 Regulations. However, evidence presented to this Inquiry highlights repeated systemic failures in this regard. For instance, many Black, Asian, and Minority Ethnic healthcare workers reported receiving inconsistent or inadequate guidance on the use of PPE, unnecessarily and egregiously exacerbating their exposure to workplace hazards.

17. THE HUMAN COST OF INACTION

17.1. The human stories behind these statistics must not be forgotten. Each infection, each death, represents a life cut short, a family shattered, and a community left grieving. As mentioned above, the disproportionate impact on Black, Asian, Minority Ethnic healthcare workers was not an inevitability—it was the result of systemic failures that must be rectified to honour the sacrifices of these individuals.

17.2. Behind every headline lies a personal tragedy. The evidence of Professor Kevin Fong, former national clinical adviser in emergency preparedness, resilience and response at NHS England,

will surely live long in the memory for all those engaged in Module 3. He vividly captured the reality of healthcare workers bearing immense risks and strain in a system stretched to its limits. Despite this, protections for staff—especially ethnic minority workers—were inadequate. Professor Fong highlighted how stretched resources—both human and material—contributed to decisions that placed NHS staff in untenable situations. Critical care staffing ratios were diluted, leaving workers overburdened and exposed

17.3. Professor Fong and others reflected on the personal sacrifices made by healthcare workers. Dr. Tilna Tilak-Kumar described how she and her colleagues were forced to purchase their own scrubs and goggles because hospitals failed to provide adequate equipment. Workers like her placed themselves in harm's way daily, driven by a sense of duty to patients despite being failed by the very institutions that should have protected them. For too many, this duty became a death sentence—avoidable deaths brought on by systemic indifference and preventable risks.

17.4. We must also remember the families left behind. The children who lost parents, spouses who lost partners, and communities who lost leaders and carers. These workers were disproportionately frontlined and disproportionately forgotten. Their sacrifices cannot go unacknowledged, and their suffering must not be repeated.

17.5. The delayed and insufficient response had profound consequences for ethnic minority communities. Beyond the immediate toll of increased infections and deaths, the inaction exacerbated existing health inequalities, deepened mistrust in public health institutions, and left ethnic minority healthcare workers feeling undervalued and unsupported.

17.6. The human cost of these failings was tragic. FEMHO contends that each delay, each missed opportunity to act, represented a preventable loss—a life that could have been saved with timely intervention. The lack of targeted action also undermined the broader public health response, as vulnerable communities were left without the resources and support needed to mitigate risk. Urgent action must be taken to reduce inequalities and a more equitable health system immediately; and to ensure that when the next emergency hits, there will not be such an unequal impact and avoidable harm is reduced as far as possible.

CONCLUSION

18. CLOSING OBSERVATIONS

18.1. The Inquiry represents a once-in-a-generation opportunity to confront the deep-seated issues of racism and structural inequality that have plagued our institutions. The pandemic has laid bare the stark realities of systemic racism, and it is now incumbent upon this Inquiry to ensure that these issues are not merely documented but addressed through tangible policies that dismantle systemic racism and build resilience for future crises. Only then can the health service fulfil its duty to serve all staff and patients with fairness and dignity. The failure to act decisively

would not only squander the momentum for change but also signal a tacit acceptance of the status quo, a status quo in which lives continue to be disproportionately impacted by institutional neglect and bias. This Inquiry must rise to the challenge and lay the foundation for a more equitable and inclusive future.

18.2. The evidence presented to the Inquiry paints a stark picture of systemic and institutional racism within the healthcare system. Ethnic minority healthcare workers were disproportionately exposed to risks, inadequately protected, and left unsupported during the pandemic. These failings are not isolated incidents but manifestations of a broader system that has marginalised these workers for decades.

19. A WAY FORWARD

19.1. Addressing structural racism requires more than piecemeal reforms. It demands a fundamental re-evaluation of the policies, practices, and cultures that underpin the healthcare system. The next section will focus on Key Recommendations for achieving this transformation.

