Mitigation of risks of COVID-19 in occupational settings with a focus on ethnic minority groups

Paper from Public Health England (PHE), Health and Safety Executive (HSE) and the Faculty of Occupational Medicine (FOM)

Submitted to SAGE Ethnicity Sub-group on 21 August 2020

Executive summary

This executive summary has been published as a consensus statement from Public Health England (PHE), Health and Safety Executive (HSE), and Faculty of Occupational Medicine (FOM).

The review of disparities of risk and outcomes of coronavirus (COVID-19), carried out by Public Health England (PHE) showed that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying of COVID-19. The review did not account for the effect of occupation, co-morbidities or obesity. Since the review a wide range of research has explored the pathways that cause ethnic inequalities and have shown that this is a complex relationship, and the relative importance of different pathways in COVID-19 ethnic inequalities is not well understood.

This is a consensus statement from PHE, Faculty of Occupational Medicine (FOM) and Health and Safety Executive (HSE) on how best to mitigate occupational risks, and specifically the known disproportionate impact of COVID-19 on ethnic minority groups. This consensus statement follows the PHE report Beyond the Data and was developed through a multi-disciplinary-cross sector group subsequent to a request by the Scientific Advisory Group for Emergencies (SAGE) that PHE, HSE and FOM were requested to consider mitigation of risks of COVID-19 in occupational settings with a focus on ethnic minority groups.

This statement recommends with moderate confidence that all individuals, including those from ethnic minority groups, should have the same approach to risk management in the workplace. It recommends reinforcement of, and implementation of, existing workplace guidance and legislation across the whole workforce, with particular support to small and medium employers and sole traders where individuals of ethnic minority groups may be over-represented. Employers, as part of their statutory duties, should ensure that a workplace risk assessment is completed as part of an overarching risk management strategy for all settings and should cover all employees, including identification of those with increased vulnerability to SARS-CoV-2 infection.

Some workers may require, or seek, health assessment and advice in relation to work. This is often initially with their general practitioner whose opinion may be communicated by the worker to their employer, often as certification (a Fit Note). For a small number of workers, assessment by an Occupational Health (OH) practitioner who has specific knowledge of the workplace is necessary. Access to an OH service is usually arranged by the employer. Occupational health assessments should be supported by a standardised individual clinical risk assessment tool to support mitigation for individuals in the workplace.

Strong stakeholder engagement is important, with a coherent approach to messaging and communication of all COVID-19 information and working with ethnic minority communities to improve levels of understanding of both risks and their mitigation in communities with higher rates of infection and death.

Main conclusions

1. Occupation is one of many factors which may increase the risk of exposure to SARS-CoV-2 infection. It is important that the approach to controlling risk in relation to occupation is delivered in a way that ensures it is equitable, recognises the range of risk factors, and is fully accessible to all staff from all backgrounds to help identify and manage risks, including those from ethnic minority backgrounds.

2. It is the employers' duty to manage risk in the workplace. Employers have a legal duty to protect all workers from harm by delivering workplace risk management for all staff, regardless of ethnicity or diversity. In this case, an equitable approach recognises that staff may have a variety of baseline risks (for example, their age, sex, deprivation, obesity and diabetes) and, where appropriate, this needs to be considered in the workplace risk management discussion.

However, there should not be an expectation of disclosure of confidential medical information by individuals as part of this process unless as part of normal practice such as healthcare settings. Those who carry out these individual discussions on behalf of the employer should be trained and encouraged to understand, appreciate and interact with people from cultures and/or belief systems other than their own. 'Culturally competent' conversations with employees should address their individual concerns related to risk, vulnerabilities and their individual situations (see annex 2).

3. Measures that protect against the risks at work for the entire population, apply equally to people from ethnic minority groups. Work place risk mitigation is best addressed through consistent and effective implementation of existing Health and Safety Executive (HSE), HMG and other guidance for employers, including recent guidance on COVID-19. This should apply to all workplaces, including small and medium sized enterprises (SMEs) which may have higher proportions of staff of ethnic minority groups in employment. Workplace guidance should ensure that control measures address the risk of exposure to COVID-19 and should be applied to all workers, rather than specific actions targeted at individuals of ethnic minority groups (to reduce risk of stigmatisation, perceptions of being unfairly targeted and inequality of opportunity).

