

Social Care Sector COVID-19 Support Taskforce

BAME Communities Advisory Group

Part 1: Report and Recommendations

Section A: Introduction

1. This is the report of the BAME [Black, Asian and Minority Ethnic] Communities Advisory Group (AG), established to make recommendations to feed into the work of the *Social Care Sector COVID -19 Support Taskforce*.

Part 1, Report and Recommendations, includes a summary literature review and selections of findings from consultations that the AG has drawn upon to make its recommendations. Part 2, is an appendix, containing the other material that informed the work of the AG.

2. The Terms of Reference for AG specifies that the focus is BAME¹ people ‘who are in receipt of social care services [‘Service Users and Carers’] and the BAME workforce [‘professionals’] within social care sector including residential and domiciliary care for older people, and residential and community services for people with learning disabilities, sensory, autism and mental health needs.’
1. The AG members are:
 - a. Tricia Pereira –Head of Operations & Adult Safeguarding London Borough of Merton [Co-Chair]
 - b. Cedi Frederick – Chair, North Middlesex University Hospital NHS Trust [Co-Chair]
 - c. Sophie Chester-Glyn – Director, Coproduce Care
 - d. Geraldine McMurdie – Head of Intermediate Care, HC-One
 - e. Dr Godfred Boahen, Policy, Research and Practice Improvement Projects Lead, British Association of Social Workers
 - f. Amrit Sumal – Compliance Director, National Care Association
 - g. Fazeela Hafejee – COVID-19 Consultant, Association of Directors of Social Services (ADASS)
 - h. Zohal Shafiq – DHSC, Chief Social Worker’s Office (policy support)
2. The expertise of the AG included senior leadership in the NHS and social care, incorporating the interface between health and care, ‘co-production’ methodology with BAME groups to influence policy, for example Parliamentary Inquiries, and social work practice, research and training.
3. The AG’s work covered the period 31 July – 14 August 2020 and therefore from the outset, it faced the huge challenge of addressing a recognised complex issue of national importance, within a tight deadline. Members believed strongly that people with lived-experience of the issues must be consulted in developing the

¹ The AG recognises that BAME is a contentious term and this is discussed in the literature reviews in the Appendix section. It is adopted here for analytic purposes and to reflect its use in public policy.

recommendations, using co-production methods (Social Care Institute for Excellence, 2015). It is for this reason that two consultations were held (discussed below).

4. The focal point of the work of the AG is *experiences within social care*, for both professionals and Service Users and Carers. Through consultations and using co-production principles, the AG has ascertained how BAME people using services, and professionals, believe that their 'race' or 'ethnicity' contributed to their receiving poorer care than white people, and identifying evidence for how these inequalities manifested in the care of BAME people during the pandemic.
5. In addition to several whole group virtual meetings, Co-Chairs met with Chairs of other AGs of the Task Force and fed back to the group. Members also used WhatsApp and email to communicate, disseminate information and discuss emerging lines of inquiry. The methodology for developing the Recommendations in this report comprised:
 - A rapid literature review (UK Civil Service, 2014) to scope overall thematic issues and appraise existing research on the employment experiences of BAME professionals.
 - An online survey of BAME professionals and Service Users and Carers
 - Two virtual consultations on Zoom of BAME Service Users and Carers and professionals, using the focus group method.
 - Key informant interviews of leaders of social care organisations and faith groups.

Section B: Rapid literature review

6. Various studies since the pandemic have evidenced the disproportionate impact of COVID-19 on BAME people and the differences within ethnic groups (Haque et al, 2020; Platt and Warwick, 2020; Public Health England, 2020). A rapid review of this emerging literature and existing studies on health inequalities and differential outcomes for BAME people in care services was undertaken. Full details are in the appendix.
7. The literature indicates that BAME health and care professionals have experienced disproportionate mortality relative to their white counterparts (Razaq et al, 2020). For instance, two-thirds of health workers who have died from contracting COVID-19 have been from the BAME population. Cook et al (2020) found that even within this 'disproportionately high rate of BAME individuals among those who have died within the NHS, over 50% of staff who have died were born outside the UK.' *Therefore, in attempting to understand the disproportionality within the workforce, migration as a potential explanation should also be analysed.*
8. With an established consensus about the association between BAME and COVID-19 infection, including mortality rates, attention is now turning to two issues. The first is identifying explanations for the association and secondly, determining the risk and protective factors for BAME people in the population and

the care workforce. The work of this BAME Communities Advisory Group addresses these two agendas.

9. Khunti et al (2020) reviewed the existing evidence to identify 'explanatory factors' for the disproportionality. *Structural* issues included the likelihood of poverty within BAME groups, exposing them to other risks factors such as overcrowding and multi-generational households. The researchers also noted that BAME people were more likely to be employed in a 'key worker' role, thereby increasing the risk of their exposure to infection (see also Haque et al (2020) for similar findings).
10. Taking an international perspective, Yaya et al (2020) suggest that structural racial disparities may explain the reasons why minorities in the USA, Norway and the UK have been disproportionately impacted during the pandemic. This argument suggests that COVID-19 is emblematic of pre-existing social inequalities manifested through 'race.'
11. By the above analysis, structural issues manifest by being implicated in poverty as well as within employment, and both combined, increase the likelihood of BAME people being infected at work and within their homes. However, it is also suggested that BAME groups have higher rates of 'co-morbidities' which increase the risk of mortality from COVID-19 (Public Health England, 2020). However it may also be that structural factors reduce BAME peoples' access to healthcare, thus leading to unmanaged co-morbidities.
12. A recent analysis by the Runnymede Trust (Haque et al, 2020) provides some evidence about how these inequalities manifested in the experiences of BAME people during the pandemic. The study noted that BAME key workers were more likely to report that they did not have access to PPE or that they had experienced 'unfair treatment' because of their ethnicity.
13. In terms of workforce issues, during the pandemic, attention turned to how to prevent and reduce BAME keyworkers' disproportionate exposure to COVID infection. The Royal College of Psychiatrists (2020) addressed this 'urgent issue' and produced initial guidance on risk mitigation, which in May 2020 was marked for urgent implementation across mental health services.
14. The Royal College of Psychiatrists report also raised questions about racism in the workplace and helpfully set out a series of recommendations around adjustments and support to be provided in the workplace. Whilst the report focuses on BAME staff in health care settings, the recommendations can be easily adapted and adopted for social care settings.

