Witness Name: Rt Hon Kemi Badenoch MP

Statement No.: 3

Exhibits: 71

Dated:

THE UK COVID-19 INQUIRY

THIRD WITNESS STATEMENT OF KEMI BADENOCH

I, Kemi Badenoch, will say as follows.

Introduction

1. The Government work at the focus of Module 7 was led by the Department for Health and Social Care, a department at which I did not serve as a minister. My former colleagues in the Office for Equality and Opportunity (formerly known as the Equality Hub) provided data to support the test, trace and isolate system where appropriate.

2. I make this statement to describe my role between 14 February 2020 and 28 June 2022 as Minister for Equalities in relation to the government's test, trace and isolate ['**TTI**'] system during the Covid-19 pandemic. I returned to government following maternity leave in April 2020. The statement is based upon information and documents within my

personal knowledge, information provided to me by former colleagues within my Private Office and the Office for Equality and Opportunity (formerly known as the Equality Hub), and my own experience of the functions and operation of government. I recognise that further documents and emails might be brought to my attention in due course, and I would welcome the opportunity to supplement, clarify or update my evidence, if necessary, in the light of any such documents. The statement should be read with my written and oral evidence in relation to Modules 2 and 4, and the corporate statements of the Equality Hub in Module 2 and Cabinet Office in Modules 4 and 7.

3. During the pandemic, I was asked by the then Prime Minister to assess the disproportionate impact of Covid-19 on different groups and work with others to mitigate it. My top priority was improving the quality of evidence and data about disparities and how best to overcome them – this included statutory protected characteristics but also other factors, including socio-economic background and geography.

4. In relation to TTI specifically, the Government's work was led by the Department for Health and Social Care (DHSC) and the Ministry of Housing Communities and Local Government (MHCLG). The work of the Equality Hub comprised:
   a. encouraging better quality data collection to highlight levels of engagement in TTI,
   b. improving public messaging,
   c. providing equalities analysis into the launch of the NHS Covid-19 app,
   d. contributing to DHSC's PSED assessments in relation to social distancing requirements including self-isolation,
   e. supporting MHCLG's roll-out of the Community Champions scheme to improve engagement in ethnic minority groups with Covid-19 guidance including the requirement to self-isolate,
   f. supporting more ethnic minority participation in TTI, including encouraging testing in local communities such as at places of worship,
   g. raising concerns about accessibility of testing in the context of Covid-19 status certification and
   h. engaging with NHST&T to address the impact of TTI policies on disproportionately impacted groups.

Function & responsibilities

5. I was elected as the MP for Saffron Walden on 8 June 2017. I served as Parliamentary Under Secretary of State (Minister for Children and Families) at the Department of

Education ('DfE') from 27 July 2019 to 13 February 2020. I took maternity leave from 4 September 2019 and returned to work on 7 April 2020. The Rt Hon Michelle Donelan MP covered my DfE role between 4 September 2019 and 13 February 2020. Between 13 February 2020 and 15 September 2021, I served as Exchequer Secretary to the Treasury and Minister for Equalities. Between 16 September 2021 and 6 July 2022, I served as Minister of State at the Department for Levelling Up, Housing and Communities (DLUHC) and Minister of State for Equalities. On 6 September 2022, I was appointed as Secretary of State for International Trade and President of the Board of Trade. On 25 October 2022 I was also appointed as Minister for Women and Equalities. Retaining those positions, I was further appointed as Secretary of State for the Department of Business and Trade on 7 February 2023. I held these positions until the General Election in 2024. On 4 November 2024, I was appointed Leader of the Opposition.

6. During the Module 7 period, the Minister for Women and Equalities was the Rt Hon Elizabeth Truss MP, a role she held between September 2019 and September 2022, alongside the roles of Secretary of State for Trade and Foreign Secretary. She had overall responsibility for the work of the Cabinet Office's Equality Hub (save for disability policies), and delegated responsibilities to junior ministers as follows.
   a. I was Minister for Equalities from February 2020 to July 2022 based in the Treasury (HMT) and then DLUHC (from September 2021). During this period, I was responsible for the Covid-19 Disparity Reports.
   b. Mike Freer MP was Minister for Equalities with responsibility for LGBT policy from September 2021 to July 2022 based in the then-Department of International Trade.
   c. Baroness Berridge of the Vale of Catmose was Minister for Women from February 2020 to September 2021 based in DfE, followed by Baroness Stedman Scott from September 2021 to September 2022 based in DWP.
   d. Justin Tomlinson MP was Minister for Disabled People from 2019 to September 2021, followed by the Rt Hon Chloe Smith MP from September 2021 to September 2022, both of whom reported to the then-Secretary of State for Work and Pensions, the Rt Hon Thérèse Coffey MP.

   Together, we had regular ministerial team meetings with bilateral meetings where necessary.

7. My responsibilities as Minister for Equalities between 16 February 2020 and 28 June 2022 included **KB/1 [INQ000185181]**:
   a. work relating to racial and ethnic disparities,

b. supporting the Minister for Women & Equalities on work relating to LGBT equality,
c. work relating to COVID-19 disparities, including the four quarterly reports on this to the Prime Minister between June 2020 and December 2021,
d. acting as sponsoring minister for the Social Mobility Commission (from April 2021) and the Equality and Human Rights Commission, and
e. oversight of the Equality Act 2010 and Public Sector Equality Duty.

8. Throughout the pandemic I worked closely and effectively with Marcus Bell and his staff at the Equality Hub.

9. While I was often briefed on issues in relation to disabled people, my colleague, Justin Tomlinson MP, the then-Minister for Disabled People (MDP), would have been responsible for considering issues relating to Covid-19 for disabled people. He was supported in this work by officials in the Equality Hub's Disability Unit (DU).

10. I was a new parliamentary under-secretary of state and as such I did not have significant involvement in the government decisions examined in this Module. Similarly, I was not a member of Cabinet nor among the most senior members of the Government making decisions on the wider Covid-19 response. I am therefore not able to give a full account of the extent to which those ministers were facilitated in considering at-risk and other vulnerable groups, although I believe I had sufficient access to the key decision-makers within my remit, including the Chancellor of the Duchy of Lancaster and the Health Secretary.

Four Nations

11. My work on Covid-19 disparities was primarily limited to England only, given that health is a devolved matter in Northern Ireland, Scotland and Wales. The Welsh and Scottish Governments led their own studies into COVID-19 disparities. While this work was not coordinated across the four nations, my quarterly reports and the accompanying letters to the Prime Minister were published online and so our evidence was readily available.

International engagement

12. I did not have any formal engagements with Ministers in countries outside the UK on the impacts of COVID-19 or any international engagements more generally save for the

roundtable with High Commissioners to encourage vaccine uptake amongst diaspora groups on 19 May 2021.

Covid-19 workstreams

13. The key Covid-19 workstreams for which I was responsible included:

a. **Quarterly reports on progress to address COVID-19 health inequalities -** On 4 June 2020, the then-Prime Minister invited me to lead on work by the Government following the Public Health England (PHE) review into disparities in the risk and outcomes of COVID-19 **KB/2 [INQ000101218]**. I was provided with eight 'terms of reference' **KB/3 [INQ000089741]** which included a requirement to provide quarterly updates to the Prime Minister and Secretary of State for Health and Social Care on progress. Between June 2020 and December 2021, the majority of my time was spent working with the Equality Hub to deliver against these eight terms of reference. The work that we achieved is best understood by reading the four comprehensive reports which were published in October 2020, February 2021, May 2021 and December 2021.

b. **Involvement in Key Decision-Making Forums –** I was not a standing member of the Covid-19-specific meetings. I did attend some of the Covid-19 Operations (Covid-O) Committee meetings in my capacity as Equalities Minister. In particular, I was involved in meetings which touched upon disproportionately impacted groups ('DIGs') and, in particular, ethnic minorities. In September 2020 a senior steering group had been set up on DIGs to drive forward the work to support these groups (which include ethnic minority people, and disabled people). The Senior Responsible Officer was Emran Miah, Director General for Decentralisation and Growth in MHCLG **KB/4 [INQ000083902]**. The Equality Hub fed into commissions and papers for this group, including the initial commission for interventions **KB/5** ([**INQ000083950**], **KB/6** [**INQ000083871**]), and Papers on DIGs were presented to Covid-O meetings on 24 September 2020 **KB/7** [**INQ000090046**] and 29 October 2020 **KB/8** [**INQ000090144**].

c. **Involvement in public health communications –** I was involved in exploring how we could improve the reach of government communications about the impact of COVID-19 on ethnic minority groups. The communication efforts that I supported across government are best explained in the 'Quarterly Reports'. I was not however involved in any integral way in the communications around TTI.

d. **Involvement in increasing vaccine uptake among ethnic minorities –** I worked extensively with the Equality Hub to support government work with national and local partners to promote vaccine uptake among ethnic minority groups, and to tackle misinformation through a series of targeted and highly innovative interventions. The

efforts that we supported across government are best explained in the 'Quarterly Reports'. This stream of work is dealt with in detail in my Module 4 statement.

