

## **Protect BAME NHS Staff**

The disproportionately high death rate of NHS staff from Black, Asian and Ethnic Minority (BAME) backgrounds in the UK has been highlighted in recent weeks. An analysis published in the Health Services Journal (<https://www.hsj.co.uk/exclusive-deaths-of-nhs-staff-from-covid-19-analysed/7027471.article>) showed the following:

**44% of Doctors are from BAME backgrounds but represented 95% of the deaths of Doctors.**

**20% of Nurses and other Health Professionals are from BAME backgrounds but represented 64% of deaths in this category.**

Although the British Government has launched its own inquiry, with more highly skilled staff dying every day, it is very concerning that the government does not appear to have any timescale for making recommendations. Public Health England has now released a formal framework for risk assessment of BAME staff and some of the Royal Colleges have released their own publications with regards to this. Furthermore, a group of GPs in Manchester, after the tragic loss of a friend and colleague, have also produced their own simple risk assessment framework and score analysis to help protect their BAME colleagues and have made workable solutions as to how those staff can continue to be protected.

The reason that I have written this document is that all the risk analysis frameworks published to date are reliant on staff being aware of pre-existing health conditions. **I propose however that there may be a proportion of staff who to date have undiagnosed health conditions as they may not yet be symptomatic. I suggest that all NHS staff in patient-facing roles have what can be termed an 'NHS frontline medical.'** **In order for this to be widely accepted, it would have to be accepted and commissioned by NHS Trusts and CCGs, likely via NHS England, Scotland, Wales and Northern Ireland.**

The reasons for the high death rates of BAME individuals have been speculated upon in recent weeks. The reasons are undoubtedly complex and multifactorial: these may include genetics, behaviour patterns, socio-economic reasons and susceptibility to disease. Indeed, it is established that Black and South East Asian populations have higher risk of developing cardiovascular disease and Type 2 Diabetes. The BMA has furthermore highlighted in their recent report, that BAME NHS staff are 50% less likely than their white counterparts to feel that they have been provided with adequate Personal Protective Equipment (PPE).

Realistically, we know that shielding all our BAME staff, whilst an ideal, is not a realistic workable solution. Male BAME employees over the age of 40 appear to be at the highest risk but there have been deaths of much younger staff who have been reported in the media as apparently fit and well.

## **Risk Factors for SARS-COVID-2**

Risk factors highlighted in Chinese reports include

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext)

- Hypertension
- Type 2 Diabetes - evidence suggests that predisposing risk factors are age over 40 (or 25 for people of South Asian origin), BAME ethnicity and obesity.
- Coronary Heart Disease
- Increasing age – NHS staff seem proportionally younger – *ONS data needed*
- Male sex
- Carcinoma
- Chronic Kidney Disease
- Smoking

## **Risks to the BAME Population**

ONS data for the general UK population has identified BAME ethnicity as greater risk than White British ethnicity.

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020>

- After taking account of age and other socio-demographic characteristics and measures of self-reported health and disability at the 2011 Census, the risk of a SARS-COVID-2-related death for males and females of Black ethnicity is 1.9 times more likely than those of White ethnicity.
- People of Bangladeshi and Pakistani, Indian, and Mixed ethnicities also had a statistically significant raised risk of death involving SARS-COVID-2 compared with those of White ethnicity.
- Males in the Bangladeshi and Pakistani ethnic group were 1.8 times more likely to have a SARS-COVID-2-related death than White males when age and other socio-demographic characteristics and measures of self-reported health and disability were taken into account; for females, the figure was 1.6 times more likely.

## **Risk to Pregnant BAME Women**

The most recent UKOSS data, which takes into account maternity admissions (i.e. only pregnancies  $\geq 13$  weeks) has found that 55% of pregnant women admitted to hospital with coronavirus from 1st March - 14th April were from BAME backgrounds i.e. four times more likely to be admitted to hospital with symptoms related to SARS-COV-2. BAME ethnicity was in fact a stronger predictor of the likelihood for hospitalisation in comparison to age and obesity, though clearly these were not mutually exclusive risks.

Most admissions were in the late second and third trimester though transmission to infants was rare. Continued social distancing was advised for this group of women.

This is compounded by the findings of last year's Confidential Inquiry into Maternal Deaths and Morbidity <https://www.npeu.ox.ac.uk/downloads/files/mbrace-uk/reports/MBRRACE-UK%20Maternal%20Report%202018%20-%20Web%20Version.pdf> which showed that black women were five times more likely to die from pregnancy related complications than white women and Asian women were twice as likely to die in comparison to white women.

## **My Proposal... an 'NHS Frontline Medical'**

I propose a simple self-filled questionnaire (which could be sent to staff but kept completely confidential and a 'yes' answer to any questions would suggest that staff should seek the advice of their own General Practitioner and bloods / further examination if necessary as detailed below. Occupational Health assessment could potentially be another alternative route.

I suggest staff identified as being in the highest risk groups who continue to work in patient facing roles be granted urgent priority for such a medical and any time off work as necessary for appointments.

Those staff who are already aware that they have chronic disease and have seen their own GP practice within the last six months could be exempted from this.

I note that there remains controversy over the role of vitamin D so I suggest whether having levels checked could be left to the discretion of individual choice in conjunction with advice from the individual's own General Practitioner

## **The Questionnaire**

- Without rewriting an already excellent document that is freely available online, I suggest that the QCancer assessment detailed below could be part of the questionnaire.

[https://www.cancerresearchuk.org/health-professional/diagnosis/suspected-cancer-referral-best-practice/qcancer#CDS\\_QCancer0](https://www.cancerresearchuk.org/health-professional/diagnosis/suspected-cancer-referral-best-practice/qcancer#CDS_QCancer0)

Have you suffered from any of the following?	Yes	No
Urinary frequency		
Thirst		
Tiredness		
Unintentional weight loss		
Recurrent symptoms of thrush		
Delayed wound healing		
Blurred vision		
Breathlessness		
Chest pain		
Palpitations		
Foot or ankle swelling		
Muscle cramps		
Nausea		
Headaches		
Erectile dysfunction if relevant		

- Do you have a Family History of Type 2 Diabetes, Cardiovascular Disease or any other conditions that you feel may put you at increased risk of serious SARS-Covid-2 disease?
- Smoking – would you like support to quit?

Depending upon responses as above, contact own General Practitioner for bloods, BP and BMI check. Bloods could include:

- U&Es
- HbA1c / glucose
- FBC
- Ferritin
- Vitamin D
- B12 / folate
- LFTs
- Cholesterol

The individual staff member can then be guided to make decisions on management of their own health guided by their GP with respect to their future risk of serious SARS-Covid-2 infection.

Whilst I appreciate that none of these changes may make differences to health outcomes in the short term, they may well improve long-term health outcomes for staff exposed to SARS-Covid-2 in future and potentially improve outcomes though long term data would have to be analysed to show if there were any statistically significant benefit.