THE UK COVID-19 INQUIRY

OPENING STATEMENT OF THE TRADES UNION CONGRESS
MODULE 1

INTRODUCTION

1. This is the opening statement of the Trades Union Congress, "the TUC", in module 1 of the UK Covid-19 Inquiry. The TUC brings together 5.5 million working people who make up its 48 member unions, from all parts of the UK, and who span a wide range of sectors profoundly affected by the Covid-19 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, and retail, communications workers, fire and rescue services, the civil service, and the arts.

2. As a core participant in module 1 of the Inquiry, the TUC is working in partnership with the Wales TUC ("**WTUC**"), the Scottish TUC ("**STUC**"), and the Northern Ireland Committee of the Irish Congress of Trade Unions ("**NIC-ICTU**"). The WTUC is an integral part of the TUC but is autonomous in some policy areas. The STUC is a separate organisation to the TUC, representing over 540,000 trade union members in Scotland from 42 affiliated unions and 20 trade union councils. The NIC-ICTU is also a separate organisation and is responsible within` the ICTU for all issues affecting nearly 250,000 members. ICTU has a membership of 43 unions. The TUC, STUC and NIC-ICTU frequently work in partnership, and the relationship is formalised through a body known as the Council of the Isles. The affiliated unions of each organisation are set out in annexes to this statement.

3. In module 1, the Inquiry will hear oral evidence from Kate Bell (Assistant General Secretary of the TUC), Rozanne Foyer (General Secretary of the STUC), and Gerry Murphy (Assistant General Secretary of ICTU).

4. The TUC seeks in this Inquiry to give voice to the experience during the pandemic of those in work, to highlight the uneven impact of the pandemic in the workplace on protected and vulnerable groups, and to emphasise the need to learn lessons so as to ensure that those

required in a pandemic to continue attending their places of work are appropriately protected.

ACKNOWLEDGMENT OF LOSS AND SACRIFICE IN IN THE WORKING POPULATION

5. As this is the first substantive hearing in this Inquiry, it is right that we acknowledge, at the outset, the very great sacrifice made by so many workers in the pandemic.

6. Those in health and social care were truly at the 'front line' in what was a national emergency. It is important not to forget the fear that would have been felt by many as they continued to provide care to the sick and elderly, notwithstanding the new and unknown risks. As the death rates surged, those trying their absolute best to preserve life inevitably suffered a very significant toll on their own well-being.

7. Of course, many others also played a role in keeping the country going during the pandemic. There were those who stacked our shelves, who drove the buses and the trains so that keyworkers could attend work, those who delivered parcels to our doors, those who worked on the production lines so food and necessary goods could continue to be produced, those who cleaned our transport and public buildings, and so many others. Many in these roles, who bore the greatest risk and sacrifice, were also those on the lowest pay, and too often in insecure work. They are, in many ways, the unsung heroes of the pandemic. In many of these occupations, vulnerable and protected groups, and migrant workers, are disproportionately over-represented.

8. Far too many lost their lives. Over 15,000 people of working age died of Covid-19. ONS statistics show that from March 2020 to the end of that first year of the pandemic, there were 8,000 deaths of working age people involving the coronavirus.[1] Nearly two thirds of those were men.

9. The death rate varied significantly as between occupations. The three occupational groups with the highest rates of death involving Covid-19 were: (a) elementary occupations; (b) caring, leisure and other service occupations; and (c) and process, plant and machine

[1] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregisteredbetween9marchand28december2020.

operatives. For men, the death rate for those in elementary occupations was over three times higher than those in professional occupations.[2]

10. The factors driving the difference in death rates are multi-factorial. Certainly, it appears to have been those in jobs with regular exposure to Covid-19, and those working in close proximity to others, that had higher death rates than compared with the general working population. But those occupations also intersect with other factors of ethnicity, low pay and poverty, insecure work, poor housing, and higher rates of pre-existing health conditions.

11. Covid-19's disproportionate impact on ethnic minority groups has been well-documented. The UK's Intensive Care National Audit and Research Centre reported in May 2020 that 34% of critically ill Covid-19 patients were members of ethnic minority groups.[3] In the NHS workforce, the statistics are particularly disturbing: *'Of the 1.2 million staff employed by NHS, 20.7% belong to Black, Asian and minority ethnic (BAME) background. However, analysis of deaths of NHS Staff during the pandemic shows that 64% of those who died belonged to BAME background'*.[4] The disproportionate impact has been linked to higher levels of co-morbid health conditions in ethnic minority groups, but also to operational decision-making, such as higher levels of deployment of BAME staff to areas with higher potential for exposure to virus.[5]

12. Certainly, the loss in life to the virus within the working age population was significant, but the pandemic was no great leveller.

