THE UK COVID-19 INQUIRY

MODULE 6

SUBMISSIONS ON BEHALF OF

THE FRONTLINE MIGRANT HEALTH WORKERS GROUP

FOR PRELIMINARY HEARING, 19th MARCH 2024

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INTRODUCTION

1. These submissions contain a brief introduction to the Frontline Migrant Health Workers Group (FMHWG/the Group), detailing their role and interest in Module 6, before making proposals in respect of module scope and expert evidence.

2. The Group are Core Participants in Module 3 of the Inquiry. At the last Module 3 preliminary hearing, we raised the issue of migrant domestic healthcare workers, i.e. those providing domiciliary health and care roles. We did so out of concern that this particular category of worker may be overlooked. We are grateful for our inclusion in Module 6 and the specific inclusion of "care provided in the home" within the module's scope.

THE FRONTLINE MIGRANT HEALTH WORKERS GROUP

3. The Frontline Migrant Health Workers Group is a collective group of two trade unions, United Voices of the World (UVW) and Independent Workers' of Great Britain (IWGB), and a consortium of community organisations, Kanlungan.

i. **Kanlungan** is a registered charitable incorporated organisation consisting of several Filipino and Southeast and East Asian grassroots community groups. They work for the welfare and interests of migrants, refugees, and diaspora communities from the Philippines and Southeast Asia living in the UK. Kanlungan works nationwide to empower their members providing immigration, welfare, and employment advice. They assist their members with mental health and wellbeing support; and campaign for workers and migrants rights through lobbying local and national government. Their members work across the care sector, including nurses, non-clinical care home staff and domestic carers.

ii. **Independent Workers of Great Britain:** IWGB is a non-TUC affiliated, national trade union. It was founded in 2012 by Latin American cleaners organising for better pay, pensions and working conditions in London. They have subsequently expanded their membership across a number of sectors, including the social care sector, where they have a significant membership, working as care workers, nannies and au pairs, cleaners, kitchen staff and receptionists, often in outsourced positions. Members are overwhelmingly working class and from ethnic minority backgrounds, in low-paid and precarious employment.

The IWGB organise and take industrial action to challenge exploitative practices which deny their members basic rights such as health and safety protections and sick pay. They have been at the forefront of organising workers who were previously unorganised. Through a decade of action, advocacy and campaigning they have become a leading grassroots trade union.

iii. **United Voices of the World:** UVW is also a non-TUC affiliated, national trade union. They organise low paid, migrant and precariously employed workers on short term contracts or working in the gig economy.

UVW is an anti-racist, member-led, campaigning trade union established to support and empower the most vulnerable groups of low-paid and predominantly ethnic minority and migrant workers in the UK. UVW brings together workers across several sectors including the care sector, many of whom worked on the frontline in care homes during the pandemic as carers, cleaners, porters and kitchen staff.

Experience:

4. The Group's members have direct frontline experience of the impact of the pandemic on those working in the care sector. They have particular insight into the unequal impact on the precariously employed, and migrant care workers.

5. The majority of the social care members of the Group are women. The majority of the Group as a whole are migrant and/or ethnic minority workers. As such they fall within the protected characteristics of the Equality Act 2010. However, the Group wishes to emphasise at the outset, that systemic issues such as outsourced employment, are applicable across the outsourced working class, regardless of ethnicity and gender.

6. The majority of the Group's care sector members work outside of the NHS and Local Authority care homes in the privatised care sector. Many, work in the informal/under-regulated care sector in private homes.

7. In the first months of the pandemic, as Government tried to free-up hospital capacity, hospitals were forced to discharge patients into the care sector or to care in their own homes. The Government's published hospital discharge policy in March 2020[1] and admissions guidance for care homes in April 2020[2]

[1] https://assets.publishing.service.gov.uk/media/5f43aa60d3bf7f67ab49afe9/COVID-19_hospital_discharge_service_requirements_2.pdf
[2] https://ltccovid.org/2020/04/04/new-uk-guidance-on-admission-and-care-of-residents-during-covid-19-incident-in-a-care-home/

ensured that asymptomatic patients were discharged, without testing or isolation, into care homes and private homes that were populated by the clinically vulnerable and staffed by the most disadvantaged workers. Testing prior to discharge was not implemented until 15th April.[3]

8. An under-funded and under-staffed National Health Service was effectively told to shunt the problem elsewhere. Care workers were placed under immense pressure to meet the needs that the healthcare system could not meet.

