FRONTLINE MIGRANT HEALTH WORKERS GROUP

OPENING SUBMISSIONS

Introduction:

1. These written opening submissions focus on the disproportionate impact of the pandemic on outsourced, non-clinical workers and migrant clinical workers; the foreseeability of that impact; the lack of measures put in place to reduce that impact; and the lack of consideration applied to them in the core-decision making process. They conclude with preliminary recommendations that we shall expand upon on closing.

The Group:

2. The Frontline Migrant Health Workers Group ("The Group") is a collective of two, non-TUC affiliated trade unions, United Voices of the World (UVW) and Independent Workers' Union of Great Britain (IWGB), and Kanlungan, a consortium of Filipino/Southeast Asian community organisations. Kanlungan members work across the healthcare sector, as nurses, healthcare assistants and cleaners. In May 2020, about 30,000 Filipinos worked for the NHS and were the largest national group after British and Indian workers[1]. UVW and IWGB have memberships across a number of sectors and include couriers, cleaners, porters, caterers and security staff who work directly within the healthcare system, in the hospitals; as well as private hire drivers who were co-opted into the system over the course of the pandemic.

3. In general terms the Group's members fall into two categories:
    a. Non-clinical workers, the majority of whom were precariously employed in outsourced positions within the healthcare sector, working in the gig economy, as "limb B workers"[2] or on short term contracts. Those members have none of the employment protections of employed NHS staff. That lack of protection and their dependence on private sector employers, left them particularly vulnerable. Largely, but not exclusively, the Group's members in this category are from ethnic minority and migrant backgrounds.
    b. Clinical nursing and healthcare assistant staff, all of whom were from a migrant background. Whilst many of these workers had the benefit of employment contracts, those contracts were linked to their immigration status. In the context of the hostile environment, that status left them particularly vulnerable. When immigration status specifies that a worker has no recourse to public funds, that worker cannot afford to be ill. When immigration status is wholly dependent on continuing employment a worker cannot refuse work that others would refuse.

4. Whilst, in some respects the two categories are distinct, there are a number of commonalities. Four of those commonalities need to be emphasised at this stage.

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[1] INQ000327667/3
[2] INQ000477577/18 § 81 - 82

5. First, these members are working class, in low and under paid employment. The majority of the members are from ethnic minorities and so fall within the protected characteristics of the Equality Act 2010. However, the Group wishes to emphasise at the outset, that systemic issues, like outsourced employment, are applicable across the working class as a whole, regardless of ethnicity.

6. Second, all these members are frontline, essential healthcare workers; without them, hospitals would not function. There would be no healthcare system. It is necessary to emphasise this at the outset because their contributions and sacrifices over the course of the pandemic, were not recognised. It is a clear feature of the Inquiry's disclosure, that there was little or no Government level consideration of these categories of worker at all. They were the unseen, unheard and unsung.

7. Third, all of them worked in a health system that had been broken up, undermined and underfunded for decades. The pandemic started as the first decade of austerity closed. In that decade there had been both a lowering of standards in the safety and quality of healthcare, and a marked decline in the living standards of healthcare workers. Hospital infrastructure was not fit for purpose. 25,000 acute and general beds had been closed. There were 7.5 million people on NHS waiting lists, 1.4 million people in need of unprovided mental health care and 12-hour trolley waits in A&E.[3] Stagnant wages and poor conditions had hollowed out the workforce to such an extent that the NHS was understaffed by over 150,000 workers. Those that remained had to work even harder to fill the gaps.

8. Fourth, the outsourced, low paid or migrant status of the Group's members left them particularly vulnerable to the pandemic, in a way that must have been foreseen. As a whole, they were systematically over-exposed and under-protected.

Outsourced health workers:

9. When the NHS was founded, non-clinical support services, such as cleaning, catering and portering, were an intrinsic and inseparable part of the public health service. Known as ancillary staff, they worked alongside nurses and doctors as part of Ward teams. A cleaner's role as the frontline of infection prevention and control, or a porter's role in patient care and management, was recognised as fundamental. They were employed by the NHS, directly managed and controlled through a public health service, and benefitting from the protection of employment contracts. They knew what their monthly wage would be, they had a public sector pension, and terms and conditions that allowed for guaranteed sick pay and more than statutory minimum holiday entitlement.

10. In 1983, ancillary staff services were the first to be offered out for tender to private providers; the first step in privatising the NHS[4]. Now known as "hotel staff" or "domestics", ancillary staff have had their labour downgraded from a supporting role to one that is wrongly considered by successive governments to be menial and treated as such. Under successive governments in the run-up to the pandemic, there was a steady increase in contracting out, or outsourcing, to the private sector. Outsourcing has extended beyond the privatisation of ancillary services and into clinical services.[5] However for the purpose of the Group's non-clinical members, the

[3] INQ000477577/5-6
[4] Professor John Lister, "Forty Years of Failure", P13
[5] "Forty Years of Failure" Ch 2

focus is on those in ancillary roles, including diagnostic services[6] such as couriers, as well as hospital security staff.

