IN THE UK COVID-19 PUBLIC INQUIRY

CHAIR: BARONESS HEATHER HALLETT

On behalf of the TUC

Sara Gorton Statement

First Witness Statement in Module 3

Dated: 6 March 2024

WITNESS STATEMENT OF SARA GORTON

I am Sara Gorton, Head of Health at UNISON and co-chair of the NHS Staff Council. My office address is UNISON Centre, 130 Euston Road, London NW1 2AY.

1. I make this statement on behalf of the Trades Union Congress ("TUC") in response to a letter dated 19 May 2023 sent on behalf of the Chair of the UK Covid-19 Public Inquiry (the "Inquiry"), pursuant to Rule 9 of the Inquiry Rules 2006. This statement is made for the purposes of Module 3 of the Inquiry, which is examining the impact of the Covid-19 pandemic on healthcare systems in England, Wales, Scotland and Northern Ireland. As requested, this statement focuses on the period of time between 1 March 2020 and 28 June 2022. I understand that a separate witness statement is being provided by Kevin Rowan on behalf of the TUC addressing the Health and Safety Executive ("HSE") and the investigation and reporting of workplace deaths during the pandemic. This statement therefore focusses on the pre-pandemic state of healthcare systems across the UK and the impact of the pandemic on healthcare staff.

2. This statement is structured as follows:
    a) Introduction;
    b) The NHS Social Partnership Forum and other engagement structures;
    c) Pre-pandemic state of healthcare systems and impact on the ability to respond to the pandemic;
        Health and Social Care Act (HSCA) 2012 and the fragmentation of health and social care
        Funding crisis
        NHS staffing crisis
        Issues with an outsourced workforce

d) Infection prevention and control
   PPE
   Ventilation

e) Impact on health and social care workers
   Covid-19 infection and Long Covid
   Mental health
   Abuse at work
   Financial impacts
   BAME workers
   Pregnant women and mothers
   Disabled workers
   Migrant workers

f) Vaccination

g) Areas of success
   Social partnership
   Practical improvements in facilities

h) Conclusion and lessons learned.

A. INTRODUCTION

3. I joined UNISON as an Assistant National Officer in 2002, working on a range of health policy and industrial issues before being appointed as a National Officer in 2004 and Deputy Head of Health in 2011. I became Head of Health in 2017, a role in which I run the union's UK bargaining, influencing and campaigning work for members working in the health sector. I lead the joint NHS Trade Unions in their interactions with Government, employers and system leaders on industrial and workforce policy and I am currently co-chair of the NHS Staff Council, the England NHS Social Partnership Forum and the Cavendish Coalition. I am therefore well-placed to speak to the issues this statement addresses.

4. I understand Mr Rowan's statement on behalf of the TUC in Module 3 sets out the role, aim and functions of the TUC and the extent of representation of workers in the healthcare sector by the TUC's member unions. I defer to Mr Rowan in that regard and do not repeat that information here.

The sacrifice of workers

5. The experience of working in the NHS during the pandemic had a profound impact on health workers.

6. For those working in or transferred to Covid-19 patient-care settings, what had been ordinary became terrifying overnight. As well as managing the physical discomfort of long hours working in personal protective equipment (PPE), staff had to cope with a psychologically insecure situation – worrying not only about their patients and colleagues but fearing the risk of harm to themselves and their families amid rising numbers of health worker deaths and a rapidly-escalating public health crisis. Many health workers died during the pandemic as a direct consequence of their work. Others have never fully recovered from the physical and mental impact of working through this period of time.

7. For those whose work transferred out of their usual setting - online or to the telephone - a vital component of their role was removed as they rapidly acquired new ways of working but lost their physical contact with their patients/service users and colleagues. This cohort included those designated 'vulnerable' due to pre-existing conditions who were shielding at home. Some roles could not be transferred out of a frontline setting, so some shielding staff were not allocated work at all, leading to isolation for many.

8. Reflecting on the impact of the pandemic on healthcare systems and how they responded, a few key themes emerge, which I address in further detail throughout this statement.

Social partnership

9. The social partnership arrangements present in the healthcare system, namely the NHS Social Partnership Forum (SPF), usually provided for early engagement between the Government and trade unions. This enabled unions to not only facilitate safe, continued work in the healthcare sector (by addressing employment issues such as securing pay progression, free car parking and so on), which in turn saved vital resource and capacity, but also to ensure that ministers, civil servants and system leaders were made aware of the real-time concerns of healthcare staff as they dealt with Covid-19 in their workplaces. As a result, they could adapt measures and guidance relevant to infection prevention and

control, risk assessments and other important issues impacting on the healthcare system, staff and patients alike.

10. That is not to say that the arrangements were perfect. As a technical point, the reach of social partnership extended only to the directly employed staff and not to bank, agency and outsourced workers or to those working in Primary Care, such as GP staff. In addition, the Government did not always listen to trade unions and guidance was sometimes produced without any opportunity for the unions to provide valuable input. This included the official infection prevention and control (IPC) guidance published by Public Health England (PHE) for NHS and Care settings, which was critical as it set out what protocols were to be applied, including giving guidance on appropriate PPE. Although trade unions would not routinely expect to be consulted over the clinical decisions contained in the guidance, advance sight of key content would have meant that gaps and likely key questions could have been flagged and anticipated. Certain policy decisions (for example, how employers were to respond to requests to 'flex up' levels of PPE in response to staff concerns) might have been usefully discussed with healthcare unions prior to publication and could have saved a great deal of time, confusion and industrial difficulty at a critical point in the pandemic response. Following the production of this initial IPC guidance at the start of the pandemic, it took intervention at General Secretary/Ministerial level to communicate the need to extend IPC guidance to cover ambulance and community settings – soon after we entered the first lockdown, Christina McAnea (UNISON General Secretary) and I met with Minister Helen Whately and we raised the issue of gaps in the guidance, including the need for setting-specific advice relating to ambulance and community services, both of which still had high volumes of contact with patients of unknown and/or Covid-positive status. This was a virtual meeting, unfortunately I do not have any materials in my possession relating to it.

11. Then, in the middle of April 2020, when the extent of shortages of PPE became evident, trade unions were not consulted on 'emergency' plans drafted by PHE. This meant that they were not able to provide reassuring information to health workers when the draft was leaked and widely covered in the media. Later on, it took significant intervention to get the issue of ventilation (covered further at paragraphs 110 and 111 below), which was a key policy issue for many healthcare unions, discussed with senior IPC leads.

12. While the testing regime and progress with NHS Test and Trace were regular items on meeting agendas of the Covid-19 SPF Engagement Group (see paragraph 29 below), trade unions were not involved in decisions about how this function was to be set up and

operated. As a result, we are not certain whether the merits of certain key options were considered. These include mobilising Local Authority Health Protection teams to support the Test and Trace function and measures to improve and regularise priority access to testing for health and social care staff.

13. One of the most significant decisions where the advice of the healthcare unions was ignored, at least initially, was over the policy of mandatory vaccination. This was first raised as a prospective policy as soon as vaccines were approved at the end of 2020, with the matter being regularly mooted as under formal consideration by March 2021. I raised union concerns and risks of the policy in most conversations I had with senior policymakers and ministers between then and the decision to implement the vaccination as a Condition of Deployment. Once published, trade unions used evidence of the industrial implications of roll-out to call for implementation to be halted. I cover this in further detail at paragraph 147 below.

Deficiencies in planning

14. As a consequence of years of underfunding and fragmentation of health and social care, by the time of the pandemic, our healthcare systems were struggling with capacity, particularly during high demand periods such as winter, and not in a position to react accordingly to the pandemic as they otherwise may have been able to.

15. There was a scramble for PPE, with stockpiles intended for a flu pandemic and inadequate for Covid and responsibility for managing PPE supply spread across multiple public bodies and private contractors. This, in effect, created a PPE 'lottery', with availability often depending on in which hospital, department or ward within a hospital the healthcare worker worked. Even when PPE was available, it was often out-of-date, or was not shaped to fit the gender and ethnicity profile of the NHS workforce.

16. As a result, we saw healthcare workers having to treat patients without PPE, use inadequate PPE or bring their own to work, putting their own health at risk and potentially contributing to the spread of the virus in hospital settings. This is set out in further detail at paragraph 97 below and in the accounts provided to our PPE hotline [Exhibit SG/85 – INQ000339483].

The staffing crisis

17. Since 2010, the NHS has faced progressively worsening staffing levels, becoming a crisis by the time the pandemic hit. During the pandemic, this resulted in a severely depleted workforce having to confront the extreme challenges posed by a global pandemic, with the NHS experiencing workforce shortages of more than 80,000 per day by January 2022. Health and social care staff were exhausted following the long hours and extreme service pressures that come with insufficient numbers to tackle a pandemic, and patient care and safety suffered. On a wider level, the staffing crisis limited the options for dealing with some of the issues that arose, such as any effective use of Nightingale hospitals.

Impact on the workforce

18. As I have already explained above, the pandemic had a profound effect on health workers, both physically and mentally. The workforce is a microcosm of society as a whole, and we saw those most vulnerable being disproportionately impacted. A number of workers faced financial issues, exacerbated by a lack of action and engagement from the Government on sick pay and effective financial support for self-isolation, and abuse whilst carrying out their work. There are worrying signs that the pandemic will have had long-term repercussions, with significant numbers of health workers suffering from Long Covid and many reporting issues with their mental health. In carrying out vital work, to protect and care for those in need, health and social care workers have suffered enormously.

B. THE NHS SOCIAL PARTNERSHIP FORUM AND OTHER ENGAGEMENT STRUCTURES

19. Over the period in which the Coronavirus Regulations were in place, trade unions sought to provide up-to-date and accurate guidance and information to members working in the NHS, and contribute to the development of policies, protocols and guidance that would keep them as safe as possible at work.

20. The work set out below was intense and highly pressured. It involved rapid assimilation of unfamiliar facts and situations, and a high level of critical thinking to consider the practical application and implementation of policy decisions. Trade unions undertook huge amounts of work to ensure speedy dissemination of information and the creation of feedback loops with frontline health workers, so that our engagement would be informed

by practical and contemporary experience. At a time when our usual routes for contact with health workers were not available to us, this necessitated a similar scaling-up and adaptation of new technologies.

21. Throughout the pandemic there were several feedback mechanisms. All unions would have had similar mechanisms, but at UNISON, as an example, we had regular contact with our Occupational Groups (Nursing and Midwifery, Ambulance, Operational Services and Science, Technical and Therapy). Each of these groups had a Chair who met and listened with branches in the regions and fed back to us. In addition, most Occupational Group members were also frontline health workers. Outside of the formal meetings and structures, frontline healthcare workers were also able to get in touch via phone, WhatsApp and email directly with those involved with the NHS SPF at UNISON who then raised the issues at formal meetings.

22. As the largest healthcare union, UNISON's head of health is the staff side chair of the NHS Staff Council in England. UNISON was a member of the Covid-19 Terms and Conditions Group, which was established as a sub-group of the NHS Staff Council and included unions, employers and the Department for Health and Social Care (DHSC). Similar groups were established for each of the partnerships in the devolved nations and these also met regularly during the period.

23. Health unions provided input to the NHS Staff Council for various items of system guidance and joint statements issued during the height of the pandemic. These covered issues such as annual leave, shielding and pay protection. Many of the principles agreed through the NHS Staff Council were followed in other parts of the UK.

24. There was some limited joint work undertaken between employers, officials and trade unions on Covid-19 preparation in advance of the formal March 2020 lockdown announcement. This focused on the IPC measures that were being taken and included a joint statement on Covid-19 published by the NHS Staff Council [Exhibit SG/1 – INQ000339374], which was published on the NHS Employers Staff Council web pages and disseminated more widely through trade unions' networks. Within UNISON, for example, we alerted all of our representatives via our regular e-bulletins and I participated in a number of media interviews to promote the guidance, including slots on the Today Programme on BBC Radio 4 and the Victoria Derbyshire show on BBC Two.

