HOUSE OF COMMONS

Women and Equalities Committee

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

Wednesday 15 July 2020

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Watch the meeting

Members present: Caroline Nokes (Chair); Nickie Aiken; Sara Britcliffe; Angela Crawley; Alex Davies-Jones; Peter Gibson; Kim Johnson; Kate Osborne; Bell Ribeiro-Addy; Nicola Richards.

Questions 76–145

Witnesses

I: Kemi Badenoch MP, Parliamentary Under-Secretary of State for Equalities, Government Equalities Office; Marcus Bell, Director, Race Disparity Unit, Cabinet Office; Jo Churchill MP, Parliamentary Under-Secretary of State for Prevention, Public Health and Primary Care, Department for Health and Social Care; Dorian Kennedy, Deputy Director, Children, Families and Communities, Department for Health and Social Care; Chris Pincher MP, Minister of State for Housing, Ministry of Housing, Communities and Local Government; Emma Fraser, Director, Housing Markets and Strategy, Ministry of Housing, Communities and Local Government.

Examination of witnesses

Witnesses: Kemi Badenoch, Marcus Bell, Jo Churchill, Dorian Kennedy, Chris Pincher and Emma Fraser.

Q76 **Chair:** Welcome to this afternoon's evidence session of the Women and Equalities Select Committee in our continuing inquiry into the impact of coronavirus on black, Asian and minority ethnic people. I am going to start the questioning this afternoon. I specifically wanted to ask all Ministers whether you could give a brief outline of how important you consider your public sector equality duty and what steps you go through when considering that.

Kemi Badenoch: The public sector equality duty is, as Equalities Minister in particular, very much at the forefront of my mind. Having due regard to the need to eliminate unlawful discrimination and advance equality of opportunity, fostering good relations, as that section of the Act says, is absolutely critical.

Jo Churchill: I would agree with everything that Kemi said. For me, it is a particular focus on making sure that, particularly through the current pandemic, absolutely everything we do has that focus, particularly on at-risk communities. For me, it is dynamic, so we should be doing it all the time.

Chris Pincher: At MHCLG, we certainly put the duty very importantly as a matter for us to be concerned with. Clearly, through the pandemic, it has been at the forefront of our mind, as it always is when submissions are presented to me and other Ministers in the Department, when we consider legislation, be it SIs or primary legislation, or when we bring forward White Papers.

Q77 **Chair:** We heard from Jo Churchill just now that she regards the duty as being dynamic. It is certainly one of the principles and the limbs of the public sector equality duty that it should be continually refreshed. What we have not seen from the GEO is the equalities impact assessment. I wondered whether there were any plans to share that with us, or perhaps you could indicate whether that is being continually refreshed.

Kemi Badenoch: The purpose of the impact assessment is to look at what is happening with policy. It is critically important that, when officials are putting together these reports, they can be frank and do not worry about the implications of what they are saying. The Minister for Women and Equalities was very clear on this: that this is not something that we plan to do, but we are continually looking at the impact assessments. Just because we are not publishing them, it does not mean we are not doing anything on them. I regularly ask to see them and make sure that, where policy intersects with my role, we are taking things into account.

Q78 **Chair:** If you were to redo that equality impact assessment now, what have you learnt over the course of the last few months that you think

would lead to different conclusions than were perhaps in it back in April?

Kemi Badenoch: Equality impact assessments belong to Departments. The last one I looked at, for instance, was on education and the impact of children not going back to school. That is going to have a disproportionate impact on disadvantaged children, in which BAME people are overrepresented. In terms of the impact assessments of Covid, those do not sit with me. Those sit with individual Departments, so it is for the Departmental Ministers to make that call.

Q79 **Chair:** Turning to Minister Pincher, we have seen from the Ministry of Housing, Communities and Local Government what arguably is quite a thorough impact assessment of the Business and Planning Bill 2020 and a public sector equality duty assessment that ran to 10 pages. Was anything in that a new finding over the course of the pandemic, or was it pretty standard fare?

Chris Pincher: With respect to the Bill, we had some time to consider it and consider it thoroughly. There were some challenges working across Departments. DfT, Home Office, BEIS and MHCLG worked together to develop the Bill. There were also some elements of it that related to very old legislation. The Highways Act 1980 springs to mind. Working across Departments, working on older legislation where there is not necessarily a depth of expertise in a particular Department to deal with it, was a challenge. On the whole, because we have had a little bit of time to consider it, we have done it pretty well.

Q80 **Chair:** Jo, you described your PSED as dynamic and continually evolving. Is there anything particularly in relation to BAME communities and coronavirus that you feel the Department of Health and Social Care has learnt over the last 17 weeks that has changed the way you look at this problem of the unequal impact of Covid?

Jo Churchill: I would like to take that in its broadest sense of health inequalities across the piece. As we are beginning to ease lockdown restrictions, we are looking at all groups that might be at risk, making sure that impact assessments are done for those groups and that, as we move forward, the proper and considered response is taken. As we have seen, things are ever evolving, such as with Leicester. That is why we need to be dynamic.

On the particular area of the impact assessment for the Coronavirus Act, for example, on which you wrote to the Department, I have in fact written to you in the recent 24 hours. That has been released in full. One of the challenges is that it is dynamic. That particular Act was unprecedented and done at pace. There were additional impact assessments as other amendments were made, so you have the entirety of the impact assessments coming to you.

Q81 **Chair:** This Committee in particular has looked at the impact of Covid on women, BAME communities and disabled people. When it comes to the health impacts, how careful is the Department to look at the issues of

intersectionality, bringing in the other risk factors that we know about, including age and interestingly, although not a protected characteristic, that it is more likely to affect men than women?

Jo Churchill: It is an excellent question and highlights what was brought forward in the PHE and ONS reports, and data gathered from research in both the academic and the public space. We know that the highest risk factor is indeed due to age. The advice has been developed by the CMOs from across all four devolved nations, because the aim is to protect everyone, irrespective of the risk factors that sit with them. As you say, intersectionality is a huge problem in this space. We know that age is the biggest determinant, but we know that gender also plays a part, and then we know there are issues around ethnicity, comorbidity and occupation. It is that intersectionality that the chief medical officer is working on, at pace, at the moment, to try to get more evidence so we can do the right intervention.

Q82 **Chair:** When you say "at pace", do we have any indication yet of when we might see some outcomes from that?

Jo Churchill: The PHE report was before us on 2 June and then 16 June. There were those two particular reports. I am not going to say I know exactly the date, but I am happy to write to you and clarify when the CMO's work will be coming forward on that.

Q83 **Chair:** Kemi, we know that "black, Asian and minority ethnic" is often used as an umbrella term but is not homogenous. I wondered if you could talk to us about how the GEO has established the individual needs of specific groups, and whether you think they have been assessed accurately and differently during the preparation of the equalities impact assessment.

Kemi Badenoch: I completely agree with you that the use of the term BAME is very problematic, because the disease impacts different people in different ways. We know that, as a cohort, BAME people are disproportionately impacted. Even within that cohort, we know that black Caribbeans and black Africans have different outcomes. Bangladeshis have different outcomes to Indians and Pakistanis. For an equalities impact assessment, we have to look at the data that is available. It is actually not GEO but the Race Disparity Unit that comes in and looks at things from that perspective. It goes into the way Departments look at things.

I can tell you, from a Treasury perspective, that we look at where the non-pharmaceutical interventions have helped people, the self-employment income support scheme for instance. If you look at BAME as an entire group, they are not more likely to be self-employed, but, if you look at Asians, they are. That support scheme, for instance, is very good when you look at the help we are providing to Asian communities. That is the way we cut the data.

To follow on from the point on intersectionality, we can use intersectionality as a way to view problems, but we do not live in a segregated society. The Government do not have a list of all the black women in the country who may be disabled, or men who may be LGBT. Even though people may be intersectional, we have to target those things specifically, and make sure that individuals can also make their own assessments, depending on what groups they fit into. Employers' risk assessments, for instance, will look at those things and that will help to cover intersectionality.

As a Minster, I cannot go to a cohort of people and say, "This is where all the disabled black women are," for instance, and then target something for them. When you look at the various combinations, they are so many that it would be virtually impossible. That is the way that certainly I am approaching it.

