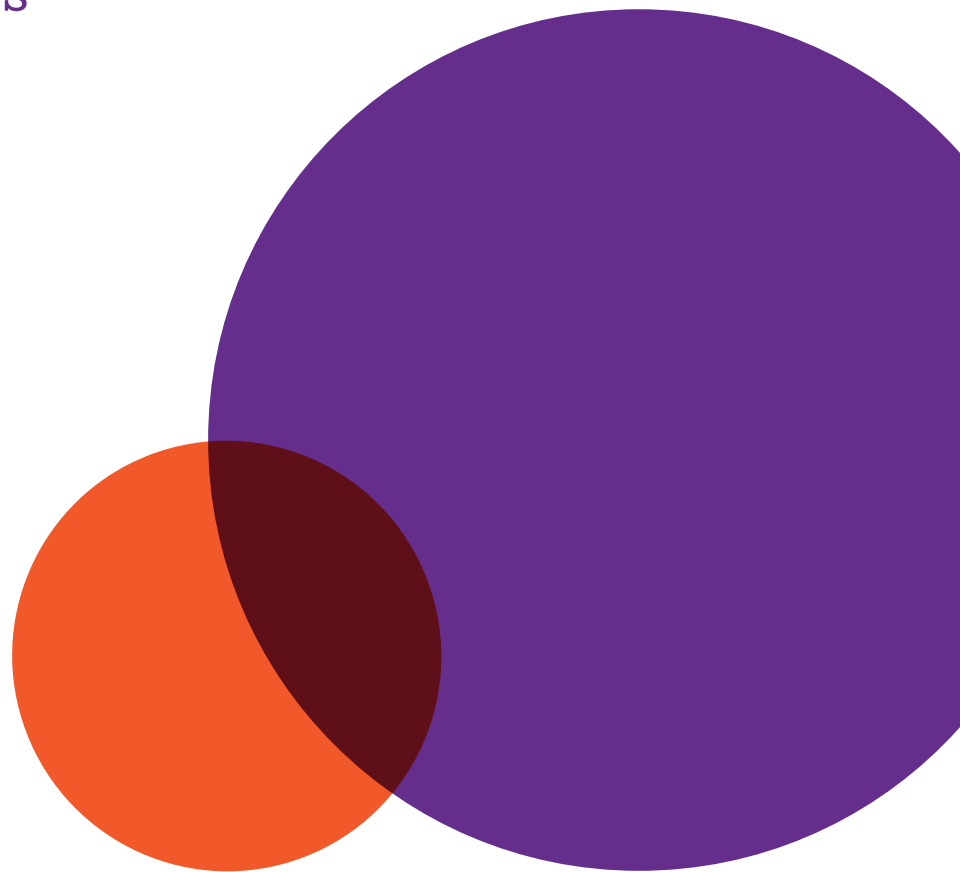


Perspectives from the front line

The disproportionate impact of COVID-19
on BME communities



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Supported by

About the BME Leadership Network

The NHS Confederation's BME Leadership Network exists to strengthen the voice of BME leaders in England and support health and care organisations to meet the needs of all communities.

It aims to:

- improve understanding of equality, diversity and inclusion and publish the benefits to help deliver better care for all
- improve and sustain the number of BME leaders working in the NHS
- profile the diverse range of BME leaders delivering solutions across the health and care system.

The network is supported by the AHSN Network, NHS Leadership Academy and the Royal College of Nursing.

To find out more, visit www.nhsconfed.org/BMEleadership

About the NHS Confederation

We are the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter @NHSConfed

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Key points

- The COVID-19 pandemic has foregrounded the issue of health inequalities in the starkest terms. From early on in the crisis, warning signs emerged of a disproportionate impact on black and minority ethnic (BME) communities, prompting questions over what accounted for the disparity and what measures could be put in place to mitigate risks and protect lives.
- This report distils the findings of a research study into the underlying factors. It is based on interviews with BME NHS leaders, clinicians, community organisations and service users, and a survey of over 100 members of the NHS Confederation's BME Leadership Network.
- Overwhelmingly, participants point to long-standing inequalities and institutional racism as root causes. Interviewees were united in the view that despite the wealth of data collected by the national bodies and numerous reviews on the relationship between health, inequalities and BME communities, the NHS and government had not taken sufficient action to address the underlying issues.
- To redress this issue, the government and health and care organisations must make every effort to pay greater attention to local and national health inequalities data and to act on the insights. More fundamentally, it will be crucial to treat long-term structural health inequities and institutional racism as critical factors when planning services and emergency responses.
- Failure to lift 'hostile environment' policies, such as eligibility checks and NHS charges for overseas visitors, was seen as a contributing factor. Concerns were raised over their potential to promote direct and indirect racial discrimination, deterring people from seeking care when needed, particularly among migrant and refugee communities. To break down barriers to accessing healthcare, the government should take immediate steps to review the potential for hostile environment policies to be a vehicle for promoting institutional racism.
- The absence of translation services and appropriate communications strategies targeting BME communities was one of the most widely reported institutional failures cited in our interviews. The government should take action on this area by commissioning a review of the availability of translation services, working with community groups and Healthwatch England. Closer working with voluntary, community and social enterprise sector organisations, supported by targeted

funding and resources, would provide an immediate opportunity to co-produce community-facing COVID-19 messaging and secure the rapid availability of translation services.

- BME health and care professionals were reported to be more likely to take on high-risk roles, including working on COVID-19 wards, due to fear that contracts may not be renewed or shifts reduced – especially if they were agency staff or had a vulnerable immigration status. This, interviewees suggested, was compounded by a bullying culture which meant that BME employees were less likely to raise concerns or share their experiences. Nearly 9 in 10 survey respondents (88 per cent) said that staff do not speak out because they fear losing their jobs. This culture was also suggested as contributing to a lack of personal protective equipment (PPE) for BME staff during the first wave.
- Additionally, risk assessments, introduced in response to the disproportionate impact on BME NHS staff, are seen to have created a layer of animosity and stigma for the BME workforce. Some interview participants suggested that the assessments were tokenistic, with additional concerns raised over the impact the COVID-19 period will have on the future recruitment of BME and migrant staff.
- Addressing these issues will require a multifaceted approach to restore confidence, build trust and foster a culture where all staff feel valued and supported. NHS organisations are encouraged to take a series of steps, including developing an organisation-specific anti-racism strategy, acting on the insights of workforce race equality standard data, supporting NHS People Plan commitments towards transparent, safer staff rostering practices, and supporting the Chief Nursing Officer's BME Action Plan on COVID-19.
- Reducing inequalities experienced by staff and people using health and care services will require concerted action by the NHS, government and wider public sector, working at scale and in a systematic and targeted way with communities. Integrated care systems have a key leadership role in this and must be supported to lead on this work.
- In addition, the health service should look to adopt a new model of leadership that welcomes and values innovators with roots in BME communities and a track record of anti-racism. Integrated care systems should lead the development of governance and human resources functions that facilitate diverse leadership in line with commitments in the NHS People Plan.

