UK Covid-19 Inquiry

Module 3

FRONTLINE MIGRANT HEALTH WORKERS GROUP

WRITTEN CLOSING SUBMISSIONS

Introduction:

1. These written closing submissions are intended to supplement the Frontline Migrant Health Workers Group's (The Group) oral closing submissions on 27th November 2024, oral opening submissions on 10th September 2024 and written opening submissions dated 24th August 2024.

2. The Group would first like to thank the Inquiry for giving their membership the opportunity to participate, to allow them to give their evidence and to ask questions. A persistent and recurring theme in the accounts of outsourced and migrant workers is that they had no voice throughout the pandemic. They could not speak out for fear of employment and immigration consequences. When they did speak, no one listened. These accounts are borne out by the evidence in this Inquiry. In the thousands of pages of documents disclosed by the mass of organisations that make up the Healthcare system, there is barely any reference to them at all. The stand-out feature of the evidence is that, even when they were making the ultimate sacrifice, outsourced and migrant workers were routinely overlooked. The Inquiry has raised their voice.

3. These submissions will emphasise

    a) the experience of, and impact on, the Group's members
    b) the predictability of that impact and
    c) the silence and inaction of Government

    The submissions end with the recommendations that the Group asks the Inquiry to make; fundamentally the need to address the core inequality of a two-tier healthcare workforce.

The Frontline Migrant Health Workers Group:

4. The Group is a collective of two, non-TUC affiliated trade unions, United Voices of the World (UVW) and Independent Workers' Union of Great Britain (IWGB), and Kanlungan, a consortium of Filipino and Southeast Asian community organisations.

5. Kanlungan members work across the healthcare sector, as nurses, healthcare assistants and cleaners. In May 2020, about 40,000 Filipinos worked for the NHS[1] and were the largest national group after British and Indian workers[2].

6. UVW and IWGB have memberships across a number of sectors and include couriers, cleaners, porters, caterers and security staff who work directly within the healthcare system, in the hospitals; as well as private hire drivers who were co-opted into the system over the course of the pandemic, to transport healthcare workers and patients.

7. The Group's healthcare worker members fall into two categories:

   a. Non-clinical workers, the majority of whom were precariously employed in low paid, outsourced positions within the healthcare sector, working in the gig economy, as 'limb b' workers[3] or on short term contracts. Those members have none of the employment protections of employed NHS staff. That lack of protection and their dependence on private sector employers, left them particularly vulnerable. Largely, but not exclusively, the Group's members in this category are from ethnic minority and migrant backgrounds.

   b. Clinical nursing and healthcare assistant staff, all of whom were from a migrant background. Whilst many of these workers had the benefit of employment contracts, those contracts were linked to their immigration status. In the context of the 'Hostile Environment', that status left them particularly vulnerable. When immigration status specifies that a worker has 'No Recourse to Public Funds', that worker cannot afford to be ill. When immigration status is wholly dependent on continuing employment a worker cannot refuse work that others would refuse.

8. Across the UK, there are many tens of thousands of healthcare workers who fall into these categories.[4]

9. Whilst, in some respects the two categories are distinct, there are four significant commonalities.

10. First, these members are all working class, in low and under paid employment. The majority of the members are from ethnic minorities. However, it is important to emphasise that systemic issues, like outsourced employment, are applicable across the entire working class, regardless of ethnicity or immigration status.

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[1] INQ000352887
[2] INQ000327667/3
[3] INQ000477577/18 § 81 - 82
[4] PHT000000114/09 P36 lines 9 - 25

11. Second, all of these members are frontline, essential healthcare workers; without them, hospitals would not function and there would be no healthcare system.

12. Third, all of them worked in a health system that had been broken up, undermined and underfunded for decades.

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

Austerity and state of the NHS:

14. The evidence has shown, time and time again[5], that the resilience of the UK had been worn down by the decade of austerity that preceded the pandemic.

