THE EMPTY ECHO

Decision-makers may listen to BAME concerns, but will they act on them? ***Asha Day*** examines the recent Public Health England report, the lessons that have been learned, and those that haven't.

In June 2020, Public Health England published *Beyond the data: understanding the impact of COVID-19 on BAME groups*, a summary of stakeholder insights (see *Beyond the data: recommendations*, right).

The report found that, compared with previous years, all-cause mortality was almost four times higher than expected among black males for this period, and three times higher in black, mixed and other females (see *Covid mortality*, overleaf.

EASY TO IGNORE?

Many readers will question why NHS organisations have been told to collect ethnicity data as part of the minimum dataset, but no penalties are paid for failing to do this. Although the Equality Delivery Scheme 2 (EDS2) should provide the levers to ensure commissioning and therefore delivery of culturally appropriate services, is it doing so? Who monitors this and what are the consequences of not delivering on EDS2?

Clinical commissioning groups should ask themselves: how can the right service that the community needs and will engage with be commissioned if you do not have this data? Without it, services are commissioned generically, but will only be effective for a portion of the community. Perhaps it's more of a case that BAME communities are not 'hard to reach', just easy to ignore.

Much of the work of the NHS ethnic health unit and the Department of Health's Race for Health programme, which supported primary care trusts in the early 2000s, were good examples of how to access, engage with and provide culturally competent services to BAME groups/communities. However, they have left little trace or legacy.

WRONG DIRECTIONS

Lessons have been learnt but have not been implemented or sustained. A term I coined in late 2019 was the 'empty echo'. When someone from the BAME population makes a statement it is often overlooked, but when a white colleague makes the same statement it is taken on board and discussed. However, this echo is empty – the true understanding belongs to the person who first articulated it. Now, taken away from them, the statement loses meaning or has a completely different connotation or direction.

So many voices have been ignored in the past. Could this be the reason we have lost so much ground in the BAME agenda? Is this why we have seen many projects make no impact and those that did make progress, not taken forward, embedded or sustained?

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WHO INSPECTS THE INSPECTORS?

The Care Quality Commission (CQC) must look at itself internally. As a regulatory body it needs to examine more rigorously across the protected characteristics.

Increasingly, BAME members of CPHVA are raising concerns that issues articulated with CQC inspectors have not been accurately reflected in subsequent reports. Inspectors have often been white and from a middle-class background. The CQC should recognise that overlooking claims is an issue to address, and this continues to be a work in progress for them.

How are the standards/objectives being demonstrated and measured? Are there any plans for financial penalties to be implemented? Could we include a 'cultural intelligence and race competency assessment' on every inspection as an added value to the CQC report, not completed by the organisation but by an independent organisation with input from BAME staff (group and local community)?

Should the CQC be made to ensure that equality, diversity and inclusion (EDI) is a core standard and to assess EDI standards as central to the overall assessment? Should we expect the CQC to measure this standard, and if not assessed as 'good' or above the overall assessment be impacted negatively? This is now a debate that the newly formed Race and Health Observatory, part of the NHS Confederation, has taken up.

For EDI to become a core standard, that must be achieved prior to any further assessment by the CQC, which must see substantial improvement in health outcomes, patient satisfaction and positive impact on staff survey results for the BAME population and workforce.

ACTIONS FOR NHS AND SOCIAL CARE ORGANISATIONS

Organisations need to ask themselves:

- Do we have a BAME network/staff support group (SSG)?
- Do we value our BAME network/s?
- Does the chair of the network perform this role as part of their role, or is it on top of the 'day job'?
- Does the BAME network/SSG have executive director sponsorship?
- How much do we want to become an anti-racist organisation?

There are also process considerations:

- Is there a governance and reporting mechanism for the BAME network/SSG?
- How does the network/SSG link into the trust's board, which has ultimate accountability?
- Does this process have meaningful dialogue?
- Can this process influence internal policy?

Many chairs have reported, at both BAME regional and national meetings, that they chair local networks on top of the 'day job'. They feel at a disadvantage to the small number of their counterparts who enjoy the role as a paid position and have the time to read and interpret rapidly generated policy and reports.

ARE WE VALUED?

