EHRC inquiry into racial inequality in health & social care workplaces

GMB Union Submission

March 2021

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FOREWORD

As we mark a year on from the start of the pandemic it is with great sadness, that we look back on the huge loss of lives many of which were avoidable. The silent emergency that has become more prevalent during this pandemic is racism. Racism in our workplaces and communities, and systemic failures in almost every powerhouse be it government, employers, or organisations.

The silent emergency and the underlying inequality brought on by the pandemic cannot be dismissed. It is what led GMB to give verbal evidence to the EHRC Inquiry and provide this submission; to document the experiences of ethnic minority workers and ensure our community's voice is heard.

Race and class inequality has always existed, the pandemic just amplified it and as we have heard the roll calls of the dead read out, we have seen in each face the stark inequalities that exist in our society and communities. They say this virus does not discriminate yet we know our society, our systems, our institutions, our policies, practices, and our economy do. After the death of Stephen Lawrence, post-Macpherson, we were going to build an inclusive Britain, eliminate unlawful discrimination and make our institutions fit for purpose. Audits were carried out and recommendations tabled, but many have forgotten why we had to amend the Race Relations Act back in 2000.

To help introduce austerity measures Theresa May's government removed 'socio-economic' as a key protected characteristic from the single Equality Act and equality impact assessments. If it had remained, the glaring injustices of austerity would have been revealed in every decision made by government today, but we would also be required to examine whether Covid and the government's response has disproportionately hit the less well off.

GMB is joining leading organisations across public policy campaigners to campaign for socio-economic to be reinstated in the equality act and a robust Equality Act that puts workers and their communities first - we hope that once EHRC conclude this inquiry, they make similar recommendations.

There has been a serious breach of trust and confidence by this government, as the evidence suggests they cannot or will not protect people from all backgrounds and as a trade union we have represented and amplified the voices of our Black members.

The GMB has led the call for the publishing of the government's EIA for the pandemic- The EHRC have a pivotal role to play in ensuring these assessments are published and a serious review needs to take place in the form of an independent inquiry.

Back in the Summer the GMB revealed that NHS England had essentially been marking their own homework and that the scope of the review, some of which was published to understand the disproportionate BAME (Black and minority ethnic) deaths, was too narrow and the last thing we needed was more reviews that make no recommendations, offer no remedy, and provide no recourse to safety or justice.

The business model that has allowed the privatising of public services is broken. We need an end to the race to the bottom of terms and conditions. We need services brought back in house and better protection for workers employment right and an end two tiering of pay terms and conditions.

In the absence of clear guidance, GMB has produced a toolkit and upskilled our union reps to demand their employers deliver safe and equitable systems of work, but the scale of the problem requires legislative
intervention. We must tackle the systemic, institutionalised failures across government departments, and we must do better by our communities.

Our members lived experiences of inequality, racism, and the lack of trust in the system exist and are demonstrated here in this report, but this is not news to us- we all knew how tough it was through our own lived experience and that of our families and friends.

As a grass roots organisation, this project has been led by employees and activists from ethnic minority backgrounds, with the aim of bringing the experiences of our members during the pandemic to life and achieving public policy change as a result.

GMB would like to thank all our members who have shared their thoughts and ideas, GMB employees who have provided their time and knowledge and thank Duncan Adam (Staffordshire University), Steve French (Shrewsbury College) and Mick Pender (Keele University), whose help and guidance have made this report possible. [1]

Rehana Azam, Melanie Bartlett, Rochelle Channer, Tyehimba Nosakhere

[1] The terms of reference used in this report reflect EHRC definitions of the inquiry and 'members' refers to black, Asian and ethnic minority GMB union members working in the health and social care sector, as defined in appendix A. The survey was undertaken during August 2020, focus groups took place 28 Jan 2021 and 18 Feb 2021.

EXECUTIVE SUMMARY

1. **Working conditions/employment status**

"Is the onus on me to ask or my employer?"

Although most ethnic minority GMB members in health & social care stated that PPE had been provided, social distancing measures were in place and risk assessments were being undertaken, we've found standards varied across the sector, with a number of specific health & safety risks being identified:

- **Access to safety information and equipment** Workers require more support and guidance from management. Safety information is often inaccessible and PPE not sufficient protection in roles where it is difficult to socially distance,
- **Policies and practices** The quality of individual risk assessments varies across workplaces. Good practice needs applying across the board to fully protect ethnic minority workers who are overrepresented in roles where social distancing was difficult,
- **Statutory employment rights** Poor terms and conditions in the social care sector (such as lack of sick pay provision) where ethnic minority groups are overrepresented, may have impacted on workers' ability to control their working lives and in turn isolate, whereas this was not an issue for GMB members in the public sector or those in unionised workplaces.

Summary of recommendations increase the powers of the Health & Safety Executive (HSE), make risk assessments public and individual risk assessments mandatory, end outsourcing in health and social care, provide full sick pay from day one, produce accessible information in different languages on health & safety, employment rights and equality legislation.

2. **If race/structural factors contributed to difference in treatment or experience**

"The head office is predominantly white, but most of the workforce is from what you would call a BME background"

Although policy developments and firm action after the first wave has helped protect many ethnic minority groups, GMB members experiences support findings that underlying inequalities and structural racism has put ethnic minorities at greater risk:

- **The division of labour** The differences in the allocation of tasks and progression opportunities between different ethnic groups has led to ethnic minority workers being on the frontline with less control over their working conditions,
- **Trust** Issues of confidence between ethnic minority workers and state institutions persist. This was reflected in members experiences of raising concerns and during conversations around vaccinations that exposed deeper distrust in the system,
- **Inequality** Data developments, increased public awareness of race issues and good policies and practices have saved lives, but health inequalities cannot be tackled without addressing economic inequalities.

Summary of recommendations publish and action Equality Impact Assessments, reinstate section 1 of the Equality Act (socio-economic status), increase public health funding in areas with increased covid fatalities, provide independent access to training and development, improve data monitoring and analysis (e.g., race pay gap), establish a working group to progress report findings and recommendations

3. Knowledge of workplace rights and access to support and redress

"I get information first from the GMB, I print it and put it on the wall on every floor. This spurs the management into action, but they are not proactive"

- **Management Support** Across the sector support varies - there is a need to develop good standard practice and ensure procedures are free from unconscious bias,
- **Worker Empowerment** Workers who were aware of their employment rights were more confident to speak up. Independent employment support and trade union organisation has helped ethnic minority workers address health & safety issues in the absence of management action.

Improving knowledge of workplace rights and access to support introduce mandatory training on race issues, provide independent support and advice to workers, increase trade union engagement, increase representation on decision making bodies, provide independent processes for handling grievances/disciplinaries and reporting discrimination/bullying

REPORT FINDINGS

Working conditions/employment status

ACCESS TO SAFETY INFORMATION & EQUIPMENT

'They are sending us so much information…it's information overload.'

As with public health messaging[i], the dissemination of health and safety information is not always reaching ethnic minority workers. Wider research undertaken by the BAME Communities Advisory Group which found carers complained information was not properly disseminated or translated[ii], was reflected in GMB members' experiences.

During focus groups, workers noted that the *provision* of information was, in most cases, not an issue, but the way it was provided created problems within workplaces. The amount of information was often overwhelming and raised questions as to whether it was digestible and helpful. A local support worker for people with learning difficulties observed;

"*[I receive] a lot of information [from management], which makes me aware of the information provided by the GMB which is digestible.*"

The key issue to arise out of information provision related more to how there was a lack of support for workers and supervisors to help implement what was required;

"*That's where they leave it. We have to do everything in response to the information, such as risk assessments. There is no support.*"

"*They don't take responsibility of taking us through the information. The responsibility falls on the workers and team leaders.*"

"*How am I supposed to work, when I don't know what to do?*"

In the absence of clear guidance from management, a GMB rep told us how they fill the information gap;

"*I have set up a WhatsApp group to pass on all the GMB information and materials to members.*"

These comments reflect wider issues with structure of management in the care homes where the participants work; remote management and a lack of resources available on the frontline leaves predominantly ethnic minority staff to cope and respond to Covid. Given ethnic minority health & social care workers have been strong advocates of public health messaging[iii], providing accessible information to this group could also have wider positive implications for ethnic minority communities, especially if translations are available and information is produced in multiple digital and printed formats.

