Witness Name: FMHWG
Statement No.: 1
Exhibits: 45
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UK COVID-19 INQUIRY
MODULE 3

WITNESS STATEMENT OF THE
FRONTLINE MIGRANT HEALTH WORKERS GROUP

The Frontline Migrant Health Workers Group (FMHWG), says as follows:

1. FMHWG is a collective grouping of two trade unions, United Voices of the World (UVW) and Independent Workers' Union of Great Britain (IWGB), and a consortium of community organisations, Kanlungan, for the purpose of their participation in Module 3 of the Covid-19 Public Inquiry. This statement is prepared jointly by leaders of those organisations, Henry Chango Lopez (IWGB – General Secretary), Petros Elia (UVW - President), and Lorie Halliday (Kanlungan – Director).

2. This statement is prepared in response to the Request for Evidence by the Chair of the UK Covid-19 Inquiry under Rule 9 of the Inquiry Rules 2006 (Reference: M3/FMHWG/01).

3. In accordance with the request, the statement will speak to the impact of the pandemic on low-paid, precariously employed workers in the healthcare system, the majority of whom are from migrant communities.

4. The statement will, for the most part, address the impact over the "relevant period" as set by the Inquiry, i.e. 1st March 2020 to 28th June 2022. On occasions it has been necessary to refer to dates outside of that period, in order to contextualise that impact. Where the accounts of interviewed members have been referred to, their initials have been anonymised for confidentiality.

Brief overview of the history, legal status and aims of the organisations

Kanlungan

5. Kanlungan is a registered charitable incorporated organisation consisting of several Filipino and Southeast and East Asian grassroots community organisations. Kanlungan works for the welfare and interests of migrants, refugees, and diaspora communities from the Philippines and Southeast Asia living in the UK. Kanlungan works across the UK to empower Filipino, East, and Southeast Asian migrant workers providing immigration, welfare, and employment advice. In addition it organises cultural and spiritual activities. It assists its members with mental health and wellbeing support; and campaigning for workers and migrants rights through lobbying local and national government.

6. In 2020, around 30,000 Filipinos worked for the NHS. This is the largest national group after British and Indian workers. Approximately 70,000 Filipinos work in nursing or domestic services more broadly. Kanlungan members work across the healthcare sector, as nurses, cleaners and domestic health care staff.

IWGB

7. The IWGB is a national trade union founded in 2012. It was established by Latin American cleaners organising for better pay, pensions and working conditions in London. They have subsequently expanded their membership across a number of sectors including couriers, cleaners, porters, security officers, and private hire drivers, many of whom work in outsourced positions providing the healthcare sector.

8. The IWGB organise and take industrial action to challenge exploitative practices which deny its members basic rights like the minimum wage, the London Living Wage, health and safety protections, and sick pay. Members are overwhelmingly working class and from BAME backgrounds in low-paid and precarious employment. Many work for 'gig economy' employers. The 'gig economy' refers to the labour market characterised by informal contracts of work often taken up via an online platform in which workers have considerable flexibility around if or when they work, but the employer often substantially

restricts how and when the work must be done. Workers are often categorised as freelance or self-employed and as such have few worker protections.

9. The IWGB has been at the forefront of organising workers previously unorganised. Through a decade of action, advocacy and campaigning the IWGB has become a leading grassroots trade union.

10. When the pandemic emerged, they were organised to advocate for frontline workers. Low paid precariously employed workers from supermarket workers, to cab drivers in general, to those specific to the IWGB kept the country moving through lock-down. For many, this came at an economic, physical and mental health cost. The IWGB worked tirelessly to make gains for these workers and have become a leading authority on the impact of the pandemic on low-paid, migrant and precarious workers, not just in London but nationally.

UVW

11. UVW is a member-led, anti-racist, campaigning trade union that exists to support and empower precariously employed, low-paid, working class and predominantly BAME and migrant workers across the UK. It is an unincorporated association with quasi corporate status by reason of its being a trade union under s.10 of the Trade Union and Labour Relations Consolidation Act 1992.

12. UVW combines industrial action and legal action to demand that all members receive at least the London Living Wage, full pay sick pay, dignity, equality and respect at work. UVW has a particular focus on challenging outsourcing, a practice that creates a two-tiered low paid workforce.

13. Outsourcing creates a two tier service. The stated purpose of outsourcing is to allow a public body to focus on its primary objective and function – in the case of an NHS hospital this would be medical services. Thus, the priority for the hospital is its doctors, nurses and management who retain contracts directly with the NHS Trust Hospital and remain 'in-house.' As a result those directly employed will know their monthly wage, they will have a public sector pension, and will have terms and conditions that allow for guaranteed sick pay and more than statutory minimum holiday entitlement.

14. Cleaners, porters and couriers, are seen as secondary service and therefore, for the hospital management, those workers are less important. Those jobs are often outsourced to a private company. A common argument made by NHS Trusts is that outsourcing will lead to efficiencies and savings. However, those outsourced workers are often contracted onto poverty wages, regularly underpaid or not paid on time. They received either little to no money for working extra time or for working on public holidays such as Christmas. Many of them lack full pay sick pay and receive only the statutory minimum of sick pay, with no money for the first 3 days of illness. They also often have to contend with gruelling, unsafe workloads and managers who abuse them with impunity. A high rate of staff turnover ensures that the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) do not protect new employed staff. Outsourced staff are typically employed on lower pay and in worse working conditions than in-house staff.

15. The United Voices of the World has run a number of successful campaigns to force NHS Hospital Trusts to bring outsourced low paid workers back in-house. Campaigns at **Irrelevant & Sensitive** (Exhibit LH/HCL/PE/01 [INQ000346794]) and **Irrelevant & Sensitive** (Exhibit LH/HCL/PE/02 [INQ000346797]) have been successful in ending the two tier system.

16. Outsourcing has a discriminatory impact because of race and class. In London particularly, there is a high, sometimes complete prevalence of BAME workers in outsourced public sector positions and a corresponding low prevalence in "in house" positions.

17. The previously outsourced **I&S** workers were much worse off than those who were working in house. We refer the Inquiry to UVW's letter to the Chief Executive of **I&S** dated 11 November 2020 (Exhibit LH/HCL/PE/03 [INQ000346795]) which at page 30 illustrates the major financial losses that outsourced workers face. This analysis illustrates the major differences between in-house and outsourced workers.

18. The issue of outsourcing impacts employment and workers' rights. It is a major issue in the health service. It pits workers against each other, but crucially slashes wages, strips workers of their better contractual employment rights and seeks to break trade unions, and thus collective bargaining.

19. UVW has members working as cleaners, porters, security staff and caterers within the NHS. Most of their members are outsourced workers serving the NHS. However, where members are employed directly by the NHS this has often been as a result of industrial action organised by the union to bring workers 'in house.'

20. UVW has **significant members across England.** **I&S**

I&S

Systemic issues:

21. The broad and united view of the Independent Workers of Great Britain, Kanlungan and the United Voices of the World is that the NHS in general and the idea of a free public health service are currently under siege.

22. The issues faced by each of the organisations over the course of the pandemic are symptomatic of, and rooted in, a wider set of systemic problems.

Austerity

23. Chronic underfunding of the NHS has led to serious understaffing and under-resourcing; leaving a weakened NHS, lacking capacity and investment and wholly unprepared to handle a pandemic of these proportions.

