

Item 3.2c

WRES briefing for boards and COVID-19 EPRR membership in the NHS

19 June 2020 Version 1

Representation in decision-making

The NHS is at its best when it has diversity of representation and thought at its heart, across its workforce, leadership and processes of decision-making.

This is as important in the day-to-day running of an organisation as it is at times of emergency.

There has been no other time in recent history when ensuring diversity in decision-making was more pertinent than in the responses to COVID-19. A growing body of evidence shows disproportionate morbidity among black, Asian and minority ethnic (BAME) communities, including those of our NHS staff who have contracted COVID-19.

Naturally, when trusts establish emergency preparedness, resilience and response (EPRR) structures, the primary aim is speed, for the very good reason of delivering care to patients. However, it is vital that diversity in leadership structures is not reduced as a consequence of this speed.

As we continue to learn more about the impact of COVID-19 on our BAME communities and staff, our immediate focus should continue to be on ensuring safety. Tackling the disproportionate rates of infection and morbidity from COVID-19 among BAME groups is as much a safety issue as it is an equality matter.

Some key areas where boards and COVID-19 EPRR structures would benefit from the diversity of thought include:

- understanding the concerns and anxieties of staff, patients and service users
 - identifying meaningful interventions to address these concerns
- the protection of staff
 - effective risk assessment of vulnerable staff groups
 - to inform redeployment decisions
 - consistent guidance and access to the appropriate personal protective equipment (PPE).

Diversity in representation will also aid the understanding of any potentially disproportionate impacts on staff, service users and patients, as well as the indirect impact of COVID-19 aftercare and the relevant support that may be required when making changes to services understanding.

Ensuring diversity and inclusion at all levels is essential for NHS organisations because it enables access to a wider range of skills, lived experience, knowledge and talents. It is essential for patients and service users, because diversity in decision-making can help to meet the needs of our diverse communities; and it is essential for staff wellbeing that staff feel cared for, listened to and valued.

How can NHS boards and COVID-19 EPRR structures improve on representation in decision-making?

For the reasons above, trusts should act now to ensure diversity in their EPRR decision-making processes.

Where those structures are already in place, they should be reviewed to ensure that the diversity of the organisation at large, and across specialisms, is reflected in the EPRR composition.

The following steps can help to make these changes:

- When selecting EPRR members for each level of command (gold, silver and bronze), be explicit in seeking members from minority groups to ensure the total membership reflects the entire workforce or local population.
- EPRR should be open to involving talent without prior experience in response structures – this can include requesting support through the various diversity leadership networks (BAME, women's, disability, faith, etc).

- Establish a diversity advisory group to provide strategic and operational input into key decisions (see case study 1.1).
- Ensure equality impacts emerging from decisions are assessed (see case study 1.2).
- Engage with your BAME staff and staff network – refer to published guidance in supporting existing networks or establishing networks where they do not exist.
- Use the network of Workforce Race Equality Standard (WRES) experts ([cohort one](#) and [cohort two](#)) that exist across the NHS (nb – clinical matters should be referred to clinically trained staff).
- Work towards increasing BAME representation at senior and board level within the organisation – the [WRES Model Employer Strategy](#) will provide guidance.
- Ensure that you are reviewing the composition of your EPRR structures as you would with leadership in the course of regular business. The checklist and calculator at Annex A can assist with reviewing your current EPRR structure.
- Act quickly and reassure staff when evidence of potential inequalities is identified. Be open to having honest and difficult conversations.
- Share replicable good practice. As we renew our approach to making decisions as part of recovery and renewal of the NHS, we must make sure we do this in a way that is inclusive. In each of our regions and ICSs, there are good examples of how this is being done. London's new People Board, for example, matches the diversity of the capital's NHS workforce, with over 40% of its places taken by BAME colleagues, and over 70% by women.

Further information on the WRES can be found on [our website](#).

Case study 1: Establishing a BAME advisory group to support COVID-19 decision-making

The Northern Care Alliance NHS Group

Purpose

The BAME Leadership Council is an important consultative forum, established to support the safety and wellbeing of BAME staff working in the Northern Care Alliance NHS Group (NCA). In particular, the group sought to consider and tackle the disproportionate impact COVID-19 has on BAME individuals.

The council will review, discuss and recommend responses to safety and wellbeing issues for BAME staff, that will in turn inform decisions to be made by the executive team and the NCA board.

