THE UK COVID-19 INQUIRY

TRADES UNION CONGRESS:

WRITTEN OPENING FOR MODULE 3

'In the beginning there was a lot of uncertainty. It was terrifying. I cried every day driving to and from work, mostly in fear of taking Covid home to my parents and child and the risk of leaving my son without his mum. There was little to no PPE. We were asked to use it sparingly, we were asked to reuse items. Like most workplaces PPE supplies were unobtainable and we were using out of date stock or given two single use face masks for a 12-hour shift. The sights were harrowing, taking people from their homes, leaving loved ones behind, knowing they would never see them again. We lost colleagues and friends.'

An Emergency Medical Technician in the ambulance service, July 2024

INTRODUCTION

1. This is the opening statement of the Trades Union Congress (**'the TUC'**) in Module 3 of the UK Covid-19 Inquiry. Approximately 900,000 healthcare workers (**'HCWs'**) are represented across a number of the unions affiliated to the TUC: UNISON, Unite, GMB, the Royal College of Midwives, the Chartered Society of Physiotherapists, the Society of Radiographers, the British Dietetics Association, the Royal College of Podiatrists, the British Orthoptic Society Trade Union, the Hospital Consultants and Specialists Association **('HCSA')**, and the POA. As a core participant in Module 3, the TUC is working in partnership with TUC Cymru (formerly known as the Wales TUC), the Scottish TUC, and the Northern Ireland Committee of the Irish Congress of Trade Unions.

2. These opening submissions address:

   (a) The **impact** of the pandemic and the pandemic response on HCWs;
   (b) The **causes** of that impact and lost opportunities to mitigate it; and
   (c) The **lessons** to be learned.

3. Given the interests and expertise of the TUC's affiliated unions, the focus will be on the impact upon healthcare workers (**'HCWs'**); although outcomes for staff and patients are inextricably interlinked.

A. IMPACT ON HEALTHCARE WORKERS

4. **The horrors of a novel pandemic**. For many HCWs tasked with caring for the most critically ill, the pandemic was full of horrors. As one NHS worker explained to the TUC:

   'I saw more people die during Covid than in the first 15 years of my work in healthcare. On my first shift I had, I had to do last offices for someone who had just died. We didn't have enough shrouds to put them in so we were just using sheets. It was relentless.'

Another HCW explained:

'My worst day was walking home after we lost eight patients in one shift. I couldn't bear to look in the mirror. I cried for two days and was sick to my stomach […] *Even writing this statement, I feel sick thinking about the many awful things which happened'.*

5. The impact of these sorts of experiences is inevitably profound. The fear was of the unknown, of the toll on patients and their families, of the risks faced by colleagues, and of exposing their own families at home to the virus.

6. **Risk of contracting the virus.** In comparison to non-essential workers, HCWs had a more than seven-fold greater risk of severe Covid-19.[1] Within the profession, factors associated with increased risk of infection included attending a high number of Covid-19 positive patients, a nursing or midwifery role, reporting a lack of access to personal protective equipment (**'PPE'**), and working in an ambulance or an inpatient hospital setting.[2]

7. **The death toll.** In the first phase of the pandemic, news reports of HCWs being treated by colleagues in intensive care units (**'ICU'**) and of HCWs losing their lives were devastatingly common. The toll was high; identifying how high is difficult given deficiencies in the data. The most accurate number of deaths forms an important part of the public record and does justice to the toll faced by HCWs. It is also important in respect of health and safety laws and regulations. For the purposes of Industrial Injuries Disablement Benefits prescription of a disease in practice relies on the risk of developing a disease being doubled in a particular workforce as compared to the general population.[3]

8. NHS England (**'NHSE'**) identified 559 NHS staff in the period to 3 July 2023 having died of Covid-19, albeit for a period early in the pandemic, *'many staff deaths'* were identified informally with reference to online reporting.[4] In contrast, ONS statistics identify 854 deaths registered between 9 March 2020 and 31 March 2022 across England and Wales where the death certificate referenced Covid-19 and where the occupation fitted the definition of a HCW.[5] Sir Stephen Powis (NHSE) suggests that the disparity relates to the ONS data capturing HCWs who had retired, and the NHS data deriving from the application of different criteria as to who qualifies as a HCW.[6] Those explanations appear unlikely given that the ONS data is limited to those of usual working age, and the criteria utilised by ONS is a more narrowly prescriptive list than that applied by NHSE. The discrepancy may in fact be because: (a) ONS statistics include HCWs in Wales and non-NHS HCWs in England; (b) NHSE statistics almost certainly missed deaths as it relied on social media reports before a formal reporting system was established; and (c) NHSE statistics may have missed deaths where the person was not *'declared as a Health Care Worker'*[7] or where the person was an outsourced worker who did not work directly for a trust.[8] We suggest that the ONS data, collected from a single source (death certificates) following processes long-established by ONS, is the most

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[1] INQ000339466/53
[2] INQ000421758/33, para. 94
[3] https://assets.publishing.service.gov.uk/media/5a80c16040f0b62302695526/iiac--iidb-prescribed-disease-decisions-faq-july-2015.pdf.
[4] INQ000412890/232, paras. 878-879.
[5] See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14554deathsinvolvingcoronaviruscovid19amonghealthandsocialcareworkersthoseaged20to64yearsenglandandwalesdeathsregistered9march2020to31march2022.
[6] INQ000412890/236, para. 890.
[7] INQ000412890/233, para. 883(d).
[8] INQ000412890/232, para. 879.

reliable source. In respect of Scotland, we commend to the Inquiry the statistics recorded by the National Records of Scotland ('**NRS**') which use the same methods and definitions as the ONS. NRS reported 54 deaths where Covid-19 is mentioned on the death certificate for HCWs aged between 20 and 64 in the period to 31 August 2022.[9] Regrettably, there appears to be a dearth of publicly available, accurate data in respect of deaths of HCWs in Northern Ireland.[10]

