HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Unequal impact? Coronavirus and BAME people, HC 384.

Wednesday 17 June 2020

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Watch the meeting

Members present: Caroline Nokes (Chair); Sara Britcliffe; Angela Crawley; Kim Johnson; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 1–43

Witnesses

I: Dr Chaand Nagpaul, Chair, British Medical Association; Professor Kamlesh Khunti, Professor of Primary Care Diabetes and Vascular Medicine, University of Leicester; Professor Lucinda Platt, Professor of Social Policy and Sociology, London School of Economics.

II: Barbara Palmer, Race Council Cymru; Rosie Lewis, Member, Angelou Centre; Naz Zaman, Member, Lancashire BME Network.

Examination of witnesses

Witnesses: Dr Chaand Nagpaul, Professor Kamlesh Khunti and Professor Lucinda Platt.

Chair: Good afternoon and welcome to this session of the Women and Equalities Committee, taking evidence on the unequal impact of Covid. I very much appreciate you attending today to answer our questions. I would like to hand straight over to Sara Britcliffe, who is going to ask the first questions of you.

Q1 **Sara Britcliffe:** Good afternoon. This is to everybody. I would just like all the panel members to introduce themselves briefly and tell us how the work that you have done in regards to coronavirus can help us with this inquiry.

Professor Platt: My name is Lucinda Platt. I am professor of social policy and sociology at the London School of Economics. I have been working in the area of ethnic inequalities in policies related to immigration and to disability for my academic career.

I am also a member of the IFS Deaton Review of inequality, which is a wide-ranging review of inequality across multiple domains that will present evidence, discussion and synthesis of that. As part of that role on the panel of the IFS Deaton Review, I recently completed with my colleague, Ross Warwick from the IFS, a report on Covid-19 and the extent to which different ethnic groups are more vulnerable, both to the health consequences and to the economic consequences of the crisis.

Professor Khunti: My name is Kamlesh Khunti. I am professor of primary care diabetes and vascular medicine at the University of Leicester. The reason I have got involved is because I was the first person on social media to alert people on 1 April that BAME people may have been disproportionately affected. This was through friends that were calling me, telling me that in the wards and intensive care there were more BAME participants. This was the first time this was alerted.

Following this, the data started coming out, four days later from my side. I have been following all the work and have been writing quite a lot on BAME as well as Covid. I developed a risk reduction framework for NHS employers, for risks to be assessed by NHS employers for their healthcare professional. I have been doing some analysis on big data regarding BAME populations. I am also advising the Department of Health and Social Care on certain aspects. I am also a member of the independent SAGE.

Dr Nagpaul: Good afternoon. It is a pleasure to contribute to this session. My name is Dr Chaand Nagpaul. I am chair of the British Medical Association Council. I am also a GP. The BMA represents 160,000 doctors across all disciplines of medical practice, both clinicians in hospitals and

general practices, but also medical academics and public health doctors, which is really relevant to the issue we are discussing today.

From our end, we have been involved in two ways. First of all, when, in early April, it transpired or was emerging that we saw the first 10 deaths of doctors all coming from a BAME background, the BMA called for the Government to investigate this, because this was extremely disturbing for us very early on in the pandemic. We also asked for not just an investigation, which was then announced the week after by the Government—the PHE review—but also immediate mitigations to prevent further avoidable ill health and death amongst BAME doctors.

By that stage, we were also aware that this was affecting the healthcare workforce more widely. We now know that, tragically, 63% of healthcare workers who have died have come from a BAME background. For the doctors that I represent, 34 out of 36 doctors who have died have come from a BAME background. The BMA was calling from the very outset for mitigations in terms of risk assessments and looking at ethnicity as a risk factor in its own right, just as we had other risk factors that protected certain sectors of the population, and for that risk factor to be assessed in the way that Professor Khunti said.

If you were at high risk, for example older with diabetes and from a black or Asian minority background, that would place you at a risk such that the work you should do should be redeployed and perhaps not be at the most infectious parts of a hospital. It was about practical suggestions. That calling, unfortunately, has taken a long while. Although we asked for that in early April, it took until the end of April for NHS England to advise all providers to carry out an assessment. It took about a month more to actually get some specific tools. We had really wanted a consistent and objective approach throughout the health service. The impact for healthcare workers has been very severe.

In addition, the BMA has been doing some surveys throughout the Covid pandemic. They are what we call tracker surveys. That was also quite revealing because, if you remember, there were severe and dangerously short levels of supplies of PPE during April and some of May. There were twice as many BAME doctors who reported feeling under pressure to see patients without adequate PPE compared to their white colleagues.

When we broke that down even more, our own surveys at the BMA have shown that this is a reflection of pre-existing, historic cultural and structural inequalities, where we know that BAME doctors are twice as likely not to complain or raise concerns in the workplace, because they feel if they do there may be some adverse repercussions. BAME doctors are twice as likely to report bullying and harassment. They are less likely to progress up the career ladder as successfully. There may be many cultural reasons why many BAME healthcare workers did not speak out when they felt unprotected.

There has also been an issue about exposure to the virus. Is it that doctors from a BAME background, and for that matter other healthcare workers, have been more exposed? Have they been in roles that have placed them at greater risk? I had hoped that data would have been collected as part of the PHE review. We called for granular information on occupational roles of those who succumbed to the illness and were admitted to hospital. That data has not been collected, but that is certainly another factor that has been suggested.

As I said, the BMA is not just a trade union representing doctors. We are a professional organisation and part of our professional work is on health inequalities. We have a public health committee and we were very concerned about the impact on the population, right from the beginning of April when the studies showed that a third of all patients in intensive care were from a BAME background, which is a totally disproportionate number compared to the population at large.

We then were getting more reports of the numbers of deaths amongst people in the community and in particular key workers. The BMA called, at a very early stage, again at the end of April, that keyworkers needed to be protected, because we were in the middle of a lockdown and we knew that key workers could not stay at home, they could not be socially distancing and they could not be doing what the Government asked. They had to keep the shops open for essential services, stock supermarket shelves, drive taxis, drive buses and cleaners had to carry on working.

We know from data that has since come out, from the Institute of Fiscal Studies, the ONS and now the PHE report, that in fact key workers have suffered disproportionately and there are greater numbers of deaths amongst key workers. There has been an inequality, you could argue, in the impact of the virus on the community as well as healthcare workers. We can discuss the reasons why that may have taken place in today's session, but the BMA has certainly been part of both aspects in terms of the impact on doctors and the community. I am very pleased that we can discuss these issues today.

Q2 **Sara Britcliffe:** Professor Khunti, to what extent is the disproportionate number of BAME people dying from coronavirus due to the nature of the virus itself, co-morbidities or socioeconomic factors?

Professor Khunti: We know at a population level that there are certain risk factors that are associated with increased mortality.

Those factors include ethnicity. If you are from a black or minority ethnic health background, you have anything from a 50% to a two-fold increased risk, depending on which data you look at. We know that males are predominantly more affected than females. The risks again are about two-fold. In terms of deprivation, if you are in the most deprived areas, you have a two-fold increased risk compared to the least deprived. We are not sure about occupation; we can discuss that. Age is a big risk factor. If a person is aged 60, compared to another person who is aged

70, they have a five-fold increased risk of mortality. If they are aged 80 they will have a 10 to 12-fold increased risk of mortality.

There are then the co-morbidities, as you mentioned. When this virus came around, we thought it was going to be similar to an influenza pandemic. Mainly people with respiratory diseases are affected more. This is a very different virus. We have seen that people who are affected are more likely to have what we call cardiometabolic co-morbidities. This is cardiovascular disease, diabetes, hypotension, chronic kidney disease and, to a lesser extent, having lung diseases such as asthma or chronic bronchitis. Obesity is another factor that has come out and shown in large databases as a risk factor as well.

If you look at it in terms of the totality of the evidence, in terms of the total deaths that we have looked at for the whole of England—61 million people—17% have been in BAME populations, so 83% have been in white populations. We need to bear that in mind. If we look at the risk factors, the risk factors that we know, such as the co-morbidities, diabetes, cardiovascular disease, obesity and hypotension, are disproportionately higher in BAME backgrounds. We can discuss all the other areas that are unknowns, like occupation and housing, later.

Q3 **Sara Britcliffe:** This is another question to you, please. As there is no definitive answer yet, if biological determinants were the primary factor, then in which areas would the Government's efforts to protect BAME people be best focused?

Professor Khunti: The biological factors are well known. There are some modifiable factors and there are some non-modifiable factors. Obviously, age and sex are non-modifiable, but having chronic diseases is definitely a modifiable factor. There are a few areas.

One of them has come out in the report that came from PHE yesterday. First of all, primary prevention is key. We need to ensure that people from BAME backgrounds are assessed regularly for any of these risk factors that are mentioned. We have an NHS health check, which is for people aged 40 to 74, but for the BAME backgrounds, because they get these conditions earlier, we should extend that to age 25 and onwards. As well as that, there is risk factor control in people with established diseases. As I mentioned, cardiovascular disease, diabetes and hypotension are disproportionately affecting these populations.

We need to make sure that we have enough cultural competency-based interventions so that we can control the risk factors, because there is some data now showing that if the risk factors are not controlled they are more likely to get severe illness and die from it as well. When I mention cultural competency, what I mean here is there is a lot of emphasis on self-assessment programmes, self-directed learning programmes, education programmes and online programmes. Those are fine for white populations, English-speaking who are literate, but we need to ensure

that these are in different languages so that they are accessible to everyone.

There is another thing we really need to look at if we are not going to widen these disparities. We have had a lockdown for three months. This lockdown may continue for a little longer. There has been disruption in terms of managing patients in primary care practices. 95% of patients are managed in primary care, in general practice. These people have not had an assessment done. This is not just the BAME population but it may affect BAME more and the deprived populations more. We need to ensure that these people are seen early and their risk factors are controlled while we are in lockdown through remote consultations, which is happening but not routinely everywhere.

When we come out of the lockdown, we need to make sure that these people are assessed, have their blood tests done and they are managed more aggressively to make sure that their risk factors are controlled.

Q4 **Sara Britcliffe:** My final question is to Professor Khunti and Professor Platt. What assessment would you make of the way data regarding the impact on BAME people has been collected and reported?

Professor Platt: One of the points I would like to make is there is a lot of discussion about the BAME population as if it is one single population. It is clearly very heterogeneous and the factors that apply to some groups do not necessarily apply to others. We can think about occupational risk and also mortality risks. If we break down the data, we find that the mortality risks are greater for black Africans compared to other groups, even if they are disproportionate for other groups as well.