Over the next 12 months, it is anticipated the group's main focus could move from solely issues of staff safety and wellbeing to address other issues faced by BAME staff in the organisation.

Responsibilities

The council will act in an advisory capacity to the executive team. It aims to make demonstrable difference to the safety and wellbeing of BAME staff by developing recommendations for action. It will do this by:

- tapping into the different perspectives and experiences of BAME staff
- reviewing all approaches to staff policies and processes, as well as staff engagement, to ensure the organisation can communicate clearly with staff regarding the impact of national and local guidance
- analysing data on risk and outcomes for BAME staff safety and wellbeing
- assessing the latest evidence and research to inform recommendation.

Membership

- Chief executive (chair)
- Chief financial officer (co-chair)
- Medical director
- Nursing director
- Operational director
- HR business partner
- Nursing BAME staff member
- Medical BAME staff member
- AHP BAME staff member
- Healthcare BAME student
- Healthcare scientist BAME staff member (diagnostics and pharmacy)
- Estates and facilities BAME staff member
- Corporate BAME staff member
- Occupational health representative
- Organisational development representative
- Co-chair from each BAME staff network
- Associate director for inclusion
- Freedom to speak up guardian (or BAME specific guardian)
- Staff-side representative
- Staff governors.

Reporting

The chair is responsible for escalating issues for consideration by the executive team, including those which require further discussion, decisions to be taken, and/or those of which the council feel the board should be made aware.

Case study 2: Evidencing due regard in COVID-19 decision-making

The Northern Care Alliance NHS Group

Background

As an impact of the COVID-19 outbreak, all NHS organisations have moved into emergency response mode, including regarding decision-making and planning. Often, decisions have had to be made relatively quickly as organisations adapt their services and workplace environments.

Large, complex, public-sector organisations responding to these circumstances will be faced with the challenge of ensuring they can meet the duties set out in the Equality Act 2010, and ensuring due regard for equality.

It has also become apparent that COVID-19 is disproportionately impacting people with particular protected characteristics.

The Equality Act 2010 requires all public sector organisations to be able to show that, in the development of any changes or decisions that impact on people, they have shown 'due regard' for how any changes may impact on people, compared with the status quo, based on their protected characteristics.

In practice, organisations work towards achieving this by undertaking an Equality Impact Assessment (EQIA). Organisations often use this process within their policy development or when undertaking service transformation in order to manage this risk effectively.

The challenge

Due to the ongoing emergency and the necessity to respond rapidly to fast evolving circumstances, decision makers have not always been clear on the extent to which they should record and demonstrate due regard for protected characteristics, or complete an EQIA.

Key questions that persist include:

- How much time needs to be given to urgent or emergency decisions being made in response to COVID-19?
- How much do we have to record?
- How do we secure an effective approach to manage risk in this area without incurring additional, inappropriate delays to a decision that needs to be implemented quickly?

Proposed solution

The NCA's solution to the current challenge is to provide a clear pathway for the recording of discussions and considerations when urgent decisions are being made by committees and groups, without adding any unnecessary delay to their implementation – see Figure 1 and Table 1 below:

Figure 1: NCA decision-making flowchart on demonstrating due regard for equality



Table 1: NCA Form for demonstrating due regard to equality on urgent decisions

Decision-making body	
Chair of decision-making body	

Lead for decision	
Date decision made	
List what potential negative impacts to status quo for protected characteristics were identified as needing to be avoided or considered when making this decision?	
Outline how any impacts to the status quo for protected characteristics have been avoided or mitigated within the decision being made	
What impacts were discussed in regard to any protected characteristics at the meeting where this decision was agreed?	
Deadline required to start implementation	
Equality team review	
Name	
Date	
Chair's action	
Name	
Date	

Case study 3: Involvement of BAME networks in COVID-19 decision-making

West Yorkshire and Harrogate Health and Care Partnership

The West Yorkshire and Harrogate Health and Care Partnership (also known as an Integrated Care System: ICS) five-year strategy sets an ambition to increase diversity in leadership across partner organisations, specifically for the BAME workforce. A paper setting out specific proposals on how the partnership could make this ambition a reality was approved at the ICS Partnership Board in March 2020.

These recommendations were co-produced with BAME staff network, which is made up of chairs and leaders from across the partnership, as well as colleagues with an active interest in this agenda.