"No attempt other than suppling PPE has been made. More effort could be made in the workplace to offer screened work areas and social distancing."

Access to suitable PPE is one of the key modifiable factors in covid exposure for healthcare workers[iv], yet studies have found less ethnic minority key workers were provided with adequate PPE compared with their white counterparts.[v]

Given this is the last line of defence against infection for workers where social distancing is difficult, although the majority of our survey respondents (87%) reported employers had supplied PPE, the remaining respondents are cause for concern. During the first wave, a Biomedical Scientist describes their working environment;

"*No wearing of masks, no social distancing, nothing in place for toilet utilities, staff have covid and working in the same environment, no windows just vents, confined space and working with covid samples from patients.*"

Even where PPE was provided, concerns around additional safety control measures and risks to health have persisted. Social distancing was seen to be problematic, due to the nature of the role, with almost half of survey respondents stating that their role prevented effective social distancing (47%) rather than their employer was not enforcing the rules (4%). One worker demonstrates the difficulty in their role;

"*My colleagues and I are very apprehensive because how will it be possible to social distance. Sometimes we have to see a patient to gather information - we call it a double up. Concerns regarding (PPE) discussed with manager, social distancing regarding the role of my job or other job role not discussed.*"

Members from our second focus group tended to highlight contradictions in the information supplied and whether PPE was appropriate for use. Worryingly, a number told us that when they raised health & safety issues early in the pandemic, such as the suitability of existing risk assessments or issues with sanitising and social distancing, the response was hostile. A mental health psychologist in an NHS Trust, highlighted that concerns were raised about the suitability of masks by consultants working on Covid wards, whilst the local manager stressed, they were safe. She noted how conflicting information raised anxieties, and how the situation had been dealt with;

"*The Asian member of staff who raised the issue ..... was made to look like a bit of a troublemaker and shut down and marginalised for raising issues on behalf of us all.*"

Working conditions/employment status

WORKPLACE POLICIES & PRACTICES

"It was not useful – a tick box exercise".

The application of the individual risk assessment process has varied from member to member, when it is clear a standard approach with sector wide standards is needed. Where risk assessments are comprehensive, they make workers feel safe, but our findings support wider research that risk assessments in the sector were sometimes conducted as tick box exercises and did not highlight the particular needs of the community.[vi]

Table 1 (below) presents data in relation to the response of survey participants' employers' response to Covid.

Table 1 Individual Risk Assessments- survey participants

Covid response	Category	Percentage
Individual Risk Assessment provided by employer	Yes	58
	No	33
	Do not Know	9

(Maximum N=120)

58 per cent of workers in the sector reported that they had undertaken an individual risk assessment (IRA), though this is no indication of whether the IRA was considered to be either robust or adequate. The free text comments clearly indicate a mixed experience of risk assessment, and some of the key comments which emerged from this question related to the lack of follow-up to the risk assessments, either in relation to individual circumstances, or at the workplace as a whole.

"*It was just general routine questions. We requested screens and not provided*".

"*Risk Assessment form (sic) were required to be completed by all BAME staff in the first instance before being offered to the rest of the Trust. Questions were asked about underlying health conditions; current post; interventions with current position and any additional action to reduce risk. Nothing has come from the submission of these forms however*".

"*No risk assessment [was] done on myself when the company knows I have health issues*"

There are examples of respondents reporting that, as a result of the risk assessment, their work has been altered to reflect their level of risk. Responses which indicated how individual risk assessments were then used to inform practice were not common, though they did indicate that there were employers who were following best practice.

"*The form was regarding BAME workers. When filled out, I was told I was at risk due to an underlying health concern, and I was exempt from working in the high-risk areas of the hospital. A few weeks later everyone was told to fill in the form regardless of whether they were in the BAME category or not. So far I haven't been asked to move into another clinical area in the hospital.*"

Members who had a decent risk assessment, which was comprehensive and regularly reviewed with their manager, have been kept safe as a result and showed great appreciation for the process;

"*Firstly, I was asked which risk category I fell into - i.e., if I had any long-term health conditions, respiratory or medical problems. I then was asked about my ethnicity. As I identify as African Caribbean, I ticked that box, and the form was then sent to my manager. Once receiving the form my manager filled out the questions as to how we could work together to make my job safe when I return. I read through and agreed with the assessment so then signed. Some things I have to adhere to, for example if I am on first response duty, I need to make sure I have gloves and a ventilator mask on at all times. If assessments can be completed over the phone, then that has been agreed that that is ok. If for any reason a resident must be seen at home, I have to make contact first to see if they have had any symptoms and ensure that a safe distance is kept during the visit. I found the risk assessment very useful and in monthly 121's with my manager we review the assessment, also I can make changes to it at any time.*"

One response highlighted the approach taken by the NHS in relation to risk assessment, though did not make clear whether they had witnessed the risk assessment working in the way which was described.

"*The NHS are carrying out a risk assessment for all staff which includes a Covid age assessment. You are asked if you are from a BAME background and depending on which one you choose this may add to your age or decrease your age. You are asked what gender you are this also has an impact on your score, and finally whether you suffer from any underlying health conditions etc. the higher the COVID age the higher the score and these individuals would be recommended to work in lower risk environments.*"

In our second focus group, participants highlighted the problems with risk assessments and shielding. One worker, a mental health psychologist, ended up working from home and then shielding. While she had undertaken an individual risk

assessment as an ethnic minority member of staff, she had had to fight to hold the assessment with the manager she had been seconded to, rather than her own line managers with whom there were potential harassment issues. The member also told us in some cases individual risk assessments had been completed by managers 'on behalf of' ethnic minority staff without their input.

In her own case a number of issues raised in the risk assessment, notably around asthma, had been referred to occupational health, but these were completely dismissed, leading her to suffer increasing anxiety. There had been no formal letter received in relation to shielding or working from home and the position was only resolved when her own partner, who had cancer, was shielding and the oncology department at the hospital instructed her to shield as well. Even then she had to use the letter from oncology to stop her management pressuring her to go out to see patients again.

This was echoed by another participant, an NHS mental health nurse, who was shielding due to a lung condition. It had taken quite a lot of time for her to receive her shielding letter from the GP (and text from the government) to formally acknowledge her status, and this had caused anxiety because the HR (Human Resources) in the Trust had been pressuring her to provide it. The proposed changes to end shielding status in the summer had also raised issues as there had been discussions about her coming to work in socially distanced workplaces, even though due to her lung condition, she was unable to wear a mask (for any period of time). While this had been resolved, finding work through redeployment of roles for those coming to the end of shielding had been problematic and the union had to be involved in extending protected pay periods, given the substantive difference between protected pay and basic (furlough) pay.

A further participant, a mental health psychologist, worked with high-risk patients in a clinical setting. The Trust had taken one to two weeks to make an assessment of working practices at the beginning of the pandemic, and she worked during this period with no PPE. The Trust then paused the work undertaken in her unit and staff either worked from home or came into the workplace to do office (administrative) work. There had, however, been no clarity from management about the basis upon which the decision over the work location had been taken. On returning there was PPE provided but uncertainty and confusing arose over the level of PPE which was required for the work. While there had been individual risk assessments for ethnic minority staff members, she was only able to talk to her programme manager and not the more appropriate assistant manager. This increased her own anxiety, and her overall view was that she '*didn't feel very protected last year*'.

"My colleagues and I are very apprehensive because how will it be possible to social distance"

First wave analysis showed men and women working in social care both had significantly raised rates of death involving COVID-19.[vii] With higher representation of some groups in at-risk occupations and insecure employment, exposure to the virus is increased for certain communities[viii] and our member experiences reflect this (see table 2 below).