24. As a result of 13 years of austerity the NHS frontline has been left with:

    i. over 7.5 million patients (and rising) on the biggest ever waiting list in England (NHS Key Statistics: July 2023, Exhibit LH/HCL/PE/04 [INQ000327656])

    ii. chronic failures in performance in A&E and growing numbers of 12-hour trolley waits. (The Independent, 10 January 2023 – Exhibit LH/HCL/PE/05 [INQ000327669]), (The Health Foundation, Exhibit LH/HCL/PE/06 [INQ000327681])

iii. disastrous and deteriorating performance on cancer care (The Telegraph, 8 June 2023, Exhibit LH/HCL/PE/07 [INQ000327690]),

iv. desperately under resourced mental health care with 1.4 million people in need of care but not provided with it (BMA, 10 June 2023, Exhibit LH/HCL/PE/08 [INQ000327691]).

v. huge delays in assessment of patients' needs for social care and equivalent gaps in provision of care (AgeUK, Fixing the Foundations February 2023, Exhibit LH/HCL/PE/09 [INQ000217378]).

vi. staff shortages of approximately 154,000 vacancies (The Guardian, 26 March 2023, LH/HCL/PE/10 – INQ000327693), (NHS Vacancy Statistics England, April2015 - June 2023, Experimental Statistics, Exhibit LH/HCL/PE/11 [INQ000327694])

25. The Covid-19 pandemic began, as the first decade of austerity closed, with almost 25,000 general and acute beds (The Guardian, 31 May 2022, Exhibit LH/HCL/PE/12 [INQ000327695]), (Royal College of Emergency Medicine, Acute Insight Series: Beds in the NHS, May 2022, Exhibit LH/HCL/PE/13 [INQ000327657]) having been lost along with 25% of mental health beds (The Guardian, 5 July 2021, Exhibit LH/HCL/PE/14 [INQ000327658]). The austerity-led failure to adequately stockpile PPE severely undermined preparedness for a pandemic in the healthcare systems. (See INQ000205178, "Emergencies and Omissions" Kirchelle and Lancaster pages 90-92).

Privatisation and outsourcing

26. Successive governments have pushed for privatisation of health care which has brought the NHS to the brink of collapse.

27. In 1984, the Conservative government under the leadership of Margaret Thatcher instructed health authorities to open cleaning, catering, and laundry services to tenders from private contractors, resulting in tens of thousands of workers losing their jobs or being transferred to contractors on worse pay and conditions (Hall & Lister, *Privatised and Unprepared: The NHS Supply Chain,* University of Greenwich, 2020 – INQ000249708). Effective trade union representation was also lost as workers were outsourced with many of the traditional trade unions abandoning these outsourced workers.

28. From 2000, the Labour government under the premiership of Tony Blair drove the contracting out of clinical care to private hospitals, "Independent Sector Treatment Centres" and private companies, facilitating the outsourcing of more work (Exhibit LH/HCL/PE/15 [INQ000249708]).

29. The move towards privatisation has accelerated in subsequent years. The Conservative government under premiership of David Cameron abolished Primary Care Trusts and Strategic Health Authorities, and replaced them with 207 Clinical Commissioning Groups, which were required to put a growing range of clinical services out to competitive tender, resulting in an increased share of NHS spending flowing to private providers (Hall & Lister, page 5 – Exhibit LH/HCL/PE/15 [INQ000249708]).

30. This privatisation and outsourcing has led to a severe decline in the working conditions and employment protections of healthcare workers. In combination with 'hostile environment' policies, this has resulted in workers being vulnerable to coercion by employers who prioritise profit over worker, patient or public safety. It has led to outsourced workers being:

    (a) forced into work without adequate PPE
    (b) disproportionately allocated to higher risk working environments
    (c) left with inadequate testing
    (d) deprived of sick pay provisions, that in many cases left them having to choose between destitution or continuing to work whilst sick.

31. Recent rapid privatisation of NHS procurement services is a significant factor in Government failure to secure an adequate supply of PPE (Hall & Lister, page 10 – Exhibit LH/HCL/PE/15 [INQ000249708]) which severely undermined preparedness for a pandemic in the healthcare systems. The inadequacy of PPE provision is a key feature of the experience of the members of the Frontline Migrant Health Workers' Group and the consequences they had to suffer as a result. For example, outsourcing of procurement:

    a. prioritised savings that standardised supplies, resulting in an unsuitable range of PPE (Hall & Lister, page 12 – Exhibit LH/HCL/PE/15 [INQ000249708])

    b. led to large expenditure on middlemen that failed to meet required need and included four levels of profit-taking (Hall & Lister, page 14 – Exhibit LH/HCL/PE/15 [INQ000249708].

c. led to profiteering (Hall & Lister, page 7 - Exhibit LH/HCL/PE/15 [INQ000249708])

Outsourcing of pandemic stockpiling led to failure to meet required standards. In 2020, the stockpile was 10-28% below 2009 recommended levels, did not include gowns and included many expired items (Hall & Lister, page 20 – Exhibit LH/HCL/PE/15 [INQ000249708].

Structural racism and the hostile environment

32. Structural racism within healthcare has led to the disproportionate exposure to risk of migrant health workers and consequently worse health outcomes.

33. Hostile environment policies leave migrant workers vulnerable to coercion from employers, particularly in cases where workers are undocumented or where visas are dependent on a continuing contract of employment.

34. Migrant workers with "no recourse to public funds" (NRPF) conditions attached to their visas found themselves effectively destitute in the event of sickness.

35. Hostile environment policies discourage precariously employed, migrant workers from seeking healthcare from NHS for fear of immigration consequences or healthcare charges, even despite Covid-19 exemption.

36. Failure to heed the warnings of frontline migrant health workers put patients, the public and those same workers at greater risk.

37. Healthcare systems would not have been so overwhelmed if the concerns of frontline migrant health workers had been taken seriously.

Wages

38. Stagnant wages in the NHS have contributed to staffing shortages that have in turn led to workers undertaking more work for the same pay. In the context of the pandemic this led to increased exposure to the virus.

39. The low wages of precariously employed, migrant healthcare workers contribute to their vulnerability to employer coercion, poor access to adequate housing and subsistence, and consequently worsened health outcomes.

40. A lack of contracted sick pay, and reliance on the inadequately funded system of Statutory Sick Pay led to some workers having no choice but to continue working when ill, exacerbating the wider public health risk.

41. The system-wide inequality of pay for those working on the front line stands in stark contrast to the multi-million-pound Government contracts awarded, without transparency, to companies that were ill-qualified to fulfil them.

The experience of workers who were either Clinically Vulnerable (CV) or Clinically Extremely Vulnerable (CEV) or who had family members who were.

42. Set out in Annex A of their Rule 9 request the Inquiry has requested information as to:

i) the ability of workers represented by FMHWG who were identified as either CV or CEV to work, including whether their vulnerability was taken into account when they were allocated a role during the relevant period, and any impact upon those workers; and

ii) the ability of workers who had family members who were either CV or CEV to work during the pandemic and any impact upon those workers.

43. During the pandemic the IWGB had to raise the problems faced by workers who were CV on a number of occasions. In their experience employers were rarely sympathetic to representations made by the union on behalf of their members.

44. An illustrative example is the union's engagement with **Outsourced Organisation (1)** in April 2020. The union requested that four clinically vulnerable members be medically suspended from their work as couriers, on full median pay, rather than being required to work and therefore inevitably exposed to significant risk of infection and potentially severe consequences. (LH/HCL/PE/16 [INQ000327662]).

45. Three of the four couriers **Name Redacted** asthma and previous stroke, **Name** **Name** ongoing medication for previous heart attack, and **Name Redacted** diabetes and previous stroke) plainly met the criteria of clinical vulnerability, whilst a fourth **Name Redacted** undiagnosed shortness of breath) potentially met that criteria.

46. All four of the couriers were employed as 'Limb B' workers (see paragraph 70 below); without a full time contract or set weekly income.

47. The employer Outsourced organisation (1) refused the request, pointing to the Government guidance. They stated that they were "*not requiring*" couriers who were shielding (those categorised as clinically extremely vulnerable) to come to work and would pay them Statutory sick pay (£94 per week at the time). However, "*those not shielding* [I.e. the clinically vulnerable] *should follow the social distancing guidance*". The clear implication was that those who were not categorised as extremely vulnerable were required to work and would be paid nothing if they did not. The social distancing guidance included: avoiding contact with anyone displaying symptoms of coronavirus and avoiding large and small gatherings in public spaces. Neither of these key pieces of guidance were compatible with the work of medical couriers, who were required to enter hospitals and move within them, through corridors, wards and public lifts.