4. The main risk factors (for example, age, sex, obesity, multiple long-term conditions) for COVID-19 are often clustered within individuals, the workplace and communities, and as such approaches to risk reduction for ethnic minority groups should take into account this broader context of risk, and the importance of a 'whole pathway' or holistic approach, to be effective.

5. Clinical risk stratification tools, such as those included in NHS Employers risk assessment guidance, can be used, as a part of a clinical assessment process, recognising the additional risk factors, in occupational health/primary care for some employees, including those of ethnic minority groups, to assist decision making about suitable deployment at work.

6. Existing clinical risk stratification tools and those in development, once available, may be a useful UK-wide support tool to clinical and occupational health conversations about risk with individuals.

7. The importance of involving ethnic minority groups in all aspects of a culturally competent response to risk reduction, including in framing research questions, participating in research projects, sharing findings and implementing recommendations, is endorsed.

8. Engagement with employers to reinforce preventive messages to reduce risk of acquisition both in the community and in the journey to and from the workplace may reduce the risk of spread of COVID-19 in the workplace.

The working group recommended several actions to mitigate risks:

a) Reinforce and re-communicate existing government COVID-19 guidance and advice to employers on their responsibilities to their employees.

b) Engage with stakeholders to support embedding action across all (relevant) population groups.

c) Other recommended key actions include:

A culturally competent approach to risk management for all including individuals of ethnic minority groups.

Strengthened and co-ordinated communication and engagement with ethnic minority communities and engagement with specialist media on transmission risk. An effective social marketing campaign aimed at reaching communities to clearly outline actions that individuals need to take to mitigate risk from COVID-19. This should include the range of multiple socio-economic, clinical, cultural and behavioural risk factors that individuals (including ethnic minority groups) may face, and should be available in different languages, accessibility formats, use diverse and inclusive imagery, and disseminated through a variety of channels to maximise reach to many communities and sectors. This campaign should also include those who support employees on rights and responsibilities and employers (including SMEs).

Further research is required to understand the risks of acquiring infection by occupation type and the interaction of this with non-occupational factors. The work should also include the impact of other factors on the health outcomes from COVID-19 disease including timely access to healthcare services, management of long-term conditions and the effectiveness, optimisation and use of risk assessment tools by clinicians. A consistent approach to clinical risk assessment tools could be developed to support clinical judgements in occupational health, primary and secondary care settings. Whilst the workplace is an important location for understanding transmission of SARS-CoV-2 infection, it is also important that transmission mechanisms in the community and in the home are understood to enable all potential routes to be considered when researching the relative contribution of each potential transmission source. Further research is also required at the systems level to understand the complex interactions between social, personal, biological and environmental factors leading to any differential outcomes in particular groups of individuals.

These actions alongside the consistent and equitable application of existing guidance for workplace risk management, summarised in the group's conclusions, will contribute to the mitigation of risks of COVID-19 in occupational settings for all workers.

Background

The remit of the SAGE 40 commission is to consider how best to mitigate occupational risks, and specifically the known disproportionate impact of COVID-19 on ethnic minority groups and to provide answers to three questions from the Chief Medical Officer for England.

1. Should everyone from an ethnic minority background be risk assessed?
2. Should those from an ethnic minority background receive different protective measures?
3. How do we protect those of an ethnic minority background in high risk occupations?

This follows the PHE review of disparities of risk and outcomes of coronavirus (COVID-19) that identified that COVID-19 does not affect all population groups equally and showed that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying of COVID-19. The key question for the commission is what can be done to reduce this risk for workers of ethnic minority backgounds. Should this be different from what is done for other workers, (who may also have demographic characteristics or health conditions which increase their risk from COVID-19)?

To progress the commission a multi-disciplinary-cross sector group chaired by PHE met for six weeks. A key conclusion from this group is that whilst this paper focuses on risk in occupational settings, community transmission and acquisition risk of COVID-19 is inter-connected and should also be considered in any actions recommended.

The group considered current approaches to workplace safety, existing regulations and risk management, factors that may distinguish an approach to specific workforces including those from ethnic minority groups, risk assessment tools in

operation including clinical risk assessments, cross-government guidance including previous outputs from SAGE on the clinically extremely vulnerable, the SPI-B report on messaging to ethnic minority groups and the questions of the Chief Medical Officer (CMO).

Findings of the PHE report

Key concerns emerging:

Stakeholder feedback in the PHE report 'Beyond the data: Understanding the impact of COVID-19' confirmed that employers were looking for more support and guidance to support their staff of ethnic minority groups. They were however uncertain whether the approach for addressing any increased risk required additional measures above and beyond recommended guidelines and this has been a key focus of the group.