11. This process of outsourcing is a systemic healthcare issue with a number of implications that are highly relevant to this Inquiry. Outsourcing is designed to reduce cost to NHS Trusts and generate profit for the private sector provider.[7] Inevitably, that involves (1) reducing the cost of labour, and (2) reducing the amount and quality of the service provided.[8]

12. The first impacts directly on the workers. Outsourced workers are often contracted on poverty wages[9], with many of them having to take on more than one job to make ends meet. Their hours are often limited or uncertain. Productivity targets result in an ever-increasing amount of work to be completed in a finite time. If outsourced workers receive holiday pay at all, it is limited to the statutory minimum. Sick pay is rarely part of an outsourced contract, invariably it is limited to the inadequately funded statutory sick pay regime. Outsourced workers become an afterthought in a two-tier system of healthcare employees. They are the poorest workers, in the most precarious work.

13. Both (1) and (2) impact on the hospitals themselves. From the perspective of a pandemic, outsourced cleaning is the most obvious example. Poor terms and conditions result in a rapid turnover of workers, who are either unable or unwilling to work so hard for so little. "*Wherever services were contracted out, the most dedicated and experienced cleaning staff, who often had been the staff best able to communicate with and support anxious patients, and supplement the level of care nurses could provide, were stripped out*".[10] Private providers reduced staffing levels and limited the terms of cleaning contracts.

14. Outsourced, "*under-paid and over-worked staff* [were] *required to work strictly to the specification in the contract and* [were] *no longer employed by the NHS or accountable to the ward sister or matron. Tasks that were not in the* [contract] *specification, or which could no longer be done in the reduced hours of work, wound up being done by nursing staff or others – or not done at all*". Pre-pandemic there were clear indications that outsourced cleaning contracts were detrimental to infection prevention and control. "*Plunging hygiene standards… created ideal conditions for the spread of… MRSA and other hospital-borne infections.*"[11]

15. The dominant route of Covid-19 infection was airborne.[12] However, bearing in mind that, "*large amounts of SARS-CoV-2 can survive on inanimate surfaces for several hours*"[13] and that the next virus outbreak may have a greater rate of surface/fomite transmission (whether by contact or droplet infection); it was and is grotesquely irresponsible to wilfully undermine the frontline of infection control, and the workers who maintain it. In the Chair's words: *money spent on systems for our protection is vital and will be vastly outweighed by the cost of not doing so.*[14]

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[6] "Forty Years of Failure" P51
[7] "Forty Years of Failure" P4 - 5
[8] "Forty Years of Failure" P13
[9] INQ000477577/4 §14
[10] "Forty Years of Failure" P13
[11] "Forty Years of Failure" P12-16
[12] INQ000474276/8
[13] INQ000474276/38 § 94
[14] UK Covid-19 Inquiry, Module 1 Report, P2

16. When the pandemic hit in early 2020, around half of the UK's hospital sites had outsourced ancillary services.[15]

The impact on non-clinical workers:

17. The pandemic emphasised and amplified the problems that outsourced workers had been facing for years. Their precarious status was demonstrated in several ways.

18. First, in relation to PPE. Most outsourced workers were still operating without PPE up until the first lockdown in March 2020. In the months that followed, even where PPE was secured it was typically unsuitable, ill-fitting, or in short supply and insufficient to protect the whole workforce. Employers of outsourced staff typically did not provide PPE as a matter of urgency. There was an embedded culture in which workers were considered replaceable combined with a lack of employer accountability and an outlook that put profit first. The result was that outsourced hospital workers were working with even less PPE than their woefully under-resourced NHS employed colleagues.

19. There were outsourced cleaners with little or no PPE working directly alongside in-house staff whose NHS employers had provided it. Some of those outsourced cleaners would then have to go on to their second jobs. Uber drivers were tasked to provide free transportation for NHS workers to and from hospitals but were given no PPE at all. There were couriers, moving to and from cancer wards and pre-natal wards, responding to haemorrhages with bags of blood, who reported clinical staff completely covered up, like "spacemen"; the couriers did not even have so much as a mask.

20. This was a plainly a gaping hole in the infection prevention and control system. It would have been a significant failing in an outbreak where the dominant mode of transmission was fomite. With an airborne virus, it was potentially catastrophic. The under protected workers then had to return to their homes fully conscious of the risks of infecting their families. Kanlungan, UVW and IWGB all made efforts to source and distribute PPE amongst their members. Invariably they did so at a fraction of the cost that Government was paying to their suppliers.

21. The Group has several examples of outsourced workers recognising the risk from Covid well in advance of their managers and pressing for PPE. There are other examples of NHS employed migrant nurses flagging the need for PPE in the early stages. Another area of commonality between migrant and outsourced staff, is that they were generally ignored by both NHS and private employers.

