

Dated: 16 April 2025

WITNESS STATEMENT OF CHRISTINA McANEA, RACHEL HARRISON AND DOMINIC
HOOK (THE TUC)

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1. We make this statement on behalf of the Trades Union Congress (the “**TUC**”) in response to letters to the TUC and TUC Cymru, dated 4 July 2024 and 10 July 2024 respectively, sent on behalf of the Chair of the UK Covid-19 Public Inquiry (the “**Inquiry**”). This statement is made for the purposes of Module 6 of the Inquiry, which is examining the impact of the Covid-19 pandemic on the publicly and privately funded adult social care sector in England, Wales, Scotland and Northern Ireland. As requested, this statement focuses on the period of time between 1 March 2020 and 28 June 2022.

Introduction – the social care sector

2. The social care sector has long been the UK’s ‘Cinderella Service’. At the time we entered the pandemic, it had become a marketised and outsourced sector. There was no national workforce strategy, no sector-specific standards for commissioning and the Department of

Health and Social Care (“**DHSC**”) did not even hold basic data such as the number of providers and locations of care homes. Despite promises to the contrary, social care reform had already stalled and the sector was considered a low political priority compared to other public services. There were approximately 18,000 social care providers in England, commissioned by 153 local authorities, operating in a light-touch regulatory environment. The sector is complex, with the term ‘adult social care’ covering care homes, domiciliary care, supported living, reablement, personal assistants and other services. It provides services for the elderly, the disabled and others requiring a broad range of support.

3. Despite most care being publicly funded, social care was and remains primarily provided by independent providers, most of whom are private companies. There has been a race to the bottom on workforce terms and conditions. Many domiciliary care staff are not paid (or not paid adequately) for travel time between care visits. Pay for overnight sleep-in shifts is usually below minimum wage. Zero hours contracts are common and occupational sick pay schemes almost non-existent. Breaches of minimum wage regulations are disproportionately common in social care and the sector has the highest vacancy rate of any in the UK economy. Furthermore, the social care workforce is majority female and more likely to be BAME, older and/or disabled than the rest of the population, with migrant workers and those with caring responsibilities also being overrepresented in the sector. The impacts from a pandemic are therefore going to be disproportionate due to the makeup of the workforce.

4. On top of this, there is a distinct lack of meaningful social partnership. Unlike the NHS and local government, social care lacked any form of national partnership working between government, employers and trade unions, despite trade unions having significant membership in the sector. According to ONS Trade Union Statistics, 39 per cent of employees within ‘*human health and social work*’ activities were members of a trade union as at 2021 [RH/001a - INQ000581719] – there are over 200,000 members of TUC-affiliated unions working in the social care sector (see paragraph 14 below). Despite this representation, many employers are hostile to trade unions, often refuse access to the workforce and refuse to recognise trade unions for the purposes of bargaining. Where unions do have national and local recognition agreements with social care employers they advocate for improved working conditions for care sector staff. In recent years, unions have played an important role in challenging the poor employment practices which are so commonplace in the care sector, including the non-payment of travel time, under-payment

for work carried out, failure to pay sick pay and the widely documented exploitation of migrant care workers.

5. This was the context for social care as we entered a global pandemic. The weaknesses of the care sector were well known before the pandemic hit. Anyone with even a passing knowledge of the sector should have realised that it needed an urgent, nationally coordinated interventionist approach to ensure the safety of care recipients and care workers. Instead, the Government's lack of understanding of the sector led to its inaction and then, when it did act, several damaging and ineffective interventions, which were inadequate, light-touch or outright punitive towards care workers. The most egregious example of this is the Infection Control Fund which transferred large amounts of public money to independent care providers without achieving its central objective of paying care workers full and normal wages for periods of self-isolation. The sector paid a heavy price for this failure.

6. This statement seeks to address these fundamental issues, and in doing so, is structured as follows:
 - (A) Structure and role of the TUC;
 - (B) The relationship between the TUC and its sister organisations in the devolved nations;
 - (C) UNISON, GMB and Unite in the social care sector;
 - (D) Pre-pandemic capacity of the social care sector;
 - (E) Engagement in the adult social care sector;
 - (F) Infection prevention and control;
 - PPE*
 - Testing*
 - Working conditions and IPC measures*
 - (G) Vaccination as a condition of deployment;
 - (H) Movement of staff between care settings;
 - (I) Visiting restrictions;
 - (J) The regulatory inspection regime;
 - HSE and CQC*
 - Risk assessments*
 - (K) Deaths;
 - Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)*

- (L) Impact of the pandemic;
- (M) Unequal impact;
 - Black and migrant workers*
 - Pregnant workers*
- (N) Reflections and recommendations;
- (O) First-hand accounts related to the adult social care sector.

(A) Structure and role of the TUC

7. The TUC supports trade unions to grow and thrive, and it stands up for everyone who works for a living. It campaigns for more and better jobs, and a more equal, more prosperous country.
8. The TUC has 48 member unions, each of which is listed at [RH/001b - INQ000119021]. The TUC exists to support its member unions and the members of those unions. In doing so, it brings together 5.5 million working people. The member unions of the TUC span a wide array of sectors, across the UK, all of which were affected by the pandemic. The sectors represented by the TUC member unions include workers in the whole range of health and social care services, construction and manufacturing, railways, aviation, education, food industries, communications workers, fire and rescue services, the civil service, and the arts. The TUC has a range of internal groups, called Statutory Committees, that represent workers with particular protected characteristics, including the Women's Committee, the Race Relations Committee, the Disabled Workers Committee and the LGBT Committee. Affiliated unions of the TUC also have their own groups or bodies.
9. During the course of the pandemic, the TUC was led by its then General Secretary, Frances O'Grady. Following her retirement, she was replaced as General Secretary by Paul Nowak, who commenced his role in January 2023.

(B) The relationship between the TUC and its sister organisations in the devolved nations

10. TUC Cymru is part of the TUC and sits within the TUC's Organisational Services and Skills Department. It is an integral part of the wider organisation but is autonomous in some

policy areas. TUC Cymru consists of trade unions that are affiliated to the TUC and who have members in Wales and trades union councils in Wales registered with TUC Cymru. TUC Cymru has devolved responsibility within the TUC for: matters which are within the powers of the Welsh Government and the Senedd; matters that are wholly specific to Wales; and developing policy on matters which impact substantially differently on Wales than elsewhere in the UK. Regarding clearly UK-wide, non-devolved matters that do not impact Wales substantially differently to the rest of the UK, TUC Cymru provides advice to the TUC on delivery in the Welsh context.

11. The Scottish TUC (“**STUC**”) is not part of the TUC; it is an independent trade union centre to which trade unions affiliate their Scottish membership. The STUC represents over 540,000 trade union members in Scotland from 43 affiliated trade unions and 20 trade union councils and is governed by the STUC General Council who are elected annually at Congress.
12. The Irish Congress of Trade Unions is also an independent trade union centre. It represents trade union members across both Northern Ireland and in the Republic of Ireland. The Northern Ireland Office (“**ICTU-NI**”) is responsible for all issues affecting nearly 250,000 members in 36 unions in Northern Ireland. Many of the functions of that office are similar to those in Head Office of the Irish Congress, although the Northern Ireland Office operates, of course, within a different environment, dealing with British trade union legislation and a significantly different economic and social environment.
13. The TUC works in partnership with its sister centres in devolved nations within the UK, either through an integrated formal structure with TUC Cymru or through collaboration with STUC and ICTU-NI where it campaigns on UK-wide issues of relevance to its members. This relationship is formalised with the STUC, TUC Cymru and Irish Congress of Trade Unions through a body known as the Council of the Isles, which brings representatives from each trade union centre on an annual basis.

(C) UNISON, GMB and Unite in the social care sector

14. Three affiliate unions of the TUC have a particular interest and presence in the social care sector: UNISON, GMB and Unite. UNISON is a public services union whose representation includes around 157,000 members in the social care sector in the United

Kingdom, across both adult and children's care work. GMB is a general union representing around 50,000 members in the social care sector in the United Kingdom, across the breadth of the sector including local authority, private residential, local authority and private domiciliary, community and health. Unite is a general union whose representation includes a broad range of workers within the social care sector, in a variety of settings and for a range of employers.

15. Trade unions operating in the social care sector represent workers on an individual basis and through recognition agreements with their employers. For both UNISON and GMB social care is one of the fastest growing sectors for membership. This trend accelerated in 2024 and 2025. All roles across the social care sector will have workers who are a member of a TUC affiliated trade union, including care workers, cleaners, managerial staff, administrative staff and so on.

16. The issues faced by the social care sector in England were and remain largely mirrored in Wales. This statement therefore only makes specific reference to the Welsh experience where it may have differed or where further detail is necessary.

(D) Pre-pandemic capacity of the adult social care sector

17. On 2 June 2023, the TUC published its report '*Austerity and the pandemic – How cuts damaged the four pillars of pandemic resistance*' [RH/002 - INQ000250949]. It pointed to analysis from the King's Fund [RH/003 - INQ000525600] that, despite small real terms pay rises between 2010 and 2020 for care workers, in order to meet the national living wage commitments, social care providers limited the overall pay bill in other ways. More care workers were now paid at or around that minimum level, with the pay differential between care workers with less than 1 year experience and those with more than 20 years' experience standing at only 15 pence per hour.

18. Poor pay had made it harder to recruit, whilst demand for services increased. The turnover rate for social care staff in England increased from 22% in 2012/13 to 31.8% in 2019/20. As the report makes clear, "*Service fragmentation, widespread privatisation and severe cuts to local authority budgets, combined with acute staffing shortages, all contributed to unmet need in social care reaching record-highs. In 2019, 1.5 million older people (15 per cent of the population aged 65+) had some level of unmet care need*".

19. Low status, low pay and poor working conditions made it difficult to retain staff in the care sector. As the GMB CEC described in its report to the GMB Congress in 2016, "*England has a turnover rate of 24.8% for all care staff with a high of 30.6% for care workers and low of 12.5% for registered managers. A Skills for Care briefing report states that a turnover of 15% presents a problem and over 20% is a major deterrent to a quality service. The cost of the constant replacement including advertising, selection, induction and training is unsupportable. At 28% turnover, an average domiciliary care agency replaces its entire workforce in less than 3.5 years, which prevents any real development*" [RH/004 - INQ000103563]. A Skills for Care report on the state of the adult social care sector and workforce, published in September 2019, stated that there were 122,000 staffing vacancies at any one time within social care just across England – an average vacancy rate of 7.8% – putting extreme pressures on the ability to provide services to adequate standards [RH/005 - INQ000103564].
20. Efforts were made early in the pandemic to try to increase capacity in the care sector, for example through volunteer initiatives and the 'bring back staff' initiative in March 2020. However, these formed part of a wider initiative on the return of nursing staff to both health and social care, and the latter was side-lined by the former. This was discussed at a DHSC Workforce meeting on 31 March 2020 [RH/006a - INQ000119097]. Roughly 20,000 clinicians had expressed an interest in returning to work, with around 7,000 of these being nurses. There were 8 regional workforce cells matching nurses to priority roles in health and care settings but also based on their personal preferences. There were no social care representatives on these boards and only 150 of the 7,000 nurses had expressed an interest in working in social care. So, despite the acute shortage of nurses in social care, there was a feeling amongst stakeholders, including care providers, that they were not being listened to and the needs of the sector were not being recognised.

(E) Engagement in the adult social care sector

21. The value of national collective bargaining and social partnership with trade unions was most apparent in the contrast between the health and social care sectors. In health, national solutions and guidance for issues such as infection control, PPE, risk assessments, sick pay and the return of retirees to professional registers could be consulted upon quickly, and clear and consistent guidance issued that could be implemented within hours. In social care, with no collective bargaining or national

partnership working there was imperfect information, delay, and inadequate solutions and guidance for the challenges of the pandemic.

22. Prior to the pandemic, DHSC did not include trade unions in regularly convened national forums dedicated to the care sector, including forums focussed on the workforce. Any engagement was on an ad-hoc basis. Ad-hoc meetings continued during the pandemic but the UK Government also established additional working groups and forums, with union involvement in all of the following from their inception:

22.1. The Workforce Advisory Group – (variously referred to internally as the ‘DHSC Workforce Group’ and the ‘Social Care Sector Covid-19 Stakeholder Group’) covering issues such as furlough in social care, workforce testing, a protocol for reporting on care worker deaths, PPE and general updates from the sector;

22.2. The Social Care Sector Covid-19 Support Taskforce – the remit of which was to oversee the delivery of the Care Homes Support Plan, the Adult Social Care Action Plan and the Winter Plan, as well as to provide advice on what needed to be in place across the sector in England to respond to Covid-19;

22.3. The Adult Social Care PPE and Testing Stakeholder Working Group – which discussed issues with PPE and testing. At some point this was formally separated into two distinct groups, the PPE Task and Finish Group and the Covid Testing Task and Finish Group;

22.4. The PPE Task and Finish Group – at some point this was renamed as the DHSC Stakeholder Group; and

22.5. The Covid Testing Task and Finish Group.

23. TUC Cymru was involved in the following groups and forums created by the Welsh Government regarding the adult social care sector:

23.1. The BAME Covid-19 Advisory Group – convened to advise the First Minister on the disproportionate impact of Covid-19 on some ethnic groups. The group worked with stakeholders from BAME communities, experts within Wales and across the UK, and international colleagues to share information and approaches to address this issue. Minutes of a meeting of 10 June 2020 are at [RH/006b - INQ000397200];

23.2. The Social Care Implementation Subgroup – chaired initially by Andrea Street;
and

23.3. The Social Care Fair Work Forum – a recommendation of the Welsh Government’s Fair Work Commission, this was a step to address the lack of social

partnership arrangement for the outsourced sector. After extensive union side lobbying, it first met in September 2020.