The PHE report identified concerns and associated anxiety among ethnic minority communities and individuals about their individual and collective risks. The review concluded that a respectful and culturally competent approach to engaging with staff is important, independent of the type of workplace or the ethnic and cultural/ religious backgrounds of the professionals who are supporting these staff.

Feedback from diverse stakeholders including community and faith organisations, trade unions, and businesses undertaken as part of the report confirmed the desire for culturally competent individual discussions about vulnerabilities to be used for all staff at risk. This should also include workers of ethnic minority groups, and these individual discussions, which may involve the use of tools or templates, should be implemented in ways that minimise stigmatisation or unfair treatment of the assessed worker.

Stakeholders would welcome guidance on how existing tools might be adapted to be more culturally competent to ensure risk assessment takes account of the diversity of staff and the features of the workplace.

Consensus of the group

Government guidance enables workplaces to assess and manage risk of transmission of COVID-19 in a way that fits their circumstances and reduces risk of transmission regardless of potential outcome. It is most important to ensure guidance is applied consistently and to ensure precautions are implemented across all settings and for all staff both equitably and accessibly. This applies to all workplaces, including small and medium enterprises (SMEs), where many individuals from ethnic minority groups may be employed.

In keeping with current government guidance, all workplaces should be COVID secure and follow a risk management strategy for COVID-19. Optimal protections should apply equally to all workers.

Reducing risks experienced by ethnic minority communities, as for the whole population, involves consideration of the risks of transmission both within community settings as well as the unique characteristics of the workplace that may be controlled to reduce transmission.

The CMO/NERVTAG QCOVID clinical risk stratification tool is likely to be a useful support to clinical conversations about risk with patients/individuals in occupational health, GP and secondary care settings providing an evidence-based, peer-

reviewed, UK-wide tool which will consider multiple risk factors to give a weighted, cumulative estimate of absolute and relative risk of acquiring and dying from (or being hospitalised by) COVID-19. It is due to be available across all clinical settings, thus yielding consistent results, and enabling clinicians to communicate these using the best available evidence for communication of COVID-19 risk.

Whilst some employers have implemented a policy of individual supplementary risk assessments for staff of ethnic minority groups, the consensus was that where required, emphasis should usually be on individual, culturally competent, two-way 'COVID conversations' for all staff, which highlight and promote reduction of risk in all environments (not just the workplace). This recognises that social, behavioural and environmental factors, external to the workplace, all impact on what may initially appear to be 'high risk' settings. The importance therefore of workers and groups of workers being diligent in the application of risk controls and behaviours that are needed in the community is also highlighted.

The consensus statement on communication and ethnic minority groups from SPI-B is a helpful framework for considering communication in relation to workplace risk within a wider framework across all elements of risk associated with COVID-19 relevant to ethnic minority groups. Messaging to ethnic minority communities should cover all elements of risk for best impact and confidence. Alignment of messaging on communications on COVID-19 risks working with specialist media would help to build audience confidence in the communication.

Response to CMO questions

Three specific questions from the CMO were considered during the deliberations. Details of the approach to workplace risk management are contained in the supplementary paper for further information.

1) Should everyone from an ethnic minority background be assessed?

Response = No. A workplace risk assessment should be completed as part of an overarching risk management strategy for that setting and should cover all employees. This risk assessment is geared towards controlling SARS-CoV-2 transmission and should be sufficient for all workers who may be exposed to the infection.

The methods by which employers carry out these risk assessments will necessarily vary according to sector, nature of work and local resources, but it is important that the individuals involved in delivering the work activity are also involved in undertaking the risk assessment. It is important that such risk assessments consider the control strategies required to address exposure to the virus from the three main transmission routes (air, person-to-person and surfaces) for all work activities undertaken. Importantly, the intent of such an approach is to manage the likelihood of transmission to reduce the risk of exposure in the work environment for all individuals to as low as reasonably practicable.

Once completed, employers must communicate findings with their workers to ensure risk controls are adequately implemented. It may be necessary for employers to consider specific factors, including for example, the age, sex or race/ethnicity of workers, at increased risk of contracting SARS-CoV-2 infection, or to reduce adverse clinical outcomes following infection and to ensure stringent application of controls.

