THE UK COVID-19 INQUIRY
BEFORE BARONESS HALLETT

MODULE 5: OPENING STATEMENT OF THE FEDERATION OF ETHNIC MINORITY HEALTHCARE ORGANISATIONS ("FEMHO")

INTRODUCTION

1. These written submissions are made on behalf of FEMHO in advance of Module 5 commencing on 3 March 2025. We thank Your Ladyship for the opportunity to present FEMHO's perspective and consider it is of critical import to consider the gravity of issues and broader context which informs FEMHO's substantial interest in Module 5. Module 5 provides a crucial opportunity to scrutinise procurement through the lens of structural and systemic inequalities. These submissions focus on these inequalities and opportunities for change.

2. FEMHO represents members at the intersection of two key and manifestly disproportionately affected groups: ethnic minorities and health and social care workers ("HCWs"). Through this dual perspective, FEMHO will endeavour to provide unique insight into government procurement decisions that were made before and during the pandemic.

3. A majority of our members come from communities that were on the frontline of the pandemic and which have suffered disproportionately. Limited access to appropriate Personal Protective Equipment ("PPE"), for example, compounded both the disproportionality and the risk faced by Black, Asian and Minority Ethnic HCWs and their communities.

4. Black, Asian and minority ethnic staff make up almost a quarter of the workforce overall (24.2%), more than two fifths (42%) of doctors, dentists, and consultants, and almost a third (29.2%) of our nurses, midwives, and health visitors. Yet representation at board level is only 13.2% and at very senior managers is lagging at 10.3%. This underrepresentation in decision-

making, including in procurement, has contributed to the disparities experienced by our members.[1]

5. FEMHO's interests in Module 5 stems from concerns that structural inequalities, exacerbated by failures to uphold the Public Sector Equality Duty ("PSED") and conduct meaningful Equality Impact Assessments ("EIA"), shaped procurement decisions during the pandemic. FEMHO is particularly concerned with the adequacy of procured items – and the effectiveness of distribution to – Black, Asian and Minority Ethnic HCWs and their communities. As always, we approach this analysis with a view to learning from what worked well as well as what did not, and what can be done better in future.

SCOPE

6. Module 5 examines procurement processes during the pandemic. FEMHO's central contention in Module 5 is that structural inequalities impacted upon procurement decisions and the availability of healthcare equipment and supplies during the pandemic. This resulted in significant shortages of appropriate PPE and equipment including ventilators and oxygen. FEMHO also contends that issues of structural inequalities shaped the availability of, and HCW access to, lateral flow tests and polymerase chain reaction ("PCR") tests.

7. FEMHO considers it essential that Module 5 examines how government procurement processes, procedures, and decision-making differentially affected Black Asian and Minority Ethnic HCWs and communities. Based on the evidence and proposals received to date, FEMHO is concerned that these critical issues may not receive adequate scrutiny.

8. We urge the Inquiry to prioritise these issues and in so doing suggest some key themes which FEMHO submits must be explored during Module 5. These include:

   a. *Diversity and inclusion in decision-making*: The Inquiry should assess the representation of ethnic minorities HCWs in decision-making roles related to procurement. FEMHO would seek to encourage initiatives that promote diversity and inclusion in leadership positions.

   b. *Cultural competence in procurement decision-making processes*: We invite the Inquiry to explore the implementation of cultural competence training for individuals involved in decision-

[1] 'See NHS Press Release 'New figures show NHS workforce most diverse it has ever been', 22 February 2023.

making processes, with a focus on understanding and addressing the unique needs and perspectives of the minority ethnic communities they serve.

c. *Equitable distribution of resources*: FEMHO would recommend the development and implementation of policies to ensure the equitable distribution of essential resources procured, such as PPE and medical equipment, to healthcare settings and monitoring of any disparities in access. The Inquiry should seek to evaluate how the procurement and distribution of key resources might have impacted health inequalities.

d. *Community engagement in procurement*: FEMHO invites the Inquiry to examine and assess whether procurement processes engaged minority ethnic communities and consider how future engagement can ensure procurement aligns with their needs.

e. *Language access and communication strategies*: The Inquiry should consider whether the procurement process encompassed effective communication and engagement strategies, including the use of unhelpful narrative concepts such as "hard to reach" and the provision of information in multiple languages and use of interpreter services to ensure accessibility and avoid barriers to its success.

