THE SEACOLE GROUP
The Network for BAME NEDs in the NHS

Impact of COVID19 on BAME Staff & Communities

PPE

Context: the number of BAME doctors / staff that have sadly lost their lives to COVID-19 is worrying and feeds into the narrative about the BAME community being disproportionately impacted.

1. Can the board provide assurance that PPE is available for all staff in our trust, community or care homes?

2. How many of our staff:

   a) are self-isolating?
   b) have lost their lives to COVID-19?

3. Have we appointed a PPE safety officer (or equivalent) to ensure staff are using the right PPE equipment in the correct way, as well as feed back any concerns?

4. Is there a structured system to determine which staff groups need the different levels of PPE (aprons, masks, visors, gowns) and whether there are any issues with obtaining the supply of PPE items? If there are gaps, what systems are in place to ensure staff safety?

5. What actions and initiatives are being taken at an ICS level in terms of a coordinated response to PPE provision? Are there actual or proposed centralised stocks for distribution to both health and social care providers?

6. What guidance on protecting staff (and in particular at-risk groups) has been provided by NHS England and NHSI? Has our trust gone above and beyond the guidance? Are we keeping a decision log / audit trail?

7. Do we have data on COVID-19 tests amongst trust staff?

8. What was the PPE advice for a viral hazard before COVID-19? Has it changed? What lessons can be learnt?

Workforce (non-PPE-related)

1. Staff (doctors, nurses, AHPs and psychologists) are being redeployed from "non-essential services" to clinical areas where capacity is needed. Reassurance is needed that there are systems and training in place to ensure that these staff are being up-skilled appropriately and supported in such difficult circumstances.

2. The psychological health of NHS staff will be critical at this time. What systems / well-being processes are being put into place to support staff psychologically / mentally. For example, some trusts have created 'wobble rooms' for staff to take time out before and during their shift.

3. We all know that bullying and harassment is experienced twice as much by BAME staff than by other groups in the NHS. Could BAME staff be less likely to complain about inadequate PPE provision leading to them being unprotected?

4. Is there a role for trust BAME networks to be more actively engaged during this period, for example, conducting surveys, facilitating better communication channels, providing practical support?

Legal duties

1. Given that we have a duty of care under the Equality Act 2010, have we, or any organisation in the NHS (including NHSE/NHSI) completed an equality impact assessment?

2. Many trusts have had a window of vulnerability regarding PPE. As a result, some members of staff have contracted the virus, which has resulted in either self-isolation or, sadly, death. NHSE/I and associated trusts (especially where a member of staff has died) could therefore be liable under the Corporate Manslaughter and Corporate Homicide Act 2007. Have we or any organisation in the NHS undertaken a health and safety review in relation to our decisions regarding COVID-19?

Communities

Context: BAME communities tend to have worse health inequalities and suffer from multiple deprivation. The housing conditions of multi-generational households and low healthy life expectancy are two of the many determinant factors. We need to make sure that all our communities (and staff) have access to the information that could save them. Not sure the messaging from government actually caters for large extended families, how to keep all isolated, how can that happen when there is no space to isolate?

The Seacole Group: strategies for HR colleagues

One of the aims of the Seacole Group is to share good practice. This is even more important as trusts explore different ways to support staff during the COVID-19 pandemic.

Below is a list of approaches adopted by trusts across the country combined with other sources of advice that we've researched. We recognise that not all will be appropriate, but our hope is that it will stimulate a discussion about what could be done in your organisation.

1. A letter from the chief executive officer/chair encouraging staff to share concerns and how the trust will show how these concerns are being acted upon.

2. A coordinated response to staff from senior team in liaison with BAME staff network leaders and/or freedom to speak up guardians outlining what is happening and why certain approaches have been adopted.

Communication to BAME staff should:

- acknowledge their fear about the safety of their current working conditions
- accept what the data is stating and outline what plans are in place to address this
- be clear about the procedures and guidelines regarding vulnerable groups, staff testing, PPE and deployment
- remind and encourage staff to utilise current hubs of support i.e. employee assistance, counselling services, staff side and staff networks.

Practical action

- Set up series of virtual meetings for BAME staff to discuss experiences /concerns and consider what other mechanisms of confidential communication are available for BAME staff to share e.g. Slido.
- Involve staff network lead and FTSUG before implementing any action so that the messages and actions are co-ordinated and inclusive.
- Hold regular meetings with staff.
- Additional focus will be needed to enable staff working from home to engage with colleagues and to not feel isolated when working remotely.

Considerations for the board

1. What more can the board do by working with local partners and the media to ensure there is culturally appropriate messaging for the very diverse communities we serve?

2. Given the BAME population of the UK is 14%, evidence suggests that 35% of this group has been impacted by COVID19. What measures can/will we be taking to ensure that staff, patents, communities are not disproportionately impacted by COVID-19?

3. The data in the system clearly shows that health inequality exists and is prevalent. How can we be assured that our response to COVID-19 takes account of this?

Cultural issues

1. What arrangements are in place for staff observing religious festivals, e.g. for Muslim staff observing for the month of Ramadan

2. What advice are we giving to families and friends of deceased patients and staff who have specific observations around death? For example, funeral arrangements and body washing.

Learning lessons

Context: *the rhetoric of a single health care system all the way through to social/community care does not appear to reflect reality – particularly if you ask anyone working in these areas of the care system. This has been clearly evidenced through how the availability and distribution of COVID-19 testing and PPE has been prioritised to this community of workers and patients.*

1. What can we do to ensure that we as a board aren't embarrassed when we discuss our vision for a joined-up system?

2. Any crisis requires an agile mindset and flexible decision-making mechanisms to cope with unknown or changing circumstances. What are our lessons as we navigate our way through this crisis? How are these and the mitigation plans being captured and actioned?