THE UK COVID-19 INQUIRY
BEFORE BARONESS HALLETT

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

INTRODUCTION

1. These closing submissions are made on behalf of the Federation of Ethnic Minority Healthcare Organisations (FEMHO) for Module 5 of this Inquiry. At the close of this module, it is essential to reflect not only on the findings that have emerged but also on the actionable steps that must follow in order to rectify the procurement failures, racial inequalities, and lack of inclusivity that have characterised the response to the pandemic.

2. The evidence presented during Module 5 has uncovered a series of critical failures in the procurement system, particularly in the provision of Personal Protective Equipment (PPE) to healthcare workers. These failures disproportionately impacted ethnic minority healthcare workers, who were left vulnerable at the height of the global crisis. The underlying issues of procurement and equality, particularly with respect to the Public Sector Equality Duty (PSED), have been glaringly exposed, and it is now time for this Inquiry to not only acknowledge these shortcomings but to make concrete recommendations for systemic change.

3. FEMHO's involvement in this Inquiry has been driven by a deep commitment to ensuring that the voices of ethnic minority healthcare workers are heard and considered in the critical decisions that affect their safety, health, and wellbeing. The need for inclusive procurement practices that respect the diversity of healthcare workers is essential, as these workers remain at the frontline, often facing not only the risk of illness but also the invisible burden of systemic inequality.

PPE Procurement Failures and the Impact on Ethnic Minority Healthcare Workers

4. The heart of Module 5 for FEMHO has been the examination of procurement processes and how these processes failed to adequately protect healthcare workers, particularly

those from ethnic minority backgrounds. Testimonies of key witnesses such as Professor Sanchez-Graells, Max Cairnduff, and Andy Wood illuminated the stark reality that, in the rush to secure PPE, essential principles of transparency, diligence, and equity were sidelined.

5. Witness testimonies and documentary evidence have confirmed that a systemic bias in the design and development of respirator masks, combined with a lack of adequate fit testing, had an outsized impact on ethnic minority workers. The root of this issue in the healthcare sector is that the FFP3 masks standardly procured are designed on the so-called Sheffield Head; based on a White Male face shape and anthropometrics. Unsurprisingly, this design is not suitable for all end-users, with women and ethnic minorities particularly affected. Given the necessity for a tight seal between the face and mask, this means that there is a high failure rate in fit-testing of these products. This results in a significant human impact, as many workers are left without properly protective equipment. Additionally, these masks are incompatible with facial hair and with certain cultural or religious dress, such as turbans or hijabs.

6. This lack of inclusive consideration in the procurement of PPE is a key failure underscored by the Inquiry's expert Professor Sanchez-Graells, who highlighted that the government prioritised speed over diligence with profound consequences. In the absence of inclusive stockpiled options for respiratory PPE, some workers faced impossible decisions (particularly in the early stages of the pandemic) where they might for example have to accept exposure risk, lose work or go against their religious and cultural beliefs and shave their beards.

7. The emergency procurement procedures were implemented in a way that disregarded the foundational principles of public procurement, particularly those that require inclusivity and equity. As Andy Wood pointed out, while the need for urgent procurement was undeniable, this urgency should not have led to the sidelining of PSED obligations. The urgency of a crisis should not diminish the need for equity; rather, it ought to highlight and amplify it. The exclusion of inclusive standards, as the evidence demonstrates, resulted in the failure to provide PPE that properly met the needs of ethnic minority healthcare workers.

8. Emily Lawson's testimony shed light on the reactive nature of steps taken to provide suitable PPE for diverse healthcare workers. It painted a clear picture of a procurement system caught off-guard, not just by the virus, but by its own operational blind spots. Matt Hancock, former Secretary of State for Health and Social Care, offered a candid reflection

on the systemic issues that have long plagued the NHS. He acknowledged that institutional racism exists within elements of the NHS and this recognition sets a crucial context for understanding the pandemic's disparate impact on different communities.[1]

9. Chris Stirling accepted that the initial emergency response protocols did not adequately factor in the diverse needs of our healthcare workforce, particularly ethnic minorities.[2] Matthew Style echoed Stirling's sentiments commenting on a system in which it became apparent that PPE was designed and purchased with a one-size-fits-all approach, and which simply does not work in a society as diverse as ours. Mr Style spoke of the "inputs" into this allocation and procurement system that wouldn't necessarily be picked up in aggregate data. Such "inputs", FEMHO submits, are manifestly vital; clearly there was a missing link or failing in the translation of these inputs to decision-makers and purchasers. Style's reflections highlight the need for systems that are as diverse as the populations they serve and the formalisation of more effective "inputs" into the system.[3]

10. Whilst witnesses pointed to a wider range of sizes and shapes being made available by the end of the pandemic, a clear picture through disclosure review and questioning of witnesses has not formed as to exactly when changes to procurement specifications and/or directions to the "buy teams" were given to diversify the products being purchased.

11. A related issue lies in the reliance on overseas manufacturing and procurement, and the instability of global supply chains resulting in delays and challenges in procuring essential products and low confidence in deals made which at times collapsed after the UK were effectively outbid by another purchaser. FEMHO echoes Mr Manners-Bell's expert recommendation that the UK ought to develop scalable manufacturing capacity with blueprints in place that can be swiftly initiated in the event of an emergency, as well as better management and maintenance of emergency stockpiles.

12. FEMHO's firm position is that the issues with PPE fit were known, entirely foreseeable and a result of institutional inertia and a lack of attention paid to equality issues. Beyond the obvious point that a single size is unlikely to fit all, given the variation in facial anthropometrics, there was already a body of evidence before the pandemic that highlighted and foreshadowed fit issues—evidence that, arguably, should have prompted decision-makers to diversify stockpiles and product specifications. HSE guidance on respiratory protective equipment at work in 2013, for example, specifically highlighted that:

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[1] Matt Hancock [11/138/8 – 11/140/10].
[2] Chris Stirling [9/85/3 – 9/89/19].
[3] Matthew Style [9/118/4 – 9/124/18].

