Witness Name: Rt Hon Kemi Badenoch MP

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THE UNITED KINGDOM COVID 19 INQUIRY

WITNESS STATEMENT OF KEMI BADENOCH

MEMBER OF PARLIAMENT FOR SAFFRON WALDEN

SECRETARY OF STATE FOR THE DEPARTMENT FOR BUSINESS AND TRADE, SECRETARY OF STATE FOR INTERNATIONAL TRADE, PRESIDENT OF THE BOARD OF TRADE & MINISTER FOR WOMEN & EQUALITIES

I, Kemi Badenoch, will state, as follows: -

Introduction

1. I am providing this witness statement to explain my role as Minister for Equalities during the period between February 2020 and February 2022. This witness statement is provided in response to a Rule 9 Request which was addressed to me through the Equality Hub in the Cabinet Office. Accordingly, the statement focuses on my role overseeing aspects of the work of the Equality Hub rather than my wider portfolio of work associated with my other ministerial positions.

2. The pandemic undoubtedly shone a spotlight on disparities. During the pandemic, I was asked by the then Prime Minister to assess the disproportionate impact of Covid on different groups and work with others to mitigate it. My top priority was improving the quality of evidence and data about disparities and the types of barriers different people face – this included statutory protected characteristics but also other factors, including socio-economic background and geography **[KB/1 - INQ000185177]**.

3. I make this statement from information and documents within my personal knowledge; information provided to me by colleagues within my Private Office, the Equality Hub; and my own experience of the functions and operation of government. The content of this statement is true to the best of my knowledge and belief. Within the limited time and using those resources made available to me, I have endeavoured to give an

accurate account of the key aspects of my involvement, through the Equality Hub, in the core political and administrative decision-making relating to the UK's response to Covid-19. It has not been possible for me to undertake a comprehensive review of all my emails and documents. I recognise that further documents and emails might be brought to my attention at a later date, and I would, therefore, welcome the opportunity to supplement, clarify and / or to update my evidence (if necessary) in the light of any such documents. I was not involved in any WhatsApp or text message communications relevant to the UK's core political and administrative decision-making in relation to the Covid-19 during the specified period.

Political Career

4. I was elected as member of parliament for Saffron Walden on 8 June 2017. I served as Parliamentary Under Secretary of State (Minister for Children and Families) at the Department of Education from 27 July 2019 to 13 February 2020. I took maternity leave from 4 September 2019 and returned to work on 7 April 2020. The Rt Hon Michelle Donelan MP covered my Department for Education role between 4 September 2019 and 13 February 2020. Between 13 February 2020 and 15 September 2021, I served as Exchequer Secretary to the Treasury and Minister for Equalities. Between 16 September 2021 and 6 July 2022, I served as Minister of State at the Department for Levelling Up, Housing and Communities and Minister of State for Equalities. On 6 September 2022, I was appointed as Secretary of State for International Trade and President of the Board of Trade. On 25 October 2022 I was also appointed as Minister for Women and Equalities. Retaining those positions, I was further appointed as Secretary of State for the Department of Business and Trade on 7 February 2023.

The Responsibilities of the Minister for Equalities

5. My specific responsibilities as Minister for Equalities between 16 February 2020 and February 2022 included **[KB/2 - INQ000185181]**:

    a. work relating to racial and ethnic disparities, including the Commission on Race and Ethnic Disparities and, subsequent to the Commission's report, publication and delivery of the Government's response, Inclusive Britain;

    b. supporting the Minister for Women & Equalities on work relating to LGBT equality, including responding to the consultation on reforming the Gender Recognition Act, banning conversion practices and hosting a global LGBT

Conference (this work was mostly reallocated to Minister Freer upon his appointment as Minister for Equalities in September 2021);

c. work relating to COVID-19 disparities, including quarterly reports on this to the Prime Minister between June 2020 and December 2021;

d. acting as sponsoring minister for the Social Mobility Commission (from April 2021) and the Equality and Human Rights Commission;

e. Equality Act and Public Sector Equality Duty oversight

6. I note that Mr Marcus Bell (Director of the Equality Hub) has addressed, comprehensively, in his corporate statement, the make-up and role of the Equality Hub. Throughout the pandemic I worked closely and effectively with Marcus and his staff at the Equality Hub. So as to avoid unnecessary duplication, and in the interests of brevity, I defer to Mr Bell's statement for his overview of the structure of the Equality Hub and the detailed work being conducted by officials.

7. The Women & Equalities ministerial team divided its work as below.

   a. The Minister for Women and Equalities was The Rt Hon Elizabeth Truss MP from September 2019 to September 2022. During this time, she also held the posts of Secretary of State for Trade (at the Department for International Trade, DIT) and Foreign Secretary (at the Foreign, Commonwealth & Development Office, FCDO). The Minister for Women and Equalities has overall responsibility for the Equality Hub's work (except disability policies, see below), and decided how to delegate responsibilities and workstreams to junior ministers.

   b. While I was in post, Junior Minister roles were organised such that:

      i. I held the post of Minister for Equalities from February 2020 to July 2022, based in the Treasury (HMT) and then DLUHC (from September 2021). During this period I had delegated responsibility for the Covid Disparity Reports.

ii. Mike Freer MP held the post of Minister for Equalities, with specific responsibility for LGBT policy, from September 2021 to July 2022, based in DIT.

iii. The Minister for Women role was held by Baroness Berridge of The Vale of Catmose from February 2020 to September 2021, based in DfE; followed by Baroness Stedman-Scott OBE from September 2021 to September 2022, based in DWP.

iv. The Minister for Disabled People post was held by Justin Tomlinson MP from 2019 to September 2021, based in DWP; followed by the Rt Hon Chloe Smith MP from September 2021 to September 2022, based in DWP. The Minister for Disabled People reports into the Secretary of State for Work and Pensions. This role was held by The Rt Hon Thérèse Coffey MP from September 2019 to September 2022.

8. My working relationship with my colleagues within the Women & Equalities Ministerial Team was mostly conducted through ministerial team meetings, which were supplemented by bilateral meetings where needed.

Introduction to Covid-19 key workstreams

9. The key Covid-19 workstreams which I was responsible for included:

   a. **Quarterly reports on progress to address COVID-19 health inequalities -** On 4 June 2020, the then Prime Minister invited me to lead on work by the Government following the Public Health England (PHE) review into disparities in the risk and outcomes of COVID-19 **[KB/3 - INQ000089740]**. I was provided with eight 'terms of reference' **[KB/4 - INQ000089741]** which included a requirement to provide quarterly updates to the Prime Minister and Secretary of State for Health and Social Care on progress. Between June 2020 and December 2021, the majority of my time was spent working with the Equality Hub to deliver against these eight terms of reference. The work that we achieved is best understood by reading the four comprehensive reports which were published in October 2020; February 2021; May 2021; and December 2021. I have extracted and summarised some key features of our work in my statement below.

b. **Involvement in Key Decision-Making Forums –** While I was not a standing member of the Covid specific meetings, I did attend some of the Covid 19 Operations (Covid-O) Committee meetings in my capacity as Equalities Minister. In particular I was involved in meetings which touched on disproportionately impacted groups (DIGs) and in particular ethnic minorities. I have set out my recollections of these meetings under the relevant heading below and my full attendance at the meetings is recorded in the Covid-O minutes.

c. **Involvement in public health communications –** I was integrally involved in exploring how we could improve the reach of government communications about the impact of COVID-19 on ethnic minority groups. The communication efforts that I supported across government are best explained in the 'Quarterly Reports'. I have extracted and summarised some key features of our work in my statement below.

d. **Involvement in increasing vaccine uptake among ethnic minorities –** I worked extensively with the Equality Hub to support government work with national and local partners to promote vaccine uptake among ethnic minority groups, and to tackle misinformation through a series of targeted and highly innovative interventions. The efforts that we supported across government are best explained in the 'Quarterly Reports'. I have extracted and summarised some key features of our work in my statement below.

10. The four key workstreams detailed above capture only a proportion of the work that I was involved in as Equalities Minister. As I have said above, the work that we achieved is best understood by reading the statement of Marcus Bell and the four quarterly reports.

February 2020 to 4 June 2020

11. As explained above, I returned to work from a period of maternity leave on 7 April 2020. I was therefore not involved in Cabinet discussions or advice to the Prime Minister, Cabinet or Cabinet Committees during the earliest phases of COVID-19 planning and response. While I cannot share direct insight from the period prior to my return from maternity leave, I believe that the UK Government did appreciate the seriousness of

the threat of Covid-19 and was making the necessary preparations to respond. This was evident in the unprecedented measures the Government took at the time, not only through non-pharmaceutical interventions but also the work I saw first-hand at HM Treasury in terms of protecting businesses and livelihoods.

