THE UK COVID-19 INQUIRY

BEFORE BARONESS HALLETT

SUBMISSIONS FROM THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

MODULE 5 SECOND PRELIMINARY HEARING, 11 DECEMBER 2024

Introduction

1. These brief submissions are provided on behalf of The Federation of Ethnic Minority Healthcare Organisations ("FEMHO") in respect of the second Module 5 preliminary hearing on 11 December 2024.

2. We will firstly reprise issues that we raised in the first preliminary hearing and reiterate the importance for the focus in Module 5 by reference to the draft list of issues provided. After, we will make brief remarks on Rule 9 requests, disclosure, experts and the listening exercise.

I. List of issues

3. As a consortium of ethnic minority health and social care workers, FEMHO's interest in procurement decisions is driven by concerns about pandemic resilience and health security. FEMHO contends that procurement decision-making rampantly manifests health inequalities and structural racism. This has been laid bare in the Inquiry so far, when one considers the problems that have surfaced regarding PPE, medical equipment and ethnicity.

4. FEMHO's substantive focus in terms of issues and lines of enquiry for Module 5 is captured in CTI's note of 15 November 2024, as follows:

> *23 a) The approach in the UK and devolved administrations to pandemic stockpiles, including their adequacy, accessibility and appropriateness for the range of physical*

characteristics of the health and social care workforce, in so far as this has not been addressed in previous modules.

23 g) The institutions and systems for the effective regulation and inspection of key healthcare equipment and supplies procured during the pandemic. The Inquiry will examine their effectiveness and whether they provided a coherent, efficient and systematic scheme to protect the safety of end-users.

It is to be noted that these issues are fundamental in nature and cross-cutting within the Inquiry. There has been reference to these matters in other modules, most notably during Module 3 on healthcare systems. However it is essential that Module 5 takes this exploration deeper in order to understand the decision-making in procurement and the underlying processes that allowed a system to exist in which structural inequalities were ingrained and exacerbated. The procurement processes during the pandemic failed to comply with established equality duties under UK law. FEMHO wishes the Inquiry to explore how, by not addressing the distinct needs of ethnic minority healthcare workers, these practices perpetuated systemic inequalities. It is important to ensure that equality law is not merely an aspirational standard but a fundamental requirement in procurement decisions; this is imperative. FEMHO seeks a robust integration of equality frameworks into procurement strategies to mitigate biases in future crises.

5. We invite the Inquiry team to revisit our written submissions from the first preliminary hearing in February 2024, and the detailed submissions on scope contained therein, for example [12]:

> *"The issue of fit testing is of particular concern given it has been evidenced that much of the typical PPE procured in the UK has been designed and manufactured based on the average facial measurements of a White man. There is thus a lack of adequate consideration for variation of facial anthropometrics between ethnicities. In addition, "standard" PPE is often incompatible with facial hair and religious and/or cultural dress such as a hijab or turban. This was an issue raised with senior NHS staff and investigated by many of our members; the British Islamic Medical Association ("BIMA"), for example, carried out a study exploring the impact of this issue."*

6. The question of appropriateness for PPE procurement decisions therefore requires an interrogation of existing standards and metrics. The system itself ought to be carefully considered with thought given as to whether central coordination in national emergencies could avoid individual NHS trusts being put in a position of vying against each other, fostering

a climate of famine and surplus and creating confusion in the types of PPE required and available.

7. The notion of what constitutes optimal size or a sufficient range of PPE needs to, as a matter of course, become more diversified. Witnesses involved in healthcare management and decision-making in Module 3 have given evidence that the range of PPE options was expanded during the pandemic, however anecdotal evidence from our members and others does not indicate that the issues were resolved satisfactorily and instead indicate that many individuals continued to experience significant challenges in accessing suitable PPE that would provide them with a protective fit. These issues were further exacerbated by the lack of clarity and divergence in opinion and guidance on when and where different standards of PPE were required. The failure to provide culturally appropriate and properly fitting PPE not only breached equality duties but also posed significant risks to national health security. Ethnic minority healthcare workers, disproportionately represented on the frontline, faced amplified exposure risks due to ill-fitting or inadequate protective gear. Addressing these gaps is essential to fortify healthcare systems against future public health threats.

8. Similarly, regarding healthcare equipment, there were high profile examples that some were just not fit for purpose based on ethnicity [19]:

> *"The lack of consideration for ethnic differentials was glaringly apparent in the provision of other healthcare equipment as well as PPE. For example, in April 2021, the Independent NHS Race and Health Observatory conducted a review that sounded the alarm about the oximeter readings from Black and minority ethnic people could be "seriously misleading" and needed further assessment. The majority of oximeters have been developed based on studies measuring oxygen levels in Caucasian and light-skinned individuals but research revealed inaccurate and ambiguous readings for those with darker pigmentation and skin tones."*

The issues highlighted in the example of the pulse oximeter devices, we say, are indicative of a wider issue that is also, to a substantial degree, a procurement question. Other examples of medical equipment found to have potentially significant variance in effectiveness include infrared thermometers. There are also linked issues with product literature and guidance, which often over-rely on physical descriptions as they would present in people of White Ethnicity such as references to "blotchy" or "pale" skin, blue lips etc. Despite awareness of these issues, the vision of the end-user, it seems, remains unstintingly white. Both manufacturers and those

making procurement decisions appear to have the same assumptions about who the end user is.

9. More widely, as health and social care workers, FEMHO shares concerns about wider procurement decisions that impacted on the availability of healthcare equipment and supplies, and access to testing for healthcare workers and their families, during the pandemic.