"*People's faces vary significantly in shape and size so it is unlikely that one type or size of RPE facepiece will fit everyone. Inadequate fit will significantly reduce the protection provided to the wearer. Any reduction in protection can put the RPE wearer's life in danger or may lead to immediate or long-term ill health.*"[4]

13. Moreover, it is evident from documents disclosed in this module that DHSC recognised this issue as it was repeatedly listed on an internal risk register from June 2020 onwards: "*that we do not provide inclusive product specifications for all end user requirements e.g. ethnic minorities, those dealing with hearing disabilities etc.*" In a version dated 11 June 2020, this risk is flagged as one of the top 5 programme risks and noted to already be an issue so flagged for discussion.[5] The risk is highlighted dark orange and given scores for likelihood, impact and overall risk. The listed "causes" of the risk in the presentation were described as follows:

"*1. Specifications not previously challenged of wide range of users.*
2. User base larger than previously considered.
3. Product manufactured by new suppliers, not aware of specification details.
4. We are not buying a diverse range of products (e.g. one size, rather than a split)."

The "consequences" listed were:

"1. Product's not fit for all user groups, therefore do not provide adequate protection.
2. Potential media or enquiry attention drawn to specification gaps reducing user group faith in products provided."

Finally, under "Current controls" the presentation states: *DMC and technical authority in place to support specification development and working closely with PHE and HSE."*

14. A later version dated 19 June 2020 again flagged this as a "highlighted risk", this time noting a need to: "*work with NHS and others on modelling differentiated demand from Trust and those who receive PPE via the LRFs (and undertake work on fitting – e.g. respirators) and procure PPE in sizes and types that fits this demand.*"[6] In this version, under the risk ratings for likelihood, impact and overall risk there are mitigated scores as

[4] [INQ000269685_0049].
[5] [INQ000534656_0055-57].
[6] [INQ000513510_0045].

well as the primary risk scores available. In all cases the risk remains "orange" or "red" on the scale.

15. The risk continues to appear on the register thereafter in versions disclosed[7], however there is seemingly little to no further detail available on mitigating action or progress with the aforementioned plans to combat the risk. The scored ratings of the risks also appear to remain unchanged throughout the versions, indicating any action that did take place over this period had little to no impact on the risk.

16. Whilst some witnesses claimed that in recognition of fit issues there was a move to purchase a wider range of products, there is also a distinct lack of supporting evidence to show if and when a direction to do so was issued, and by whom. The evidence of those involved in the "buy side" also seemed to contradict this assertion. Andy Wood, for example, gave evidence that his team bought products as per the "*specification that the NHS was buying before the pandemic and it was the specification we bought within the pandemic, so there was no change in terms of what we were asking suppliers to supply us with*".[8]

17. Whilst Julian Kelly said he thinks consideration was given to the fact that one size would *not* fit all pre-pandemic when setting requirements for the PIPP stockpile[9], Paul Webster's evidence was that: "*the specification didn't involve the sizing element that was clearly, with hindsight, something that would have been beneficial. But at the time, it wasn't… at the time there wasn't that expectation or recognition that size and shape was going to be so important, which is why the specification for FFP3s in the PIPP stockpile were as they were*."[10] Matt Hancock similarly gave evidence that "*the stockpile did not include nearly enough PPE that specifically could be fit tested to non -- essentially non-white features… the pure and straightforward physical differences that need to be taken into account. They were not taken into account enough in the stockpile that we inherited, and that must be addressed*".[11]

18. Helen Macnamara appears to have highlighted and lobbied for action in respect of poor fit of PPE for women from April 2020. Emails disclosed in this module reveal her querying: "*Has the PPE conversation picked up the fact that most PPE isn't designed for female*

[7] [INQ000339236]; [INQ000513509]; [INQ000513514]; [INQ000551651]; [INQ000513513]; [INQ000551658]; [INQ000551661]; [INQ000551664]; [INQ000551670]; [INQ000551671]; [INQ000513508] [INQ000513511].
[8] Andy Wood [4/194/2 – 4/194/23].
[9] Julian Kelly [6/171/12 – 6/172/22].
[10] Paul Webster [6/137/7 – 6/139/16].
[11] Matt Hancock [11/138/19 – 11/139/18].

bodies and yet the overwhelming majority of people who need PPE are women (77% of NHS staff are female, 89% of nurses and 84% of careworkers). There has been quite a bit of commentary on this. To state the bleeding obvious women's bodies are different and particularly face shape with masks. If you need more on this let me know! But would reassuring to know that it is being taken into account in this new supply. I didn't know who to annoy with this so chose you. But by all means tell me where to better direct my questioning."

19. One response to this email confirmed: "*I have not heard it discussed at all at the top level meetings*". Simon Ridley also replied: "*I will be honest: it is not something that's been in conversations I have had thus far.*"[12] There is a later follow up email stating: "*Astonishing. 2 weeks later and finally raised in one of these meetings.*"[13] No evidence of similar lobbying by senior officials on behalf of ethnic minority workers has been located and it was some considerable time even after these exchanges that workers on the frontline were able to access a wider range of PPE sizes and shapes.

20. Had there been tighter consideration of equality, diversity and inclusion principles and duties by those involved, decisions might have gone through additional filters or safeguards and there could have been earlier changes made to specifications and more options available on the frontline at an earlier stage. By the time there was a signal change to the "buy side" to diversify the products being purchased, however, many lives had already been lost. Lives would have continued to be put at risk even after the decision to diversify purchases was made whilst appropriate products were sourced, purchased, checked, delivered and distributed. This unconscionable delay must never be repeated.