48. The union argued that the workers fell into the CV category and particularly given the exceptional nature of the pandemic, and the fact that the workers were regularly exposed through their work with hospitals and testing centres for Covid, they should be properly protected. The IWGB argued Outsourced organisation (1) *response to them, from what I gather, is that they should follow social distance and get £94 week to live off. It is extremely worrying that* Outsourced organisation (1) *would think that their workers, who are at the frontline of this crisis picking up and delivering Covid-19 samples, are worth, and can survive on £94/week. This is even more flagrant when some workers will have to self-isolate for a period of 12 weeks. Ultimately this will mean financial destitution for these workers and it is not compliant with health and safety regulations as some people will be forced to come into work and put their health at risk in order to be able to survive. Can I understand if* Outsourced organisation (1) *position is that these measures are health and safety compliant and the basis for it?*" (Exhibit LH/HCL/PE/16 [INQ000327662]).

49. Despite a chain of correspondence the employer was completely unwilling to allow the workers to be furloughed, or to receive an average pay and to shield despite their obvious health conditions. The workers in question were forced to work, it was either that or effectively starve as they would not be able to afford to live on £94.00 per week Statutory Sick Pay. IWGB caseworkers encountered similar approaches from a number of private companies providing outsourced cleaning services to hospitals. (Exhibit LH/HCL/PE/17 [INQ000327666], Exhibit LH/HCL/PE/18 [INQ000327664]).

Treatment of low-paid, migrant and precariously employed health workers during the relevant period

Kanlungan

50. Kanlungan Filipino Consortium represents a wide range of South and East Asian healthcare workers both within the NHS and outsourced workers in the healthcare systems. Filipino workers are the second largest non-British national group employed by the NHS (Exhibit LH/HCL/PE/19 [INQ000235265]). Kanlungan members were on the frontline of the pandemic as nurses, cleaners, porters and other ancillary work roles.

51. As early as January 2020, our members had begun to notice the spread of Covid-19 through the health service and with a rising sense of urgency became concerned for their safety. Regrettably, their concerns were not taken seriously.

52. One of our members, "AZ", an NHS nurse, was interviewed in July 2023 about the situation she encountered in her work from January 2020 onwards. AZ raised concern in January 2020 with the hospital management where she worked concerning safety protocols and personal protective equipment but was advised there was not yet cause for alarm or additional processes. When AZ tried to bring her own PPE to work to protect herself she was told that she should not wear it at work because it would panic patients and other staff, and that she may be reprimanded by the Infection Control department. "AZ" continued to raise concerns, but she saw that complaints were only taken seriously when also raised by her white colleagues. In contrast she was treated as a troublemaker. As cases soared and policy gradually changed, the need for PPE was made abundantly clear; but AZ reports that it was never acknowledged that her concerns and requests had been entirely reasonable. As set out in our report, "Nursing Narratives: Racism and the Pandemic" (Exhibit LH/HCL/PE/20 [INQ000327661]), it is our experience that this kind of treatment of Kanlungan members was typical rather than exceptional during the relevant period.

53. As the pandemic escalated, the risk to Kanlungan members only increased. With Covid cases surging, hospitals were increasingly overwhelmed by admissions. As a result, the risk of exposure to staff was extreme. Kanlungan was increasingly receiving reports from our members that Filipino nurses were being disproportionately asked to work on high-risk Covid wards. Our understanding is that this took place as a result of pressure

from managers and was no doubt exacerbated by the low-bargaining power of workers with insecure immigration status. Many of our members' migration status is tied to their work which has the effect of reducing their ability to challenge management decisions without risking their leave to remain in the country. As such, Filipino nurses were exposed to greater risk.

54. The report "Nursing Narratives: Racism and the Pandemic", co-researched by Kanlungan examines this issue. In the course of our research, all the Filipino nurses we spoke to had personally experienced discrimination regarding work allocation during the pandemic (Exhibit LH/HCL/PE/20 [INQ000327661]). Of 353 respondents to the research, 34 were Filipino. 44% of those Filipino respondents said they had been unfairly allocated to Covid positive areas. This risk was compounded by the lack of adequate PPE. One Filipino nurse remarked 'we were chosen to be exposed' (INQ000327661), a statement that is tragically reflected in the infection and mortality rates amongst Filipino nurses (Exhibit LH/HCL/PE/21 [INQ000327667]).

55. The "Nursing Narratives: Racism and the Pandemic" report, noted a culture of neglect, with nurses articulating a lack of care or value attributed to Black or Brown lives. The structural racism ranged from some Black and Brown workers being refused swab tests in the first wave although white staff from the same hospital had received tests, to the unfair distribution of gifts from the public **I&S** a Filipino nurse who has left the NHS, described how charitable donations from the public were first given to those close to the nurse managers, with migrants only getting what was leftover). A Filipino nurse contributor remarked at page 20 (Exhibit LH/HCL/PE/20 [INQ000327661]): *"...they would just tell you; you are hired to work here. Just work, I don't care if you die or not, I don't care if you are sick or not, just work."*

56. In the early stages of the pandemic 22% of staff deaths were Filipino nurses – this despite the fact that they only comprise 3.8% of the workforce (Exhibit LH/HCL/PE/21 [INQ000327667]). Kanlungan were deeply alarmed by these figures.

57. In April 2020, Kanlungan organised a meeting with NHS managers, including the Racial Equality Workforce and representatives of the Department of Health and Social Care. The NHS managers verbally acknowledged the disproportionate impact on Filipino staff members at the meeting, with regard to the overrepresentation of Filipino nurses in infection and mortality statistics and the assignment of Filipino nurses to high-risk wards. Kanlungan did not receive any written acknowledgment of this and were

not informed of any specific steps that were or would be taken to address the situation. Kanlungan did not make written representations to this meeting.

58. Whilst the disproportionate impact on Filipinos was at its worst in the first six months of the pandemic, it has been widely documented that there was a disproportionate impact on Black and ethnic minority healthcare workers throughout the pandemic. Likewise, our members continued to report throughout the relevant period that they felt pressured to accept assignments to high-risk wards. In this context, it is the view of Kanlungan that our members' lives were not considered as valuable as their British counterparts.

IWGB/UVW

59. The majority of both IWGB and UVW members are precariously employed workers from BAME communities. IWGB / UVW members, as stated, are workers in roles such as hospital cleaners, porters, security staff and medical couriers, their frontline work put them at an increased risk of exposure to Covid.

60. Many IWGB/UVW workers work for companies that won outsourced contracts from NHS Trusts. The view of the unions is that outsourced contracts create a two-tier work force. Employers of outsourced staff typically did not provide PPE as a matter of urgency and in the same way as those who were 'in-house.' Where it was provided it was often in short supply and unsuitable. As such, these outsourced workers were disproportionately exposed to the virus without adequate protection on a group-differentiated basis in a clear example of structural racism.

61. As early as January 2020, IWGB members in medical courier roles raised concerns about their exposure to the novel samples they were collecting. As cases and samples for testing began to rise, they could see from the frontline the increasing severity of the pandemic in advance of many.

62. Their early concerns both at the spread of Covid, and the lack of PPE were largely dismissed or ignored by both NHS and private employers. IWGB and UVW members saw their requests for PPE were not treated seriously. Most were still operating without PPE up until the first lockdown in March 2020. In the months that followed, as they continued to work even where PPE was secured it was typically in short supply and insufficient to protect the whole workforce.

63. As an example, bicycle and motorbike couriers working for Outsourced Organisation (1) a private diagnostic contractor of the NHS, raised concerns around the absence and inadequacy of PPE. They also raised the need for regular testing. Their employer claimed that there was insufficient evidence that regular testing would reduce the spread of the virus among the workforce, despite the clear efficacy demonstrated throughout the relevant period (Exhibit LH/HCL/PE/16 [INQ000327662]).

64. It is the view of IWGB and UVW that their members were well placed to identify the growing risk they were being exposed to. Yet their safety concerns were dismissed by employers, whose responsibility it was to assess and mitigate this risk, on the basis of their status as low-paid, precariously employed migrant workers.

