Impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) staff in mental healthcare settings | assessment and management of risk

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Notes: The staff referred to in the report include all staff (doctors, trainees and students, nurses, allied health professionals, social workers and support staff) working in the NHS and the independent sector in mental healthcare settings

Black, Asian and Minority Ethnic (BAME, used in this report), or Black and Minority Ethnic (BME) refer to individuals from various ethnic backgrounds other than White.[i] We recognise that within BAME groups, there are some groups which may be more at risk than others, and data is emerging on this issue.

Due to a rapidly evolving situation, and the absence of complete data on this topic across the nations of the UK, some references in this report relate to England based data and guidance. However, the report and its recommendations have been developed to be relevant and applicable across the UK.

Introduction

The Royal College of Psychiatrists (RCPsych) has responded to the urgent issue of the high and disproportionate numbers of deaths of BAME staff due to Covid-19, by producing initial guidance on risk mitigation for urgent implementation across all mental health care organisations in the UK.

The extent of the problem

There is evidence of a wide disparity in deaths from COVID-19 amongst BAME people compared to White health and care workers in the United Kingdom (around 2/3rds of healthcare staff who have died are from a BAME background whereas they make up around 20% of the overall workforce).[ii]

Table 1- Age, gender and ethnicity of those who died from COVID-19 in health and social care staff groups.[iii]– published on 22/4/20).

	Nurses and midwives	Healthcare support workers	Doctors and dentists	Other staff
Number	35	27	19	25
Age; yrs. median (IQR [range])	51 (46-57 [23-70])	54 (42-64 [21-84])	62 (54-76 [36-79])	51 (34-58 [29-65])
Male; %	39	22	94	55

BAME; %	71	56	94	29
BAME workforce; %*	20	17	44	-
*For comparison, the approximate % of BAME the NHS workforce is included in the final row.				

This disproportionate death rate is also reflected in the general population in the UK where it has been found that after taking into account age, measures of self-reported health and disability, and other socio-demographic characteristics, black and people of Bangladeshi and Pakistani origin were still almost twice as likely as white people to die a Covid-19-related death.[iv]

These shocking figures have understandably led to widespread fear, anxiety and grief amongst BAME staff and their communities, with calls for urgent measures to protect them against the higher Covid-19 risk. Also, there are strong signals that existing inequalities and inequities experienced by BAME healthcare staff are being amplified by the crisis, which needs further research.[v] The adverse impact is felt by the entire mental health workforce and involves further direct and indirect harm through longer term morbidity, physical impairment and psychological consequences of this unequal disease burden to staff, their families and communities.

Current knowledge of the risk factors associated with disproportionate mortality of BAME workers due to COVID-19

A significant proportion of the mental healthcare workforce (for Psychiatrists- 39% of RCPsych members, and 33.3% of doctors on the General Medical Council specialist register for psychiatry) is from a BAME background.[vi] BAME staff contribute strengths and diversity to healthcare and offer immeasurable value to the NHS, which would collapse without them. All healthcare organisations have a duty of care towards their staff, and the actions that organisations take now in response to this crisis will have significant implications for the future health of the workforce and health and care service delivery.

The disproportionately high death rates in BAME staff appear to be only partially explained by age, gender, socio-demographic features and underlying health conditions.[vii] Attention needs to be given to the potential contribution of other known inequalities, including racism experienced by health workers of BAME origin; and the full extent of disadvantage needs to be better researched and understood.[viii] While further research is awaited however, protecting those who are most at risk (BAME older, male and pregnant, those with pre-existing health conditions as well as the group where several factors intersect) will benefit all staff, patients and services.

The government has commissioned Public Health England to conduct an inquiry but action is needed urgently before the findings are reported, as lives continue to be lost.

How occupational COVID risks might relate to documented inequalities and inequities

In the table below, known and documented inequalities and inequities for BAME staff [ix] are linked to their possible impact on COVID-related risks in mental healthcare settings. There are several personal anonymised, narratives available for the examples below.

