

# Health and Social Care Committee Science and Technology Committee

## Oral evidence: Coronavirus: lessons learnt, HC 877

Tuesday 1 December 2020

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Members present:

Health and Social Care Committee: Jeremy Hunt (Chair); Paul Bristow; Rosie Cooper; Dr James Davies; Dr Luke Evans; Neale Hanvey; Barbara Keeley; Taiwo Owatemi; Sarah Owen; Dean Russell.

Science and Technology Committee: Greg Clark; Aaron Bell; Dawn Butler; Andrew Griffith; Mark Logan; Graham Stringer; Zarah Sultana.

Questions 620 - 704

### Witnesses

**I:** James O'Rourke, family carer; and Steve Scown, Chief Executive, Dimensions UK.

**II:** Iain Bell, Deputy National Statistician and Director of Population and Public Policy, Office for National Statistics; and Professor Kevin Fenton, Regional Director, PHE London & Regional Director of Public Health, NHS London

**III:** Dr Habib Naqvi, Director, NHS Race and Health Observatory, NHS Confederation; and Professor Dr Ramani Moonesinghe, National Clinical Director for Critical Care, NHS England and NHS Improvement.

## Examination of witnesses

Witnesses: James O'Rourke and Steve Scown.

**Chair:** Good morning and welcome to the House of Commons Health and Social Care and Science and Technology Select Committees, where today we are doing a special joint evidence session, as part of our coronavirus: lessons learnt inquiry, on the impact of the virus on two disadvantaged groups—people from minority ethnic groups and people with learning disabilities.

We have three panels. The second two panels will look at the issues facing people from minority ethnic groups. We have some very important expert witnesses, including Iain Bell from the Office for National Statistics; Professor Kevin Fenton from Public Health England; Dr Habib Naqvi, the chair of the NHS Race and Health Observatory; and Professor Ramani Moonesinghe, who is from NHS England and is also an anaesthetist at UCLH.

In our first panel, we are going to look at the issues facing people with learning disabilities. A special welcome to Steve Scown from the charity Dimensions, which is one of the biggest UK organisations looking after people with learning disabilities in their own homes. I also welcome James O'Rourke, who is going to talk to us about his experiences trying to visit his brother Tony, who has learning disabilities, and how challenging that was during lockdown.

Q620 **Barbara Keeley:** Thank you, James, for giving us evidence this morning. Can you tell us about your, and your brother Tony's, experience during the pandemic?

**James O'Rourke:** Can I start by saying that Ann's account has been very helpful. It actually demonstrated not only the difficulties I have had with visiting my brother, but what countless people with learning disabilities up and down the country have had to face. Thank you, Ann, for your testimony.

It has to be noted that my family is just one of tens of thousands of families who have been denied access to their loved ones through ignorance of Government guidance, but more importantly of legislation. It is with this in mind that, while denial to see my brother has been and continues to be painful, there are countless others who have been subject to quite inhumane practices by care providers.

I wanted to set the scene; that is what is happening across the country. I am representing not just my family but other families throughout the country who have gone through much worse than my family have gone through. I will break it down into two: the first lockdown back in March, and then the second lockdown.

The first lockdown was incredibly frustrating but understandable, given that we did not understand what the virus was about. The guidance was



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scant. We did not have social bubbles then, and there was lack of proactivity, certainly from the care staff who support my brother. There was a blanket ban, to be fair, in the first lockdown. We had to advise and support the staff, ironically, to help with communication guidance with my brother. That was a revelation because we now communicate with Tony using video technology, and I cannot stop him talking now. If I was on the telephone, it would be much more difficult, so there has been a positive from this horrible coronavirus.

The second lockdown, for us as a family, was horrendous. I need to put in some context. Tony lives in a one-bedroomed flat, which he shares in a block with others. There are 12 flats. It is allegedly supported living, but the care provider treated it like a residential care home and completely locked it down, not giving us any access to Tony whatsoever. Over a period of three weeks, I had to email the care provider backwards and forwards, arguing that there were ways in which we could mitigate the risk to Tony, the staff and the other tenants when visiting him, but they were quite belligerent and were not willing to listen to our proposals.

One of the main concerns, Barbara, was the fact that there was a total lack of understanding relating to the Mental Capacity Act and what it meant for individual people's needs. We said that it is a statutory obligation that people should have their capacity tested to see if they understand what the blanket ban was about. When we asked about that, we were told that they did not do an MCA because no other carer had complained.

I just happened to be very lucky. I am an ex-social worker. I used to be a social worker back in the 1980s when we were closing down the hospitals that we still have. I was able to use both my professional expertise and the expertise I am gaining through the work I do now.

**Q621 Barbara Keeley:** It was really helpful that you could do that. In trying to get over the belligerent attitude and the blanket ban, were you and your family in contact with other families? Do you know how other families felt about it, or have you battled it on your own?

**James O'Rourke:** I have fairly much battled it on my own, but through the work that I am doing now—I am an independent reviewer for care and treatment reviews, so luckily I have contacts—I have had some very friendly free advice from barristers on Twitter, who have helped me draft emails. I was not totally alone, but in Tony's block I think we were the only family who challenged their blanket ban.

**Q622 Barbara Keeley:** How does that fit into what it is normally like? How does it fit in with the normal experience of you and your family supporting your brother? Were you surprised at that from the care provider?

**James O'Rourke:** Absolutely, because I used to be one of their trustees. Yes, I was very surprised by their reaction. It was not just the staff



supporting Tony directly. It was actually at board level that there seemed to be misunderstanding of the legislation around mental capacity and doing best interest meetings. We eventually did one, and I had to make the painful decision that because of the support bubble regime my mother would have contact with Tony directly. She can visit him at his flat and he can visit her at her place in Essex, but unfortunately I cannot. That is now having an impact. My brother is now, in my mother's words, pining for me, because we are very close and I cannot see him.

**Q623 Barbara Keeley:** It is difficult. What do you think we can learn more widely about the care of people with learning disability? This seems like a terrible set of events in terms of you being able to see your brother and how he feels about that.

**James O'Rourke:** Some of the guidance from Government could be a bit clearer. There was guidance around residential care and guidance around supported living. Supported living is such a wide term. It is misunderstood. Tony's is supported living. It is ironic that one of my best friends, who I sit on the committee with, works for Dimensions. He lives in a flat and he has not been subject to the same restrictions as my brother has. It just happens that my brother had 24-hour care and my friend does not. There was discrimination between the two, albeit they were living in the same type of accommodation.

There needs to be more training around the Mental Capacity Act. Staff somehow need to be taught how to think outside the box. I used to work in the 1980s in what was then residential care. We did not have supported living in the way we do now. I pride myself on the fact that we were able to think outside the box. I think we have lost that skill. People are directed to do things, and they do it within the letter of the law, whether that be legislation, or indeed diktat from management.

**Q624 Barbara Keeley:** Thank you. I am sorry it has been such a difficult time. I hope things carry on, but it is a great thing that you have the skills and contacts that you have and are able to battle it. You should not have to battle, and I am really sorry to hear that you have had to do that.

**James O'Rourke:** Absolutely. Barbara, you have been involved in many other things in relation to people with learning disabilities. It seems to be more of a battle now than it ever has been, and we need to recognise that.

One of the things I was looking at this morning before joining you was the Joint Committee on Human Rights saying in June that blanket bans were unlawful. They were advising the NHS on how they should manage blanket bans, or visiting in hospitals, for instance. I know I am digressing from my own family experience; but for the grace of God it could be my brother in one of those hospitals. I would want to be able to visit him.



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I have been at care and treatment reviews where family have been completely banned from visiting their loved ones, which exacerbates the reason why they are in hospital.

**Barbara Keeley:** Yes, I have heard that from families as well. Thank you very much.

Q625 **Chair:** Could you specify what it is precisely in the Mental Capacity Act that the staff looking after Tony did not understand?

**James O'Rourke:** I am not a lawyer. I am not an expert in mental capacity; I have learnt as I have gone along. If anything affects Tony, they should carry out an assessment to see whether he fully understands it. There are a number of tests, and I am sure you are aware of them, Chair. One of them is to understand information and retain information.

They did not do that. They imposed a blanket ban. In fact, they did not inform the tenants. They just informed the families through a letter.

Q626 **Chair:** If they had done those tests, they would have been able to exempt him from a blanket ban and allow him to make a judgment as to whom he wanted to see; is that correct?

**James O'Rourke:** He does not have the capacity to make that decision, which is why the MCA is there. Eventually, after weeks of debate around it, we got a mental capacity assessment that said that Tony did not have capacity. We then did a best interest meeting, which determined the best way of managing the visitations.

What we agreed was that my mother would visit. There were various ways of getting into the building to mitigate risk, and that was all documented. The irony was that I had already put that proposal to them three and a half weeks earlier. It took me three and a half weeks to come to a best interest meeting to agree exactly what I had already advised them to do.

Q627 **Chair:** Basically, they should have moved much more quickly into the best interests discussion, and that would have allowed a discussion with you that could potentially have allowed Tony to have some visiting, rather than the blanket ban.

**James O'Rourke:** Yes. The issue about Tony's block is that it is 12 individual flats. They could not get their head around the fact that that is what it was. My friend who works for Dimensions lives in his flat, and he was able to have visitors. My brother was in his own flat, and they just could not understand. If I was living in that flat I could have visitors, but because he had a learning disability it seemed that they were saying, "Well, we're going to lock it down because he's got a learning disability." We have to recognise that people with learning disabilities are susceptible to Covid, but there are ways in which we can mitigate that risk. They did not understand how to do that.

