COVID 19 - Identifying inequalities through Equality Impact Assessments

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Evidence so far

Research on critical care patients with Covid-19 found:

- The average age of patients was 59.5 years
- There were nearly three times the number of men as women - 72% male; 27.9% female
- More than a third were overweight - with a BMI of 25-30
- 38% were obese - with a BMI of over 30
- The younger the patient, the more likely they were to survive
- Underlying health conditions /comorbidities
- BAME people make up 35 percent of all patients in intensive care

Deaths:-

- 14 doctors who died were BAME
- Almost three-quarters of the 51 healthcare workers whose deaths have been announced are also from BAME backgrounds
- 23 people of Filipino origin have died

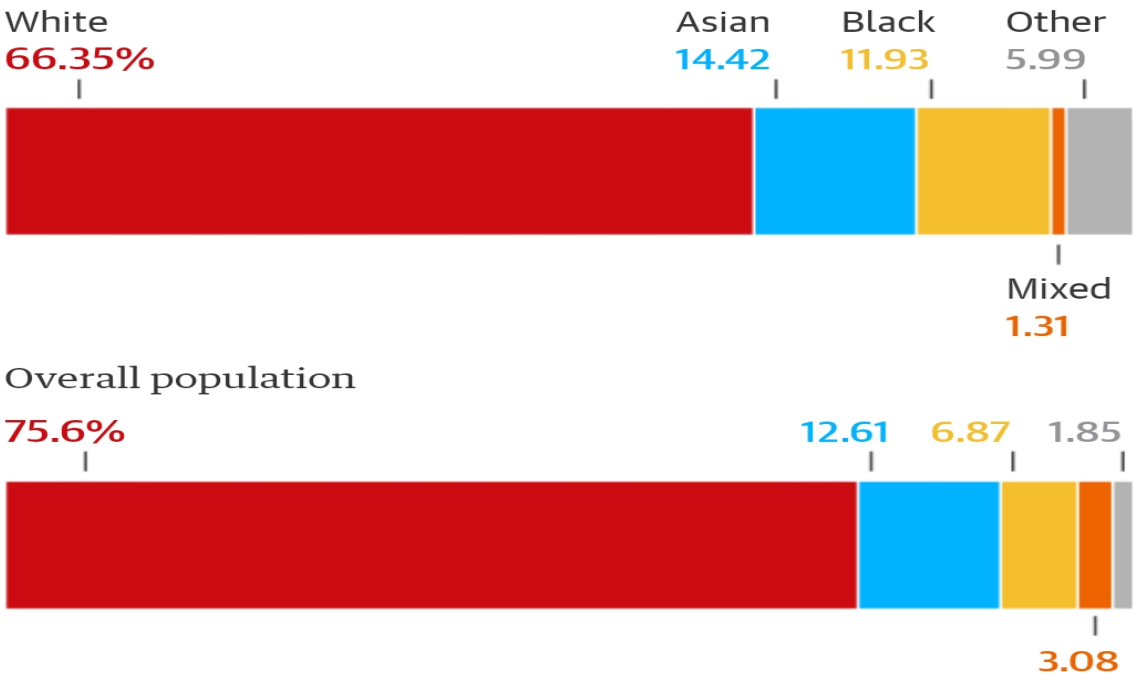
Care Quality Commission

Table 1 Patient characteristics: Demographics and medical history

Demographics	Patients with confirmed COVID-19 and 24h data (N=5578)	Patients with viral pneumonia (non-COVID-19), 2017-19 (N=5782)
Age at admission (years) [N=5577]		
Mean (SD)	59.5 (12.6)	58.0 (17.4)
Median (IQR)	60 (52, 68)	61 (48, 71)
Sex, n (%) [N=5574]		
Female	1556 (27.9)	2641 (45.7)
Male	4018 (72.1)	3141 (54.3)
Currently or recently pregnant, n (% of females) [N=1486]		
Currently pregnant	16 (1.1)	58 (2.2)
Recently pregnant (within 6 weeks)	21 (1.4)	29 (1.1)
Not known to be pregnant	1449 (97.5)	2554 (96.7)
Ethnicity, n (%) [N=4873]		
White	3192 (65.5)	4951 (88.4)
Mixed	75 (1.5)	52 (0.9)
Asian	727 (14.9)	325 (5.8)
Black	544 (11.2)	155 (2.8)
Other	335 (6.9)	117 (2.1)
Body mass index, n (%) [N=4811]		
<18.5	31 (0.6)	310 (5.5)
18.5-<25	1239 (25.8)	1933 (34.2)
25-<30	1696 (35.3)	1691 (29.9)
30-<40	1499 (31.2)	1330 (23.5)
40+	346 (7.2)	394 (7.0)

