Equality and Human Rights Commission

Experiences from health and social care: the treatment of lower-paid ethnic minority workers

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Acknowledgements

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We are grateful to race equality organisations, charities, inspectorates, trade unions, employer bodies, health and social care organisations, governments and arm's-length bodies who contributed valuable evidence to our inquiry while they were responding to the immense challenges of COVID-19.

We also thank members of our Expert Advisory Panel who generously provided us with their time and expertise, and helped shape our evidence gathering.

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Foreword

The coronavirus (COVID-19) pandemic put a massive strain on Britain's health and social care services. Staff laboured tirelessly to support our health and wellbeing, often while unable to see or care for their own loved ones. They faced the threat of infection on every shift, and many lost their lives. Sacrifices have been made that must not be forgotten. We owe them all a debt of gratitude.

Lower-paid frontline health and social care staff were disproportionately affected by ill health and death by contracting COVID-19 at work. People from ethnic minority groups are over-represented in these roles, which include cleaners, carers, porters and security workers. Data from the Office for National Statistics shows that people from ethnic minority groups were dying from COVID-19 at higher rates compared with White British people.

There is little research on the experiences of lower-paid support staff in the NHS or frontline care workers. We conducted this inquiry to remedy this. It was challenging to collect evidence. We were under lockdown, and health and social care staff were facing severe pressures. It soon became clear that lower-paid workers are under-represented in official data.

Nonetheless, we uncovered some concerning issues. Despite the essential services these workers provide, and the risks they take in looking after us and our loved ones, many operate with insecure work contracts or as casual staff with no contracts at all. We encourage governments and employers to address the issues raised in this report to improve the experiences of all lower-paid workers, including those from ethnic minority backgrounds. Implementing our recommendations will help those who helped us all through the pandemic.

We must ensure that the working conditions of lower-paid workers in this sector are improved across Britain, and that their vital contribution to the functioning of our economy and society is recognised.

Baroness Kishwer Falkner

Chairwoman, Equality and Human Rights Commission

Executive summary

We launched this inquiry to assess the treatment and experiences of lower-paid ethnic minority workers in health and social care. The inquiry covered Britain (England, Scotland and Wales) and took into account the different contexts of the health and social care systems operating in each nation. Our findings apply to Britain as a whole, unless stated otherwise.

The areas we set out to examine included:

- the numbers of hours worked
- workplace policies, procedures and culture
- the tasks allocated
- the ability of workers to access redress, and
- training and development opportunities.

The full terms of reference for this inquiry are available on our website.

Lower-paid workers in health and social care generally have had greater exposure to COVID-19 than workers in other sectors. Between April 2020 and January 2022, 57% of people reported to have caught COVID-19 at work were from the health and social care sectors. In 2021, the Health and Safety Executive reported that the exact figure was likely to be even higher.[1]

We focused on the ethnic minority lower-paid workforce, and the evidence we have gathered means that we only draw conclusions about this group of workers. However, some of our findings can be applied across the lower-paid workforce in general, and implementing the recommendations we make in this report is likely to improve the treatment and experience of all lower-paid workers in these sectors.

We are Britain's equality and human rights regulator. Our human rights powers in Scotland extend to reserved matters. Under Section 16 of the Equality Act 2006, we have a power to conduct inquiries to find out more about equality and human rights issues. Based on our findings, we make recommendations for change and improvement in policy, practice or legislation.

[1] **Health and Safety Executive (2021), Management Information: Coronavirus (COVID-19) disease reports** (figures published up to week ending 23 October 2021, accessed November 2021).

NHS organisations and local authorities are required to comply with the Equality Act 2010 (Britain's anti-discrimination law), particularly the Public Sector Equality Duty (PSED), which was created under the Act. The PSED exists to bring consideration of equality and good relations into the day-to-day business of public authorities. It consists of a general equality duty, supported by specific duties. These specific duties are additional requirements placed on many public bodies to help them better perform the general equality duty.

In Wales and Scotland, certain public bodies are also subject to the Socio-economic Duty (SED). The SED comes from Section 1 of the Equality Act 2010 and aims to deliver better outcomes for those who experience socio-economic disadvantage.

Our definition of social care

In this report we refer to social care as any formal residential or nursing care, homecare (known as 'care at home' in Scotland) and day care for adults. This may be long- or short-term care, provided by the public, private or third sector (for example, a voluntary or community organisation that is neither private nor public), and funded in any way (including care funded by direct payments). We do not include informal or unpaid care. The term social care is used throughout to mean adult social care.

Our definition of ethnic minority

In this report, the term 'ethnic minority' refers to:

- mixed or multiple ethnic groups
- Asian or Asian British groups
- Black or African or Caribbean or Black British groups, and
- White ethnic minority groups (sometimes referred to as White Other).

White ethnic minority groups included in this category are:

- Gypsy or Irish Traveller
- Scottish Gypsy / Traveller, and
- White people from any country outside the UK and Ireland, including European countries.

We haven't included the following White ethnic groups: English, Welsh, Scottish, Northern Irish, Irish or British.

Our justification for this definition is given in the Appendix (pages 62–63). It aligns with **the UK Government's definition of ethnic minority**, which is 'all ethnic groups except the white British group', except that we have also excluded White Irish people for this inquiry. Not all sources in this report use the same definition. Where we have drawn on a source that combines the White Other group with the White British group, we have said so.

Other definitions can be found in **our terms of reference**.

What we found

Data limitations

Our approach to this inquiry is explained fully in the Appendix (pages 60–63). We sought out and thoroughly analysed all available and relevant data. We soon identified that there was a lack of robust workforce data on lower-paid ethnic minority workers in parts of the health and social care sectors. In social care particularly, approaches to worker registration and data collection vary across England, Scotland and Wales, and there is no data available on the treatment and experience of the workforce as a whole (even registered workers).

There was better data available for the healthcare sector, particularly for England. There is an annual NHS workforce survey of staff directly employed by NHS organisations, which differs in England, Wales and Scotland. Several questions from the staff survey in England form part of the **Workforce Race Equality Standard** (WRES) in England. However, there was an absence of data available for workers not employed directly by the NHS. The NHS staff surveys don't break down the respondents by pay grade, so we were unable to differentiate between the treatment of lower-paid and higher-paid ethnic minority workers. In addition, the NHS definition of Black and Minority Ethnic (BME) staff, for the purposes of the WRES, excludes the White Other group.

As part of our qualitative research, we held interviews and focus groups with more than 90 lower-paid health and social care workers. These were from a range of ethnic backgrounds, including Filipino, Black African and White groups, and a small number of White British staff to ensure we captured a full range of perspectives.

We also requested submissions from workers to our online call for evidence, and 53 people responded. Given the social disadvantages faced by many lower-paid workers in this sector, combined with the pressures of the COVID-19 pandemic, the low response rate is unsurprising but should be kept in mind for the findings that follow.

We recognise the limitations of this qualitative evidence base. The reader should not assume that all workers share the experiences reported here. It's also important to acknowledge that ethnic minority groups are extremely diverse and may have very different experiences. Some may face more severe or obvious discrimination than others.

By gathering evidence from multiple sources, we have been able to address some of the limitations of the existing workforce data and present the most comprehensive picture available of the experiences and treatment of lower-paid ethnic minority workers in health and social care. Immediate action is needed to improve data collection on this workforce. We make recommendations for how this should be achieved.

Incomplete data

Because there is an incomplete picture of the groups of workers identified for this inquiry across Britain, their treatment and experiences are not sufficiently known, measured or monitored. NHS England's workforce plan sets out actions to support transformation across the NHS, but it lacks basic workforce data to understand the treatment and experiences of outsourced workers.

There are, potentially, legal implications to this issue. Gathering comprehensive, accurate equality data, including on those in their workforce in lower-paid, outsourced and commissioned-out roles, can help employers to show that they are complying with the Public Sector Equality Duty (PSED). Even independent sector providers, of which there are many in adult social care particularly, may be subject to the PSED if they carry out a public function, or if commissioning bodies stipulate certain equality policies or procedures in their contracts.

In Scotland and Wales, certain organisations that are responsible for planning services for health and social care, including health boards, local authorities and Integration Joint Boards, have an additional specific duty to gather or collect and use employee data. For those organisations, a failure to do this would also be a failure to comply with the specific duties of the PSED. We recognise that data deficiencies, and strategies to address them, vary across England, Scotland and Wales.

Different treatment and experiences at work

Our inquiry has found a number of concerns about the experiences and the treatment of lower-paid ethnic minority workers in health and social care. Our findings are drawn from a range of sources, reflecting different contexts in health and social care. More details about what we found are on pages 25–36.

Experiences of discrimination

We commissioned the University of Kent to conduct statistical analysis on the 2019 findings of the NHS England staff survey. This found a far greater proportion of ethnic minority staff reported being discriminated against because of their ethnicity by patients and the public, or managers and colleagues, than White staff:

- 18% of ethnic minority staff in all pay bands across the NHS reported experiencing discrimination from patients or other members of the public, compared with 4.6% of White staff
- 14.5% of ethnic minority staff reported experiencing discrimination from a manager or other colleague, compared with 6% of White staff.

In addition, BME staff in England were less likely than their White peers to be appointed from a candidate shortlist across all positions. There are limitations to this analysis of the NHS survey because it doesn't specify pay grades. The results, however, do reflect what we heard from lower-paid workers. Participants in our research described numerous perceived disadvantages in the workplace.

Fewer training opportunities and lack of representation in senior roles

Several lower-paid ethnic minority workers and other contributors reported a lack of training opportunities, particularly in social care. England's Skills for Care survey[2] identified a lack of career progression and representation in senior positions among the top-three challenges facing ethnic minority workers in social care.

[2] Skills for Care (2020), Investigating the issues facing the BAME workforce and the impact of COVID-19 [accessed April 2022].

Comparing the 2020 experiences of NHS White and BME staff across all pay bands in England provides a mixed picture. The percentage of very senior management positions held by BME staff has grown in recent years (from 5.3% in 2017 to 6.8% in 2020) but it remains well below the NHS target of 19%.

Overall, White staff were slightly more likely than BME staff to access non-mandatory training, though the difference is very small and varies by region (in London, the South East and South West, BME staff were more likely to access such training). Data provided by NHS Clinical Commissioning Groups also shows that BME staff were relatively more likely to access non-mandatory training and continuous professional development compared with White staff.

NHS data from Clinical Commissioning Groups in England shows that only 41% of BME staff believed their organisation provided equal opportunities for career progression or promotion, compared with 88% of White staff.[3]

Increased risk in the workplace

Ethnic minority workers in our inquiry reported being given higher-risk tasks and being redeployed to COVID-19 wards during the pandemic more often than their White or White British colleagues. They said that they had no choice but to continue working at increased risk because they were unable to afford to take time off. While this issue could affect workers of all ethnicities, it was particularly serious for migrant workers (non-UK nationals who are living and working in the UK).

Typically these workers are subject to some form of immigration control with no 'recourse to public funds' (a restriction placed on a person's visa that means a person cannot claim most benefits, tax credits or housing assistance paid by the state).

UNISON's analysis of **a union members' survey**, which was submitted to this inquiry, found that between March and December 2020, 67% of Black workers in bands 1 and 2 (the lowest paid) said they had worked in COVID-19 wards, compared with 51% of their White colleagues in the same pay bands (according to responses from members working in healthcare).

Commissioning and outsourcing leading to poor pay and insecure work

Commissioning refers to an agreement in which an organisation authorises an external provider to deliver services on their behalf (for example, care homes).

Outsourcing refers to an agreement in which one company or organisation hires another company or organisation (known as a third party) to run an activity and / or a service that may have been run formerly in-house (for example, cleaning).

[3] **NHS England (2021), Workforce Race Equality Standard 2020 Data analysis report for NHS Trusts and Clinical Commissioning Groups** [accessed April 2022].

Workers on casual, zero-hours contracts are not guaranteed any regular work. Resolution Foundation's analysis of the Labour Force Survey (2017–2019) suggests one in 10 frontline care workers are on zero-hours contracts. This is much higher than the one in 40 of the working population as a whole.

In England, data produced for our inquiry by Skills for Care identified that ethnic minority care workers in the independent care sector were more likely to be on zero-hours contracts than their White British colleagues. This was the case particularly for homecare workers in the independent sector, where 71% of ethnic minority workers were on zero-hours contracts compared with 59% of White British workers in March 2020. The reasons for this disparity are likely to be complex, and it was beyond the scope of this inquiry to explore them all. The end result, however, is a two-tier workforce. Ethnic minority staff tend to be over-represented in lower-paid, commissioned-out and outsourced roles.