KEY RECOMMENDATIONS

20. OVERVIEW

20.1. The evidence presented in Module 3 has laid bare systemic failures that disproportionately impacted ethnic minority healthcare workers and communities during the COVID-19 pandemic. These failures are deeply rooted in structural inequalities, institutional neglect, and longstanding barriers to equitable healthcare outcomes. Addressing these issues demands clear, targeted, and actionable recommendations to ensure that the lessons of this Inquiry translate into meaningful change. This section will first outline key recommendations to address the critical issues identified, including PPE, risk assessments, equipment failures, communication strategies, structural racism, and long-term health inequalities. We will then introduce a suggested framework for NHS staff equity and race reform. This piece of work conceived, developed and proposed by FEMHO, represents a bold and transformative blueprint for tackling structural racism within the NHS.

21. SYSTEMIC RACISM

21.1. To address the entrenched issues of structural and institutional racism in the NHS, FEMHO submits the following policy recommendations:

21.1.1. Improve the collation of robust and accurate data on race and ethnicity: to be made available contemporaneously so that improvements can be made in real time and not years later.

21.1.2. Acknowledge and Address Structural Racism: The NHS must recognise that structural racism shapes the inequalities faced by ethnic minority healthcare workers and patients. Public health strategies should address the broader social determinants of health, including housing, transport, and economic opportunities. Health outcomes cannot be separated from the structural inequalities that create them. Addressing these factors requires collaboration across government departments and public bodies to ensure a holistic approach to health equity.

21.1.3. Implement Comprehensive Anti-Racism Policies: Within the NHS, clear anti-racism policies must be developed and enforced. These policies should define institutional racism and set out mechanisms for holding individuals and organisations accountable. The WRES should be reinstated and properly funded, with consideration given as to whether it may be best placed within the NHS Race & Health Observatory. CQC's role in ensuring accountability of employers must also be strengthened.

21.1.4. Mandatory anti-racism training for all NHS staff should be introduced, focusing on recognising and addressing both structural and institutional biases. The importance of embedding anti-racism into the culture of the NHS cannot be overstated.

21.1.5. Tailor Risk Assessments to Address Inequalities: Risk assessments must account for the specific vulnerabilities of ethnic minority workers. This includes considering pre-existing health conditions, workplace roles, and exposure risks. Employers should be required to document and act on these assessments, and there ought to be mandatory compliance checks in place to ensure accountability.

21.1.6. Promote Representation at All Levels: Ethnic minority representation in NHS leadership and decision-making roles must be prioritised. Programmes to mentor and support ethnic minority staff should be implemented to create a pipeline for leadership positions. Diverse leadership ensures that decision-making reflects the realities of all staff, not just the majority. FEMHO calls for active measures to address the underrepresentation of ethnic minorities in senior roles.

21.1.7. Strengthen Mental Health Support for Ethnic Minority Workers. The NHS must provide tailored mental health support for ethnic minority staff, recognising the unique challenges they face. This includes offering culturally sensitive counselling services and peer support networks. Mental health services must be accessible and inclusive to address the disproportionate impact on ethnic minority workers.

21.1.8. Improve Access to Long COVID Care. Ethnic minority workers affected by Long COVID must receive priority access to specialist care. The NHS should establish dedicated

clinics with clear pathways for treatment and workplace adjustments. Long COVID services be tailored to address the specific needs of ethnic minority healthcare workers.

21.1.9. Foster an Inclusive Organisational Culture. The NHS must create an organisational culture that values and respects diversity. This includes addressing power imbalances, encouraging open dialogue, and embedding cultural competency into training programmes.

22. **PPE**:

22.1. The evidence presented to this Inquiry provides clear lessons about the importance of equity and inclusivity in PPE provision. FEMHO urges this Inquiry to adopt the following recommendations:

22.1.1. Improved Fit Testing Processes: A universal standard for rigorous fit testing must be established and enforced, with specific provisions to address the needs of diverse facial features and cultural considerations. Employers must be held accountable for ensuring compliance.

22.1.2. Inclusive PPE Design: The NHS and public health bodies must collaborate with manufacturers to develop alternative PPE designs that accommodate a wider range of physical and cultural characteristics. These designs should be included in national stockpiles to ensure availability in future crises.

22.1.3. Comprehensive Data Collection: Ethnicity data must be integrated into all aspects of PPE provision, from fit testing to distribution. This data should be used to identify disparities, inform policy, and ensure that resources are allocated equitably.