The partnership recognised that to truly transform leadership and improve the outcomes for our people, we must ensure that the ambition is not seen as the responsibility of the network or our BAME staff, but that everyone in West Yorkshire and Harrogate recognises that they have a role in making this a success.

The disproportionate deaths of BAME health and care staff during the COVID-19 pandemic brought this agenda into sharp focus and, in the view of both the partnership and the staff network, called for immediate action.

The West Yorkshire and Harrogate BAME network has been working hard to support the system-wide response as well as the response within their own organisations and focused its activity into several key areas including involvement in decision-making.

The BAME networks across the partnerships supported and were equal partners with the West Yorkshire and Harrogate Association of Acute Trusts (WYAAT) to develop a consistent approach to COVID-19 risk assessments to ensure diverse expertise in decision-making and the ability to flex interventions to meet local need. The BAME networks also shared some top tips and additional guidance with WYAAT organisations and the Mental Health, Learning Disabilities and Autism Collaborative to support the conversations.

This approach has now been implemented across all acute and mental health organisations across the West Yorkshire and Harrogate Health and Care Partnership.

You can find out more here on the [partnership's website](#).

Case study 4: A system-led COVID-19 BAME disparity advisory group

South East Region

The South East regional BAME disparity advisory group was established in response to the emerging evidence of the disproportionate impact of COVID-19 on BAME staff. The group is co-chaired by the Regional Director (Anne Eden) and the Director of ICS Assurance (Scott Durairaj) and involves BAME leaders from across the region to ensure its decisions are BAME led.

The group's purpose is to identify, develop and spread opportunities to minimise the disparity of impact from COVID-19 on the BAME workforce and communities across the region.

Delivery is led through five working groups with each meeting starting with a personal story to remind members about the urgency and importance of this work.

The working groups are:

1. Addressing population disparity

This workstream is designed to support prevention of COVID-19 in BAME communities and has piloted a variety of responses and clinical interventions in Slough. Working across the Frimley health system, with colleagues from primary care and Public Health England, exploration is upon the introduction of contact tracing for targeted groups within BAME communities, working with BAME community leaders to co-design support for local communities.

An example of the community approach underway in Slough can be found as case study 4.1.

2. Addressing workforce disparity

Building on national guidance, the team produced a 'gold standard' risk assessment to support organisations in the region to undertake meaningful assessments. The tool was made available on mobile phones and was supported by guidance for managers which included a board checklist, health and wellbeing guide and advice for line managers on how to manage the risk assessment conversation. Metrics and a dashboard were also created to help executive teams understand and interrogate progress within their organisation.

An example of an organisational approach at Surrey and Sussex Healthcare NHS Trust can be found as case study 4.2.

3. Corporate NHS England NHS Improvement BAME workforce

The group recognised that the needs of BAME staff employed in the regional team may be different to those of frontline NHS facing roles. Senior leaders in the region have

demonstrated their commitment to this work and established two-way communication to ensure that the disproportionate impact of COVID-19 can be discussed openly. Network leads have ensured that the BAME staff network is able to co-design solutions in partnership with both HR and health and wellbeing teams.

4. Communications and engagement

The group's purpose and determination to make a positive difference is at the heart of all communication, helping to create a sense of shared endeavour among leaders in the region. Communication is informed by insight from a range of engagement networks across the South East region in ensuring they are both meaningful and impactful.

Open and transparent communication is an important part of the BAME advisory group's culture, with all meeting papers and action notes being made available to staff via a website.

5. System implementation and dissemination

While maintaining regional oversight of this work, an important aspect is that decisions are co-led by the six healthcare systems in the region.

The Regional Director has engaged directly with systems leaders to ask each system to submit an action plan to respond to the community and workforce disparity during COVID-19. Plans are reviewed, feedback is given, and recommendations shared.

An example of a whole system approach at Sussex Health and Care Partnership ICS can be found as case study 4.3.

Case study 4.1: Diverse representation in decision-making – a community approach to protection from COVID-19

Frimley Healthcare System

Background

Increased rates of COVID-19 are impacting communities with high numbers of BAME residents. Over half (54%) of Slough's population fall within this category and 27% do not speak English as a first language.

Other factors that make this community vulnerable include high deprivation, high population density neighbourhoods and multigenerational, larger households.

Aim and approach

An inclusive partnership has been created in the area to pilot a multi-agency approach which can identify and promote effective interventions. This is supporting individuals and communities to:

- protect themselves and their families by taking preventative steps
- benefit from GP and community services that are easy to access
- reduce their morbidity and mortality risk
- tackle health inequalities.