Q84 **Nickie Aiken:** I was wondering what you are most proud of that your Department has done during this crisis for women and equalities, if anything.

Kemi Badenoch: The Race Disparity Unit has really come into its own. That unit was only set up three years ago and I cannot even imagine what would have happened if it was not there. They have been able to help interpret much of the analysis that has come through from Public Health England, a lot of very technical and clinical information. Usually a Department outside of the Department of Health and Social Care would not be able to look at this.

That has been really great in looking at the review I am carrying out, and the various terms of reference in there. We have been very forward looking and we have looked internationally. There is actually not very much going on globally, looking at this subject. If you look at countries that have lots of ethnic minorities as a population, France for instance, they do not even collect this data. The Race Disparity Unit is quite a unique unit and we are very proud of the work it is doing.

Jo Churchill: I suppose it would have to be how we have protected the NHS and seen the whole system come together. When you separate women off, you are in danger of missing the bigger picture. For example, women have been some of the most influential in the workforce, coming forward to give us the ideas of how we break down barriers and work better together. Only this morning, I was talking to my community health teams. On the delivery of health services, we have broken down barriers across the health divide that I hope do not come back. When you are looking at health inequalities, you are looking at access as being one of the key determinants, and actually making sure that the system works as a whole system for the betterment of everyone. At that point, it is also better for women.

As Kemi said, we need to target specific things. For example, we currently have a review into perinatal mortality going on. That is being

led by the chief medical officer. That is a specific piece of work because the rate of mortality in black women is actually fivefold and in Asian women is double that of white women. That is a specific targeted problem. Generally, overall, the better working of the system for those involved in it and those accessing it is what I am proudest of across the piece, and the way we have built systems with the private and the public sector.

Q85 **Chair:** Kemi, you mentioned the assessment of non-pharmaceutical interventions. We know that you have been engaging with expert groups, charities and other organisations on the policy development process. Which groups have you been engaging with on that?

Kemi Badenoch: That would be a DCMS competency. The Treasury does not do the face-to-face interaction. We approve the funding. I think I had calls very early on with the National Community Lottery Fund, if that is what you mean.

Q86 **Chair:** No, specifically in a written answer on 30 June you said that, on the equalities impacts of non-pharmaceutical interventions on those with protected characteristics, the Government had engaged with expert groups, charities and other organisations. That is not you.

Kemi Badenoch: No, it would not be me directly. That would be the information we got from other Departments. If you remember, I was on maternity leave as well, so most of those things quite likely happened very early on, in terms of immediate announcements. For a question like that, we would normally feed in what other Departments are doing, rather than referring it to another Department and delaying the PQ. The day-to-day liaising with charities and so on is done by DCMS.

Q87 **Chair:** Have you met with the Equality and Human Rights Commission?

Kemi Badenoch: Yes.

Q88 **Chair:** How recently? We took evidence from them and they said the only Government Minister they had met was Victoria Prentis.

Kemi Badenoch: That is not true. I spoke to them yesterday or the day before—

Chair: Okay, so that is subsequent to their evidence.

Kemi Badenoch—and also about two weeks before then.

Q89 **Bell Ribeiro-Addy:** The first question is for Jo and Chris. Throughout our various evidence sessions focusing on the impact of coronavirus on BAME people, this Committee has heard numerous reports about different issues that face these communities: language barriers, problems with access to healthcare, differential healthcare treatment, overcrowded housing and so many different others. These issues are well-known disadvantages, documented over many years. How would you say that your respective Departments have taken into account these pre-existing issues facing BAME communities during departmental coronavirus policy

planning and implementation discussions? If it has not been done, why not?

Jo Churchill: I will kick off in the health sphere. These 17 weeks have been an acute learning curve. I can go to the recent past, the lockdown in Leicester, and give you some specific examples of how we have learnt and how we are delivering. We now deliver guidance in a multiplicity of languages. Particularly for Leicester, that would be the Gujarati, Punjabi and Polish communities. We also have provided testing that goes to people's individual doors, to offer testing for symptomatic and asymptomatic, but it also has translation facilities with them. Translation on telephone calls, to explain what self-isolation is, is now available as well, in order that we can better communicate how to keep everyone safe. It has also been translated into the Welsh language, which might be of interest.

We have also worked with faith leaders and influencers, so in Leicester in particular, using the councils and so on, to make sure that we use all avenues or channels of communication properly, in order that people can get to services. We also have done a specific piece of work on PPE. For example, there are now 2,000 power respirators for Sikh doctors, in order that they can more easily be fitted. Very early on, we had feedback that PPE was not gender specific and there were very different needs for different individuals. Both the NHS and the Department have focused very much on making sure we can address some of those things. Looking forward, those are now embedded within the system.

Chris Pincher: I echo Jo's points about dealing closely and consistently with faith leaders. We do that at MHCLG too. Stephen Greenhalgh, Lord Greenhalgh, is the Minister who deals with that directly. There are two further points that I would make to the Committee. First, MHCLG is essentially a provider to local authorities, which we think are best placed to judge the needs of individual communities, because they are closer to the ground. Those local authorities provide language support and translation services.

Depending on the need in individual communities, those services may be to a greater or to a lesser extent. For example, London boroughs like Camden, Southwark and Newham are very good at providing such support, and Manchester and Birmingham city councils outside London. The funds that we provided to local authorities, £4.3 billion to local authorities for the crisis, have certainly supported local authorities in dealing with the challenges they may face with communities on the ground.

The second point I would make is on the support we have given to local resilience forums, the organisations that exist locally, based on local police authority areas, tasked with making sure that category 1 agencies effectively respond to the emergency. Part of the consideration that each LRF had was for community cohesion. We embedded resources into each LRF to make sure they had the right sort of advice and support. The

resilience and emergencies team of MHCLG grew from a fairly small number to, I think, well over 200 during the course of the emergency to support the LRFs, which support local authorities. That was the mechanism by which we provided that sort of support.

Q90 **Bell Ribeiro-Addy:** To follow up to both of you again, there is a bit of concern about some advice that has been given to individuals who are self-isolating but living in overcrowded housing and being asked to use a separate bathroom. Can you explain a little bit about that advice and how you have communicated it to people who are more likely to live in overcrowded housing?

Jo Churchill: It was flagged to me as a particular problem because very often, in overcrowded situations or in multigenerational households, you had a problem of people being unable to have a different bathroom. The PHE advice was around particular interventions, making sure that the person who was symptomatic went last and that then the bathroom was thoroughly cleaned, so that the minimum spread of the virus happened. I will ask my official to come in here and explain a little more broadly what was done specifically, as far as cascading that information down, which I think is the nub of your question. As far as I am aware, it was, but I would like to seek clarification if it is all right with the Committee.

Dorian Kennedy: On that point, what you have said is a very clear description. I am afraid I do not have the information to hand about the cascade route for that. If that is something I could forward in writing, I would be more than happy to do so.

Chris Pincher: Shall I add to that, from an MHCLG point of view? We have continually updated our guidance. I think on 1 June we updated it, reminding people that they can, if they need to, refer to their local authority, if they are in overcrowded shared accommodation, to seek alternative housing solutions if that is necessary and possible. All local authorities need to provide a reasonable preference to certain groups, and that includes for issues like overcrowding and insanitary or unsuitable accommodation. We have been careful to maintain our advice through the epidemic to make sure that people in overcrowded accommodation, whoever they may be, have the right advice available to them.

Q91 **Bell Ribeiro-Addy:** Kemi, my next question is for you. The public face of the Government at daily media briefings was 97% male and majority white. In one of our previous oral evidence sessions, the chair of BMENational highlighted the importance of diversity of the country's leadership to ensure that questions about specific impacts on BAME people were being answered and that people were being held to account.

We also heard in a previous oral evidence session, on 22 April, the former Minister, Liz Truss MP, dismiss our Chair's concerns about the lack of female representation at the daily coronavirus briefings and stated that she does not like tokenism. Does the Department think that an increase

of BAME representation at the daily briefings would have been tokenism? Do you share the concerns of BAME groups that crucial decisions were being made and continue to be made without their input?

Kemi Badenoch: Why don't I tackle that last question first? It is completely wrong to say that BAME people were not involved in the decisions. The Chancellor is an ethnic minority. So is the business secretary. I have been Cabinet meetings and sub-Cabinet meetings where they have been taking the lead on a lot of the interventions that we are making to ensure that people are being protected. They have had a voice.