24. Unions also had occasional engagement with the Local Government Association through collective bodies, engagement with Local Authorities and/or Health and Social Care Trusts through branch structures and local arrangements, and engagement with Public Health England on PPE guidance for care workers, as well as ad hoc meetings with the Care Quality Commission (“**CQC**”). Furthermore, UNISON met with the Equality and Human Rights Commission (“**EHRC**”) and contributed extensive written evidence to the EHRC’s inquiry into the treatment of ethnic minority workers in health and social care (see further below).

25. As with England, there was no arrangement in place at the start of the pandemic for routine engagement with the Welsh Government about the adult social care sector. TUC Cymru wrote to the Deputy Minister for Health and Social Services, Julie Morgan, in May 2020, echoing GMB’s call for a sectoral social partnership arrangement to be established in social care [RH/007 - INQ000180894]. As the letter states, this was something that unions had been calling for for some time and TUC Cymru believed that a number of issues that had already arisen in the pandemic could have been dealt with far more efficiently if such a structure existed, and in a way that created better, fairer and more equal outcomes for both the workforce and those in receipt of care. Nevertheless, and in contrast to England, the Welsh Government did take note and established the Social Care Forum, bringing together government, employers and unions to address issues in the sector. The first meeting of the Forum took place on 10 September 2020 [RH/008 - INQ000525602] and further meetings were held monthly from then on. It became the route through which unions lobbied for and informed key policy decisions, including the Covid-19 Statutory Sick Pay Enhancement scheme, the risks associated with mandatory vaccination and issues to do with workforce retention and pay rates, which resulted in the Welsh Government committing to the Real Living Wage policy for registered social care workers.

26. There was also ad hoc engagement with social care officials when concerns were raised, and routine engagement with the Welsh Government through update calls on PPE and testing, which had been arranged to update on supply issues in health and social care. Later in the pandemic, unions were brought into discussions about the criteria for bonus payment schemes, to review guidance and to discuss the arrangements for the sick pay scheme.

27. TUC Cymru engaged both the Welsh Government and Care Inspectorate Wales (“CIW”) as part of an effort to understand who was responsible for workers’ health and safety in the social care sector and how this was being considered as part of the inspection regime. In meetings facilitated by the Welsh Government this point was made, as well as an unsuccessful push for the inspectorate to consult with workplace health and safety representatives when carrying out workplace inspections. CIW, however, was focused on the safety and well-being of people using social care services, not the staff [RH/009 - INQ000525603], therefore engagement with them was limited.

28. TUC Cymru had some engagement with the Welsh Local Government Association, the Association of Directors of Adult Social Services Cymru, representative bodies of care providers and Social Care Wales, but only through meetings convened by the Welsh Government.

(F) Infection prevention and control (“IPC”)

29. During the pandemic, unions were fully aware of the need to ensure essential services, including those provided in the care sector, continued with the least disruption possible. However, this had to be balanced with the welfare and safety of staff and wider public health objectives. On 3 April 2020, the TUC published a report, ‘*Protecting workers’ safety in the coronavirus pandemic*’ [RH/010 - INQ000119236], which set out issues with IPC being experienced across a range of sectors. The TUC received over 1,000 contacts from workers about unsafe working, such as:

- 29.1. over 450 people saying they had not been supplied with appropriate PPE;
- 29.2. over 420 saying they did not have adequate hygiene or social distancing measures in place; and
- 29.3. more than 240 workers saying that their employer was not putting in place specific support for vulnerable colleagues.

30. These were undoubtedly the experiences regarding IPC shared by staff in the care sector – that same TUC report contained a case study from someone working in a care home in Shropshire, who stated: “*Our cleaner is off work ill at the moment, so the residential home is being cleaned by just one person, once a week. Nothing is getting disinfected properly – a wipe down isn’t enough. We should be having our temperature taken when we arrive at work, but the thermometer has gone missing so this isn’t happening. Masks are only*

just now being given and not all staff are wearing them". It also relayed the account of an individual working in social care in the North West who was worried that they did not have any protection from the virus at work: "We have to go into people's homes to provide personal care, but we have only been provided with paper type masks, I haven't got mine yet, so we are relying on hand washing as a method of preventing the spread of the virus. Basically nothing has changed in the way we work, although they have said they will let us know if anyone is suspected or confirmed to have the virus".

PPE

31. A poll carried out by Survation on behalf of GMB in April 2020 found that fewer than half (47%) of all care workers in England, Wales and Ireland felt that they had been provided with adequate PPE to safely do their job [RH/011 - INQ000525604], and of those, 85% considered their health was consequently being put at risk, whilst 44% working in residential care had considered quitting the care profession as a result.

32. From early in the pandemic onwards, unions raised concerns with the UK Government as to the availability of and guidance related to PPE in the social care sector. The following chronology details the serious issues with PPE for those working in the care sector, and how these persisted for a sustained period:

32.1. On 19 March 2020, UNISON participated in the first Adult Social Care workforce and Covid-19 Task and Finish Group meeting and already felt the need to highlight "*concerns around access to PPE*" across the care sector. They were told that "*distribution is being stepped up and the NHS and social care bodies will be getting equal priority*" [RH/012 - INQ000119095].

32.2. On 25 March 2020, UNISON sent a letter to Matt Hancock (then Secretary of State for Health & Social Care), repeating concerns from staff in the health and social care sector regarding the availability of PPE [RH/013 - INQ000339480]. It also explained that confusion existed over gaps between Public Health England ("**PHE**") and World Health Organisation guidance and urged Mr Hancock to instruct employers to take measures to protect staff and the people they care for. Such measures included explaining to staff the reasoning behind decisions on PPE, ensuring staff access to the correct PPE, carrying out suitable risk assessments and providing training on the use of PPE.

32.3. On 29 March 2020, GMB also sent a letter to Matt Hancock raising serious concerns regarding health and social care workers [RH/014 - INQ000119096]. GMB highlighted the complete lack of suitable PPE for staff across health and social care and the failure of a consistent message from Government. They called for a response from Government as to what they were doing to address the “*crisis within a crisis*”.

32.4. By 31 March 2020 early warning signs were being fed into the government about PPE supplies having run out in social care settings with UNISON noting from a DHSC workforce group of the same day that “*There is growing disquiet from across the group that as with volunteer initiative last week, that the care-sector is being completely side-lined by the NHS in the response to the crisis. This sentiment came out a lot more forcibly in a discussion around PPE. I registered that we've had a lot of members raise concerns about the lack of it and the provider representative bodies expressed real anger that hardly any PPE is reaching social care providers and that it is all being diverted to the NHS. It was reported that some care workers are having to resort to wearing marigold gloves. There is no coherent approach to PPE distribution/access/co-ordination in local areas and providers are getting increasingly frustrated*” [RH/006a - INQ000119097]. The note of the meeting goes on to say “*So quite a testy meeting. DHSC are keen to do more to thank the care workforce and ensure their contribution is recognised by the wider public (see Matt Hancock's letter to the workforce earlier this week) but they are being undone by failing to address fundamental problems like PPE provision*”.

32.5. That same day, UNISON sent a letter to the then Prime Minister, Boris Johnson, requesting an urgent call to discuss action on the lack of PPE for public service workers, including in health and social care [RH/015 - INQ000339481].

32.6. On 1 April 2020, health and social care unions, including UNISON, the RCM, GMB, CSP, BDA, Unite and the TUC, issued a joint statement calling on the Government to urgently increase the supply of PPE to staff in the NHS and social care sector [RH/016a - INQ000339482]. The statement set out how the unions were hearing from members every day that, despite repeated assurances from the Government, even where PPE was provided, people were being asked to work with inadequate or out-of-date protective equipment. Staff were also being threatened with disciplinary action for raising concerns about unsafe working conditions (see, for example, internal GMB emails referred to below) regarding a particular care home owner refusing to issue PPE and threatening to send home a

worker without pay if they wear a mask, and UNISON's PPE survey of social care workers in England, Wales and Scotland, carried out in June 2020 [RH/017 - INQ000581726]). The unions called for the Government to put in place clear systems for employers to report shortages and shortfalls, and guarantee that no member of staff will be put under pressure to perform tasks without adequate protective equipment. They sought an urgent meeting and urgent action to ensure that PPE was making it to the front line.

32.7. Following each of UNISON's formal communications with Boris Johnson and Matt Hancock, the UNISON General Secretary (at the time, Dave Prentis) received phone calls from Matt Hancock regarding the issues raised in that formal correspondence. These verbal conversations focussed on PPE, or the lack of, what UNISON was hearing about these issues and what measures the Government was putting in place to provide more PPE for NHS and social care staff. We are not able to go into more specific detail on what those measures were as we do not have records of those phone conversations.

32.8. By this point, UNISON had set up a PPE alert 'hotline' where it received numerous testimonies from public sector workers, including those working in hospitals and care homes, regarding the lack of PPE [RH/018 - INQ000339483]. As the UNISON press release states, these testimonies were passed directly to Mr Hancock by letter. Unfortunately, we do not have copies of the testimonies and we are unable to locate a copy of the letter to Mr Hancock, however it will have formed part of UNISON's regular communications with the Health Secretary during the pandemic that resulted in conversations between government ministers and the UNISON General Secretary. GMB also heard from a member working at a residential home for people with dementia where a number of residents were experiencing Covid-19 symptoms and yet staff were not given any uniform to wear or any visors/eye shields, staff were having to wear one face mask for entire shifts and there was a lack of communication with staff, with no sight of health and safety risk assessments [RH/019 - INQ000525605]. Staff felt so vulnerable they purchased their own PPE.

32.9. A UNISON note from the DHSC Workforce Group meeting on 3 April 2020 shows the government failing to understand the frustrations and urgency of the necessity for PPE across the social care sector that had been raised in previous meetings, with the note revealing that [RH/020 - INQ000119098] *"they gave some figures on PPE deliveries that were made to the NHS yesterday (5 million aprons. 21*

million gloves etc) but gave no specific figures about what was reaching care providers. Probably because they were stung by the criticism at the last meeting about the lack of PPE provision for the care sector they've now set up a dedicated social care PPE task and finish group. I've asked that we are allowed to sit on it and they said the person leading the group will get back to us soon". Opportunities were being missed for providers in social care to be able to have sight of or provide feedback on guidance on PPE, with the UNISON note stating "*in the absence of a comprehensive testing program care workers are naturally going to want to be issued with the most enhanced level of PPE possible because a lot of them are feeling worried for themselves, families and services. Interestingly the care providers were not asked to give comments on or given sight of the new PHE guidance ahead of its publication and they were a bit annoyed about that*".

32.10. A UNISON note of the 7 April 2020 DHSC Workforce Group meeting [RH/021 - INQ000119099] reveals that despite concerns having been raised weeks prior "*there is still confusion around how providers are meant to acquire PPE from the local resilience forums and whether there is a parallel supply chain in operation*".

32.11. By 10 April 2020, at another DHSC Workforce Group meeting, government was failing to deliver on its promises to providers [RH/022 - INQ000119100]: "*Despite the promises made by civil servants at the PPE meeting yesterday there has been no communication with providers to tell them about the state of PPE supply routes which is obviously concerning for them. They also still haven't received the FAQs document related to the new PHE PPE guidance*".

32.12. On 14 April 2020 providers were still having to raise PPE as a priority during the DHSC Workforce Group meeting, with a UNISON note saying [RH/023 - INQ000119101] "*providers continued to raise their frustration at the guidance that has been issued by Public Health England over the use of PPE. They said the new guidance PHE circulated at the weekend has provoked even more questions for them*".

32.13. Meanwhile, GMB was calling for an urgent meeting with Helen Whately, then Minister for Care, by way of letter dated 16 April 2020, to discuss the concerns of their members following reports of serious failings by employers who were still not providing care workers with the correct PPE [RH/024 - INQ000119102]. They had not yet received a response to their 29 March 2020 letter to Matt Hancock on the same issues,

referenced above. It is worth noting that GMB sent a further letter to Helen Whately on 11 May 2020 as they had still not received any response to their previous correspondence [RH/025 - INQ000119104] and then, with there still having been no response, again on 21 July 2020 repeating the request for a meeting [RH/026 - INQ000119105].

