Member briefing

April 2020

NHS CONFEDERATION
BME Leadership Network

The impact of COVID-19 on BME communities and health and care staff

This briefing considers the evidence on the impact of COVID-19 on black and minority ethnic (BME) communities and health and care staff. It explores potential underlying factors, recommends areas for action and offers practical advice on how to mitigate risks. Intended for senior health and care leaders, it aims to inform decision making and influence change.

Key points

- Emerging evidence suggests that COVID-19 is having a disproportionate effect on people from BME backgrounds. Early analysis also points to an overrepresentation of BME health and care professionals among coronavirus fatalities.
- Some BME groups are at higher risk of certain diseases and conditions – this may suggest an increased likelihood of developing COVID-19. A number of BME staff from various socio-economic backgrounds, including hospital consultants, nurses and healthcare assistants, have died as a result of the virus.
- Co-morbidities and socio-economic status are being put forward as possible explanations for the high number of people from BME backgrounds affected, but it is important not to assume that correlation equals causation.
- The NHS Confederation welcomes the government's announcement of an inquiry into the issue. But further and more immediate action is needed to mitigate risks to BME communities and health and care workers. This need to include an examination of the availability of personal protective equipment, testing, cultural and religious observances and data collection for BME communities.
- There needs to be better and more transparent collection and reporting of ethnicity data to understand the full impact of COVID-19 on BME patients. This could include recording ethnicity when health and care staff and patients are tested for the virus.
- The NHS Confederation is supporting NHS England and NHS Improvement to address the impact on BME communities and will involve organisations from across its membership and the BME Leadership Network to do so. We will continue to raise members' concerns to ensure the NHS and government respond to these issues and mitigate risks.

NHS Leadership Academy
Royal College of Nursing
The AHSN Network

Introduction

Emerging evidence in the UK and abroad suggests that black and minority ethnic (BME) communities are being disproportionately affected by COVID-19, with concerns mounting over the overrepresentation of BME health and care professionals among coronavirus fatalities. The government has agreed to an inquiry to understand why such a high number of people from BME backgrounds are dying from the virus. The review, to be led by NHS England and NHS Improvement and Public Health England, is welcome.

This briefing explores the potential underlying factors and recommends areas for action. Intended for senior health and care leaders, it aims to inform decision making, influence change and offer practical advice on how to mitigate the risks to BME communities and staff.

Health inequalities

Health inequalities can be defined as the avoidable and unfair differences in people's health across different population groups within society. It can also mean differences and biases in the access, quality and experience of care, and wider determinants of health, such as housing.

Sir Michael Marmot, in the report Fairer Society, Healthy Lives[1], asserts that "inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work and age". In Health Equity in England: The Marmot Review 10 Years On[2], he asserted that outcomes are "even worse for minority ethnic population groups and people with disabilities". In light of the COVID-19 pandemic and the emerging impact on BME staff and communities, Marmot's findings will need to be clearly understood to address a complex picture.

Health risk factors

According to the 2011 Census[3], 14 per cent of people in England and Wales are from black and minority ethnic backgrounds. BME groups generally have poorer health and worse health outcomes than the overall population:

- the risk of developing diabetes is six times higher in some BME groups[4]
- there are significantly higher rates of asthma incidence in BME population groups[5]
- people from some BME backgrounds in the UK are at higher risk of developing heart and circulatory diseases more than white Europeans[6]

- in England, people from some BME groups have a higher risk of hypertension than the general population[7]

- the Adult Psychiatric Morbidity Survey found that black men are more likely than their white counterparts to experience a psychotic disorder in the last year.[8]

People from BME backgrounds often have poorer access to healthcare services as well as poorer experiences of care and treatment.[9] They are also less likely to raise concerns or make complaints about the standards of their care.[10]

BME communities appear to be overrepresented among the groups at risk of facing serious complications if they contract the coronavirus. An Intensive Care National Audit and Research Centre's (ICNARC) latest audit in on COVID-19 cases found that around 34 per cent of 4,873 critically ill patients were from a BME background.[11] In comparison, only 11.6 per cent of patients with viral pneumonia between 2017-19 were from BME backgrounds.[12]