21. Powered Air Purifying Respirators (PAPR / hoods) were often cited as another alternative option for healthcare workers —particularly for minority ethnic individuals and others for whom standard PPE did not provide a protective fit due to factors such as face shape, facial hair, or cultural dress—since a close facial seal is not a prerequisite for this equipment. Indeed, there existed prior to the pandemic IPC guidance about the use of PAPR as alternative PPE for individuals with beards and/or for others who could not

[12] [INQ000286049_0002].
[13] [INQ000286059_0001].

achieve an adequate fit.[14] PAPR continued to be referred to as an alternative to FFP3 masks both in guidance at the time and in witness evidence in this Inquiry.[15]

22. Minutes of a NERVTAG meeting on 28 January 2020 discussed the potential use of hood respirators, noting not only that they "*are not currently available within the NHS*" but that "*hoods are being brought up globally and should a decision be made later this could pose a risk in terms of availability.*" A decision was made that: "*There was not any clear evidence at this time that would suggest that hoods may be needed now or in the future of this incident*."[16]

23. Jonathan Marron of the Department of Health and Social Care (DHSC) gave evidence to the Inquiry that 2,500 PAPR were later purchased in April 2020 for use within the NHS and that Public Health England (PHE) arranged their onward distribution. He states that they remained a catalogue item for SCCL available for direct purchase throughout the pandemic.[17] However, a DHSC Programme Delivery Board presentation dated December 2020 noted amongst key updates that a discussion had commenced "*re powered hood provision to those unable to use FFP3 masks.*"[18] It stated that finance were investigating options of "*provision/reimbursement/grant/tax benefits*" but it had been "*agreed in principle that provision of hoods is not possible – due to number of models and manufacturers this also applies to spares and battery packs*." Under recommendations / next steps the slide confirmed a decision had been made that DHSC was "*unable to provide powered hoods to colleagues unable to use FFP3 masks.*"

24. It was around the same time as this documented decision, that Professor Paul Elkington on behalf of the University of Southampton says in his witness statement that they were then contacted out of the blue and asked if they could provide 100,000 of their PeRSos PAPR product for immediate deployment; this followed months of up-until-then unsuccessful lobbying for NHS England to implement widespread PAPR use.[19]

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[14] See, for example, 2016 guidance from Public Health England re: MERS-CoV [INQ000022734]; PHE Guidance dated 15/01/20 [INQ000074966_0004]; HSE briefing dated 23/04/20 [INQ000529211_0016]; Historic guidance on PAPR provision for those with facial hair was also specifically flagged in a meeting of NERVTAG on 27 March 2020 – [INQ000220132_0007]
[15] See, for example, South Warwickshire University NHS Foundation Trust [INQ000515876_0012 §66]; Fiona McQueen, CNO of Scotland [INQ000502216_0008, §27]; Dr June Brown on behalf of the Grampian Health Board [INQ000514289_0019, §101] Julian Kelly of NHSE [INQ000528585_0053-54, §243]; Jonathan Marron of DHSC [INQ000528391_0188, §711]; and Neil Guckian on behalf of the Western Health and Social Care Trust [INQ000536166_0009-0011, §24].
[16] [INQ000119614_0010, §5.6].
[17] [INQ000528391_0188, §711].
[18] [INQ000551692_0004].
[19] [INQ000581862_0003, §9].

25. Evidence heard from witnesses and seen in documents disclosed[20] accords with the common recollection amongst FEMHO's membership that PAPR products were rarely available to staff. By way of illustration, the BMA reported feedback to PHE in April 2020 that: "*There is a lack of alternatives to standard PPE for those with religious needs or those who need adjustments for their disability — e.g. PAPR hoods for those who cannot get FFP3 mask to fit because they wear a beard for religious reasons*."[21]

26. Despite the clear articulation of need, from the evidence reviewed there is little indication that this feedback was acted upon in any systematic or timely way and it appears that there was no real drive to procuring more of this equipment. The continued inaccessibility of such alternatives speaks to a failure to accommodate diversity in PPE provision at a structural level, and the continued prevalence of structural discrimination in society as a whole.

27. Cost is often cited as an underlying reason for the lack of procurement and supply of this type of equipment. However, evidence suggests that the overall cost difference was not significant and due to the reusable nature of PAPR equipment could even work out more cost effective over time.

28. The Inquiry heard evidence in Module 3 in relation to PAPR, 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.[22] Despite the alternative options available, however, single use "one size fits all" masks, requiring face fit testing, became the default and PAPR was rarely made 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.

29. The lack of suitably designed respirator options and fit testing to account for diverse facial features directly undermined the safety of ethnic minority healthcare workers, leaving them vulnerable to exposure, infection, and even death during the pandemic.

30. The emotional trauma and grief borne by families who lost loved ones and the healthcare professionals who did they best to care for them risking their own lives due to inadequate protective measures are profound and must be addressed. Module 5 was the first set of

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[20] See, for example, BMJ Article dated 05/01/21 'Frontline healthcare workers' experiences with personal protective equipment during the COVID-19 pandemic in the UK: a rapid qualitative appraisal' which noted the lack of PAPR hoods available for staff [INQ000493399_0008].
[21] [INQ000117851_0007].
[22] [Module 3 Transcript Day 4, [4/38/10 – 4/39/11].

hearings in this Inquiry in which impact witness evidence was not heard. The absence of this powerful reminder of the very human and personal impact and cost of the subject-matter under examination was sorely felt. FEMHO trusts that the Chair and the Inquiry team will keep individual testimony from previous modules, and written impact evidence prepared for Module 5 at the forefront of their minds when considering the procedural evidence heard more directly and drafting the report and recommendations.

Lack of engagement and consultation

31. Oversights in the design and stockpiling of PPE were exacerbated by a lack of consultation with relevant stakeholders, including minority ethnic organisations and healthcare providers who could have helped to identify and address these needs early in the process.