25. As moves were made to lock down in March 2020, the chairing team of the NHS Staff Council (Staff Side Secretary, Hannah Reed (Royal College of Nursing), and I) met with DHSC officials to scope out aspects of terms and conditions/working practices that could be temporarily altered to support staff to stay at work safely. This engagement in-part informed the '*Temporary Covid-19 - Terms and Conditions*' guidance that was published by the NHS in March 2020. The aims of this set of temporary changes were: to support NHS staff to deliver their essential services as safely as possible during the lockdown period; to ensure that Trusts (and units within Trusts) did not have to spend time and resource making decisions that could be made centrally; and to enable central provision of clear and consistent advice, guidance and instruction across the whole service. This included using trade unions' communication networks (websites, phonelines, email inboxes and other distribution channels) to provide information to NHS workers. Trade union representatives within Trusts and other provider organisations worked through appropriate structures with management to put these temporary changes into operation.

26. Over the course of the pandemic, a Covid-19 Terms and Conditions Group was established to add to or further define these temporary changes including agreeing their scope of application. This group met regularly, and in general at least once a week from April 2020 until the end of 2021.

27. As well as UNISON Head of Health, I am also the co-chair of the NHS SPF in England. The NHS SPF is a formal social dialogue grouping which brings NHS employers and trade unions together with policymakers to consider NHS workforce policy issues. SPF structures were adapted to consider the broader workforce issues arising from the Covid-19 pandemic (i.e. those not dealing with terms and conditions of employment). Fortnightly meetings of the SPF took place from April 2020. These were chaired either by the Minister (Helen Whately, then Edward Argar) or by a senior civil servant, and regular contributors to the meetings and workshops included: Professor Susan Hopkins (PHE); Dame Jenny Harries (Deputy CMO); Dido Harding (NHS Test and Trace); and Professor Stephen Powis, (NHS England). Recurring topics at these meetings included:

    a) Covid-19 Regulations;

    b) Infection Prevention and Control guidance;

    c) PPE;

    d) Test and Trace Programme; and

e) Vaccines (from December 2020).

28. Ahead of most of these meetings, I met with the Minister and my employers-side Co-Chair to identify key topics for discussion within the set agenda and anticipate points of policy difference that were likely to emerge.

29. A new SPF group was established called the Covid-19 SPF Engagement Group. The group met weekly from 30 March to 21 July 2020, after which meetings became fortnightly. The group took forward detailed conversation arising from the wider SPF and progressed outputs like joint guidance and policy positions on specific topics, including infection prevention and control, PPE, staff deployment, racial inequalities and vaccination. We received briefings from policymakers, who used the group to test ideas and receive stakeholder engagement. We then had the opportunity feed in comments to draft guidance or to take part in events to question and challenge nascent policies. An example is the updated guidance on NHS staff self-isolation and return to work following COVID-19 contact, produced in August 2021 [Exhibit SG/2 – INQ000339375]. Where appropriate, single-topic workshops were also convened so focus could be given to an emerging, contentious or complex issue.

30. The National SPF issued three influential statements on the conduct of industrial relations during the pandemic (in April [Exhibit SG/3 – **INQ000192690** July [Exhibit SG/4 – **INQ000192877** and September 2020 [Exhibit SG/5 – **INQ000192986**. As the September statement sets out, although Covid-19 would continue to be a presence in workplaces, the local circumstances in which SPF partners were managing the impact of the pandemic were varied. As a result, the decision was taken to stop issuing England-wide industrial relations statements, with partners instead keeping under review local industrial relations arrangements.

31. In addition, the SPF Wider Group and Engagement Groups continued to regularly meet each month. I exhibit notes of some SPF meetings between March 2020 and April 2021 [Exhibit SG/6 – INQ000119025]; [Exhibit SG/7 – INQ000119026]; [Exhibit SG/8 – INQ000119027]; [Exhibit SG/9 – INQ000119028]; [Exhibit SG/10 – INQ000119029]; [Exhibit SG/11 – INQ000119030]; [Exhibit SG/12 – INQ000119041]; [Exhibit SG/13 – INQ000119054]; [Exhibit SG/14 – INQ000119067]; [Exhibit SG/15 – INQ000119081]; [Exhibit SG/16 – INQ000119092].

32. The SPF also produced a 'stocktake' in September 2021, reflecting on the period from 19 March 2020 to the end of March 2021 and assessing the SPF's efficacy during that time, which I exhibit at [Exhibit SG/17 – INQ000330917], and its key achievements between April 2020 and March 2022 are set out at [Exhibit SG/18 – INQ000339450].

33. The role of the NHS trade unions in our interaction through the SPF structures was to:

    a) Acquire information on a range of topics related to Covid-19 to inform trade union communication and advice to health worker members;

    b) Provide feedback from health workers to policy-makers and employers about this information and seek further clarity/guidance as appropriate;

    c) Flag common questions or challenges to existing policy decisions and advocate for change/additions where appropriate;

    d) Influence policy decisions under consideration;

    e) Contribute to decisions about how policy positions, scientific and technical advice, and political announcements could be best implemented;

    f) Identify topics on which joint union advice and guidance was appropriate; and

    g) Identify topics on which joint SPF/Staff Council advice and guidance was needed.

34. Trade unions also contributed to work outside of these structures including contribution to policy decisions, process guidance and provision of advice and feedback on significant topics such as:

    a) Deployment of students;

    b) Access to childcare/education for NHS keyworkers;

    c) Re-start of healthcare education;

    d) Returners/volunteers;

    e) Role design and banding of the temporary vaccination workforce; and

    f) Visa policy for NHS workers from overseas.

35. In addition to leading the trade union delegation in these formal interactions, I also participated in a range of additional meetings to progress specific topics. One such topic was the Coronavirus Life Assurance Scheme, where I had a number of detailed policy conversations with senior officials in order to provide input to the Scheme. One outcome of my conversations was that the criteria for the Scheme was widened to include staff outside clinical occupations working in relevant settings, so the families of these staff were eligible to claim from the Scheme as some small compensation for their loss.

36. Another such topic was the policy on vaccination of NHS workers, which I address in detail later in this statement. Mandatory vaccination for NHS staff had been called for since the vaccine was made available in December 2020. I discussed this topic with a range of senior officials including the NHS's Chief People Officer Prerena Issar; the DHSC's Director of Workforce and directly with Ministers at regular intervals. These interactions contributed to re-consideration of the mandating policy and delay of the decision for a year. Once the Prime Minister had determined in late 2021 that regulations would be brought in from 1 April 2022 to make vaccination a Condition of Deployment, I had regular direct conversations with Health Minister Edward Argar to seek a reversal of the policy and to ensure trade unions would be able to engage officials on the implementation detail so that negative impact on the service could be mitigated.

37. As the Coronavirus Regulations were removed, NHS trade unions were also involved in discussions and decisions about appropriate lifting or wind-down of policies and protocols, including the multiple Covid-19 terms and conditions changes that were in place.

C. PRE-PANDEMIC STATE OF HEALTHCARE SYSTEMS AND IMPACT ON THE ABILITY TO RESPOND TO THE PANDEMIC

38. The foundation to a public health system that is able to respond to a major crisis such as the Covid-19 pandemic is, firstly, a system that functions effectively, such that it can be resilient when crisis hits. A system stretched to breaking point, if not beyond, will inevitably struggle to respond. The pandemic threw into sharp relief the structural and foundational problems in health and social care which trade unions, commissioners and policymakers have been concerned about for over a decade. Some of the issues are addressed in the TUC report of 1 February 2022 [SG/19 – INQ000103541]. The NHS and social care sectors have dealt with years of chronic underfunding and understaffing pressures, with

the workforce being overworked and undervalued by government before having to deal with the pandemic.

Health and Social Care Act (HSCA) 2012 and the fragmentation of health and social care

39. The HSCA 2012 brought in extensive structural reforms of the NHS and public health more widely, transferring significant public health functions to local authorities (also known as the 'Lansley reforms'). System leaders, particularly at NHS England, had recognised the dysfunctionality built into these reforms. This resulted firstly in the 'NHS Five Year Forward View' [Exhibit SG/20 – INQ000113169], in October 2014, and then the NHS Long Term Plan [SG/21 – INQ000113233], launched in January 2019, which pointedly sought a different approach to how the health and care system should be organised, joining up different parts of the system and favouring cooperation over competition. However, they were hamstrung by the legislation, with the 2012 Act remaining in place all the way through until the Health and Care Act 2022 finally removed some of the most extreme elements of the Lansley package. Jeremy Hunt himself describes having to go out of his way to ignore the 2012 Act due to the fragmentation it imposed "*as far as he could*", given the legislation he had inherited, and labelled some of it "*frankly, completely ridiculous*" [Exhibit SG/22 – INQ000339452].

40. The King's Fund, in 2015, described the organisational changes resulting from the Act as having "*created a system of considerable complexity and confused accountabilities. Reforms that were intended to simplify and streamline the organisation of the NHS have had the opposite effect and have resulted in a vacuum in system leadership at a local as well as national level*" [Exhibit SG/23 – INQ000339453]. It went on to label the changes as "*both damaging and distracting. Damage is evident in the serious fragmentation of commissioning, the bewildering complexity of regulation (to use the words of the Berwick review into patient safety), and the loss of continuity as leaders have been replaced and organisations have been restructured. Distraction has resulted from a requirement to undertake fundamental restructuring when there ought to have been a focus on improving patient care and delivering greater efficiency at a time of constrained budgets*".

41. At the time, Unite had concerns that these reforms could lead to the fragmentation of public health and substantial cuts due to local government's tighter budget constraints. In December 2015, in its written evidence to the House of Commons Select Committee 'Public Health Post-2013' [SG/24 – INQ000145936]. Unite explained that its concerns had

been realised, setting out in detail the negative impact of the changes to public health in conjunction with the wider cuts agenda. Unite members reported:

a) Swingeing cuts to public health services;

b) Reductions in staff terms and conditions, training and pay;

c) Poor morale and de-professionalisation;

d) Loss of status, independence and innovation within the service; and

e) False economies, as reduced services and quality leads to greater costs in acute services down the line.

42. The TUC had alerted the Government to its concerns regarding the fragmentation of services in its 2011 Budget submission [SG/25 – INQ000103543] at paragraph 5.8, stating "*The TUC has serious concerns about the direction of government policy on public services. Our vision for public services is for directly delivered, world class services, with genuine equality of access and high levels of quality for users and workers. We therefore have serious concerns that the Government's vision for public services will lead to fragmentation, increased private sector involvement and irreconcilable tensions such as between the plurality of provision and democratic accountability*". At paragraph 5.12, the TUC warned of the impact upon patient safety, stating "*The Government's proposed reforms of the NHS are likely to cost up to £3 billion to implement at the same time as fundamentally altering the make-up of the health service. Coming at the same time as increasing demographic pressures and a requirement to make £20bn in savings, there is a very real risk that the quality of patient care will suffer. Despite the Government's stated intention to protect NHS spending, unions are already reporting cuts across the health service*".

43. The TUC raised similar concerns again in its 2015 Comprehensive Spending Review submission [SG/26 – INQ000103545] and, on 5 April 2017, the Select Committee on the Long-term Sustainability of the NHS published a report [SG/27 – INQ000103544], which stated:

> *We asked many of our witnesses the same question—what does the healthcare system of 2030 look like and what do we need to get there? As a result, we were able to obtain a very clear articulation of what key components a sustainable system would need to include. A number of consistent themes emerged: (1) The urgent need to shift*

more care away from the acute sector into primary and community settings; (2) Widespread support for closer integration of health and social care services (as far as organisation and budgets are concerned); and (3) The need to resolve the current fragmentation of the health system, which is making the provision of co-ordinated care impossible and frustrating efforts to move toward place-based systems of care.

44. As a consequence of the above, health and social care systems were fragmented and less able to respond in a strategic manner to the pandemic.

Funding crisis

45. By the time of the Covid-19 pandemic, the NHS had been subject to a decade of funding cuts. The 2019 NHS Long Term Plan [**SG/21** – INQ000103546], to which I refer above, stated that funding for the NHS would rise on average by 3.4% in real terms over the next 5 years. By contrast, NHS funding rose by an annual average of 6% in real terms between 1997/98 and 2009/10. Providers reported a deficit of £571 million in 2018/19, even after an injection of additional central funding [SG/29 – INQ000103547].