15. In that decade there had been both a lowering of standards in the safety and quality of healthcare, and a marked decline in the living standards of healthcare workers. Hospital infrastructure was not fit for purpose. 25,000 acute and general beds had been closed. There were 7.5 million people on NHS waiting lists, 1.4 million people in need of unprovided mental health care and 12-hour trolley waits in A&E.[6] Stagnant wages and poor conditions had hollowed out the workforce to such an extent that the NHS was understaffed by over 150,000 workers. Those that remained had to work even harder to fill the gaps. The NHS was left in an "*extremely fragile state*" with "*dangerously low capacity*"[7].

16. In the recent review of the NHS, Lord Darzi[8] put its "*current dire state*" down to "*chronic underinvestment* and *the most austere decade of funding in its history*", with a *"public health grant… slashed by more than 25% in real terms since 2015"* [9] He describes a "*chronically weakened"* system, with "*downgraded capacity and capability, with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems.";*[10] a health system "*starved of capital"* with "*chronic underinvestment in its infrastructure".*[11]

17. At the same time, in Lord Darzi's words: "*the nation's health deteriorated*". "*Many of the social determinants of health - such as poor-quality housing, low income, insecure employment -*

[5] For example: Evidence of Sir Christopher Wormald 12/11/24, from 10:11:03.
[6] INQ000477577/5-6
[7] INQ000360607
[8] INQ000474367 Darzi Report September 2024' Annex at INQ333474366.
[9] INQ000474367/6
[10] INQ000474367/111
[11] INQ000474367/110

have moved in the wrong direction over the past 15 years with the result that the NHS has faced rising demand for healthcare from a society in distress.[12]

18. In simple terms: (a) The NHS was left underfunded, under-resourced and understaffed and (b) the underlying health of the nation had declined significantly.[13]

19. These two core features of austerity formed the baseline from which the Group's membership entered the pandemic: (a) as workers in the "*weakened*" and "*downgraded*" NHS and (b) as workers whose low pay and precarious employment status ensured that their "*social determinants of health*" had moved furthest in the "*wrong direction*".

Underfunding and Outsourcing:

20. When the NHS was founded, non-clinical support services, such as cleaning, catering and portering, were an intrinsic and inseparable part of the public health service. Known as ancillary staff, they worked alongside nurses and doctors as part of Ward teams[14]. A cleaner's role as the frontline of infection prevention and control, or a porter's role in patient care and management, were recognised as fundamental. They were employed by the NHS, directly managed and controlled through a public health service, and benefitted from the protection of employment contracts. They knew what their monthly wage would be, they had a public sector pension, and terms and conditions that allowed for guaranteed sick pay and more than statutory minimum holiday entitlement.

21. In 1983, ancillary staff services were the first to be offered out for tender to private providers; the first step in privatising the NHS[15]. Now known as "hotel staff" or "domestics", ancillary staff have had their labour downgraded from a supporting role to one that is wrongly considered to be menial and treated as such. Under successive governments in the run-up to the pandemic, there was a steady increase in contracting out, or outsourcing, to the private sector. Outsourcing has extended beyond the privatisation of ancillary services and into clinical services.[16] However for the purpose of the Group's non-clinical members, the focus is on those in ancillary roles, including diagnostic services[17] such as couriers, as well as hospital security staff.

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[12] Darzi letter accompanying the report.
[13] For example: Evidence of Sir Christopher Wormald 12th November 2024 10:11:00
[14] INQ000474329/10
[15] INQ000474329/13 Professor John Lister "Forty Years of Failure"
[16] INQ000474329/23 "Forty Years of Failure"
[17] INQ000474329/51 "Forty Years of Failure"

22. Outsourcing is designed to reduce cost to NHS Trusts and in doing so, to generate profit for the private sector provider.[18] Austerity policies and associated underfunding have contributed to a rise in outsourced labour, particularly in non-clinical workers. NHS Trusts believed that outsourcing would cut some of the costs that they had been forced to cut. When the pandemic hit in early 2020, around half of the UK's hospital sites had outsourced ancillary services.[19] Inevitably, outsourcing necessitates both reducing the cost of labour, and reducing the amount and quality of the service provided.[20]

23. Reduced labour costs impact directly on the workers. Outsourced workers are invariably contracted on poverty wages[21], with many of them having to take on more than one job to make ends meet. Their hours are often limited or uncertain. Productivity targets result in an ever-increasing amount of work to be completed in a finite time. Their outsourced status ensures that these workers do not have the contractual protections of inhouse employees, making them more vulnerable to dismissal. If they receive holiday pay at all, it is limited to the statutory minimum. Sick pay is rarely part of an outsourced contract, invariably it is limited to the inadequately funded statutory sick pay regime. Outsourced workers become an afterthought in a two-tier system of healthcare employees. They are the poorest workers, in the most precarious work.