f. *Support for minority-owned businesses*: FEMHO advocate for the Inquiry to consider the impact of procurement policies and whether those in place supported and promoted businesses owned by individuals from minority ethnic backgrounds in the supply chain. This approach may have reduced some of the problems that impacted on minority ethnic communities as highlighted below. These policies could include initiatives to increase the diversity of suppliers and ensure fair representation in procurement processes.

g. *Regular diversity audits*: The Inquiry should assess whether diversity audits were conducted to identify and address racial disparities in procurement decisions, with disaggregated data analysis.

h. *Transparency in decision-making*: FEMHO advocates for transparency in the decision-making processes related to procurement. Ensuring that stakeholders, including organisations such as FEMHO, have access to information on how decisions are made allows for accountability and informed participation and public trust. This is particularly important in

the context of considering historical mistrust or experiences of discrimination that might influence the willingness of minority ethnic communities and/or businesses to engage with procurement supply chains.

i. *Collaboration for inclusive protocols*: Finally, it should be explored whether there was collaboration between HCWS and organisations, government agencies, and community representatives to develop inclusive protocols and algorithms for healthcare equipment. This collaborative approach can help to identify and address biases that may disproportionately affect minority ethnic communities. Collaboration and mutual aid arrangements between the four nations should also be examined.

Availability and appropriateness of PPE/RPE

9. The decision to downgrade Covid-19 from High Consequence Infectious Disease ("HCID") status, allowing the use of PPE and not Respiratory Protective Equipment ("RPE"), contradicted available scientific evidence and increased exposure risks for our members as it offered less protection. Meanwhile, as we heard repeatedly in Module 3, PPE that was provided to HCWs was often poorly fitting and therefore of limited value.

10. The effectiveness of PPE (including RPE) depends primarily upon it fitting properly to provide a proper seal. In 2016, updated recommendations from the New and Emerging Respiratory Virus Threats Advisory Group ("NERVTAG") facemask and respirators sub-committee made the following observations, noting that it was not within its remit to develop guidance on infection and control and the use of PPE/RPE: "*Fit testing in the face of an emerging pandemic is a major challenge but it is important. Adding 'call down' fit testing as part of the procurement (including the fit testing solution etc.) would be advantageous. Just in time fit testing was proposed – however, there may not be sufficient time to put this in place, between pandemic virus emergence and the first UK impact… there is no substitute for a rolling programme of fit-testing in NHS trusts during inter-pandemic periods. There should be a caveat about fit testing in any recommendations.*"[2] This ought properly to have been incorporated into the procurement and distribution process for PPE during the pandemic, but seemingly was not.

[2] 'NERVTAG Sub-committee on the pandemic influenza Facemasks and Respirators stockpile: Formal Recommendations to the Department of Health', 1 September 2016. [INQ000130548]

11. As a result, fit testing of PPE during the pandemic was inconsistent and of variable quality and outcome. We are not aware of any evidence of a rolling unified programme of fit testing or the training of fit testers. The British Safety Industries Federation ("BSIF") appears to have been concerned enough about the absence of fit testing in the NHS that they developed a simplified fit test course, which was offered to the Department of Health and Social Care ("DHSC") to roll out to NHS Trusts in order to enable them to have fit test capability of their own. We understand that the DHSC declined this offer, saying that procurement was determined at an individual Trust level.

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.[3] There is thus a lack of adequate consideration for variation of facial anthropometrics between ethnicities and genders. In addition, "standard" PPE is often incompatible with facial hair and religious and/or cultural dress such as a hijab or turban.[4] Evidence heard so far in this Inquiry has confirmed what should perhaps have been obvious - that one-size does not fit all when it comes to PPE - and this was an issue raised with senior NHS staff and investigated by many of our members early into the pandemic; the British Islamic Medical Association ("BIMA"), for example, carried out a study exploring the impact of this issue.[5]