Each employer should consider how to approach this best, given the type of business and their knowledge of their own staff and working conditions. Currently, in addition to informing all staff of workplace COVID-19 controls being implemented, it seems sensible to suggest that individual conversations with employees that have been identified to be at increased risk as described above are undertaken, to ensure that an appropriate work plan is agreed and periodically reviewed. Of fundamental importance in this conversation is to explain and reinforce workplace-specific guidance, as well as more general government guidance relating to reducing SARS-CoV-2 transmission in the community.

2) Should everyone from an ethnic minority background receive different protective measures?

Response = No. The workplace risk assessment should identify the most effective control strategies for all exposed workers (using the hierarchy of control), which should mitigate exposure to the virus from the three routes of exposure.

The hierarchy of control is applied in this order: Elimination of the risk; control by physical means; control by systems of work; and finally, the provision of appropriate personal protective equipment (PPE) as the last resort control measure.

In most workplaces, application of controls in this hierarchy should manage the risk for all workers without the need for PPE. Exceptions include, for example, clinical settings. Any decisions relating to the extent and nature of PPE use are a function of the nature of the anticipated work, the COVID-19 secure workplace risk assessment process, and any actions that are subsequently taken to manage and thus mitigate those risks.

PPE availability should take account of the challenges of providing suitable PPE to workers with facial hair. Other forms of PPE, such as air fed respirators, will be needed.

3) How do we protect those of an ethnic minority background in high-risk occupations?

Protection of these workers will be achieved by actively protecting all workers appropriately and correctly in those high-risk occupations, consistent with government recommendations. It is fundamentally important that workers in all occupations should have access to the appropriate suite of protective measures that are supervised and maintained to a high standard. All workers should be encouraged and empowered by their employers to request and use the appropriate and recommended level of protection for their work-related activities.

Office for National Statistics (ONS) has identified certain occupations, and groups of similar occupations that have higher death rates from SARS-CoV-2 infection. Those analyses did not include adjustment for some important factors such as ethnic group, place of residence or health conditions. Subsequent data from a large study (Williamson et. al.) assessing risk factors for death from SARS-CoV-2 infection have considered many other factors, but not specifically occupational exposures.

New evidence can help to determine whether and when occupational risks of exposure to/ acquiring SARS-CoV-2 infection applies and whether there are types of occupation and roles of concern. Emerging research studies will also help to determine how we should respond to importantly elevated risks that need to be

addressed quickly. It will also, importantly, help our understanding of whether other non-occupational factors are relevant and could explain some of the previously observed differences in mortality from COVID-19 by occupation. For example, do certain occupational groups share other personal, health and other characteristics and behaviours that may place them at an increased risk of death from COVID-19? It is also important that the approach does not lead to unfair and unjustified stigmatisation of certain groups in some workplaces, leading to unintended negative consequences.

Certain workplaces have also been implicated in the media in “workplace outbreaks”. Investigation of these shows the complex and dynamic interactions between the workplace setting, workforce and community factors. They underline the fact that workplace interventions are often just one facet of managing transmission of SARS-CoV-2, and if approached in isolation management of community transmission of infection will not be optimised. If urgent workplace specific actions are needed, these will be recommended and should be instituted as rapidly as possible based on the findings from the outbreak management team. For example, changes to onsite accommodation for agency workers, improved social distancing, better infection control procedures and resources, and improved worker communication and supervision.

Proposed next steps

The working group has recommended key actions in five areas.

1. **Government departments should reinforce their guidance in relation to workforce risks through clear communication of how it should be applied and managed.**

Government departments have a key leadership role to play in supporting their own workforce and acting as system leaders to stimulate change, build education and awareness, and improve practice in the public, community and private sector. Clear and consistent communication about workplace risks, provided through multiple channels reflecting the diversity and inclusiveness of our communities will be required to ensure messages are received, understood and implemented effectively.

Key actions:

- Government to support and resource the recommended approach to communication to support mitigation of risk for ethnic minority groups across workplaces recognising the principles of effective communication and engagement with vulnerable and marginalised groups.
- PHE to work with HSE/FOM/CMO and other stakeholders to reinforce messaging to both employers and ethnic minority communities of the existing approach, guidance and principles regarding the mitigation of risk in the workforce.
- It will be important to ensure strong engagement with and mobilisation of employer bodies, professional bodies, trade bodies and trade unions to promote the approach especially noting needs for small business and sole traders.