Section C: Consultations with Service Users and Carers & BAME professionals

15. This section presents a summary of the findings of the consultations with the BAME workforce and Service Users and Carers which have informed the AG

Recommendations. The consultations were held on Zoom and were attended by 36 professionals and 11 Service Users and Carers.

16. Due to the short time that the AG had to complete this work, the virtual sessions were advertised on the weekend of Friday 7 August and held on 10 August and this presented some limitations around reaching a wide 'sample'. However that so many people attended the engagement sessions at such short notice demonstrates the willingness of the BAME community to engage in finding solutions. There has also been direct contact with the AG from the community for more consultations on this topic, arguing that they are 'long overdue'.

17. Experience of BAME social care professionals during the pandemic

- a) One of the surprising findings from this engagement session was the number of professionals who were also unpaid or informal carers and community advocates. They described this as their 'double roles' and attributed this to the particular nature of BAME family structures in which members are expected to provide informal care. Combining this with work created additional stress.
- b) They also highlighted their unexpected roles as community advocates due to services closing because of the 'social distancing' requirements. As community advocates, they provided information and explained, translated or interpreted guidance and highlighted to the community the importance of following the Government's public health messages. They were sources of information and advice in their communities and external families. Many reported that this role caused additional stress, however positively, it also increased their confidence and ability to be self-advocates.
- c) Participants who were also carers reported feelings of frustration by the response from non-BAME staff who seemed not to understand or appreciate their 'double roles' and considered making the necessary adjustments for them.
- d) The lack of testing was reported as a major issue affecting all roles in social care, causing a lot of anxiety. During the consultation, the following sentiments were echoed throughout "*we cannot get any testing for supported living...unless there is an outbreak, that's when they will test and that is unacceptable*".

18. Fear

- a) Participants said that, at the peak of the pandemic, they were fearful for the own safety, the safety of other staff and colleagues, and the safety of Service Users and Carers
- b) There was an immense amount of uncertainty and unknowns and the professionals reported feeling exposed and unsupported. They were fearful about how Service Users and Carers would cope in the absence of direct contact from professionals - "*We also work a lot with people with complex mental health needs, but many of the service users did not get much support from other agencies [during the pandemic]*".

19. Experiences of differential treatment and risk assessments

- a) Participants felt that they were devalued, and their concerns were not taken seriously – *“one person’s COVID-19 was rapid, they went to hospital but they were sent home”*.
- b) There was an overwhelming focus by participants on risk assessments. This was a serious concern for them and participants reported that they felt delays in risk assessments exposed them to unnecessary risks – *“risk assessments were given later on, after there was a push for them”*.
- c) Where organisations conducted risk assessments for BAME staff, colleagues resented this, arguing that this was unfair – *“White or non BME/BAME colleagues asked about why I was having a workplace risk assessments and not them – it would have been fairer to implement a policy to assess or screen everyone”*.
- d) Participants expressed the view that sometimes risk assessments were conducted as ‘tick boxes’, *“[employers] covering themselves”* instead of identifying the support that BAME staff needed.
- e) Risk assessment did not highlight the particular needs of the BAME community – for instance additional care responsibilities were not communicated and captured in the risk assessments.

20. Action points for policy makers

21. Below is what the BAME professionals in the consultations regarded as priorities for the Government to address the issues that they faced during the pandemic:
- a) Engagement and dialogue with the workforce in order to better understand the impact of COVID-19 on frontline workers, thus informing a more appropriate level of support and resources that are needed.
 - b) The Government should address the instability and discrimination in the workforce which cause presenteeism, where employees who are not fully well and functioning because of an illness, or injury may still attend work and may seek health intervention later rather than earlier on, or self-medicate with over counter remedies. Presenteeism can interfere with adhering to the self-isolation requirements.
 - c) Government should ensure regular testing of the social care workforce – as has been shown in this section, a significant part of the BAME care workforce also has caring responsibilities and frequent testing may reduce anxiety and ensure their safety both at home and work. The Royal College of Psychiatrists (2020) argued that ‘testing 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.’
 - d) At the time of writing, policy is being regularly updated and reviewed as more is known about the virus. Testing and tracing to other settings, has been extended to, for example supported living services, not just registered care services.
 - e) However many of the participants were not aware of this development. Although it could be said that all workers have a personal responsibility to keep themselves updated, more work needs to be done to ensure that policy

updates are more widely publicised and that workers at all levels in social care are aware of their rights and policy developments that directly affect them.

- f) Increased psychological support for BAME staff and for this to be provided in a culturally appropriate manner.
- g) Address the fear within the BAME workforce, better use of evidence and data to support and clearly explain the disproportionate impact of COVID-19 on the BAME workforce.
- h) Acknowledgment of intersectionality of workers who have dual roles and of workers who have a disability, e.g. who are Deaf or Hard of Hearing Lip-readers who are impacted by wearing traditional masks and face coverings or workers who may have health conditions.
- i) Acknowledge the impact of structural racism in the workplace and show how this impacts on the ability of BAME professionals to challenge unsafe practices..

22. Experiences of BAME Service Users and Carers

- a) Participants noted that the pandemic occurred against the backdrop of austerity and reduction in services, alongside longstanding barriers to BAME Service Users and Carers accessing services. They believed that these combined led to the disproportionate impact of COVID-19 on BAME communities.
- b) During the pandemic 'social distancing' caused difficulties within a cultural context – *“in our culture we support each other, we visit family but we were not allowed to do that, that was very difficult...it was isolating and lonely...so difficult.”* This also included mourning and grieving in culturally appropriate manner.
- c) During the pandemic, barriers to accessing services were compounded by difficulty in knowing where to get support – *“in terms of the COVID thing it has been appalling, if I didn't have experience of how the system worked, I would be needing mental health services myself [from the frustration]”*.
- d) Alongside this there has been lack of services and for multigenerational carers, this has been especially difficult – *“I have a disabled son who was able to go to college. All they did was send homework. My wife is also disabled , we have had no practical help.”*
- e) Service Users and Carers could not obtain PPE, including culturally-appropriate equipment. They also did not know where to seek advice if the person that were caring for contracted COVID.
- f) Service Users and Carers complained about a 'communications gap' during the pandemic - *“communication has broken down, you feel you are on your own, even doctor says that they cannot help...I think lack of communication so people do not know who to turn to...you are left in a situation where you are going round and around.”*
- g) Information was also not translated and what was available was usually online, adding another barrier to access

