IN THE MATTER OF THE UK COVID-19 INQUIRY
BEFORE BARONESS HALLETT

SUBMISSIONS ON BEHALF OF
THE FRONTLINE MIGRANT HEALTH WORKERS GROUP
FOR THE THIRD PRELIMINARY HEARING IN MODULE 3, 10 APRIL 2024

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1. These submissions are provided on behalf of the Frontline Migrant Health Workers Group (FMHWG), consisting of the Independent Workers' Union of Great Britain (IWGB), United Voices of the World (UVW) and Kanlungan Filipino Consortium (Kanlungan), in advance of the third preliminary hearing in Module on 10 April 2024.

2. Our brief submissions respond to information received in the Inquiry's recent update notes and CTI's note of 13 March 2024.

Rule 9 requests

3. We are grateful for the Inquiry's update on the progress of the Rule 9 evidence gathering progress and welcome the Chair's decision to issue section 21 notices to those departments/agencies whose responses are overdue. Given the centrality of those departments in the pandemic response, it is particularly concerning that their evidence is so delayed. We appreciate that the preparation of this evidence is a substantial task, but there is insufficient justification for their delay and there is a risk that Core Participants (CPs) will be unable to properly engage with the existing disclosure without the context provided by these central departments' evidence.

4. For this reason, we reiterate submissions made by other CPs in previous hearings and modules that the Inquiry would be assisted by both disclosure of the Rule 9 requests and a direction for the state CPs to provide position statements. This would allow the

Chair and CPs to understand the key points of the evidence that state CPs will provide, and their position on the key questions to be examined in this module as their evidence relates to it. This is a particular concern given that disclosure was still being made throughout the public hearings and after closing submissions in Module 2. Such delays to disclosure present a barrier to engaging with evidence collected from the government and public bodies which, for example, may need to be raised in opening submissions and which may not receive adequate scrutiny if disclosed during or after witnesses have given oral evidence.

5. We understand the gravity of the task before the Inquiry, and we respectfully submit that position statements would go some way to reduce disadvantage to CPs in properly analysing the disclosure of state CPs where there is a possibility that a similar schedule of disclosure will take place in Module 3.

6. We also support the Covid-19 Bereaved Families for Justice UK in their submissions that the Rule 9 witness statements received from state bodies thus far have been too general in nature and that further detail ought to be sought.

Spotlight hospitals

7. We note the information provided concerning the spotlighting of 22 particular hospitals in collecting evidence in Module 3. We agree with the Inquiry's approach with regard to spotlight hospitals and provide some brief submissions on points that ought to be considered in order to obtain all relevant information.

8. With regard to the topics covered in the Spotlight Rule 9 requests at paragraph 13 of CTI's note to the Inquiry dated 13 March 2024, we respectfully submit that the Inquiry Legal Team should ensure that the following points are addressed:

    - 13a. Staff shortages prior to and during the pandemic - respondents ought to speak to the proportion of outsourced staff that worked in the hospital, in both clinical and non-clinical roles, and the proportion of migrant staff with work dependant visas, in both clinical and non-clinical roles and the extent to which staff shortages impacted on this cohort of staff.

- 13b(i). The practical effect of efforts to increase staff capacity – respondents ought to speak to how the use of private sector contracts was employed in attempts to increase staff capacity.

- 13c. The impact of redeployment of staff to different specialisms or to different hospitals – respondents ought to speak to how decisions with regard to which staff were redeployed were made; whether protected characteristics of staff were considered in these decisions; whether equality impact assessments took place in the preparation of redeployment policies; and what steps were taken to protect the safety and wellbeing of redeployed staff.

- 13d. Vaccination as a condition of deployment – the impact of vaccination conditions on staff on precarious contracts.

- 13e. Any difficulties in disseminating and implementing IPC guidance – what actions, if any, to liaise with companies delivering outsourced services with regard to best practice for disseminating and implementing IPC guidance to outsourced staff; what actions, if any, were taken to ensure delivery of IPC guidance and training was provided to outsourced staff in languages other than English.