- Working alongside specialist media and ethnic minority groups will be important to ensure communication is consistent and culturally appropriate.

2. Achieving an effective approach to risk management for ethnic minority groups

Successful engagement of ethnic minority groups by employers will depend largely on a respectful and culturally sensitive approach to engaging with staff, recognising the heterogeneity in their workforce, and specific concerns of various groups given the evidence on differential impacts of COVID-19.

To assist this engagement, and given the need to engage a wide range of stakeholders in as comprehensive a manner as possible, there should be support for developing appropriate and easily accessible tools and training materials (videos, case-studies, e-learning tools etc.) that can assist employers, at whatever level, to be able to understand what actions should be prioritised.

Key actions:

- PHE to work with HSE/FOM/CMO on guidance and principles for ensuring culturally competent policies, programmes and guidance. This may be used to guide all policy makers but can also be used to evaluate the competency of existing products.
- Department of Health and Social Care (DHSC) to consider opportunities for strengthening social marketing targeting ethnic minority communities and other potentially vulnerable groups as part of providing reassurance on returning to work whilst managing intersecting risks between work and the community. This is ideally done as part of wider public communication and engagement with ethnic minority communities on the prevention and control of COVID-19.
- SAGE to consider alignment of recommendations to develop specific resources for ethnic minority communities (e.g. toolkits) to guide conversations about risk and risk mitigation as part of an overarching and integrated approach.

3. Support & strengthen risk Assessment

The aim to adopt a consistent approach to using evidence-based, peer-reviewed, UK-wide, individual clinical risk assessment tools has the potential to be a key element of supporting COVID-19 risk management discussions in the workplace when used by clinicians in both occupational health, GP and secondary care settings. The CMO has commissioned work through New and Emerging Respiratory Virus Threats Advisory Group (NERVTAG) to produce research and a tool (QCOVID) that provides an opportunity to facilitate individualised discussions between a patient and their clinician about COVID-19 risk. The work is being led by the University of Oxford and the tool will, allow patients to understand their risk in the context of their personal clinical and community history, and to discuss proportionate ways to mitigate risk where possible.

Key actions:

- Department for Health and Social Care (DHSC) to continue its engagement with partners to develop research and, as appropriate,the QCOVID tool and support its potential dissemination, implementation and evaluation.
- The CMO commissioned NERVTAG/QCOVID tool to ideally be the single recommended tool for use in England.
- DHSC/NHSE/CMO team to work with clinical partners to support professional development regarding use of the QCOVID tool and the communication of evidence and risk using outputs from the Winton Centre for Communication of Evidence and Risk, Cambridge University,
- DHSC/CMO team should ensure on-going partner and public engagement, with particular regard to ethnic minority groups and employing evidence-based and clear communication strategies drawing on the work from the Winton Centre for Communication of Evidence and Risk.

4. Strengthen public communication and engagement with ethnic minority communities on transmission risk alongside other communication on risks for severity of the disease.

Messaging on workplace risk for ethnic minority groups needs to be culturally appropriate & tailored to the influences of those communities and accessible to them for effective communication. To be effective, messaging should be within and aligned to a wider approach to communication with these communities covering all aspects of risk communication on COVID-19 including infection, severity of disease and transmission. This will ensure consistency of message and increase confidence in the content of the information provided.

Key actions:

- DHSC/PHE/FOM working with specialist media outlets to consider appropriately targeted social marketing campaigns or other means of education and engagement to encourage uptake of appropriate individual assessments by those who may be at increased risk, and how to understand the results, will be required and ensure delivery as appropriate.
- DHSC/PHE/ working with NHS England and NHS Improvement (NHSEI) to ensure that messaging on occupational risk and its management for ethnic minority groups is aligned with and disseminated with wider messaging and communications strategies with ethnic minority groups across government and at local level.
- DHSC, NHSEI, and FOM to identify examples of best practice case studies for employers for sharing externally as well as with other government departments.
- Expectation of assessments for individual staff with increased vulnerabilities should be disseminated as part of wider communication on the recommended approach drawing on experience of use of the NHS employers' tool and other case studies.