46. As a result, health and social care systems were already struggling to cope with demand. Indeed, between 2011/12 and 2015/16, ambulance services demand increased at almost twice the rate of funding [SG/30 – INQ000103548]. A report by the Health Foundation and the Institute for Fiscal Studies in May 2018 [SG/31 – **INQ000113277** found that UK spending on healthcare would have to rise by an average 3.3% a year over the next 15 years just to maintain NHS provision at the 2018 levels, and by at least 4% a year if services were to be improved. Social care funding would need to increase by 3.9% a year to meet the needs of an ageing population and an increasing number of younger adults living with disabilities. That was in order to meet 'ordinary' demand, and without even contemplating the impact of a global pandemic.

47. Individual NHS trade unions used a variety of routes to raise concerns and give evidence of the impact of the severe funding constraints, including through formal contributions to Select Committee processes, work with think tanks and other stakeholders, and contributing to the TUC's work to challenge public sector funding decisions.

48. The TUC highlighted the impact that a crisis of funding across public services was having on capacity and patient safety through numerous budget submissions to the Government, including 2011 budget submission **SG/25** – INQ000103543], the March 2014 budget

submission [SG/33 – INQ000103550], the 2015 budget statement and the 2016 budget submission [SG/34 – INQ000103552]. The 2016 budget submission also raised concerns from others on the impact of the sustained funding crisis, citing a survey by the Kings Fund, which found that over half (53%) of NHS Finance Directors claimed that services have worsened in the previous 12 months as a result of financial pressures. Performance metrics across the health service supported this, with negative impacts in key target areas such as waiting lists, A&E waiting times, cancer treatment times and delayed discharges.

49. In a submission on the 2016 Autumn statement [SG/35 – INQ000103553], the TUC urged the government to bring forward investment in both physical infrastructure and in the vital social infrastructure provided by public services. It highlighted on the following page that "*The NHS and social care services are facing financial crises as a result of an unprecedented squeeze on funding which is set to last until the end of this parliament at the earliest. Evidence from Sustainability and Transformation Plans suggests that financially-led reconfiguration of services will lead to closures and additional service rationing in a number of areas of the country as the NHS struggles to find ways to find efficiency savings within a context of flat-lining funding*". It is worth noting that "*until the end of this parliament"* effectively meant until immediately before the pandemic, with that parliament expected to last until 2020 following the 2015 General Election.

50. The TUC's 2017 Autumn budget statement [SG/36 – INQ000103554] warned that public services were finding it increasingly hard to deliver effective, safe and sustainable services as a consequence of the continued funding crisis. It also pointed to the November 2016 joint report by the TUC and NHS Support Federation '*NHS Safety: Warnings from All Sides*' [SG/37 – INQ000103555], which found that throughout the previous 12 months there had been an unprecedented wave of organisations flagging up significant concerns about the growing crisis in the NHS. Fifteen different groups issued reports in 2016 sounding the alarm, including Royal Colleges, trade unions, NHS providers, health experts and the government's own Mental Health Taskforce.

51. The TUC submission for the 2018 Autumn budget statement [SG/38 – INQ000103556] highlighted that the funding crisis had led to a situation where capacity demands were unable to be met.

52. The NHS in Wales faced similar issues. A report by Nuffield Trust in June 2014 [SG/39 – INQ000103557] found that funding for the NHS in Wales had increased in real terms each year between 1992/93 and 2010/11 by an average of 4.7% a year, however, since 2010/11

that trend had ceased, with funding instead falling by an average of 2.5% a year in real terms between 2010/11 and 2012/13. They estimated that there would be a funding gap of £2.5 billion for the NHS in Wales by 2025/26, based on the rate of efficiency savings at the time and assuming even further efficiency savings worth 3.7% a year in real terms after 2015/16.

53. Shortly after publication of the Nuffield Trust report, the Wales TUC warned of the challenges faced by NHS Wales, calling for support for what was such a vital public service [SG/40 – INQ000145937]. They stated, "*NHS Wales is facing growing pressure and increasing demand on its services due to a complex mix of financial constraints, changing demography and long term public health challenges. As austerity at a UK level continues to deliver unprecedented cuts to the overall Welsh budget, all of our public services now face unjust funding pressures*".

54. As a consequence of the above, by the time of the pandemic, NHS systems were struggling with capacity, particularly during high demand periods such as winter, and not in a position to react accordingly to the pandemic as they otherwise may have been able to. This is coupled with the impact of a lack of investment in NHS infrastructure – common issues I was aware of in the early months of the pandemic included supplies of oxygen within particular buildings, feasibility of infection control measures in certain buildings (for example, available facilities for decontamination), the need for agile risk assessments taking into account the layout of specific buildings and ventilation (which I discuss further below).

NHS staffing crisis

55. Over a decade of real-terms cuts to earnings, determined by government pay policy, has contributed to a staffing crisis across many parts of our public services – perhaps most notably in the current NHS staffing crisis.

56. The value of NHS workers' wages has been severely eroded by the public sector pay cap introduced by HM Treasury from 2011/12 and ongoing pay restraints thereafter. TUC analysis shows that wages of NHS staff are still below 2010 levels after taking into account inflation, even after factoring in the 2021 pay award for staff [**SG/19** – INQ000103541]. By the point of the pandemic, workers across the NHS had faced significant real-terms pay cuts.

57. The April 2017 Select Committee on the Long-term Sustainability of the NHS report **SG/27** – INQ000103544] described that (at [153]):

> *There is an indisputable link between a prolonged period of pay restraint, over-burdensome regulation and unnecessary bureaucracy on the one hand and low levels of morale and workforce retention on the other. We recognise the necessity of public sector pay restraint when public expenditure is under considerable pressure. However, by the end of this Parliament, pay will have been constrained for almost a decade.*

58. In March 2010, the total vacancies among NHS medical and dental staff (hospital doctors and dentists excluding training grades) was 4.4% [SG/43 – INQ000103558]. By June 2019, that had risen to close to one in ten jobs, with a vacancy rate of 9.2%. Nursing and midwifery continue to experience some of the worst recruitment and retention issues.

59. The results of a UNISON UK-wide annual survey of nursing professionals, published in April 2016, revealed that staffing levels had worsened significantly in the previous year [SG/44 – INQ000145938]. Almost two-thirds – 63%, up from 45% the previous year – of respondents said they felt there were inadequate numbers of staff on the wards to ensure safe, dignified and compassionate care. More than two-thirds (70%) reported not having enough time to spend with each patient. Three-quarters (75%) said because they were so busy, there was no time to comfort or even talk to patients. Nearly half (47%) the survey respondents thought their organisations were at serious risk of a care failing developing, and more than one in ten (15%) felt that care failings were already happening in part, or across, their workplaces.

60. Similarly, in October 2016, the TUC commissioned YouGov to survey NHS workers across England to find out from staff at the frontline what the impact of NHS finances was having on clinical standards and patient safety **SG/37** – INQ000103555]. The responses received gave a very strong message:

    a) 7 in 10 (69%) NHS workers said that reductions in staffing and resources were putting patient care at risk.

    b) 9 in 10 (88%) NHS staff believed the health service was under more pressure than at any time in their working lives.

    c) Three-quarters (77%) of NHS workers thought resources and staffing in the NHS had gone down in the previous five years.

d) Two-thirds (60%) of NHS staff said their employer had cut patient services to make financial savings.

61. There are also inadequate numbers of professionals in training, such that the high levels of vacancies will inevitably continue without some long-term planning. Considering the number of vacancies in the NHS and social care respectively prior to Covid-19, it is obvious there are insufficient numbers of people in training for careers or career progression in both health and social care. The removal of nursing bursaries and those for other allied healthcare professions and the introduction of fees was a huge barrier to many people being able to start training to work in the NHS. In 2017 the Nursing Times revealed nursing degree applications fell by 23% from 43,800 in 2016 to 33,810 in 2017 in the wake of the bursary loss [SG/46 – INQ000145939]. This only addresses the nursing and allied health care profession shortages, but there are shortages across all professions in the NHS.

62. Again, similar issues were faced by the NHS in Wales. A review panel, independent of the Welsh Government, was established in April 2015 to consider many of the issues affecting the NHS in Wales highlighted by the Nuffield Trust report (to which I refer above). Martin Mansfield, then General Secretary of the Wales TUC, was a panel member. The panel produced a review in February 2016 [SG/47 – INQ000103560] concluding "*The long term strategic direction for pay in the NHS must be to keep pace with wage growth in the wider economy if the NHS is to avoid serious recruitment and retention difficulties, a worsening of staff morale and a decline in levels of competency*".

63. The already worsening staffing levels were then further depleted by Brexit, which had an immediate impact on the availability of staff from EU countries and resulted in a sudden drop on registrants from other countries. By November 2019, since the Brexit referendum, more than 10,000 EU nationals had left the NHS, including almost 5,000 nurses [Exhibit SG/48 – INQ000339454].

64. There was, therefore, a perfect storm – the staffing crisis in the NHS as we entered the pandemic meant a system already under significant stress and strain struggled to cope. The crisis resulted in any further pressures, such as staff sickness caused by the pandemic and the lack of available PPE, being felt even more acutely than they otherwise might have been.

The impact of staffing levels during the pandemic

65. As at December 2019, there were 106,000 vacancies across the NHS in England, including over 44,000 vacancies in nursing [Exhibit SG/49 – INQ000339455]. A survey by the Royal College of Physicians in 2019 found that 40% of consultants and 63% of senior trainee doctors reported daily or weekly gaps in hospital medical cover [Exhibit SG/50 – INQ000339456]. Across 2019/20, the UK had 2.4 hospital beds per 1,000 people, compared to 5.7 in France, 7.8 in Germany and 12.6 in Japan [Exhibit SG/51 – INQ000339457] and The King's Fund has documented the more than halving of hospital beds in 30 years, from around 299,000 in 1987/88 to 141,000 in 2019/20 [Exhibit SG/52 – INQ000339458]. Whilst the largest decline was seen in mental health and learning disability capacity due to the drive to cut residential hospitals, general and acute beds also fell by 44% over the period.

66. Staffing shortages became acutely visible as the pandemic hit in March 2020, when the Royal College of Physicians reported one in four doctors were absent either due to sickness or self-isolation [Exhibit SG/53 – INQ000339459], with 37,760 registered nurse vacancies at the end of June 2020 [Exhibit SG/54 – INQ000339460]. Meanwhile, in HCSA's Doctors at Work Survey 2020, 71% of doctors reported vacancies in their department, and 24% said there were vacancies in their department which were not officially recognised [Exhibit SG/55 – INQ000339461]; [Exhibit SG/56 – INQ000339462]. I do not have any evidence to provide on critical care capacity specifically, as there was no reporting to trade unions through the SPF or other routes of the assessment of the capacity that was needed or available within intensive care units (ICUs) or other critical units within Trusts. Issues relating to clinical decisions would be more likely to have been raised through local clinical governance routes and escalated to the clinical directorates of NHS England. However, GMB published two press releases in March 2020, criticising the Government's planned closures of ICUs at Epsom and St Helier hospitals, pointing to the potential impact of further deaths, particularly in the context of the pandemic and existing shortages of critical care beds [Exhibit SG/179 – INQ000425422]; [Exhibit SG/180 – INQ000425423].

67. As evidenced in UNISON's written submission to the Health and Social Care Committee on recruitment, training and retention [Exhibit SG/57 – INQ000339463], by January 2022 the staffing shortages remained a fundamental issue. The NHS was experiencing workforce shortages of more than 80,000 per day, with the military deployed to Trusts in

London to help plug staffing gaps, and in social care it was estimated that there were more than 100,000 vacancies in the sector.

68. Furthermore, firefighters stepped in to undertake certain additional activities in the health sector. The Fire Brigades Union (FBU), the fire and rescue service National Employers and the National Fire Chiefs Council (NFCC) (a charity/company of chief fire officers, with close links to the Home Office and the Cabinet Office) entered into a unique UK-wide tripartite agreement on 24 March 2020 [Exhibit SG/58 – INQ000119055]. This reduced non-essential activities before the first UK-wide lockdown and implemented an agreed approach to managing additional activities taken on by fire and rescue services the day after the first lockdown commenced, including ambulance service assistance. Throughout 2020 the national agreement was expanded, with more activities authorised, including delivery of PPE, face-fitting for masks to be used by frontline NHS and clinical care staff and the assembly of single-use face shields for the NHS and care workers.