13. It was not just a significant loss in life in the working age population, but its extent was avoidable. When excess deaths in G7 countries are compared, during the first wave of the pandemic (March to June 2020), the UK had the most excess deaths when considered per week as a proportion of expected annual deaths.[6] To February 2021, the UK had the second highest excess deaths in the G7, when considered as a percentage share of expected deaths.[7] A significant proportion of the deaths in the UK were avoidable. This Inquiry must, of course, establish why.

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[2] A death rate of over 60 per 100,000, as compared with a death rate of less than 20 per 100,000.
[3] https://post.parliament.uk/impact-of-covid-19-on-different-ethnic-minority-groups/.
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7563090/.
[5] Ibid.
[6] https://www.health.org.uk/publications/long-reads/comparing-g7-countries-are-excess-deaths-an-objective-measure-of-pandemic-performance.
[7] Ibid.

RESILIENCE AND CAPACITY: A TALE OF AUSTERITY

14. The central theme of the oral evidence in this module will be the legacy of austerity. It will rest on a simple but inescapable truth: that, no matter what planning is put in place, public services stretched to breaking point by over a decade of budget cuts and fragmentation will severely impaired in their ability to cope with the shock of a national emergency such as a pandemic. Preparedness requires not only planning, but also capacity and resilience in public services, including in health care, social care, public health, education and transport. It also requires a population which has equitable access to stable and fairly paid jobs, social welfare support and affordable housing.

15. The threats posed by austerity have been warned of by the TUC and its member unions for many years. But it will be a striking feature of the evidence in this module that so many witnesses, from across government (particularly in the devolved nations); from those at the centre of public health services, and health and social care; and from a range of professional organisations, will describe so consistently the disastrous consequences of austerity. Those consequences, and the impact upon the pandemic response, have been considered in a recent report of the TUC: *Austerity and the pandemic – How cuts damaged four vital pillars of pandemic resilience*.[8]

16. The relationship between austerity and pandemic preparedness was multi-faceted. It certainly impacted the resilience and capacity of public services. The longstanding challenges of the underfunding and over-capacity of the NHS are well known. Even prior to the pandemic, every winter the NHS would 'run hot' with winter flu, let alone a pandemic of a novel virus. Social care has suffered with a lack of adequate funding over a lengthy period. There have been huge cuts to local authority budgets, affecting, particularly, areas such as social care, education, and local authority health and safety enforcement. Going into the pandemic, the whole range of public services was stretched. Many were already beyond capacity.

17. Austerity also exacerbated the deep structural social and health inequalities that exist in our society. The unequal impact of the pandemic largely illuminated pre-existing inequalities. Austerity contributed to those inequalities in a myriad of ways. We are all dependent to varying degrees on those public services, but the degrading of such services by austerity

[8] https://www.tuc.org.uk/research-analysis/reports/austerity-and-pandemic.

particularly impacts upon those already suffering with socioeconomic disadvantage. Health inequalities have been exacerbated by chronic underfunding in public health services. The link between economic deprivation and health inequality is well established, and a series of welfare benefit cuts hit the poorest in society, particularly those of working age. Since 2010, £14 billion has been cut from support to households through social security and welfare benefits,[9] predominantly in the period 2010 to 2016 when David Cameron was Prime Minister and George Osborne was the Chancellor. Working age poverty increased from 7.9 million adults in 2010 to 8.2 million in 2020. Child poverty increased from 3.6 million children in 2010/11 to 4.3 million in 2019/20. The proportion of people in poverty living in a household with work increased from 48 percent in 2010 to 57 percent in 2020. [10]

18. In February 2020, just as Covid-19 started to circulate in the UK, the *Marmot Review 10 Years On* was published. Its author, Professor Marmot, is amongst those who is to give evidence in this module. The report painted a damning picture of health inequalities in the UK. It described that the preceding decade had *"been marked by deteriorating health and widening health inequalities"*. Moreover, that the *"damage to health [had] been largely unnecessary"*, and *"other countries are doing better."* The explanation for the UK doing so poorly was austerity, with the report stating that *"The increase in health inequalities in England points to social and economic conditions, many of which have shown increased inequalities, or deterioration since 2010"*.[11] It described that the more deprived the area, the shorter the life expectancy, and that the social gradient had become steeper over the years of austerity. The decade of austerity had seen the first time that life expectancy had stalled, at least since 1900. It also described how ethnicity intersects with socioeconomic position to produce particularly poor outcomes for minority ethnic groups.[12] It described one of the social determinants of health being work, but that although employment rates had increased since 2010, the number of people on zero hours contracts had increased significantly. It described that *"those with a lower socioeconomic position, younger people, those in lower paid jobs and non-White people are all more likely to experience poor quality work with attendant impacts on health and health inequalities"*.[13] It observed that rates of real pay had not increased and more people in poverty were actually in work, than out of work.[14]

[9] https://neweconomics.org/2021/02/social-security-2010-comparison.
[10] https://www.tuc.org.uk/research-analysis/reports/austerity-and-pandemic.
[11] INQ000108755, at page 4.
[12] Ibid, at page 5.
[13] Ibid, at page 23.
[14] Ibid, at page 24.