Provision of Personal Protective Equipment (PPE)

Kanlungan

65. Kanlungan members faced a chronic shortage of suitable PPE throughout the relevant period. Both in-house NHS staff, and outsourced healthcare workers faced acute problems. As discussed above, the need for PPE was not even acknowledged by many employers until the pandemic had escalated to a severe level requiring national lockdown. This despite the calls of multiple workers, unions and community organisations including Kanlungan members.

66. Many of Kanlungan members faced the problem of ill-fitting PPE that was not fit for purpose as a result. NHS staff underwent 'fit tests' to assess the suitability of PPE for them, but those who failed did not necessarily receive improved equipment. As a nurse, our member AZ did not pass the 'fit test' in March 2020 but, rather than provide alternative equipment, her managers simply assigned her to another area of the hospital that was perceived as 'lower risk'.[1] This reassignment involved preparing recently admitted patients to surgery including testing them for Covid. As such, the risk of exposure to Covid plainly remained in this role yet ill-fitting PPE was considered acceptable in this area. It took until September 2020 for "AZ" to receive PPE that suitably fit her. Upon receiving this, "AZ" was told to "*...guard it with [her] life.*" as it would not be easily replaced if lost or damaged.

[1] Client interview with AZ on 08/07/2023

67. The "Nursing Narratives: Racism and the Pandemic" report noted discrimination in access to PPE (page 14, Exhibit LH/HCL/PE/20 [INQ000327661]). "Nurses spoke of PPE being hidden by managers and handed out to individuals through preference, the preferred nurses usually being white". One interviewee, a Filipino nurse, reported that "*…some people sometimes hoarded it, especially the FFP3 masks and the N95. It was the whites who were close to the managers and storekeepers.*" (Nursing Narratives, page 9, INQ000327661)

68. Shortages of PPE throughout the relevant period were frequent. Kanlungan members report that new PPE would only be reordered when stocks grew close to exhaustion rather than proactively reordered to ensure consistent availability to meet need. Whilst the procurement of PPE for in-house NHS staff was clearly mismanaged and substandard, conditions were even worse for outsourced staff of private companies.

69. Kanlungan members in outsourced cleaning and portering roles often worked alongside NHS staff whose PPE was much more substantial. Notably, in some hospitals catering staff were in-house, whereas cleaners and porters were outsourced. This led to staff with different employment statuses working closely together with varying levels of protection.

70. Domestic healthcare workers, i.e. healthcare workers directly employed in individual households, faced perhaps the most precarious conditions related to worker protections and PPE. We appreciate that the Inquiry intends to deal with care workers in Module 6. In the context of this Module, Kanlungan wishes to emphasise that hospitals and primary healthcare services were often overwhelmed during the relevant period, and domestic healthcare workers met the needs of many that the healthcare systems were unable to meet. The overflow of healthcare work into this sector is an indicator of the lack of resources available to the NHS.

71. In an attempt to mitigate the impact of the lack of PPE amongst our members, in particular outsourced and domestic workers, Kanlungan staff and volunteers took on a mask-making initiative to distribute amongst members. As homemade masks, these were inevitably below medical protective standards but they appeared to be our only option to attempt to mitigate the risk to which our members were exposed.

IWGB

72. It is the view of the IWGB that both healthcare employers and the government failed our members in the provision of suitable PPE. IWGB members carried out essential frontline tasks during the relevant period but were wholly let down by Government. The roles of these essential workers include medical couriers, cleaners, porters and security staff and are outsourced workers for private companies in the majority.

73. From the outset of the pandemic, IWGB actively demanded that employers provide the necessary protective equipment and take steps to protect workers. Alex Marshall, IWGB's President, noted:

> "*We had to think of ways that we could try and make it safer... we demanded regular testing and regular temperature checks because we wanted to know if we had it because we knew we were highly exposed not only going back to our families but we were going in and out of cancer wards. We went into pre-natal wards. And there are babies coming out you know weeks early and we were just saying for God's sake I don't want to be responsible, for spreading this thing, so let's help me out.*"

74. After significant pressure, some employers made some piecemeal concessions. For example such as providing a single 100ml bottle of sanitising fluid or a reimbursement of up to £20 for PPE that workers had to procure themselves.

75. However, these were plainly inadequate, and many workers had to continue buying their own PPE where possible throughout the relevant period. IWGB members "MI" and "DO," provided an interview on the situation they faced during the relevant period whilst working at the I&S Hospital as outsourced hospital cleaners. They reported that there was a requirement to change face mask every three hours but that these were not proactively provided by their employer. Instead workers had to proactively request each time.[2]

> "*There was a lack of information, PPE and training. We were meant to change face mask every 3 hours, but we had to ask every time, it was not provided as*

[2] Client interview with MI and DO dated 19/07/2023

standard, there was no dedicated area to find PPE, no dedicated area to change, we had to ask directly for this every time."

76. "MI" and "DO" make the point that there was little to prevent cross-contamination whilst cleaning. They were expected to use the same equipment to clean Covid contaminated areas as corridors and other areas of the hospital, rather than dispose and replace PPE and cleaning equipment.[3] One IWGB member, an outsourced cleaner remarked:

"*I was only given PPE when cleaning a contaminated room nowhere else, and I had to ask for it directly, it wasn't given as standard, and I had to fetch it from a person at the...hospital site*".

77. IWGB members reported that there was a notable difference between PPE for in-house NHS staff for whom equipment was provided more proactively, and for outsourced staff for whom it was only provided reactively and often with struggle.

78. Alex Marshall recalls an account given to him by two Brazilian workers, who couriered blood for transfusions.

"*They said they were walking onto wards where people were you know looking like space men they were completely covered up and they had literally nothing. They had no gloves, they had no masks they had nothing and they were just walking through with bags with you know bags of blood because they had to respond to a major haemorrhage*".

79. In some cases, employers tried to argue against approved standard protections. For example, **Outsourced Organisation (1)** contradicted guidance that biological samples require three layers of packaging before transport by arguing that the diagnostic specimen container provided to couriers – a plastic transportation container - was sufficient as a third layer, ignoring that couriers would have to handle the specimen without this third layer first and exposing them further to undue risk. IWGB was engaged in a dispute on this matter for some time before **Outsourced organisation (1)** accepted that three layers were necessary excluding a courier's bag.

[3] *Ibid*

80. Outsourced organisation (1) had also failed to undertake risk assessments to ascertain whether any of its workers were vulnerable under the criteria set out in government guidelines. Following an inspection by the Health and Safety Executive (HSE), it was found that Outsourced organisation (1) had committed multiple breaches (Exhibit LH/HCL/PE/22 [INQ000203416]). HSE had been slow to action on health and safety breaches by employers until we took legal action regarding the lack of recognition of health and safety rights for 'limb b' workers, and this inspection was only undertaken following the beginning of litigation.

81. 'Limb b' workers are those who fall under s230(3)(b) Employment Rights Act 1996 which describes those who are not employees but work under 'any other contract, whether express or implied and (if it is express) whether oral or in writing, whereby the individual undertakes to do or perform personally any work or services for another party to the contract'. They are typically more casual working contracts but there is only a limited right to send someone in their place to carry out the work required. They often include couriers, cleaners and other outsourced roles. IWGB also note that even where multiple breaches were found to have been committed by employers, HSE did not always take enforcement action.

82. Many medical couriers are 'limb b' workers rather than employees and faced greater risk in refusing to work in unsafe conditions as employers argued that they were not covered by s44 Employment Rights Act 1996 which provides that a worker must not be subject to any detriment for taking appropriate action in response to serious and imminent danger in the workplace. In response, IWGB brought a claim for judicial review against HSE that confirmed that 'limb b' workers are within scope of the provision (Exhibit LH/HCL/PE/23 [INQ000203417]). Despite the successful litigation, we saw little change in the behaviour of employers and no effort on the part of government to enforce the law.

83. In addition to the provision of PPE itself, outsourced hospital cleaners reported problems with clear guidance, information and training from management. "MI" and "DO" reported that PPE and training was only provided from mid-March 2020 onwards, and that the single training session took place at 6am whilst some cleaners including "MI" were working a shift elsewhere. Training was not translated, despite many workers having limited English skills and it was not repeated for those who missed part or all of the session.[4]

[4] Client interview with MI and DO dated 19/07/2023

84. There was a lack of guidance in general about how to properly use PPE and new staff members were not given training and other workers took it upon themselves to share what they knew of how to use PPE effectively.[5] Sometimes workers were also denied information they needed to appropriately protect themselves and others in the hospital.

