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

MODULE 7: FIRST PRELIMINARY HEARING ON 27 JUNE 2024
WRITTEN SUBMISSIONS FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

I. INTRODUCTION

1. These submissions are made on behalf of the Federation of Ethnic Minority Healthcare Organisations ("FEMHO") in advance of the first preliminary hearing for Module 7 on 27 June 2024. FEMHO welcomes its designation as a Core Participant of Module 7. We are also a designated Core Participant in Modules 2, 3, 4 & 5 of the Inquiry.

2. FEMHO is a multi-disciplinary consortium representing over 55,000 individual members and 43 organisations and networks. Straddling the intersection of two key and manifestly disproportionately affected groups, we advocate for ethnic minority communities and health and social care workers ("HCWs") from these communities across the UK. Our membership spans across levels of seniority and includes a broad spectrum of healthcare workers including, but not limited to doctors, nurses, midwives, dentists, pharmacists, biomedical scientists, physiotherapists, radiographers, speech and language therapists, healthcare assistants, paramedics, social workers, medical secretaries, public health practitioners, managers, IT staff, chaplains, cleaners, porters, catering and other support staff.

2. FEMHO looks forward to assisting the Inquiry in undertaking a comprehensive examination of the UK government's Test, Trace, and Isolate ("TTI") system and strategy. In particular, we hope to provide valuable insights into how the TTI system was rolled out and operated within healthcare settings, its effectiveness and how it impacted on ethnic minority HCWs and communities, and to suggest areas for further investigation and recommendations. Our primary concerns and suggestions for this module at this early stage focus on three key areas: the differential impact on ethnic minority communities, trust and cultural competencies, and data transparency and usage.

II. DIFFERENTIAL IMPACT ON ETHNIC MINORITY COMMUNITIES

3. FEMHO has grave concerns about the UK government's preparation and strategy regarding TTI. We believe it is essential to acknowledge and examine the contextual background that led to the systemic shortcomings of the TTI strategy, specifically how pre-existing inequalities were exacerbated by this aspect of the pandemic response. These inequalities include economic disparities, overcrowded housing conditions, and precarious employment situations, which are prevalent in ethnic minority communities. Additionally, we urge the Inquiry to scrutinise the governmental decision-making processes, assessing whether adequate foresight, culturally competent planning and adherence to the public sector equality duty ("PSED") were applied to mitigate these predictable risks. Understanding these failures will provide a comprehensive view of the TTI strategy's ineffectiveness and its disproportionate impact on ethnic minorities.

4. Our members were disproportionately affected by the pandemic and the subsequent TTI strategy. Areas such as Bradford, Luton, and Blackburn—areas with significant ethnic minority populations—saw significant TTI failures due to socio-economic factors including overcrowded housing, low-income jobs, and insecure employment, which made adherence to isolation guidelines nearly impossible for some.[1] These communities, already facing systemic disadvantages, found themselves further marginalised by a TTI system that did not account for their specific needs and circumstances. The lack of targeted support and consideration for these vulnerable populations resulted in lower compliance rates and higher transmission rates in these areas.

5. The Health Foundation's report in June 2021[2] corroborates these issues, noting that lower testing and isolation adherence rates were predictable given the financial insecurity and lack of support for individuals, particularly those from ethnic minority groups. Inadequate government economic support for deprived communities, considered alongside the UK's dubious status as the country with the lowest sick pay in the OECD, further exacerbated these issues. The government's failure to provide sufficient financial assistance for self-isolation, coupled with the rejection of two-thirds of applicants for the £500 self-isolation support payment, left many unable to comply with TTI measures without facing severe financial hardship. Others, in particular migrants, had legitimate and serious concerns and hesitancy to

[1] BBC Article: 'Coronavirus: Inside NHS Test and Trace - how the 'world beater' went wrong' dated 20/11/20.
[2] Health Foundation Report: 'What have we learned from a year of NHS Test and Trace?' dated 03/06/21.

engage in the TTI system due to being on an employment-dependent visa and/or having no recourse to public funds status. Some even found they could not access tests online as they did not pass the government website identity check.[3] The failure to support individuals adequately not only undermined the efficacy of the TTI strategy but also perpetuated health inequalities, disproportionately affecting ethnic minority communities.