The ICNARC findings are consistent with emerging international data. In Chicago, 70 per cent of recorded deaths were from black residents, who make up 29 per cent of the population.[13] In Milwaukee County, 50 per cent of cases and 81 per cent of deaths are African American, who are only 26 per cent of the population.[14] And in Michigan, where 14 per cent of the population is black, African Americans make up 35 per cent of cases and 40 per cent of deaths.[15]

As of 14 April 2020, London has the highest number of people in hospital beds with COVID-19, followed by the Midlands.[16] Proportionately, London also had the highest number of deaths, followed by the Midlands.[17] As per the 2011 Census, London is the most ethnically diverse region in England and Wales, where 40.2 per cent of residents identify as BME.[18] The West Midlands is the next region where BME groups are most likely to live.

Areas for action

We welcome the government's announcement of an inquiry into why people from BME backgrounds appear to be disproportionately affected by the coronavirus, to be led by NHS England and Improvement and Public Health England. However, at the time of writing, details are yet to be provided on the scope of the investigation or its timeframes.

Further work is required to identify why people from BME backgrounds are at higher risk of developing COVID-19 and dying from the virus. Analysis is also needed to determine whether there is any causality between the number of BME people in a region and the spread of the virus.

(continued overleaf)

In the more immediate term, we recommend that:

- primary care clinicians check to ensure that shielding lists include BME patients from at-risk groups
- there is an immediate focus on targeting BME community organisations to work in partnership with – the NHS Confederation's BME Leadership Network can help to access organisations at pace and deliver immediate messaging to NHS organisations, to help keep staff and communities safe
- Public Health England works with community groups on targeted information campaigns for BME groups – this could include better visibility of BME groups in coronavirus communications and ensuring that messages are comprehensively translated into different languages, especially given the closure of many local community hubs; families may be socially distancing and not able to help vulnerable family members in the same way
- more should be done to ensure that the experience of BME communities, working with NHS organisations, is well facilitated, ensuring that information similar to Public Health England's guidance in different languages is published in accessible ways, learning from the experience of the Windrush scandal.

The BME workforce

The 2015 McGregor-Smith Review, Race in the Workplace, found that one in eight of the working-age population was from a BME background, yet BME individuals made up only 10 per cent of the workforce and hold only 6 per cent of top management positions.[19] A 2015 study by the Joseph Rowntree Foundation identified that a higher proportion of BME individuals tended to work in lower paying occupations, often manual roles.[20] In addition, around three-quarters of the health and social care workforce are women[21] and women make up 77 per cent of the workforce.[22]

Taken together, this suggests that during the COVID crisis, BME individuals may be in keyworker roles for which it is not possible to work from home (such as bus drivers), may not be eligible for furlough or statutory sick pay, and may have to rely on public transport to travel to work. This possibly increases the risk of contracting the virus as it may not be able to practise safe social distancing.

The higher representation of BME employees in lower grade jobs is also the case within health and social care. In the NHS, BME staff are overrepresented in band 5 and significantly under-represented in senior pay bands.[23]

Workforce Race Equality Standard (WRES) data from 2019[24] shows that:

- 19.7 per cent of staff working for NHS trusts and clinical commissioning groups (CCGs) in England are from a BME background; this has been increasing year on year
- the highest proportion of BME staff are in NHS trusts across the London region, at 44.9 per cent (92,477)
- acute trusts have the highest proportion of BME staff at 21.5 per cent (202,686) and ambulance trusts have the lowest at 5.1 per cent (2,385)
- just over one in every five (21.8 per cent; 77,219) of all nurses, health visitors and midwives in NHS trusts and CCGs is from a BME background.

Other data shows that 44 per cent of doctors of all grades are from BME backgrounds and 31 per cent of senior doctors from an Asian background.[25]

BME health and care staff from various socio-economic backgrounds, including hospital consultants, nurses and healthcare assistants, have died as a result of COVID-19.

Co-morbidities and socio-economic status are currently being put forward as possible explanations for the high number of people from BME backgrounds affected, but it is important not to assume that correlation equals causation.

