

Risk Assessments and Beyond

NHS England and NHS Improvement





Using the evidence to keep people safe

With emerging evidence of the impact of COVID-19 on BAME communities, on 15 April 2020 Simon Stevens convened a meeting of leaders in healthcare and representative bodies such as the British Medical Association and Royal College of Nursing to agree a plan of action to support staff. The NHS response has been underpinned by three principles of protecting, supporting and engaging our staff.

Public Health England's more recent data analysis reaffirms much of what we have learnt since the pandemic started.

The largest disparity found was by age. Among people already diagnosed with COVID19, people who were 80 or older were seventy times more likely to die than those under 40.

Risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in those in Black, Asian and Minority Ethnic (BAME) groups than in White ethnic groups.

People of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British



Using the evidence to keep people safe

The Intensive Care National Audit and Research Centre (ICNARC) report published on 22 May found that Black and Asian patients were over-represented among those critically ill with confirmed COVID-19 receiving advanced respiratory support. The report found that 15.2% and 9.7% of critically ill patients were from Asian and Black ethnic groups respectively

Stakeholders called for further efforts to strengthen health promotion programmes and improve early diagnosis and clinical management of chronic diseases as a strategy to improve overall health, increase resilience and reduce the risk of adverse COVID-19 associated health outcomes. Stakeholders pointed to racism and discrimination experienced by communities and more specifically by BAME key workers as a root cause affecting health.

The PHE report '[Beyond the data: Understanding the impact of COVID-19 on BAME groups](#)' heard deep dismay, anger, loss and fear from stakeholders about the emerging data and realities of BAME groups being harder hit by the COVID-19 pandemic than others, exacerbating existing inequalities. In their view, COVID-19 did not create health inequalities, but rather the pandemic exposed and exacerbated longstanding inequalities affecting BAME communities in the UK.

Strategies to create healthy and supportive workplaces that have zero tolerance for discrimination and empower BAME staff to raise concerns about occupational risk and safety are essential. So too is work with local communities to rebuild trust and reduce the fear of using health services in the aftermath of COVID19.



Why a risk assessment?



All employers are recommended to risk-assess staff at a potentially greater risk and make appropriate arrangements accordingly.

We are still responding to a Level 4 emergency and risk assessments form part of a legal duty to keep staff safe at work. They are also an important part of reassurance for concerned members of staff, protecting their mental health and wellbeing during the pandemic and in preparation for potential further outbreaks.



The Faculty of Occupational Medicine have published a risk reduction framework which outlines risk factors in light of available scientific evidence. This has been followed up with updated guidance from NHS Employers issued on 28th May and signposting to useful materials and publications.



Employer guidance

Governance

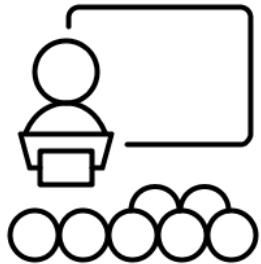
The following guides have been drafted by the South East NHSEI team in partnership with Roger Kline



- Is the Board sighted on and has it put in place **appropriate accountability and resource into Covid 19 workforce assessment and support?**
- Is the Board clear on the additional risks BAME staff face?
- Is Occupational Health centrally involved in oversight and support?

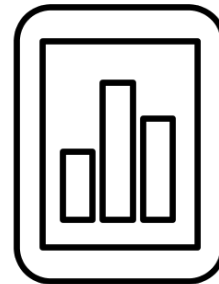


- Is there **BAME representation** in senior decision making/oversight?
- Is your BAME Network fully involved in decision making around the risks to BAME staff?



- Is there an emphasis, wherever possible on strong **staff engagement** to both receive suggestions and hear concerns, before significant changes in working practices?
- Bear in mind research (Francis Speak Up report 2015) and recent reports indicate some groups of BME staff are less likely to raise concerns either because they don't believe they will be heard or because of possible adverse consequences for them.

<http://freedomtospeakup.org.uk/>

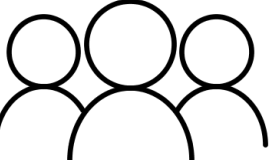


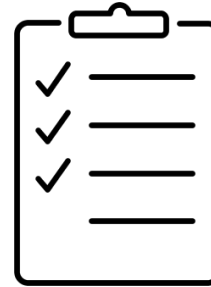
- Does your organisation hold **data** on staff Covid 19 sickness and staff Covid 19 deaths by department, grade, and protected characteristic?
- Are you being **proactive in using such data** to triangulate with soft intelligence from areas of concern – and with other workforce data e.g. WRES and WDES data esp. inc. bullying?