10. Given the evidence heard in Module 3, FEMHO would wish Module 5 to explore why the UK government did not leverage its buying power. The UK government should have leveraged its procurement power to influence global manufacturers to produce more inclusive and equitable equipment. Rather than deflecting responsibility as a "global issue", decision-makers must advocate for and invest in diverse product development, ensuring equipment such as pulse oximeters and PPE cater to varied anthropometrics and skin tones.

11. Pandemic preparedness must account for the intersectionality of race, socio-economic status, and health vulnerabilities. FEMHO would invite this module to consider a review of stockpiling strategies to ensure inclusivity in resource allocation. Intersectional analysis should inform all aspects of public health planning, embedding equity as a cornerstone of pandemic resilience. A more centralised point of intelligence, with effective engagement with and input from a wide range of stakeholders, may be an appropriate option to assist in enforcing clarity in guidance and decision making on procurement.

12. Accordingly, we make the following specific submissions on the draft list of issues recently shared with CPs:

    a. We are disappointed that there is no mention of inequality considerations in the draft given the significance of the issue – not specifically acknowledging this vital line of enquiry is at odds with the Inquiry's previous commitment to keep inequalities at the "*forefront*" of the investigation and runs the risk of diluting the need to explore the aspects of procurement that resulted in such disparate impact for ethnic minority groups during the pandemic. We respectfully urge the Inquiry to ensure that inequality remains a guiding principle in all its investigations, with specific attention to procurement policies and their disparate impacts.

    b. Within areas 1b and 2, and key issue 1, we request confirmation that the Inquiry will assess the adequacy of pre-existing PPE stockpiles, focusing on their inclusivity and ability to

provide effective protection for ethnic minority healthcare workers. This includes evaluating the availability of PPE options designed to fit diverse facial structures and accommodate cultural dress, such as beards, turbans, and hijabs. Addressing these considerations is critical to ensuring equitable safety measures in future crises;

c. Within key issue 4, we invite the Inquiry to investigate the distribution processes for 'non-standard' PPE options, such as appropriate RPE for ethnic minority healthcare workers and power-assisted respirator hoods. The examination should include whether these items were equitably allocated and how logistical barriers were addressed to ensure access for those in higher-risk or frontline roles;

d. Within areas 2 and/or 3 we invite the Inquiry team to confirm they will explore the procurement of pulse oximeters and other medical devices with potential racial bias such as infrared thermometers and safety concerns associated with their use. This should include evaluating how the known inaccuracies of these devices for darker skin tones influenced health outcomes and whether procurement processes factored in the need for inclusive and equitable medical technology;

e. Within areas 1g and/or 3, and key issue 7 we invite the Inquiry team to confirm that consideration of equality law and duties will be factored into its exploration of procurement principles, regulations and standards. Specifically, the Inquiry should assess whether these frameworks adequately safeguarded against discriminatory outcomes and ensured equitable access to essential resources during the pandemic:

f. Within key issue 2.10, we urge the Inquiry to examine the capacity and deployment of AI in procurement processes, with a focus on whether these systems were designed to operate in a culturally sensitive and inclusive manner. This includes evaluating whether AI systems considered the diverse needs of healthcare workers and communities, particularly in their data inputs and decision-making processes; and

g. Within key issue 5, we invite the Inquiry to confirm that the involvement of ethnic minority stakeholders in the procurement process will be assessed. The Inquiry should explore whether their input was actively sought and incorporated into decision-making to ensure that policies and resource allocations were equitable and reflective of the needs of diverse communities.

II. Rule 9 requests

13. FEMHO notes that paragraph 6 of CTI's note states that the Inquiry does not consider that it needs to hear from specific companies or individuals connected to them about particular contracts "*as these will be of limited probative value.*" Notwithstanding this, FEMHO repeats its request that relevant state actor CPs should provide position statements, consistent with the Inquiry's promise to keep this issue under review from 17 October 2022. This is so, for the reason that there were different approaches to procurement from various government departments and NHS Trusts. In the absence of any settled understanding or a centralised approach, the Inquiry – and non-state CPs – would be assisted by the position statements to understand the respective state actors' approach to procurement and their mode(s) of operation.

14. To date, FEMHO has not received a Rule 9 request in this module and it is as yet unaware as to whether it is on the list of requests still planned to be made in coming weeks. We respectfully reiterate our request that a witness statement from FEMHO is obtained and oral evidence heard from a representative member. The insights FEMHO members offer will provide valuable assistance to the Inquiry in understanding those aspects within the procurement process and decision-making that resulted in inequalities and disparate harm, and will be a valuable resource in considering not only where the underlying issues lie but how things could be rectified and improved in future. Whilst some of the evidence FEMHO has provided for previous modules will be relevant, a new statement focused on the discrete issues under examination in Module 5 will allow much more targeted insights to be provided by our membership.

III. Disclosure and experts

15. FEMHO notes that the disclosure process is still fraught with delay. Material continues to be made available in tranches. At the same time, Professor Manners-Bell's report on supply chains is expected to be provided by 29 November, 2024 with observations due by 13 December. Prof Sanchez-Graells' report on public procurement is expected to be provided by 6 December, with observations due on 20 December. The extremely tight turn around of this material continues to place enormous pressure on all CPs, particularly those working across multiple modules, including FEMHO. We appreciate the efforts of the Inquiry team and the

constraining factors described in recent updates, however it is critical that sufficient time is allowed for CPs to review and digest disclosure to be properly prepared and meaningfully participate in the hearing process.

IV. Listening Exercise

16. As previously indicated, after the pilot (a summary of which has been disclosed) the Inquiry has decided that a full every story matters report would not be pursued for this module. We are content that this seems appropriate, given the nature of the issues under investigation in this module.

Conclusion

17. FEMHO appreciates the full consideration of the Chair given to all the matters raised above. We are grateful for the attention paid to these important matters and remain hopeful that they will be carefully addressed within the Inquiry process.

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