If you look at occupation, you find that black Africans are most likely to be working in not just key worker roles but health and social care key worker roles, and in particular social care roles. Professor Khunti mentioned that for occupation we might need to know a bit more about that, but ONS published a report that analysed mortality rates by occupation, and they found that social care roles, particularly men in social care roles, were particularly vulnerable. The work that I have done has shown that black African men are seven times as likely as white British men to work in social care key worker roles, which are some of the most at risk of mortality, according to the ONS figures.

We need to not talk about the BME population so much but to talk about specific factors that affect particular groups more. That will make it more straightforward to identify what mitigating action should take place. Again, thinking about health risk, I looked in population survey data at having relevant long-term illnesses that might put people more at risk. It was older Bangladeshi men in particular who were more likely to have such health risks, not necessarily all minority groups. That is one thing.

Another thing we need to look at is in relation to the way ethnicity and immigration intersect. Some minority groups of working age are

predominantly non-UK-born. Others are predominantly UK-born. Caribbean is about 30% of working age non-UK born. Black African is about 85%. In thinking about how we present and collect information, and what mitigating strategies might be in place, we need to take into account the fact that settlement status and immigration status are likely to be salient. We know already that for a lot of social care roles we are very dependent on foreign-born workers of different sorts. This may impact their working conditions. It may impact the extent to which they are able to undertake mitigating actions.

There is also how they are communicated with and how they are assessed for mitigating actions. Crucially, we need to start thinking in a more granular way and that will be more informative for policy. That would be my main point about that. I can say more but I do not want to take everybody else's time. I will let the others get in.

Dr Nagpaul: It is also worth recalling that in the peak of the pandemic, or as we were approaching the peak, we had a lockdown, the purpose of which was that, if people mixed, the infection was just going to spread further. The key workers were not protected. As we have heard, some occupations have far higher levels of BAME people working within those roles. They were mixing with others. If you are driving a taxi, you are literally a few feet away from another in an enclosed environment. Those working on a cashier in a supermarket may have been in close contact with 100 customers or more in a day. This was in the peak. There were those who were driving buses, those who were keeping shops open as independent shopkeepers and so forth.

Whilst it is obviously important to focus on the biological and other co-morbidity factors, there was also an issue around protection, which was not happening in the right way. There was a shortage of PPE, so it was obviously prioritised for the health service, and the care sector thereafter, but many key workers went unprotected. It stands to reason that they would have been exposed and many would have become infected as a result.

Professor Platt: Could I just follow up briefly on that point? We know there were issues around social care workers, but one clear illustration of this is that another area that ONS highlighted as having disproportionate deaths was one that you might not immediately think of as an at-risk population: security guards.

Of course, security guards had to keep on working and security guards are public-facing. We are also picking up roles here that are not necessarily very powerful in terms of their relationship with their employer. 40% of security guards are from a minority ethnic background. Again, some groups are particularly likely to be security guards, such as black Africans, black Caribbeans and Pakistanis. In addition, a third of security guards are non-UK-born, even though the non-UK-born only

makes up 18% of the working age population, so that is again double the chances.

One final issue brings these issues of health conditions, co-morbidities, vulnerability and key worker issues together. I looked at the extent to which key workers and people who had health conditions that made them vulnerable were living together. For households where the household reference person was black African, this was likely to apply to 40% of households, compared to around 20%. It was double the rate for the white British population. The factors also combine and the sorts of analysis that we have seen have not been able to take account of the way those factors interrelate. I am assuming when we talk about housing we will come on to some more of those household issues.

Professor Khunti: In terms of your question regarding data, we have in the UK and in England some of the best datasets in the world. We are envied around the world in terms of the data that we hold. The problem is that some of the data is not held centrally at one place. If you think about the data that I have been mentioning, we have data on the whole of the GP systems, so everything that a GP holds in terms of what chronic diseases patients have. We have data on hospital admissions. We have data on ONS for mortality. We have the PHE data, which is the number of people that have been tested. We have data from intensive care units and hospitals as well, in terms of the severity.

What we are having a problem with is that all of the datasets sit differently and it is very difficult to get all of the datasets together under one umbrella. That is one of the things that we need to push for. Get all of the data under one umbrella, because we are very unique. We have one single NHS number, so we can link all of this data, unlike many other countries. This will enable us to look at the totality of the evidence.

Professor Platt just mentioned that black Africans have an increased risk compared to some of the Asian communities, but when you look at the different datasets the risks are very different. These are from the same populations. The reason is that they are adjusting, or what we call accounting, for different factors. PHE will not be able to account for if patients have obesity or for their occupation, while the Office for National Statistics will.

The other issue we have is that the last census was done in 2011, so some of the data we are relying on are quite old, and we do not have any of the recent data.

Finally, if we really want to be proactive, we have good data within the General Medical Council. Chaand can talk to that. There is no reason why that cannot be linked to all of the datasets within England. We have nurses' databases that could be linked.

Then the other area, which I am sure we can talk to later, is about the behavioural aspects. We do not have good-quality behaviour data at

population level that could be linked to these databases to really get us a bit more detail of the nuances and factors that are causing it. As Professor Platt mentioned, there are huge differences by ethnicity. In terms of the Bangladeshi, Indian and Pakistani communities, although they are classed as south Asians, there are major differences in terms of their cultural norms, their risks factor profiles and their health behaviours. We may find that there are differences within the different ethnic groups as well.

Q5 **Chair:** Thank you for that. Can I just ask a follow-up question to Professor Platt? As I understand it, at the moment ethnicity is not recorded on death certificates. Would it be helpful if it were, to enable a clearer picture or, as Professor Khunti was just suggesting, do we just need to make sure that datasets can be used more effectively together? I hesitate to use the word "merged".

Professor Platt: There is a lot of good evidence that we can link data together more effectively. There is a lot of work on doing that. I work with a lot of social science data and we are doing a lot of work trying to link data in, with appropriate consents.

One recommendation is that ethnicity is recorded in death records. That would be very valuable, because not everybody dies in hospital and so we do not necessarily have the records from hospital record of ethnicity. By the same token, it raises some ethical issues that we need to think about, because usually ethnicity is self-report. We need to think about how that would be recorded on a death certificate, given that it could not be self-report. This is not an insuperable problem, but it is one that does need to be thought through and there has to be a well-made case about how that is done sensitively and appropriately, and about who does it. It would be very valuable in expanding the evidence base.

You can add ethnicity by linking, but then it depends on the person having been somewhere else in the system. If their ethnicity is recorded elsewhere then you can capture that in their deaths. That is part of what the ONS were doing in their analysis, which followed ours, of deaths. That would be one way of enhancing that information. Otherwise, you are making some extrapolations. Certainly, it is an agenda to pursue, to think about where we record it.

Dr Nagpaul: Having ethnicity recorded would be helpful, but we do have other ways, like the ONS did, to match the ethnicity data in hospital admission to the deceased. There was a workaround.

I want to just highlight that we should not be considering death as the only barometer here. We need to also understand why so many more BAME people ended up in hospital. If you have been in hospital for four weeks and then you are discharged, you may not have died but it has caused enormous distress and has had a huge impact on the individual and their family. We should not only be collecting death data. What we have asked for is more than just ethnicity. It will not give you the full

picture, for the reasons we have talked about, because you need to understand the ethnicity in the context of the work they were doing or the exposure they had.

Death should be one barometer, but for the medical profession it would be good to understand whether more doctors, nurses and others who were admitted to hospital were working in roles without protection. Is that the same for taxi drivers and those that worked in supermarkets, for example, or as security guards? We should have had more data. Something that I have flagged up is that it should have been collected proactively. We have got national datasets, but we need to also be agile and collect data in real time when we can see that the situation demands it.

Q6 **Bell Ribeiro-Addy:** My first question is for Dr Nagpaul. You articulated quite clearly how soon yourself and colleagues at the BMA began to notice the disproportionate impact on BAME colleagues and the BAME community overall. Some of this information was actually published in the media and this has now been confirmed by the Public Health England review. In your opinion, with all of this data, have the Government been too slow to act on specific measures to circumvent this situation where BAME people are disproportionately being affected?

Dr Nagpaul: The phenomenon, this really alarming statistic that we were experiencing of almost all doctors who had died coming from BAME backgrounds, was a surprise to us, as was the impact in the community. We did not have expectations to have all the answers immediately. We knew that a review would need to take time and that, even at the end of it, there would be multiple factors with a new virus.

What should have been done much more rapidly was to mitigate and take action early on to protect those healthcare professionals, and for that matter key workers as well, from further harm. This is an infectious disease. It is caught by being close to other people. It is therefore obvious that if you are a healthcare worker looking after patients who have got infection, you are at risk. Action should have been taken much earlier on to protect those healthcare workers. We know that did not happen. Risk assessments and acting on those risk assessments should have happened earlier.

In fact, I wrote two letters, following on from the initial call for the investigation, to NHS England, because I was concerned that we were hearing from doctors across the country, telling us that they were still continuing to work and their management had asked them to carry on working. They did not feel safe, but they did not have an objective way of expressing that. A risk assessment would have been able to do that. It does do that. It could have allowed people to be re-deployed at a much earlier stage.

On top of that, the other action that should have taken place is on PPE. That is not just relating to BAME doctors or healthcare workers, but there

was a shortage of PPE that meant that many frontline staff were not adequately protected. We know that care staff were actually given PPE at a later stage than healthcare staff. There was a backdrop of the lack of protection on top of the lack of immediate action in risk assessment and redeployment of staff.

I should tell you that in general practice, like in my own GP practice, we carried out our own risk assessments. We had staff who we felt were at risk. We offered them the ability to work from home or do telephone or video consultations. That sort of action was perfectly possible early on in the pandemic.

Q7 **Bell Ribeiro-Addy:** Just to follow on from that, we can see that advice for those at risk of complications from Covid-19 is widely available in English. Up until 14 May, it was made available in 10 different languages, three different font sizes, available in British Sign Language and in a video clip, which is good. The latest advice on the Government website for those shielding only appears to be available in English. Do you think the Government have done enough to ensure that guidance for at-risk people is accessible to members of the BAME community, and do you have any ideas on what more they could be doing?

