The impact of COVID-19 on people from BAME groups

A summary of recent reviews and evidence

Introduction

Over the past two months, the disproportionate impact of COVID-19 on black, Asian and minority ethnic (BAME) people has become increasingly clear. Evidence showing higher prevalence of the virus and significantly worse health outcomes for BAME groups is a major concern for the NHS, and trusts as they seek to protect both staff and patients.

This briefing summarises the most significant data now available and the key sources of information trusts may use to support their actions in response. It includes an overview of *Covid-19: review of disparities in risk and outcomes* published yesterday by Public Health England (PHE), evidence from the Office for National Statistics (ONS), NHS Employers updated risk assessment guidance, and work in this area undertaken by trade unions and other professional bodies. It also highlights some of the actions trusts have already taken to engage with and improve working conditions for BAME staff during the pandemic.

Key points

- COVID-19 has had a disproportionately high impact on BAME people and communities. Data from the ONS indicates those from BAME groups are several times more likely to die from the disease than those from white ethnicities. Other early analysis also points towards BAME health and care staff being at greater risk of dying.
- PHE's rapid review into disparities in the risk and outcomes of COVID-19 contains similar findings to the earlier ONS analysis, with additional information on excess deaths of BAME groups supporting the view that certain groups are at higher risk.
- Recent guidance from national bodies, including the risk assessment guidance from NHS Employers and the risk reduction framework from the Faculty of Occupational Medicine have been welcomed by trust leaders following calls for comprehensive, evidence-based responses to the challenge felt across the NHS. Additional material from royal colleges and unions contains further advice for specific settings and staff groups to minimise risk.
- Staff safety is of paramount importance to all trusts. Trusts have been actively working to address these issues at a local level and in collaboration with others, and continue to seek best practice to protect and support their staff, patients and communities through the pandemic.

Outline of existing evidence

Impact of COVID-19 on BAME patients and communities

In early May, the ONS released provisional analysis into COVID-19 deaths by ethnic group. The headline finding was that the risk of death by COVID-19 for some ethnic groups was significantly higher than for those of white ethnicity. In particular, those of black ethnicity were more than four times as likely to die from COVID-19 than those of white ethnicity, while those of Bangladeshi and Pakistani, Indian, and mixed ethnicities also had a statistically significant raised risk of death involving COVID-19. Age and other socio-demographic characteristics were also considered based on the 2011 census. This analysis concludes that the difference between ethnic groups in COVID-19 mortality is partly a result of socio-economic disadvantage and other circumstances, but that the remaining part of the difference remains unexplained.

An analysis report within the Institute for Fiscal Studies' Deaton Review of Inequalities, also released in May, considers additional characteristics to better understand ethnic disproportionalities in health outcomes. Their findings suggested that the factors underpinning the risk of infection and economic vulnerability were more elevated for BAME groups. Occupational exposure and prevalence of at-risk underlying health conditions were found by this study to partially explain the disproportionate mortality for some groups. Many people from ethnic minorities are more economically vulnerable to the current crisis than white ethnic groups, which the report notes will place them at greater risk of negative health outcomes.

Subsequent analysis by the health think tanks and others expanding on the ONS data reaches similar conclusions. It is noted that while people from BAME groups are likely to have higher levels of exposure to the virus, the actual risk for various groups of contracting COVID-19 will only be understood once the results of larger infection and antibody studies are published.

Impact of COVID-19 on BAME NHS and care staff

Work to investigate the impact of COVID-19 on BAME NHS and care staff is ongoing, but initial analysis points towards a significantly elevated risk of death for these groups. Looking at all staff employed by the NHS, those from BAME groups account for approximately 21% of the overall workforce, and within this approximately 20% of nursing and support staff and 44% of medical staff are from BAME groups. However, analysis by Tim Cook et. al, suggests that BAME individuals account for 63% of all NHS staff deaths from COVID-19, including 64% of deaths of nursing and support staff and 95% of deaths of medical staff.