22. A particularly pertinent example is the medical couriers who worked for I & S), a private testing and diagnostic company with a large number of outsourced contracts with the NHS. The couriers had seen a marked increase in testing samples and raised concerns as early as January 2020. They were receiving Covid samples that were not properly packaged and they knew that they were being exposed. They were told that they were over-reacting. They were eventually provided with the bare minimum of PPE and given no guidance on how to use it. When they were grudgingly provided with hand sanitiser, they were given so little that they had to re-fill them from NHS hospitals. Bearing in mind that their employers were a medical testing company, it is remarkable that the couriers' attempt to introduce regular testing, was refused. The grounds were

[15] "Forty Years of Failure" P3

said to be that there was insufficient evidence that regular testing would reduce the spread of the virus among the workforce.[16]

23. Recognising the risk of airborne transmission, the couriers tried to introduce measures whereby they would not have to travel into hospital lifts and Covid wards. They introduced their own social distancing measures in their loading bay, well in advance of Government workplace social distancing. All their initiatives were worker led. It was the couriers who recognised the danger in having workers sent out to different hospitals in I & S, becoming exposed, and then returning to a cramped central hub with no protections in place, before being sent out again to different hospitals. The couriers were the frontline of infection prevention and control at I & S. Ultimately, the Health and Safety Executive investigated I & S and found several contraventions of health and safety law.[17]

24. I & S

25. The lack of contractual sick pay for many outsourced workers is a fundamental issue at any time. A choice between continuing to work whilst unwell or facing prolonged periods without an income is inevitably a key driver in health inequalities. The tragic death of UVW member, and outsourced cleaner, Emmanuel Gomez[19] is a demonstrative example. In the context of a pandemic, this clearly takes on an additional dimension.

26. When employed NHS staff contracted the virus and were required to self-isolate, they could do so in the knowledge that they had a contractual financial safety net. Their outsourced colleagues who did not have contractual sick pay, and whose employers refused to make exceptions in the extreme circumstances, did not have that privilege. The default pay protection for outsourced workers is Statutory Sick Pay (SSP). At the time of the pandemic that stood at £94.25 a week, well below the cost of living. For an outsourced worker, already living hand to mouth, sickness can very rapidly lead to eviction and destitution.

27. There would undoubtedly have been many cases of outsourced workers who were unable to afford to self-isolate and continued to work whilst infected by Covid. The implications for the precariously employed worker and the wider infection control issues are obvious.

28. A functioning state that purports to protect its citizens from a pandemic cannot put hospital workers in a position where they have to make that sort of a choice. As a matter of fundamental principle, every healthcare worker should be able to afford to be ill.

[16] INQ000477577/14
[17] I&S
[18] INQ000474282/3
[19] INQ000477577/25

29. Outsourced workers were particularly exposed to the implications of understaffing. The health system had chronic staff shortages pre-pandemic in any event; and outsourced staff contracts invariably contracted fewer workers than were actually required to do the work.

30. As nosocomial infection rates increased, employed staff who were able to comply with orders to self-isolate did so. 89% of NHS staff absences were reported to be Covid related.[20] Outsourced workers were expected to cover shortages. Some had to take on increased workloads and job variations without training or consultation. Security guards found themselves taking on patient facing roles by covering porter absences. Cleaners found themselves required to cover twice their usual workload in the same time period and reported that this prevented them from having time to disinfect themselves before moving between Covid and non-Covid wards. The risk implications for both the worker and the wider public are self-evident. An understaffed sector cannot be resilient. The root causes of understaffing have to be understood and addressed.

Migrant clinical staff:

31. In the context of dwindling funding, stagnant wages and a lack of UK financial support for nursing training, one strategy that the NHS has used to address the staffing crisis is to outsource recruitment overseas. The NHS actively sought to dramatically increase the cohort of internationally educated nurses, with particular reference to the Philippines, from September 2019 onwards.[21] This international recruitment continued during the pandemic with nursing staff facilitated to travel to the UK with dedicated testing and quarantine exemption regulations for new arrivals.[22] This approach allowed the NHS to expand this cohort of nurses who have more precarious circumstances than most nurses who have trained in the UK – with migration status often dependent on employment, they have considerably weaker bargaining power. In a sense, the NHS was able to outsource its funding pressures and staffing risks onto this more precarious cohort of employees.

32. The disproportionate impact on ethnic minority and migrant staff was apparent to NHS management from the early stages of the pandemic. Yet despite this knowledge, there appears to have been little action taken to inform and protect these internationally educated nurses in an environment in which they were likely to be exposed to a much greater risk than their white British colleagues.