22.1.4. Cultural Competency Training: Employers and healthcare leaders must receive training to understand the cultural and religious needs of their workforce. This training should emphasise the importance of representation and inclusivity in decision-making processes.

22.1.5. Proactive Planning and Stockpiling: Lessons from the pandemic must inform future preparedness efforts, with a focus on equitable distribution and accessibility of PPE. A precautionary approach is essential to protect vulnerable workers.

23. **ENGAGEMENT AND COMMUNICATION**

23.1. To address these issues, FEMHO submits the following recommendations:

23.1.1. Inclusive Public Health Messaging: Public health campaigns must be designed to address the linguistic and cultural diversity of the population. This includes translating

materials into multiple languages and collaborating with community leaders to ensure messages resonate with diverse audiences.

23.1.2. Representation in Decision-Making: Ethnic minority representation must be increased at all levels of public health policy and decision-making. This is essential to ensure that policies are inclusive and address the specific needs of underrepresented groups.

23.1.3. Cultural Competency Training: Healthcare providers and policymakers must receive training to understand the cultural and linguistic needs of their communities. This training should be embedded into professional development programmes and evaluated for effectiveness.

23.1.4. Targeted Risk Assessments: Employers must conduct specific risk assessments for ethnic minority workers, taking into account their unique vulnerabilities. This includes addressing factors such as pre-existing health conditions, workplace roles, and cultural considerations.

23.1.5. Engagement: Public health bodies must actively engage with ethnic minority communities to build trust and ensure that their voices are heard. This includes establishing advisory groups and creating mechanisms for continuous feedback.

23.1.6. Co-Produce Public Health Interventions: Effective engagement requires active collaboration with communities in designing and implementing public health initiatives. Co-production ensures that interventions are culturally relevant, accessible, and aligned with the priorities of ethnic minority populations.

23.1.7. Invest in Community Outreach: Outreach programmes should target vulnerable and hard-to-reach groups, using culturally sensitive methods to promote healthcare access. This includes mobile health clinics, community health ambassadors, and the use of trusted communication channels within ethnic minority communities. Outreach is a vital tool for addressing healthcare inequities and ensuring that public health initiatives reach ethnic minority communities. Targeted outreach efforts can help to overcome barriers such as language, cultural differences, and geographical isolation, making healthcare services more accessible.

23.1.8. Train Healthcare Staff in Cultural Competency: Healthcare providers must be equipped with the skills to engage effectively with diverse communities. Cultural competency training should be integrated into professional development programmes, with a focus on building empathy, understanding, and trust.

23.1.9. Promote Representation in Leadership: Increasing the representation of ethnic minorities in public health leadership roles is essential to fostering trust and ensuring

that policies reflect the experiences of diverse populations. Leadership pipelines and mentorship programmes can support this goal.

23.1.10. Ensure Transparency and Accountability: Public health bodies must demonstrate accountability by communicating openly about their actions, listening to community feedback, and making changes based on that input. Transparency in decision-making processes helps to rebuild trust and encourage engagement.

24. THE NHS STAFF EQUITY AND RACE REFORM LONGLIST

24.1. Born from the hard truths revealed during the pandemic and from decades of experience at all levels within the system from our membership, the LongList challenges the status quo by embedding equity and anti-racism at the core of NHS operations. We recognise that these proposals may face resistance from those clinging to conventional approaches. However, incrementalism has failed to address the systemic inequities that continue to harm NHS staff and undermine the institution's ability to deliver equitable care. This LongList is not about superficial changes or temporary fixes; it is a decisive, evidence-based strategy designed to dismantle entrenched disparities, empower marginalised voices, and ensure that fairness and equity are foundational principles of the NHS. These reforms are critical not only for moral reasons but also for the practical necessity of creating a resilient and inclusive workforce capable of meeting the challenges of the future.

24.2. The NHS Staff Equity and Race Reform LongList is a transformative list of concrete, actionable and evidence-based amendments to carve structural racism out of the foundations of the NHS. It is aimed at supporting NHS staff as they begin to face ambitious plans for reform, following bruising battles against COVID-19. As part of the government's 10-year plan to reshape the healthcare system, the LongList emphasises the need to recruit, train, and retain a resilient workforce where staff are empowered, supported, and valued. The list seeks to address disparities among NHS staff, to ensure that equity, fairness, and inclusion are hallmarks of the NHS ecosystem.