32.14. On 16 April 2020, the Association of Directors of Adult Social Services, UNISON, Unite, GMB and the TUC issued a joint statement on a critical lack of PPE for social care staff, calling on the Government to publish a national procurement and distribution strategy for PPE that includes the social care sector [RH/027 - INQ000525606]. On 17 April, at a DHSC Workforce Group meeting "*providers voiced their continued exasperation at the PPE supply situation. The clipper system is still not up online and some providers are worried that they will run out of face masks over the weekend*" [RH/028 - INQ000119106]. Clipper Logistics was the contractor used by the UK Government to store and deliver PPE into the care system.

32.15. It was on 17 April 2020 that the first meeting of the standalone PPE Task & Finish Group also took place. Notes of that and subsequent meetings can be found at [RH/029a - INQ000525607] and we refer to specific meetings further below.

32.16. The next day UNISON contacted PHE and DHSC raising urgent concerns about new PHE guidance, published on 17 April 2020, on how to work safely in care homes, which advised reusing PPE [RH/029b - INQ000581720] [RH/030 - INQ000119107]. There were concerns that this change in guidance on the use of PPE was being driven by problems with securing supplies of PPE to social care providers rather than protecting the health and safety of service users and staff. Members had expressed concern over the dangers of reusing masks in multiple homecare settings (risking spreading the disease in the wider community) and in residential care homes (risking spreading the disease from one resident to another). The response to UNISON a week later did not properly address the specific issues raised and it was effectively silent on the risks when it came to movement between homes.

32.17. GMB again raised issues surrounding PPE with the UK Government on 18 April 2020, by way of another letter to Matt Hancock [RH/031 - INQ000119108]. GMB made it clear that its members were consistently raising concerns over the supply and quality of PPE. Despite having made repeated representations to Government departments, GMB felt the need to formally set out a number of questions to

Government regarding the revised PHE guidance and supplies and testing. GMB can find no record of a response from the Government.

32.18. The new PHE guidance had opened the door for care providers to justify no provision of PPE if there are no Covid-19 symptoms in the care setting, regardless of any individual concerns staff may have. One of the FAQs, on page 4 of the guidance, stated that PPE may not be required where no resident had symptoms of fever or cough and no staff member or visitor had experienced these symptoms in the preceding 14 days, whilst the risk assessment flowchart on page 10 confirmed that if there were no symptoms in the home then PPE was not recommended. Indeed, around 22 April 2020, GMB became aware of a small, private care home who did just that [RH/032 - INQ000525608]. A member of staff had concerns about their health so decided to purchase and wear a mask when giving close care to residents. The employer wrote to the staff member saying the mask was unnerving residents and if the staff member wore it again they would be sent home without pay. GMB raised the overarching issue with the PHE, resulting from the guidance, and spoke to the owner of the care home extensively, highlighting the need for risk assessments and evidence of people with symptoms but the owner strongly resisted, and the home did not recognise trade unions. Eventually, a week later, the care home management announced that full PPE, including masks, now had to be worn with immediate effect by all staff.

32.19. On 24 April 2020, PPE was once again raised at the DHSC Workforce Group meeting, with a UNISON note stating [RH/033 - INQ000119109], "*Public Health England's new guidance for the use of PPE in homecare settings has still not been published much to the frustration of the UKHCA (it is now a week late). I presume the urgent points we've raised with PHE [see [RH/030 - INQ000119107]] have something to do with that*".

32.20. On 26 May 2020, GMB wrote to Yvonne Doyle at PHE again raising serious concerns over the 17 April 2020 guidance on PPE in care homes that had been issued by the Government and PHE (referenced above) [RH/034 - INQ000119110]. GMB highlighted that the guidance was insufficient and unsuitable for staff in the care sector, with aprons not providing the appropriate protection and the sinks in many care settings not allowing the guidance for hand washing to be followed. There were also reports of local authority infection control units giving instructions for the re-use of single use items such as face masks. PHE replied on 2 June 2020, answering some

of GMB's questions but not addressing some of the major concerns [RH/035 - INQ000119111].

32.21. In June 2020, GMB again wrote to PHE expressing concerns over the supply of out-of-date PPE, namely FFP3 face masks, and the insistence by Government and employers that they were safe to use [RH/036 - INQ000119112]. PHE advised GMB to contact DHSC [RH/037 - INQ000119113]. GMB therefore wrote to Matt Hancock at the DHSC, on 2 August 2020, restating their concerns and requesting clarification on a number of points relating to the testing of supplies and advice given by the Government to employers on the use of out-of-date stock [RH/038 - INQ000119115]. DHSC did not respond until 20 October 2020, some two months later, answering some but not all of the GMB's questions [RH/039 - INQ000119116].

32.22. At a DHSC PPE meeting on 1 October 2020, there were widespread complaints about the fact that PHE had just issued new guidance on the use of gloves, with no consultation with, and no notice given to, stakeholders [RH/040 - INQ000525609]. DHSC said that even they had been taken by surprise. The particular potential impact on domiciliary care workers was noted.

32.23. On 28 October 2020, a note from UNISON reveals frustration that recommendations from the DHSC Workforce Group were seemingly not being acted upon despite the forum having by this time been in place for eight months: *"I asked how the various recommendations in the taskforce will be monitored and by whom. E.G. Recommendation 4 is one we put in and as far as I'm aware nothing has been done about it"*. Recommendation 4 was that *"organisations should work to agree joint mechanisms for enabling staff to raise concerns about access to adequate supplies of PPE"* [RH/041 - INQ000119117].

32.24. GMB then raised the issue of levels of PPE with NHS England in December 2020 [RH/042 - INQ000119118]. GMB explained that its members on the frontline were still reporting unsatisfactory access to appropriate PPE to ensure their safety at work. GMB expressed concerns that the stockpiles of PPE were based on the guidance at the time, which did not reflect emerging evidence about Covid-19 and its transmission. It appeared that the assessment of what constituted appropriate levels of PPE was being based on stock supplies and not the relevant scientific evidence. GMB called for the relevant bodies to work with the union to review and strengthen the current PPE guidance for health and social care workers.

32.25. GMB sent similar letters, at the same time, again to Matt Hancock [RH/043 - INQ000119119] and PHE [RH/044 - INQ000119120].

32.26. Although the quantity of PPE became less of an issue as we went into 2021, there remained concerns regarding the quality of PPE provided. Following discussions with a large adult social care operator, UNISON contacted DHSC on 20 January 2021, highlighting some of the quality issues, including a high number of gloves that had split, masks breaking and a high failure rate with aprons [RH/045 - INQ000525610].

32.27. There was also some confusion and disagreement regarding the free provision of PPE to providers. Initial infection control funding did not specify that PPE could be purchased, it was only provided for free by way of a UK Government plan launched in September 2020. However, this was to end on 31 March 2021. This was repeatedly discussed at PPE Task and Finish Group meetings (see 3 December 2020 [RH/046 - INQ000525611] and 19 March 2021 [RH/047- INQ000525614]), and was part of UNISON's feedback on DHSC's draft PPE Q&A, agreeing with the UK Homecare Association's view that there would be an issue for providers (which in turn meant an issue for workers) if free PPE just suddenly stopped at the end of March without any indication as to what would then follow [RH/048 - INQ000525615]. A new scheme was implemented on 1 April 2021, continuing until 31 March 2024.

33. In Wales, TUC Cymru and its affiliate unions had extensive engagement with the Welsh Government on IPC measures in the adult social care sector:

33.1. By way of briefing documents, summarising for the Welsh Government the key and current issues being raised by the range of unions. For example, the 18 March 2020 briefing note highlighted reports in the care sector of people being required to provide their own PPE [RH/049 - INQ000068452]. The 27 March 2020 briefing note repeated these concerns and highlighted reported issues with social distancing and staff still attending work when they should be self-isolating because they could not afford to go onto SSP [RH/050 - INQ000068454]. The 3 April 2020 briefing note again set out issues regarding the supply of PPE and members of the social care workforce unable to self-isolate due to the inadequacy of Statutory Sick Pay ("**SSP**") [RH/051 - INQ000068455].

33.2. On 12 April 2020, TUC Cymru and BMA Cymru issued a joint statement on the need for greater clarity on the stock and supply of PPE, calling for assurances that all health and social care staff get the PPE they need and for independent inspectorates to ensure that supplies reached where they were required [RH/052 - INQ000180916]. The statement also highlighted fears of inconsistencies in the provision of PPE at social care providers in the private and third sectors.

33.3. Unions also engaged in correspondence with the Welsh Government between March and July 2020 regarding insufficient supply of PPE to social care staff [RH/053 - INQ000068458] (to which we have not found a response) [RH/054 - INQ000339545] [RH/055 - INQ000180891] [RH/056 - INQ000180892].

Testing

34. Unions identified the importance of testing in the care sector from early in the pandemic. In April 2020, the TUC set out the 'five things that social care workers need' [RH/057 - INQ000525616] and one of these was a clear deadline for making testing available to all in the care sector who need it. UNISON attended several DHSC testing meetings (also referred to as Task and Finish Group meetings) between April and December 2020, the notes of which we provide [RH/058 - INQ000525617] [RH/059 - INQ000525618] [RH/060 - INQ000525619] [RH/061 - INQ000525620]. Testing was also raised as an issue at various DHSC Workforce meetings, referred to in the paragraphs below.

35. The recurring issues being raised at these meetings were around access to testing for care workers, particularly uncertainty regarding agency and domiciliary care workers, and the fear of financial consequences for testing positive.

36. UNISON were told at a DHSC Workforce meeting in April 2020 that every care worker that needed a test would get a test [RH/028 - INQ000119106]. However, providers were already pointing out that there were different testing arrangements for workers being put in place in different parts of the country, which was causing difficulties, with some workers being tested every day, others only once or twice a week and a number only being tested if they had symptoms. Various questions and concerns around testing in adult social care were then raised at the Task and Finish Covid-19 Testing Sub-Group meeting a few days later [RH/059 - INQ000525618], including whether agency workers would be eligible for

testing and the accessibility and communication regarding different referral routes for “care workers” and domiciliary workers.

37. Indeed, the April 2020 poll conducted by Survation on behalf of GMB (referred to above) [RH/011 - INQ000525604] revealed that 99% of all care workers surveyed had not been tested for Covid-19.
38. In May 2020, at a DHSC workforce meeting, providers voiced their frustration with the testing regime and the lack of priority afforded to care workers [RH/062 - INQ000525622]. Around the same time, members were raising concerns with GMB – one care home worker explained that there was uncertainty over testing of agency workers and a lack of testing for new residents and existing residents who are admitted to hospital but then return [RH/62a - INQ000525623].
39. Then, in August 2020, DHSC assessed that CQC inspectors did not meet the criteria for weekly asymptomatic testing. In GMB’s view, by not including CQC inspectors in the routine testing programme, care home staff and residents were being put at risk, with inspectors potentially spreading the virus in those settings [RH/063 - INQ000525624].
40. At a DHSC testing meeting on 18 August 2020, UNISON shared their latest survey data on testing of care workers [RH/064 - INQ000119062]. 18% of all care home workers had still not been tested once for Covid-19 and 46% of those who had been tested had only been tested once. This meeting also saw discussion of whether visiting professionals to care settings (CQC inspectors, occupational therapists, social workers and so on) should be subject to the same level of testing as staff. There was a lack of clarity on the issue, so the DHSC launched a pilot scheme where visiting professionals would be tested on a weekly basis in Northamptonshire, Cambridgeshire and Peterborough over a 4-week period to try to gain an idea of the numbers involved and the nature of testing required. Due to capacity issues, DHSC decided that the pilot would only involve visiting professionals whose role requires them to come within 1 metre of residents, therefore, again, excluding CQC inspectors. This was not received well – care providers were unhappy given the emphasis on restricting care worker movement between homes and reports that some homes were refusing to grant CQC inspectors entry, whilst UNISON members at the CQC were also upset that they were not being tested each week. DHSC did acknowledge that it was a problem that CQC inspectors were not being tested regularly, but said it was all down to problems with capacity in the sector and that they would revisit the issue urgently.

41. Testing in care homes became a significant issue again in September 2020. GMB was hearing of test results taking a week to come back and there was uncertainty around whether a member of staff wearing full PPE who comes into contact with a colleague or resident who had tested positive for Covid-19 should be considered as a 'contact' for the purposes of contact tracing and isolation [RH/065 - INQ000525625]. This uncertainty was still an issue in December 2020, with GMB hearing of care staff in Wales being told to turn off test and trace on their phones whilst on shift, on the assumption they would be wearing the 'correct' PPE [RH/066 - INQ000525626].
42. In December 2020, GMB wrote to Public Health Wales, expressing concern that domiciliary care staff were not included in the regular testing programme that was in place for care staff in residential homes [RH/067 - INQ000525627]. GMB sought clarification as to why there was this distinction between the two specific work groups within the care sector. GMB sent an identical letter to Vaughan Gething, Minister for Health in the Welsh Government at the time [RH/068 - INQ000525628]. GMB is not able to find any record of a response from either Public Health Wales or Mr Gething. GMB officers had a close relationship with Mr Gething, so it is possible that the issue was resolved in person, however, unfortunately, the relevant officials are no longer with GMB so we are unable to provide any further details.
43. Also in December 2020, stakeholders were given a demonstration by DHSC of the 'Palantir' dashboard that contained all the data relating to testing [RH/069 - INQ000119064]. Whilst it held a wealth of potentially useful information on testing in the care sector, from national data (such as how many care staff are tested across the country each week, the number of positive cases and deaths) to data at an individual care employer level (such as the ratio of staff and residents tested in each setting), unions were concerned about a range of private care providers being given access to detailed and sensitive information, which may then be used for commercial gain.
44. At a Task and Finish Group meeting on 22 February 2021, concerns were raised regarding the low number of PCR results being recorded by home care workers in comparison to the number of kits sent out across the sector [RH/070 - INQ000525629] [RH/071 - INQ000525630]. UNISON pointed out in the meeting that care workers were worried about not being paid if they tested positive, particularly homecare staff, which DHSC agreed with and explained that the use of the Infection Control Fund was at the discretion of employers. We address the Infection Control Fund further below.