Those who gave evidence to our inquiry agreed that a combination of inadequate national funding for social care and the widespread local commissioning of care to private providers combined to create conditions of poor pay and job insecurity for those in lower-paid roles. This is having a greater impact on ethnic minority workers who are more likely to be working in independent care.

In healthcare, many lower-paid roles, including hospital cleaners, porters and caterers, are outsourced to private companies (especially in England). This has led to workers feeling isolated and detached from their place of work. They are often paid less and have poorer terms and conditions than those who are employed directly. Stakeholders, including trade unions, perceive that lower-paid ethnic minority workers are significantly over-represented in NHS England's outsourced operations. We received evidence of outsourced NHS services being brought back in-house because of the negative impact on ethnic minority workers.

Low awareness of employment rights

In adult social care, our evidence suggests that workers often are unaware of their rights and entitlements. This was the case particularly for homecare workers. There were various reasons for this. Sometimes it was due to remote, 'hands off' management of workers – particularly in the case of commissioned-out roles. Unclear payslips and language barriers for migrant workers increased this lack of awareness. Generally speaking, those working in outsourced roles in healthcare often were unaware of their rights.

The backdrop to this issue is a highly fragmented independent social care sector, with a vast number of providers of different sizes and types. The use of zero-hours contracts and commissioning-out of services is widespread. Ethnic minority workers are more likely to work in the independent sector and, in this sector, to be on zero-hours contracts.

In 2021, the UK Government confirmed its plans to bring together existing employment enforcement bodies (HM Revenue and Customs National Minimum Wage Enforcement, the Employment Agency and Standards Inspectorate, and the Gangmasters and Labour Abuse Agency) to form a new Single Enforcement Body for employment rights. Our findings highlight the positive role that this organisation could play in improving the treatment and experiences of workers in health and social care. It should improve access to information about employment rights and how to complain, and ensure employers meet their obligations. However, the lack of a legislative timetable for this creates uncertainty.

Fear of raising concerns and a lack of ways to do so

We heard that lower-paid ethnic minority workers in health and social care are less likely to raise concerns out of fear that they may lose their jobs, particularly if they are in insecure roles or on zero-hours contracts. They don't think they would be listened to or protected, or that their rights would be upheld. Some contributors and workers told us how these workers were sometimes victimised after raising concerns. This supports previous findings from the **Freedom to Speak up review** in 2015, which was set up to provide advice and recommendations to ensure NHS staff in England were able to raise concerns.

There are more opportunities for healthcare workers to raise concerns compared with those working in social care. NHS staff surveys (in England and Wales) enable all staff directly employed by the NHS to have their say on their treatment and experiences at work. Scotland runs a separate survey but the findings are not analysed by race, so we have not drawn on it in this report. The survey data is used to make improvements.

However, surveys have limitations. Lack of access to technology and language barriers can make it difficult to engage lower-paid workers, especially if the survey uses jargon without providing definitions. Outsourced workers are not included in the survey, meaning their experiences go unheard. There is no equivalent option for those working in social care to express their views and concerns about their employment.

Our recommendations for change

Our recommendations are aimed at governments, local authorities, NHS providers, and health and social care regulators. They include:

- providing strong leadership in health and social care providers to model behaviours expected of others and make diversity and inclusion a priority
- ensuring health and social care employers meet the Public Sector Equality Duty in a way that is evidence-based and transparent and reduces racial inequality
- implementing regulatory frameworks in health and social care to address inequality issues, make workplaces fairer to improve staff welfare, and raise standards and quality of care
- improving awareness of and compliance with employment rights, including by bringing forward proposals to introduce a Single Enforcement Body
- developing accessible ways for workers to raise concerns and access redress if they believe they have experienced discrimination
- providing mandatory training for managers on dealing with workforce complaints, including relating to bullying and harassment on the grounds of race
- implementing outstanding recommendations (from, for example, the **Low Pay Commission**) on low pay and advancing Fair Work, and
- developing national structures for better data collection on the health and social care workforce, including equality data and employment outcomes and experiences, to ensure workplace equality for all and targeted steps to support lower-paid ethnic minority workers.

We have produced additional briefings for policymakers which go into further detail on what we want to see specifically in England, Scotland and Wales.
The recommendations in our report are numbered 1 to 20. They follow the same numbering system as in the policy briefings, which are available from the **inquiry page on our website**.

Introduction

We launched our inquiry in 2020 to explore and analyse the treatment and experiences of lower-paid ethnic minority workers in health and social care.

The inquiry covered Britain (England, Scotland and Wales) and took into account the different contexts of the health and social care systems operating in each nation. Our findings apply across Britain unless stated otherwise.

Lower-paid workers in health and social care have had greater exposure to COVID-19. Between April 2020 and January 2022, 57% of people reported to have caught COVID-19 at work were from the health and social care sectors. The Health and Safety Executive reports the exact figure is likely to be even higher.[4] In addition, analysis of records at the start of the pandemic found that 6 in 10 healthcare workers who died from COVID-19 were from an ethnic minority group.[5]

For this inquiry, the areas we set out to examine included:

- the numbers of hours worked
- workplace policies, procedures and culture
- the tasks allocated
- the ability of workers to access redress, and
- training and development opportunities.

The full terms of reference for this inquiry are available on our website.

[4] **Health and Safety Executive (2021), Management Information: Coronavirus (COVID-19) disease reports** (figures published up to week ending 23 October 2021, accessed on November 2021).

[5] Hussein, S. (2022), Low-paid ethnic minority workers in health and social care during COVID-19: A rapid review. Manchester: Equality and Human Rights Commission.

Why we are involved

We are Britain's equality and human rights regulator. In Scotland our human rights powers cover reserved matters. Under Section 16 of the Equality Act 2006, we have power to conduct inquiries to find out more about equality and human rights issues. Based on our findings, we make recommendations for change and improvement in policy, practice or legislation.

Public Sector Equality Duty

NHS organisations and local authorities are required to comply with the Equality Act 2010 (Britain's anti-discrimination law), particularly the Public Sector Equality Duty (PSED), which was created under the Act. The PSED exists to bring consideration of equality and good relations into the day-to-day business of public authorities. It consists of a general equality duty, supported by specific duties. The specific duties are additional requirements placed on many public bodies to help them better perform the general equality duty.

The PSED requires public authorities to 'have due regard to' (consciously consider) the need to:

- eliminate discrimination, harassment and victimisation and any other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not, and
- foster good relations between people who share a protected characteristic and those who do not.

These are often referred to as the three aims or needs of the general duty.

In Scotland and Wales, the specific duties include gathering and using employee data to better perform the PSED, and specific duties on procurement that we explore later in this report.[6] In Wales and Scotland, certain public bodies are also subject to the Socio-economic Duty (SED). The SED comes from Section 1 of the Equality Act 2010 and aims to deliver better outcomes for those who experience socio-economic disadvantage.

Data limitations in our inquiry

Our approach to this inquiry is explained fully in the Appendix (pages 60–63). We considered evidence from England, Wales and Scotland. We received first-hand accounts of workers' experiences. Our expert interviews, including with health and social care and employment bodies, provided further insight. We also analysed the best workforce data that was available.

We soon identified that there was a lack of robust workforce data on lower-paid ethnic minority workers in parts of the health and social care sectors, particularly in social care. In social care approaches to worker registration and data collection vary across England, Scotland and Wales and there is no data available on the treatment and experience of the workforce as a whole (even registered workers).

[6] In Wales, Regulations 9 and 18 of The Equality Act 2010 (Statutory Duties) (Wales) Regulations 2011. In Scotland, Regulations 6 and 9 of The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012.

Data available for the healthcare sector was better, particularly for England. There is an annual NHS workforce survey of staff directly employed by NHS organisations, which differs in England, Scotland and Wales. Several of the questions from the staff survey in England form part of the **Workforce Race Equality Standard** (WRES) in England. However, there was an absence of data available for workers not employed by the NHS directly. The NHS staff surveys don't break down the respondents by pay grade, so we were unable to differentiate between the treatment of lower-paid and higher-paid ethnic minority workers. In addition, the NHS's definition of Black and Minority Ethnic (BME) staff for the purposes of the WRES excludes the White Other group (which we include in our definition of ethnic minority for this inquiry – see pages 62–63).

As part of our qualitative research, we held interviews and focus groups with more than 90 lower-paid health and social care workers. These were from a range of ethnic backgrounds such as Filipino, Black African and White groups, including a small number of White British staff, to ensure we captured a full range of perspectives. We also requested submissions from workers to our online call for evidence, and 53 people responded. Given the social disadvantages faced by many lower-paid workers in this sector, combined with the pressures of the COVID-19 pandemic, the low response rate is unsurprising.

We recognise the limitations of this qualitative evidence base. The reader should not assume that all workers universally share the experiences reported here. It is also important to acknowledge that ethnic minority groups are extremely diverse and may have different experiences. Some may face more severe or overt discrimination than others.

We focused on the ethnic minority lower-paid workforce, and the evidence we have gathered means that we only draw conclusions about this group of workers. However, some of our findings can be applied across the lower-paid workforce in general, and implementing the recommendations we make in this report is likely to improve the treatment and experiences of all lower-paid workers in these sectors.

By gathering evidence from multiple sources, we have been able to address some of the limitations of the existing workforce data and present the most comprehensive picture available of the experiences and treatment of lower-paid ethnic minority workers in health and social care. Immediate action is needed to improve data collection on this workforce and we make recommendations in this report for how this should be achieved.

Our recommendations

Our recommendations are aimed at governments, local authorities, NHS providers, and health and social care regulators across Britain. In addition to this report we have produced briefings for policymakers which go into further detail on what we want to see specifically in England, Scotland and Wales.

Our recommendations are numbered 1 to 20 in this report. They follow the same numbering system in the policy briefings, which are available from the **inquiry page on our website**.

Social care

In this report we refer to social care as any formal residential or nursing care, homecare (known as 'care at home' in Scotland) and day care for adults. This may be long- or short-term care, provided by the public, private or third sector (for example, a voluntary or community organisation that is neither private nor public), and funded in any way (including care funded by direct payments). We do not include informal or unpaid care. The term 'social care' is used throughout to mean adult social care.

Ethnic minority

In this report, the term 'ethnic minority' refers to:

- mixed or multiple ethnic groups
- Asian or Asian British groups
- Black or African or Caribbean or Black British groups, and
- White ethnic minority groups (sometimes referred to as White Other).

White ethnic minority groups included in this category are:

- Gypsy or Irish Traveller
- Scottish Gypsy / Traveller, and White people from any country outside the UK and Ireland, including European countries.

We haven't included the following White ethnic groups: English, Welsh, Scottish, Northern Irish, Irish or British.

Our justification for this definition is given in the Appendix (pages 62–63). It aligns with **the UK Government's definition of ethnic minority**, which is 'all ethnic groups except the white British group', except that we have also excluded White Irish people for this inquiry. Not all sources in this report use the same definition. Where we have drawn on a source that combines the White Other group with the White British group, we have said so.

Other definitions can be found in **our terms of reference**.

Who works in lower-paid health and social care roles?

Healthcare

Lower-paid roles in healthcare are those paying up to about £10 per hour (£10.85 in London). This is roughly equivalent to the UK 2020 Living Wage, which was £9.90 per hour (£11.05 in London). This includes NHS pay bands 1 and 2 and some band 3 roles. They include roles such as:

- domestic assistants
- catering assistants
- health records clerks
- receptionists
- housekeeping assistants
- nursery assistants, and
- administrative staff.

Some of these workers are members of an **'NHS staff bank'**. Staff banks are managed by a trust or through a third-party organisation who contract healthcare professionals for temporary shifts at trust hospitals. Some roles may be outsourced, which is where a hospital trust has a contract with an external, third-party organisation to provide a service.
For example, cleaning in a hospital may be done by workers from an agency.

The pay bands for in-house employees are set out in Agenda for Change which is the main pay system for staff in the NHS, excluding doctors, dentists and senior managers. It is also known as the **NHS Terms and Conditions of Service** and the NHS in England, Scotland and Wales can amend them to suit their particular needs. For this inquiry we considered bands 1–3 as lower-paid roles.