32. This apparent oversight is all the more troubling given the importance of engagement and support for the success of public health emergency responses was recognised as far back as 2007, when the Department of Health and the Cabinet Office report 'National Framework for Responding to an Influenza Pandemic' noted: *"Even well developed and robust local plans and preparations are unlikely to be successful during a pandemic without the active support of individuals, families, faith groups and communities."*[23]

33. It was not until March 2021 that DHSC commissioned the CO-COVID-19 Taskforce Field Team to consult directly with health and social care frontline workers.[24] In his witness statement, Jonathan Marron says this focused particularly on those from ethnic minority backgrounds to better understand their experiences of PPE, and that the findings included:

"a. Some staff felt that they had been given lower priority than others in PPE provision. These staff were more likely to include those working in social care; those working in more deprived areas where rates of COVID-19 and mortality tended to be higher; and those working where the proportion of frontline workers from ethnic minority backgrounds was higher;

b. A lack of confidence in some to raise concerns or a feeling that they would not be listened to;

c. Reports that that the fit of PPE should have been better, the range more varied, and a request for approved clear masks;

d. Clearer national PPE guidance that is consistently communicated to frontline staff; and

[23] [INQ000022690_0089].
[24] See statement of Jonathan Marron of DHSC [INQ000528391_0217, para 806].

e. Requests for greater agility in future emergencies, recognising that there were many positive lessons learned from the pandemic experience."[25]

34. FEMHO considers this was a valuable exercise, but one which should have taken place much earlier in the pandemic. Had it been done sooner, the issues facing ethnic minority staff could have been better understood and procurement decisions altered to ensure a wider range of protective equipment purchased and distributed to ensure equality in access to suitable, well-fitting PPE.

35. Ultimately, Jonathan Marron admitted in his oral evidence that this is an area they can "*do a much better job*" in.[26] As Rosemary Gallagher noted, within PPE procurement teams "*the clinical voice was completely absent*."[27] It is also notable and fair to reflect on the fact that the key decision-makers responsible for the health sector who gave evidence about these issues to the Inquiry are themselves not from ethnic minority groups and thus lack lived experience and perspective. While there remains a continued absence of diversity in leadership, this makes proper engagement all the more important.

36. DHSC acknowledged feedback in its Lessons Learned review that: "*engagement with different ethnic and marginalised groups was limited and, when it did occur, there was little opportunity for teams to get feedback on the practical implementation of published guidance.*"[28] This inevitably had a knock on impact on distribution, as without clear insights and data on needs of local workforces, decision-makers lacked valuable information. Andy Wood agreed that advisory panels in future ought to be "*representative of the customer base, which, you know, is all ethnicities*".[29]

37. The lack of oversight and/or exclusion from engagement and consultation on decisions is a key reminder of the structural discrimination and inequality that ethnic minority communities continue to face in all aspects of life. Day to day decisions continue to be made across the UK without these voices being heard or understood and as a result steps taken often don't meet the needs of those marginalised population groups; it is a reflection of systemic inertia and discrimination.

38. FEMHO considers it essential that future procurement must break away from this pattern and not only hear but actively incorporate the voices of diverse communities to ensure that

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[25] [INQ000528391_0218, para 806].
[26] Jonathan Marron [3/214/2 – 3/215/12].
[27] Rosemary Gallagher [10/47/16 – 10/48/17].
[28] [INQ000551480_0010, para 8.4].
[29] Andy Wood [4/196/3 – 4/197/2].

the needs of all are met effectively and equitably. In particular, it hopes the Government will follow through on its Lessons Learned report recommendation: "*that future pandemics should ensure that NHS staff from BAME backgrounds are included in emergency planning and decision-making structures.*"[30] Further detail and specifics on how the promised changes in the government's lessons learned reports are to be achieved would be gladly welcomed by FEMHO; otherwise its members fear they will remain aspirational and in the event of a further pandemic or public health crisis they will be facing the same issues and the same outcomes.

Reflection on Testimonies and Evidence

39. Throughout this Inquiry, we have heard testimony after testimony, each painting a stark picture of a procurement process fraught with lapses in inclusivity and transparency. Sir Christopher Wormald's evidence in Module 1 confirmed that the DHSC had stocked lower levels of PPE, specifically respirators suitable for Black staff, and that little planning had been done to consider the equality of PPE provisions[31]. This was a clear failure to ensure that all healthcare workers were given equal protection and access to adequate safety equipment during the pandemic.

40. Furthermore, the powerful evidence presented throughout Module 3 highlighted the human impact and harm caused by inadequate PPE supplies, as well as racial bias in key equipment such as pulse oximeters. Matt Hancock, former Health Secretary, admitted in his oral evidence that 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.[32] Sajid Javid was unable to confirm whether by the time he assumed the role of Health Secretary—or at any point thereafter—PPE supplies had been diversified to accommodate a broader range of people.[33] This evidence clearly underscores the deep racial disparities embedded within the healthcare system and set the scene for Module 5's exploration of how these disparities were exacerbated by procurement decisions.

41. In particular, FEMHO asks the Inquiry to remember the powerful evidence provided by Professor J. S. Bamrah on behalf of FEMHO. His testimony revealed the persistent and

[30] [INQ000087223_0011-12].
[31] [PHT000000005_0037-38].
[32] [PHT000000130 192/19 – 196/9].
[33] [Module 3 Transcript 37/58/19 – 37/60/9].

widespread nature of the issues that members faced as a result of inadequate procurement:

"*The consistent picture from across our members was one of discrimination through unavailability or inadequate PPE and fit testing rejection… Our members were routinely expected to go onto high-risk clinical areas without adequate PPE, if any at all… many of our members felt they were pressured into this and did not have the discretion to refuse. Even some pregnant nurses were threatened with disciplinaries if they refused.*"[34]

42. Issues of trust and transparency were central to the evidence heard in this Module. FEMHO echoes the recommendations made by the Inquiry expert Professor Sanchez-Graells, and the submissions made in oral closings by the bereaved family groups and the UK Anti-Corruption Coalition as to the damage and harm caused by the special treatment of official's referrals and alleged profiteering and the need for honesty, transparency and candour to be a key lesson learnt. It was, in FEMHO's view, distasteful and tone-deaf at best for those involved to attempt to belittle and deflect questions in the way they did, given the severity of the issue and its harmful impact.