6. The rollout of testing was slow. Even in hospital settings, workers were only routinely screened for Covid regardless of symptoms from around November 2020. This was long after it was recognised that it seemed to be spreading even via asymptomatic carriers and that transmission in hospitals was particularly high, with amongst the highest levels of infection and death being in support staff in the healthcare sector, such as cleaners, security staff and porters.[4]

7. Further, access to testing was not always straightforward when HCWs had symptoms; our members have reported test shortages, delays in distribution, confusion over guidance on testing, isolation periods and retesting and the use of personal data, as well as issues with timing of lateral flow testing, for example late positives resulting in staff having to be excused during shifts, with rostering, staff shortage and financial implications. Provision of testing for agency and support staff was also an issue. So too was the enforcement of isolation after "exposure" alerts had been notified through the TTI app. Amongst the health workforce there appears to have been a huge variance in the use of the app, and adherence to instructions to isolate. This was a particular issue in hospitals where naturally geographic proximity and exposure led to what many called the "pingdemic" and instructions to delete the app.

8. Our members also report unequal treatment in regard to the enforcement of TTI. We have heard of alarming instances where minority ethnic staff were told that TTI policies did not apply to them, and/or where they were called back to work before their isolation period was due to end and before they had recovered. Many felt unable to object to these instructions and felt pressure to comply, as well as a strong sense of duty to remain able to work and care for the public given staff shortages. There was concurrent confusion over the guidance and approach to isolation for HCWs who lived together (including younger, more junior HCWs who live in shared accommodation with peers).

[3] BBC Article 'I was refused a home Covid test after credit check' dated 07/11/20.
[4] Al Jazeera Article 'Hospital cleaners more exposed to COVID-19 than ICU doctors' dated 11/09/20.

III. TRUST, CULTURAL COMPETENCIES, AND ENGAGEMENT

9. A crucial failing of the TTI strategy was the lack of culturally competent approaches and trust-building measures. Historic distrust in public health initiatives, language barriers, stigma, and lack of engagement significantly hampered participation in TTI among ethnic minority communities. Despite efforts from individual FEMHO members and our member organisations to bridge these gaps, our contributions were underutilised. The government's approach often lacked sensitivity to the unique challenges faced by ethnic minority communities, resulting in ineffective communication and outreach. For instance, the failure to provide TTI information in multiple languages alienated non-English speaking members of the community, while culturally insensitive testing practices deterred participation. Meanwhile our communities were branded "hard-to-reach" as if the blame lay with us.

10. Research from other screening programmes had already highlighted these barriers prior to the pandemic,[5] and the pilot schemes during the pandemic even flagged it as a potential issue, yet the TTI system developed did not adequately address them. For example, TTI materials were not available in multiple languages, and swab testing practices were culturally insensitive. These issues could and should have been anticipated and mitigated from the outset.

11. The absence of proactive and inclusive engagement strategies led to widespread mistrust and non-compliance. Moreover, the government's response to concerns raised by FEMHO and other community organisations was often dismissive, further eroding trust. Our members worked hard to help our communities, but it was difficult to dispel the weight of misinformation, myths and hearsay associated with TTI that were circulating particularly amongst minority ethnic communities when government was not engaging or countering it. This systemic neglect not only compromised the effectiveness of the TTI strategy but also deepened existing health disparities, leaving ethnic minority communities disproportionately vulnerable to Covid-19.

[5] For example, disparities in uptake of screening programmes for HIV, cancer and antenatal screening are well evidenced.