12. I am aware that some Equality Hub staff were redeployed following the first national lockdown. The decision to redeploy Equality Hub Staff was a decision made by the then Minister for Women & Equalities. The work of the Race Disparity Unit was essential in conducting the disparities work the Prime Minister asked me to lead. In my opinion our work was not affected in output or outcome by the challenges of navigating Covid. The redeployments, which predominantly were a feature of the early to mid 2020, did not impact or prevent me from making direct representations at any time during the pandemic.

13. I have been asked to comment on what went well and what obstacles we faced. As explained I was on maternity leave and therefore I cannot comment on work prior to 7 April 2020. However, in my experience of our broader work responding to COVID-19, I found that our work with external experts, particularly Dr Raghib Ali and Prof Keith Neal (who I later appointed as expert advisers on Covid-19 and ethnicity), was of particular value and worked very well (I explain this in more detail below). The Race Disparity Unit did not have any prior epidemiological expertise and so their insights, provided to us completely free of cost to the taxpayer, were incredibly useful. We did experience some obstacles in relation to data sharing with NHS England, described in detail later in this statement, leading to the inclusion of a priority recommendation in my final quarterly report that an independent strategic review be undertaken of the dissemination of healthcare data and publication of statistics and analysis.

14. A further obstacle related to the sharing of the findings of my quarterly reports with the Joint Committee on Vaccination and Immunisation (JCVI). DHSC officials informed their Equality Hub counterparts that it would be inappropriate for a government minister to write to the Chair as this could be seen as me trying to influence the operationally-independent Committee. This was not my intention and the letters I sent to the JCVI simply relayed the findings from my first three reports to the Prime Minister.

15. I have been asked whether, in my view, the UK Government gave sufficient consideration during this initial period to the impact of Covid-19 and its decision-making on 'at risk' and other vulnerable groups in light of existing inequalities, and on groups

with a protected characteristic. As with my other answers relating to the initial period, I am not able to comment on Government work prior to my return from maternity leave on 7 April 2020. However, I do believe the government took this issue seriously and that this led the Health Secretary in May 2020 to commission PHE to conduct a Review into factors impacting health outcomes from COVID-19 **[KB/5 - INQ000185183]**. The Review analysed how different factors – including ethnicity, gender and obesity – could impact on people's health outcomes from COVID-19.

Quarterly reports on progress to address COVID-19 health inequalities

16. On 2 June 2020, PHE published the findings from their review into disparities in the risks and outcomes of COVID-19 **[KB/3 - INQ000089740]**. On the same day, the Health Secretary made a statement to Parliament in which he indicated that I would lead work to respond to the review's findings. Discussions between No10 and Equality Hub advisers and officials followed in order to confirm this and finalise the terms of reference for the work.

17. The PHE report highlighted some apparently significant disparities in both risk and outcomes from COVID-19. I read this PHE report with concern and on 4 June 2020, I spoke about it in the House of Commons **[KB/6 - INQ000185182]**. I regarded it as important to ensure that the Government reviewed the impact and effectiveness of their actions to lessen disparities in infection and death rates of Covid-19, and to determine what further measures were necessary. I recognised that more needed to be done to understand the key drivers of the disparities identified by PHE and the relationships between different risk factors and I was alive to the need for the Government to commission further data, research and analytical work by the Equality Hub to clarify the reasons for the gaps in evidence highlighted by the report. I was clear that taking action without taking the necessary time and effort to understand the root causes of those disparities only risked worsening the situation. I was also alive to the important point that equalities are not something that only happens in the Equalities Office; equalities happen across Whitehall. It was important for every Department to appreciate that it had responsibility to ensure that it made the right policies for all the people who are impacted by their activities.

18. Later that day I formally announced that I had been invited by the Prime Minister to lead on work by the Government following the PHE review. I said at the time: *"This government is rightly taking seriously the initial findings from the PHE report published*

earlier this week. However, it is also clear that much more needs to be done to understand the key drivers of the disparities identified and the relationships between the different risk factors. That is why I am now taking this work forward, which will enable us to make a real difference to people's lives and protect our communities from the impact of the coronavirus" **[KB/4 - INQ000089741].** The Terms of Reference for the work that the Prime Minister had asked me to carry out were as follows:

a. **TOR 1** – *"Review the effectiveness and impact of current actions being undertaken by relevant government departments and their agencies to directly lessen disparities in infection and death rates of COVID-19. Factors to be considered – but aren't limited to – should include age and sex, occupation, obesity, comorbidities, geography, and ethnicity;"*

b. **TOR 2** – *"Modifications to existing, or development of new policy, should be considered and discussed with the relevant Ministers responsible. This ongoing work will include looking at the extensive guidance that is already currently available;"*

c. **TOR 3** – *"Commission further data, research and analytical work by the Equality Hub to clarify the scale, and drivers, of the gaps in evidence highlighted by the Report;"*

d. **TOR 4** – *"Consider where and how the collection and quality of data into the disparities highlighted can be improved on, and take action to do so, working with the Equality Hub, government departments and their agencies;"*

e. **TOR 5** – *"Lead engagement on the disparities highlighted with Departmental Ministers;"*

f. ***TOR 6*** – *"Build on and expand the stakeholder engagement undertaken by PHE, to consolidate and develop the qualitative insights gained and how they may support further actions that should be taken to address the disparities highlighted;"*

g. ***TOR 7*** – *"Strengthen and improve public health communications to ensure they can reach all communities across the country;"*

h. ***TOR 8*** – *"Provide quarterly updates to the Prime Minister and Secretary of State for Health and Social Care on progress being made to address health inequalities by departments and their agencies."*

19. As explained above, between June 2020 and December 2021 the majority of my time was spent working with the Equality Hub to deliver against these terms of reference. I worked most closely with the Race Disparity Unit (RDU), colleagues across other government departments and agencies, and in particular the Department of Health and Social Care (DHSC), PHE, the Cabinet Office (including the COVID-19 Taskforce) and the Ministry of Housing, Communities and Local Government (MHCLG), to assess initiatives to lessen the disparities highlighted by the PHE report. The work that we achieved is best understood by reading the four 'quarterly reports'. In the following paragraphs I have sought to highlight some of the main features of these reports. I, along with Marcus Bell and the staff at the Equality Hub, worked tirelessly to produce the reports, implement the recommendations and ultimately to mitigate, so far as reasonably practicable, the impacts of COVID-19. It has not been possible for me to draw out every aspect of each report or workstream, but I would gladly provide further evidence on any particular area that would assist the Inquiry.

The first 'Quarterly report on progress to address COVID-19 health inequalities'

20. The first 'Quarterly report on progress to address COVID-19 health inequalities' was published on 22 October 2020 and summarised: (i) the work that I and the RDU undertook to address the terms of reference; (ii) the work undertaken across government since the report of the PHE review was published on 2 June. The executive summary of the report reaffirmed that: *"The current evidence clearly shows that a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions contribute to the higher infection and mortality rates for ethnic minority groups, but a part of the excess risk remains unexplained for some groups. Each successive publication of results is filling the gaps in the evidence base and refining our previous understanding of the impact of different risk factors. This is set to continue over the months ahead."* Under my direction the RDU reviewed the actions that government departments and their agencies had initially put in place to mitigate the impacts of COVID-19. This work is summarised in Annex B to the report.

21. It is important to note that on 16 June 2020 PHE had published a rapid literature review and results of stakeholder engagement called: 'Beyond the Data: Understanding the impact of COVID-19 on BAME groups' which made a number of recommendations **[KB/7 - INQ000185178]**. Even before we published the first Quarterly Report the government had already delivered against many of the recommendations, a number of which had been subsumed into the work led by myself and the RDU. Annex A of the first Quarterly Report summarises the government's progress against each of the PHE recommendations.

22. On 21 October 2020 I wrote a letter to the Prime Minister and the Secretary of State for Health and Social Care setting out the work that I and the RDU had been engaged in to deliver against the terms of reference. I explained that: "...*We now know much more about the impact of the virus than we did in June and the evidence base is growing fast. The current evidence clearly shows that a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions contribute to the higher infection and mortality rates for ethnic minority groups, but a part of the excess risk remains unexplained for some groups. Each successive publication of results is filling the gaps in the evidence base and refining our previous understanding of the impact of different risk factors: this is set to continue over the months ahead"* **[KB/8 - INQ000215047]**. As I set out in my letter, the government had not, however, simply waited for new data to emerge before acting. I gave an example that over 95% of frontline NHS workers from an ethnic minority background had, by October 2020, had a risk assessment to ensure good understanding of the necessary mitigating interventions in place. On 21 October 2020, I delivered an oral statement to Parliament announcing the first quarterly report **[KB/9 - INQ000185179]**.