On the daily briefings, we have had not just the two of them. We have had the Home Secretary, who is an Asian woman. We have had Jonathan Van-Tam, who is the deputy chief medical officer I believe. We have had Jenny Harries. I forget her name now, but the chief nursing officer, I believe, has also done that. Probably at the beginning of the crisis, when the briefings were happening, it was very much the Prime Minister and the Health Secretary. To say that people should be judged on the colour of their skin and their gender, rather than what they are saying, is wrong.

On the point about things being tokenistic, I feel that, if it is done in the wrong way, it can look tokenistic. I was asked, for instance, at one point, whether I would want to do a daily briefing, but I did not feel, as a junior Minister, that it would give the right impression. It would look like, when we were talking about black issues, we then bring a black person on to talk about that, but not about the wider things. I am not just the Equalities Minister; I am also a Treasury Secretary. We also need to be very careful about giving the impression that ethnic minorities do ethnic subjects, women do women's subjects and everybody does everything else.

Q92 **Bell Ribeiro-Addy:** I definitely do not disagree with you there. It is more that BAME groups have expressed that they do not feel that their views are being represented at these briefings. When you look at the situation overall and you calculate how many Ministers came out, 97% were male or white. That has been the main issue.

Kemi Badenoch: I take your point. There was probably also another thing that we wanted to make sure of, which is that people should not feel that advice has to come from people who look like them. If that happens, the converse is true, where, when an ethnic minority is speaking, people might feel, "This person is only speaking for their sub-group." That perception is a challenge, but we should not just accept it. We should also try to reinforce the positive messaging that it does not matter what you look like. It is what you are saying that is absolutely critical. The messaging we are giving as a Government is for everybody.

Q93 **Chair:** Should we have heard from the Work and Pensions Secretary, given that the Minister for Disabled People sits in her Department and we have seen a massive increase in the number of people using universal

credit?

Kemi Badenoch: I cannot comment on that. It would not be my place to say. I do not know what discussions were had with the Work and Pensions Secretary. For all I know, she may have been asked and said no, so I cannot really comment.

Q94 **Chair:** But you were definitely asked to do it and we have no evidence that the Work and Pensions Secretary was.

Kemi Badenoch: I am telling you because I know that I was. That was my choice to not do it, so it is quite possible that other people have been asked and also said no.

Q95 **Bell Ribeiro-Addy:** Following on from that, do the Ministers represented here feel as if, at every single point of time that they have been making policy that would affect BAME people, they have consulted these particular groups, particularly when devising and implementing coronavirus policy? How often do you meet with other Cabinet colleagues, as Departments working on coronavirus policies, to ensure that they are also consulting with BAME groups?

Jo Churchill: From my point of view, I have worked very closely throughout the pandemic. In my portfolio I have primary care, so I will speak to that, if you see what I mean. At the peak of the pandemic, we were meeting weekly with stakeholders from pharmacy, where, for example, 43% of registered pharmacists are from a BAME background. I have a constant dialogue with Nikki Kanani, the lead for NHS England who looks after the GPs. I have regularly met with other members from BMA, BDA, all the royal colleges and so on. As I said this morning, I have met with my community health stakeholders. Right across primary care and community care, which is my portfolio, we have a very high proportion of BAME workers. When they are giving their services to their patients, this is about everybody looking after everybody.

We are making sure there is infection control and information about testing. When they had issues that they wanted to talk to a Minister about, my door was open. I very much feel that went on in my part of the portfolio. More broadly, we obviously speak on a very regular basis as a Department. For example, I am very keen to get on with the obesity strategy, which is a key health inequality and has a link to Covid outcomes, which is why I am so keen to do it. That is very much a piece of cross-Government working. This week alone, I have spoken to Ministers from three other Departments about it.

Chris Pincher: Like Jo in DHSC, and the GEO and other Departments, we are keen to work, and do work closely, with BAME community representatives. Apart from what I mentioned Stephen Greenhalgh does, dealing with faith and different community groups, within and without the Covid emergency, through our support for LRFs, we have again been engaging with those groups and communities on the ground. Our No. 1 priority is to continue to support public health. We are keen to continue

to work with the GEO and BAME community groups and representatives to make sure that appropriate voices are heard and that our policy decisions, as they are formulated, digested and executed, are done effectively.

Kemi Badenoch: The Race Disparity Unit has been working closely with faith leaders, voluntary sector community representatives and BAME business leaders to ensure that advice and relief measures are available to those who need them. When it comes to ministerial cross-Whitehall working, specifically on this PHE review I have a monthly meeting where I feed in what is going on and make sure that I take in any information or data that is relevant from those Departments.

Q96 **Bell Ribeiro-Addy:** My next question is to Kemi again. On 16 June, Public Health England published a summary of stakeholder insights into factors affecting the impact of coronavirus on BAME communities. This report includes seven recommendations but no timeframes for their implementation. In a written statement from you on the same day, you said that the recommendations from the PHE review will contribute to and inform the next stage of work that you are taking forward, but that did not include the timeframe or clarification of what exactly the next stage of work would be.

Because a month has passed since then and there are concerns from loads of groups that we are not seeing any evidence as yet of this further work taking place, would you be able to tell us what you are going to do to take the recommendations of the review forward and any further details on the timeframe?

Kemi Badenoch: Many of the recommendations, even at that time, were already in train. The purpose of my review is to pick up on where there are gaps in the knowledge from the original report, which we actually commissioned. That is extremely critical because, unless we know why things are happening, we cannot have any actions that will address those things, so we need to deal with the why.

On the stakeholder recommendations, this was qualitative research, so it was people asking rooms of people how they were feeling and what they thought would be useful. Without an evidence base, we can only look at those sorts of recommendations more broadly. For example, the first one was collecting more data on ethnicity, which is something that RDU is already doing. It is not something that you do in a week or even a month. It is years of changing things, maybe even looking at census data, all sorts of various organisations.

At the moment, given that the priority is looking at interventions to stop the spread of this disease, the collection of data is a longer-term piece of work. It is not something we are going to deploy resources to when we need that to be fighting Covid.

Other recommendations were on publishing occupational risk assessment tools. NHS Employers has created some excellent frameworks on that. The recommendation also said we need further research to fill the gaps in PHE's review, which is exactly what my work is. Those are the sorts of things that are taking place.

One of the challenges is in letting people know what is going on when you are doing the busy work. The timelines within the framework are quarterly reporting, which goes to the PM. This started in June, so I should have something to say by September for those people who are wondering what is going on there.

Q97 **Bell Ribeiro-Addy:** Finally, to all the Ministers, there is a lot of talk and discussion at the moment about systemic racism within society, particularly in the light of the Black Lives Matter movement and the disproportionate deaths of BAME people from Covid. Do you agree with many other groups that systemic racism has led to the disproportionate number of deaths in the BAME community?

Kemi Badenoch: This is a really important point, because that was something that many of the people who were interviewed in the qualitative report said. They talked about the work environment that they were in, mainly NHS workers saying they found the NHS was being institutionally racist. We cannot make those sorts of judgments without looking at the data. While that report had those anecdotes, and we take them very seriously, the report also said there was no evidence base for some of these comments. When we hear things like that, it is really important that we look at ways we can address them. That is where one of the recommendations around cultural competency within risk assessments is relevant. When we go back to look at what the definition of cultural competency is, there is no fixed definition.

We really must reinforce that this is a disease that is hitting everyone in society. If you are an 80-year-old man, you are 70 times more likely to catch this disease than if you are a 40-year-old black woman like me. While we accept that many people have found the situation very challenging, we also need to make sure we are discussing these things in proportion. We do not say, for example, that there is a systemic bias against elderly people, even though they are hugely disproportionately impacted.

Q98 **Bell Ribeiro-Addy:** By coronavirus?

Kemi Badenoch: Yes. While there are undoubtedly individual situations where this will be apparent, on the whole, it is actually making people more scared to come forward when we keep reinforcing this point. As a classic example, we are now finding that people do not want to take part in vaccine research because they are hearing things about the Government, and sadly a lot of this rhetoric has been used in Parliament, using black people as cannon fodder and that being black is a death sentence. All these kinds of statements are reducing trust in the system.