85. For example "DO" reported that he was disciplined for asking what type of contaminant was present in an operating theatre as this would depend on what type of cleaning protocol and PPE was required. For asking this he was disciplined rather than being provided with the necessary information.[6]

86. In the experience of the IWGB, there was a general lack of national guidance relating to PPE and the particular requirements of suitable PPE in different roles. In their view the national guidance was aimed at those who were able to work at home. In the alternative those in frontline roles such as cleaners, couriers, porters and security staff were left with little information about what standard of PPE they required. As a result it proved difficult to ask for PPE, as they were unsure what they should use, and when they did, it was often difficult to hold their employers accountable in protecting their safety.

UVW

87. Many UVW members did not have ready access to PPE. Outsourced employers did not readily make PPE easily available.

88. To ensure that members had this basic level of protection, UVW sourced 2000 masks from Hong Kong via a mutual aid network. They did so despite the apparent shortages within the healthcare system itself. UVW then put together a team of volunteers and organised the logistics of distributing the masks across London to members who needed them, to help mitigate their risk of exposure. The members who received the masks included outsourced cleaning and security staff at hospitals and also the Ministry of Justice. In effect, UVW assumed the responsibility of protecting workers at sites where employers and Government had failed them. They did so at a fraction of the cost of the, widely reported, failed contracts for PPE provision that the Government engaged in.

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[5] *Ibid*
[6] *Ibid*

89. UVW also sourced and distributed hand sanitiser gel to members who needed it and where it was not provided by their employers.

90. UVW members also reported problems with training and guidance, in respect of PPE and more generally. A significant problem was a lack of communication that was notably more prevalent for outsourced workers. Hospitals were issuing instructions but were communicating with the outsourced employers rather than the staff who were directly engaged in frontline work. Equally, cleaning staff who were able to give insight based on their direct experience, had to communicate via their contracted employers. Communication between hospitals and their outsourced cleaning staff went via human resources personnel and management supervisors at the Employer contactors. More often than not these individuals were not competent enough to accurately pass on what was often highly detailed work specific information. This led to unnecessary delay and mis-communication.

91. In the view of IWGB, UVW and Kanlungan the government's failure to centrally facilitate the distribution of PPE to frontline workers or to make clear directions to employers that all workers must be provided with suitable PPE was the central cause of this lack of action on the part of employers.

Staffing shortages

Kanlungan

92. Staffing shortages in the NHS have been well-documented in recent years. Pre-pandemic shortages of nursing staff already put unreasonable pressure on nurses to cope with large workloads which was only aggravated as there was increasing Covid-19 illness amongst the existing cohort.

93. This lack of staff within the NHS created an environment of extreme stress which contributed to exhaustion and poor mental health. It is reasonable to assume that this extreme stress may also have contributed to poor physical health and may have increased infection rates amongst nurses, alongside the lack of PPE and increased exposure risk (Exhibit LH/HCL/PE/24 [INQ000327671]).

94. In addition, the inadequate staffing levels had the effect that management often pressured nurses to return to work before they were well enough. This had a disproportionate effect on Kanlungan members as, primarily Southeast Asian, migrant workers who feared the impact on their job and visa status if they refused their managers' requests.

95. As an example Kanlungan member "AZ", an NHS nurse, was diagnosed with Long Covid after contracting Covid at work. The diagnosis took several months to be finalised, and "AZ" was continually pressured to return to work during this time despite her continuing symptoms.[7] Once diagnosed, "AZ" received greater support in her sick leave until she was ready for a phased return but nonetheless continued to be pressured to return to work quicker than she was advised by her doctor. Once beginning her phased return, she received full pay for the first four weeks before her wages were reduced to only the hours she worked, effectively reducing her income by 85%. "AZ" is unable to work any additional hours at this stage and the reduction of her wage has caused significant personal stress which has, in turn, aggravated her Long Covid symptoms. "AZ" reports that she has lost trust in the ability of the NHS to protect her safety as an employer as a result of their refusal to acknowledge her early PPE concerns, and now their lack of support in her phased return to work now that she is living with Long Covid contracted during her service to the NHS.[8]

IWGB

96. There were staff shortages across all our members in frontline healthcare roles, largely due to sick leave as a result of their continuous exposure to the virus in the workplace as well as the associated stress.

97. For example, in hospitals there was a severe shortage of cleaners. Our member "MI" reported that she had to clean 70 hospital rooms per day at the height of the pandemic because her work partner was on extended sick leave. She was expected to complete double the work with no assistance and for no extra pay, causing her overwhelming stress and exhaustion.[9]

UVW

[7] Client interview with AZ dated 08/07/2023
[8] *Ibid*
[9] Client interview with MI and DO dated 19/07/2023

98. UVW report that the pandemic exacerbated pre-existing staff shortages. Outsourcing and privatisation had already led to downsized contingents of staff, which in turn led to high staff turnover as overworked employees contracted long term illnesses, were dismissed or found work elsewhere. The system was not able to cope with the additional stress brought about by a pandemic.

99. A particular feature of the impact of the pandemic was that staffing shortages led to staff having their job roles varied without consultation or contractual variation. This included security staff at one hospital having to assist with porter work, helping to transport patients, despite them having no training.

Sick pay and broader financial support

Kanlungan

100. It is the view of Kanlungan that the statutory sick pay scheme is not fit for purpose. The SSP scheme currently provides £109.40 per week Statutory Sick Pay (SSP) and there is an eligibility criteria (Exhibit LH/HCL/PE/25 [INQ000327672]).

101. Indeed, in the view of Kanlungan it aggravated the disproportionate impact of the pandemic on precariously employed, migrant healthcare workers. During the relevant period, the majority of outsourced workers didn't have access to contractual sick pay and relied solely on statutory sick pay (SSP) which in 2020, and at that time was set at a rate of £94.25 per week. This is well below the cost of living. Even with the temporary amendment to SSP rules in March 2020 to allow SSP to be paid from the first day of illness, the rate of pay was insufficient to avoid the risk of destitution.

102. Furthermore, SSP was not available to those workers without employee status and we found that the Self Employment Income Support Scheme (SEISS) was inaccessible to many of our members due to language barriers and administrative intensity. For undocumented healthcare workers, there was no access to sick pay or financial support in the likely event of illness and they were entirely at the whim of their employers in this regard.

IWGB

103. It is the view of the IWGB that the SSP scheme and systems of financial support during the relevant period were entirely unfit for purpose and require complete overhaul to prevent the avoidable detriment to worker safety and public health in future.

104. When the SSP rules were extended in March 2020 as mentioned above, they did not include 'limb b' workers. IWGB actively took up the campaign. The IWGB wrote to then Prime Minister Boris Johnson on 19 March 2020 to request that SSP be extended to include 'limb b' workers and that the 'lower earnings limit' be removed, but we received no response (Exhibit LH/HCL/PE/26 [INQ000203413]). We began judicial review pre-action protocol of this decision on 23 March 2020 (Exhibit LH/HCL/PE/27 [INQ000203418]) and received a response from the Government Legal Department on 27 March 2020 (Exhibit LH/HCL/PE/28 [INQ000203419]).

105. The government's response cited Employment and Support Allowance (ESA) and Universal Credit (UC) as alternatives to SSP during the relevant period on the basis that the seven-day waiting period and work capability assessment had been temporarily waived from ESA and that UC applicants could request up to one month's advance. However, these schemes were exclusionary and/or inaccessible for many of our members and for the following reasons:

i) First, ESA requires sufficient national insurance contributions in the previous two to three years which would exclude many of our members who had started working within that time and therefore fell outside of these parameters.

ii) Second, both of these benefits are also exclusionary to those with no recourse to public funds – an already seriously at-risk group - which also applies to many of our membership.

iii) Third, unlike SSP which is administered by the employer, both ESA and UC are also administratively intensive, making them inaccessible to many of our members because of language barriers and/or lack of available time. For this reason, some of our members would be deterred from applying for these benefits even if they were eligible.