Dr Nagpaul: In the early stages of the pandemic, in fact, the messaging around how the virus infects and what measures you need to take to protect yourself were not in other languages except English. In the initial weeks, we did have a situation where the BAME community may not have been as informed. Also the messaging needs to be culturally sensitive. It would be hard to now know what impact that had. Also speaking as a GP, we had a situation with the NHS 111 helpline. It could not cope initially. You will remember it took several hours to get through. Again, many from the BAME community may not have been able to express themselves when they needed help.

Also the move towards the online version of 111, when everyone was being advised to log in, again meant that not just BAME people but others who were not as digitally capable or able—the visually impaired, for example—were not able to seek the right help and also were not given the best or may not have received the right health promotional and disease prevention advice. They may have, for instance, not adhered to the same strict rules around social distancing and handwashing in the early stages, because that messaging may not have been understood or heard.

Professor Khunti: In terms of the languages that we need to get information out to, that is absolutely right. We need to do that. This was quite late coming on, although a lot of people have been asking for this. It is not just about language and linguistics. It is also about how these messages go out within the communities. If we look at the BME populations, it is no use to just sending these out directly by mail to them. We do need to use other channels. For example, the BME community works through community networks, through faith groups,

through pharmacies and through key opinion leaders. These are the networks that we really need to use for any information we get.

I was really pleased with yesterday's PHE report that came out with recommendations. There are seven recommendations. Two of the recommendations are about culturally competent Covid education and prevention campaigns. I am really pleased that the PHE report has come out with these recommendations.

Professor Platt: Just briefly to add to that, the issue of communication is key. It is not just about who is protected but understanding whether people are getting access to appropriate care or not. In an attempt to protect the NHS, people are being deflected from that and possibly also are very anxious about being infected. The amount of publicity that was then given to the fact that minority ethnic groups were more vulnerable to Covid is likely to increase that. We potentially see some evidence for this.

One thing that was new in the PHE report was that it provided a breakdown of not only Covid-related excess deaths, but also non-Covid-related excess deaths. They were also higher in minority ethnic groups, which suggests they are not accessing healthcare that should be accessed. Some of this may be just caught up in the fact that there have been cancellation of appointments and so on, but it does suggest that there is some issue about actually accessing care as well as about protection.

Professor Khunti: Can I just come in a little bit about the way translations occur? Most people think that translation into different languages is translating it from English to whatever language you are thinking about—Hindi, Gujarati, Punjabi, Urdu—and then back-translating, and if that works, that is adequate enough.

There are nuances. You need to use that group, as such, who you are developing language tools for and work with them to see if that makes sense to them. There are major nuances. There are some words that are not available and not used in certain languages. For example, there is not a word in Gujarati, Hindi, Punjabi or Urdu that you can use for "virus". You need to work with the community groups and focus groups to make sure they are specifically directed at that language that they are working in.

Q8 **Bell Ribeiro-Addy:** My final question is regarding the second part of the report released by Public Health England on Tuesday, which found that racism and social and economic inequalities increase the prevalence of diseases such as obesity and diabetes. That may be behind the unequal impact of Covid-19. The report gave seven suggestions, which Professor Khunti touched on. With those seven suggestions in mind, do you agree with these measures? Is there anything else that you would recommend that the Government should be doing to reduce health inequality?

Professor Khunti: The issue about discrimination has come out in the report after speaking to 4,000 people, and quite rightly so. We know that structural discrimination has been present for many years. What we still do not know is whether this has a direct consequence in terms of the increased mortality or infections rates in BAME populations. We know housing is an issue. We know occupation is an issue that we have talked about. We are not sure of a direct relationship. For example, last year, when we looked at the PHE report, there was proportionately less mortality in BAME populations. We do not talk about that. That is an important issue.

There are healthcare issues. When we look at the US, there are huge differences between the US and the UK. Access to healthcare is very difficult in the US compared to the universal health coverage that we have in the UK. This is an emerging topic. We need more data to say, "Is it directly as a consequence of people being structurally discriminated that they have this increased risk?" Chaand mentioned earlier that this was the case and they have some evidence of that from the BMA report. For other occupations, we do not know as yet. We need to get more data on that.

Dr Nagpaul: What is important here is that the issue of race and ethnicity is very much interlinked with many of the other risk factors and inequalities. For example, we know that you have twice the likelihood of dying if you come from a deprived community compared to a more affluent one, yet we also know that there are twice as many BAME people who live in deprived areas. If you look at housing and overcrowding, 30% of Bangladeshis live in overcrowded housing, compared to 2% of the white population. It varies even within the ethnic groups, with about 15% of black Africans in overcrowded environments. It is not the same. You begin to see that the issues are interlinked.

There may be and there probably are race inequalities that have led to a greater proportion of BAME people living with low wages, working in those key roles that could not allow them the same protection, who were not able to work at home. They are interlinked.

In terms of career progression, I have mentioned before that in the medical profession you have a far lower chance of climbing the ladder if you are BAME. You have less likelihood of being shortlisted, for example, for the top position of being a consultant. If you are shortlisted, there is less likelihood of being appointed. We see this disparity. I am sure that would apply in other professions too.

It is a case of the interplay between being BAME and inequalities that have led to BAME people being disadvantaged through those other socioeconomic and deprivation factors. They have come together and been exposed. To actually solve this is going to require a really decisive approach by Government to enable proper, equal opportunity and fairness that allows, whatever your colour, equal ability to succeed in

society and therefore not have this disproportionate impact that we are seeing at the moment.

Professor Platt: The recommendations from the report seem sensible. They are not perhaps very specifically linked to particular actions, responsibilities or timeframes, but they are looking at the present. These disparities did not come from nowhere. They have shocked and surprised me to some extent, and I have worked in ethnic inequalities for many years, but they have to be seen against that background of, "We know discrimination exists". Experimental audit studies show that and that it continues.

We have legislation, so we need to think about how that legislation can be more effective. We know a lot about occupational segregation and pay gaps that are caused by occupational segregation. We need to think about how that arises within the system, about access to different jobs and about opportunities. It is a long programme. We need to think about careers advice. We need to think about how people make the transition from university, or from education at lower levels, to the labour market and how they do that in equal ways.

Yes, the recommendations are fine, but there is a bigger issue about things we already know. This is on the back of wider inequalities. If we could address some of those wider inequalities more effectively, which we have known about for a long time, then we would have seen fewer of these patterns.

We also need to consider the role of the safety net and social security in that as well, and the extent to which issues like child poverty are starting to rise and family circumstances are changing. There is very little leeway for households and families, when a crisis such as this hits, for them to feel secure and to be secure going forward. That again affects some groups more than others. Again, this is stuff we already knew. We need to think a bit more about why we have not acted on what we already knew.

Professor Khunti: If we look at the public health perspective of this, this is about wider determinants of health. I know we are concentrating on BAME here and, as Chaand mentioned, that deprived population may have enhanced in terms of disparities here, but remember that the majority of the deaths have occurred in deprived populations, where BAME populations may also have a disproportionately increased prevalence there. However, 84% of deaths have occurred in the most deprived areas. This is not about BAME; this is about wider social determinants of health. We need to fix all of that. If we fix that, that will help everyone, including the BAME populations.

Q9 **Chair:** We are about to come on to exactly that. I wanted to ask about housing and the impact of overcrowded housing and how that has affected the spread of Covid. Particularly, I would like you to give a little thought as to what you think the best policy levers might be, whether

from local government or from central Government, to alleviate the challenges on overcrowded housing and how we can best help people self-isolate in those circumstances.

Professor Platt: We know that there are big differences in overcrowding across ethnic groups. Chaand already referred to some of the rates. It is 2% among white British and 30% among Bangladeshi, with the other groups in between those two rates. Clearly, this makes it harder to entirely self-isolate. It is also clear that these overcrowding rates are not driven specifically by London. Overcrowding is higher in London, but it is not driven by that. Overcrowding also has an age gradient. Older people are less likely to be overcrowded, but again it is not the age profile that explains that. Minorities have higher rates of overcrowding in all age bands.

There is still work ongoing about how infection operates within households, but clearly that makes it harder to socially isolate, along with lack of space. We could draw attention to the fact that overcrowding is more likely in social rented housing as well. Even in social rented housing, minorities are four times as likely to be overcrowded. Is social rented housing providing adequate space? We might want to ask whether there has been any increase in overcrowding in social rented housing as a consequence of the spare room levy, which means that there are not really very easy opportunities for those bigger households to socially isolate.

Those responsibilities are divided. Some are at local authority level. There are also issues about access to green space. We also know that minorities are less likely to have access to a garden. This stresses the importance of public green space for people to be able to get apart from each other.

As well as in more overcrowded households, I have also looked at levels of multi-generational households, where there are children, working-age and pension-age people living together. This is not particularly common, but it is much more common, again, for Pakistani and Bangladeshi houses, with about 5% compared to less than 1% for the white majority. Again, those are situations where you have more vulnerable older people living with children, for whom the intention is that they are going back to school, which creates some challenges. Again, thinking about how that intersects with local authority and education policy will be important.

The area where the urban environment may be relevant is not only in relation to green space but also thinking about how that space is used for people to walk and to be outside, so the use of pavements and the access to cycling for those who can cycle.

Q10 **Chair:** Nicola Richards is going to come on to ask questions about that, so we can leave that for now. Can I ask the two other panel members whether there is anything they wish to add about overcrowded housing?

Professor Khunti: There are the immediate effects and there are the long-term effects. The immediate effect is that the Government need to make provision for people if they are found to be positive. We do not have a test, trace and isolation policy. If someone is positive in an overcrowded house, they cannot socially distance, so alternative accommodation needs to be given. If there are key workers in the house, again, alternative accommodation needs to be given to key workers so that they can continue working.

There are then the longer-terms issues that Professor Platt mentioned, about urbanisation and improving homelessness. This is just not for BAME. This is for the deprived population and the Gypsy and Traveller populations. We really need to improve housing for all those populations and reduce poverty and social exclusion for these populations.

Dr Nagpaul: Coming out of this there has to be a Government policy to reduce overcrowding as a principle, because it has negative health impacts on people, in terms of wellbeing or otherwise, even without a Covid crisis. Having a disparity of 30% of Bangladeshis living in overcrowded housing and 2% of the white population is a statistic we cannot just carry on presiding over. There needs to be some concerted policy action, in my view.