23. Differential treatment

- a) Participants indicated a strong believe that they experienced differential treatment in social care because of their 'race'. For some, the pandemic 'magnified' existing differences – *"The common shared theme is racism...that is the same old and it is the COVID pandemic which has made it even more difficult on top of the usual struggles [of accessing services]."*
- b) Examples included appointments being cancelled without explanation and 'struggling' to have their symptoms taken seriously by professionals. On this point a carer noted that *"People just seemed to struggle to be taken seriously, their symptoms [of COVID] have not been recognised and taken seriously and in the end they had to put their foot down."*
- c) Some of the participants suggested that their experiences of 'not being taken seriously' stemmed from what they termed *"medical racism – the assumption that black people can take more pain, their COVID symptoms are taken less seriously even when they report it, just the fact that Black people are not taken seriously at all."*

Case study – prescription of vitamin D supplements

A number of participants reported that at the height of the pandemic, they were told by their GPs that they, or the people they cared for, required vitamin D supplements as BAME people can be at greater risk with lower levels. However some GPs refused to prescribe the medication, even for Service Users and Carers on low income. For some participants in the online consultations held by the AG, this was an example of health inequalities at play. If it is the case that BAME people required vitamin D supplements, why has there not been widely publicised? And why is the medication not provided free on the NHS?

24. Good practice occurred where a member of the community, sometimes a Faith Leader, or an organisation, acted as a 'Trusted Person' to:

- 'Filter' and signpost people to sources of information
- Translate guidance and other information
- Act as an advocate to breakthrough barriers to access
- Support people during bereavement by 'translating' guidance on funerals into cultural practices

25. Action points for policy makers

26. BAME Service Users and Cares involved in the consultation suggested the following action points for the government:

- A 'multi-pronged' approach involving:
 - I. Public information campaign explaining to BAME communities the conditions under which they have rights to care and support.
 - II. 'Myths-busting' about the stigma that BAME people are 'super-spreaders'.
 - III. Training of the health and social care staff about how institutional discrimination within health and care services operate – *"you need to*

start at that point and then look at every sinew (of discrimination)...all of those things that we know already...I feel like people want us to get rabbits out of the hat but we know these things."

- Monitoring of racial disparities in social care outcomes in local areas and taking action to remove them.
- Provision of culturally appropriate services.
- Provide priority slots in hospital and GP appointments for older people and carers from BAME communities with specific cultural and religious needs.
- The Government should fund a helpline with options for languages that people can access for information about services.
- Central government should have designated funding for BAME community groups. There is evidence that these were disproportionately affected by austerity and yet they (and faith groups) appear to have been particularly effective in filling the gap in support caused by the withdrawal of services during the 'Lockdown'.
- The NHS 'one size fits all' health screening should be adjusted so that where BAME communities experience certain conditions earlier, for example higher rates of high blood pressure, diabetes etc, they can access screening.
- Focus on vitamin D screening for BAME communities and have supplements for people diagnosed with low levels prescribed on NHS.
- Require hospital and care homes to add vitamin D for BAME residents following regular blood tests.

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Section D: BAME Communities Advisory Group Recommendations

1. **We recommend that the work of the BAME Communities Advisory Group continue beyond the timeframe set out by the Social Care COVID-19 Taskforce, with involvement of the Minister for Women and Equalities.**
 - The wide ranging issues of inequality raised through our work and the clear and obvious benefits of communicating directly with BAME individuals, carers, people who work in social care, faith group leaders and others require further consideration.
2. **We recommend that people with lived experience; who are in receipt of social care, their support networks and people who work in social care are at the forefront of developing social care policy and guidance that affects BAME communities.**
 - The future work of the BAME Communities Advisory Group should include facilitation and coordination of this.
 - The Advisory Group have found that BAME leaders and individuals have not been hard to reach and have been very forthcoming.
3. **We recommend that there is parity between staff working in the NHS and social care in research, the design, development and delivery of programmes that support BAME staff through this and future pandemics**
 - BAME workers within Social Care should be included in the Jointly funded research study by UK Research and Innovation (UKRI), the National Institute for Health Research (NIHR), and University of Leicester-led UK-REACH (UK Research study into Ethnicity and COVID-19 outcomes in Healthcare workers) Or an equivalent study to be funded for Social Care.
4. **We recommend that The NHS Confederation, Care Providers Alliance and British Association of Social Work come together to share best practice and coordinate their advice and support to Employers and BAME staff.** This would include:
 - Developing co-produced online resources and training for employers on how to support and protect BAME staff and how to implement guidance and information equitably.
 - Tailored mental wellbeing support for BAME care staff and those receiving care and support.
 - Issuing guidance which further clarifies employer's responsibilities to prioritise support for frontline BAME staff working in social care, including prioritising PPE, consideration of adjustment to working patterns, conditions and/or locations and improving general health and wellbeing.
 - Encouraging employers to discuss these measures not only with BAME staff but all staff.