How many workers identify as an ethnic minority?

A full picture of the number of ethnic minority workers in lower-paid roles isn't available for various reasons. The NHS's definition combines White Other groups with White British groups under the White category. Data gathered by the NHS is based on those who have chosen to share their ethnicity. A number of workers choose not to share their ethnicity, and this rate is particularly high in Scotland. The NHS data also doesn't account for outsourced roles and agency workers, many of whom are from ethnic minority groups.

The following figures provide an indication:

- In Wales, data from December 2020, provided for this inquiry by NHS Wales, suggests that 3.9% of the lower-paid workforce identified as ethnic minority, compared with 4.4% in the 2011 Census (see Appendix pages 64–65). This increases to 6.3% if including Gypsy or Irish Traveller and White Other groups.
- In Scotland, data from March 2018, provided for this inquiry by the Scottish Government, suggests that 3% of the lower-paid workforce declared their ethnicity as ethnic minority, compared with 4% in the 2011 Census. This increases to 7.1% if including White Gypsy / Traveller, White Polish and White Other groups.
- In England, data from September 2020 suggests ethnic minorities are 17.8% of the lower-paid workforce, compared with 14.6% in the 2011 Census. This increases to 19.3% if including Gypsy / Irish Traveller and White Other groups.

According to this data we know that, out of the total number of NHS workers who chose to share their ethnicity, more than 71,000 lower-paid workers are from ethnic minority groups in Britain. This does not include those working in the many lower-paid roles that have been outsourced, primarily in England.

Social care

As stated in **our terms of reference**, lower-paid roles in the social care sector include:

- care workers
- some senior care workers
- personal assistants, and
- other operational support roles, such as cleaners.

The social care workforce consists of:

- care workers whose roles are commissioned out to private- and third-sector organisations (referred to in this report as the independent care sector)
- care workers employed by local authorities or the NHS, and
- personal assistants employed by the person for whom they care.

How many workers identify as an ethnic minority?

Across Britain the majority of care is provided by the independent care sector. In the 2011 Census (see Appendix pages 64–65), 4.7% of England's population was from the White Other ethnic group, rising to 12.7% in London. It was 1.9% in Wales and 3.2% in Scotland. Data provided to us by Skills for Care identified an over-representation of those from the White Other ethnic group working in the independent sector in England (7% of all workers in social care). We do not have equivalent data for Wales and Scotland.

- In England in 2020, 22% of the independent care workforce and 16% of the local authority workforce identified as ethnic minority.[7]
- In Scotland, data provided for this inquiry by the Scottish Social Services Council showed that in 2020, 5.7% of the independent care workforce and 1.8% of the local authority workforce identified as ethnic minority (this data doesn't include White minorities).[8]
- In Wales, data provided for this inquiry by Social Care Wales showed that in July 2021 the number of registered workers who identified as ethnic minority were 4.3% from private providers, 4.4% from third-sector providers and 5.4% from the local authority workforce. However, alternative data from 2019, published in 2021, suggests this is as low as 0% for the local authority workforce.[9]

We know that more than 1.6 million people work in adult social care across Britain, and that generally this is a lower-paid workforce. For example, in 2019–20, 73% of independent-sector adult social care workers in England were paid less than the real Living Wage.[10] Unlike for the NHS, from these data sources we cannot calculate the number of lower-paid workers in adult social care who are from ethnic minority groups.

[7] **Skills for Care (2020), The state of the adult social care sector and workforce in England** [accessed February 2021].

[8] See also: **Scottish Social Services Council (2020), Scottish Social Service Sector: Report on 2020 Workforce Data** [accessed April 2022].

[9] **Data Cymru (2021), Social Care Wales – workforce profile 2019: local authority Regulated Services** [accessed February 2021].

[10] **Living Wage (2020), News: three-quarters of care workers in england were paid less than the real living wage on the eve of the pandemic** [accessed March 2022].

Migrants working in lower-paid health and social care roles

England

In England, 13.5% of NHS staff in hospitals and community services reported a non-British nationality in September 2020.[11] In March 2020, 58% of ethnic minority care workers (including White Other groups) in the independent sector workforce were migrant workers (31% non-EU and 27% from the EEA), according to data provided by Skills for Care.

Scotland

We were unable to obtain comparable data for NHS workers in Scotland. It is estimated that in 2018, 5.5% of workers in the adult social care sector in Scotland were non-UK, EU nationals.[13]

Wales

In 2020, approximately 8% of staff with an identifiable nationality working in NHS estates and operational support services in Wales were non-British; the majority of these (6.3%) were EU nationals. An estimated 6.4% of staff in registered social care services were non-UK, EU nationals.[12]

[11] NHS Digital (2020), NHS Workforce Statistics – September 2020 [accessed February 2022].

[12] Portes, J., Oommen, E. and Johnson, C. (2020), UK migration policy and the Welsh NHS and social care workforce. Cardiff: Wales Centre for Public Policy [accessed April 2022].

[13] Scottish Government (2018), EU workers in Scotland's social care workforce:contribution assessment [accessed February 2021].

Women working in lower-paid health and social care roles

Several contributors to our inquiry referred to the higher numbers of women working in the care sector.

England

In September 2020, 79% of lower-paid workers in NHS hospital and community health services were female (according to an analysis we commissioned of NHS England workforce data). Women made up 82% of the adult social care workforce in March 2020.[14]

Scotland

In Scotland, in September 2020, 79% of all NHS workers were women, although the data doesn't tell us how many are in lower-paid roles.[15] In social care data is only available by sub-sector and shows that, at the end of 2020, 85% of adult care home workers and 77% of housing support / care-at-home workers were women.[16]

Wales

In Wales, in March 2019, 77% of all NHS workers were women, although the data doesn't confirm how many are in lower-paid roles.[17] Women also made up 87% of local authority social care workers and 83% of commissioned-out care workers.[18]

While the workforce data referred to in this section is the best available to us, the way in which it is collated across England, Wales and Scotland means that it doesn't provide a consistent picture of the workforce. The limitations of this data are discussed further in our report.

[14] **Skills for Care (2020), The state of the adult social care sector and workforce in England** [accessed February 2021].

[15] **NHS Education for Scotland (2022), Scotland Workforce dashboard, Overall Staff in Post** [accessed February 2022].

[16] **Scottish Social Services Council (August 2021), Scottish Social Service Sector: Report on 2020 Workforce Data** [accessed February 2021].

[17] **Health Education and Improvement Wales (2019), NHS Wales' Workforce Trends (as at 31st March 2019)** [accessed February 2022].

[18] **Data Cymru (2021), Social Care Wales – workforce profile 2019: Commissioned Care Provider Services** [accessed February 2021].

Incomplete data

There is a lack of robust workforce data on lower-paid ethnic minority workers across Britain, particularly in social care.

Different approaches and their flaws

We have an incomplete picture of the lower-paid ethnic minority workforce in health and social care across Britain because their treatment and experiences are not sufficiently known, measured or monitored.

Social care

In England, not all social care providers volunteer information on their workers. The figures from the Skills for Care 2020 workforce report only represent about 50% of the entire workforce.[19] Similarly in Wales, figures from the Social Care Wales workforce reports do not represent the entire workforce (for example, only 71% of commissioned-out care providers responded to the 2019 workforce survey)[20] and the data provided to us on the registered workforce does not account for everyone working in the sector.

In Scotland the workforce data is taken from a census of all registered social care workers. While we have some information on the ethnicity of the workforce in Scotland, the ethnicity for more than a quarter of the total workforce is unknown. There is also no breakdown by pay band of the workforce. Because the ethnicity of the social care workforce in Scotland is often not declared, we have limited understanding of these workers and their experiences. There is limited data on which to base action to improve outcomes.

[19] Skills for Care (2020), The state of the adult social care sector and workforce in England [accessed February 2021].

[20] Data Cymru (2021), Social Care Wales – Workforce Profile 2019: Commissioned Care Provider Services [accessed April 2021].

We issue an annual return for all services to complete, and reporting is based on that; it seems to be a persistent problem of people not declaring what their ethnicity is. I think there is a hearts-and-minds awareness campaign that we need to engage in, because people are still reluctant to declare.

– Regulator, Scotland

Healthcare

For healthcare generally there is better data available. For example, in England there is the NHS staff survey, of which there is no equivalent in social care. Structures are in place for collating information on the experiences of the healthcare workforce, although these vary across England, Wales and Scotland.

In England, the Workforce Race Equality Standard (WRES), a tool introduced in 2015, helps NHS trusts and Clinical Commissioning Groups meet their PSED obligations by self-assessing against nine indicators of workplace experience and opportunity. We heard there are plans in Wales to develop and pilot an All-Wales workforce wellbeing survey in social care.

A scheme based on the WRES for local authority social care departments is also in its early stages.

In England, the UK Government has announced its intention to expand the roll-out of the WRES to include social care – developed by Skills for Care. It is however unclear if this will include carers not directly employed by the local authority, who are the majority. The intention is that 'local authorities will use data to create plans for ensuring staff from ethnic minority backgrounds are treated equally, feel included and valued, their health and wellbeing are prioritised, and they have access to culturally appropriate support.'[21]

However, there are limitations to the staff surveys and the WRES. The NHS staff surveys are not open to outsourced workers. The WRES also doesn't collect data about agency staff, bank staff and workers in outsourced roles. A number of contributors to our inquiry highlighted that this created a data gap on race equality in parts of the workforce.

[21] Department of Health and Social Care (2021), People at the Heart of Care: adult social care reform [accessed April 2022].

There's always been quite a focus in the WRES about leadership and getting Black and Minority Ethnic staff up the pay grades . . . so I don't think it's necessarily been a good vehicle for change for the really low-paid staff.

– Regulator, England

NHS England's workforce plan[22] sets out actions to support transformation across the whole NHS in England. However, it lacks basic workforce data to be able to understand the outsourced workforce, their treatment and experiences.

What we recommend

1. **The UK, Scottish and Welsh governments** should work with key stakeholders, including the health and social care sectors, to:

    a. fulfil their PSED obligations by developing new and improving existing sector-wide national structures for gathering more comprehensive health and social care workforce data on race and all other protected characteristics, and

    b. support organisations to gather and use this data to identify and address poor outcomes experienced by lower-paid ethnic minority workers, including commissioned-out and outsourced workers.

As much as possible, such data should include:

c. the disaggregated (organised) ethnicity of all health and social care workers, (including commissioned-out staff in social care and outsourced workers in the NHS)

d. information from workers about their experiences in the workplace, including data on bullying and harassment, progression and training, and

e. pay data, disaggregated (organised) by ethnicity.

We encourage the use of existing staff surveys and consultation methods to gather this data.

[22] NHS (2020), We are the NHS: People Plan 2020 / 21 – action for us all [accessed February 2022].

Different treatment and experiences at work

Some lower-paid ethnic minority workers report they are treated in an unfair or discriminatory manner. Some experience bullying, harassment and abuse related to their race. Ethnic minority staff generally have worse employment outcomes than their White peers.

Bullying, harassment and abuse

We gathered substantial evidence of poor treatment of ethnic minority workers in the workplace. Bullying and harassment can affect workers of any background. However, many ethnic minority workers felt that others were treating them in a negative or unfavourable way because of their race or nationality.

Examples included being treated with contempt, being belittled by managers and colleagues, and having concerns unreasonably dismissed.

Migrant workers often felt they were belittled for not understanding certain cultural references, words or phrases. Such treatment ranged from subtle behaviours, often experienced on a daily basis, to more open expressions of prejudice.

NHS staff experiences

The findings from our qualitative research (such as interviews and focus groups) are supported to some extent by data from the NHS staff surveys in England and Wales. In 2020, in England 30.3% of BME staff, and 27.9% of White staff (all White groups, including White Other minority groups), reported experiencing harassment, bullying or abuse from patients, relatives or the public.[23]

Response rates to these staff surveys are low: 47% in England and 20% in Wales in 2020. NHS Scotland captured ethnicity data on its staff survey for the first time in 2020, but at the time of writing this was not available so we don't have a comparable picture of staff experiences of discrimination and harassment. In 2019 there were almost 570,000 responses to the NHS staff survey in England, representing 48% of the workforce.

[23] NHS England (2021), Workforce Race Equality Standard 2020: supporting data [accessed April 2021].

