IN THE MATTER OF THE UK COVID-19 PUBLIC INQUIRY
BEFORE BARONESS HALLETT

MODULE 3 SECOND PRELIMINARY HEARING
WRITTEN SUBMISSIONS FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

Introduction

1. FEMHO makes these submissions ahead of the second preliminary hearing for Module 3, having had sight of Counsel to the Inquiry's (CTI's) note and the Inquiry's provisional list of issues. We are grateful for these and are encouraged by the obvious responsiveness to key themes that have been pressed by FEMHO to date, as they are now reflected in both these documents.

2. Our brief written submissions herein, will seek to contextualise and reinforce the lines of enquiry that we have advocated for in Module 3. At this point, our primary emphasis in Module 3 may be described in three parts: i) ensuring that the *lived experience* of FEMHO members is heard and that it informs lines of enquiry; ii) identifying the role that inequalities and cultural competences played in the quality of healthcare delivery during the pandemic; and iii) unpacking the reliance on science and evidence and its implications for FEMHO members and its wider community.

I. Lived experience in healthcare settings

3. The investigation of the Covid-19 pandemic in the UK is largely an examination of the healthcare system. As a consortium of Black, Asian and Minority Ethnic health and social care workers, the experience of FEMHO members tells a major part of the story of how the pandemic was handled (or not), in real terms. Moreover, the early stage of the pandemic is notoriously characterised by the disproportionate rates of infection and death amongst ethnic minority healthcare workers. There is much to be learnt about the classification and recording of these deaths during the early stages of the pandemic. As a consequence, it is vital that the Inquiry's investigation in Module 3 takes account of the experience of our members, who were

at the frontline and most affected by these experiences. FEMHO would like to present evidence to the Inquiry, both in written and oral form, that speaks to the disparities in healthcare experiences, impacts and outcomes among our members.

4. In previous submissions to this Inquiry, we have highlighted the significant issues of data capture in the early stages of the pandemic. Far beyond the failure to use data concerning race and ethnicity in anticipating risk, there was also a failure to acknowledge the pandemic's toll on Black, Asian and Minority Ethnic healthcare workers within the healthcare system. Initial accounts came from the press and were presented from anecdotal accounts. Module 3 of this Inquiry presents an opportunity for establishing a public record of that period of the pandemic, within the healthcare system.

5. Importantly, FEMHO is keen for the inquiry to examine whether and how bereavement services, hospice and end of life care, as well as hospital memorialisation efforts, were inclusive and proportionate. The Inquiry must examine seemingly facially neutral policies such as those for hospital visitation, and how they might have played out in an atmosphere of fear, uncertainty, high death rates among ethnic minority communities and wider concerns of racism. There are many horrendous stories within our ranks, including that of a 12 year old boy from a minority ethnic community who died alone from Covid. The Inquiry's investigation should surface whether such stories were exceptional or closer to the norm, in terms of experience of Black, Asian and Minority Ethnic people who were hospitalised.

6. FEMHO also seeks to urge the need for an expansive view of the healthcare system, for the Inquiry's investigation. It is important for the scope of the Inquiry's investigation not to be narrowly focused on hospitals, but to extend to other spaces where healthcare was administered. We believe that we can help the Inquiry learn about: i) how staffing challenges impacted our members' delivery of healthcare and how this contributed to general access to critical care, along with the effectiveness of nightingale hospitals in serving Black, Asian and Minority Ethnic communities; and ii) the (in/)adequacy of emergency services in their responses to the needs of Black, Asian and Minority Ethnic communities and the (in/)effectiveness of cross-sectional cooperation in managing the crisis. In addition, FEMHO would like to present evidence of the challenges faced by ethnic minority healthcare workers, including training, availability, the removal of the NHS surcharge and its significance, sacrifices

made to continue working which prevented members from being with family abroad in their final moments and the concept and toll arising from Cultural Taxation.[1]

7. FEMHO believes that its members are uniquely well-placed to assist the Inquiry in learning about the experience of healthcare workers, as members of disproportionately affected communities and through a constellation of other intersecting identities that include race, ethnicity, gender, national origin, religion and disability. An important lesson from Module 3 must be to learn about the experiences of Black, Asian and Minority Ethnic voices, in all their intersectional identities, both within healthcare (from professionals) and from their wider communities. The intersectionality of ethnicity and religion is particularly important in examining experiences within healthcare We wish to flag that even as the spectre of Long Covid struggles to gain proper recognition in the aftermath of the pandemic, there is increasingly an issue of equitable diagnosis of the condition for members of the Black, Asian and Minority Ethnic communities.

