Witness Name: Habib Naqvi

Statement No: 1

Exhibits: 17

Dated: 13 October 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF HABIB NAQVI

I, **Habib Naqvi**, will say as follows: -

1. My name is Habib Naqvi. I am the CEO of the NHS Race and Health Observatory (the '**Observatory**'). I have worked for the Observatory since its inception in April 2021.

2. Prior to joining the Observatory, I worked at NHS England where I directed the development and implementation of national programmes, including the Equality Delivery System ('EDS'), and the award-winning NHS Workforce Race Equality Standard ('WRES'). I also worked for several years at the Department of Health and Social Care where I led national equality and diversity policy, including on the health sector's response to the UK government's review of the Public Sector Equality Duty.

3. I make this statement in response to the request the Observatory received under Rule 9 of the Inquiry Rules 2006.

The Role of the Observatory

4. The Observatory was formally established, as an independent body, in April 2021 after a short period of advance work initiated in October 2020. The organisation was created in recognition of a longstanding and ongoing need to tackle racial and ethnic

inequalities in health. It was first announced in June 2020 by Simon Stevens, then Chief Executive of NHS England in response to a special issue of the BMJ on Racism in Medicine. We describe ourselves as a proactive investigator, working with partners to undertake new research and synthesising existing evidence to ensure that our health and care system works for everyone, regardless of their race. We make practical recommendations for national policy leaders and, crucially, we support the real-world implementation of those recommendations through innovative anti-racism methodologies.

5. The Observatory's ultimate aim is to help close the gap on ethnic inequalities in health and care. We do this by gathering the best possible evidence, listening to the voices of those who interact with the health and care system, and building an enduring network of passionate and influential people who share our commitment to equality.

6. Although we are an independent body, we work in close partnership with, and receive funding from, NHS England to support its work in tackling racial and ethnic health inequalities. We are hosted by NHS Confederation but are led by an independent board and governance structure. The Board membership is at **Exhibit HN/1 - INQ000249825**. As such, the Observatory makes its own decisions about what to focus on and what to fund. We have a global remit which includes convening an international group of academic experts in the field of race and health. In addition, we have an ongoing partnership with the USA Centres for Disease Control and Prevention ('CDC') which aims to explore, among other things, the impact of COVID-19 in both nations, and to identify shared solutions to shared problems in race and health.

7. Our core work is split across five workstreams which we describe as follows:
    a. *Improving health and care - We are committed to focusing on areas in health and care that have long shown ethnic inequalities in access, experience or outcomes – working to reshape policy and practice so that they support fair health and care for all, from neonatal health to end of life care.*
    b. *Empowering vulnerable communities - The most vulnerable in society are often those who experience the cumulative impact of health inequalities. Our work to identify and tackle ethnic health inequalities recognises the complexity of the social determinants of health as well as the resulting effect that can have on individual personal choices.*
    c. *Innovating for all - Digital technology has great potential to improve how the health and care sectors deliver their services in a modern way, providing faster,*

safer, and more convenient care. It is essential that new and innovative approaches, technologies, and data collection structures are designed to help reduce ethnic health inequalities and tackle structural racism.

d. *Creating equitable environments - We are committed to rebuilding and supporting health and care systems, change levers and management leadership behaviours to tackle ethnic health inequalities and promote quality of care, safety, compassion and a fairer experience for patients, NHS staff, and diverse communities alike.*

e. *Collaborating globally - We work both nationally and internationally, connecting with organisations and key stakeholders from across the country and around the world. We are committed to the sharing of innovative research, practice, and learning between communities and across borders.*

How we work

8. There are three strands to the Observatory's model, all of which are vital in the pursuit of racial equity in health for patients and workers. At every stage of our operating model, we include the voices of people with lived experience of racism and discrimination to ensure that the work we do meets the needs of the people it is designed to help and empower. These three strands are:

    a. **Research –** We are committed to drawing upon the best quality evidence about racial and ethnic inequality in health. This means not only enabling original research to fill knowledge gaps, but also synthesising and mobilising existing evidence. We want to put evidence in the hands of the people who can use it, whether that be policymakers, healthcare planners, providers, professionals, members of the public, or service users. We make evidence accessible through the creation of tools and digital resources, meaning the evidence can be tailored and adapted according to need. We are supported by an academic reference group and a community reference group through this and each stage of our work.