The second is practical support in the midst of what we have seen, which is a pandemic. I hope there will not be, but if there are future infectious diseases or if there is another wave, we need to look at the messaging given. The messaging included that, if a person in the household was infected, they should use a separate bathroom; that sort of luxury would not be even remotely possible in an overcrowded house. There were no practical suggestions of how to deal with that. As Professor Khunti has said, with this highly infectious disease, there could have been interventions to allow separation or temporary accommodation.

There were issues around, when a person is infected, use of masks in the house. Masks were provided for some patients initially, but that should have been adopted in a much more rigorous manner so that other members of the household were not infected.

I am a GP in north-west London, which had the peak first, in the part that I live in. We had situations where two members of the same household died on the same day. I can think of a specific example of a son and a father. That just made it hit home how this virus behaves in crowded housing. You need practical interventions that need to be culturally sensitive as well as a determined policy after today that we have to reduce overcrowding as a social principle. It is not right.

Q11 **Nicola Richards:** BAME people are more likely to reside in urban areas. I know this has been touched upon but, as the lockdown eases, what measures should be put in place in urban areas to ensure the risk for BAME people is minimised?

Professor Platt: As has been stressed, it is about all populations as lockdown eases, in terms of what measures are put in place. Where there will be differences is the extent to which some provision affects people of different ages. Most minority groups are younger, on average, so there are more young people and more people in education; that is post-16 as well as pre-16. It is a big question, but I have already touched on this in my previous answer, going over the brief.

We need to think about how the urban environment allows people to use space in a way that is as healthy as possible, and about putting in provision for less use of public transport for those who can avoid using it, so, where it is possible, to walk or to cycle. The use of public spaces is clearly very important, as is what happens in relation to how people are kept safe going to and at school. I know this is something that head teachers and people responsible for education are thinking a lot about, but, again, that is where young people are going to be coming into a lot of contact with each other. How to manage that successfully is going to be a challenge, not just within school but as they leave and as they exit school. There are issues about how those person traffic processes are organised and urban traffic processes are organised.

There is something about potential opportunities as well. A lot of places have been shut down that people would previously use. Thankfully, that does not include many parks, unlike some other countries, but it includes places like libraries, which are used by people for information. They provide alternative spaces and they also provide internet access. How we can have safe spaces that also provide those facilities is going to be a very important question for making the urban environment good for everyone.

Dr Nagpaul: The virus has not vanished. We are still seeing more than 1,000 new cases every day. That is just those that have been tested. There are several thousand more that will not have been tested. The virus has not disappeared. It is really important in urban areas, where people are close to each other and you have population density, to make sure that those who are returning to employment are properly looked after and that their employers have put in place mitigations, such as ensuring workforce adaptations of social distancing, ensuring face coverings and ensuring Perspex shields if you are in an environment where you are mixing with the public and so forth.

That is happening in some places, but it needs to happen in all working environments. Whilst the lockdown is easing and we have the virus, we must continue to protect our BAME communities, who will be overrepresented in some of those roles in public transport, in construction, shops, taxis and all of those. I would want to see that happen as a norm. I am concerned if it is not, because otherwise they are still prone to becoming infected.

Q12 **Chair:** To interject at that point, Dr Nagpaul, are you saying that face

coverings should be mandatory in every workplace?

Dr Nagpaul: I am saying that we have at the moment a policy that social distancing protects you from infection. Therefore, if you are not able to socially distance yourself and you are going to be, say, two or three feet away from other people, it is important that the person is protected. Otherwise, it does not make sense to have any principle around social distancing. Many people cannot socially distance. If I look at the health service, this is why we called for face protective equipment, because we cannot be distancing ourselves from patients and people.

Employers should ensure social distancing in the first instance. If social distancing is not possible, they need to make sure there are screens or face coverings being employed as a means of reducing transmission when social distancing is not possible.

Professor Khunti: This messaging needs to go to the wider public and not just the key workers. We have seen this weekend that things are opening up and you have seen overcrowded shops. The messages need to continue, as we have already said. The virus is still here. There is still this risk. We need to continue socially distancing. We need to make sure that messaging comes in the culturally appropriate manner. If people think that we are not under lockdown, some people get this sense of relief that we are out of the worst. We are not out of the worst yet. We have to prepare for the second wave as well. We need to continue this campaign about social distancing. If you are in workplaces where you are unable to social distance, then face masks are a key area that we need to look at.

Q13 **Nicola Richards:** How does deprivation specifically impact BAME communities during a pandemic? What actions should the Government take to minimise deprivation experienced by these communities?

Professor Platt: Can you just clarify what you mean by "deprivation"?

Nicola Richards: We are talking about housing specifically in this set of questions but it links into health and economic deprivation.

Professor Platt: The issue about deprivation and minority ethnicity is not that it necessarily affects minority ethnic groups specifically, but that more suffer from it because of their employment situation, their self-employment situation or because they are more likely to have children, who need to be fed.

Issues that address deprivation tend to help all of those who are deprived. We talked about overcrowded housing. Not living in overcrowded housing is good for everyone. It is not particularly good for minority communities; it is just that they are more likely to be in overcrowded housing.

That applies to things like economic safety nets as well. The risks of being deprived are greater for certain populations groups, for example lone

mothers. All lone mothers benefit from a good safety net, especially if they lose work or if they are not able to work because they are having to home-school their children. It is just that some groups are more likely to be lone parents, so black Caribbean, black African and white British are more likely to be lone parents than other ethnic groups.

We can look carefully at those who are most deprived. One issue, again, is child welfare and child poverty. To the extent that this is greater among minorities, it will be reduced if there is greater support for families with children, across things like the universal credit system and child benefits. For issues like receipt of free school meals, the rates of free school meals are much higher among some minority groups, but they provide a valuable support for all poor children.

There is a broader issue about ensuring that those sorts of safety net issues are there for all who need them. That will help some minority communities who are more vulnerable more.

Dr Nagpaul: The trouble is that deprivation results in poor health outcomes, which is why you have to tackle deprivation as a root cause. If you remember the peak of the pandemic, the messages we got during lockdown were, "Stay at home. Do not use public transport. If you do have to go to work, drive to work". If you are in a deprived environment, you cannot do any of those. You cannot work at home, because your job requires you to be physically present. Many of these workers were in insecure employment. You do not have the luxury of driving to work because you do not own a car. You have to use public transport. You can see how deprivation really does disadvantage people.

We have to tackle deprivation, but some of the other issues that came out about working from home were that many workers, especially those from deprived communities, did not have the technology and the enablement to work from home. Something we can take forward is to make sure that is a much more real provision: for everyone to be able to be digitally connected, to prepare for any future pandemic or, for that matter, if there is a second wave. It just highlights that being from a deprived community unfortunately leads to inequalities. That is why we need to tackle that.

Professor Khunti: As we keep seeing, this is about the wider social determinants of health. It is the deprived population, where many of the BAME populations reside, that is causing this problem. We need to ensure that we have as reduced an exposure risk to the virus as possible. There are a number of aspects one could look at. We need to make sure that there is a test, trace and isolation policy that is functional. We may need to concentrate on the deprived population and the BAME population a lot more.

We have talked about the wider health inequalities, especially in terms of co-morbidities. We need to make sure these patients are looked after and their risk factors are managed.

We also looked at the employment inequalities. We need to make sure that the workplace environment is improved. If people are going back to work, there is a possibility of social distancing. They can do stages in terms of people coming into work and providing the right PPE.

We have already mentioned about the housing issues as well. They really need to be fixed. In the short term we may not be able to, except for people who have been tested positive and need to have alternative accommodation for them. In the longer term, there should be Government policy and cross-party policy regarding improving housing and improving inequalities in that area.

Q14 **Nicola Richards:** What do you recommend local authorities do to reduce housing insecurity and deprivation? Specifically we are talking about BAME people, but I know Professor Platt's point is that when you tackle this in general it will help the BAME community too.

Professor Platt: There are issues about effective use of housing stock that we need to pay attention to, so that it is well used and well maintained, because housing is central to wellbeing. Deprivation often means there is the housing and then there is the poverty. Those things go together. More deprived areas are more deprived because they have more people in. Some of these issues are beyond local authorities directly.

Local authorities do, of course, have some emergency funds that they can use and that they do use, but a lot of it, as I said in my answer to a previous question, comes down to having both an effective safety net and effective employment opportunities. We need to understand where employment opportunities are not very good, and not only invest in local areas to increase employment opportunity but understand why people are not moving to jobs where there are jobs.

We have seen some of this. There is a study of Manchester where there is an area with high employment demand and an area with high unemployment. Why are the people from one not trying to get the jobs in the other? Local authorities have some work to do there. That could be related to transport infrastructure. It could also be related to communications. They are not simple questions with simple answers in terms of matching people to jobs.

Q15 **Chair:** Can I interrupt? We are getting very short on time. Could I perhaps suggest that, if there is more information that you could provide us, you could do it in writing, on that specific subject about what local authorities could do? As you said, it is very complex.

Professor Platt: Yes, that is fine.

Q16 **Chair:** Do our other two witnesses wish to contribute briefly on that point about local authorities and housing?

Dr Nagpaul: I would just reiterate that there is an inequality if you have 30% of Bangladeshis in overcrowded housing compared to 2% of the white population. There is something that needs to be addressed; there is an inequality.

The second is advocacy. I say this as a GP; patients come back asking for letters. It is not easy to negotiate with a local authority, to argue your case, if you are in an overcrowded environment and you want to be having larger housing or be rehoused into different accommodations. I believe there is something around the BAME community, some more than others, who really are disadvantaged because they may not speak English as well. They may not be able to put their point across as well. There needs to be better advocacy, to really make sure that their needs are being met.

Professor Khunti: You need a minimum wage at least to help affordability. Employment and housing go together. You need to ensure that people are not in poor quality employment, they are not on zero-hour contracts and they have career development paths. All of that would help ensure that they have enough funding to get on the housing ladder. Housing needs to be made affordable and we also need tailored interventions in terms of the space, with local authorities looking at creating more green space for people to exercise and get out.

Q17 **Kim Johnson:** Hello, panel. My question is to Professor Khunti. Since the start of this pandemic and the growth of the Black Lives Matter movement, racism and systemic inequality have become very prominent. We have had numerous reports over the years, including the NHS "snowy white peaks" report; recommendations have been identified. However, sadly, very little action has been taken to address the problems. Can you explain what you feel needs to happen and who needs to do it?