23. At this point in the pandemic, I was absolutely committed to reviewing the actions that government departments and their agencies had put in place to mitigate the impacts of COVID-19. I am of Nigerian heritage and the higher infection and mortality rates for ethnic minority groups was directly impacting me, my family, friends and community. This was a very personal issue, and it was clear to me that there was much good work underway, but I believed that departments needed to do more, and be more innovative, in their work to address the disparities. As I sought to reinforce in my letter to the Prime Minister, I was committed to the need to avoid stigmatising people from ethnic minority groups and I wanted to know more about the impact Covid-19 had on the day to day

lives of those from ethnic minority groups, drawing on their direct experiences. I had therefore commissioned qualitative research to gain a deeper insight on this issue.

24. I appointed two expert advisers on Covid-19 and ethnicity - Dr Raghib Ali and Professor Keith Neal **[KB/10 - INQ000083926]**. Dr Ali and Professor Neal proved to be an invaluable resource and brought unique insights and medical expertise, as well as acting as critical friends in shaping my work over the following months. Dr Ali and Professor Neal played an important role in reviewing the emerging data on Covid-19 disparities, quality assuring the four quarterly reports to the Prime Minister, briefing the media on the findings of the reports, and (in the case of Dr Ali) speaking at events and recording videos to help increase vaccine uptake among ethnic minority groups. I also worked closely with the government's senior responsible officer for the impacts of COVID-19 on disproportionately impacted groups, Emran Mian, and the SAGE ethnicity sub-group. I met Emran Mian on 21 July 2021 to talk about the links between our strands of work. I had similar discussions with Professor Kamlesh Khunti and Osama Rahman, the co-chairs of the SAGE Ethnicity sub-group, on 21 October and 16 December 2020.

25. The first quarterly report made thirteen recommendations, all of which were accepted in full. In my letter to the Prime Minister and the Secretary of State for Health and Social Care I emphasised the following recommendations in particular:

    a. *"The recording of ethnicity data as part of the death certification process should become mandatory, as this is the only way we will be able to establish a complete picture of the impact of the virus on ethnic minorities. I know that there is good work underway across government to develop a solution to this, and this must be a priority for the coming months. I understand that legislative changes will be required, and these should be brought forward at the earliest opportunity by DHSC".*

    b. *"Ensuring that new evidence uncovered during my review relating to the clinically extremely vulnerable is incorporated into health policy".*

    c. *"Ethnic minorities are grossly under-represented on the national vaccine register, which is voluntary. We must reduce fear and build confidence among ethnic minority people, tackling misinformation and anti-vaccination messages*

which have been directed at them, and rebuilding trust in government messaging".

d. *"We must support the deployment of a risk model to understand individual risk that is being developed from research commissioned by the Chief Medical Officer. This work is being led by an expert subgroup of academic, scientific and clinical experts and the University of Oxford".*

e. *"Anecdotally, we know there is much good work being done by local authorities and Directors of Public Health so that we can learn the lessons of what works at a local level. There should be a rapid, light-touch review of local authority action to support ethnic minority and hard-to-reach communities."*

26. The thirteen recommendations made in the first quarterly report provided the framework for the work that I and the RDU engaged in over the following months. The work which I undertook with the Equality Hub in the months between October 2020 and February 2021 is best summarised in the subsequent quarterly reports.

27. In order to implement and action this work I held regular meetings with my officials and the output and actions flowing from these meetings are reflected in the subsequent quarterly reports. The principal meetings I attended with my officials relating to COVID-19 disparities included regular meetings with the RDU on a minimum of a weekly basis. These were stocktake meetings, discussing progress against each of the terms of reference, any emerging issues and risks and the development and drafting of the four quarterly reports.

28. In addition to meetings with my officials, I attended many meetings with colleagues across government, including:

    a. Meetings with The Rt Hon Elizabeth Truss MP (in her capacity as Minister for Women and Equalities) and Justin Tomlinson MP (in his capacity as Minister of State for Disabled People, Health and Work).

    b. Meeting with Officials in Number 10 Downing Street - in particular, I held meetings with the Director of the Policy Unit, Munira Mirza, to update her on workstreams.

The second 'Quarterly report on progress to address COVID-19 health inequalities'

29. The second 'Quarterly report on progress to address COVID-19 health inequalities' was published on 26 February 2021 **[KB/11 - INQ000089744]**. This second report looked at the cause of the higher infection and mortality rates for ethnic minority groups in more detail and set out some of the work undertaken to fill the gaps in our understanding and to mitigate the risks of COVID-19 infection. The report explained our increased understanding of the drivers of these disparities.

30. In particular, the report explained that the impact of COVID-19 on certain ethnic minority groups had changed between the first wave and the early second wave of Covid-19. It concluded that *"...changes within such a short time period strongly suggest that ethnic inequalities in COVID-19 outcomes are driven by risk of infection, as opposed to ethnicity itself being a risk factor for severe illness or death from COVID-19."* The report further concluded that: *"The direct impacts of COVID-19 improved for ethnic minorities as a whole during the early second wave. For example, in the first wave, Black African men were 4.5 times more likely to die from COVID-19 than White British men of the same age but in the early part of the second wave the risk of death was the same for Black African and White British men. At the same time, however, the second wave has had a much greater impact on some South Asian groups. Work is underway to consider why the second wave to date has had such a disproportionate impact on Pakistani and Bangladeshi groups. Relevant considerations include regional patterns in first and second waves of the virus, household occupancy and multigenerational households, deprivation, and occupational exposure."* It is correct to say that the focus of this work was the disproportionate impact COVID-19 has had on ethnic minorities. There was wider work underway across government to consider the impact the virus has had on other groups, such as disabled people. Marcus Bell has addressed some of these workstreams in his Equality Hub witness statement.

31. At Annex A the report set out the progress made under the terms of reference and in implementing the recommendations from the first report. In particular, the report highlighted a number of positive measures which had been implemented since the publication of the first quarterly report. These included but were not limited to:

    a. **Community Champions** – *"In order to improve public health communications with those communities most at risk from COVID-19, the government released £23.75 million in funding to local authorities last month under the Community*

Champions scheme, following an expressions of interest exercise. This funding is enabling local authorities to work with grassroots advocates to tailor public health communications and to use trusted local voices to promote healthy living, encourage vaccine uptake and counter misinformation. The government will monitor the impact of the scheme and share the findings with other local authorities."

b. **Ethnic Minority Research Projects** – *"To improve our understanding of the health, social, cultural and economic impacts of COVID-19, the government has just invested a further £4.5 million of funding in new research projects looking at ethnic minority groups."*

c. **Mass Testing Pilots** – *"In order to prevent the spread of the virus and to protect frontline workers, many of whom are from an ethnic minority background, the Department for Transport and the Department for Health and Social Care included transportation workers in mass testing pilots covering the Christmas travel period. These are now being rolled out more widely."*

d. **Community Asymptomatic Testing** – *"The government also successfully piloted community-led, localised, asymptomatic testing at places of worship in ethnically diverse areas, building trust within the community and enabling a higher number of positive cases to be detected."*

32. It was important to ensure that ethnic minorities were not considered a single group that faces uniform risk factors in relation to Covid-19. The report summarises the findings of research commissioned by the RDU into a small group of ethnic minority people's personal experiences of COVID-19. Some important themes emerged from this work. For example, participants felt that communications tended to frame ethnic minorities as a homogeneous group that is vulnerable to COVID-19, which they found stigmatising. The research also showed the challenges some participants had in navigating public health advice and applying it to everyday situations, as well as adapting to the pace of change with the guidance. We committed to sharing these insights with other government departments to improve policymaking.

33. A very significant development since the first quarterly report was the approval and roll out of COVID-19 vaccines. The report summarises how the vaccination programme was being prioritised and the implications of this for ethnic minority groups, as well as

the analysis of likely take up rates for these groups. On 13 February 2021, the government published its UK COVID-19 vaccine uptake plan which highlighted a range of barriers to uptake and some of the work taking place across government and at a local level to minimise the impact of these **[KB/12 - INQ000185184]**. This includes establishing NHS vaccination centres in suitable sites in the community, such as places of worship. I have explained the work I did to increase vaccine uptake among minority groups in more detail below.