- We recommend that alternative and creative methods of engagement are developed and utilised to widen participation. Online platforms have proven to be successful to facilitate inclusion with younger BAME people.
5. **We recommend that research and accurate data is widely and quickly shared from Government to local authorities to inform the development of strategies that minimise local outbreaks.**
 6. **We recommend that faith and ethnicity be recorded on death certificates and data sets with**
 7. **We recommend the development of a ‘Trusted Places and Trusted People’ strategy as the way of disseminating awareness, knowledge and information.**
 - Using evidence to inform - For BAME communities, community led works.
 - Using existing and relevant legislative frameworks e.g. The Care Act 2014 & Localism Act 2011 to facilitate local level decision-making with communities and individuals.
 - People are more likely to listen to people they know, trust and identify with; be that through religious, community or other affiliation, where information is translated into multiple languages or shared through mother tongues.
 - This is particularly important with messages of prevention i.e., self-health improvement, flu vaccination etc.
 8. **We recommend that greater efforts are made to improve cultural ‘competence’ at Government level.**
 - This includes understanding the impact of the closure of places of worship and the timing of issuing closures. Many religions are a rules based and only the Faith leader can issue a “breaking of the rules” in order to prevent harm or to minimise risks to others. e.g. directing people to not group or come together. Therefore clear messages from Government, are necessary.
 9. **We recommend that there is increased robustness in co-ordination of the Health and Social Care System, thus working better together to support BAME staff in social care between the NHS and Local Authority, Social Care and Public Health.**
 - Specifically, more sharing of information, learning and best practice emerging from NHS employers to social care employers on how to support and protect BAME staff including risk assessment processes and procedures, protective measures, campaigns and guidance.
 10. **We recommend that guidance is produced and clearer expectations set, that deliver improved messaging on the need to protect BAME workers across social care.** (in line with evidence which details the higher risk posed to them)

27. Part 2: Supporting Material

28. Appendix 1: Rapid literature review

1. Various studies since the pandemic have evidenced the disproportionate impact of COVID-19 on Black, Asian, Minority and Ethnic (BAME) people and the differences within ethnic groups (Platt and Warwick, 2020).
2. Kirby (2020) has noted that 'The UK's Intensive Care National Audit and Research Centre data, up to April 30, shows that of 6574 patients with COVID-19 in intensive care, one third were from non-white ethnic groups; ethnic minorities make up only 13% of the population as a whole.'
3. There is also a recognition the BAME health and care professionals have experienced disproportionate mortality relative to their white colleagues. For instance, two-thirds of health workers who have died from contracting COVID-19 have been from the BAME population. Cook et al (2020) found that even within this 'disproportionately high rate of BAME individuals among those who have died' within the NHS, over 50% of staff who have died were born outside the UK.'
4. With an established consensus about the association between BAME and COVID-19 infection, including mortality rates, attention is now turning to two issues. The first is identifying explanations for the association and secondly, identifying the risk and protective factors for BAME people in the population and the care workforce. The work of this BAME Communities Advisory Group addresses these two agendas.
5. Khunti et al (2020) reviewed the existing evidence to identify 'explanatory factors' for the disproportionality. *Structural* issues included the likelihood of poverty within BAME groups, exposing them to other risks factors such as overcrowding and multi-generational households. The researchers also noted that BAME people were more likely to be employed in 'key worker' roles, thereby increasing the risk of their exposure to infection.
6. Taking an international perspective, Yaya et al (2020) suggest that structural racial disparities may explain the reasons why minorities in the USA, Norway and the UK have been disproportionately impacted by COVID-19. This argument suggests that COVID-19 is emblematic of pre-existing social inequalities manifested through 'race.'
7. The BAME Communities AG's terms of reference include concepts such as 'BAME', 'social care', and 'who are in receipt of social care services', used routine by professionals and policymakers. However these are contentious concepts and their political implications and limitations were recognised by the AG from the outset.

8. The use of 'BAME' in public policy

- a) The Black, Asian and Minority Ethnic (BAME) classification emanated from the 1991 census for policymaking in health, social care and immigration ². But the nomenclature is contested for a number of reasons.
- b) One argument is that the collective category, BAME, does not reflect how people recognise themselves and their self-identity. For instance 'African' does not capture the ethnic and religious differences of people who originate from the continent (Aspinall, 2011). Similarly some people of Chinese origin reject 'Asian' as not representative of their identity.
- c) A second reason why BAME is rejected is because it is positioned as a marker of *difference* from the majority white population, with the latter treated more favourably. In this respect, proponents believe that BAME is functioning, socially, as a marker of 'race', a discredited and rejected concept which posits that there are genetic differences between people signified by their skin colour.
- d) Notwithstanding these objections, it is argued that BAME is useful analytic category in public services because, while invented, it nevertheless shows *differential outcomes* for people so classified. For instance the *Race Disparity Audit* found that 'Employment rates have increased for all ethnic groups, but substantial differences remain in their participation in the labour market; around 1 in 10 adults from a Black, Pakistani, Bangladeshi or Mixed background were unemployed compared with 1 in 25 White British people.' (Cabinet Office, 2017).
- e) Similarly there is a longstanding association between ethnicity and access to healthcare, and ethnic minority doctors in the NHS are less likely to be promoted to be consultants, more likely to face official complaints and more likely to report poorer health (Kmietowicz et al, 2019).
- f) Therefore in policy-making and academic literature, BAME has been used for analytic purposes, and there is a consensus that certain principles have to be followed to address the limitations of the category (Mir et al, 2012). This is the approach adopted by the BAME Communities AG.

9. Examining the constituents of 'social care'

- a) The National Audit Office (NAO) (2018) defines social care as:
Adult social care covers social work, personal care and practical support for adults with a physical disability, a learning disability, or physical or mental illness, as well as support for their carers. Adults with care needs cannot perform some activities of daily living such as washing, dressing, cooking, and shopping without support. These needs are often multiple and interrelated with other needs. Adult social care is therefore part of a complex system of related public services and forms of support.

² UK Government. No date. List of Ethnic groups

- b) In the NAO's conceptualisation above, adult social care encompasses the spectrum of welfare services such as benefits, health, housing, local authority adult (statutory) services and leisure provision.
- c) It has also been argued that due to increased eligibility threshold, there are many people who *need* services but do not receive them. Therefore in exploring the reasons for the high mortality rate of BAME people during the pandemic, there should be an equal focus on how their ethnicity might have limited their access to services, and increased the risk of infection and/or mortality (Haque et al, 2020).
- d) The social care workforce is usually taken to mean the section of the workforce providing social, as opposed to, health care. Social care services are also provided within health settings and jointly by health and social care staff. Furthermore some health professionals provide care – for instance figures from 2018 suggested that there were 41, 000 registered nurses in social care (Royal College of Nursing, 2018).
- e) The workforce also consists of regulated and unregulated professions. The latter are required to follow Codes of Practice (and ethics) and regulatory standards. Others, such as social workers and nurses in mental health, will have statutory duties, which have to be discharged by law. Social care staff, who are unregulated, have critical roles in peoples care, and they may feel that they have ethical obligations to discharge those duties, even where they also face risks of being infected by COVID-19.