Introduction

From early on in the pandemic there were warning signs that COVID-19 was taking a disproportionate toll on black and minority ethnic (BME) communities, 'exposing the fault lines in society'.¹ In April 2020, data from the Intensive Care National Audit and Research Centre threw this into sharp focus. It revealed that 35 per cent of almost 2,000 COVID-19 patients in critical care wards were from a BME background – nearly three times the proportion in the UK population (13 per cent).² BME staff in the NHS were also dying of coronavirus at a higher rate than expected.³

Mounting evidence

In May 2020, an Office for National Statistics study⁴ explored whether the risk of dying from COVID-19 is greater among the black and other minority ethnic groups than among the white ethnic population. The study took into account a number of geographic, demographic and socio-economic factors, as well as living arrangements and health measures from the 2011 Census.

It showed that, after controlling for age alone, in Britain's black communities, women were 4.3 times and men 4.2 times more likely to have a COVID-19-related death than white women and men. In Bangladeshi and Pakistani communities, men were 3.6 and women 3.4 times more likely to have a COVID-19-related death (see figures 1 and 2 on page 8 for the full breakdown by ethnicity). The ONS concluded: 'These results show that the difference between ethnic groups in COVID-19 mortality is partly a result of socio-economic disadvantage and other circumstances, but a remaining part of the difference has not yet been explained.'

Also in May, in a University of Oxford and London School of Hygiene & Tropical Medicine study,⁵ researchers reviewed health data of more than 17.4 million UK adults and concluded that: 'People from Asian and black groups are at markedly increased risk of in-hospital death from COVID-19, and contrary to some prior speculation, this is only partially attributable to pre-existing clinical risk factors or deprivation.' The study, co-led by Professor Liam Smeeth, remarked that: 'It is very concerning to see that the higher risks faced by people from BME backgrounds are not attributable to identifiable underlying health conditions.'

This was followed by a University College London study,⁶ based on an analysis of NHS data from English hospitals in March and April 2020, which found that, after adjusting for age and region, BME groups were two to three times more likely to die with COVID-19. Lead author Dr Rob Aldridge said: “Our findings support an urgent need to take action to reduce the risk of death from COVID-19 for BME groups.”

Prompted by the growing media coverage of the issue, the government commissioned Public Health England (PHE)⁷ to conduct a rapid review of the disproportionate impact of COVID-19.

The ensuing report, led by Prof Kevin Fenton,⁸ found that the highest age-standardised diagnosis rates of the virus were in people of black ethnic groups, with the lowest in people of white ethnic groups. An analysis of survival among confirmed COVID-19 cases showed that, after accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of white British ethnicity.

People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicity had between 10 per cent and 50 per cent higher risk of death when compared to white British. Death rates from COVID-19 were higher for black and Asian ethnic groups when compared to white ethnic groups.

These rates ran counter to previously reported data that suggested all-cause mortality rates were lower in Asian and black ethnic groups. Compared to previous years, all-cause mortality was almost four times higher than expected among black males for this period, almost three times higher in Asian males, and almost two times higher in white males. Among females, deaths were almost three times higher in this period in black, mixed and other females, and 2.4 times higher in Asian females compared with 1.6 times in white females.

Figure 1: Risk of COVID-19-related death by ethnic group and sex, England and Wales, 2 March to 10 April 2020 – age-adjusted model

Ethnicity	Sex	Odds ratio compared to white
Black	Female	4.28
Black	Male	4.2
Bangladeshi/Pakistani	Male	3.55
Bangladeshi/Pakistani	Female	3.35
Other	Male	2.68
Indian	Female	2.67
Indian	Male	2.39
Other	Female	2.05
Chinese	Male	1.93
Mixed	Male	1.81
Mixed	Female	1.61
Chinese	Female	1.15

Source: Office for National Statistics

Figure 2: Risk of COVID-19-related death by ethnic group and sex, England and Wales, 2 March to 10 April 2020 – fully adjusted model (after accounting for age, socio-demographic factors and self-reported health and disability)

Ethnicity	Sex	Odds ratio compared to white
Black	Male	1.93
Black	Female	1.89
Bangladeshi/Pakistani	Male	1.81
Bangladeshi/Pakistani	Female	1.61
Indian	Female	1.43
Other	Male	1.34
Indian	Male	1.32
Chinese	Male	1.18
Other	Female	1.08
Mixed	Male	1.03
Mixed	Female	1.03
Chinese	Female	0.75

Source: Office for National Statistics

Explaining the disparity

Despite the evidence of the virus' disproportionate impact on BME communities, there was no consensus among commentators and policymakers on the reasons behind it. Growing evidence from quantitative studies suggesting that socio-economic deprivation explained a substantial part of the excess COVID-19 risk, especially if co-morbidities were taken into account, were increasingly highlighted. The PHE report⁹ noted a broad consensus among BME stakeholders that COVID-19 had exposed and exacerbated long-standing inequalities affecting BME communities. And it was these inequalities that offered explanations for the COVID-19 ill health outcomes.

The factors identified in the report include exposure risk and disease progression, including overrepresentation as key workers; poor targeting of public health strategies; poor chronic disease management; and racism and discrimination. These factors are compounded by workplaces that have not gone far enough in tackling discrimination and empowering BME staff to raise concerns.¹⁰

Root causes and exacerbating factors

Members of the NHS Confederation's BME Leadership Network – senior and middle management BME leaders across health and care – raised similar concerns at a series of network events. Their concerns and experiences offered a unique perspective on the unequal impact of the pandemic and its potential underlying causes. To investigate this further, we began discussions with the Health Foundation, an independent charity committed to bringing about better health and health care for people in the UK, to explore members' experiences. This report details what we found and is based on a range of candid insights, personal experiences and a survey of more than 100 BME leaders across the health and care sector. We are grateful to the Health Foundation for supporting this research.

With the UK in the grip of a second surge, the insights presented here serve to mobilise action to mitigate the risks to BME communities and staff – both now and in the aftermath of the pandemic. The findings will make for difficult reading, placing the spotlight on a set of uncomfortable truths.

Methodology

Our research had two core aims:

1. Record, explore and understand the experiences and perceptions of the COVID-19 pandemic among NHS BME staff and communities.
2. Consider how the insights from the experience of staff and communities can increase the understanding of causes and effects of the pandemic's disproportionate impact.

During June and July 2020, we conducted a series of interviews with BME Leadership Network members and stakeholders and surveyed members for their views. A total of 115 members participated in the survey.