33. The standard visas for skilled or health and care workers require that the applicant is entering the UK to fill a specific job. The conditions of the visa include that the worker has no recourse to public funds (NRPF). That means almost all public funds, including free childcare or disability support (in the event of a long-term condition), which a nurse would normally be entitled to, are excluded. The visas are dependent on the worker maintaining their employment and there are restrictions on any change to that employment. In effect, migrant nursing staff are internationally outsourced, cheap labour; another precarious category of healthcare worker.

34. In the words of a Filipino nurse who has left the UK since the pandemic *'they look at* overseas *workers* as *commodities, whom they buy through recruitment from other countries to get to their land* to *work* as *their* slaves. *We are nothing but a disposable commodity'.*[23]

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[20] INQ000231467
[21] INQ000479043
[22] INQ000479043
[23] INQ000327661/14

35. When a nurse's immigration status is entirely dependent on them maintaining the employment listed on their visa, they are inevitably vulnerable in their workplace. It is not only their jobs that are dependent on their compliance, but their very presence in the country, the lives they have built, their homes, and the stability of their families. Over the pandemic that vulnerability manifested itself in a number of ways.

36. Migrant workers were disproportionately allocated to higher risk working environments. A research paper "Nursing Narratives: Racism and the Pandemic", led by Sheffield Hallam University and co-conducted with Kanlungan, found that 44% of Filipinos surveyed felt that they had been unfairly delegated to high-risk or COVID-19 positive wards compared to their white peers.[24]

37. These workers, particularly new nurses or those on lower pay grades, were unable to protest these allocations for the same reason that they were given them in the first place; they were either afraid of, or threatened with, losing their employment visas if they raised complaints.[25]

38. As pre-existing chronic understaffing was exacerbated by the pandemic, self-isolating Filipino staff found themselves being pressured to return to work before they were well enough to do so.[26]

39. Filipino nurses' inability to refuse unsafe allocations or orders to return to work led to pre-existing racist perceptions becoming entrenched. The idea that Filipino workers were "docile, submissive and hard-working"[27] became self-perpetuating as they could not refuse the demands increasingly made of them.

40. There were also cases of migrant workers being refused swab tests in the first wave of the pandemic, whilst white colleagues in the same hospital received them;[28] and reports of migrant workers being de-prioritised for PPE distribution,[29] and denied access to FFP3 masks.[30]

41. The No-Recourse to Public Funds condition applied to visas put migrant staff in similar positions to outsourced colleagues in the event of sickness. Whilst their status as employed staff entitled them to NHS occupational sick pay; if the period of occupational sick pay is exceeded, for example in the event of Long Covid, NRPF conditions preclude the payment of SSP.

42. These are key examples of ways in which insecure status led to exposure to greater risk. One Filipino nurse remarked 'we were chosen to be exposed'.[31]

43. All of this was exacerbated by the Hostile Environment policies introduced in 2012 and bolstered by the Immigration Acts in 2014 and 2016. The Hostile Environment was ostensibly targeted at undocumented migrants (who will be a greater focus for the Group's submissions in Module 6) however the narratives that were promoted perpetuated racism and discrimination.

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[24] INQ000327661/10
[25] INQ000327667/7
[26] INQ000477577/21 § 94
[27] INQ000327667/3
[28] INQ000477577/12
[29] INQ000327667/6 & 7
[30] INQ000327661/11
[31] INQ000327661/9

44. Workplace racism exhibited itself in many ways, from the unfair distribution of gifts from the public, to the increased levels of bullying, harassment and workplace pressure[32], that were experienced by ethnic minority health workers including those at the top of the medical professional hierarchy.[33] Guidance was often not translated into migrant languages because "*Translation into foreign languages is discouraged except in extraordinary circumstances because it conflicts with the government's approach to integration which relies on English language use.*"[34] Despite the large Filipino population in health and social care, the official language of the Philippines, Tagalog, was not even listed in the Government's final report on COVID inequalities in December 2021.[35]

45. These institutional factors were aggravated by the racialisation of the pandemic. Between 2020 and 2021 there was a 300% increase in hate crimes against East and Southeast Asian communities in the UK due to the association of the virus with China.[36] As an example in March 2021, a Filipina nurse in Southampton, still in her uniform after a 12-hour hospital shift, was threatened with physical violence and told to "go home to China" by a group of young people.[37]

46. All in all, migrant nursing staff felt that their lives were not considered as valuable as their British counterparts. There was a feeling of disposability. At the heart of this was the juxtaposition between Government policies; on the one hand importing cheap labour to address understaffing that their ideologies had created, and on the other promoting a narrative that demeaned and de-humanised those same workers.

47. The issue is encapsulated in a set of inter-departmental government emails disclosed in this Inquiry. The DHSC organised the recruitment of a planeload of nurses from India to try and resolve NHS staffing shortages.[38] But the plan was abandoned because "*nursing staff shortages have not been the main focus of the media… but given how angry people are about the health system, the optics might not be good*".[39]

48. There is a need for honesty. Successive Governments have underfunded the NHS, stripped it of its workforce assets and ensured wage stagnation so that even the most dedicated staff leave. They have used migrant nursing to address this understaffing. These nurses must be treated equally, with respect, dignity and the recognition they deserve.