Table 2 Social distancing- survey participants

Covid response	Category	Percentage
If required to implement social distancing measures in the workplace, are they being adhered to?	No, because it's extremely difficult to socially distance in my role	45
	No, because the employer is not enforcing them	4
	Not applicable	15
	Yes	36

(Maximum N=120)

In the majority of cases, it wasn't a case of poor management, but the composition of the work members did, with 45 per cent finding it extremely difficult to socially distance in their role. Some participants provided further information;

"*Sometimes we have to see a patient to gather information - we call it a double up. Concerns regarding (PPE) discussed with manager, social distancing regarding the role of my job or other job role not discussed.*"

"*Socially distancing [in problematic] as too many workers in the office, no permanent desk, using same desk phones, all using the same kitchen and toileting facilities.*"

A consistent theme to emerge was that, by the second wave, employers were now generally following government guidelines but that they were not addressing the additional stress and anxiety staff faced while working in the pandemic. This was reflected by one member, who worked with people with learning difficulties:

"*[The employer has done] about 60% in terms of addressing staff being protected (PPE and education). But they are not addressing staff anxiety…. They are not addressing staff wellbeing.*"

This was particularly the case around staffing levels in social care where staff isolating, or suffering, from Covid could not be replaced by agency staff as the work involved going from one patient's home to the next. As one care worker noted:

"*We have had 85% of the staff down with Covid, including managers and we are not getting the emotional support we need…. I have been working 14-15 days straight, each around 15 hours. When I caught covid, I thought Thank God, it will be a way of getting a break!*"

We have repeatedly heard of the increased burden our members have carried throughout the pandemic and the toll it has taken on individuals' mental health is immeasurable. Added to the day-to-day pressures' racism puts on an individual, workers are left exposed and under supported.

This clearly has wider health implications for ethnic minority workers in the social care sector, which has started to be acknowledged on a governmental level. As the SAGE ethnicity sub-group noted in January 2021;

> Social threats in day-to-day life due to individuals' experiences of racism (either structural or as a result of another's actions) can lead to psychosocial stress which has direct biological effects. Stress has been associated with less effective immune functioning, with evidence that this impact might differ across ethnic groups. It is therefore possible that stress-related pathways could increase susceptibility to the virus but direct evidence in relation to COVID-19 remains limited though is developing. There are early indications that the adverse mental health consequences of the pandemic might also be disproportionately affecting ethnic minorities.[ix]

The disproportionate impact the pandemic has had on the mental health of ethnic minority workers in the health and social care sector cannot be ignored and support measures need to be put in place alongside any changes to workplace policies and procedures.

Working conditions/employment status

STATUTORY EMPLOYMENT RIGHTS

"My main concerns are the safety of my health and that of my family. As well as not being paid should I have to self-isolate as instructed by government"

Through our years organising within health and social care, we have seen the development of a two-tier workforce over years of outsourcing within the sector. Research commissioned by Unison back in 2014 explains:

> The two-tier workforce appears to be returning, following the withdrawal in 2010 of the Code of Practice on Workforce Matters in Public Sector Service Contracts. Together with the impact of the Alemo-Herron vs Parkwood judgment and recent changes to TUPE, the employment rights framework affords employees much less protection than before.[x]

Given most GMB members are in the public sector, or in unionised workplaces in the private sector, slightly favourable terms and conditions are to be expected - especially in terms of sick pay provision from day one which we have long campaigns for. Although the majority of the workers in focus groups told us they had no issues with sick pay, we found a scattering of issues in the social care sector where we know some ethnic minority groups are over-represented, one of the main reasons we call for all services to be brought back in house.

Some members reported being only entitled to Statutory Sick Pay (SSP) whilst isolating and had to fight for full wages. One member explained that even after losing a significant number of residents to covid, it was only after pressure from unionised workers that sick pay provision was provided;

"People had to go home and get £95 a week and they kept on complaining... GMB actually won covid related [full] sick pay and so members and non-members were happy."

The anxieties of the staff in this case had been addressed by the regular GMB union meetings which had placed pressure on the employer to ensure a safe system of work. This included ensuring that all staff received an individual risk assessment and that staff received full pay when they were off sick due to Covid, predating the Covid-19 Statutory sick pay enhancement scheme introduced in October 2020.

Although there have been moves to offer improved covid related sick pay many workers in the sector are still not aware. The IPPR and Runnymede Trust research found only around a third of BME people had heard of the measure making Statutory Sick Pay available from the first day of self-isolating (34%, vs 52% of white people).[xi] One

member in local government was not aware of, and had not been able to access this scheme, and the additional sick pay available to staff in her area was the £500 self-isolation support scheme that had to be applied for.

"*We have 5 staff off sick right now and the staff meant to be on shift has been reduced down to 2 in the morning and 2 in the evening, when we are supposed to have 3 in the morning and 3 in the evening, and they are avoiding bringing agency staff in. People weren't aware of covid related pay.*"

It is vital, whoever their employer may be, that employees are aware of their statutory rights and the economic support available. The BAME CAG have acknowledged more work needs to be done to ensure that workers at all levels in social care are aware of their rights and the policy developments that directly affect them[xii], but this needs to be done at an accelerated pace; now is already too late for the workers who have suffered financial hardship and cared for the most vulnerable throughout the pandemic without the support they deserve.

With ethnic minorities more likely to experience in work poverty[xiii] and to be in insecure employment[xiv] workers across the sector have had to make choices about their safety with economic pressures in mind.

Without the support net of full sick pay, self-isolation becomes extremely costly, and leaves individuals with difficult decisions to make. Loss of earnings and financial hardship is more likely among most ethnic minority groups, which could lead to individuals not self-isolating due to financial concerns for their families[xv], an issue that requires further legislative action to fully protect workers.

One key recommendation on this issue is that outsourced contracts, where ethnic minority workers are often overrepresented, should have obligations to provide the same terms and conditions as public sector workers, especially in terms of sick pay. Not doing so risks employees attending work sick and putting themselves, colleagues and service users in danger. GMB maintains that where jobs have been outsourced, they should be brought back in house and ensure pay parity and equal terms and conditions with public sector workers.

If race/structural factors contributed to difference in treatment or experience

DIVISION OF LABOUR

"The head office is predominantly white, but most of the workforce is from what you would call a BME background."

Studies throughout the pandemic have continued to find correlations between the types of role ethnic minorities are employed in and their risk of exposure. There is emerging information on the division of labour within health and social care and the risks this leave workers exposed to. With non-medical positions in the NHS dominated by white workers, ethnic minority groups are over-represented in public facing roles with increased exposure risk[xvi] and have reduced opportunities to work from home.[xvii]

Initially, our first focus group of GMB members did not identify any particular issues with the treatment of ethnic minority staff at work, but as conversations developed, it became apparent the composition of the workforce at each workplace reflected racial divisions;

"*The head office is predominantly white, but most of the workforce is from what you would call a BME background*" - care worker

"*My manager is Filipino, the deputy is Filipino, but black people work the floor and there is only one worker that is white. I believe Head Office have segmented the workforce. Black people are the ones on the real frontline*" - care worker

"*My manager is white Polish and the deputy black British. The support workers are all black, there are only 3 white staff*" - local support worker for people with learning difficulties

This had the effect that for most ethnic minority staff they had to work in the care setting or be shielding or furloughed, while (predominantly white) senior managers were able to work from home. Even where working from home might have been an option, this was not always possible due to a lack of equipment. As a focus group participant noted, as a deputy manager she had been furloughed when she could have worked from home because the employer was unable to provide her with a laptop. Another member outlined the difference of treatment across their team;

"*... members of staff including myself [are] being treated differently during this difficult time. One example, being I have members of my team who have been allowed to work from home whereas I have been expected to come into work and work the entire lock*

down. This has added to stresses as I am aware risk is heavily reduced if you are able to work from home."