24.3. There are three central tenets of the NHS Staff Equity and Race Reform LongList:

24.3.1. **Diverse and Trained Interview Panels:** Ensure all interview and promotion panels include members from diverse backgrounds and undergo mandatory training on cultural awareness, bias mitigation, and institutional discrimination. Regular evaluation of these training programs will drive measurable changes in workplace behaviour, ensuring fair assessments, reducing bias, and creating an equitable environment where all staff have equal opportunities and feel valued.

24.3.2. **Empowered Support Networks and Mentorship**: Establish strong support networks and tailored mentorship programs for Black, Asian and Minority Ethnic staff to address systemic barriers to career progression. Black, Asian and Minority Ethnic staff cannot be expected to drive change alone, especially without access to the leadership, resources, and security needed to enact meaningful reform. Structured support is essential to providing equal access to guidance, resources, and opportunities.

24.3.3. **Equity in Procurement Practices**: Embed equity into NHS procurement policies by mandating diversity and inclusion audits, anti-racist scoring in tenders, and supplier diversity requirements. Introduce anti-racism training and accountability mechanisms for suppliers to ensure alignment with NHS values of inclusivity and anti-racism. These measures promote a healthcare system that upholds equity and fairness throughout its supply chain.

25. AMENDMENTS TO THE NHS TERMS AND CONDITIONS OF SERVICE HANDBOOK

25.1. The NHS Staff Council should be asked to make amendments to the NHS Terms and Conditions of Service Handbook, which would formally recognise and value internal Black, Asian and Minority Ethnic Staff Networks as essential contributors to equality efforts within the NHS. This measure would align the NHS with other leading institutions, such as the British Army and the BBC, which formally support such networks to foster inclusivity and provide support. Formal recognition will also help ensure that Black, Asian and Minority Ethnic staff have the structured backing, resources, and visibility needed to foster both individual and systemic progress within the NHS. Proposed amendments are:

25.2. **Addition to Equal Opportunities (Part 5, Section 30):**

Proposed Amendment: Introduce language that formally recognises Black, Asian and Minority Ethnic Staff Networks as essential components of NHS diversity and inclusion efforts. This section could state that NHS organisations should support Black, Asian and Minority Ethnic Networks through dedicated resources, official time allocations, and structured funding, positioning them as a valuable resource in achieving equity in NHS workplaces.

Rationale: Formal acknowledgment helps validate these networks, providing them with a foundation to request necessary support and visibility.

25.3. **New Section on Mentorship Programs for Black, Asian and Minority Ethnic Staff:**

Proposed Amendment: Introduce a dedicated subsection within *Section 31: Recruitment, Promotion, and Staff Development* outlining that NHS employers should have a mentorship program specifically aimed at Black, Asian and Minority Ethnic staff. It should include provisions for mentors to be equipped with training on the unique challenges faced by Black, Asian and

Minority Ethnic staff and require that mentors reflect a diverse background to support understanding and empathy.

Rationale: Targeted mentorship can help Black, Asian and Minority Ethnic staff navigate workplace challenges by providing guidance, support, and advocacy. The pandemic underscored the challenges Black, Asian and Minority Ethnic staff face in navigating systemic barriers without proper mentorship. Tailored mentorship programs can help address these barriers, as the lack of senior representation and guidance left many Black, Asian and Minority Ethnic employees vulnerable.

25.4. **Resource Allocation and Paid Time for Black, Asian and Minority Ethnic Network Activities (Section 25):**

Proposed Amendment: Modify *Section 25: Time off and Facilities for Trade Union Representatives* to include designated paid time for Black, Asian and Minority Ethnic Staff Network activities, including regular meetings, mentorship program coordination, and representation at organisational leadership discussions. Additional amendments should clarify the protection of Black, Asian and Minority Ethnic Network leaders from repercussions in their primary roles.

Rationale: Ensuring that Black, Asian and Minority Ethnic network leaders have access to resources and paid time supports sustained engagement and effectiveness of these networks, recognising their organisational value. The pandemic disproportionately affected the work-life balance of ethnic minority workers, who often took on additional responsibilities without sufficient compensation or flexibility.