    b. **Influence** – We use the evidence we commission to influence leaders through practical recommendations for policy and practice. This means translating complex research into succinct briefings; working collaboratively with the government, the NHS, and arms' length bodies to ensure that policymaking is informed by an understanding of race and racism; and working alongside other

research organisations to focus greater resource on understanding why and where racial inequalities exist. Our recommendations are targeted, actionable, and applicable at every level.

c. **Implementation –** On the basis of our recommendations, and in response to the needs of the communities we work with, we support the implementation of new policies and practice at a national, system, and provider level. We fund and lead anti-racist improvement and implementation practices and are actively working in partnership with healthcare systems, regulators, and providers. Our approach to implementation is based on iterative co-design principles, so centers the experiences and knowledge of individuals with relevant lived experience. The approach is constantly tested and challenged to ensure it is having the intended impact.

The Observatory's work on COVID-19

9. Although the Observatory was officially established shortly after the start of the COVID-19 pandemic, it was not created in response to the pandemic and plans for the organisation were being developed long before evidence was available on ethnic disparities in mortality from the disease. Even so, the fact of these disparities meant that COVID-19 became an early point of focus for the organisation and some of our earliest commissioned work has looked into the impact of the COVID-19 pandemic on both patients and workers from ethnic minority backgrounds, helping to highlight its unequal impact on communities, and drive positive action from government and the NHS. Relevant publications are summarised below:

    a. **Pulse Oximetry and Racial Bias (Exhibit HN/2 - INQ000249826)–** In March 2021, the Observatory published a rapid review into the accuracy of Pulse Oximeter readings for individuals from Black, Asian and minority ethnic backgrounds. Pulse oximetry is a simple, cheap, and non-invasive means of testing the level of oxygen in a person's blood, and this was heavily relied upon, especially for patients to self-administer at home, during the COVID-19 pandemic. However, a growing body of evidence dating back to 1990 has highlighted inaccurate and variable readings from the device when used on darker skin. The differential accuracy of pulse oximetry could have serious clinical implications and may have contributed to the increased mortality of ethnic minority patients during the pandemic. This rapid review examined the

evidence on the accuracy of pulse oximetry in patients with darker skin and provided both strategic and practical recommendations to help narrow any potential health inequalities between different ethnic groups.

The recommendations included; a specific ask for an urgent review of pulse oximetry medical products used in the UK to be conducted by the Medical and Healthcare Products Regulatory Agency (MHRA), identification of suitable parameters to identify hypoxia by critical care and respiratory academic groups, NHS England and NHS Improvement, a review of all medical equipment and devices to be commissioned by the Department of Health and Social Care, and for further research to be prioritized from research bodies such as the National Institute for Health Research (NIHR). This review led directly to the NHS and MHRA updating their guidance for patients using pulse oximeters at home, and to the NIHR funding a large-scale study on the efficacy of pulse oximeters. The findings also led to the Government announcing an independent review into equity in medical devices (led by Dame Margaret Whitehead).

b. **Vaccination Hesitancy (Exhibit HN/3 - INQ000249827) –** In June 2021, we worked alongside Healthwatch England to produce research on vaccine hesitancy, which outlines missed opportunities with regard to increasing public confidence in the COVID-19 vaccine. Looking specifically at groups with lower vaccine take up, the research aimed to understand the reasons behind the mistrust and low confidence from certain communities who were also being targeted for the vaccine. The engagement and research highlighted the following themes:
    i. Individual agency: Participants preferred to decide about the vaccine after providing themselves with all the information. Limiting or removing an individual's agency from their decision making may result in them looking for alternate information.
    ii. Independence of institutions: People are more likely to trust the NHS when it acts independently from the Government. There was general distrust of those who had any possibility of standing to gain commercially from the roll-out.
    iii. Real-world experience: Many trust messages from frontline healthcare workers about COVID-19 and the vaccine more than communication from senior leaders.
    iv. Transparency: It's essential to make all information about the vaccine

public and accessible. The more transparent an organisation, the more trustworthy it is deemed.

v. Targeted messaging: Targeted campaigns and messaging left Black and Asian people feeling singled out and forced into a decision. A more effective way to reach out would be to engage directly through their local communities.