Professor Khunti: I would not profess to be an expert in this area. Structural discrimination has been there for many years, as we heard earlier. All of this discrimination needs to be eliminated at all levels. This needs to be done in terms of raising awareness about discrimination in the workplace. It starts at school. We know that. I grew up in an inner-city area. We need to make sure people have enough training in terms of cultural competency, because there are biases, either conscious or unconscious, as you know. We need to ensure that they are looked at. Overall, at all levels, we need to ensure that we raise awareness and make sure that we rapidly get rid of this structural discrimination.

We said earlier that we do not know whether this has enhanced these inequalities. We do not have the good-quality data. Irrespective of whether it has or not, we need to get rid of discrimination.

Q18 **Kim Johnson:** Dr Nagpaul, Mary Agyapong was a heavily pregnant, 20-year-old black nurse when she died of coronavirus in April. She worked on a general ward. I want to know what problems you have experienced with PPE that will specifically have impacted on black health and social

care workers.

Dr Nagpaul: We have plenty of anecdotes. Plenty of doctors reported to us in the first month or two of the pandemic, when there were national shortages of PPE. As I said, in our own surveys, twice as many BAME doctors were reporting to us their concerns. They felt that they were put in positions of seeing patients when they did not feel adequately protected. Remember that these were times when there were not adequate numbers of gowns and face masks in a ward. It was also the time when Public Health England's own recommendations were less stringent than the WHO's. The reports we got were of doctors telling us that they literally did not fell protected.

Early on, for example, there were designated Covid areas, but the non-Covid areas were considered to be low risk. Many doctors knew that you could not really artificially distinguish between the two, because the virus was spreading on a day-by-day basis. In fact, the sone of one of the doctors who died went to the media afterwards. He rang me up and went through a set of emails where the father, the doctor, had actually pleaded for the ability to wear a mask in a non-Covid ward. He was not granted that and a few days later four patients in the non-Covid ward developed Covid. The doctor then also became infected, was in intensive care a week later and did not make it.

It is that sort of experience. We also know that nurses and doctors from a BAME background are less likely to speak out. They fear that if they speak out they will be seen to be troublesome. They fear that they may be blamed for systemic failings. They fear for their career progression. There is a higher prevalence of bullying and harassment, twice as much affecting BAME healthcare workers.

When you add that all together, you can see that in the backdrop of a shortage of PPE, many did not perhaps speak out enough or, in fact, the system did not support them enough. We cannot prove it, of course, but it does stand to reason that some of the early deaths would have been as a result of exposure and not being protected adequately.

Q19 **Kim Johnson:** Would you say that senior officers within NHS trusts were complicit in some of the deaths of some of these frontline black care and medical professionals?

Dr Nagpaul: The biggest issue was we did not have the PPE. It was an awful time at the beginning to go to work and for healthcare professionals not to know that there was adequate provision of basic protective equipment. When you have that sort of situation, that creates the problem. This issue of BAME workers feeling bullied and harassed at a greater rate, feeling unable to speak out the same as their white counterparts, predated the Covid situation. This inequality has existed for a long time. The General Medical Council did a commissioned report called *Fair to Refer*, which also shows that BAME doctors are more likely

to be referred for disciplinary processes because their employer does not support them in the same way. They are excluded.

We know that in medicine racism starts even at medical school, where medical students do not attain in the same way compared to their white counterparts. They are not often included in social learning in the same way. I mentioned career progression earlier. BAME doctors are disadvantaged in holding the most senior positions in the health service.

This is something that has existed for a while. The Covid pandemic has exacerbated some of that. Therefore, we must now not look at this piecemeal but radically change the way in which we allow people to be treated fairly. Remember, this is not something that we should just put right because it is wrong; actually, we all suffer, society suffers and the nation suffers. In the case of the medical profession, we are not allowing the full potential of our medical and healthcare workforce to be its best to look after the nation, because some sectors are disadvantaged. They are not allowed to become their best. We need to look at this in terms of the social responsibility for the nation, as well as doing what is right.

Q20 **Kim Johnson:** Do you believe that the race equality commission, which was reported in the Sunday papers and is going to be led by someone that does not believe that racial inequality exists, is going to have any major impact on the systemic issues faced by black people in this country today?

Dr Nagpaul: Our view as a profession, and my view, is we have had enough reports; we have had enough reviews; we have had previous commissions. We have talked today. We know what the problems are. We now need an action plan. That is what we asked for from the publication of the PHE review. Each of those recommendations now needs to be populated with timescales of action plans and what needs to be done. Remember that the Government commissioned the PHE review. As the commissioner, they now need to respond, not with some other commission but really with what is going to be done now. We have discussed many of the issues that can be done very quickly and others that may take some time. That is what needs to happen.

Q21 **Kim Johnson:** Actions speak louder than words, doctor. Thank you for that.

Professor Platt, frontline key workers will tend to have zero-hour and precarious contracts and are often considered as being high risk due to their health conditions, but they are forced to work to support themselves and their families. What do you believe to be the impact on black workers when they have been in these shutdown sectors?

Professor Platt: Yes, there were the frontline workers and there were the shutdown sectors. Looking at it already, there are some minority groups that clearly are being more affected by being in shutdown sectors. I have looked at who was working in shutdown sectors prior to the

beginning of 2020, and we see that Bangladeshi men were much more likely to be working in these shutdown sectors.

I have also looked a little bit at data that is being collected currently on who is losing employment. While the furlough scheme has protected many jobs, we can see again that Bangladeshi, Pakistani and black African workers seem to be losing work at higher rates, which highlights some of the issues in the security of tenure that you are pointing to. Getting very detailed information at the moment on what is currently happening is challenging, but it tends in that direction, certainly.

Q22 **Angela Crawley:** My questions are also to Professor Platt. Just picking up on the points you made there regarding the specific sectors that have been impacted by a higher representation of black and Asian minority ethnicities. You mentioned specifically Bangladeshi and Pakistani as those who have been impacted by shutdown as a result of Covid. How could the Government have considered these sectors when drafting the fiscal measures that support workers?

Professor Platt: One of the issues, for Pakistanis in particular, is around self-employment. Rates of self-employment are very high for Pakistanis; it is around 26% of Pakistani men, compared to around 15% for the white British majority. While there were quite generous provisions for self-employment, they required a wait and they also interact with the universal credit system. People might have made claims through universal credit, and then, if they claimed for SEISS and got the payment, that could have made their claim for universal credit invalid. The intention was to bring in something that was protective, but the ways in which it interacted with the benefit system could have been better thought through.

It is also about who was being missed. We know that the payments are more likely to go to those who have employees and are self-employed than those who are self-employed without and who have started work only recently.

In the longer term, it just highlights the vulnerabilities of the self-employed sector, which again is something we have known for a while, but it takes a crisis like this to really bring it into sharp relief and think about how these own-account self-employed workers could perhaps be more effectively brought into national insurance systems and sick leave systems. That is an agenda for the future but it is something important.

Q23 **Angela Crawley:** I appreciate the point you made about the vulnerability of the self-employed. Specifically, are there any other measures the Government could have taken to help those in insecure employment during the recovery stage of the pandemic, which obviously we are experiencing now?

Professor Platt: Yes, we hope that this is the recovery stage. I know that the furlough scheme is being wound down steadily. There needs to

be some thought given to whether all workers will be able to return to work at the same rate and then what happens to those where it is not viable. Yes, across the board it sounds quite logical to have a winding down of the furlough scheme, but there are specific impacts on particular occupations where they will not be able to restart. The hospitality sector is going to struggle for some time. In the hospitality sector, different work groups work in that disproportionately. 8% of Bangladeshi men are chefs and 24% work in the restaurant industry more generally.

Q24 **Angela Crawley:** Absolutely, and there are really positive examples of where the furlough scheme has been applied more flexibly in other countries to account for these kinds of variabilities.

Just coming on to the next section, you have outlined gender pay gap as a factor, childcare and child poverty as being just some of the factors that specifically and predominantly affect women more. Taking account of that sex-adjusted occupational risk, how has the pandemic impacted on black, Asian and minority ethnic female workers? What immediate actions should the Government take to mitigate the impact for female worker?

Professor Platt: What we know about impact on female workers so far is that the impacts have not been as great for female workers as they have for male workers. That is partly, to some extent, because they are less likely to be in work in the first place, in particular for some groups, so they cannot be so severely affected. In other cases, it is because of the differences in hours. Again, there is less potential for a reduction in hours.

Where we have seen that women are more affected is in terms of trying to manage work and childcare. All the current evidence to date evidence suggests that women are doing a lot more in terms of doing the home-schooling and looking after children, where there are children in the family. This is particularly challenging for those who are lone parents and lone mothers. Again, we know that black Caribbean and black African women are more likely to be both participating and lone mothers. They are particularly faced with challenges in this dual role at this time.

Many will be desperate for children to go back to school. How that return to school is managed will be very important for them. What happens in September and what happens if schools are then shut again will be crucial for women workers. Otherwise, there could be real dangers that this has a long-term scarring impact on careers and on incomes, as well as not being ideal for the children either.

Chair: Can I thank the panel for your contributions? They have been incredibly helpful. If there is anything that you feel you have missed, please feel free to send it to us in writing afterwards. Can I just conclude by saying thank you?

Examination of witnesses

Witnesses: Barbara Palmer, Rosie Lewis and Naz Zaman.

Q25 **Chair:** Good afternoon and welcome to the second session of this afternoon's Women and Equalities Committee sitting. Thank you to our panel for joining us this afternoon. What we are hoping to get out of this afternoon's session is something of the lived experience of BAME communities during the last few months of the coronavirus pandemic. I hope to make this session as conversational as possible and certainly appreciate that there will be some aspects that you will wish to talk about more than others. I hope that we will learn a great deal about the communities you have been working with over the past few months. Could I just start by asking each of you in turn to give a little bit of the experience you have had over the past 12 weeks?

Barbara Palmer: I am Barbara Palmer, part of the RCC and part of the Windrush Elders group. I am a nurse by profession. I work part-time. I have a son who suffers from learning disability and epilepsy. Suddenly his services were taken away, so he became very anxious, to the point that one of the times I was quite concerned about whether he would have an epileptic seizure and end up in hospital. That worried me quite a bit, because the last time he had quite a bad seizure he was in ICU. All of those things worried me about him. If the chance arose that he had to be in hospital, not having the social support of family, friends, the community and so forth was quite worrying.

I am also his main carer because he lives at home with me. I work part-time with a zero-hours contract, so there are all those issues. I am concerned about being in work and doing the best I can, in terms of providing care for individuals and keeping myself and colleagues safe. I am also concerned in terms of the family and the risk to the family of coming home from work.