10. The BAME social care workforce

- a) The overall context for the BAME workforce issues discussed in this section is the longstanding recognition of barriers faced by ethnic minorities in the labour market. The recent Government review '*Race in the workplace: The McGregor-Smith Review*' found evidence of inequalities, including reduced opportunities for promotion and 'examples of discrimination and outright racism that are illegal and clearly have no place in any 21st century company' (p. 7).
- b) The Review recommended a 'road map', including, the collection of data on race disparity in the workplace, enhanced organisational and managerial accountability, increasing awareness of diversity issues, transparent and fair recruitment and specific actions by government.
- c) Within the social work workforce, the category 'BAME staff' include both ethnic minorities who are British and those recruited from overseas. In an analysis of the demography of the workforce, Skills for Care (2019) show that:
 - I. BAME people comprise 21% of the workforce – this is an over-representation of their 14% of the population of England. Black/African/Caribbean/Black British account for nearly 50% of the BAME workforce.
 - II. 8% (115,000 jobs) have an EU nationality and 9% (134,000 jobs) have a non-EU nationality. The top-10 countries of origin for non-British born

staff were Romania, Poland, Nigeria, Philippines, India, Zimbabwe, Ghana, Portugal, Jamaica, Italy.

- d) With 17% of the workforce being non-British, immigration policy is another important strand of the discussion. In review of the literature, internationally recruited BAME nurses were found to have encountered positive experiences, which included supportive workplaces (including by their managers and supervisors) and 'highly effective' establishment of equal opportunities in their workplaces (West and Nayer, 2016).
- e) However other research has shown that non-British BAME staff do not oppose discrimination because they are unaware of their employment rights and some are also concerned that their visas would be cancelled by their employers, if they did so (Pendleton, 2016).
- f) Other studies have shown that where BAME staff have complained about differential treatment, they report that their allegations have been denied or there has been 'indifference (telling BAME individuals to 'just get over it').' (Ross, 2019).
- g) Furthermore in some of the regulated professions in social care, BAME people are over-represented in Fitness to Practice investigations or complaints. In social work, this disproportionality is recognised by the regulator Social Work England, although there are few studies which explore the reasons for this over-representation (Samuel, 2020).
- h) It may be the case that staff feelings about their immigration status, or their experiences of differential treatment, influence whether they choose to challenge unsafe practice, demand their employment rights and challenge managers where they are exposed to unacceptable risks.
- i) In regard to management, Skills for Care (2019) found that only 17% of senior management roles are filled by BAME people even though they comprise 21% of the workforce. This means that they are under-represented in management positions. However there are differences in occupations, as in some roles they are over-represented. These include social work (25%), registered nurse (38%), care worker (24%).

Appendix 2: Analysis of the online survey

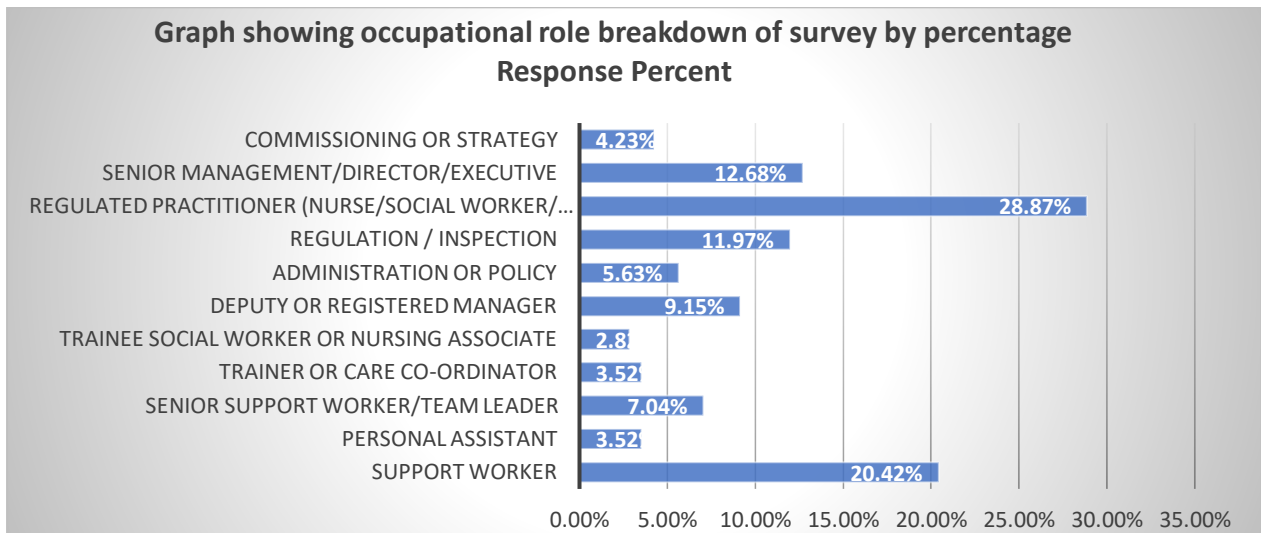
1. The BAME Communities Advisory Group conducted an online survey to inform its recommendations.
2. Two surveys were created. One for people who work within the sector (The Workforce Survey) and another for people who use care services (The Service User Survey).
3. The surveys were open for completion from 6th – 11th August 2020. The surveys were promoted by the Advisory Group to BAME staff via professional bodies and workforce networks as well as carers networks and social media. 142 responses were received from the social care workforce and 12 responses from people who receive social care services.

- Respondents reported a lot of support and trust in employers and provider organisations. People were less positive about the information supplied by government about COVID-19.
- Respondents felt that Government information lacked clarity. Some felt that their teams or employers did not understand the risk to BAME groups, the intricacies within 'BAME' or in some cases did not believe the compounded risks they faced from existing inequalities.
- Most respondents felt that the government should work closer with care providers and local authorities. Others stated that there should be collaboration with community groups or faith leaders.
- There were strong responses for better support around PPE, better guidance for BAME people working in social care and people who use services and for better use and knowledge of risk assessments.