19. Those matters should be of fundamental concern to society generally. They are certainly relevant to understanding resilience in response to a pandemic. These inequalities mean that the health and social care sectors are treating a population with significant and growing health problems. Decreasing funding and increasing need creates a perfect storm. It also means that the impact of a pandemic on many of the higher risk occupations – those who continued to attend work and have exposure to the virus and work in proximity with others – was an impact upon a working population that already had worsening rather than improving levels of health.

20. Austerity also almost eradicated any meaningful service able to enforce health and safety in workplaces. The primary regulator for health and safety in places of work is the Health and Safety Executive ("HSE"). In 2009/10, the HSE received £231million in government funding. Ten years later, as the pandemic hit, its annual funding from government had reduced to £123million. Over that same period, the number of prosecutions in health and safety breaches had fallen by 70%. On 11th May 2020, as many had already returned to work, Boris Johnson stated that *"we are going to insist that business across this county look after their workers and are covid-secure and covid-compliant. The Health and Safety Executive will be enforcing that, and we will have spot inspections to make sure that business are keeping their employees safe."*[15] But that was a vacuous attempt at reassurance in circumstances that had left the HSE so depleted in its resources. By early June 2020 the HSE had already received over 6,000 additional concerns from workers about social distancing and other pandemic related matters. Those concerns resulted in the sum total of 47 physical inspections of workplaces, and one prohibition notice. The Health and Safety Executive Northern Ireland faced – and indeed continues to face – similar difficulties.

21. The lessons learnt in this inquiry as to pandemic planning and preparedness will no doubt be many and varied, but the central and salutary lesson from the pandemic should be a fundamental re-evaluation of the critical importance and value of our public services. Specific planning for future pandemics must rest on a foundation of public services that are valued and adequately funded.

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15 https://hansard.parliament.uk/commons/2020-05-11/debates/D92692B5-165B-4ACB-BC97-4C3F25D726EE/Covid-19Strategy.

HEALTHCARE: BEYOND CAPACITY

22. When the pandemic struck, the NHS was in crisis; after a decade of underfunding, it was struggling to cope with increasing demand. As the TUC set out in its March 2014 budget submission, '*the combination of £20bn efficiency savings and real terms funding cuts has equated to a four per cent cut in the budgets of hospitals and community health services every year from 2010 to 2014, with income falling far behind increased demand*'.[16] In 2022, the Health Foundation reported that actual average annual spending on health in the UK between 2010 and 2019 would have needed to increase by £40bn just to match EU14 average spending per person.[17] Although, as the Inquiry will hear, devolved governments in Scotland, Northern Ireland and Wales attempted to protect the health services from the worst of the chronic underfunding, the level of budgets set centrally meant that health care across the UK was impacted by austerity.

23. Long-term underfunding resulted in low levels of pay within the sector. TUC analysis shows that wages of NHS staff are still even now below 2010 levels after taking into account inflation, even after factoring in the 2021 pay award for staff.[18] This, alongside poor working conditions and the exit of the UK from the European Union, has contributed to a staffing crisis in the NHS. Going into the pandemic, the vacancy rate in the NHS was 9.2%. Over the preceding 10 years, the number of nurses per capital in the UK grew by less than one per cent – despite demand for care rising by one third.[19]

24. The Inquiry will hear how year-on-year real term cuts to NHS funding has led to low investment in NHS capital, which has had a negative impact on estates, infrastructure, and equipment. This in turn has reduced the ability to carry out infection control measures.

25. That has all resulted in a bed capacity crisis. The UK entered the pandemic with the second lowest number of hospital beds per 1,000 inhabitants in the UK and EU OECD nations.[20] Germany had over three times the number of hospital beds per capita than the UK, and five times the number of critical care beds.[21]

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[16] INQ000103550.
[17] INQ000108751.
[18] INQ000103541.
[19] https://www.tuc.org.uk/research-analysis/reports/austerity-and-pandemic.
[20] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-hospital-beds-data-analysis.
[21] Ibid.