The British Association of Physicians of Indian Origin has been vocal in raising these issues with NHSE/I, highlighting the risk factors to their members and calling for proper protection and testing to be prioritised by all employers, including stratified risk assessments for those on the frontline. The Royal College of Nursing has surveyed its members in relation to access to PPE, with a much smaller proportion of those from BAME groups reporting they had adequate protection, compared to those from white ethnicities.

Public Health England review, 2 June 2020

On 2 June, Public Health England (PHE) published its report, *Disparities in the risk and outcomes of COVID-19*, commissioned by the Secretary of State for Health and Social Care as a rapid review in response to the emerging evidence set out above. This review offers a broader analysis of the factors impacting the risk of a poor outcome within the pandemic including age, geography, deprivation, occupation, residence (with a focus on care homes), alongside ethnicity.

The review shows similar findings on the risk of death to the ONS figures, with black men almost four times more likely to die; black women over three times more likely to die; and Asian men and women also more than twice as likely to die than the average person carrying COVID-19. In previous years, "all cause mortality" rates have been lower in BAME groups than for those of white ethnicity, but this has been reversed as a result of the pandemic.

It should be noted that the analysis draws on the testing data, which at the time of the study was mainly offered in hospitals to those with medical need – so those in other settings in the community will be under-represented. Excess mortality is modelled for the period 20 March to 7 May, to compare with the expected number of deaths by ethnic group against corresponding dates in 2014 to 2018. Deaths in BAME groups were shown to be between 2.4-3.9 times higher than expected in this period, while deaths of those of white ethnicity were 1.6-1.7 times higher.

The review also includes an analysis on prevalence of the disease in different communities, with black men and women respectively approximately three times and twice as likely to be diagnosed than white men and women, and Asian men and women slightly more likely than white men and women to be confirmed positive for COVID-19. PHE included information on hospitalisation rates (which the review notes to treat with caution), in which BAME people with COVID-19 are not found to have been disproportionately admitted. However, BAME people carrying the virus are more likely to have been admitted to intensive care units (ICU), with a particularly high rate for Asian men and women.

The review's authors note the limitations of their work, particularly the fact that their findings do not account for occupation or comorbidities in terms of the impact on different ethnic groups. They acknowledge that the relationship between ethnicity and health is complex, and involves a combination of factors which have a net result in some people within BAME communities being at increased risk of acquiring the infection. The review points out that BAME people are more likely to live in urban areas, in overcrowded households, in deprived areas, and have jobs that expose them to higher risk. Additionally, individuals from BAME groups are more likely than those of white British ethnicity to be born abroad, which means they may face additional barriers to accessing services created by cultural and language differences.

In relation to NHS staff deaths, the review contains little new data, with the earlier work of Cook et. al (summarised above) referenced to evidence a disproportionately high number of BAME staff among those who have died.

The review does not include a particular focus on what these findings mean for the NHS or make recommendations for policy reform in response. Media commentators have reflected on the removal of evidence from the stakeholder and community engagement process that supplied evidence to the review, including on wider health inequalities. Following publication on 2 June, Matt Hancock announced that the equalities minister Kemi Badenoch "will be leading on this work and taking it forward, working with [PHE] and others to further understand the impact."

Latest national guidance

Since evidence of the disproportionate impact of COVID-19 on BAME staff first began to emerge, national NHS bodies and trusts at a local level have sought to find the best way to respond. As organisations which collectively employ over 1.2 million staff – including a significant number of BAME people – trust boards have been concerned from the outset about the increased risk of harm faced by their BAME colleagues both in and outside of their working environments.

While more complete evidence is obtained, trusts want a clear steer from the centre to support the process of identifying and managing the increased risk from COVID-19 for BAME staff. Below, we summarise the current guidance available.

NHS Employers guidance on risk assessments

Last week, NHS Employers published risk assessment guidance commissioned by the government in response to this challenge. The guidance updates a previous iteration released at the end of April, with the new version providing consideration of factors affecting risk, and usefully including suggested methods to mitigate risk, and advice to support sensitive and difficult conversations with staff.

This updated resource on risk assessment - developed with the support of feedback from the sector – is generally seen by trusts as a useful tool to support local conversations and action plans to respond to the concerns and increased risk of BAME staff. In particular, trusts may consider incorporating some or all of the ten "outputs and actions" (see below) as risk mitigation techniques, and should review the material provided to support conversations between line managers and members of staff reporting to them on their health and wellbeing and feelings of risk during the pandemic.