Working conditions and IPC measures

45. As explained above, there has been a race to the bottom on social care workforce terms and conditions. Many domiciliary care staff are not paid for travel time between care visits. Pay for overnight sleep-in shifts is below minimum wage. The use of agency staff and zero hours contracts are common and occupational sick pay schemes are almost non-existent. Analysis from Skills for Care [RH/072 - INQ000103565] shows that over a third of care workers were on a zero hours contract in 2019/20, a figure that has remained constant over a number of years. 14% of care workers were on non-permanent contracts in 2019, on the eve of the pandemic, either through bank, agency or temporary employment. This insecure nature of the work profoundly impacted care workers during the pandemic, including their ability to shield and/or isolate, and attempts to reduce the spread of the virus.
46. On 16 April 2021, the TUC published a report titled '*Covid-19 and Insecure Work*' [RH/073 - INQ000119085]. This report explained how many insecure workers miss out on sick pay altogether or have no choice but to rely on SSP alone. At the time, early 2021, 13% of people received no sick pay at all while self-isolating. Almost 2 million workers did not qualify for SSP due to the lower earnings limit and for those who did, the low level of SSP (£96.35) meant that the average worker would lose around 80% of their earnings. As the report made clear, "*Insecure workers already experience a pay penalty when compared to the pay of an average employee. For these workers, money may already be tight, with fewer savings in the bank to fall back on. Self-isolation or taking time off sick may not be a realistic option for insecure workers with financial commitments [...] The lack of [an] adequate sick pay system forces people to make an impossible choice between isolating and paying their bills*". The ONS study, '*Impact of coronavirus in care homes in England: 26 May to 19 June 2020*' [RH/074 - INQ000346701], showed that care homes that used more agency staff or that did not offer sick pay were more likely to have higher levels of Covid-19 infection amongst residents. Care homes using bank or agency nurses or carers were more likely to have a higher number of cases in residents compared to those care homes who never used bank or agency staff.
47. Unite produced a presentation setting out many of the issues with social care pay, terms and conditions described above – more than 70% of care workers earn less than £10 per hour, 28% of care workers earned the National Living Wage in 2019 and 50% of domiciliary care workers are on zero-hours contracts [RH/075 - INQ000525632]. It also provided

results from a Unite survey that revealed 37% of care workers did not feel safe at work, 14.5% had had to buy some of their own PPE, 23% reported that their employer did not have a procedure in place for situations where workers and service users had Covid-19 symptoms, 30% did not have access to safe and clean washing facilities while at work and 37% were not paid if they self-isolated or were off sick.

48. In Wales, the lack of collective bargaining and formal structures for employer engagement in social care was determined as a key factor that has resulted in significant issues for the sector, including regarding PPE and workers choosing not to self-isolate as they would only be eligible for SSP (see the BAME Covid-19 Advisory Group socio-economic subgroup report of June 2020 [RH/076 - INQ000227599], described in more detail later in this statement). GMB engaged in correspondence with the Minister for Health and Social Services in the Welsh Government across March to July 2020, on the issue of sick pay in the care sector and its impact on self-isolation (including the Infection Control Fund referred to below), and called for the Welsh Government to ensure that social care employers commit to full and normal pay from day one of sickness [RH/055 - INQ000180891] [RH/056 - INQ000180892] [RH/007 - INQ000180894] [RH/077 - INQ000180895]. Eventually, at the end of October 2020, the Welsh Government did announce that social care staff would be eligible for full sick pay.
49. UNISON members in the care sector were also reporting that the low level of SSP was putting pressure on them to return to work when they should be self-isolating, which UNISON raised with DHSC in April 2020 [RH/078 - INQ000525633]. This was highlighted again by the CQC and others at a DHSC Workforce meeting in June 2020, with a significant number of care workers not wanting to be tested mainly because they feared the potential loss of income if found to be positive [RH/079 - INQ000525634].
50. Campaigning and lobbying by UNISON eventually led to the Government setting up the flawed Infection Control Fund, which was intended to provide the funds for the sector to cover pay for self-isolation. This was supposed to deliver on the Health Secretary's pledge to "*ensure that when social care staff need to be away from work for infection control purposes, they are not penalised for doing so*" [RH/080 - INQ000339424]. However, the social care sector, with over eighteen thousand different employers, was not well understood by both officials and ministers and, as a result of this fragmentation, interventions were slow to formulate and then to permeate. For example, many care home employers refused to take government money offered through the Infection Control Fund (held at local authority level on behalf of DHSC) to boost sick pay for staff for fear that this

would set a precedent and expectation of sick pay above the statutory minimum after the pandemic receded. Failure to pay staff to self-isolate was acknowledged by DHSC as a significant reason as to why the virus continued to spread in the care sector in June 2020 [RH/081 - INQ000119068]. Exhibited to this statement are several emails and documents detailing these issues between June and December 2020 [RH/082 - INQ000119058]; [RH/083 - INQ000119060]; [RH/084 - INQ000119061]; [RH/064 - INQ000119062]; [RH/085 - INQ000119063]; [RH/069 - INQ000119064]; [RH/086 - INQ000119066]; [RH/081 - INQ000119068]; [RH/087 - INQ000119070]; [RH/088 - INQ000119072]; [RH/089 - INQ000119073]; [RH/090 - INQ000119075]; [RH/091 - INQ000119076]; [RH/092 - INQ000119077]; [RH/093 - INQ000119078]; [RH/061 - INQ000525620].

51. Further, on the day the Infection Control Fund was launched, UNISON expressly warned the Secretary of State, Matt Hancock, of the danger of social care providers using Fund money for purposes other than infection control/support for staff required to isolate, with there being no mechanism in place for local councils to enforce or monitor the use of funds provided [RH/094 - INQ000525637]. Helen Whately replied to this letter on 10 June 2020, stating that local authorities must ensure that funding is allocated on condition that the recipient care provider uses it for infection control measures and take reasonable steps to recover the money if not [RH/095 - INQ000525547].

52. However, a survey of UNISON social care members in July 2020 found that more than half of care workers (52%) said their employer was still paying less than £100 a week or nothing at all if they needed to shield or self-isolate [RH/096 - INQ000339425] [RH/097 - INQ000525548]. It is noticeable that the union's January 2021 survey of Black¹ workers in social care (see [RH/098 - INQ000339477]) showed the numbers of Black care workers dropping to either SSP or no pay were even higher: 57% across all care, 69% in residential care, 73% in domiciliary care. These figures completely undermined government claims to have dealt with the issue of sick pay using the Infection Control Fund and pointed to enduring problems for Black workers. As UNISON warned when the Fund was launched, it relied too heavily on social care providers positively engaging with the scheme and councils were given no additional resources to police implementation. Indeed, in July 2020, GMB, the RCN and UNISON all fought to ensure that at least 15,000 care workers employed by Four Seasons Health Care at 185 facilities received full pay for any

¹ UNISON uses the term 'Black' in a broad, political and inclusive way for people with a shared history and experience of racism and reduced opportunities. The use of the term 'Black' is broadly consistent with the term 'BAME'.

coronavirus-related absence, where they had previously been struggling on SSP [RH/099 - INQ000525549].

53. The impact for a care worker not receiving this financial support was obvious. A GMB survey, carried out in July 2020, showed that 81% of the respondents across the UK would be forced into work if they became ill on SSP and a further 80% would be forced to consider borrowing off friends and family or taking on debt to make ends meet [RH/100 - INQ000525550].

54. At a DHSC workforce meeting in July 2020, one care provider suggested that the data collected by DHSC on the use of the Infection Control Fund had been misinterpreted and that actually most employers were paying staff [RH/083 - INQ000119060]. They asserted that the main barrier to employers passing on money to care workers under the Infection Control Fund was the worry that they would then be sued by workers who had to self-isolate before the Fund came into being and therefore received no money. They went on to state that bringing in comprehensive sick pay would be problematic as frontline staff would abuse it and ring in sick after a 'heavy night'. This spoke volumes about the attitude of some care providers towards social care staff and demonstrates why UNISON had raised concerns regarding the lack of any mechanism to enforce or monitor the use of funds by providers under the Infection Control Fund. Again, at a November 2020 Task and Finish Group meeting, UNISON had raised the issue of how the DHSC were ensuring providers complied with the intended purpose of the Infection Control Fund [RH/101 - INQ000525552]. The DHSC explained that they were using capacity tracker data to try to gain clarity on non-compliance, as well as working with the CQC in terms of inspection tools.

55. Despite the various assurances, union fears came to pass. In December 2020, one employer stated in a letter to UNISON that they had directed the funding under the Infection Control Fund at one care home to cover "*unavoidable and necessary costs*", which did not include pay during self-isolation [RH/102 - INQ000525553]. This brazen admission by one of the largest social care providers in the UK laid bare the inherent failings of the Fund. Another care provider stated in an email that they would only pay SSP as "*Local Authorities have given various areas [for] which the Infection Control Grant can be used and as an organisation, we are not using it to pay staff their full wages whilst isolating*" [RH/103 - INQ000581721]. A third provider sent an email to a member of staff stating that as per company policy and the staff member's contract, they were only required to pay SSP [RH/104 - INQ000525555]. They went on to explain that different local

authorities had funded different amounts to care companies and *“it may be that your local authority has not funded enough to cover certain situations (such as wage losses) [...] However we have been instructed to only pay SSP regarding Covid”*. Unions also received reports from a number of members working in social care whose employer refused to pay full wages to staff isolating, despite the existence of the Infection Control Fund [RH/105 - INQ000525556] [RH/106 - INQ000525557].

56. Allied to non-compliance was the uncertainty around the exemption from self-isolation for double-vaccinated social care staff that was introduced in July 2021. UNISON attended a stakeholder session with DHSC and others on 22 July 2021 and the impression was that DHSC was making it up as they were going along [RH/107 - INQ000525558]. Concerns were raised that there was insufficient clarity regarding when and how the policy would apply and whether social care staff would still be paid if they were told by their employer not to isolate but refused.

57. Such were the failures of the Infection Control Fund that, in December 2021, UNISON wrote a letter to Dame Meg Hillier, Chair of the Public Accounts Committee, asking if Dame Hillier would consider launching an investigation into the creation of, and spending via, the Infection Control Fund [RH/108 - INQ000525560]. UNISON cited emerging evidence that care providers in receipt of Fund money may have seen their profits inflated by access to the fund and reports from its members that it remained a widespread practice to expect care workers to lose hundreds of pounds per week in wages if they needed to self-isolate.

58. It is clear from the above that the Infection Control Fund and the lack of support offered to care workers was a significant issue in the pandemic. It is likely that the absence of sick pay schemes, or at least effective schemes, and the knock-on effect of staff not self-isolating when sick, contributed to Covid-19 outbreaks amongst residents in care homes. The DHSC’s own Vivaldi study, carried out between 26 May and 20 June 2020, concluded that *“There is some evidence that in care homes where staff received sick pay, there are lower levels of infection in residents”* [RH/074 - INQ000346701].

(G) Vaccination as a condition of deployment

59. The issue of vaccination as a condition of deployment was divisive, with many union members having different opinions on the proposed policy. The TUC's view was that everyone who can have the vaccine should, and that care users must be protected. However, mandatory vaccination was the wrong approach to achieve these outcomes, with potentially damaging consequences for employment relations and efforts to recruit and retain staff [RH/109 - INQ000119269]. Its response to the Government consultation on making vaccination a condition of deployment in the health and wider social care sector in October 2021 laid bare many of the issues around the policy [RH/110 - INQ000525561]. This was consistent with UNISON, GMB and Unite's position [RH/111 - INQ000525562] [RH/112 - INQ000525563] – we were strongly supportive of the vaccination programme, and encouraged members to take up the vaccine through numerous communications aimed at boosting trust and confidence in the process, but we were also clear that compulsion would be counterproductive and could lead to increased resistance, equalities and ethical issues, and a potential worsening of the staffing crisis. Some workers, particularly BAME workers, choose not to receive vaccinations due to mistrust of state/Government institutions. There were concerns due to the unproven nature of the vaccines, ethical concerns that the Government was mandating that workers must be injected, fear that the vaccine might be a masking agent for nefarious purposes (such as 'tracking' nanobots) and cultural and historical concerns such as those surrounding the MMR vaccine and the Tuskegee study. GMB's submission in March 2021 to the EHRC inquiry into racial inequality in health and social care workplaces [RH/113 - INQ000581722] set out one member's view on mandatory vaccination: *"I don't think it is the business of employers to pressure staff into taken them [vaccines]. Companies shouldn't police people's personal lives and [their decisions] shouldn't affect our ability to make a living.... And I can understand historical concerns from our communities, where there's been a misuse of these things. You look at America, going back to the 1940s and 1950s where racist doctors and white supremacists' organisations were testing this on the black populations."*

60. Feedback in a Workforce Advisory Group meeting on 8 April 2021 set out many of the anticipated issues, including the possible staff exits that might result [RH/114 - INQ000525564]. At a Social Care Sector Covid-19 Stakeholder Meeting on 22 April 2021, UNISON made it clear that they were opposed to mandatory vaccination and that there was already a perception amongst some care providers that this was a done deal, which had led to some care workers losing their jobs [RH/112 - INQ000525563]. GMB received

similar reports of carers being taken off the rota for refusing vaccination [RH/115 - INQ000525565].