13. Sir Chris Wormald admitted in Module 1 that the department had stocked lower levels of PPE suitable for Black staff working in healthcare, and that little planning had been done to consider the equality of PPE provisions.[6] In his Module 3 evidence he further admitted that the stockpile did not have enough diversity in it and there was still work to be done to improve this.[7] Matt Hancock, in his Module 3 evidence, also admitted there was a lack of adequate consideration for variation of facial features between ethnicities in the stockpiled PPE managed by Public Health England, who reported into DHSC.[8] Sajid Javid was unable to confirm whether by the time he took up the role as Health Secretary or thereafter PPE supplies had been diversified to

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[3] See, for example, The influence of gender and ethnicity on facemasks and respiratory protective equipment fit: a systemic review and meta-analysis', J. Chopra, N. Abiakam & H. Kim et al, BMJ Global Health 2021, 11 November 2021.

[4] E.g. that fitted and were effective with individuals who wear turbans, have beards etc. – see, for example, 'Hospitals inspect doctors for beards and tell those with more than a day's stubble to shave', D. Sheridan, The Telegraph, 1 April 2020.

[5] The impact of keeping a religious beard in the COVID-19 pandemic: an online cross sectional survey study exploring experiences of male medical healthcare professionals', A. Hamed, A. Latif, M. Haris, S. Patel, M. I Patel, S.A.R. Mustafa, O. Khan, A. Shoaib & A. Waqar, 1 November 2020, medRxiv.

[6] [PHT000000005_0037-38].

[7] [PHT000000124] 41/2-12; 118/15-119/10.

[8] [PHT000000130] 192/19-196/9.

ensure they fitted a broader range of people.[9] Module 5 must carefully consider and build on this alarming evidence to examine why and how it came to be that our stockpiles of PPE were so limited in range and what can and must now be done to ensure procurement processes result in more equitable supplies.

14. The Inquiry must also consider whether single use, instead of reusable, RPE and PPE was procured on the false assumption that it would be capable of being reused and due to cost considerations, rather than procuring more expensive but safer re-usable products. We have also heard reports that reusable equipment was not procured or made available because of concern on the part of the Health and Safety Executive ("HSE") about the capability of healthcare employers to manage reusable RPE/PPE programmes, due to a lack of training, management capability and decontamination facilities. These decisions significantly impacted the safety of FEMHO's members.

15. Powered Air Purifying Respirator hoods ("PAPR") would have been particularly useful in the protection of minority ethnic (and other) people for whom other "standard" PPE did not provide a protective fit due to factors previously discussed[10], because close fitting is not a requirement. Though cost difference is often assumed to be the underlying reason for the lack of procurement and supply of this type of equipment, we understand that the cost difference was not significant. We heard evidence in Module 3 on this, including that Jaguar Land Rover had offered manufacturing services to Sir Stephen Powis to assist in the production of PAPR but their offer was not taken up.[11] Despite the alternative options available, single use "one size fits all" masks, requiring face fit testing, became the default and PAPR was rarely available to HCWs. Meanwhile, the lack of availability and escalating cost of single use PPE resulted in serious consideration of, or their actual reuse, against the safety guidance of manufacturers.

16. Concerns were also raised about PPE that was mislabelled, expired, or otherwise unfit for purpose, rendering it incapable of providing adequate protection and necessitating its withdrawal from the healthcare supply chain.

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[9] Module 3 Day 37, 58/19-60/9.

[10] Including differing facial anthropometric characteristics and for those with facial hair and/or who wear religious dress such as a hijab or turban.

[11] Module 3 Transcript Day 4, 37-8-40/2.

17. Minority ethnic HCWs, were more likely to work in hazardous conditions without adequate RPE or PPE than White colleagues[12], and to make matters worse, the least empowered to speak up about it. A survey revealed, for example, that only 43% of minority ethnic nurses received eye and face protection equipment, compared to 66% of White British nurses (RCN, 2020); and 49% of minority ethnic nurses had been asked to reuse single use equipment, compared with just over a third of White British respondents.[13] A FEMHO member organisation, the British Association of Physicians of Indian Origin ("BAPIO")'s Institute of Health Research, conducted similar research which identified that over 78% of respondents to a survey (predominantly hospital doctors from a Black, Asian and Minority Ethnic background) reported either lack of, or inappropriate, PPE.[14] We have also heard evidence about individuals being threatened with disciplinary action in some instances where they asked for, or sourced and wore their own, PPE to try and protect themselves.