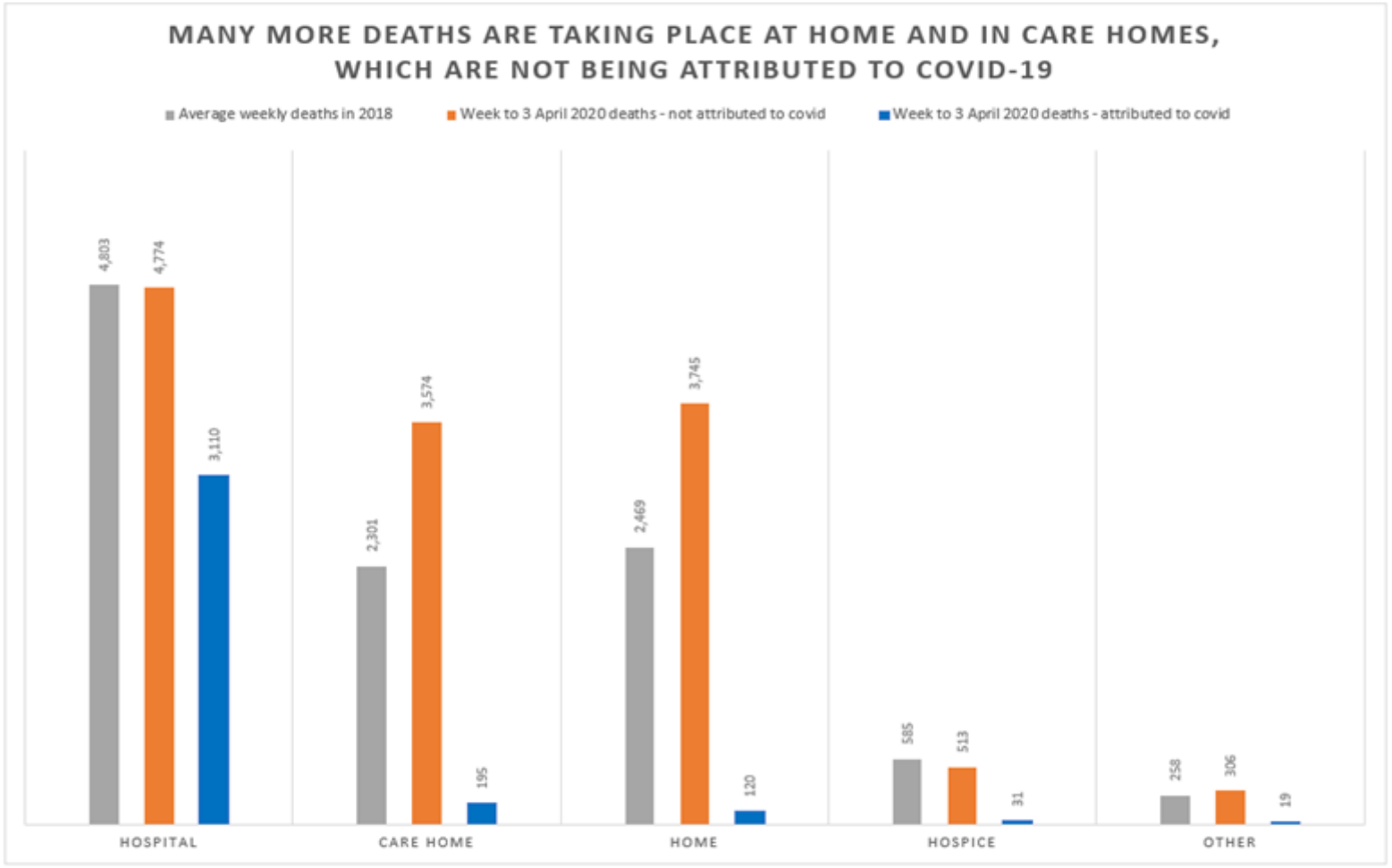
COVID Patients

Sample of patients from across England, Wales and Northern Ireland



Guardian graphic. Source: Intensive Care National Audit & Research Centre (ICNARC). Based on 3,883 patients admitted to critical care units in England, Wales and Northern Ireland