We commissioned the University of Kent to conduct statistical analysis on the 2019 findings. This found that:

- 18% of ethnic minority staff (more than 17,000 people) reported experiencing discrimination from patients or other members of the public, compared with 4.6% of White staff (this was a separate question from the one about harassment, bullying or abuse).
- 14.5% of ethnic minority staff (around 14,000 people) reported experiencing discrimination from a manager or other colleagues, compared with 6% of White staff.
- 82% of ethnic minority staff (around 20,000 people) who said they had been discriminated against by patients and the public, or managers and colleagues, felt it was because of their ethnicity; whereas only 22% of White staff who said they had been discriminated against felt that it was because of their ethnicity.

There are limitations to this analysis because the survey doesn't specify pay grades. The results, however, do reflect what we heard from lower-paid workers. Workers spoke about their experiences of discrimination, bias and prejudice because of their race. For example, some felt marginalised at work or mocked for their religion. Some workers felt they had fewer career development opportunities and weren't given credit for their work.

> I have experienced and witnessed bullying, racism and victimisation from staff and managers. I have kept some of my experiences to myself and some I have complained about to management. Unfortunately it has always led to the same result: nothing gets done, it is brushed aside and you are made to feel and look like a troublemaker.
>
> **– Ethnic minority worker, England**

Our review of existing research[24] identified that bullying and discrimination are associated with higher levels of burnout. The evidence from this review suggested that tackling bullying and discrimination at an organisational level could result in better outcomes for workers and patients.

Social care staff experiences

We have no comparable data on the experiences of ethnic minority workers in adult social care. The only known data available is a January 2021 UK survey of UNISON's Black members working in social care. Data provided from this survey was included in UNISON's submission to this inquiry.

[24] Hussein S. (2022), Low-paid ethnic minority workers in health and social care during COVID-19: a rapid review. Manchester: Equality and Human Rights Commission.

It found that almost half of respondents had experienced racism or discrimination at work in the last year.

UNISON's use of the term Black is unlikely to include White ethnic minorities, who are likely to be included in the White category with White British. Its definition is likely to capture many people of Black African, Black Caribbean and Asian heritage. **There is more information on UNISON's website about its use of the term Black**.

Our review of existing research[25] found that social care workers frequently experienced subtle, underhand forms of racism from colleagues and managers, which were difficult to prove or act upon. Evidence provided in a focus group indicated that lower-paid ethnic minority workers are perceived to be given fewer shifts than their White colleagues and are criticised for their language skills (particularly migrant workers, who felt these criticisms were often unjustified).

Contributors also shared examples of clear, obvious racism from service users who, for example, refused to be seen in public with Black carers and expressed openly racist attitudes and remarks. One participant in our qualitative research reported feeling depressed after being insulted racially.

Unsupportive line management

We heard reports that colleagues and employers in both sectors are sometimes reluctant to tackle racist abuse from patients or service users. This was highlighted in our review of existing research which identified that obvious or direct racism towards ethnic minority workers from service users was often not taken seriously by managers and supervisors.

A 2019 UNISON and Nursing Times survey of NHS line managers (of all ethnicities) in the UK found that 52% of respondents who described themselves as line managers did not feel that they had received 'adequate training to deal with issues of racism against staff in the workplace'. The biggest barriers were a lack of support from senior managers, difficulty knowing how to challenge poor behaviour from patients, and a fear of getting it wrong.[26]

Our review of existing research identified unsupportive line managers of lower-paid ethnic minority workers in health and social care as one of the reasons for fewer positive social networks in the workplace.[27]

[25] Ibid.

[26] **Nursing Times, Exclusive: High level of racial discrimination face by nurses revealed, 2 October** [accessed February 2022].

[27] Hussein S. (2022), Low-paid ethnic minority workers in health and social care during COVID-19: a rapid review. Manchester: Equality and Human Rights Commission.

Impact on mental health

Race discrimination, bullying and harassment at work has a negative impact on mental health and wellbeing. This has been highlighted by our contributors, workers we spoke to and reports such as the Health and Social Care Committee report on workforce burnout.[28] Contributors told us that ethnic minority workers are less likely to raise concerns, which worsens their mental health. We explore this point further on in our report.

Less favourable treatment from line managers

We received reports of ethnic minority staff facing excessive criticism and reproach for mistakes, which they felt was unfair. Some felt that White staff were treated more favourably. These accounts support data reported by NHS England, which shows that in 2020 ethnic minority staff were more likely to enter the formal disciplinary process compared to White staff.[29] These have been taken directly from engagement with workers and we are not always able to specify whether they refer to White British or White Other staff. Also, the NHS survey doesn't include White Other ethnic groups, who are included in the White category.

Allocation of hours and leave

Our evidence contains examples of lower-paid ethnic minority workers who felt they were treated differently to their White or White British colleagues when allocated working hours, particularly when requesting extra hours (although again, these accounts were taken directly from engagement with workers and therefore we are unable to specify whether they refer to White British or White Other workers). Some ethnic minority respondents said they had not been permitted annual leave or time off for religious holidays, unlike White colleagues, or had struggled to find someone to cover their shift. Some staff felt their employers lacked a sense of fairness, understanding and even-handedness when handling such requests.

[28] **House of Commons, Health and Social Care Committee (2021), Workforce burnout and resilience in the NHS and social care. Second Report of Session 2021–22** [accessed April 2022].

[29] **NHS England (2021), Workforce Race Equality Standard** [accessed April 2022].

Fewer training and progression opportunities

Our review of existing research highlighted that training opportunities in both health and social care were generally about meeting mandatory requirements like health and safety, rather than career development. Ethnic minority groups and women were affected by this the most.[30] According to data produced in 2020 by NHS England, White staff were slightly more likely than BME staff to access non-mandatory training, though the difference is very small and varies by region (in London, the South East and South West BME staff were more likely to access such training).

Data provided by NHS Clinical Commissioning Groups also shows that BME staff were relatively more likely to access non-mandatory training and continuous professional development compared to White staff.[31]

Our research with workers in Scotland and Wales suggested the existence of a two-tier workforce, in which outsourced staff struggled to gain new qualifications and progress in their careers. While this can affect staff from all backgrounds, those from ethnic minorities are over-represented in outsourced roles.

The evidence we gathered suggests that ethnic minority staff often felt they had little support for career progression from management. They felt that managers had occasionally blocked their development deliberately. This had led to over-qualified ethnic minority staff getting stuck in junior positions for long periods.

Data produced by NHS England shows that, in 2020, White applicants were more likely to be appointed from shortlisting across all positions compared with ethnic minority applicants. This likelihood has varied over time but was slightly higher in 2020 than it was in 2016.[32] This reflects the contributions made to this inquiry by ethnic minority workers.

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[30] Hussein S, (2022), Low-paid ethnic minority workers in health and social care during COVID-19: A rapid review. Manchester: Equality and Human Rights Commission.

[31] **NHS England (2021), Workforce Race Equality Standard 2020 Data analysis Report for NHS Trusts and Clinical Commissioning Groups** [accessed April 2022].

[32] **NHS England (2021), Workforce Race Equality Standard 2020: supporting data** [accessed April 2022].

Limited progression for social care workers

Working in the NHS and in local authority-provided care often is seen to offer better training opportunities than in independent-provided care. This affects lower-paid ethnic minority social care workers especially, who are over-represented in the independent sector and less likely to be employed directly by local authorities.

We received reports that workers whose first language is not English, or who recently have arrived or started working in the country, face additional barriers by not knowing where to find training opportunities or how to apply for them. The adult social care workforce offers limited opportunities to progress in it, as most roles are entry-level with no recognised training pathways for staff.

Lack of representation in senior roles

Ethnic minority respondents to a Skills for Care survey in England identified lack of progression and representation in senior positions among the three top challenges facing ethnic minority workers in social care. In the NHS, the percentage of very senior management positions held by BME staff has grown in recent years (from 5.3% in 2017 to 6.8% in 2020) but it remains well below the NHS target of 19%. In addition, we found that ethnic minority workers in health and social care often were over-qualified for their lower-paid positions. This is true particularly for migrant workers because overseas qualifications are not always recognised.

Based on their proportion of the workforce as a whole, ethnic minority staff are under-represented in senior management and over-represented in frontline roles in adult social care. Ethnic minority women also are less likely to be in management roles compared to White British women. According to our analysis of Skills for Care data for the independent sector in England, in March 2020:

- 27% of care workers and 21% of senior care workers were from an ethnic minority (including White Other)
- 16% of registered managers and 17% of senior management were from an ethnic minority, and
- 58% of ethnic minority workers in senior management roles were women, compared with 72% of White British workers.

“

There are fewer registered managers from Black or Minority Ethnic backgrounds. The majority of the staff are in the caring roles, so they are at the entry-level roles. Across the whole sector, progression is an issue. Just having the opportunities, the right modelling, the right coaching and the right training is lacking. It could be vastly improved.

”

– Tricia Pereira, Director of Operations, Skills for Care, in her **oral evidence to the Health and Social Care Committee on Workforce burnout and resilience in the NHS and social care, January 2021**

Professionalising and formalising employment in social care

In evidence submitted to our inquiry we found that care workers often don't consider their work to be a profession or career. This is due to the casualised nature of these jobs and few opportunities for progression or specialisation. Initiatives to provide more formalised employment, with appropriate training and support for professional development, vary across Britain.

In Scotland and Wales, for example, the workforce is required to register. In England, the Department of Health and Social Care, announced plans to professionalise the sector, including a voluntary ‘skills passport’, which will contain a record of skills, behaviours and achievements that can be shared with new or potential employers.[33]

[33] **Department of Health and Social Care (2021), People at the Heart of Care: adult social care reform** [accessed April 2022].

Increased risk during the coronavirus (COVID-19) pandemic

Contributors to our inquiry told us that ethnic minority workers reported being allocated higher-risk tasks and being redeployed to coronavirus (COVID-19) wards more often than their White or White British colleagues. This has been reported widely elsewhere.[34] We heard how workers felt that they had no choice but to continue working at increased risk.

For this inquiry UNISON sent us its analysis of a union members' survey. The analysis showed that between March and December 2020, 67% of Black workers in bands 1 and 2 (the lowest paid) said they had worked in COVID-19 wards, compared with 51% of their White colleagues in the same pay bands (according to responses from members working in healthcare).

Personal protective equipment (PPE)

Some lower-paid ethnic minority social care workers highlighted the shortages and inadequate distribution of suitable personal protective equipment (PPE) at the start of the COVID-19 pandemic.

Our review of existing research highlighted that ethnic minority workers were more likely to work in hazardous situations without adequate PPE compared with their White counterparts.[35]

Risk assessments

Evidence from our qualitative research suggests that those directly employed by the NHS or local authority had access to earlier, regular and more meaningful risk assessment than those working for private contractors, agencies or in private care homes. Most participants employed directly by the NHS had been risk-assessed and some were given the option to transfer to 'non-COVID-19' wards or other relatively safe areas, such as receptions.

However, we did receive some examples of lower-paid ethnic minority workers who felt that risk assessments were often tick-box exercises and their concerns were not always taken seriously. This was in spite of emerging evidence that people from ethnic minorities were dying from COVID-19 at higher rates. We also found that outsourced workers in the NHS were often not given a risk assessment because it wasn't clear who was responsible for doing them.

[33] Department of Health and Social Care (2021), People at the Heart of Care: adult social care reform [accessed April 2022].

[34] For example, see ITV News (2020), 'Discrimination' on frontline of coronavirus outbreak may be factor in disproportionate BAME deaths among NHS staff, 13 May 2020 [accessed April 2022].

[35] Hussein S. (2022), Low-paid ethnic minority workers in health and social care during COVID-19: A rapid review. Manchester: Equality and Human Rights Commission.

Good practice in Wales

We heard about the introduction of the **all-Wales COVID-19 Workforce Risk Assessment Tool**, which was set up in May 2020 to look at the reasons why ethnic minority workers in health and social care are affected disproportionately by the virus. Inquiry contributors from the healthcare sector spoke positively about this tool, saying that trusts had been monitoring and reporting on the numbers of staff who had done the risk assessment.