**Chair:** Thank you very much for joining us this morning. I know that the



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Committee would want to send their best wishes to Tony and your family as we go through this second lockdown and all the challenges that undoubtedly lie ahead in the Christmas period.

We are now going to watch the testimony that you referred to at the beginning. It is a video from a lady called Ann McCallum, who herself has a learning disability and advocates for other people with learning disabilities. Ann is going to talk about the difficulties that she experienced during lockdown.

*Video by Ann McCallum played to the Committee.*

Q628 **Chair:** Ann was speaking for a charity called Dimensions UK, which is the biggest UK charity supporting people with learning disabilities living in the community. We now have as a witness Steve Scown, who is chief executive of Dimensions. Steve, thank you very much for joining us this morning. What is your reaction to what we heard from Ann, and what we heard from James about his brother Tony's situation?

**Steve Scown:** I have heard that a number of families unconnected with Dimensions have had similar experiences, Chair. I am pleased that James's friend is not having that experience. It has been incredibly difficult for providers throughout the pandemic of the last nine months. A point I wish the Committee to hear is that, consistently, the Government guidance for registered care homes has been issued weeks in advance of guidance for supported living services.

James was right in saying that supported living services are not a single, binary service like a registered care home. There is a range of different models. The guidance for supported living is consistently weeks behind registered care. There has been a clear focus on large registered care homes for older people, and I understand that, but there are different models of registered care and there is a wide range of supported living services.

For example, the visiting guidance for supported living came weeks after registered care homes. That put providers in a difficult position. The testing regime has now been issued for registered care homes, and testing is just about sorted. We are still waiting for testing guidance on supported living. There has been a consistent lag throughout the pandemic between different types of services. That has placed providers of all sorts in a very difficult position.

At Dimensions, we have tried to take a risk-based approach. We have consistently stated publicly that we will follow Government guidance, but when it is not there we have to use our best judgment and take a risk-based approach.

Q629 **Chair:** Public Health England estimates that people with learning disabilities are two to four times more likely to die from Covid than the average. Why do you think that is?



**Steve Scown:** In part, people with learning disabilities have a much shorter life expectancy than people without. That is a well-known fact. I think I am right in saying that it is at least a decade, so there is an inherent disparity to begin with. Also, people with learning disabilities often have underlying health conditions that make them more susceptible to Covid. Equally, some of the difficulties they have had accessing the NHS during the last nine months have made treating their usual, normal illness—if I can use that phrase—much harder. We have had instances where people we support have not been admitted to hospital because they are not deemed poorly enough, whereas in the past they would have been. We have had difficulty getting GPs to visit. Often, the only way we have been able to access medical treatment is to dial 999.

There is a whole range of issues. There are people's underlying health needs, but there is also accessing health support generally at the time when they are ill. That has been our experience.

Q630 **Chair:** Last week, we asked the Health Secretary why the vaccine guidance currently says that all older people, including healthy older people, should get the vaccine before anyone with learning disabilities under the age of 65. I wondered whether you had any views on that.

**Steve Scown:** Unfortunately, I am not aware what his answer was.

Q631 **Chair:** He said he would look into it.

**Steve Scown:** Good. That is probably consistent throughout. The Government's eye has very much been on older people, perhaps for understandable reasons. That goes back to my point about the guidance being generally written for very large residential care homes for older people. The Government's eye is very much turned on that client group.

Q632 **Chair:** Going back to the points you were making earlier about the underlying differences in life expectancy, it is actually 14 years' lower life expectancy for a man with learning disabilities and 18 years' lower life expectancy, on average, for a woman with learning disabilities. I want to ask a broader question about whether the health inequalities for people with learning disabilities have been the fundamental reason that has caused the issue with people being more likely to be a victim of Covid.

**Steve Scown:** The honest answer is that I cannot answer that question from an expert perspective. My judgment is that people's underlying health difficulties are a significant factor. I would go back to saying that part of the reason is the difficulties they have in accessing decent healthcare.

Q633 **Chair:** James, do you want to add to that point?

**James O'Rourke:** It is around the life expectancy. One of the things that we are noticing in care and treatment reviews is that it is about communication. For instance, Tony would not be able to tell you where the pain is, so it is difficult for a GP or a medical person to be able to



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determine what the issue is, whereas you or I can say, "The pain is here specifically." Tony cannot do that, so that in itself contributes to life expectancy, because Tony cannot communicate to tell you where the pain is.

**Steve Scown:** That is one of the reasons why allowing support staff or families to accompany people to hospital is so important. Often they are the interpreter, if you will forgive the phrase. During Covid that has not been the case. We have had 43 people admitted to hospital during Covid. On no occasion have families or staff been allowed to go with them. That has made their treatment much more difficult for our health colleagues.

Q634 **Barbara Keeley:** You have talked about underlying health conditions, but we know, from the work on learning from early deaths among people with learning disabilities, that there are very many other factors, like lack of screening and lack of appropriate treatment.

Can you talk us through the root causes of the inequalities that we have just been talking about, and what can be done about them? It is important that we do not just take it that there are inequalities, so that's it and we can expect more deaths from Covid. I do not think that would in any sense be acceptable. What are the root causes, and what can we do?

**Steve Scown:** We have to admit the point that people with learning disabilities are not valued as equal members of society. We have seen that in a number of instances. I would cite as evidence for that the number of DNARs that have been placed on people we support without any consultation with their families or anybody who knows them and their best interests. That tells me there is a fundamental problem about how people with learning disabilities are valued in society and within the system. That is certainly one thing.

Another thing is that it is often very difficult to get reasonable adjustments made for people accessing health services. Dimensions has done some work with My GP and My Campaign to try to educate health practices and GPs on what reasonable adjustments are and how easy they can be. That can help.

One of the things we have done a lot of work on is getting annual health checks as part of the rhythm and routine of life. We have made great strides in that. Unfortunately, they have almost come to a crashing halt. A real priority for me, going forward, is re-energising the annual health checks and getting them back up and running.

The other point is to do with training for health staff. I know that a lot of work has been done on that. If we are to raise the value of people in the eyes of our health colleagues, they need to understand the needs of people with learning disabilities more.

Q635 **Barbara Keeley:** You touched on issues with DNACPRs. Can you tell us more about those?



**Steve Scown:** Basically, we saw an increase in people leaving hospital with a DNAR—do not attempt resuscitation, if I have my acronym right. We had medical staff placing those on medical records without due process. That basically means that if the person becomes ill you do not attempt to resuscitate. The fact that they were placed on files without any meaningful conversation with families or any other professional is, frankly, disgraceful.

Q636 **Barbara Keeley:** In terms of the people that Dimensions is caring for, what access to critical care, if they need it, do you think is there, or are you doubtful that you would get access to critical care if people needed it? We have seen in the Public Health England report very high statistics for people with learning disabilities dying of Covid.

**Steve Scown:** Are we talking about the pandemic period?

**Barbara Keeley:** Yes.

**Steve Scown:** It is incredibly challenging. The people we support are less likely to be admitted to hospital now than they were. That is a fact. Our experience is that it is incredibly difficult to access medical attention—for example, a GP diagnosis. For me, it comes back to an equal footing and how people are valued.

Q637 **Barbara Keeley:** How is that expressed to Dimensions support staff? Is there a feeling that it is done on a blanket basis?

**Steve Scown:** Yes. We have done a lot of work to skill up our support staff to challenge medical professionals. I trained as a nurse many years ago, and in those days what the doctor said stood and nobody would challenge it. Today, we do a lot of work with our support staff, who have done a really great job throughout this pandemic, mainly challenging medical professionals and saying, “You cannot do that,” and having that blunt conversation.

I am very proud of some of our staff, pre-Covid, who would not walk out of surgeries until the doctor listened and came to a view. It takes very strong advocacy these days for people with learning disabilities to access appropriate healthcare. That has been exacerbated in Covid because you do not physically get into the same room as a doctor these days. It is over a phone, and that is an incredibly difficult advocacy job for our staff. We say, “It is really important; stand up; value the person; this is what we are here for. You are here to help this person have a great life; and in these days your job is keeping the person alive. If that means standing up to professionals and holding your ground, then we’ve got your back.”

**Barbara Keeley:** I am sure that all of us on the Committee want to thank your staff for doing that. People with learning disabilities need people to battle for them, and it is good to hear that your staff are doing that. Thank you.

Q638 **Taiwo Owatemi:** Thank you, Steve, for all that you and your staff have



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been doing. I want to ask more about the guidance that was given to care providers. We heard earlier from James that he did not find that the guidance was clear enough. How clear do you think the advice given to organisations has been in order for them to be able to interpret and implement it, especially from the first lockdown until now?

**Steve Scown:** On the whole, I have understood it and my senior managers have understood it. Sometimes, it has not seemed very logical, if I am being honest. I can think of a few occasions. Generally speaking, we have had to do an awful lot of simplifying for our support staff.

One of the interesting statistics is that in the first 100 days of the pandemic we received 100 guidance notes—one a day. That is a lot of information to receive, interpret and communicate to our 7,000 staff on the frontline. Often, the guidance would change a few days later. The guidance has often made sense. It has often seemed illogical and contradictory. It has changed very frequently, and we have had to work incredibly hard to help our staff keep on top of it, especially when we tell them, “You now need to do X, Y and Z,” and maybe a week and a half later, “It’s no longer X, Y and Z but A, B and C.” It has required an awful lot of organisational calories.

Q639 **Dawn Butler:** Thank you, everyone, for your evidence today. On the back of that last response, what would make clear messaging? How would you like the Government to respond? A hundred bits of information over 100 days is a lot for anybody. Do you have any suggestions for what lessons can be learnt?