106. For these same reasons regarding national insurance contributions, recourse to public funds and administrative intensity, ESA and UC are also inaccessible for self-employed independent contractors. It was essential that the government establish a scheme that would also facilitate sick pay for these low-paid self-employed independent contractors that would create a viable route to taking time off.

107. In short, the government failed to realise that these benefits were simply not fit for purpose when it came to facilitating the safety of our members and managing the wider public health risk by ensuring frontline healthcare workers could afford to take time off and/or isolate when they fell ill. They could not afford to rest or to self-isolate because the risk of destitution was simply too great. This devalued the lives of outsourced migrant workers and increased the public health risk given the increased exposure and broad range of contact these workers have.

108. 'Limb b' workers were also excluded from the Coronavirus Job Retention Scheme (CJRS) which provided public funding to cover 80% of the wages of furloughed employees. This created a further barrier to financial stability for our members who were facing significant loss of income as a result of the pandemic.

109. The Self-Employment Income Support Scheme (SEISS) was introduced on 26 March 2020 and began accepting application in May 2020 for a grant of 80% of three months' average trading profits. The scheme was open to both self-employed independent contractors and 'limb b' workers. The introduction of the scheme was welcome, but its limitations made it inaccessible to many of our members and its provisions were not equal to that of the CJRS. It covered fewer months than the CJRS and excluded those who began trading after 6 April 2019 or who derived less than half of their income from self-employment.

110. The government's decision to exclude these workers from the scheme left them with little to no safety net from severe financial hardship. In doing so, the government also failed to consider the disproportionate impact of this exclusion on people with no recourse to public funds who would be unable to fall back on benefits such as Universal Credit, further entrenched the existing inequalities between workers. The scheme was also administratively intensive and inaccessible to many precarious workers facing language, technical and/or time barriers. Even those who were eligible often found that their financial hardship continued as a result of the costs and arrears they had already accrued by this date, and found that 80% of their already modest income was simply insufficient to cover their living costs.

111. Where workers did take time off, they were placed under pressure to return to work whilst still feeling ill due to economic pressure and pressure from managers.[10]

112. For example, IWGB members, "MI" and "DO" work in an NHS hospital as cleaners. However, they work for an outsourced company that has a contract with the hospital. They have advised that the company they worked for did not pay sick pay equally. Sick pay was not contractually guaranteed, and instead paid on a discretionary basis by the employer. Inevitably this created a culture of favouritism, which led to discrimination. It led to some receiving sick pay when self-isolating whilst others did not. "MI" also reported that she only received full sick pay for two weeks off with Covid after filing a grievance and seeking assistance from IWGB.[11] During this investigation it also emerged that she had not been paid for 90 previously worked hours.

UVW

113. The majority of UVW members could not afford to stay at home and/or self-isolate with only SSP to cover their living costs. Consequently, as frontline workers in health services they continued to work in conditions that had the potential to compromise their health. In March 2020, after consultation with their members, UVW launched a public campaign for an increase in Statutory Sick Pay (SSP) which was at the time £94.25 per week and significantly below the cost of living. The campaign was directed primarily at Government but also at employers at a local level.

114. An important illustrative example was the death of UVW member Emanuel Gomes. Emanuel was a cleaner working for private contractor **Outsourced Company (2) who provided** outsourced cleaners to a number of public sector buildings, including **I&S** **I&S** (see UVW Campaigning section below). Emanuel was based at the Ministry of Justice, rather than a healthcare building, however his circumstances were indicative of the difficult choices that many precariously employed workers faced. Despite being ill, with potential Covid-19 symptoms, in the days before his death, he could not afford to take time off. His brother told the Guardian "*Emanuel went to work feeling sick but the life of an immigrant is like this. He knew that if he didn't work he*

[10] Client interview with MI and DO dated 19/07/2023
[11] *Ibid*

would get to the end of the month and he wouldn't have enough money to survive". (Exhibit LH/HCL/PE/29 [INQ000198900]).

115. The eventual finding that Emmanuel's cause of death was not Covid-19, does not detract from the wider point; the lack of a living wage when ill, significantly contributes to severe illness and mortality rates amongst the precariously employed.

Barriers faced by those without recourse to public funds.

Kanlungan/IWGB/UVW

116. Many of our respective memberships have no recourse to public funds (NRPF) conditions applied to their visas or have no recourse to public funds as a result of being undocumented.

117. For example some of the members of Kanlungan are domestic healthcare workers. These workers provide health care support in private residences. They are often employed directly by an individual or family to provide care for an elderly person. Many coming from the Philippines are granted a visa with 'No Recourse to Public Funds.' Kanlungan report that these workers were vulnerable to coercion and exploitation on the part of their employers.

118. Workers with NRPF status were often fearful of seeking medical treatment for fear of debilitating medical charges or negative immigration consequences, even when working within the wider healthcare system. Undocumented healthcare workers, such as domestic workers, were particularly vulnerable in this way. It is our view that mortality rates among precariously employed, migrant healthcare workers were worsened by the use of NRPF conditions.

Problems with access to vaccination

Kanlungan

119. Several Kanlungan members, particularly those who are undocumented, were concerned about NHS charges and immigration consequences of seeking vaccination. Whilst Covid-19 was excluded from NHS Charging Regulations, research has demonstrated that migrants continue to be deterred from seeking medical care even

where conditions are excluded, such as treatment for tuberculosis. There was little guidance or effort on the part of local or national governments to reach this community. In response, Kanlungan set up vaccination hubs that did not require any registration or documentation to help fill this need. This scheme was later taken on in conjunction with Hackney Council and then implemented nationally.

IWGB

120. Outsourced cleaners working at I&S Hospital did not have access to Covid-19 vaccination whereas the directly employed employees of the hospital did. The vaccination programme appeared to function as a two-tier system which treated employees as more important than outsourced staff despite their shared risk of exposure. It was only through pursuing a grievance procedure with the hospital that IWGB was able to secure vaccinations for these workers.

Impact of the pandemic on low-paid, migrant and precariously employed health workers

Illness and mortality rates

Kanlungan

121. In first months of pandemic, there were disproportionately high mortality rates among Filipino nurses – approximately 22% of the nurses who died from Covid-19 were Filipino (Exhibit LH/HCL/PE/21 [INQ000327667]). Kanlungan were alarmed by this and engaged directly with NHS as mentioned above. Kanlungan recorded 80 deaths of their members working in the healthcare sector during the relevant period. This figure only covers individuals whose families gave permission for the data to be collected whereas the reality is much greater.

IWGB/UVW

122. IWGB and UVW have not recorded specific illness and mortality rates amongst our members, however we note the widely publicised national illness and mortality statistics that demonstrate the disproportionate impact of Covid-19 on communities of colour. Our members are migrants and people of colour in the majority and are also disproportionately exposed to aggravating risk factors such as overcrowded and/or

insecure housing, low wages and lack of access to free healthcare and public funds as precarious frontline workers.

123. As such, we note that our membership was among those exposed to the greatest risk of illness and death throughout the relevant period. Whilst mortality rates amongst this group have not been recorded in detail by IWGB or UVW, we submit that this data is crucial to understand the impact on this group and that the Inquiry ought to seek to attain these records to properly assess the impact on precariously employed, migrant health workers.

Mental health and trauma

Kanlungan

124. Our members were forced to work through constant anxiety and fear for their own safety, aggravated by the lack of PPE and the disproportionate allocation of Filipino nurses to high-risk wards (Nursing Narratives, pages 9-10, INQ000327661).

125. In addition to their own safety, our members feared for the safety of their families and households that were at risk of exposure to Covid via the members and also at risk of financial struggle if the member was unable to continue working. Many of our members reported a severe decline in their mental health.