When we need people who are ethnic minorities to come forward to take part in research so we can find a vaccine that is going to help them, we find that they are shying away from that. That is a problem that, if we see it happening further on, people would call systemic racism, but it is something completely different. We must make sure that everything we do and say is based purely on evidence.

Jo Churchill: It is completely unacceptable, wherever. Trials are historically also male-biased, but very little work has been done on ensuring a good representation of females in trials for vaccines or anything else. We need to make sure that we have the evidence. That is why I am particularly pleased that not only was it brought out in the PHE report, but I am fairly sure that this Committee did a report on it, a couple of years ago or so, that also highlighted some of the challenges around evidence collection. Although people see it as a coverall, unless we have the data, the right interventions are exceedingly difficult to make sure we can overcome it. Making sure we have the data would be one.

We also need BAME representation throughout the NHS and other areas of delivery, so that they have a voice, in order that we have interventions that look after everybody, arguably. I very much take on board Kemi's point that we are building a society where we assess risk. The mortality risk from Covid is 70% more for an 80 year-old than for a 40 year-old. That rather comes back to the intersectionality point. Making sure we get the correct focus and lens on this for workers, but also for society generally, is hugely important if we are going to make the right policies for everybody.

Q99 **Bell Ribeiro-Addy:** You have both made a reference to data. I was wondering what you believe your duty is, or your Departments' duties are, on data collection anyway, in regards to the Equality Act. I would have thought that data collection was something that public bodies would and should do, particularly when it comes to health.

Kemi Badenoch: It is a good question. A lot of data collection is voluntary, which means that it is what people choose to say and give. Universal credit is a really good example where we cannot actually tell what is going on because many people do not complete that data. We try as much as possible to get a full picture of what we are doing, but this goes back to the point I made earlier. We are collecting data. Are we talking about BAME? Are we talking about black? Are we talking about black Caribbean or black African?

A really key piece of data that I would like to see, which we do not see, is whether people are recent immigrants. That means that they, quite likely, have a completely different health profile to somebody who is born and brought up here, yet they might look identical to someone like me, for example. I am an immigrant from Nigeria. I moved here when I was 16 and the healthcare that I would have had between zero and 16, not in this country, would have an impact.

It is a bit of a moving feast because the data that you might need five years ago is completely different to what you are looking at today, so it is constantly being reviewed. That is one of the terms of reference within my review: what we need to know, where we are collecting it and what we are not collecting. Of course, yes, it is important that public sector bodies collect data, because that is what you need for equalities impact assessments. The data might not necessarily be coming from within that Department. It might be from surveys. It might be from ONS. There are all sorts of different types of information. You need to be really specific about what you want to know and then work out the best place that can provide it.

Jo Churchill: That is why it is good news that the National Institute for Health Research has called for proposals around Covid and disparities moving forward, which will also feed into it. Of course, it is a key area for the Secretary of State. He has laid out that technology and better data collection is key to where we want to see the Department moving forward, so we can be much more targeted in helping specific groups, be they women, ethnic minorities or older people, in what we do.

I would also point out that, at times, you have to take interventions for the right reasons—so for example, shielding. That was on the advice of the CMOs and we shielded specific groups. That was in order to protect them.

Chris Pincher: I agree very much with what Kemi and Jo have said about being evidence-led. Every year, MHCLG publishes data and provides data on racial disparities in housing to the Race Disparity Unit. That presents evidence about, for example, the disproportionate number of Bangladeshi households that are overcrowded. The evidence about whether overcrowding, and overcrowding in a particular BAME community, feeds into Covid-19 transmission is emerging. It is important that we work closely together to collate that evidence, sift it and look at it very carefully. We have said that we will ask our departmental chief scientific officer to work with UKRI and the GEO to undertake research that will give us evidence upon which we can make informed and sensible policy decisions.

Q100 **Sara Britcliffe:** My questions are to Jo, but if the Ministers would like to come in that is fine. We have touched on this, but to what extent are the disproportionate mortality rates and levels of transmission for BAME groups due to the nature of the virus itself or other factors?

Jo Churchill: That is quite a broad question. If you are looking at the virus itself, there are still a lot of unknowns. We are learning all the time, both from international research and from our own research, hence the change of focus that we have seen with some of the non-pharmaceutical interventions and some of the advice. As we understand more about the virus, we are able to target that advice in order that we can best deal with it, for example giving advice on where or not a face mask might be appropriate, as we are beginning to unlock, ensuring that we keep

patients and staff safe in hospital by saying that visitors wear a facemask, as well as staff wearing a face mask in appropriate areas.

The guidance varies because situations vary. As we are learning more about the virus, we are adapting and changing the advice, and that has been so since the beginning. If you are looking for a specific definitive, this virus is different. It is a new virus and different to anything we may have dealt with or been prepared for before. It is different to SARS. It is different to the flu virus that comes upon us each year. We are learning all the time. Looking forward, making sure that infection control is absolutely paramount, that we repeat the messages of social distancing, handwashing and so on, and that risk assessments within the NHS but, more broadly, right across occupations are carried out appropriately, is all key to keeping people safe.

Q101 **Sara Britcliffe:** I agree that this virus is different and the Government do not have a definitive answer yet. Do you know when the Government will be able to give that definitive answer?

Jo Churchill: Can I tease out of you a definitive answer in what aspect? As I say, we are learning more about the way the virus spreads, about the way we treat viruses, about the after-effects of the virus and what potential ramifications that will have for people's ongoing health. We are 17 weeks in. I suppose the fact that we are now doing more asymptomatic testing would be another area where we have learnt and responded. Could I understand a little more clearly exactly what you are trying to get to?

Q102 **Sara Britcliffe:** Whether it is the nature of the virus itself that is causing the disproportionate mortality rate, or whether it is other, outside factors.

Jo Churchill: It is a highly complex situation where you have multiple variables that impact. We know, for example, as has been said in here, that age is one of the bigger variables. Gender is one of the bigger variables. Weight is, or the level of obesity. We know that, where people who are overweight or obese are admitted into hospital, their trajectory—so, their ability to beat the disease, not enter intensive care or not pass—is much decreased. We also know that certain comorbidities feed into it. We really do not know enough to say which one of these factors is the overriding factor. There is still a lot of research needed and a lot of regression analysis. While we know that certain factors give a raised risk of Covid and of a poorer trajectory, as yet we do not know exactly how those variables interact. That is the work the chief medical officer is doing.

Q103 **Sara Britcliffe:** When it became clear that more BAME health workers were dying, what did your Department specifically do?

Jo Churchill: At that point, we specifically asked for the PHE report to be done, which was brought forward on 2 June, and then Professor Fenton's report, which was brought forward on 16 June. Those were both published in full. We have ensured that specific risk assessments to at-

risk groups are done, in order that people who may be at higher risk, which may be older members of staff, members of staff with comorbidities and so on, are potentially redeployed, given jobs elsewhere or allowed to work from home. Right across the economy, we have seen much more flexibility, which is a huge benefit. It has even been within the health service. I frequently talk to doctors, particularly in general practice. I think 97% of all practices are enabled to do both telephony and video consultations, for example.

On 24 June, it was asked that those risk assessments be completed for at-risk groups within two weeks and totally within four weeks. That data is made immediately available to workers within the health service. Again, there is transparency.

Q104 **Sara Britcliffe:** Has the failure in supplying sufficient PPE led to more BAME health workers dying?

Jo Churchill: It has been our total focus to ensure that PPE reaches the front line for all staff. As I explained earlier, we have worked with the NHS but also with the Foreign Office, DIT and Lord Deighton on the "make" supply chain to ensure we have a much more resilient supply chain for PPE. Looking forward, we have delivered over 20 billion items. On the "make" stream of work, we have now ordered 3 billion items from UK manufacturers, so that we know we are not reliant totally on PPE from external sources. Again, we have looked at both BAME and gender specificity in making sure that what we are producing is fit for purpose.

Q105 **Kim Johnson:** My questions are all on health impacts and are all directed towards Jo. First, can you tell us the number of black people tested overall, the number of black health workers tested and the total number of black deaths from Covid? I know that we have touched on the issue about the collection of data. If you could answer that as best you can, that would be great.