25.5. **Inclusion in Career Development Pathways (Part 6: Operating the System):**

Proposed Amendment: In *Section 40: National Bodies and Procedures*, mandate that the NHS Staff Council collaborates with Black, Asian and Minority Ethnic Staff Networks to review career progression for Black, Asian and Minority Ethnic employees periodically. Include measures that assess and address obstacles specific to Black, Asian and Minority Ethnic staff progression, enhancing visibility and mobility within NHS leadership pipelines.

Rationale: Involving Black, Asian and Minority Ethnic Networks in career progression reviews allows the NHS to tailor development programs that address inequities in advancement opportunities.

25.6. **Commitment to Structural Inclusion:**

Proposed Amendment: Within *Section 1: Principles and Partnership*, add a subsection explicitly committing NHS organisations to structurally support Black, Asian and Minority Ethnic

Staff Networks as part of organisational policy, encouraging integration of Black, Asian and Minority Ethnic voices in policy-making and decision-making processes.

Rationale: A foundational commitment to the structural inclusion of Black, Asian and Minority Ethnic voices promotes a culture where minority ethnic staff feel valued and heard at all organisational levels. COVID-19 revealed that Black, Asian and Minority Ethnic voices were often excluded from high-level decision-making, resulting in policies that inadequately addressed the needs of these communities.

26. AMENDMENTS TO THE NHS TERMS AND CONDITIONS FOR THE SUPPLY OF GOODS AND THE PROVISION OF SERVICES

26.1. The NHS Terms and Conditions for the Supply of Goods and the Provision of Services is an example of a leading document that guides and directs how the NHS works. It serves as a useful site to embed an anti-racist approach for the NHS. This is crucial because structural racism permeates all aspects of the healthcare sector. To address structural racism and embed an anti-racist framework in NHS procurement practices, the NHS Terms and Conditions for the Supply of Goods and the Provision of Services could incorporate the following concrete measures.

26.2. **Mandate Diversity and Inclusion Audits (Schedule 2, General T&Cs):**

Action: Add a clause requiring suppliers to conduct and report on annual diversity and inclusion audits. These audits should track workforce diversity, pay equity, and representation in leadership positions within the supplier's organisation.

Rationale: This requirement would encourage suppliers to actively engage in anti-racist practices within their own workforce, fostering a supply chain that reflects NHS values. By requiring suppliers to undergo diversity and inclusion audits, the NHS can ensure that those contributing to the healthcare supply chain are committed to reducing disparities that left minority communities more vulnerable during the COVID-19 crisis.

26.3. **Implement Anti-Racist and Social Value Scoring in Tender Processes:**

Action: Update tender evaluation criteria to include anti-racist practices and contributions to social value. Scoring criteria could assess a supplier's commitment to fair employment practices, support for minority-owned businesses, and proactive measures to reduce racial discrimination in their organisation.

Rationale: Embedding these criteria into procurement scoring would prioritise suppliers who actively contribute to equity and anti-racist initiatives. Additionally, the pandemic illustrated the importance of equitable resource allocation, as Black, Asian and Minority Ethnic communities suffered from unequal access to healthcare and protective measures.

26.4. **Add Supplier Diversity Requirements (Schedule 1, Key Provisions):**

Action: Require a minimum percentage of procurement spending to be directed toward minority-owned businesses or suppliers with a demonstrated commitment to anti-racist practices. Additionally, provide flexibility to adjust these targets based on local demographics.

Rationale: COVID-19 disproportionately affected minority-owned businesses, many of which struggled during economic downturns. Promoting supplier diversity directly supports the growth of minority-owned businesses, creating a more inclusive and representative supply chain.

26.5. **Enforce Anti-Racism Training and Policies (Schedule 3, Information and Data Provisions):**

Action: Require suppliers to implement anti-racism training for their employees and provide evidence of anti-discrimination policies. Suppliers must also report any incidents of racial discrimination, including actions taken to address them.

Rationale: Many healthcare suppliers lacked specific policies to protect minority staff from discrimination during the pandemic, exacerbating already strained working conditions. Requiring training and accountability for racial discrimination prevents discriminatory practices and ensures that suppliers align with NHS's commitment to an inclusive environment, reinforcing anti-racist values across the supply chain.

26.6. **Introduce Accountability Measures for Non-Compliance (Schedule 2, General T&Cs):**

Action: Include specific penalties or contract termination rights for non-compliance with diversity, inclusion, and anti-racism provisions. This could also encompass a corrective action period before penalties apply.