Involvement in Key Decision-Making Forums

14. All major decisions relating to the UK Government's response to Covid-19 were decided by the Prime Minister. He was closely supported in decision-making by senior Cabinet members, but primarily by the former Health Secretaries (Rt Hon Matt Hancock and Rt Hon Sir Sajid Javid), the Chief Medical Officer (Professor Sir Chris Whitty), the former Chief Scientific Advisor (Lord Vallance) and the former Deputy Chief Medical Officer (Professor Sir Jonathan Van Tam). Advice was provided through the Scientific Advisory Group for Emergencies (SAGE). Two Cabinet Committees, formed during this time, brought together key ministers for decision-making - Covid-19 Operations Committee ('Covid-O') (chaired by the Chancellor of the Duchy of Lancaster) and the Covid-19 Strategy Committee ('Covid-S') (chaired by the Prime Minister). Covid-O's remit was to deliver the policy and operational response to Covid-19 **KB/9 [INQ000089797]**, whilst Covid-S's remit was to drive the Government's strategic response to Covid-19, considering the impact of both the virus and the response to it, and setting the direction for the recovery strategy. I attended some of the Covid-O Committee meetings in my capacity as Equalities Minister. In particular, I was involved in meetings which touched upon disproportionately impacted groups.

15. As explained above, I returned to work from a period of maternity leave on 7 April 2020. I was therefore not involved in Cabinet discussions or advice to the Prime Minister, Cabinet or Cabinet Committees during the earliest phases of Covid-19 planning and response. While I cannot share direct insight from the period prior to my return from maternity leave, I believe that the UK Government appreciated the seriousness of the threat of Covid-19 and was making the necessary preparations to respond. This was evident in the unprecedented measures the Government took at the time, not only through non-pharmaceutical interventions, but also in the work HM Treasury did to support businesses and livelihoods.

Involvement of the Equality Hub

16. While I cannot speak in detail to the work done by other departments and ministers, the Equality Hub and its units regularly engaged with policy teams across government and the Covid-19 Taskforce to provide an expert view on any equalities considerations in the

work for which they were responsible. This could take the form of a phone call, or a document being shared with a quick turnaround for comments.

17. I also understand that Equality Hub officials met regularly with their colleagues in the Covid-19 Taskforce and fortnightly from November 2020 onwards. This enabled the Equality Hub to support the Taskforce in considering disproportionately impacted groups ('DIGs'). The Equality Hub also attended regular (usually monthly) meetings with the Covid-19 taskforce and worked closely with Special Advisers in No. 10 (Daniel El-Gamry, who also worked very closely with me) who advised Ministers on ethnicity issues and officials from the Government Office for Science. In these meetings the Equality Hub shared data, arguments and evidence on DIGs. I had little direct contact with the Covid-19 Taskforce as this relationship was managed at official level, but I understand officials in the Equality Hub had a good working relationship with colleagues in the Taskforce.

18. Officials from the Equality Hub and CTF regularly attended meetings of the SAGE Ethnicity Subgroup which provided advice to ministers to ensure equalities considerations were factored into planning. **KB/10** [**INQ000566419**]

My attendance at Covid-O meetings

19. As mentioned above, I attended Covid-O meetings in my capacity as Equalities Minister:
    a. **24 September 2020 KB/11 [INQ000090183]**. I was briefed to support funding for the Community Champions scheme, improve our existing communications campaigns, continue to raise awareness and gain a better understanding regarding disproportionate impact, and to support businesses with higher numbers of employees from DIGs **KB/12 [INQ000185145]**. It was agreed that the Covid-19 taskforce would ensure that future decisions would fully factor in the likely impacts on DIGs and the DHSC would take steps to collect more granular data. **KB/13 [INQ000090234]**.
    b. **9 October 2020 KB/14 [INQ000090178]**. Shortly in advance of the meeting I had received a final draft of the guidance from MHCLG/DHSC **KB/15 [INQ000090256]**. It was agreed for DHSC to work with MHCLG to make clear the advice to Clinically Extremely Vulnerable individuals at each Local Covid Alert Levels (tiers) given an individual may have lived in one tier and worked in another and what would be necessary beyond what is advised/required for the rest of the population. **KB/16 [INQ000065363].**

c. **29 October 2020 KB/17 [INQ000090185]**. The SRO for DIGs presented a paper **KB/8 [INQ000090144 exhibited above]** I was briefed for the meeting to support the government investing in community-led testing, increased testing at places of worship, rolling out the announced Community Champions scheme and improving health outcomes in education settings and high-risk occupations (e.g., hospitality, taxi drivers and social care workers). I also supported the package improving uptake of flu vaccination in groups most at risk and high Covid risk areas **KB/18 [INQ000185175]**. The Committee agreed with the proposed measures and to urgently address clarity of communication with certain groups **KB/19 [INQ000090299]**.

d. **10 December 2020 - KB/20 [INQ000185157]**. My brief included seeking agreement for the new COVID-19 predictive risk model to be applied at population level to support vaccine prioritisation, that an update be provided on progress with the clinical support tool and the next steps for the potential public-facing tool be set out. Further, that the model should properly reflect the best evidence around ethnicity and ensure that the risk model and the JCVI advice aligned, and that decisions on prioritisation needed to stand up to public scrutiny **KB/21 [INQ000185174]**.

e. **25 January 2021 KB/22 [INQ000091823]**. I took away actions to explore how best to tackle disinformation, ensure trusted partners be used in the campaign who were trusted voices and establish indicators for measuring the effectiveness of the communications campaign **KB/23 [INQ000092300]**.

f. **17 March 2021 KB/24 [INQ000092064]**. I was briefed on the point that measures to mandate vaccination needed would come with the significant workforce, equalities, and potential legal risks. I had liaised with the BAME Communities Advisory Group, who expressed concern that making vaccines a condition of deployment would risk damaging trust with the workforce. My brief also noted that the policy would impact most significantly on ethnic minority workers and especially women and could result in workforce shortages. I did not support mandating vaccines in the NHS at that stage given the overall risks **KB/25 [INQ000185173]**. My brief included reservations about extending the policy to those working in care homes who have no direct contact with residents. The committee agreed with the Department for Health and Social Care's proposal that secondary legislation should be introduced to make vaccination a condition of deployment for those working in older age residential care homes, including a carefully considered handling plan **KB/26 [INQ000092400]**.

g. **20 May 2021 KB/27 [INQ000091937]**. I had reservations about mandating certification. I also had concerns about the inability of individuals to self-administer

at-home testing **KB/28 [INQ000185176].** One of the actions of the committee was for the Covid-19 Taskforce to work with the DU, NHSx and the UK Health Security Agency to ensure people with disabilities could access a different testing route where they were required to undertake a test but could not undertake a home test **KB/29 [INQ000083897].**

h. **15 June 2021** – I attended a further Covid-O on vaccination as a condition of deployment in adult social care settings **KB/30 [INQ000092238 and KB/31 INQ000185169]**.

20. In my own work I found the Covid-O Committee to be an effective mechanism for bringing data, analysis, and information to key ministers and enabling them to reach collective agreement swiftly, and I am aware that Ministerial Covid-O meetings were supported by shadow meetings of officials, which were often attended by Equality Hub officials between September 2020 and towards the end of 2021.