II. Inequalities and cultural competencies

8. As the chief purveyor of healthcare within the UK, the NHS employs large numbers of Black, Asian and Minority Ethnic communities.[2] In particular, Black, Asian and Minority Ethnic healthcare workers are particularly well represented within the ranks of nurses; and generally in lower ranking, public-facing roles within the NHS. This picture stands in stark contrast with the levels of representation at the most senior levels of the NHS. It has been noted previously that there is a link between diversity in healthcare management and the effectiveness in the delivery of healthcare.[3]

8. A serious issue facing the delivery of healthcare to Black, Asian and Minority Ethnic communities during the pandemic was data processing and communication. It has already been

[1] "Cultural taxation" is a term used to refer to when staff of color take on additional work as representatives of ethnic groups but are not compensated for these tasks. There has been a long-standing lack of resourcing for this work, which many FEMHO members take on to tackle inequalities for their colleagues and communities and dedicate significant time to with no remuneration and little recognition. For more on this see article published 17 March 2021 on iNews "'It's cultural taxation': The doctors and nurses fighting ethnic minority vaccine hesitancy in their own time".

[2] The NHS People Plan for 2020/2021, published July 2020, p.24, states that the NHS is the largest employer of Black, Asian and Minority Ethnic people in the country.

[3] See McKinsey & Company: Diversity wins: How inclusion matters, 19 May 2020 for commentary on the principle across sectors. For evidence focused on the healthcare sector, see the NHS Leadership Academy in 2012 report which showed that NHS Trust Boards that represent the diversity of the local communities they serve have been demonstrated to deliver consistently better services. Similarly, a workforce in which there is diversity across all levels of seniority also has proven to deliver better patient care. See, for example, NHS Staff Management and Health Service Quality Report, Michael West & Jeremy Dawson 2012 & 'Does the experience of staff working in the NHS link to the patient experience of care? An analysis of links between the 2007 acute trust inpatient and NHS staff surveys, Jeremy Dawson, July 2009.

noted that the egregious failure to identify the disproportionate death rates among minority ethnic healthcare workers, came anecdotally and not from within the formal NHS or government systems. FEMHO notes that the coding of ethnicity in primary care records is a fairly recent introduction and the inclusion of ethnicity in death certification is still not universal, despite the experience of the pandemic. The Inquiry will need to investigate how data relating to race and ethnicity was accessed and processed within the NHS and beyond, during the critical stages of the pandemic that will be investigated.

9. The generation of appropriate public health messaging during the pandemic was another fraught aspect of healthcare delivery. Very often, there was reference to the need to engage with "*hard to reach*" communities, which was/is shorthand for Black, Asian and Minority Ethnic communities. The notion of conveying healthcare messages in culturally appropriate ways became, without exaggeration, a matter of life and death. A huge part of the distress during the pandemic surrounded attitudes towards dying (e.g. end of life decisions) and general communication practices around death and burial. The absence of a formalised system that acknowledges such diversity was problematic. As such, the lack of cultural competencies at a senior policy level within the NHS had a directly negative impact. A capacity for reflexivity within the NHS in respect of the little data that did exist about race and ethnicity – especially during the early stages of the pandemic – might have stimulated more robust responses. In this module, the Inquiry must investigate the NHS and other relevant bodies' capacity to demonstrate these cultural competences. Was a lack of diversity in the most senior levels of the NHS leadership a bar to more nimble responses in the unfolding disaster of disproportionate deaths among Black, Asian and Minority Ethnic healthcare workers? Would more diverse senior leadership have resulted in earlier, more culturally appropriate public health messaging and interventions? These, we submit, are vital questions that must be examined in this module.

10. FEMHO welcomes the instruction of experts on structural racism, Professors James Nazroo and Laia Bécares. Our position is that the experience of FEMHO members as workers and users of the healthcare system, reflects wider issues of health inequality, occasioned in no small degree by structural racism. Given the high percentage of certain illnesses within particular ethnic and racial groups that would heighten vulnerabilities to respiratory illnesses; and the high percentage of Black, Asian and Minority Ethnic staff that are in public facing roles that were likely to be put at higher risk of exposure to Covid-19 and other respiratory viruses, it is

unsurprising that Black, Asian and Minority Ethnic workers and their communities suffered disproportionately adverse health outcomes and death rates. The Inquiry, with the assistance of the structural racism and discrimination experts, will need to address how economic, political and social factors and intersecting inequalities coalesced to produce these adverse, racialised outcomes within the healthcare system during the pandemic.