In-depth interviews were held with:

- **15 frontline BME leaders** (all members of the BME Leadership Network), including doctors, nurses and clinical support staff from acute, community, mental health and primary care, to explore their 'sharp end' experiences
- **ten strategic BME leaders** (also members of the BME Leadership Network), including trust chief executives, chairs and non-executive directors, to explore their perspectives on the strategic challenges and responses
- **ten leaders of BME and migrant community organisations** delivering health-related services to vulnerable people in London and the West Midlands, to explore their perceptions, challenges and insights (including additional community-based data sets that could inform our data analysis)
- **six identified vulnerable service users** from these community organisations, to explore their perceptions and experiences of the pandemic.

To strengthen the research, we also conducted interviews with **12 community partners** to assess how far BME Leadership Network members' perceptions and experiences were reflected in the wider community.

Our community partners included:

- a large BME-led specialist migrant and refugee association based in London
- a women-only mental health and employability support group in the West Midlands
- an ESOL (English for speakers of other languages) and immigration advice service in Birmingham
- a London-based health clinic supporting those unable to register with a GP or access mainstream NHS services because of hostile environment policies
- a health and social care self-help support group for BME women in the South East of England
- a support service and campaign group for Middle Eastern and Afghan women and girls at risk of 'honour' based violence, forced marriage, child marriage, female genital mutilation and domestic violence
- a national non-governmental organisation working and campaigning in support of migrant rights in the UK
- an organisation supporting BME people into employment through training and advocacy
- a migrants and refugees support group operating across the West Midlands
- a migrants and refugees support group in Yorkshire
- a community organisation providing support to people with mental health problems in West Midlands
- an organisation supporting undocumented migrants in London.

Further information about the methodology can be found in [Appendix 1](#).

Uncovering what lies beneath

Overwhelmingly, participants in our research point to two main factors deemed to lie behind the disproportionate impact of COVID-19 on BME communities: long-established inequalities and institutional racism.

The sections that follow explore these issues in detail, drawing on the insights, views and experiences of BME Leadership Network (BLN) members, community organisations and service users. Throughout this report, we feature examples of people's experiences of the first wave of the pandemic. They serve to illustrate the challenges faced by vulnerable people from BME backgrounds over this time.

A matter of trust

Before delving into the issues, it should be noted that there were shared concerns over the COVID-19 response in relation to all communities. Several interviewees were of the view that the government, NHS England and NHS Improvement (NHSEI) and Public Health England had not been as effective as they could have been in managing the first wave. Concerns were also raised over the mixed messages delivered in the daily Downing Street press conferences,¹¹ seen to erode public trust,¹² the proliferation of misinformation and the impact the delay in moving to the first lockdown may have had on the death rate.¹³

“

Here is an issue about trust. Nobody trusts our politicians. There is a disconnect. They may be genuinely really caring, but we just don't know unless you know them very well. Until they can gain that trust, the communities are not going to listen.

BLN Member

“

The policies kept changing. It was confusing – even if you are an English speaker, which I am. If I find it confusing as a healthcare professional, if you are a layperson who doesn't speak English terribly well, it probably makes it ten times worse.

BLN Member

“

There was so much going around [saying] that if you go to A&E, you're going to die. So people did not access care until they were probably critical or dying because they just were scared they were going to die in hospital.

BLN Member

Some respondents were also critical of the coordination between the arm's-length bodies and the absence of a prevention strategy. Taken together, these elements were seen as vulnerabilities affecting the overall pandemic response.

Inequalities and health

Interview participants frequently suggested that the main reason behind the differential outcomes for people from BME backgrounds was that COVID-19 had exploited healthⁱ and socio-economic inequalities. Several suggested that these inequalities, long-established and widely known, had not been adequately considered in planning for the pandemic.

“

I think it would be reasonable to say that what has contributed to the disproportion[ate] number of deaths is a lack of action on addressing decades and decades of health inequalities. And some of that is partly because of a lack of interest, a lack of financial resources and commitment. So you have to say that there are some structural inequality issues for this group of patients which have never been addressed...

BLN Member

“

[It's] not just race, but poverty. And not funding where the funding is needed – that is just typical. The rich getting richer and actually not having that ethical, moral will at a government level to do the right stuff for the most deprived areas.

BLN Member

ⁱ Health inequalities definition: “Avoidable, unfair and systematic differences in health between different groups of people.” King’s Fund, (2020) What are health inequalities? www.kingsfund.org.uk/publications/what-are-health-inequalities

“

One thing we found during COVID is that amongst the BME communities, children were more affected.

Community Partner

Across the board, respondents pointed to the fact that the areas with the highest rates of COVID-19 infections and/or deaths in the first wave were those with the highest levels of deprivation and enduring inequalities.

“

It is much more that if you are already living in a household where you have... three generations in the house... social isolation will be difficult. If you add that to having low-paid jobs, you think if you don't bring in income, that gas and electricity you have to pay by meter will run out. People will then feel you have to go out to work.

BLN Member

“

If you are taking a step back, you always have found that BME communities have been marginalised. BME communities tend to have low socio-economic status. BME communities tend to have poorer outcomes both in terms of health, physical and mental wellbeing and BME communities tend to live in overcrowded situations.

BLN Member

More specifically, housing deprivation was identified as a significant risk factor¹⁴ – particularly by community partners. They expressed concern that the areas seeing recurrences of the virus in the first wave were those with poor quality housing. Most minority ethnic groups experience higher levels of housing deprivation than the white British, with Bangladeshi and black African people most likely to be housing deprived.¹⁵

“

The council with the highest COVID-19 death rate in the country has branded the virus a ‘housing disease’ and is now drawing up plans looking at how to tackle its severe impact in the area.

Community Partner

“

We have seen decades where people are dying in poor postcode areas, poor housing, and the willingness to spread the money evenly across the country, rather than targeting where it has the maximum effect. That’s why mortality rates have also been decreasing for people in poverty over the last two or three decades, rather than improving.

BLN Member

Interviewees were united in the view that despite the wealth of data collected by Public Health England and numerous reviews on the relationship between health, inequalities and BME communities,^{16,17,18} the NHS and government had not taken sufficient action to address the issues.

“

Why was it a surprise that BMEs would be more adversely affected? Because if you had these conversations around health and inequalities [it would be clear] that COVID-19 would lead to some people being affected more adversely than others.

BLN Member

“

Public Health England knows where disproportionately health outcomes are going to be and they're mostly related to postcode. Postcode identifies areas of deprivation. Postcode identifies areas for poor health. Postcode identifies if there are multiple occupancies or large families. Postcode identifies poor employment... So, now you've got yourself a picture of where you expect the highest mortality rates for COVID-19. I could predict them beforehand, I can predict them now, it also happens to be the area where we have the largest percentage of BME communities.

BLN Member

H's story

H has a 13-month-old daughter and was taken to a mother and toddler unit in late March 2020. She was distraught and had been told by the housing manager that she could not refuse to stay there. The unit, occupied by other mothers and their children, had had no hot water for the past two months, dirty carpets, bathroom and toilets, and old window frames.

Every child living there had been on antibiotics for some infection or other. The cellar was flooded with sewage, infested by dozens of rats and a dead fox in the outhouse. "Babies and toddlers should not be living in this place, it should be closed down," an independent contractor visiting the premise said.