Involvement in Key Stakeholder Engagement

21. I attended many engagements with stakeholders, including public bodies and charities, in relation to the impact of Covid-19 and the impact of the response to Covid-19 on at-risk and other vulnerable groups. Many of these engagements are reflected in the quarterly reports and have been provided to the Inquiry in previous witness statements for other modules.

a. On 15 July and 22 July 2020, I met with Lord Bethell, then DHSC Minister for Innovation, to discuss test and trace and the impact on ethnic minorities **KB/32 [INQ000185142] and KB/33 [INQ000566418].**

b. On 25 August 2020 I met with Professor Sir Ian Diamond, National Statistician to discuss his offer of support on behalf of the Office for National Statistics for the Commission on Race and Ethnic Disparities **KB/34 [INQ000185143].**

d. On 11 September 2020, I met with Dr Chaand Nagpaul of the British Medical Association on the subject of Covid disparities **KB/35 [INQ000185144].**

e. On 21 October 2020, I held a meeting with the SAGE Ethnicity Sub-group co-chairs to discuss the links between the Covid disparities review and SAGE work **KB/36 [INQ000185147, KB/37 INQ000566417 (readout)].**

f. On 18 November 2020, I met with Jo Bibby of the Health Foundation to talk about Covid health disparities **KB/38 [INQ000185149]**.

g. On 2 December 2020, I met the DCMO, Dr Jenny Harries, to update her on health disparities ahead of the second Quarterly report being published **KB/39 [INQ000185154]**.

h. On 8 December 2020, I met with Michelle Donelan, Minister for Universities in the Department for Education. This meeting was to share findings from my work on Covid-19 disparities, including that government departments needed to take a consistent approach to how they communicate about Covid-19 and ethnicity, and highlighting the recommendation from my first Covid-19 Disparity Report, that departments need to put in place systems for monitoring the effectiveness of their policies to address Covid-19 disparities **KB/40 [INQ000185151]**.

i. On 14 December 2020, I met again with Dr Chaand Nagpaul of the BMA for a follow-up meeting on disparities before meeting with the Deputy Chief Medical Officer, Jenny Harries for an update on disparities ahead of the quarter 2 disparities report **KB/41 [INQ000185153 and KB/39 INQ000185154 exhibited above].**

j. On 15 December 2020, I met again with the SAGE Ethnicity sub-group chairs (Kamlesh Kunti and Osama Rahman) for an update meeting on disparities. On the same day, I also met with Professor Keith Neal, who I appointed as a Covid-19 and ethnicity expert for a one-year period **KB/42 [INQ000185155]**. The day after (16 December 2020) I had a similar meeting with Dr Raghib Ali, who I also appointed as a Covid-19 and ethnicity expert for the same period **KB/43 [INQ000185152]**.

k. On 21 April 2021, I held a roundtable with the security industry to consider mitigations for the impact of Covid-19 on ethnic minority security guards **KB/44 [INQ000185164]**.

l. Later that month on 29 April 2021, I met with Joan Saddler (Associate Director of the NHS Confederation's BAME Leadership Network). We discussed CRED and the disproportionate impact of Covid-19 on ethnic minority front-line health workers **KB/45 [INQ000185165]**.

m. On 10 May 2021, I held a meeting with the President of the Royal College of Physicians on the topic of Covid-19 health disparities **KB/46 [INQ000185166]**.

n. On 21 July 2021 I met with the Deputy Chief Medical Officer, Tom Waite, on the topic of Covid-19 disparities and vaccine uptake **KB/47 [INQ000185170]**.

o. Also on 21 July 2021, I met Emran Mian, the Government's SRO for disproportionately impacted groups based in MHCLG.

22. Whilst evaluating data and evidence about the impact on different ethnic groups, I worked with the following stakeholders through analytical officials in the Equality Hub:

a. NHS organisations

b. Public Health England
c. Office for National Statistics
d. Department of Health and Social Care
e. Office for Statistics Regulation
f. Nuffield Trust
g. The King's Fund
h. OpenSafely
i. SAGE working group on ethnicity
j. VirusWatch
k. Policy Lab
l. UK-REACH

Quarterly reports on progress to address COVID-19 health inequalities

23. On 2 June 2020, PHE published the findings from their review into disparities in the risks and outcomes of COVID-19 **KB/2 [INQ000101218 exhibited above]**. On the same day, the Health Secretary made a statement to Parliament in which he indicated that I would lead work to respond to the review's findings. Discussions between No10 and Equality Hub advisers and officials followed in order to confirm this and finalise the terms of reference for the work.

24. The PHE report highlighted some apparently significant disparities in both risk and outcomes from COVID-19. I read this PHE report with concern and on 4 June 2020, I spoke about it in the House of Commons **KB/48 [INQ000185182]**. I regarded it as important to ensure that the Government reviewed the impact and effectiveness of their actions to lessen disparities in infection and death rates of Covid-19, and to determine what further measures were necessary. I recognised that more needed to be done to understand the key drivers of the disparities identified by PHE and the relationships between different risk factors and I was alive to the need for the Government to commission further data, research and analytical work by the Equality Hub to clarify the reasons for the gaps in evidence highlighted by the report. I was clear that taking action without taking the necessary time and effort to understand the root causes of those disparities only risked worsening the situation. I was also alive to the important point that equalities are not something that only happens in the Equalities Hub; equalities happen across Whitehall. It was important for every Department to appreciate that it had responsibility to ensure that it made the right policies for all the people who are impacted by their activities.

25. Later that day I formally announced that I had been invited by the Prime Minister to lead on work by the Government following the PHE review. I said at the time: *"This government is rightly taking seriously the initial findings from the PHE report published earlier this week. However, it is also clear that much more needs to be done to understand the key drivers of the disparities identified and the relationships between the different risk factors. That is why I am now taking this work forward, which will enable us to make a real difference to people's lives and protect our communities from the impact of the coronavirus"* **KB/3 [INQ000089741 exhibited above].** The Terms of Reference for the work that the Prime Minister had asked me to carry out were as follows:

TOR 1 – *"Review the effectiveness and impact of current actions being undertaken by relevant government departments and their agencies to directly lessen disparities in infection and death rates of COVID-19. Factors to be considered – but aren't limited to – should include age and sex, occupation, obesity, comorbidities, geography, and ethnicity;"*

TOR 2 – *"Modifications to existing, or development of new policy, should be considered and discussed with the relevant Ministers responsible. This ongoing work will include looking at the extensive guidance that is already currently available;"*

TOR 3 – *"Commission further data, research and analytical work by the Equality Hub to clarify the scale, and drivers, of the gaps in evidence highlighted by the Report;"*

TOR 4 – *"Consider where and how the collection and quality of data into the disparities highlighted can be improved on, and take action to do so, working with the Equality Hub, government departments and their agencies;"*

TOR 5 – *"Lead engagement on the disparities highlighted with Departmental Ministers;"*

TOR 6 – *"Build on and expand the stakeholder engagement undertaken by PHE, to consolidate and develop the qualitative insights gained and how they may support further actions that should be taken to address the disparities highlighted;"*

TOR 7 – *"Strengthen and improve public health communications to ensure they can reach all communities across the country;"*

TOR 8 – *"Provide quarterly updates to the Prime Minister and Secretary of State for Health and Social Care on progress being made to address health inequalities by departments and their agencies."*

26. As explained above, between June 2020 and December 2021 the majority of my time was spent working with the Equality Hub to deliver against these terms of reference. I worked most closely with the Race Disparity Unit (RDU), colleagues across other government departments and agencies, and in particular the Department of Health and

Social Care (DHSC), PHE, the Cabinet Office (including the COVID-19 Taskforce) and the Ministry of Housing, Communities and Local Government (MHCLG), to assess initiatives to lessen the disparities highlighted by the PHE report. The work that we achieved is best understood by reading the four 'quarterly reports'. In the following paragraphs I have sought to highlight some of the main features of these reports. I, along with Marcus Bell and the staff at the Equality Hub, worked tirelessly to produce the reports, implement the recommendations and ultimately to mitigate, so far as reasonably practicable, the impacts of COVID-19. It has not been possible for me to draw out every aspect of each report or workstream, but I would gladly provide further evidence on any particular area that would assist the Inquiry.

27. The first ten doctors to die from Covid-19 were all from ethnic minorities and the findings in the PHE report on ethnicity were stark. It was for this reason that the quarterly reports focussed on ethnic minorities while the Disability Unit led a separate strand of work on the impact of Covid-19 on disabled people.