43. This testimony highlights the direct, human toll of the procurement failures, where ethnic minority workers were not only left exposed but also subjected to unethical pressures to continue working in unsafe conditions. The situation was compounded by instances of disciplinary threats made against workers, including pregnant nurses, if they attempted to protect their own health by refusing to work without adequate PPE. FEMHO members recall all too easily the palpable fear that underscored the tangible human costs of procurement failings; this must not be permitted to happen again.

The Public Sector Equality Duty and Systemic Failures

44. The Public Sector Equality Duty (PSED), as enshrined in UK law, mandates that all public authorities, including those responsible for procurement in healthcare, must have due regard to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between people of different protected characteristics. Yet, as evidenced during this Inquiry, the PSED was repeatedly sidelined in the rush to secure PPE and other supplies.

[34] [INQ000399526_0008, §24].

45. In the early stages of decision-making, it appears that the PSED was not analysed or considered at all. For example, a March 2020 submission to the Secretary of State concerning efforts to 'ensure rapid PPE availability to NHS England,' disclosed in this module, included a cover sheet with tick boxes to indicate actions taken.[35] Notably, the PSED box had not been ticked, indicating no equality analysis had taken place. This, in FEMHO's view, is a grave missed opportunity as, had it been, there may have been more consideration given to the diverse needs of the workforce and a wider range of PPE obtained from the outset.

46. The Judgment in the Judicial Review launched by the Good Law Project and the Runnymede Trust also noted that "*There is no evidence from anyone saying exactly what was done to comply with the public sector equality duty when decisions were taken on how each appointment was to be made*" on the appointments of Dido Harding and Mike Coupe.[36]

47. The DHSC, in its Lessons Learned Review dated September 2020, stated that there had been: "*insufficient data available to consider equality issues around PPE provision*" but that a retrospective equality impact assessment was being undertaken to *"help address these concerns*."[37] By September 2020, of course, it must be remembered that countless healthcare workers had already lost their lives, including a disproportionate number of minority ethnic staff.

48. This oversight is not a mere procedural failing; it is a breach of fundamental legal duties that are designed to protect the most vulnerable in society. Specifically, it is arguable that there were breaches of the European Convention on Human Rights Articles 2 (right to life) and 14 (discrimination), as well as the Equality Act 2010.

49. Concern over this was raised by many at the time. By way of example, the Sikh Council UK wrote to the Health and Safety Executive in May 2020, in relation to the requirement to be clean shaven to wear most respirator masks. It explained:

"*It is one of the fundamental tenets for a practicing Sikh to NOT cut any bodily hair for it is as the great Creator has made us. As such, the person who has chosen to follow the Sikh way of life, means he/she has made a solemn promise to maintain a strict code of conduct. For Sikhs, their duty of care is intrinsically interlinked with their faith. Therefore, we ask*

[35] [INQ000551543].
[36] [INQ000176449_0032, §116].
[37] [INQ000551480_0008].

that no Sikh healthcare professional is forcibly made to choose between breaking their faith or breaking their front line roles to help patients. This would also be in breach of the Equality Act 2010."[38]

50. A potential workaround was suggested by the Sikh Council, and HSE was also contacted separately about the "Singh Thattha" method, another alternative designed by members of the public to try and enable existing masks to provide a protective fit for those with facial hair. Richard Brunt of HSE, however, explained in his witness statement that the HSE rejected these suggestions.[39]

51. As made clear in testimonies and documentary evidence, the lack of adequate safeguards, such as proper impact assessments and inclusive procurement processes, resulted in decisions that disproportionately harmed ethnic minority workers. Every decision that deprioritised the PSED not only undermined legal mandates but also compromised the very lives it sought to protect.

52. Alarmingly, evidence heard during the hearings demonstrated a misunderstanding or ignorance to key issues even today. FEMHO members were shocked, for example, to hear Max Cairnduff – a key decision-maker and director involved in procurement decision-making at the Cabinet Office – say "*The PPE is itself, I think, I may be wrong, relatively agnostic: a mask is a mask*".[40] This shortsighted and ill-informed view is deeply troubling and suggests that despite the wealth of evidence aired, these issues are not being taken seriously and lessons have not been learnt.

53. Andy Wood did not seem to have an understanding of what PSED is.[41] Chris Young admitted it "*was not something that [he] had personal consideration of*".[42] Tim Jarvis' response when asked whether to his knowledge PSED was discussed or considered in relation to procurement decisions simply replied: "*I don't know.*"[43] Dr Jandziol had "*no visibility of how that was established to take into account equalities*".[44] Jean Freeman was open in admitting: "*there can be a temptation in Scotland, I think, if I'm completely frank, to say that this is an issue that we don't have much of, and I think that's (a) not correct, not accurate, and (b), it doesn't actually matter, in terms of whether you do or not. You should still be doing it.*"[45]

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[38] [INQ000269687].
[39] [INQ000560897_0077-78], see in particular §296-298.
[40] Max Cairnduff [4/62/18 – 4/63/11].
[41] Andy Wood [4/192/22 – 4/193/12].
[42] Chris Young [14/49/24 – 14/50/25].
[43] Tim Jarvis [7/36/19 – 7/37/19].
[44] Dr Jandziol [8/170/4 – 14].
[45] Jean Freeman [13/44/15 – 13/45/20].

54. Others—particularly those on the "buy side" – sought to deflect responsibility and shift blame to those responsible for setting product specifications, claiming that they simply sourced and purchased what they were instructed to.[46] It is therefore crucial that this Inquiry recommends stringent guidelines to ensure that PSED is not only considered, but embedded as an integral component of all procurement decisions.

55. FEMHO advocates for more inclusive procurement practices. What happened during the pandemic, and the ambivalence shown towards equality duties, highlights the need for a procurement process that actively considers the diverse needs of the workforce, including ethnic minority workers. This Inquiry has exposed how these needs were ignored or inadequately addressed. It is now evident that a more robust, inclusive procurement framework is essential — one that embeds equity at the heart of emergency preparedness.