**Steve Scown:** That is the \$64,000 question, Dawn. Obviously, if it could be simpler and briefer, it would be helpful. There should be more asking and listening.

The pandemic has been a challenge for all of us. All of us have had to make decisions that we never thought we would have to make and consider issues that we had only thought of in our worst nightmares. There is an awful lot of knowledge and expertise out there. If there could be a better way of engaging people on the frontline to understand what the impact of this is, and what would the impact of that be, it would be helpful.

Last Saturday, I received a mobile phone call, which I was unable to answer, asking me if I was able to contribute some thoughts on visitation in supported living services. They said, “We need you to get back to us in 45 minutes.” That was on a Saturday. I did not pick the call up, and therefore I was not able to respond. There has to be a better way to engage people who are dealing with this on the frontline, so that the guidance can be worked through and simplified. There are hundreds of thousands of colleagues working at the frontline. It needs to be simple.

Q640 **Greg Clark:** I want to pick up on something that Steve said earlier about testing. Regular testing was introduced, after a lot of pushing, in



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registered care homes. In terms of supported living, are residents now getting regular tests in your view?

**Steve Scown:** No.

Q641 **Greg Clark:** It is still not happening?

**Steve Scown:** No. From the issuing of the guidance, our estimate is that it took four weeks for it to become a functioning system happening consistently around the country. There is always a lag in getting it ready, but at the moment supported living is not getting regular testing. We have decided that we are going to buy our own tests to try to enable families to have Christmas visits, for example. That is the only way we think we are going to get them.

Q642 **Greg Clark:** And yet you have people, sometimes in vulnerable conditions, living in close proximity, not terribly dissimilar from people in registered care homes.

**Steve Scown:** Correct; yes.

**Greg Clark:** Thank you very much.

Q643 **Chair:** I think James O'Rourke wants to come back in.

**James O'Rourke:** There are two things. On testing, neither Tony nor my family has ever been offered a test. That would be useful to allow me to go and see Tony, in addition to my mother.

On what Steve was saying about guidance, there are groups out there. The NHS has the Learning Disability and Autism Advisory Group, which I sit on. I wonder whether that is a body that could be brought in. It has people with learning disabilities and autism. It has carers like me. We are working online now. If nothing else, we could be shown some of the drafts of guidance and maybe advise on how that guidance could be disseminated to the likes of Steve and others.

**Chair:** Thank you. Those are very good points. That brings us to the end of our first panel. It has been a very instructive panel. We have seen a very clear picture of people with learning disabilities at the back of the queue, behind people in care homes who have had a lot of national attention. They, in turn, have complained about being at the back of the queue behind the needs of the NHS. I think we have focused rightly on the issues facing people with learning disabilities.

The Health and Social Care Select Committee will consider whether we should come back to looking at health inequalities for people with learning disabilities more generally. That will be something that we consider whether we should do over the coming years.

You have given us very important evidence this morning, Steve, James and Ann. Thank you so much for your evidence and for joining us.

Examination of witnesses



Witnesses: Iain Bell and Professor Fenton.

Q644 **Chair:** The second panel focuses on issues affecting people from minority ethnic groups who, as we know, have also had a much higher likelihood of dying from Covid than the population more generally. I welcome our panellists: Iain Bell, the deputy national statistician at the Office for National Statistics, and Professor Kevin Fenton from Public Health England, the co-author of the report published in June about the impact of the virus on people from minority ethnic backgrounds.

Thank you both very much for joining us this morning. Thank you for your sterling work during the pandemic more generally and, indeed, to your teams.

Let me start with Iain Bell. BAME is a very broad term. It covers all minority ethnic groups. Could you help us to understand in a bit more detail the impact of Covid on different communities within that umbrella term? Which groups are more likely to suffer from serious disease, and why?

**Iain Bell:** I will start by walking through a bit of the analysis we undertook about risk of mortality from Covid-19. For different ethnic minority backgrounds, we looked at a range of socioeconomic factors by linking the 2011 census with our mortality information. Since then, we have also linked hospital records to get comorbidity information.

There are four different factors that are coming through as being linked, which may explain some of the higher differences in mortality for ethnic minorities. The first is that people from ethnic minority backgrounds are more likely to be in roles that are less likely to be able to home-work and are higher risk. Our analysis showed that one in five were working in higher-risk occupations, compared with 11% of the population.

The second area is multi-generational households with higher occupancy. From the English housing survey, for example, we know that if you take their definition of "overcrowded"—more than one person per bedroom—for the white population, 2% live in such accommodation; for Bangladeshis, it is 24%; for Pakistanis, 18%; and for black Africans, 16%. We also know that those living in urban high-density areas are more at risk, as are those resident in more deprived areas.

When you put that together, those factors explain half the higher rate of mortality in men and two thirds of the higher rate for women. For some ethnic minority groups, for females, the differences in those factors explain it totally—in particular, Bangladeshi women. That still left significant differences—

Q645 **Chair:** Sorry. I want to check that I did not miss those. You said there were four different factors. Just spell out the four again, please. I got more likely to be in high risk occupations and more likely to be in multi-generational households. What were the other two?



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**Iain Bell:** Living in high-density areas and more likely to be living in deprived areas.

**Chair:** Thank you.

**Iain Bell:** Even after those factors, it still left significant differences. For males, the mortality for black Africans was 2.3 times as high. For Bangladeshis it was 91% higher, and for black Caribbeans it was 69% higher. For Indians it was 52% higher. For Pakistanis it was 60%, and for mixed it was 23% higher. For females, black African mortality was 55% higher and black Caribbean 34% higher, with Indian at 23% higher and Pakistani 51% higher. As I mentioned earlier for Bangladeshis, the difference was wholly explained there.

I would caution that there were factors that we still cannot explore and that may explain more of those differences. For example, we know that the majority of the infections would have been of working-age people, but mortality was significantly higher for older people. There are factors we have not been able to look at, such as the occupation of the first case in a household and factors associated with that.

The final bit is that we added pre-existing medical conditions to the analysis based only on hospital episode statistics. That did not explain much more of the difference at all. We know that not all pre-existing conditions will be present on hospital records. We are currently doing a bit of work to look at GP records to understand pre-existing conditions more fully.

Q646 **Chair:** I want to make sure that I have properly understood what you said. You are saying, for example, that black African men are two to three times more likely to die from Covid, even after you have taken account of factors like deprivation, multi-generational households, high-density living and a higher propensity to be health workers and in other high-risk professions. Is that what you are saying?

**Iain Bell:** Yes; 2.3 times as likely. That is correct.

Q647 **Chair:** At what stage in the pandemic did the ONS become aware of that higher propensity for people from minority ethnic groups to die from Covid?

**Iain Bell:** We became aware quite early in the pandemic. Indeed, in our first publication in early May—I will confirm the exact date—we looked at that.

Q648 **Chair:** Let me bring in Professor Fenton, who I very much enjoyed working with when I was Health Secretary. It is nice to see you again in a different capacity.

We have heard very striking evidence from the ONS that even when you discount those four factors, and even when you discount the long-term health conditions that a lot of people talk about, such as a higher propensity for diabetes in minority ethnic groups, there is a significantly



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higher likelihood of someone dying from Covid. What do you think the reason for that is?

**Professor Fenton:** Thank you very much for the invite this morning. The findings that have been described by my ONS colleagues were certainly seen in PHE's review of inequalities and outcomes related to Covid. We similarly saw differences across ethnic groups, with Bangladeshi groups significantly more likely to have higher death rates than other groups. For all ethnic groups in our study, we identified higher risk compared with the white British population.

After adjusting for age, sex and geographic area of residence, we too were not able to account for all of that difference. That is exactly the reason why PHE also did an accompanying report to our work, which was a qualitative stakeholder engagement session to go beyond the data and to begin to ask questions as to why we were seeing those differences, and what are some of the social, cultural and contextual factors that might drive them. The work that we did uncovered a number of factors that both increased the risk of acquisition of Covid and the severity of the disease, as well as increasing the risk of death with Covid. It was qualitative work through stakeholder interviews.

Briefly, there are three key things that are important. The first is the ability for us to truly understand the impact of the pre-existing, long-standing inequalities that many of these communities have been faced with, and how, coming into the pandemic, that would have placed those communities at risk. They are at risk because of their housing conditions, their health conditions and their ability to engage with the system effectively. Those were factors that would have made those communities start at a disadvantage.

Secondly, there are factors related to how communities were accessing care, and the likelihood of them accessing care early in the course of their disease and therefore benefiting from high-quality care. Those were pre-existing relationships with the health sector, trust in health services and the ability to understand symptoms and to present early to healthcare settings. We have heard from some of our stakeholders that even navigating NHS 111 was challenging. Therefore, we know from our data that people perhaps did not present as early in the course of their disease as they could have.

Thirdly, there are the factors that increase the risk of severe disease and death. As we have heard from my ONS colleagues, those are factors such as multiple comorbidities, mental health issues and severe enduring mental ill-health. There are factors related to obesity and other pre-existing conditions. All of those drove the risk of severe disease and death.

There are a number of contextual factors that epidemiological studies were not able to identify or quantify, certainly not in that phase of the



pandemic. That is why the stakeholder interview was so critical in unpacking them.

Q649 **Chair:** Iain Bell, did you look at the impact of obesity and work out whether that could explain some of the difference that you talked about?

**Iain Bell:** Where it was recorded on hospital records, we looked at and accounted for it, but if it was only recorded on a GP record and not present on a hospital record, we have yet to fully account for it. The bit of work we are currently undertaking is to look into and explore that.