Care homes – high impact on older people



Excess deaths in care homes are not known yet – early indications are that it is important to look at "all cause mortality" as well as people with a COVID 19 diagnosis. (the same is true for deaths in community)
Could be undiagnosed COVID deaths or other causes, potentially some caused by changes to healthcare

This is relevant for health care organisations in terms of healthcare support to care homes

Figures from HSJ research

EIA's Our Approach

Regulatory

- *Overall CQC context of support to the sector – pausing inspections and carrying out other tasks – such as supporting social care workers testing implementation, information collection from providers*
- *Still monitoring care quality and will still take action if there is deliberate or avoidable harm*
    - Build equality and human rights issues into our COVID 19 monitoring – for Mental Health Act (now underway) and Health and Social Care Act (in development)
    - Focus on how we can continue to gather views of people using services, family, staff, advocacy organisations
    - Supporting providers with equality and human rights issues through communications
    - Using independent voice to flag national issues of concern

Internal workforce

Impact on our colleagues due to:-

- Social distancing
- Homeworking
- Lockdown

Key equality and human rights issues emerging in health and social care – may change over time

Not all on current EIA – as fast moving situation

1. Age and disability: Access to NHS inpatient services for people in care homes – advance care planning and DNACPR

- Blanket decisions on not providing treatment/ DNACPR have a negative impact on older and disabled people, including potentially avoidable death e.g. GP decisions
- Both CQC and NHSE have now issued statements/ guidance on the importance of individual decision making, engaging with patients and their representatives.
- *CQC position: All blanket decision making based on equality characteristics about advanced care planning and DNACPR is unacceptable*
- ***National policy clear – imperative to check in practice***

2. Disability discrimination in decisions for individuals about access to critical care/ then access to ventilation once in acute

- NICE guidelines on access to critical care now amended so that ”clinical frailty score” does not disadvantage disabled people who are well – necessary because it is based on ability to do daily tasks
- Critical care limit not yet reached – no need for prioritisation above usual measures
- Some confusion due to other advice in circulation – working with EHRC on this
- *CQC/ EHRC position: nobody should be denied access to essential healthcare during this crisis due to an unrelated disability/condition or their age*
- ***National policy clear – imperative to check in practice***

Key issues continued

3. Age/ disability: Discharge of COVID 19 + and COVID - people from acute settings into care homes potentially putting other residents at risk

- Potential improvement now that testing will take place ahead of discharge
- Some concerns still expressed that some care homes are not able to maintain infection control well enough to accept new people safely, even if COVID 19 status known
- *CQC position: fast moving situation which we are monitoring to help ensure safety through inspector conversations with adult social care providers*
- ***CQC Monitoring of care home COVID 19 deaths now – may help address issues 1,2, and 3***

4. Disability: More vulnerable people with a learning disability and autistic people being admitted and/ or unable to be discharged from inpatient units

- Leading to more people being placed or staying in settings unsuitable for long term care
- Potentially more admissions due to difficulties with community placements, temporary closure of residential special schools etc and capacity of local authorities to carry out assessment and case management activities (Care Act easements in Coronavirus Act). Already flagged by Joint Committee on Human Rights.
- Anecdotal evidence that this is also affecting pace of discharge planning for people in inpatient settings
- *CQC position: System still needs to work to stop community placements breaking down and to enable discharge planning to continue. We have flagged some concerns to government through our role in the National Preventive Mechanism.*
- **Advocacy still needed to help keep discharge plans moving**