61. As part of its response to the Government consultation, GMB carried out a survey of social care workers in May 2021 [RH/116 - INQ000525566]. Of the 727 surveyed, over 46% did not agree with mandatory vaccination for workers in adult social care homes. However, despite union responses to the consultation, the Government decided to introduce the policy.

62. It was further discussed in a Workforce Advisory Group meeting on 22 September 2021, where it was again acknowledged by DHSC that it may contribute to major recruitment and retention issues in the care sector [RH/117 - INQ000525567]. UNISON queried how many care homes across the country could potentially close that winter as a consequence of the policy, which, worryingly, DHSC had not yet properly considered. Meanwhile, there were numerous complaints from providers as to how it would all be implemented in practice.

63. When introduced, mandatory vaccination became a huge distraction to a sector that needed to concentrate on persuasion and reassurance. It exacerbated staffing shortages and lowered workforce moral at the worst possible time. UNISON's response to the consultation on revoking vaccination as a condition of deployment across all health and social care detailed the impact of the policy on care workers [RH/118 - INQ000339448], in particular, given the rates of vaccine uptake, the disproportionate impact on Black care workers who would have been disproportionately more likely to lose their jobs and to be bullied or pressurised at work.

64. The response also set out a number of lessons to be learned. These included:

64.1. the importance of Government listening to unions, employers and other stakeholders;

64.2. the need for Government to implement a scheme covering care home workers who were dismissed and now returning to their employer, including addressing any issues arising from pension contributions and continuity of service; and

64.3. the need to rebuild trust and confidence with staff, and the right way forward being encouragement and persuasion rather than coercion.

65. In Wales, TUC Cymru lobbied against the introduction of vaccination as a condition of deployment in the social care sector, highlighting the risk of staff leaving the sector. See for example, GMB's correspondence with the Minister for Health and Social Services in March 2021 [RH/119 - INQ000525570] [RH/120 - INQ000525571] and representations made through the Shadow Social Partnership Council in the same month [RH/121 - **INQ000314507**]. The Welsh Government did listen and it was never implemented. However, some social care providers who worked across England and Wales still required vaccination as company policy.

(H) Movement of staff between care settings

66. In late March 2020, GMB raised concerns with a care provider that insufficient steps had been taken to reduce the risk of cross-infection between two care homes following a confirmed case of Covid-19 [RH/122 - INQ000525573]. GMB called for both homes to be placed into isolation with no staff moving between them, to mitigate the risk to both staff and the community. The care provider responded as follows: *"Any movement between care homes is considered carefully by the Area Director with input from a senior member of the clinical team. Where there is an actual risk identified, the move will not take place. The assessment will take consideration of the outbreak in the service, guidance from public health and the job role of the person concerned. Please be assured that Residents who are symptomatic or confirmed as having COVID-19 are isolated within their own room and any Colleague delivering direct care continues to do so with the provision of PPE, as advised by the Government."*

67. However, movement of staff between different settings continued to be an issue. Around late April/early May 2020, there were discussions between DHSC, the CQC and providers on restricting staff movement, both within and between care settings. This was then discussed at a DHSC Workforce meeting on 5 May 2020 [RH/123 - INQ000525574], where DHSC informed others that a series of draft measures and recommendations had been agreed. UNISON queried whether they included steps to ensure that care workers would not lose out financially as a result of not being able to work for more than one employer and DHSC explained that this was covered in the documents, although there were funding issues that needed to be resolved.

68. This was still being discussed in DHSC Workforce meetings in July 2020, indeed, at a 29 July meeting it was the principal issue covered [RH/092 - INQ000119077]. DHSC explained that movement of care staff between settings was one of the main reasons behind the spread of the virus in the sector. The DHSC taskforce had been holding workshops and put forward some possible solutions but it was clear that the underlying problem was that care workers were not being paid enough and significant numbers had to work for multiple employers to try and make ends meet. Until that was dealt with then there would always be a struggle to encourage staff to limit working between different establishments. The absence of sick pay and the ongoing problems with the Infection Control Fund also presented major barriers.
69. UNISON raised these issues again at a November 2020 Workforce Advisory Group meeting [RH/124 - INQ000525576]. They queried whether DHSC had given any thoughts to resolving disputes that arise over payments to workers who lose their second job (whether that is a dispute between the care worker and their employer(s) or a dispute between two care employers over who pays for the workers lost pay). There was a risk that care workers could be substantially left out of pocket for a number of weeks, which they simply could not afford. DHSC said they were looking to do more work on this issue as they recognised it could be a problem. DHSC also pointed out that because the Infection Control Fund was discretionary funding they could not instruct it to be spent in a certain way (a fundamental issue with the Infection Control Fund, as already set out above).
70. In December 2020, the policy on restriction of staff movement was still being reviewed by Ministers. At a Social Care Sector Covid-19 Stakeholder Meeting on 17 December, UNISON re-emphasised two significant issues that remained: 1) whether staff would be compensated if giving up other work to be restricted to one place of work and 2) what the status of their other job would be, i.e. would they be considered suspended and could return when able to [RH/125 - INQ000525578]. UNISON made it clear that bringing out regulation without addressing these issues would cause major problems.
71. UNISON were told at a Workforce Advisory Group meeting on 8 January 2021 that DHSC were expecting to make an announcement on plans to limit staff movement the following week, but they gave no real insight into what those plans would be [RH/126 - INQ000525579]. The issue remained unresolved throughout the pandemic – minutes from a Health and Safety Forum meeting in March 2021 show unions still raising the issue of movement of staff between care homes (as well as wider issues around the impact of

Covid-19 on agency workers in the sector) with the Welsh Government and Public Health Wales [RH/127 - INQ000180896].

(l) Visiting restrictions

72. Enabling visits to care homes was raised at a February 2021 DHSC testing meeting and subsequently discussed between UNISON and [NR] the lead at DHSC on the programme to enable visits [RH/070 - INQ000525629]. UNISON explained that care workers shared the objective to enable safe visits but that there were concerns that some employers may rush reintroducing visiting without ensuring it is as safe as possible. In addition, due to the weak regulatory structure, any employers not following the proper processes would be unlikely to be brought into line. [NR] said he was liaising with the CQC to ensure a reasonable prospect of identification of poor visitor practice and that he was looking at producing comprehensive guidance on safe visiting. He indicated that he would welcome UNISON involvement in producing such guidance for staff.

73. However, there was no progress in the subsequent months, and by May 2021 it was being reported at a DHSC stakeholder group meeting that there were issues with visitors to care homes [RH/128 - INQ000525581]. A number of providers had said that it was proving to be very difficult to ensure visitors complied with Covid-19 protocols. DHSC said that they would produce materials for care homes to display and speak to relatives' associations to try to remind visitors, but there was little hope amongst stakeholders at the meeting that this would have any impact. Moving from rules to guidance had resulted in many doing as they please. Indeed, UNISON and others were still raising the issue and the need for clear guidance for visitors at a DHSC PPE Stakeholder Group meeting on 9 July 2021 [RH/129 - INQ000525580], and again a week later at a subsequent PPE Stakeholder Group meeting [RH/130 - INQ000525582], where there was much confusion, with UNISON stating that if the Government was not able usefully to guide, there would be a vacuum that UNISON and trade associations would need to fill. Having a plethora of different guidance would not be a sensible place to end up, but the Government would have left no choice. As far as we are aware, this issue persisted with no formal national visitor guidance ever being produced.

(J) The regulatory inspection regime

HSE and CQC

74. Neither the Health and Safety Executive (“HSE”) nor the CQC had any type of industrial advisory committee to provide a forum for tripartite discussions. Added to this, HSE had explicitly advised that they did not consider Covid-19 to be within their legal remit, as it had been specified as a public health matter – see an email from the HSE to GMB on 26 March 2020 [RH/131 - INQ000581723]. Meanwhile CQC were widely seen to be struggling to regulate the care sector before the advent of the pandemic, and did not appear to have a clear policy function to discuss the handling of Covid-19 and care settings.
75. As a result, issues relating to inspection and enforcement were raised at the NHS Social Partnership Forum, but these were not discussed in the context of social care as it was not within the remit of that body. There was, therefore, no meaningful discussion with Government or regulators regarding regulation, inspection and enforcement in the care sector.
76. There was a similar lack of clarity on who was responsible for inspecting compliance with regulations and guidance in Wales. CIW suspended inspections, and, as already set out above, engagement with unions was limited. On 22 May 2020, TUC Cymru called for the creation of a national enforcement forum in Wales to coordinate workplace health and safety compliance and enforcement activity once lockdown was eased [RH/132 - INQ000180941]. TUC Cymru urged the Welsh Government “to work with us, employers, business and enforcement agencies to establish a national forum to coordinate enforcement activity related to the 2-metre social distancing law and other workplace measures designed to prevent the spread of coronavirus”, suggesting that the forum should “produce Wales’s enforcement strategy, as well as online advice and training on how to reopen and operate safely.” The forum was created, however the lack of clarity over enforcement of workplace regulation persisted, with an email from TUC Cymru to the EHRC in July 2021 regarding social care stating, “There is very little information about LA [Local Authority] enforcement here in Wales. We still don’t know the extent to which they have prioritised care settings” and “The Welsh regulations relating to the right for care workers on zero hours (non-guaranteed) contracts falls to Care Inspectorate Wales to enforce, as far as we understand it, but we are not sure if they actively monitor this” [RH/133 - INQ000581724].

Risk assessments

77. Unions had significant concerns regarding the lack of effective risk assessments in the social care sector. In March 2020, GMB became aware of a confirmed case of Covid-19 at [Irrelevant & Sensitive] with the provider, [I&S] neither having put in place any risk assessments to protect the staff, nor taken any steps to reduce the risk of cross-infection between care homes [RH/134 - INQ000525584]. Furthermore, in April 2020, GMB raised the issue of outreach visits being undertaken by care workers in the London Borough of Waltham Forest. This generally involved two workers visiting a service user's home and taking them out into the community for walks. After protracted correspondence, GMB eventually obtained a generic risk assessment in relation to this activity, which was inadequate – it had downgraded the risk of Covid-19 from 'high' to 'medium', removed PPE as a control measure, with the measures to prevent the risk including observing social distancing, which was impossible with vulnerable adults [RH/135 - INQ000525585]. GMB was forced to issue a press release, endorsed by Stella Creasy MP, calling on the London Borough of Waltham Forest to exercise duty of care for its staff and service users [RH/136 - INQ000525586].

(K) Deaths

78. At a DHSC Workforce meeting at the beginning of May 2020, DHSC informed stakeholders that they were starting to take steps to investigate deaths in care worker settings. They were looking to establish an advisory board "*to help steer the work of the body that will be tasked to investigate death in the sector*" [RH/137 - INQ000119230]. UNISON was asked to sit on the advisory board but then just a week later DHSC informed UNISON that they would not be using an advisory group but instead pursue routes using existing NHS resource for social care as well, rather than an external investigator.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR)

79. At the request of UNISON, DHSC agreed to work with the HSE to consider whether poor employment practices may have contributed to care worker deaths [RH/028 - INQ000119106] [RH/138 - INQ000525587]. At a DHSC Workforce meeting on 2 June 2020, UNISON was informed that medical examiners would review the medical records of all deceased care workers that they had been notified of and, if they determined that Covid-

19 was contracted at work, they would tell the employer they should notify the HSE via a RIDDOR report [RH/139 - INQ000525588]. HSE would then decide what deaths they would investigate, with a focus on reducing future health and safety risks in the workplace. However, this was still dependent on the employer making the RIDDOR notification in the first place – as the TUC has made clear, there was significant under-reporting of deaths under RIDDOR, with the ONS recording 886 health and social care worker Covid deaths between 9 March and 28 December 2020 but only 271 reported deaths under RIDDOR between 10 April 2020 and 17 April 2021 [RH/140 - INQ000119177].