34. The report explains how we had continued our work on developing and improving targeted communications campaigns to encourage uptake of vaccines among ethnic minority groups and to counter misinformation, both nationally and locally. The second quarterly report set out five 'next steps' which I was committed to driving forward in tandem with government colleagues:

    e. ***Central and local government interventions*** – *"MHCLG to share with local authorities' examples of good practice from the review of local authority activity. MHCLG to share with local authorities the findings from the initial, one-month review of returns from Community Champions."*

    f. ***Vaccination programme*** – *"Minister for Equalities to write to the Joint Committee on Vaccination and Immunisation (JCVI) summarising the latest data and evidence set out in this report, to inform future advice on vaccine prioritisation. The government will continue to monitor data on vaccine uptake among ethnic minority groups and, if necessary, take further steps to address any barriers among these groups."*

    g. **Data and evidence** – *"The RDU will share the findings from the qualitative research into people's personal experiences of COVID-19 across government, particularly in relation to the stigmatisation felt by a number of participants in relation to being singled out as 'BAME'. Departments and other agencies should publish a statement on GOV.UK outlining their plans to move their data collections to the Government Statistical Service's (GSS) harmonised ethnicity data standard. Harmonisation is hugely important as it allows analysts to gain deeper insight and value from data. NHSE/I, working with DHSC and others, should publish a quarterly report on progress in improving the recording of ethnicity in health care records. Departments should provide updated datasets on COVID-19 risk factors and secondary impacts for publication on the*

Ethnicity facts and figures website in line with the schedule in Annex C. This provides transparency of process to users - promoting trust and authority - as well as informing them when the most up-to-date data will be made available."

h. **Engagement** – *"The Minister for Equalities, the government advisers on COVID-19 and ethnicity, and the RDU will continue a programme of engagement over the next quarter. This will include work to promote vaccine uptake, alongside the engagement led by the Minister for COVID-19 Vaccine Deployment."*

i. **Communications** – *"The government will continue to tailor its communications strategy on vaccine roll out to reflect the latest evidence on vaccine uptake among ethnic minority groups. The government will work closely with the new Community Champions to disseminate important public health messages, promote uptake of vaccine and tackle misinformation Government communications will reflect the findings of the qualitative research into people's personal experiences of COVID-19 and will ensure that ethnic minorities are not treated as a single group and that public health messaging is not stigmatising."*

35. In February 2021 I wrote a letter to the Prime Minister and the Secretary of State for Health and Social Care to update them on the work that I and the RDU had been doing since the publication of the first quarterly report. In that letter I explained that: *"In addition to the next steps I have outlined above, I will continue a programme of engagement with those groups and communities most disproportionately affected by COVID-19. My work over the next quarter will also take account of any relevant recommendations from the Commission on Race and Ethnic Disparities, which is due to report to you (Prime Minister) very shortly. We will also need to begin to consider how we address the longer-term impacts of the pandemic on ethnic minorities and other disproportionately impacted groups, as part of our future, post-Covid recovery strategy"* **[KB/13 - INQ000185159].** The Commission's report was published on 31 March 2021 and included a chapter on health disparities **[KB/14 - INQ000089803]**. In that chapter it noted that, due to the extensive work being carried out elsewhere, the Commission had not focused in detail on COVID-19 in their report. The Commission welcomed the recommendations made in the government's first quarterly report on progress to address COVID-19 health inequalities, particularly "continuing to improve our understanding of ethnic minority audiences and interests of each ethnic minority

outlet to ensure messaging is targeted and nuanced, and build on the existing communications programme with respected third party voices to improve reach, understanding and positive health behaviours." On 1 March 2021, I responded to an urgent question in Parliament following publication of the second quarterly report **[KB/15 - INQ000089745]**. The work which I undertook with the Equality Hub in the months between February 2021 and May 2021 is best summarised in the subsequent quarterly reports.

The third 'Quarterly report on progress to address COVID-19 health inequalities'

36. The third quarterly report on progress to address COVID-19 health inequalities was published on 25 May 2021 **[KB/16 - INQ000089776]**. This third report provided an update on cross-government work to address the disparities highlighted by the PHE report since my last report was published on 26 February 2021. In particular the report summarises work across government and through national and local partnerships to improve vaccine uptake among ethnic minorities. This approach is summarised as a data-informed approach; targeted communication and engagement; and flexible deployment models, which we viewed as the cornerstones of vaccine equalities delivery. The report emphasised the success of the: *"Community Champions scheme that was launched in January, outlining activity across the 60 local authorities that received funding through this scheme. By the end of the second month, there were over 4,653 individual Community Champions working on the programme, who are playing a vital role in tackling misinformation and driving vaccine uptake. This work is being supported by 2 organisations, Strengthening Faith Institutions and Near Neighbours, which also received funding under the Community Champions scheme".*

37. There were also positive results from a number of cross-government communication campaigns aimed at encouraging vaccine uptake amongst ethnic minorities. The report explained that: "*this has included using effective media channels and building on relationships established with influencers and local communities to reach ethnic minority groups with information about vaccines in multiple languages. The main activity in the government's vaccines confidence campaign this quarter has included: a video with Nadiya Hussain encouraging vaccine take-up amongst British Bangladeshi audiences; an open letter from Sir Lenny Henry and others aimed at Black groups; press partnerships featuring questions and answers from trusted clinical voices; a social media campaign addressing vaccine misinformation."* We assessed that: *"Taken together, these initiatives have led to increases in both positive vaccine*

sentiment and vaccine uptake over time across all ethnic groups, although variances still remain. Vaccine confidence has increased in 3 consecutive research periods and the vast majority of people say they have already been vaccinated or would be likely to accept a vaccine. Research by YouGov, in partnership with the Institute of Global Health Innovation at Imperial College London, suggests that the UK continues to top the list of the 29 countries in the study, in terms of people who are willing to be, or already have been, vaccinated."

38. This third report summarises the data for deaths in the second wave up to 31 January 2021. The data confirmed the finding from the second report that people from South Asian ethnic groups, particularly the Pakistani and Bangladeshi groups, were at the greatest risk of death from COVID-19 during the second wave. Black African and Black Caribbean people were also at slightly higher risk, but this could be accounted for by geographical factors, socio-demographic characteristics and pre-pandemic health. In black Caribbean men and women and black African women there was no excess risk after accounting for these factors, but substantial excess risk remained for men and women from the Pakistani and Bangladeshi ethnic groups. The report explored why the second wave had such a disproportionate impact on Pakistani and Bangladeshi groups. The government and partner agencies had taken steps to tackle these disparities over the last quarter, including promoting vaccine uptake within these groups and issuing new guidance on reducing infection within multi- generational households (translated into Bengali and Urdu) and on how to install screens in taxis and private hire vehicles.

39. The report set out ten 'next steps' which I was committed to driving forward in tandem with government colleagues:

    a. *"The Minister for Equalities to share the findings of her third quarterly report with the Joint Committee on Vaccination and Immunisation.*

    b. *Department of Health and Social Care (DHSC) to consider how to apply the findings of the review of experiences of frontline healthcare workers and the UK-REACH study.*

    c. *NHS England's published data on vaccination uptake by ethnicity should be further disaggregated to provide percentage uptake by vaccine priority group cohorts and sex. This should include levels of unknown ethnicity and an*

assessment of how this might affect the interpretation of vaccination uptake for different ethnic groups.

d. *NHS England and Improvement (NHSEI) should publish data about the use of the NHS COVID-19 app by different ethnic groups. This will inform activity to increase the uptake and continued use of the app.*

e. *DHSC and the NHS should further investigate practical barriers to vaccine uptake by ethnicity to assess and address any intention-action gap.*

f. *DHSC should ensure that NHS organisations and GPs are provided with clear guidance and protocols about how ethnicity should be requested and recorded in health records.*

g. *RDU should engage with the Office for Statistics Regulation about priorities for improving the quality (including harmonisation, robustness and reliability) of ethnicity data on health records, drawing on others' expertise as appropriate, and report back in the final quarterly report.*

h. *the Minister for Equalities and the Minister for COVID-19 Vaccine Deployment will continue a programme of engagement in the next 3 months, focusing on promoting vaccine uptake and encouraging asymptomatic testing, particularly for those within higher risk occupations, as sectors reopen.*

i. *as the COVID-19 vaccine rollout continues, the government's Vaccine Confidence campaign will aim to inform, educate and empower those aged 18 to 50 to take up their vaccine. Using the tagline 'Every Vaccination Gives Us Hope' content will take an optimistic tone, aiming to reach and persuade younger audiences, including ethnic minority groups.*

j. *at each step of the government's roadmap out of lockdown, tailored guidance and communications will continue to be shared through community and media channels to maximise reach and impact".*

40. On 24 May 2021 I wrote a letter to the Prime Minister and the Secretary of State for Health and Social Care to update them on the work that I and the RDU had been doing since the publication of the second quarterly report **[KB/17 - INQ000185180]**. In that

letter I explained the data analysis which suggested that the second wave (up until the end of January) continued to have a much greater impact on those from Bangladeshi and Pakistani groups, while outcomes for those from other ethnic groups improved when compared with the first wave. I confirmed that: *"I will continue my programme of engagement, focusing on promoting vaccine uptake but also encouraging ethnic minorities to participate with NHS Test and Trace and register with the NHS COVID-19 app, as we progress along the roadmap…"* The work which I undertook with the Equality Hub in the months between May 2021 and December 2021 is best summarised in the subsequent and final quarterly report.