H was eventually moved to a hostel while alternative accommodation was found. B, a community support worker helping H and who visited her while she was there, sent a report on the unit to the local MP's office. The office shared the response they received from the landlord, which denied all of B's claims and those of the independent contractor.

Mothers and toddlers at the unit had to endure poor hygiene and lack of hot water at a time when a national health emergency was unfolding. They were really worried about the coronavirus. The housing manager and landlord put up handwashing notices, but there was no soap.

Recounting her discussions with H, B said: "Our conversations are always dominated by worries over food for children, bed-bug infestation, access to healthcare and constant references to poor hygiene in the bathrooms and showers in the older parts of the 310-bed hostel."

Another tenant at the hostel told B she had an operation in her country where the surgeon told her to avoid infections and gave her medication. "I am terrified of going to the dirty toilets and I cannot get my medication renewed," she said.

A third said, "I have had to leave my two small children in my country, I cry all the time. I am desperate. I need medication and counselling support." The nurse just said: "try not to think about your children."

Institutional racism

People from BME backgrounds often have poorer access to healthcare services, as well as poorer experiences of care and treatment.¹⁹ Increasing evidence points to racial discrimination as a risk factor for disease and a contributor to racial disparities in health.²⁰ It is associated with poorer mental health, physical health and general wellbeing.²¹

Alongside unaddressed inequalities, our study found a consistent view that institutional racism within public bodies, including the NHS, had directly contributed to the unequal impact of COVID-19 on BME health and care staff and communities.

“

Institutional racism is a fact of life and something that we could have eliminated through proper quality analysis. We have all failed in every single public sector organisation... We just need to get on top of it and start to understand that this is having a disproportionate impact, particularly on health outcomes.

BLN Member

There is much debate on the nature and functions of racism in the NHS.^{22,23} Racism in health services is associated with negative patient experiences, including lower levels of healthcare-related trust and satisfaction, worse communication leading to poorer outcomes from delayed or restricted access, and a lack of adherence to treatment uptake.²⁴ BME cancer patients in the UK, for example, report lower satisfaction, less positive experiences of care and lower confidence in healthcare professionals.²⁵ In primary care, there are substantial ethnic differences in patient experiences. Evidence also suggests that improving the experience of patients in low-scoring practices would not only improve the quality of care provided to their white patients, but would also substantially reduce ethnic group differences in patient experience.²⁶

92%

of respondents
want the role
of institutional
racism in
health services
acknowledged

Over 9 in 10 survey respondents (92 per cent) called for greater acknowledgement of the role of institutional racism in health services.

Institutional racism defined

Institutional racism was defined in the Stephen Lawrence Inquiry Report. It makes clear that institutional racism is embedded in all public institutions, not just the NHS:²⁷

“The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour that amount to discrimination through prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people.”

Service delivery and access

Several interviewees were of the view that institutional racism had had an impact on services provided to BME communities and therefore their health outcomes. They suggested that the suppression of non-COVID-19 service demand and intensification of barriers to accessing services (explored later on in this report) may have exacerbated this position. Given the greater risk, needs and unmet demand that were likely to have existed before the pandemic, measures to suppress demand were deemed to have had a disproportionate impact on people from a BME background. This, some suggested, may have been compounded by previous poor experience of NHS services.

“

For some in the BME community, their reluctance to go immediately to A&E is partly to do with trust, partly to do with stereotyping, and I have to say, partly because they’ll have a poor experience.

BLN Member

A hostile environment

Respondents highlighted particular concern over policies that were designed to enact 'hostile environment' legislation within the NHS, such as eligibility checks²⁸ and NHS charges for overseas visitors.²⁹ The policies, introduced in 2012 to make life difficult for undocumented migrants living in the UK, were notably brought to life by the Windrush Scandal in 2018. Interviewees warned that such measures could be promoting direct and indirect racial discrimination, deterring people from seeking care even when needed. The failure to lift them during the first wave was identified as a potential contributory factor to the disproportionate impact on BME communities.

“

Refugees and migrants would not dare to go to hospital because they will have to pay. They will actually be very unwilling to go in time, and understandably so.

BLN Member

“

You look at recent immigration, people who for political reasons or something else, have found themselves in the UK, they too have suffered greater consequences. Because sometimes they haven't been registered, haven't felt that they could actually go into hospital or seek advice and support because of their status.

BLN Member

“

The main cause of anxiety is the fear of coming to the attention of the Home Office, being detained and then deported. They also fear getting sick and needing hospitalisation and not being able to afford the treatment and/or being reported to the Home Office. As well as that, the need to earn money so that they can support their families at home is a constant anxiety.

Community Partner

Racial discrimination on the front line

One of the key challenges described by interview participants working within the NHS was the degree to which white colleagues and leaders fail to notice that there is a problem with racial discrimination.

“

At [a national NHS event] last year, there was a launch of a black leaders' report. What was interesting was within that room there were very few white people. That's part of the problem: there's a lack of engagement and I think a lack of engagement at a top level. If you look at our boards, our boards are not diverse. There's very little in terms of people of colour.

BLN Member

The 'snowy white peaks'³⁰ of NHS leadership was frequently cited as a critical factor in the lack of understanding of BME staff and communities.

“

The NHS management structure – the higher you go, the less likely you are to see anyone from a non-Caucasian background. It's the structures within hospitals that result in differential promotion rates between different ethnic groups. It's difficult to describe, it's ingrained (racism) in my years of experience in the NHS.

BLN Member

“

People don't even understand the demographics they serve.

BLN Member

Role risks

BME staff were reported to be more likely to take high-risk roles, including working in frontline COVID-19 wards, due to fear that their contract may not be renewed or shifts reduced, especially if they were agency staff or had a vulnerable immigration status. Institutional racism was suggested by BME Leadership Network members as a reason for more staff from BME backgrounds working on the front line or in COVID-19 wards compared to white colleagues.

“

Most hospitals have a big percentage of their low-level staff being of BME origin. So BME people are at higher risk of exposure than their white contemporaries.

BLN Member

“

If you raise your concerns, you're the person – 'that troublemaker' – and you're always worried that you might lose this job or I need my visa renewed. And I think that is a quiet threat but no one is talking about it, but it significantly impacts both preparation for BME staff and also the ability to protest when they don't have appropriate PPE.

BLN Member

Bullying

Financial and safety anxieties were often made worse by a culture of bullying and intimidation. Although the NHS has a bullying policy,³¹ many interviewees, both managers and clinicians, reported that bullying and harassment were a fact of life for many BME employees.

This culture was seen as a potential consequence of senior managers needing to project a positive picture of their organisation. It was felt they were more likely to take note of middle management than listen to those on the front line. As a result, BME employees were less likely to raise their concerns or share their experiences.