11. We repeat our call for the structural racism experts to not just produce their report but also be made available for questions during the evidential hearings. It is imperative that Core Participants have the opportunity to directly interact with the experts, ask clarifying questions, and delve deeper into their analyses. An interactive and open dialogue, which is only possible through oral testimony, allows for a dynamic exploration of the subject that written reports alone cannot accommodate.

III. Reliance on science and evidence

12. During the pandemic, the notion of fidelity to "*science*" and "*evidence*" was presented as the holy grail in healthcare messaging. The implicit assumption was that science was fool proof; and that scientifically generated evidence was hermetically sealed from any lay person challenge. This held out an invitation for all communities – notably Black, Asian and Minority Ethnic communities – to trust the NHS, scientists, drug makers and the government in mitigating the effects of the pandemic. There were many issues at the root of this proposition, which will need to be explored in Module 3. The nub of the issues, however, remains one of trust.

13. The Inquiry has indicated that it will examine issues related to the pulse oximetry machine, where essentially, the machine was found to have been modelled off White Male bodies. The consequences of not apprehending warning signals from darker skin tones or non-White bodies, was exposed by studies to be potentially fatal.[4]

14. In the development of drugs, there are significant questions about how Black, Asian and Minority Ethnic people were engaged in clinical trials. At the advent of vaccines, there was a looming question of whether some newly developed versions of the vaccine presented a cognisable risk to those with sickle cell disease, who were mainly from Black-African and Black Caribbean communities. The Inquiry confirms that the issue of how Covid-19 came to be

[4] 'Pulse Oximeter Bias Highlighted in Rapid Review', NHS Race & Health Observatory, 14 April 2021.

downgraded from a high consequence infectious disease (HCID), thereby not requiring the use of Respiratory Protective equipment (RPEs), will be explored. There is a strong body of opinion which holds that this decision more reflects budgetary constraints rather than rigorous public health analysis on this important aspect of infection control.

15. FEMHO posits that in relation to its members and wider community, the lack of trust in matters of science and evidence must be viewed through the prism of health inequality and structural racism. These issues must be addressed openly and fearlessly in Module 3, as has been promised in previous modules. The Inquiry must also explore whether resource allocation served to undermine science and evidence-based conclusions, further undermining trust in the healthcare system.

IV. Provisional List of Issues

16. FEMHO welcomes the provisional list of issues provided with CTI's note and, in particular, the confirmation that: "R*unning throughout the Module will be consideration of whether the healthcare decisions to be examined disproportionately affected any particular group(s) in society; the measures put in place to reduce the unequal impact of the pandemic on minorities or vulnerable healthcare workers or patients and whether any unequal impact was foreseeable.*" Whilst this commitment is encouraging, and we appreciate that the list of issues is not designed to be an exhaustive document, we note that aside from 2(e) ("*Core decision making and leadership: the extent to which healthcare inequalities were considered as part of the core decision-making process*") there is no other specific reference to issues of ethnicity, inequality and/or disparate impact in the list.

17. Though the module is at an early stage, and we have not yet had sight of any disclosure, there are a number of critical questions and lines of enquiry that FEMHO considers critical to a full and thorough investigation in this module and thus wishes to set out now to the Inquiry team. FEMHO invites the Inquiry to add these to the list of issues and/or to confirm that they will fall within the scope of issues to be considered during the module:
    a) How did the government communicate with Black, Asian and Minority Ethnic communities and healthcare workers about the risks of Covid-19 and the measures being taken to mitigate those risks, and was this communication culturally appropriate and effective?