9. **Long Covid.** Long Covid ranks as amongst the foremost concerns for those HCWs represented by TUC affiliated unions. The incidence of Long Covid in HCWs has been high. As the Long Covid CP Group highlight, ONS data recorded 4.4% of HCWs reporting symptoms of Long Covid as at 2 January 2023.[11] As observed by Professor Brightling and Dr Evans, the risk and incidence of Long Covid in HCWs is still being understood.[12]

10. For those who have suffered or continue to suffer with Long Covid, the impact is often profound. As described to the TUC by an NHS employee: *'Long covid has affected many of my colleagues and some people have even had to come out of work, a place many had worked for up to 25 years'*. South Warwickshire University NHS Foundation Trust describes staff members who have suffered Long Covid and, shockingly, *'ultimately resulted in dismissal due to an inability to return to work'* with a *'life-changing impact on those individuals, with applications for ill health early retirement refused by the NHS Pensions Agency due to a lack of knowledge about the long-term effects and likelihood of recovery'*.[13] That experience has been replicated across the UK. The financial impact is also felt by those able to remain in work. An NHS clinical support worker who spent 62 days on the ICU before subsequently being diagnosed with Long Covid explained: *'I was absent from work for a period of two and a half years. I continued to be paid by the trust on a basic rate. No enhancements were paid for weekends that I would have normally worked which had an impact on my family's financial commitments.'*

11. The TUC is particularly concerned by the failure to prescribe Covid-19 and/or Long Covid as an occupational disease, which further constrains the support and financial compensation available to HCWs who contracted the virus in the workplace.[14] There is evidence that DHSC were concerned about whether classifying Covid-19 or Long Covid as an occupational disease would enable staff to bring claims against the NHS.[15] The Industrial Injuries Advisory Council has recommended prescription for health and social care workers, but this has not been enacted by the Department for Work and Pensions.[16]

12. **Mental health and morale.** The profound impact on HCWs' mental health and workforce morale has been caused by the challenge of a pandemic combined with: working in already stretched health services; in depleted and strained workforces; facing risks with poor PPE;[17] widespread redeployment without adequate training and support; in England, pursuit by government of a policy of vaccine as a condition of deployment; and so on. Daniel Mortimer

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[9] See: https://www.nrscotland.gov.uk/files/statistics/covid19/covid-deaths-22-monthly-data-week-37.xlsx.
[10] We understand that this data was collected by the Northern Ireland Statistics and Research Agency, but it does not appear to be available within the disclosure made to Module 3, nor in opensource documents.
[11] INQ000370954/54, para. 6.3.
[12] INQ000421758/33, para. 95.
[13] INQ000472879/7, para. 31. See, similarly: INQ000370954/54, para. 6.3
[14] Cf. the evidence as to occupational risk at: INQ000397188/23, paras. 79-81.
[15] INQ000283383/5.
[16] See: https://assets.publishing.service.gov.uk/media/637f32dcd3bf7f154726c7fc/covid-19-and-occupational-impacts.pdf.
[17] See, for example, INQ000471161/34, para. 150.

(NHS Confederation) describes the *'moral conflict'* experienced by HCWs between *'the professional standards they signed up to and the way they were being asked to work, such as, for instance, having insufficient resources and/or colleagues to provide care and/or witnessing poor standards of care'*.[18] An ambulance care assistant told the TUC that they feel sadness about having brought obviously infected patients to care homes where many later died, but reflects that they were *'simply following instructions'*. Others describe it being *'physically, mentally and emotionally draining'* for staff.[19] As Alastair Henderson (Academy of Medical Colleges) describes: *'The workload and the psychological impact of the pandemic caused widespread exhaustion and burnout.* […] *in January 2021 an RCP survey reported that 64% of respondents felt tired or exhausted'*.[20] NHSE describes the high prevalence of mental illness in NHS staff.[21] The 2021 NHS Staff Survey found that 46.5% of respondents felt *'burn out'* at the end of their shift.[22]

13. **Financial loss.** There was also a generally unseen financial impact upon staff in the pandemic. As Sara Gorton (UNISON/TUC) describes, the pandemic came with unexpected expenses for HCWs. A HCSA survey of doctors found that 42% reported additional costs or lost income.[23] A quarter of respondents to a UNISON survey reported HCWs or their family under financial difficulty in 2020.[24] Costs included the cost of purchasing equipment such as PPE, and equipment to enable homeworking. Many outsourced workers were not covered by the NHS scheme which aimed to ensure HCWs could isolate when required without suffering loss of pay.[25] There were significant financial consequences for those who were unable to work in high-risk environments, but not clinically *extremely* vulnerable so as to access the same pay provisions as those shielding.[26] Some of those living with persons who were clinically vulnerable felt they could not continue high-risk work and were forced to give up employment or substantially change working patterns to protect loved ones.[27]

14. **Unequal impact.** Across the impacts felt above, the impact fell unequally. It warrants careful attention within Module 3. By way of example:

    (a) Black, Asian and Minority Ethnic[28] HCWs, particularly those from Black and Asian groups, were more likely to suffer severe disease, i.e. hospitalisation and death, than their white counterparts.[29]

    (b) ONS statistics of deaths of HCWs aged 20-64 in England and Wales show significantly higher numbers of deaths of female HCWs; 514 deaths as compared with 340 deaths of male HCWs.[30] The healthcare workforce is majority female (76.7% of the NHSE