26. Over time, the capacity of the NHS to see and treat patients in a timely manner has decreased. In February 2020 there were already 4.43 million people on waiting lists for elective treatment.[22]

27. Due to problems with funding, staffing, equipment, bed spaces and waiting lists, the NHS in early 2020 did not have the capacity to meet existing demand. The Nuffield Trust for Research and Policy Studies in Health Services stated in their 2016 Annual Statement, "*Slowing improvement in some areas of quality, combined with longer waiting times and ongoing austerity suggests the NHS is heading for serious problems.*"[23] The result, by 2020, was a crisis in patient and workforce safety.

28. The NHS was simply not able to respond to the challenges of the pandemic as effectively as it could have if this crisis had been averted or resolved at an earlier stage by appropriate investment and oversight. It is a crisis which continues to develop, with NHS waiting lists reaching 7.33 million in March 2023,[24] a workforce burned out by the demands of the preceding years, and vacancies at a 5-year high in December 2022.[25] If we are to fare better and prevent such devastating loss of life in the next health emergency, appropriate levels of funding and a long-term recovery strategy must be implemented.

SOCIAL CARE: THE CINDERELLA SERVICE

29. The social care sector is critical to pandemic response. Those reliant upon social care were at the highest risk of coronavirus. The health service is also reliant upon a functioning social care system that can care for the elderly and allow patients to be discharged from our hospitals.

30. Prior to the Covid-19 pandemic, plans for the NHS to surge capacity in an emergency placed significant reliance on the ability of the social care sector to provide additional bed capacity. The difficulty with this was flagged by Exercise Cygnus in 2016: *"Local responders also raised concerns about the expectation that the social care system would be able to provide the level of support needed if the NHS implemented its proposed reverse triage plans, which would entail the movement of*

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[22] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis.
[23] INQ000108801.
[24] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis.
[25] INQ000190680.

patients from hospitals into social care facilities".[26] The difficulties which arose during the pandemic in respect of this policy were not only foreseeable, they were foreseen.

31. The long-standing crisis in the social care system is described in Ms Bell's statement.[27] As described, unions such as the GMB had repeatedly drawn the attention of Government and the public to the crisis which has been unravelling in the social care system for over two decades.

32. The concerns described by Ms Bell find company in a number of the statements before the Inquiry. This Inquiry will hear that the crisis in social care has been caused by numerous factors, including: successive reductions in central government funding to local authorities, simultaneously combined with increased demand; an unsustainable business model; low pay resulting in staffing shortages and insecurity of work for those within the sector; lack of strategic planning or capability to foresee challenges; absence of a centralised data system; fragmented and ill-equipped physical infrastructure; and lack of centralised oversight.

33. A report by the Care and Policy Evaluation Centre and the Nuffield Trust, 'Building a resilient social care system in England: What can be learnt from the first wave of Covid-19?' (May 2023), conducted thematic analysis which identified the following three lessons for the sector:[28]

> *"**The system.** A range of deeply rooted systemic issues, with unclear roles and responsibilities among levels and areas of government, impacted the coordination and timeliness of the response to the pandemic.*
>
> ***People.** A lack of deep understanding of the social care sector (in terms of who draws on support, the paid and unpaid workforce, and the range of different services) among those leading the response meant that measures and guidance were insufficiently sensitive to the diversity and complexity of this vast sector.*
>
> ***Resources.** A lack of sustained investment, and instead a reliance on sporadic injections of funding, over the preceding decade resulted in the sector entering the pandemic with patchy data, limited spread of technology and innovation and a residential care estate that was not fit for purpose."*

34. The government has consistently failed to listen to the voices of those within the sector, and to ensure there is sufficient knowledge of and expertise in social care within central government. The failure to include social care in pandemic planning created difficulties for

[26] At page 9 of the report.
[27] INQ000177807, at paragraphs 55 to 68.
[28] INQ000108858, at page 3.

the sector. As is set out in the TUC's report, 'Austerity and the pandemic – How cuts damages four vital pillars of pandemic resilience':

> *"Understaffed social care teams also had to learn and understand how to implement Covid safety procedures for home visits and in residential care. This was made harder by the lack of inclusion of social care in many of the government's preparedness exercises, resulting in a lack of clear contingency plans for the sector".*[29]

35. The workforce within the sector felt abandoned prior to the pandemic; the pandemic has only increased this sentiment. Underfunding of the sector has resulted in low levels of pay, which in turn has caused job security and a high staff turnover. Poor working conditions were reflected in death rates in the first few months of the pandemic. The Office of National Statistics confirmed that up to, and including, 20 April 2020, the death rates involving Covid-19 among male social care staff was 23.4 deaths per 100,000 men aged 20 to 64, compared with a national rate of 9.9.[30] Among women, the social care death rate was 9.6 deaths per 100,000, compared with 5.2 for the general population.[31] The lack of support for the care sector is relevant to issues of discriminatory impact of the pandemic, with care workers being more likely to be older, disabled, and members of BAME groups than other workers