b) Did the government allocate sufficient resources and funding to address health inequalities and the heightened risks faced by Black, Asian and Minority Ethnic communities and healthcare workers during the pandemic, and were these resources effectively deployed?
c) To what extent did political considerations influence the government's pandemic response and planning, and did this impact the health outcomes of Black, Asian and Minority Ethnic communities and healthcare workers?
d) Were there any early warning signs or indications that Black, Asian and Minority Ethnic communities and healthcare workers were at higher risk of adverse health outcomes during the pandemic, and if so, how were these signals responded to by the government?
e) Were healthcare workers from Black, Asian and Minority Ethnic backgrounds provided with appropriate PPE and training to reduce their risk of contracting and spreading COVID-19? If not, how was this issue handled once identified?
f) Were healthcare workers from Black, Asian and Minority Ethnic backgrounds given priority for COVID-19 testing and vaccination, given their higher risk of exposure and mortality? If not, how was this issue handled once identified?
g) How did the government engage with and involve Black, Asian and Minority Ethnic communities and healthcare workers in the pandemic response, particularly in decision-making processes and communication strategies? If there was engagement, state when and how?
h) Were any specific measures put in place to provide mental health support and resources for Black, Asian and Minority Ethnic healthcare workers who may have experienced trauma, grief, and stress during the pandemic?
i) Were any specific policies or interventions implemented to address the disproportionate impact of COVID-19 on Black, Asian, and Minority Ethnic communities and healthcare workers, and were these effective in mitigating the impact? What were those policies? If no policies were implemented, why not?
j) Was there any consideration given to the intersectional identities of Black, Asian, and Minority Ethnic healthcare workers and communities, such as gender or socioeconomic status, in the response to the high death rates?
k) Was there any engagement or consultation with Black, Asian, and Minority Ethnic communities and healthcare workers in the development of policies or interventions to address the high death rates, and if not, why not?
l) Did any political or economic factors influence the response to the high death rates among Black, Asian, and Minority Ethnic healthcare workers and communities, and if so, how?

m) How did the response to the high death rates among Black, Asian, and Minority Ethnic healthcare workers and communities compare to the response to the pandemic overall, in terms of funding, resources, and decision-making?

V. Key Lines of Enquiry for the Listening Exercise

18. We are grateful for the Inquiry team's indications of the key lines of enquiry currently under consideration relevant to the scope of Module 3 in the listening exercise, and the commitment to carry out targeted research to reach a wide range of individuals, communities and groups whose voices who are traditionally under-represented and seldom heard. We would be grateful for further insight into how and when this research will be made available to Core Participants and how it will be synthesised alongside similar information provided via Rule 9 statements and questionnaires.

19. There has been limited time to consider the key lines of enquiry set out in annex to CTI's note, so we may have further observations to contribute in due course, however as a starting point we would like to raise concern that currently there is no indication that any of the research is being targeted towards minority ethnic healthcare workers and communities. Given the disproportionate impact on these groups, and historic patterns of these voices not being heard, we urge the Inquiry to rectify this as a matter of urgency and include targeted research specifically aimed at hearing from minority ethnic healthcare workers on the pressures and issues they faced during the pandemic.

VI. Update on Rule 9 requests

20. FEMHO respectfully reiterates its previous requests that the Inquiry reconsider decision not to disclose copies of the Rule 9 requests to Core Participants. Without sight of the requests themselves, and with disclosure expected to be released on a rolling basis, we consider that it will be near impossible for Core Participants to determine whether there are any gaps in good time ahead of the evidential hearings. This approach therefore runs the risk that there will be no time for such gaps to be meaningfully addressed and/or that there may be delays to the timetable to obtain the material necessary to purposefully fill any such gaps.

VII. Evidence

21. As detailed above, we request that select evidence is considered from our members of their experiences as professionals within the healthcare system, both in written and oral form.

22. FEMHO welcomes the confirmation in CTI's note that the Inquiry intends to ensure that relevant evidence obtained in other modules of the Inquiry will be made available in Module 3, and that this will include evidence from Module 1 and expert evidence on health inequalities.

23. We further note the Inquiry's intention to start the process of disclosure of Module 3 material to Core Participants in the coming weeks, and the estimated start date for evidential hearings of Autumn 2024. At this stage we would merely ask that the Inquiry maintain flexibility in these dates and ensure that sufficient time is allowed for Core Participants to review the disclosure and be properly prepared for the hearings. This will ensure a fair and comprehensive evaluation of the data, leading to informed conclusions.

24. We are troubled to learn of the issue regarding NHS Wales retention of emails and the potential deletion of relevant data but thank the Inquiry team for bringing it to the attention of Core Participants. Pending the awaited further information on this matter we may wish to make more detailed submissions in due course.

Conclusion

25. FEMHO invites the Inquiry to pursue the lines of enquiry proposed, as we have submitted above, in relation to ethnic minority healthcare workers and their communities. We consider this imperative to ensuring a proper understanding of the key facts and questions or why and how such disproportionate impacts were suffered so that it will not be repeated in future.

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