The fourth 'Quarterly report on progress to address COVID-19 health inequalities'

41. The fourth and final 'Quarterly report on progress to address COVID-19 health inequalities' was published on 3 December 2021 **[KB/18 - INQ000089747]**. This final report provides a further update on cross-government work to address the disparities highlighted by the PHE report. It looked back to previous quarters and set out how our understanding of and response to COVID-19 changed over the lifecycle of this work. Appendix B of the report also includes a summary of progress against recommendations from previous reports, the lessons learnt from this work and an action plan for addressing some of the longer-term issues identified during the course of this project. It is important to read this report alongside the government's response to the report of the Commission on Race and Ethnic Disparities, published in March 2022, which explains measures to address longer-term health inequalities **[KB/19 - INQ000089814]**.

42. The report explains how the government's approach evolved as our understanding of the risk factors developed. It recognises that the most significant measure to protect ethnic minorities from the risk of COVID-19 infection and to save lives has been the vaccination programme. Our efforts on this front are explained in earlier reports but centred on work with national and local partners to promote vaccine uptake among ethnic minority groups and to tackle misinformation through a series of targeted interventions.

43. The report made some wide-ranging recommendations which the Prime Minister accepted in full. Many of these recommendations are applicable to future pandemics and health inequalities more generally and I have addressed these below.

Involvement in Key Decision-Making Forums

44. All major decisions relating to the UK Government's response to COVID-19 were decided by the-then Prime Minister (Boris Johnson). He was closely supported in decision making by senior Cabinet members, but primarily by the former Health Secretaries (Matt Hancock and Sajid Javid), the Chief Medical Officer (Prof Chris Whitty), the former Chief Scientific Advisor (Sir Patrick Vallance), the former Deputy Chief Medical Officer (Jonathan Van Tam). Advice was provided through the Scientific Advisory Group for Emergencies (SAGE). Two Cabinet Committees, formed during this time, brought together key ministers for decision making - Covid-19 Operations Committee (chaired by the Chancellor of the Duchy of Lancaster) and the Covid-19 Strategy Committee (chaired by the Prime Minister). The Covid 19 Operations Committee's (Covid-O) remit was to deliver the policy and operational response to COVID-19 **[KB/20 - INQ000089797]**, whilst the Covid-19 Strategy Committee's remit was to drive the Government's strategic response to Covid-19, considering the impact of both the virus and the response to it, and setting the direction for the recovery strategy. I attended some of the Covid-O Committee meetings in my capacity as Equalities Minister. In particular I was involved in meetings which touched on disproportionately impacted groups.

45. I also attended a meeting with the second Deputy Chief Medical Officer, Dr Jenny Harries, where I updated her on health disparities ahead of the second Quarterly report being published **[KB/21 - INQ000185154]**. As specified earlier in my statement, I wrote several letters to the Prime Minister and the Secretary of State for Health and Social Care, updating them of the progress of work I and the RDU were undertaking as part of the Quarterly reports. **[KB/22 - INQ000185171]**.

46. As I was a junior minister at the time, I was not a member of Cabinet nor among the most senior members of the Government making decisions. I would therefore not be able to give a full account of the extent to which those ministers were facilitated in considering at-risk and other vulnerable groups. I had appropriate access to the key decision makers within my remit, including the Chancellor of the Duchy of Lancaster and the Secretary of State for Health but as mentioned, was not part of the group of the most senior members of the Government making decisions on Covid-19 response. In my own work I found that the Covid-O Committee provided an extremely valuable forum through which to secure collective agreement. Although I recall that there were frustrations raised at the time around papers being circulated at the last minute (often

due to the speed with which meetings were organised and agendas produced) all structures have limitations and I cannot think of a better structure in the circumstances. I attended meetings of the committee on a number of occasions (as I set out in detail later in this statement) and found that the Committee served as an effective mechanism for bringing data, analysis, and information to key ministers and enabling them to reach decisions swiftly. I am aware that Ministerial Covid-O meetings were supported by shadow meetings of officials, which were often attended by Equality Hub officials between September 2020 and towards the end of 2021. I also understand that Hub officials met regularly with their colleagues in the Covid-19 Taskforce, including fortnightly meetings with the RDU and DU from November 2020. This joint-working enabled Hub officials to support the Committee in considering disproportionately impacted groups.

47. While I cannot speak in detail to the work done by other departments and ministers, the Equality Hub and I undertook work at a range of different points and avenues that ensured that decisions about the type and duration of NPIs could be taken with full regard to the available information regarding at-risk and vulnerable groups. Much of this has been set out elsewhere in this statement. Examples would include the work set out in Marcus Bell's Equality Hub witness statement, in which officials in the Equality Hub attended star chambers set up by the C-19 Strategy Unit that were designed to test and challenge departmental policies on NPIs. Senior officials within the Hub attended a series of meetings between May and July 2020 to provide equalities insight, and outline equalities considerations. More detail on these meetings is provided in paragraph 81 of Marcus Bell's statement.

48. I would also point to my quarterly reports, which certainly had an important influence on decisions regarding NPI's. For example, we found that, in the second wave of the pandemic, the risk of dying from Covid-19 was much higher for the Bangladeshi and Pakistani ethnic groups. In response, RDU worked with other government departments on measures designed to protect those from South Asian groups. This included helping to draft updated guidance on preventing household transmission, which was particularly important given the higher percentage of people from the Bangladeshi and Pakistani ethnic groups living in multi-generational homes **[KB/23 - INQ000089748].** In January 2021 this was translated into a range of languages including Arabic, Bengali, Gujarati, Punjabi and Urdu. RDU also worked with the Department for Transport (DfT) on measures to protect taxi drivers, as around a third of taxi drivers and chauffeurs are Bangladeshi or Pakistani men who were particularly at risk.

Measures introduced by DfT included requiring passengers to wear masks in taxis (from September 2020), **[KB/24 - INQ000089749]** guidance to drivers about how to protect themselves from Covid-19 (November 2020), and on fitting screens in their vehicles (March 2021) **[KB/25 - INQ000089750]**.

49. I met Emran Mian, the government's Senior Responsible Officer for Disproportionately Impacted Groups on 21 July 2021. I had little direct contact with the COVID-19 Taskforce as this relationship was managed at official level. I understand officials in the Equality Hub officials had a good working relationship with colleagues on the Taskforce and worked together to highlight to decision-makers the disproportionate impact of COVID-19 on certain groups (including disabled people and ethnic minorities).

50. I did attend some of the Covid-O Committee in my capacity as Equalities Minister. In particular I was involved in the meetings which touched on disproportionately impacted groups (DIGs) or where I perceived that an update on my work would be beneficial to the committee. My full attendance at the meetings is recorded in the Covid-O minutes. In particular I recall attending the following meetings (I have only focused here on the attendances that were relevant to my role as Equalities Minister rather than those relevant to my other ministerial portfolio):

    a. **24 September 2020** – I attended a Covid-O which addressed DIGs **[KB/26 - INQ000090183]**. I was briefed for the meeting to support funding for the Community Champions scheme, the proposal to improve our existing communications campaigns, to continue to raise awareness and gain a better understanding regarding disproportionate impact, and to support businesses with higher numbers of employees from DIGs **[KB/27 - INQ000185145]**. An action arising out of this meeting was that the Covid-19 taskforce would ensure that decisions on future interventions fully factored in the likely impacts on DIGs and the DHSC would take steps to encourage the collection of more granular data wherever possible. **[KB/28 - INQ000090234]**.

    b. **9 October 2020** – I attended a Covid-O which addressed shielding/support for Clinically Extremely Vulnerable (CEV) people **[KB/29 - INQ000090178]**. Shortly in advance of the meeting I had received a final draft of the guidance from MHCLG/DHSC **[KB/30 - INQ000090256]**. It was agreed for DHSC to work with MHCLG to make clear the advice to CEV individuals at each Local Covid

