IN THE UK COVID-19 INQUIRY

Before the Right Honourable Baroness Hallett D.B.E.

MODULE 6 PRELIMINARY HEARING:
SUBMISSIONS ON BEHALF OF THE NATIONAL ASSOCIATION OF CARE AND SUPPORT WORKERS

Introduction

1. The National Association of Care and Support workers ('NACAS') expresses its gratitude to the Chair and the wider Inquiry team for designating it as a Core Participant ('CP') in Module 6. NACAS welcomes the opportunity to assist the Inquiry to fulfil its Terms of Reference ('ToR').

2. NACAS was established in 2016 as an independent professional body that advocates for care and support workers, promotes the recognition and value of their work and provides them with support, education and other resources. Prior to its conception, there was no dedicated professional organisation that provided a voice for care workers. Its ethnically diverse and growing membership (of about 12,500) work in the full range of adult social care roles across the frontline care and support worker profession, including within care homes and homecare, whether employed, self-employed or engaged on zero-hours contracts.

3. Pre-pandemic, and even more acutely during it, the care sector relied on the sense of commitment and responsibility of care workers who are most often themselves vulnerable as a result of their class, gender, ethnicity and/or immigration status. The overwhelming majority of the UK's 1.5 million care workers are women (80%) and Black and Minority Ethnic groups and migrant workers are significantly over-represented as compared to the general population (21% cf. 14%; 17% cf. 13%, respectively). One in five live in poverty. As a result, care workers suffered the terrible impact of Covid-19 disproportionately. The mortality rates for those employed in social care were among, if not, the highest by occupation in the UK.[1] It is in those most adverse of conditions that care workers, who were often overwhelmed, drained and exhausted, worked to deliver services.

4. Those services and the act of caring itself involves an emotional investment in and a commitment to those in need. It follows that NACAS's membership were and remain deeply concerned for those whom they cared for during the pandemic. It is only in the knowledge that the bereaved are well-represented and to avoid repetition that the principal focus of these submissions is on the impact on care workers.

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[1] See ONS data here.

Scope of Module 6

5. The pandemic confirmed and magnified what had been publicly and authoritatively declared with alarming regularity long before Covid-19 emerged: social care in the UK is in crisis.[2] In the experience of NACAS and based on the available post-pandemic research[3], the root causes of that crisis are the same unaddressed systemic and structural issues that impacted the ability of social care to respond to Covid-19, including by implementing protective measures, effectively: **(a)** a fragmented and unintegrated social care sector; **(b)** a lack of care sector visibility and representation; **(c)** unclear accountability; **(d)** inadequate regulation; **(e)** insecure funding, fragile business models and a resultant scarcity of investment, and **(f)** an overburdened, underpaid and undervalued workforce operating in some of the worst working conditions in the UK; all of which had been exacerbated by a decade of austerity.

6. It follows that while NACAS recognises, as set out in CTI's note at §21, "*that it is not part of the Inquiry's Terms of Reference to consider the state of the adult social care systems in the United Kingdom prior to the pandemic, save where necessary to understand how the pandemic impacted on adult social care*", it expects the Inquiry will find it necessary to give careful and detailed consideration to aspects of the pre-pandemic adult social care systems if it is to understand how and why the pandemic impacted those systems with such devastating consequences.

7. At this stage, taking up CTI's invitation to identify broad areas of inquiry that the CPs would wish the Inquiry to consider as part of its provisional scope, NACAS invites the Inquiry to consider the following areas, all of which are rooted in its experience, a survey of the membership ahead of the preliminary hearing (the results of which are appended to these submissions) and the available research:

   a. Was the care sector sufficiently involved in pre-pandemic planning? Was the learning from that planning disseminated to and embedded in frontline care services and training and guidance for care workers?

   b. Did the sporadic funding arrangements for the care sector impact on the pandemic response, including strategic planning and the robustness of the

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2 J. Elias et al, *Towards a New Deal for Care and Carers,* Report of the PSA Commission on Care (2016), commissioncare.org.