[18] INQ000410447/43, para. 126.
[19] INQ000477351/56, para. 251.
[20] INQ000396735/77, para. 25.
[21] INQ000412890/197, para. 754.
[22] INQ000412890/194, para. 744.
[23] INQ000339416.
[24] INQ000339415/2.
[25] INQ000471985/25, para. 86.
[26] INQ000409574/35, para. 85.
[27] INQ000260635/15, paras. 29-30.
[28] We recognise the limitations and problems inherent in using terminology which groups together a large number of ethnicities which each have a distinct history and present context. We have attempted, wherever possible based on the underlying data, to be specific regarding the ethnic group relevant to a statistic or submission. Nevertheless, the source data we rely on in many cases does not provide sufficient detail, and we consider it critical to be able to compare the data for those groups which are impacted by structural racism against data for those which are not.
[29] See, for example: INQ000249828/86.
[30] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14

workforce).[31] Women are over-represented in roles with the most patient contact and which saw some of the highest rates of death from Covid-19, such as nurses and healthcare assistants.[32]

(c) Research published in the British Medical Journal suggests that the pandemic widened mental health inequalities for Black, Asian and Minority Ethnic HCWs.[33] This is supported by research from the mental health charity, MIND.[34]

(d) In respect of Long Covid, Professor Brightling and Dr Evans note (and ONS statistics demonstrate) that *'Long Covid is more common in females, middle age, pre-existing health conditions including obesity and social deprivation. It is also known that female sex, obesity, and pre-existing health conditions make someone more likely to develop severe Long Covid rather than milder disease'*.[35] There is likely an intersection with the disproportionate impact upon Black, Asian and Minority Ethnic HCWs. In December 2021, academics at University College London announced a three-year study to investigate the long-term health impact of Covid-19 on NHS healthcare workers from diverse ethnic backgrounds and roles and the report is awaited.[36]

15. **Legacy impact.** The legacy of the pandemic for HCWs extends far beyond its end. The scarring drip by drip effect of working in an unrealistically stretched and underfunded service, operating in matters of life and death, was compounded and accelerated by the experiences of the pandemic. Even as the pandemic ended, the apparently renewed public appreciation of health services gave way to HCWs having to battle for adequate pay, compounding poor morale. It is patients that face the acute dangers of waiting lists approaching 8 million - close to double the figures prior to the pandemic, and more than triple the figures in 2010 - but it is the workers who sag under the weight of that burden, in a system that gives them neither the means nor facilities to address it. As an NHS podiatrist explained to the TUC:

> *'We knew patients would suffer and they would ulcerate without the routine care. Our ulcer caseload has tripled since 2020 because of the lack of routine care. The pressures on other specialities means we are holding on to patients that we shouldn't be. Our role has changed significantly and the stress has continued to get worse, but we are told to get back to normal'.*

16. Staffing and workforce retention. There are real concerns that experience of the pandemic will have an ongoing impact on recruitment and retention. One paramedic told the TUC:

> *'In the earlier part of the pandemic a lot of pressure was applied to leave people at home, that were sick and would normally have been admitted to hospital. It was a dark period. We were also worked to the bone, and eventually I was burnt out and have now left the ambulance service to work elsewhere in patient care'.*

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[31] See: https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/
[32] See: https://www.england.nhs.uk/2021/03/nhs-celebrates-the-vital-role-hundreds-of-thousands-of-women-have-played-in-the-pandemic/
[33] See: https://mentalhealth.bmj.com/content/23/3/89.
[34] See: https://www.mind.org.uk/news-campaigns/news/existing-inequalities-have-made-mental-health-of-bame-groups-worse-during-pandemic-says-mind/.
[35] INQ000421758/32, para. 87.
[36] See: https://www.ucl.ac.uk/news/2021/dec/impact-long-covid-ethnic-minority-healthcare-workers-investigated.

17. As Ms Gorton (UNISON/TUC) sets out, the Joint Staff Side Submission to the Pay Review Body 2021/22 noted that one in five healthcare professionals were more likely to leave their role as a result of the pandemic.[37] The same submission in 2022/23 in fact found that vacancy rates in England had increased from 5.9% in March 2021 to 7.6% in October 2021.[38] In 2022 the Care Quality Commission ('**CQC**') reported that: *'More staff than ever before are leaving health and social care and providers are finding it increasingly challenging to recruit, resulting in alarmingly high vacancy rates that have a direct impact on people's care. Without action now, staff retention will continue to decline across health and care, increasing pressure across the system and leading to worse outcomes for people'*.[39] The Welsh Government similarly describes recruitment and retention issues *'exacerbated by the COVID-19 pandemic and the economic situation* […] *due to stress, fatigue, burnout, unattractive working conditions and poor professional development opportunities'*.[40] Research published by the GMC in August 2024 demonstrates that higher proportions of doctors are reducing their hours and refusing additional work due to stress and burnout.[41]

B. CAUSES, AND LOST OPPORTUNITIES TO MITIGATE THE IMPACT

18. The huge effort of, and harm suffered by, HCWs should, of course, be acknowledged and remembered. However, our system of healthcare should not depend on heroism to rise above a lack of preparedness, resilience, and safe working practises. That is why frustration was sometimes felt at the clap for the NHS: making one's own PPE and returning to the fray, surrounded by dying patients and colleagues may be admirable, but it should not be necessary. HCWs responding to a TUC survey described the clap as *'rubbing salt in the wounds'*, *'a slap in the face'* and *'a publicity stunt'*. Admiration and gratitude, though entirely justified, may be misplaced if what is really warranted is anger that the situation arose at all, and a desire for accountability and change. The core causes and missed opportunities to mitigate the impacts described above appear to be as follows:

19. **Preparedness.** The lack of adequate planning for a pandemic, set out in the Module 1 report, was undoubtedly a significant contributory factor to the harm suffered by staff and patients in healthcare. The Inquiry's recommendations will be an important starting point in mitigating the harm of the next pandemic.