Alert Levels (tiers), taking account of the fact an individual may live in one tier and work in another. Guidance also to ensure that CEV individuals know what is advised for them specifically at each tier, beyond what is advised/required for the rest of the population. **[KB/31 - INQ000065363]**.

c. **29 October 2020** - I attended a Covid-O which addressed the subject of a package of interventions for DIGs **[KB/32 - INQ000090185]**. I was briefed for the meeting to support the government investing in community-led testing, increased testing at places of worship, rolling out the announced Community Champions scheme and improving health outcomes in education settings and high-risk occupations (e.g., hospitality, taxi drivers and social care workers). I also supported the package improving uptake of flu vaccination in at risk communities and high COVID risk areas **[KB/33 - INQ000185175]**. The Committee agreed with the proposed supplementary package of measures to prevent disproportionate outcomes for DIGs and that the Government needed to urgently address clarity of communication with certain groups **[KB/34 - INQ000090299]**.

d. **10 December 2020** - I attended a Covid-O which addressed the subject of risk stratification **[KB/35 - INQ000185157]**. My brief included seeking agreement for the new COVID-19 predictive risk model to be applied at population level to support vaccine prioritisation, that an update be provided on progress with the clinical support tool and the next steps for the potential public-facing tool be set out. Further, that the model should properly reflect ethnicity and ensure that the risk model and the JCVI advice aligned, and that decisions on prioritisation needed to stand up to public scrutiny **[KB/36 - INQ000185174]**.

e. **25 January 2021** - I attended a Covid-O which addressed vaccine uptake **[KB/37 - INQ000091823]**. I took away actions to explore which community representatives and influencers have been effective so far in tackling disinformation to date and ensure partners to be used in this campaign are trusted voices and establish indicators for measuring the effectiveness of the communications campaign **[KB/38 - INQ000092300]**.

f. **17 March 2021** - I attended a Covid-O on the subject of vaccines as a condition of deployment in Health and Adult Social Care settings **[KB/39 - INQ000092064]**. I was briefed on the point that any measures to increase

vaccination rates needed to be balanced against the significant workforce, equalities, and potential legal risks. I had liaised with the BAME Communities Advisory Group, who expressed concern that making vaccines a condition of deployment would risk damaging trust with the workforce. My brief also noted that the policy would impact most significantly on ethnic minority workers and especially women and could result in workforce shortages. I did not support mandating vaccines in the NHS at that stage given the workforce risks **[KB/40 - INQ000185173]**. The Committee held that the Department for Health and Social Care should develop a robust handling plan to address vaccine hesitancy and equality issues relating to vaccine uptake and provide a plan to assess and mitigate the likely impact of these measures on the adult social care workforce, focusing on DIGs and high-risk areas. It was decided that the Department for Health and Social Care was to work with HM Treasury to agree how plans to mitigate potential workforce shortages resulting from these regulations would be funded. My brief included reservations about extending the policy to those working in care homes who have no direct contact with residents, a large proportion of whom are likely to be from an ethnic minority background. The committee agreed with the Department for Health and Social Care's proposal that secondary legislation should be introduced to protect the most vulnerable from COVID-19 by making vaccination a condition of deployment for those working in older age residential care homes, including a carefully considered handling plan **[KB/41 - INQ000092400]**.

g. **20 May 2021** - I attended a Covid-O on the subject of Domestic Covid-Status Certification: Progress Update **[KB/42 - INQ000091937]**. My brief expressed reservations about mandating certification, which could disproportionately impact on some of those groups who have been worst affected by COVID-19 and risk undermining the promotion of the vaccine among ethnic minorities if certification is seen as mandating vaccination or stigmatising those with lower vaccination rates. I had concerns about the inability of individuals to self-administer at-home testing and for individuals who would find repeated testing severely destressing **[KB/43 - INQ000185176].** One of the actions of the committee was for the Covid-19 Taskforce to work with the DU, NHSx and the UK Health Security Agency to ensure people with disabilities could access a different testing route where they are required to undertake a test, but cannot undertake a home test **[KB/44 - INQ000092490].**

h. **15 June 2021** – I attended a further Covid-O on the subject of vaccination as a condition of deployment in adult social care settings **[KB/45 - INQ000092238 and KB/46 - INQ000185169]**.

Involvement in Covid-19 public health communications

51. I was closely involved in exploring how we could improve the reach of government communications about the impact of COVID-19 on ethnic minority groups. The communication efforts that we supported across government are best explained in my quarterly reports. I found that the public were significantly more likely to trust messages regarding COVID-19 that came from figures within their own community, or from clinicians, rather than politicians. In working to improve the reach of COVID-19 communications to different groups I therefore predominantly focused on engaging persuasive individuals from the relevant communities and professions, rather than political figures. We did everything we could with the resources available and in circumstances that were without precedent (in the context of a pandemic).

52. In particular, I convened a cross-government effort to develop an ethnic minority engagement communications plan in time for the Eid Al Adha holiday at the end of July; conducted media interviews supporting government guidance to ethnic minority groups around local lockdowns; and reached out to the 23 embassies and high commissions of those nationalities most likely to be impacted by COVID-19 for their help in communicating through their diaspora **[KB/8 - INQ000215047]**. I emphasised across government that we must continue to be as innovative as we could in targeting our communications to hard-to-reach groups, especially those at greatest risk in areas of local lockdown and rising concern. I also encouraged departments to raise awareness of particular risks that could be impacting on ethnic minority groups. By way of example, living in a multi-generational household could be a risk factor, and we needed to ensure that advice on what could be done within homes to minimise transmission was widely available **[KB/23 - INQ000089748].** We knew from the data that those from the Bangladeshi and Pakistani ethnic groups were particularly at risk in the second wave of COVID-19 and were more likely to live in multigenerational households. It was essential therefore that the guidance was translated into a range of languages, including Bengali, Punjabi and Urdu. On 21 April 2021, I convened a roundtable with the security industry to consider mitigations for the impact of Covid-19 on ethnic minority security guards, a large proportion of whom are from an ethnic minority background, set out later in my statement **[KB/47 - INQ000185164]**.

53. Once the vaccine became available my activity focused increasingly on the vaccination rollout. I encouraged communications aimed to help address concerns of those hesitant about the vaccine. I have addressed this in more detail below.

Involvement in increasing vaccine uptake among ethnic minorities & vulnerable groups

54. I worked extensively with the Equality Hub to support government work with national and local partners to promote vaccine uptake among ethnic minority groups, and to tackle misinformation through a series of targeted interventions. The efforts that we support across government are best explained in the quarterly reports.

55. I shared the findings of the first three quarterly reports with the Chair of the Joint Committee on Vaccines and Immunisation (JCVI) (in December 2020, March 2021, and May 2021 to help inform the vaccination programme **[KB/48 - INQ000083875, KB/49 - INQ000083884 and KB/50 - INQ000185168]**. I sought to promote vaccine uptake in any way possible. In particular, I felt some level of personal investment in the vaccine programme was required and so I participated personally in a clinical trial of the Novavax vaccine in order to encourage other ethnic minorities to come forward. I also encouraged colleagues in Government and Parliament to do the same. I received my first vaccination as part of the trial on 13 October 2020, attended a number of further follow-up appointments and received the final results at the end of February 2021 **[KB/51 - INQ000185146 and KB/52 - INQ000185150]**. I also worked with specialist agencies to hold a series of roundtables for ethnic minority healthcare professionals and religious and community leaders to act as ambassadors within their communities, detailed later in my statement. These sessions provided an opportunity to feed back concerns, recommend approaches and have specific questions answered by health experts such as Dr Raghib Ali and Dr Mary Ramsey, the Head of Immunisation from PHE. We worked with over 90 faith, healthcare provider networks, influencers and experts from a range of communities to better understand vaccine hesitancy.

56. On 25 March 2021, I wrote to Professor Wei Shen Lim, Chair of the JCVI **[KB/53 - INQ000185162]**. In that letter, I said:

"I am keen to explore further options for increasing uptake, such as allowing adult family members living in the same household to be vaccinated at the same time, which could help to overcome some of the resistance we have seen among those groups at

greatest risk of hospitalisation from COVID-19. This is something I am discussing with colleagues and NHSEI, to see whether it is feasible for local Directors of Public Health to be given 'clinical discretion' to adopt such a policy."