18. From as early as March 2020, many FEMHO's member organisations wrote to key figures, including Matt Hancock MP, Sir Chris Whitty, Sir Simon Stevens, the Chief Executives of all NHS trusts and Charlie Massey raising concerns about the availability, accessibility and suitability of procured PPE for HCWs.

19. The above issues are of vital importance to the Module 5 investigation. Ensuring the procurement of diverse PPE, accommodating different facial shapes, facial hair and religious dress, along with a robust individualised fit testing programme, could have avoided or at least mitigated much of the discriminatory impact of inadequate PPE planning and resources suffered by our members during the pandemic.

Fitness for purpose of healthcare equipment and cultural competency

20. The failure to adequately consider ethnic differentials was glaring in the provision of healthcare equipment beyond PPE. In April 2021, the Independent NHS Race and Health Observatory conducted a review that sounded the alarm about the oximeter[15], an important Covid-19

[12] Experiences from health and social care: the treatment of lower-paid ethnic minority workers', Equality and Human Rights Commission, 9 June 2022, p.32.
[13] The Independent SAGE Report 6, 'Disparities in the impact of COVID-19 in Black and Minority Ethnic populations: review of the evidence and recommendations for action', The Independent SAGE, 3 July 2020, p.6.
[14] 'An Online Survey of Healthcare Professionals in the COVID-19 Pandemic in the UK: Perceptions of Risk Factors', Chakravorty, I., Daga, S., Dave, S., Chakravorty, S., Menon, G. ., Bhala, N. ., Mehta, R., & Bamrah, J., Sushruta Journal of Health Policy & Opinion, 13(2) 2020, p.8.
[15] Pulse oximeters test the level of oxygen in a person's blood by attaching a clip-like device to a person's finger, toe, or earlobe, sending a beam of light through the body to measure and diagnose lower than normal blood oxygen levels. Pulse oximeters may be used at home to detect hypoxia associated with acute Covid-19.

response tool. It found that the accuracy of pulse oximeter readings from Black and minority ethnic people could be "*seriously misleading*" and needed further assessment.[16] 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 skin tones.

21. Another major risk related to the oximeter was that treatment could be delayed by individuals over-relying on physical descriptions within the product guidance of pulse oximeters, which were found to inappropriately use terms such as '*pale*', '*blotchy skin*' or skin or lips '*going 'blue'* which do not typically apply to Black and darker-skinned minority ethnic people. Dr Habib Naqvi, Director of the NHS Race and Health Observatory**,** opined: "*This review has stressed the need to ensure healthcare equipment and devices are culturally competent and sensitive, whilst not contributing to the array of current and historic health inequalities."* Studies have similarly shown there to be "*significantly less accurate*" readings using infrared thermometers for Black Patients.[17]

22. Concerns have also been raised that various healthcare devices, including predictive assessment protocols, algorithms and other artificial intelligence, may be designed and operating with racial biases. Take, for example, the July 2023 review of neonatal assessment and practice which found that guidance for three key health checks after birth (the Apgar scoring system, jaundice and cyanosis checks) all involve assessments made based on the baby's skin colouring.[18] Guidance for this seems to be heavily based on presentation in White European babies, with literature encouraging HCWs to look out for skin that is "pink all over", or turning "blue" or "grey" as indicators for example. Serious health conditions can be underestimated for darker skinned babies as a result of this guidance. Tools such as these have become increasingly prevalent in clinical decision-making and were widely used during the pandemic. Additionally, there were significant shortcomings in ensuring that -related information was accessible in multiple languages, creating barriers for diverse communities.

23. By 2020, the HSE had lost most, if not all of its specialists in PPE/RPE from its field team; an issue that does not appear to have been considered an area of critical importance. By the start of the pandemic, the Personal Protective Equipment (Enforcement) Regulations 2018 had come

[16] Pulse Oximeter Bias Highlighted in Rapid Review', NHS Race & Health Observatory, 14 April 2021.
[17] 'Racial Bias Deeply Rooted in Healthcare Technology and Medical Devices', Chartis, 28 October 2022.
[18] 'Review of Neonatal Assessment and Practice in Black, Asian and Minority Ethnic Newborns: Exploring the Apgar Score, the Detection of Cyanosis, and Jaundice', F. Fair, A. Furness, G. Higginbottom, S. Oddie & H. Soltani, NHS Race & Health Observatory, July 2023.

into effect to ensure the quality of PPE/RPE in general use and standards of PPE/RPE imported into the UK. However, no active work appears to have been done to bring this into effect and, as we understand it, there is no publicly available evidence of market surveillance to test the quality of imported regulations, during which time millions of items of PPE/RPE were procured.