69. It should be noted that, in November 2020, just as the second lockdown began, the NFCC withdrew from the agreement. The FBU and the National Employers therefore formed a new bilateral agreement, with plans to expand the additional activities. Then, in January 2021, without any prior warning to firefighters or the FBU, the National Employers unilaterally walked away from the bilateral agreement. As Frances O'Grady put it at the time, "*By turning their back on the national safety agreement, employers and fire chiefs are turning their back on us all*" [Exhibit SG/59 – INQ000192237]. As a result, the FBU instead took the initiative to form temporary, local agreements itself with fire and rescue services to continue to offer assistance to the depleted healthcare workforce.

70. The staffing crisis is a fundamental factor in the healthcare decisions made in the pandemic and the pandemic's effect on healthcare systems, workers in the sector and patients. It had a real impact on the response, beyond the immediate and perhaps most obvious issue of staffing critical care beds. It restricted both the availability and efficacy of options and solutions to the problems we faced. For example, Nightingale hospitals could, in theory, have alleviated the strain on the NHS and/or offered an alternative to care homes for those discharged from hospital to free up beds. However, the reality is that there were not enough numbers to staff them – entering the pandemic with over 100,000 vacancies in the NHS there was little chance of the Nightingale hospitals ever being able to operate in any meaningful way. I address Nightingale hospitals further below.

71. Whilst the public perception of health and social care staff may have improved during the pandemic, the pressures on workers were only worsened. The pandemic led to a very significant impact on levels of resilience, workforce stress and burnout across the NHS and social care sectors (as described by the GMB in its submission to the Health & Social Care Select Committee inquiry into staff burnout [SG/60 – INQ000103559]). During the pandemic, health and social care staff were exhausted following the long hours and extreme service pressures that come with tackling a pandemic with a depleted workforce. This was coupled with the fear of spreading the virus to patients and their own families and friends, PPE shortages, and dealing with more patient and service user deaths. Staffing levels are a root cause of workplace burnout, which in turn has led to increased sickness absence and further depleted the workforce, as set out by the Chartered Society of Physiotherapy (CSP) in its written evidence to the Health & Social Care Select Committee in September 2020 [Exhibit SG/61 – INQ000339464].

Deteriorating patient safety

72. The crises in funding and staffing led to a serious deterioration in patient safety by the time we entered the pandemic. A survey published by the RCM in March 2020 revealed that half of maternity units were understaffed, which was impacting on "*the quality of care women are receiving and most importantly it is affecting the safety of our maternity services*" [Exhibit SG/62 – INQ000339465]. Furthermore, the consequential redeployment of midwives to cover essential services meant that other key services, such as home births and births on midwife-led units were cut back, reducing the choice for women.

73. The HCSA's joint report with EveryDoctor, '*Never Again: Covid from the frontlines*', published in March 2022 [Exhibit SG/63 – INQ000339466], lays bare the effect such understaffing can have on the provision of services. To deal with this shortfall, many NHS Trusts turn to temporary staff. At a higher cost per head than full-time staff, this high level of dependence on temporary or locum staff, including substantive staff working additional shifts, equates to a massive expense for our already financially strained health service. Alongside the purely financial cost, there are a raft of other issues associated with this level of staff shortages. The higher turnover associated with temporary staff degrades the long-term sustainability of NHS workplaces. Institutional memory becomes limited, community relationships are disrupted, and the ability for doctors to build trust and provide continuity of care to their patients is constrained.

74. The current crisis in emergency services is by no means a new one. The GMB stated in 2014: *"The cracks are already beginning to show as a result of Coalition policy, most notably in the emergency services we all rely on. In the past year we've witnessed the disgraceful sights of tents set up outside A&Es to hold emergency patients who can't be admitted fast enough. Our elderly, waiting in corridors to be admitted on wards because community services are in meltdown. Dozens of A&E departments across the country face closure or downgrading"* [SG/64 – INQ000103567]. Subsequently, in a statement to the GMB Congress in 2017 it described that by December 2016 waiting times for A&E had risen again with record breaking waiting times of 12 hours, and the elderly *"waiting in corridors to be admitted on wards because community services are still in meltdown"*. It described that the GMB's ambulance service members *"are being pushed to the brink"* [SG/65 – INQ000103568].

75. The TUC's 2016 report '*NHS safety – Warnings from all sides*' **SG/37** – INQ000103555] described that since the beginning of that year there had been an unprecedented series of warnings raising the alarm about the pressures on the NHS. A number of organisations had issued warnings, supported by evidence from NHS staff, about threats to patient care. That included reports from unions, but also bodies such as the Royal College of Physicians and the BMA. In that same year, Unite and the RCM made submissions to the House of Commons Health Committee, which published a report in September 2016 on 'Public health post-2013' [SG/67 – INQ000103569]. That report expressed the view that *"Cuts to public health and the services they deliver are a false economy as they not only add to the future costs of health and social care but risk widening health inequalities. Further cuts to public health will also threaten the future sustainability of NHS services if we fail to manage demand from preventable ill health."*

76. The pandemic confirmed such fears around patient care. In UNISON's written evidence to the Public Accounts Committee in July 2020 [Exhibit SG/68 – INQ000339467], the union explained that, in March 2020, it had undertaken a survey of more than 60 nurses, midwives, healthcare assistants, students and allied health professionals about the issue of workforce shortages and safe staffing in their services [Exhibit SG/69 – INQ000339468]. When asked, in relation to their most recent shift in work, whether they had enough staff to provide safe, dignified care nearly half (47%) disagreed, and more than half (51%) disagreed that the skill mix and experience of their team was sufficient to provide safe, dignified care. Two-thirds (65%) disagreed that staffing levels were sufficient to supervise and support students and other learners, while the same percentage disagreed that staffing levels provided them with enough time to meet their continuing professional

development (CPD) requirements. Worryingly, more than half (53%) felt that the wellbeing of their patients was affected by unsafe staffing levels and 56% agreed that the safety of their patients was compromised by unsafe staffing levels. Staff from community settings reported an ongoing decline in the numbers of community nurses at the same time as demand for their services continues to rise (the number of nurses registered with specialist community and public health qualifications has fallen every year since 2016). This resulted in less time available to deliver care, making readmission to hospital more likely for many patients.

77. The issue did not go away, in November 2021, a further UNISON survey revealed that nearly a third (31%) of care staff believed dangerously low staffing levels were negatively affecting the care provided [Exhibit SG/70 – INQ000339469].

Nightingale hospitals and private hospitals

78. The understaffing of the health sector also had an impact on the efficacy of Nightingale hospitals, as I refer to above, and private hospitals during the pandemic. Nightingale hospitals were built to provide emergency critical care facilities in the early phase of the pandemic at a cost of £220 million. The bill rose to £532 million once running costs and decommissioning are taken into account. The rapid and effective conversion of these facilities from conference halls and arenas to critical care hospitals was impressive yet the new hospitals were barely used. The King's Fund highlight the need for an investigation to determine the reasons for Nightingale underuse, citing many possible factors including the nature of Covid-19 making it near impossible to transport severely ill patients, the locations of the Nightingales and how this relates to local NHS facilities, and the limited range of services falling short of what would be required to treat a patient suffering from Covid-19 with its complexities. Additionally, the role of chronic understaffing in the NHS must be considered as a contributory factor [Exhibit SG/63 – INQ000339466].

79. In reality, private hospitals were underutilised during the first and second waves. While it was hoped that they could provide a facility for urgent elective NHS procedures, instead the amount of NHS funded elective care work in private hospitals fell by 45% compared to the year before the pandemic. This is in part reflective of understaffing across the health sector. Many doctors within the private sector also work in the NHS. During Covid-19, some doctors were working long hours in the NHS and not available for work in private hospitals. In summer 2020, the requirements on private hospitals in the contract were revised downwards so that providers could restart private work alongside Covid-19 NHS

work, and to remove many private hospitals from the contract [Exhibit SG/63 – INQ000339466].

Recruitment and retention

80. The impact of the pandemic on recruitment and retention rates in healthcare may not become entirely clear for some time, however, early indications are concerning. Midwifery workforce figures from the NHS, published in July 2021, revealed that the number of NHS midwives working in England in May had fallen by almost 300 in just two months [Exhibit SG/71 – INQ000339470]. This was the fastest fall for those two months in any year since 2009.

81. The Joint Staff side submission to the Pay Review Body 2021/22 [Exhibit SG/72 – INQ000339471], highlighted the impact of the pandemic on the intention of staff to stay in the NHS, with over one in five healthcare professionals more likely to leave their role as a result of the pandemic. It warned that, with a major recruitment drive already underway, it was important to make the NHS an attractive long-term proposition for the future, through greater flexibility and better pay and reward packages, so that the recruitment drive could be used to tackle understaffing and build resilience into the system.

82. However, a year later and despite these warnings, the Joint Staff side submission to the Pay Review Body 2022/23, submitted in March 2022 [Exhibit SG/73 – INQ000339472], showed that the position had in fact worsened. We pointed to data released in September 2021, which showed that overall vacancy rates in England had soared from 5.9% in March 2021 to 7.6% at the midpoint in the financial year [Exhibit SG/74 – INQ000339473]. Furthermore, as of December 2021, there were 93,000 vacancies across the NHS, with shortages in every specialism and more than £6bn per annum being spent on locum doctors and agency nurses to fill gaps. HCSA's '*Learning the lessons of the pandemic*' survey from July 2022 saw almost half of respondents state that clinical staffing levels in their Trust were worse compared with the start of the pandemic [Exhibit SG/75 – INQ000339474]; [Exhibit SG/76 – INQ000339475].

83. The submission to the Pay Review Body also highlighted that high vacancy rates are contributing to the pressure being placed on existing staff, leading to burnout and low morale and in turn, contributing to people leaving their jobs. At this point in time, March 2022, the primary driver of staff wanting to leave was the pressure that they felt at not being able to deliver the appropriate quality and standard of care. Across all staff side

unions, staff were not just frustrated, but often traumatized by their inability to deliver care at the level and quality that they are required to.

Issues with an outsourced workforce

84. It was much harder for ministers and system leaders to exert an influence over those services which existed beyond their direct control. While the NHS remains a public organisation, in recent years, more and more outsourcing has occurred. In the case of cleaners, security staff, and porters, this has largely been about trying to cut costs at the expense of the workforce. Black workers are disproportionately represented among these occupational groups. Over time, pay and terms and conditions, including sick pay and pension provision, fall far behind what the same workforce would receive if they worked for the NHS in-house. This two-tier arrangement made it harder to ensure that activities such as risk assessments for Black workers were taking place in these parts of the system.

85. Early on in the pandemic, trade unions were alive to the issues this could present to staff in the healthcare sector and worked to extend the temporary Covid terms and conditions to outsourced employees. On 2 March 2020, GMB called for NHS Trusts to guarantee that all outsourced staff are guaranteed no loss of pay, no detriment to their sickness and absence record and no loss of annual leave entitlement [Exhibit SG/77 – INQ000339476].

86. Similar issues were also set out by UNISON in its written response to the Equalities and Human Rights Commission Inquiry into racial inequality in health and social care workplaces [Exhibit SG/78 – INQ000339477]. Agreements that UNISON reached for directly employed NHS staff covering full pay for Covid sickness and self-isolation, or for staff required to shield and unable to work from home, proved very difficult to enforce for staff who were either outsourced, worked in primary care, or worked via bank or agency arrangements. Even when agreement in principle was reached through the Covid Terms and Conditions Group to communicate the application of specific provisions to outsourced NHS workers, it took months to get this commitment published.

