Royal College of Nursing Submission: Labour review into the impact of COVID-19 on Black, Asian and minority ethnic (BAME) groups, written evidence, July 2020.

The Royal College of Nursing (RCN) is the largest trade union and professional body across the world, representing 450,000 nursing staff in the UK.

This submission focuses on the experiences of our BAME members and is complimentary to the virtual roundtable which some of our members took part in with Baroness Lawrence on 30th June to describe their lived experience.

Summary

- Currently, 19.7% of all staff working in the NHS are from BAME backgrounds. In nursing, 21.8% of registered nurses, health visitors and midwives are from a BAME background.[i]
- Skills for Care estimates that 38% of the registered nursing workforce in social care are from a BAME background.[ii]
- Our BAME members have reported feeling unsafe and unsupported in the workplace, they have had a disparate experience of COVID-19 to their White British counterparts.
- Lived experience and emerging evidence is showing that BAME health and care staff are at increased risk, yet organisations and the government has been slow to respond and act.
- COVID-19 has not created health and structural inequalities, it has revealed and exacerbated existing structural and institutional inequalities and barriers which exist across health and care, but also across wider society.
- It is imperative that both the government led inquiry and cross-government commission into the impact of COVID-19 on BAME communities is transparent, engages with stakeholders and people with lived experience. Any recommendations made must result in tangible action, be measurable and be evaluated in full.
- The government must invest in a cross-governmental strategy to tackle health inequalities which sets out clear objectives, measurable recommendations and timeframes with the funding required to achieve them.

1. The experience of BAME nursing staff during COVID-19

1.1 Throughout COVID-19, it has become increasingly evident that BAME communities, including health and care staff, are disproportionately affected by COVID-19 infection and mortality. Every day that BAME health and care staff are disproportionately affected by COVID-19 is another day that people and their families are needlessly put at extra risk.

1.2 There are increasing reports of BAME staff being asked ahead of others to care for people with COVID-19. Anecdotally, our members have reported feeling invisible, dispensable and not valued. Some nurses have reported experiencing racism and stigma because of how their race and ethnicity have been affected by COVID-19, so individuals believe that they are also carrying the infection.

Personal Protective Equipment (PPE)

1.3 Adequate and correctly fitting PPE is critical for staff safety in all settings during the pandemic; it reduces exposure to the infection and therefore significantly reduces risk of death. Our latest member survey shows that for nursing staff working in high-risk environments (including intensive and critical care units), only 43% of respondents from a BAME background said they had enough eye and face protection equipment. This is in stark contrast to 66% of white British nursing staff. Furthermore, 70% of BAME respondents said that they had felt pressured to care for a patient without adequate protection as outlined in

the current PPE guidance, almost double the 45% of white British respondents who had felt this pressure. We know that many BAME people are employed in social care where PPE has also been slow to be distributed.

1.4 Sadly, nearly a quarter of BAME nursing staff said they had no confidence that their employer is doing enough to protect them from COVID-19, compared with only 11% of white British respondents. Most worryingly, respondents reported that they did not feel comfortable speaking out about their concerns and we know that in some places, organisational cultures may inhibit BAME staff from raising concerns for fear of reprisal. Additionally, migrant nursing staff on tier-two visas report feeling inhibited about raising concerns as a result of their immigration status.

1.5 The most common reason respondents told us for not reporting concerns was because they did not believe any action would be taken (68%) and almost a third (29%) were fearful of speaking out. Anecdotally, BAME members have reported that they feel uncomfortable and uneasy speaking to management about their concerns because managers are disproportionately from White British backgrounds. The obvious bias and prejudice they witness in opportunities available to BAME staff to progress into management roles means that they are then put off engaging with the system. This structural exclusion of BAME staff is unacceptable and is not conducive to ensuring patient and staff safety. These stark differences in the lived experience of BAME staff, particularly within the NHS, suggest that further action needs to be taken on the part of employers to comply with the spirit and letter of the Equality Act 2010 and the public sector equality duty in order to restore trust and confidence across the workforce.

Risk Assessments

1.6 Many RCN members from a BAME background have reported that they have been unable to access risk assessments; a common theme that also came from the engagement the Chief Nursing Officer's BAME strategic advisory group had with frontline staff. The development of a risk assessment tool for employers to use was only made available in May and guidance for BAME staff on how to stay safe at work given their elevated level of risk was also delayed. Whilst this has not be the experience of all staff, it should be a cause for concern that any nurse who is eligible for a risk assessment and who hasn't had one, is potentially working in an unsafe environment for their own health and wellbeing.

1.7 We expect all employers to be proactively carrying out comprehensive and continuous equality impact assessments and risk assessments on staffing issues relating to COVID-19, including reviewing the allocation of shifts, and access to PPE and to fit testing for BAME workers. Further to this, confidential discussions with staff must be had so that they can be supported to be redeployed with their consent if this is appropriate.

2. Explaining the disproportionate impact of COVID-19 on BAME groups

Research and evidence

2.1 The recent Public Health England (PHE) reports make clear the long-term and potentially devastating impact of COVID-19 on many communities, in particular the worrying impact on Bangladeshi, Black and other BAME people.

2.2 The reports mirror what we hear from our own members - that BAME health care staff in particular, face an elevated level of risk. However, the recommendations included in the report are ambiguous; they are not targeted and therefore lack accountability. They fail to provide a clear timeframe for implementation which will make it difficult to measure progress. This is concerning given the immediacy and urgency of the situation - concrete, strategic and operational actions at a national level are needed now in order to mitigate any further disparities.