Jo Churchill: Making sure that we are testing absolutely everybody who needs testing has been a key priority. All hospital, NHS, care home and domiciliary staff can access tests, making sure going forward that we can test both symptomatic and asymptomatic. We now have a testing regime that can manage to test up to 300,000 a day. This is due in no small part to the joint working of the private sector, the NHS and PHE.

We started this from a standing start, developing the tests and actually developing the whole infrastructure with the Lighthouse testing. We now have mobile testing. We have at-home testing. There is a need to get tests to the front line. We now have those tests being turned round in 97.5% of cases within 24 hours, and in 91% less than 24 hours, to make sure that anybody can access a test. I would refer you to my very first answer, where I said that we are ensuring we can reach out to multiple communities by having translators and volunteers from different areas of our society who are seen as trusted leaders, so that we give the right support to people across the piece.

I will refer you back to the fact that our data is not clear on ethnicity. As far as numbers of deaths go, I cannot give you clear sight on the actual breakdown on those deaths or on the tests, but that data is now being collected.

Q106 **Kim Johnson:** There has been criticism of some of the self-swab tests and the fact that some people are not undertaking the testing as effectively as possible, so we are getting a high incidence of false positives. Is any work going to be undertaken on how to improve the testing on those types of swabs?

Jo Churchill: Testing is an ongoing stream of work, looking at different forms of testing and making sure we are exploring every opportunity. Different tests are difficult to apply in different circumstances. Some disadvantaged groups do not understand why you want to test and so on, so we are looking at tests that are easier, either by a pinprick or by saliva. All this work is ongoing. The simpler the test can be, the easier it is for people to do it. We are also looking at point-of-care tests, which are not ready yet. If we can develop those, that has huge ramifications for being able to ensure that we keep on top of any outbreaks and so on. Testing is a key piece of work. Unless we know that we are keeping on top of that R rate and what we are doing is working, it will take us longer to get back to normal and we will be more susceptible to transmission.

Q107 **Kim Johnson:** There is an issue at the moment in the fact that ethnicity is not recorded on death certificates. Do you know whether changing that will be looked at?

Jo Churchill: That is not something that I can answer to. Kemi will take that.

Kemi Badenoch: I can answer that. That is definitely something I am looking at within the review. It is different in Scotland than it is in England, and it is not clear exactly why that data is not being collected. It might not have been an issue before, but it would definitely feed into exactly what is happening. RDU is looking at whether that data can be collected in the future. I am not sure it is going to be collected in time for the immediate dealing with Covid, unfortunately, but it would have been helpful.

Q108 **Kim Johnson:** This is the second question, Jo. We know that black people are more likely to contract and die from the virus. What steps has the Health Minister taken to ensure that public health response and support services available to children and young people during the pandemic are culturally sensitive and accessible and that the guidance is available in a wide range of languages?

Jo Churchill: As I explained earlier, we now give the guidance in a number of languages. We also have translation services on telephone services. Ensuring the appropriate channels to enable people to get the right information is the only way we are going to beat this virus. Those

things are taken as part of looking at individual situations and individual guidance.

We are just undertaking a review of guidance as we have moved out of the peak, to ensure that not only is it available in different languages, but we must not forget, for example, to ensure that clear face masks are available, which we have signed a contract for this week, for people who need to lip read if they are hard of hearing or deaf, and braille is available, working with the RNIB, and so on. Again, it comes back to the intersectionality point. Making sure everybody can get the information they need in a way that is accessible to them is what we have been working on from the beginning. It has been a steep learning curve.

Q109 **Kim Johnson:** Over the last 17 weeks, we have gathered quite a lot of information. What policies is the Department of Health and Social Care developing to protect black people if there is going to be second peak of the pandemic?

Jo Churchill: The policies we are moving forward with are, as I have talked about, test and trace, and making sure PPE is appropriate for all frontline staff and those who want to use it. It is across the piece. While we are looking at this, there is still the overriding evidence that age and gender, age in particular, are the highest determinants of a poor outcome if you contract Covid. We are making sure that everybody has access to testing facilities, PPE, appropriate work risk assessments and so on, so that we have a service that is fit for winter pressures, and I hope not a second wave, but, should we go into a second wave, that frontline equipment, testing and guidance is all fit for purpose.

Q110 **Kim Johnson:** I know we are currently working on a vaccine. Has the Department considered if it will disseminate the vaccine to vulnerable groups, including black people, first? If so, how will it do it?

Jo Churchill: Yes, we are working on a vaccine, but that is still some way away. We are making sure that we have a resilient vaccine strategy, so that vaccines are appropriately dispensed throughout all our communities, because we may well still be having social distancing. We need a strategy that puts, as the flu strategy does, those who are at risk at the top of the list, to ensure that we get to those who need it most. Vaccines work from the fact that you need to protect a large proportion of the population. We are now concentrating on working up a robust strategy so that, as and when a vaccine is developed, we can get it to as many as people as we can, as quickly as we can.

Q111 **Kim Johnson:** This is my final question. The first 10 doctors who died of the coronavirus were black. I wanted to know whether you felt that unconscious bias and racism had anything to do with that.

Jo Churchill: Where anybody has lost somebody through Covid, it is a tragedy. There were pharmacists, pharmacy technicians, general practitioners, nurses, community staff and domiciliary staff. This is an indiscriminate disease and it targets without bias across the piece on age

and gender. Preparing and doing those risk assessments is an important part of what we are doing in order to make sure we are fit and ready for the winter and moving forward. We have learnt a lot through this crisis and this new virus, but we have an awful lot more to learn.

Kim Johnson: Thanks so much for responding to those questions.

Q112 **Nicola Richards:** My question is similar to what Sara asked earlier about PPE. Do you know why there was a reported lack of PPE for specifically BAME communities? Have you done any work to look into that, if it was happening, where and why? I would like to know that.

Jo Churchill: I have done stakeholder engagement. Funnily enough, I was talking to the RCN only this morning about the results of its survey. There seems to be a disparity between how people felt PPE was disbursed. As Chris said, we used many different conduits. We had a system to distribute PPE that was built for about 235 trusts. That then was scaled up in a matter of weeks to 58,000 different outlets. As General Sir Nick Carter said, it was the biggest challenge of his entire army career that has spanned some 40 years to disperse PPE throughout the system. It was a challenge because we had stock but there was a worldwide pandemic.

We are building resilient supply lines and a UK manufacturing base. There are the lines we set up, including Clipper distribution, which went to GPs and some of our smaller care homes that we know were having challenges accessing PPE, to make sure that PPE was available across the piece. We had the NSDR line if people felt that they had crises at any point. That would ensure delivery within 24 hours. The calls to that line have substantially reduced, which indicates that we got to a much better place.

It was an acute challenge, stepping up at that point to deliver across a health and social care that has approximately 2.5 million people working in it and 58,000 outlets. That is why we brought the British Army in, to ensure that we had assistance and help in order to master the logistics. I do not know if Chris wants to add anything else. MHCLG was absolutely fundamental in making sure that some of the local solutions to ensuring that everybody had access to PPE worked.

Chris Pincher: Thanks, Jo. I would simply add to what you have said, to outline the enormity of the task undertaken by DHSC and other Departments, but also of course local agencies on the ground. Jo mentioned also the MoD and our servicemen and women. It is worth reflecting on the way in which normally we deal with emergencies. Ordinarily, it is because there is a flood or some other sort of localised issue that occurs in West Yorkshire, Derbyshire or wherever it may be. The local resilience forum has to stand up for a short period in order to deal with that emergency.

In this case, all 38 LRFs around the country were stood up. They had to test their resiliency and business continuity plans, and have had to manage them over a very long period. That is the context, the terrain, in which what Jo has just described has operated.

Q113 **Chair:** Can I ask a question on LRFs? We all welcome the job they did and the role they played. It is not really fair to say, is it, that they had the PPE they needed when they were expecting it, to disseminate more widely across the various areas they were dealing with? I am sure each of us, as Members of Parliament, had panicked calls from care homes, spoke to our LRFs, heard tales of LRFs expecting deliveries of PPE at one time and them arriving sometimes hours or days later, being less than they were expecting. Is it reasonable to suggest that the system worked well?