Migrant workers affected disproportionately

Our evidence shows that the COVID-19 pandemic particularly affected migrant workers who are not eligible for sick pay and have no 'recourse to public funds' (a restriction placed on a person's visa that means an individual cannot claim most benefits, tax credits or housing assistance paid by the state). Some contributors and participants in our qualitative research told us that this meant migrant workers in health and social care were unable to self-isolate if told to do so. As a result they were in a situation that put the health of patients and staff at risk, as well as their own. This was particularly the case for workers who were subject to some form of immigration control. One participant in the research said that 'we had to keep working in the midst of it' while other colleagues could access benefits and government support.

Good practice in Scotland

A participant in a Scotland focus group talked about the benefits of discretionary payments made by Scottish local authorities under public health legislation, to extend the **self-isolation support grant** to workers with no recourse to public funds.

Some contributors felt that the complexity of immigration laws and rules means that migrants find it difficult to understand their employment rights. If someone's circumstances change, this can also affect their immigration status and their right to work or access public funds. This led to some migrant workers feeling vulnerable and fearful about raising concerns.

This reflects the findings of our report, **The Invisible Workforce: Employment Practices in the Cleaning Sector (2014)**. Migrants felt vulnerable to poor treatment because of their lack of understanding of UK employment rights.

Limitation of the visa extension scheme

The visa extension scheme was introduced in spring 2020 to address the financial and administrative pressures on migrant health and social care workers during the pandemic. NHS and care workers whose visas were due to expire would have them extended for a year free of charge 'in response to the COVID-19 pandemic'.[36]

Initially all NHS and care workers whose visas were due to expire had them extended free of charge for a year. Prior to January 2021 this applied to non-EEA workers who required a visa to work in the UK. Workers from the EEA prior to the UK's withdrawal from the EU (and those who were living in the UK before 11pm on 31 December 2020 but were required to apply for the Settlement Scheme by the deadline of 30 June 2021 to get settled or pre-settled status) didn't have to apply for leave to remain or a visa.

An extension to the scheme only applied to skilled-worker visa holders. We heard in our evidence that the lowest-paid healthcare workers and most social care workers were excluded from the scheme because they classified as low-skill.

During the pandemic, the UK Prime Minister announced that health and social care workers would be exempt from the Immigration Health Surcharge visa fees. Prior to January 2021 this applied to non-EEA workers who required a visa to work in the UK. Workers from the EEA prior to the UK's withdrawal from the EU (and those who were living in the UK before 11pm on 31 December 2020 but were required to apply for the Settlement Scheme by the deadline of 30 June 2021 to obtain settled or pre-settled status) didn't have to apply for leave to remain and didn't have this restriction. EU nationals who arrived after 1 January 2021 to visit the UK are subject to a 'No Recourse to Public Funds' condition.

Reimbursements were provided for workers who had paid the fees since 31 March 2020.[37] Contributors to this inquiry noted this is likely to have reduced the financial and legal burden on lower-paid migrant workers in health and social care.

[36] **GOV.UK (2020), Home Secretary announces visa extensions for frontline health and care workers, 29 April** [accessed April 2022].

[37] **GOV.UK (2021), Health and care staff can claim immigration health surcharge reimbursement, 1 October** [accessed April 2022].

Lack of accountability for the workforce

Health and social care across Britain is regulated primarily for its quality. We heard that the Care Quality Commission (CQC) in England, Care Inspectorate Wales, Care Inspectorate in Scotland and the Scottish Social Services Council, all have lines of inquiry into staff welfare and workforce equality. In particular, the CQC assesses the outcomes of progress made by hospital trusts in England against the **NHS Workforce Race Equality Standard** (WRES). It also published a review of how the WRES has affected its regulation of healthcare providers.[38]

However, there is a lack of accountability for commissioned-out staff in social care and outsourced healthcare workers. This has a greater impact on ethnic minority workers who we heard are more likely to be employed in the independent social care workforce and outsourced healthcare roles.

What we recommend

2. **The UK, Scottish and Welsh governments** should take action to address the racial inequalities identified by our inquiry and the structural factors that cause them.

3. **The Scottish and Welsh governments should** ensure that regulatory frameworks for health and social care are implemented effectively to address the equality issues raised by the findings of this inquiry, recognising the impact that these can have on the care of patients and service-users, as well as the welfare of staff.

4. **Health and social care regulators in England, Scotland and Wales should**, where their remits allow, review existing assessment frameworks and how they are implemented to ensure that these fully address the equality issues for ethnic minority workers raised by the findings of this inquiry, and the implications for the welfare of staff.

5. **NHS trusts, health boards and local authorities in England, Scotland and Wales, as well as integrated care systems in England, should** take account of racial inequalities faced by lower-paid ethnic minority workers, including commissioned-out staff in social care and outsourced workers in the NHS, and the structural factors that cause them, as identified in this report. For example, this should include taking action to improve the collation and use of workforce equality data (on outcomes as well as treatment and experiences), working with the workforce to build confidence and increase the disclosure of ethnicity data. We will monitor steps being taken by these organisations to address the racial inequalities and structural factors identified in the report.

[38] **Care Quality Commission (2021), The impact of the Workforce Race Equality Standard in our regulation since 2015** [accessed April 2022].

6. **The UK, Scottish and Welsh governments should** work with key stakeholders to develop strategies for professionalising the adult social care workforce (through worker registration if this is not already in place), or amend existing strategies to ensure that they seek to address the poorer employment outcomes experienced by lower-paid ethnic minority and female workers. This should include:

   a. strategic workforce planning that addresses the impact of casualised employment practices

   b. the development of career pathways to support progression or specialisation for adult social care workers

   c. inclusive recruitment that addresses the lack of representation in senior roles

   d. lifelong training that is accessible to all, and

   e. worker registration.

   Such strategies should include performance indicators for improving the outcomes for ethnic minority workers where appropriate. There should be clear lines of accountability for monitoring and reporting progress.

7. **The Scottish and Welsh governments should** take account of our inquiry findings as part of their planned reviews of the specific duties. This should ensure that public authorities, in meeting their PSED obligations, are evidence-based, improvement-focused, and address the most persistent and entrenched inequalities.

Commissioning and outsourcing leading to poor pay and insecure work

Commissioning of social care and outsourcing some roles in healthcare (by local authorities and hospital trusts / boards, respectively) has resulted in more insecure work and poorer pay and terms and conditions than for those working for the public sector directly.

Commissioning refers to an agreement in which an organisation authorises an external provider to deliver services on their behalf (for example, care homes).

Outsourcing refers to an agreement in which one company or organisation hires another company or organisation (known as a third party) to run an activity and / or a service that may have been run formerly in-house (for example, cleaning).

Many contributors to this inquiry suggested that underfunding of the social care sector has contributed to poor pay and terms and conditions for the lowest paid. It has led also to the use of zero-hours contracts. This has been reported elsewhere: for example, by the UK Parliament's Health and Social Care Committee.[39] Many contributors commented that this way of working results in providers only meeting minimum standards and rates of pay. The impact this has on workers is not considered.

[39] House of Commons, Health and Social Care Committee (2020), Social care: funding and workforce. Third Report of Session 2019–21 [accessed February 2022].

> The current method of competitive tendering based on non-committal hourly rate-based tenders and framework agreements has created a model of employment that transfers the burden of risk of unpredictable social care demand and cost almost entirely onto the workforce.
>
> – **Fair Work Convention (2019), Fair Work in Scotland's Social Care Sector in 2019**.

Several contributors to our inquiry suggested that, when making decisions on commissioning care services to external companies, the main focus was often on the price. Contributors suggested the PSED is not working very well when it comes to commissioning, with insufficient evidence of it having led to tangible improvements.

Undervalued work and low pay

Social care is a skilled and demanding profession, particularly when providing care for people with complex needs, such as dementia.

Contributors, however, often felt that, broadly speaking, the value and importance of social care were not recognised and it is often regarded as low-skilled work. This was the case particularly for staff in commissioned-out social care services, on whom many care recipients rely. A small study from Wales in 2020[40] found that 'local authority social care employers and the NHS appear to pay more and offer more favourable terms and conditions compared to independent and third-sector providers.' Basic pay is enhanced by more factors in the NHS and local authorities, such as Bank Holiday working, night work, overtime, sick pay and maternity pay (above and beyond the statutory allowance).

When considering the overall employment experiences of health and social care staff, it is worth acknowledging that care workers in England and Wales are among the lowest paid workers in Britain:

- In England in March 2020, the median hourly rate for adult social care workers in the independent sector was £8.50 an hour.[41]
- In Wales in 2020, the median minimum basic pay in the independent sector was £8.25 and £9.74 for local authority providers.[42]

Some contributors thought the reason for low pay was because these workers very often are women.

[40] **Wallace S., Garthwaite T., Llewellyn M. (2020), Review of Evidence of Variation in Terms and Conditions for Social Care Employment Contracts in Wales. Cardiff: Welsh Government, GSR report number 64/2020** [accessed April 2022].

[41] **Skills for Care (2020), The state of the adult social care sector and workforce in England** [accessed April 2022].

[42] **Wallace S., Garthwaite T., Llewellyn M. (2020), Review of Evidence of Variation in Terms and Conditions for Social Care Employment Contracts in Wales. Cardiff: Welsh Government, GSR report number 64/2020** [accessed April 2022].

Why do we pay so little for people who look after our families? It's crazy. We don't see that as important, I would argue, because it's predominantly been the work of women . . . It's not about a market force, I don't think, it's about actually we don't think it's got that much value. . . . So, by improving the pay of that sector, you don't just improve their economic ability to have an impact on society, you change the way they feel valued, the contribution they make, and the importance of the work that they do.

– Stakeholder in Wales for this inquiry

Actions being taken to increase pay

The real Living Wage

The **National Minimum Wage** was first set in 1999 and had the immediate effect of raising the low pay of more than 2 million people. A report by the Low Pay Commission in 2019 said the National Minimum Wage led to the lowest paid workers on average seeing their pay grow faster than all other workers.[43] While the rate of National Minimum Wage has grown over the years, it has never reached the same rate as the **real Living Wage**.

The real Living Wage is a voluntary rate set in November by the **Living Wage Foundation**. It is calculated to reflect the basic cost of living. The rate in November 2019 was £10.55 per hour in London and £9.00 per hour for the rest of the UK. This increased in November 2020 to £10.75 per hour in London and £9.30 per hour for the rest of the UK.

In Scotland since April 2021 the social care workforce has been paid the real Living Wage. The Welsh Government has made £43 million available for health boards and local authorities to roll out the real Living Wage to registered workers in care homes, homecare and personal assistants. Workers receive a direct payment, beginning in April 2022.[44]

[43] **Low Pay Commission (2019), 20 years of the National Minimum Wage** [accessed April 2022].

[44] **Welsh Government (2022), Implementing the Real Living Wage for social care workers in Wales** [accessed April 2022].

Scotland

In Scotland, the National Care Home Contract, negotiated across Scotland through the Convention of Scottish Local Authorities (COSLA), has helped raise carers' wages. The **Independent Review of Adult Social Care** (IRASC) supports all five recommendations made in the 2019 report by the Fair Work Convention.[45]

The Scottish Government has committed to implementing the recommendations of the IRASC. It also states that it will develop a minimum standards framework for terms and conditions for ethical commissioning so that fair work requirements and principles can be met and delivered consistently.

Wales

In Wales, the **Social Care Fair Work Forum** has been convened to improve working conditions in social care. The Welsh Government, in addition to designating £43 million towards paying care workers the real Living Wage, is providing an additional payment of £1,498 to eligible care workers.[46]

England

In England, there are plans in the **Health and Care Bill** to establish **Integrated Care Boards** as statutory bodies, meaning that they will have to comply with the PSED. We believe this is an opportunity to tackle inequalities in health and social care services and address workforce inequalities experienced by lower-paid ethnic minority workers.

[45] **Fair Work Convention (2019), Fair work in Scotland's Social Care Sector 2019** [accessed: 13 August 2021].

[46] **Welsh Government (2022), Written Statement: Social care additional payment aligned to the real living wage** [accessed April 2022].

More zero-hours contracts in frontline social care

According to Resolution Foundation's analysis of the Labour Force Survey (2017–2019), across the UK zero-hours contracts are used more in frontline social care (one in 10 workers) compared with the working population as a whole (one in 40).[47]

In England, data produced for our inquiry by Skills for Care identified that ethnic minority care workers in the independent care sector were more likely to be on zero-hours contracts than their White British colleagues. This was the case particularly for homecare workers in the independent sector, in which 71% of ethnic minority workers were on zero-hours contracts compared with 59% of White British workers in March 2020. As with other racial disparities in outcomes, the causes of this difference are likely to be complex and multifaceted.