“

The biggest challenge is that this is not something that is recognised by directors, senior executives of NHS organisations, or even other employers, because often, they will say that our middle managers are doing a great job and they don't want to hear that there is a debate. It still means that it is the people who have raised concerns will bear the brunt of the outcome of whichever discussion. So often, the staff will keep quiet, just to keep their jobs and the biggest factor before someone gets residency in this country. You are thinking 'I want a reference to move forward' or 'I want my visa renewed'.

BLN Member

88%
of respondents
said staff do
not speak out
because they
fear for their jobs

Nearly 9 in 10 survey respondents (88 per cent) said that staff do not speak out because they fear for their jobs.

PPE

A culture of bullying and denial was suggested as contributing to a lack of personal protective equipment (PPE) for BME staff during the first wave. The wearing of PPE is a key part of the Health and Safety at Work Act 1974,³² which states that employers have a duty of care as well ensuring the 'health, safety and welfare' of their employees and others on the premises and that they should be provided with adequate PPE to do their job safely.³³

Problems relating to the adequate supply of PPE were documented in the media during the early stages of the pandemic.³⁴ However, interviewees suggested that there were continuous concerns about the availability of PPE, as well as poorly fitting and inappropriate equipment.

“

I've noticed in other trusts and other colleagues that people feel that that they've often not been able to get access to the right kinds of PPE, but that they then are still sent off to do the work that they need to do and people are worried about raising the issue because they feel bullied.

BLN Member

“

At the beginning we had difficulties around PPE and they felt that they weren't able to access PPE... [Now] feedback through our BME Network is that they feel they have had access... [but] ... the masks don't fit our faces. If you're your face isn't standard European, whatever standard European is, then there's an issue about the mask fitting and if the mask fit doesn't fit properly, then how do you get protection?

BLN Member

“

There's an issue with the suitability of equipment for different ethnic groups and different protected characteristics, and the fact that we've not thought about that before now.

BLN Member

V's story

V works in the neuro/stroke ward of an NHS trust. She caught the virus early on, suffered severe lower-back pain, high temperature, and loss of smell and appetite. She was off work for two weeks and then her husband caught it and the family had to isolate. She was off for another six weeks.

During the first week in March, staff at the trust lacked the necessary PPE. V said that up to half the staff were off at any one time and then they employed agency staff. She worked in a nurse-led unit. She worked longer hours when they were busy and was depressed and stressed for much of the time.

Risk assessments

NHS England and NHS Improvement (NHSEI) responded to concerns over the disproportionate impact of COVID-19 on BME staff in a letter to all NHS trusts in April.³⁵ It outlined the evidence of increased risks among some BME staff and suggested they be prioritised for COVID-19 screening and FIT testing for high-level protection FFP3 masks.

Although this was seen as a positive statement, many interviewees working on the front line said it had also created another layer of animosity and stigma for the BME workforce. This was mirrored in our survey, with almost two-thirds of respondents (60 per cent) agreeing.

“

Not only are you creating the environment for stigma, you're also alienating the rest of the people who have always managed poorly. There are categories of people who are at higher risk. If you're a man, you're more likely to have a poorer outcome, because evidence shows that if you have long-term conditions, you have a poor outcome, if you are BME you have a poorer outcome, so we would expect all these categories to be picked up, it would have taken the issue of just being BME and white. Now they have made it a BME versus white issue.

BLN Member

68%

of respondents suggested risk assessments were tokenistic because they did not change working practices

Others suggested risk assessments were tokenistic because they did not lead to changes in working practices. Almost 7 in 10 survey respondents (68 per cent) shared that view.

“

I have had the risk assessment done. And then you are told you can work from home a couple of days. But because we were moving patients, everything that was all thrown in the bin. So my question is: COVID is still there, right? I'm still at risk. Then you get an email saying that you all have to come in, obviously, your white colleagues and everyone else and other colleagues are being included. So in my head I'm thinking what happened to the risk assessment?

BLN Member

While much of the discussion on PPE and risk assessments focused on acute settings, the challenges in primary and community settings received less attention, despite the significant risks to large numbers of BME staff.

“

I was back to the front line in community health. Unfortunately, after two weeks I came down with COVID-19 myself, because we had no protection in the community. Yet we're still seeing people on the front line, running clinics (with no PPE) and unfortunately I got it.

BLN Member

“

Most of our staff and patients are BME (in primary care), what could we do differently? We did risk assessments and shielded them and sent them home, then we were told to do a BME risk assessment. How is that helpful for me? All our staff are BME; are you going to send in other staff?

BLN Member

“

We've done everything we can, we've gone out and bought our own laptops for our staff and we don't know if that funding is definitely going to come through to us. We took that risk for our staff, as our staff are really important to us. We bought 100 oxygen meters for our patients, at a cost to the practice, which we then delivered to their homes, which cost £2,000 because the services weren't coming through and we didn't want them wandering around trying to get their own and then we had to hire a new admin person take it to their homes.

BLN Member

Future challenges

NHS interview participants frequently raised concerns over how they would be treated following the pandemic.

“

Our BME staff group is a really small staff group and I've got a really active and enabled BME network. They've come together on a weekly basis to support one another, but that isn't sustainable. What additional resources do we need to give to staff organising themselves? It's a really hard time for them now.

BLN Member

There were also concerns about the future of BME staff in the NHS and the impact of COVID-19 on BME communities, with fears that fewer BME and migrant staff will want to work for the health service.

“

I think it's a suspicion for me that it's going to significantly impact recruitment into NHS roles for the future. I think if there's one message that came through to the public is that if you're from a BME background, you are less safe working in the NHS than if you are if you are white. I suspect we'll have a significant drop off of recruitment.

BLN Member

“

What's really interesting that hasn't been discussed so much is the impact of trust amongst the workforce... staff evaluating their career plans or people planning to do less sessions, retire early or... move into the private sector.

BLN Member

55%
of respondents
shared the view
that vulnerability
of staff to the
virus may affect
recruitment

Over half of survey respondents (55 per cent) shared the view that the vulnerability of staff to the virus may affect future recruitment.

Communication

74%
of respondents agreed that lack of targeted messages and advice to BME communities contributed to the unequal impact of the virus

The absence of translation services and appropriate communications strategies targeting BME communities was one of the most widely reported institutional failures cited in our interviews. Nearly three-quarters of survey respondents (74 per cent) agreed or strongly agreed that lack of targeted messages and advice to BME communities contributed to the unequal impact of the virus on BME communities.

“

The thing that has really highlighted for me is that the NHS and councils rely on children or family members to translate rather than doing it themselves and it's really showing that there is a need for translation services. It's about getting messages through.

BLN Member

“

There was no targeted communications in different languages to BME communities that was all done by Doctors of the World or celebrities or Imams. You know everybody else but the NHS was doing it.

BLN Member

“

I think there is there is no doubt that the current channels of communication are fundamentally archaic, they don't work with what could be aligned with a BME lifestyle or BME system.