Special concerns regarding care homes

24. The procurement of PPE for care home workers ought to be carefully and specifically assessed as part of Module 5. Black, Asian and Minority Ethnic people again make up a substantial proportion of the workforce in care homes. Professor Dame Jenny Harries in her written evidence to the Inquiry stated that "*each 'business' has the responsibility for looking after its own staff and PPE stock…*" and "*that general central government had not previously taken formal responsibility for PPE funding, procurement or provision on behalf of the care sector*".[19]

25. In Module 2, FEMHO sought to ask a question about whether – in the context of a global pandemic and national emergency – the government should have borne more responsibility for looking after care sector workers on the frontline with regards to PPE. This is a particularly pertinent issue for Module 5 to explore in more detail, and which FEMHO can assist with, in circumstances where care homes were expected by central government to meet the deficit in terms of the ability of the NHS to care for often elderly people, some of whom were dying and would ordinarily be in hospital, during periods in which the NHS was overwhelmed. Our members report that they were left to obtain PPE for themselves and colleagues (in some instances resorting to sourcing supplies from beauticians, veterinary surgeries and even butcher's shops) as they were effectively excluded from government procurement and distribution.

Procurement of lateral flow tests and PCR tests

26. Our members were amongst those who experienced issues at the start of the pandemic with the availability of tests for HCWs and their families. FEMHO also has concerns about whether and when instructions on lateral flow and PCR tests were made available to the public in a range of languages. For example, it appears that the UKHSA did not produce guidance on lateral flow tests in other languages for publication on the government website until 29 January 2021, with information not added on the interpreter service until 10 August 2021, and further languages

[19] Fourth Witness Statement of Professor Dame Jenny Harries, paragraphs 9.38 to 9.40 at [INQ000273807/134-135].

not added until 22 October 2021, 9 November 2021 and 11 April 2022.[20] Communities themselves, and in particular HCWs within those communities, were therefore left to organise and fund translation and dissemination of critical information about self-administering the tests. FEMHO members, as trusted members of their communities, once again played a key role in filling this gap.

CONCLUSION

27. In summary, FEMHO submits that key questions must be answered in Module 5 and recommendations made for the future which address how inclusivity can be better embedded in procurement processes. The elimination of discriminatory outcomes and the promotion of equitable access to essential healthcare resources is central to this investigation. Action must be taken now so that, going forwards, the health service procures and maintains a supply of devices, instruments and equipment that is fit for purpose and provides for *all* HCWs and patients, regardless of ethnicity, race, gender or other characteristics. Additionally, procurement policies should foster greater representation and diversity in decision-making, ensuring that the failures experienced during the pandemic are never repeated.

28. FEMHO acknowledges the extensive list of witnesses. There is a concern that live witnesses are heavily skewed towards the "procurement" side, perhaps missing out on the importance of the supply/demand and "ground" players, however we trust the written statements will be borne in mind throughout. We look forward to a robust examination of evidence and meaningful engagement with witnesses to ensure that inequalities in procurement processes and systems are addressed in order to ensure a fairer, more resilient procurement system that serves all communities equitably.

29. FEMHO urges the Chair to ensure that the Inquiry's findings lead to lasting change. The failures of pandemic procurement had grave consequences for minority ethnic HCWs and their communities. It is not enough to recognise these shortcomings—there must be concrete reforms to guarantee that procurement policies are fair, transparent, and inclusive. FEMHO stands ready to assist in shaping a procurement system that protects all healthcare workers, regardless of background, and ensures equitable access to life-saving resources in future crises.

[20] 'How to do a coronavirus (COVID-19 rapid lateral flow test', UK Health Security Agency, GOV.UK, originally published on 23 December 2020, updated on 30 April 2024 (See the updates).

30. 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.

14 February 2025

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