Ethnic minority care workers in the independent sector were also slightly less likely to be on permanent contracts compared with their White British counterparts (83% compared with 91%), and slightly more likely to be on temporary (6% compared with 2%) or bank / pool contracts (8% compared with 6%) than their White British counterparts.

The use of zero-hours contracts results in fewer employment rights and less job security. For example, workers may have insufficient contractual hours to qualify for statutory sick pay. This increases the risk of staff working with COVID-19 symptoms because they cannot afford to lose pay.

> I felt pressure to come back to work because I was losing money, which I knew would affect me, it did affect me. I'm not the only one, it's going to affect a lot of people and because of that, most people that are supposed to self-isolate, they are not going to do that.
>
> **– Ethnic minority worker, England**

Zero-hours contracts can benefit some workers. For example, they offer flexibility for caring responsibilities or fitting work around studies. However, these contracts potentially benefit the employer more than the worker. This one-sided flexibility is well recognised.[48]

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[47] **Resolution Foundation (2020), What happens after the clapping finishes?** [accessed April 2022].

[48] For example, see **Taylor, M. (2017), Good Work: the Taylor review of modern working practices. Department for Business, Energy & Industrial Strategy** [accessed February 2022] and **Low Pay Commission (2018), Low Pay Commission response to government on 'one-sided flexibility'** [accessed April 2022].

The Welsh Government introduced the **Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017**, which require service providers to offer homecare workers the choice of a guaranteed-hours contract after three months of employment. However, it is unclear how successful these regulations have been at providing job security because the Welsh Government hasn't reviewed whether employers are complying with the regulations.

Local authority actions to improve workers' conditions

We heard some local authorities are working to secure improvements in job quality and security for workers in public sector supply chains. Some providers, when commissioning care services, have used purchase power as leverage to get providers to sign up voluntarily to paying a higher rate than the **National Living Wage**.

Others felt that commissioners, when commissioning services, could use existing contract legislation to ensure that workers' rights are embedded in the suppliers' contracts and that the terms of the contract are monitored. For example, Powys County Council has a scheme to offer financial incentives for providers that improve pay and conditions for care workers.[49]

[49] **Powys County Council (2021), 'Paid care workers to get improvements to pay and conditions thanks to pledge', 11 March** [accessed 13 August 2021].

Outsourcing in healthcare

We heard that outsourcing in healthcare is much more common in England compared with Scotland and Wales, but we were unable to find any data sources. Stakeholders, including unions, perceive that lower-paid ethnic minority workers are significantly over-represented in NHS England's outsourcing operations, but it is not possible to verify due to the lack of workforce data collected.

Contributors told us that outsourcing support services, such as cleaning and portering, has a negative impact on pay and terms and conditions for lower-paid workers. This can lead to workplace hierarchies, with those employed directly on open-ended contracts and fixed hours having better terms, conditions and pay than agency workers and those on zero-hours contracts or employed by private companies. This is supported by research:

> "The uneven use of private-sector contractors by healthcare providers can lead to workers performing very similar support roles in different trusts, and sometimes even in the same trust, receiving different pay rates: for NHS in-house employees, pay rates are set out in Agenda for Change, while for outsourced staff pay rates are typically lower and unilaterally set by the private-sector employer.[50]"

[50] Kessler, I. Bach, S. Griffin and R. Grimshaw, D. (2020), Fair Care Work: A post COVID-19 agenda for integrated employment relations in health and social care. King's Business School [accessed April 2022].

Our evidence shows that some NHS trusts in England have transferred some services to an NHS subsidiary company that does not need to comply with the pay terms and conditions for staff employed by the NHS directly.[51] However, one contributor told us that some subsidiary companies are being brought back in-house and new ones not being created because trade unions have drawn attention to the problems these cause for many ethnic minority workers. One participant in our qualitative research felt that the differences in pay, terms and conditions between NHS and agency staff was fundamentally unfair:

> "So if it was only run by the NHS everyone would have the same bonus, equality, pay, sick leave. But it's run differently and the contract is different. Even though you are working doing the same job, it's still the payment and all the things – when you have a contract you have certain facilities, you get certain benefits. And for some people you are working in the same job but you are not getting the benefits. We are doing the same job but he is getting paid more, I'm getting less."

– Ethnic minority worker, England

Once for Scotland

The Once for Scotland[52] approach includes nationally agreed workforce policies for permanent, temporary and bank staff, which apply to all health services staff (except doctors and dentists).

The Scottish Government told us this ensures that staff working for outsourced services covered by Once for Scotland receive broadly the same terms and conditions of employment as workers employed by the NHS directly. We understand that a small number of outsourced workers are not covered for historical reasons, although it is unclear how many workers are affected.

[51] Dunhill, L. (2018), Exclusive: Thousands of NHS staff to transfer to subsidiary companies, Health Services Journal, 14 February [accessed April 2022].

[52] NHS Scotland (no date), 'Once for Scotland' workforce policies [accessed 13 August 2021].

Actions to improve working conditions in the NHS

We uncovered examples of outsourced NHS services being brought back in-house in England. We came across one trust that was bringing cleaning and catering back in-house to boost workforce equality and support staff from ethnic minority groups.

The Chief Executive of Epsom and St Helier University Hospitals Trust recognised the issues outsourcing was having on lower-paid ethnic minority workers:

> Some 40 percent of our cleaning, catering and portering staff are from Black, Asian and minority ethnic: communities already hit particularly hard by COVID-19. This is absolutely the right time to welcome these teams back to the NHS family, with all of the benefits that brings.[53]

[53] Clover, B. (2021), Hospital brings cleaning and catering in-house to 'support minority-ethnic communities'. Health Services Journal, 21 June [accessed 13 August 2021].

What we recommend

8. **The UK, Scottish and Welsh governments should** provide leadership to public bodies commissioning care services and ensure that guidance relating to the commissioning of public services is in place to:

   a. set out clear expectations for commissioners on the contractual obligations with regard to providing detailed and consistent workforce datasets for all contracts

   b. ensure more evidence-based, improvement-focused and transparent compliance with the PSED, and

   c. ensure that commissioning helps address the poorer outcomes faced by ethnic minority workers and there are checks in place for assessing compliance with such guidance.

9. **NHS health boards and trusts and local authorities in England, Scotland and Wales, as well as Integrated Care Systems in England and Integration Joint Boards in Scotland, should:**

   a. take ownership and accountability for PSED considerations when making decisions on commissioning and outsourcing that affect the workforce

   b. undertake and publish evidence-based Equality Impact Assessments which assess the impact commissioning and outsourcing decisions will have on groups with protected characteristics, including ethnic minority workers

   c. monitor contractors to ensure the required workforce data is provided

   d. develop a procurement strategy that is equality impact assessed, and which takes into account the equalities issues outlined in this report, and

   e. consider ways in which the existing procurement process and duties can be used to improve compliance with the PSED's general duty; for example, by considering how the equality issues outlined in this report can be incorporated into the principles of the **Social Value Model** in England and Wales, the procurement duty and **Social Impact policy in Scotland**, and tendering and contract management processes.

10. **The Welsh Government should:**

    a. ensure Regional Partnership Boards are listed bodies under part 2 of Schedule 19 of the Equality Act 2010 and therefore subject to obligations under the Equality Act 2010 (Statutory Duties)(Wales) Regulations 2011.

    b. work with the Social Care Fair Work Forum and other key stakeholders to review whether providers are offering guaranteed hours in social care (in accordance with Regulation 42 The Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017) and resolve any barriers to meeting those requirements

    c. use our inquiry findings and recommendations to advance fair work for lower-paid ethnic minority workers, including in relation to the proposed Social Partnership and Public Procurement (Wales) Bill, and

    d. take into account the experience of lower-paid ethnic minority workers in its pursuit of fair work and in its social partnership engagement, and use this inquiry and our **'Is Wales Fairer?'** report to inform its approach to improving and measuring outcomes.

11. **The Department for Business, Energy and Industrial Strategy should:**

    a. publish the outcome of its **2019 consultation on one-sided flexibility** as a matter of urgency

    b. introduce legislation as a matter of urgency to take forward the outstanding **recommendations from the Low Pay Commission**, and

    c. ensure there is a strategy in place to monitor and review the impact of the one-sided flexibility changes on workers, including by protected characteristic.

12. **The Scottish Government, Convention of Scottish Local Authorities (COSLA) and other key stakeholders in Scotland should:**

    a. publish a clear timetable for implementing the recommendations from the Fair Work Convention's social care inquiry in full, and give full consideration to the challenges faced by lower-paid ethnic minority workers raised in our inquiry findings, including workers' voices.

Low awareness of employment rights

Lower-paid ethnic minority workers in health and social care, particularly migrant workers, have a low awareness of their employment rights.

Barriers to understanding rights

Social care

We heard that the fragmented nature of social care, the large number of providers, as well as the use of zero-hours contracts and agency workers, made it more difficult for workers to be aware of their rights. This has a greater impact on ethnic minority workers who, as previously noted, are more likely to work in the independent care sector while being on zero-hours contracts.

Participants at a focus group in Wales described management as being remote and 'hands off'. This leaves many workers on their own to resolve issues, which restricts their ability to understand their rights.

During a focus group in Wales, social care workers told us they had a low awareness of when or whether they were able to take holidays and what (if any) holiday pay they were entitled to. We heard from workers and other contributors that those employed by agencies or on zero-hours contracts didn't understand whether they were entitled to statutory sick pay or how much they would be entitled to. There was a general view that they couldn't afford to take time off due to illness because either their income would stop completely or be reduced dramatically.

One contributor told us how it can be difficult for homecare workers to know if they are receiving the National Minimum Wage or if their travel time was paid for. Some employers provided payslips that didn't show details of how many hours had been worked. We recognise this as a long-standing issue.[54]

[54] See **Gardiner, L. (2015), The scale of minimum wage underpayment in social care. Resolution Foundation** [accessed April 2022], and **Albert, A (2021) 'Care workers more likely not to be paid minimum wage due to practices such as unclear payslips.' Home Care, 21 May** [accessed April 2022].

Healthcare

In the healthcare sector, outsourcing has also created a barrier to understanding employment rights. This was typically because neither NHS bodies nor contracted organisations were making sure workers knew their rights. In addition, lower-paid and ethnic minority workers lacked access to technology and other means of communication that might improve awareness of their rights. Some outsourced and agency workers told us they were unable to access information circulated by their employer (for example, because they were not given an official NHS email address).

Particular issues for migrant workers

Contributors told us of a number of issues that prevent migrant workers from understanding their rights. When information is available, it is not always accessible to migrant workers whose first language is not English. This may be because it has not been written in plain English or a translation is not available.

Improving awareness of rights in Wales

We heard how Welsh health boards are using a variety of tactics to improve workers' awareness of their rights, including:

- buddy systems
- staff networks
- closed social media groups
- staff apps
- WhatsApp groups
- improved communication strategies for reaching lower-paid workers without access to technology, and
- a more in-depth induction for bank staff.

Lack of trade union membership and reduction in advice agencies

Trade unions play an important role in making sure that the rights of workers are understood, respected and upheld. Research shows that unionised workplaces are fairer and safer than non-unionised workplaces.[55]

Workers' low awareness of their rights is worsened by the lack of unionisation in the social care sector. Contributors to this inquiry told us that because the social care sector is so fragmented, with so many different employers and high staff turnover rates, it is difficult to organise and represent social care workers. They told us that some employers simply don't want staff to be unionised or aware of their rights.

Some contributors and workers raised concerns about the effectiveness of unions in supporting ethnic minority workers. Some of the unions we spoke to recognise that they need to do more to support ethnic minority workers joining unions and make unions more representative of the workforce.

In addition to the lack of unionisation, contributors told us that the reduction in advice agencies in recent years across Britain (including law centres, **Citizen's Advice Bureaux** and race equality councils) makes it even more difficult for workers to confirm and challenge breaches of their employment rights.

Efforts to improve workers' rights

Partnerships

In Scotland, the Scottish Government, NHS employers, trade unions and professional organisations work in partnership to reach agreements on issues affecting the workforce. In Wales, partnerships between employers and trade unions is strong and similar arrangements are emerging in England in response to the COVID-19 pandemic. The Welsh Government has also published the Social Partnership and Public Procurement (Wales) Bill which would introduce new social partnerships and socially responsible public procurement duties, if passed.