Rationale: The urgency of enforcing anti-racist practices became evident during COVID-19, as non-compliance with safety and equity measures had tangible, life-threatening impacts on ethnic minority staff. Clear consequences for non-compliance would reinforce the seriousness of anti-racist commitments and hold suppliers accountable for fostering an inclusive environment.

27. **AMENDMENTS TO THE NHS STANDARD CONTRACT**

27.1. **Mandate Supplier Diversity in Procurement Processes (GC12 Assignment and Sub-Contracting):**

Amendment: Add provisions requiring providers to source a specified percentage of their supplies from minority-owned businesses or organisations committed to anti-racist practices. This could also include incentives for suppliers who support Black, Asian and Minority Ethnic communities through employment and community engagement.

Rationale: Supplier diversity would promote inclusivity within NHS operations and support economic empowerment for marginalised groups.

27.2. **Anti-Racism Accountability and Reporting (GC8 Review and GC15 Governance):**

Amendment: Require providers to undergo regular anti-racism audits and report findings to the NHS and relevant oversight bodies. Reviews should focus on the inclusivity of service delivery, representation in management, and policies aimed at preventing racial discrimination.

Rationale: Accountability through structured reporting can drive ongoing improvements and hold providers to high standards for anti-racist practices.

27.3. **Strengthen 'Freedom to Speak Up' Provisions for Racial Discrimination (GC5 Freedom to Speak Up):**

Amendment: Enhance protections for staff reporting racial discrimination by including specific anti-racist policies within 'Freedom to Speak Up' frameworks. Staff should be encouraged to report any observed racial biases, with assurance of protection from retaliation.

Rationale: Strengthening whistleblower protections in cases of racial discrimination can help address issues of structural racism and provide staff with a secure platform to raise concerns.

27.4. **Integration of Anti-Racism Goals in Performance and Remedial Action Plans (GC9 Contract Management):**

Amendment: Require that performance and remedial action plans include goals related to diversity, equity, and inclusion. Providers could face penalties for non-compliance with diversity standards or failure to improve Black, Asian and Minority Ethnic representation in their workforce.

Rationale: Incorporating anti-racism objectives into contract performance ensures that providers prioritise these goals and are held accountable for meaningful action.

28. **AMENDMENTS TO NHS ENGLAND STANDING ORDERS**

28.1. **Expand the Board's Commitment to Anti-Racism (SO1 Purpose and SO4 The Board):**

Amendment: Introduce an explicit commitment to anti-racism within the Board's purpose and strategic leadership role. This could include mandating that all strategic decisions undergo a racial equity impact assessment to consider how policies affect Black, Asian, and Minority Ethnic communities.

Rationale: This would ensure that anti-racist values are foundational to decision-making and strategic planning across NHS England.

28.2. **Establish a Diversity and Inclusion Committee (SO6 Appointment of Committees & Sub-committees):**

Amendment: Form a dedicated Diversity and Inclusion Committee tasked with monitoring and evaluating racial equity within NHS England. This committee could set goals, assess progress, and hold NHS entities accountable for anti-racist outcomes

Rationale: A dedicated committee focused on diversity ensures continuous oversight, emphasising NHS England's commitment to anti-racism at a governance level.

28.3. **Implement Training Requirements for Board Members (SO8 Duties and Obligations of Board Members):**

Amendment: Make anti-racism and cultural competence training mandatory for all Board members and senior leadership. Such training should be updated periodically to reflect evolving best practices.

Rationale: Equipping leaders with anti-racism knowledge empowers them to make informed decisions and better support Black, Asian and Minority Ethnic employees and communities.

28.4. **Incorporate Equity in Delegation and Decision-Making Powers (SO7 Delegation of Powers):**

Amendment: Ensure that powers delegated to committees and sub-committees include a mandate to prioritise racial equity and review decisions with a lens of diversity, equity, and inclusion.

Rationale: Embedding racial equity in decision-making processes at all levels helps to ensure that policies and practices consider and address potential racial biases.

28.5. **Mandate Public Reporting on Racial Equity Initiatives (SO5 Meetings of the Board):**

Amendment: Require public reporting on the progress of equity, anti-racism and diversity goals in NHS England's annual reports, including updates from the Diversity and Inclusion Committee.