The partnership brings together Frimley Health and Care ICS, Slough Borough Council and Public Health and community, faith and voluntary sectors. The pilot has the following areas of work:

- improving information – development of a risk profile, enhanced ethnicity recording and sharing of NHS England and NHS Improvement data and BAME health impact assessments
- community awareness and engagement: social marketing, multilingual communications, and engagement with faith and cultural leaders to help build community resilience
- prevention and harm reduction, including frailty detection and management and mental ill health prevention
- clinical management
- enhanced community swabbing for hard-to-reach symptomatic patients in the community
- preventive GP practice outreach work by proactively managing patients in the community for blood pressure, diabetes and weight management

- proactive remote pulse oximetry home monitoring for patients with suspected COVID-19/positive COVID-19
- workforce: undertaking risk assessments with health and care staff and volunteers and understanding and capturing staff experiences.

Case example

I have approximately 5,000 patients of which 90% are from a BAME background. When COVID-19 started in our area, I recognised that many of my patients lived in large, multigenerational households and this could potentially impact the spread of infection within a single household. To protect both the patients, staff and wider community, Kumar Medical Centre (KMC) decided to review any suspected COVID-19 patients in their own homes. Home visits are carried out with full PPE and has enabled the GP practice to keep COVID-free.

Furthermore, by visiting the patient at home, I could assess the other family members and discuss the importance of self-isolation within the household. All COVID-positive patients were coded on our system and as we knew who lived with them, an alert was placed on other members within the household in case another family member became ill.

As a result of this approach, we have now implemented the 'hot car' service in Slough, which visits any suspected COVID-19 patient at home for all GP practices. We are hoping to expand this service with additional swabbing facilities and remote pulse oximetry home monitoring.

A local voluntary group - One Slough - has also been a great source of help with communicating to families and supporting vulnerable members within the community. They have helped with providing food, medical supplies and will be part of our wider support in accessing these hard to reach communities.

It has been an emotional period where our practice has lost patients and a staff member. Our own families are at risk too, but I know our patients appreciate the care we are taking, and as each day passes, we are learning how to help the next patient.

We are now embarking on a proactive approach, introducing preventative measures, as identified above, and are beginning to look at evidence and understand the virus and its effect on our BAME community.

Dr Priya Kumar
Kumar Medical Centre, Slough
GP and Primary Care Lead for Slough

Case study 4.2: Diverse representation in decision-making – an organisational approach to protection from COVID-19:

Surrey and Sussex Healthcare NHS Trust (SASH)

Background

To help reduce transmission of COVID-19, trust leaders wanted to ensure all 5,000 staff, including those in support service roles, felt safe.

It was committed to ensuring all colleagues understood the emerging evidence that COVID-19 was having a disproportionate impact on BAME communities and what the trust could do proactively to protect them.

SASH established a BAME staff network in 2018 to listen to their BAME colleagues and offer advice and guidance to trust leaders. This network has been integral to the approach described below.

Approach taken by SASH

- Early risk assessment of vulnerable staff. This included talking to all staff with higher risk factors and offering the opportunity to work in a lower risk area or from home. This early intervention has helped to minimise COVID-19 sickness absence and mortality rates and offers an example of good practice as described in the South East regional risk assessment tool.
- Hosting socially distanced peer to peer drop-in sessions for BAME staff to discuss concerns and talk to experts face to face, including members of the BAME staff network, clinicians, senior leaders, infection control, workforce, wellbeing, communications and chaplaincy teams. This has reassured staff.
- Feedback is collated from the drop-in sessions and is being used to keep all staff updated and involved, ensuring a high level of ongoing support for BAME staff in particular.
- Offering tailored support and communications channels to different communities and for staff who do not speak English as a first language, including:
 - a dedicated WhatsApp group to keep those informed of support on offer
 - a dedicated app for staff to access individual peer to peer support
 - new COVID-19 action cards for staff specifically for facilities teams, porters and housekeepers, with step-by-step infographics to help them understand proper application and removal of PPE and working in COVID-19 areas.

Staff say that they clearly understand how to keep themselves and their colleagues safe at work and were enthusiastic about having the opportunity to talk to the media recently about the positive work the trust has been doing.