87. At a policy level UNISON was assured that Trusts and boards should be working with contractors and banks to ensure that staff were paid in full so that they do not attend work when they may be infectious, or, for shielders, place their health at risk. In practice, many contractors, banks agencies and general practices did not do this, did not do it in full, or ceased to do it – reverting to Statutory Sick Pay (SSP) or nil pay. Dr Claudia Paoloni,

President of HCSA, sent a letter to Matt Hancock on 19 March 2020, seeking engagement and summarising a number of concerns affecting the ability of the NHS and its staff to respond to the pandemic in a safe and sustainable way [Exhibit SG/79 – **INQ000119088**], including agency staff only being able to access SSP when self-isolating. Dr Paoloni stated:

> "*We welcome confirmation that NHS staff who have been asked to self-isolate will receive full pay from day one. However, we are extremely concerned that the same is not true of staff employed by an agency, many of whom are only able to access Statutory Sick Pay. We have already been made aware of cases where very little support is being offered to agency doctors who are self-isolating, and we are concerned that this could result not only in financial hardship, but also the possibility of presenteeism. We would ask that all agencies supplying NHS staff be advised to provide full pay from day one of self-isolation and that any financial support required is underwritten by the government.*"

88. I address SSP further below.

D. INFECTION PREVENTION CONTROL

PPE

89. The availability and supply of PPE was a major problem, particularly in the early stages of the pandemic. Union member evidence demonstrates the challenges in sourcing PPE; the provision of out of date or not to standard equipment, and the efforts to improvise when supplies ran low/out. I am unable to provide any detailed evidence as to the impact of the decision in March 2020 to no longer classify Covid-19 as a High Consequence Infectious Disease, but I know the decision was questioned by unions who were concerned by what this meant for the level and provision of PPE (see for example the exchange of correspondence between GMB and Yvonne Doyle (PHE) in March and April 2020 [Exhibit SG/181 – INQ000425424]; [Exhibit SG/182 – **INQ000119091**).

90. As the NAO has reported, there were numerous failings built into the system when it came to the distribution of adequate levels of PPE [Exhibit SG/80 – INQ000145895]. For example, there were no government targets for the management of the NHS Supply Chain when it came to the resilience of supplies to the NHS; the government's stockpiles of PPE

were intended for a flu pandemic and were inadequate for Covid; and responsibility for managing PPE supply was spread across multiple public bodies and private contractors (see also the NAO's November 2021 report, '*Initial learning from the government's response to the Covid-19 pandemic*' [Exhibit SG/81 – INQ000128524_0027]). The situation was, at times, dire.

91. A snap poll by HCSA in March 2020, as lockdown was announced, demonstrated that 80% of hospital doctors did not feel safe, 69% were not confident that PHE guidance was adequate and a further 34% reported that their own employer was not following the WHO guidance on the use of masks in healthcare settings [Exhibit SG/63 – INQ000339466]. HCSA received numerous accounts from GPs and hospital doctors at the time, describing in detail the issues they faced with the lack of PPE and the risks this posed for staff and patients alike. For example:

    a) GP in Leeds on 1 March 2020: "*No protective equipment at all, no information, no training, no support and no swabs. When we tried to order our own [we were] told public health have a supply they should be distributing, nil so far. We were always understaffed and underfunded, now we are underprepared, this will break us.*"

    b) Hospital doctor in South West England on 30 March 2020: "*We cover one of the cohort wards with confirmed positive patients. I was on it all weekend. We only have plastic aprons, gloves and surgical masks. There is 1 shared visor per bay (of 6 patients) for all healthcare workers. No gowns or FFP3 masks. I've been coughed on repeatedly. Both SHOs [Senior House Officers] covering the ward last week are off sick. I'm not sure how many other healthcare workers are off. I'm just waiting … It's terrifying … It doesn't feel safe examining a coughing Covid patient on humidified O2 with an apron and a surgical mask. We still don't have visors.*"

    c) Hospital doctor in Ipswich on 16 April 2020: "*Yesterday my hospital ran out of gowns. We had to use a pinny for intubation a baby as we didn't have any gowns available … If a baby had been born prematurely we wouldn't have had sterile gowns to put umbilical lines in! There is definitely a shortage.*"

    d) GP in Coventry on 4 June 2020: "*My GP surgery that I work with is currently struggling with stock of surgical facemasks for PPE, recently we had a day where there were none for patients or staff to wear, and at the moment we've had to stop giving them to patients because of low stock for staff … We've had barely any from*

the CCG – I was told we were given one box only and requests for more had been ignored or delayed … Our practice has been buying their own but running out of suppliers with stock now."

92. On 25 March 2020, UNISON sent a letter to the then Secretary of State for Health and Social Care, Matt Hancock, explaining that the union had been receiving reports of issues with PPE, particularly in the Ambulance, community and domiciliary care sectors, and asking Mr Hancock to urgently instruct employers to take measures to protect staff and the people they care for [Exhibit SG/82 – INQ000339480]. These measures included: ensuring staff could access the correct PPE; providing suitable and effective training on how to use PPE; confirming what measures were being taken to address supply and distribution issues; and providing staff with clear instructions on what to do in the event of PPE not being available.

93. UNISON sent a further letter on 31 March 2020, this time to the then Prime Minister, Boris Johnson [Exhibit SG/83 – INQ000339481]. The letter repeated the point that many public service workers were fearful and concerned about the lack of PPE in their workplaces and requested an urgent conversation with Mr Johnson regarding a demand for action on the lack of PPE.

94. On 1 April 2020, health and social care unions, including UNISON, the RCM, GMB, CSP, BDA, Unite and the TUC, issued a joint statement calling on the Government to urgently increase the supply of PPE to staff in the NHS and social care sector [Exhibit SG/84 – INQ000339482]. The statement set out how the unions were hearing from members every day that, despite repeated assurances from the Government, even where PPE was provided, people were being asked to work with inadequate or out-of-date protective equipment. Staff were also being threatened with disciplinary action for raising concerns about unsafe working conditions – leading up to the Easter weekend in 2020, UNISON's contact centre and health service team dealt with numerous issues of concern related to safety of equipment and working conditions. We referred most of these for intervention and resolution at local level but two particular examples that I recall as requiring several interventions were:

    a) Staff within a particular community service in Yorkshire and Humberside who were deployed to deal with patients of unknown Covid status. Their local management had determined that the services to be delivered necessitated a lower level of PPE than the staff wanted in order to feel safe entering people's homes. There was a

stand-off which lasted several days which escalated into threats of disciplinary action on one side and refusal to attend the workplace on the other. This issue was escalated up through my team to me and then I raised it with colleagues at NHS England/NHS Employers.

b) A large hospital Trust in the Eastern region proposed a change to working practices to launder and re-issue 'one-use-only' disposable items of PPE. They provided local reps with information from their testing of this process and sought approval from the local trade unions to use the PPE items in this way. This had caused conflict between the Trust and the local unions, as the reps were unable to advise use of these disposable items in this way, although the reps recognised the extreme shortages of PPE that the Trust was grappling with.

95. The unions called for the Government to put in place clear systems for employers to report shortages and shortfalls, and guarantee that no member of staff will be put under pressure to perform tasks without adequate protective equipment. They sought an urgent meeting and urgent action to ensure that PPE was making it to the front line.

96. Following each of UNISON'S formal communications with Boris Johnson and Matt Hancock, the UNISON General Secretary (at the time, Dave Prentis) received phone calls from Matt Hancock regarding the issues raised in that formal correspondence. These verbal conversations focussed on PPE, or the lack of, what UNISON was hearing about these issues and what measures the Government was putting in place to provide more PPE for NHS and social care staff. I am not able to go into more specific detail on what those measures were as we do not have records of those phone conversations.

97. By this point, UNISON had set up a PPE alert 'hotline' where it received numerous testimonies from public sector workers, including those working in hospitals and care homes, regarding the lack of PPE [Exhibit SG/85 – INQ000339483]. Such testimonies included accounts of staff being asked to wear bags over their faces for lack of surgical masks and a woman caring for vulnerable adults who described being coughed and sneezed on by residents, with only small plastic aprons no larger than an adult bib, and no face guards, for protection. As the UNISON press release states, these testimonies were passed directly to Mr Hancock by letter. I am unable to locate a copy of that letter, however it will have formed part of our regular communications with the Health Secretary during the pandemic that resulted in conversations between government ministers and the UNISON General Secretary.

98. A further snap poll of members by the HCSA in April 2020 reported 37% of their Trusts did not have an adequate amount of long-sleeved gowns and 47% the same in respect of full-face visors, while 44.5% of respondents said they had purchased their own PPE [Exhibit SG/63 – INQ000339466]. Dr Paoloni of HCSA sent an additional letter on 27 April 2020 to Matt Hancock (following her letter of 19 March 2020, referred to above) highlighting several issues with the supply of PPE, which required urgent attention [Exhibit SG/86 – INQ000339484]. The letter explained that shortages of PPE appeared to be a system-wide issue rather than a matter of rebalancing supplies between Trusts. HCSA expressed concern that PPE guidelines were being driven by supply problems and not safety, and that where a choice needed to be made between contradictory sets of guidance, it was often the lower standard that was adopted. Doctors on the frontline were asking for an honest assessment of the availability of PPE, and for clear and consistent guidance, based upon expert opinion and best practice. Dr Paoloni called for national guidance to be issued to mitigate the risk caused by PPE shortages and for an unequivocal statement from Matt Hancock that no staff member should be prevented from raising safety issues. The HCSA is not aware of any response from Mr Hancock to Dr Paoloni's letter.

99. Meanwhile, a survey of RCM members in April 2020 found that one-third of respondents reported experiencing shortages of PPE [Exhibit SG/87 – **INQ000280547**]. In response to concerns from members, the RCM worked with other health trade unions and professional bodies to hold the Government and employers to account for providing appropriate and adequate protection for members working in maternity care, on ensuring that services were properly resourced and equipped to protect staff and on ensuring that new staff or those returning to services were properly supported through training and supervision [Exhibit SG/88 – INQ000280548]; [Exhibit SG/89 – INQ000280549]; [Exhibit SG/90 – INQ000280550]; [Exhibit SG/91 – **INQ000280551**]

100. For a lot of doctors their PPE situation depended on in which hospital, or department or ward within a hospital, they worked. An HCSA focus group in August 2021 saw one doctor from the South West stating that they had adequate PPE, another from Birmingham stating the opposite and a third, based in Kent, explaining that: "*I was a junior doc working in ICU and it was two different worlds. In ICU we had all the gear, full PPE, FFP3, we had everything we could possibly want, but if you had to go to a ward you had no chance of getting anything … people who were working on the ward had barely anything … so you had to move with PPE that you had found on your own unit to assess patients, which became quite difficult*" [Exhibit SG/92 – INQ000339490].

101. When PPE was supplied, hundreds of thousands of items did not pass basic safety standards [Exhibit SG/63 – INQ000339466]:

a) Hospital doctor, South East England, 19 March 2020: "*Just wanted to flag up the mask issue about them being out of date – assume you've had loads of examples? This what we've got … Absolutely scandalous!*"

b) Hospital doctor, Greater Manchester, 1 May 2020: "*Last week the only masks available for all staff on the Covid wards went out of date in 2005 … The masks were surgical masks with elastic bands to go around your ears. You couldn't wear them for more than about 30 seconds without having them slip down past your nose. We were getting around it by tying knots in the elastic for a tighter fit … The fact these masks were 15 years past their use by date aside, I think I speak for the majority in saying that no-one felt particularly safe wearing them …*"

102. GMB was receiving numerous reports from members saying they were being provided with out-of-date PPE. For example, members were given face masks in the North Cumbria Integrated Care NHS Foundation Trust with out-of-date stickers from 2012, with the elastic straps having perished, either not offering a tight fit or falling off entirely [Exhibit SG/93 – INQ000410942]. Certain FFP3 masks provided to members in the London Ambulance NHS Trust displayed out-of-date stickers dating back to 2014, overlapped by another sticker saying 2016 and then a final sticker showing 2019, with no date at all on some surgical masks and Tyvek suits with an expiry date of 2012 [Exhibit SG/94 – INQ000410943]. GMB also received accounts regarding out-of-date PPE supplied to staff at Barnsley Hospital and Harrogate Hospital, with photographs showing a sticker dating back to 2016 and a further sticker blacked out [Exhibit SG/95 – INQ000339493].