Q650 **Chair:** Are there any early indications from the work that you are seeing at the moment?

**Iain Bell:** What we found from the earlier work on the hospitals is that it did not explain much. That does not mean it is not important, but the model has already accounted for deprivation. If we take cardiovascular disease as an example, we know that the Bangladeshi community have significantly elevated rates of cardiovascular disease. However, that did not come through as explaining much, because factors such as deprivation, which were already in the model, already explained some of that difference. My instinct, without having seen it, is that we also know that obesity is often highly correlated and highly related to deprivation and other factors. I am not expecting it to explain huge amounts more. It may explain some more, but I do not think it will explain much more.

Q651 **Chair:** Professor Fenton, you did a big report in June that highlighted these issues. Are you satisfied with the Government's response to that report since you published it?

**Professor Fenton:** I am very pleased that a nominated Minister—the Minister for Equalities—has been asked to take this work forward, because it is important both in understanding the first wave of the pandemic and in driving the recommendations arising from that work. The Minister for Equalities has been tasked with taking the work forward, looking at the cross-government actions that are in place to address inequalities, doing further stakeholder engagement work, commissioning additional research and, of course, looking at the effectiveness of measures that have already been put in place.

Bear in mind that the PHE report was commissioned in April, completed in May and released in June, during the first wave of the pandemic. It provided initial understanding of the impact of the first wave on different groups. It was vitally important that on the basis of the recommendations there was a high-level Government Minister charged with taking the results forward and driving actions. That, of course, does not prevent actions by colleagues like me working in regions with local authorities. It has not stopped the NHS doing fantastic work in this space, nor has it stopped community-based organisations taking the work forward, but having a high-level Government Minister leading it has been a definite plus for the work and will help to drive further change.



Q652 **Chair:** You have a slightly awkward position because PHE is a Government agency. I remember from my own time in office that you were prepared to speak out independently at critical moments. Are there aspects that you feel the Government have not responded to as fast or as extensively as you would have hoped, given that that report was in June and we are now in December?

**Professor Fenton:** One of the things we did in PHE was to examine the degree to which all seven recommendations were implemented and applied. The ones that we were most concerned about as we were moving through the pandemic were the availability of data that would help us to characterise the effectiveness of our Covid prevention interventions—for example, the performance of testing and contact tracing and how that varies across ethnic groups; and the provision of culturally competent messaging and campaigns, as well as programmes to help to mitigate the impact of Covid on BAME communities and to reduce inequalities.

A lot of good work has taken place so far, but as we move into the second wave, and perhaps subsequent waves, of the pandemic, we need granularity of the data for both testing and contact tracing, as well as how a lot of the new innovative testing technologies are being delivered, received and taken up by communities, so that we can truly understand whether we are targeting our interventions appropriately, whether they are being accepted by communities and whether they are having an impact.

The good news, certainly in London, is that we are not seeing the significant ethnic and racial differences that we saw in the first wave of the pandemic, but I know that the pattern slightly varies across the country. That is an area where we need to continue to do more just to ensure that we have better data and better programmes that are culturally competent as part of the response.

Q653 **Chair:** That was a very diplomatic response, but can I push you? Are you really saying that you would have liked to see mass testing, for example of the Bangladeshi community, much earlier?

**Professor Fenton:** No, but I am saying that for the testing services that were provided—for example, pillar 2 testing; to ensure that we had data on ethnicity earlier in the pandemic. Now we have that data routinely available, and it is helping us to understand our testing patterns.

Ethnicity data for contact tracing, for example, is less well developed, and at this time we do not have routine reporting on the performance of our contact tracing services across different ethnic groups. That means that we are not really able to understand the degree to which we need to enhance some of those interventions for them to work.

Similarly, understanding how communities receive messages related to prevention of Covid is critically important—how they respond to some of



the national campaigns and their understanding of tiers. Again, we do not have surveillance systems that routinely enable us to understand how those messages and interventions are landing with different groups and, therefore, what we need to do to enhance them. That is an area where, as we move through the second wave, we can do better, and we will need to do better to help to reduce inequalities.

**Q654 Sarah Owen:** Iain, I want to pick up on the points that the Chair raised around the difference within the entire BAME community, and the different impact that coronavirus has had. You pointed to the differences for black and Bangladeshi people, but there are also other differences within our diverse communities. Are you saying that there is not enough data yet to identify why there is a difference in mortality rates within our diverse communities?

**Iain Bell:** There is a mixture of some within-household data that is difficult to get hold of—taking an entire household and looking at it together. Let's take the example of somebody who is in a high-risk occupation and picks it up. They bring it into the household, and the mortality is in a different member of the family but within the ethnic group. We do not yet have the data to look at that fully. The Covid-19 infection survey will enable us to do that. We will carry on doing that and looking at it in order to get those results.

**Q655 Sarah Owen:** You picked up on the Bangladeshi example, but I want to know how the UK has done in comparison to other countries when it comes to ethnic minorities. If you look at the figures for Bangladesh as a whole, their mortality rate from Covid is 6,644. How many Bangladeshis have died in comparison here in the UK? If you look at the Filipino figures, for example, within the NHS, more Filipino nurses have died in this pandemic in the UK than in the entire Philippines. I want to know what the UK could be doing differently, perhaps learning lessons from other countries.

**Iain Bell:** We have largely done our international comparisons so far within the European Union. We need to update them because it is very clear that, internationally, different countries are having very different autumn periods or, if they are in the southern hemisphere, spring periods. We need to update those international analyses. I do not have exact figures to hand on international deaths to compare, but I will get back to you on the Bangladeshi numbers that you asked for.

To jump back to your original question, if I may, the other bit is about not fully having enough data. As Professor Fenton rightly pointed out, the qualitative work really adds to that. There are some bits that we will never be able to fully explore utilising the data; in particular, things such as whether people are less likely to access medical services in a timely way is not as observable. That is why the work in the round, utilising both the quantitative data we utilise and qualitative research, becomes really important to provide a diverse picture. I will get back to you with the international comparisons as well.



Q656 **Sarah Owen:** Professor, you mentioned the statistics and data needed around ethnicity for contact tracing. That was something the Health Committee raised with Baroness Dido Harding at the very beginning. We were assured that she was taking very seriously the huge impact on our black, Asian, minority and ethnic communities. What is the level of data that you have available on contact tracing and ethnic minorities?

**Professor Fenton:** I understand that the data is now available. Initial cuts of the data suggested that the quality of the data was not as robust as we would have liked. I believe that over the summer, going into the autumn, more work has been done to improve the quality, so that we can use it routinely, both for surveillance and to evaluate the effectiveness of our contact tracing programme.

As it stands at the moment, we get robust analyses and data for the delivery of testing and the uptake of testing by ethnic group. That enables us to look at differences in case rates, for example, and the incidence of disease. We do not yet have routine outputs on contact tracing performance, either for the index cases or their contacts. We are not yet able routinely to look at that. I think that is where we will need to continue to push, moving forward.

Q657 **Sarah Owen:** Have you seen a difference in the level of contact tracing for ethnic minorities that is locally delivered or nationally delivered by Serco?

**Professor Fenton:** Again, in the absence of the routine data, we are not able to look at some of those differences and variations by ethnic group. As you know from a number of other analyses and reports, locally enhanced contact tracing provides very good outcomes, in part because it is closer to communities and able to engage communities in much more culturally competent ways.

Even in a city such as London, we see significant variations by borough across the city. That may well reflect some of the local complexities, working with more disadvantaged communities or ethnically diverse communities, or the capacity of the healthcare system and the care system to engage those communities for contact tracing. We are doing work in London now; for example, more of our boroughs are doing locally enhanced contact tracing to understand why we see those differences, and then to see if the ethnicity data, as and when it becomes available, can help us to explain some of those variations as well.

Q658 **Sarah Owen:** Lastly, is there enough data that you do have to suggest that there are some immediate actions that could be taken within this crisis, and some long-term actions that could address health inequalities?

**Professor Fenton:** Absolutely. The PHE reports that were published in June this year did exactly that. There were seven recommendations arising from that work, which was built on both the epidemiological study that we did, as well as the stakeholder engagement activity with more than 4,000 individuals, plus a rapid literature review that was done at



that time. It highlighted seven key recommendations, which were designed to be implementable, scalable, acceptable and appropriate, as we moved from wave one of the pandemic and into wave two. We wanted to ensure that every level of the system was focused on a few things and was able to do them well in preparation for the autumn.

In London, we established a governance structure to look at implementation. We have audited and worked with our ICSs to see the degree to which they have implemented recommendations. We have worked with local authorities across the city on all seven of those recommendations. I believe the recommendations give us a really good steer for what we can do to help to mitigate the impact on communities. You can see from our most recent epidemiological data in London that we are having a much better second wave than at this point in the first wave.

**Q659 Dr Evans:** Thank you to the panel for coming along. My question is, first of all, to the professor. I am very keen to see what work has been done. You have talked about the medical aspects and the socioeconomic side, but what about the biological aspects? We know that the virus comes through in the ACE2 receptor once it has gone through the mucosa. There is evidence that there is a disparity in ethnicities between the amount of ACE2 receptor representations that we may have, and different ethnicities have a different immune response. Given the fact that you have accounted for all the areas that you have already talked about and matched them off, how much does this lead to the biology of the simple difference between different ethnicities?

**Professor Fenton:** It is certainly a question that, as an epidemiologist, I am interested in learning more about. The reality is that we know that there are genetic differences, as you have mentioned, both in the immune response as well as the susceptibility to a number of conditions that can, in turn, influence the severity of Covid and the risk of death from Covid. We are still in a relatively early phase of understanding how those genetic differences might manifest in clinical outcomes and epidemiological outcomes. Work commissioned both by NIHR and MRC over the summer will certainly help to unpack some of the differences and how they influence clinical outcomes.