Rationale: Public accountability reinforces NHS England's commitment to anti-racism and allows stakeholders to track progress on equity initiatives. This aligns with the NHS Race and Health Observatory's call for accountability in promoting equity and transparency.

28.6. **Formalise Recruitment and Promotion Standards for Diversity (SO4 Composition of the Board):**

Amendment: Amend the Board's recruitment policies to ensure that hiring and promotions prioritise diversity, with transparent criteria aimed at increasing Black, Asian and Minority Ethnic representation in senior leadership.

Rationale: During COVID-19, ethnic minority staff often felt silenced or feared retaliation for raising concerns about unequal treatment and safety. By setting explicit diversity goals in hiring and promotions, NHS England can create a more representative and inclusive leadership structure.

28.7. **Strengthen 'Freedom to Speak Up' and Anti-Discrimination Policies (SO8 Standards of Business Conduct):**

Amendment: Reinforce protections for employees who report instances of racial discrimination or bias, including mechanisms for handling complaints with strict confidentiality and protections against retaliation.

Rationale: Strengthening these protections encourages employees to report incidents of discrimination, fostering a safer and more supportive environment for Black, Asian and Minority Ethnic staff.

29. **AMENDMENTS TO AN NHS TRUST'S RECRUITMENT AND SELECTION POLICY**

29.1. **Mandatory Diversity in Panel Composition:**

Action: Amend the policy to require that all interview and promotion panels include members from diverse backgrounds, especially from Black, Asian, and Minority Ethnic (BAME) groups. Explicitly outline that panels should reflect a range of perspectives and experiences.

Rationale: A diverse panel helps minimise the risk of unconscious bias and ensures fairer assessments by bringing varied perspectives.

29.2. **Bias Mitigation Training for Panel Members (Section on Training Needs):**

Action: Update the training requirements to include mandatory training for all panel members in cultural awareness, bias mitigation, understanding microaggressions, and identifying institutional discrimination. Outline refresher training requirements to ensure skills are up to date.

Rationale: Ensuring panel members are trained to recognise and counteract biases supports a fairer selection process and reinforces a commitment to equity.

29.3. **Policy Enforcement with Monitoring and Accountability (Section on Monitoring Compliance):**

Action: Introduce a structured process to track and audit panel diversity and compliance with training requirements, with regular reviews conducted by the People and Organisational Development Directorate. Non-compliance should result in corrective measures or additional support.

Rationale: Monitoring reinforces accountability, ensuring the policy is consistently implemented and identifying areas where support or changes may be needed.

29.4. **Implement an Anti-Discrimination Checklist for Panel Use (Section on Interviews and Other Assessments):**

Action: Provide all panels with a standardised checklist covering anti-discrimination protocols to guide the assessment of candidates fairly. This checklist should prompt the panel to consider issues of equity and inclusivity throughout the interview process.

Rationale: A checklist ensures consistent application of anti-racist principles, helping panel members actively reflect on their decisions to avoid bias.

29.5. **Inclusion of Equity-Focused Interview Questions (Section on Job Descriptions and Person Specifications):**

Action: Amend the guidance to encourage interview questions that assess candidates' awareness and commitment to diversity and inclusion, especially for roles that involve people management.

Rationale: Equity-focused questions help gauge candidates' alignment with the NHS Trust's values on inclusivity, promoting a workforce that values diversity at every level.

30. **RACE EQUALITY DECISION AUDITS**

30.1. Recent research[63] shows that the Equality Act and Public Sector Equality Duty (PSED) often falls short of its intended purpose due to weak enforcement mechanisms and a lack of actionable frameworks for implementation. While the PSED aims to mainstream equality into public sector decision-making, its 'due regard' standard is frequently criticised as being too vague, leaving room for perfunctory compliance rather than meaningful action.[64]

30.2. The first proposal in the LongList, is a ***Race Equity Decision Audit*** – a tool designed to embed racial equity into decision-making and policy development at DHSC and NHSE. It addresses PSED's shortcomings by serving as a more accessible mechanism to scrutinise policy decisions related to racial equity – critical in a context where failures to address inequalities occurs at many [unseen] levels of policy development. This can transform the PSED from a legal obligation into a driver of tangible outcomes.