A different picture emerged in the second focus group where the participants working in the NHS were more likely to be working in either more ethnically diverse teams or as one of only a few ethnic minority staff. One member reflected upon his experiences in the stroke rehabilitation unit, where there were concerns among staff when one of the patients contracted Covid. As he noted, a senior member of staff was:

"*Happier pushing me and the Turkish member of staff forward into taking more of the risks [to treat the patient] than she was willing to herself…. It is a question of whether higher up people see BAME staff as disposable."*

One member, an ophthalmologist in NHS Trust, believed that while the Executive at the Trust had been good in reacting to Covid, there were 'pockets in the Trust' where ethnic minority staff would experience different treatment. This was based upon an assessment of prior behaviour by managers and her own treatment. In her team two of the three ethnic minority members had already left due to issues with the line manager, while she had taken secondment to 'escape'. She had been on the same grade for 18 years and had been interviewed seven times in the last five years for promotion, but never got the advertised job. While her appraisals had identified concrete actions to progress her career, these had never been followed up or supported, leaving her to try and take on additional duties and work to progress her own career.

A recent analysis for IPPR and the Runnymede Trust provides some evidence about how these inequalities manifested in the experiences of ethnic minority people during the pandemic. The study noted that key workers were more likely to report that they did not have access to PPE or that they had experienced 'unfair treatment' because of their ethnicity.[xviii]

Ethnic minority staff, especially those working in certain parts of the workforce, including frontline staff, those in clinical roles and junior administration in these trusts were more likely to be adversely impacted by the formal disciplinary process.[xix]

Service users and carers could not obtain PPE, including culturally appropriate equipment. They also did not know where to seek advice if the person that they were caring for contracted COVID-19.[xx]

These experiences of our members support findings that suggest COVID-19 risk is driven higher occupational exposure and broader issues of structural racism,[xxi] of which a number of recommendations aim to tackle.

If race/structural factors contributed to difference in treatment or experience

TRUST

"Not been listened to and taken seriously which resulted in a 2-week admission to ICU at Papworth Hospital due to covid virus."

Table 3 below outlines whether or not survey participants have raised any concerns with their employer.

Table 3 concerns raised in relation to health and safety

Covid response	Category	Percentage
Raised any health and safety concerns with the employer	I do not have concerns	9
	I have not raised any concerns	33
	Yes, but my concerns have not been addressed	10
	Yes, my concerns have been fully addressed	20
	Yes, my concerns have been partly addressed	27

In the majority of cases at least some action had been taken around members concerns, but worryingly, the highest group is those who didn't raised any concerns, even though they had them. Conversations with our focus groups could provide some indications as to why. The reps we interviewed had no issues with raising concerns, as is to be expected from trained union representatives. They were aware of their rights and were confident to challenge management. The importance of being able to do this was highlighted by a care worker who had raised a grievance to support a colleague;

"She was a pregnant black woman, but her manager would not address her issues and there had been no individual risk assessment. When I got it [the grievance] heard the management found out she was pregnant! They argued she had never asked for one [a risk assessment], but I told them it was their duty. As a result, she was able to ask not to work where there were [residents with] Covid."

This was quite a different picture for our second group (non-reps) who cited occasions where their concerns had been dismissed.

"Rather than address the concerns, they focus on stress."

Another participant noted that concerns raised by ethnic minority staff, in his recent experience, by black African workers, are more likely to be dismissed. While he did not believe this was direct racism, he thought that characterisations of how black workers express themselves and how they are vocal was used to minimise their concerns. As he noted:

"*Culture is used as a discounting mechanism.*"

Participants shared various experiences with us where they believed their concerns and conduct were assessed in a different way to their white colleagues. Significantly, and echoing the findings of research by Klein[xxii], an NHS worker noted that:

"*Whenever any issues are raised in my workplace about my conduct, even trivial issues, these are more likely to lead to formal investigations than [with] issues which are raised in relation to white staff.*"

What was clear is that experiences before the pandemic influenced how comfortable people felt raising issues and challenging management. Our members' stories reflect wider findings of the BAME Communities Advisory Group, who have acknowledged the impact of structural racism in the workplace it's bearing on the ability of ethnic minority professionals to challenge unsafe practices[xxiii], with vast implications for workers safety.

Wider issues of trust were also exposed in conversations around vaccines. With studies finding ethnic minority groups are less likely to have had their vaccine[xxiv] we asked both our focus group a specific question around vaccines.

The debate during both focus group was wide ranging on being vaccinated, though some participants had already had the vaccine. Generally, the view was to take it.

"*I always said I'll take it. I cannot control my asthma, and this is a respiratory disease. I took mine [the vaccine] as soon as I could.*"

"*I'll take the vaccine…. I need to protect myself and the clients I work with.*"

"*I have underlying health conditions. I am grateful to the work that has been done to create these vaccines, I have already had the vaccine.*"

However, that there was scepticism about taking the vaccine among some of the participants and their colleagues from ethnic minority communities about the vaccine and a number of possible explanations were provided;

"*They are offering the vaccine, I have not taken it, I have never taken any vaccine, I am trying to convince myself. I was thinking have never had Covid, so what is the point. When I tested positive, I came home, and I am asthmatic, but it didn't any impact on*

me. So, my manager called me and said you should take it [name]. But I am still thinking whether I should take it…I'm still yet to convince myself."

"*We have all been offered the vaccine… I am still thinking about it. I need to give it a little more thought and time, be provided with a little more information and wait for a bit to see how things develop."*

"*It's not compulsory, but many colleagues don't want to take it, don't believe in the vaccine."*

There were mixed views about being required to take the vaccine. While one participant claimed she would have a vaccination if it were a requirement of working in social care, others highlighted how some of their colleagues would resist this.

"*[My colleague would] rather lose her job than take the vaccine. Sit at home on benefits. Definitely not having it!*"

"*Many of my team are concerned and believe it's a conspiracy against BAME people. Others want to wait and see after others have taken it."*

However, the was an understanding of why there might be resistance to taking the vaccine, notably among the ethnic minority community, and opposition to making this a requirement. As members observed:

"*I don't agree with employers making staff take it. It should be an individual's informed choice."*

"*I don't think it is the business of employers to pressure staff into taken them [vaccines]. Companies shouldn't police people's personal lives and [their decisions] shouldn't affect our ability to make a living…. And I can understand historical concerns from our communities, where there's been a misuse of these things. You look at America, going back to the 1940s and 1950s where racist doctors and white supremacists' organisations were testing this on the black populations."*

What is clear is that people have a multitude of reasons for lacking trust in management to address their concerns, and trust in the government to do right by ethnic minority groups. There is no single workplace policy or legislative change that could address this - it will take a multitude of strategies and continued action to rebuild trust amongst ethnic minority workers in the sector and beyond.

If race/structural factors contributed to difference in treatment or experience

INEQUALITY

"I also worry of the inequalities across the team"

Although it is difficult to measure the impact that socio economic differences have had on GMB members specifically, given the sample size and the information available, the union fully accepts wider findings social class has impacted on health outcomes for ethnic minority workers, during the pandemic and before, across the health and social care sector and beyond. As data analysis has developed, empirical evidence has emerged confirming what unions have long surmised – that deprivation indicators correlate with increased exposure risk, poorer outcomes, and mortality rates.[xxv]

Infectious transmission is more intense in densely populated and deprived areas with socially and physically connected, multigenerational households, which are generally more common in ethnic minority communities. Such living environments can make efforts to isolate vulnerable or older individuals difficult, especially in overcrowded living conditions.[xxvi] Although members ethnicities have sometimes been considered during individual assessments, there has been little consideration for the additional socio-economic risk factors that exist outside the workplace; such as occupation, population density, use of public transport, household composition and housing conditions.