Inequalities in testing procurement and provision

56. Although addressed in less detail than PPE, the procurement of testing was also an important area of focus in this module. The evidence confirms that inequalities and structural discrimination were both embedded in the process and exacerbated as a result of it. Andrew Lewis, for example, noted in his witness statement on behalf of Liverpool City Council that LFT testing was lowest in the most deprived areas, and challenges with digital exclusion, language barriers, misinformation, fear of income loss from self-isolation and wider socio-economic inequalities proved to be a "*substantial challenge*" which had not been factored into planning for, or the roll out of the system.[47]

57. A report from the National Audit Office in December 2020 noted that familiarity with the process for booking a test had been flagged as: "*especially low among people from black, Asian and minority ethnic communities, with a majority unaware of the 119 coronavirus test booking service.*"[48] The system for supporting the roll out of testing had thus failed to ensure adequate communication and information sharing to achieve maximum participation.

58. Common barriers faced —such as lack of private transport, inability to work remotely, limited time available to travel to test centres, concerns about self-isolation and its financial

[46] See, for example, Gareth Rhys Williams [3/119/13 – 3/121/12]; Max Cairnduff [4/62/7 – 4/64/8]; Andy Wood [4/192/22 – 4/193/12]; Tim Jarvis [7/36/3 – 7/36/18]; Steve Barclay [7/161/3 – 7/163/1]; Jonathan Irvine [14/148/20 – 14/149/15]; and Richard Davis [14/177/14 – 14/178/2].
[47] [INQ000521967_0027].
[48] [INQ000421476_0047].

impact, and digital exclusion—were not properly taken into account in the decision-making around the procurement and implementation of the testing regime. Dr Jandziol (a commercial specialist who worked in the complex transactions team at Cabinet Office) gave evidence that there was a reactive push to increase access via home testing kits, but was unable to recall any targeted action to increase access for ethnic minority communities.[49]

Racial bias in medical equipment procured and utilised during the pandemic

59. In Module 3, FEMHO made detailed submissions regarding the procurement of racially inclusive medical equipment and the historic ambivalence and structural inequalities that led to key equipment such as pulse oximeters being designed and developed in a way that ultimately created a dangerously non-inclusive product.

60. Pulse oximeters were a critical diagnostic tool utilised during the pandemic, not just in hospital settings but in GP surgeries and in home care and monitoring. Despite there being research dating back to the 1990s suggesting systemic issues with the functionality of these devices, it was not until well into the Covid-19 pandemic that the issue gained widespread attention prompting long-overdue action to be taken. The NHS Race and Health Observatory in a report dated March 2021, for example, confirmed at this time that: "*pulse oximeters consistently overestimated oxygen saturation during hypoxia in individuals with darker skin tones.*"

61. As noted in FEMHO's closing statement for that module, "*The failure of pulse oximeters to accurately measure oxygen saturation in individuals with darker skin tones stands as a stark symbol of structural racism and inequality embedded within healthcare. This issue is not merely a technical flaw but a manifestation of systemic neglect that has perpetuated health disparities and undermined trust in medical systems.*" FEMHO submits that the failure of procurement teams to identify and rectify this issue in a timely manner demonstrates a similarly stark reflection of the credence given to this issue.

62. In addition to the issues with pulse oximeters, wider research has identified racial biases in the performance and functionality of other equipment. As reported by the 2024 DHSC Independent Review into Equity in Medical Devices, this includes infrared thermometers, AI-enabled devices and polygenic risk scores in genomics.[50]

[49] Dr Jandziol [8/166/3 – 8/170/13].
[50] [INQ000438237].

63. Sajid Javid who commissioned this review during his tenure as Health Secretary, stated the following in his witness statement to this Inquiry: : "*The main policy proposal that I thought of to tackle this was that if the US and the UK - who are the two biggest purchasers of medical equipment in the world insisted that it would only purchase products which had been tested in all races, then global manufacturers would do so.*" He goes on to explain that he raised this with his US counterpart but *"it did not come to fruition because I resigned*".[51] Putting aside the obvious question as to why the UK could not take action and insist on such requirements without US support, FEMHO considers the collapse of this initiative due to Mr Javid's resignation to be a significant step backwards.

64. The fact that devices procured and utilised as key medical equipment failed to work effectively on all skin tones —and that this known issue was left to persist with no suitable alternatives procured—provides, in FEMHO's view, clear evidence of systemic biases that continue to persist. It follows directly that devices designed and procured without proper diversity considerations are more likely to lead to adverse outcomes putting individual's lives in danger and exacerbating distrust and perceptions of neglect.

65. The lack of inclusivity in healthcare planning and procurement has persisted far too long. The time for action is now. FEMHO urges the Inquiry to make robust recommendations given the clear and urgent need for reform in this area.

The Need for Inclusivity in Future Procurement Processes

66. In the wake of these failures, it is imperative that future procurement processes are built on the principles of transparency, accountability, and inclusivity. The evidence presented during Module 5 has shown the devastating consequences of failing to consider the specific needs of ethnic minority healthcare workers, not just in terms of PPE but also in policy development, workplace safety, and systemic reforms. FEMHO's contribution has been essential in highlighting these issues, and it urges this Inquiry to consider the following key recommendations:

    a) Inclusive Procurement Framework: FEMHO calls for the establishment of a comprehensive, inclusive procurement framework that holds decision-makers to account and explicitly includes provisions for requiring suitably diverse PPE specifications, ensuring that all healthcare workers, irrespective of race or ethnicity,

[51] [INQ000302485_0027, §85].

have access to equipment that fits their needs. Internally at the NHS, experience clearly demonstrates that unless leaders are given clear and mandated direction on issues there will be no change; the system works to rules and if there is no rule incentivising or commanding action it unfortunately will not follow no matter how many recommendations are made.[52] Clear protocols, requirements, principles and operating procedures are needed therefore to effectively change course. FEMHO have sought to outline suggested amendments to core NHS procurement literature including the Terms and Conditions for the Supply of Goods and the Provision of Services and the NHS Standard Contract in Annex 1 to this closing statement. Such changes, FEMHO submits, would provide for appropriate and tighter protection and guardrails for equitable operation.