20. **System resilience.** The foundation for effective pandemic response is system resilience and the existing capacity of services. As in the Module 1 Report, the 2011 pandemic preparedness strategy *'correctly identified'* that the impact a pandemic would have on the population would be determined by three factors: the characteristics of the disease, the *'capacity of healthcare services'* and other public services, and the behavioural response of the population.[42] Significant evidence in this respect has already been gathered in Module 1. We referred in Module 1 to much of the evidence resting on a *'simple but inescapable truth: that, no matter what*

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[37] INQ000471985/24, para. 82.
[38] INQ000471985/24, para. 82.
[39] INQ000398569/4.
[40] INQ000442326/3.
[41] See: https://www.gmc-uk.org/news/news-archive/struggling-doctors-are-cutting-hours-to-safeguard-their-wellbeing.
[42] Module 1 Report, para. 4.10.

planning is put in place, public services stretched to breaking point by over a decade of budget cuts will be severely impaired in their ability to cope with the shock of a national emergency such as a pandemic'.[43]

21. The Inquiry was right to find in the Module 1 report that: *'the surge capacity of the four nations' public health and healthcare systems to respond to a pandemic was constrained by their funding'*; the NHS was running *'close to, if not beyond, capacity in normal times'*; and that *'severe staff shortages'* and unfit hospital infrastructure *'had a directly negative impact on infection control measures and on the ability of the NHS and the care sector to 'surge up' during a pandemic'*.[44]

22. Significant evidence was heard in Module 1 on capacity and resilience of healthcare systems, from a range of witnesses. Much of the evidence is referenced in the TUC's closing submissions to that module.[45] It was to the effect that the NHS capacity and resilience was not just poor, but *'bottom of the table'*. As described by Dame Sally Davies, *'by comparator data compared to similar countries, per 100,000 population we were at the bottom of the table on number of doctors, number of nurses, number of beds, number of ITUs, number of respirators,* [number of] *ventilators'*.[46] Many witnesses in Module 1 described a similar picture and described the NHS struggling to meet 'normal' demand, let alone having sufficient surge capacity for a pandemic.

23. One lesson of the pandemic is that the consequence of running a system without surge capacity is acute in the pandemic phase, but also enduring. Given the gaps in planning, and the lack of surge capacity, it is a real credit to the commitment, skill, determination and dynamism of workforce that we did not run out of intensive care beds. The real price has been longer term in the impact more generally on the ability of the NHS to meet needs for healthcare. It inevitably contributed to the drastically increasing waiting lists now approaching 8 million and median waiting times doubling to 14.2 weeks.[47] The trajectory of healthcare services becomes an ever-heavier ship, increasingly difficult to turn.

24. **Staffing.** Healthcare depends on its staff: sufficient in number; sufficiently trained; sufficiently remunerated; in a safe workplace; and, for all those reasons, with good retention rates.

25. Staffing vacancies. Going into the pandemic, there were 106,000 vacancies across the NHS in England alone, including over 44,000 vacancies in nursing.[48] Nigel Edwards of the Nuffield Trust explains that failures to train and retrain sufficient staff to keep pace with increasing demand had led to significant and chronic workforce shortages.[49] As set out by Amanda Pritchard of NHSE, workforce supply issues were particularly acute in some professions (such as nursing), but the difficulties extended across the workforce and included laboratory scientists, cleaners, porters, administrative staff and facilities management, all of whom were essential in the response.[50]

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[43] INQ000235209/6, para. 21.
[44] Module 1 Report: page 123, para. 5.84; page 2; page 122, para. 5.82.
[45] INQ000235209/6-12, paras. 21(a)-(bb), and INQ000235209/13-15, paras. 28-35.
[46] Transcript [Day 6/151/7-11].
[47] See: https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis.
[48] INQ000339455/1 and https://digital.nhs.uk/data-and-information/publications/statistical/nhs-vacancies-survey/february-2015---september-2019-provisional-experimental-statistics.
[49] INQ000148416/8, para. 32.
[50] INQ000490250/65, paras. 235-237.

26. These issues led to serious difficulties in staffing critical care units. Dr Magda Smith of the King George Hospital explains that *'The most significant area of staff shortage experienced was in nursing staff within the Intensive Therapy Unit. The pre-pandemic vacancy rate for Intensive Therapy Nurses was already at 19%; therefore, ensuring safe staffing levels was challenging with a combination of absences, a 50% reduction in the availability of agency staff to provide support'*.[51]

27. With lower staff-patient ratios, there is a knock-on effect on patient safety and pressure on staff. Barts Health NHS Trust describes that the critical care team *'regularly raised concerns about the ability of staff to run the number of beds needed to meet the demand for critical care and open beds in the new facility'*. Further, mass redeployment *'led to a major dilution of trained staff (traditionally 1:1 nurse to patient ratio to 1:4 ratio and at peak 1:5 critical care nurse to patient ratio) and put significant additional pressure on the trained staff'*.[52] FEMHO make similar observations.[53]

28. Staffing and the Nightingale Hospitals. Nightingale hospitals were constructed at a cost of over £530 million.[54] There are reservations about whether use of Nightingale hospitals would ever have been an effective method of providing increased capacity for critically ill patients given they are divorced from the essential infrastructure surrounding hospitals which enables them to function effectively, and the questionable effectiveness of infection prevention and control ('**IPC**') in single large spaces. In the event, as Sara Gorton (UNISON/TUC) explains they were, *'underutilised and rendered largely pointless, at least in large part due to a lack of staff'*.[55] At times of a significant surge, when such hospitals might be most useful, scarce clinical staff were desperately needed at their 'home' hospital.[56] Sir Sajid Javid described Nightingales having not been effective for the *'primary reason* [that] *we simply did not have sufficient doctors and nurses to operate them'*.[57] Indeed, an ambulance worker told the TUC: *'We took no patients to the new COVID centres in London as they were not staffed'*.