Section 1 of the Equality Act 2010 sets out a socio-economic duty on public bodies aimed at ensuring all government departments and key public bodies addressed "persistent inequality of social class, your family background or where you were born" in a systematic way. Since coming into law however, successive UK governments have failed to enact this part of the Act and economic inequality continues to grow. There has been progress however outside of the UK government, with the Scottish Government enacting the socio-economic duty through the introduction of its Fairer Scotland Duty in April 2018 and the Welsh Government intending to introduce the duty to come into force on the 31 March 2021. A range of public bodies in England, mainly local authorities, have also worked to incorporate the socio-economic duty into their approach to developing policy to varying degrees including Manchester, Newcastle, Oldham, Wigan, Bristol, York, and the London Borough of Islington. Such moves across the country demonstrate the ability to act if the will is there. GMB stands beside the EHRC, the Social Mobility Commission and the UN Committee on Economic, Social and Cultural Rights in calling for the enactment of the socio-economic duty as a matter of urgency.

Knowledge of workplace rights and access to support and redress

MANAGEMENT SUPPORT

"Management are not pushing the covid rules and are leaving it up to the workforce"

GMB members reported varying standards of management; good managers have offered invaluable support, whereas others lack a comprehensive understanding of safety standards and the issues effecting ethnic minority workers. In comparison to other sectors, health and social care members concerns were more likely to be listened to and actioned, but 1 in 10 had raised concerns with management that had not been addressed (see table 4 below).

Table 4 Raising health and safety concerns across sectors

Have you raised any health and safety concerns with your employer?

	Yes, my concerns have been fully addressed	Yes, my concerns have been partly addressed	Yes, but my concerns have not been addressed	I have not raised any concerns	I do not have any concerns
Health and Social Care	20	27	10	33	9
All other sectors	16	20	16	36	12

Although the number who have not raised concerns is alarming, Overall, the response from management demonstrated the majority were taking their safety responsibilities seriously. Good practice was identified by a number of members, who have followed guidelines and regularly reassessed risks and policy developments;

"I found the risk assessment very useful and in monthly121's with my manager we review the assessment."

The key area of concern is inaction, which in some case has led to severe health problems for workers:

"*Not been listened to and taken seriously which resulted in a 2-week admission to ICU at Papworth Hospital due to covid virus.*"

"*I wouldn't trust them as far as I could throw them!*"

"*One employee has been tested positive for covid and nobody was sent home to self-isolate. I ended up self-isolating myself then I had mental health problems with it all. Now I am off sick due to work related stress.*"

With increased risk of exposure and viral dose in social care roles[xxvii], mistakes like this leave ethnic minority workers on the front line especially vulnerable. Considerations must be made for independent processes in which workers can report issues in the absence of management action.

Consultation between management and staff was often cited as an issue for survey participants;

"*My concerns were the fact that my agency would not make sure that I was informed if I had to care for covid patients, as I had sent them an email and exempted myself from being put at risk. I had also stopped working for the agency due to the fact that I was vulnerable and would put my children and husband, who has high blood pressure and severe asthma, at risk. The agency only asked for my risk assessment when the hospital had asked if a risk assessment was done by the agency.*"

"*I have concerns because we are working with tenants who have different medical conditions and are vulnerable. Also, we have tenants discharged from hospital that we don't know which medical condition they have or if they have been tested for covid19.*"

One member explained that, whilst working for a disability charity previously, their employer had been very slow at getting PPE organised and the individual risk assessments were 'very basic'. Swab and PCR tests were finally conducted, but the whole process was conducted without any meaningful discussions with staff;

"*It was filtered down [to staff] using fear not consultation.*"

Workers reported management sometimes had a lack of understanding around safety standards. One focus group participant believed that managers simply did not know how to deal with the ethnic minority questions in the individual risk assessments or provide the right support. As the only ethnic minority member of staff not shielding, she felt she had been asked to take on a lot more work. This, combined with the lack of information, led to increased anxiety and she had to approach GMB for support.

"*Under the impression my employer has a duty of care towards all staff who meet BAME criteria. I would be keen to understand why I and others have not been accessed. Is the onus on me to ask or my employer?*"

For those shielding or working from home, some members reported a sense of feeling forgotten or overlooked. One participant, a mental health psychologist, who had been homeworking (and shielding) noted that the Executive in her Trust had provided weekly updates and as far as she was aware information was being provided. However, there had been no specific guidance on homeworking, and it had taken time to get her appropriate equipment to meet the DSE assessment. The concern now was that she felt forgotten:

"*Because I am not in the office and because I have been shielding, I've not gone in. So, if things are happening …I don't have access to this.*"

There are many examples of good management practice, but these standards need applying across the board and available universally for all workers, whether they are in health or social care, the public or private sector, on the frontline or working from home. Improving independent reporting processes and increasing worker engagement are amongst some of the recommendations suggested.

Knowledge of workplace rights and access to support and redress

WORKER EMPOWERMENT

"The union had weekly meetings, it was a lot of challenges, we were always there talking about safe systems of work"

GMB will maintain there is no better way of protecting ethnic minority health and social care workers' health and safety than by good union organisation - with direct worker involvement in decision making and healthy challenges to employer policies and practices.

The reps we spoke to demonstrated various occasions where they had used their knowledge of employment rights or their experience of union organising to influence management to make safe systems at work. In the case of two care workers, it was a case of management reacting to the information supplied by the GMB to reps and workers or the pressure that been applied;

"I get information first from the GMB, I print it and put it on the wall on every floor. This spurs the management into action, but they are not proactive…."

"The first pandemic was very horrific, we lost lots of residents and staff were scared, there was no testing… I noticed the manager wasn't doing the individual risk assessments to all the staff…I took it to my regional organiser and then it went to the national office and they introduced individual risk assessments. They were actually trying to get it done. And then they started the testing and my manager called me one day and said, 'well done GMB fought for this weekly testing', I said at that's good at least you recognise the union fought for it."

Where good union organisation exists and workers are involved in, it is not only the workers that see the benefit but management too. During the pandemic, health and safety has come to the forefront but GMB reps were already prepared with expertise and knowledge that proved invaluable to colleagues and helped protect vulnerable people being caring for.

In our second focus group, the participants who were not reps, reported on the value of having support outside of management structures. One member shared a recent experience with a manager. When she raised questions about her anxieties over Covid the response of management was to focus upon the emotional issues and ask whether she was stress.

"Rather than address the concerns, they focus on stress and return to the risk assessment and emphasise that you are low risk."

It was only with the support of her GMB rep, who encouraged her to meet with the manager and to meet regularly with the team in her unit to address concerns together, that issues could be taken forward.

There were some examples of internal bodies or figures who provided additional support and advice in times of need, which participants spoke positively about;

"Fortunately, our free speech guardian is quite good, so I managed to speak to him…."

Any independent support and advice available is invaluable for ethnic minority workers who have may have limited trust in internal procedures. One member explained why people in their team would not feel comfortable raising complaints through the internal processes;

"I did raise my head above the parapet about my boss. And the problem is that she is so well known in the Trust that I didn't feel comfortable that I would be listened to. I know from talking to other BAME staff that they would definitely say to you that they would not be comfortable because of the judgements, because they are BAME staff and we are seen as …troublemakers, dismissed and minimised and some of the micro aggression that comes with it."

The experiences of our members demonstrate vehicles that empower workers help to ensure their safety and that of their service users and should be encouraged and embedded across the entire sector.

CONCLUSIONS

We must recognize the effect racial discrimination and structural disadvantage has had on covid outcomes for ethnic minority workers. Acknowledging and mitigating against the risks these workers face is key to protecting the health of the nation.

The research we have undertaken with GMB members provides clear evidence of inequality for ethnic minority workers in the health and social care sector. Various studies have shown ethnic minority workers have been at risk of high exposure due to the roles they are in, and this is no different for the health and social care sector. The division of labour has seen ethnic minorities overrepresented in front line roles with high exposure risk and underrepresented in management roles where they could more likely work from home or have more control over their working lives.

Racial inequality is an issue the entire country must face, but the health and social care sector has a unique opportunity to influence wider society. With a high proportion of ethnic minority workers across the country in all areas of the sector, tackling racial discrimination will have wider ramifications for our communities. Ethnic minority health and social care workers can be the biggest advocates of public health messaging in their communities, if provided with accessible resources and information. Ensuring fair pay or increasing progression opportunities can change economic outcomes for entire families and help alleviate wider deprivation. Health and social care can lead by example.