4. Demographics

5. The ethnicity of respondents was mainly African (31%), Caribbean was second (26%), Indian third and the largest group within Asian categories (15%). Of the mixed/multiple ethnicity groupings, White and Black Caribbean was the largest proportion in the responses (9%). There were a number who selected 'Other' and opted to describe their ethnicity (16%).
6. In terms of religion, Christian was by far the most popular choice for respondents (59%). 'No religion' was second (16%), Muslim third (11%) and Hindu fourth (8%). The rest of the religious groups including 'other' had less than 3% of respondents included in each.
7. The majority of respondents were female (69%) and the rest of the respondents identified as male. The majority of social care workers were aged between 45-54 (36%) or 55-64 (25%). 21% of respondents were in the 35 -44 age bracket. 13% were between 25 – 34 years and the rest of the age groups all had less than 3% represented in each.

8. 50% of the survey respondents lived in urban areas, 39% in a suburban areas and only 11% said they lived in a rural area. This is reflected in regionality where most respondents lived in London and the South East (48%) or England Midlands (24%).
9. **Professional Profile:** In terms of professional field, most of the respondents worked in social work (51%). The second highest professional profile was from care and support including nursing (34%), and others worked in a health or Allied Health Professional field (15%).



10. Common experiences

11. Respondents were asked ‘what would improve support for BAME staff?’ The following word cloud provides some insights into the answers provided. It shows that alongside practical measures like PPE for basic safety, issues such as awareness and understanding of ethnic diversity could be improved.



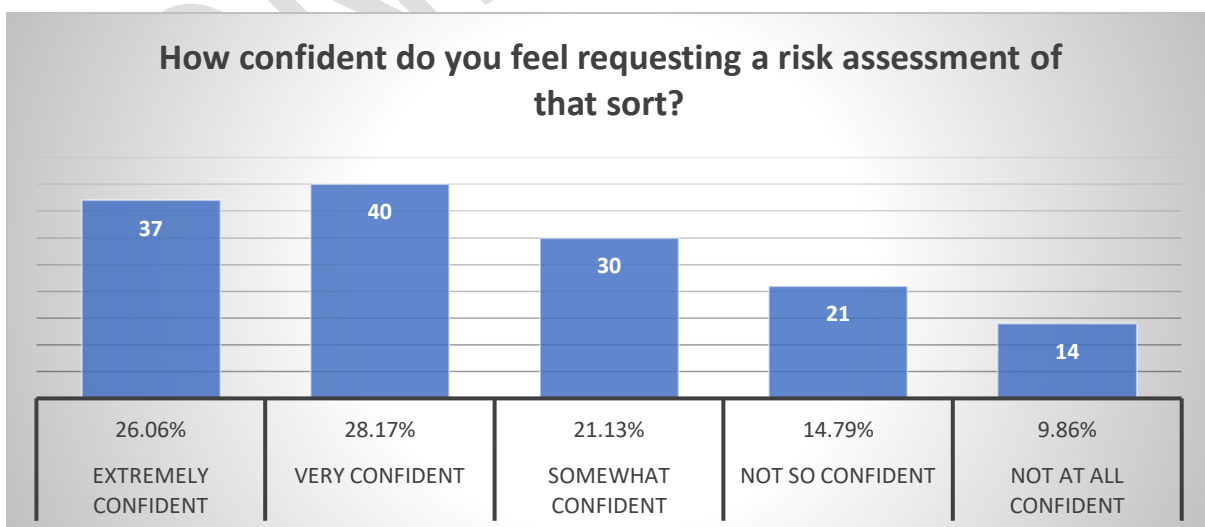
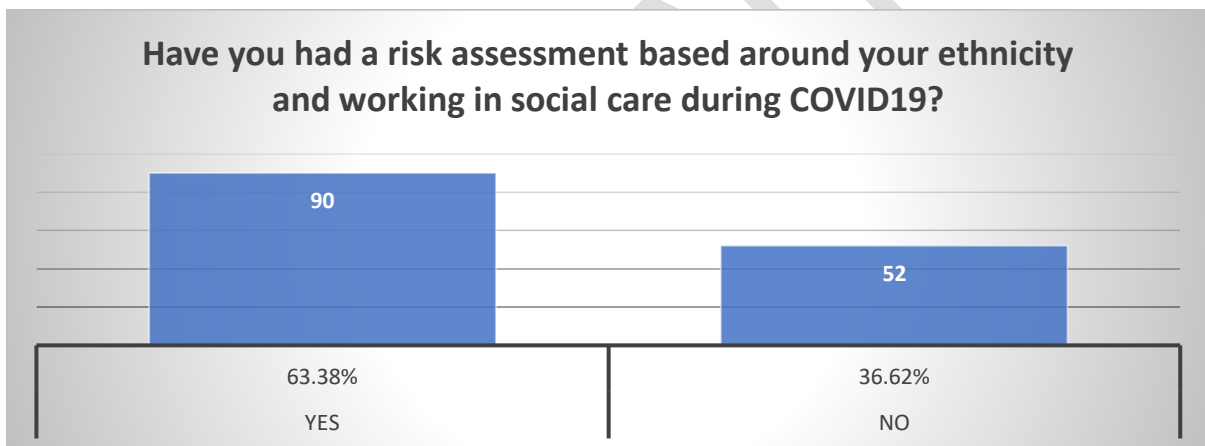
12. The most popular answers focussed on clearer information, understanding and seeing this improved in people’s direct experiences at work or in the community. The analysis shows that respondents were aware of the higher risk and aware of inequalities they faced but were not confident about getting

support related to their ethnicity or they viewed the support as a ‘tick box exercises’. 8% of answers specifically cited information or support not being ‘appropriate’, whilst **35% of responses criticised the ‘support’** they were offered around ethnicity from their employer, local authority or workforce support measures.