103. Similar issues were found in the North West Ambulance Service (NWAS) [Exhibit SG/96 – INQ000410944].

104. Furthermore, fit testing of PPE proved to be a recurring issue. In April 2020, a Unite representative at NWAS raised concern with NWAS that the Trust was not following Government advice in relation to fit testing [Exhibit SG/97 – INQ000410945]. CSP also became aware, in May 2020, of the University Hospital Leicester NHS Trust deciding to fit 'check' rather than fit test PPE, with the Trust saying this was due to the number of differing models and difficulties in supply [Exhibit SG/98 – INQ000339496]; [Exhibit SG/99 –

INQ000339500]; [Exhibit SG/100 – INQ000339379]. This placed both staff and patients at risk. A fit test is required by regulation during the initial selection of PPE or whenever there is a change to the type or model of mask/ a change in circumstances of the wearer that could alter the fit of the mask, before the mask is worn in a hazardous environment, to ensure there is an adequate personal fit and seal to protect the wearer from fine aerosols containing virus particles. It must be carried out by a competent person as described by the HSE and involves either qualitative fit testing (a pass/fail test based on the wearer's subjective assessment of any leakage through the face seal region by detecting the introduction of bitter- or sweet-tasting aerosol as a test agent) or quantitative fit testing (an objective, numerical measure of face fit using, for example, ambient particle counting or controlled negative pressure). A fit check, on the other hand, is simply good practice carried out by the user, provided they are trained to do so, to ensure the fit of the mask is checked every time it is used. It is not a regulatory requirement, and it is not a substitute for fit testing. The Trust also sought to justify this decision on the basis that it was the approach being undertaken by other Trusts [Exhibit SG/101 – INQ000339380], indicating a joined-up approach by a number of NHS Trusts across the country. CSP raised this with University Hospital Leicester at the time, seeking assurance that fit testing would take place, failing which they would escalate the matter to the HSE [Exhibit SG/102 – INQ000339387]. CSP did indeed then refer the matter to the HSE, which confirmed that the Trust's reasoning was not a valid justification for not fit testing and that fit checking was no substitute [Exhibit SG/103 – INQ000339391]. The Trust did eventually recommence fit testing, but this appeared to be solely due to them receiving a large consignment of PPE rather than any appreciation of or reaction to the safety concerns [Exhibit SG/104 – INQ000339395].

105. Not only were there issues with the supply, availability and standard of PPE, but there was a lack of clarity in the guidance for use of PPE, with voids in guidance often being filled by unions. Responses to HCSA snap surveys demonstrated an improved understanding as time elapsed, however hospital doctors remained concerned about a complex and contradictory framework of ever-changing advice [Exhibit SG/105 – INQ000339399]. This was compounded by inconsistent implementation at local or even departmental level. There had been 21 separate updates to Covid-19 infection prevention and control guidance between 1 January and 7 May 2020 alone. The resulting confusion led to multiple policies being adopted locally, sometimes even within the same hospital. There was also a perception that the guidance often reflected supply rather than safety. One particular example was the failure to mandate mask-wearing in all areas of hospitals despite extremely high levels of Covid-19 across the community and the unavailability of

rapid testing. These factors effectively made it impossible to tell who had Covid-19, whether patients, staff or visitors [Exhibit SG/63 – INQ000339466].

106. At the time, PHE also mandated only wearing higher level FFP3 masks during high-risk aerosol-generating procedures ("AGPs") for "suspected or confirmed cases". In March 2020, front-line staff underlined the impracticality of this policy in the absence of any testing regimes, reporting how they had performed AGPs on apparent non-Covid-19 patients without PPE, only to learn subsequently that the patient had been self-isolation due to Covid-19 symptoms [Exhibit SG/63 – INQ000339466]. Furthermore, CSP had concerns early on in the pandemic that chest physiotherapy did not fall under the PHE's definition of AGPs, despite it potentially generating aerosols [Exhibit SG/106 – INQ000339400]. Midwives were also expressing concern and distrust that the advice regarding PPE was not protecting them, with a feeling that the advice on not needing FFP3 masks unless carrying out AGPs was based on a lack of equipment rather than best practice [Exhibit SG/107 – INQ000410936]; [Exhibit SG/108 – INQ000410937].

107. HCSA pushed for a broadened definition of PPE and for greater provision, writing letters to public health bodies [Exhibit SG/109 – INQ000119089] and working in partnership through bodies such as the Aerosol Generating Procedures (AGP) Alliance. However, the PPE definition appears unchanged and the impression is that those involved in AGP Alliance, including Dr Paoloni, were frustrated with the limited outcomes to their work due to Government inaction. PPE requirements for infection control have been widely challenged up to present times, as they are predicated on droplet rather than aerosol transmission. Covid-19 is airborne, so the PPE specification is inappropriate and continues to underestimate the transmission risk.

108. On 1 April 2020, HCSA called publicly for a change of guidance to redefine entire hospitals as a Covid-19 positive environment and mandate surgical masks for all areas. In a letter to PHE, Dr Paoloni warned: "*Staff and patients may not even be aware they are spreading the virus because the symptoms can be so slight … by shifting to a policy where staff and patients are considered potential Covid-19 carriers, we will be cutting the prospect of infection and reducing the chances of crucial NHS staff being taken ill at the worst possible time*". It was not until 15 June 2020 that this warning was heeded and facemasks were introduced in all areas of hospitals [Exhibit SG/63 – INQ000339466].

109. There was also conflicting advice from international and UK bodies on the level of PPE required. The first round of UK guidance fell short of standards set by the WHO, which

specified all healthcare workers should wear a mask, goggles, gown and gloves, and surgical masks in both clinical and non-clinical areas. UK guidance had only set these standards for staff working in designated 'high-risk areas' where they would be performing AGPs. This term itself went on to generate criticism, with many highlighting the fact that many more medical procedures than those listed include the risk of a patient generating aerosols, even by the act of breathing. While medical organisations representing staff advocated a safety-first approach to guidance which would mean greater PPE use, there was staunch resistance by policymakers to acknowledge the potential risk of aerosol transmission in enclosed spaces. It was only months later, as more evidence emerged on the ability of viral particles to linger in the air, that advice to the public caught up with what the workforce had argued all along. Eventually, on 27 January 2022, the UK Health Security Agency updated guidance on healthcare settings to reflect that Covid-19 can be spread through airborne transmission, and therefore FFP3 masks should be available to all staff working with patients with suspected or confirmed Covid-10. However, this information was not adequately communicated to employers, leading to concerning variations in practices between Trusts [Exhibit SG/63 – INQ000339466]. CSP also raised concerns regarding the inconsistencies in public messaging on airborne transmission of Covid-19 and the IPC guidance in force, writing in February 2022 to the CMO, Sir Professor Chris Whitty, (as part of the Covid Airborne Protection Alliance ("CAPA")) [Exhibit SG/110 – INQ000074820] and to the NHSE [Exhibit SG/111 – INQ000339405], requesting urgent review and clarification. The CMO forwarded CAPA's letter to the UK Health Security Agency, who then responded on 21 March 2022, stating that that the UK IPC Cell had recently agreed minor changes to guidance and its prominence on the IPC guidance website [Exhibit SG/183 – **INQ000300486**

Ventilation

110. Ventilation was a vital tool in infection prevention and control that was not, at least initially, given the attention it warranted. Health unions raised this with the Prime Minister by way of a joint letter in February 2021 [Exhibit SG/112 – INQ000114283], pointing to the scientific evidence that Covid-19 spreads via the airborne route and that the virus is readily transmitted in healthcare settings beyond formally classified AGPs. The unions urged the Government to, in coordination with the devolved administrations, ensure all health and social care providers assess and improve the quality of ventilation in all settings to reduce the risks of airborne spread, and to update all guidance (including the UK IPC guidance) accordingly. I am not aware of a response to this letter, but the issues addressed in the letter were later discussed by healthcare unions with senior policymakers at a roundtable

meeting on this topic, organised through the NHS SPF (although I am unable to recall the date of this meeting or provide any documents relating to it). GMB took steps to share information with its members in NHS workplaces regarding the importance of ventilation as well as the standards to be expected and the guidelines to be adhered to [Exhibit SG/113 – INQ000410938].

111. Whilst hospitals did generally have high ventilation standards, this was not the case in ambulances. The measures available to staff, and the guidance provided, were limited to travelling with the windows open and keeping the door open when parked and turning on the air exchange system with the vents open [Exhibit SG/114 – INQ000339408]. There were protracted arguments in England and Scotland on uprating ventilation in ambulances, which were never satisfactorily resolved (see for example, [Exhibit SG/115 – INQ000410939]; [Exhibit SG/116 – INQ000339410]). Ambulance staff were therefore left exposed to unnecessary increased levels of risk, due to a failure of proper leadership and guidance from Government.

E. IMPACT ON HEALTH AND SOCIAL CARE WORKERS

Covid-19 infection and Long Covid

112. Health and social care workers were on the front line in the fight against Covid-19. They showed resilience and dedication, whilst at the same time putting their own health at risk. By the end of 2020, 886 healthcare workers were recorded as dying with Covid-19 [Exhibit SG/117 – INQ000119177]. A study published in December 2020 found that healthcare workers were 7 times more likely to have severe Covid-19 infection than those with other types of 'non-essential' jobs [Exhibit SG/63 – INQ000339466]. Overall, in 2020, healthcare workers had the highest excess mortality (13.3%) of all occupations compared with non-essential workers and those unemployed [Exhibit SG/118 – INQ000339411].

113. This is consistent with the reports that unions were receiving during the pandemic. According to a poll carried out by GMB in February 2021, more than one in three

ambulance workers had contracted Covid-19 by that point in the pandemic, with 84% of them saying they had caught the virus while on the job [Exhibit SG/119 – INQ000339413].

114. GMB's March 2021 survey on mental health in the NHS and Ambulance Service revealed that over 41% of respondents believed they have suffered with Long Covid, and over 33% of those had had to take further time off work as a result of Long Covid symptoms [Exhibit SG/120 – INQ000339414]. Furthermore, UNISON's survey of health workers, carried out in April 2022, found that over 16% of NHS workers reported they either had previously had or continued to have Long Covid [Exhibit SG/184 – INQ000425427].

115. NHS Trade Unions issued a joint briefing in October 2021, providing guidance to trade union representatives on the importance of ensuring employers recognise Long Covid and the impact it has on NHS workers' health, and that those employers take the necessary steps to support staff [Exhibit SG/185 – INQ000425428]. UNISON has sought to support its members (including those working in the healthcare system) who have been affected by Long Covid. Since December 2022, the union has produced bargaining guidance on supporting members with Long Covid or post-Covid-19 syndrome (last updated in January 2024) [Exhibit SG/186 – INQ000425429]. In May 2022, Christina McAnea wrote a strongly worded letter to the Equality and Human Rights Commission (EHRC), reinforcing the rights of those suffering from Long Covid under the Equality Act 2010 [Exhibit SG/187 – INQ000425430].

116. Over the course of the coming months, UNISON is aiming to carry out a survey of healthcare workers, before a full members survey, regarding Long Covid. Once that data has been collated we can, of course, provide it to the Inquiry for this and future modules.

Mental health

117. Not only did the health sector workforce suffer physically, but the mental toll on the workers was also damaging. From watching colleagues become ill and in some cases die; to contracting Covid, often more than once; to having to cover for colleagues who were absent, often for long periods, health sector workers were exposed to extreme levels of mental stress for almost the entirety of the pandemic. There will likely be chronic issues with PTSD and Long Covid for many years as a result.

118. A UNISON survey of 14,004 health staff between 9 and 30 October 2020 saw almost half of respondents state that they had not coped well mentally during the pandemic

[Exhibit SG/121 – INQ000339415]. Increased workload and increased contact with severely unwell patients were the third and fourth biggest reasons respectively. More than half had sought mental health support.

119. HCSA's 'Doctors at Work' survey of 905 hospital doctors, conducted in November/December 2021, saw 70.3% of respondents describing morale in their workplace as very low or low, and one in 10 hospital doctors reported that they had had suicidal thoughts in the previous 12 months [Exhibit SG/122 – INQ000339416].