49. Migrant nurses were dying at a rate that far outstripped many of their colleagues. In the first months of the pandemic 53% of UK healthcare workers who died from COVID were migrants.[40]

50. There was no Government monitoring or data recording of the disproportionate impact and mortality rate in the Filipino healthcare community. Despite being the third largest national group in the NHS, official data gathering does not include Filipinos as an ethnicity monitoring category. The impact on the community fell to be measured by community organisations like Kanlungan and Filipino nursing associations. It was very quickly clear that

[32] INQ000474298
[33] INQ000346166/11
[34] INQ000302496 footnote 71
[35] INQ000302496/56
[36] INQ000327667/5
[37] INQ000327667/6
[38] INQ000193514
[39] INQ000193433
[40] INQ000235267/2

because Filipinos are over-represented in health, care, and domestic work, the Filipino community was disproportionately impacted on all sides – with a particularly devastating impact for those with precarious or no leave to remain in the UK.

51. Despite comprising only 3.8% of the nursing workforce, in the first months of the pandemic up to May 2020, Filipinos accounted for 22% of COVID-19 deaths among nurses.[41] That is a devastating statistic.

52. But despite these sacrifices, the policies and narrative of the Hostile Environment have continued. In early August this year, Filipino nurses in Sunderland, on their way to hospital to cover emergency shifts, were targeted and attacked by far-right rioters who threw rocks at their taxis.

Exposure:

53. The Groups' members form two clear subgroups of precariously employed workers; both of which were created by Government policy. They were all exposed, alongside their employed or non-migrant colleagues, by the nature of their work in hospitals. That exposure was amplified by the fact that viral transmission was airborne, with aerosols generated simply by breathing and talking, remaining in the air for hours and transported around poorly ventilated hospitals by air currents, significantly contributing to spread.[42]

54. Whether they were nursing staff, in close direct care contact with their patients; or cleaning staff and porters engaged in labour-intensive physical work; security staff exposed by proximity to every hospital entrant; couriers, in close contact with samples and moving from ward to ward, or drivers, in the confines of their vehicles; they were all exposed to concentrated COVID for extended periods of time.[43]

55. They were additionally exposed by the nature of their precarious employment, their immigration status, and by systemic racism. Ultimately, they were exposed by their poverty. They were on the lowest incomes, living in multi-occupancy, multi-generational homes, in the most deprived areas using public transport to get to their precarious employment. They were the most exposed, the least able to resist infection and the least protected.

Foreseeability:

56. Long before COVID, the scientific consensus accorded with a basic common-sense proposition: The poorer someone is, the more vulnerable they are to a pandemic such as this; the more likely they are to be infected and the more likely they are to die. As Professor Marmot stated[44] "*it is entirely predictable… the lower the socio-economic position, the greater the deprivation, the greater the consequences".*

57. "Being in good employment is protective of health. Good work is ***"free of the core features of precariousness****,* ***such as lack of stability and high risk of job loss****,* ***lack of safety measures*** *(exposure to toxic substances, elevated risk of accidents) and the* ***absence of minimal standards of employment protection****". Conversely,* ***poor working conditions are characterised by low-pay, insecurity, few opportunities for advancement,***

[41] INQ000327667/7
[42] INQ000474276 § 51 and 54
[43] INQ000474276 § 78
[44] PHT000000004 P58

***and working in conditions that are harmful to health**… Insecure and poor-quality employment is also associated with increased risks of poor physical and mental health."*[45]

58. Since 2010, there has been an increase in poor-quality work, with "*several new types of poor-quality work emerging, putting health equity at risk. **From a health inequalities perspective, low paid, insecure and health-damaging work is not a desirable option.***[46]

59. That particular exposure and vulnerability was amplified for ethnic minority groups, in part because of the prevalence of ethnic minority workers in outsourced positions[47]: people from ethnic minority groups are *"more likely to be **in low-paid**, **poor quality jobs**, with few opportunities for advancement, **often working in conditions that are harmful to health**. Many are trapped in **a cycle of low-paid, poor-quality work**". "Workers from minority ethnic groups are **more likely to be on zero-hours contracts** than White workers: 1 in 24 minority ethnic workers is on a zero hours contract compared with one in 42 White workers, and **minority ethnic workers are more likely than White workers to be on agency contracts**"*. However, notwithstanding this damning statistic, the Group does not seek to call for zero hour contracts to be equally allocated, they do not call for zero hours contracts to be distributed 'fairly', they don't call for the pain to be shared – they call for the pain to end and for the end of zero hours contracts completely – they have no place in a public health service.