5. Research and development

Findings from PHE and HSE's research suggest that considerations for research may include:

- Assessment of confidence of occupational health, general practice and other clinicians in the use of the risk stratification tool(s) with appropriate monitoring and evaluation.
- Assessment of the dynamic interaction between individual, community and workplace risks for acquisition and transmission of SARS-CoV-2 and how this may vary for particular ethnic minority groups.
- Training in and assessment of the use of the QCOVID tool and its implementation, as appropriate, with feedback to identify optimal approaches to the use of the tool.
- Research with employers, especially in SMEs, on the factors that facilitate or hinder conversations about risk with staff in general, and with those who may be at increased risk specifically to identify opportunities for practical training and support.
- Consideration of how messaging related to risk is received and understood by different ethnic minority groups, and the factors influencing how these are adapted and implemented.
- Recognising that good and promising practice currently exists nation-wide, research to capture and understand lessons learnt in order to disseminate and accelerate adoption will be helpful, especially if there is diversity in the types of businesses and contexts studied.
- Stigma about COVID-19 and factors impacting the ability to work and go to school.
- Occupational exposures and an understanding of the extent to which non-occupational personal health and other characteristics are relevant to some occupations and may be associated with an increased level of infection & death thereby explaining some of the early associations seen with groups.
- Understanding of other factors likely to impact on mortality including infection rates, management of long-term conditions and access and severity of disease on attendance at NHS.
- Research to investigate potential disparities in access to PPE and reasons why staff from certain backgrounds including ethnic minority staff may feel they are without a voice in raising concerns about such disparities.

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ANNEX 1: Background work and guidance informing the paper

1. Existing principles and approach to workplace risk management

A review of existing principles and the approach to workplace risk management was undertaken. Details are included in the attached supporting document**: '**Existing Principles and approach to Workplace management'.

2. Understanding the Increased Risks: SARS-Cov-2/COVID-19 and Black, Asian and minority groups

Whilst the evidence shows that COVID-19 has a disproportionate impact on people from ethnic minority groupsthe relationship between ethnicity and health is complex and likely to be the result of a combination of factors. To develop effective action, it is important to understand these factors.

Firstly, people of ethnic minority communities are likely to be at increased risk of *acquiring the infection*. This is because people of ethnic minority groups are more likely to live in urban areas (1), in overcrowded households (2), in deprived areas (3), and have jobs that expose them to higher risk (4). People of ethnic minority groups are also more likely than people of White British ethnicity to be born abroad (5), which means they may face additional barriers in awareness such as of COVID-19 symptoms and accessing services that are created by, for example, cultural and language differences. This is in line with the findings of the PHE's "Review of disparities in risks and outcomes of COVID-19", which found that the highest age standardised diagnosis rates of COVID-19 per 100,000 population in the first wave of the pandemic in the UK were in people of Black ethnic groups (486 in females and 649 in males) and the lowest were in people of White ethnic groups (220 in females and 224 in males).

Secondly, people of ethnic minority communities are also likely to be at increased risk of poorer outcomes once they acquire the infection. For example, some co-morbidities which increase the risk of poorer outcomes from COVID-19 are more common among certain ethnic groups. People of Bangladeshi and Pakistani background have higher rates of cardiovascular disease than people from White British ethnicity (6), and people of Black Caribbean and Black African ethnicity have higher rates of hypertension compared with other ethnic groups (7). Data from the National Diabetes Audit suggests that type II diabetes prevalence is higher in people from ethnic minority communities (8). Additionally, one study from Birmingham found those of South Asian descent more likely to have higher disease severity on admission to hospital and more likely to need ICU support (9).

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3. Evidence-based assessment of Covid vulnerability

The original policy on shielding was developed rapidly in spring 2020, using a classification of vulnerability that was based largely on extrapolation from experience with other infections, since evidence on outcomes from COVID-19 was understandably limited at that time. That classification was subsequently used in various tools to guide management of occupational risks from Covid-19, including the NHSE Risk Assessments for staff tool.

Since then, quantitative evidence on differences in vulnerability to Covid-19 is emerging, including from large population-based studies linking databases from primary and secondary care. That evidence has been used to develop the Covid-age tool, which was first published on 20 May 2020, and is being continually updated

and refined as new data are published. The resource is designed to assist health professionals when advising patients about possible occupational risks from Covid-19. It includes ethnicity along with many other risk factors but is still limited by limited published epidemiological data.