What has been clear, is that there are huge levels of distrust, within health and social care and beyond, in the willingness of institutions to tackle racial injustice. Time and time again we have heard of our members not being listened to and having to turn to the union for support. Changes in internal structures and processes can go some of the way to addressing this, but there is a clear need to increase the independent support available for ethnic minority workers it they are to be truly empowered in their workplaces. By listening to workers, we protect them and the people they care for, recognizing their voices are an infinitely invaluable resource.

It is a complete disgrace that the people who look after the most vulnerable in our society are often not cared for when they are ill - all health and social care workers require full sick pay from day one. Universal standards need application across health and social care, in both the public and private sector; every ethnic minority worker deserves access to comprehensive policies and procedures and decent terms, conditions and pay. Failure to address employment conditions within the sector would be willfully ignoring modifiable risk factors that could safeguard against unnecessary mortalities in the future.

Lessons of the pandemic need to be learned –and challenged by the EHRC where shortfalls have taking place. The government's woeful approach to Equality Impact Assessments must be confronted and responsibility needs to be taken for the pain and suffering government policies have inflicted on disadvantaged communities. Extension of equality legislation and improved data analysis will help identify some of these inequalities, but effective strategies need to be put in place and monitored, with full resources for the EHRC to do so.

Our members voices have been clear- our communities are all acutely aware of the racial inequalities that exist. Now it is time to do something about them.

RECOMMENDATIONS

Improve working conditions and end insecure employment

1. End the disparity in terms, conditions and pay between staff working in the public and private sector across health and social care. To eliminate two tier workforces the government must end outsourcing within Public Services including NHS and local authority services.

2. Amplify the voices of NHS and Social Care ethnic minority workers; undertake fully funded, worker focused research to assess and address current shortfalls in government legislation and workplace policies.

3. Develop a library of best practice and tools which support employers to undertake Equality Impact Assessments and help employers and employees understand the key requirements of Equality Legislation.

4. Ensure all health care workers, whether in the public or private sector, receive full sick pay from day one. The government should underwrite any wages lost to covid-related absence until this is legislated for.

5. Make it mandatory that workplace risk assessments are available to all staff and that all health & social care workers (and those working in health care facilities), public or private sector, have comprehensive individual risk assessments that include ethnicity and socio-economic factors.

6. Strengthen the role and powers of the EHRC and Health & Safety Executive (HSE) in dealing with race and equality issues at work, holding employers to account when safety breaches occur and addressing working practices that contribute to poor mental health. If additional resources are required, these should be provided.

7. Provide accessible information on health and safety, employment rights and equality legislation in different languages and formats.

8. Provide universal mental health support to all health and social care workers across public and private sectors.

Tackle institutional racism and change structures within the health service

1. Establish a key stakeholder group for NHS & Social Care consisting of front-line workers, trade unions, employers and government departments, including the Minister for Women and Equalities and Health Minister, to address the inquiries findings and progress recommendations

2. Analyse and publish the impact the government's COVID-19 policies and emergency legislation has had on ethnic minority communities and others with protected characteristics.

3. Require Government to publish all Equality Impact Assessments undertaken in full, together with evidence of how the government have sought to mitigate the impacts on communities disproportionately affected.

4. Undertake and publish an Equality Impact Assessment on The Health and Social Care Act 2012, The Care Act 2014 & Localism Act 2011.

5. Re-instate section 1 of the Equality Act and recognise socio-economic status as a protected characteristic.

6. Increase investment in public health funding for physical and social infrastructure that supports good health outcomes, targeted at local authority areas where there has been increased COVID-19 fatalities for ethnic minorities.

7. Recognise the work undertaken by Professor Kevin Fenton and implement the recommendations tabled with a clear plan for monitoring these.

8. Develop and promote a fully funded programme of training and development for health and social care workers, that ethnic minorities can access without the need for management sign off.

9. Improve data recording, monitoring and cross analysis, including but not limited to;
    - Strengthened coordination of Health and Social Care Systems
    - Increased powers of the EHRC to access and publish equality data and reporting, and to independently challenge government shortfalls and enforce targets
    - Publish race pay gap reporting across the public and private sectors
    - Inclusion of socio-economic factors for all monitoring and analysis
    - Recording of faith and ethnicity on death certificates
    - Introduce systems to analyse differences in grading, pay, terms and conditions and sick pay provision between the public and private sector and for different demographic groups.

Improve knowledge of workplace rights and access to support

1. Produce resources and mandatory training for employers on the key issues around race in the health and social care sector, including but not limited to; how to support and protect BAME staff, how to implement guidance and information equitably, understanding unconscious bias, selection and recruitment practices (inc. historical practices and subsequent structures)

2. Embed independent support and advice across the health and social care sector, including but not limited to; trade union engagement, staff race networks and free speech guardians

3. Recognize and encourage the role unions and their representatives make in the workplace to build safe and equitable systems at work. Embed functioning safety committees and union equality officers across health and social care workplaces, with representation from ethnic minority workers. Recognize the role of union equality representatives.

4. Increase ethnic minority representation across senior management structures, decision making bodies and employee forums. Call for Race Gap monitoring to be made mandatory.

5. Establish an independent leadership programme within health and social care, which provides access to training, resources, funding and networking for ethnic minority workers.

6. Build local internal networks of BAME leaders across all levels of health and social care that have a two-way dialogue with key stakeholders with the health trust, CCGs, Local Authorities, and trade unions

7. Introduce an independent process for handling grievances and disciplinaries and an anonymous service for reporting bullying, harassment, and discrimination.

Appendix A- Survey Methodology

The survey, an online self-completion questionnaire, was open to GMB members who identified as Black, Asian & Ethnic Minority between during August 2020

The purpose of the survey was to map members' experiences during the Covid-19 Pandemic. The survey included both closed and open-ended questions. The survey questions are included in Appendix B. Attached in Appendix E is a collection of all the responses provided to the open-ended question 'What are your main concerns around your health or safety at work?'.

The survey collected information on the following key areas:

- Demographic information about the respondents, including individual risk factors;
- Current working arrangements; and
- Employer responses to the Covid-19 Pandemic.

For the purposes of this report the health and social care sector is understood to be employees and workers engaged in the workplaces below. The survey generated 720 (N=720) responses from ethnic minority GMB members, of which 120 were members working in the Health and Social Care sector.

- Agency and private medicine (N=9)
- Ambulance Services (N=9)
- Clinics, Health Centres (N=1)
- General Practices (N=1)
- Hospitals, Nursing Homes etc (N=34)
- NHS Contractors (N=3)
- NHS Establishments (N=61)
- Personal Services (N=1)
- Supported Living and Community Services (N=1)

Due to missing data on some questions, the number (N) on which the percentages are calculated may not be 120 when looking at the health and social care sector or may not be 720 when considering the full achieved sample. Due to rounding, reported percentages may not sum to 100.