60. The theme of poor employment, particularly in relation to ethnic minority workers, was expanded on in the report of Professors Nazroo and Becares: [48] "***Ethnic differences also exist in the employment profile of ethnic minority people. They are more likely than the White majority group to be employed in sectors that increase their risk of exposure to an infectious agent, such as in transport and delivery jobs, or working as health care assistants, hospital cleaners, social care workers, and in nursing and medical jobs**."*

61. All in all, it was clear, pre-pandemic, that the Group's members in outsourced, precarious and migrant positions were particularly vulnerable and exposed to the virus. The health picture "*coming into the pandemic was stalling life expectancy, increased regional and deprivation-based health inequalities, **and worsening health for the poorest in society**."*[49]

62. The Marmot and Bambra review of Government contingency planning concluded[50] that "*Pre-existing health inequalities were only considered in a minimal way in… pandemic planning and then largely in relation only to age and clinical risk factors. **Wider issues of vulnerability (such as socio-economic status or ethnicity) were seldom considered in the UK.**"*

63. In oral evidence Professor Bambra disputed the DHSC evidence that inequalities impacts are "routinely assessed": *In the documents that we have looked at… out of a whole body of work there was only one from 2011, so I don't think we could see that as routinely assessed in regards to the planning.*[51] Professor Bambra

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[45] INQ000195843 § 21.3
[46] INQ000195843 para 55
[47] INQ000195843 § 28.3 & 28.4
[48] INQ000280057 § 36 & 63
[49] INQ000195843 § 46
[50] INQ000195843 §146
[51] PHT000000004 P52

concluded powerfully, *it would be quite difficult for* [Government] *to think about why* [people with health inequalities] *might be at risk when* ***they're not thinking about them at all.***[52]

64. A key feature of this Inquiry's disclosure is that **no one** appears to have thought about these workers. In June 2020, NHS England wrote to healthcare providers reminding and obliging them to conduct risk assessments for healthcare workers. The focus is on "**their** staff". Whilst there is recognition of the need for ethnic minority staff risk assessments, there is no reference to migrant staff labouring under visa conditions and exposed to greater risk. There is no reference to, or recognition of, the outsourced workers working alongside "**their** staff".[53] This is an important example, because it deals with the lack of recognition of risk, but it is just one of many similar documents[54] that demonstrate the extent to which the Group's members were unseen.

65. The starting point for consideration of these workers must be that Government should have known about the additional need to protect the most vulnerable socio-economic categories of the population. The chronology suggests very strongly that Government did know and did nothing about it.

66. In February 2020, the Marmot Review was published. It was a timely reminder *that people from disadvantaged backgrounds or deprived areas, and* [ethnic minority] *backgrounds, were not only more likely to have underlying health conditions because of their disadvantaged backgrounds, but they were also more likely to have shorter life expectancies as a result of their socioeconomic status (including greater representation in poorly paid and insecure employment).*[55]

67. In April 2020, NHS England certainly became aware that the mortality rate was extremely high in ethnic minority healthcare workers.[56] A report to the Chief Medical Officer, that is undated but from its context appears to be from March to May 2020, recognizes that age, geography, **socio-economic factors and ethnicity** may all be directly or indirectly associated with increased risk of severe illness from Covid-19.[57] On 9th April 2020, the Department of Health and Social Care received media requests[58] to comment on reports that ethnic minority communities were being hit harder, and criticisms that Government was not being honest about the scale. By the 12th April 2020 Chris Whitty (CMO) was referring to the known increase in death rates among ethnic minority healthcare workers.[59]

68. A DHSC email exchange on 19th April 2020 reiterates the recognition of increased death rates in ethnic minority HCWs, and specifically notes that DHSC analyses of hospital death rates do not include "domestics".[60] A conscious decision had been made to not even count the deaths amongst this group of workers.

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[52] PHT000000004 P54

[53] INQ000051089

[54] For example: INQ000192661, INQ000192711, INQ000118646, INQ000226623, INQ000068547, INQ000068552, INQ000048239, INQ000069540, INQ000249084, INQ000069000, INQ000069109,

[55] INQ000215514/2

[56] INQ000117760

[57] INQ000068989/2e

[58] INQ000068818

[59] INQ000068786

[60] INQ000068863

69. On 20th April 2020 there was clear international recognition of high hospital infection rates and the increased risk to healthcare workers.[61] On the same day, it is clear that the DHSC were aware that outsourced clinical staff were not being supplied with the same access to testing as their in-house colleagues.[62] On 22nd April 2020 Health Service Journal, the publication for healthcare leaders, published an exclusive on the data around ethnic minority healthcare worker deaths.[63] It reported that 71% of nurse and midwife deaths, 56% of healthcare support worker deaths and 94% of doctor and dentist deaths were from members of ethnic minority communities. It noted the high number of deaths among Filipino staff and "*a sense that the cases included many from the lower paid roles and those on the lower rungs of the hierarchy*". Also on 22nd April 2020, Professor Kevin Fenton (the Regional Director of PHE London) wrote to the CMO[64] raising his "deep concern" and "*strong sense that COVID has simply covered worsening socio-economic inequalities in society*". On 28th April 2020 the BMA attended Downing Street raising the disproportionate rate of serious illness and deaths in ethnic minority practitioners, suggesting that all ethnic minority practitioners be issued with FFP3 masks, and pointing out that because the majority of doctors who had died were **migrant** there was a concern that they were being pressured into more frontline work.[65] It cannot have escaped Government's notice that if migrant doctors were being pressured into COVID wards, then those further down the professional hierarchy would be similarly exposed.