Areas for action

HSJ analysis published on 22 April has found that BME individuals account for 63 per cent of staff deaths.[26] We need to better understand the level of risk facing BME staff in clinical situations and whether there is more that can be done to make sure they are protected.

The NHS Confederation is working with NHS England and NHS Improvement to develop risk assessment and mitigation strategies. Guidance is being prepared to assist employers in carrying out workplace risk assessments with their teams, and national efforts to understand the risk factors are also being urgently taken forward.

Other COVID-19 impacts on ethnic minority groups

Personal protective equipment (PPE) and testing for COVID-19

NHS Staff Survey and WRES data consistently evidence BME staff reporting discrimination, harassment and victimisation, which suggests a fear of speaking out . A number of NHS BME staff members – particularly nurses who are more likely to be asked to work on COVID wards – have told us that they do not always feel confident enough to make demands for PPE and testing for COVID to ensure safety in the workplace.

As well as the lack of availability of PPE in some health and care services, feedback from BME staff has highlighted that some forms of PPE may not be suitable. This could be because some Muslim health and social care workers wear hijabs, for example, and so attaching facemasks and goggles may be difficult. Some Muslim and Sikh men may have a beard for religious reasons and may not feel comfortable removing them, affecting the fit of facemasks. NHS Employers, which is part of the NHS Confederation, has published guidance about the use of PPE for staff, which includes information about cultural considerations.

Withdrawal of key services

As a result of the pandemic, some key services, such as translation and interpretation, are at risk of being withdrawn. This, in addition to strict no-visitor policies, means some patients may not be able to articulate their health and care needs, leading to a deterioration in their health.

Data from Public Health England and elsewhere has shown falls in A&E and GP surgery attendance. To deal with the pandemic, many key clinical services have been scaled back. This could be having an impact on mortality and morbidity rates which are already higher in BME groups,[27] and potentially means that some patients may not be seeking medical advice when they should be, leading to potential further complications in their health.

Cultural and religious observance

April has been a month of religious events, featuring Easter, Passover and Vaisakhi celebrations. The holy month of Ramadan starts around 23 April this year and could have an impact on the Muslim population, but also the health and social care staff who may also be observing. Ramadan involves a daily period of fasting for Muslims starting at sunrise and finishing at sunset over the month. This means abstaining from food, drink (including water) and smoking.

NHS Employers has published guidance for employers to support their staff. This year will be vastly different as there may be limits to communal activity and access to prayer facilities, quiet rooms and multi-faith rooms, which have been largely suspended.

As part of the nationwide lockdown announcement on 23 March, to help reduce the risk of spreading COVID-19, guidance was published about funeral and measures were put in place which included restricting the numbers of people who can attend funeral ceremonies.[28] Some councils have taken steps to ban funeral ceremonies.[29]

This has meant that some family members have not been able to attend the funeral of their loved ones, particularly if they had to practise social isolation themselves. In addition, the backlog in undertaking burials has meant that Muslim and Jewish burials may not be able to take place in a timely way as per their religious beliefs.[30]

Areas for action

Government planning and guidance should take into account religious and cultural celebrations and observances which may be taking place over the next few weeks. The Inter Faith Network has issued advice involving diverse faiths within the context of COVID-19.

The announcement made in the daily Downing Street press briefing on 18 April to change restrictions on funerals is welcome, and we look forward to further updated guidance. However, consideration needs to be given to the emotional impact some people suffer as a consequence of the initial restrictions that were put in place.

Data collection

The Care Quality Commission (CQC) has updated its regulation 15 death notification form to add a question about whether deaths are from confirmed or suspected cases of COVID-19. This form includes a range of information on protected characteristics, including ethnicity. The regulator has said it will share this data with system partners to understand the impact of COVID-19 better.

Health and social care employers are also required to report deaths, certain types of injury, some occupational diseases and dangerous occurrences that 'arise out of or in connection with work' to the Health and Safety Executive.[31]

Areas for action

A clearer diagnosis is needed on the scale of the problem and whether the NHS' response to the pandemic is inadvertently exacerbating inequities in access to care and health outcomes. A Race Equality Observatory could assist with some of these problems in future.