120. In a 2021 study of ICU staff, almost half reported symptoms consistent with a probable diagnosis of post-traumatic stress disorder, severe depression or anxiety or problem drinking. Factors identified by the study as relevant were long working hours, caring responsibilities compounded by lockdown school closures, and troubles with PPE supplies leading to increased anxiety around Covid-19 infection [Exhibit SG/123 – INQ000339417]. Meanwhile, the RCM found that the mental health of midwives from BAME backgrounds was particularly impacted, with reports of considerable trauma and a lack of support from employers [Exhibit SG/124 – INQ000339418].

121. Psychological issues have undoubtedly been compounded by physical exhaustion from working long hours. Yet, in the HCSA December 2020/January 2021 doctors at work survey (referred to above), less than half of the HCSA survey respondents indicated they would be able to take full annual leave allowance in that current leave year [Exhibit SG/55 – INQ000339461]; [Exhibit SG/56 – INQ000339462]. The average number of days taken was 16 since the start of the pandemic, with a median of 15. Meanwhile, some NHS Trusts sought to resolve the issue through encouraging staff to trade annual leave for money in a 'buy back leave' scheme, which ignores the vital need for staff rest and recovery. HCSA has also received anecdotal reports from doctors of NHS employers disallowing unused leave to be carried over, leading to staff losing out as a result of their contribution to the pandemic response [Exhibit SG/63 – INQ000339466].

122. A survey by UNISON, published in March 2021, revealed that 70% of NHS and social care staff in London had been so overwhelmed by work-related stress that they felt unable to cope, with 54% saying they had considered quitting the NHS or social care altogether due to the pressures experienced over the previous year [Exhibit SG/125 – INQ000339419].

123. This tallies with data from FirstCare in August 2021, showing a leap of 37% in NHS staff off work with mental health-related absence from 9,500 in February 2021 to 13,000 in June 2021 [Exhibit SG/63 – INQ000339466]. This also represents an increase of over 40% on the same months in 2020.

124. Unions engaged through partnership structures on the development and promotion of a range of short-term, nationally commissioned staff support measures, including a confidential helpline and free access to well-being apps [Exhibit SG/126 – INQ000339420], but it is clear that the impact of the pandemic on the mental health of health sector workers was profound and it is an issue that is likely to persist for some time. There needs to be planning, with trade union involvement, for the longer term psychological and mental health impacts for staff, with measures sustainably funded, visible and equally accessible to all staff across organisations, including indirectly-employed staff.

Abuse at work

125. Sadly, the pandemic also saw a rise in verbal and physical abuse towards healthcare workers from members of the public. A survey of 1,000 GPs conducted by the primary care publication 'Pulse' in September 2021 saw 74% state that levels of patient abuse had increased 'significantly' or 'slightly' since before the pandemic [Exhibit SG/127 – INQ000339421]. In January 2021, South Western Ambulance Service reported an 85% increase in overall incidents and twice as many assaults over the festive period in 2020/21 as in the previous year [Exhibit SG/128 – INQ000339422].

126. Midwives and maternity support workers also suffered an increase in abuse from pregnant women, their partners and families, largely in relation to visitor restrictions that were in place to maximise the safety of women, their partners and families and maternity staff. According to a survey by RCM in November 2020, seven out of 10 midwives had experienced such abuse in the pandemic, with one midwife saying "*Women feel we are robbing them of the maternity care they want. They are angry and feel we do not understand. No matter how much we try to explain some women and families can be incredibly verbally abusive. This is soul destroying. We are trying our best, but not everyone sees that*" [Exhibit SG/129 – **INQ000280495**].

Financial impacts

127. The pandemic also impacted on health and social care workers financially, which in turn added to the toll on their mental health. Four in 10 doctors (42.3%) responding to HCSA's Hospital Doctors at Work survey reported additional costs or lost income during the pandemic [Exhibit SG/122 – INQ000339416]. Many of the additional costs NHS frontline staff faced involved them having to compensate for basic equipment that should have been provided by their employer. Costs ranged from £50 for PPE through to £6,500. This included measures to support home working such as broadband or heating, and infection control items such as clothing which could be sterilised at high temperatures or personal items of PPE or hospital garments. The average cost was £1,390 [Exhibit SG/63 – INQ000339466].

128. Over a quarter of the respondents to UNISON's October 2020 survey of health staff (referred to above) stated that the pandemic had placed either themselves or their family under financial difficulty that year.

129. This must all be placed in the context of the issues surrounding sick pay. In many cases, staff faced an unacceptable choice between doing the right thing from an infection control/health and safety standpoint or continuing to be able to pay their bills and feed their families. At the heart of this were the issues of funding – who should pay for the increased cost of paying staff in full – and an abdication of responsibility for this wider workforce. The reality for many in low-paid and insecure work was that self-isolating in accordance with government guidance would leave them without the money upon which to support themselves and their families.

130. The TUC continued its pre-pandemic efforts to press the case for reform to sick pay to ensure it was accessible to all workers, through the removal of the lower earnings limit and set at a rate that enabled people to live. On 3 March 2020, the TUC called on the UK Government to respond to the pandemic by providing emergency support for the millions of UK workers who were ineligible for SSP [Exhibit SG/130 – INQ000192239]. Frances O'Grady had written to UK ministers warning that inadequate provision of sick pay could stop people taking public health advice, and some may feel they have no choice but to go to work. The TUC published the report, '*Sick pay for all – How the Corona Virus has shown we need urgent reform of the sick pay system*' [Exhibit SG/131 – INQ000119057].

131. The report pointed to the fact that the earnings threshold for SSP disproportionality impacted women, those in insecure work, and young and older workers, who were more likely to be without sick pay. Further, the rate of SSP (at £94.25) was low, and amongst the lowest compared with European counterparts. It also expressed the TUC view that workers should be treated as suspended from work when required to self-isolate such that they can receive full pay, and that it was vital that those required to self-isolate could access statutory sick pay.

132. In social care, even before the pandemic, large swathes of the workforce operated without any occupational sick pay scheme. This means that any sick leave would automatically result in them losing significant amounts of pay. In the context of the pandemic, this trend meant that many care workers were under huge financial pressure to attend work, even when they should have immediately self-isolated according to public health advice.

133. Campaigning and lobbying by UNISON eventually led to the Government setting up the flawed 'Infection Control Fund', which was intended to provide the funds for the sector to cover pay for self-isolation. This was supposed to deliver on the Health Secretary's pledge to "*ensure that when social care staff need to be away from work for infection control purposes, they are not penalised for doing so*" [Exhibit SG/132 – INQ000339424]. However, the social care sector, with tens of thousands of different employers, was not well understood by both officials and ministers and, as a result of this fragmentation, interventions were slow to formulate and then to permeate. For example, many care home employers refused to take government money offered through the Infection Control Fund (held at local authority level on behalf of DHSC) to boost sick pay for staff for fear that this would set a precedent and expectation of sick pay above the statutory minimum after the pandemic receded. I exhibit several emails detailing these issues between June and December 2020 [Exhibit SG/133 – INQ000119058]; [Exhibit SG/134 – INQ000119060]; [Exhibit SG/135 – INQ000119061]; [Exhibit SG/136 – INQ000119062]; [Exhibit SG/137 – INQ000119063]; [Exhibit SG/138 – INQ000119064]; [Exhibit SG/139 – INQ000119066]; [Exhibit SG/140 – INQ000119068]; [Exhibit SG/141 – INQ000119070]; [Exhibit SG/142 – INQ000119072]; [Exhibit SG/143 – INQ000119073]; [Exhibit SG/144 – INQ000119075]; [Exhibit SG/145 – INQ000119076]; [Exhibit SG/146 – INQ000119077]; [Exhibit SG/147 – INQ000119078].

134. A survey of UNISON social care members in July 2020 found that more than half of care workers (52%) said their employer was still paying less than £100 a week or nothing

at all if they needed to shield or self-isolate [Exhibit SG/148 – INQ000339425]. It is noticeable that the union's January 2021 survey of Black workers in social care [see Exhibit SG/78 – INQ000339477] showed the numbers of Black care workers dropping to either SSP or no pay were even higher: 57% across all care, 69% in residential care, 73% in domiciliary care. These figures completely undermined government claims to have dealt with the issue of sick pay using the Infection Control Fund and pointed to enduring problems for Black workers. As UNISON warned when the Fund was launched, it relied too heavily on social care providers positively engaging with the scheme and councils were given no additional resources to police implementation.

BAME workers

135. The Government was aware of the potential disproportionate impact of Covid-19 on BAME workers from relatively early on in the pandemic. On the 6 May 2020 SPF conference call, involving, amongst others, NHS England, DHSC and trade unions, it was recognised that there was a need to act urgently in respect of 5 key areas [Exhibit SG/149 – **INQ000119026**

a) Protection of staff, with improvement of risk assessments to include the impact on BME workers;
b) Engagement with staff, where BME staff feel comfortable to convey their experiences of Covid-19;
c) BME representation in decision-making;
d) Rehab and recovery, acknowledging there might be a higher emotional toll on BME workers; and
e) More diverse representation in media.

136. In June/July 2020, UNISON surveyed Black members on their experiences of work and Covid-19, with over 50% of the respondents working healthcare and nearly 20% in social care [Exhibit SG/150 – INQ000339426]; [Exhibit SG/151 – INQ000339427]. The results confirmed just how Black workers were significantly and disproportionately impacted by the Covid-19 pandemic. Only 6% of respondents had been redeployed to a new job role to allow them to work from home or carry out a job with less risk. Over a third (35%) had felt pressured to go to work when they did not feel their workplace was safe. 60% had not been offered an individual risk assessment and, of those who had had an individual risk assessment, a significant minority (35%) did not feel it adequately addressed the risks they faced. Only half of those requiring PPE to ensure their safety at

work reported being issued with the correct level of PPE for the setting in which they work. 58% had not received training in safe use of PPE (putting on, taking off, laundering, disposal) and 11% had a request for PPE turned down by their employer.

137. UNISON's analysis of a members' survey found that between March and December 2020, 67% of Black workers in bands 1 and 2 said they had worked in Covid-19 wards, compared with 51% of their White colleagues in the same pay bands [Exhibit SG/152 – INQ000339428].

138. Unions did what they could to try to combat these issues. For example, on 6 May 2020, the RCM produced 'wraparound' guidance for BAME healthcare workers [Exhibit SG/153 – INQ000119184]. This assisted those workers in understanding legislation that offered protection to the BAME community, as well as explaining the role played by risk assessments in the workplace and how they should be carried out. The RCM also issued guidance to maternity staff, outlining particular principles of care for BAME women [Exhibit SG/154 – INQ000119185], with further detailed guidance again in July 2020 [Exhibit SG/155 – INQ000119186]. GMB created a Risk Indicator Tool for BAME workers, to assist those workers in assessing the individual risk they faced [Exhibit SG/156 – INQ000192257].

Pregnant women and mothers

139. The RCM has provided a separate witness statement in this module, which addresses the operation of maternity services and changes to antenatal and postnatal care, however it also sets out some of the issues faced by pregnant women and mothers here. Early in the pandemic, many pregnant women working in healthcare were concerned by the lack of official guidance as to how to keep themselves and their babies healthy while also caring and supporting pregnant women. The RCM expressed its frustration at the continued lack of clarity from Government on the protection of pregnant healthcare workers, pointing to the Prime Minister's public advice that all pregnant women were particularly vulnerable to Covid-19, which was made without consultation with the RCM, undermined the clinical evidence at the time, caused significant and unnecessary anxiety and was eventually withdrawn [Exhibit SG/157 – INQ000192258].

140. The RCM, the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of Anaesthetists and the Obstetric Anaesthetists' Association jointly issued guidance on 21 March 2020,

outlining how pregnant women working in healthcare settings could achieve the recommendation for everyone in the UK to limit unnecessary social contact and providing clarity for them and their employers [Exhibit SG/158 – INQ000192259].