In the community, there have been quite a number of deaths: individuals, including colleagues that I know, dying of Covid-19, and individuals dying from sickle cell anaemia. There are all these issues that impact on our community. We start as a community that is disadvantaged and marginalised. We have a lot of elder people in the community. We have the Windrush Elders group as well. I am a part of that. There are people at home, caring for families, and the isolation that they feel. There are also people who have families in hospital and other care settings and are not able to see their relatives. In our community, we rely a lot on support from our community and, because of the Covid-19 that has not been forthcoming. It has impacted our community quite a lot.

Rosie Lewis: We really welcome you inviting the Angelou Centre along today. Thank you. We are based in the north-east of England and are an open-access community centre for black and minoritised women. Pre-Covid, we were a training centre and a health and wellbeing centre, but

also we provide a range of services related to violence against women and girls. That is what I will be focusing on, in terms of the lived experience of the women we support. We have had to increase our provision of specialist multilingual therapeutic services. We have had to find a way to deal with the digital inequity the women have faced.

Particularly for us, it has been about the escalation of violence that many of the women we have supported have gone through during lockdown and the amount of additional support we have had to provide. That is from very basic things to do with welfare banks that we have had to set up, making sure women have food provision, to thinking about how we make sure that women are safe and protected. We have also had to deal with an increase in referrals to our services. We provide refuge accommodation for women without recourse to public funds, who are destitute.

We are here to represent and amplify the voices of the women we support. Throughout the lockdown, we have had regular consultations with women about their experiences throughout Covid. What we and the women are dealing with correlates with much of the research pre-Covid and stuff that has come out of the *Beyond the Data* research. We are supporting women who are facing socioeconomic deprivation. There is definitely a lack of equity in terms of access to services, safety and protection particularly for women without recourse to public funds and corresponding poor health access. As you can imagine, women without recourse to public funds cannot equitably access health. Maternal poverty has been a big issue among the women, as well as food scarcity and mental health issues. I am hopefully going to include many of the quotes of the women as we go throughout, to make sure their voices remain central.

Naz Zaman: I am Naz from Lancashire BME Network. We work across the 14 districts of Lancashire and have approximately 100-plus members that we represent. Some of the evidence that I will give today will be as a result of consulting with our members and communities. They have been really forthcoming with a response to some of the question that I am hoping you might ask.

In terms of me as an individual, we were in lockdown and working remotely as an organisation. We found that there was a negative experience around mental health and isolation for even our staff. That is not even looking wider. I have really welcomed the fact that we have been fortunate enough to return back to work. At the start of lockdown I had my children off school at home, so I was a working mum. My husband was not furloughed so I had a real struggle and it affected my own mental health because I also am a foster carer and had four looked-after children who were living with me. I have one now. I also have an elderly mother who is shielding and has chronic health conditions. I myself am pre-diabetic and I think that is genetic. There are lots of things going on for me as an individual.

In terms of work, as an organisation, we are responding to emergency needs and the needs of our members, which are diverse and varied. As we present the evidence, I am hoping that some of our members' views will come across in the evidence. There will be some replication of the evidence given by the previous panel because we can reinforce what has already been said.

Q26 **Chair:** That is really important to us, that we hear your members' voices and get the lived experience of what the previous panel may have told us. Rosie, you mentioned women without recourse to public funds. We know that was an issue raised by Stephen Timms MP with the Prime Minister a few weeks ago in the Liaison Committee. It has certainly been a matter that has been discussed significantly during the committee stage of the Domestic Abuse Bill. Can you tell us specifically how the no recourse to public funds clause has impacted the women you have been working with?

Rosie Lewis: One of the main issues to raise is that there is no safety net for women without recourse to public funds. They cannot access safety and protection, as in they cannot access refuge accommodation. They cannot access healthcare equitably. There is very little chance for them to be able to escape from violence and from perpetrators. They are often excluded from society in many ways. It makes it very hard for them to be able to access services. They have often been told by perpetrators that they cannot access any support from a lot of agencies and when they actually go to agencies they are often turned away.

There are a lot of issues around further exploitation and having no choice but to return to situations of violence and abuse. For us, working with women with no recourse to public funds, it has become one of the greatest issues in terms of looking at health socioeconomic inequalities. Ten places that we provide in our refuges are specifically for women without recourse to public funds. Let me tell you: that is a rarity in the UK at the minute.

During Covid, we have seen an increase in homelessness, an increase in statutory services unfortunately telling women they cannot be supported or helped and an increase in women whose underlying health conditions have been massively exacerbated.

I am going to give you a brief example. I am going to call her Mo to anonymise her case. She is actually in one of our refuges at the minute. She has had cancer previously. She has co-morbidity health issues. She has a number of things that are going on. We support her through our no recourse to public funds refuge space. If she was not supported, she could not get access to her medication, she could not get her appointments in terms of surveillance around her oncology, she could not get access to food and she would not be able to even travel to any of her appointments, if she did manage to get any.

There is a real restriction that has come because of the lockdown that has retraumatised many of these women, in terms of feeling as if they are subject to state surveillance. Every day they are living in fear, in terms of how they will be treated by authority. Mo gave a quote and I would like to quote her here: "Honestly, it is all just too crippling. I live in a refuge. I have no recourse to public funds. If I was not here, I would not have support. However, it is emotionally daunting. To say 'Alone together'"—which has obviously been one of the key messages from the Government—"might be fine, but to some of us, including me, I feel that society has forgotten us and that the Government have forgotten vulnerable women".

Another point for you around no recourse to public funds is the immense impact this has on women's mental health and wellbeing. Again, that reinforces many of those health and socioeconomic inequalities. I will leave it there.

Q27 **Chair:** Not necessarily using Mo as an example, what impact is the no-recourse condition having? We know that in an emergency people can and should be able to access healthcare, but how is the no-recourse condition impacting almost their willingness to present at NHS services in a crisis?

Rosie Lewis: They are not presenting. Although it was said for people without recourse to public funds to access NHS services, in the small print it said that you would have to pay if it was not proven that you had Covid. We can think of the way the testing has been, especially at the beginning. We know a number of women that we supported, including women who came into our refuges, were not even accessing 111 support. We have had to provide a lot of support to give confidence to women to access healthcare. We have also had to come up with the funds to be able to support women to be able to access very basic healthcare.

It has had a big impact. We have known of women who had underlying heart conditions who have not accessed any support. We have had women in extended communities who we believe have not only been seriously ill but it has affected their mental health. They have had serious mental health episodes. We also believe, in extended refugee and asylum communities, especially communities where there has been no recourse to funds, that people with underlying health conditions have died because they have not presented to the NHS. It is a huge factor in terms of discrimination and inequality.

Unfortunately, the public messaging that went out was not very clear. It fell into the hands of many perpetrators, who tell their victims, "You will never get support from agencies. You cannot go to the hospitals. They will put you in a detention centre or a madhouse, or they will deport you".

Q28 **Chair:** You just spoke then of the messaging. Do you think at this stage there is more that the Government can and should do, recognising that

we are 12 weeks in? That is 12 weeks when women in particular have felt very anxious, alone and unable to access services. Do you think the messaging at this stage could be changed, improved or enhanced to make it clearer to vulnerable women? If so, how?

Rosie Lewis: Definitely, yes. I think it was raised before. Specialist services like ours are putting a lot of work into making sure that women have more confidence. They are very fearful, because of the messaging going backwards and forwards. They are not being very clear and are not necessarily culturally competent or aimed at multilingual women or accessible to a lot of multilingual communities. It has meant that women, particularly the women we support, are very fearful to go out. They are very fearful to know what they should be doing in terms of social distancing. We have given a lot of advice and support there. Often, they are becoming further prisoners in their own houses, if they actually have accommodation.

Unfortunately, the messaging has not been clear. It has been a little bit uncertain. The Government have been very reliant on voluntary agencies like us to be able to provide that adequate messaging and support women. I can tell you that many of the women without recourse to funds that we support, both inside the refuge and outside, are too fearful to come above ground. We are looking at an explosion in terms of the number of women who are going to be needing response and recovery support now we are coming out of lockdown.

Q29 **Chair:** Naz, you were nodding a lot through that. Is there anything you would like to add?

Naz Zaman: I would like to echo what Rosie has said, whether it is women who have no recourse to public funds or women generally. I used to be a domestic violence adviser in my previous life and we have members who run refuges and deliver women's services. We sit on the domestic violence strategic group in Lancashire and we have seen a significant decrease in the number of women presenting and accessing services. That is not to say that the issue has gone away or there is no longer an issue around domestic abuse.

Our feeling is that, with the lockdown measures, women are not presenting or victims are not presenting at services or accessing services. They do not actually know if services are still there. Nobody is aware of what is and is not available. If English is not your first language, you are more vulnerable than most because you are not accessing the mainstream messages. There is no joined-up and sustained comms around getting those messages out to vulnerable communities. There is going to be a pandemic within a pandemic, if you will. Once we come out of crisis and services start to open, people start leaving their homes, victims feel they are able to access services and make calls without being listened in on, they will be accessing services and we will see a sharp rise.

Q30 **Sara Britcliffe:** This is to Naz and Rosie. As someone from Lancashire, Naz, hi. It is about the local authorities and the comms. Have you found they have been quite proactive, or are you finding that the local authorities are not really pushing where people can go to receive that help? I know in Lancashire I have not seen much of that, so it is a question there.

Naz Zaman: I hail from Hyndburn, Sara, so nice to see you. I recognise the accent. In Lancashire, when the lockdown first happened, as an organisation we reacted very quickly, with no resources, because we have seen this happen before. This is nothing new to us, where there are not consistent messages, consistent comms, and we have always done this. We took it upon ourselves, as a voluntary sector organisation, to put together some scripts around social distancing as soon as we were aware that BAME communities and BME communities were more affected, there were higher incidence and death rates. We took action.

For that action, we made 10 social distancing videos in community languages with pre-made scripts that were following Government guidance. We got local professionals who were recognised in their communities to develop those videos and we circulated them. In the space of three weeks, we had reached in excess of 37,000 people at grassroots level and those messages were getting out. We were approached by Greater Manchester NHS and other bodies, asking us to work with them to produce further videos. For example, antenatal services said, "Can you do videos around antenatal?" We do not have the capacity so we stopped there, because we felt like at least we had made some inroads and had tried to protect people.