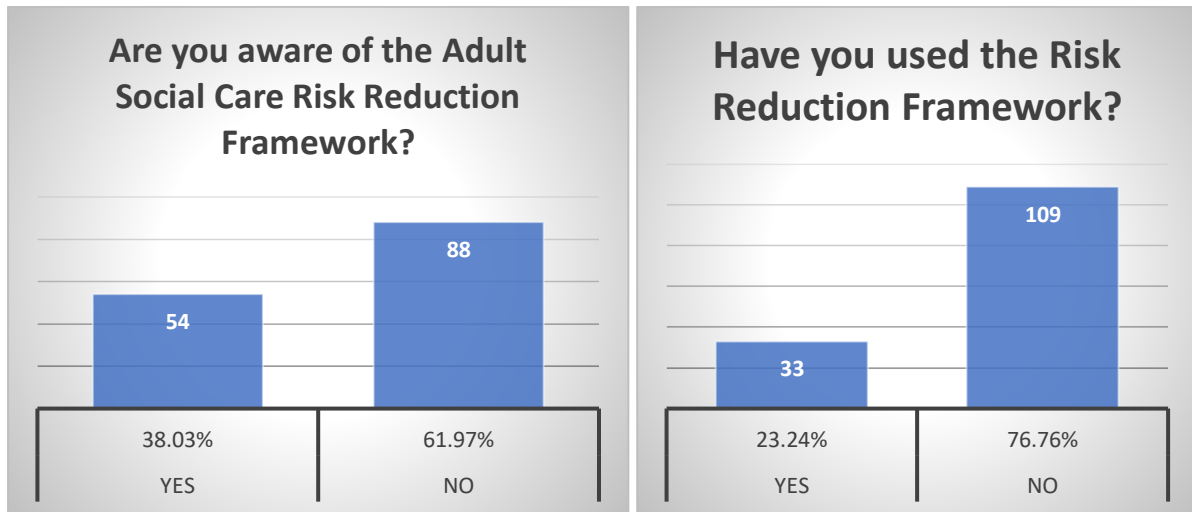
13. Respondents felt that there needed to be better reassurance that their needs or concerns would be properly understood. They demanded **better representation in decision-making**. It is also worth noting that **risk assessments** were frequently mentioned even before the questionnaire requested a response on this issue.

14. Confidence in support

15. Our quantitative section showed that risk assessments were often a successful measure for BAME staff to feel more secure in their work, and that there was a much higher level of confidence around support coming from employers than the government or official guidance. The majority of the respondents had been risk assessed regarding ethnicity and COVID19 and felt confident requesting this from their employer.

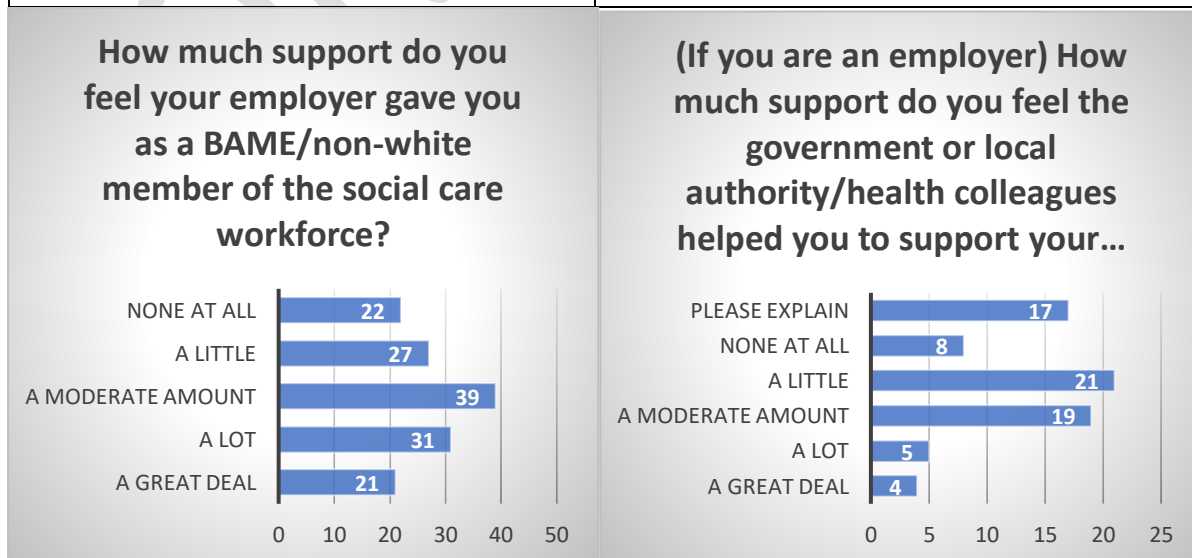


However, awareness and take up of the Adult Social Care Risk Reduction Framework was much lower.



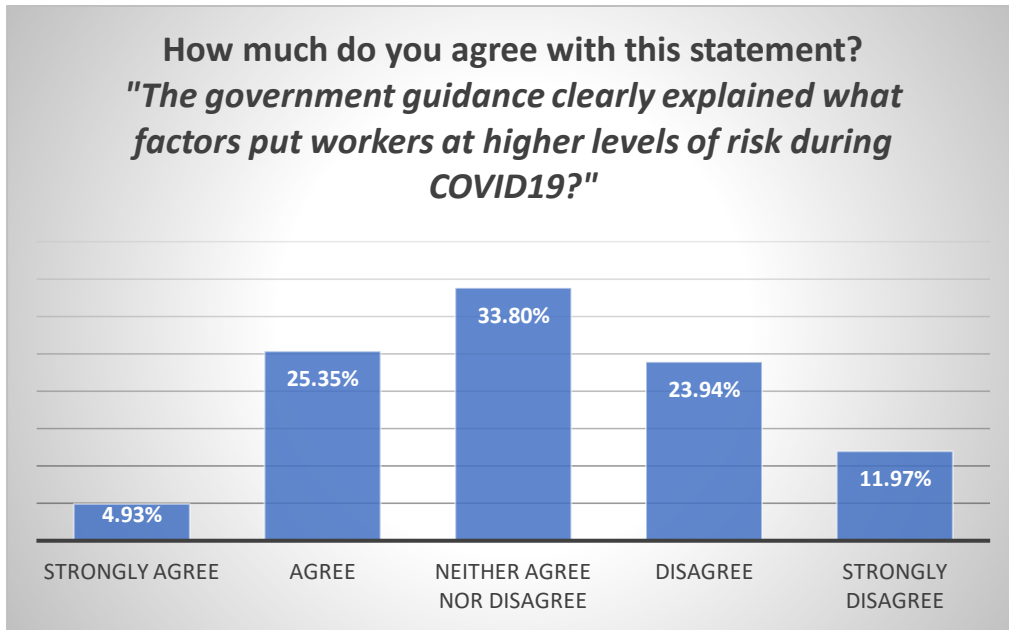
16. Confidence in asking for a relevant adjustment from an employer and the general level of support for BAME staff from employers scored higher than the level of support respondents felt they received from the government.