36. The Inquiry will see a powerful theme emerge, which we say underpins the forementioned challenges: that the Government has repeatedly undervalued and de-prioritised the social care sector, to the extent that it has become widely known as the 'Cinderella service'.[32]

37. The crisis in social care has not emerged without warning; in addition to the TUC and its affiliated unions, organisations including the Nuffield Trust, The King's Fund, Age UK, ADASS and the Health Foundation have made sustained efforts prior to 2020 to draw attention to the fragility of the social care system and to offer advice, research, and recommendations in respect of addressing this issue. Furthermore, the Government's own planning and preparedness exercise, Exercise Cygnus, highlighted the vulnerability of the social care sector to civil emergency and provided a series of recommendations in respect of social care. But, as the Inquiry will hear, these recommendations were largely unacted upon.

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[29] https://www.tuc.org.uk/research-analysis/reports/austerity-and-pandemic.

[30] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/coronaviruscovid19relateddeathsbyoccupationenglandandwales/deathsregistereduptoandincluding20april2020, at paragraph 5.

[31] Ibid.

[32] https://www.nao.org.uk/reports/the-adult-social-care-workforce-in-england/.

38. After two decades of stagnation, fragmentation, and unanswered calls to action, now is the time to act and ensure that long-overdue reform and investment begins. The TUC urges the Inquiry to ensure that the future resilience and preparedness of the social care sector is at the top of the agenda.

PANDEMIC RESPONSE IN A FRAGMENTED HEALTH AND SOCIAL CARE SECTOR

39. Pandemic response across public health and social care requires effective planning and co-ordination. That is challenging by reason of the scale of the services that are being provided. It is made more challenging, if not impossible, by the increasingly fragmented nature of our health and social care services.

40. The Health and Social Care Act 2012 ('HSA') implemented wide-ranging reforms to the NHS and public health, which included abolishing various organisations, creating new organisations and re-arranging responsibilities within that structure.[33] Crucially, public health functions were transferred away from the NHS, and to local authorities. This split of public health functions weakened expertise within the NHS in public health, and impaired overall co-ordination. The 2012 Act also abolished the Health Protection Agency, and established Public Health England (PHE), but in 2021, in the midst of the pandemic, PHE was disbanded with the Government describing that PHE had failed to "*focus on our health security, while also preventing ill health to improve the general health of the population*".[34] The repeated restructuring and reorganisations of the health protection function created confusion and decreased understanding around which individual, department or body was responsible for which task or function, and reduced levels of training and expertise within the sector. The Government foreword to the new UK Health Security Agency ('UKHSA') recognised that the system in place from 2013 to 2021 did not provide a "*public health system fit for the future*".[35]

41. The problem of fragmentation is particularly acute in the social care sector. The problem has been not so much one of repeated restructuring and reorganisation, but one of neglect: there has been no attempt to structure at all. Adult social care in England is now provided by around 18,000 organisations. The overall workforce is larger than that in the NHS: 1.54m people work in adult social care, compared to 1.37m in the NHS. Yet, there is no equivalent

[33] Those reforms are set out in detail in Kate Bell's Module 1 Rule 9 witness statement (INQ000177807 at paragraphs 22 to 30) and have been recounted to the Inquiry in numerous witness statements.
[34] INQ000145934.
[35] Ibid.

to NHS England, which seeks to provide some strategy and direction to the sector. The TUC has repeatedly called for a national Social Care Forum, to "*bring together government, unions, employers, commissioners and providers to coordinate the delivery and development of services, including the negotiation of a workforce strategy*".[36] Co-ordinating a national effort across a hotchpotch of private organisations is impossible. In terms of data, the Inquiry will hear that records in relation to the care sector are vitally lacking. At the beginning of the pandemic, no single national database existed, and local authority records were incapable of providing a clear picture of the number of people needing or working in the care sector, nor their demographic characteristics. It was not known – and is still not known with any level of precision - how many residential care homes were in operation across the UK.

42. The overall picture is of key functions, central to pandemic response, being fragmented and spread across the NHS, PHE, local authorities, and the many thousands of social care providers, without a clear means of national oversight and co-ordination.

FAILURE OF LOCALISM

43. Local authorities and local resilience forums were constrained by the years of underfunding to public services which preceded the pandemic. In addition to austerity policies, local government and organisations were also constrained in their ability to plan and prepare for civil emergency by the approach of central government. The evidence before the Inquiry suggests that there was a failure by central government to establish trust and open communication with local government and local organisations in both directions, such that planning and preparedness exercises and operations by central government did not benefit from local understanding and expertise, and local authorities and organisations were not kept in the loop, which in turn impacted on the ability to plan and prepare effectively at a local level.