One of the things that we must be really careful about is not looking for simple or easy solutions to complex and difficult issues. It is in fact the interaction between genetics, your social conditions, your clinical conditions and demographic characteristics; they all come together to drive risk. We have to look at this in the round rather than—I know this is not what you are suggesting—identifying one or other factors as being the most important.

**Q660 Dr Evans:** I am keen that you pick up on that because it is exactly what *The Lancet's* systematic review in the summer picked up. It pointed at those biological, medical and social aspects. Out of those, is there any evidence emerging of which is a predominating factor? This will lead to



my question to Iain. There is the obesity aspect and the diabetic aspect. We know that south Asians are six times more likely to have diabetes. Afro-Caribbean people are twice as likely to have diabetes. With obesity, Chinese and Bangladeshi men are much slimmer compared with south-east Asian women. How do you feel about those factors? Is there any emerging evidence to point to which seems to be leading, between the three of those?

**Professor Fenton:** We know, epidemiologically, the factors that generate health and wellbeing. Social and structural conditions have much greater impact on your overall health and wellbeing. Those are your living conditions, whether you are in employment, whether you had a good education, whether you have access to a supportive and loving environment, and whether you are living and working within a context in which discrimination, stigma and other factors such as those are not negatively impacting you. Those are much bigger determinants of your wellbeing than, for example, access to care or your genetic profile.

Similarly with Covid, if asked to say which is likely to be the most important of the range, I would again go back to the importance of social and structural factors, in part because, if you are living in poverty, you are much more likely to have a range both of risk behaviours that would increase the risk of acquisition of disease and of conditions that put you at risk of more severe disease because of the strong relationship between non-communicable or chronic diseases and poverty. You are much more likely to experience factors such as poor housing and poor access to health services. You are much more likely to experience stigma and discrimination, as we found in our report. Those will in turn influence how you engage with healthcare services and your ability to take up preventive measures, such as staying at home during the lockdown period.

Those social and structural factors are where I would say we will have the greatest opportunity, but also the greatest challenge, in addressing some of these inequalities.

Q661 **Dr Evans:** That is really helpful. Those are some of the things that we can try to drive and change, hopefully, in this panel.

Iain, I noticed that you said you offset for age, sex and medical conditions in your data. You pointed specifically at hospital data that you used. It will not surprise you that, as a GP, I feel that a lot of those patients, particularly the younger ones of an ethnic background, do not necessarily seek health behaviours and therefore you do not have data on their obesity or their pre-diabetic state.

How are you going to mitigate for those? You can drive anything through the input and output that you get, and clearly that is going to be key to understanding why so many younger people of ethnicity are struggling when it comes to Covid.



**Iain Bell:** If I may, I will briefly go back to the question for Professor Fenton. From the factors we have looked at so far, the socioeconomic is clearly driving a lot of the explanation. It explained half of the excess mortality rates for males from ethnic minority backgrounds and two thirds of the rate for females. That is before we fully account for all the factors.

Q662 **Dr Evans:** We know that for people with health inequalities, obesity is a big problem, particularly around the midlands and in the north, if there was a crude map that you could put across for obesity to show where things are highest at the moment. Is that what you mean, or are there factors within that?

**Iain Bell:** What I mean is that the main factors driving that are around employment and being more likely to be in employment where you are unable to socially distance to the same extent or are at a higher risk. It is also about household conditions and living in high-density areas, multi-occupancy households and, finally, about being in more deprived areas.

On the question about obesity, we have only hospital-recorded obesity data at the moment. We are currently looking at how we can get the GP records, to get a more accurate picture of obesity and link that into the picture. However, as you know, the map you refer to correlates with and maps over a map of deprivation. Therefore, the complication, as Professor Fenton says, is how much is structural and how much is obesity within that, and determining out that factor.

Q663 **Dr Evans:** Iain, within that and looking at the general population, in what order would you put age, sex, obesity and ethnicity? Is there a way you would stratify the biggest concern you have?

**Iain Bell:** Not at this stage. We have further work to do to get there; we particularly need to add the GP records before I could fully get to that answer.

Q664 **Zarah Sultana:** We know that ethnic minority groups are disproportionately represented in frontline roles, whether in the NHS, transport or retail. However, exposure alone does not entirely explain why they are disproportionately vulnerable to Covid-19, because key workers from white groups are also exposed.

The Runnymede Trust reports that some ethnic community groups were significantly less likely to be given adequate PPE; 50% of Bangladeshi workers, 2% of Pakistani workers and 41% of black African workers reported that they had not, compared with their white British counterparts, which was 21%. Do you believe that employers inside and outside the health profession have done enough to protect workers from ethnic minority backgrounds from exposure to coronavirus?

**Professor Fenton:** That is certainly an area that we were very concerned about when we began our PHE review at the beginning of the summer. In part, that was because, at that time, there were so many



news items and articles showing the disproportionate impact of Covid in the first wave on BAME healthcare workers.

In our stakeholder engagement work, a number of key factors were highlighted that could have explained the disparity. The first is the aspect of agency. Many BAME workers felt less empowered, less able to speak up and less able to express their concerns about PPE risk or any vulnerabilities they might have. That may have placed them at risk, and that was certainly seen in the literature review as well. A second key factor that stakeholders mentioned was the feeling that in work environments that were not conducive to promoting health and wellbeing, and were not engaging with staff and looking at risk assessments, staff felt less empowered and less able to ask for PPE, or may have experienced what they felt was disproportionate distribution, utilisation or access to PPE as well.

A third factor that was really important is understanding the intersection between workplace risk and risk that takes place outside the workplace. Many people in key worker positions or healthcare worker positions, especially in the first wave, may have been coming from communities where there was significant ongoing community transmission, as mentioned by Iain. There were factors such as deprivation, household composition, overcrowding and living in highly dense neighbourhoods.

There was perhaps a failure to link the risk that those healthcare workers may have had with their community risk, so that placed them at increased risk. Today, we have a much better understanding of how the risks are all related to each other. Recently, as you may be aware, PHE, working in partnership with the Faculty of Occupational Medicine and the Health and Safety Executive, released a joint statement about what we can all do to reduce risk for healthcare workers, as well as all workers, when it comes to Covid.

There are three key levels of action. One is ensuring that workplace wellbeing provides a context for all engagement in protecting workers. The second is ensuring that all guidelines are implemented and that you work with staff and employees around understanding risk, explaining risk and communicating around risk. The third is to understand the relationship between the community and the workplace, and ensuring provision of appropriate PPE as required.

**Chair:** Could I ask you to keep your answers brief? I am sorry, Professor Fenton, but we have another panel to come.

Q665 **Zarah Sultana:** I have one more question. The Runnymede Trust say that they fear that the same is happening in the second wave, and ethnic minority communities are being disproportionately hit again. In November this year, *The Lancet* produced an article that had urgent actions and policies needed to address Covid-19 among UK ethnic minority communities. I am going to run through some of the recommendations and then it will be a simple yes or no question, and you



can expand slightly if you want to.

Essentially, they argue that we need to prioritise testing for ethnic minority workers and their households, which is something that has been mentioned. We need to ensure that ethnicity is recorded at all contact points along the healthcare continuum; that we combat racist stigma in communities and workplaces; and that we have culturally and linguistically competent outreach campaigns. They touch on targeted financial support, which is something I am particularly concerned about; lack of adequate sick pay makes it very difficult for people in low-paid work to self-isolate.

Another interesting one was around isolating off-site from households. That touches on the point about multi-generational households and households that have many people in them. They mentioned Covid-19 anti-racism laws for workplaces, urgent grants to support private rental and social housing and rules on social bubbles that are adapted to multi-generational households.

I just want to get your thoughts on those and whether you think that the Government need to implement them ASAP.

**Chair:** Can I ask you to be fairly brief in your answer, Professor Fenton? That was a very long list.

**Professor Fenton:** Yes. In terms of the degree to which they are being implemented, there is variable progress with each of them. There are some where the Government are definitely making good progress. There are others that remain challenging. I would argue that they are exactly the sort of interventions that are needed. In a city such as London, we observe so much variation geographically, and across groups, that the social and cultural, as well as the clinical quality of care, is really critical. Yes, I agree with them, and there is variable implementation.

Q666 **Chair:** Can you tell us which are the ones where you think progress needs to be faster?

**Professor Fenton:** Given what we now know about some of the financial and economic realities of people's ability to, for example, isolate and stay away from work, I would think that interventions related to financial support, the provision of grants and how we get them into the hands of the neediest are among those that we absolutely need to think about, as we move through the second and subsequent waves of the pandemic.

Q667 **Dr Davies:** The two panellists have done a really good job of exhausting nearly all discussion topics in this area. To summarise where we are up to, you have told us that you think occupational roles are important, as well as multi-generational households, high-density housing, deprivation, biological or genetic factors and poorly quantifiable cultural issues, but we still have charts that show that some ethnic minorities are at much greater risk of harm from Covid.

Where do you think the gap lies? Is it confounding factors? Are there



things that have not been considered? Is it the issues I have just listed, but weighted incorrectly? Is there any other investigation that we need to do as a country and that you think should be prioritised?

**Iain Bell:** There are likely to be unobserved and confounding factors that are yet to go in. I mentioned earlier in the discussion some of those points, such as transmission within households between the index case into the household and wider.