How confident would you feel asking your employer for an adjustment if you had concerns about your safety?	
Extremely confident	22.54%
Very confident	30.28%
Somewhat confident	25.35%
Not so confident	16.20%
Not at all confident	5.63%



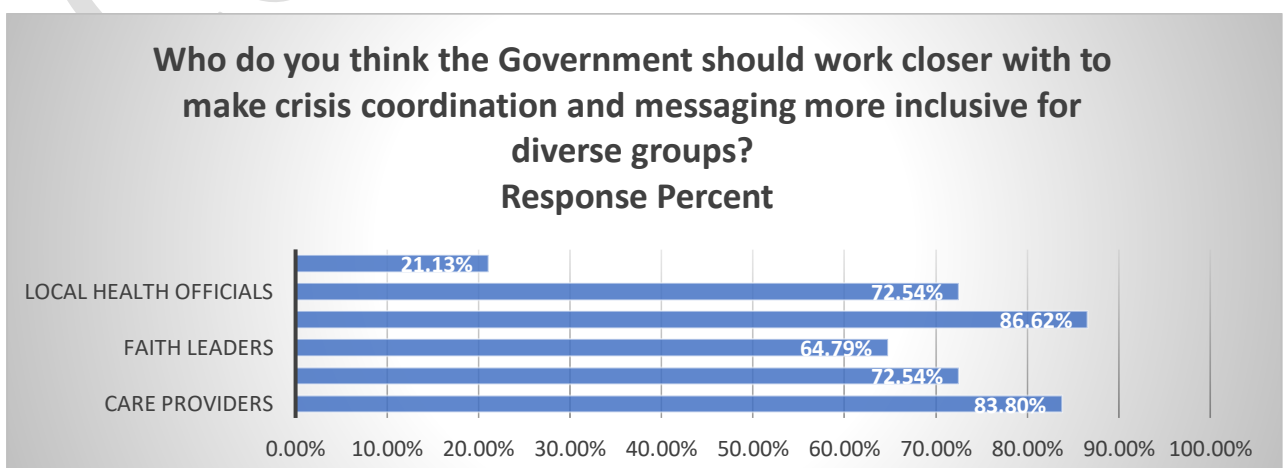
17. It is also important to note that almost every respondent who chose to provide information under the 'please explain' tab regarding government support, described **little or no support from the government**.

The following chart shows that a slight majority leaned towards disagree or strongly disagree regarding the clarity of government guidance.



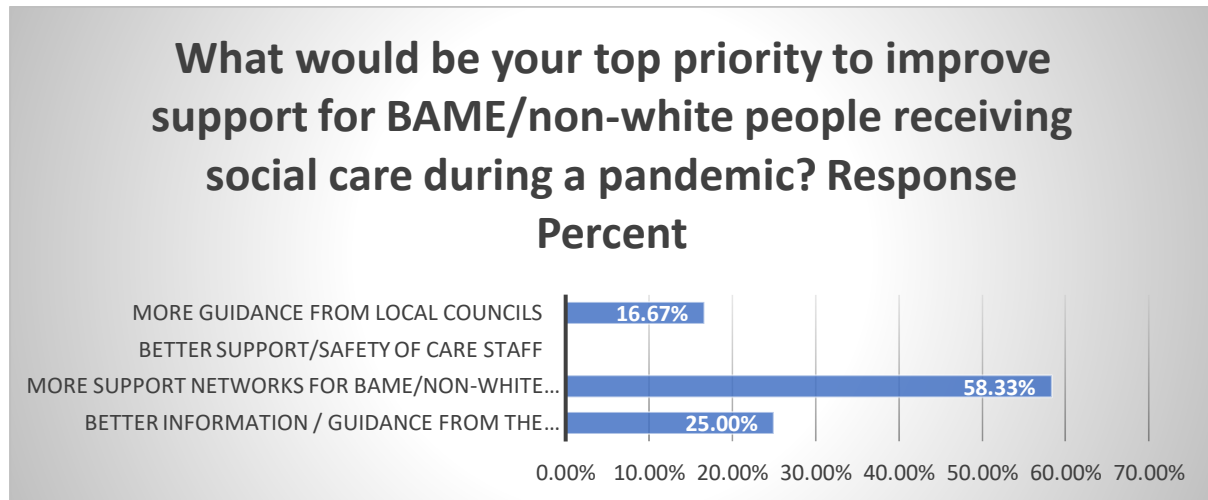
18. "We must remember that this is a pandemic. We have never experienced anything like this before so we need to have more direction from the government to support workforces. The problem lies with the government not the work place". Also, "inconsistent messaging from government and local government."

19. Another important claim about support at different levels that can be discerned from the survey is that BAME care workers we put care provider organisations and local authorities at the top of the list of organisations they feel government should work closer with, slightly higher than those who said community groups or faith leaders.



20. Good / Poor Practice

When asked to comment on examples of good practice for supporting BAME staff during COVID19, many respondents reported that they did not know of any good practice. Of those who did, a large proportion revolved around management or employers giving direct support. For many this included seeing a risk assessment done well, for others it was as little as a conversation or simple acknowledgement that they understand there are distinct issues that BAME staff face.



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Part 3: References

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Part 4: Witnesses

The Advisory group met several individuals and people with lived experience who receive social care and their families, carers and support networks.

Additionally, the Advisory Group interviewed the following and we thank them for their contributions.

Association of Directors of Adult Social Services (London ADASS)

Professor Ivan Browne, Director of Public Health, Leicester

Clenton Farquharson, Social Care Future

Kamlesh Khunti, Professor of Primary Care Diabetes & Vascular Medicine, University of Leicester

Hannah Neal, Merton BAME Voice

Paul Plant, Deputy Director, Public Health England

National Church Leaders Forum

The Muslim Council of Britain

The Council of African and Afro-Caribbean Churches UK

The Board of Deputies of British Jews

The Sikh Council UK

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