44. The Inquiry will hear that the approach in respect of planning and preparing for civil emergencies had too strong a focus on identifying and analysing risk at a national level, rather than listening to local perspectives. Central government appears to have adopted a paternalistic approach to planning and preparedness which failed to recognise that a sustained and complex crisis would require both plans which were enriched by local

[36] https://www.tuc.org.uk/research-analysis/reports/fixing-social-care.

expertise and local response, and which was informed by open communication with central government.

45. Not only did national exercises fail to adequately include local government, local resilience forums and local organisations, but those at the local level struggled to get access to documentation of the outcomes and recommendations flowing from national exercises.

46. Evidence before the Inquiry shows that, as the pandemic progressed, central government recognised the need to better involve and resource local response, and that this yielded stronger results than the approach adopted in the planning and preparedness phase.

47. A study by a team of researchers at the Blavatnik School of Government, entitled '*Crisis Preparation in the Age of Long Emergencies: What COVID-19 teaches us about the capacity, capability and coordination governments need for cross-cutting crises*' considered the division of responsibility between central and local government in the context of response to civil emergency:

> *'the decision on local capabilities* […] *asks a profound question of the state: do we want strong, capable, locally based resilience mechanisms that are capable of taking and implementing locally based decisions within a national framework? If so, that requires a reimagining of the balance between central and local government that is not currently prevalent in policy debates in England, and a reversal of decades of centralisation and the hollowing-out of local capabilities. It is possible to envisage a far stronger network across England of local resilience capabilities across everything from data collection to response mechanisms, building on strong community knowledge. A better connected and integrated local–national system could also provide central government with a richer picture and the confidence to attempt less 'blunt' and costly national measures'*.[37]

48. That study concluded, *'one of the most significant recommendations from this study is a fundamental rethink of the role of local government and local capabilities in England, if the state as a whole is to have the capability to manage long emergencies'*.[38]

PANDEMIC PREPAREDNESS ACROSS THE RANGE OF WORKPLACES

49. Although there is an important focus in this module and in pandemic preparedness on public health services, preparedness is necessary across a range of workplaces. As above, many of the highest risk occupations were outside of healthcare, and were in the elementary occupations. In any pandemic, there will be a need for food to be produced, for parcels to be

[37] Professor Ciaran Martin, CB Dr Hester, and Kan Maximillian Fink, *'Crisis Preparation in the Age of Long Emergencies: What COVID-19 teaches us about the capacity, capability and coordination governments need for cross-cutting crises'* (Blavatnik School of Government and University of Oxford: March 2023).
[38] Ibid.

delivered, for transport to operate, and so on. Preparedness for these sorts of sectors is crucial: it is where the virus can spread if not managed appropriately, it is where the death rate was at its highest, and it is where much of the unequal impact of a pandemic is felt. Preparedness is a necessity for these sectors too: they, and the national effort, also depend upon a range of effective non-pharmaceutical interventions.

50. Achieving that objective requires a focus of central government and local authorities. But, these sectors are very substantially operated by the private sector. The demands of preparedness and pandemic response are different.

51. First, the relevant government departments must identify where there will likely be a need to step in to support industries, including on matters such as the procurement of PPE. Many sectors were without necessary PPE for significant periods. The range of key sectors must feature in pandemic planning.

52. Second, there need to be effective mechanisms for joint working between government and the relevant industries, including unions. The Inquiry in this module, and certainly in module 2, will hear of differences in this respect between the devolved nations. In England the arrangements for working with professional and representative organisations across sectors are limited. Elsewhere, particularly in Wales, there is an approach of social partnership, in which there were pre-existing and improving structures to enable partnership working between the government and industries. That is critical on matters such as the production of adequate workplace guidance, and the government being able to quickly be alerted and respond to challenges faced in the workplace. Repeatedly in the pandemic, guidance documents affecting millions at work were produced with virtually no notice or consultation.

53. Third, there is a need for fair work. Many 'front line' workers were in low paid jobs, with poor employments rights. One of the most important NPIs was self-isolation. But, those working, for example, a menial job on a processing plant, will very often face the difficulties of being in insecure work, of experiencing in-work poverty, and have, at most, a right to extremely limited sick pay (if at all). For many, self-isolation would be a choice between not self-isolating, or self-isolating but not having the money to live and eat. The TUC has raised repeated concerns about the limitations of statutory sick pay, and repeatedly raised it during the pandemic in connection with the effectiveness of self-isolation as an NPI. The Government response on sick pay was unplanned for and late. It was also half-hearted. In

the single month of the 'Eat Out to Help Out' scheme, the government spent £840million on supporting dining out. The following month, local authorities were given a mere £50million to fund the self-isolation support payment scheme to support the many thousands of key workers on low pay who would struggle to live if they were to self-isolate.

