Witness Name: Runnymede Trust
Statement No.: M1/TRT/01
Exhibits:
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UK COVID-19 INQUIRY

WITNESS STATEMENT OF The Runnymede Trust

The Runnymede Trust is a race equality think-tank which has looked at how responsive the government was to the vulnerabilities of Black and minority ethnic communities during the COVID-19 pandemic. We are responding to section 4(J) from the 'List of Issues', which asks: *"To what extent were pre-existing inequalities and vulnerabilities considered and accounted for by public health bodies as part of their pandemic planning?"*

I, Dr Halima Begum, CEO at the Runnymede Trust, will say as follows -

1. Disparities faced by BME communities were not fully considered by the government when making decisions about the response to COVID-19. This is demonstrated by the lack of any equality impact assessment of the emergency social and economic measures rolled out by the UK government. This was a lost opportunity to understand and assess the impact of government measures to mitigate the impact of coronavirus on people with protected characteristics. It has meant that many groups have fallen through the cracks, without any social or financial support to buffer the devastating impact of COVID-19.

2. We were still calling on the government in January 2021 to immediately conduct Equality Impact Assessments on all government actions in relation to the pandemic, and to ensure that these include recommendations for action to minimise inequalities **[INQ000186550]**. We asked that the government do this in consultation with the groups affected, and act on the resulting recommendations.

3. A key criticism of government preparedness relates to local funding. The public health grant has been cut by 26% on a real-terms per person basis since 2015/16 **[INQ000186556]**. Cuts in local public health spending have fallen more heavily on the most deprived areas, as explained by the Health Foundation **[INQ000186556]**. These cuts have fallen even more heavily on BME communities; since 2014/15, the ten most ethnically diverse local authorities have suffered over £15 million more in public health budget cuts compared to the ten least ethnically diverse local authorities **[INQ000186548]**. This longer term negligence meant there was less public health structural resilience in deprived areas when the pandemic hit.

4. It was not new or unknown information that the best and most rapid way to get support out to the frontline and marginalised groups would have been at a local, community level. The nature of transmission of the virus and experiences of previous epidemics globally should have been evidence of utilising community engagement structures to prevent and control the spread of the virus. This should therefore have been considered by the government as part of its pre-pandemic planning. Research published in *BMJ Global Health* in August 2020 explains that community engagement has been deemed a "fundamental component of past outbreaks", for example, Ebola **[INQ000186542]**. The researchers expressed concerns over the lack of involvement of communities and 'bottom-up' approaches used within COVID-19 responses.

5. A key problem with the national track and trace scheme was that it was not close to the ground. Despite local teams outperforming the national Test and Trace Service on successfully tracing contacts, the funding was asymmetrical **[INQ000186541]**. Local authorities received an additional £300m for contact tracing in 2020, while the centralised Test and Trace Service received £10bn **[INQ000186548]**. In future, emergency health protection funding for local authorities should be prioritised.

6. There is much evidence on the disproportionate mortality and morbidity amongst Black and minority ethnic healthcare professionals. Indeed, the first ten doctors to

die were from BME backgrounds. Protections for these frontline staff were not adequately considered and they did not have the same access to usable PPE as their white counterparts **[INQ000186537]**. Greater proportions of BME key workers (32%) reported that they were not given appropriate PPE compared with their white peers (20%) **[INQ000186540].** Among those in this position, 50% of Bangladeshi, 42% of Pakistani and 41% of Black African respondents reported that they had not been given adequate PPE.

7. BME staff faced greater difficulty in accessing PPE that fitted correctly, with types of mask that did not fit particular faces **[INQ000186538]**. Doctors from ethnic minority backgrounds were also less likely to speak out against safety concerns in fear of how this might impact their careers **[INQ000186551]**. As recommended by the Health and Social Care Select Committee in its *'Coronavirus: lessons learned to date'* "the Government must learn from the initial shortage of appropriate PPE for these staff and set out a strategy to secure a supply chain of PPE that works for all staff in the NHS and care sectors." **[INQ000186552]**

8. A lack of meaningful and intersectional data impeded the ability of the government and authorities to enact the appropriate public health interventions early enough. Researchers from the Universities of Nottingham and Leicester explain this aptly: "One of the key lessons that we should learn from the response to this pandemic is the importance of setting up a robust system for data collection, aggregation, and analysis as a pandemic-preparedness measure rather than a response. This action will not only help to ensure future responses are quicker and more effective than was the initial response to COVID-19 but also that the government is better prepared to identify and address the multiple and intersecting factors driving health inequities." **[INQ000186553]**