80. These issues were apparent almost immediately. At a DHSC Workforce meeting on 23 June 2020, DHSC were aware that some employers may feel they did not need to alert the HSE to a care worker death and the Local Government Association explained that some employers were apparently nervous about making reports of staff deaths because of liability worries [RH/141 - INQ000525591]. UNISON asked for the latest figures on care worker deaths, which the DHSC had at around 60 deaths, compared to the 200 care worker deaths recorded by the ONS. UNISON also asked whether, where a care home worker had died, they were looking at the results of the whole care home testing process to ascertain how many other positive tests were recorded, which might indicate infection prevention and control failings. DHSC stated that they were not carrying out this analysis but would potentially consider doing so. The impression was one of a lack of coherent strategic approach to this issue.

81. HSE did carry out an investigation into the fatality of a staff member who had tested positive for Covid-19 at Irrelevant & Sensitive Care Home in Northampton in January 2021. HSE's letter to the care home in May 2021 identified several contraventions of health and safety law by virtue of failing to reduce the risk to employees of contracting coronavirus at work, citing inadequate arrangements in place for social distancing and cleaning in the workplace [RH/142 - INQ000525593]. Furthermore, the care home had failed to carry out suitable or sufficient assessments of risk and its Generic Risk Assessment had been produced in April 2020 but not reviewed since, despite the ever-changing guidance and information issued. Unfortunately, this simply highlights the importance of a robust reporting, inspection and enforcement regime, and begs the question how many infections and deaths may have been avoided had that been in place.

(L) Impact of the pandemic

82. The impact of the pandemic on care workers was profound. We set out at the end of this statement a number of first-hand accounts of those who worked in the sector during the pandemic.
83. On an overarching level, the pandemic has left an indelible mark on those working in the care sector. A GMB survey of more than 1,200 care workers, carried out between December 2020 and January 2021, identified significant mental health impacts, with 75% saying that their work during the pandemic had had a serious negative impact on their mental health [RH/143 - INQ000525594]. Women, disabled and residential care workers, and those who were only entitled to SSP, all reported lower mental health scores.
84. This has in turn impacted on retention and recruitment of care staff, both during and after the pandemic. At a PPE Stakeholder Group meeting in July 2021, all attendees reported what they considered to be record numbers of people leaving for “*less unpleasant*” and better paid work, and extreme difficulties in recruiting to fill the places that were being left [RH/129 - INQ000525580]. At a Health and Safety Forum meeting in September 2021, unions in Wales were highlighting the challenges of retaining staff in the social care sector, and Public Health Wales agreed to look at potential specific measures in the sector [RH/144 - INQ000068485]. A November 2021 UNISON survey of more than 1,600 care employees highlighted the impact on retention and recruitment, with 97% of workers saying their care employer was experiencing staffing shortages, mainly due to burnout, overwork and low pay [RH/145 - INQ000525595]. 67% of staff were thinking of leaving social care, with the most common reason being burnout, stress and mental health and wellbeing.
85. The 2022 Skills for Care report highlighted similar concerns [RH/072 - INQ000103565]. Vacancies in England had increased by 52% in one year, meaning on any given day there were around 165,000 vacancies, the highest since records began. Care workers under 20 years old had the highest turnover rates and workers on zero hours contracts or lower pay levels were more likely to leave. The report concluded that we may need an extra 480,000 people working in social care by 2035 to keep pace with demand – an alarming statistic when the report also explains that we stand to lose a further 430,000 people in the years before then if those aged 55 and over decided to retire.

86. The level of support provided by the UK Government for the mental health and wellbeing of adult social care workers was negligible to non-existent. DHSC was said to have been working on a document for the wellbeing and recognition of care workers, which would include a phoneline to ring if they were dealing with bereavement, trauma or stress [RH/137 - INQ000119230], however no such phoneline was created and we are unaware of any document being published. The Welsh Government did produce resources and guidance, such as the document “*Your health and well-being – supporting the health and well-being of the social care workforce*”, first published in April 2020 [RH/146 - INQ000581725]. However, although useful, it was more important to address the underlying causes of severe stress, such as PPE supply, and it is very likely that there is a long-term negative mental health impact on care workers as a result of the pandemic that has not really been acknowledged.

(M) Unequal impact

87. The unequal impacts of the Covid-19 pandemic were keenly felt in the care sector as a result of the demographic of the workforce, who are majority female and more likely to be BAME, older and/or disabled than the rest of the population [RH/147 - INQ000103561].

Black and migrant workers

88. At a meeting of the Social Care Sector Covid-19 Support Taskforce on 12 August 2020, UNISON raised the issue of Black staff feeling less empowered to ask for PPE where supply was insufficient [RH/148 - INQ000525596].

89. UNISON’s February 2021 written submission to the EHRC inquiry into racial inequality in health and social care workspaces [RH/098 - INQ000339477] set out the key issues affecting Black and migrant adult social care workers during the pandemic. The submission explains how Black workers are disproportionately represented in the social care workforce and it has become one of the lowest paid sectors in the UK economy, with around 25% of the workforce being employed on a zero-hours contract. The submission points to UNISON’s January 2021 survey of Black members working in social care (referred to above, [RH/098 - INQ000339477]), which found that almost half of respondents (46%) had experienced racism or discrimination at work in the past year, and

only 60% had felt able to raise concerns regarding infection control and safety with their managers or employers. 77% in residential care stated that they did not have access to the PPE they needed.

90. On migrant workers, the submission explains that they make up 16% of the social care workforce. Migrant workers play a vital role in the provision of health and social care services in the UK, and this was certainly the case during the pandemic. However, an often-overlooked impact of the pandemic was the uncertainty and barriers that it presented to migrant workers' visas. The Home Office slowed operations and the immigration guidance available was unclear. On top of this, for certain periods test centres for English language proficiency were closed, and priority application processing services were not available meaning some migrant workers had to surrender their passport for 6 months or more as part of the Indefinite Leave to Remain ("ILR") application [RH/149 - INQ000339434]. Such uncertainty and delay caused additional stress for such workers already under huge stress by virtue of their work on the frontline of the pandemic response, as UNISON heard from a number of its migrant worker members [RH/150 - INQ000339435] (names have been changed to protect identities):

90.1. *"Mary, a UNISON member and her husband, both from Nigeria work in social care. They say they are working every hour they can in order to save money for the visa renewal fees for themselves and their three children. They struggle to save money and feed their children, who are not eligible for child benefit. They do not know how they will find the money they need when their visas come up for renewal. They are anxious about the risks they are taking in being exposed to COVID-19 and the consequences for their three children if anything happens to them but feel they have been left with little choice but to work every single hour they are offered. They are not eligible for the visa extension scheme nor is she eligible for the new NHS and Social care visa with its reduced costs and exemption from the HIS."*

90.2. *"Susie, a UNISON social care member from Cameroon who is a single mother with three children currently on sick leave and surviving on Statutory Sick Pay was left destitute due to NRPF. When she was still at work, she was given one mask a day to last with all clients. She was receiving statutory pay of £94 a week. She says she "just lives day by day". She is struggling to save for a suitable accommodation and to feed her family. She and her three children are currently living in a 2-bed place. She is not eligible for the visa extension scheme nor is she eligible for the new NHS and Social care visa with its reduced costs and exemption from the IHS."*

90.3. *“Rebecca, a social care worker from Ghana told us she was made to feel like a criminal once her employer found out her visa had expired. “I applied for my visa extension six months ago, paid all the fees, surcharge and here I am still waiting for the decision. It is difficult and stressful as I have no functional visa. My employer stopped me from working even though my solicitor confirmed that I can still legally work. The way I am being treated makes me feel like I have committed a crime.””*

91. UNISON called for the Government to automatically grant ILR to all migrant key workers [RH/151 - INQ000339436]; [RH/152 - INQ000339437]; [RH/153 - INQ000339438]. Lobbying and campaigning delivered some progress. The NHS visa was introduced which resulted in better outcomes in terms of exemption from visa fees for all NHS workers and eventually care workers too. However, problems remained. The contrast with France, where migrant health and care workers were given citizenship in recognition of the work they did in this period, is stark. Virtually all of these workers were excluded from the Home Office’s visa extension in Spring 2020, and they were subject to the ‘No Recourse to Public Funds’, leading to additional financial worries and stress.

92. In Wales, the BAME Covid-19 Advisory Group was convened to advise the First Minister on the disproportionate impact of Covid-19 on some ethnic groups. The group worked with stakeholders from BAME communities, experts within Wales and across the UK (especially PHE), and international colleagues to share information and approaches to address this issue. The socio-economic sub-group published a report in June 2020 which made recommendations in relation to the health and social care workforce [RH/076 - INQ000227599]. These recommendations included: taking immediate action to improve the quality of recording of ethnicity data; ensuring wide dissemination of the All Wales Covid-19 Workforce Risk Assessment Tool backed by robust employer and employee advice; and addressing any unfair or illegal discrimination at work.

Pregnant workers

93. There was a lack of clear, consistent guidance for pregnant workers in the care sector. GMB engaged with the care provider **I&S** on pregnancy risk assessments in social care, with **I&S** employing a large number of young female workers. The company had local managers producing risk assessments that were just lists of potential measures, with no prioritisation or assessment of specific tasks [RH/154 - INQ000525597]. After being challenged by GMB, they employed a new Head of Health and Safety, but the risk

assessments remained inadequate due to a lack of specific guidance to refer to and they were not produced to the required standard until June/July 2020 [RH/155 - INQ000525598] [RH/156 - INQ000525599]. **I&S** had engaged effectively with GMB to rectify the issue, but the fact that it took almost the entire period of the first lockdown to do so shows the issues faced by pregnant women in the sector.

(N) Reflections and recommendations

94. The TUC's report '*Austerity and the pandemic – How cuts damaged the four pillars of pandemic resistance* (referenced above [RH/002 - INQ000250949]) set out a number of recommendations. These included:

94.1. The need for staffing levels to increase, through greater investment and social partnership between Government, unions and employers.

94.2. The need to fix the recruitment and retention crisis in social care, banning zero-hours contracts and delivering a new £15 sectoral minimum wage.

94.3. To increase the attention given to social care services in contingency planning exercises, so that the social care workforce role, and requirements such as staffing levels, are better understood before a future pandemic.

95. There is a need to learn the lessons from what worked well in the NHS during the pandemic and introduce partnership structures including trade unions, employers and government. Not only will this benefit how the sector works on a day-to-day basis, and enable the possibility of greater join-up between the inter-related health and social care systems, it will also enable dialogue and negotiation around sector-wide systems and policies for managing future pandemics. For example, arrangements for sick pay and inputting into guidance for social care.

96. In addition, we would ask the Chair of the Inquiry to consider the following recommendations, which, unless otherwise specified, apply to both England and Wales:

96.1. Ensure that full wages are paid for all social care workers who need to self-isolate, in accordance with arrangements put in place in the NHS during the pandemic i.e. there should be no financial detriment to care workers as a result of complying

with the requirement to self-isolate. This should apply to all workers regardless of role and employment status – to include ancillary, agency, and bank workers. This should be mandatory with regulatory consequences for providers/employers/agencies who fail to comply. Workers and their representatives should have the ability to report non-payment to an independent body, and any monitoring should consult workers on the efficacy of the payment system, not only employers. Payments should be made as part of the worker's usual pay, should be administered by the employer (not requiring the worker to facilitate or apply for the payment) and the mechanisms and policies for this should be set up in advance of the pandemic as part of pandemic planning.

96.2. Create social care and trade union seats on Integrated Care Boards (“ICBs”) and Healthcare Boards. ICBs and Healthcare Boards are mainly an NHS function, with the aim of joining up care leads to better outcomes for people. Trade unions are not given a seat on these boards, nor is a representative of the local social care provision. These boards therefore have a significant blind spot to both workers' safety and the impact on the care systems locally. If both these seats were recommended on ICBs, it would have held up accountability to those decision-makers in the pandemic. In late 2024, the regulations were amended to include worker representation on Wales Regional Partnership Boards.

96.3. Ensure government has created and maintains a central database of all social care employers to facilitate monitoring of interventions in the sector and communications from government and to help provide a more accurate assessment of the capability of the sector. This would also contribute to the possibility of a future government being able to pull central levers to affect change in the sector at a time of crisis.

96.4. Undertake work to identify and create a platform for communicating with workers in the care sector. In Wales, Scotland and Northern Ireland, registration of social care workers has been operational for decades. Registration means that each worker has a registered number and account, which identifies their work experience, qualification and other details. Further thought needs to be given to whether registration would be an appropriate mechanism in England, or whether another means would be more effective. The fragmented nature of the care sector disarms government from being able to contact the workforce, instead, relying on the employer to pass information on to them. It would be helpful to establish a platform which enables greater communication to care sector workers, and by care sectors (so that

they are able to report health and safety breaches by their employer to their local authority). Trade unions should be involved in establishing such a mechanism, and workers should be consulted on the mechanism.