3 Scottish Covid-19 Inquiry Research found here; Natasha Curry, Camille Oung, Nina Hemmings, Adelina Comas-Herrera and William Byrd, B*uilding a resilient social care system in England What can be learnt from the first wave of Covid-19?*, LSE and Nuffield Trust Research report (May 2023); Janine Owens, Alys Young, Rosie Allen, Amelia Pearson, Patricia Cartney, Catherine Robinson, Rebecca McPhillips, Sue Davies and Martyn Regan, *The Impact of COVID-19 on Social Care and Social Work in the UK: A Scoping Review*, British Journal of Social Work (2023) 00, 1–20; Jermaine M Ravalier, Paula McFadden, Patricia Gillen, John Mallett, Patricia Nicholl, Ruth Neill, Jill Manthorpe, John Moriarty, Heike Schroder, Denise Curry, *Working Conditions and Well-Being across the COVID Pandemic in UK Social (Care) Workers*, British Journal of Social Work (2023) 53, 1225–1242.

sector including its bed capacity, workforce, infrastructure and PPE stockpile?

c. Did the business models for the care sector impact on the pandemic response? Was there a difference in the response as between public, small-scale private and large-scale private care providers?

   (NACAS notes that both private and public models are expressly identified in the ToR. There is evidence, for example, that pay and conditions in the few remaining publicly owned care homes are better[4]; such conditions lead to better staff retention rates[5]; the financialisaton of a significant part of the sector by large corporate providers has led to a reduction in investment in staff and physical infrastructure[6], and all of those issues are thought to have contributed to the pandemic response).

d. Were, and if so, when were the views of the care sector appropriately represented in scientific, civil service and central government bodies and decision-making?

e. When was a central government plan developed for adult social care? Was it adequate?

f. Were the lessons to be learned from the experience of the social care sectors in other countries which the pandemic reached first considered and implemented?

g. Was there adequate coordination at a national and local level between the health and social care sectors? Did the integrated health and social care systems in Scotland and Northern Ireland lead to better outcomes than the fragmented systems in England and Wales?

h. Was the care sector adequately consulted about decision-making and changes to rules and guidance?

i. Were the structure, diversity and roles of the social care workforce (including, for example, the particular challenges faced by the self-employed and agency staff) understood and taken into account when rules and guidance were being developed? Was prompt consideration given to the availability of testing and PPE (particularly for the

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4 International Labour Organisation, *Care Work and Care Jobs for Future of Decent Work*, Geneva: International Labour Office, ILO (2018), p.xli: "*public provision of care services tends to improve the working conditions and pay of care workers, whereas unregulated private provision tends to worsen them, irrespective of the income level of the country"*; see also Bowman (2015) cited in D. Burns, L.Cowie, J.Earle, P.Folkman, J.Fround, P.Hyde, S.Johal, I.Rees Jones, A.Killett and K.Williams, *Where Does the Money Go? Financialised Chains and the Crisis in Residential Care, Centre for Socio-Cultural Change Public Interest Report* (March 2016), p.21, which notes that hourly wages in the few care home still operated by local authorities are on average higher than they are in private care sector.

5 Read and Fenge, *'What does Brexit Mean for the UK Social Care Workforce?'*, p.679.

6 Emma Dowling, *The Care Crisis What Caused It and How Can We End It?,* (Verso, 2022), p.127-139.

self-employed) and the impact of the absence of sick pay for many care workers?

j. Was the impact on care workers of the decision to discharge untested patients into adult social care adequately considered? What support and guidance was made available to care providers and care workers to assist them care for such patients? How did care workers' roles change when required to care for those with Covid-19?

k. Was any criticism that has been made of care workers for contributing to the spread of the virus, including into and between care settings, justified and/or fair?

l. What financial and other support was available for care workers during the pandemic? Was it available consistently across the UK and within the four countries? Was it comparable to the support available to healthcare workers?

m. Was the additional funding provided by central government during the pandemic to the care sector adequate and timely? How much of that funding reached frontline care services?

n. Was there a robust and comprehensive understanding of who uses and provides care at national and local governmental level? Were there clear lines of communication between national and local government to all stakeholders across the dispersed care system? Did any communication issues lead to a less coordinated and uneven care sector response?