These findings prompted action in the form of improved engagement with affected communities and better communications materials to promote vaccination uptake. The research also led to key lessons for future public health campaigns and tackling health inequalities.

c. **Rapid Evidence Review (Exhibit HN/4 - INQ000249828) –** Released in February 2022, our rapid evidence review found that, among many other areas of inequality (see below), there was evidence to suggest that the Covid-19 infection was higher in ethnic minority staff in the NHS, particularly for Black and Asian staff, which exacerbated and created additional ethnic health inequalities. Nguyen and colleagues study which tested over 2 million frontline healthcare workers in the UK and US found that frontline ethnic minority staff were five times more likely to report a positive Covid-19 test compared with a White general population reference group. A further study by Shorten and colleagues testing 4,000 staff members in clinical and non-patient facing roles found that Black and Asian staff were more likely to test positive for antibodies than White staff. The pandemic disproportionately affected ethnic minority healthcare workers' working environment, in terms of access to adequate personal protective equipment (PPE) and the greater negative effect of the pandemic on ethnic minority staff mental health. A study by Carvalho and colleagues found that the successful fit of respiratory protective equipment was less likely in all ethnic minority groups compared with White healthcare workers. There was also an indication of a greater negative effect of the pandemic on ethnic minority staff mental health, with a study from Gilleen and colleagues finding that ethnic minority healthcare workers were more likely to report post-traumatic stress disorder symptoms compared to White health care workers. In a further study by Kapilashrami and colleagues of 500 healthcare workers in the UK, it indicated that ethnic minority healthcare workers were twice as likely as White healthcare workers to work in areas with Covid-19 cases. This study also found that ethnic minority healthcare workers were more likely to be involved in service level implementation and planning and hold more

staffing and redeployment responsibilities compared to White healthcare workers.

d. **Long-COVID (Exhibit HN/5 - INQ000249829) –** We have funded an ongoing longitudinal cohort study of the impact of long-COVID on Black, Asian, and ethnic minority healthcare workers who are over-represented in the 'frontline' NHS workforce, and at increased risk of COVID-19 infection and adverse outcomes. The study, REACH-OUT, builds on the UK-REACH (United Kingdom Research study into Ethnicity And COVID-19 outcomes in Healthcare workers) study to estimate the prevalence of long COVID among healthcare workers, and understand the impacts on the mental, physical, and occupational health of diverse communities in the UK at both home and work. Though no findings have yet been released, we have published a report which presents the first six-monthly update on the programme, outlining its rationale and the methodology which will be used to drive the work. This study will run until mid-2024. A second update report released in August 2023 is at **Exhibit HN/6 - INQ000302497**.

e. **Elective backlog (Exhibit HN/7 - INQ000249831) –** In November 2022, we released a joint report with the Nuffield Trust on ethnic inequalities in the elective backlog caused by COVID-19, seeking to explore whether the millions of hospital procedures cancelled due to COVID-19 impacted ethnic groups equally. This research explored the variation in the treatment rates for routine hospital care both before and during the COVID-19 pandemic, looking at changes in elective activity overall, and specifically in relation to common hospital procedures across five main ethnic groups. The report showed that Asian groups have suffered a larger deficit of care than white groups. This may have been influenced by increased exposure to Covid-19 leading to greater concern about coronavirus risk, or the shift towards remote consultations for many services resulting in some communities being less able to engage with digital modes of service delivery, for which language can be a barrier. The research also showed that the fall in hospital activity due to the pandemic and associated lockdowns had a disproportionate impact on people in more deprived areas, who already had higher levels of health care need, than those in less deprived areas. Whilst the report is primarily focused on ethnic variations, it also considers variations by deprivation and region because the proportion of ethnic minority groups is higher in more deprived areas, in cities

and in some regions.

f. **Trust in primary care –** As a result of our learning from the pandemic, especially observations about trust as a structural determinant of ethnic health inequality, we have also initiated a piece of work exploring the extent to which trust informs and impacts interactions in primary care. This work will be undertaken throughout 2023 and published in 2024.

Observations based on our work

10. The work we have published (as set out above) outlines some of the immediate impacts of COVID-19 in terms of access, experiences and outcomes in the NHS. It is important to recognise, however, that the pandemic did not emerge in a vacuum, and that the disproportionate impact of the disease on ethnic minority communities was largely due to pre-existing health inequalities, themselves deeply informed by structural racism. Our Rapid Evidence Review (**Exhibit HN/4 - INQ000249828**) reviews literature across five domains: mental healthcare, maternal and neonatal healthcare, digital access to healthcare, genetic testing and genomic medicine, and the NHS workforce. Among its key conclusions, the review finds:

> *Ethnic inequalities in access to, experiences of, and outcomes of healthcare are longstanding problems in the NHS, and are rooted in experiences of structural, institutional and interpersonal racism. For too many years, the health of ethnic minority people has been negatively impacted by: lack of appropriate treatment for health problems by the NHS; poor quality or discriminatory treatment from healthcare staff; a lack of high quality ethnic monitoring data recorded in NHS systems; lack of appropriate interpreting services for people who do not speak English confidently and delays in, or avoidance of, seeking help for health problems due to fear of racist treatment from NHS healthcare professionals.* (Kapadia et al, 2022)

11. It is important that the impact of the pandemic (further explored below) be seen through this lens, understanding the ways in which structural, institutional, and interpersonal racism have informed the experiences and health outcomes of Black, Asian, and minority ethnic communities.

12. For these reasons, explorations into the disproportionate impact of COVID-19 on ethnic minority communities, should be considered alongside broader inequalities. The

following reports, published by the Observatory, will be important in this respect:

a. Ethnicity coding in English health service datasets (June 2021)
b. Ethnic health inequalities and the NHS (June 2021)
c. Mapping existing policy interventions to tackle ethnic health inequalities in maternal and neonatal health in England (December 2022)
d. Digital apps and reducing ethnic health inequalities (January 2023)
e. Sickle cell digital discovery report: Designing better acute painful sickle cell care (January 2023)

Mortality

13. When we look at COVID-19 deaths in the UK by ethnicity, we see higher mortality rates among Black and Asian groups than the White majority population, as set out in Mona Abdalla's conclusions at **Exhibit HN/8 - INQ000302498**. In the first wave, this disparity was stark. For the Black African group, the mortality rate during the first wave of the disease was 3.7 times greater than for the White British group for males, and 2.6 greater for females. For Bangladeshi people the rate was 3.0 for males, 1.9 for females; for Black Caribbean groups 2.7 for males, 1.8 for females; and for Pakistani groups 2.2 for males, 2.0 for females.By the point of the second wave, these figures rose for Bangladeshi people, reaching 5.0 and 4.1 for men and women respectively. Although the relative risk went on to fall over successive waves for Black Caribbean and African groups, most Black and South Asian groups continued to be at higher risk than their White counterparts. This is set out in the UK Office for National Statistics (ONS) report at **Exhibit HN/9 - INQ000302499.**

14. The ONS report, **(Exhibit HN/9 - INQ000302499)**, looking at mortality rates across roughly the first year of the pandemic adjusted for 'location, measures of disadvantage, occupation, living arrangements and pre-existing health conditions', factors they concluded 'accounted for a large proportion of excess COVID-19 mortality risk in most ethnic minority groups'These statistical analyses, while useful, had the effect of moving the conversation on disparity away from conversations about the impacts of structural racism. It meant the government's policy interventions at the time focused on the *effects* of structural racism (such as occupation and living conditions) without ever engaging with the *causes* of these inequalities, including racism itself.

15. The pandemic was a crisis, and there were many acute and time-sensitive issues that had to be dealt with quickly and practically. In this sense, policymakers might be forgiven for focusing their efforts on the effects rather than the causes, but it is vital

that we do not let this tendency seep into everyday policy discourse. The Office for Health Improvement and Disparity ('OHID') was created during the pandemic. In explaining its priorities on its webpage at **Exhibit HN/10 - INQ000302489**, it mentions neither race nor ethnicity, focussing instead on long-standing public health initiatives such as smoking, exercise and addiction. Important though these initiatives are, a failure to appreciate the nuanced interplay of structural forces that drive inequality in this country means that OHID's focus on the effects rather than the drivers will only ever scratch the surface. To deliver long term change we must be able to consider both in tandem – the acute impacts of ethnic health inequalities, as well as the deeply ingrained causes of those inequalities.

Vaccination

16. Vaccine hesitancy in Black and Asian communities has been evidenced in a number of studies focussed on the general population of the UK as detailed in **Exhibit HN/11 - INQ000302490**. As an example, data drawn from a subset of participants in the UK Household Longitudinal Study (n=12,035) and set out in **Exhibit HN/12 - INQ000302491**, showed that while overall vaccine hesitancy was low (17%), the rate of hesitancy was significantly higher in in Black (71.8%) and Pakistani/Bangladeshi (42.3%) ethnic groups. The highest intention to vaccinate was seen among those in the White British or Irish groups (84.8%) and the "any other Asian background" group, which includes participants of Chinese ethnicity. When asked to give reasons why they were hesitant about the vaccine, most (42.7%) were concerned about the effects of the vaccine. In some cases, there was a notable difference in reasons given across different ethnic groups, with Black or Black British participants more likely to state they 'Don't trust vaccines' (BMJ, 2021).