70. On 4th May 2020, a study at I&S revealed high positivity in test results among Health and Care workers. In an email exchange with the CMO, Patrick Valence flagged it as "clearly a major concern".[66] The report was flagged as 'Not for Public release'. On 5 May 2020, Public Health England produced a report[67] clearly concluding that ethnicity was an important factor in mortality rates. It listed all of the markers of social deprivation; occupation, population density, use of public transport, household composition and housing conditions, as potential contributors to the death rates. The data[68] was clear that the two most deprived quintiles of the population were "*significantly associated with increased odds of death*". The report was marked 'Official Sensitive'.

71. On 7th May 2020, Ministers were made aware that health and social care workers were almost ten times more likely to test positive for COVID than the general population.[69] On the same day, the Office of National Statistics (ONS) released data[70] analysing the high risks of mortality in ethnic minority communities, flagging socio-economic deprivation as a contributor. Also on 7th May 2020, a report referred to as the "Goldacre paper" was published. It was clearly known to the DHSC, because it was referenced in internal emails.[71] It stated "*We have quantified a range of clinical risk factors for death from COVID-19, some of which were not previously well characterised, in the largest cohort study conducted by any country to date. People from Asian and black groups are at markedly increased risk of in-hospital death from COVID-19… Deprivation is also a major risk factor with, again, little of the excess risk explained by co-morbidity or other risk factors*."

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[61] INQ000068887
[62] INQ000068874
[63] INQ000226458/8
[64] INQ000068904
[65] INQ000117871
I&S
[67] INQ000069221
[68] P 13 and 29
[69] INQ000069130
[70] Referenced in INQ000226458
[71] INQ000069524

72. On 10th/11th May 2020 the government published its report on COVID titled "Our Chance to re-build". Two different versions of this document have been disclosed. The first[72] is an early draft (10th May 2020) and the second[73] (11th May2020) appears to be the final published draft.

73. At page 38 of the first draft, when dealing with higher risk categories of the population, the report states "*It is clear the virus disproportionally effects men, older people, people who are overweight and people with some underlying health conditions*". There is no mention of ethnicity, socio-economic disadvantage, or occupation. A reviewer of the draft has added a proposed amendment "*Start with older people (biggest risk). Maybe add ethnic minorities"*. By the final draft[74] the sentence had been amended to prioritise the risk to the elderly, but the suggested inclusion of ethnicity had been ignored. Again, there is no mention of deprivation or occupation.

74. At the time of publication, the Government already had the PHE data indicating that ethnicity and deprivation were clear factors in mortality. They had had them for at least 5 days.

75. On the same day, the ONS published its findings on high-risk occupations.[75] That analysis did not include data on the deaths of any migrant worker who had arrived in the UK after 2011.[76] Nevertheless, cleaners, security guards, nursing assistants, care workers, hospital porters, kitchen catering assistants and taxi drivers were among the occupations with the highest mortality rates. The Government knew that this material was awaited.[77] It would not have been difficult to discover its delivery date and inform the public accordingly.

76. As a result of their exclusion from "Our Chance to Re-build" none of these factors were highlighted for the "risk-based targeting of protection measures" that the document emphasised.

77. On 3rd July 2020, the Independent SAGE group submitted a report to Government.[78] Authored by Sir David King, the former Chief Scientific Advisor, the report flagged socio-economic disadvantage, overcrowded, multi-generational housing conditions and occupation as major risks. The occupations that were specifically emphasised as having "*increased...risk of exposure, infection and death*" were "*transport and delivery jobs, health care assistants, hospital cleaners, social care workers, taxi drivers, security guards, and… nursing and medical jobs*". The report raised concerns that "*some of these occupations have been the last to receive supplies of personal protective equipment*", that racial inequalities had led to ethnic minority healthcare workers having "difficulty" acquiring PPE, the higher mortality rates in ethnic minority health workers and that mortality rates in deprived areas were twice that of the least deprived.

78. The Hostile Environment was also raised as a cause of migrants having limited access to healthcare. 'No Recourse to Public Funds' conditions were specifically identified as exacerbating "precarity and destitution". The report noted how critical Statutory Sick Pay was to ensure self-isolation and shielding the vulnerable. It was clear that SSP was too low for working families to live on and that many low pay/zero-hour workers and migrants were not eligible for it.