Key issues - continued

5. Disability: Increased use of restraint to ensure social distancing

- Especially in mental health and adult social care settings – eg chemical restraint and confining people to rooms
- *CQC position: Some restriction necessary to ensure right to life, should use least restriction possible but recognise this is not a "perfect science" when little is known about COVID 19 transmission. Need to ensure restrictions do not result in inhumane or degrading treatment*
- ***Focus needed on how human rights principles being used, alongside MHA and MCA to ensure best practice in decision making on restrictions whilst using health and social care services***

6. **Disability: Asymptomatic people being admitted to Mental Health Inpatient wards low priority for COVID 19 testing but there are high transmission risks for other patients and staff**

- Right to life for person being admitted (e.g. suicide prevention) and right to life for other patients and staff – minimising likelihood of infection
- CQC have escalated this issue
- ***Interested to hear from people in MH trusts whether this is now resolved***

Key issues - continued

7. Ethnicity: Disproportionate number of BME people dying of COVID-19

- Emerged since we wrote the EIA – we are reissuing the EIA to cover this issue
- Looking at how CQC can contribute – CQC represented on working group via Safina Nadeem
- Potential for CQC to analyse death notifications (adult social care and detained patients only) by ethnicity as we collect this data.
- Difficulty as no ethnicity recording on Death certificates – needs addressing in long term and important to ensure ethnicity accurately recorded in hospital recording systems (eg HES)?
- *CQC position: we will support system partners leading this work*

8. Ethnicity: Access to healthcare for undocumented migrants, refugees and asylum seekers

- COVID 19 exempt from NHS charging – but need to ensure all healthcare workers understand this – and also reach out to people who may be concerned about receiving healthcare
- Call from Doctors of the World to drop all NHS charging during COVID 19 to make this simpler for NHS staff and patients
- *CQC position: Providers should ensure that they follow revised national guidelines on charging. There may need to be additional proactive work to give undocumented migrants, refugees and asylum seekers confidence in approaching health services including local outreach work. Dropping healthcare charges could be considered nationally.*
- ***National policy clear – imperative to check in practice and to consider outreach to communities where people may be concerned about approaching healthcare***

Other emerging issues (from CQC children's, health and justice work and engagement with voluntary sector and individuals)

- **Age and disability:** Potential for excess deaths due to stopping routine care for long term conditions (also specific concern from some BME organisations)
- **Disability:** increase in mental health issues due to social distancing – in particular many young people going to A&E with mental health concerns
- **Age/ Disability** – decreased referrals to children's healthcare and CAMHS may cause surge after lockdown, also difficulties in transition planning for young people
- **Age –** reduced visibility of children at risk or subject to safeguarding (including by health services) due to lockdown
- **Ethnicity –** Access to healthcare during COVID 19 for victims of modern slavery, potential increase in modern slavery due to economic impacts of lockdown – role of NHS in spotting this *(new leaflet arriving soon)*
- **Gender –** access to health related support for domestic and sexual violence – e.g sexual assault referral centres
- **Disability and ethnicity:** Accessible and translated information about COVID 19 (note requirements of Accessible Information Standard) *CQC has been sharing accessible and translated information on COVID 19 through our provider newsletter*
- ***Other groups – Prisoners and people in immigration detention centres:*** access to PPE, hand gel and specialist care, difficulty social distancing , impact on mental health of social distancing through greater restrictions/ restricted visiting including suicide risk, access to health and social care if released

Internal workforce impacts

Age -COVID 19 will have a larger impact on older colleagues.
Younger colleagues may feel more isolated if living alone.
We know that our younger colleagues more likely to be in a shared house so may have limited access to space for homeworking.
Carers - more likely to be in contact with people who are more vulnerable to COVID 19.
Closure of schools and other childcare facilities due to COVID 19 will have a disproportionate impact on our colleagues who are carers of children.
Carers need more time away from work to organise caring responsibilities
Single parents may be under more pressure due to not having support concerns about the level of life-saving care that will be offered if the person they care for has a medical condition.

Internal workforce impacts

Race - Higher rates of COVID 19 in BME communities data

Increased worry about family members overseas may heighten anxiety and colleagues may need to have contact at different times during day or night.