- 96.5. Put in place a joint workforce plan for mental health with the NHS. As the social care sector and NHS are so reliant on each other, a joint mental health workforce plan should be drafted to significantly increase the mental wellbeing of the workforce long-term and ensure that care workers have access to mental health support on the same basis as NHS workers. Care workers should have access to fully funded workplace therapy with mental health professionals.
- 96.6. Conduct work to address institutional racism in the care sector workforce, including by taking steps to improve diversity in leadership roles, and addressing bullying, harassment and discrimination. This may include: increasing the role of the NHS Race and Health Observatory in relation to the social care workforce, introducing the WRES for all care sector employers, and introducing centralised monitoring of EDI plans and compliance with them.
- 96.7. Prescribe Covid-19 as an occupational disease and create a compensation scheme. For many workers, carrying out their job puts them at greater risk of exposure to Covid-19. That risk, for HCWs, is especially high. On that basis, the Industrial Injuries Advisory Council (“IIAC”) concluded in November 2022 that Covid-19 should be prescribed as an occupational disease for frontline healthcare workers. The TUC endorses the IIAC’s recommendation to this Inquiry, and further suggests that a bespoke compensation scheme should be created in respect of Covid-19, which could be similar in many respects to the scheme designed to compensate those affected by mesothelioma as a result of workplace exposures.
- 96.8. Implement a whistleblowing hotline. Fear for their jobs was a barrier to reporting malpractice by employers for many care workers, and for those who did there was no escalation of their complaints, whilst often nothing was ever done when reported to the CQC or the Local Authority. Implementing a whistleblowing hotline would support those who felt most vulnerable to report breaches and long-term follow-up action could be enforced through the agency responsible for running the hotline.
- 96.9. Implement a Workforce Plan which includes both short- and long-term actions and takes into the need for improved working terms and conditions and greater

diversity in leadership roles. This must include having a workforce planning strategy that the whole sector engages with and space and facilities within care homes necessary to deal with a surge in demand. This is the only way to reduce reliance on agency and bank workers, and in so doing reduce movement of care staff in a future pandemic.

96.10. Undertake work to recognise, professionalise and improve working terms and conditions for the care sector workforce. Improved working terms and conditions, higher levels of respect and recognition and greater access to formal professional qualifications for the workforce will reduce vacancies and turnover, and reduce the necessity for staff to hold multiple job roles, reducing overall staff movement between care settings, including during a pandemic.

96.11. Introduce standardised regulations to dictate what 'safe' staffing levels mean in the adult social care context. Without standardised regulations, many adult social care employers cut costs by employing too few staff. In a pandemic, it is impossible to correctly manage adequate staffing levels if there is no measure as to what 'safe' is, as this is solely decided by the care provider.

96.12. Empower and resource local authorities to improve IPC measures in the private sector. During the pandemic, because Local Authorities are well adapted to conducting risk assessments, access to PPE and health and safety measures were quickly put in place for local authority workers, while private providers were often ill-equipped to do this. Residents and the workforce would be provided safer environments if local authorities were able to take a greater role in improving IPC measures and standards in the private care home sector.

96.13. Ensure that there are stocks and well-understood plans for distribution of appropriate PPE for all involved in social care and that training/guidance on its proper use is provided to all roles in the sector. Care workers at all levels and of all employment statuses should have access to appropriate levels of PPE from the moment that cases of the pandemic condition are identified in the UK.

96.14. Ensure that care workers get access to testing as soon as available, on the same basis as NHS workers. At the start of the pandemic social care was at the back of the queue, which had serious consequences.

- 96.15. No hospital discharges to care homes should take place without a test and/or quarantining measures (where tests have not yet been developed) and without risk assessed measures being put in place.
- 96.16. Health and Safety Committees at national and local levels. Consultation machinery for the care sector should be implemented at UK, national and local levels as soon as a pandemic is declared. At UK/national level this should operate on a tripartite basis, consisting of DHSC, UKHSA, care employers and unions. Regionally, Local Authorities (or Local Resilience Forums) should play the co-ordinating role. These bodies should work to set policies and procedures; work with HSE and other expert bodies to produce up-to-date guidance on control measures; and monitor the key metrics, including worker and care recipient infections and deaths, sickness absence and self-isolation rates, PPE supply levels and usage, and vaccination uptake rates. In Wales, this should bring in Public Health Wales as well as Local Authorities, HSE and devolved and non-devolved government.
- 96.17. Ensure that social care is included in all future pandemic planning exercises and that the frameworks and lines of accountability recommended in the Chair's Module 1 Report include social care.
- 96.18. Recognise the important role of Care Quality Commission and Care Inspectorate Wales inspections, including during pandemics and increase the role of the HSE in the care sector during pandemics disproportionately affecting works in the sector. The suspension of inspections and the failure of the HSE to pivot its inspection regime towards the sector during the Covid-19 pandemic undermined the regulatory regime and meant that no body took responsibility for addressing the disproportionate mortality and suffering in the sector.
- 96.19. Vaccination as a condition of deployment should be avoided, opting instead for the more effective policy of providing information and reassurance. Greater work should be conducted to identify and improve mechanisms for sharing information about vaccines and offering consultations and reassurance to workers who require additional support.
- 96.20. Care workers should receive priority eligibility for any vaccination programme.

- 96.21. Establish mechanisms to appropriately measure and record infections, long term sequelae and deaths in the care sector workforce.
- 96.22. Improve visibility of data on ethnicity through death certificates, RIDDOR reports and data on infections and deaths.
- 96.23. Improve risk assessments for all workers, with particular regard for those 'on the frontline' and with a high risk of exposure. Consideration should be given to establishing a national risk assessment tool for use in a future pandemic, such as that developed in Wales.
- 96.24. There should be an automatic presumption that visas are extended in any future pandemic, to remove uncertainty for migrant workers.
- 96.25. Consider granting Indefinite Leave to Remain to migrant care workers in any future pandemic. This would mitigate the administrative complexity of managing complicated immigration rules, would provide greater security for the workforce and benefit essential services.
- 96.26. No health or care worker should have to pay the Immigration Health Surcharge, rather than just exemptions for those who qualify for the Health and Care Worker Visa.
- 96.27. The system of No Recourse to Public Funds should be suspended. It left many migrant families destitute, including those of migrant workers in the NHS and social care.
- 96.28. Widen the visa extension scheme in any future pandemic. The use of automatic free visa extensions during the pandemic was welcome, but should be broadened in a future pandemic to cover the whole of the NHS and social care workforce so that the least well-paid workers are also covered.
- 96.29. Visa sponsorship should be decoupled from individual employers as a way of removing the ability of unscrupulous employers to use the threat of deportation against migrant workers. The visa sponsor could be a government department. This would reduce the fear often experienced by migrant workers as a result of individual employers holding the power of dismissal and deportation over them.

(O) First-hand accounts related to the adult social care sector

97. The Assistant General Secretary of the TUC, Kate Bell, provided a witness statement in Module 2 of this Inquiry [RH/157 - **INQ000282333**], detailing first-hand accounts from workers impacted by the Covid-19 pandemic. We repeat here those accounts related to the adult social care sector, along with further accounts provided in response to an ongoing survey of union members. The nation in which the member worked is specified where known.

97.1. *“Covid eventually came into my place of work in October/November 2020. I was in work when a member of staff rang in to say she had tested positive. Shortly after this, the first service user tested positive. He had been in hospital and brought it back into the care home. Our PPE was not what we were expecting, we had all seen on TV what hospitals had been supplied with and we thought we would be given the same masks, gowns, etc. Our PPE ended up being a plastic pinny that appeared to be the same as was used in the catering sector for sandwich making, and masks that we were informed by management were “there to protect the residents”, not us, which was very demoralising. Eventually we were given visors. I felt that the PPE provided was not adequate.*

I bought myself some safety glasses to try to protect myself a little better. We didn't have the correct equipment to deal with the airborne virus. I don't think the Council understood how the home was affected by the virus or how to deal with it in the setting of the care home.

Staff were worried sick in case we caught it and took it home to our families. I remember conversations with fellow night staff where they were spraying shoes with disinfectant before putting them in the car to go home; stripping off at the front door and putting all of their work clothes and shoes on a hot wash and running up to the shower, even before speaking to a family member.

Covid stopped all activities in the home - coffee mornings and bowling cancelled; stopped going out for lunch. You could physically see the mental anxiety and decline of your service users.

Eventually residents caught it and it went through the home. It was very distressing looking after elderly residents who are actually dying, with blue lips and bulging eyes, trying their hardest to get air in their lungs and writhing around the bed in agony from aches and pains in joints and headaches. One of the worst parts for both staff and

residents was knowing that no doctor or nurse will enter the building to administer anything to ease the pain, and them being unable to say goodbye to family. All we could do was be there for them.

I had a shift where a resident was dying and she was in total distress as she knew she was dying and she could get no peace. Myself and the other member of night staff cried as there was nothing we could do except try to keep her comfortable. To watch a strong lady in her 90s die with no family or loved ones to hold their hand broke our hearts.

We actually felt forgotten. It seemed like the only worthy news was just the NHS. There was very little coverage regarding District or Community Nurses; re-ablement; homecare and residential care; and DMH (Disability and Mental Health).

It was like we all had to just get on with it, with PPE so flimsy we didn't feel it would protect us. We felt unsupported by the office staff or managers. They never came out of the office to ask how we were or whether we were coping or managing.

The Head of Care Services at the time told us we were worth every clap. We felt insulted by this as she never saw what we had witnessed. The public support was primarily for the NHS. Additionally, we felt further insulted when we were given five hours extra holidays - not even a full shift off for what we did over those six weeks.

One of the worst memories were the funeral directors coming in to collect a deceased resident. It looked like something from a movie. They were in full Hazmat gear. We were stood there in plastic pinnies and masks. Night staff cried so much during this time. We were each other's support system.

I remember vividly when and how I caught it. I was assisting two members of staff cleaning a room and showering a service user who was Covid positive. This was the Saturday night. All day the following Tuesday I physically ached, my bones and joints hurt like nothing I'd ever experienced before, my headache would feel like it would make my head explode. The supervisor on shift rang that afternoon to say that one of the night staff had rang in with a scratchy throat and had been advised not to come in. I explained how unwell I felt. She said she was desperate and had tried everyone else, so reluctantly I agreed. On the Thursday morning my test result came back positive, to this day I do not know how I got through that shift.

Covid was like nothing I had experienced before. I had bone and joint pain, headaches, and light aversion for a full week. I had no energy. I was left with a blood clot in my leg and have symptoms of long Covid.

During all of this no-one saw anything of their family. I myself had at that time a grandad of 90 and my Mum, both of whom had health issues. I was unable to visit or see either of them for nearly two months. I have now lost both my Pops and Mum. I will never get those months back.

Covid has left a lasting impression on care, so many staff have left as they have been sickened by the way it was dealt with. Many staff have said that if Covid hits us hard again they will walk out of work and never go back in. Who can blame them? I think Covid will always affect us in whatever we go on to do in life, I've had flashbacks from writing this and a few tears remembering. I'm sure some staff have PTSD."

97.2. *"In March 2020, I began working at a new branch of a national domiciliary agency. During that time, we observed news reports about Covid-19 cases in a nearby town. However, we still lacked significant information from the Local Authority and the Government. Our clients and carers were understandably anxious. They wanted information that we didn't possess.*

The local authority requested us to determine who needed urgent care and who could wait, mainly because they hadn't decided whether to reduce services or not. Carers were hesitant to visit clients who had recently left the hospital, fearing exposure to Covid-19. However, the hospital discharge team informed us that we couldn't refuse care, even if the client had tested positive. We were warned that any refusal would result in a safeguarding action against us. Over the following months, we resumed care for numerous clients with Covid-19, which led to a rapid spread of the virus among both clients and staff.

At the outset, we encountered difficulties in maintaining a full staff roster. This wasn't due to the furlough scheme, which didn't apply to our workers, but rather stemmed from the ambiguity surrounding key worker status during school closures. Some schools lacked clear guidelines on who qualified as key workers, and regrettably, the care sector was not initially included. I remember addressing this issue with a school head, emphasizing that our operations remained active, making our employees the children of key workers by definition. Nonetheless, social care seemed to be overlooked until the eleventh hour.

In April 2020, the first cases emerged from local hospitals, and we began encountering clients who tested positive for Covid-19. During this critical period, obtaining personal protective equipment (PPE) remained a significant challenge. Our regular orders for gloves and aprons were redirected to hospitals, depleting our essential supplies. In

our determined efforts to secure masks and visors, we explored every available avenue. Fortunately, I had a contact in the supply chain who managed to procure a crate of visors. This resource allowed us to provide each carer with a visor, facilitating regular disinfection between client visits.

Over time, the NHS established a PPE scheme, which provided us with the much-needed access to PPE. But before then, the situation was dire.

In June 2020, a concerning incident unfolded when one of our carers began feeling unwell towards the end of their shift at 16:00. At that point, they had already visited nine clients throughout the day. The carer promptly returned home and arranged for a PCR test. We took swift action by notifying all the affected clients, who also sought testing.

Unfortunately, when the results came back indicating that the carer had contracted Covid-19, it was disheartening to learn that seven out of the nine clients had also tested positive, despite the use of PPE during their visits.

This situation prompted concerns about safeguarding, given that the carer had continued working during the day even though they hadn't realized they had Covid-19 until they fell ill in the afternoon. Despite our explanations, the local authority seemed to delay addressing the looming safeguarding issue longer than seemed reasonable.