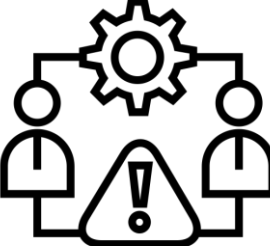
Employer guidance

Risk assessment and deployment

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- Is there a focus to ensure some staff groups are specifically included in risk assessments e.g. **returners, agency staff, newly qualified staff, staff returning from sick or annual leave, and night shift staff**?
 - Is there clarity about the role of the agency in risk assessments and the role of the Trust in ensure safe working arrangements?



- Is there effective management and governance **follow up to risk assessment** both for individuals and at employer wide basis?

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- Do **deployment decisions** correlate with risk assessments i.e. done fairly and proportionately?
 - There is growing evidence that BAME staff believe they are (and may well be disproportionately redeployed to “Covid 19 wards.”

<https://tinyurl.com/y9yn8wj4>



- Are specific steps being taken proactively to ensure **BAME staff are specifically being risk assessed** not just for health risks but for exacerbating workplace treatment factors?



Employer guidance

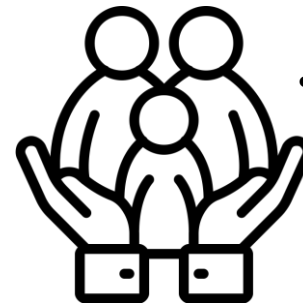
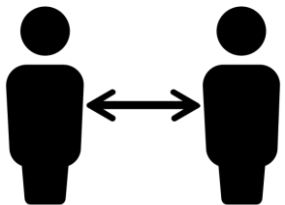
Protection

- Is sufficient PPE appropriate available and if not are decisions to **allocate** done on the basis of need and risk – and done transparently between staff groups?
- Is the **PPE Fit** process effective without disproportionate impact on some staff groups, notably BAME and female staff?



- NHS Confederation, has published [guidance about the use of PPE for staff](#), which includes information about cultural considerations.

- Are managers clear that **social distancing** must be observed in role/function? How is that validated?

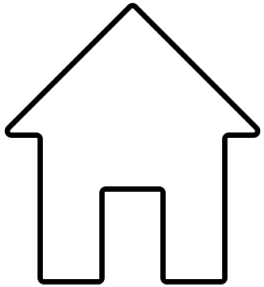


- Is there clarity about PPE expectations in **community, primary and social care** with transparency about provision, training and fit and potential disproportionality?

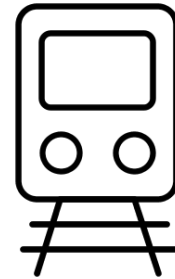


Employer guidance

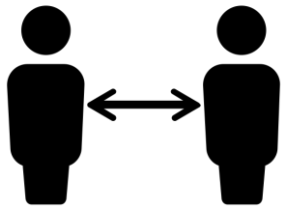
Removal from risk areas



- Is the default position for staff who could effectively **work from home** or who have vulnerable family members at home that they work from home?



- In reaching decisions about working from home or site, is there an acknowledgement of risks from travelling on **public transport** which should be avoided wherever possible?

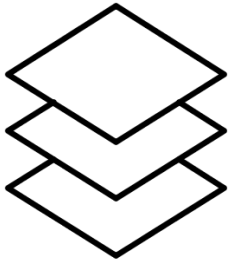


- Is **social contact with co-workers** minimised with audit of open plan offices, shared workstations or hub environments and maximum use of homeworking?
- Are all possible similar steps taken in Outpatient clinics and reception areas?

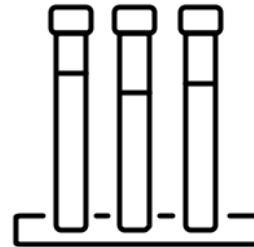


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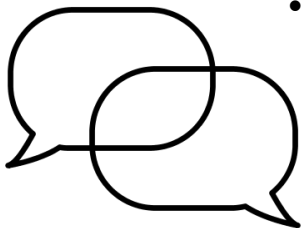
Test



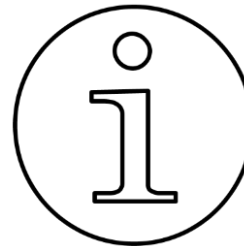
- Is there a transparent policy of **prioritisation** to include all staff identified by risk assessment as being at greater risk (notably BAME staff) and any staff with additional exposure e.g. travelling to work?