29. Staffing and private hospitals. Private hospital provision *might* have been a means to support healthcare provision as NHS resources were increasingly drawn into pandemic response. In practice, that, too, was frustrated by staffing levels. The amount of NHS funded elective care in private hospitals fell by 45% in 2020 as compared to 2019.[58] As Sara Gorton (UNISON/TUC) describes, many doctors within the private sector also work in the NHS, and were working long hours in response to the pandemic, impacting upon their availability for work in private hospitals. The BMA suggests that agreements for the use of private hospital were not a good use of money, precisely because of the staffing issue: *'the UK Government's deal often simply secured access to hospital buildings and equipment but without the staff to run them'*.[59] And: *'leaked documents suggest two-thirds of private hospital capacity went unused in the summer of 2020'*.[60]

30. Temporary, outsourced and indirect workers. With a workforce shortfall of over 100,000 workers in the NHS in England alone, there is a huge reliance on temporary staff engaged via

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[51] INQ000477351/6, paras. 27-28.
[52] INQ000471161/17-18, para. 80.
[53] INQ000399526/13, para. 40.
[54] https://www.kingsfund.org.uk/insight-and-analysis/blogs/was-building-nhs-nightingale-hospitals-worth-it. See also: INQ000471985/23, para. 78.
[55] INQ000471985/48, para. 158.
[56] INQ000409251/282, para. 1133.
[57] INQ000485736/46, para. 102e.
[58] INQ000471985/23, para. 79.
[59] INQ000185355/29.
[60] INQ000397270/14.

banks and agencies.[61] The experience is described by a number of the 'spotlight' hospitals.[62] Whilst the extent of the use of temporary staff meets a short-term demand, it has significant disadvantages. It leads to a less consistent and reliable workforce, because agency staff are not contracted to work in a specific role, or even for a specific trust. It is therefore more difficult to undertake workforce planning, especially during a crisis, and shortfalls in staffing can arise suddenly and without notice. It likely poses challenges to effective IPC as temporary staff move between wards, departments, hospitals and trusts more frequently than permanent staff. Excessive reliance on temporary staff does not facilitate team cohesion and mutual support to the same degree as within teams of permanent workers.

31. Staffing roles which are outsourced to private companies by the NHS, along with indirect workers such as those employed by GP surgeries, are not subject to NHSE's working terms and conditions, nor do they fall within the remit of the usual structures of social partnership. Outsourced and indirect workers were therefore less likely to have access to adequate pay when required to self-isolate, and it was more difficult for unions to negotiate sick pay, risk assessments, and other measures likely to curb the spread of infection and the impact of severe disease from Covid-19. It is a feature that contributes to the disproportionate Impact of the pandemic on particular groups, including lower income workers and Black, Asian and Minority Ethnic workers. As Sara Gorton (UNISON/TUC) sets out:

> *'In the case of cleaners, security staff, and porters,* [reliance on outsourcing] *has largely been about trying to cut costs at the expense of the workforce. Black* [Asian and Minority Ethnic] *workers are disproportionately represented among these occupational groups'*.[63]

32. Ultimately, excessive reliance on temporary and outsourced staff carries with it many hidden costs, both financially and in terms of quality of care.[64]

33. Staffing and redeployment. The mandatory redeployment of staff to roles in which they were neither adequately trained nor experienced had a serious mental health impact and an impact upon patient safety. It resulted in the cessation of many non-essential services, with a resultant impact upon waiting times for non-urgent treatment. As Dr Magda Smith (King George Hospital) describes: *'Whilst all staff were risk assessed ahead of redeployment, this was not voluntary, and the overall process was not popular among staff.* […] *Redeployment had an impact on staff morale'*.[65] Indeed, a report from MBRRACE-UK notes that:

> *'some staff who had been redeployed from their very different usual roles were unfamiliar with the critical care equipment, including ventilatory support, they had to use and monitor* […] *Some were operating in these roles after very minimal training and inevitably errors occurred.* […] *Consideration should be given to establishing a minimum standard of orientation before working in a new clinical environment'*.[66]

34. A BMA survey reported high incidence of staff not receiving an induction or adequate training, and doctors holding *'understandable fears about working in high pressure, demanding*

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[61] See: https://www.nuffieldtrust.org.uk/resource/the-nhs-workforce-in-numbers.
[62] INQ000477593/4, paras. 9-10; INQ000477436/3, para. 9; and INQ000477351/6, paras. 27-28.
[63] INQ000471985/25, para. 84.
[64] See: https://www.nhsprofessionals.nhs.uk/-/media/tbscg/project/nhs/article/guides/0586-white-paper-may-2015-true-cost_v2_web.pdf.
[65] INQ000477351/13-14, paras. 56-58.
[66] INQ000221912/14.

environments, where they could be potential future liabilities'.[67] A physiotherapy team lead told the TUC:

> *'When lockdown occurred we stopped doing outpatient clinics and my team was redeployed to the hospital wards and community nursing. I know that PPE was insufficient and I was very worried for the immediate well-being of frontline staff. Also, there was very little preparation or training for staff – who were suddenly asked to perform very different roles'.*

35. It appears likely that redeployment contributed to the disproportionate impact of the pandemic along lines of ethnicity. Black, Asian and Minority Ethnic HCWs were more likely to be redeployed into frontline roles. A General Medical Council survey found higher rates of redeployment for doctors from a black or black British ethnic group (56%), or mixed or multiple ethnic groups (50%).[68] There is evidence that minority ethnic staff in nursing roles were three times as likely to be redeployed than white nursing staff[69] and FEMHO report anecdotal evidence of Black, Asian and Minority Ethnic HCWs being redeployed to redzones more frequently than their white counterparts, but feeling unable to voice concerns.[70]

36. **Vaccination as a condition of deployment ('VCOD').** From late 2020, unions were working hard to support voluntary uptake of the Covid vaccines, in order to avert the need for any VCOD policy – as a briefing paper for Covid-O sets out: *'Unions have so far been supportive of vaccine rollout and are encouraging their members to take up the vaccine locally'*.[71] Despite high vaccination rates amongst staff, in 2021 the UK Government pushed ahead with plans to introduce a VCOD policy and conducted a consultation on the proposed legislation in October 2021. Numerous representative bodies raised concerns. Over 90% of NHS staff were already vaccinated, and there was concern that VCOD would cause real difficulties for staff and the service, for little meaningful benefit.[72] An NHS Providers survey of November 2021 revealed that 91% would likely need to redeploy staff if the policy came into effect, and 89% were concerned about losing staff as a result of the policy.[73] In the event, the Government continued its plans before a U-turn in January 2022.