COVID-19 risk may be higher for some colleagues who live in extended families

There has been some evidence of a rise in hate crimes. Colleagues may face racism or discrimination which can cause anxiety and distress.

BME Less likely to speak up about safety

Religion and Belief

Social distancing may have different impacts for people in different religious groups, particularly in relation to end of life care. For example, where it is more important in some religions that the person sees either their family/ or a religious or spiritual leader/ official when they are nearing death. Not being able to do this may cause heightened distress.

Restrictions around visiting places of worship and celebrating key festivals in congregation may cause additional anxiety and distress for colleagues

Internal workforce impacts

Gender - Men more likely to get COVID

Social distancing, working from home and COVID 19 may have a disproportionate impact on women for the following reasons

- Women are more likely to be informal carers
- Women are more likely to be main carers for young children
- Women more likely to volunteer in the community and support neighbours
- Emotional support for children who may want this from their mothers
- The National Domestic Abuse helpline has seen a 25% increase in calls since the government lockdown social isolation measures were put in place.

Pregnancy & Maternity

Social distancing for pregnant women might have an impact on their ability to manage their own healthcare, including mental health

Colleagues going through the adoption process there may be increased emotional and mental impact if delays caused.

Colleagues going through IVF may result in increased emotional and mental impact if delays

Internal workforce impacts

LGBT

Some LGBT people may not have large supportive social circles and can often be isolated from their families.

More likely to have mental health conditions and COVID 19 could potentially heighten anxiety

Social distancing might have a higher impact for people who rely on their external contacts for advocacy/ social networks

People may have to delay their transitioning / treatment due to the virus which may cause anxiety/ distress.

People may have to isolate with family members who do not support their sexual orientation/ gender identity and may be subject to emotional or physical abuse as a result of this

For some LGBT people the risks of homelessness, insecure employment, restricted access to healthcare and other inequalities may deepen. The LGBT in Britain - Health Report by Stonewall shows us that LGBT people are at greater risk of marginalisation in time of crises

Internal workforce impacts

Disability

People with underlying health or long-term health conditions and weakened immune system

Closure of offices, schools and other care facilities will have a significant impact :-

- Lack of reasonable adjustments in place at home if usually office-based
- Possible heightened anxiety
- Impact of social distancing on mental health
- Colleagues with mental health conditions may not be able to access their regular face to face support and or not be able to access treatments

Managers may not be able to pick up declining mental health due to reduced face to face time

Disabled people may have concerns relating to the decision-making around live-saving care and equipment.

Fixed term contracts

People on fixed term contracts, which are due to end in the next few months, have raised issues of heightened anxiety and worry about future employment due to the difficulty in the current economy and job market.

Mitigations

Employee Information Pack, carers , homeworking tips, wellbeing, reasonable adjustments
Wellbeing Newsletter
Contact for helplines /external support organisations included in the Employee Information pack and promoted through network intranet pages and the wellbeing newsletter.
Line managers encouraged to have regular conversations with colleagues about worries and anxieties
Equality Networks – joint statement
Reasonable Adjustments prioritised
Chief Executive weekly calls
Virtual Connection and D&I events running
PAM assist Employee Assistance Programme includes a 24-hour helpline
Homeworking top tips have been developed to support colleagues to consider mental and physical wellbeing as well as staying connected.
Directorates to undertake a review of all fixed term contracts ending in the next 3 months, work with individuals to explore available avenues to preserve their employment

NHSE/I priorities

Dr Habib Naqvi – Deputy Director WRES

Next Steps

- Public Health England is to start recording coronavirus cases and deaths by ethnicity
- We may need to risk assess certain groups of NHS workers if they are older or have other medical conditions - they should be shielded and prevented from exposure to the virus.
- Death certificates currently don't have information on ethnicity
- CQC building human rights issues into our regulatory methodology during COVID 19 – these often have high impact on people in equality groups, e.g. right to life and restraint issues
- CQC developing ways of hearing feedback from people using services during COVID 19 when we are no longer routinely inspecting, including targeted feedback from equality groups
- CQC continue to gather emerging equality issues and use this to plan communications with providers and national policy work, in conjunction with others such as NHS equality and Diversity Council and Equality and Human Rights Commission

Questions

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