9. The pre-pandemic, 2019, breakdown of the care sector workforce had an estimated 61% of care sector workers employed by private providers (a notable increase on 2012 figures) and 18% by voluntary providers, with just 7% employed by Local Authorities and 6% by the NHS. The average pay for the latter two categories of worker was just over £10 an hour. The average for those working in the private sector was around £8.40 an hour, below the national living wage, at the time, £8.72. There was, and is, a heavy reliance on outsourced workers, particularly in the private sector. Around 25% of workers in the sector and 35% of care workers were on zero-hours contracts. A full third of adult social care jobs in the private sector were classified as insecure. In domiciliary care, the numbers are far higher, with 56% of home care workers on zero hours contracts. Almost a quarter of the national care sector workforce are from ethnic minority backgrounds, with that figure rising to around 70% in London. Nationally, 82% of social care workers are women.[4]

10. It cannot have come as any surprise to anyone, that on 11th May 2020 the Office of National Statistics was reporting that care workers and home care workers were among the occupations at the highest risk of death. Historically,

[3] https://www.england.nhs.uk/coronavirus/documents/new-requirement-to-test-patients-being-discharged-from-hospital-to-a-care-home/

[4] https://committees.parliament.uk/writtenevidence/6736/pdf/
https://www.careengland.org.uk/state-adult-social-care-sector-and-workforce-england/
https://careengland.org.uk/wp-content/uploads/2020/11/The-state-of-the-adult-social-care-sector-and-workforce-2020.pdf
https://kanlungan.org.uk/wp-content/uploads/2020/07/A-chance-to-feel-safe-report.pdf

the main social determinant of health inequality is income. The poorer you are and the more precarious your employment, the more exposed you are and the more likely you are to die.

11. Care sector workers are some of the lowest paid workers in the country even when they have the benefit of a permanent employment contract. Outsourced workers, who lack the contractual protection and bargaining power to demand safer conditions from their employers, were at even greater risk. Migrant care workers were all the more vulnerable; when immigration status is tied to employment, you cannot refuse unreasonable demands from employers without losing both your job and your home. Migrant workers who were undocumented or had overstayed had no protection at all.

Care home workers:

Understaffing:

12. The Group's care sector members report low staff retention and chronic understaffing pre-pandemic. Self-evidently, a lack of sufficient staff leads to unsafe working environments. This was inevitably exacerbated when the virus ripped through the care sector.

13. Outsourced workers covering pre-existing staffing shortages, had to take on increased workloads and job variations without training or consultation. Care home workers with precarious contracts often worked in more than one care home, as they were sent to fill gaps caused by understaffing and staff sickness. This further increased the risk of virus spread when infection control in care homes was not properly managed.

14. The causes of understaffing are multi-faceted. Low pay is plainly a major consideration. The precarious nature of outsourced employment is another. Group members undertaking bank and agency work in the private sector put pre-COVID understaffing, in large part down to profit margins. As one of the Group's interviewed workers put it: "It's about profit, not about proper care".

15. An understaffed sector cannot be resilient. The root causes of understaffing have to be understood and addressed. The Government's post-pandemic response to the shortage of workers in the sector was to issue employment linked visas to 70,000 overseas workers in 2023, in effect outsourcing the problem internationally and subsidising the cost of care in the UK through low wages. This does not address the root cause of the problem. In the context of this Government's hostile environment policies, it creates precisely the further sub-class of worker that the Group's members have reported.

    i. Migrant workers being disproportionately allocated to higher risk working environments, and unable to object because their immigration status is dependent on them maintaining their contracts of employment.
    ii. Workers with No-Recourse to Public Funds (NRPF) conditions applied to their visas finding themselves destitute in the event of sickness.
    iii. Workers with NRPF conditions fearful of seeking medical treatment due to the risk of debilitating medical charges or negative immigration consequences.
    iv. Sick workers, with work dependent immigration statuses, being pressured to return to work before they were well enough, in order to cover the staff shortages that have not been properly addressed.
    v. No Recourse to Public Funds (NRPF) conditions prevent those most exposed to danger from accessing appropriate services and support.