The first 'Quarterly report on progress to address COVID-19 health inequalities'

28. The first 'Quarterly report on progress to address COVID-19 health inequalities' was published on 22 October 2020 **KB/49 [INQ000086832]** and summarised: (i) the work that the RDU and I undertook to address the terms of reference; (ii) the work undertaken across government since the report of the PHE review was published on 2 June 2020. The executive summary of the report reaffirmed that: *"The current evidence clearly shows that a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions contribute to the higher infection and mortality rates for ethnic minority groups, but a part of the excess risk remains unexplained for some groups. Each successive publication of results is filling the gaps in the evidence base and refining our previous understanding of the impact of different risk factors. This is set to continue over the months ahead."* Under my direction the RDU reviewed the actions that government departments and their agencies had initially put in place to mitigate the impacts of COVID-19. This work is summarised in Annex B to the report.

29. It is important to note that on 16 June 2020 PHE had published a rapid literature review and results of stakeholder engagement called: 'Beyond the Data: Understanding the impact of COVID-19 on BAME groups' which made a number of recommendations **KB/50 [INQ000176354]**. Even before we published the first Quarterly Report the

government had already delivered against many of the recommendations, a number of which had been subsumed into the work led by myself and the RDU. Annex A of the first Quarterly Report summarises the government's progress against each of the PHE recommendations.

30. On 21 October 2020 I wrote a letter to the Prime Minister and the Secretary of State for Health and Social Care setting out the work that I and the RDU had been engaged in to deliver against the terms of reference. I explained that: "…*We now know much more about the impact of the virus than we did in June and the evidence base is growing fast. The current evidence clearly shows that a range of socioeconomic and geographical factors such as occupational exposure, population density, household composition and pre-existing health conditions contribute to the higher infection and mortality rates for ethnic minority groups, but a part of the excess risk remains unexplained for some groups. Each successive publication of results is filling the gaps in the evidence base and refining our previous understanding of the impact of different risk factors: this is set to continue over the months ahead"* **KB/51 [INQ000215047]**. As I set out in my letter, the government had not, however, simply waited for new data to emerge before acting. I gave an example that over 95% of frontline NHS workers from an ethnic minority background had, by October 2020, had a risk assessment to ensure good understanding of the necessary mitigating interventions in place. On 21 October 2020, I delivered an oral statement to Parliament announcing the first quarterly report **KB/52 [INQ000185179]**.

31. At this point in the pandemic, I was absolutely committed to reviewing the actions that government departments and their agencies had put in place to mitigate the impacts of COVID-19. I am of Nigerian heritage and the higher infection and mortality rates for ethnic minority groups was directly impacting me, my family, friends and community. This was a very personal issue, and it was clear to me that there was much good work underway, but I believed that departments needed to do more, and be more innovative, in their work to address the disparities. As I sought to reinforce in my letter to the Prime Minister, I was committed to the need to avoid stigmatising people from ethnic minority groups in how the government communicated about COVID-19. Those in government responsible for TTI communications would have been aware of this. I wanted to know more about the impact COVID-19 had on the day to day lives of those from ethnic minority groups, drawing on their direct experiences. I had therefore commissioned qualitative research to gain a deeper insight on this issue.

32. I appointed two expert advisers on Covid-19 and ethnicity - Dr Raghib Ali and Professor Keith Neal **KB/53 [INQ000083926]**. Dr Ali and Professor Neal proved to be an invaluable resource and brought unique insights and medical expertise, as well as acting as critical friends in shaping my work over the following months. Dr Ali and Professor Neal played an important role in reviewing the emerging data on Covid-19 disparities, quality assuring the four quarterly reports to the Prime Minister, briefing the media on the findings of the reports, and (in the case of Dr Ali) speaking at events and recording videos to help increase vaccine uptake among ethnic minority groups. I also worked closely with the government's senior responsible officer for the impacts of COVID-19 on disproportionately impacted groups, Emran Mian who was based in MHCLG, and the SAGE ethnicity sub-group. I met Emran Mian on 21 July 2021 to talk about the links between our strands of work. I had similar discussions with Professor Kamlesh Khunti and Osama Rahman, the co-chairs of the SAGE Ethnicity sub-group, on 21 October and 16 December 2020.

33. The first quarterly report made thirteen recommendations, all of which were accepted in full. In my letter to the Prime Minister and the Secretary of State for Health and Social Care I emphasised the following recommendations in particular **KB/51 [INQ000215047 exhibited above]**:

    a. *"The recording of ethnicity data as part of the death certification process should become mandatory, as this is the only way we will be able to establish a complete picture of the impact of the virus on ethnic minorities. I know that there is good work underway across government to develop a solution to this, and this must be a priority for the coming months. I understand that legislative changes will be required, and these should be brought forward at the earliest opportunity by DHSC".*

    b. *"Ensuring that new evidence uncovered during my review relating to the clinically extremely vulnerable is incorporated into health policy".*

    c. *"Ethnic minorities are grossly under-represented on the national vaccine register, which is voluntary. We must reduce fear and build confidence among ethnic minority people, tackling misinformation and anti-vaccination messages which have been directed at them, and rebuilding trust in government messaging".*

    d. *"We must support the deployment of a risk model to understand individual risk that is being developed from research commissioned by the Chief Medical Officer. This work is being led by an expert subgroup of academic, scientific and clinical experts and the University of Oxford".*

    e. *"Anecdotally, we know there is much good work being done by local authorities and Directors of Public Health so that we can learn the lessons of what works at a local*

level. There should be a rapid, light-touch review of local authority action to support ethnic minority and hard-to-reach communities."

34. The thirteen recommendations made in the first quarterly report provided the framework for the work that I and the RDU engaged in over the following months.

35. One of the recommendations was for work to continue to improve public health communications. According to paragraph 56 of the report this was to include:

"• An ongoing multichannel communications strategy to address language and cultural barriers, with a particular focus on targeted community engagement and adapted versions of the national marketing campaign. This is supported by approximately £4 million additional marketing investment dedicated to targeting ethnic minority audiences.

• Working with specialist marketing agencies and targeting audiences based on language and religious holiday interest with bespoke creative and messaging. Core marketing materials are translated into multiple languages by central teams and, where bespoke translations are requested by local authorities and external stakeholder groups, these are funded centrally.

• Continued use of press partnerships, which includes 600 national and regional titles and 65 ethnic minority titles (the combined circulation of these is 1.5 million), to communicate key messages like *Hands, Face, Space* and Test and Trace.

• Working with existing influencers and continuing to recruit new ones that can communicate public health messages with credibility and impact among those less likely to trust or respond to government sources. Micro-influencers are also used on a local level for more targeted communications. Reiterating health messaging around key calendar moments, such as religious festivals that ethnic minority people are partaking in, forms a core pillar of the central COVID-19 marketing strategy. Roundtables are regularly held with religious leaders to advise on, co-create and share communications for specific festivals to their wider communities. Most recently, this has included a translation of safe worshipping and gathering guidance into Yiddish ahead of Yom Kippur and Sukkot.

• The Minister for Equalities also reached out to embassies and high commissions from countries whose nationals were most at risk to utilise their knowledge and insight to identify specific ways in which to build on the government's communications approach among diaspora groups. A number have responded to this request and their recommendations have been integrated into the strategy.

• PHE's *Better Health* campaign to tackle obesity as a way to increase resilience against COVID-19 was launched on 27 July with ethnic minority people included as a key target audience among others.

• PHE's Campaign Resource Centre, accessible across the country, is an online platform that is being used to host all national and local marketing materials including translations into languages spoken among ethnic minority audiences.

• Test and Trace language translation services, including for those requiring British Sign Language, are now available both on 119 via the phone and at testing sites. The new app is available in 11 languages with more to follow. This makes it easier for all people, including those who are not proficient in English, to understand and access these vital services. Promotion of Test and Trace has included community ethnic minority radio stations in England.

• Ongoing polling and focus groups with ethnic minority audiences to better understand how government communications are being received and how this affects COVID-safe behaviours. This research provides detailed analysis on key insights including the awareness of social distancing guidance and recognition of public health campaigns, and perceptions of localised campaigns. Insights gained from this workstream are fed into future communications to improve awareness of health messages and compliance.

• The Minister for Equalities took part in interviews with BBC Asian Network and BBC Radio Manchester in August, following the then local northern lockdowns, reaching out to people from ethnic minority backgrounds in those areas, reassuring them, and spreading awareness of the government's messaging."