30.3. In NHSE and DHSC, while Freedom to Speak Up Guardians and similar mechanisms provide avenues for raising general concerns, there remains a significant gap when it comes to handling

[63] Barrett, D. (2023) 'Implementation behaviours and a strength-based approach to equality and human rights implementation', Industrial Law Journal, 53(3), pp. 370–406. doi:10.1093/indlaw/dwad020

[64] Hepple, B., Coussey, M. and Choudhury, T. (2000) Equality - A new framework: Report of the Independent Review of the enforcement of UK anti-discrimination legislation. Oxford: Hart Pub. Manfredi, S., Vickers, L. and Clayton-Hathway, K. (2017) 'The Public Sector Equality Duty: Enforcing Equality Rights through second-generation regulation', Industrial Law Journal, 47(3), pp. 365–398. doi:10.1093/indlaw/dwx022.

grievances about the rejection of initiatives and policy proposals that address racial disparities. This gap can perpetuate systemic racial inequities if critical ideas are dismissed without thorough consideration or accountability. Is the persistent problem of staff inequalities because of a lack of equality, diversity and inclusion (EDI) improvement plans?

30.4. A Race Equity Decision Audit [REDA][65] is a short auditory process where a senior third-party person acts as a 'third pair of eyes' to evaluate whether policy proposals addressing racial health inequalities have been fairly and adequately considered. This short audit would not deal with HR or personnel issues. It would focus solely on internal decision-making within DHSC and NHSE. It assesses whether the rejection of a policy idea was based on robust evidence, or if implicit biases, lack of urgency, or systemic blind spots influenced the decision. Any NHSE or DHSC official could apply for a REDA and if certain criteria are met, a senior third-party person (e.g., 2nd Perm Sec) would investigate the claim. If a rejected proposal is found to have merit, or a decision is found to lack robust justification, the audit can recommend further consideration, ensuring that innovative ideas addressing racial disparities are not unfairly dismissed internally within DHSC or NHSE.

30.5. Potential Process Outline:

30.5.1. Application for Audit and Initial Screening: Any NHSE or DHSC official who believes a policy proposal addressing racial health inequalities has been unfairly rejected can apply for Decision Audit. Applications must meet specific criteria, such as:

(a) The initiative or policy proposal in question must directly addresses racial health disparities and be in scope for DHSC/NHSE to enact.

(b) There is credible evidence suggesting the decision or rejection may have been influenced by systemic blind spots, biases, or gaps in the decision-making process. Or key considerations misinterpreted.

(c) The proposal must have the potential for significant positive impact on racial equity in health outcomes.

(d) Other DHSC/NHSE internal resolution processes are inappropriate for addressing the concerns raised.

30.5.2. Audit Investigation: If criteria are met and application accepted, the senior third-party auditor examines the case, including:

(a) The rationale provided for rejecting the proposal.

(b) Evidence and data used to support the decision.

[65] GENERAL DISCLAIMER: The REDA is intended to serve as an exceptional measure for cases involving racial equity policy proposals being developed within DHSC or NHSE. The Decision Audit emphasises constructive engagement, senior allyship and advocacy, without imposing undue administrative burden.

(c) Possible influences of implicit biases or systemic blind spots.

30.5.3. Outcome and Recommendations:

(a) If the decision is found to lack robust justification, the auditor may recommend reconsideration of the proposal.

(b) If the auditor determines the decision was fair and justified, they may (i) suggest ways to refine the rejected proposal for potential reconsideration, ensuring alignment with organisational priorities or resource constraints; or (ii) Offer recommendations for enhanced communication and transparency in the decision-making process to mitigate misunderstandings in future cases.

30.5.4. Draft Decision Audit Template:

Section	Details
1. Policy Proposal Overview	Proposer describes the policy proposal being developed/considered within DHSC/NHSE. Outlines the racial health inequality it aims to address.
2. Decision Rationale	Decision-maker provides rationale for rejecting the proposal, including evidence or data used.
3. Proposer's Perspective	Proposer explains why they believe the decision is unfair. Providing supporting evidence or reasoning.
4. Third-Party Analysis	Auditor assess the strength of the rationale provided by the decision-maker. Identify potential gaps or biases.

20 DECEMBER 2024

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