Royal College of Nursing Submission: Women and Equalities Inquiry into the unequal impact of COVID-19 on Black, Asian and minority ethnic (BAME) people.

Written evidence, July 2020.

Background

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 BAME nursing staff. Nursing staff have shown unstinting professionalism and dedication to patient care throughout the COVID-19 pandemic, often in challenging circumstances. All nursing staff, irrespective of their background, have been and always will be key workers.

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] and 38% working in adult social care are from a BAME background.[ii]
- Every day that BAME health and care staff are disproportionately affected by COVID-19 is another day these workers and their families are needlessly put at extra risk.
- Our BAME members have reported feeling unsafe and unsupported in the workplace, and we know from our surveys of members, that they have had a disparate experience of COVID-19 to their White British counterparts.
- Lived experience and emerging research is telling us that BAME health and care staff are at increased risk of contracting COVID-19 and becoming critically ill as a result, yet employers and Government have been slow to respond with coherent strategies and actions designed to mitigate and manage these risks.
- COVID-19 has not created health and structural inequalities; it has uncovered 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 different communities is transparent, engages with stakeholders and BAME people. Any recommendations made must result in tangible action, be measurable and be evaluated in full.

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

Nursing staff make up the largest part of the health and care workforce. Embedded within our communities, institutions and services as both providers and recipients of health care across all settings; nursing staff witness and experience the systemic and structural inequalities present within our health and care service, as well as across the country which have been brought into sharp focus by COVID-19.

NHS England have published annual data since 2015, the *Workforce Race Equality Standards* (WRES) to highlight and evidence the inequalities faced by BAME staff in NHS Trusts. According to 2019 WRES data, there were 66,513 BAME nurses working at Agenda for Change bands five and six, compared with 2,096 BAME staff working in management band eight.[iii] Also, in 2019, there were 4,995 less White British nursing staff in band five compared to an increase of 3,064 BAME nursing staff in the same band that year. Often bands four to six will be frontline professionals providing care, therefore, as BAME staff are overrepresented in these pay bands, their exposure to the viral load of COVID-19 increased. The WRES provides powerful and compelling evidence but this has not been utilised effectively to investigate and level up the experiences of BAME health care staff and patients.

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.

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. 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. This is unacceptable and is not conducive to ensuring patient and staff safety. We also know that in some places, organisational cultures may inhibit BAME staff from raising concerns for fear of reprisal, especially for migrant nurses. Moreover, given management structures favour White British staff, this further causes BAME staff to feel disengaged and unheard.

We expect all employers to be proactively ensuring the safety of all staff during this pandemic and beyond. Employers must conduct 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.

Health and care worker deaths related to COVID-19

From the outset of the pandemic, the RCN has been calling for Government and relevant bodies to collect and publish data on the number of nursing staff who have: contracted COVID-19; received hospital treatment for COVID-19 after testing positive and sadly died. The Office for National Statistics (ONS) have only recently began publishing COVID-19 related deaths by occupation for England, Wales and Scotland which do include health and care worker deaths, but this has been too slow and remains incomplete to fully inform policy and decision making. In particular, the deaths of staff in social care is not further broken down by role so there is no understanding of the impact on nursing staff.

We expect this mortality data to include information on nationality and ethnicity along with an understanding of role and setting where the staff member worked. Whilst there is no official data on the nationality of health care workers that have died of COVID-19, analysis of existing data reveals a disproportionate number of deaths for certain groups; Filipino nurses for example comprise just 3.8% of the UK workforce but sadly represent 22% of NHS nurse deaths.[iv] This data is not yet being routinely collected by Government for every setting. This information is vital to scrutinising the safe working environments of all staff, and to compare the level of risk which staff face compared to the general population. There is increasing concerns that BAME workers are at significant risk, and so information about ethnicity will be important to assess trends and make recommendations for future action as necessary.

Explaining the disproportionate impact of COVID-19 on BAME groups

The recent Public Health England reports make clear the long-term and potentially devastating impact of COVID-19 on many communities, however we are concerned by the impact on particular communities including Bangladeshi, Black and other BAME groups.

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 in order to mitigate any further disparities.

Many of the recommendations are also actions that we would expect the Government and employers to already be carrying out as part of their aims to create a diverse and inclusive health 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.

We expect a pragmatic use of the current evidence base and the lived experience of BAME people - which is showing us the heightened risks - by the Government. There are a large number of studies that give consistent indications of systemic racism throughout health and care provision and the wider system. Research can always explore these issues in more depth, but as there is mounting evidence and existing reviews, these must be utilised to drive urgent action given the inequalities of health outcomes during this pandemic.

The use of biology as an indicator can also be a distraction, and the disparities between BAME groups contracting and dying from COVID-19 will not be understood by biology alone. This creates a narrative that is unhelpful and of limited scientific use as there are multi-layered and complex

structural and societal factors which require examination before the true impact will be understood and causation definitively assigned. Similarly, explanations for the disproportionate mortality rate of BAME staff have also focussed on issue of culture. We know from our members that some nurses are less likely or feel unable 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.

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 review and forthcoming Commission so that there is understanding on how different protected characteristics interact to create disadvantage or benefit within this pandemic. We have called for the UK Governments to move quickly to develop clear, cross-governmental strategy and costed action plans to tackle racial disparities across society.

The UK 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;
- expand the scope of all inquiries and commissions to include understanding in full the role of institutional racism and systemic inequality within health and care from people with lived experience;
- 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.

Additional barriers migrant BAME nursing staff have faced during COVID-19

There are currently 77,065 non-EEA internationally educated nurses working in health and care across the UK. Hostile migratory policies, including visa restrictions and conditions imposed on migrant nurses have resulted in additional and nuanced issues for this group during COVID-19. Throughout the pandemic, Government have made some short-term concessions focused at alleviating some of the issues and at increasing the international workforce capacity more generally. However, these actions do not go far enough.

Financial pressures for migrant staff are particularly concerning. Anecdotally some RCN members of have reported the impact that no recourse to public funds (NRFP) is having on their lives. Whilst British nationals shielding or self-isolating will benefit from the security of public funding, we are concerned that migrant workers are being forced to choose between continuing to work despite being at risk, or otherwise staying at home and falling into destitution. This is wrong and will put staff and patient lives at risk. The vital contribution and value of our internationally educated workforce has come to the fore during the pandemic. We expect that migrant nursing staff are treated as equal. The Government must lift NRPF for the duration of the pandemic and use of state support must not impact on any nurse's future application for settlement in the UK.

For more information, please contact: Rachael Truswell, Public Affairs Adviser, Rachael.Truswell@rcn.org.uk or 0207 647 3607.

[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] [iii] 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