36. The work which I undertook with the Equality Hub in the months between October 2020 and February 2021 is best summarised in the subsequent quarterly reports. In order to implement and action this work I held regular meetings with my officials and the output and actions flowing from these meetings are reflected in the subsequent quarterly reports. The principal meetings I attended with my officials relating to COVID-19 disparities included regular meetings with the RDU on a minimum of a weekly basis. These were 'stocktake' meetings, discussing progress against each of the terms of reference, any emerging issues and risks and the development and drafting of the four quarterly reports. In addition to meetings with my officials, I attended many meetings with colleagues across government, including:

    a. Meetings with The Rt Hon Elizabeth Truss MP (in her capacity as Minister for Women and Equalities) and Justin Tomlinson MP (in his capacity as Minister of State for Disabled People, Health and Work); and

b. Meeting with Officials in Number 10 Downing Street - in particular, I held meetings with the Director of the Policy Unit, Munira Mirza, to update her on workstreams.

The second 'Quarterly report on progress to address COVID-19 health inequalities'

37. The second 'Quarterly report on progress to address COVID-19 health inequalities' was published on 26 February 2021 **KB/54 [INQ000089744]**. This second report looked at the cause of the higher infection and mortality rates for ethnic minority groups in more detail and set out some of the work undertaken to fill the gaps in our understanding and to mitigate the risks of COVID-19 infection. The report explained our increased understanding of the drivers of these disparities.

38. In particular, the report explained that the impact of COVID-19 on certain ethnic minority groups had changed between the first wave and the early second wave of Covid-19. It concluded that *"...changes within such a short time period strongly suggest that ethnic inequalities in COVID-19 outcomes are driven by risk of infection, as opposed to ethnicity itself being a risk factor for severe illness or death from COVID-19."* The report further concluded that: *"The direct impacts of COVID-19 improved for ethnic minorities as a whole during the early second wave. For example, in the first wave, Black African men were 4.5 times more likely to die from COVID-19 than White British men of the same age but in the early part of the second wave the risk of death was the same for Black African and White British men. At the same time, however, the second wave has had a much greater impact on some South Asian groups. Work is underway to consider why the second wave to date has had such a disproportionate impact on Pakistani and Bangladeshi groups. Relevant considerations include regional patterns in first and second waves of the virus, household occupancy and multigenerational households, deprivation, and occupational exposure."* It is correct to say that the focus of this work was the disproportionate impact COVID-19 has had on ethnic minorities. There was wider work underway across government to consider the impact the virus has had on other groups, such as disabled people. Marcus Bell has addressed some of these workstreams in his Equality Hub witness statement.

39. At Annex A the report set out the progress made under the terms of reference and in implementing the recommendations from the first report. In particular, the report highlighted a number of positive measures which had been implemented since the publication of the first quarterly report. These included but were not limited to:

a. **Community Champions** – *"In order to improve public health communications with those communities most at risk from COVID-19, the government released £23.75 million in funding to local authorities last month under the Community Champions scheme, following an expressions of interest exercise. This funding is enabling local authorities to work with grassroots advocates to tailor public health communications and to use trusted local voices to promote healthy living, encourage vaccine uptake and counter misinformation. The government will monitor the impact of the scheme and share the findings with other local authorities."*

b. **Ethnic Minority Research Projects** – *"To improve our understanding of the health, social, cultural and economic impacts of COVID-19, the government has just invested a further £4.5 million of funding in new research projects looking at ethnic minority groups."*

c. **Mass Testing Pilots** – *"In order to prevent the spread of the virus and to protect frontline workers, many of whom are from an ethnic minority background, the Department for Transport and the Department for Health and Social Care included transportation workers in mass testing pilots covering the Christmas travel period. These are now being rolled out more widely."*

d. **Community Asymptomatic Testing** – *"The government also successfully piloted community-led, localised, asymptomatic testing at places of worship in ethnically diverse areas, building trust within the community and enabling a higher number of positive cases to be detected."*

40. It was important to ensure that ethnic minorities were not considered a single group that faces uniform risk factors in relation to Covid-19. The report summarises the findings of research commissioned by the RDU into a small group of ethnic minority people's personal experiences of COVID-19. Some important themes emerged from this work. For example, participants felt that communications tended to frame ethnic minorities as a homogeneous group that is vulnerable to COVID-19, which they found stigmatising. The research also showed the challenges some participants had in navigating public health advice and applying it to everyday situations, as well as adapting to the pace of change with the guidance. We committed to sharing these insights with other government departments to improve policymaking.

41. A very significant development since the first quarterly report was the approval and roll out of COVID-19 vaccines. The report summarises how the vaccination programme was being prioritised and the implications of this for ethnic minority groups, as well as the analysis of likely take up rates for these groups. On 13 February 2021, the government

published its UK COVID-19 vaccine uptake plan which highlighted a range of barriers to uptake and some of the work taking place across government and at a local level to minimise the impact of these **KB/55 [INQ000087230]**. This includes establishing NHS vaccination centres in suitable sites in the community, such as places of worship. I have explained the work I did to increase vaccine uptake among minority groups in more detail below.

42. The report explains how we had continued our work on developing and improving targeted communications campaigns to encourage uptake of vaccines among ethnic minority groups and to counter misinformation, both nationally and locally. The second quarterly report set out five 'next steps' which I was committed to driving forward in tandem with government colleagues:

    a. ***Central and local government interventions*** – *"MHCLG to share with local authorities' examples of good practice from the review of local authority activity. MHCLG to share with local authorities the findings from the initial, one-month review of returns from Community Champions."*

    b. ***Vaccination programme*** – *"Minister for Equalities to write to the Joint Committee on Vaccination and Immunisation (JCVI) summarising the latest data and evidence set out in this report, to inform future advice on vaccine prioritisation. The government will continue to monitor data on vaccine uptake among ethnic minority groups and, if necessary, take further steps to address any barriers among these groups."*

    c. **Data and evidence** – *"The RDU will share the findings from the qualitative research into people's personal experiences of COVID-19 across government, particularly in relation to the stigmatisation felt by a number of participants in relation to being singled out as 'BAME'. Departments and other agencies should publish a statement on GOV.UK outlining their plans to move their data collections to the Government Statistical Service's (GSS) harmonised ethnicity data standard. Harmonisation is hugely important as it allows analysts to gain deeper insight and value from data. NHSE/I, working with DHSC and others, should publish a quarterly report on progress in improving the recording of ethnicity in health care records. Departments should provide updated datasets on COVID-19 risk factors and secondary impacts for publication on the Ethnicity facts and figures website in line with the schedule in Annex C. This provides transparency of process to users - promoting trust and authority – as well as informing them when the most up-to-date data will be made available."*

d. **Engagement** – *"The Minister for Equalities, the government advisers on COVID-19 and ethnicity, and the RDU will continue a programme of engagement over the next quarter. This will include work to promote vaccine uptake, alongside the engagement led by the Minister for COVID-19 Vaccine Deployment."*

e. **Communications** – *"The government will continue to tailor its communications strategy on vaccine roll out to reflect the latest evidence on vaccine uptake among ethnic minority groups. The government will work closely with the new Community Champions to disseminate important public health messages, promote uptake of vaccine and tackle misinformation Government communications will reflect the findings of the qualitative research into people's personal experiences of COVID-19 and will ensure that ethnic minorities are not treated as a single group and that public health messaging is not stigmatising."*

43. In February 2021 I wrote a letter to the Prime Minister and the Secretary of State for Health and Social Care to update them on the work that I and the RDU had been doing since the publication of the first quarterly report. In that letter I explained that: *"In addition to the next steps I have outlined above, I will continue a programme of engagement with those groups and communities most disproportionately affected by COVID-19. My work over the next quarter will also take account of any relevant recommendations from the Commission on Race and Ethnic Disparities, which is due to report to you (Prime Minister) very shortly. We will also need to begin to consider how we address the longer-term impacts of the pandemic on ethnic minorities and other disproportionately impacted groups, as part of our future, post-Covid recovery strategy"* **KB/56 [INQ000185159].** The Commission's report was published on 31 March 2021 and included a chapter on health disparities **KB/57 [INQ000089803]**. In that chapter it noted that, due to the extensive work being carried out elsewhere, the Commission had not focused in detail on COVID-19 in their report. The Commission welcomed the recommendations made in the government's first quarterly report on progress to address COVID-19 health inequalities, particularly "continuing to improve our understanding of ethnic minority audiences and interests of each ethnic minority outlet to ensure messaging is targeted and nuanced, and build on the existing communications programme with respected third party voices to improve reach, understanding and positive health behaviours." On 1 March 2021, I responded to an urgent question in Parliament following publication of the second quarterly report **KB/58 [INQ000089745]**. The work which I undertook with the Equality Hub in the months between February 2021 and May 2021 is best summarised in the subsequent quarterly reports.