16. If migrant workers are to fill the gaps caused by an under-funded, privatised system, then they have to be properly treated and protected when they do so.

PPE:

17. Group member's report a total lack of PPE in care homes at the outset of the pandemic, leaving them exposed and unprotected when hospital patients were discharged into their care. As one of many examples: at a nursing home in North London, UVW workers took to making their own masks by laminating pieces of plastic, and then fixing them around their heads with elastic that they

sourced from their leggings. When they were eventually provided with masks, they were given one single use surgical facemask, for each 12-hour shift. Many workers had to source and buy their own PPE.

18. When employed staff were finally provided with PPE, outsourced staff, without the employment protections of their “in house” colleagues, were often forced to work without the same protection.

19. When PPE was provided it was frequently in the face of employer intransigence, obstruction or refusal; after their employed colleagues had received theirs. It was often of a lower standard, inadequate and ill-fitting, and provided without guidance on usage.

20. There are frequent examples of direct-contact care staff raising concerns with their employers about chaotic mismangement; in part arising from the fact that the care sector lacked the infrastructure that the NHS had, in part because of a lack of accountability in some parts of the private sector. They report failures to observe regulations and protocols on preventing the spread of the virus; the refusal of staff requests to isolate patients and employers ignoring staff concerns about the admission of hospital patients who clearly should have remained in hospital. Care workers reported that management failed to enforce restrictions on visitors to care homes, putting residents and workers at increased risk, and demonstrating a concerning lack of regulation and oversight.

21. Outsourced workers report employers refusing to provide sick pay. The inadequacy of Statutory Sick Pay (the default pay protection of outsourced workers) led to sick workers facing destitution or in some cases, facing no option but to continue to work despite that sickness.

22. Employed staff had increased access to the vaccination programme, whilst outsourced colleagues, who worked alongside them, did not.

Domestic/domiciliary workers:

23. Domestic/domiciliary care workers make up a large cohort of the Group's members, particularly the Kanlungan membership. Many have employment contracts that form the basis for their continued immigration status, often with NRPF conditions attached.

24. A large proportion have irregular immigration status and are informally employed without contracts. Their roles often involve giving complex care to elderly and/or disabled people, and they often work long hours with little time off, and/or provide 24/7 live-in care.

25. During the pandemic, domestic workers in both categories were exposed to significant risk through a lack of PPE provision, and through an expectation to continue caring when either they or their employers were infected with Covid-19. Many of their employers are at greater risk of serious illness and death from the virus. This put additional pressure on workers' behaviour and movements, and in some cases, employers' expectations passed the threshold into coercive control and abuse. Kanlungan reports members who were coerced by their employers and/or employers' family to self-isolate with their employer whilst they had Covid-19, but provided no subsistence for the worker who as a result had no access to food, medicine and other essential items.

26. These workers were invisible to national statistics and so did not inform, what were already significantly higher infection, and subsequently mortality, rates in ethnic minority communities.

27. They faced the same issues as their outsourced colleagues and their documented colleagues but with the additional burden of the Government's hostile environment policies.

28. Those policies forced irregular migrants into exploitative work, with wages around £6 an hour and examples of live-in carers working a 60-hour week for £2 an hour. SSP and other support were inaccessible to the undocumented, pushing them into "no work no pay" positions and transient and crowded

housing, making it all the more difficult to stay safe from the virus. As one member put it “When you have nothing, you cannot say ‘No’”.

29. The hostile environment also deterred members from seeking healthcare, including testing and vaccination, for fear of deportation. Charges for NHS care, at up to 150% of cost, were prohibitive and debts to the NHS led to data-sharing with the Home Office.