b) Consultation with Stakeholders: Future procurement processes must include meaningful and ongoing consultation with stakeholder organisations, including ethnic minority healthcare workers and representative bodies like FEMHO, to ensure that the voices of those most affected are heard early in the decision-making process. It is vital that the needs of marginalised population groups are appreciated and properly understood; evidence underscores this is best done via representatives with lived personal experience and insights to bring to the table.

c) Accountability for PSED Compliance: It is essential that all future procurement processes comply with PSED requirements. There should be more stringent mechanisms for monitoring compliance, ensuring the spirit of the legislation is achieved and that those responsible for any failures to meet these obligations are held to account. Equality requirements and guidelines ought to be built into public contracts to affect a mindset and procedural shift in industry handling and responsibility for minimising inequality through their provision of services. As a minimum there ought to be a firm stipulation for suppliers and manufacturers to demonstrate adherence to equality, diversity and inclusion principles and duties.

d) Diversity in Leadership and Oversight: To avoid future procurement failures, it is critical that leadership positions within the procurement and health systems includes diverse perspectives, including those from ethnic minority communities. Diversity in decision-making roles will ensure that the needs of Black, Asian, Minority Ethnic healthcare workers are understood and prioritised at every level of the procurement process.

[52] By way of positive example and outcome, since a directive was made at NHSE level, ethnicity data is now routinely collected within post-mortem investigations. Before the directive, although it was a known issue there was little recording of this data.

Key Takeaways from Module 5

67. Systemic Failures in Inclusive Procurement:

    The procurement processes during the pandemic were marred by a lack of inclusivity, particularly concerning the needs of ethnic minority healthcare workers. The failure to design and procure PPE that met the diverse needs of the workforce resulted in undue exposure risks for many healthcare workers, exacerbating racial disparities in healthcare safety.

68. Sidelining of Public Sector Equality Duty (PSED):

    The PSED, which mandates consideration of equality in public procurement, was routinely overlooked during the pandemic. This failure, compounded by a broader lack of understanding and implementation of inclusive policies, resulted in discriminatory PPE provision and unsafe working conditions for ethnic minority healthcare workers.

69. Urgent Need for Systemic Reform:

    The evidence has underscored the urgent need for systemic reform in procurement processes. Future procurement must ensure that equality and inclusivity are embedded from the outset, addressing the gaps exposed during this Inquiry to create a more equitable healthcare system for all healthcare workers, regardless of ethnicity.

Conclusion

70. The three key takeaways above, and the suggestions contained within the Annex to this closing statement, should serve as the foundation for the work that follows this Inquiry. The systemic failures in inclusive procurement, the repeated disregard for PSED, and the urgent need for reform compel us to move beyond reflection on past mistakes and toward meaningful change. We must act with a clear sense of urgency to reshape procurement practices and integrate inclusivity at every level. We have the opportunity to rebuild not just for resilience but for fairness, ensuring that our systems are capable of protecting all members of society equally.

71. It is clear that the failures identified during this Inquiry have had a lasting impact on the health and safety of ethnic minority healthcare workers, leaving them exposed and vulnerable during a global crisis. Many are still suffering with Long Covid; others continue to be affected by the psychological toll of losing friends and colleagues, and by what they

endured personally on the frontline. The evidence revealed here highlights gaps in the procurement system and underlying inequalities due to wider societal structural discrimination that must never be allowed to persist. FEMHO's participation in this Inquiry has been essential in raising these critical issues, and it urges the Inquiry to take decisive action to rectify these systemic failures.

72. However, the failures revealed in this Inquiry should not be seen as an endpoint, but as a catalyst for meaningful reform. This Inquiry has provided us with clear insights into the gaps and oversights within our healthcare systems, but we must now look ahead, with a sense of purpose and urgency, to implement the changes necessary to safeguard the lives and wellbeing of all healthcare workers, irrespective of their ethnicity.

73. FEMHO believes that the road to reform lies not just in acknowledging past mistakes, but in re-envisioning a healthcare system that places equity and inclusivity at the heart of all decision-making processes. The evidence gathered through this Inquiry must drive the development of a proactive—rather than reactive—procurement framework. We must ensure that, in future health crises, procurement processes are designed with equity as it's foundation, not as an afterthought.

74. This is not merely about fixing broken systems; it is about transforming those systems to be fit for a diverse society. A society in which ethnic minority healthcare workers, and all those who serve on the frontlines, are valued, protected, and respected. A society where inclusive procurement practices are not the exception but the norm, and where transparency, accountability, and diversity are integrated into every facet of healthcare policy and practice. For this we need better data systems and collation, better engagement and consultation between senior leadership and minority groups to build trust and understanding of need, better identification and protection for the vulnerable, more inclusive decision-making, more stringent adherence to equality duties and incentives or mandates embedded in processes along with proper scrutiny to ensure the fulfilment of these objectives across the country.

75. As this Inquiry moves towards its conclusion, FEMHO calls for systemic change that will lead to the creation of a more inclusive, fair, and equitable healthcare system. One that learns from its past mistakes, embeds effective check points in systems and actively paves the way for an equitable healthcare system; a system where the safety and needs of every healthcare worker, irrespective of their ethnic background, are not just considered but are held central and protected. FEMHO asks that the recommendations of this Inquiry reflect

the need for transformational change, to move beyond generalised proposals and piecemeal adjustments and towards an overhaul of procurement processes that places equality at their core.

76. FEMHO believes that the lessons learned from this Inquiry must be used to inform future policy decisions, ensuring that the diverse needs of the healthcare workforce are properly considered in all future emergency responses. Let this be a turning point—not only to acknowledge the failures of the past, but to embrace a future built on a commitment to equitable care for all, underpinned by inclusive procurement practices that reflect and support the diversity of the workforce at the heart of our healthcare system.