44. On the issue of public messaging, I was closely involved in exploring how we could improve the reach of government communications about the impact of COVID-19 on ethnic minority groups. I found that the public were significantly more likely to trust messages regarding COVID-19 that came from figures within their own community, or from clinicians, rather than politicians. In working to improve the reach of COVID-19 communications to different groups I therefore predominantly focused on engaging persuasive individuals from the relevant communities and professions, rather than political figures. We did everything we could with the resources available and in circumstances that were without precedent (in the context of a pandemic).

45. In particular, I convened a cross-government effort to develop an ethnic minority engagement communications plan in time for the Eid Al Adha holiday at the end of July; conducted media interviews supporting government guidance to ethnic minority groups around local lockdowns; and reached out to the twenty-three embassies and high commissions of those nationalities most likely to be impacted by COVID-19 for their help in communicating through their diaspora **KB/51 [INQ000215047 exhibited above]**. I emphasised across government that we must continue to be as innovative as we could in targeting our communications to hard-to-reach groups, especially those at greatest risk in areas of local lockdown and rising concern. I also encouraged departments to raise awareness of particular risks that could be impacting on ethnic minority groups. By way of example, living in a multi-generational household could be a risk factor, and we needed to ensure that advice on what could be done within homes to minimise transmission was widely available **KB/59 [INQ000089748].** We knew from the data that those from the Bangladeshi and Pakistani ethnic groups were particularly at risk in the second wave of COVID-19 and were more likely to live in multigenerational households. It was essential therefore that the guidance was translated into a range of languages, including Bengali, Punjabi and Urdu. On 21 April 2021, I convened a roundtable with the security industry to consider mitigations for the impact of Covid-19 on ethnic minority security guards, a large proportion of whom are from an ethnic minority background, set out later in my statement **KB/44 [INQ000185164 exhibited above]**.

The third 'Quarterly report on progress to address COVID-19 health inequalities'

46. The third quarterly report on progress to address COVID-19 health inequalities was published on 25 May 2021 **KB/60 [INQ000089776]**. This third report provided an update on cross-government work to address the disparities highlighted by the PHE report since my last report was published on 26 February 2021. In particular the report summarises

work across government and through national and local partnerships to improve vaccine uptake among ethnic minorities. This approach is summarised as a data-informed approach; targeted communication and engagement; and flexible deployment models, which we viewed as the cornerstones of vaccine equalities delivery. The report emphasised the success of the: *"Community Champions scheme that was launched in January, outlining activity across the 60 local authorities that received funding through this scheme. By the end of the second month, there were over 4,653 individual Community Champions working on the programme, who are playing a vital role in tackling misinformation and driving vaccine uptake. This work is being supported by 2 organisations, Strengthening Faith Institutions and Near Neighbours, which also received funding under the Community Champions scheme".*

47. There were also positive results from a number of cross-government communication campaigns aimed at encouraging vaccine uptake amongst ethnic minorities. The report explained that: "*this has included using effective media channels and building on relationships established with influencers and local communities to reach ethnic minority groups with information about vaccines in multiple languages. The main activity in the government's vaccines confidence campaign this quarter has included: a video with Nadiya Hussain encouraging vaccine take-up amongst British Bangladeshi audiences; an open letter from Sir Lenny Henry and others aimed at Black groups; press partnerships featuring questions and answers from trusted clinical voices; a social media campaign addressing vaccine misinformation."* We assessed that: *"Taken together, these initiatives have led to increases in both positive vaccine sentiment and vaccine uptake over time across all ethnic groups, although variances still remain. Vaccine confidence has increased in 3 consecutive research periods and the vast majority of people say they have already been vaccinated or would be likely to accept a vaccine. Research by YouGov, in partnership with the Institute of Global Health Innovation at Imperial College London, suggests that the UK continues to top the list of the 29 countries in the study, in terms of people who are willing to be, or already have been, vaccinated."*

48. This third report summarises the data for deaths in the second wave up to 31 January 2021. The data confirmed the finding from the second report that people from South Asian ethnic groups, particularly the Pakistani and Bangladeshi groups, were at the greatest risk of death from COVID-19 during the second wave. Black African and Black Caribbean people were also at slightly higher risk, but this could be accounted for by geographical factors, socio-demographic characteristics and pre-pandemic health. In

black Caribbean men and women and black African women there was no excess risk after accounting for these factors, but substantial excess risk remained for men and women from the Pakistani and Bangladeshi ethnic groups. The report explored why the second wave had such a disproportionate impact on Pakistani and Bangladeshi groups. The government and partner agencies had taken steps to tackle these disparities over the last quarter, including promoting vaccine uptake within these groups and issuing new guidance on reducing infection within multi- generational households (translated into Bengali and Urdu) and on how to install screens in taxis and private hire vehicles.

49. The report set out ten 'next steps' which I was committed to driving forward in tandem with government colleagues:

i. *"The Minister for Equalities to share the findings of her third quarterly report with the Joint Committee on Vaccination and Immunisation.*

ii. *Department of Health and Social Care (DHSC) to consider how to apply the findings of the review of experiences of frontline healthcare workers and the UK-REACH study.*

iii. *NHS England's published data on vaccination uptake by ethnicity should be further disaggregated to provide percentage uptake by vaccine priority group cohorts and sex. This should include levels of unknown ethnicity and an assessment of how this might affect the interpretation of vaccination uptake for different ethnic groups.*

iv. *NHS England and Improvement (NHSEI) should publish data about the use of the NHS COVID-19 app by different ethnic groups. This will inform activity to increase the uptake and continued use of the app.*

v. *DHSC and the NHS should further investigate practical barriers to vaccine uptake by ethnicity to assess and address any intention-action gap.*

vi. *DHSC should ensure that NHS organisations and GPs are provided with clear guidance and protocols about how ethnicity should be requested and recorded in health records.*

vii. *RDU should engage with the Office for Statistics Regulation about priorities for improving the quality (including harmonisation, robustness and reliability) of ethnicity data on health records, drawing on others' expertise as appropriate, and report back in the final quarterly report.*

viii. *the Minister for Equalities and the Minister for COVID-19 Vaccine Deployment will continue a programme of engagement in the next 3 months, focusing on promoting vaccine uptake and encouraging asymptomatic testing, particularly for those within higher risk occupations, as sectors reopen.*

ix. *as the COVID-19 vaccine rollout continues, the government's Vaccine Confidence campaign will aim to inform, educate and empower those aged 18 to 50 to take up their vaccine. Using the tagline 'Every Vaccination Gives Us Hope' content will take an optimistic tone, aiming to reach and persuade younger audiences, including ethnic minority groups.*

x. *at each step of the government's roadmap out of lockdown, tailored guidance and communications will continue to be shared through community and media channels to maximise reach and impact".*

50. On 24 May 2021 I wrote a letter to the Prime Minister and the Secretary of State for Health and Social Care to update them on the work that I and the RDU had been doing since the publication of the second quarterly report **KB/61 [INQ000185180]**. In that letter I explained the data analysis which suggested that the second wave (up until the end of January) continued to have a much greater impact on those from Bangladeshi and Pakistani groups, while outcomes for those from other ethnic groups improved when compared with the first wave. I confirmed that: *"I will continue my programme of engagement, focusing on promoting vaccine uptake but also encouraging ethnic minorities to participate with NHS Test and Trace and register with the NHS COVID-19 app, as we progress along the roadmap…"* The work which I undertook with the Equality Hub in the months between May 2021 and December 2021 is best summarised in the subsequent and final quarterly report.

The fourth 'Quarterly report on progress to address COVID-19 health inequalities'

51. The fourth and final 'Quarterly report on progress to address COVID-19 health inequalities' was published on 3 December 2021 **KB/62 [INQ000089747]**. This final report provides a further update on cross-government work to address the disparities highlighted by the PHE report. It looked back to previous quarters and set out how our understanding of and response to COVID-19 changed over the lifecycle of this work. Appendix B of the report also includes a summary of progress against recommendations from previous reports, the lessons learnt from this work and an action plan for addressing some of the longer-term issues identified during the course of this project. It is important to read this report alongside the government's response to the report of the Commission on Race and Ethnic Disparities, published in March 2022, which explains measures to address longer-term health inequalities **KB/63 [INQ000089814]**.