57. I was able to share progress in this regard in my third quarterly report to the PM, noting that: *"Short-term pilots of family vaccines have now been completed in Luton, Newham, Slough, Liverpool, Sandwell, Oldham and Newcastle and the evaluation will be published shortly. These pilots were aimed at improving local responsiveness and vaccination uptake in underserved populations with a focus on multi-generational households. The pilots tested the benefits of a locally-led and clinically informed decision to vaccinate outside current cohort prioritisation to increase uptake"* **[KB/16 - INQ000089776].**

58. The concept of family vaccinations was also reflected in guidance issued by the NHS on supporting vaccine uptake during Ramadan. The guidance was published on 9 April 2021 and encouraged vaccine delivery partners to consider how to adapt vaccine delivery for maximum uptake, how to support the many Muslim members of staff working for the NHS, and how best to reach the Muslim population and disseminate vaccine messaging during Ramadan **[KB/54 - INQ000185163].**

Involvement in Key Stakeholder Engagement

59. I attended many engagements with stakeholders, including public bodies and charities, in relation to the impact of Covid-19 and the impact of the response to Covid-19 on at-risk and other vulnerable groups, and groups with a protected characteristic. Many of these engagements are reflected in the quarterly reports and also those listed below. The list below is not comprehensive but does include significant engagements which are not captured elsewhere in the quarterly reports or my statement:

    a. On 15 July and 22 July 2020 I met with Lord Bethell to discuss test and trace and the impact on ethnic minorities **[KB/55 - INQ000185142].**

    b. On 25 August 2020 I met with Professor Sir Ian Diamond, National Statistician to discuss his offer of support on behalf of the Office for National Statistics for the Commission on Race and Ethnic Disparities **[KB/56 - INQ000185143].**

c. On 2 September 2020, I co-hosted a Maternal Health Roundtable in order to discuss evidence-driven suggestions from expert attendees for the Government to consider in any next steps it takes to improve outcomes for ethnic minority women and their babies **[KB/57 - INQ000185148].**

d. On 11 September 2020, I met with Dr Chaand Nagpaul of the British Medical Associate on the subject of Covid disparities **[KB/58 - INQ000185144].**

e. On 21 October 2020, I held a meeting with the SAGE Ethnicity Sub-group co-chairs to discuss the links between the Covid disparities review and SAGE work **[KB/59 - INQ000185147].**

f. On 18 November 2020, I met with Jo Bibby of the Health Foundation to talk about Covid health disparities **[KB/60 - INQ000185149]**.

g. On 8 December 2020, I met with Michelle Donelan, Minister for Universities in the Department for Education. This meeting was to share findings from my work on Covid-19 disparities, including that government departments needed to take a consistent approach to how they communicate about Covid-19 and ethnicity, and highlighting the recommendation from my first Covid-19 Disparity Report, that departments need to put in place systems for monitoring the effectiveness of their policies to address Covid-19 disparities **[KB/61 - INQ000185151]**.

h. On 9 December 2020, I attended the Westminster Health Forum as part of the workstream to look at the disproportionate maternal mortality in ethnic minorities.

i. On 14 December 2020, I met again with Dr Chaand Nagpaul of the BMA for a follow-up meeting on disparities before meeting with the Deputy Chief Medical Officer, Jenny Harries for an update on disparities ahead of the quarter 2 disparities report **[KB/62 - INQ000185153 and KB/63 - INQ000185154].**

j. On 15 December 2020, I met again with the SAGE Ethnicity sub-group chairs (Kamlesh Kunti and Osama Rahman) for an update meeting on disparities. On the same day, I also met with Professor Keith Neal, who I appointed as a Covid-19 and ethnicity expert for a one-year period **[KB/64 - INQ000185155]**. The day after (16 December 2020) I had a similar meeting with Dr Raghib Ali, who

I also appointed as a Covid-19 and ethnicity expert for the same period **[KB/65 - INQ000185152]**.

k. On 4 January 2021, I met with the BAME Communities Advisory Group to discuss impacts of Covid-19 on ethnic minority social care workers and on 7 January I met with the National Pharmacists Association for a roundtable on considering how to increase vaccine uptake **[KB/66 - INQ000185156].**

l. I held further roundtables considering how to increase vaccine uptake with a focus upon Pakistani and South Asian Groups (DeG) on 5 February 2021 and with community leaders / groups on 5 March 2021 **[KB/67 - INQ000185160]**.

m. I met with both the Chancellor of the Duchy of Lancaster (CDL) and the Home Secretary on 30 March 2021 to discuss vaccine certificates.

n. On 21 April 2021, I held a roundtable with the security industry to consider mitigations for the impact of Covid-19 on ethnic minority security guards **[KB/47 - INQ000185164]**.

o. Later that month on 29 April 2021, I met with Joan Saddler (Associate Director of the NHS Confederation's BAME Leadership Network). We discussed CRED and the disproportionate impact of Covid-19 on ethnic minority front-line health workers **[KB/68 - INQ000185165]**.

p. On 10 May 2021, I held a meeting with the President of the Royal College of Physicians on the topic of Covid-19 health disparities **[KB/69 - INQ000185166]**.

q. The following day, on 11 May 2021, I met with the Minister for Vaccine Deployment, then the Rt Hon Nadhim Zahawi and we discussed how to increase vaccine uptake among ethnic minorities.

r. On 19 May 2021, I held a roundtable with High Commissioners to encourage the uptake of vaccines amongst diaspora groups.

s. The next day (20 May 2021) I met with Lord Greenhalgh to discuss DLUHC's work in promoting vaccine uptake **[KB/70 - INQ000185167]**.

t. On 21 July 2021 I met with the Deputy Chief Medical Officer, Tom Waite, on the topic of Covid-19 disparities and vaccine uptake **[KB/71 - INQ000185170]**.

Role in relation to medical and scientific expertise, data and modelling

60. In my work, I was always concerned about the overall risk groups faced, rather than that posed by Covid-19 infection alone. For example, issues such as the impact of stigmatisation from poor communications were also important to consider and keep under continuous review. This was something that I raised in my quarterly reports. This included the second report's summary of the findings of research commissioned by RDU into a small group of ethnic minority people's personal experiences of Covid-19. Participants in the research felt that communications tended to frame ethnic minorities as a homogeneous group that was vulnerable to Covid-19, which they found stigmatising. My final report also recommended that the Government and health agencies ensure that public health communications do not stigmatise ethnic minorities when explaining that they may be more vulnerable or at higher risk. This recommendation was accepted by the Prime Minister.

61. Each of my four quarterly reports considered data quality, with a particular focus on ethnicity data. The reports gave recommendations to improve the quality of health ethnicity data collection, analysis and reporting.

62. The fourth report summarised the government's approach to understanding the most important factors that impact on this data quality **[KB/18 - INQ000089747].** Focussing primarily on how the ethnicity of patients is requested by health professionals and recorded in their health records, it outlined next steps to improve ethnicity data in different data collections and analyses. These next steps included:

    a. a series of recommendations designed to improve the coding of ethnicity in health datasets
    b. reviewing data access and sharing, and dissemination of microdata for research, and aggregated statistical data
    c. collecting ethnicity as part of death certification process
    d. harmonising ethnicity classifications in government datasets
    e. ensuring clear reporting of data analysis methods and data quality
    f. increasing representation of ethnic minority groups in surveys and clinical trials
    g. increasing and improving the use of long COVID codes

h. better reporting of unknown ethnicity
i. continuing to hold statistics producers to account to ensure the quality of ethnicity data and statistics meet users' needs
j. Investigating the feasibility for better guidance and signposting for health statistics
k. developing the ONS database for health and care statistics in England

Appendix F of the fourth report summarises how actions were prioritised, and progress against them at that time (December 2021) **[KB/72 - INQ000089782]**.

63. Whilst evaluating data and evidence about the impact on different ethnic groups, I worked with the following stakeholders through analytical officials in the Equality Hub:
    a. NHS organisations
    b. Public Health England
    c. Office for National Statistics
    d. Department of Health and Social Care
    e. Office for Statistics Regulation
    f. Nuffield Trust
    g. The King's Fund
    h. OpenSafely
    i. SAGE working group on ethnicity
    j. VirusWatch
    k. Policy Lab
    l. UK-REACH

Involvement in Public Sector Equality Duty (PSED) and Equality Impact Assessment (EIA)

64. As Marcus Bell explains in his witness statement, individual government departments are responsible for understanding the equality impacts of their own policies through compliance with the PSED. Neither the Equality Hub nor I are routinely involved in reviewing or monitoring other government departments' equality impact assessments or their approach to PSED. It is correct to say that occasionally we are asked to give guidance to departments about their equality duties.