Adjustments to limit staff risk and exposure to COVID-19 – NHS Employers guidance

1. Limiting duration of close interaction with the patient (for example, preparing everything in advance away from them).
2. If possible, maintaining a two-metre distance from the patient.
3. Avoiding public transport/rush hour through adjustments to work hours.

4. Asking patients to wear a mask for staff member interaction.
5. Asking that only the patient is in attendance for home visits/outreach where possible.
6. Providing surgical mask for staff members for all interactions with patients or specimens.
7. Redeploying staff to a lower risk area.
8. Advising staff to leave the area for 20 minutes when AGP is undertaken on suspected/ confirmed COVID-19 patient.
9. Encouraging remote working.
10. Varying working patterns.

The identification of greater risk for large groups of staff poses a significant challenge for trusts, as they seek to protect their workforce and the quality of patient care during the pandemic simultaneously. While there has been some discussion in the media about the potential for automatic mass re-deployment of BAME staff away from patient-facing activity, the new guidance provides a steer for individual organisations to approach these challenges in a manner which responds directly to identified risk within their organisation and, crucially, the expressed wishes and feelings of their BAME staff.

Faculty of Occupational Medicine framework

In late April, the Faculty of Occupational Medicine (FOM) published a *Risk Reduction Framework for NHS Staff at risk of COVID-19 infection*. This document was drawn up by an independent collaboration of primary and specialist care clinicians, members of equality and inclusion committees, NHS leadership, public health specialists, occupational health specialists, trust leads and researchers.

The FOM framework provides some data on the impact of COVID-19 on high risk groups, and separates risk reduction into "workplace assessment" and "workforce assessment" categories. A risk assessment tool included in the document "may help employers to supplement risk assessment of their staff, particularly of high risk and vulnerable groups to ensure staff safety." The FOM document emphasises that responses to increased risk among vulnerable groups should "consider all aspects including the workforce, workplace and the individual." It adds, "there is a need for supportive conversations between staff and managers which take into account staff concerns and preferences allowing effective decision making about deployment."

Royal College of Psychiatrists – guidance on risk mitigation for BAME staff in mental healthcare settings

In early May, the Royal College of Psychiatrists (RCPsych) produced initial guidance on how risk can be mitigated for BAME staff in mental health care organisations across the UK – both in the NHS and the independent sector. Many of the practical recommendations can be extrapolated across to other

health care settings. The intention is for this guidance to be updated as further information is published.

The guidance makes suggestions of steps which can be taken by organisations to assess and mitigate risk, including a call to undertake risk assessments for all BAME staff. Further suggestions come under seven categories which the college says comprise a healthy organisational response to COVID-19 and inequality: staff wellbeing and support; inclusive leadership; PPE and infection prevention and control care champions; quality improvement; support for line managers; data; and board level accountability. A risk assessment tool is also included in the document.

Joint request from NHS trade unions – blueprint for return to work

In mid-May, 16 NHS trade unions and professional colleges published a request for UK governments and employers to work with the co-signed unions to deliver their 'Blueprint for Return', containing 9 asks to ensure safety for staff in the resumption of paused services.

The blueprint focuses on: provision of PPE and safety of communal staff areas; risk assessments for all staff; unlimited testing for staff and patients; extending COVID-19 pay arrangements, to ensure payment for all overtime worked; ensuring work/life balance; establishing safe staffing levels; support for those affected by COVID-19; facilitation and support of staff access to childcare; and reflecting NHS staff work during the outbreak in future pay uplifts.

The unions are expected to publish full joint staff-side guidance on risk assessments in June.

British Medical Association – guidance on risk to BAME doctors

The British Medical Association (BMA) has compiled guidance on the risks which COVID-19 poses to BAME doctors.

The guidance suggests that trusts provide comprehensive risk assessments for all staff; prioritise high risk staff for testing and antibody testing and vaccine if/when available; develop a culture where all staff feel empowered to speak out; tackle any real or perceived discrimination that may occur in the workplace; assess why BAME staff are under-represented in senior roles within the NHS, and improve equality and diversity in these roles; and consider hiring a BAME co-leader.