Jo Churchill: From my point of view, we worked at pace, 24/7, to make sure that people did not run out. That is what the NSDR line—the national supply disruption response line—was all about, to make sure that emergency supplies could be got to people. Smaller care homes were a challenge, so we then put them on to the Clipper system, which was a free system that they could sign up to in order to get PPE. This was an enormous logistical operation, making sure that people had enough PPE.

The challenge is making sure that we could spread it so that people did not run out. We were running extremely hot in various parts of the country, so making sure that those areas of the country had suitable and sufficient supplies perhaps, on occasions, meant that others had less, because the rate of infection in their area and their need was considerably less. That was how we operated the system until we got much more of a handle on ensuring that supply lines were fluid and robust.

Chris Pincher: I entirely agree with you, Jo. The LRFs were able to help DHSC and NHS England ensure that the NHS was not overwhelmed at a critical point. Yes, there were challenges. Yes, there were distribution challenges, but that was the nature of a wholly unique set of circumstances, this epidemic. It is a great tribute to the efforts of the local directors of public health, the police, the fire and rescue services, as well as local authorities, which came together to deal very effectively, over a long period, with this emergency. As Jo has said, although there were challenges with, for example, PPE, nobody effectively ran out.

Q114 **Alex Davies-Jones:** Jo, you mentioned you have 3 million items of PPE on order should there be another wave, et cetera. Is that including individual gloves, or is that including pairs of gloves? We know there was some confusion before where items were counted but they were not counted as pairs; they were counted as individual items.

Jo Churchill: Gloves for medical purposes are used in ones, twos, threes and fours. It depends on the procedure as to whether you need one glove, two gloves, three gloves or four gloves. That is why they are

counted individually, because you may need to change your gloves during a procedure, or you may only need to have one in order to safely do a procedure. That is why they are counted like that.

The items we have secured are largely in the face masks, but we have also worked with UK manufacturers on ensuring fluid resistant gowns and scrubs, hand sanitisers and a whole plethora of things. I would have to write to you with a little more on the specifics of the exact state of the orders, but I am quite happy to refer back to the make team and give you some clearer idea about the UK manufacturing base that is now building up across all four nations.

Q115 **Alex Davies-Jones:** How much of the PPE has come from British manufacturers?

Jo Churchill: The make workstream has been led by Lord Deighton. That is a specific workstream that has been developed to build UK resilience in PPE. It will not cover our entire PPE needs because, as I say, we have distributed some 2 billion items, and that is an awful lot of items. We are making sure that we have better diversity in our supply chains, so if there is a tightening, we have alternative suppliers and better supplier relationships. Should we go into a situation where there is an uplift in demand, we have those relationships in place. There were many offers of help that were not always, when they were investigated, solid. Let us put it that way.

Q116 **Bell Ribeiro-Addy:** I have been listening to the responses. Obviously we are doing this inquiry on the basis that we believe there is enough evidence and concern that there are issues with the BAME community and coronavirus. I wanted to understand whether that is the Government's position as well—that there are disproportionate deaths and effects on the BAME community because of the coronavirus. Is that the Government's position?

Kemi Badenoch: That is certainly what the PHE review stated: that it could see disproportionate outcomes but could not explain why.

Q117 **Bell Ribeiro-Addy:** That is the Government's position.

Kemi Badenoch: That is what the medics have said. We do not have different facts. That is what the facts state.

Q118 **Kate Osborne:** Good afternoon, everybody. My questions are to Kemi and they are all around employment. The first one is that we have heard through oral evidence to this Committee how Bangladeshi, Pakistani and black African workers seem to be losing work at higher rates, and that black and ethnic minority groups have been hard hit during this pandemic, as they are overrepresented in shut-down sectors, such as catering, restaurants, taxi industries et cetera. Taking this into consideration, could you tell us what discussions you had with the Treasury, before the Chancellor's announcement last week, about the profile of BAME workers in shut-down sectors and how the Government

can specifically support these workers as lockdown eases?

Kemi Badenoch: As a Treasury Minister, these are considerations that we take in as and when the policies are being formulated. We have looked to support the people who are most in need, and BAME people are very overrepresented in the poorest income sectors. The distributional analysis we have done shows that the interventions we have made have mainly benefited those people. I am sure all the MPs on this Committee would have had letters from people who earned over the thresholds who were complaining that we were not targeting things at them. It is because we have been targeting at these very communities and the very people you are talking about.

Q119 **Kate Osborne:** Do you think what was set out last week sufficiently meets the needs of BAME workers experiencing a loss of income? How are the Government measuring the effectiveness of the measures that are now in place?

Kemi Badenoch: Yes, I believe they will meet the needs. The purpose of the measures announced last week was to kick-start an economic recovery. These are not health interventions; they are economic interventions. It is absolutely critical that we get the economy going because there are health impacts from people becoming unemployed and GDP contracting. That is why making sure that businesses continue to survive is important. The jobs bonus to ensure that people are kept on, rather than let go when furlough ends, is going to directly impact those groups you are talking about. We have seen that, certainly in the restaurant sector, there is an overrepresentation of ethnic minorities.

I know many people did not think that the voucher scheme was a very good policy. We think it is actually an excellent policy, because it is directly targeting those places where people feel, "We do not necessarily want to do that at the moment because we are scared of the virus," making sure that they can stay in business. It is absolutely critical that we keep people in work, and that people can continue earning and have all the support that is available. I think that the package, which was to support jobs, protect and create them, is working.

Analysing the effects of the previous interventions is something I believe the Treasury does on an ongoing basis, but I do not have those facts to hand at the moment.

Q120 **Kate Osborne:** Some largely forgotten-about key workers are those in the civil service who carry out facility management functions, such as catering staff, cleaners, porters, reception and maintenance staff et cetera. Many of these workers are female and BAME, and are on outsourced contracts that are often low paid, have statutory minimum employment terms and no trade union recognition, while those who are employed directly by the civil service are predominantly white and often on better terms and conditions. Could you tell us a bit about what work the Government is doing to close this equality gap in your own

Departments, ensuring that all workers have the same enhanced terms and conditions?

Kemi Badenoch: I am sure I can write to you on that. That is not information that I have to hand. In terms of the way the civil service is managed, a lot of that is done via the Cabinet Office. I do not have any specific details about what contracts are in place in my own Department, so I am sorry, but I would not be able to answer that question.

Q121 **Kate Osborne:** Okay, but you could write to us please. More widely, evidence to this Committee has highlighted that BAME groups are more likely to be in some form of precarious and insecure work, and BAME workers are more likely to be on zero-hour contracts than white workers. How will the Government support these BAME workers into secure employment?

Kemi Badenoch: In terms of what the Government do, we try to make sure that those people who are on the lowest incomes are protected generally. The Government do not move people between jobs, if that is what you mean. More broadly, we have policies on apprenticeships, for example, and investments in education, which should help to ensure that people have regular, stable incomes. On an individual basis, that is not something that we would do policy-wise. People on zero-hours contracts are on those contracts for different reasons and those contracts may work for them. It is not the Government's policy to do away with zero-hours contracts. It is for people to find the employment that works well for them. Where the employment is precarious, we have safety nets in place.

Q122 **Kate Osborne:** It was more about people working in secure employment, and those contracts and terms and conditions being decent ones, rather than changing people into different employment altogether.

Kemi Badenoch: You are referring to labour market policy. Labour market policy would be a BEIS competency. That is not something I can specifically speak to.

Q123 **Kate Osborne:** In an oral evidence session on 17 June, Professor Platt highlighted that one of the issues for Pakistanis in particular is around self-employment, as rates of self-employment are very high for Pakistanis, with around 26% of Pakistani men being self-employed. I think you referred to this briefly earlier. This is compared to around 15% of the white British majority. Many of those who are self-employed have had to interact with the universal credit system while they have waited for further support from the Government and some have not received any support at all. Taking this into consideration, how will the Government further support self-employed BAME people through this economic recovery?

Kemi Badenoch: We do not target policies on a race basis. There are many suggestions that come to me about what we should do specifically. Many of those things would be against the Equality Act. We are not

allowed to discriminate, even positively. We are not allowed to discriminate on race. Whatever we do for BAME people in terms of financial Government interventions has to be done for everybody else. That is the right thing to do. We do not live in a segregated society.