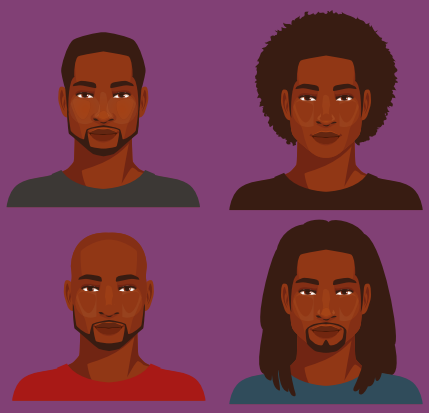
We must prioritise financial resources, time and executive leadership for BAME networks/SSGs within organisations' commitments. Many of these chairs are still asking 'Am I really valued?' Organisations should demonstrate how these groups have added value to health outcomes for patients and the workforce.

Solutions have been found across the globe, and success has been seen when there has been active engagement and commitment at the chief executive level, including active sponsorship of BAME leaders in senior positions. Reverse mentoring (where a non-BAME senior staff member immerses themselves in a BAME worker's experience) has been positively evaluated but because it is a one-to-one programme, results can be slow. A new programme, reciprocal mentoring, is now being introduced but is yet to gain traction.

BEYOND THE DATA: RECOMMENDATIONS

1. Comprehensive and quality ethnicity data collection and recording as part of routine NHS and social care data collection systems.
2. Community participatory research to understand the social, cultural, structural, economic, religious, and commercial determinants of Covid-19 in BAME communities.
3. Improvement of access, experiences and outcomes of NHS, local government and integrated care systems commissioned services by BAME communities.
4. Faster development of culturally competent occupational risk assessment tools to reduce the risk of employees' exposure to and acquisition of Covid-19, especially for key workers.
5. Culturally competent Covid-19 education and prevention campaigns.
6. Culturally competent health promotion and disease prevention programmes for non-communicable diseases promoting healthy weight, physical activity, smoking cessation, mental wellbeing and effective management of chronic conditions.
7. Covid-19 recovery strategies to actively reduce inequalities caused by the wider determinants of health to create long-term sustainable change.

COVID MORTALITY



All-cause mortality was almost

4x

higher than expected among black males for this period, almost

3x

higher in Asian males and almost

2x

as high in white males

Among females, deaths were almost

3x

higher in this period in black, mixed and other females, and

2.4x

higher in Asian females compared with

1.6x

in white females

Organisational boards need to demonstrate that race and equality progress is measured with specific, measurable, achievable, realistic and time-related (SMART) criteria. This must be reported on at every board meeting and the findings reflected on across the organisation.

LISTEN UP

We cannot continue to ignore the BAME voice and fail to recognise that racism has had a large part to play in health inequalities long before the Covid-19 pandemic. Covid has demonstrated the impact of the history of racism and its actions across the BAME population and workforce in the NHS.

The BAME community does not want or need any more research or reports – the issues are known and have not changed. When research is undertaken in BAME groups, these groups should conduct it themselves. When developing research proposals, use BAME groups and workers to inform and focus this process.

Do NHS trusts have BAME membership as a 'norm' on interview panels? If we delve further, do they have the confidence that they will be heard and views taken into account? Do they have equal status? Are these representatives part of the whole selection process, or only at interview – or are they just part of the 'empty echo'?

BIG PICTURE IN THE NHS

There are wider questions that NHS organisations need to ask themselves too.

- Do NHS trusts have BAME representation on policy scrutiny committees?
- Do NHS trusts have BAME representation on the gold command of Covid, especially when it these groups that have been more adversely affected?

The BAME workforce demands that their contribution is recognised and rewarded in terms of career development and progression. We do not want to be more qualified, less promoted and continually advised to do another course. We want and deserve opportunities to develop.

As we face the 'second wave' of Covid, we must get this right this time around – but more importantly for the next generation of BAME groups, who will demand no less than the gold star service that all communities should already be receiving.

Asha Day is vice-chair CPHVA, and clinical team lead and chair BAME Network, Leicestershire Partnership NHS Trust.

TIME TO REFLECT

How can we ensure that BAME voices are heard and, more importantly, acted upon throughout the community practitioner profession? Join in the conversation on Twitter **@CommPrac** using **#BAMEvoices**

For references, visit **bit.ly/CP_features**