Appendix B- Survey Questions

About you

Name
E-mail
GMB membership number (if known)
Postcode
Employer name
Occupation/Job title

I am currently…. (tick as many apply)

Working at my usual place of work
Working from home
Furloughed
Facing redundancy
Unemployed
Shielding
Other (please note)

COVID 19 risk factors

What best describes your gender?
Do you identify as Trans?
What is your sexual orientation?
What is your age?
Do you consider yourself to have a disability or long-term health condition?
What best describes your ethnic group or background:

Tick as many of the following that apply to you
Extremely clinically vulnerable individual (received a shielding letter)
Clinically vulnerable (underlying health condition, pregnant etc)
I am a key worker
I live with a key worker
I do not have access to a garden
I travel to work on public transport
I live with someone who received a shielding letter
There are children in my household in primary or secondary education
I live in an overcrowded household (Your home is overcrowded by law if 2 people of a different sex aged 10 or over have to sleep in the same room. The rule does not apply to couples who share a room. Children under 10 are not counted)

Your experience at work

1. Has your employer undertaken an Individual Risk Assessment with you?
   Yes

No

Please provide further details (such as what you were asked whether it was useful or why one has not yet been carried out)

2. If your employer has advised you require Personal Protective Equipment (PPE), has all of it been provided?
   Yes
   No
   I do not require PPE

3. If you are required to implement social distancing measures in your workplace, are they being adhered to?
   Yes
   No, because my employer is not enforcing them
   No, because it is extremely difficult to socially distance in my role
   Not applicable

4. What are your main concerns around your health or safety at work?

5. Have you raised any Health & Safety concerns with your employer?
   Yes, my concerns have been fully addressed
   Yes, my concerns have been partly addressed
   Yes, but my concerns have not been addressed
   I have not raised any concerns
   I do not have any concerns

6. We will be conducting group interviews with workers in different sectors to better understand our members experience across industries. Would you be interested in taking part?
   Yes
   No

7. Would you like more information about any of the following... (tick all that apply)
   Becoming a GMB workplace representative (helping your colleagues)
   Becoming a GMB Health and Safety Rep (ensuring your employer maintains Health and Safety standards)
   GMB's Black, Asian and Ethnic Minority Worker Campaigns
   GMB's Race Network

Appendix C - Focus Group Methodology

Two focus groups were held; one with GMB activists (representatives and members of the union's race network, 28 January 2021) and a second with GMB members who had participated in the survey (18 February 2021). The role of each participant is detailed below.

Focus Group Participants

Focus Group 1: 28 January 2021
Participant A – care worker
Participant B – care worker
Participant C – local support worker for people with learning difficulties
Participant D – mental health nurse in NHS Foundation Trust (shielding)

Focus Group 2: 18 February 2021
Participant E – disability charity worker and then stroke rehabilitation worker
Participant F – mental health psychologist in NHS Trust
Participant G – ophthalmologist in NHS Trust (shielding)

Each focus group ran as a Zoom meeting for approximately one hour, with the participants giving informed consent to share their views anonymously.

Each focus group was structured around the key questions in Appendix D, which emerged from the survey responses and developments in public data. The questions were designed with assistance from colleagues at Keele University and Shrewsbury College who observed and analysed the interviews, but the groups were convened by GMB employees who identified as Black, Asian & Ethnic Minority.

Appendix D- Focus Group Interview Questions

- How well do you think your employer has handled your safety during the Covid pandemic?
- Do you feel that your employer has responded to staff any differently based upon ethnicity or race, and if you do, why do you think this is the case?
- How much information have you had from your employer and from the GMB in relation to understanding Covid?
- Do you feel confident to raise issues with your employer and, if not, why?
- What are your views in respect of vaccination and public discussions around the requirement to be vaccinated to continue working in certain roles?

Appendix E: Individual anonymised responses: 'What are your main concerns around your health or safety at work?'

Health and Social Care survey respondents' comments relating to concerns about health and safety at work.

Role/Job Title	Response
Consultant Counselling Psychologist	The use of public transport covering large areas of England. In the South, there is a policy where we should leave 7 days gap in between visits. However, my Managing Director has decided not to apply this rule in the North and Midlands. I am currently forced to visit services to services without any gap.
Rehabilitation Assistance	My main concerns are: My health conditions which put me in the high-risk category. I am a Rehab Assistant and have to work with patients. My colleagues and I am very apprehensive because how will it be possible to social distance. Sometimes we have to see a patient to gather information - we call it a double up. Concerns regarding (PPE) discussed with manager, social distancing regarding the role of my job or other job role not discussed.
Emergency Medical Technician	Catching infection
Quality Support	Cleanliness of office space if required to return to the office.
Fleet Multi Skilled Technician	Employer not enforcing social distancing
Emergency Ambulance Crew	Front line workers are not following social distancing, or they can't as space is limited.
Emergency Ambulance Crew	Very crowded at work specially in the early morning and evening at nights.
Emergency Call Co-Ordinator	Action has been taken and it's good to see that but there's only so much that can be done in the setting of my workplace
Care Assistant	My main concerns are the safety of my health and that of my family. As well as not being paid should I have to self-isolate as instructed by government.
Support Worker	Being of Indian heritage and ethnic minority, the dangers around deaths with covid
Care Assistant	Each of every staff should do Covid-19 test
Staff Nurse	My concerns were the fact that my agency would not make sure that I was informed if I had to care for covid patients, as I had sent

	them an email and excepted myself from being put at risk. I had also stopped working for the agency due to the fact that I was vulnerable and would put my children and husband, who has high blood pressure and severe asthma, at risk. The agency only asked for my risk assessment when the hospital had asked if a risk assessment was done by the agency.
Care Assistant	To ensure when I go back to work the environment is safe to work in.
Carer	Management not keeping us up to date with changes there doing till last minute.
Domestic Assistant	I work in a health centre where patients with Covid-19 are treated. I have to access those rooms as part of my house keeping duties. Before I went into self-isolation there was a lack of PPE for our team. I have raised concerns about health and well-being. However, I am not sure whether these concerns have been dealt with while I have been shielding.
Independent Living Coordinator	My main concern would be when visiting residents and making the initial contact via the phone that they are honest in whether they have or anyone in the household has had any symptoms. I would like to think that most residents would be honest and responsible. It does worry me though that you can still have the virus without showing symptoms. I always have the required PPE in my car so I try to be as prepared and responsible as I can.
Health Care Assistant	Having to wear the same mask at every client room so that's a concern for me
House Keeping	The fact I have to travel by public transport to get there.
Support Worker	Other staff members not wearing masks and following social distancing rules. Also, residents not following social distancing.
Practitioner	No attempt other than suppling PPE has been made. More effort could be made in the workplace to offer, screened work areas and social distancing,
Care Management Officer	No face-to-face interaction with peers...Isolation
Children Residential Support Worker	Should history repeat itself being placed at a high risk of Covid 19 due to age and ethnic background. I would welcome a thorough BAME risk assessment for myself and other BAME colleagues in my department in or to keep safe.
Care Assistant	Not given full PPE, only a face shield for COVID calls. No overalls, no arm protection, no shoe protectors.... Only a few people do cover calls as people have letters.
Social Care Officer	Socially distancing as too many workers in the office, no permanent desk, using same desk phones, all using the same

	kitchen and toileting facilities… Workers not cleaning up after themselves.
Residential Childcare Practitioner	Social distancing because of the work I do. No support or consideration to ethnic minorities
Medical Secretary	Main corridor is used as a cut-through and even though there are notices on the doors - doctors/nurses still walk through our department.
Clinical Lead and Psychologist	I am working from home so there are no obvious concerns. However, shielding is coming to an end and from August we will be allowed to go out. I feel anxious that I will be asked to come into the office even though I can work from home.
Staff Nurse	So many people coming to the ward out of working hours and it's difficult to know who is exposed to covid but this is inevitable as people choose to come at that time to avoid long A/E queues.
Senior Biomedical Scientist	No wearing of masks, no social distancing, nothing in place for toilet utilities, staff have covid and working in the same environment, no windows just vents, confined space and working with covid samples from patients.
Therapy Technician	Visiting patients who have Covid-19. I was very ill in March due to the Covid-19, and I was admitted to hospital. In March I was sent to help patients in Hillingdon Hospital and was not informed and then they didn't give me PPE
Theatre Practitioner	As a nurse you can't socially distance at all from either other members of staff as you work as well as from the patients. We have PPE graded but I failed the other mask fitting test, so you just presume you are safe but there still unaddressed concerns especially being diabetic
Healthcare Assistant	We have a duty of care and you are the first person as an HCA to deal with the patients and then long after we are told what is right or wrong after exposure to all illnesses
Healthcare Assistant	Dividing my ward into 2 and one part is covid, the other one non-covid patients. My main concern is we were told not to tell the non-covid patient that the other part is covid but each time an admission is made, the positive covid patient has been moved from the non-covid area to the covid area and yet they said Covid is an airborne Disease! What makes them think a patient with covid even covered with mask cannot still spread covid to patients who do not have it? Secondly, as all the fire safety doors are opened in the covid area it can also be spread as well. The staff who are looking after covid Patients were meant to be in that zone until the end of their shifts by having their breaks and attending to the covid patients. Both a lot of staff were seen