37. Powerful evidence on the destructive impact is given by a number of the 'spotlight' hospitals. By way of example, on behalf of South Warwickshire NHS Foundation Trust, it is stated:

> *'The impact of VCOD cannot be underestimated, particularly the damage to the HR teams who were facing the prospect of dismissing long-serving, caring, compassionate members of staff.* [...] *The impact on staff morale was also huge, causing considerable upset for those staff who, for whatever reason, chose not to be vaccinated.* [...] *there was significant damage to employee relations and for some individuals this has not recovered. There were a number of managers who refused to have conversations with their staff members, instead insisting that this was done by HR, as they fundamentally disagreed with the government approach'*.[74]

38. The Government had also pressed on notwithstanding an awareness that VCOD would have a disproportionate impact upon Black, Asian and Minority Ethnic workers, pregnant workers, and workers with pre-existing health conditions. A March 2021 SSHD paper acknowledged

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[67] INQ000185355/22.
[68] INQ000326297/34.
[69] INQ000249828/82.
[70] INQ000399526/13, para. 42.
[71] INQ000280024/9-10, para. 47.
[72] INQ000396735/35, para. 115.
[73] INQ000401270/35, para. 130.
[74] INQ000472879/7-8, paras. 33-37. See, similarly: INQ000477436/9, para. 24; INQ000471161/12, para. 57; INQ000477351/15, para. 65; INQ000474214/12-13, paras. 2.32-2.38; and INQ000477597/20, para. 66.

that VCOD *'risks creating/exacerbating tensions between staff and their employer, which may be particularly relevant for BAME staff, many of whom are already hesitant about taking up the offer of the vaccine'*.[75] The same was noted in a June 2021 Covid-O meeting[76] and had been made clear by consultees.[77] The proposals, and the decision to pursue VCOD for healthcare workers was, ultimately, incredibly damaging amongst groups of workers who were most deserving of clear messaging from government that they would be protected and valued.

39. **Workplace risk assessments.** Workplace risk assessments are a requirement, and, if done effectively, can mitigate harms of a pandemic, including of disproportionate impact. Their use was promoted by unions. Sir Stephen describes NHSE having promoted uptake on risk assessments for Black, Asian and Minority Ethnic staff, with the establishment of the Risk Assessment Delivery Unit on 6 July 2020. It is said that, by May 2021, over 1 million staff risk assessments had been performed, including 96% of staff of Black, Asian and Minority Ethnic backgrounds.[78] However, unions were not aware or nor engaged by the Risk Assessment Delivery Unit. Furthermore, there were concerns with slow take up, with NHSE having to write to Trusts in June 2020 to request that at-risk staff had assessments.[79] Further difficulties included out-sourced worked not having the benefit of a risk assessment, risk assessments not taking ethnicity into account, and concern that some were treated as a 'tick-box' exercise.[80] A senior NHS physiotherapist told the TUC:

> *'I did not feel safe during work. My employer assessed risk to us, however, did not take personal circumstances into account and so ineffective measures were put in place'.*

40. TUC Cymru worked with the Health and Social Care Sub-Group of the First Minister's BAME Advisory Group to develop the all-Wales Covid-19 Workforce Risk Assessment Tool, which was set up in May 2020, initially for NHS Wales, to accurately assess the risk posed to HCWs, and later social care workers, from Covid-19. The risk assessment tool took into account ethnicity as well as pre-existing health conditions. As the Equality and Human Rights Commission reported, the *'contributors from the healthcare sector spoke positively about this tool, saying that trusts had been monitoring and reporting on the numbers of staff who had done the risk assessment'*.[81]

41. **Health and safety regulation and enforcement.** There was a lack of effective health and safety regulation and enforcement. The Health and Safety Executive ('**HSE**') is the primary regulator for staff safety in healthcare in England; the CQC being the primary regulator for patient safety.[82] The HSE is in many respects an effective and respected regulator, although its capability is hugely frustrated by its drastically decreased funding.[83] In respect of health care regulation in the pandemic there were two particular problems:

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[75] INQ000280024/9-10, para. 47.
[76] INQ000092238/4, para. (l).
[77] See, for example: INQ000292480/36, paras. 134-135 and INQ000391161/17.
[78] INQ000412890/213, para. 810(a) and INQ000412890/214-221, paras. 811-835.
[79] INQ000396735/33-34, paras. 109-110.
[80] See, for example: INQ000399526/15-16, paras. 46-51.
[81] INQ000136934/33. See, similarly: INQ000427706/6-9, paras. 19-26.
[82] See: https://www.hse.gov.uk/agency-agreements-memoranda-of-understanding-concordats/assets/docs/mou-cqc-hse-la.pdf, para. 7.
[83] See, for example, the TUC Module 1 opening submissions, page 6, para. 20; INQ000235209/27-28, paras. 85-88; the TUC Module 2 opening submissions, page 9, para. 26; INQ000215036/65-70, paras. 209-224; INQ000399530/5-6, para. 15.