2.3 Many of the recommendations are also actions that we would already expect the Government and employers to be carrying out as part of their aims to create a diverse and inclusive health and care service and workforce. It will be important for all of these recommendations to have longevity and for the equality agenda to continue post pandemic.

Biology, culture and intersectionality

2.4 Biology can also be a distraction and discussions around Vitamin D deficiencies do not fully explain the disparities between BAME groups contracting and dying from COVID-19; the true picture will not be understood by biology alone. There are multi-layered and complex structural and societal factors which require examination before the true impact will be understood. The Workforce Race Equality Standard (WRES) provides a powerful and compelling body of evidence but this has not been utilised effectively to level up the experiences of BAME health and care staff and patients.

2.5 Typically, explanations for the disproportionate mortality rate of BAME staff have tended to focus on issue of culture. We know that some nurses are less likely to speak up and raise concerns and therefore may continue working in an unsafe environment which increases their risk. However, culture is not a single experience and employers must create open and safe spaces for staff to raise concerns so that these learned behaviours do not mean staff put themselves at heightened risk.

2.6 The impact of COVID-19 will require a new policy and analytical lens which includes understanding the role of racism and systemic inequality. This should be built into the scope of the Government's Inquiry so that there is understanding on how different protected characteristics interact to create disadvantage or benefit within this pandemic.

Data

2.7 We expect pragmatic use of the current evidence base by the Government now. There are a large number of studies that give consistent indications of systemic racism throughout health care. Though research can always explore these issues in more depth, there is mounting evidence and historical reviews which can be utilised given the backdrop of health outcomes inequalities during this pandemic.

2.8 Separately, but of paramount importance is the need for data to be collected and published on the number of health and care staff who have caught COVID-19, whether they received treatment after a positive test, and those that have sadly died from the infection. This data must be collected by nationality and ethnicity along with an understanding of the role and setting where the staff member worked so that the true impact of the pandemic is known. We welcomed the recommendation from the latest Public Health England report which set out the need for mandatory data collection on BAME patient outcomes and workforce. This now must be acted upon by Government with urgency and regularly published.

2.9 In order to begin to fully address the structural inequalities our members describe which affects them, their patients and other members in their communities, we expect the UK government to:

- invest in a cross-governmental strategy to tackle health inequalities which sets out clear objectives, measurable recommendations and timeframes with the funding required to achieve them.
- expand the scope of the Government's inquiry to include understanding in full the role of institutional racism and systemic inequality within health and care.
- collect and publicly report on the number of health and care workers who have contracted COVID-19, received treatment and died by their role, setting, ethnicity and nationality as well as whether they had any underlying health conditions. This will provide a clear and accurate picture of the impact of COVID-19 on people with multiple protected characteristics.

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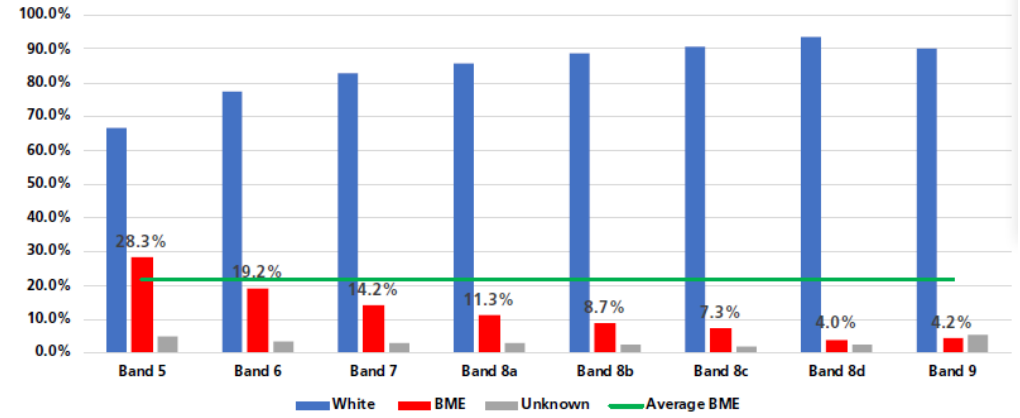
Additional Information

Appendix 1

NHS England have been published annual data, *the Workforce Race Equality Standards*[iii] to highlight and evidence the inequalities faced by BAME staff working in NHS Trusts since 2015. The graphs below highlight stark differences in the bands at which BAME staff work, as opposed to their White British counterparts. Often Bands 4,5 and 6 will be ward based frontline professionals, and as you progress up the pay scales, your managerial and non-clinical responsibilities increase, in this instance reducing your exposure to the viral load from COVID-19.

Figure 5: Nursing, health visiting and midwifery staff by AfC pay bands and ethnicity across the NHS trusts and CCGs in England: 2019



Data source: NHS workforce statistics website.

[i] NHS England Workforce Race Equality Standard, Accessed June 2020, Available here: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf

[ii] Skills for Care, Adult Social Care Workforce Data, Nurses in Social Care, Accessed June 2020, Available here: https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/Topics/Nurses-in-social-care.aspx

[iii] NHS England, Workforce Race Equality Standard, February 2020. Accessed June 2020. Available here: https://www.england.nhs.uk/wp-content/uploads/2020/01/wres-2019-data-report.pdf