IV. DATA AND STRUCTURAL ISSUES RELATED TO RACE AND ETHNICITY

12. The lack of robust data on race and ethnicity within the TTI system is another critical concern. This deficiency was highlighted in the Committee of Public Accounts report[6], which found that NHST&T was unable to establish a baseline for measuring the impact of TTI on underrepresented groups, including ethnic minorities. The absence of comprehensive and disaggregated data made it impossible to accurately assess the reach and effectiveness of the TTI strategy among ethnic minority communities. This lack of data transparency and accountability hindered efforts to address disparities and improve the system's responsiveness to the needs of these groups. Furthermore, the inability to track and analyse data on ethnic minority participation in TTI initiatives meant that the government could not implement targeted interventions or measure the impact of their strategies effectively.

13. The absence of transparent data reporting, particularly regarding the Covid-19 app, further eroded trust and compliance within our communities. The lack of clarity on how our data would being used and the perceived risks of data misuse discouraged many from engaging with TTI measures. Historical instances of data misuse by the government have left ethnic minority communities wary of sharing personal information, fearing potential repercussions. This mistrust was compounded by the government's failure to provide clear and consistent information about data privacy and protection measures. The data vacuum not only impeded efforts to monitor and improve TTI effectiveness but also contributed to a sense of exclusion and vulnerability among ethnic minority groups. The lack of appropriate targeted support and resources for our communities further exacerbated these issues, leading to lower compliance rates and higher transmission rates in areas with significant ethnic minority populations.

V. FRAMEWORK FOR MODULE 7 INVESTIGATION OF THESE ISSUES

14. To ensure a thorough examination, we suggest Module 7 focus on the following areas:

    a) **Economic Support and Compliance**: Investigate how financial assistance and sick pay policies affected compliance with TTI measures among ethnic minority communities.

[6] See Public Accounts Committee Report 'Test and Trace Update' 21/10/21

b) **Cultural Competency**: Assess the effectiveness of government engagement and communication strategies with ethnic minority communities, considering language barriers, cultural sensitivities, and historic distrust.

c) **Data Collection and Usage**: Examine the adequacy of data collection on race and ethnicity within the TTI system, its impact on monitoring and improving TTI effectiveness, and the role of data transparency in building trust.

d) **Case Studies and Testimonies**: Include case studies and testimonies from ethnic minority healthcare workers and community members to provide a nuanced understanding of the TTI strategy's impact and highlight areas for improvement.

15. Whilst we appreciate the investigation is at an early stage, we consider that expert evidence ought to be obtained from a specialist in race inequality (potentially in the form of a follow up report by the experts instructed for Module 2 on these issues Professors James Nazroo and Laia Becares) to provide detailed opinions on the inequality issues relating to TTI.

16. In relation to Rule 9 requests, FEMHO respectfully reiterates its position adopted in previous modules and implores the Chair to reconsider her position on disclosure of the requests. 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.

VI. CONCLUSION

17. It is crucial to delve into the systemic shortcomings of the TTI strategy and understand how these failures perpetuated health disparities and the overall disproportionate impact of the pandemic on minority ethnic groups and marginalised vulnerable populations. By examining

these issues, FEMHO hopes the Inquiry can uncover the root causes of these disparities and develop actionable recommendations to prevent similar failures in the future.

18. Accordingly, we urge the Inquiry to focus on these critical areas to ensure that the lessons learned lead to more equitable and effective public health strategies in the future. FEMHO is committed to contributing our lived experiences and professional expertise to aid this vital investigation. Our insights will help highlight the specific needs and challenges faced by ethnic minority communities, ensuring that future public health initiatives are inclusive, culturally competent, and capable of addressing the unique vulnerabilities of these populations.

19. We thank the Chair and the Inquiry team for the opportunity to participate in Module 7. FEMHO looks forward to working collaboratively to ensure a thorough examination of the TTI strategy and its impact on ethnic minority communities, ultimately leading to more effective and equitable public health policies.

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