126. Whilst the conditions would have been challenging in any case, the lack of support, staffing shortages, lack of PPE and repeated surges of the virus aggravated the lasting impact on our members. Many felt their complaints and concerns were not listened to which contributed to a feeling of powerlessness. Our member "AZ" reported that her mental health severely declined during the early months of the pandemic when her complaints were ignored. Now living with Long Covid, "AZ's" mental health has continued to decline as a result of increased anxiety, fear of judgement, and a lack of hope about the future.[12]

IWGB

[12] Client interview with AZ dated 08/07/2023

127. The impact of the pandemic and its associated working conditions on frontline workers cannot be overstated. The lack of guidance on safety measures and the chronic shortage of PPE caused severe and consistent anxiety to nearly all key workers.

128. Frontline workers were unsure what was the appropriate level of precaution to take, so often took extreme steps in attempt to protect themselves and families. For example, one member slept in their car throughout lockdowns to prevent exposing family to risk. Another member would remove and change all clothes at the front door every day to reduce risk to family.

129. The lack of PPE increased the risk of exposure that all frontline workers faced and in turn increased their anxiety of infecting their families and households. IWGB members, "MI" and "DO", reported that they felt scared and powerless throughout the relevant period, they were exposed to huge risk and a greater risk than necessary as a result of ignored complaints and a lack of PPE, training and guidance. The pressure to maintain income in a climate of economic downturn and shortage of employment opportunities only increased the opportunity for exploitation. "DO" reported that "*Our employers did not see us as people, but only object of labour.*".[13] Outsourced companies were more interested in efficiency and protecting profit margins than their workers, despite the vital work that these workers did to protect and support others.

UVW

130. UVW noted a marked difference in mental health deterioration between outsourced and "in-house" workers. All members were exposed to increased risk, but outsourced workers bore an additional burden (see the UVW campaigning section below). UVW were particularly well placed to monitor the difference.

131. As dealt with below, members at the **I&S** were brought "in-house" in April 2020 whereas other workers, such as those at **I&S** faced the first months of the pandemic in outsourced positions.

[13] Client interview with MI and DO dated 19/07/2023

132. Individual accounts such as that of an interviewed outsourced cleaner at I&S "*My [mental health] was very, very low, you know, due to the pandemic and due to the stress we had from being outsourced*" were reflected across the wider membership of UVW. Members "*felt unsafe, undervalued, disrespected and...[with] their heightened exposure to risk and to Covid positive places in hospitals and care homes.*" [Petros Elias]

Monitoring and campaigns

Kanlungan

133. Kanlungan undertook the following monitoring and campaigning efforts during the relevant period:

(i) Vaccine campaign – Kanlungan set up the first vaccine hubs to allow migrants to access vaccinations without fear of immigration repercussions. They then worked alongside Hackney Council to implement the hubs more broadly. This approach subsequently became a national policy.[14]

(ii) At the outset of the pandemic it quickly became clear to Kanlungan that an exceptionally high number of Filipino frontline healthcare workers were dying from Covid-19. In response, they initiated a community monitoring project to track deaths amongst the Filipino migrant community. Through monitoring of social media, news coverage, hospital and NHS trusts, and via their network of participatory organisations they pulled together early quantitative research of the impact of the pandemic on front-line staff. This was supported by qualitative research, as Kanlungan convened focus group discussions with Filipino healthcare workers and facilitated a mental health support group for workers who shared experiences of widespread discrimination and harassment, leading to disproportionate exposure to Covid-19.

(iii) Shrine of love – Kanlungan created an online collection of portraits of members who lost their lives as a result of the Covid-19 Pandemic. The list is not exhaustive as it is only made up of those members whose families consented to their personal information being shared (Exhibit LH/HCL/PE/30 [INQ000327677])

[14] Client interview with Kanlungan on 06/07/2023

(iv) In response to concerns raised about the inability of members to access Covid information, Kanlungan successfully lobbied for Covid-19 public health information to be translated into Tagalog. As a result the NHS set up a Filipino language helpline for staff.

(v) Kanlungan co-led a wide-ranging piece of research on the impact of racism on BAME nurses working over the course of the pandemic. The research paper, "Nursing Narratives: Racism and the Pandemic" (Exhibit LH/HCL/PE/20 [INQ000327661]), (produced alongside Sheffield Hallam University and other grassroots organisations), exposed the racism and discrimination experienced by migrant nurses working in the NHS. The research has spawned multiple peer-reviewed academic publications.

(vi) In order to document and quantify the impact of Covid-19 on migrants with insecure status and undocumented migrants, Kanlungan published two reports ('A chance to feel safe' (Exhibit LH/HCL/PE/19 [INQ000235265]) and 'Essential and Invisible: Filipino irregular migrants in the UK's ongoing COVID-19 crisis' (Exhibit LH/HCL/PE/31 [INQ000327678]). They also produced a zine (Hear Our Voices) co-created with undocumented migrants. Kanlungan additionally co-founded the Status Now 4 All Network, a campaign calling for all undocumented migrants to be immediately regularised to guarantee access to healthcare, housing, and employment.

IWGB

a. IWGB undertook the following monitoring and campaigning efforts during the relevant period:

(i) In February 2021, IWGB launched a national campaign backed by 30 MPs calling for the indefinite extension of the CJRS and for compliance to be made compulsory for employers. Despite continuous efforts to engage with the government concerning the welfare of their members, the only responses received were those that were legally required under pre-action protocol (Exhibit LH/HCL/PE/32 [INQ000203415]).

(ii) IWGB members who worked as outsourced cleaners (contracted by **Outsourced Organisation (3)**) at **I&S** Hospital (a private hospital owned by HCA International) raised concerns that they were being instructed to work on Covid

wards without adequate training and without prior warning of contamination risk (Exhibit LH/HCL/PE/33 [INQ000327680]). There was also a notable lack of PPE, lateral flow tests and access to vaccinations (Exhibit LH/HCL/PE/33 [INQ000327680]). The cleaners reported that they were then given no time to wash/disinfect themselves before being sent to clean other (non-Covid) wards. They raised additional concerns that cleaners who contracted Covid-19 were not paid when self-isolating; this had led to cleaners, who were unable to afford the unpaid sick-leave, continuing to work whilst unwell (Exhibit LH/HCL/PE/33 [INQ000327680]).

An IWGB campaign in response led to Outsourced Organisation (3) making changes in their working practices including better pay, employee status, better uniforms, access to vaccination, removal of abusive managers and reduction of excessive workloads (Exhibit LH/HCL/PE/34 [INQ000327682]).

(iii) Approximately 90 IWGB members were couriers for Outsourced organisation (1), a large private provider of laboratory services to clinicians and hospitals. Outsourced organisation (1) secured a large number of outsourced NHS contracts for Covid-19 and had a contract with the Department of Health and Social Care to create a new high-volume Covid-19 testing facility. Despite Outsourced organisation (1) purported expertise in pathology (Exhibit LH/HCL/PE/35 [INQ000327683]) their couriers were exposed to dangerous conditions whilst collecting samples from hospitals all over London. Alex Marshall, medical courier and IWGB President said: "*This is a medical company that has doctors in full protective gear dealing with samples every single day but because we were couriers we were just cannon fodder to them.*"

IWGB reported Outsourced organisation (1) to the Health and Safety Executive and ran a Campaign raising media awareness of the lack of training, inadequate PPE provision, inadequate testing for couriers, and other safeguarding issues around couriers handing virus specimens. This included articles in The Independent, The Guardian, Sky News, Morning Star and several other local and sector publications. Outsourced organisation (1) were found to have committed numerous health and safety breaches, which the company ultimately accepted (Exhibit LH/HCL/PE/22 [INQ000203416]). Following the campaign, eight couriers who were involved the campaign were made redundant by Outsourced organisation (1) and IWGB assisted them in bringing claims to the employment tribunal including current IWGB President

Alex Marshall (Exhibit LH/HCL/PE/36 [INQ000327684]), (Exhibit LH/HCL/PE/37 [INQ000327685]).

(iv) IWGB launched a similar campaign in respect of Outsourced Organisation (4), another company where IWGB members worked as couriers, many handling virus specimens. IWGB wrote to their CEO complaining of issues experienced by members (the same as those experienced by Outsourced organisation (1)). Even though the CEO did not acknowledge the letter, the company soon after implemented a £100 per week payment to couriers who contracted Covid.