65. On 15 July 2020, in response to a question on the importance of the PSED from the Women and Equalities Select Committee session *"Unequal Impact? Coronavirus and*

BAME people", I reflected on the importance of impact assessments, the role they play and the attention they are given. I was asked whether there were plans to share the equalities impact assessments prepared for the response to the pandemic. I explained that it is critically important that, when officials are putting together these reports, they can be frank and do not worry about the implications of what they are saying. I noted that the Minister for Women and Equalities had been very clear on this point and confirmed that we did not plan to publish the impact assessments. I noted that we kept our assessments under continuous review and that our decision not to publish should not be taken as an indication that the work was not taking place. I noted that I myself regularly ask to see impact assessments for work within my remit and make sure that they are taken into account. I further reiterated where the ownership of equality impact assessments sits (namely with each Government Department). By way of example, I referred to the most recent impact assessment I had reviewed, which assessed the impact of children not returning to school. I noted that this would have a disproportionate impact on disadvantaged children, in which ethnic minority people are overrepresented. I reiterated that the impact assessments of different Covid-19 measures did not sit with me, but with Ministers in the departments making those decisions. **[KB/73 - INQ000089805].**

66. On 8 December 2021, I wrote to all government ministers on the subject of the PSED. I reminded them that their departments are responsible for proper consideration of the equality impacts of their policies and of their ongoing duty to consider equality in their work and their departments. I also provided them with advice on how their departments might approach equality impact assessments and the appropriate documentation of their decision making **[KB/74 - INQ000089735]**.

67. I understand that, during the period April 2020 to August 2020, the Equality Hub contributed to a number of PSED assessments at the COVID Taskforce's request. These are set out in more detail in Marcus Bell's statement.

Effectiveness of Core Decision Making

68. Although I recall that there were frustrations raised at the time around papers being circulated at the last minute (often due to the speed with which meetings were organised and agendas produced), all structures have limitations and I cannot think of a better structure in the circumstances. I made sure to participate in Covid-O meetings where I was able to add to advice and discussions on disproportionately impacted

groups or where I perceived that an update on my work would be beneficial to the committee. Further detail on these meetings and my representations can be found in the relevant section, earlier in my statement. Inevitably there was a lot of advice being given at this time, much of it conflicting and I consider that significant consideration was given to those in 'at risk', and otherwise vulnerable groups.

69. In my experience, the Government's core decision-makers and advisors had a diverse range of experience, with significant epidemiological expertise present at the highest levels. For example, Chris Whitty as Chief Medical Officer and Jonathan Van Tam as Deputy Chief Medical Officer had deep epidemiological and public health expertise and were central to Covid-19 governance and advice. Wider governance and advisory structures, including SAGE and my own work, also brought in a wide range of expertise and experience in order to inform decision making.

Miscellaneous Questions

70. As I have set out elsewhere in this statement, our understanding of the drivers of disparities in Covid-19 outcomes evolved and grew over time. As our understanding developed, informed by data, analysis and expertise, the relevant arms of Government updated policy, guidance and advice accordingly. As I have outlined elsewhere in this statement, this was achieved through joint-working across Government, co-ordinated by the Covid-19 Taskforce and the relevant Cabinet Committees, meaning that advice and decisions could reflect the latest data and analysis in the round, rather than be limited by departmental boundaries. This was particularly important as it was clear that Covid-19 risk was driven by a number of factors and that assessing individuals' risk only in reference to a particular identity group in isolation could in itself create misperceptions and dangers. This risk, as well as the comprehensive and whole-Government scope of the Covid-19 response governance and advisory structures, meant that it was neither necessary nor advisable to consolidate responsibility for all disproportionately impacted groups in one department. The status quo in respect of division of responsibilities was helpful, not unhelpful.

71. The Equality Hub took as its starting point the disparities highlighted by the PHE report, 'COVID-19: review of disparities in risks and outcomes'. This found that the largest disparity was by age, that the risk of dying among those diagnosed with COVID-19 was also higher in males than females; higher in those living in the more deprived areas than those living in the least deprived; and higher in ethnic minority groups than

in white ethnic groups. The report concluded: “These inequalities largely replicate existing inequalities in mortality rates in previous years, except for [ethnic minority] groups, as mortality was previously higher in White ethnic groups” **[KB/3 - INQ000089740]**. Given the unexplained nature of the disproportionate impact of COVID-19 on ethnic minorities, and the very real public concerns about this, it was right that the Equality Hub’s work had a particular focus on ethnic minority people.

72. That said, the terms of reference for the COVID-19 disparities work were not limited to ethnic minority people. This work identified that the underlying disparities were driven by factors such as occupation (particularly for those working in frontline roles who were unable to shield), living in multi-generational households with school-age children and living in high population density areas with poor air quality and higher levels of deprivation. These factors are not exclusive to those from ethnic minority backgrounds.

73. Marcus Bell’s witness statement outlines in detail the extensive work the Equality Hub undertook in identifying and championing the needs of disabled people across government during the pandemic. This included building the evidence base to understand the impact of Covid-19 on disabled people and highlighting issues with senior officials in the Covid Taskforce to support decision making, and in particular a commission to all departments to identify proposals for policies or interventions to mitigate Covid-19’s disproportionate impact among disabled people. I would refer to his statement’s detailed outline of this work.

74. As just one example, I would cite the 8 December 2020 Covid-O meeting on DIGs, which agreed to a cross-government package of work to respond to the disproportionate impacts of Covid-19 on disabled people. The package spanned: (i) data/evidence building (ii) infection control measures to reduce mortality for disabled people, especially in care home settings (iii) ameliorating secondary impacts (including education and digital exclusion), and (iv) accessible communications. DU put further advice to DWP Ministers giving options on whether to announce the cross government package agreed by Covid-O to address the needs of disabled people **[KB/75 - INQ000083896]**. This was subsequently followed by a range of blogs on the DU webpage on some of the measures put in place.

International Engagement

75. I did not hold any formal engagement with Ministers in countries outside the UK on the impacts of COVID-19. However, as mentioned earlier in my statement, I held a roundtable with High Commissioners to encourage the uptake of vaccines amongst diaspora groups on 19 May 2021.

Four Nation Approach

76. My work on COVID-19 disparities was primarily limited to England only, given that health is a devolved matter in Northern Ireland, Scotland and Wales. The Welsh and Scottish Governments led their own studies into COVID-19 disparities. While this work was not coordinated across the four nations, my quarterly reports and the accompanying letters to the Prime Minister were published online and so our evidence was readily available.

Role in public health and coronavirus legislation and regulations

77. Whilst officials in the Equality Hub contributed to relevant PSED analysis, I was not directly involved with the development of public health and coronavirus legislation and the proposals included in this. I have included specific details of my contributions in my statement above.

78. There was clear annoyance, anger and upset over perceived breaches of rules and standard by those in authority. Clearly the focus on this at the time fuelled scepticism and was unhelpful overall in terms of the compliance narrative, however I do not think that it impacted people's wellbeing or their decision to comply with the rules generally.

Women and Equalities Select Committee

79. On 10 June 2020, the Women and Equalities Committee launched three new inquiries covering:

    a. Coronavirus and BAME people **[KB/76 - INQ000089807, KB/77 - INQ000089808]**.
    b. Gendered economic impact **[KB/78 - INQ000089810, KB/79 - INQ000089811]**.

c. Disability and access to services **[KB/80 - INQ000089812, KB/81 - INQ000089815, KB/82 - INQ000089816, KB/83 - INQ000089817, KB/84 - INQ000089818]**.

80. On 15 July 2020, I attended the Women and Equalities Committee to provide oral evidence in the session relating to: ""Unequal Impact? Coronavirus and BAME people" **[KB/85 - INQ000089805].** On 4 November 2020 I attended the Women and Equalities Committee session "Unequal impact? Coronavirus and the gendered economic impact" to provide oral evidence **[KB/86 - INQ000089809]**. On 7 July 2021, I attended the same committee to provide further evidence as part of the "One-off session: Covid reports follow-up" **[KB/87 - INQ000089819]**.

Key challenges and lessons learned

81. The structural model adopted by the Race Disparity Unit - which brought together analysts, policy officials and two independent, expert advisers - was highly effective. It meant that emerging data could be interpreted quickly and translated into meaningful policy interventions. This was rightly recognised at Research Capability 2021, with the RDU receiving the ONS Research Excellence Award. I do not consider that structural changes to the Equality Hub are necessary – the quality of work produced is down to the people, not to the structure itself.

82. My fourth quarterly report includes detailed lessons learnt from our work and an action plan for addressing some of the longer-term issues identified during the course of the project I was assigned by the Prime Minister. I endorsed these recommendations and rather than repeat them here I am able to speak to the lessons learned that appear in my report.

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: 26th June 2023