BLN Member

Many of the community organisations we interviewed sought to fill this gap to protect their communities:

“

We have been translating things like when they say you're only supposed to take six people to a wedding, or a funeral, but if they can't access the information, how do they know if they doing right or wrong? They break the rules if they are not educated about the information. So what we've been doing in the community during COVID: there's a colleague of ours and when there is a death he puts out a message via WhatsApp and other means to say 'please don't go to the house adhere to the COVID rules' to remind people because we do get carried away. Again, that's not been translated into any other languages. So, apart from getting these messages, how are they going to adhere to the rules if they don't understand what the message is?

Community Partner

“

We're working with public health to ensure that material is available in relevant community languages for the people that we're working with. So when we work with people from 100 different nationalities, obviously a few of them are the only person who speaks that language, but there's a real diversity of languages and the community that we're in is very diverse as well. So ensuring that those kind of COVID-19 messages, in terms of what to do regarding self-isolation, test and trace, that kind of stuff, has been, something we've done in addition.

Community Partner

Interview respondents occupying clinical roles also shared their own concerns over the accessibility of advice provided by 111 or 999.

“

I had an experience with 111... access was just so difficult to get through, because it was overwhelmed, understandably. But again, the communication you're getting when you got through... there are no translations into any other language. There was no option of you saying I don't understand English as there are some people who cannot articulate themselves well in English.

BLN Member

“

Everything's done online or via telephone. And again, it comes down to language, they either have to get someone to call on their behalf to make an appointment or even if they're doing video calls in the way of consultation, how are they going to explain the situation?

Community Partner

“

The language barrier and the competence barrier has been made much more significant during this lockdown.

Community Partner

These problems were more acute for refugees and migrants. Community partners also reported that people had become scared of going to hospital for routine appointments for fear of contracting COVID-19, being alone in hospital and needing to cope without family support.

G's story

"My mum's 88 and went in for a blood transfusion. She's never been left alone in hospital and when she was, I was on the phone 24/7 because they didn't have any interpreters. They didn't have anybody who could speak to her and translate from English – even just to take her to the toilet. So I had to ring them and say 'Have you taken her to the toilet?' or 'Have you given her any food?'

"She's a diabetic. A porter, who came in to change her bed, could speak our language. She got him to ring me and I spoke to her. 'You have to be here,' she said and started crying because she was scared.

"The next time she had a blood transfusion she refused to go in because of what had happened the first time."

The Black Lives Matter movement

Respondents suggested that the issues raised by the pandemic have been taken more seriously in the context of the global Black Lives Matter movement.³⁶ Some reported optimism that possibly, for the first time, anti-racism would be part of a genuine conversation within the health service.

“

The COVID-19 outcomes that were being raised as an issue could have been swept under the carpet if it weren't for the global movement around Black Lives Matter. And I think that's why it's easier to have these conversations now. It's easier to talk to people about racism because prior to this, it was almost as though, if you were to talk about these issues, it felt that you were complaining, whingeing, as if you had a chip on your shoulder.

BLN Member

“

There has been a change in focus from the deficit model to one now saying what people need to do is change, educate your top quarter, sort of stand up and challenge and have uncomfortable conversations about white privilege too because we have a lot of conversations all the time. I think it's actually about the NHS now being able to respond to that effectively, and to hold that, you know, some of those conversations and really have a shift in its own culture.

BLN Member

Future demand

Community partners identified two issues that will likely impact on future demand for health and care services from BME communities: domestic violence and trauma.

The increase in domestic violence during COVID-19 has been well documented in the UK and worldwide issue.³⁷ In addition, the trauma of people dying alone with families unable to say goodbye,³⁸ combined with restrictions on funerals, were identified as major compounding issues for many BME communities who traditionally have extended periods of communal mourning.

“

We closed down hospitals without due care and attention to families' mental health and wellbeing. They couldn't go and see their loved ones in care homes, they couldn't see their loved ones in hospitals. They couldn't come and grieve at funerals which is something that in future debriefs and inquests will come back to haunt them because, many of the funerals could have had 50 or 60 people, reducing them to six people certainly wasn't risk assessed in a way in which I would say was proportionate to the decision they made.

Community Partner

“

It's been a real problem for many BME communities, not having proper funerals, not allowing the grieving process to take place, a lack of touch, hugs and even before then...you are not allowed to visit sick people or to give help or support when you would normally.

Community Partner

Viewpoint

The insights generated by this research will make for difficult reading, placing the spotlight on a set of uncomfortable truths that for too long have gone unaddressed. What unites the contributors in this research is a suboptimal experience of the healthcare system, either as a service user or employee, both sets of whom share the characteristic of being from a BME background.

As has been well documented, the COVID-19 pandemic has served to foreground these issues in the starkest terms and mobilised efforts to redress structural inequalities. Over recent months, questions have continued to be raised over why the pandemic has taken a disproportionate toll on people from a BME background. Our research points to two key reasons:

- First, that the NHS has failed to adequately address the long-standing health and socio-economic inequities³⁹ that have disproportionately impacted BME communities.⁴⁰
- And second, that institutional racism has negatively impacted on the accessibility and quality of services available to BME communities, as well experiences of discrimination among BME staff within the organisation.

During the first wave, these were compounded by: an initial lack of and appropriateness of PPE for BME staff; the higher number of BME staff in high-risk roles; a notable absence of communication strategies and services aimed at BME communities; and the continued enactment of 'hostile environment' policies.

The perspectives shared by BME Leadership Network members and community partners here tend to support the perception that: "... ethnicity, inequity and racism remain uncomfortable topics within health policy making circles...⁴¹." This report aims to mark a turning point by putting forward a set of actions that address these issues head on.

Recommendations for government

1. Review the potential for policies such as eligibility checks and overseas visitor charges to be a vehicle for promoting institutional racism. Such policies facilitate the hostile environment, disproportionately impacting BME staff, patients and service users.
2. Treat long-term structural health inequities and institutional racism in the NHS as critical factors in any further research or work on the impact of COVID-19 on BME communities. The independent Race and Health Observatory, hosted by the NHS Confederation, will be a key in this respect.
3. Commission a review of the availability of translation services, working with community groups and Healthwatch England.

Recommendations for the arm's-length bodies

4. NHS England and NHS Improvement should address the inequities of the 'snowy white peaks' through active talent management strategies supported by explicit career pathways, as signalled in the People Plan. These pathways should be objectively defined, evaluated, remunerated and recruited to.
5. NHS England and NHS Improvement, as well as NHS organisations, should reflect on the robustness and effectiveness of BME staff networks and how far they are resourced and empowered to deliver critical messages rather than managing short-term reputational risks.

Recommendations for NHS organisations and integrated care systems

6. Ensure community engagement strategies are locally developed with oversight from integrated care systems, through their responsibility for person-centred joined-up care based on the needs of communities and reducing health inequalities. Integrated care systems are urged to use population health planning tools, pay greater attention to local data on health inequalities and to act on the insights.