Paradigm for understanding the impact of inequalities on BAME staff:	
Established inequalities for BAME/BME staff	***Potential* impact during pandemic, and possible increased Covid-19 related risks**
Workforce Race Equality Standard (WRES) 2019 (all NHS staff)	
More likely to report personal experience of discrimination	Less likely to raise concerns for e.g. re Personal Protective Equipment (PPE). Less likely to report unacceptable, discriminatory behaviours, Less likely to request redeployment. May face discrimination around FIT testing for PPE for e.g. due to beards, veils, turbans
Formal disciplinary processes more likely	More likely to fear being reported or warned for raising concerns around Covid-19 risks or asking for safer work alternatives
Experiencing bullying and harassment from staff more likely	Adverse psychological impact, isolation at workplace, reduced input into rota design, less likely to call out inappropriate practice
Experiencing bullying and harassment from patients and relatives more likely	May wear less PPE so as not to cover their face - may affect ability to deliver safe care
Fewer BAME leadership role models	May be a barrier to raising concerns by BAME staff who may not feel understood or taken seriously. May prevent an open discussion around options and mitigations. Leadership may be disconnected from staff
Reduced pay progression and promotion	May adversely affect job security if on a temporary visa, possible increased carer burden due to family members being affected by COVID
Fewer opportunities for non-mandatory training	May adversely influence exam success, career progression and pay, which could increase chances of duration of frontline exposure during Covid-19
Reduced perception of opportunities for career progression	May lead to disengaged, disaffected staff who are unlikely to raise concerns or ask for appropriate protection re Covid-19
Reduced recruitment opportunities	Recruitment work, exams, career progression reviews etc. halted or reduced due to COVID-19 so less likely to change jobs if unhappy or dissatisfied with job, therefore less likely to raise concerns
GMC 'Fair to Refer' report (2019) all registered doctors	
Less likely to receive constructive feedback	Barrier to raising concerns and receiving support, relating to Covid-19 risks.
Inadequate induction and support	Reduced awareness of and access to protection during COVID- e.g. PPE, infection prevention training, remote working,
Reduced exposure to learning experiences, senior mentors or resources	Increased anxiety, stress, isolation, less confidence to ask questions, call out

	unacceptable behaviours, express opinions
Difficulties accessing leadership team and being heard	Less engaged, having a limited voice in the organisation, reduced input into safe rotas, redeployment, working from home
Blame culture exacerbates feelings of being an outsider	Lack of sense of belonging can adversely affect psychological safety. Important to consider specific issues for international graduates who may be new to the country, and trainees. More likely to accept what's offered, e.g. workplace PPE, risky placements, unsafe rotas, lack of remote working equipment or opportunities.
Bias and stereotyping	Discrimination on cultural, religious or ethnic grounds may impair safety and protection at work, reduce opportunities to speak out and advocate for required protection such as working remotely. Not wanting to be seen as different, vulnerable, as a problem, the "good immigrant" narrative.
GMC, RCPsych, Health Education England (HEE)	
Differential attainment in examinations	Delay in career progression, lower pay, lack of confidence and reduced job security may lead to lesser say in safe rotas or redeployment

A robust sensitive risk assessment is required for all staff to offer them the best protection possible, this will protect all people in the organisation including BAME staff and patients.

Risk assessment

Risk assessment should be carried out for all BAME staff as a priority so that a personalised risk mitigation plan can be put in place for each member of staff. This requires an open collaborative conversation between the staff member and line manager, aided by the Human Resources/People team and Occupational Health as required. An open-ended question like "What can I do to help, how can we help you?" is a good starting point. The risk assessment tool in the appendix is intended to aid a structured conversation, in a safe space, exploring all potential risks. No template can fully capture the sensitivity of the discussion and it must avoid becoming rigid, reductionist or a tick-box exercise. Regular review, which acknowledges concerns as understandable, validating and respecting staff is likely to promote consensus. Further guidance on risk assessment from NHS Employers is evolving.[x]

A good, collaborative risk assessment will enable robust risk mitigation to be implemented and support the staff member to feel more confident about being protected at work while undertaking duties in the care of others.