The other aspect, which Professor Fenton touched on briefly, is self-isolation. That is really important. We know from King's College that 70% of people fully intended to self-isolate for a fortnight, but only 18% actually did once they had Covid. I do not have figures around self-isolation by ethnic minority, but that feels to me a very important concept given what we know about the likelihood to live in deprived areas.

The final bit is behavioural. We have recently expanded our opinion survey, which will give us more insight for different ethnic minority groups about behaviours. We know that behaviour often drives this pandemic. The gap around the behavioural work feels important, if you are asking me where the gap is.

Q668 **Dr Davies:** Finally, do you think you are going to get to the bottom of that so that we can fully explain the situation?

**Professor Fenton:** It is going to be an evolving journey. As we have more research and more experience in responding to the pandemic, we will continue to improve the ways in which we are responding.

A good example is that today is World Aids Day. I began my own career working on that pandemic. As new treatments have become available, with better surveillance, better data and better research, we have been able to target and engage communities and help to drive rates down. We are now at the point for HIV where we think of ending HIV within the next decade.

Similarly, as things evolve with Covid, I fully anticipate that we will see a reduction in inequalities, better engagement and real honesty about some of the social and structural factors that are driving the pandemic today and tomorrow.

**Dr Davies:** That is very positive. Thank you.

Q669 **Dawn Butler:** Iain, with regard to obesity, is enough work being done to highlight the fact that health BMI is also influenced by ethnic background, and the scores applied are generally to people from white backgrounds? If you have an ethnic minority background, you are more likely to be perceived as overweight. Is enough work being done for people to understand that with regard to obesity?

**Iain Bell:** The short answer is probably not. As we undertake the next phase of research, we will endeavour to make sure that we fully account for it and try to explain it as well as we can, and look at that area. My



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view is that, particularly in relation to Covid, obesity has been looked at as being, in the round, just one of the risk factors, without getting into the level of detail you are talking about. I think it is incredibly important that we do that as we go through the next stage of research.

**Q670 Dawn Butler:** Professor Fenton, do you think there is enough work being done in regard to vaccinations for people with blood disorders such as sickle cell and thalassaemia?

**Professor Fenton:** We are at a relatively early stage of doing the work that needs to be done to prepare the diversity of our communities for the vaccine. We know this because of data showing that there is high vaccine hesitancy, high misunderstanding and myths within the community. Within that, we need to do work with vulnerable groups within the BAME community, whether by blood disorders or by other multiple comorbidities.

In London, as we look at what we do to prepare Londoners for the vaccine, we are working with our community organisations and faith groups to begin conversations about the information needed, the best channels to get through to them and how best to work with groups that are dealing with some of those risks. There is definitely more work to be done and we need to be doing it very quickly, given that the vaccines are almost here.

**Dawn Butler:** Thank you both for your evidence today. It has been very interesting.

**Q671 Greg Clark:** Can I follow up on a question that Sarah Owen asked about working with other countries? Iain Bell, you mentioned work that was being done with Bangladesh to look at some of the research being done there. Is the ONS working with other countries consistently around the world to understand the impact of the disease on people of different ethnic backgrounds?

**Iain Bell:** In short, we have been working with the World Health Organisation to get more consistent recording through death certification. At the start of the pandemic, what became clear was that the UK system for death registration was providing some of the most timely and up-to-date estimates available. We have been working with the World Health Organisation and Eurostat to get better international reporting. It is fair to say that at this stage we have yet to look particularly into black and minority ethnic communities and Asian communities, but I am happy to take that away and look into it in the next phase of work.

**Q672 Greg Clark:** Given the global reach and standing of the ONS, I would have thought that you might be in a good position to work with other countries' statistical authorities and scientific bodies to give some understanding to help us, and the rest of the world.

**Iain Bell:** That is correct, and we are working closely, as I said, with the World Health Organisation to give that understanding, and with Eurostat



and other national statistics agencies. The main bit we need to take forward, which you and Sarah Owen rightly prompted, is the need to do this with a particular focus on black, Asian and minority ethnic groups. I am happy to take that away.

**Q673 Chair:** I wonder if I could be even more specific on that, Iain, and ask you to write to us with your analysis as to why there is a discrepancy between the mortality rates for Covid for minority ethnic groups in this country, making a direct comparison with countries where they are the ethnic majority, and what lessons you draw from that. I think that is a very important bit of analysis for us to understand.

**Iain Bell:** I would be delighted to do that, Chair.

**Chair:** Thank you. Thank you both very much indeed for joining us, Professor Fenton and Iain Bell. It was fascinating evidence and we are very grateful for your time.

## Examination of witnesses

Witnesses: Dr Naqvi and Professor Moonesinghe.

**Q674 Chair:** We now move on to our final panel this morning. I am very pleased to welcome Dr Habib Naqvi, the director of the NHS Race and Health Observatory, and an academic with a background in equality and diversity policy; and Professor Ramani Moonesinghe, representing NHS England. She is the national clinical director for critical and perioperative care, and also an anaesthesia consultant at UCLH. Thank you both very much for joining us. We are extremely grateful.

I want to start by asking Professor Moonesinghe a very simple question: 21% of NHS staff are minority ethnic, but they accounted for 63% of healthcare worker deaths. Why do you think that is?

**Professor Moonesinghe:** Many of the same reasons why people in the general public from black and minority ethnic backgrounds are more likely both to be exposed to and to suffer adverse outcomes from Covid affect our workforce. While 21% of the workforce is from a black, Asian or minority ethnic background, the weighting according to income and therefore deprivation is not equal across paygrades. For example, there is a much higher proportion of the workforce who are in lower-paid work, and a smaller proportion in higher-paid work and in very senior management roles. The same interplay and the same intersectionality that there is between deprivation and ethnicity in the community is likely to have had an impact within the NHS workforce as well. That is the increased risk of infection.

With the increased risk of poor outcomes, similarly there are a number of long-standing issues related to comorbidities and prior health conditions that are likely to have affected colleagues from black and minority ethnic backgrounds, and the same issues around access and potentially later presentation. A recent publication that looked at timing of presentation



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with confirmed Covid or symptoms of Covid indicated that the biggest risk factor for later presentation was being a healthcare professional. Second only to that was being in a minority ethnic group. The two things interact with each other.

There are multiple reasons. I think they are similar to the reasons in the general community. That gives us an opportunity to try to act on them both in the short term and the long term.

Q675 **Chair:** Can I ask you about a reason that would not be similar to the general community? In May, Chris Hopson, who as you know is chief executive of NHS Providers, told the Committee that, “one of the consistent issues that is raised with our trust chief executives is that some of the different types of PPE masks do not fit particular types of face...that has been raised as an issue particularly for certain groups of black and ethnic minority staff.” Do you think that NHS England and NHS Improvement moved too slowly to support BAME NHS staff when it came to PPE?

**Professor Moonesinghe:** First of all, the procurement and provision of PPE is a Department of Health and Government responsibility, but obviously implementation of practice around appropriate use of PPE is the responsibility of the NHS and the employer.

There are many actions that the NHS has taken to try to reduce risk related to PPE. Around the specifics of fitting PPE and masks—fit testing and fit checking—a huge amount of work has been done on education and implementation to ensure that fit testing is done appropriately, and to try to empower colleagues who do not feel that it has been done appropriately to speak out. There are many ways in which we are trying to do that.

More recently, we are trying to innovate in this area—

Q676 **Chair:** Let me jump in, if I may. What I am trying to understand is, was it too slow when it came to minority ethnic staff? It does not matter whose fault it was, but were we too slow as a country to understand the particular challenges faced by minority ethnic staff when it came to PPE?

**Professor Moonesinghe:** That is a difficult question to answer because, of course, our knowledge on that has evolved. We started the pandemic with very little understanding of those issues. As time has gone on, our understanding has improved. What I can say is that, as soon as there were issues relevant to black and minority ethnic groups, both within the workforce and without—some of the data previous speakers have talked about and data from our Intensive Care National Audit and Research Centre that first highlighted disparity in outcome from Covid between ethnic groups—we took rapid progress on trying to implement risk assessment and pass the risk assessment leads into the fit testing and so on.



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I am not sure that I can answer the question on whether we were too slow, but I can say that we have taken comprehensive action to address this.

Q677 **Chair:** Dr Naqvi, let me ask you for your view on that issue, and more generally on the speed of the response by the NHS and the Government to the particular issues faced by minority ethnic staff working for the NHS and care system.

**Dr Naqvi:** I agree with the professor on that one, Chair. As soon as the NHS learnt that there was a disproportionate impact of the virus on our ethnic minority staff and communities, the NHS went about pulling the trigger on what they could do to protect staff. As the professor highlighted, that has evolved over time, as we have learnt more about the virus and the impact of the virus on our ethnic minority communities.

Q678 **Chair:** Let me ask a more general question of you, Dr Naqvi. Research by the Joint Committee on Human Rights found that 60% of black people in the UK do not believe that their health is as equally protected by the NHS as it is for white people. What is your experience and understanding of that issue?

**Dr Naqvi:** There comes a time, I guess, within any society when the evidence becomes so irrefutable that the only way forward is with concerted focus, effort and action. We know, from decades of research and data, of the stratification in health and health inequalities within society as a whole. Yes, it exists in terms of specific conditions—the cancers, cardiovascular disease, mental health and maternity health that we all know of—but this year we have seen the impact of a pandemic that has shone yet another light on the ethnic differences that we see within health inequalities. Concerted, focused work is absolutely needed to look at the root causes and the social and cultural factors that Professor Fenton highlighted, in order to shift the dialogue on equality going forward.

Q679 **Chair:** What do you think the NHS can do to increase trust between minority ethnic communities and the health service?