52. The report explains how the government's approach evolved as our understanding of the risk factors developed. It recognises that the most significant measure to protect ethnic minorities from the risk of COVID-19 infection and to save lives has been the vaccination programme. Our efforts on this front are explained in earlier reports but centred on work with national and local partners to promote vaccine uptake among ethnic minority groups and to tackle misinformation through a series of targeted interventions.

53. The fourth report summarised the government's approach to understanding the most important factors that impact on the quality of ethnicity data **KB/62 [INQ000089747 exhibited above].** Focussing primarily on how the ethnicity of patients is requested by health professionals and recorded in their health records, it outlined next steps to improve ethnicity data in different data collections and analyses. These next steps included:

a. series of recommendations designed to improve the coding of ethnicity in health datasets
b. reviewing data access and sharing, and dissemination of microdata for research, and aggregated statistical data
c. collecting ethnicity as part of death certification process
d. harmonising ethnicity classifications in government datasets
e. ensuring clear reporting of data analysis methods and data quality
f. increasing representation of ethnic minority groups in surveys and clinical trials
g. increasing and improving the use of long COVID codes
h. better reporting of unknown ethnicity
i. continuing to hold statistics producers to account to ensure the quality of ethnicity data and statistics meet users' needs
j. Investigating the feasibility for better guidance and signposting for health statistics
k. developing the ONS database for health and care statistics in England.

54. Obstacles we had experienced in relation to data sharing with NHS England led to the inclusion of a priority recommendation in the report that an independent strategic review be undertaken of the dissemination of healthcare data and publication of statistics and analysis.

55. Appendix F of the fourth report summarises how actions were prioritised, and progress against them at that time (December 2021) **KB/64 [INQ000089782]**.

Public Sector Equality Duty

56. As Marcus Bell explained in his Module 2 statement, individual government departments are responsible for complying with the PSED. DHSC had overall responsibility for ensuring that equality impacts were considered in the design and delivery of TTI policies **KB/65** [**INQ000198850**].

57. Neither the Equality Hub, nor the equalities minister, routinely reviewed government departments' equality impact assessments or their approach to PSED, but they may be asked to give guidance to departments on their equality duties.

58. For example, in April to August 2020, the Equality Hub contributed to a number of PSED assessments at the COVID Taskforce's request on social distancing including the requirement to self-isolate (see further below) and of more general relevance to TTI a PSED analysis of the decision to make vaccination a condition of deployment in health and social care settings, raising concerns about impacts on the workforce, a large proportion of whom were from an ethnic minority background.

59. In addition, the Equality Hub supported officials responsible for PSED in other government departments, including through the Cross-Government PSED Network which was used to share knowledge and expertise. Officials ran a session on 9 June 2020 for the PSED Network **KB/66** [**INQ000083886**] and helped to advise departments on how to carry out effective impact assessments in emergency response situations **KB/67** [**INQ000083887**]. GEO shared guidance with departments, and the CTF once established, on how to factor equalities considerations into policy making **KB/68** [**INQ000083914**].

60. On 15 July 2020, in response to a question on the importance of the PSED from the Women and Equalities Select Committee session *"Unequal Impact? Coronavirus and BAME people"*, I reflected on the importance of impact assessments, the role they play and the attention they are given. I was asked whether there were plans to share the equalities impact assessments prepared for the response to the pandemic. I explained that it is critically important that, when officials are putting together these reports, they can be frank and do not worry about the implications of what they are saying. I noted that the Minister for Women and Equalities had been very clear on this point and confirmed that we did not plan to publish the impact assessments. I noted that we kept

our assessments under continuous review and that our decision not to publish should not be taken as an indication that the work was not taking place. I noted that I myself regularly ask to see impact assessments for work within my remit and make sure that they are taken into account. I further reiterated where the ownership of equality impact assessments sits (namely with each Government Department). By way of example, I referred to the most recent impact assessment I had reviewed, which assessed the impact of children not returning to school. I noted that this would have a disproportionate impact on disadvantaged children, in which ethnic minority people are overrepresented. I reiterated that the impact assessments of different Covid-19 measures did not sit with me, but with Ministers in the departments making those decisions. **KB/69 [INQ000089805].**

61. On 8 December 2021, I wrote to all government ministers on the subject of the PSED. I reminded them that their departments are responsible for proper consideration of the equality impacts of their policies and of their ongoing duty to consider equality in their work and their departments. I also provided them with advice on how their departments might approach equality impact assessments and the appropriate documentation of their decision making **KB/70 [INQ000089735]**.

62. Issues surrounding the domestic and international legal obligations relevant to the government's approach to equality issues, including the PSED, are better addressed by Marcus Bell.

Action taken specific to TTI

TTI in Covid-O meetings

63. TTI measures were discussed at the following Covid-Os: on 24 September 2020 **KB/71 [INQ000083870]**, 29 October 2020 **KB/8 [INQ000090144 exhibited above]** and 20 May 2021 **KB/27 [INQ000091937 exhibited above]** – see paragraph 19 above.

TTI in key stakeholder engagement

64. On 15 July and 24 July 2020, I met with Lord Bethell, the then-Minister for Innovation, to discuss test and trace and the impact on ethnic minorities **KB/32 [INQ000185142 exhibited above]** and **KB/33 [INQ000566418 exhibited above].** Cabinet Office

communications teams undertook to help increase ethnic minority participation in TTI but I was not involved in this.

65. The Equality Hub had very little direct engagement with stakeholders on TTI. The impact of TTI policies may have come up in broader meetings to discuss Covid-19 disparities (e.g. in meetings with the BMA) but this was quickly overtaken by vaccines work.

Coverage on TTI in the quarterly reports

First quarterly report

66. The First Quarterly Report published on 22 October 2020 **KB/49 [INQ000086832 exhibited above]** noted several improvements by NHS T&T, including: the collection of data on ethnicity as part of contact tracing; the introduction of translation services to improve the accessibility of virtual and in-person NHS T&T services; and, the promotion of NHS T&T through regional press partnerships, including community ethnic minority radio stations, as well as social media campaigns targeted towards ethnic minority audiences. The report made thirteen recommendations, including further improvements in relation to communications to engage hard-to-reach groups and build confidence among ethnic minority people.

67. I am asked whether I or the Equality Hub had any involvement in assessing adherence to the TTI rules and guidance and the efficacy of public messaging and can confirm we were not so involved.

68. I am asked whether the First Quarterly Report's recommendations applied to TTI (in particular recommendations 2, 3, 7 and 10) and would say that they were more relevant to government interventions generally.

Second quarterly report

69. The Second Quarterly Report, published on 6 February 2021 **KB/54** [**INQ000089744 exhibited above**], and in particular Annex A, recognised successful efforts by DHSC and MHCLG to remove some of the main identified barriers to engaging with NHST&T by running pilots of community-led, localised, asymptomatic testing at places of worship in ethnically diverse areas such as Brent and Wolverhampton. The report noted that testing rates in those areas had increased significantly. The report also cited

partnerships with respected community figures and organisations to help build trust in NHST&T services and dispel existing myths as well as community-volunteer-led testing, to learn and address the barriers to engagement and increase take up of testing.

70. I am asked whether I or the Equality Hub advised or otherwise worked with NHST&T in relation to any TTI-specific initiatives including testing pilots and would say that it was more a case of our reporting what other government departments were doing rather than taking a lead on any such initiatives ourselves.

The third quarterly report

71. The Third Report, published on 25 May 2021 **KB/60 [INQ000089776 exhibited above]**, at paragraph 64, recognised the link between financial hardship, deprivation, lower socio-economic status, and having a dependent child in the household, with lower adherence to full self-isolation, not requesting a test, and poorer symptom recognition. The report made a number of recommendations, including in relation to encouraging asymptomatic testing - particularly for those within higher risk occupations - as sectors of the economy reopened. The Report's content including the links identified was available to those directly responsible for TTI policies and their implementation.

72. I am asked whether I or the Equality Hub provided any advice to NHST&T or other decision-makers on improving adherence to TTI measures and can confirm that save for the matters referred to in paragraph 66 above, neither I nor the Equality Hub were asked to provide any such advice, and none was given.