I sit on the excess death cell for the LRF. There are various other cells like the warning and informing cell and the vulnerable people cell. Then there are the various structures like the health structures and the local authority structures. We have found it quite frustrating and we have seen this many times before, so it is nothing new to us, that those structures do not talk to each other. There is no pooling of resources. There is no consulting what I would deem as the experts in the community as to what is and is not going to work. It has come to the point where, even now, many weeks in, we are still fighting a losing battle trying to get those structures to understand what will and will not work.

It is not about making cartoons and dubbing them in community languages. My mum is not going to listen to a cartoon dubbed in a community language. It is not about just putting letters out there. I have the letter from the Government and I have kept it. It is going in a time capsule. We have not opened it. Many people will be the same as me. It is about using the right mediums. If you have access to specialisms and specialist knowledge, use that. It is not being utilised. That is my experience and it has been time and again.

Rosie Lewis: Naz has given a brilliant on-the-ground account of it, so I will talk a little bit more structurally. In terms of the local authorities,

there is a major issue with the public sector equality duties being implemented and about transparent and accountable processes. We work across many local authorities, so I am not going to focus on one local authority. We work across three areas of the region as well. What has been happening is there has been a lot of general messaging, usually via emailing out, with an expectation that the voluntary sector will then cascade that information.

There have been no resources. I do not know of anyone, any organisations like ourselves, battered women's organisations, that have benefitted from resources from local authorities, and I am talking nationally. That is a huge issue and it is something we have to start addressing post-Covid and post-lockdown, in terms of accountability around equality duties.

Another thing I want to bring in is very regionally specific in the north-east. We have one of the fastest growing demographics in the country and yet, outside of health, our statutory services have less than 5% black and minoritised people working in them. That goes back to the thing that has been raised around cultural competence and about a proportionality in terms of who is representing the communities. We have inner-city schools in some areas that have 40% black and minoritised children and young people. You can see already there is a massive inequality. Because that workforce is very white and static, unfortunately we are losing a lot of the rich constructive work that could be done by the local authorities.

I want to finish on this, because when we talk about local authorities we have to bring in the legislative bodies and those that have duty of care, like adult safeguarding and children's safeguarding. I want to give you a quote from one of the women from our Covid crisis consultations: "Despite being so unwell, I had to continue to look after the children. I kept getting blackouts. Everything is worse for me, as already I have bad health: high blood pressure, kidneys, diabetes and asthma. I felt like I could not breath most of the time"—because she had had Covid—"The social worker knew of this and they did not help me. They took my eldest daughter away and, since then, I just do not think they care to help".

What happens is, when you do not have a culturally competent statutory workforce, they can be very reactive in times of crisis. That has to be understood, because there is going to be a post-lockdown impact in terms of the outcomes for black and minoritised communities and relationships between communities and the statutory sector. It is very important that gets grounded within us reviewing public sector equality duties.

Barbara Palmer: We have similar but different issues in our community in terms of inequality and individuals having access to services. There have also been problems with understanding the information that has been sent out to individuals, and of course in this lockdown people do not

have that support in the community, so advocacy is a problem. I am quite aware of someone who has been sent information from the hospital and they have not been able to fully understand. This causes a lot of stress on individuals.

I am also aware that there is food poverty in terms of individuals being able to access food, to the point that there have been members in our community that have not had enough food. Therefore, members from the community have had to set up a food distribution centre, safely, to be able to provide food for individuals. These are elderly people. These are people off the street who are experiencing hunger.

There are many problems right across the board where individuals and the community are trying to address some of these issues, without funding as well. It can be quite problematic, but of course we continue to serve our community as best as we can, providing food, information as far as we can about housing, access to health and all these different situations. We are supporting our elders, particularly our Windrush Elders group, who are quite isolated, feel lonely and need a lot of support.

Q31 **Bell Ribeiro-Addy:** Barbara, I am not quite sure how you did it, but you have managed to answer my first question mostly. I would only ask further if there are any other stark differences that you can see between how different BAME communities have been impacted by the pandemic.

Barbara Palmer: In terms of health, there have been individuals who have been having problems accessing health and it has had a negative impact on their health. It has been problematic for individuals in the community who would normally support them. Also, in terms of people, funerals have been quite a problem in our community. Church is central to a lot of individuals in our community. Church provides spiritual guidance, a social network and pastoral care, and this has not been forthcoming. This social interaction within our community that has not been forthcoming has left a lot of people feeling quite anxious and depressed, leading to domestic violence and such issues, which we continue to try to address, quite often without recourse to help.

Q32 **Bell Ribeiro-Addy:** Naz, I wanted to ask how easy, or rather how difficult, you might have felt it was to secure a lot of the Government support that has been promised for different things, different schemes in different areas. How easy or difficult has that been for the people you work with?

Naz Zaman: We obviously are the voluntary sector, so in terms of the voluntary sector first, one of our goals is to support the smaller groups to access funding opportunities and capacity-build them around governance and policy systems. We have had to set up weekly briefings and meetings with our membership because we understood that, in the normal day-to-day arena, they were struggling to access funding. There was an inequality in how much funding was accessed by BAME voluntary, community and third-sector organisations. That problem is now further

compounded with the crisis and the fact that many staff and organisations are struggling. Staff are furloughed or organisations were micro organisations without staff, relying on volunteers.

They are all doing frontline work, emergency work very many of them, and resourcing that through bits of fundraising. Generally speaking, they are not attracting the level of funding they need. I had a conversation just yesterday around the fact that we are looking at crisis but we are not looking at post-crisis and recovery. The impact of the lack of resource in this sector is going to be felt when we hit the recovery phase. Right now, we are all in a reactive mode. We are getting on with things, regardless of whether we are resourced or have the capacity. We are doing the job that is needed, so through delivery and emergency stuff. All that kind of thing is going on but the funding is not proportionate to the amount of work that is being done. It is a real issue.

In terms of small businesses, we again made a concerted effort to try to raise awareness of Government schemes among the self-employed and small businesses. You have to remember that a lot of, for example, taxi drivers are self-employed. They might be on zero-hour contracts. I have had conversations with self-employed people who were not aware of the Government schemes. Had it not been for the fact that we sent out a generic Facebook post about the Government schemes, I am not sure how many people would have accessed that support.

Q33 **Bell Ribeiro-Addy:** You talked about post-Covid. I think that is something that is on everyone's mind, or everyone is hoping for. What challenges do you foresee for the BAME community following the pandemic?

Naz Zaman: It depends on what sector you are looking at. The voluntary sector itself supports the communities at grassroots level. If we do not sustain the activity of the sector, the community is inevitably going to suffer, because there will be a lack of services. There will be a widening of inequalities, the wider determinants of health that the professor has referred to, things like economic activity, education, and things around justice and equality, employment. All that is going to be affected and those inequalities are going to widen. There are no two ways about that. It is how we mitigate and risk-manage what is going to happen in the future and what we can see on the horizon. I can see a widening of lots of health inequalities.

Q34 **Bell Ribeiro-Addy:** Rosie, the Government recently announced plans to scrap the migrant health surcharge for NHS workers. We have spoken a lot about no recourse to public funds. Do you think that this surcharge should be scrapped for all migrants? Are there any other Government policies of a similar nature that could be amended in some way that would support a lot of the people you are working with at the moment?

Rosie Lewis: That surcharge and everything that came around that really reflected the inequalities and systemic and institutional issues in

racism that we have that are embedded in many of our systems. The fact that was so explicitly being carried out while many of those health workers were saving lives, and supporting communities as well, is an absolute disgrace. It is very reflective of the things that are going on for the women and children we support, in terms of that no recourse to public funds, which includes the health surcharges, et cetera. We need to abolish that. It is an inhumane ruling. It exacerbates vulnerabilities and exploitation and, by continuing to go ahead, it is in the name of the British people.

There is a simple way of doing it: extend the domestic violence concession for all women so they can access health support, get access to services and emergency crisis accommodation, et cetera. That would mean they would have an income and could escape from the abuse they are being put through.

I have already talked about public sector equality duties. Coming back to it, it brings together some of the issues around funding. We need to ringfence funding for specialist services. That has to be directed by the Government. It is not coming from local authorities either. There are many systemic issues that come together. A lot of this, unfortunately, is around certain Bills that are going through at the minute, particularly around the Domestic Abuse Bill, many of the issues that are happening around there in terms of inequalities for migrant, black and minorities communities, and things that are going ahead through the immigration Bill. There are a lot of interconnected issues that need to be dealt with. Our ask would be, at a base level, "Please can we abolish the no recourse to public funds ruling?" It is inhumane.

Q35 **Bell Ribeiro-Addy:** Lastly, you touched on ringfencing particular budgets. Are there any other actions you think public bodies or Government could take immediately to limit the impact of the coronavirus on BAME communities, if we could change it today?

Rosie Lewis: If we change it today, it would be amazing. Thank you for that wish. There are a few key things. If you consider that Covid is disproportionately impacting on black and minoritised communities, you would think the simple response would be to proportionately fund black and minority-led community services or the people that are doing that work with the communities to help to do that health intervention and the recovery support that is needed. That is particularly around mental health, where black and minoritised communities are already massively excluded and under-supported in terms of mental health recovery support.

As black and minoritised women-led services, we receive a fifth of the funding of white-led services that are equivalent to us. It is a disgrace. When our numbers are so great, when the need is so great, how can we proportionately support? There is definitely something that needs to be around looking at what those services do. The Public Health England report was a very welcome report. There was some very important stuff,

but I would reiterate that a lot of the themes that came through have come through decades of research before.

One thing is around who the funding goes to. We need to be very careful about how we are supporting organisations that are not necessarily patriarchal or male-led organisations and community leaders. From a lot of the recommendations that are coming out, I am seeing that, around this issue in terms of post-lockdown, post-Covid support, it seems to be about going through community leaders again. It is like we are going back 30 years. There is stuff around funding, resourcing, making sure it is proportionate and making sure we are looking at where the funding is going as well.

Q36 **Chair:** Can I ask a follow-up question on that, Rosie? You mentioned the patriarchy and funding going to male-led organisations. Do you think part of that is driven by the fact that there have been so few women's voices playing a part in decision-making at the highest levels?

Rosie Lewis: Yes, absolutely. We know that has gone on throughout Covid. Women have not been at the table enough. Women of colour have not been at the table enough. Unfortunately, we could have come up with many good solutions that might have helped us to relieve some of the suffering that has gone on. There has been a very reactionary, sometimes, response when we have had times of crisis, to go to community and religious leaders. That is not to knock the good work they can do, but how is that reaching women who are living in maternal poverty, who are isolated and have been through abuse? How is that reaching them? How is that supporting those women? Where are those women's voices?