- Do all staff know about rapid access testing for symptomatic staff and household members? Are testing arrangements in place for staff in isolation or working from home?



- Are all staff aware of the voluntary screening programme for asymptomatic staff? Managers should review whether the staff member has a means to access this testing programme and support them with this.



- Are managers confident (and do they get support) in having **honest and difficult conversations with BAME staff** about their circumstances?

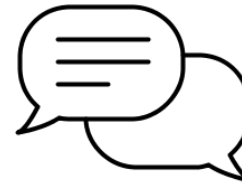


Employer guidance

Engagement and Communication



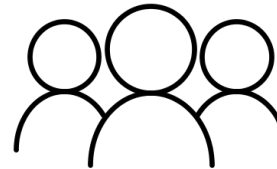
- Are BME staff prominent in decision making on this issue both through networks with access at Board level but also other means e.g. senior BAME managers?



- Is there a clear **narrative** about this work, inc. EDI implications, owned by leaders and managers who are confident in sharing it?



- Are arrangements in place through STPs and more widely to identify, understand and **share better practice**?



- Are there regular conversations with staff to keep them appraised of emerging evidence, to feed back on actions taken and to ensure a continuous two way dialogue?

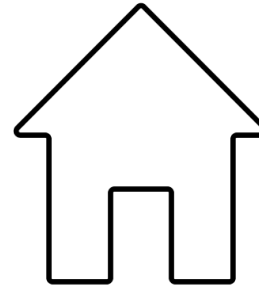


Employer guidance

Support for staff



- What steps have been taken to understand the staff needs during and after the Covid 19 pandemic with particular attention to **BAME staff**?



- What support is in place for staff in **self-isolation** or who are/have been ill with Covid 19?

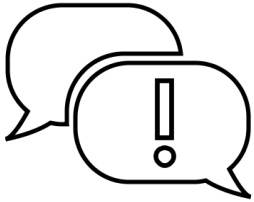


- Are staff are aware that [psychological support](#) is available for any staff member concerned about their vulnerability to Covid 19?

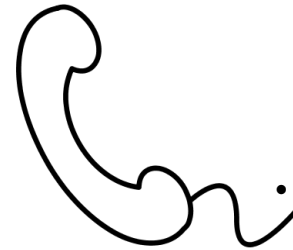


Line manager guidance

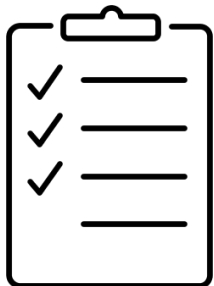
- Please remember that individual staff have a right to confidentiality about any health condition they may have. To enable you to complete the Risk Assessment you can ask staff if they have a condition which is identified in the governments 'social distancing' guidance or the 'shielding' advice however you do not need to know the specific details of the condition, that is confidential to the staff member.



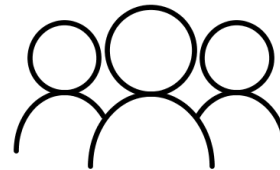
- If an individual staff member chooses to inform you of the specific health condition that is their choice and they must not feel that they have to disclose this information to you
- If there is uncertainty about an individual's health risk you or the staff member can contact Occupational Health to discuss this further in a confidential manner.



- A Risk Assessment should be completed for all vulnerable and/or BAME and /or pregnant staff and/or anyone else who the manager feels may be at risk.



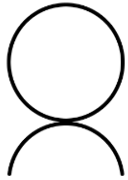
- All staff should be reassured that COVID-19 related absence (e.g. self-isolation for symptoms, isolation as a household member and isolation in relation to shielding) is supported by the Trust and will not impact negatively on their pay or career progression.



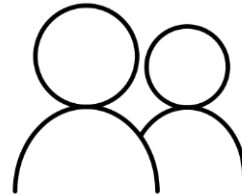


Line manager guidance

The risk assessment



This can be undertaken by line manager, supervisor, who can be supported by designated senior manager or Health and Safety representative



Involve the member of staff

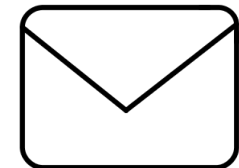


Identify risks using risk matrix provided



Consider the recommended actions to minimise risk

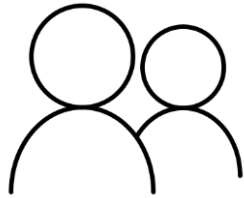
Where a risk assessment identifies that a staff member is at high risk, staff should be redeployed to a lower-risk area, the Individual should avoid caring for any suspected or confirmed COVID-19 patients. If they are clinical, consider if a non-clinical role is available. Should these not be possible, consider home-working if enabled / operationally feasible; if none of these options are feasible then the staff member will likely need to be medically suspended and the line manager should contact the Employee Relations / Medical Workforce team if this is the case.