73. Paragraph 65 of the Third Report reads as follows: "Analysis of the NHS COVID-19 app data [https://www.nature.com/articles/s41586-021-03606-z_reference.pdf] suggests that a large number of COVID-19 cases were averted by contact tracing via NHS app, ranging from approximately 100,000 to 900,000. Roughly 1.7 million notifications were sent as a result of 560,000 app users testing positive between 24 September and the end of December 2020. The analysis also estimated that an increase of 1 percentage point in the number of users of the app meant a 2.3% decrease in COVID-19 cases. Greater app use is associate with areas being more rural, with less poverty and greater local Gross Domestic Product. People from ethnic minorities, especially the Pakistani and Bangladeshi groups, are more likely to live in the most deprived areas or in poverty https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/pay-and-income/people-in-low-income-households/latest#by-ethnicity]. However, no firm

conclusions can be drawn from the analysis on app use by ethnic minority groups, or the impact on them of contact tracing via the app, as ethnicity information is not collected as part of it. However, RDU understands that the NHS Test and Trace team monitors the app's usage by different groups."

74. I am asked whether I or the Equality Hub provided any advice to NHST&T or other decision-makers on this analysis and improving app usage and can confirm that we provided no such advice, not least because we did not have access to the app data ourselves. In the Third Quarterly Report (at page 7) we recommended that "NHS England and Improvement should publish data about the use of the NHS Covid-19 app by different groups. This will inform activity to increase the uptake and continued use of the NHS Covid-19 app."

Fourth quarterly report

75. The fourth quarterly report published on 3 December 2021 **KB/62** [**INQ000089747 exhibited above**] recognised further measures to improve the accessibility of NHST&T services, including the Pharmacy Collect service which had enabled 80% of the population in England to be within a 20 minute walk of testing at a community pharmacy and enabled more testing in deprived areas. Such measures, together with local partnerships, and accompanying improved engagement and communications had coincided with a 53% increase in the uptake of testing services by ethnic minorities since June 2020. The report made recommendations included ensuring communications remained diverse and inclusive, maintaining community partnerships to improve understanding and tailor communications, and recruiting trusted voices to land messaging where necessary.

76. Page 12 of the Fourth Report reads as follows: "As restrictions were eased over the summer, NHS Test and Trace (NHSTT) has ensured that those who have been worst hit by COVID-19 are protected and supported. Measures include:

• The Pharmacy Collect service. Providing an additional route to regular testing, the service facilitates access to testing for people without COVID-19 symptoms. Over 97% of pharmacies across England are now providing tests, having handed out over 159 million tests so far. 80% of the population in England has access to a community pharmacy within a 20 minute walk and there are now 2 to 3 times more such pharmacies in deprived areas than in more affluent areas

• Increasing targeted community testing in disproportionately impacted groups and among employees of small businesses, and conducting workforce testing in higher-risk occupations. Since 1 July, over 1 million supervised tests have been carried out under targeted community testing. Community testing has proven to have a 4-times-higher positivity rate than other types of asymptomatic testing

• The Department for Education worked with the Cabinet Office marketing team to deliver an autumn term return campaign targeting students in higher education and further education, encouraging asymptomatic testing."

77. Page 61 of the Fourth Report reads as follows: "NHS Test and Trace messaging, and COVID-19 communications for mass gatherings such as religious festivals, were coordinated through a cross-government working group, working particularly closely with MHCLG and Cabinet Office to ensure messages were culturally sensitive and relevant. The Places of Worship Taskforce and Faith Leader roundtables provided insight on festivals and events, which were used to communicate COVID-19 messaging and any step changes in the PM's roadmap. For example, dedicated guidance was developed and shared on gov.uk's Places of Worship page and Festival guidance page to advise on restrictions and best practice, shared and updated ahead of specific religious festivals and events."

78. Page 75 of the Fourth Report reads as follows. "1.11 The government will work closely with the new Community Champions to disseminate important public health messages, promote uptake of vaccine and tackle misinformation --- Status Completed --- Progress update. The government has continued to work closely with the Community Champions. Additionally, as part of this scheme, funding was also provided to Strengthening Faith Institutions (SFI) and Near Neighbours (NN) in order to utilise their networks with at-risk communities. Both organisations are partnering with a host of community organisations as well as Community Champions across England and are making a real difference in vaccine uptake. For example, SFI, in collaboration with community partners and champions, has organised 15 community-led webinars and roundtables to date. These include consultations with NHS Test and Trace for South Asian, black, Jewish, Sikh and other groups, and webinars for Arab Muslim, Gujarati Khoja, Somali, black Christian and black Muslim groups."

79. I am asked whether I had a role in decision-making around any NHST&T initiatives, and I can confirm I did not.

PSED assessments in relation on TTI

80. I am asked whether I or the Equality Hub contributed to the PSED assessments requested by the Covid-19 Taskforce and can confirm that we did not so contribute. In any event, it was not for us to review the quality of those assessments.

Enforcement in relation to TTI

81. I am asked whether I or the Equality Hub had any involvement in advising on compliance with coronavirus legislation and regulations and can confirm that we were not so involved.

TTI in relation to women

82. I am asked whether I addressed any concerns relating to women and TTI in my Ministerial work and can confirm that I did not. These were issues for the Minister for Women (Baronesses Berridge and Steadman-Scott). However, I understand that the Equality Hub worked with NHS Test and Trace and DHSC on the implications of the Covid-19 app for victims of domestic abuse and stalking by joining them up with policy leads in the Home Office, the Victims Commissioner and charities including Refuge and Women's Aid.

Lessons learned and legacy

83. I am asked for reflections on the TTI system. As this system was administered by other government departments, I would not be best placed to offer a reflective view on implementation of the relevant systems and processes.

84. I am asked to consider how to mitigate vulnerabilities to prepare for future pandemics, lessons learned on protecting disproportionately impacted groups and how well equipped decision makers were.

85. I have been asked for my reflections on what went well and what obstacles we faced. In my experience of our broader work responding to COVID-19, I found that our work with external experts, particularly Dr Raghib Ali and Prof Keith Neal (who I later appointed as expert advisers on Covid-19 and ethnicity), was of particular value and worked very well (I explain this in more detail below).

86. The Race Disparity Unit did not have any prior epidemiological expertise and so their insights, provided to us completely free of cost to the taxpayer, were incredibly useful. In my view, the structural model adopted by the Unit - which brought together analysts, policy officials and two independent, expert advisers - was highly effective. It meant that emerging data could be interpreted quickly and translated into meaningful policy interventions. This was rightly recognised at Research Capability 2021, with the RDU receiving the ONS Research Excellence Award. I do not consider that structural changes to the Equality Hub are necessary – the quality of work produced is down to the people, not to the structure itself.

87. We did experience some obstacles in relation to data sharing with NHS England, leading to the inclusion of a priority recommendation in my final quarterly report that an independent strategic review be undertaken of the dissemination of healthcare data and publication of statistics and analysis.

88. A further obstacle related to the sharing of the findings of my quarterly reports with the Joint Committee on Vaccination and Immunisation (JCVI). DHSC officials informed their Equality Hub counterparts that it would be inappropriate for a government minister to write to the Chair as this could be seen as me trying to influence the operationally independent Committee. This was not my intention and the letters I sent to the JCVI simply relayed the findings from my first three reports to the Prime Minister. I am unaware of any other issues regarding the distribution of my quarterly reports with other bodies responding to the pandemic. Indeed, the quarterly reports were made publicly available at the time they were produced.

89. I am aware that some Equality Hub staff were redeployed following the first national lockdown. The decision to redeploy Equality Hub Staff was a decision made by the then-Minister for Women & Equalities. The work of the Race Disparity Unit was essential in conducting the disparities work the Prime Minister asked me to lead. In my opinion our work was not affected in output or outcome by the challenges of navigating Covid-19. The redeployments, which predominantly were a feature of early to mid-2020, did not impact or prevent me from making direct representations at any time during the pandemic.

90. My fourth quarterly report (at pages 18, 35, 44, 53 and 64) includes detailed lessons learned from our work and an action plan for addressing some of the longer-term issues

identified during the course of the project I was assigned by the Prime Minister. I endorsed these recommendations and rather than repeat them here I am able to speak to the lessons learned that appear in my report if so required.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed:

Personal Data

Dated:

14/04/2025