There is definitely a lot of work to be done around proportional representation and women of colour being at the table. Particularly in relation to the response to Covid and the recovery phase we are going to go through as a nation, we have to make sure that black and minoritised women's voices are there as we try to rebuild confidence in communities being able to access health support, being able to recover from the trauma they have gone through. Also, we would make sure that the decision-making would be very sensible, proportionate and supportive of the people who are in the most need and have been the most affected.

Q37 **Kim Johnson:** My question is to Naz. It is about the level of support that she receives from Lancashire County Council and whether the council is representative in terms of diversity of the community that it serves. Often, black people are underrepresented in council, in chambers and in senior positions.

Naz Zaman: Before I answer your question, I want to add something to what Rosie said. If there was one ask, my one ask, and it always has been the same ask, is education. This crisis has taught us that we are not a fast-moving machine when it comes to education and responding to a crisis, but education is still the way forward. Whatever it is we do, we

need to make sure we access the right channels to educate people, not necessarily the same old community leaders channels. In terms of males and representation of females, males in many communities are still the gatekeepers of knowledge. We need to find alternative means of getting that knowledge and information out to the women in our communities to empower them and give them the information so they can make informed decisions for themselves.

To your question, it has become more and more apparent over the last three months that I have been asked to be involved in lots of conversations around faith, race and equality. Race and equality is high on the agenda. I am suddenly being pulled pillar to post to sit on various panels, forums and meetings. A meeting where BME was on the agenda happened today. The meeting started at 1 pm. I got the invite at 2.30 pm because someone flagged up that there was no one from a BME background to represent the communities or give that perspective. It is very much still an afterthought.

At local authority level, yes, there is still underrepresentation and whatever representation there is is male-dominated. Within our south Asian communities—I am not sure about black and other communities—there is a male dominance within politics and influencing positions. There is this patriarchal thing going on where, if you have extended community, you have standing within the community, you are automatically classed as the leader to go to, and you are not necessarily representative or working for the communities that you are claiming to serve. It is a little bit harsh, but it is the reality at ground level.

Q38 **Kate Osborne:** As a north-east MP, I want to say a big thank you to Rosie for all the work the Angelou Centre does. As an ex-foster carer, I want to take my hat off to Naz. I can only imagine the issues and difficulties you would have, having four looked-after children at this time. Thank you to you as well.

My first question is to you, Barbara. Welcome to you too. I think we can all agree that NHS workers have done a fantastic job through this pandemic and we appreciate everything that you do and you have done. As an NHS worker, can you tell me how your job has changed since the beginning of the crisis. What impact have those changes had on you and your colleagues?

Barbara Palmer: I actually work in social care at this point. It has had an impact on us. In terms of PPE, I have seen where there has been insufficient PPE and where there has been sufficient PPE. It is quite telling for us as nurses, in terms of doing the best we can for our patients and residents when there is not enough PPE to protect us so we feel safe in administering our work and in terms of risk to us.

I definitely welcome the idea of risk assessment for our BME population. A lot of our doctors and nurses have unfortunately died from Covid-19, disproportionately. That needs to be looked into, as to why it is

happening. It is quite challenging at times for individuals, in terms of doing our job, if there is not sufficient PPE. It puts our residents, patients and ourselves at risk, and consequently our families.

Q39 **Kate Osborne:** Would you be happy to share with us any other challenges that you have experienced, particularly as a BAME worker? You mentioned that you are on a zero-hours contract.

Barbara Palmer: A lot of us as nurses, and indeed right across the board for individuals from our community, have to work because of responsibilities. A lot of us are part-time workers who have zero-hour contracts and therefore are, essentially, no work, no pay. When you have your families to attend to, it puts you in a position where you feel you have to work. It can be quite challenging, in terms of having a real choice at times of whether to work or not. We do not always have the financial support. Perhaps there are other people and therefore it can be quite challenging.

Q40 **Kate Osborne:** Leading on from that, are there any examples of good practice or support that have helped you, and particularly BAME colleagues, that you can share with us at all?

Barbara Palmer: I have seen, quite recently, when you go into the workplace—some homes—your temperature is taken and you are asked questions about whether you have symptoms of Covid. That is really reassuring, in terms of starting at a point where everyone has been tested and you go into the workplace. From that point of view, it gives you peace of mind to know that you are working with your colleagues and everyone has been tested and is free of Covid symptoms.

Q41 **Kate Osborne:** Other than mentioning that at times there was sufficient PPE, are there any other measures you can think of that could have been put in place to help you and your BAME colleagues?

Barbara Palmer: A lot of us are frontline workers and, as was mentioned earlier on, a lot of our BAME nurses are perhaps a little bit timid in terms of asking the questions about PPE. For whatever reason, people may feel a bit challenged and people do not want to be seen as not being fully part of the team and things like this. You can see where individuals from our community might be a little bit timid in asking about PPE, in terms of ensuring those are in place in order to do their job properly.

Q42 **Kate Osborne:** My next question is to everyone. We know from Public Health England's report that during this pandemic BAME people have been disproportionately impacted by Covid-19. I know Bell asked this around policy. If there was one thing that you could change that would make your life easier during this pandemic, what would that be and why would it help?

Rosie Lewis: Without sounding like a broken record, abolish the no recourse to public funds rule. Extend domestic violence concession to all migrant women.

Also, let us use the research. We have decades of excellent research. We have new research that has come out from the Women's Resource Centre, Sisters of Frida—we have not even talked about women of colour with disabilities—the Institute of Race Relations, et cetera. We have a lot of research. We do not need to keep reinventing. We need to actually implement. What I often see coming out of particularly the latest *Beyond the Data* report from Public Health England is that the recommendations made are not going to be effective if we do not find the right ways to implement them.

Sorry; I have obviously put in multiple things there, rather than one, but abolish no recourse to public funds and let us really sort out the public sector equality duties. They are the foundation of making sure our communities are proportionately supported and represented and that they are safe and protected.

Naz Zaman: It is going to be difficult to limit it to one, but I will try my very best. I have written down in big letters for myself that basically we need to have sustained change on addressing the wider determinants of health. There is no point saying, "We are going to deal with diabetes", or "We are going to deal with domestic abuse", in isolation. We need to look at all the underlying issues and keep sustained action so we can create sustainable change. That is where my frustrations have come from, over many years of working in this sector and other sectors. We see the start of change and we see the start of a journey, but that journey never finishes, or it is never seen through to the end, or we come to a point where we get told, "The funding has run out. We are going to park it and we will pick it up later", and it is never picked up.

We always start a journey. My worry about this journey is that this crisis is a warning and a wake-up call to say, "Something needs to change". With things that are happening internationally and are now happening in the UK, combining the pandemic with the race equality issue, we need to wake up and start some action. We need to see it through. If we do not see it through, we are simply going to have the same issue again. Whatever the crisis might be in the future, we will experience the same issues again. It is about addressing the underlying issues, whether it be deprivation or economic inactivity. Whatever it is, we need to start looking at that. When we come out of this crisis, as I said earlier, we will find that there is going to be a huge widening of inequalities. We are then at the stage where we are dealing with a much bigger issue than the one we currently have.

Barbara Palmer: A lot of research has been done. The answers are quite stark and staring us in our faces. It is time for action in terms of looking at what the report is saying and taking definite steps to address those

inequalities, right across the board. That is education, so therefore educating our communities, educating women so that women have a seat at the table. In a lot of the activities that I have noticed have gone on over these few weeks with Covid-19, women have been at the forefront, making a difference in the community, looking after their families and so forth, across housing and work.

Work is going to be a big issue for the BAME community in terms of young people. Already, they are disproportionately unemployed. There are lots of issues that need to be addressed in terms of going forward, finding solutions and answers and making our community fairer and more equal.

Q43 **Kate Osborne:** Lastly, to all of you, is there anything else that you wish to share with the Committee about your experiences during this pandemic?

Rosie Lewis: I will share a few quotes from the women if that is okay, so I can really make sure their voices come across. "When I got Covid, it was awful. I was staying in a flat with six children. I was already depressed and then my asylum was refused. This created so much added pressure. I was very stressed. I could not sleep. I had nothing to eat and my children suffered". We must not forget about children and particularly young people. This has had a disproportionate impact on their mental health and their wellbeing.

Finally, we need to push to raise awareness about the need to have specialist black-led women's services and organisations and black-led organisations that are at the forefront of taking forward this work and are being resourced and supported. This is a quote about a women who accessed our service. She was saying, "The Angelou Centre right now is my life. I get food and money. I would not survive in Covid if they did not come and give me and my kids food. I do courses. They listen to me when I cry. Covid is just like the abuse, but I cannot escape".

Naz Zaman: I just have a couple of things, because I have had that much information come through. I am going to try to be succinct and pick on the points that have come through consistently. One of the issues that has come through very strongly is carers, whether they be unpaid carers or carers who are paid through direct payments but working for family members, not necessarily for a private company or an employer. Those carers are low-skilled carers who are at the frontline and are at risk of catching Covid-19, but there is very little protection for them. They do not know where to get the protection from. It has been raised a significant number of times. There needs to be protection for those frontline workers.

There is a lot of talk about NHS staff, but, when we look at wider responsibilities and wider caring professions, there is a lack of emphasis on those caring professions. There are a lot of unpaid carers and a lot of carers who work for their families who are not acquiring PPE. They feel

like they cannot ask their family for PPE because it is still their family and how does the family source the PPE. There is a lack of information and knowledge around where to source that PPE. We are putting those people at risk and we are putting the people who they look after at risk as well. That has come through really strongly.

The other thing that people have raised with us, and I think it would be remiss if I did not raise this here, is what Rosie mentioned. We cannot forget the children. The Covid-19 generation will always be remembered as the generation of the pandemic. Those who are already experiencing underachievement because they live in areas of high deprivation or attend schools that are underachieving, are now at home in an extended holiday. They are not being taught anything. They are not doing remote learning or online learning because their parents may not have the skills, knowledge, experience, digital skills or even English as a first language to be able to teach them at home. We are, again, widening that gap.

Chair: Thank you to all of the panel for your participation today. It has been incredibly useful and informative. If there is anything that you wish to add in writing at a later date, please do. I will finish by thanking you very much for your contribution today.