54. Fourth, there is a need for effective regulation in workplaces. That includes both an effective, funded Health and Safety Executive, as addressed above, and also local authorities being able to fund adequate numbers of health and safety officers.

CONCLUSION

55. The importance of this Inquiry is lost on no one who is involved in it, and we commend the Inquiry for bringing an investigation of such scale and breadth to its first substantive hearings, in such a comparatively short timescale. It is an invaluable and unique opportunity not only to learn the lessons of the great tragedy that was the Covid-19 pandemic, but also to shed light on, and to improve, some of the decision-making processes of the governments in our four nations. The themes of and lessons to be learnt in relation to planning and preparedness, and particularly that of austerity, are important. They will be not just for this module, but will be recurring themes in each of the modules to come.

SAM JACOBS

RUBY PEACOCK

Doughty Street Chambers

12TH June 2023

THE UK COVID-19 INQUIRY

ANNEX A: TUC AFFILIATED UNIONS

Accord – Lloyds Banking Group, TSB and other financial services

Advance - Santander and Santander businesses in the UK

Aegis - Finance sector staff at Aegon UK, Atos UK, Skipton Building Society, Yorkshire Building Society

AEP – Educational psychologists and assistant educational psychologists in public and private sector

AFA-CWA – Mobile civil aviation workers (flight attendants/cabin crew)

Artists' Union England – Freelance visual artists, applied arts, sound and performance

ASLEF – Railways – drivers, operational supervisors and staff

BALPA – Airline pilots; commercial helicopter pilots and technical rear crew

BDA – Dieticians in the public and private sector

BFAWU – Workers in food industries

BOSTU – Orthoptists

Community – General union covering a range of sectors including steel and other metals, third sector and logistics

CSP – Chartered physiotherapists, physiotherapy students and support workers

CWU – BT, O2, Post Office, Royal Mail Group and other telecoms companies

EIS – Teachers, lecturers, associated educational personnel in Scotland

Equity – Professional performers and creative practitioners

FBU – Fire and rescue services

FDA – Senior staff in civil service, public bodies and NHS

GMB – General union covering a range of sectors, including social care, manufacturing, energy and public services

HCSA – The Hospital Doctors Union

MU – Musicians including live and recording artists, composers, teachers and writers

NAHT – Head teachers, deputies, assistant head teachers and school leaders across sectors

NAPO – Probation and family court staff

NARS – Racing staff employed by licensed racehorse trainers

NASUWT – Teachers and head teachers in all sectors from early years to FE across the UK

Nautilus International – Merchant navy and all related areas

NEU – Teachers, headteachers, lecturers and support staff in all education sectors

NGSU – All staff at the Nationwide Building Society

NHBSCA – All staff at the National House Building Council

NSEAD - Art, craft and design educators across all phases and sectors

NUJ – Journalists, copywriters, designers, presenters, producers and website content providers

NUM – Coal mining and associated undertakings

PCS – Government departments and agencies, public bodies, private sector IT and other services

PFA – Professional football

POA – Staff in penal or secure establishments or special hospitals

Prospect – General union covering a range of sectors, including creative industries, defence, scientific and professional staff and energy

RCM – Practising midwives and maternity support workers in the UK

RCP - NHS, independent practice and private chiropodists and podiatrists

RMT – Railways, underground, metro, bus, road transport, taxi, maritime and offshore

SoR – Radiographers and related staff in NHS

TSSA – Administrative, clerical, professional and technical employees of railways, buses, London Underground, travel trade

UCAC – Teachers, headteachers, education advisors and lecturers across all sectors in Wales

UCU – Academic and related staff in HE, FE, land-based, adult and prison education.

UNISON – General union covering a range of sectors, including local government, health and social care, utilities, energy, education and voluntary sector

Unite the Union – General union covering a range of sectors, including manufacturing, aerospace, aviation, transport, voluntary and public services

URTU – Drivers, ancillary and warehousing workers in the logistics and food sectors

USDAW – Call centres, catering, distribution, food processing and manufacturing, retail and warehouses

WGGB – Writers working in TV, radio, film, books, theatre, comedy, video games and multimedia

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ANNEX B: STUC AFFILIATED UNIONS

Aegis - Finance sector staff at Aegon UK, Atos UK, Skipton Building Society, Yorkshire Building Society

Associated Society of Locomotive Engineers and Firemen (ASLEF) - Railways – drivers, operational supervisors and staff

Association of Educational Psychologists - Educational Psychologists in the United Kingdom

Bakers, Food and Allied Workers Union (BFAWU) - workers throughout the food sector from production to retail