- 13g. Issues relating to obtaining PPE (both in terms of quantity and quality); respondents ought to speak to the distribution of PPE, once obtained, including whether the hospitals ensured distribution to outsourced staff.

- 13j. Impact of the pandemic on the health and wellbeing of those working in the healthcare system, including Long Covid: the analysis of that impact to include both clinical and non-clinical staff, outsourced and "in-house" staff.

9. We support the Covid-19 Bereaved Families for Justice UK in their submissions that it is insufficient that the Rule 9 requests concerning spotlight hospitals have been made to senior managers only. It is respectfully submitted that it is essential that evidence is obtained from staff on the frontline in these hospitals to consider them to have been adequately 'spotlighted'. Senior management are not in a position to provide this frontline evidence and the voices of frontline staff, in both clinical and non-clinical roles, ought to be heard.

Impact evidence

10. We are grateful to the Inquiry for inviting the Frontline Migrant Health Workers Group to provide a list of proposed witnesses to give evidence at the public hearings and are in the process of preparing this list. We require some additional information with regard to anonymity and accessibility concerns raised by some potential witnesses before providing our list.

11. We take this opportunity to reiterate the importance of the first-hand experiences of frontline migrant workers in precarious jobs in the pandemic response and the crucial role they played in caring for patients, infection control, facilitating Covid testing and more. They often undertook this work with little to no protection, either by way of PPE to protect them from infection or contractual protections to prevent them from being exploited by their employers when they raised concerns.

12. As low-income, precariously employed migrant workers, many of our clients' cohort of members are vulnerable as a direct product of these circumstances. Their contracts are precarious with little protection from unfair dismissal or discipline, their leave to remain is often directly tied to their employment, and they broadly receive low wages. Many of them also have caring responsibilities and serious health conditions including Long Covid following the work they undertook in the pandemic response. For these reasons, there may be practical barriers for many of our proposed witnesses to giving oral evidence in-person at Dorland House, and/or concerns regarding anonymity.

13. We seek direction from the Chair for these proposed witnesses whose evidence is essential to the module, but who fear reprisal from their employers if they give public evidence, or whose caring responsibilities or disability prevent them from travelling to the hearing without undue burden.

14. We request that Counsel to the Inquiry provide information as to

    (a) whether arrangements can be made for witnesses to give evidence anonymously in these circumstances and

    (b) whether arrangements can be made for witnesses to give evidence remotely where it would be unduly burdensome for them to attend in person.

Disclosure

15. We are grateful for the Inquiry Team's ongoing work to collect and prepare disclosure in Module 3. We are conscious that there is likely to be a very large volume of disclosure given the breadth of this module and it is essential that CPs have adequate time to consider this. In Module 2, over 100,000 pages were disclosed in the six months before the public hearings, a further over 100,000 pages were then disclosed in the month preceding the public hearings, followed by further disclosure during public hearings and after closing submissions. This process of disclosure plainly restricts the ability of CPs to scrutinise evidence to any reasonable degree.

16. We respectfully request urgent clarification from the Inquiry with regard to the predicted number of documents and schedule of disclosure so that we can adequately prepare for the resourcing needed . As mentioned above, we are concerned about the impact of the disclosure of further documents after the beginning of public hearings and hope that all necessary actions are taken to avoid and minimise this .

17. We support the submissions of the Covid-19 Bereaved Families for Justice UK that a clear roadmap for disclosure must be provided to CPs and that all tranches of disclosure must be made by the end of June 2024. We respectfully request that the Chair uses all the powers at her disposal to ensure this.

Experts

18. The Inquiry has received our separate representations dated 27 March 2024 (see our Annex A) that the Chair and CPs would be assisted by the instruction of an expert in the use of private sector contracting and outsourcing in the healthcare systems at the outset of and during the relevant period. We do not seek to repeat those representations here, but briefly summarise our reasons below for completeness.