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[72] INQ000069181
[73] INQ000069192
[74] INQ000069192 P40
[75] References at INQ000069200 & INQ000235286
[76] INQ0000089742/21
[77] INQ000069221/18
[78] INQ000215514

79. Governmental exclusion of these obvious categories of risk had far-reaching implications. Two examples that span the pandemic are:

1: The Health and Safety Executive guidance on enforcing action against employers who did not protect their workers was predicated on two fundamentally false propositions: First, that workers *"are not at risk of air-borne infection unless they are within a metre of someone who aerosolises the virus … The two-metre rule ensures people are not in reach of each other and will therefore not spread the virus by touch. Risk controls should focus on these factors".* Second, the dangerously myopic assertion that *the working population is generally healthier than the population at large*. The only vulnerability factor identified for enforcement purposes was whether a worker was in receipt of the NHS shielding letter because they were clinically extremely vulnerable.[79] The guidance legitimised the treatment of outsourced and migrant staff by their employers.

2: Public Health England's list of categories for the first phase of vaccination, as late as April 2021,[80] prioritised "frontline health workers" as second in line. However, there was no guidance on how to define the term "frontline". Bearing in mind the general focus on clinical staff and the overall lack of consideration for non-clinical, outsourced and migrant staff it is no surprise that the Group's members report a two-tier[81] vaccination system which treated in-house employees as more important than outsourced staff despite their shared risk of exposure. On PHE's prioritisation list, a 49-year-old outsourced cleaner, who was traveling to hospital on public transport, earning minimum wage and living in a multi-occupancy flat in the most deprived area in the country would have been in category 10, the lowest category for prioritisation. To contextualise that, a 29-year-old stockbroker, working online in the garden of their stately home, would have been in the same category. A 50-year-old stockbroker would have been prioritised above the cleaner.

80. The Government's final report on progress to address COVID inequalities, published on 3rd December 2021 stated: "*We **now** know… the main factors behind the higher risk of COVID-19 infection for ethnic minority groups include occupation (particularly for those in frontline roles, such as NHS workers), living with children in multigenerational households, and living in densely populated urban areas with poor air quality and higher levels of deprivation."*[82]

81. The report also noted that the process of identifying risk factors was not complete, because of data gaps for "*some occupations and some aspects of social exclusion such as migratory status*". The data gap on mortality rates for "domestics" had been identified by the DHSC twenty months before. Outsourced workers and migrant staff were not even considered worthy of data gathering.

82. The Government's insertion of the word "now" to imply recently acquired knowledge is not an accurate reflection of the evidence.

83. No risk assessments were ever conducted on the basis of income and deprivation, or vulnerability to exploitation. Where precarious and migrant workers should have been prioritised for PPE, testing, sick pay, and vaccination, exactly the opposite occurred.

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[79] INQ000269803

[80] INQ000302492

[81] INQ000477577/27 § 119-120

[82] INQ000302496/4

Conclusion

84. The working poor, migrants and the precariously employed, were inevitably going to be more vulnerable to the pandemic. That vulnerability led to higher mortality rates in their occupations and communities.

85. The trauma of working in COVID-19 wards and witnessing the death of friends or colleagues, alongside the awareness of their own increased exposure, has caused long lasting damage to their mental health.

86. Increased exposure to the virus has led to higher incidence of Long Covid[83] and other Covid related health complications. For outsourced staff with precarious contracts, a Long Covid diagnosis can result in a complete loss of employment and possible destitution, furthering the existing socio-economic damage caused through pandemic related job loss.[84] For migrant nurses on restricted visas, job loss constitutes a breach of their visa conditions, and a loss of their right to live and work in the UK. Even on returning to work, migrant and outsourced healthcare workers living with Long Covid often face an uphill battle in requesting reasonable adjustments and have little bargaining power.

87. It is important that this Inquiry asks why these categories of worker were so comprehensively ignored and exposed; and we ask Counsel to the Inquiry for focused questioning on the lack of consideration. An understanding and acknowledgement of the root causes is the first step to ensuring that it is not repeated.

88. The July 2020 Independent SAGE report made recommendations[85] to address the *immediate impact on the course of the pandemic, and longer-term action to reduce health inequalities.* The Group endorses those recommendations which included increased Statutory Sick Pay, the removal of NRPF conditions from migrant visas and wider Government action on the social determinants of health. There should be a focus on working-class populations, migrant populations and ethnic minorities.

89. The Group has made further specific recommendations in our Rule 9 statement but will return to recommendations in closing submissions once the evidence has been heard.

90. It is clear that in respect of healthcare workers, there can be no continuation of a two-tier system. Outsourced health workers must be brought in-house and/or protected. Migrant health workers must be given the same terms as their non-migrant colleagues. A workforce as important as this, can never be left so unprotected again.

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[83] INQ000280198/ 20

[84] INQ000215514/3

[85] INQ000215514/13-18