All Risk Assessments and accompanying Action Plans should be recorded and sent to the Employee Relations team



Staff guidance



All NHS staff are now being offered risk assessments to prevent further infection of staff by COVID-19.

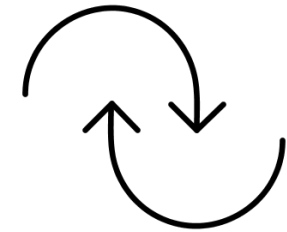
The risk assessments have two components.

The first is to check that you (or those living with you) have no health conditions that are likely to make you particularly vulnerable to COVID-19.



The results of this might be to confirm you can carry on with your current work subject to appropriate PPE and to social distancing (including working from home where possible) – or it might be that you need to move to a different role or even work from home (if that is possible).

All staff, but especially BAME staff, should be reassured that COVID-19 related absence (e.g. self-isolation for symptoms, isolation as a household member, and isolation in relation to shielding) is supported by the Trust and will not impact negatively on their pay or career progression.

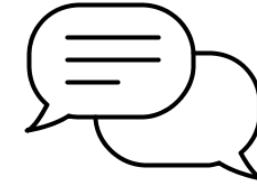
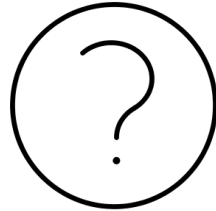


The second is to ensure that nothing else within your treatment in the workplace places you at additional risk.

The purpose of both risk assessments is to ensure that all staff are able to work safely, but it also recognises that some staff will need additional careful risk assessment. This group includes, but not exclusively, BAME staff who are both at greater risk from long term health conditions and from their treatment at work.



Staff guidance



1. Are you confident that you have been provided with appropriate PPE equipment and that the FIT process was carried out safely?
2. If not are there particular concerns you would like to raise or suggestions you would like to make in respect of either issue?
3. Are you satisfied that social distancing rules are being met in all aspects of your work?
4. If not are there particular concerns you would like to raise or suggestions you would like to make?
5. Do you have caring responsibilities for vulnerable family members at home or have home living arrangements that make social distancing difficult?

6. Have you been redeployed?
Was the basis on which you were redeployed satisfactorily explained?
If you were redeployed was appropriate PPE and FIT undertaken?
If so do you have any concerns or suggestions about the process and support arising from that process?
7. Do you still feel you should be redeployed to work from home or to a non-clinical area?
8. If you are an agency worker, a bank staff worker, a returner, or a newly qualified, night shift worker or returning from sick leave member of staff do you feel you have been treated less well than other staff doing similar jobs in the Trust?
9. Have you tried to raise any concern or suggestion? If you did, was your concern or suggestion acted on? If you had a concern but didn't raise, what would have given you confidence to do so?
10. Do you feel you had all the support you would have hoped for from the Trust to cope with additional pressures COVID-19 may have caused you personally?



Beyond the risk assessments

After the speeches: what now for NHS staff race discrimination? Roger Kline, 2020

Equality, diversity and inclusion must finally become core Board business. No one should be a member of any NHS Board if they cannot confidently explain to staff and managers (and interview panels) why tackling race discrimination is important for the NHS and demonstrate what they are doing personally to achieve this. To gain the insight required to act requires difficult face to face discussion, reading, and listening and acting on lived experience.

Every leader must seek out and understand their local challenges, looking for risk not comfort. They must be familiar with Workforce Race Equality Standard (WRES) data and other equality data such as turnover, exit interviews, and absenteeism rates disaggregated by site, occupation, and service. Those challenges include patient and community experience. The repeated refusal of individual Boards (and national bodies) to be honest and open with equality data is a serious shortcoming that must end.