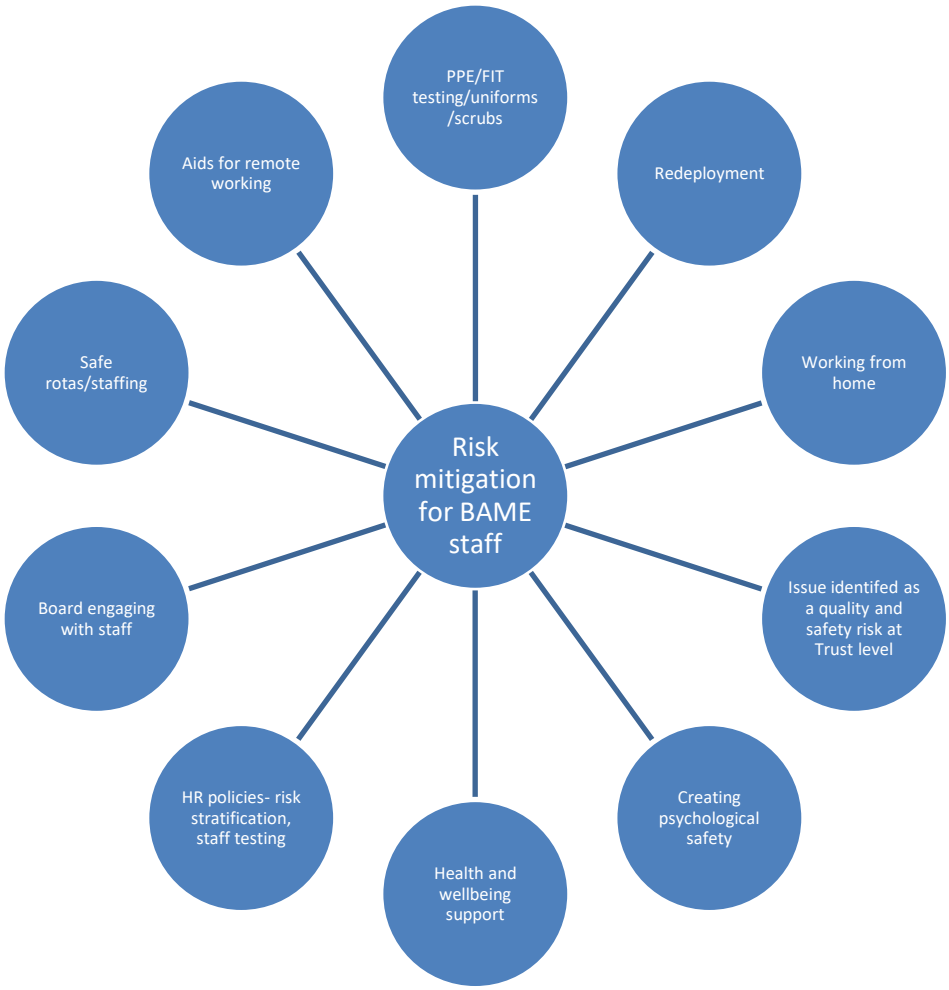
Risk mitigation

Surveys and accounts from various professional medical and nursing bodies indicate that PPE and, remote working facilities are not consistently available to all staff, with particular problems being faced by BAME staff.[xi] Measures to reduce exposure to risk must be implemented as a priority to protect the lives of staff and patients. The measures will need to

be in place for some time as the pandemic takes it course, so need to be sustainable. Regular feedback to see whether interventions are working is vital.

Longer term work designed to improve organisational culture and capability will also enhance risk management.

The spider diagram and accompanying text below indicates some immediate steps that can be taken by organisations to mitigate risks for all staff, including BAME, older male and pregnant staff. There is separate government guidance for staff who are shielding and can work from home if they are well enough to do so.[xii]



PPE: Appropriate PPE should be made available as a priority for all staff in all clinical settings, in keeping with national guidance[xiii] with clear requirements for each: inpatients, dementia wards, liaison teams in Accident and Emergency departments and acute hospital wards, community settings, care homes, patients' homes and for various procedures: seclusion and restraint, ECT, and chest compressions as part of Cardio Pulmonary Resuscitation (CPR). We recommend that locally agreed guidelines based on national guidance be followed for CPR.[xiv] ECT should be treated as an AGP as per PHE guidance.[xv] FIT testing for FFP3 masks as required should be carried out as a priority. If adequate PPE is provided, staff can be protected from Covid-19 even in high risk areas like ITU and anaesthesia.[xvi] If staff fail FIT testing, the risks should be reviewed.