**Dr Naqvi:** There are a number of things. One of the key things is to have a combination of both a top-down and a bottom-up approach to interventions and communication. Going forward, trust will be absolutely essential as the vaccines come into play. We need to look at highlighting the effectiveness and safety of those vaccines, and dispel misinformation and mistrust so that people can make informed decisions. Trust is an absolutely critical element for the NHS to focus on as it moves forward.

Q680 **Neale Hanvey:** Unfortunately, my video is not playing ball, but I hope you can hear me. First of all, professor, I would be interested to hear what your sense is of unconscious bias, or perhaps some form of racial preferencing, rather than necessarily racism. Do you feel that unconscious bias has played a role in the deployment of staff from black and ethnic minority backgrounds? Have you any sense of that?



**Professor Moonesinghe:** I haven't. This is a good opportunity to talk about the risk assessment process that has been implemented. There is a three-pronged approach. The first is around workplace evaluation. The second is around workforce evaluation. The third is about individualised risk assessment for individual members of staff.

The important bit of the risk assessment, obviously, is putting in place mitigation, should issues be identified that need to be addressed for an individual member of staff. For example, we can say that, in a point prevalence evaluation of risk assessment in secondary care conducted over the summer, 96% of staff from black, Asian and minority ethnic groups had been risk assessed with mitigation agreed. Deployment or redeployment is not the main approach in outcomes of the risk assessment. It is mostly based around trying to ensure that staff have a choice and that their working conditions are optimised for their individual needs.

As a succinct answer to your question, I am not aware of the unconscious bias you speak of. That does not mean it does not exist, but I am not aware of it. I do not have a sense of that.

Q681 **Neale Hanvey:** Thank you very much; that is very reassuring. The second point I would like to ask about is this. In terms of visibility and leadership within health services, do you feel that there needs to be some emphasis placed on developing leadership roles for black and minority ethnic members of staff?

**Professor Moonesinghe:** The workforce race equality standards have been implemented for some years. The most recent report, reflecting the 2019 data, was published just before the pandemic took hold in the UK earlier this year. It shows progress, but there is still room for improvement in the area of, for example, very senior management roles and the gradient that I have already spoken of between ethnic groups and pay levels in the NHS. There is work to do, but what the report shows is that there has been improvement year on year. Our hope is that that will be accelerated as a result of the increased issues, and the spotlight that Covid has unfortunately put on the issues for black and minority ethnic groups both in the general population and in the NHS. We are working on it. There is still room for improvement and there is a lot more to do.

Q682 **Neale Hanvey:** Dr Naqvi, do you have anything to add to either of those points?

**Dr Naqvi:** The NHS is part of the problem and part of the solution at the same time. If we are in the business of reducing ethnic health inequalities, which we are, we need a workforce and leadership that is representative of the diverse populations that we serve. While the workforce race equalities standard has been making progress year on year, and there are some early green shoots, it is not mission



accomplished. The NHS has identified the challenge and has put in place interventions to tackle that challenge head on.

Q683 **Sarah Owen:** Professor, I want to come back to your point that staff have a choice. Do you believe that within the NHS all black, Asian and minority ethnic staff genuinely have a choice? It is something we have heard reported. You particularly said that we find more black, Asian and minority ethnic staff in patient-facing roles. Do you genuinely believe that black, Asian and minority ethnic staff have had a choice during this pandemic?

**Professor Moonesinghe:** We have done work to try to address the issues around risk assessment and providing choice for staff. I am not sure that my belief is important. What we need to do is look at the data that has been collected to try to understand the experiences of staff as well as the experiences of the general population, as far as black and minority ethnic groups are concerned.

A number of interventions have been implemented. Some were planned pre-pandemic and some have been accelerated as a result of the pandemic, around, for example, health and wellbeing conversations. A lot of the focus of the NHS People Plan this year has been on giving a voice to the full diversity of our workforce. Some of that is through supporting leadership diversity, as we have just discussed. Some of it is through other arrangements such as, for example, education and improving accountability within NHS organisations to make sure that all staff are represented. The CQC will evaluate trusts and healthcare organisations on whether or not they are making progress on equality, diversity and inclusion.

The main thing is building confidence for all our staff to speak up, but particularly for black, Asian and minority ethnic staff. Work is ongoing to try to support that through, for example, freedom to speak up guardians and so on.

Q684 **Sarah Owen:** Looking at the evidence, which is what you want to look at, the first 10 doctors to die in the pandemic all came from overseas. I have already highlighted the fact that there have been more deaths of Filipino nurses in the UK than in the entire Philippines. Do you think the measures that you have talked about that had been put in place before the pandemic are enough? Do you think more needs to be done and, if so, what?

**Professor Moonesinghe:** If you look at the photographs that the British Medical Association has published of the doctors who have died during the pandemic, it is evident that there are many more people from black, Asian and minority ethnic backgrounds who sadly died in their roles. That cannot be ignored, but the causes for it, as we have spoken of all morning, are multifactorial. Some of that will be around access. Some of it will be around comorbidities and so on. Some of it will be around the



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confidence to speak up. I cannot differentiate between those areas on the basis of the evidence I have seen.

**Q685 Sarah Owen:** You can see how this is difficult for us to hear, given that we saw front pages of nurses using repurposed bin bags as PPE. I have had friends and family members tell me that there were not FFP3 masks that fitted them because they are of south-east Asian descent and they did not fit at the beginning of the pandemic. That has lessened, and they have been able to get a supply chain of PPE that actually fits their faces, but at the beginning of the pandemic that was not there. Are you saying that you genuinely cannot tell whether that was a factor in the numbers of BAME healthcare worker deaths?

**Professor Moonesinghe:** I think we need to see better data on the likely reasons why we have seen that increased impact on black, Asian and minority ethnic healthcare workers. Research specifically to look into that has been commissioned by the National Institute for Health Research.

The issue of PPE is difficult and is being addressed. I think that perhaps this is going out of my lane as a member of the NHS rather than the Department of Health or the Government.

**Q686 Barbara Keeley:** We are looking at a number of at-risk groups today. We heard earlier from a provider of supported living for people with learning disabilities about the staff having to battle to get them hospital care. Public Health England has done an analysis that points to a rate of death from Covid-19 for adults with learning disabilities of between 3.6 to four times the general population. Professor Moonesinghe, what is your response to that, and how can we ensure that people with learning disabilities receive access to hospital care and to critical care?

**Professor Moonesinghe:** As always, and as is evident from Covid in general, the Covid situation has highlighted long-standing issues around access for many different groups with protected characteristics. Those with learning disabilities are no exception to that.

We are engaging with people of all protected characteristics, including learning disabilities, through co-production to try to improve their access and how we communicate with them. We are also trying to improve the data that we have that will enable us to evaluate our progress in these measures. For example, a lot of work has been done on mental health in various stages of the pandemic response to try to tackle the issues around access. That is for people not just with learning difficulties but with mental health needs more generally. Co-production is one aspect of that. Improving data, so that we understand the issues, is another.

We have recently changed the situation report that hospitals have to provide to NHS England around admissions and levels of treatment that patients with Covid-19 are receiving to include a measure of learning disabilities, autism and mental health. That will enable us to track, from



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an operational perspective, where there are any issues, and to address them prospectively if we find them.

Q687 **Barbara Keeley:** I am talking about learning disabilities and not learning difficulties, which is a different thing. The factors that you have talked about are very long term: the co-production and the data issues. Do you not see this as an urgent and pressing problem? As I mentioned, the Public Health England analysis shows a death rate for that group of 3.6 to four times the general population. I regard that as a pretty serious finding.

**Professor Moonesinghe:** It is an extremely serious finding.

Q688 **Barbara Keeley:** What could we do?

**Professor Moonesinghe:** One thing we need to be sure of is that access is equal for people with protected characteristics. Your question was specific around critical care. A report has recently been published looking at access to critical care for patients with learning disabilities—my apologies—and we saw in that that there was a level of access for patients with learning disabilities similar to the general population in that regard.

All these issues are multifactorial, so there may be a higher incidence of comorbidities in some patients with learning disabilities. There may be a higher incidence of other risk factors as well. We need to look at all of these issues in the round in order to help us understand that and take immediate action.

Q689 **Barbara Keeley:** We also heard that support staff were not able to attend hospital to explain for the person with learning disabilities what their symptoms were and where the pain was. It seems to be a serious failing that support staff are not able to do a role that they do the rest of the time. Is that something that should change?

**Professor Moonesinghe:** I think that is something that should change. We are taking action in other areas to enable support for individuals in hospital—for example, in maternity health to enable partners to be present in maternity services. That is something we need to look into, and I can come back to you. I do not have the specifics of our response, but I can come back to you on that.

Q690 **Dean Russell:** Professor, earlier in the year, I asked the Secretary of State about support for those with disabilities, in particular hearing disabilities and those who are deaf, who have been having to use a charity-based app to be able to access certain care. I believe that is being supported from December through to March, but there are no guarantees further than that.

I just want to get your sense of what research and evidence there has been in terms of the impact on the deaf community in accessing services, especially where they need to rely on phone calls, for example; and what



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the longer-term plan is for that. As we look into vaccine roll-out and testing, it is absolutely critical that the deaf community can access healthcare in the same way as everyone else in the population.

**Professor Moonesinghe:** I am afraid that I do not have the information that you require on that. I will provide a written response later.

**Dean Russell:** If you could, I would appreciate that; thank you. My next question is around the observatory generally. I am keen to understand what the long-term plans are. I appreciate that there are challenges at the moment and over the next six months, but what are the long-term goals and outcomes you want to achieve through it?