Going back to the point about self-employment, many of the people who were self-employed went on to universal credit at the earlier part of the lockdown. Since then, the self-employment income support scheme has come in. I hope I am correct: I think it pays up to where you earn £50,000. That is the threshold, which should cover many of the sorts of people you are referring to, because they would be low paid. I do not know any taxi driver who earns six figures, for example. That is what we are doing.

The sum total of the interventions the Treasury has put in place, before last week's announcement, was £160 billion. I cannot emphasise enough just how unprecedented this package is. Our distributional analysis has also shown that, of this £160 billion, most is targeting those people who are least well off. We are doing as much as we can, but we cannot target things to people based on race. That would open up all sorts of problems and quite possibly is illegal as well.

Q124 **Kate Osborne:** I hope you have not misunderstood what I have said. I actually meant targeting everybody, but specifically these areas that have high black, Asian and ethnic minority workers.

Kemi Badenoch: That is what the self-employment income support scheme has been doing.

Q125 **Angela Crawley:** My question specifically relates to social security and the issue of poverty. I wanted to ask specifically, how many new universal credit applicants are from the black, Asian and minority ethnic community? How many people who are currently on universal credit are black, Asian and minority ethnic?

Kemi Badenoch: This was raised earlier in the session. Ethnicity is only recorded for a portion of people on universal credit. On top of that, it is an optional survey, so we do not have exact accurate figures. The level of response for universal credit claimants is well below the 70% minimum threshold, so any attempts to get some meaning from these figures is likely to be misleading. I do not think we can give you any figures on that that would be accurate.

Q126 **Angela Crawley:** Do you not think the Government need to have this level of disaggregated data in order to identify and support those who need that support the most?

Kemi Badenoch: We can look at additional data to collect. I worry sometimes that we focus so much on data, but do not also look at the stigmatising effects we can have. If we start talking about lots of people who are unemployed, or claiming credit, being from certain communities, there is also, anecdotally, a stigmatising effect there. While we do as

much as we can to make sure we get a full picture, there are advantages but there are also disadvantages from doing this. I take your point about the collection of data.

Q127 **Angela Crawley:** I understand. I think for many people, especially those who are self-employed, who have found themselves in this situation due to precarious employment, zero-hours contracts or because they worked in a lockdown sector, it may not have been their first choice, but they have been asked to turn to the universal credit system. We have heard that many people in the black, Asian and minority ethnic community in particular have experienced additional levels of poverty and this has been impacted by the Covid pandemic. For many, that has amplified the situation they have found themselves in. Do you think that more needs to be done specifically to tackle wider inequalities and poverty? Specifically, is that type of data of those in the black, Asian and minority ethnic community required to do that accurately?

Kemi Badenoch: There is always more than can be done to tackle poverty and inequality. This Government's mission is levelling up. You will hear it so many times. Levelling up is not just a regional thing. It cuts across all sorts of different characteristics. The employment rate for working-age people, certainly for those within an ethnic minority group, was at its highest just before the Covid pandemic started. I think it will take some time to see what the outcome of the pandemic has been specifically on communities. We do not have a full picture just yet. We are still in the middle of it. This is certainly a priority for me, as Equalities Minister and as a Treasury Minister. We are not leaving anybody behind.

Q128 **Peter Gibson:** My questions are focused primarily on housing and are directed specifically to Chris. Those in the rented accommodation sector will have been rightly relieved by the moratorium on evictions. What plans do you have to protect tenants when the moratoriums end? Will we have a cliff edge or will there be a phased return to normal?

Chris Pincher: I think we have done a very effective job in protecting those who may fear eviction. We have done two things specifically, as you all know. One is to extend the notice period by which landlords must give notice of a desire to repossess their property to three months. That policy is in place to the end of September. Working with the courts and with MoJ, we have stayed the in-flight court actions until the middle of August. We have also increased the local housing allowance to the 30th percentile of local market rates, which enables people to more effectively pay for their rent.

We have also, as Kemi has made very clear, which is a Treasury matter rather than an MHCLG matter, worked with the furlough scheme to ensure that people remain in income. The DWP has increased welfare benefits through the universal credit to the tune of, I think, £6.5 billion. We have worked across Departments to ensure that tenants who may worry about their tenancy certainty are protected.

Going forward, we clearly need to make sure that mediation is at the heart of support that tenants get. That is work we have been doing with the judiciary and with the Ministry of Justice. We also of course need to make sure that the decisions that the Treasury may make in future to support people's work, so the economy revives and people are employed, also work effectively. There are a range of measures that, across Departments, we have taken to make sure that tenants are protected from eviction.

When we are in a more stable position, we will bring forward the renters' reform Bill. As you know, we promised in our manifesto to remove section 21, which is no-fault evictions. We will continue to work in the meantime with our colleagues in MoJ and with the judiciary to make sure that we have an effective return to normal.

Q129 **Peter Gibson:** Do you believe that the BAME community has been adversely affected by the poor condition of housing?

Chris Pincher: There is certainly no doubt that a number of studies have demonstrated a correlation between, for example, dampness and overcrowding, and that BAME communities are disproportionately represented in overcrowding households. The Bangladeshi community, for example, is one that I mentioned earlier on. Where we have to be careful, because evidence is still emerging, is the connection between BAME community overcrowding in households and Covid-19. Anecdotal evidence has been provided. PHE has provided its view, but we need to collect as much evidence as possible and tread carefully to make sure we get the right evidential base upon which to decide what is going on and therefore what the policy should be.

Q130 **Peter Gibson:** To follow up on that point, we had an answer earlier from Jo in respect of the intergenerational accommodation that typically BAME communities inhabit, the advice given to them in respect of isolating and the difficulties they have in doing that in an overcrowded property. I understand from the official that we are going to get some further information on that. I wonder if you can supply to us any further information that your Department may have provided to overcrowded homes, in regard to self-isolation and guidance that should have been given or could be given in respect of that.

Chris Pincher: We have continuously updated our guidance, as I said, to make sure the public in general and communities in particular know what the right thing to do is. We have done that in combination with advice from DHSC and Public Health England. We always want to be evidence-led. If there is anything specific that you would like us to supply, we can certainly try to do that. If perhaps through the Chair you ask for further information that may support your Committee's report, we will do our best to support you in that.

Q131 **Peter Gibson:** This is the last question from me, Chris. Is your Department developing a strategy to improve conditions in social housing

and privately rented accommodation?

Chris Pincher: We will bring forward the social housing White Paper later this year, which I am sure a number of sources will help inform, including possible the deliberations of this Committee. We will bring forward the renters' reform bill in a more stable environment, which is designed to help reinforce and improve tenants' rights, protection and experience. There are a number of measures, in both specific legislation that we have announced and the White Paper that will be coming forward, which I hope will ensure that communities in general and BAME communities specifically find that their experience in the private rented sector is enhanced.

Q132 **Alex Davies-Jones:** Chris, in 2018-19, 11.5% of black, Asian and minority ethnic households reported feeling unsafe in their homes, compared to 5.4% of white households. This represents a rise from 4.5% from the 2017-18 figures and 3.2% for white households. What is the MHCLG's understanding of the challenges that BAME households face?

Chris Pincher: As I said earlier, there is a clear connection between overcrowding and BAME households. There is probably, therefore, a connection with dampness because the two, overcrowding and dampness, go hand in hand. There is no evidence as yet that I have seen to demonstrate that BAME households are more at risk or more fearful of eviction as a result of Covid-19, but as I said, the evidence on Covid is emerging.

That is why we have strengthened the provisions of the Housing Act 2004. That is why we announced, just a few days ago, the voucher scheme, for example, to improve the energy efficiency and energy performance of rented-sector homes. That will provide vouchers up to the value of £5,000 to help fund energy works like pulling out bad insulation and putting in better insulation, which will clearly improve low-income households' experiences. I hope that is one example of how we can improve the experience of BAME households, whether they are in the social rented sector or the private rented sector.

Q133 **Alex Davies-Jones:** Kemi, I suppose this is a question for you, which overlaps slightly. Given the evidence we have heard regarding overcrowding, and how housing has impacted and made worse the potential for coronavirus on BAME individuals, would you consider the role that the housing system plays in entrenching racial inequalities and ensure this forms the official part of your commission's work on the BAME work?

