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Rt Honourable Baroness Heather Hallett DBE
Fieldfisher
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Sent by email to: chambers@18rlc.co.uk; halletth@parliament.uk

Dear Baroness Hallett

COVID-19 Public Inquiry: FEMHO submissions on the terms of reference

Further to our letter dated 22 December 2021, we write to request your commitment for the inclusion of some key questions in the Terms of Reference to the Covid Inquiry, that affect black and minority ethnic ("BAME") communities. As a federation of individuals, groups and networks representing BAME clinicians, researchers and ancillary workers, we are concerned with the disproportionately adverse health outcomes of our members from COVID-19, both at the workplace and within our communities.

It is common ground that BAME health and social care sector workers are overrepresented in frontline roles and underrepresented at the level of senior management, both within the NHS and across other spaces in health and social care. The mortality rate among BAME health and social care workers was especially evident in the first stage of the pandemic, at a time when there was little contemporaneous record keeping about the disease in general - and particularly so, with regard to the racial and ethnic identity of those who were being infected.

We believe that the type of outcome experienced by the BAME community raises serious questions about systemic underlying health inequalities and about how such inequalities ultimately impact in a way that is referrable to race and ethnic origin. This belief has only been strengthened by the findings of the NHS Race & Health Observatory's report published this week. It is only with thorough and detailed investigation through the inquiry that this phenomenon can be uncovered, real lessons learned and appropriate recommendations made.

Our diverse group of BAME health and social care workers represent over 40 different groups and networks across the sector. We are uniquely well placed to assist the inquiry on the relevant issues from both the health and social care space and on its impact on our members from within our communities.

In the accompanying appendix to this letter, we have set out a series of key questions reflecting our concerns, which we consider of vital importance for inclusion in the inquiry's terms of reference. We look forward to receiving and engaging in the consultation on the wider draft terms of reference document when it is published in due course.

Yours sincerely

Sent on behalf of FEMHO and the organisations listed below:

1. African Caribbean Medical Mentors (ACMM)
2. AskDoc
3. Association of Afghan Healthcare Professionals-UK (AAHPUK)
4. Association of Pakistani Physicians and Surgeons UK (APPS UK)
5. Association of Pakistani Physicians of Northern Europe (APPNE)
6. Bangladesh Medical Association UK (BMAUK)
7. Bangladeshi Doctors in the UK (BD Doc UK)
8. Better Health 4 Africa (BH4A)
9. Black Women in Health (BWIH)
10. British Association for Physicians of Indian Origin (BAPIO)
11. British Caribbean Doctors and Dentists (BCDD)
12. British Egyptian Medical Association (BEMA)
13. British Indian Nursing Association (BINA)
14. British Indian Psychiatrists Association (BIPA)
15. British International Doctors Association (BIDA)
16. British Islamic Medical Association (BIMA)
17. British Pakistani Psychiatrists Association (BPPA)
18. British Sikh Doctors Organisation (BSDO)
19. British Sikh Nurses (BSN)
20. British Somali Medical Association (BSMA)
21. Cameroon Doctors UK (CamDocUK)
22. Filipino Nurses Association UK (FNA UK)
23. Ghanian Doctors and Dentists Association UK (GDDA-UK)
24. Medical Association of Nigerians Across Great Britain (MANSAG)
25. Melanin Medics
26. Midlands Egyptian Society (MES (Medical))
27. Muslim Doctors Association (MDA)
28. Nepalese Doctors Association (NDA UK)
29. Nigerian Nurses Charity Association UK (NNCAUK)
30. PalMed UK
31. Seacole Group
32. Sikh Doctors and Dentists Association UK (SDDA(UK))
33. Sri Lankan Psychiatrists Association UK (SLPA(UK))
34. Sudan Doctors Union UK (SDU-UK)
35. Syrian British Medical Society (SBMS)
36. Uganda Nurses and Midwives Association UK (UNMA-UK)
37. UK Black Pharmacists Association (UKBPA)
38. UK Ugandan Medical Doctors Association (UK UMDA)
39. United Iraqi Medical Association (UIMA)
40. Zimbabwe Doctors Association UK (ZDA-UK)
41. Zimbabwean Allied Medical Professional Association (ZAMPA UK)

Encs:

Appendix 1: FEMHO submissions on the terms of reference for the UK COVID-19 Public Inquiry

Copy of NHS Race & Health Observatory Report: Ethnic Inequalities in Healthcare: A Rapid Evidence Review, 14 February 2022

Appendix 1: FEMHO submissions on the terms of reference for the UK COVID-19 Public Inquiry

Preface: As with all areas within the scope of the inquiry, in regard to the issues identified below, we expect there to be sufficient evidence obtained, disclosed and investigated from all relevant sources, to enable the production of a definitive narrative of key events and decisions, robust factual findings and appropriate recommendations to ensure that the UK learns from the lessons of this pandemic and is better equipped to handle the remainder, as well as any similar, future health crisis. It will be crucial that the success and/or failure of steps taken throughout is investigated along with a review of what alternatives could and should have been pursued such that lessons can properly be learned.

1. Disproportionately high levels of infection and deaths amongst black and minority ethnic communities as a whole:

a) *Has there been accurate recording and reporting on COVID-19 infection and mortality rates based on race and ethnicity for each phase of the pandemic? If not, why not?*
b) *Has there been an appreciable difference in rates of COVID-19 mortality amongst people from different races and ethnicities during the course of the pandemic?*
c) *Has there, as a matter of fact, been disproportionately high levels of COVID-19 infection, adverse health outcomes and deaths amongst black and minority ethnic communities in the UK? If so, why is this the case?*
d) *What systems existed for the collection of relevant data to identify such disparities in infection and mortality rates? Further:*
    i. *What organisation(s) was accountable for taking action as disparities emerged?*
    ii. *At what point could and should this disparity have been identified by the Government and/or other state agencies and by what means?*
e) *Did Government and/or other state agencies take adequate, effective and timely action to protect black and minority ethnic communities once the disparity had been identified? What if any other steps could and should have been taken?*
f) *Were appropriate equality impact assessments and/or other equivalent measures carried out in respect of key government decisions, policies and guidance throughout the pandemic?*
g) *Was adequate engagement and external accountability put into place, for example through local government-established scrutiny processes and via the Public Accounts Committee?*
h) *To what extent have pre-existing racial inequalities contributed to the disproportionate impact on, and adverse health outcomes suffered amongst, black and minority ethnic communities? Further:*
    i. *What could and should have been done to reduce known race and health inequalities in recent years?*
    ii. *What impact might these missed opportunities have had on COVID-19 outcomes for black and minority ethnic communities?*
    iii. *What should be done now to reduce health inequalities and protect black and minority ethnic communities going forwards?*
i) *Was official information, messaging, advice and guidance on COVID-19, including on matters relating to vaccination, provided to black and minority ethnic communities in an accessible and culturally appropriate manner?*
j) *Has there, as a matter of fact, been a lower take up of the COVID-19 vaccine amongst black and minority ethnic communities? If so, why is this the case?*
k) *What steps have been taken to tackle myths and misinformation surrounding the COVID-19 vaccine?*
l) *How effective has the "community champions" scheme been in increasing uptake in the COVID-19 vaccine amongst black and minority ethnic communities? What, if any, other measures could and should have been taken?*

2. Disproportionately high levels of infection and deaths amongst black and minority ethnic health and social care workers in particular:

a) *Has there, as a matter of fact, been disproportionately high levels of COVID-19 infection, adverse health outcomes and deaths amongst black and minority ethnic health and social care workers? If so, why is this the case?*
b) *What systems, if any, existed for the collection of relevant data to identify such disparities in infection and mortality rates amongst health and social care workers? Further:*
    i. *What organisation(s) was accountable for taking action as disparities emerged?*
    ii. *At what point could and should this disparity have been recognised by healthcare providers and employers, Government and/or other state agencies?*
    iii. *Was effective action taken by healthcare providers and employers, Government and/or other state agencies at the appropriate time?*
c) *Once the disparity had been identified, were adequate and timely steps taken to provide a safe working environment to protect black and minority ethnic health and social care workers? What if any other steps could and should have been taken? In particular:*
    i. *Was clear and comprehensive information and guidance on protection from issues and risks to staff from black and minority ethnic communities disseminated within the health and social care sector in a timely manner?*
    ii. *Were appropriate and culturally sensitive equality impact assessments, or other equivalent investigations, carried out in respect of key policies, protocols and guidance in health and social care workplaces and were reasonable adjustments provided for?*
    iii. *Did health and social care employers across the UK establish proactive approaches enabling robust, comprehensive, culturally inclusive and effective risk assessments for black and minority ethnic staff, including considerations of both physical wellness and mental health and options for redeployment where appropriate?*
    iv. *Was the provision and allocation of PPE adequate, particularly in respect of black and minority ethnic staff given the known risks to these groups?*
    v. *Was the PPE 'fit testing' regime appropriate and effective for black and minority ethnic staff?*
    vi. *Were reasonable adjustments made to ensure that appropriate PPE was provided to staff accommodating factors such as cultural or religious dress?*
    vii. *Was sufficient guidance, training and compliance mechanisms put in place for areas of the health and social care sector unaccustomed to PPE such as mental health services and district nursing where black and minority ethnic staff are disproportionately represented?*
    viii. *What opportunities were there for black and minority ethnic staff to safely express preferences and/or concerns as to their working environment in light of their personal circumstances and particular vulnerabilities?*
    ix. *Was adequate support put in place for black and minority ethnic health and social care workers to cope with the unique challenges they were facing and the consequent toll on their and their families' mental health?*
d) *What level of representation, engagement and consultation was made available to black and minority ethnic health and social care staff in respect of emergency planning and decision-making structures? Was this adequate and appropriate?*
e) *In light of the experiences of black and minority ethnic health and social care workers during the pandemic:*
    i. *Are the current laws and policies governing black and minority ethnic staff employed in the health and social care sector adequate and appropriate?*
    ii. *Could and should more have been done to address the unique challenges and disproportionate impacts on this group, for example by the Health and Inequalities*

Minister, the Department for Health & Social Care's Race Equality team, NHS England and/or the NHS Workforce Race Equality Standard group.

f) *To what extent have pre-existing racial inequalities within the health and social care system contributed to the disproportionate impact on, and adverse health outcomes suffered amongst, black and minority ethnic staff? Further:*
   i. *What could and should have been done to reduce known inequalities in recent years?*
   ii. *What impact might these missed opportunities have had on COVID-19 outcomes for black and minority ethnic staff?*
   iii. *What should be done now to reduce these inequalities and protect black and minority ethnic staff going forwards?*

3. Wider questions as to the adequacy of health and social care sector policies, systems, procedures and guidance for staff:

a) *Did Government and/or other state agencies suitably prepare to protect front line health and social care sector workers for a health crisis such as COVID-19?*
b) *Were adequate protective measures put in place by health and social care providers, Government and/or other state agencies in a timely and adequate manner?*
c) *Were clear, comprehensive and effective systems, policies, information and guidance put in place and disseminated in a timely and adequate manner to mitigate and minimise the risk of transmission in health and social care settings? Was there sufficient internal and external accountability in respect of these measures?*
d) *What were the NHS' staff self-assessment policies and were these adequate?*
e) *What opportunities were there for staff to safely express preferences and/or concerns as to their working environment in light of their personal circumstances and particular vulnerabilities?*
f) *Were concerns raised by staff about policies, systems, procedures, guidance and the safety of their working environment handled appropriately?*
g) *Was the provision and allocation of PPE across health and social care settings adequate and appropriate?*
h) *Did NHS employers and care home providers assure training and compliance around the appropriate use of PPE equipment?*
i) *Was sufficient guidance, training and compliance mechanisms for PPE, including clear "don and doffing" training guidelines, put in place in an accessible format for all staff?*
j) *At what stage was adequate testing and tracing made available for frontline workers and their families? Could it have been made available at an earlier stage and, if so, when?*
k) *Was adequate support provided by employers to staff who needed to shield and/or self-isolate as a result of being exposed, infected and/or vulnerable? What other steps could have been taken?*
l) *Was adequate and appropriate support established in a timely manner to help staff and their families cope with the toll the pandemic has taken on their mental health?*
m) *Was the phenomenon of "long Covid" identified in a timely manner?*
n) *Have adequate and appropriate steps been taken to address, treat and support those with long Covid?*
o) *Is adequate and appropriate resource and research being directed at treatments for both acute Covid and long Covid?*