‘I’m happier now I know that I’m following the guidelines and I’m well supported and have the PPE.’ Priscilla, Clinical Support Nurse

Case study 4.3: Diverse representation in decision-making – a whole system approach and response plan

Sussex Health and Care Partnership ICS

Background

The Sussex BAME COVID-19 Response Programme has set out a framework for action across Sussex, which draws on work already being carried out by partner organisations in the system to mitigate the risk to the BAME workforce and local community; and the additional support put in place to save lives through measures to protect staff via health and social risk assessments, testing at scale, provision of PPE and monitoring data.

The plan also includes a strategy for full engagement with BAME staff and BAME communities and stakeholders in Sussex.

The programme will act as a single focal point for coordinating the Sussex response and will co-ordinate, track and report on all actions being undertaken by health and care partners in Sussex. The system programme is being led by one of our BAME executives: Executive Managing Director at Brighton and Hove Clinical Commissioning Group, alongside the ICS SRO as co-lead.

Framework of the Plan

The Sussex BAME COVID-19 Response Plan is underpinned by three key domains:

1. Safeguarding our workforce

The first includes both the health and social care workforce across Sussex and covers:

- Training and compliance on appropriate use of PPE, guidance on re-fit tests, support of use of PPE
- Staff testing
- Risk assessment
- Prehospital care (eg telephone follow up of staff who are ill)
- Recovery (eg review of the quality, access and cultural appropriateness of the current health and wellbeing along with mental health offer for BAME communities).

2. Safeguarding our population (clinical)

We need to mitigate risk in the community and ensure our BAME communities with long term conditions (eg diabetes, hypertension, cardiovascular disease) are reviewed. A locally commissioned service has been put together to use the relationship that already exists with general practice to help us do that more quickly.

3. Engagement and communication

A key element here is to bring together and work effectively with our BAME workforce and resident population. It includes engaging and establishing conversations with existing BAME, faith and other staff networks; improving COVID-19 meaningful communication amongst BAME community groups; ensuring culturally appropriate awareness and support in the workplace for BAME staff; increasing BAME representation in communications and on the media.

In addition to the three key domains, a governance structure has been created to sustain the action plan in the long term.

Key achievements to date

A key achievement regarding all the actions and plans that have been delivered is the very short timeframe in which all the activities below have happened.

1. Safeguarding staff

- Sussex BAME staff engagement event, Friday 5 June - over 300 people participated.
- Primary care communication on guidance and standard operating procedures issued to general practice.
- All partners in the Sussex Health and Care Partnership are developing appropriate risk assessments for staff.

2. Safeguarding our community

- Medical leads: Chief Medical Officer, Chief Clinical Information Officer, Senior Information Risk Owner, Sussex Clinical Commissioning Groups; Deputy Medical Director – Sussex Community Foundation Trust, have been appointed.
- A COVID-19 emergency locally commissioned service (LCS) has been compiled and signed off, which will offer extended health services to local BAME communities.
- Meetings with senior public health researchers at Brighton Medical School have taken place to discuss collaborative work to support this programme. The University has funding for research to support domiciliary care and care homes.
- The Director of Public Health for East Sussex has been appointed the public health lead for the population workstream.
- Working groups have been set up with Sussex Departments of Public Health to agree a strategic approach to collating data in Sussex to support this programme.

3. Communication and engagement

- A Sussex BAME health and care staff engagement event took place in early June 2020, with over 300 people attending.
- Creating partner events with the Voluntary and Community Sector (VCS) to engage with health and care workers in the Third Sector, working with BAME network leads.
- External communications and engagement plans have been developed to support the workforce and population workstreams.
- A key stakeholder engagement advisory group has been established and the first meeting has taken place.
- VCS partnerships have been commissioned to undertake targeted engagement in key hard to reach localities.
- Establishing groups and links with local linguists and community leaders to support the programme.

Annex A: EPRR diversity tools

The WRES team has developed simple tools to assist users in reviewing the diversity of their EPRR structures.

EPRR checklist

In reviewing the diversity of EPRR structures, you should maintain a log of lessons learned, and ensure you ask yourself the following questions:

- How often is EPRR membership reviewed?
- How often does EPRR meet?
- Who is included in EPRR membership?
- Is EPRR membership multi-disciplinary?
- Is EPRR membership representative of the workforce/local population with regards to protected characteristics?
- What mechanisms does EPRR have to listen to the voices of staff and underrepresented groups?