We need to ensure there is accurate data collected on deaths among frontline health and care staff, with greater understanding of the reasons behind why a disproportionate number of BME staff have been affected – and action taken to mitigate the risks and ensure adequate protection for those at greatest risk.

Death certificates have information about age, gender and region but do not currently record ethnicity. Consideration should be given to change this so that ethnicity is recorded, and this information used to drive changes and improvement.

The NHS Confederation is scoping a project to identify and review existing data sets and will seek community insights through qualitative research. We will be working in partnership with NHS England and NHS Improvement to make data more transparent.

NHS Confederation viewpoint

COVID-19 has been a monumental challenge not just for health and care services, but the whole population. It is deeply troubling to see the emerging evidence that it is having a disproportionate effect on people from BME backgrounds.

As a membership organisation representing the whole healthcare system, the NHS Confederation will continue to spotlight the issues and push for further analysis to understand the reasons behind the trends. We will also look to find practical solutions that help our members and partners to improve the situation – in the short, medium and long term – and share best practice.

We will mobilise our members within our BME Leadership Network and the voice of BME leaders to increase pressure on the government and arm's-length bodies to take action. We are involved in NHS England and NHS Improvement workstreams on the impact of COVID-19 on BME communities and will continue to work with them and Public Health England to look critically at the issues and develop solutions.

If you have concerns, need advice or would like to share what your organisation is doing on this area, please contact Sabina Hafesji, senior policy adviser, at sabina.hafesji@nhsconfed.org

References

1. Marmot M, Goldblatt P, Allen J et al (2010), Fairer Society, Healthy Lives: The Marmot Review. The Institute of Health Equity accessed, April 2020.
2. Marmot M, Goldblatt P, Allen J et al (2020), Health Equity in England: The Marmot Review 10 Years On. The Institute of Health Equity, accessed April 2020.
3. Gov.UK (2019), Population of England and Wales, accessed April 2020.
4. Stratton IM, Alder AI, Andrew H et al (2000), 'Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study'. The BMJ 2000; 321:405, accessed April 2020.
5. Cumella A and Haque A (2018), On the Edge: How Inequity Affect People with Asthma. Asthma UK, accessed April 2020.
6. British Heart Foundation, Ethnicity, accessed April 2020.
7. Public Health England (2017), Health Matters: Combating High Blood Pressure, accessed April 2020.
8. Mental Health Foundation (2019), Black, Asian and Minority Ethnic (BAME) communities, accessed April 2020.
9. Race Equality Foundation (2 April 2020), Coronavirus Information and Resources, accessed April 2020.
10. Care Quality Commission (2019), Press release – 'New research for the Care Quality Commission shows racial disparity in people raising concerns about their care', accessed April 2020.
11. Intensive Care National Audit and Research Centre (17 April 2020), ICNARC Report on COVID-19 in Critical Care, accessed April 2020.
12. Ibid.
13. Ramos E, Zamudio MI (5 April 2020), 'In Chicago, 70 per cent of COVID-19 deaths are Black'. WBEZ, accessed April 2020.
14. Johnson A and Buford T (6 April 2020), 'Early data shows African Americans have contracted, died of coronavirus at an alarming rate'. Medscape, accessed April 2020.
15. Eligon J, Burch ADS, Searcey D and Oppel Jr RA (14 April 2020), 'Black Americans face alarming rates of coronavirus infection in some states'. The New York Times, accessed April 2020.
16. Gov.UK (14 April 2020), Conference slides – 'Stay Home, Protect the NHS, Save Lives: Transport use change; New UK cases; People in hospital beds with COVID-19 (Great Britain), Global death comparison', accessed April 2020.
17. Serle J, West D (April 2020), 'Coronavirus death mapped: 780 additional deaths reported'. HSJ, accessed April 2020.
18. Gov.UK (2019), Regional Ethnic Diversity, accessed April 2020.
19. McGregor-Smith R (2017), The Time to Talk is Over. Now is the Time to Act: Race in the Workplace –The McGregor-Smith Review. Department for Business, Energy and Industrial Strategy, accessed April 2020.
20. Catney G and Sabater A (2015), Ethnic Minority Disadvantage in Labour Market. Joseph Rowntree Foundation, accessed April 2020.
21. OECD (2019), Gender Equality: 'Women are well-represented in health and long-term care professions, but often in jobs with poor working conditions', accessed April 2020.
22. NHS Employers (2019), Infographic – Gender in the NHS, accessed April 2020.