Boards should stop signing off “action plans” unless those proposing them can demonstrate why they are likely to work. In considering clinical interventions, we look for such evidence. A typical NHS “action plan” on race discrimination consists of improving policies and procedures, introducing better training, and some positive action. Yet research found ‘attempts to reduce managerial bias through diversity training and diversity evaluations were the least effective methods of increasing the proportion of women in management’

Boards must be proactive and preventative. If they don’t use research and data (including lived experience) to drive interventions, inserting accountability at every stage, they will fail. Rather than adding a BME member to a disciplinary panel, for example, managers must not start a disciplinary investigation unless they can demonstrate it is the appropriate and fair response to an alleged offence and not discriminatory in itself

Boards must embed accountability. Start by setting clear measurable time-limited goals, ensuring managers and staff understand why, and then holding themselves (and their managers) to account. There should be consequences and/or incentives when agreed diversity goals are not met, as for any other key performance indicator (KPI). helping build their capacity and confidence at every level, recognising that requires investment of time and determination by leaders.



Beyond the risk assessments

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Boards and teams must prioritise psychological safety so they become inclusive, welcoming the difference that BME staff bring, recognising that when they are really included and valued, able to bring themselves to work, there are immense benefits for all ⁷. Boards must understand that whilst improved BME representation is crucial, the benefits are limited without inclusive behaviours and culturally sensitive psychological support

Boards and leaders must model the inclusive behaviours they expect of others, with consequences if they do not. Culture is largely shaped by what leaders do and don't do. Good leaders put themselves in the shoes of others, listen, enable, polish the skills of others, and are honest about mistakes. They make diversity and inclusion a personal priority, not leaving it to those subjected to poor behaviours to challenge them. Demonstrable values should be a core part of appraisals.

Equality, diversity and inclusion are drivers of service improvement so must stop being primarily a matter of compliance delegated to junior staff

The focus of NHS work around race equality must change. Remorselessly challenging racism must go hand in hand with supporting those who want to eliminate discrimination, question their own privilege and be allies. Such support must tackle the bizarre absence of a properly resourced national good practice repository on diversity and inclusion

It is time to step up national accountability. Good governance has accountable metrics. Why, for example, are Trusts that cannot demonstrate serious progress on race equality still receiving a CQC Good or Outstanding rating?



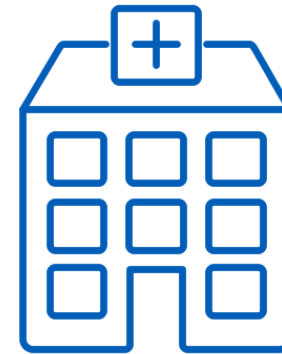
Case studies



[AT Medics](#) – How a large London primary care organisation conducted risk assessments to empower and protect their staff.

[Thistlemoor Medical Centre](#) – How a primary care medical centre changed working practices to reduce Covid-19 transmission and support its staff.

[North West London integrated care system](#) – How an ICS worked with members organisations to support line managers in risk assessing and protecting staff.



[Derbyshire Community Health Services NHS Foundation Trust](#) – How an NHS Trust rapidly set up a versatile COVID-19 risk assessment tool and training to support line managers.

[Leeds Teaching Hospitals NHS Trust](#) – How a large hospital trust supported BAME staff having a disproportionate impact emerging from COVID 19.

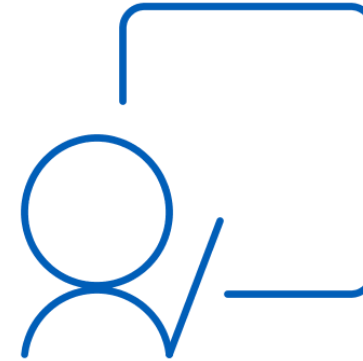


Case studies



[United Lincolnshire Hospitals NHS Trust \(ULHT\)](#) – How a large acute hospital trust managed IPC issues when staff were wearing a hijab or headscarf and alternative solutions.

[Manchester University NHS Foundation Trust](#) – How an NHS Foundation Trust tackled the issue of fit testing a respirator mask to those unable to clean shave for religious reasons.



[Surrey and Sussex Healthcare NHS Trust](#) – How an NHS Trust ensured that staff were using PPE appropriately and in particular those who don't speak English as their first language.

[Ashford and St Peter's Hospitals NHS Foundation Trust](#) – How an NHS Foundation Trust ensured that staff were fully trained on using PPE.

[Chelsea and Westminster Hospital NHS Foundation Trust](#) – How an NHS Foundation Trust ensured that outsourced staff were given the appropriate level of protection, training and care as those employed by the NHS.