o. Were the rules governing Do Not Attempt Cardiopulmonary Resuscitation ('DNACPRs') and visitation that care workers were expected to implement necessary and fair to care home residents and families?

p. Was clear, practical and timely guidance governing isolation, testing, infection prevention and control, DNACPRs and visitation issued to the care sector?

q. Did any such guidance take into account the complexity of adult social care infrastructure, in particular residential care buildings and equipment, the capacity of small organisations to interpret and accommodate ever-evolving guidance and the ability of frontline care workers to implement it in practice?

r. Did any such guidance specifically consider the position of frontline care workers? Was it adequately communicated to them?

s. Was appropriate consideration given to the impact on care workers of the mandatory nature of vaccination requirements imposed by some employers?

t. Did any or all of the following factors contribute to the pandemic response by the social care sector: **(i)** low pay (that in as much as 11% of cases may be below the minimum wage[7]); **(ii)** poor working conditions (including, for example, the non-payment for travel time, telephone calls and transport costs); **(iii)** increasing workloads including unsafe staff to client ratios; **(iv)** insecure employment (approximately 25% of carers are on zero hours contracts rising to 60% concerned in homecare); **(v)** the low status attributed to the work of caring; **(vi)** its false characterisation by some as unskilled work; **(vii)** the lack of opportunities for training and career progression; **(viii)** workforce shortages; **(ix)** low staff retention and high turnover rates; and **(x)** the absence of professional regulation for most social care jobs?

u. Were care workers disproportionately affected by the pandemic including in terms of sickness and mortality rates, their mental health and the financial implications?

v. Were the consequences of systemic issues with, for example, funding and investment borne by frontline care workers? If so, what were they?

w. Did the impact of the pandemic differ for those who were employed, agency workers and self-employed, including those on zero hours contracts?

x. What changes should be made to address the systemic and structural issues within the care sector that impacted on the pandemic response to ensure that, in the event of a further pandemic, the response of the care sector is effective?

y. Have any of the changes adopted to date by government been effective? Have any changes had unintended consequences such as contributing to the exploitation of vulnerable care workers?[8]

8. NACAS recognises that a number of these areas may form part of the Inquiry's work in other modules. It takes the opportunity to identify all the issues of concern to its membership and notes that it may be appropriate for those overlapping issues to be addressed in Module 6 insofar as they relate to the impact of the pandemic on care workers.

Care settings

9. NACAS understands that, as set out at ILT's note at §20, for pragmatic reasons the Inquiry must focus its attention on certain care settings and

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7 Low Pay Commission and Resolution Foundation research cited in Department for Business, Innovation and Skills and HM Revenue Customs, *Ensuring Employers Comply with National Minimum Wage Regulations,* London: National Audit Office (2016), p.120.

8 Unseen UK, *Who Cares? A Review of Reports of Exploitation in the Care Sector* (2023): see here.

considers that adult residential care homes and homecare will provide the Inquiry with a sufficient evidential base to make meaningful recommendations.

Factual evidence

10. Appended to its CP application were some of the examples of the type of evidence that **(a)** NACAS could provide to the Inquiry of its role in the care sector response and **(b)** evidence the NACAS membership could provide (which, if it would assist the Inquiry, NACAS could collate). The examples included **(a)** the adequacy and availability of PPE, testing, training and guidance on a number of topics; and **(b)** the impact of policies such as DNACPRs and infection and prevention control measures on care workers and those for whom they cared.

Expert evidence

11. NACAS notes the contents of ILT's note at §33c. NACAS would not wish to prioritise any one particularly vulnerable group over another, but notes that those who were less or unable to understand what was happening to them during the pandemic presented particular challenges for care workers, which may warrant close attention by the Inquiry.

Disclosure

12. NACAS notes and respectfully adopts the submissions of other CPs in earlier modules about the prompt provision of disclosure to ensure CPs have adequate time to prepare and contribute to the Inquiry's work.

13. As a new CP in the Inquiry, and as suggested at §45 of ILT's note, NACAS would also be grateful if the Inquiry could direct it to the relevant parts of the evidence from earlier modules, including the oral evidence, that touch on the issues in Module 6.

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