Clear instructions are needed about the correct PPE garments and how to don and doff them. Sensitive conversations about cultural factors and PPE are required.

We advocate uniforms or scrubs in inpatient and liaison settings for staff who are likely to come into close contact with patients (for example, medical staff and mental health nurses).

There is ongoing debate for and against use of face masks/face coverings in general for staff, patients and the public, guidance will be updated as the evidence evolves.

Patients should be offered an explanation and reassurance about staff wearing PPE.

Staff testing: There is now a national testing process for England.[xvii] It should be offered to all staff with consideration given to prioritising BAME staff and their families, as a means of identifying those who are infected and to rule out infections, to enable healthy staff to attend work.

Aids for remote working: It is advised that organisations provide resources for remote working (audio and video consultations and assessments) for all staff as a priority. Emerging guidance is awaited regarding the legality of using video facilities for assessments under each nation's relevant mental health legislation. This will require a balance between staff availability and safety and patient rights and preferences.

Redeployment: Older male, BAME staff should be considered for redeployment to lower risk areas. A proactive offer by the manager as part of an ongoing review, keeping staffing needs in mind, will engender confidence that the staff member's needs are being taken seriously.

Separating COVID and non COVID wards, with different staff and different locations, may provide safer working spaces for some staff.

Working from home: If completely working from home or redeployment is not possible, a balance between working from home and office may be a way of reducing Covid-19 risk exposure. This should be carefully and actively considered rather than staff being made to feel guilty.

Safe rotas/staffing: There is anecdotal evidence that BAME staff members are more likely to be on out of hours or Section 12 rotas and on inpatient wards and ECT suites in patient facing roles, or they may be less likely to complain if they are put on rotas which may be unsafe for them. Managers need to keep in mind these issues and facilitate conversation and work plans accordingly with BAME staff. Ensure equality impact assessments of rota changes or other emergency adjustments to service delivery during the Covid-19 crisis for e.g. introduction of a new rota staffed by SAS doctors that may unintentionally place more BAME staff on the frontline.

Other infection prevention and control measures like social distancing in all work areas including patient areas, staff areas and communal areas and hand washing as per national guidance need to be maintained strictly.

Support for BAME healthcare workers to manage additional impact of COVID

Vitamin D supplements: Although there is no evidence to suggest that Vit D confers specific protection towards COVID -19 or prevents respiratory complications of COVID-19, low levels of Vit D may predispose to severe infections. Vit. D testing can identify those with below normal levels. The group advocates benefits on balance of Vitamin D supplements in the recommendations. The attached references provide guidance on doses and mental healthcare provider organisations are advised to work with their pharmacy departments to discuss ways of making this advice available to staff, especially BAME staff as a priority as they may be overrepresented in those with low levels of Vitamin D.[xviii]

BAME staff engagement: Engagement with BAME employees- Staff networks, staff side committees, Question and Answer and other engagement events with Board and senior staff can ensure the BAME voice is heard by leaders. Use staff forums to initiate debate. It is also important to discuss this issue in all mainstream staff side fore and not just in BAME networks - these issues are not just BAME issues but have relevance to all staff and to the whole organisation.

Psychological Safety: Reminders of avenues available to speak out, e.g. about poor access to equipment, bullying, and links between the Freedom to Speak Up Guardian (FTSU) and BAME staff to reduce fear of raising concerns, should be shared with staff. Balint Groups and Schwartz Rounds can also help as a way of getting people together in a safe space to share experiences and be supported.

Healthy organisational responses to COVID and inequalities

Staff wellbeing and support: For all staff groups, prompt, proactive psychological support is imperative. Certain staff groups such as SAS doctors or locum doctors, with a higher proportion of BAME ethnicity who have well documented long-term inequality, isolation, harassment and lack of belonging with reduced professional support compared to consultant and trainees, will require additional and concerted efforts at engagement in support resources.

Hotel or alternative accommodation for staff needing to distance from highly vulnerable shielded relatives may be welcomed as a way of enabling staff to keep their families safe.

It is important for managers to stay in touch with those who are shielding/ isolating/ redeployed/ working from home.

Inclusive leadership: The need for visible, compassionate inclusive leadership allowing staff to feel confident in, connected to and trust their leaders, has never been higher. This is a critical factor in staff feeling able to speak up and feel assured that their concerns will be addressed.[xix]

PPE and IPC Champions can support through webinars, CPD, ward walkabouts etc.