When we resumed care for clients who were already aware of their positive Covid-19 status, we encountered a notable challenge. We didn't receive any additional specialized equipment for this task. Consequently, we had to improvise by crafting our makeshift Covid containment kits. These makeshift "Covid boxes" were fashioned from waterproof crates filled with essential PPE supplies and plastic suits. Carers would don these protective suits outside the client's property before entering, in an attempt to contain the infection. However, it's important to note that this makeshift solution wasn't consistently effective in preventing the spread of the virus.

The issue of mandatory Covid-19 vaccinations became a significant point of contention within our staff. Many were understandably unhappy about being compelled to receive the vaccine, leading to a "No Jab, No Job" stance, which prompted some carers to resign. I empathized with their concerns because I, too, had reservations about the vaccine. My reluctance stemmed from my recent experience with asymptomatic Covid-19, which was detected through a routine PCR test. Despite having had the virus, I was still mandated to receive the vaccine, and unfortunately, I fell ill after receiving the jab.

In addition to the vaccination debate, I also had a weekly responsibility of visiting one of the company's assisted living facilities to conduct PCR tests on the clients. My training for this task was limited to an NHS online course on swabbing.

However, after visiting a dedicated test centre and observing their comprehensive setup, despite changing PPE between rooms, I couldn't help but feel that our own procedures put us at a higher risk of inadvertently spreading the virus due to our less robust safety measures.

When a semblance of normality began to return, it became apparent that the entire experience had been profoundly traumatic for many of the exceptional career carers I had the privilege to work with. The trauma was so overwhelming that some of these remarkable individuals chose to leave the care profession, unable to overcome the emotional toll of what transpired. Whether it was witnessing the loss of clients, some of whom had been under our care for years, or grappling with the pervasive fear and uncertainty brought about by the unknown nature of the pandemic, they found it too challenging to continue in the industry.

In this context, the act of clapping for carers, though well-intentioned, came to be seen by many as more of an inadvertent insult rather than genuine praise.”

97.3. *“I have worked in the care sector for over 20 years. I am currently assistant chef but started out as wellbeing coordinator in 2010. This was my job role when Covid hit but I am also a qualified carer. As a company, we locked down our Home in March 2020, just before the official first national lockdown.*

We were lucky to be supplied with PPE, but as we didn't know what we were dealing with at first it was just aprons, gloves and after a while face masks.

We managed to keep our residents covid free until May 2020. We had a new resident who came from hospital, and had tested negative before admission which was the company ruling at the time.

Two weeks in, I went into his room to ask what he wanted for breakfast and he was in a blind panic. He couldn't breathe and was in a state. I pressed the emergency buzzer and sat holding his hand trying to calm him down. An ambulance was called and paramedics came in hazmat suits and he was admitted straight onto the Covid ward in hospital. Unfortunately, he passed away three days later. He was our first Covid death but not our last.

As Covid took hold in our care home we were asked to do daily lateral flow tests and bi-weekly PCR tests. Staff started catching Covid as did our residents. Family were allowed in when our residents caught Covid and were end of life, but like us were afraid of the infection and the majority refused. My job then entailed sitting doing Zoom calls with our dying residents so their families could be there to comfort them. I sat holding their hands, sometimes crying with them. I think of my residents as my extended family and felt their loss.

As the virus caught hold, staff were dropping off sick so I started doing care shifts, sometimes up to 60 hours a week because we were so short-staffed. On one particular shift on our nursing unit, we had five residents all close to end of life. We spent the shift going from one to another checking they were comfortable, clean and yes, still breathing. It was horrendous. I came home to my family which included my 3-year-old granddaughter who lived with me at the time, hoping I wasn't going to bring this horrible illness home with me.

At the height of this outbreak we had 80% of our patients who were Covid positive, and staff were still dropping off sick with it too. The deaths continued and we hit the National news as a Home with the highest death rate in our area and countrywide. Our death rate hit 30 residents, devastating for us and the families concerned. We utilised our PPE, we had strict infection control measures in place but it still spread.

We came into work one day and had ITV, BBC and Sky news all camped outside our boundary fence, cameras pointed into windows, trying to get staff "to say a few words about the situation". We were on the main news as the Home that lost so many. It was heart breaking. It was a scary time, one that is forever etched into my mind. A time of fear, loss and one I hope never to be repeated in my lifetime."

- 97.4. *"During Covid 19 we were all sent to work from home. The managers were in a safe place making decisions on care workers health and wellbeing without those carers having a voice except through their trade unions. GMB union were at this time fighting to get PPE and the authority stuck to government guidance through the full process and refused to move. GMB requested that they had face visor and the FFP3 masks. This was refused even though they had them in stock. GMB and UNISON paid a private provider to get the visors to the care staff as the employer refused.*

The anxiety we felt about those care staff and them catching Covid became unbearable sometimes. It was like giving them a pair of sunglasses to protect their eyes while setting off an atomic bomb. FFP3 masks were available on the highways

along with air fed masks but they refused to let care staff use them. Our concerns were then, and are still now, that a number of them caught covid, on average five times. The long-term health issues for these staff are unknown and a national register should be started now.

In one care home 17 people died in 17 days, and the only thing the Local Authority could do was send in a team to look at and see if they had stuck to the hygiene guidelines. It was shocking! They were used as cannon fodder for the NHS. They are still paid less than most retail workers and have the potential of long-term conditions hanging over them.

They did not need claps - they needed PPE. Unfortunately, that was out of our control due to the poor advice and preparation from Government. Face fitting for masks could have been undertaken as a priority and the refusal will affect my members for life.”

97.5. *“I worked as a care worker in a residential care home during the pandemic. On 22 November 2020 after displaying Covid symptoms, I informed my manager, who advised me to contact the NHS. I did this and was notified by the NHS that I was required to self-isolate. I was provided with an Isolation Note. Having to self-isolate had a significant detrimental impact on me. I am a lone parent, and my employer only pays Statutory Sick Pay to its employees who are required to self-isolate. I was worried about having no money and the difficulty this would cause me, particularly so close to Christmas.*

I contacted UNISON and was informed about the £500 Isolation Grant that was available under the Test and Trace Support Payment Scheme. I contacted my local council but was told that I needed an 8-digit code from the Test and Trace app in order to access the grant. I explained that I did not have an 8-digit number as I did not have a smart phone capable of running the Test and Trace app. I explained that I had an isolation note from the NHS. I was told to ring 119 and to ask for an 8-digit number, which I did. I was then asked a series of, what I consider to be, irrelevant questions, including with whom I had been in contact that had tested positive. I explained that it was a 94-year-old resident who was discharged to the care home from hospital on 17 November 2020. I was then told to go onto the resident’s phone to get the code off the app. This was extremely unhelpful advice as what I was being advised to do is unquestionably unlawful. Moreover, however, the resident, who was now deceased, had been suffering from dementia and did not have a smart phone prior to her death.

To treat care workers this way was utterly reprehensible. Me and my colleagues were at the forefront of the nation's response to Covid and I was left in financial hardship simply because I didn't own a smart phone.

UNISON wrote to Miriam Cates MP on the 10 December 2020 to make representations on my behalf. She was asked to help to remove the bureaucratic barrier so that I may receive the Isolation Grant as a matter of urgency. I never received the payment and I had to borrow money to make it through Christmas."

97.6. *"I was working as a registered nurse in a care home during the pandemic. At the start our PPE was grossly inadequate. It was terrifying seeing nurses on the news in Italy wearing full hazmat suits and fully protective PPE and all we got was face masks, plastic gowns and gloves. We accepted donations from businesses for face visors. I knew someone with a 3D printer, and he printed some for us.*

We frequently ran out of PPE and had to ration face masks, keeping it to one mask in the morning and one in the afternoon. We changed these if we were in contact with someone with Covid. The aprons varied in quality. Some of them were so thin they ripped and your hand went through them so easily. The masks also varied in quality. Often the straps ripped really easily. We made hair bands to stop the mask from hurting our ears and homemade pillowcase like bags for carrying our uniforms home in. We never had the high protection face masks. In fact I took some of my own to work but quickly ran out of them.

My family did not want me to put myself at risk but I felt I had no choice. My parents were shielding themselves and I felt scared to take covid to them as I was so high risk of carrying it, so I kept away from them mostly.

Early on in the pandemic, before we were doing weekly covid testing, one of our residents passed away. It was obvious to me that he died from covid. His deterioration was very fast over the course of one week and was consistent with the way I'd seen other people die from covid. Covid was not on his death certificate.

When I was looking after someone with severe asthma, I realised that covid was fully in the room, droplets would be everywhere. When I asked about better protection there was none, and no specific covid policy for looking after someone with asthma who was on nebulisers. We continued to use the same basic PPE. I soon caught covid from a resident who I was looking after who had asthma. It was obvious that I was

going to catch it from him and I tested positive a couple of days later after giving him a nebuliser. Luckily, I wasn't too poorly with it.

At the end of each shift the policy was to change our clothes. We'd take our soiled uniforms home and wash them in our own washing machines. There was no staff uniform laundry service as you would get in a hospital. This did not feel that safe either. I'd always go straight in the shower after getting home and used to wash with Hibiscrub which I'd bought online. I was scared I'd spread covid at home in my own shower. I knew staff who would not sleep in the same room as their partners and would not eat meals with their immediate family for fear of passing it on to them.

It was traumatic not allowing residents freedom to come and go and not allowing family in to see them. I was challenged a few times by relatives and had to simply quote the government policy to them. Although it was protective, I felt like they were imprisoned. Although we were in lockdown the rest of us were free to mostly come and go as we pleased. Residents were denied seeing their families and many became very isolated and low in mood.

The care home managers did their absolute best with what resources they were given. I put no blame on them. The government made so many errors and were ill prepared with next to no PPE. It was a terrible time for all of us, I am one of the lucky ones and did not lose anyone close to me."

97.7. "I worked with social services for around 20 years as a support worker, working with adults with learning disabilities. I really enjoyed the work. Before funding was cut to the sector and a lot of day centres shut down, I would mostly work in adult learning centres. Disabled people would come to the centres to do arts and crafts, woodwork, pottery, and gardening. The centres were fantastic. Then when funding reduced, I would take disabled persons out in the community to do the same kinds of activities. I loved my work.

When the pandemic first hit of course everyone was really scared, and I was too. I continued working in my role. When the vaccine was announced, I was really concerned because I researched it and found out it could cause blood clots. I have a family history of blood clots and members of my family have died as a result. When the vaccine became mandatory for people in my profession, I was dismayed. I felt all my agency and bodily autonomy was being taken away. It created an awful tension at work because there was a lot of pressure to get the vaccine. Many of my colleagues were also worried, but they all ended up getting the vaccine. I was the only person

who held out. I really thought it was morally wrong and potentially dangerous. I was dismissed because of my refusal to have the vaccine. I had a breakdown. Luckily, I had my family around me but I had to leave work for three months because I was so depressed. I lost a lot of weight and it was a really dark period for me. I am now doing better and have left the care sector to work in a different context with vulnerable adults, but I am still so angry about how I had my rights and autonomy taken away from me.”

97.8. *“Everyone was frightened of what was happening because of the uncertainty of the whole pandemic. PPE was just gloves and masks, it wasn’t until later in the second wave that full PPE was issued. We were told we had to have the vaccination otherwise our job could be at risk.” – England.*

97.9. *“Working on the frontline in a care home at the spike of the pandemic we had no PPE equipment at all. To the point my nurse in charge brought in visors that her husband used as a construction worker [...] There was little sympathy, advice or risk assessment put in place. I wasn’t offered furlough as I didn’t qualify and I had to take the decision to stop work with the worry of no pay.” – Scotland.*

97.10. *“At the start we were being told that we only needed to wear PPE if the person had symptoms and that only one person was to tend to a resident as there was not enough PPE. A hospital admission with Covid was sent into the care home and we were not notified – admissions were not required to isolate even though we asked, we were told it was not the guidance. We were asking for the home to be closed to the public to protect them but we were told it was not government guidance and it was at the discretion of providers. We were not listened to or protected.*

Families were not allowed to come in when their family members were dying. They had to watch us holding their loved-ones hand through a window.

We lost 13 residents in less than 10 days.” – England.

97.11. *“Care Homes were quite frankly forgotten about at the beginning by the Government. We struggled to get PPE as the hospitals were given priority. We were blamed for the pandemic spreading but we were the ones who were sent people who had Covid without being informed. Trying to tell a resident with dementia that they*

need to stay in their room is impossible as they did not fully understand the risk they posed to others.

We were told we were important skilled workers yet we remain classed as unskilled workers. Every day I sent staff home with symptoms of Covid and we relied on agency workers. I had domestic and kitchen staff working as carers alongside their usual job role. I received no support from some elements of my management.” – England.

Statement of Truth

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

Signed:

Personal Data

Christina McAnea

Dated: 16 April 2025

Personal Data

Rachel Harrison

Dated: 16 April 2025

Personal Data

Dominic Hook

Dated: 16 April 2025