23. NHS England (2019), NHS Workforce Race Equality Standard: 2019 Data Analysis Report for NHS Trusts, accessed April 2020.
24. Ibid.
25. Gov.UK (2020), NHS Workforce, accessed April 2020.
26. Cook T, Kursumovic E and Lennane S (22 April 2020), 'Exclusive: deaths of NHS staff from COVID-19 analysed'. HSJ, accessed April 2020.
27. Public Health England (2017), Public Health Outcomes Framework: Health Equity Report – Focus on Ethnicity, accessed April 2020.
28. Gov.UK (31 March 2020), Press release – 'New advice for safe funerals after discussions with faith leaders', accessed April 2020.
29. Sherwood H (4 April 2020), 'UK councils begin to ban funeral ceremonies due to coronavirus'. The Guardian, accessed April 2020.
30. Chowdhury S (12 April 2020), 'Coronavirus: burials changing for Muslims amid UK's high COVID-19 death rate'. Sky News, accessed April 2020.
31. Health and Safety Executive (2013), Reporting Injuries, Diseases and Dangerous Occurrences in Health and Social Care: Guidance for Employers, accessed April 2020.

About the BME Leadership Network

The BME Leadership Network exists to strengthen the voice of BME leaders in England and support health and care organisations to meet the needs of all communities. It meets quarterly and seeks to improve understanding of equality, diversity and inclusion and improve and sustain the number of BME leaders working in the NHS and profile the diverse range of BME leaders delivering solutions across the health and care system.

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

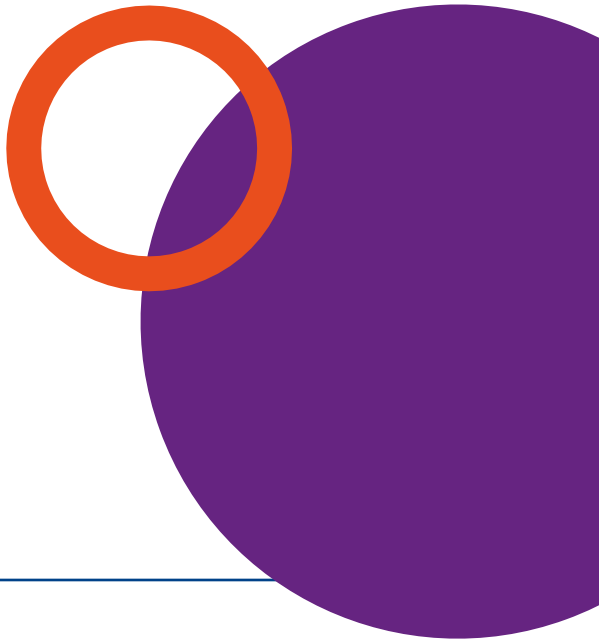
About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Wales and Northern Ireland.

In England, we represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems. We represent local health boards in Wales, and health and social care trusts in Northern Ireland. We also have a Brussels office where we focus on EU legislation, Brexit, policy and our international engagement.

Finally, in England we also run NHS Employers, which supports the health service in its role as the nation's largest employer, negotiating pay, supporting workforce development, and fostering good practice in recruitment and retention.

To find out more, visit www.nhsconfed.org



NHS CONFEDERATION
BME Leadership Network

18 Smith Square, Westminster, London SW1P 3HZ

Tel 020 7799 6666 Email enquiries@nhsconfed.org

www.nhsconfed.org Follow the NHS Confederation on @nhsconfed

If you require this publication in an alternative format, please email enquiries@nhsconfed.org

© NHS Confederation 2020. You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work. Registered charity no. 1090329