Kemi Badenoch: The PHE review is looking at this. It is something we need to establish if we are to find out exactly why BAME people are being disproportionately impacted, so looking at the housing conditions, where the housing is and household size. All those things will feed in. I say the PHE review; it is the work I am doing following from on the PHE review.

Q134 **Alex Davies-Jones:** Jo mentioned some of the issues that her

Department has been tackling in regard to language barriers for the public health messaging. We have also heard about the lack of information in accessing some of the Government's job retention schemes and the language issues they have been facing when trying to access those. What support have your Department and the Government put in place in that regard?

Kemi Badenoch: That has not been brought to my attention. Where is this from?

Q135 **Alex Davies-Jones:** This is evidence that we have had from black, Asian and minority ethnic people, that they have had difficulties.

Kemi Badenoch: To the Committee?

Alex Davies-Jones: Yes.

Kemi Badenoch: Okay. We can look at that. I am not aware of that coming to the Treasury.

Q136 **Alex Davies-Jones:** The information has not been put into different languages, for example.

Kemi Badenoch: For the job retention schemes and the supports for those who are self-employed, all of it is on gov.uk. Some information on gov.uk in is in other languages, but we do not translate everything into every single language. For instance, I am a classic example. English is my second language, but just because it is, it does not mean I cannot access the information on there. For those people within black populations, if you look at the colonial history, the majority mainly speak English. Wherever possible, we try to have translation services, usually via local government, charities and so on. There are other options in place, but it is not necessarily the case that we can put lots of different languages and lots of different information on the gov.uk website. That is not necessarily the best way of delivering the support those people need. There are other avenues.

Q137 **Alex Davies-Jones:** My last question is to all of you. We have heard evidence on the weakness of the data collected and reported when it comes to BAME deaths. You mentioned that you are looking to put that on the death certificate in future.

Kemi Badenoch: We are looking to understand why and see what we can do.

Q138 **Alex Davies-Jones:** Do you think that the data being collected and reported on BAME impacts of coronavirus are currently good enough?

Kemi Badenoch: I was deeply unhappy with the PHE report that we commissioned, because I was expecting information around comorbidities and other factors, occupational information, for example. From the perspective of the Equalities Minister, after waiting six weeks, we then had that report that, while helpful in confirming what we knew, rather than being anecdotal, did not actually explain the why. That is the work I

am taking forward. From that perspective, no, because, if it was, I would not have to be doing the work that I am doing.

I was very unhappy with that but, as the Minister, the responsibility at the end of it lies with me. That is why I am very focused on getting the data, rather than just complaining that it is not there. Whatever data we are going to get will hopefully be able to help tackle this virus and feed back to the Department of Health and Social Care and Public Health England. We are working not just across Whitehall but with lots of different organisations and bodies to get to the bottom of that.

Q139 **Alex Davies-Jones:** Your last comment actually follows on. This data you are gathering will help. What data exactly are the Government gathering? There have been a lot of questions on what you are and are not collecting.

Kemi Badenoch: This is probably a good point for me to bring in Marcus Bell, who is head of the Race Disparity Unit. They are the ones who are doing the actual work. I am overseeing it. He can provide some more information on exactly what is happening with the data.

Marcus Bell: We are particularly interested in more data about comorbidities and occupation. As the Minister said, that was covered to some extent by Public Health England but not in enough detail. If I can give a very concrete illustration, the Public Health England report told us that people from an ethnic minority background are more likely to work in high-risk occupations and are more likely to die because of Covid, but it did not tell us which occupations people who have died from Covid actually pursued. To get a really granular, detailed understanding of what is going on, that is the kind of data that we need to have more of.

Q140 **Alex Davies-Jones:** Are you able to share with the Committee what specific data has been collected in regard to the black, Asian and minority ethnic impact since the pandemic started?

Marcus Bell: I will try to answer with how we are building on the Public Health England report. We are working with Public Health England but also with universities and academics who collect and analyse NHS data in ways that perhaps have not been done before. We are working particularly with the Centre for Evidence-Based Medicine at the University of Oxford, which has done a very interesting analysis of NHS data that sheds some new light. That is the beginning. We are not at the end of the road with that yet.

Q141 **Alex Davies-Jones:** It is NHS data on what, specifically, if you do not mind pinning down some of the specifics?

Marcus Bell: All the relevant factors that have been mentioned by the Minister have a bearing on whether people's chances of dying are higher. I will not give a complete list now, but the kinds we are interested in include age, geography, occupation, underlying health conditions and other factors. I would add housing as well, as the Minister has just been

talking about that. To get a thorough understanding of causes and risk factors, you need to look into all those issues that may be confounding variables in understanding the ethnicity data.

Q142 **Alex Davies-Jones:** I think the Committee would welcome a full list, if you could provide that to us.

Kemi Badenoch: It is on the terms of reference.

Jo Churchill: From our point of view, it is very complex. It is very challenging, but it does not mean that we should not be doing it. At NHSX, NHSEI and NHS Digital, we are working with the Minister for Equalities, with Kemi, to ensure we build that completeness and quality of data around ethnicity and so on. To be frank, we do not have complete datasets sitting where you can extrapolate the information easily and swiftly. Indeed, at times, it is difficult to have data transfer between the different parts of the health system, even.

We have a lot of work to do in this space, but there is a keenness and a willingness. If there are any silver linings to be had from the experience of the pandemic, one is the change in how data moves around the health system and the keenness of everybody to push forward with this agenda. That means data is captured in a much fuller way, so that, right across the health service, people can have an appropriate and proportionate view into people's data, in order to best help them with health inequalities and so on. All this is obviously work in progress.

Q143 **Chair:** Can I go back to Jo on that point about data capture? Do you have any anxieties about the amount and type of data you are capturing? Do you have any plans to share it with other parts of Government?

Jo Churchill: To me, health data should be treated as carefully as the money in your bank. It is hugely important. That was why I was very pleased to see the National Data Guardian put on a statutory footing. The oversight of the ICO and so on. Making sure that we capture a patient's data, but that we are transparent and its dissemination is proportionate and appropriate throughout the health system, so people can be treated better, is what I am very keen on seeing.

My personal view is that we should treat data with the utmost care, and I say that as somebody who has had cancer a few times. The ramifications for people making assumptions about your long-term health and things like that are very relevant in this space. I would argue that nothing will be done without due diligence over it. Data is a very powerful thing if used correctly, but it must be used correctly.

Q144 **Chair:** We only have a couple of minutes left. I wanted to take you, Jo, back to something you said about trusted voices. You also referenced the conversation I think you had this morning with the Royal College of Nursing.

Jo Churchill: It was with the chief nurse.

Q145 **Chair:** Do you think that individuals like Dame Donna Kinnair are absolutely the sort of trusted voices we should be listening to? She has an incredible position of respect among nurses. How do you feel about her concerns that, although the ONS is now capturing the occupation of people who have died from Covid, this is only very recent information? We do not yet appear to know any statistics around those in the nursing profession who have caught Covid, those who have been hospitalised with it and the steps taken to make sure they make a recovery and are safeguarded. We do not have any information, it would appear, about their ethnicity and how that correlates with the impact of Covid on them.

Jo Churchill: It goes back to some of the points that Kemi was making, though, about looking at what is appropriate to make the right decisions. This morning, I was talking to the community health stakeholders, including CQC, QNI and so on. We spoke across the piece about BAME representation throughout the health service, all the things that are important that I have heard Donna speak about. Actually, a lot of the conversation this morning was about the value of the community nurse, irrespective of whether they were from a BAME background, about the respect in the profession, about the resilience of that profession and so on. I suppose my answer to you would be that making sure that the data we capture is relevant and that people are giving freely is where we start, because, as Kemi said, this is not a segregated society.

Alex Davies-Jones: Kemi, we have just checked the terms of reference and there are some factors listed, but it says it is not a complete list. It also states that these are factors we looked at, not data currently held. If you could send us that full list of specified factors, it would be helpful.

Kemi Badenoch: Okay.

Chair: Thank you to the Ministers in the room and to Chris Pincher, who has had the comfort of doing it from his own office this afternoon, for your time and for your answers. If there is anything you wish to follow up in writing, please do so.