7. Ensure closer working with voluntary, community and social enterprise sector organisations, through targeted funding and resources, to facilitate sustained co-production of community-facing COVID-19 messaging and the rapid availability of translation services.
8. Develop an organisation-specific anti-racism strategy that is grounded in patient care led models of improvement, community-led models of service redesign and integrated systems of community accountability. The independent Race and Health Observatory will be a key system resource.
9. Act on the insights from WRES data and the NHS Freedom to Speak Up Guardian, addressing issues of bullying and discrimination. Specifically, organisations should support NHS People Plan commitments towards transparent, safer staff rostering practices and increases in BME Freedom to Speak Up Guardians and BME network leaders who are part of recovery, restoration and senior decision-making structures.
10. Ensure the sustained availability of PPE, particularly to frontline staff as well as effective 'fit testing' for all staff, facilitating maximum workforce safety. NHS organisations should support the Chief Nursing Officer's BME Action Plan on COVID-19 as a part of the People Plan offer towards keeping staff safe and attracting BME staff working in the NHSⁱⁱ.
11. Adopt a new model of NHS leadership that welcomes and values innovators with roots in BME communities and a track record of anti-racism. Integrated care systems should lead development of governance and human resources functions facilitating such diverse leadership in line with NHS People Plan commitments.

System working

Reducing inequalities experienced by staff and people using health and care services will require concerted action by the NHS, government and wider public sector, working at scale and in a systematic and targeted way with communities to address inequalities and regain trust. Integrated care systems have a key leadership role in this and must be supported to lead on this work.

ii NHS Employers has developed a comprehensive [web page](#) detailing guidance for NHS organisations on how to enhance their existing risk assessments, particularly for at-risk and clinically vulnerable groups within their workforce.

The move towards greater system working provides an opportunity to shift the dial on a number of issues raised in this report. West Yorkshire and Harrogate Health and Care Partnership's recent [review of the impact of COVID-19](#) on its BME communities, for instance, provides an important example of cross-sector action to tackle the root causes of inequity.

As a BME Leadership Network, we will continue to listen to and work with members, and the wider NHS Confederation, to develop and showcase actionable steps to address the issues identified in this report.

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We would also like to thank to all our BME Leadership Network members who participated in the interviews, or completed the survey, your contributions are greatly appreciated.

We would particularly like to thank the community partners for making the time to speak to us in the midst of continuing to provide support to the most vulnerable.

Appendix 1: Methodology

In June 2020, the BME Leadership Network engaged a research agency to ensure the independence of the research study. All work was carried out in accordance with Market Research Association Guidelines standards, including guarantees of participant confidentiality.

We gratefully acknowledge the Health Foundation's funding and full support at all stages in this research.

Samples

The methodology triangulated data from three sources: tele-depth interviews with network members, a Delphi survey of network members and interviews with community partners. The samples for each group are summarised below:

1. BME Leadership Network membership

At the time of the survey the BLN had 325 members made up of leadership roles across the following main categories: nursing and midwifery, GPs, consultants, medical directors, allied health professionals, community and voluntary sector organisations leaders, non-executive directors, including chairs, and NHS chief executives. Members are located across England with notable representation from senior clinical leaders in the North of England.

Employing organisations: acute trusts, mental health trusts, community trusts, primary care and clinical commissioners, third sector, arm's-length bodies and royal colleges.

2. Tele-depth interview sample

The breakdown of the participants for the tele-depth interviews was evenly split between gender and job type. Over a third (38 per cent) were of Indian background, a quarter had an African background (25 per cent), while over a tenth had a Caribbean background (13 per cent). One third of each of the sample were drawn from 45–54 and 55–64

years age group. The majority of participants were based in London (71 per cent) with the rest based in the North West, Yorkshire and the Humber (8 per cent each), the South West, West Midlands and East Midlands (4 per cent each).

3. Delphi survey sample

Of the 115 participants, nearly three-quarters were female (74 per cent) compared to men (25 per cent). Nearly four-fifths were aged between 45–54 years old (37 per cent), nearly a quarter were aged between 34–44 or 55–64 years old (23 per cent and 24 per cent respectively), while a tenth were aged under 35 years old and a minority were aged over 65 years old (4 per cent). When asked about region, the majority lived and/or worked in Greater London (32 per cent), followed by West Midlands (20 per cent), the South East, South West (both 15 per cent), North West (13 per cent), Yorkshire and the Humber (8 per cent), East Midlands (8 per cent), North East (7 per cent) and the East of England (3 per cent). Over a half of participants were managerial (53 per cent), a third were healthcare professionals/clinicians and the remaining fifteen per cent were board members.

The ethnic breakdown of the sample showed the largest groups of respondents were Indian (30 per cent), Caribbean (17 per cent), African (14 per cent), Pakistani (7 per cent) and White (6 per cent).

4. Community sample

Our community partners included:

- a large BME-led specialist migrant and refugee association based in London
- a women-only mental health and employability support group in the West Midlands
- an ESOL and immigration advice service in Birmingham
- a London-based health clinic supporting those unable to register with a GP or access mainstream NHS services because of the hostile environment
- a health and social care self-help support group for BME women in the South East of England
- a support service and campaign group for Middle Eastern and Afghan women and girls at risk of 'honour' based violence, forced marriage, child marriage, female genital mutilation and domestic violence

- a national NGO working and campaigning in support of migrant rights in the UK
- an organisation supporting BME people into employment through training and advocacy
- a migrants and refugees support group operating across the West Midlands
- a migrants and refugees support group in Yorkshire
- a community organisation providing support to people with mental health problems in West Midlands
- an organisation supporting undocumented migrants in London.

Data collection

Tele-depth interviews

Tele-depth interviews took place between 18 June and 20 July and lasted between 20 and 45 minutes each. The interviews explored participants' thoughts on how the nation and the NHS had dealt with COVID-19 pandemic and explored their perceptions of the underlying reasons for the disproportionate effect of COVID-19 on BME communities, including issues which were not widely discussed, as per the topic guide.

A total of 27 people registered to take part in the study, but due to tight timescales and acute demands on staff time, only 24 interviews were completed. However, given that most interviews lasted longer than anticipated the amount of relevant data collected exceeded initial expectations.

At the culmination of the tele-depth interviews, the initial thematic analysis of the data highlighted a number of recurring themes across the interview sample. To assess the extent to which these apparent themes might reflect the broader perspective of the BME Leadership Network membership, and therefore provide additional insight into how members' perspectives might inform understanding of the disproportionate impact, it was agreed add a first stage Delphi review to the methodology to fine tune the analysis.

Delphi reviews are used widely in health research and provide a systematic and interactive method of gaining opinions independent experts. They are also robust methods for gaining consensus on difficult and complicated topics and exploring areas where data is limited or lacking.