19. The use of private sector contracts and outsourcing across clinical, surgical, non-clinical, facilities and equipment services in the healthcare systems was varied and prevalent across both primary and secondary care. Furthermore, the use of private sector contracting dramatically increased during the relevant period in attempts to meet surging demand. There have been significant concerns raised from within and outside the healthcare sector about the impact of private sector contracting on the healthcare system with regard to unfavourable contract terms and value for money,

fairness of tendering processes and the impact of approved supplier lists, varying standards of patient care, efficiency of collaboration with public services, working conditions and the overall impact on healthcare efficiency over time.

20. Not only is the use of private sector contracting of particular relevance to Module 3's scope of analysis, the network of private and public services across the healthcare system is highly complex. There is broad variation in the extent to which different health trusts, primary care practices, and hospitals use private sector contracts and blended private and public services often take place in the same setting. This undoubtedly has an impact on service outcomes but it is impracticable for CPs to properly analyse the varied use of private sector contracting and its impact on the healthcare systems without expert assistance.

21. For this reason, we submit that the Inquiry would be greatly assisted by instructing an expert to comment on the following:

    - the network of services in the healthcare systems that were privatised and those which were public, and the contracting relationships between the public and private bodies involved;
    - how the use of private sector contracting evolved over the course of the pandemic; and
    - what impact these contracts have had on funding, working conditions, standards of care and effectiveness of pandemic response.

22. We submit that Dr John Lister of Coventry University, or Professor David Hall of University of Greenwich Public Services, International Research Unit are the primary experts in this field and are best places to provide expert evidence on this subject.

<u>Public hearings</u>

23. We note that the Module 3 public hearings are currently scheduled for a period of 10 weeks commencing on 9 September 2024. The current schedule allows only 40 days in total for evidence to be heard. Considering the breadth of the questions to be answered and evidence to be considered, we respectfully submit that this appears to be an underestimation of the time required. We are concerned as to whether the Inquiry will be able to fulfil its Terms of Reference if only this time is allowed. Given this our clients believe that a significant period of additional time is required for the Inquiry

to meet its Terms of Reference and to ensure that witness evidence can be explored by CTI and non-state legal teams.

Provisional outline of scope

24. We support the submissions of Mind, and other Core Participants, on the urgent need for mental health to be included as a key area of examination in Module 3. We understand that the Inquiry's position is that there is insufficient time to consider this topic beyond the limited scope of in-patient mental health services for children. However, we submit that that mental health is fundamental to an understanding of the impact of the pandemic on the healthcare systems, and adequate time must be provided to consider it. Mental health is not a subordinate or complimentary aspect of health, it is essential, often life-changing or life-threatening, and constitutes one of the most wide-reaching impacts of the pandemic on public health.

25. With particular reference to FMHWG's members, the trauma of working unprotected, physically and contractually, on the frontline of a pandemic cannot be understated. They carried the stress of an understaffed healthcare system and worked through their fear, uncertainty and exhaustion to provide essential services in the pandemic response. The impact of these experiences on these workers' mental health, and the ability of the healthcare systems to respond to the pandemic as a result of healthcare workers' declining mental health, is paramount to the task at hand in this module.

26. We remain at the Chair and Inquiry Team's service.

27 March 2024

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Annex A

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Baroness Hallet
UK Covid-19 Inquiry

By email only: 03modulesolicitors@covid19.public-inquiry.uk

27 March 2024

Dear Baroness Hallet,

Representations for expert evidence in Module 3

We write on behalf of the Frontline Migrant Health Workers Group to make submissions for additional expert evidence in Module 3.

FMHWG welcomes the Chair's decision to disclose expert evidence on health inequalities and pandemic preparedness from previous modules. The reports of Professors Marmot and Bambra and Drs Kirchelle and Lancaster are clearly comprehensive and pertinent with respect to health inequalities and UK pandemic preparedness.

However, we submit that what these reports do not cover is an analysis of the use of the private sector when contracting and outsourcing in the healthcare systems. In addition the reports do not cover the impact on healthcare resources and value for money, standards of care, effectiveness of pandemic response, and working conditions of healthcare staff in the context of the level of outsourcing.