Single Enforcement Body

The UK Government announced a Single Enforcement Body for employment rights which includes powers to inspect and enforce rights and a focus on vulnerable workers. This has been welcomed widely.[56] Our findings highlight the potentially positive role such a body could play in improving the treatment and experiences of workers. However, the lack of a legislative timetable for this creates uncertainty.

[55] **OECD (2018), Good Jobs for All in a Changing World of Work: The OECD Jobs Strategy. Paris: OECD Publishing** [accessed April 2022].

[56] See **Citizens Advice (2020), On the Edge, Insecure work in the pandemic** [accessed April 2022] and **Bell, T. Cominetti, N. and Slaughter, H. (2020), A new settlement for the low paid: Beyond the minimum wage to dignity and respect. London: Resolution Foundation** [accessed April 2022].

Other actions in Wales

The Welsh Government is taking steps to address low awareness of employment rights with the roll out of an Employee Assistance Programme (EAP) for the adult social care sector. It also introduced a pilot **BAME helpline for Wales** in October 2020 with one of its aims being to provide specialist employment advice. **The Welsh Government has committed to establishing an equalities legal service** to provide support on unfair and discriminatory employment practices.

The **Acas helpline** (available in English and Welsh) also provides advice on how to deal with workplace issues.

What we recommend

13. **The Department for Business, Energy and Industrial Strategy should:**

    a. set out a legislative timetable for introducing a Single Enforcement Body and ensure it is sufficiently resourced to meaningfully monitor and enforce compliance with employment rights, and

    b. legislate to ensure that access to information on workers' rights, including where to go if they want to raise a concern, is detailed in the statement of particulars provided under Section 1 of the Employment Rights Act 1996. Information on rights should be consolidated in an accessible format to which employers can direct their employees.

14. **The Single Enforcement Body should:**

    a. use the PSED to prioritise the development of a strategy for ensuring that lower-paid workers have better access to information about the employment rights afforded to their employment status and know where to go if they have a complaint or need to access redress

    b. include a specific focus on the needs of migrant workers, ensuring that they have early access to accessible information on their employment rights

c. encourage employers to understand and comply with employment rights by working with businesses, trade unions and industry bodies to increase awareness of employer obligations, and

d. undertake targeted enforcement action to address the most serious breaches of employment law relevant to its remit.

15. In the absence of a Single Enforcement Body, **HM Revenue and Customs National Minimum Wage Enforcement, the Gangmasters and Labour Abuse Authority, and the Employment Agency Standards Inspectorate should:**

    a. be responsible for putting the above strategies in place (overseen by the Director of Labour Market Enforcement) to ensure public bodies comply with the PSED.

16. **The UK, Scottish and Welsh governments should:**

    a. convene national working groups (or use existing ones), comprised of sector representatives, the Equality and Human Rights Commission, Acas, labour market enforcement bodies, employer bodies and relevant trade unions, to collaborate on promoting awareness of employment rights in the health and social care workforce as part of strengthening compliance with the PSED

    b. (in collaborating with these different groups) focus on raising awareness of employment rights among lower-paid ethnic minority and migrant workers, and

    c. conduct a review of the availability of accessible services that provide specialised support and advice on unfair and discriminatory employment practices, with a view to improving these services; ensure that such services are focused specifically on supporting lower-paid ethnic minority workers and migrant workers.

Fear of raising concerns and a lack of workers' voice

Lower-paid ethnic minority workers are fearful of raising concerns in health and social care workplaces. There are limited opportunities for them to have their voices heard in the workplace, particularly in social care.

There are several reasons why workers are afraid to raise concerns, but the fear of job loss was considered a primary one. This was a particular issue for workers with insecure roles and zero-hours contracts.

We were also told that workers who did raise concerns were sometimes victimised afterwards. For example, they were passed over for promotion or denied access to the same opportunities as other colleagues, had their shifts cut or had to change shifts to avoid victimisation. This led to them feeling very hesitant to speak out.

The **Freedom to Speak Up review from 2015** was set up to provide advice and recommendations to ensure NHS staff in England were able to raise concerns. It identified that ethnic minority staff were more likely to report fear of victimisation as a reason for never having raised a concern (24.1% compared with 13.8% of White respondents).

For migrant workers there is an additional fear of causing problems for their financial situation or visa status, which can be dependent on employers (particularly where workers provide live-in care). This makes them more hesitant to raise issues, particularly during the COVID-19 pandemic when they had concerns for their safety.[57]

We heard that workers were reluctant to challenge unsafe conditions during the pandemic because they thought they might be labelled a troublemaker or perceived as 'playing the race card'. Contributors giving evidence used language such as 'don't rock the boat'[58] and 'suffer in silence'. This leaves workers vulnerable to some employers who might take advantage of their reluctance to refuse work, for fear of having their hours cut or being dismissed. For example, social care sector workers could be told to take on additional roles, such as shopping, cleaning and cooking in addition to their caring roles.

[57] Henry, L., Linton, K., Carter, N., and Moore, S. (2022), Low-paid workers in health and social care during COVID-19. Manchester: Equality and Human Rights Commission.

[58] Ibid.

Lack of influence at work and low confidence in systems

The fear that ethnic minority workers experienced in raising concerns was part of a bigger picture around a lack of voice and influence in the workplace. Our inquiry found that there are limited opportunities for lower-paid ethnic minority workers to have their voices heard in the workplace, resulting in their experiences, their needs and potential solutions to improve situations not being heard or actioned.

Our evidence shows that workers weren't confident that the systems in the workplace would allow them to be heard, protected and have their rights upheld. In Wales, the First Minister's 'Black, Asian and Minority Ethnic COVID-19 socioeconomic subgroup', established in 2020, also suggested that lack of trust in the system was a key reason for few workers using existing manager support channels.

We heard that lack of confidence often comes from previous bad experiences of how their or others' concerns had been dealt with. Evidence from our qualitative research showed that, even where concerns had been raised, the appropriate action was not always taken. Sometimes, no action was taken at all and the concern was ignored. Several participants in our qualitative research from Wales raised this point. They felt the managers listened and appeased them at the time of the complaint but no action followed. This discouraged them from making any further requests.

Efforts to help workers be heard in the NHS

Staff survey

Compared to social care, in the healthcare sector there are more opportunities for workers to raise their concerns (although barriers still exist). Across Britain, the NHS staff survey is one of the main ways for the NHS to hear from staff and find out how they are being treated. Survey results are analysed by protected characteristic group in England and Wales. As mentioned earlier, NHS Scotland captured ethnicity data on the staff survey for the first time in 2020, but this was not available at the time of writing.

However, surveys have limitations. Lack of access to technology and language barriers can make it difficult to engage lower-paid workers, especially if the survey uses jargon without providing definitions. The NHS Wales and England surveys do not provide definitions or examples of harassment and discrimination (racial or otherwise). Some workers may not understand whether their experiences fall into these categories.

Outsourced workers are not included in the survey, meaning their experiences go unheard, nor are their experiences taken into account when considering the treatment and experiences of the workforce. One contributor told us that there is some consideration happening for this group of workers to be included in future NHS England surveys.

Staff networks and forums

We heard that NHS organisations across Britain have new initiatives to support ethnic minority workers to have their voices heard. This includes creating a respectful environment to raise concerns in response to the COVID-19 pandemic.

Research shows that staff networks and forums can potentially improve workplace culture in the NHS.[59] Ethnic minority staff support networks play a key role in the NHS. Organisations that already had networks and groups in place have received increased interest or attendance and other organisations have been prompted to create similar groups. They are seen generally as useful by those who are able to attend – though they need to be suitably resourced and staff should be actively supported to attend.

The Scottish Government plans to support the establishment of ethnic minority staff networks in all health boards to feed into a National Race Equality Forum that will be able to react to feedback on the experience of ethnic minority workers. It is also linking up smaller health boards with larger ones so that ethnic minority workers have access to support.

Freedom to Speak Up Guardians in England

Freedom to Speak Up Guardians were introduced to NHS trusts in England in 2016 to proactively identify and tackle barriers to speaking up and raising concerns, and act as a confidential channel for workers to have their voices heard. We heard that the success of the Freedom to Speak up Guardians differs between organisations and they were not always viewed by workers as being effective.

The **National Guardians Office** told us how they are working to improve the network of Speak Up Guardians and help remove barriers to speaking out. This includes recently published research on workers' experiences of accessing their Freedom to Speak Up Guardian and the impact of ethnicity on speaking up.[60] The research includes the National Guardians Office's next steps for action in this area.

Support and advice in Wales

In Wales, we heard how one trust was working with other public sector bodies to help ethnic minority workers to access support. The Welsh Government also introduced a pilot **BAME helpline for Wales** in response to the pandemic and called for more help for ethnic minority workers to access advice and support.

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[59] **Ross, S., Jabbal, J., Chauhan, K., Maguire, D., Randhawa, M. and Dahir, S. (2020), Workforce race inequalities and inclusion in NHS providers. London: The King's Fund** [accessed April 2022].

[60] **Kline, R. and Somra, G. (2021), Difference Matters: the impact of ethnicity on speaking up. London: National Guardian's Office** [acessed April 2022].

Whistleblowing in Scotland

We heard that the Scottish Government has introduced the Independent National Whistleblowing Officer for NHS workers (and members of the public), which came into force in April 2021.[61] This is the final stage of the process for workers to raise whistleblowing concerns about the NHS in Scotland. This service does not extend to social care.

Less support available in the social care sector

There is no equivalent NHS annual staff survey for the social care workforce. One contributor stated that some providers do survey staff but that the results aren't published. Social Care Wales are running a pilot staff survey with the intention of rolling it out across the whole of the workforce in Wales.

We heard of few formal staff support networks in social care (except in local authorities). Instead, many workers rely on families and friends, and informal, often community-based groups and social networks. Informal networks were particularly important for migrant workers who may not have family members around them. In England, the UK Government plans to introduce Freedom to Speak Up Guardians to enable workers to raise concerns with employers about quality of care, staff wellbeing and working conditions. At time of writing, it remains to be seen how these will operate in practice.

What we recommend

17. **NHS organisations and local authorities across Britain, as well as Integrated Care Systems in England, should:**

    a. ensure leaders in these organisations address organisational cultures and develop a culture where concerns can be raised freely and there is confidence that appropriate action will follow; leaders should model behaviours they expect of others and make diversity and inclusion a priority

    b. work with trade unions and employer bodies to ensure that there are a range of accessible ways for lower-paid workers (including outsourced and commissioned-out workers) to share feedback and concerns as well as ask questions; these could include taking forward proposals for Speak Up initiatives where these are not already in place, access to trade unions, workplace surveys and staff networks (which should be funded and staff supported to join), and

    c. ensure that mechanisms are designed to address barriers that prevent lower-paid ethnic minority workers and migrant workers from speaking up, and that they are equally accessible to all groups, irrespective of sex, disability or any other protected characteristic.

[61] Independent National Whistleblowing Officer (2021), How can I raise a whistleblowing concern? [accessed 13 August 2021].

18. **The Social Care Fair Work Forum in Wales should:**

    a. consider our inquiry recommendations, including on how lower-paid and ethnic minority workers and migrant workers' voices are heard, in its deliberations on improving pay and conditions in social care.

19. **The Scottish Government, in establishing the National Care Service, should:**

    a. review extending the role of the new Scottish Public Services Ombudsman's Independent National Whistleblowing Officer (INWO) to cover adult social care, as well as the NHS, in the context of the interrelationship between the INWO, Care Inspectorate and the Scottish Social Services Council.

20. **UK, Scottish and Welsh governments should:**

    a. work collaboratively with the health and social care sectors, regulators and relevant bodies to mandate training for all managers and individuals required to handle workforce complaints to ensure that they are able to respond appropriately

    b. include specific training on handling concerns and complaints relating to bullying and harassment on the grounds of race, and

    c. ensure that such training is supported by workplace policies on handling grievances and compliant complaint procedures which support workers to hold managers to account for non-compliance.

Conclusion

Our report highlights the very challenging circumstances faced by lower-paid ethnic minority workers in health and social care. We found that many ethnic minority staff, especially those in commissioned-out and outsourced roles, were unaware of their rights and fearful of raising concerns with managers. The focus of our inquiry was on ethnic minority staff but it is reasonable to assume some of these issues affect the lower-paid health and social care workforce as a whole.