141. On 1 May 2020, Gill Walton, Chief Executive of the RCM, gave evidence to the Health and Social Care Committee [Exhibit SG/159 – INQ000119189]. Ms Walton provided insight on a number of issues, including the disproportionate impact of the virus on women from BAME backgrounds and the RCM's BAME staff, perinatal mental health, the increase in domestic abuse and the implications of that for pregnant women and the availability of PPE in the community setting, which had been an issue for midwives. Ms Walton also explained the role that the RCM and others had played in ensuring the publication of essential guidance, with the RCOG, the RCM and the RCPCH pooling their knowledge, resource and expertise to produce guidance, most of which was used and referred to by PHE, the NHS and across the world. The RCM continued to provide guidance for pregnant healthcare workers and for the care of pregnant women throughout the pandemic on a range of issues, supported by the latest scientific evidence and expert advice. The TUC also played its part, launching a blog on 2 April 2020, titled: '*Pregnant and worried about coronavirus? Here's what you need to know*' [Exhibit SG/160 – INQ000192260]. The blog provided advice, as well as calling upon the UK Government to raise awareness of existing legal protections for pregnant workers.

142. However, the lack of official guidance remained an issue. In its written evidence to the joint inquiry held by the Health and Social Care Committee and Science and Technology Committee, which began in October 2020, the RCM set out in detail its observations on the Government's lack of clear communication and messaging on important issues concerning pregnant women [Exhibit SG/161 – INQ000119192]. For example, they highlighted the Prime Minister's statement on the risk to pregnant women (referenced above) and the Government's failure to clearly explain and correct misinformation regarding maternity unit visits, with 70% of midwives experiencing abuse from pregnant women, their partners and families.

143. On 10 December 2021 the TUC along with Maternity Action wrote to Maria Caulfield at DHSC, expressing concerns regarding the latest guidance for pregnant employees [Exhibit SG/162 – INQ000119195]. The updated guidance published in November 2021 had removed reference to increased risks for women in their third trimester and affiliates had fed back to the TUC that employers were now misinterpreting this as meaning they no longer had to take action to mitigate risks, including carrying out individual risk

assessments and putting employees on maternity suspension if risks could not be mitigated. This came at a time when vaccine hesitancy amongst pregnant women was still high and the Omicron Variant was prevalent.

Disabled workers

144. As early as April 2020, the impact of the pandemic on disabled healthcare workers was being raised as an issue. At a meeting of the NHS Equality and Diversity Council on 23 April 2020, comments were made regarding the fear that both BAME and disabled staff felt at work, and that in the social care sector there were "*real concerns [about] both age and disability discrimination*" [Exhibit SG/163 - **INQ000280436**].

Migrant workers

145. Migrant workers play a vital role in the provision of health and social care services in the UK, and this was certainly the case during the pandemic. However, an often-overlooked impact of the pandemic was the uncertainty and barriers that it presented to migrant workers' visas. The Home Office slowed operations and the immigration guidance available was unclear. On top of this, for certain periods test centres for English language proficiency were closed, and priority application processing services were not available meaning some migrant workers had to surrender their passport for 6 months or more as part of the Indefinite Leave to Remain (ILR) application [Exhibit SG/164 – INQ000339434]. Such uncertainty and delay caused additional stress for such workers already under huge stress by virtue of their work on the frontline of the pandemic response, as UNISON heard from a number of its migrant worker members [Exhibit SG/165 – INQ000339435]. UNISON called for the Government to automatically grant ILR to all migrant key workers [Exhibit SG/166 – INQ000339436]; [Exhibit SG/167 – INQ000339437]; [Exhibit SG/168 – INQ000339438]. Lobbying and campaigning delivered some progress. The NHS visa was introduced which resulted in better outcomes in terms of exemption from visa fees for all NHS workers and eventually care workers too. However, problems remained and remain. Although the DHSC appears to recognise the importance of migrant workers to the NHS and social care, the Home Office remains committed to the hostile environment

that migrant workers face. The contrast with France, where migrant health and care workers were given citizenship in recognition of the work they did in this period, is stark.

146. There was also confusion regarding the NHS Surcharge. On 31 March 2020, the Government announced that doctors, nurses and paramedics with visas due to expire before 1 October 2020 would have them automatically extended for one year, and the extension would be exempt from the Immigration Health Surcharge. It was unclear at the time whether this included midwives, with the Nurse and Midwifery Council, the regulator for nursing and midwifery professions in the UK, asking the RCM that question [Exhibit SG/169 – INQ000410941]. It subsequently became apparent that NHS midwives were excluded from the extension, something that the RCM called on Government to rectify [Exhibit SG/170 – INQ000339441]. Almost a month later, the Government reversed its decision and announced that midwives and social workers would be included in the group of healthcare workers entitled to automatic visa extensions (though not at that time social care workers or any others who were not registered professionals) [Exhibit SG/171 – INQ000339442]. However, to the anger and frustration of the RCM, 6 weeks on from the Government's announcement midwives and other NHS workers were still paying the £400 levy [Exhibit SG/172 – INQ000339443].

F. VACCINATION

147. Vaccination became and remained a significant issue in 2021, with confusion over the safety of the new vaccine, then huge uncertainty around mandatory vaccination of healthcare workers. This was a significant wedge issue, with members split between those who viewed it as a critical safeguard, and those who saw it as an infringement of their rights [Exhibit SG/173 – INQ000339444]. The UK Government attempted to ensure mandatory healthcare staff vaccination against Covid-19, which was ultimately only used for social care workers. This coercive approach was very different to the more persuasive methods used in Scotland and Wales.

148. Whilst supportive of the vaccination programme, encouraging its members to trust the process [Exhibit SG/174 – INQ000339445] and providing tips on the communication and handling of Covid-19 vaccination programmes for healthcare workers (see for example UNISON's briefing to its sister public service unions in Europe who were also going through mass vaccination programmes, circulated in March 2021 [Exhibit SG/175 – INQ000339446]), UNISON made it very clear at the time that introducing vaccination as

a condition of deployment (i.e. mandatory vaccination) in the NHS and social care was wrong and counterproductive. In September 2021, on the day of the launch of the consultation into making Covid vaccination compulsory for frontline health workers in England, I warned that mandatory vaccinations in care had resulted in an exodus of staff and the Government was in danger of repeating that mistake [Exhibit SG/176 – INQ000339447]. I explained that "*The key to convincing hesitant staff is persuasion, not force. Pushing NHS staff to get vaccinated will create resentment, destroy already fragile morale and reduce take-up*".

149. We made similar points in the consultation on revoking vaccination as a condition of deployment across all health and social care [Exhibit SG/177 – INQ000339448]. Healthcare unions had made it clear that mandatory vaccination would undermine the vaccine programme and cause staffing shortages. The unions instead had urged the use of persuasion over coercion. But these warnings had been ignored by the Government and now, in February 2022, the Government was announcing that it intended to revoke mandatory vaccination. However, the damage had been done – diverting vital resources within health and social care to focussing on the policy and damaging staff relationships with the Government and employers, leaving a legacy of distrust and toxicity.

G. AREAS OF SUCCESS

150. Despite the obvious, and often extreme, challenges faced by the healthcare sector, there were some positives. As a general point, the pandemic reminded everyone of how lucky we are to have the NHS and that it is a national system – the pandemic response benefited from this feature, as it gave ministers and system leaders the ability to issue central guidance and get the necessary response from the services they are ultimately responsible for. This is in stark contrast to the fragmented social care system, in which ministers lack the necessary levers to effect change.

Social partnership

151. The main positives in the handling of the pandemic stemmed from the ability of the healthcare system to use partnership working to provide some level of certainty and reassurance to staff. Such reassurances were not always immediately forthcoming, but the well-established social partnership system enabled unions to ensure that ministers, civil servants and system leaders were made aware of the real-time concerns of healthcare

staff as they dealt with Covid-19 in their workplaces, so that they could adapt measures and guidance. The best examples of this as lockdown was approaching in March 2020 were provisions on full pay for staff needing to self-isolate, Covid special leave for staff unable work due to shielding, and Covid sick pay for those on Covid-related sick leave.

152. Subsequently, additional guidance was agreed on issues around staff childcare, automatic pay progression where pay step reviews could not take place, and overtime. Central overtime agreements were also reached in Scotland, Wales and Northern Ireland. The Covid Life Assurance scheme for England was announced in April 2020 and, due to the involvement of the unions, was not restricted to specific groups of staff and was separate from any benefits that may be payable through membership of the NHS Pension Scheme.

153. Before the March 2020 lockdown, agreements were reached with the Nursing and Midwifery Council and Chief Nursing Officers on the scheme for students to opt to take up employment during the pandemic; and for overseas nurses to join the temporary register. These agreements were applied appropriately across the rest of the UK and, following this model, a parallel agreement was made for other groups of staff with the Health and Care Professions Council.

154. There were other specific examples of the benefits of partnership working in the devolved nations. In Scotland, a Fair Work statement was agreed which allowed for the agreement of a number of measures and joint communications covering aspects such as social distancing, redeployment, staffing levels and Covid sick pay. In Northern Ireland, measures were agreed for a temporary uplift for Band 5 ICU and respiratory nurses to Band 6.

Practical improvements in facilities

155. In addition, a feature of the first wave was goodwill from the public and industry, leading to practical improvements for NHS workers (for example, supermarket opening hours for NHS staff, third sector and local business donations of food packages to NHS workplaces, hot food and overnight lunch boxes provided in some Trusts and suspension of car parking charges for NHS employees at their workplaces in Scotland and England (a measure already in place in Wales prior to the pandemic)).

156. These measures must be retained to avoid financial detriment for NHS workers. The Government has already reneged on parking passes for health and social workers and volunteers, which ended free parking in local authorities in July 2021, and individual Trusts are following suit [Exhibit SG/178 – INQ000339449]; [Exhibit SG/63 – INQ000339466].

H. CONCLUSIONS AND LESSONS LEARNED

157. The Covid-19 pandemic has left a significant mark on health and social care staff. Many health workers died during the pandemic as a direct consequence of their work. Others have never fully recovered from the physical and mental impact of working on the frontline.

158. A global pandemic was always likely to present significant challenges. However, the impact of the pandemic on our healthcare systems, workers and patients did not need to be so severe. A decade of underfunding and fragmentation of health and social care in the years preceding the pandemic saw the NHS already stretched to breaking point even before March 2020. Added to this was the progressive deterioration of staffing levels, which by the time of the pandemic had become a full-blown staffing crisis. As a result, our healthcare systems were ill-equipped and underprepared and our workforce was depleted, overwhelmed and burnt out, with damaging consequences for workers and patients alike. Even where there may have been spare beds capacity there was not the personnel to staff those beds. Potential alternative solutions such as Nightingale hospitals were underutilised and rendered largely pointless, at least in large part due to a lack of staff.

159. It is clear that, to ensure resilience going forward and in order that we are better placed to confront the next pandemic or civil emergency that will present itself, the NHS workforce crisis must be resolved. The NHS needs to be an attractive long-term proposition for the future, with proper Government funding, through greater flexibility and better pay and reward packages. If we continue with the status quo then we will neither be able to recruit nor retain enough staff to tackle the current backlog, let alone another pandemic. NHS staff, their bank accounts and health services are all running on empty. This is laid bare in HCSA's '*Learning the lessons of the pandemic*' survey from July 2022, referred to above. Almost 70% of respondents did not believe that their workplace was better placed than in 2020 to cope with any similar future pandemic; 77% felt that more medical staff was the most important factor to ensure the NHS is better able to cope with any future pandemic and also cope better with non-pandemic demand; 76% were either not that

confident or not confident at all that the NHS as a whole was now better placed to deal with any future pandemic; and 79% were either not that confident or not confident at all that the lessons of the pandemic will be learned and remain embedded [Exhibit SG/75 – INQ000339474]; [Exhibit SG/76 – INQ000339475].

160. What is also clear is that the ability of the healthcare system to use partnership working, provided some level of certainty and reassurance to staff. The NHS SPF facilitated engagement between NHS employers and trade unions together with policy-makers – it is important that such structures and engagement are maintained and strengthened. It is through partnership working that issues affecting not just workers, but patients and the healthcare system as a whole, can be best addressed.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: **Personal Data**

Sara Gorton

Dated: 6 March 2024