42. First, the HSE continued to regard healthcare as an area with lower risk and for lower intervention. The HSE has regulatory responsibilities across all sectors and proceeds by focusing its efforts (such as proactive inspections) on higher risk workplaces. Healthcare is generally seen as lower risk due to the controls in place and receives less focus, particularly for proactive inspection. That, effectively, remained the case during the pandemic, despite the marked increase in risk to HCWs from the virus. In a similar vein, Covid-19 was reclassified as a 'significant' rather than a 'serious' workplace risk, which essentially took prohibition notices off the table as an enforcement option in relation to Covid-19. As is set out in Kevin Rowan's first witness statement, the TUC considered that this decision was based on a flawed analysis of the risk to workers posed by Covid-19.[84]

43. HSE intervention was further undermined by underreporting in respect of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations. The HSE acknowledged underreporting, stating in May 2020 that there was significant under-reporting in the NHS in particular.[85] TUC analysis shows that this problem persisted and was *'continuously raised'* in tripartite meetings with NHS Employers and HSE.[86] Underreporting was contributed to by HSE's own guidance that there needed to be a written medical diagnosis of Covid-19 and a nexus or likely link between the dangerous occurrence, disease or death and the work activity or environment in existence at the time. The HSE may have been anxious to avoid a tidal wave of Covid-19 reports, but the guidance left such discretion to employers as to essentially act as a 'Get Out of Jail Free' card.

44. Second, there was a lack of clarity as to respective roles. The pandemic response falls at the intersection between workplace health and safety (HSE), public health matters (DHSC) and patient safety (CQC). There was a real sense during the pandemic that matters of regulation and enforcement fell through the cracks, particularly in relation to the workforce. In future, the HSE should have both the mandate and capacity to respond dynamically to a crisis and to increase its operations in the healthcare sector. Although the HSE received one-off spot funding of £14 million in May 2020, which was a welcome development, it did not result in an increase in warranted inspectors. As we set out in Module 2, the engagement which resulted was outsourced, and largely took place offsite, by telephone.[87]

45. In this module, the HSE suggests that the CQC is the 'primary regulator' in the healthcare sector in England.[88] The TUC considers it essential that the HSE and CQC are viewed as two sides of the same coin: regulation and enforcement for the workforce, and for patients. Furthermore, unions have long had concerns about the performance of the CQC as a regulator – the recent interim report in the review into the CQC's operational effectiveness notes that: a quarter of calls to the reporting call centre were dropped before they were answered; there are delays in the provider registration process; many organisations have not been re-inspected for a number of years (with an average age of provider ratings of 3.7 years); and 1 in 5 providers have never been rated.[89] These problems were compounded by the pandemic; the

[84] INQ000397188/18, paras. 58-61.
[85] INQ000397188/19, para.65.
[86] INQ000397188/22, paras. 77-78. See also: INQ000421758, para. 94
[87] INQ000215036/68, para. 217.
[88] INQ000347822/2, para. 8.
[89] INQ000474296/6.

CQC paused routine inspections in March 2020[90] and, additionally, employees of the CQC reported to their unions significant difficulties in accessing PPE, tests and vaccinations.

46. **PPE.** The evidence will show that: PPE provision was inadequate (especially at the outset of the pandemic); a significant proportion of the products which were provided were inadequate or out of date; and deliveries of PPE were disorganised and unreliable. FFP3 masks, goggles, visors, gloves and aprons appear to have been particularly unreliable in supply. HCWs having to resort to purchasing or even making their own PPE was not acceptable. To take just one example of a HCW response to a TUC survey:

> *'Initially, a fellow workmate and I asked for PPE and were told it was unnecessary, so I went home and made cloth facemasks for myself and others I worked closely with.'*

47. Adequate fit testing is crucial in guarding against an airborne virus. Fit testing is required by regulation when PPE is initially selected and whenever there is a change to the model of the mask, and must be carried out by a competent person as described by the HSE.[91] Unions received numerous reports that fit testing was not being carried out appropriately or consistently.[92] A paramedic told the TUC: *'Fit testing for the masks was poorly performed and required frequent rechecking as types of mask changed frequently'.* A physiotherapist redeployed an as ICU nurse also explained: *'During the first wave, we were given different masks and told we didn't need to be fit tested on those (which we then had to be tested with them after the first wave)'.*

48. There was a shortage in fit testers. It came to the attention of unions that a number of Trusts were forgoing fit testing and merely requiring fit checking, which is simply good practice carried out by the user, provided they are trained to do so.[93] This is corroborated by the evidence of Richard Brunt, HSE, who explained that the Chief Executive for NHS Trusts asked NHSE to remove the requirement for fit testing and replace it with fit checking. The request was denied as fit testing *'is essential to ensure that respiratory protective equipment actually protects* [...] *Not only could this lead to frontline staff being inadequately protected, it would also undermine the regulatory requirements and established expectations of HSE guidance'*.[94]

49. Responses to the TUC survey indicate that access to PPE varied significantly between job roles and wards and departments within hospitals. For example, one NHS worker explained:

> *'Myself and those working on intensive care where PPE was prioritised felt fairly safe* [...] *My colleagues on other wards did not feel safe, they had little Access to PPE and were told they did not need it'.*

And a portering supervisor told the TUC:

> *'It did not feel like the porters were playing any sort of role and it felt like they didn't matter. When we were transporting covid patients from wards for scans and procedures and also to the mortuary, getting in lifts in enclosed spaces* [...] *no proper PPE provided, just plastic aprons and gloves, but no proper masks'.*

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[90] INQ000474296/6.
[91] INQ000471985/32, para. 104.
[92] INQ000471985/31-32, para. 104. Similarly, see: INQ000471398/23-24, paras. 93-94 and INQ000281189/7-8, paras. 18-21.
[93] INQ000471985/31-32, para. 104.
[94] INQ000347822/66, para. 301-303 and INQ000347822/67, para. 306.