**Dr Naqvi:** The first thing to say is that there is an urgency of focus on Covid-19, but we are also looking ahead to the medium to longer-term things that we could put in place to have a positive impact on reducing the health inequalities that we see for our ethnic minority communities.

We are establishing ourselves but also, at the moment, focusing on the vaccine and, as I said before, looking at what we can do to highlight the effectiveness and safety of the vaccines and look at dispelling misinformation and mistrust, so that people can be well informed and make informed decisions around the vaccine. We are looking at maternity health and, of course, maternal mortality rates, which are higher among black women, for example. We are looking at mental health as well.

The observatory will do three things. First, it will bring together research, evidence and rapid reviews. It will then turn that into actionable insight and recommendations for the system. Thirdly, it will help and support the system to implement those recommendations on the ground. It is an observatory so, yes, it will be observing, but it is not passive in its function. It will be a proactive investigator that will look at deep-rooted issues in our health system and in society as a whole in order to transform the issues that we see with regard to health inequalities. It will do that in collaboration with other organisations going forward.

**Dean Russell:** Thank you.

Q691 **Dr Evans:** I have a quick question to follow up Sarah's points to the professor. In your intensive care medicine, I am interested to know if there are any indicators as to why people of ethnicity—particularly Afro-Caribbeans—might be more susceptible to becoming more unwell. Is there any research to suggest why that is the case, and is there any way of picking that up and protecting particularly Afro-Caribbeans, but any ethnicity, from ending up on an intensive care unit?

**Professor Moonesinghe:** It is fair to say that, like many other things in the pandemic, our understanding of this is evolving. It is clear that there is an impact on people of minority ethnic backgrounds, despite accounting for other comorbidities such as diabetes and so on, which are in turn more common in those groups, as we have already discussed.



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One potential reason might be access and late presentation, which I have already mentioned. Data recently published indicates that, for every day that passes, there is a 1% increased risk of mortality as a result of that, or in association with that. Interventions being undertaken to try to improve that include the virtual ward programme, which has been recently rolled out and is being concurrently evaluated. It has a particular focus on looking at the needs of black, Asian and minority ethnic groups in accessing it.

The aim is to try to identify individuals, while they are still in the community, who have either tested positive for Covid or have symptoms strongly suggestive of it. It will provide pulse oximetry in the community to measure their blood oxygen saturations, and then implement interventions to enable them to be identified earlier and to come to hospital earlier should their blood oxygen levels fall. There are innovations like that.

There is always the risk that, with new innovations, one widens health inequalities. Having a focus on ensuring that we do not do that through prospective evaluation is an example of the sort of thing we are trying to do in order to address that gap.

Q692 **Greg Clark:** Professor Moonesinghe, you are the national clinical director for critical care for NHS England. I do not know whether you heard our first panel, where we had evidence that people with learning disabilities were much more likely to have do not attempt to resuscitate CPR notices imposed on them. Did you know that?

**Professor Moonesinghe:** I was aware of a recently published report that addressed that, yes.

Q693 **Greg Clark:** During the course of the pandemic, when did this first come to your attention?

**Professor Moonesinghe:** When I saw the report published a few weeks ago by Bristol University.

Q694 **Greg Clark:** Have you evaluated it? Do you think it is credible?

**Professor Moonesinghe:** In my role for critical care, I should say that the majority of do not attempt resuscitation orders are not made within the walls of critical care; they are made prior to critical care admission. They may indeed be made prior to hospital admission. The majority of those orders would be made on normal wards treating patients with Covid-19 or, indeed, any other condition.

Q695 **Greg Clark:** In the report that you have seen, which was looking at the experience during the pandemic, is that an accurate summary? Do you think it is the case that people with learning disabilities have had a much higher notification of do not resuscitate?

**Professor Moonesinghe:** I think one of the things that we would have to look at is how that compares to normal circumstances; how that



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compares to do not attempt resuscitation orders being placed on people with learning disabilities in normal circumstances and not in Covid-19, if you see what I mean, in order to understand the context.

Q696 **Greg Clark:** Have you looked at that?

**Professor Moonesinghe:** I have not seen that, no.

Q697 **Greg Clark:** Who is looking at it?

**Professor Moonesinghe:** I will get back to you on that.

Q698 **Greg Clark:** But here we have something that was brought to our attention by witnesses and seems to have been going on throughout the pandemic. It seems to me appalling, if it is the case, that that should be happening. First of all, it is concerning that it has not been picked up through the automatic process of review within the NHS if it is a fact. Secondly, now that it has come to public attention, surely there must be very urgent mobilisation to put a stop to it.

**Professor Moonesinghe:** I think the issue is really around whether the do not attempt resuscitation orders are appropriate or not. Not every patient would benefit from cardiopulmonary resuscitation. That decision has to be made on an individual patient basis. It is the reason why, first of all, I would be interested to know how the observations that have been made during Covid-19, and with patients with Covid-19, differ from those made in normal circumstances.

Secondly, it is important to look at the quality of the decision making, essentially. What factors were considered when making the orders? Were the orders agreed with the patient and/or their family as appropriate? We need to understand what is underpinning this quantitative data more qualitatively in order to understand what the issues are and address them.

Q699 **Greg Clark:** Of course, we understand, very sadly, the need for these notices. They have always been there in one form or another, but the idea that during the pandemic there should be increased recourse to them for people with learning disabilities seems very concerning.

Finally on this, part of the point of this inquiry is to learn lessons. Some of them will be lessons where we look back and prepare for the next pandemic of whatever sort. We hope there will not be one, but we all know that it is necessary to be prepared. Some of the lessons will apply now. It is important that, when they surface, they should be applied now. Can you give me a sense of the urgency with which you are going to conduct the review of DNAR notifications?

**Professor Moonesinghe:** Again, I do not have the information that you would like on the speed of any review that will be conducted internally within the NHS about them. As I say, it may not be a quick response because one needs to look at DNACPR orders for those with learning disabilities and for people without learning disabilities in order to



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understand if there is a differential risk for those with learning disabilities in this context, and to understand the reasons underpinning those decisions. Again, it is something I can get back to you on with a written response after this hearing.

**Greg Clark:** I would be very grateful if you did that as quickly as possible and communicate to your colleagues that it is something that requires urgency in terms of the review, and for its conclusions to be able to be acted on within the rest of the pandemic rather than when it is too late.

Q700 **Chair:** I want to follow that up, if I may, by making a proposal, Professor Moonesinghe. It is three weeks until a lot of people will be stopping for Christmas. Perhaps you could write to us by Friday 18 December, not telling us the timescales for any inquiry—because this is an urgent issue—but telling us what the NHS has actually done already to address those issues. It is absolutely essential that we go into Christmas knowing that the issue is behind us. Would that be okay?

**Professor Moonesinghe:** Of course.

Q701 **Rosie Cooper:** I would like to thank Greg for raising the issue of do not resuscitate orders. I have raised the question many times, both in Parliament and at the Health Select Committee. So far I have always got an equivocal view, "Oh well, there are reasons."

If a patient has competence, capacity and/or relatives who are easily identified and available to speak to, is it legal to put a DNR notice on the file without due reference to them?

**Professor Moonesinghe:** We should always consult patients and their relatives in these decisions.

Q702 **Rosie Cooper:** My experience is a million times that that is not so and that clinicians can put pressure on families. I will use my own personal experience. I was told by a junior doctor that she would not sign up my father for a blood transfusion unless we had a plan that included do not resuscitate. He had a good quality of life for another year. Why is that okay? If you should always do it, what is the sanction that stops you doing it? Is it legal? Is it illegal? Who polices that?

**Professor Moonesinghe:** One thing that is important to recognise is that cardiopulmonary resuscitation is the final event of a pathway of care and treatment. Decisions are made throughout a patient's care, in discussion with them and/or their family as appropriate, about treatment escalation. A key part of the way in which healthcare professionals have worked during Covid is to try to understand what is in the patient's best interests, what they want and what healthcare professionals believe to be in their interests, and to work together to establish treatment escalation plans. There is an emphasis both on considered decision making between multiple healthcare professionals when coming to those decisions as well as, obviously, on consulting patients and families.



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In terms of a response to your question, I do not know the specific circumstances of your personal experience, apart from what you have told me. It sounds like it was a poor experience, and I am sorry for that. The considerations are not just around resuscitation, which is ultimately not successful in the vast majority of patients who undergo resuscitation. As I say, it is the end of the pathway. What is perhaps of at least equal importance is the treatment they receive up until that point and ensuring that they have equal understanding of and access to the treatment that they need.

Q703 **Rosie Cooper:** What should happen if a do not resuscitate order is placed on a file, unknown to the patient and the family? What is your message to families who are in that position today?

**Professor Moonesinghe:** They should raise their concerns.

Q704 **Rosie Cooper:** With whom? Who polices it? The very people who put the DNR notice on the file?

**Professor Moonesinghe:** In the in-patient setting one would report it to the patient advisory liaison service, to ask them to look into it.

**Rosie Cooper:** Thank you. I think we need more help with that. Perhaps the CQC should be the place to go with it.

**Chair:** Thank you very much indeed. We have had a very important session on the DNAR issue; the gap in our understanding of the higher mortality rates for people from minority ethnic groups, even accounting for deprivation and other socioeconomic factors; the issue of access to healthcare; and the broader issue of discrimination, particularly against people with learning disabilities, which has not been talked about as much as it should.

Thank you to our witnesses, Dr Naqvi and Professor Moonesinghe, for joining us this morning. Thank you to members of both Committees. I conclude this morning's session.