While identifying some key differences in England, Scotland and Wales, our qualitative research also found evidence of race-related bullying, harassment and abuse of ethnic minority staff. In some cases this was clear and obvious, such as patients using racial insults. Of more widespread concern was the sense that ethnic minority staff were being disadvantaged in the workplace by prejudice and bias on the part of managers and colleagues. This perception of unfairness is damaging to any working environment. Quantitative data showing unequal outcomes in pay and promotion supports these concerns.

This report has highlighted that workers often were afraid to raise their concerns and unaware of their rights. A lack of representation in senior roles, poor access to training opportunities, higher numbers of zero-hours contracts and over-representation in disciplinary processes for lower-paid ethnic minority workers all point to a persistent problem. Our review of existing evidence identified numerous ethnic inequalities in health and social care work outcomes.[62]

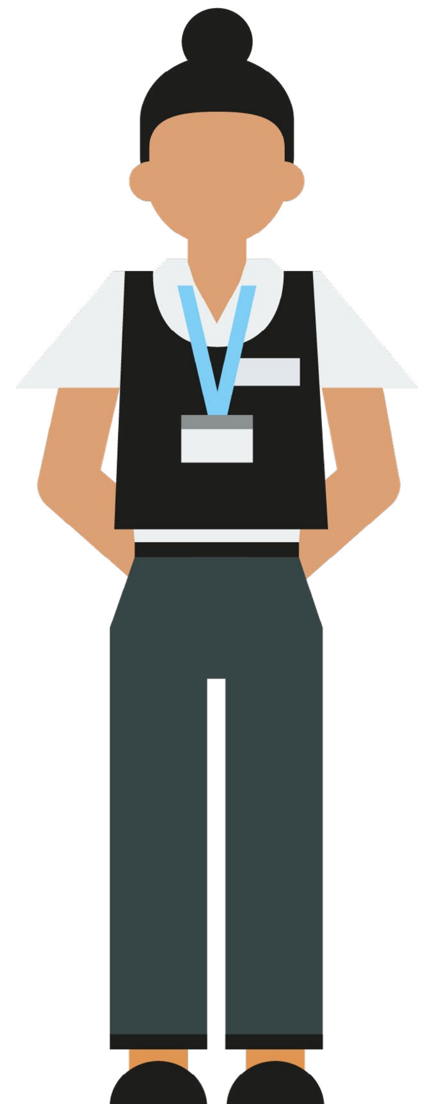
Racial inequalities are complex and linked with broader social determinants. These broader societal drivers were outside the scope of our inquiry. Our primary concern is that bad practice perpetuates racial inequalities for workers in health and social care. In this context, many employers risk breaching equality legislation, and our regulatory priority is to ensure that racial discrimination does not occur in any workplace. Clearly, in the health and social care sectors there is much room for improvement.

[62] Hussein S., (2022), Low-paid ethnic minority workers in health and social care during COVID-19: A rapid review. Manchester: Equality and Human Rights Commission.

Although our review of existing research acknowledged that there has been some progress in developing policies specific to employment race equalities in Britain, it concluded that these national-level policies sometimes don't lead to equality in the workplace.[63] Commissioning and outsourcing further detaches workers from support structures and access to information, and leads to a lack of accountability for the workforce.

We want to see greater consideration of the PSED and a subsequent positive impact on lower-paid ethnic minority workers. Data regarding the workforce and their experiences is important in meeting both the requirements of the PSED and the needs of workers. However, we found serious data gaps, particularly in the social care sector. The fragmented nature of social care and the lack of opportunities to raise concerns effectively silences part of the social care workforce, putting lower-paid ethnic minority workers at a particular disadvantage.

We have made recommendations that are directed at governments and other bodies in a position to take the most relevant action. Urgent action is needed to recognise and address the poor workplace situations experienced by these crucial workers. At a time when governments across Britain are actively prioritising significant reform of health and social care, and given the concerns being raised around the sustainability of the workforces in light of the COVID-19 pandemic, now is the time for action.



[63] Ibid.

Appendix

How we carried out this inquiry

This report uses a wide range of evidence gathered between December 2020 and May 2021, including:

- interviews and desk-based research
- an online call for evidence
- qualitative and quantitative research, and
- a rapid review of existing evidence on the work experiences and outcomes of ethnic minority workers in health and social care; this looked at 51 publications relevant to our inquiry.

We looked at evidence dating back to 1 January 2017 and, exceptionally, important evidence collated before then.

We analysed the workforce data available to us, including unpublished data that we requested. For our qualitative evidence, we sampled in sufficient numbers and geographic coverage to enable common themes to come through.

We also received advice from an Expert Advisory Panel, with members representing race organisations, charitable bodies, trade unions and academics.

We conducted a thematic analysis of the experiences, perceptions and opinions of research participants and combined this with statistical data where possible (for example, relating to pay, training and disciplinary processes). We also cross-checked this evidence with the responses to our calls for evidence, interviews and meetings with relevant organisations and a review of the available literature.

In our call for evidence and qualitative research, we wanted to hear directly from workers who had worked in health or social care between 1 January 2019 and 31 March 2021. We included time before the pandemic deliberately to try and understand whether treatment and experience differed or was similar.

Interviews and desk-based research

We conducted 59 in-depth qualitative interviews with relevant stakeholders (25 in England, 15 in Scotland and 19 in Wales). We held more than 30 informal meetings with relevant organisations to discuss our findings and recommendations.

We spoke to race equality organisations, charities, inspectorates, trade unions, employer bodies, and health and social care organisations (including care provider organisations). We engaged directly with a range of government departments and arm's-length bodies. We refer to these organisations collectively as 'contributors' throughout this report.

Our inquiry also uses published research, official statistics and policy documents.

Online call for evidence

We invited ethnic minority people working in lower-paid jobs in health and social care to tell us about their workplace experiences. In addition, we invited responses from health and social care workers, irrespective of their race, who had witnessed workplace incidents relating to the treatment of lower-paid ethnic minority workers (for example, bullying or harassment of ethnic minority colleagues). The purpose of including these workers was to ensure that we did not exclude the perspectives of staff who could provide useful workplace intelligence or information. Such staff would include, for example, those on higher pay grades and / or those who were not from an ethnic minority. We carefully assessed each submission to check its content was relevant to our terms of reference, before including it in our analysis. We also invited responses from organisations and providers.

We received 53 responses from ethnic minority workers, 23 from staff that had witnessed workplace incidents, and 15 from organisations and providers that were in the scope of our inquiry. All details have been anonymised in this report.

Qualitative research

We commissioned qualitative research to understand workers' experiences. The research involved: four case studies made from interviews with 40 ethnic minority workers and four White British workers in England, Scotland and Wales; and five focus groups with 20 ethnic minority and two White British workers. Participants included NHS healthcare assistants, porters and security workers, and residential, home and personal care workers employed across the public, private and third sectors.

We also commissioned three organisations to carry out country-specific interviews and focus groups with ethnic minority workers. This was particularly important for Scotland and Wales where there is less workforce data available. There were 33 ethnic minority workers who participated:

- 9 NHS workers in England
- 13 health and social care workers in Wales, and
- 11 workers in Scotland (mainly from social care).

To deploy our resources most efficiently we consulted umbrella bodies and representative groups rather than service commissioners and frontline health and care providers, of which there is a large number. We relied on these organisations to represent the priorities of their members accurately, and recognised that these too will vary from one organisation to another.

Our qualitative research and call for evidence for this inquiry draw on the experiences of various ethnic minority groups and individuals. The limitations with data meant that we were generally unable to differentiate between the treatment and experience of different ethnic minority groups, and we have deliberately avoided making direct comparisons between them. Where inquiry participants have reported differences in treatment between ethnic minority and White staff, we have reported this faithfully (without specifying a White group in particular, unless stated by the participant).

Quantitative research

We sought and analysed available workforce data in both the health and social care sectors. This included commissioning new, statistical analysis of existing quantitative datasets to extract what information we could about the employment outcomes and experiences of health and social care staff.

We commissioned quantitative analysis of NHS and social care workforce data across England, Scotland and Wales including:

- Skills for Care workforce data – a voluntary return by social care providers in England
- NHS England workforce data – analysing the distribution of NHS staff across pay bands by protected characteristic
- NHS England and Wales staff surveys – exploring differential treatment of ethnic minority staff in their responses (the NHS Scotland staff survey did not have the relevant data publicly available), and
- Labour Force Survey data – analysing employment composition, average hours worked, part-time status, permanent and temporary jobs by age, sex, disability, religion and race.

Our definition of ethnic minority

The Office for National Statistics states that ethnicity can include country of birth, nationality, language, skin colour, national / geographical origin and religion. Membership of an ethnic group is complex and multifaceted.[64]

In this report, the term ‘ethnic minority’ refers to: mixed or multiple ethnic groups, Asian or Asian-British groups, Black or African or Caribbean or Black-British groups, and White ethnic minority groups (sometimes referred to as White Other). White ethnic minority groups included in this category are Gypsy or Irish Travellers, Scottish Gypsy / Travellers and White people from any country outside the UK and Ireland, including European countries. It does not include the following White ethnic groups: English, Welsh, Scottish, Northern Irish, Irish or British.

[64] **Office for National Statistics (no date), Ethnic group, national identity and religion: Measuring equality: A guide for the collection and classification of ethnic group, national identity and religion data in the UK** [accessed April 2022].

We included White Other groups in our inquiry because the Equality Act 2010 states that 'race' can mean your colour, nationality and ethnic or national origins. It is worth noting that European migrants represent a large proportion of the health and social care workforce across Britain. We considered it important to include their experiences in our inquiry.

In the 2011 census, 4.7% of England's population were from White Other ethnic groups, rising to 12.7% in London. It was 1.9% in Wales and 3.2% in Scotland. The following tables contain 2011 Census data on the ethnicity and country of birth of the populations of England, Scotland and Wales.

2011 Census data on ethnicity and country of birth

Ethnicity of the population according to Census 2011			
	England	**Scotland**	**Wales**
All usual (permanent) residents	53,012,456 (100%)	5,295,403 (100%)	3,063,456 (100%)
White (English / Welsh / Scottish / Northern Irish / British / Irish)	42,796,237 (80.7%)	4,916,877 (92.9%)	2,869,536 (93.7%)
Other White	2,484,905 (4.7%)	167,530 (3.2%)	58,717 (1.9%)
Mixed / multiple ethnic groups	1,192,879 (2.3%)	19,815 (0.4%)	31,521 (1%)
Asian / Asian British	4,143,403 (7.8%)	140,678[65] (2.7%)	70,128 (2.3%)
Black / African / Caribbean / Black British	1,846,614 (3.5%)	36,178[66] (0.7%)	18,276 (0.6%)
Other ethnic group	548,418 (1%)	14,325 (0.3%)	15,278 (0.5%)

Data for England and Wales sourced from **Nomis official labour market statistics (2011), Ethnic group table KS201EW**; data for Scotland sourced from **Scotland's Census (2011), Ethnic Group table KS201SC**.

[65] Includes Asian Scottish.

[66] Includes Black Scottish, African Scottish and Caribbean Scottish.

Population's country of birth according to Census 2011			
	England	**Scotland**	**Wales**
All usual (permanent) residents	53,012,456 (100%)	5,295,403 (100%)	3,063,456 (100%)
United Kingdom	45,675,317 (86.2%)	4,926,119 (93%)	2,895,585 (94.5%)
Channel Islands and Isle of Man	24,653 (<0.1%)	1,662 (<0.1%)	1,398 (<0.1%)
Ireland	395,182 (0.7%)	22,952 (0.4%)	12,175 (0.4%)
Other Europe	2,255,168 (4.3%)	147,629 (2.8%)	59,879 (2%)
Africa	1,290,611 (2.4%)	46,742 (0.9%)	22,006 (0.7%)
Middle East and Asia	2,529,137 (4.8%)	104,530 (2%)	57,929 (1.9%)
The Americas and the Caribbean	663,091 (1.3%)	33,353 (0.6%)	10,310 (0.3%)
Antarctica and Oceania	179,200 (0.3%)	33,353 (0.6%)	10,310 (0.3%)
Other	97 (<0.1)	8 (<0.1%)	1 (<0.1%)

Data for England, Wales and Scotland sourced from **Nomis official labour market statistics (2011), Country of birth table QS203UK**.

Contacts

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