Understaffing and migrant labour:

24. Austerity has exacerbated understaffing in the NHS. Dwindling funding, stagnant wages and a lack of financial support for nursing training, have combined to create a staffing crisis. To address that crisis the NHS has had to increasingly outsource recruitment overseas, leading to a greater reliance on migrant labour for both clinical and non-clinical staff.

25. However, even those migrant healthcare workers with the benefit of an employment contract do not share the same working conditions as their British colleagues and are comparatively financially disadvantaged. Having been educated overseas, that the British state has not contributed to, those workers start at a financial disadvantage by having to pay for their visa applications. Application fees amount to a tax on simply working in the country, even though they are filling essential roles that would not otherwise be filled.

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[18] INQ000474329/4-5 "Forty Years of Failure"
[19] INQ000474329/3 "Forty Years of Failure"
[20] INQ000474329/13 "Forty Years of Failure"
[21] INQ000477577/4 §14

26. The standard visas for skilled or health and care workers include conditions that the worker has 'No Recourse to Public Funds' (NRPF). NRPF conditions ensure that migrant workers are excluded from accessing almost all public funds[22] that a British-born worker would normally be entitled to, including for example, Universal Credit, Child Benefit, Housing Benefit,[23] state pension, free childcare or disability support in the event of a long-term condition. Migrant healthcare workers perform an essential public service but are forced to do so from a more precarious socio-economic position, without the social safety nets that help protect their colleagues, simply because they are migrants.

27. Further, and critically, Health and Care Worker visas require that the applicant is entering the UK to take a specific job with a named employer. The visas are then dependent on the worker maintaining that employment and there are restrictions on any change to that employment, including a 60-day time limit to find a new sponsor if they leave their job. When a healthcare worker's immigration status is entirely dependent on them maintaining the employment listed on their visa, they are inevitably vulnerable and pliable in their workplace. It is not only their jobs that are dependent on their compliance, but their very presence in the country, the lives they have built, their homes, and the stability of their families. In effect, migrant healthcare staff are internationally outsourced, cheap labour; another precarious category of healthcare worker.

The 'Hostile Environment':

28. The financial precarity of outsourced migrant healthcare workers was exacerbated by the 'Hostile Environment' policies introduced in 2012 and bolstered by the Immigration Acts in 2014 and 2016. The policies prevented those without leave to remain from accessing housing, healthcare, education, employment, bank accounts and benefits.[24] The 'Hostile Environment' was ostensibly targeted at undocumented migrants, however the narratives and policies that were promoted and implemented perpetuated racism and discrimination at institutional, structural and interpersonal levels. The Group's members reported having "*limited choices, they were forced into situations, be that housing, be that more dangerous situations at work, because they just did not feel they could push back and have their voices heard… the 'Hostile Environment' is so deeply entrenched in the society that we live in that you even have situations with people who can access these resources who are so scared to access them because they think they are unwelcome, they think they are going to be deported… they don't feel welcome… they fear repercussions… that's how deeply entrenched it is.*"[25]

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[22] INQ000176357/45 "*no entitlement to a majority of welfare benefits*" House of Commons Women and Equalities Committee.
[23] INQ00215514/15
[24] "A Chance to Feel Safe" INQ000235265/7
[25] Evidence of Alex Marshall 10th October 2024 PHT000000114/15 p60 line 16

29. Workplace racism led to the increased levels of bullying, harassment and workplace pressure[26], that were experienced by ethnic minority health workers including those at the top of the medical professional hierarchy.[27] Guidance was often not translated into migrant languages because "*Translation into foreign languages is discouraged except in extraordinary circumstances because it conflicts with the government's approach to integration which relies on English language use.*"[28] Despite the large Filipino population in health and social care, the official language of the Philippines, Tagalog, was not even listed in the Government's final report on COVID inequalities in December 2021.[29]