Quality Improvement (QI): QI approaches involving rapid evaluation of the impact of actions taken to mitigate risk can be effective in embedding change. Collect feedback regularly is important.

Support for line managers: Managers may need support in risk management conversations.

Data: Monitoring of sickness absence relating to COVID-19 by ethnic group should be implemented.

Board level accountability: Boards need to take ownership of information, actions, corporate risks and effectiveness of interventions.

Note: NHS provider organisations are referred to as Trusts in England and Health Boards in the devolved nations of Wales, N Ireland and Scotland.

Appendix

Risk Assessment tool for staff during the COVID-19 pandemic:
https://www.rcpsych.ac.uk/docs/default-source/about-us/covid-19/risk_assessment_tool_covid19.pdf

References

[i] NHS. NHS workforce race equality standard: 2019 data analysis report for NHS trusts. 2019. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf [Accessed May 2020]

[ii] Health Services Journal. Exclusive: deaths of NHS staff from COVID-19 analysed. 2020. Available from: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article [Accessed May 2020];
Kline, R. Better late than never. 2020. Available from: https://www.linkedin.com/pulse/better-late-than-never-roger-kline [Accessed May 2020]

[iii] Health Services Journal. Exclusive: deaths of NHS staff from COVID-19 analysed. 2020. Available from: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article [Accessed May 2020

[iv] Office for National Statistics. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. 2020. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020. [Accessed May 2020]

[v] NHS. NHS workforce race equality standard: 2019 data analysis report for NHS trusts. 2019. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf [Accessed May 2020];
The Kings Fund. Ethnic Minority Deaths and COVID-19: What are we to do? 2020. Available from: https://www.kingsfund.org.uk/blog/2020/04/ethnic-minority-deaths-covid-19 [Accessed May 2020];
NHS confederation. The impact of COVID-19 on BME communities and health and care staff. 2020. Available from: https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/BRIEFING_Impact-of-COVID-19-BME_communities-and-staff_FNL.pdf [Accessed May 2020]

[vi] The Royal College of Psychiatrists. 2019 Year End Stats. 2020;
General Medical Council. Data explorer: Register: ethnicity. 2020. Available from: https://data.gmc-uk.org/gmcdata/home/#/reports/The%20Register/Stats/report [Accessed May 2020]

[vii] Office for National Statistics. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. 2020. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020. [Accessed May 2020];
Khunti, K., Singh, K S., Pareek, M., Hanif, W. (April 2020) Is ethnicity linked to incidence or outcomes of covid-19? BMJ 2020; 369: m1548. Available from: https://www.bmj.com/content/369/bmj.m1548.full [Accessed May 2020];
Docherty, A., et al., (April 2020) Features of 16,749 hospitalised UK patients with COVID-19 using the ISARIC WHO Clinical Characterisation Protocol. Pre-print. Available at: https://www.medrxiv.org/content/10.1101/2020.04.23.20076042v1 [Accessed May 2020];
Yang, J., et al., (May 2020) Prevalence of comorbidities and its effects in coronavirus disease 2019 patients: A systematic review and meta-analysis. Int J Infect Dis, 2020. 94: p. 91-95.

[viii] Office for National Statistics. Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020. 2020. Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/cor

onavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020. [Accessed May 2020];
The IFS Deaton Review. Are some ethnic groups more vulnerable to COVID-19 than others? 2020. Available from: https://www.ifs.org.uk/inequality/chapter/are-some-ethnic-groups-more-vulnerable-to-covid-19-than-others/ [Accessed May 2020];
Pareek, M. et al (2020) Ethnicity and COVID-19: an urgent public health research priority. Available from: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30922-3/fulltext [Accessed May 2020]

[ix] NHS. NHS workforce race equality standard: 2019 data analysis report for NHS trusts. 2019. Available from: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf [Accessed May 2020];
General Medical Council. Fair to refer? 2020. Available from: https://www.gmc-uk.org/about/what-we-do-and-why/data-and-research/research-and-insight-archive/fair-to-refer [Accessed May 2020];
General Medical Council. Differential attainment. 2020. Available from https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/differential-attainment [Accessed May 2020]