British Air Line Pilots Association (BALPA) - pilots, winchmen and flight engineers

British Dietetic Association (BDA) - the science of dietetics in the private and public sector

British & Irish Orthoptic Society (BOS) - orthoptists

Chartered Society of Physiotherapy [CSP] - physiotherapy and health service

Communication Workers Union [CWU] - BT, O2, Post Office, Royal Mail Group and other telecoms companies

COMMUNITY – merger of the Iron and Steel Trades Confederation (ISTC) and the National Union of Knitwear, Footwear & Apparel Trades (KFAT)

Educational Institute of Scotland [EIS] - teachers, lecturers, associated educational personnel (Scotland)

EQUITY - performance workers in theatre, film television, radio and variety

FDA - civil service, public bodies and NHS

Fire Brigades Union [FBU] - local authority fire brigades

GMB - General union covering a range of sectors, including social care, manufacturing, energy and public services

Hospital Consultants and Specialists Association - hospital consultants, associate specialists, specialist registrars (within 2 years of CCT) and staff grades

Musicians' Union [MU] - performers engaged in the music profession including music writers and instrumental music teachers

National Association of Racing Staff [NAORS] - Racecourse staff

National Association of Schoolmasters Union of Women Teachers [NASUWT] - education

National Union of Journalists [NUJ] - journalists

National Union of Mineworkers - Mining

National Union of Rail, Maritime and Transport Workers [RMT] - railways and shipping, underground, road transport

Nautilus International - Maritime professionals at sea and ashore.

Prison Officers Association [Scotland] - Staff in penal or secure establishments or special hospitals

Prospect – General union covering a range of sectors, including creative industries, defence, scientific and professional staff and energy

Public and Commercial Services Union [PCS] - government departments and agencies, public bodies, private sector information technology and other service companies

The Royal College of Midwives Area covered - midwifery

Scottish Secondary Teachers' Association - education

Scottish Artists Union Area covered - artists

Scottish Society of Playwrights - playwrights in Scotland and Scottish playwrights abroad

College of Podiatrists

Society of Radiographers [SoR] - National Health Service

Transport Salaried Staffs' Association [TSSA] - Administrative, clerical, professional and technical employees of railways, buses, London Underground, travel trade

Union of Shop, Distributive and Allied Workers [USDAW] - Call centres, catering, distribution, food processing and manufacturing, retail and warehouses

UNISON Scotland - General union covering a range of sectors, including local government, health and social care, utilities, energy, education and voluntary sector

Unite the Union - General union covering a range of sectors, including manufacturing, aerospace, aviation, transport, voluntary and public services

United Road Transport Union (URTU) - HGV, LGV, lorry, truck drivers and warehouse staff

University & Colleges Union [Scotland] - academic and related staff in higher education

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ANNEX C: ICTU AFFILIATED UNIONS

AHCPS - The Association of Higher Civil and Public Servants

Association of Irish Traditional Musicians

ASTI - The Association of Secondary Teachers Ireland

BATU - Building and Allied Trades' Union

BFAWU - The Bakers Food and Allied Workers Union

British Actors Equity Association - Workers in performance and creative industries

Chartered Society of Physiotherapy

Communication Workers' Union - UK

Communications Workers' Union

CONNECT – Engineering and manufacturing

Energy Services Union (Of Ireland)

FBU - The Fire Brigades Union

FDA - professionals and managers in public service

Financial Services Union

Fórsa – civil and public service

GMB - General union covering a range of sectors, including social care, manufacturing, energy and public services

Guinness Staff Union

IFUT - The Irish Federation of University Teachers

INTO - The Irish National Teacher's Organisation

Irish Medical Organisation

Irish Nurses and Midwives Organisation

MLSA - The Medical Laboratory Scientists Association

NASUWT - The National Association of Schoolmasters and Union of Women Teachers

NIPSA - civil and public services and community and voluntary sector

NUJ - The National Union of Journalists

OPATSI - The Operative Plasterers & Allied Trades Society of Ireland

PCS - workers in the public sector including Border Force and HMRC

POA UK - The Prison Officers Association represents workers in Prison, Correctional and Secure Psychiatric Workplaces

Prison Officers' Association

Prospect – a general union

RMT - The National Union of Rail, Maritime and Transport Workers

Royal College of Midwives

SIPTU - the Services Industrial Professional and Technical Union

Society of Radiographers

The Pharmacists Defence Association

TSSA - The Transport Salaried Staffs' Association

TUI - The Teachers' Union of Ireland

UCU - academics, lecturers, trainers, researchers and academic-related staff

Unite The Union

USDAW - workers in the retail, distributive, manufacturing and service sectors

UTU - The Ulster Teachers' union

Veterinary Ireland

Veterinary Officers Association