Delphi review

Emails were sent to all 325 BLN members with a link to an online study, using Smart Survey, to ask for their level of agreement on 58 statements identified through the thematic analysis. Despite the time and work constraints for the respondents the response was excellent (n = 115 35 per cent). Data collected from the Delphi review was analysed using SPSS, a comprehensive software package for survey analysis and tabulation.

The key themes identified through thematic analysis were honed by the team into 58 statements for the Delphi review. Each of the 58 statements was scored using a seven-point Likert scale from 1–7, where 1 was 'do not agree at all' and 7 was 'yes, totally agree.' The mean score was calculated by adding up each score and dividing by the number of people answering the question and used to facilitate understanding how important the participants felt that the statement was i.e. the higher the mean score the higher the level of agreement with the statement. The themes were driven from the qualitative data however the scores from the Delphi review are giving some depth after being scored by BLN members.

The mean scores on the Delphi survey were used to identify where the key themes generated from the depth-interviews had wider resonance across the BLN membership and were used to guide the narrative findings.

Significance testing was conducted on the mean scores of all the statements to identify statistically significant differences (@ 95 per cent significance) in survey responses based on gender, age, region and ethnicity. No statistical significant differences were identified between respondents from the different BME communities. Women were more likely than men to agree that the stresses and anxiety of the challenges of life meant BME staff more vulnerable to having compromised immune systems (6.24 v 5.32) and that white privilege was at every level (6.63 v 5.93). White respondents (n=7) were less likely to consider living in multi-generational/overcrowded households to be a significant issue than those from an Asian background (5.2 versus 6.02). The Black respondents were more likely to report that the policy of risk assessments for BME staff creates animosity/stigmatisation within the workforce, than the white ethnic groups (5.78 v 3.5); a lack of well being support for NHS staff (5.22 v 3.14) and that they were more concerned that BME agency staff were more likely to be sent to a COVID-19 ward or front line because of racism (6.24 v 4.18). Inadequate testing and tracing for patients leaving hospital was felt to be more important for those aged between 45–54 years old than those under 45 (6.45 v 5.38).

This was reversed when asked about NHS charging/data sharing with participants aged under 45 years were more concerned than those aged 45–54 (5.85 v 4.22).

Community perspectives

To strengthen the research we conducted interviews with 12 community partners to assess how far the BLN members' perceptions and experiences were reflected in the wider community. Our members tend to be among the most advantaged within the BME communities, occupying high-skilled, well paid and secure employment. We therefore wanted contrast their perceptions with those among the more disadvantaged sections of our communities especially migrants and refugee who are among most vulnerable and face particular challenges accessing NHS care.

The community-based element of the research was overseen by a small advisory group. Our initial intent was to speak directly to service users, but on advice from the advisory group we agreed to limit direct contact as there was insufficient time for the researchers to build the necessary trusting and secure relationships that such vulnerable people need. Tele-depth interviews were conducted with representatives of 12 community organisation during July to explore the experiences of the communities they serve during COVID-19 pandemic. Thematic analysis was then employed to identify any shared perspectives and areas of disagreement with BLN members.

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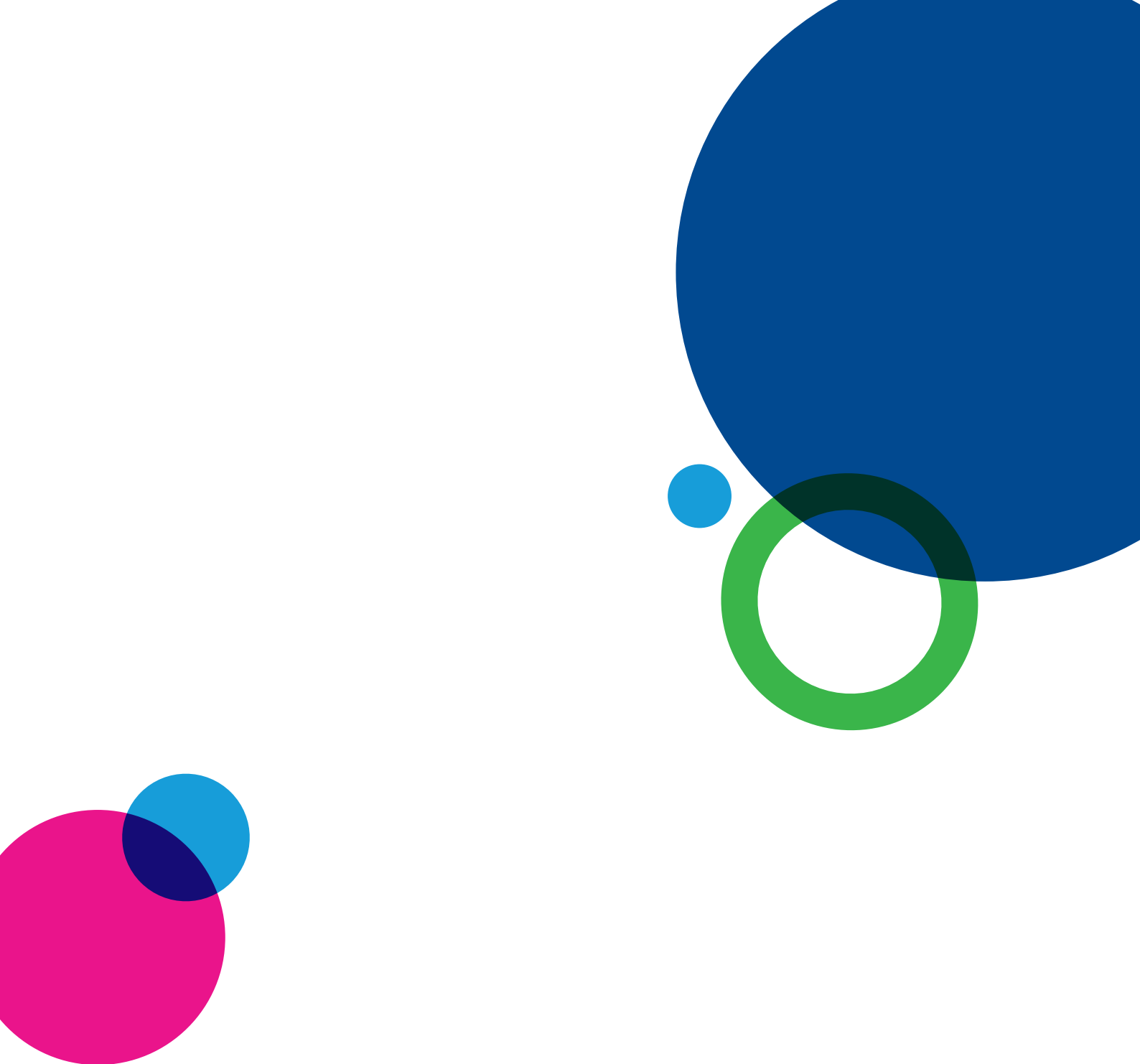
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