[x] NHS Employers. Risk Assessments for staff. 2020. Available from: https://www.nhsemployers.org/covid19/health-safety-and-wellbeing/risk-assessments-for-staff [Accessed May 2020]

[xi] Royal College of Psychiatrists. RC Psych Member Survey Summary – COVID 19. 2020. Available from: https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/04/21/mental-health-units-facing-care-home-style-crisis-without-better-protection-from-covid-19 [Accessed May 2020];
Cooper, K. The British Medical Association BAME doctors hit worse by lack of PPE. 2020. Available from: https://www.bma.org.uk/news-and-opinion/bame-doctors-hit-worse-by-lack-of-ppe [Accessed May 2020];
British Association of Physicians of Indian Origin. BAPIO COVID-19 survey of over 2000 HCWs reveals BAME background is an independent risk factor. 2020. Available from: https://www.bapio.co.uk/bapio-covid-19-survey-of-over-2000-hcws-reveals-bame-background-is-an-independent-risk-factor/ and Chakravorty I, Daga S, Dave S, Chakravorty S, Bhala N, Menon G, Mehta R & Bamrah JS. An online survey of healthcare professionals in the COVID-19 Pandemic in the UK. Sushruta 2020 (Jul) vol13(2): ePub 25.04.2020 (pre-print v1.2*) DOI: 10.38192/13.2.9 [Accessed May 2020];
Mitchell, G. Nursing Times. Nurse safety 'still being compromised' by PPE shortcomings. 2020. Available from: https://www.nursingtimes.net/news/coronavirus/nurse-safety-still-being-compromised-by-ppe-shortcomings-08-04-2020/ [Accessed May 2020]

[xii] UK Government/Public Health England. Guidance on shielding and protecting extremely vulnerable people from COVID-19. 2020. Available from: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19 [Accessed May 2020];

[xiii] UK Government/Public Health England. Coronavirus (COVID-19): personal protective equipment (PPE) hub. 2020. Available from: https://www.gov.uk/government/collections/coronavirus-covid-19-personal-protective-equipment-ppe [Accessed May 2020]
[xiv] Resuscitation Council UK. COVID-19 Resources: Healthcare Settings. 2020. Available from: https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/covid-healthcare-resources/ [Accessed May 2020];
UK Government/Public Health England. PHE statement regarding NERVTAG review and consensus on cardiopulmonary resuscitation as an aerosol generating procedure (AGP.) 2020. Available from: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/phe-statement-regarding-nervtag-review-and-consensus-on-cardiopulmonary-resuscitation-as-an-aerosol-generating-procedure-agp [Accessed May 2020]

[xv] UK Government/Public Health England. COVID-19: personal protective equipment use for aerosol generating procedures. 2020. Available from: https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures [Accessed May 2020]

[xvi] Health Services Journal. Exclusive: deaths of NHS staff from COVID-19 analysed. 2020. Available from: https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article [Accessed May 2020]

[xvii] UK Government/Public Health England. Coronavirus (COVID-19): getting tested. 2020. Available from: https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested [Accessed May 2020]

[xviii] Martineau AR, Jolliffe DA, Greenberg L, Aloia JF, Bergman P, Dubnov-Raz G, et al. (2019) Vitamin D supplementation to prevent acute respiratory infections: individual participant data meta-analysis. Health Technol Assess 2019;23(2);
Lee, J. van Hecke, O. Roberts, N. (2020) Vitamin D: A rapid review of the evidence for treatment or prevention in COVID-19. Available from: https://www.cebm.net/covid-19/vitamin-d-a-rapid-review-of-the-evidence-for-treatment-or-prevention-in-covid-19/ [Accessed May 2020];
South London and Maudsley Trust. Protocol for Vitamin D Prophylaxis during COVID-19 Pandemic. 2020.

[xix] The Kings Fund. Covid-19: why compassionate leadership matters in a crisis. 2020. Available from: https://www.kingsfund.org.uk/blog/2020/03/covid-19-crisis-compassionate-leadership [Accessed May 2020];
Kline, R. Leadership in the NHS. BMJ Leader 2019;3:129-132. Available from: https://bmjleader.bmj.com/content/3/4/129 [Accessed May 2020]