50. The inadequate supply of appropriate PPE had a huge and detrimental impact on staff morale and mental wellbeing, as well as staff and patient safety.[95] Significantly, Black, Asian and Minority Ethnic HCWs were more likely to be working in hazardous situations with inadequate PPE, contributing to the disproportionate impact of the pandemic.[96]

51. **Workplace guidance.** As in other sectors,[97] lacking and late guidance caused uncertainty and anxiety in decision-making. Cardiff and Vale University Health Board note that there were difficulties with disseminating IPC guidance as it changed so often and often arrived out of hours, leading to a lack of confidence from staff.[98] Responses to a TUC survey of HCWs suggested that those in non-clinical roles, such as cleaners and porters, had more difficulty accessing updated guidance. A hospital cleaner explained:

> *'I did not feel safe or protected! I had no supervision for a whole year.* [...] *I had to find out different changes to guidance every day from NHS staff! I was under so much pressure and stress, it was like no one cared about us, our safety or our mental health. I still have flashbacks now'.*

52. London Ambulance Service NHS Trust notes that there was conflicting advice from PHE and the UK Resuscitation Council as to whether chest compressions would amount to an AGP.[99] The problem was exacerbated for the NHS in Wales: *'A problem in Wales was that* [PHE] *guidance was usually announced on a Thursday, but guidance from Public Health Wales (PHW) the following afternoon (Friday). This caused an unnecessary level of anxiety for staff aware, through the media, of the PHE Thursday guidance" but unsure whether or not these changes would be effective in Wales until following day'.*[100]

53. Specific clinical settings found that there was a scarcity of guidance specific to their workplaces. For example, Dr Michael Mulholland (Royal College of General Practitioners) explained that the early stages of the pandemic, there was a lack of clarity about how PPE should be used in primary care. In March 2020, 76% of GPs said that it was important to have more guidance on PPE.[101] Furthermore, Alastair Henderson (Academy of Medical Colleges) noted that: *'There were major concerns from colleges and other staff organisations over the content and clarity of initial guidance on PPE in acute and mental health secondary care settings'.*[102]

54. One NHS hospital worker informed the TUC:

> *'The advice and guidance around infection and control was constantly changing, with very poor communication to staff about what the changes were, why they were being made, and it often felt like the guidance changed in response to what PPE was available rather than what was necessary to manage the risk to staff* [...] *Guidance was also vague from the government, meaning decisions often felt like they were being made at a local level, leading to significant variation* [...] *Hospitals in neighbouring areas had completely different advice, increasing uncertainty and anxiety'.*

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[95] See, for example, INQ000349686/33, paras. 86-87; INQ000471389/34-35, paras. 139; and INQ000471161/34, para. 150.
[96] INQ000399526/8-9, para. 24; INQ000399526/9, para. 25; and see the comparative survey evidence discussed at INQ000399526/10, para. 27.
[97] See the TUC Module 2 opening submissions: pp. 13-16, paras 38-42.
[98] INQ000480136/35, para. 144-148.
[99] INQ000303177/92-93, paras. 334-335.
[100] INQ000475209/13-14, paras. 91-93.
[101] INQ000339027/23, paras. 122-123.
[102] INQ000396735/29-30, paras. 96-97.

55. **Social partnership.** As in Modules 2, 2A, 2B and 2C,[103] the response to a pandemic is strengthened by effective consultation with partners such as unions. In England, the Social Partnership Forum ('**SPF**'), which brings together NHSE, trades unions, the DHSC and NHS Employers, was largely an effective forum for developing guidance, and responding dynamically to the pandemic. However, there is a feeling that the work of the SPF was at times hampered by a failure to implement decisions reached in partnership and by a failure to engage with unions at an early stage on key developments affecting the workplace, instead using the SPF to disseminate and implement pre-determined policy decisions. That is not to detract from the important work and contributions of the SPF – it is a marked improvement upon the situation in the social care sector and ensured important protections for HCWs during the pandemic. The efficacy of the SPF is also limited by the fact that outsourced workers are mainly outside the SPF's remit. The SPF had limited capacity to negotiate the terms and conditions of outsourced workers and the speed of implementation was slow.

C. LESSONS TO BE LEARNED

56. As the evidence proceeds, the Inquiry is invited to consider the recommendations that are needed in a number of areas:

(a) Resilience and surge capacity, which is the foundation of effective pandemic response.
(b) The workforce, which is a key aspect of resilience, but warrants detailed and distinct consideration of matters such as workforce planning, recruitment, retention, redeployment and the reliance on bank and agency staff.
(c) IPC measures, including physical distancing, ventilation, PPE, testing and vaccination.
(d) Measures to protect the health and wellbeing of the workforce, including risk assessments and working terms and conditions, such as the provision of sick pay.
(e) Measures to prevent the disproportionate impact upon particular groups, especially: Black, Asian and Minority Ethnic workers, women, disabled workers and low-income or outsourced workers.
(f) Regulation and enforcement of the healthcare sector, including specific consideration of the need for both proactive and responsive inspections throughout a pandemic.
(g) The accurate recording of the impact of the pandemic upon the workforce, including the numbers of HCWs impacted by death, hospitalisation and long-term sequelae.
(h) The consistency and scope of partnership working and the efficacy of the pre-existing mechanisms, including the Social Partnership Forum.

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[103] See, for example, TUC Module 2 opening submissions, pages 23-24, paras. 59-62; INQ000399530/32-33, paras. 96-100; TUC/STUC Module 2A opening submissions, pages 2-5, paras. 5-17; TUC/TUC Cymru Module 2B opening submissions, pages 2-5, paras. 7-18; TUC/TUC Cymru Module 2B closing submissions, pages 1-4, paras. 4-17; TUC/NIC-ICTU Module 2C opening submissions, pages 5-9, paras. 18-34.