The guidance also references the BMA's member surveys – in particular, the results showing that BAME respondents were almost twice as likely to lack the confidence to raise concerns than white respondents, and that 64% of BAME respondents reported feeling pressured to work in settings with inadequate PPE (as opposed to 33% of white respondents).

How trusts are responding

In response, many trusts have been proactively working to address these issues on a local level and in collaboration with others. NHS Providers would be happy to help facilitate conversations between members keen to find out more about the examples below, and to share further case studies:

- Leicester Partnership NHS Trust, Northamptonshire Healthcare NHS Foundation Trust and Sussex Partnership NHS Foundation Trust have worked together to share information and expertise to support colleagues from BAME backgrounds. The collaboration has focused on developing a shared data set to inform the approach to risk assessment across the three trusts, and to inform a set of shared outcomes to support BAME staff. Similar principles were initiated in an East London trust, with a data collection exercise carried out to inform a second round of risk assessments.

- Derbyshire Community Health Services NHS Foundation Trust have had a BAME risk assessment process in place since April which they have shared with primary care and local authority colleagues, and this has been identified as a case study of good practice by NHS England.

- The work at Guys and St Thomas' NHS Foundation Trust and Norfolk and Norwich University Hospitals NHS Foundation Trust to develop risk assessment matrixes, guidance for line managers, occupational health advice for staff and staff FAQs was noted in the NHS Employers risk assessment guidance.

- Surrey and Sussex Healthcare NHS Trust's work to ensure all staff felt safe and were using PPE appropriately was highlighted in a recent NHS England briefing. Also featured in this briefing was a collaboration between primary and secondary care in North West London to provide a COVID-19 'hot hub' patient assessment centre and key worker testing services.

- The West Yorkshire and Harrogate Health and Care Partnership BAME network offers a forum for staff to raise concerns and share steps to improve conditions in workplaces, and Bradford District Care NHS Foundation Trust has been active in tackling COVID-19 fake news and misinformation within certain community groups as well as working with the Bradford Institute for Health Research to use local data to inform policy. Birmingham and Solihull Partnership NHS Foundation Trust has similarly been involved in local work to highlight the geographical communities most at risk that could benefit from targeted support to stay safe.

- In addition, since April, through our daily engagement with trust leaders, we have heard their observations, concerns and activity in relation to their BAME staff. Themes included enhanced support in the form of letters to BAME staff, promoted activity on trust's BAME networks and

groups as well as listening events with trust leaders. Details of the risk assessment process were also compared across trusts and systems, with a number of examples of seeking to work collaboratively on the response to this challenge across the health and care landscape.

NHS Providers View

Commenting on the publishing of the Public Health England review, the deputy chief executive of NHS Providers, Saffron Cordery said:

"We welcome the publication of Public Health England's rapid review into factors impacting health outcomes from COVID-19.

"This review supports earlier findings by the Office for National Statistics, helping to give us a clearer picture of the disproportionately large toll this pandemic has taken on black, Asian and minority ethnic people and communities and the reasons why. Trust leaders are concerned about increased risk to BAME staff, reflecting the wider inequalities long faced by BAME staff in the NHS workforce, and this report will add to existing resources supporting a more informed response to this challenge.

"We look forward to seeing how the government plans to respond to these concerning findings."

NHS Providers chief executive Chris Hopson and deputy chief executive Saffron Cordery also issued a statement of solidarity:

"Over the past few days we have been saddened by the terrible death of George Floyd in America.

"On behalf of NHS trust leaders, we want to add our voice to the many voices around the world who are rightly calling out racial injustice.

"Within the NHS, there is still much work to do to remove racial prejudice, and we must continue to invest in support for equality and diversity across the health and care system.

"It is unacceptable that instances of bullying and harassment and discrimination continue with more prevalence for BAME staff within the NHS. And more must be done to promote BAME staff into senior positions.

"Your voices are heard, and we are with you. We will continue to voice the need to stamp out discrimination and bullying."