30. Members of IWGB’s Nanny and Au Pair branch were often employed as carers on an informal basis without access to the legal recourse on which formally employed workers can rely. The Group appreciates that the care of children will be dealt with in a later module and hopes that this specific sector of informally employed, often migrant worker will be considered then.

Impact:

31. The Group’s membership experienced the grief and the fear and the strain of their colleagues and patients. They cared for residents who should have been in hospitals, and they were with them when they died. They did so whilst exposed and unprotected themselves, taking the virus back home to their own families when they finished work. They did all of that on a wage that cannot be lived on, in work that is wrongly considered to be menial.

32. In the words of one of the Group’s members, a worker who refused to move when management told her to go to the care home window to acknowledge clapping: “I don’t need claps. I need proper PPE and dignified pay”.

Provisional scope:

33. The Group appreciates that the scope is provisional and dependent to a large extent on the material obtained under the Rule 9 process. In making those Rule 9 requests, we ask that the Inquiry consider the experience of the Group’s membership and ensures that that informs the subsequent list of issues.

34. In respect of Provisional scope point 2:

The structure of the Care Sector and the key bodies involved in the UK and Devolved Administrations at the start of and during the pandemic. This will include staffing levels and bed capacity immediately prior to the pandemic.

35. When expert evidence is sought on structure and capacity, we submit that it should include a full breakdown of providers: including the proportion of Local Government, NHS, and private employers across the sector.

36. Where capacity is found wanting, there has to be an analysis of the rationale behind that failure in capacity. We appreciate CTI's emphasis that the **pre-pandemic state** of social care services is only part of the Inquiry's terms of refence when it is necessary to understand how the pandemic impacted on those services. We submit that no meaningful recommendations can be made without an analysis, not just of the staffing levels in the sector but the reasons for those staffing levels. In a sector such as this, where understaffing, recruitment, retention, pay, working conditions and underfunding are historic problems, the analysis has to be able to explore the history.

37. The analysis must look at pay and conditions. It should look at the percentage of workers in precarious employment; outsourced, agency, bank, and zero hours contract positions (a) across the whole sector and (b) as a comparison between the public and private sectors. And it should look at the rationale for placing keyworkers such as these in these positions of precarious employment.

38. The structural analysis should examine the percentage of staff from migrant backgrounds, with work visas linked to their employment.

39. In respect of the domiciliary care sector, an analysis of the extent to which that is regulated and, to the extent that it is possible, estimates of the contribution of undocumented workers to the sector.

40. Provisional scope point 3: *The key decisions made by the UK Government and the Devolved Administrations in respect of the Care Sector, including the decisions relating to the discharge of people from hospitals into adult care and residential homes in the early stages of the pandemic.*

41. This analysis must include the consideration given to the impact on staff and the particular need to protect them, given that the government knew they were in the most deprived quintiles of the working population. The evaluation of that consideration should extend to specific categories of staff who were all the more vulnerable due to their precarious employment and their immigration statuses.

42. If there are to be regional analyses conducted: Bearing in mind that the significant majority of care staff in London were from ethnic minority backgrounds, the analysis must include the consideration of staff who had been made vulnerable by hostile environment immigration policies.

43. Provisional scope point 4 and 8: *The management of the pandemic in adult care and residential homes. This will include the measures preventing the spread of Covid-19, such as infection prevention and control measures, testing for Covid-19, the availability and adequacy of personal protective equipment (PPE), restrictions on access by/to healthcare professionals and visits from loved ones.*

    8: Infection prevention and control measures for those providing care in the home, including by unpaid carers.

44. When expert evidence is sought in respect of infection prevention and control, we ask that that includes:
    i. Evidence on the surface transmission time of the virus, the impact of that on decontamination/cleaning staff and processes and the consideration given to those workers.

ii. An analysis of the failure of PPE supply chains and an exploration as to why PPE was not available for care sector staff.

Katharine Newton KC

Old Square Chambers

Piers Marquis

Doughty Street Chambers

On behalf of the Public Interest Law Centre.

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