As part of the recovery strategy, the government is aiming to improve further the clinical assessment of vulnerability through development of a bespoke CMO commissioned NERVTAG/QCOVID risk stratification tool. The plan is that once validated and peer reviewed, this will be available across the UK for use in primary and secondary care, to identify clinical risk. The implementation plans for both clinical and non-clinical settings and for community engagement/social marketing of the new tool are currently under development. Provided it is consistent with the overall balance of evidence on determinants of vulnerability, and in a suitable format, it is expected to supersede other tools such as Covid-age for individual risk discussions, including potential use for occupational health enquiry, with the advantage that the same source of information will be used as in primary and secondary care. The FOM would thus find it valuable to have the tool available to occupational health clinicians on the same basis as in primary and secondary care.

Further details of this work are included in the attached supporting document titled: 'CMO paper Work and Risk'.

4. Employer guidance:

A range of organisations have already developed risk assessment tools for use in the workplace and guidance for implementation including from NHS employers, which includes a number of different examples. Tools have also been developed for use in Wales and Scotland. The FOM has published a position statement on the ethical considerations around using risk stratification tools in an occupational environment and concludes that ,

'…tools which assist clinicians to stratify risks associated with C19 have significant potential benefit. However, their use must only form part of a robust and thorough clinical assessment process conducted under the supervision of appropriately qualified health professionals, within the limits of those professionals' competence.'

https://www.fom.ac.uk/wp-content/uploads/Coronavirus-risk-assessment-ethics-v3-FINAL.pdf

ANNEX 2: Culturally competent key principles for the workplace

Cultural competence is defined in many ways but fundamentally it is the ability to communicate and interact effectively with people regardless of difference. It's about understanding the way we deliver health care and responding to the needs of our diverse population. Cultural competence is a key aspect of providing both quality and safe care

Cultural competence applies to individual behaviours but also organisational systems, processes and culture. Being 'culturally competent' means having the knowledge and skills to be aware of one's own cultural values and the implications of these for making respectful, reflective and reasoned choices. Cultural competence provides a framework and set of approaches to help ensure that the needs of all people and communities are met in a responsive and respectful way.

The following are five essential elements recommendations to consider in culturally competent key principles for the workplace

- **Value diversity** - valuing diversity means accepting and respecting differences. Even how one chooses to define family is determined by culture. Diversity between cultures must be recognised, but also the diversity within them. People generally assume a common culture is shared between members of racial, linguistic, and religious groups, but individuals may share nothing beyond similar physical appearance, language, or spiritual beliefs;
- **Cultural self-assessment** - through the cultural self–assessment process, staff are better able to see how their actions affect people from other cultures. The most important actions to be conscious of are usually taken for granted;
- **Consciousness of the dynamics of cultural interactions** - there are many factors that can affect cross–cultural interactions. There often exists an understandable mistrust towards members of the majority culture by historically oppressed groups;
- **Institutionalisation of cultural knowledge** - the knowledge developed regarding culture and cultural dynamics must be integrated into every facet of a service or agency. Fully integrated cultural knowledge is the only way to achieve sustained changes in service delivery. Communities are not static, there is a need for continual ongoing development to reflect emerging communities and changing needs.
- **Adapt to diversity** - the fifth element of cultural competence specifically focuses on changing activities to fit cultural norms. Cultural practices can be adapted to develop new tools for treatment - i.e. a child or family's cultural background provides traditional values that can be used to create new interventions.

ANNEX 3: Multi-disciplinary group membership for SAGE 40 commission

- Kevin Fenton, Regional Director, PHE London & Regional Director of Public Health, NHS London
- John Simpson, Senior Medical Advisor, PHE
- Virginia Murray, Senior Public Health Advisor, PHE
- Allison Streetly, Deputy National Lead, Healthcare Public Health & Senior Public Health Advisor, PHE
- Colin Brown, Infectious Diseases Consultant, PHE
- Ines Campos-Matos, Head of Migration Health, PHE
- Anne de Bono, President Faculty of Occupational Medicine
- Shriti Pattani, Faculty of Occupational Medicine
- Professor Andrew Curran, Chief Scientific Adviser, HSE
- Professor David Fishwick, Chief Medical Adviser,HSE
- Rick Brunt, Deputy Director, Head of Operational Strategy,HSE
- Nisha Mehta, Clinical Advisor, Department of Health and Social Care
- Jenny Harries, Deputy Chief Medical Officer, Department of Health and Social Care
- David Coggon, Professor of Occupational and Environmental Medicine, University of Southampton
- Dominic Smales, Race Disparity Unit, Cabinet Office
- Julia Hippisley-Cox, Professor of Clinical Epidemiology & General Practice, University of Oxford.