	gaining access from the covid area to the non-covid area with scrubs which was not changed at all. They are come to the staff room where staff members who are looking after non-covid patients sits to have breakfast and lunch without social distancing nor changing of their scrubs.
Medical Secretary	Being BME and working within the hospital setting when I could, with appropriate I.T, work at home.
Senior Healthcare Support Worker	In my case my underlying condition means that I pick up infections in my respiratory area very, very easily. My patient group are highly likely to have cough colds and we are about to hit winter pressures.
Senior Healthcare Support Worker.	I have more than one co morbidity - lung disease and asthma. My lung condition means I'm very high risk of catching anything. It's happened before causing the damage I already have.
Ward Administrator	We need more computers and screens to protect ourselves
Band 7 Midwife	I feel at my age and with high blood pressure problems, I should not be front line with patients
Nurse	PPE
Endoscopy Technician	That we can't be able to exercise social distancing due to lack of space and PPE has been compromised a lot. It has been reduced to just using the aprons only instead of using proper gowns. and also lack of uniforms (scrubs)
Ophthalmic Technologist & Retinopathy Grader	My main concerns are the length of time spent in my clinical room in a patient facing role with patients who are classed as vulnerable due to medical reasons. As the capacity of the patients we see increases as lock down eases, I worry how I will have enough time to safely don and doff PPE and thoroughly clean down equipment used and the room area for the next patient, especially as I work in the community as well as across the three hospital campuses. Unfortunately, not all community clinics are allowing us to use their waiting rooms, which means my patients specifically will need to stay in my room for a longer duration of 15 minutes after receiving eye drops. I also worry of the inequalities across the team, due to members of staff including myself being treated differently during this difficult time. One example, being I have members of my team who have been allowed to work from home whereas I have been expected to come into work and work the entire lock down. This has added to stresses as I am aware risk is heavily reduced if you are able to work from home.

Primary Mental Health Practitioner	Returning to work in schools and health centres to facilitate consultations and training which is my role
Bank Healthcare Assistant	Physical intervention with patients such as doing physical or vital signs observations, physical restraints during life threatening incidents (ligatures), aggression, self-harming, visual observations to ensure safety of patients, moving and handling.
Nurse	Before the BAME form was implemented I was moved to the COVID ICU for two shifts. I actually felt safer there as I had full PPE. On the cardiac ICU where I work normally, we wear surgical masks for all patients. These are flimsy and do not provide an adequate seal around your face to prevent any contamination. The rules keep on changing on regards to what we wear, previously we had to wear FFP3 masks if our patient was ventilated, on NIV masks, Airvo. Then the rules changed again that we now wear surgical masks for everyone. For extubating and suctioning patients, we wear FFP3 masks and a visor.
CAMHS Crisis Nurse	No been listened to and taken seriously which resulted in a 2-week admission to ICU at Papworth Hospital due to covid virus
Senior Support Worker	Lack of duty of care by employer to protect staff when we are verbally and physically abused by patients constantly
Healthcare Assistant	PPE and Social distancing were only implemented weeks after some patients tested positive for the virus.
Support Worker	The likelihood of contracting the virus is high.
Community Mental Nurse	Going into people-s homes with a normal mask. Administering treatment. I would feel happier if I had a FFP3 mask.
Porter	My employer has tried their best but is down to the managers of the department. They did not care about employee health or safety rather than to do the work. My manager cannot even give water when the person is dying etc...
Project Co-Ordinator	Being in the 'at risk' category - when it comes to returning to the workplace, I would like to be sure that I am not forced to go back in until the social distancing measures are firmly in place and I am confident they would work, or a vaccine is available.
CBT Therapist	Being BAME and at increased risk via second wave
Mental Health Nurse	Other colleagues not adhering to the procedures.
Radiographer	Catching covid-19. Getting stressed. Getting laid off.
Optometrist	I will get covid-19. I am immunocompromised but if I don't work, I will starve, as I need money to put food on the table. My employer is also using my holidays and has furloughed me, but I still have to work as well.

Receptionist	They have not had a risk assessment of normal employees and am not sure if it is safe to go into work
Chef De Partie	One employee has been tested positive for covid and nobody was sent home to self-isolate. I ended up self-isolating myself then I had mental health problems with it all. Now I am off sick due to work related stress.
Health Activities	Due to having midwifes and health visitors working in our building the 2 metre/ 1 metre distancing is ignored often. We constantly ask these professionals to adhere to the rules, but they take no notice. Health visitors and midwifes are always coming in ignoring the signs and requests from children centre staff.
Care Support Worker	Just to keep safe as possible
Residential Care Worker	No adequate PPE. Additionally, constantly placed in localities where social distancing is impossible due to physical interventions where young people spit
Senior Care Assistant	No risk assessment done on myself when the company knows I have health issues
Theatre Practitioner	I am not sure the work environment is covid secure.
Paramedic	Transmission of virus to you without knowing
Receptionist	I work with the public and my mother who is diabetic lives with us.
Care Assistant	I work in a Care Home where the majority of residents have dementia, are elderly and frail and we have suffered losses due to COVID-19. I work regular night shifts and there always seems to be a shortage of staff, staff having to move from one location to another to cover absences. I feel there is a health and safety issue not only for residents but staff as well. Residents with dementia tend to wander day or night and are liable to falls.
Senior Care	I have concerns because we are working with tenants who have different medical conditions and are vulnerable. Also, we have tenants discharged from hospital that we don't know which medical condition they have or if they have been tested for covid19.
Care Assistant & Nursing Assistant	My main concern is worrying about [working at] every working place because Covid-19
Senior Residential Childcare Worker	If one person is infected there is a higher risk that everyone in the home might get infected. We work with children and if one of the children is infected, we don't have measures to protect everyone.
Support Worker	Some of the people I support have been going out into the community on their own since the Pandemic started and don't always stick to social distancing. I worry about catching Covid19

	and passing on to my husband and family. I had been working in a house with very low risk but in June I was sent to another house and now next week a different house once again.
Clerk of Works	Asthma and keeping clear of covid 19
Housing Officer	Visiting tenants in their home
Hostel Supervisor	Going into residents' homes
Radiographer's Assistant	Very difficult for staff to socially distance due to workspace size.
Healthcare Assistant	Not knowing as a black person, if I'm at more risk to covid 19, than my other colleagues.
Finance Assistant	A past medical condition has resulted in me have irreversible scarring on my lungs so I am likely to have breathing difficulties if I contract the virus. Hence, I am worried about returning to the office even though they have implemented social distancing
Staff Nurse	Looking after COVID patients whilst waiting for redeployment, increases the likelihood of getting COVID 19.
Nursing Assistant	I'm worried about working in red wards which have COVID -19 positive patients.
Clinic Manager	Fairness being practiced across the board
Community Nurse	Not being able to maintain social distancing despite measures being in place. New starter nurses/ health care assistants had started and needed help with laptop issues etc which couldn't have been rectified by standing two metres away. We were told to wear masks in the office from June as well as fans being taken away and a one way in one way out system.
Staff Nurse	Having asthma
Process Operator	Management are not pushing the covid rules and are leaving it up to the workforce to push the rules.
Pharmacy Advisor	It's a small shop so everyone is always close by
Ambulance Technician	PPE - is it the right level, why did it take so long to get proper equipment? What should happen if members of staff contract the virus?
Healthcare Worker	I cannot guarantee that everyone will respect social distancing rule when not at work and it is not possible to socially distant myself at work
Community Registered Nurse	To be exempt from seeing Covid + patients

Endnotes

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[xvi] *Ibid.*

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