9. The feasibility, impact and implications of self-isolation measures were not considered sufficiently by the government in pre-pandemic planning. Many minority ethnic individuals found it harder to self-isolate because of the conditions in which they live and work. Self-isolation was already difficult – under 20% of people with Covid-19 symptoms were found by SAGE to be isolating

appropriately in 2020 – but poor housing and financial precarity made it almost impossible without additional support. **[INQ000186545]**

10. The impact of housing conditions on the exposure to the virus was not sufficiently considered in pre-pandemic planning. Nearly one third of Bangladeshi households and 15% of Black African households are classified as overcrowded, compared to only 2% of white households **[INQ000186544].** Moreover, Black and minority ethnic people are more likely **[INQ000186546]** to live in cold and damp homes, putting them at greater risk of contracting the virus **[INQ000186543]** as well as more serious health consequences if contracted. Government figures **[INQ000186546]** in the two years to March 2019 showed that Mixed White and Black Caribbean (13%), Bangladeshi (10%), Black African (9%) and Pakistani (8%) households were more likely to have damp problems than White British households (3%). The Department for Levelling Up, Housing and Communities set out interventions for tackling overcrowding among British Bangladeshi and Pakistani households in December 2022 **[INQ000186544].**

11. Our research shows that over the last decade, Black and minority ethnic communities have been falling faster and deeper beneath the poverty line **[INQ000186554]**. They were disproportionately affected by labour market disruption through successive national and regional 'lockdowns' with less employment protection and a much greater likelihood of job and income loss. Emergency social security measures and financial support, such as the £20 uplift to Universal Credit, were unable to fully mitigate the effects felt by Black and minority ethnic households during the pandemic. Bangladeshi and Black African households had only 10p for every £1 in savings held per White British household, and were more likely to experience difficulty paying their bills, meaning taking time off work to self-isolate was often unaffordable [**INQ000186548**]. Compared to white men, Bangladeshi men were four times more likely to be employed in shut-down sectors of the economy during COVID-19, Pakistani men were almost three times more likely, and Black African and Black Caribbean men were both 50% more likely to work in sectors affected by COVID-19 **[INQ000186554].**

12. The government should address the root causes of health, housing and employment inequality that led to worsened health and broader life outcomes for many during the pandemic. In the longer term, there is a need for the government to invest in good work, affordable housing, and particularly larger social housing, so that families on low income are not forced to live in overcrowded and poor-condition privately rented housing.

13. Inclusivity in relation to COVID-19 public health messaging was not appropriately planned for or considered, as the majority of the messaging was delivered in English. Written evidence received by the Health and Social Care Select Committee as part of its *'Coronavirus: lessons learned to date'* report was critical of the Government's efforts to engage and communicate with people from Black and ethnic minority groups **[INQ000186552]**. The Local Government Association said the Government should focus on "improving messaging about health-seeking behaviour" to these communities "such as encouraging people from Black British heritage to go into hospital if they need to" **[INQ000186547]**. BME communities use more grassroots and community mechanisms for communications and public health messages did not cascade or reach the front line fast enough. There was an assumption that public health messaging at national level would reach these communities.

14. Locally based public health messaging is deemed more successful because of the proximity to communities and the ability to engage in a more culturally competent way, as argued by Professor Kevin Fenton **[INQ000186549]**. This messaging should also be mindful of cultural and social norms, understanding differences between ethnic minority groups and being cognizant of the fact some minority ethnic communities may be less willing to trust health communication that comes from the government, as explained by Public Health England **[INQ000186539].** Health guidance should be accessible and inclusive, taking different communities into consideration.

15. The UK Government's pre-existing Hostile Environment policies — such as No Recourse to Public Funds (NRPF), right to rent and work checks, and NHS charging and data-sharing — worsened the effects of COVID-19 across all areas

of life for undocumented migrants. These policies have a disproportionate impact **[INQ000186555]** on BME people, and they exacerbated financial insecurity, precarious employment, insecure housing and barriers to healthcare for undocumented people, at a time when access to safety and support had never been more critical. During the pandemic nearly 1.4 million people were excluded from financial support altogether if they were affected by NRPF, with the vast majority (an estimated 82%) affected being from a Black, Asian or minority ethnic background **[INQ000186554].**

Throughout the preparedness phase, the government did not appreciate the risk that race and ethnicity posed. This had been an ongoing feature of its health planning during the pre-pandemic stage and until the vaccines were rolled out. It is imperative that the government factors in both race and the impact of racism as well as socio-economic determinants in its emergency plannings and for lessons learned.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 25th April, 2023