The importance of private sector contracting in Module 3

Private sector contracting in the healthcare systems has steadily increased since 2012, and the private sector share of NHS spending rose by 25% during 2020-21 in attempts to meet surging capacity. This demonstrates the importance of private sector contracting both in the state of play of the healthcare systems at the outset of the pandemic, and in the response to the pandemic within the healthcare systems and departments.

The Provisional Outline of Scope recognises the salience to Module 3 of considering the use private hospitals in the pandemic response. However, the use of private sector contracting in the healthcare systems is prevalent across both primary and secondary care, within and alongside public hospitals, and in both clinical and non-clinical services. These services are all central to Module 3's analysis, and the role of private sector contracting is a fundamental aspect of how they were able to respond to the pandemic and how they evolved over the course of the pandemic.

The need for expert evidence

We submit expert evidence on the use of private sector contracts and outsourcing in the healthcare systems is essential to the Inquiry because of this subject's importance to Module 3's analysis and because it is highly complex. The network of private contracts, including fully outsourced services, public services with a private element, public hospitals with private equipment and/or testing services, private staffing within public hospitals is not possible for Core Participants to map out without expert assistance.

The Inquiry must undoubtedly consider these matters in order to fulfil its terms of reference, and we submit that it will be impracticable to do so without an expert report that comments on:

- the network of services in the healthcare systems that were privatised and those which were public, and the contracting relationships between the public and private bodies involved;
- how the use of private sector contracting evolved over the course of the pandemic; and
- what impact these contracts have had on funding, working conditions, standards of care and effectiveness of pandemic response.

To elaborate on the importance of this subject to the module, there have been serious concerns raised, from both within and outside the NHS, about the impact of private sector contracting and outsourcing on UK healthcare systems. These include:

- **Cost** – outsourced healthcare contracts are often expensive and involve unfavourable contract terms for public sector healthcare trusts. This depletes public sector NHS funding that was already dramatically reduced by public spending cuts from 2010 onwards.

- **Tendering** – many private sector contracts are now awarded through framework agreements and approved supplier lists rather than a genuine competitive tender. This removes the opportunity from in- house NHS bodies to apply to carry out these services and drives down standards through lack of competition.

- **Standards of care** – there are several examples of substandard care in healthcare services managed by private sector organisations.

- **Confusion between public and private services** – the working relationships between public and private providers of care are often inefficient, impractical and difficult to understand even by those working in them. This is often an uneven standard of both care and employment amongst already confusing NHS reorganisation.

- **Lack of reinvestment in NHS** – private sector contract fees are paid to private interests and result in a lack of reinvestment in the NHS and public sector health services.

- **Reduction of NHS workforce** – private sector hospitals are not involved in training clinical staff so their employees must be gleaned from the NHS cohort.

- **Management consultancy** - expensive management consultants have provided little value at huge cost whilst NHS staff have suffered consistent real-terms wage loss. There have been no audits of the use of management consultants in the NHS.

- **Working conditions** – support staff / non-clinical staff outsourced into private sector employment have experienced significantly worse pay, contractual terms and treatment at work.

Our clients are particularly aware of this because of the direct impact that outsourcing has had on them, their working conditions and the risk and harm they were exposed to during the relevant period of the pandemic. However, in addition to their own concerns, they are also acutely aware of the wider impact of private sector contracting on the healthcare systems which is relevant to all CPs, and indeed the whole nation.

We understand the matter of procurement will be dealt with in detail in Module5. However, we submit that the subject of healthcare privatisation and its impact on the pandemic response of the healthcare systems goes far beyond procurement of PPE and specialist medical equipment alone.

We submit that the Chair and all Core Participants would be greatly assisted by an expert report on this subject in order to properly consider the relationships between the bodies

delivering care, and to understand the structural, logistical and clinical impact that private sector contracting and outsourcing had in the pandemic response from the treatment of staff to the delivery of COVID care, to the delivery of non-COVID care.

In the first instance, we propose Dr John Lister of Coventry University, and/or Professor David Hall of University of Greenwich Public Services International Research Unit, as the primary experts on this subject.

We are grateful to the Chair for her consideration of this matter, and we remain at your service to provide any additional information required.

Kind regards,

PILC

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