(v) IWGB represents a large number of private hire drivers. Many of these worked for Uber during the pandemic. Following an offer from Uber to provide free travel to NHS workers, the drivers became a de facto NHS transport provider, ensuring that staff were able to get to their hospitals. These drivers started with no PPE and then later were provided with token PPE from their employers such as Uber. IWGB understands that some drivers received as few as 5 masks in total during the course of the pandemic. Many drivers subsequently contracted Covid-19. On behalf of these drivers the IWGB campaigned for screens to separate them from passengers though Uber did not agree to this.

UVW

134. UVW undertook the following monitoring and campaigning efforts during the relevant period:

(i) The primary cause of high exposure to COVID-19 amongst UVW members was outsourcing. Members' status as "outsourced" was the root of their inadequate PPE, their inappropriate work allocation, their overwork, poor pay and inadequate access to sick pay.

(ii) There is a clear racial demographic to outsourcing, with a majority of outsourced workers in London being BAME and a markedly lower percentage in "in-house" public sector work. The high reported mortality rates in BAME communities are linked to the precarious nature of outsourced employment.

(iii) Consequently, the focus of UVW campaigning was on ensuring that outsourced workers were taken "back in house", particularly in respect of workers who were outsourced in hospitals, returning to NHS employment. This campaigning and industrial action started pre-pandemic, and the onset of COVID-19 highlighted

the inequalities and led to campaigns intensifying. For example, outsourced facilities staff at I&S including all cleaners, porters and caterers were brought "in-house" in April 2020, after sustained industrial action led by UVW. In total 1200 facilities staff across the I&S were brought in-house.

(iv) At the outset of the pandemic, workers at I&S were outsourced to Outsourced organisation (2) one of the largest private contractors in the UK. They reported intensification of work, inadequate PPE, failed communication, inadequate guidance, allocation to infected COVID wards without appropriate training, management coercion to work in unsafe conditions and financial pressure to continue working even when sick.

(v) A successful UVW campaign led to all facilities staff at I&S Hospital being brought "in-house" in August 2020.

(vi) Some of the cleaning staff had worked at I&S as outsourced workers for two decades. Newly "in-house" staff reported being valued, and with their new status as "NHS staff" being appreciated and treated as colleagues of equal status.

(vii) Cleaners at I&S working for outsourced cleaning company Organisation (5) reported sub-standard PPE, a lack of information in respect of their exposure to the virus, and managers informing cleaning staff that they could not refuse to work in Covid wards. UVW ran a campaign demanding that any worker who raised concerns about COVID-19, refused to undertake certain duties or outright refused to work for fear of either contracting or transmitting COVID-19 will suffer no detriment or dismissal as provided for under section 7 of the Health and Safety At Work Act 1974 (HSAWA 1974) and Section 44 and 100 of the Employment Rights Act 1996 (ERA 1996).

Engagement with government

Kanlungan

135. Kanlungan made the following submissions to government during the relevant period:

(i) Meeting with NHS to discuss disproportionate exposure to risky wards and mortality rates of Filipino nurses.

(ii) Open letter with RAPAR calling for LTR to be granted to all undocumented migrants – 27 March 2020

(iii) Open letter with StatusNow4All for ILR to be granted to all undocumented migrants – 27 March 2021

IWGB

136. IWGB made the following submissions to government during the relevant period:

(i) Oral evidence session regarding 'the impact of coronavirus on businesses and workers' at the Business, Energy and Industry Strategy Committee – 17 November 2020

(ii) Meeting with Health and Safety Executive regarding 'research around the provision of PPE to 'limb b' workers' – 24 June 2021 (Exhibit LH/HCL/PE/38 [INQ000346796], Exhibit LH/HCL/PE/39 [INQ000346791])

(iii) Letter to then Prime Minister Boris Johnson regarding additional protections needed for precarious frontline workers including PPE, safety guidance, sick pay and others – 19 March 2020 (Exhibit LH/HCL/PE/26 [INQ000203413])

(iv) Letter to then Chancellor of the Exchequer regarding extension of the CJRS (Exhibit LH/HCL/PE/40 [INQ000203420])

(v) Pre-action letter to HM Treasury – 23 March 2020 (Exhibit LH/HCL/PE/24 [INQ000327671])

(vi) Press release regarding Covid-19 demands – 23 March 2020 (Exhibit LH/HCL/PE/41 [INQ000203421])

(vii) Pre-action letter to Health and Safety Executive – 4 May 2020

(viii) Pre-action letter to Secretary of State for Work and Pensions – 4 May 2020

(ix) Letter of cross party MPs calling for income and safety protections for Deliveroo riders – 13 May 2020

(x) Press release regarding #FairFurloughNow campaign – 16 February 2021

UVW

137. During the pandemic one of the major issues affecting the members of UVW was the lack of a full pay sick pay scheme available to them. As a result of Government complacency in this area the UVW launched a public campaign following consultation with our members directed primarily at the Government but then that same demand was levelled against employers at a local level as well.

138. Due to the fact that we were mainly concentrating on defending our members, and engaged in legal representation and industrial action we did not have the capacity to engaged directly in lobbying Government.

139. This was set out in a comprehensive set of proposals and demands levelled at employers and Government (Exhibit LH/HCL/PE/42 [INQ000327686]).

Lessons learned and recommendations

140. The pandemic has helped to underline one important fact in relation to the NHS in Britain and indeed healthcare all over the world: the private sector is not the answer to any of the big problems or the big challenges. Rather it is part of the problem.

141. Given this we the organisers of the three major organisations, Kanlungan; United Voices of the World and the Independent Workers of Great Britain believe as a starting point the following broad recommendations should be made by the Inquiry:

i) End outsourcing and privatisation in the NHS and bring outsourced staff back in-house at equal pay and terms. Outsourcing has led to a two-tier work force. Our members on the frontline have faced super-exploitation in the pursuit of profit. Wages have been reduced, and work conditions worsened. It is profiteering on the back of the lowest paid.

ii) Improve public funding for the NHS and public health. Ministers continue to gaslight us about spending. They often claim it is 'more than ever before.' The reality is the opposite. Since 2010 the health budget has grown by less than the previous average increase in spending – bringing real terms cuts as resources lag behind rising costs.

iii) End 'hostile environment' policies and overhaul migration system that devalues the lives of migrants, exposes them to harm and increases the overall public health risk posed by a future pandemic. There is a need to allow all people living in the UK regardless of immigration status to be able to access all levels of health services without fear of immigration enforcement. This will also guard against future problems of those who fear accessing services.

iv) End 'no recourse to public funds' conditions applied to visas. The NRPF rule leaves workers living in fear of losing their jobs and open to abuse. It leaves them potentially at the mercy of employers.

v) Overhaul sick pay system to provide access to sick pay to all employed, limb b and self-employed workers at a living wage rate. Sick pay should be paid at the full wage rate. Without this it leaves workers who are sick, either working or risks them starving.

vi) Early engagement with unions and community organisations to inform decision-making and understanding of needs of workers.

vii) HSE to have the statutory power to enforce breaches and punish. The HSE has seen its funding cut. In 2021-22 it was 43 per cent down on 2009-10 in real terms (Exhibit LH/HCL/PE/43 [INQ000327687]). Staff numbers have been cut by 35 per cent since 2010 on a like-for-like basis (Exhibit LH/HCL/PE/44 [INQ000327688]). Due to the austerity programme it received just £123 million from government in 2019/20, compared to £231 million in 2009/10. Lower funding means fewer inspections: over the same ten-year period, the number of workplaces investigated by a safety inspector fell by 70% and over a twenty year period (2001-2021) the number of prosecutions has fallen by 91% (Exhibit LH/HCL/PE/45 [INQ000250949]).

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.

Name: Lorie Halliday, Kanlungan

Signed: ___ Personal Data _____

Dated: 30 April 2024

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.

Name: Henry Chango Lopez, IWGB

Signed: _ Personal Data _____

Dated: 30 April 2024

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.

Name: Petros Elia, UVW

Signed: __ Personal Data _____

Dated: 08 May 2024