77. FEMHO remains steadfast in its commitment to supporting the Inquiry's efforts in crafting a healthcare system that not only survives future crises but thrives by recognising the strengths and contributions of all its members, regardless of background, ethnicity, or experience. FEMHO thanks the Chair and Inquiry team for their attention to these critical issues and stand ready to assist in any way that may ensure that this Inquiry's findings lead to lasting, positive and meaningful change.

ANNEX 1

Amendments to NHS Procurement Practices: A Commitment to Anti-Racist Reforms

The testimony presented during Module 5 has clearly shown that the procurement process failed to adequately address the diverse needs of minority ethnic healthcare workers. To prevent a repeat of these systemic failures and to ensure that procurement practices support all workers equally, FEMHO proposes a series of amendments to both the NHS Terms and Conditions for the Supply of Goods and the Provision of Services and the NHS Standard Contract. These proposed changes are designed to embed anti-racist practices into the procurement process, ensuring diversity, equity, and inclusivity at every level.

Suggested amendments to the NHS Terms and Conditions for the Supply of Goods and the Provision of Services

1. Mandate Diversity and Inclusion Audits (Schedule 2, General T&Cs)
FEMHO proposes the introduction of a clause that requires suppliers to conduct and report on annual diversity and inclusion audits. These audits should track workforce diversity, pay equity, and representation in leadership positions within the supplier's organisation. By requiring suppliers to engage in anti-racist practices and foster a diverse supply chain, the NHS can better align procurement practices with the values of equality and fairness. This will ensure that suppliers are actively working to reduce disparities and that those contributing to the healthcare supply chain are committed to equality.

2. Implement Anti-Racist and Social Value Scoring in Tender Processes
It is essential to update the tender evaluation criteria to include anti-racist practices and social value contributions. This should assess a supplier's commitment to fair employment practices, support for minority-owned businesses, and efforts to reduce racial discrimination within their organisation. By embedding these criteria, NHS procurement will prioritise suppliers who actively contribute to equity and anti-racist initiatives, ensuring that the supply chain is inclusive and reflective of NHS values.

3. Add Supplier Diversity Requirements (Schedule 1, Key Provisions)
A specific percentage of procurement spending should be directed toward minority-owned businesses or suppliers with a demonstrated commitment to anti-racist practices. Additionally, targets should be flexible to account for local demographics and be managed regionally through NHS England. Promoting supplier diversity will not only support economic empowerment for minority communities but also ensure a more inclusive and representative supply chain for the NHS.

4. Enforce Anti-Racism Training and Policies (Schedule 3, Information and Data Provisions)
FEMHO proposes requiring suppliers to implement anti-racism training for their employees and provide evidence of anti-discrimination policies. Suppliers must also report any incidents of racial discrimination, along with actions taken to address these issues. This will ensure that suppliers align with the NHS's commitment to an inclusive environment and prevent discriminatory practices, reinforcing anti-racist values across the supply chain.

5. Introduce Accountability Measures for Non-Compliance (Schedule 2, General T&Cs)
To enforce these anti-racist provisions, FEMHO proposes the inclusion of specific penalties or contract termination rights for non-compliance with the diversity, inclusion, and anti-racism provisions. A corrective action period should also be included before penalties apply. These measures will ensure that non-compliance with equity standards is addressed swiftly, reinforcing the seriousness of anti-racist commitments within the NHS procurement process.

Suggested amendments to the NHS Standard Contract: Strengthening Anti-Racism Accountability

In addition to changes to the NHS Terms and Conditions, FEMHO proposes key amendments to the NHS Standard Contract to further embed anti-racism in procurement and service delivery:

1. Mandate Supplier Diversity in Procurement Processes (GC12 Assignment and Sub-Contracting)
FEMHO advocates for a provision that requires suppliers to source a specified percentage of their supplies from minority-owned businesses or organisations committed to anti-racist practices. Suppliers who support minority ethnic communities through employment and community engagement should be incentivised and held to account. This will promote inclusivity and economic empowerment for minoritised groups within the NHS supply chain.

2. Anti-Racism Accountability and Reporting (GC8 Review and GC15 Governance)
FEMHO recommends requiring providers to undergo regular anti-racism audits and report findings to relevant NHS oversight bodies. These reviews should assess inclusivity in service delivery, management representation, and policies to prevent racial discrimination. Regular reporting and accountability measures will encourage providers to prioritise anti-racist practices and hold them to high standards of inclusivity.

3. Strengthen 'Freedom to Speak Up' Provisions for Racial Discrimination (GC5 Freedom to Speak Up)

FEMHO proposes enhancing protections for staff reporting racial discrimination by introducing specific anti-racist policies within the 'Freedom to Speak Up' frameworks. Staff should be

encouraged to report racial biases, with protections against retaliation. Strengthening these protections ensures that whistleblowers feel safe and supported in reporting instances of structural racism, allowing the NHS to address these issues swiftly.

4. Integration of Anti-Racism Goals in Performance and Remedial Action Plans (GC9 Contract Management)

FEMHO recommend that performance and remedial action plans include clear goals related to diversity, equity, and inclusion. Providers who fail to meet diversity standards or fail to improve ethnic minority representation in their workforce should face penalties. This ensures that anti-racism objectives are embedded into the day-to-day operations of NHS providers, driving consistent progress in combating discrimination.

Conclusion

The need for systemic reform in NHS procurement is clear. The failures revealed throughout this Inquiry have shown that ethnic minority healthcare workers were disproportionately impacted by inadequate PPE and discriminatory practices in procurement. FEMHO calls for actionable change, where inclusive procurement is embedded into the NHS's operational framework, and where anti-racist practices are embedded at the heart of every decision made.

FEMHO is confident that, should the Inquiry advocate for these reforms, it will help build a healthcare system that not only withstands future crises but thrives—ensuring that ethnic minority healthcare workers are protected, valued, and respected. By incorporating these anti-racist reforms, the NHS can better serve its workforce, address historical inequalities, and ultimately provide equitable care to all communities.