17. In the UK, workers in health and care were among the highest priority groups in the UK government's vaccine roll out. The COVID-19 vaccination first phase priority groups is set out at **Exhibit HN/13 - INQ000302492.** Not only was it understood that this group would be at high risk of catching the virus, but it was also seen as imperative that they be protected in order that they could continue to care for the wider population. From the start of the vaccine roll out, however, there were reports that uptake among Black and minority ethnic staff was lower than among White groups. A number of studies have sought to better understand this hesitancy including at **Exhibit HN/14 - INQ000302493** and **Exhibit HN/15 - INQ000302494**. Most prominently, reasons include mistrust of the vaccine itself due to a lack of longitudinal data; mistrust of the

National Health Service and the government; fears around historical unethical research; and a lack of transparency about the number of Black, Asian and minority ethnic people involved in vaccine trials.

18. A common theme among these studies is trust. As provided in Healthwatch's insight report at **Exhibit HN/16 - INQ000302495**, as the pandemic progressed, there was some success in increasing vaccination uptake on the basis of effective community engagement, where transparent and collaborative dialogue paved the way for increased trust. Gradually, these lessons were taken on board by policymakers, and vaccine uptake increased through interventions such as deploying vaccines in places of worship, targeted communication campaigns linked to religious festivals, and working with trusted community leaders. This is set out in the Race Disparity Unit report at **Exhibit HN/17 - INQ000302496.** Important though these interventions proved to be, it is possible that they could have been avoided if that mistrust was not so endemic prior to the pandemic. We have seen that building trust takes time, and we need to restore the social contract between the government and ethnic minority communities if we are to avoid these inequities being repeated in future public health crises.

History of representations

19. We have made available all of our evidence to the Department of Health and Social Care and have engaged frequently with the Office of Health Improvements and Disparities, including at roundtables for the latter organisations', now scrapped, white paper on health disparities. We have also made specific representations to this Inquiry, as listed below.

20. In February 2022, we wrote to the Inquiry with the following two requests:
    a. That lessons learned be viewed through an equalities lens, and that the disproportionate impact of the disease on minority ethnic communities is recognised in the conclusions and recommendations that come out of it.
    b. That the Inquiry consider the particular needs of asylum seekers.

21. On 28 February 2023, we agreed to be signatory to a letter to the Inquiry authored by The Runnymede Trust. The letter contained four requests namely that the Inquiry:
    a. Investigate structural racism as a key issue in every module;
    b. Instruct an expert witness in the field of structural racism to shed light on the state of the UK's preparedness in the lead up to the pandemic;
    c. Rethink the Listening Exercise and ensure that those most impacted are included

in a supportive and accessible way, to enable full trust and participation in this process;

d. Ensure migrants' rights groups and Gypsy, Roma, and Traveller ('GRT') communities are represented as Core Participants.

22. In response to our representations, we were invited to join the UK Covid-19 Inquiry Equalities Forum, which met for the first time on the 4th May 2023.

Summary

23. Our work concerns racial inequality in health in the broadest sense, drawing together evidence not only on the inequitable outcomes experienced by ethnic minority communities, but also investigating the structural causes of those inequalities. COVID-19 was a clear example of the ways in which structural inequality is embedded and a clear example of its impact.

24. As our research has shown, there are a number of lessons to be taken from the pandemic and from the experiences of these communities, briefly summarised here:

    a. Trust, or a lack of trust, between ethnic minority communities and a variety of public service providers was a major barrier to vaccination uptake and an impediment to efforts to share information. Attention needs to be given to trust as a structural determinant of health inequalities.
    b. Effective community participation is a fundamental pre-requisite to effective public health communication, especially during a crisis.
    c. Health inequalities cannot be understood in isolation. Any attempt to understand or learn from inequalities evident during the pandemic must be viewed in the context of structural and institutional racism and the way it impacts where a person lives, the work they do, and other stressors.
    d. Tackling structural racism means not just looking at the provision of care, but also the "upstream" factors that dictate how appropriate that care might be. This includes diversity in medical research and clinical trials; diversity in the design and testing of medical devices; bias in clinical education; and bias in procedures and policy.

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: 13/10/2023