30. These institutional factors were aggravated by the racialisation of the pandemic. Between 2020 and 2021 there was a 300% increase in hate crimes against East and Southeast Asian communities in the UK due to the association of the virus with China.[30] As an example in March 2021, a Filipina nurse in Southampton, still in her uniform after a 12-hour hospital shift, was threatened with physical violence and told to "go home to China" by a group of young people.[31]

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

32. Despite comprising only 3.8% of the nursing workforce, in the first months of the pandemic up to May 2020, Filipinos accounted for 22% of COVID-19 deaths among NHS nurses.[32]

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

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[26] INQ000327661/6 'Nursing Narratives' and INQ000474298/12 'Witness 2'
[27] INQ000346166/11
[28] INQ000302496 foot note 71
[29] INQ000302496/56
[30] INQ000327667/5
[31] INQ000327667/6
[32] INQ000327667/7

The Experience of the Group's members:

34. Ultimately underfunding, understaffing and hostility towards migrant workers, perpetuated a two-tier system of healthcare workers. The Group's members experienced the pandemic as part of this second tier. They worked in exactly the kind of *low income, insecure employment* that Lord Darzi referred to in his report.

35. The *social determinants of health* have moved in the wrong direction in society as a whole. The Inquiry has heard from several witnesses that the pandemic magnified that movement.[33] But critically the *social determinants of health* have moved starkly in the wrong direction **within the healthcare workforce**; the very workforce that exists to protect the rest of us. As Alex Marshall, the President of IWGB, told the Inquiry, the pandemic poured petrol on an inferno that was already blazing[34].

Exposure:

36. As a starting point, in common with all key workers, all the Group's members had to work. There were no furloughs for any of these healthcare workers on the front line. The nature of their work meant that they were exposed, and they were always going to be exposed irrespective of whether the primary mode of transmission was contact, droplet or airborne. As it was, their exposure was amplified by the fact that viral transmission was airborne, with aerosols generated simply by breathing and talking, remaining in the air for hours and transported around poorly ventilated hospitals by air currents, significantly contributing to spread.[35]

37. Obviously, the nurses and healthcare assistants were directly patient facing and delivering care. It has been less acknowledged that cleaners and porters spent prolonged periods in wards doing physical work in close proximity to both patients and staff. Hospital security guards spent prolonged periods in hospitals often at the point of entry, in proximity to all hospital entrants, and sometimes undertaking additional physical tasks such as portering. Medical couriers had to enter wards and hospitals and return to a central hub with other couriers who had also recently entered wards and hospitals, before moving to a different hospital and repeating the process. Taxi-drivers were contracted to transport healthcare

[33] For example, the evidence of Sir Christopher Wormald 12th November 2024 at 10:11:10 and Professors Marmot and Bambra INQ000195843/74
[34] PHT000000114/12 page 45 line 20
[35] INQ000474276 § 51 and 54

workers and patients to and from hospitals and spent prolonged periods with them in the confined space of a vehicle.

38. Professor Beggs, in both his written and oral evidence to the Inquiry acknowledged that physical exertion is an infection risk that is often overlooked from both an 'Infection Prevention and Control' perspective and more generally. As a risk factor, exertion would apply to cleaners, doing the physical work of cleaning; and porters, doing the physical work of lifting and moving patients. Exertion has implications for both far-field and near field infection[36] (cleaners in near and far-field, porters in the near field). The longer the shift and the harder the work, the higher the risk.

39. Alex Marshall[37] explained that hospitals were very dangerous places during a pandemic. Whilst they should not have been, the simple fact is that they were. Government was fully aware of that fact as Matt Hancock[38] has confirmed; *more people caught Covid in hospitals than almost any other setting.*

40. All of these workers were **hospital** workers. It is a fundamental injustice that workers, in the same workplace and doing the same jobs, as inhouse and British born workers were more exposed than their colleagues. The two-tier worker system manifested itself in a number of ways over the pandemic.

PPE:

41. In respect of PPE: 'Witness 1' gave direct evidence of the experience of many thousands of outsourced migrant workers.[39] When gowns, aprons, gloves and better masks were provided to inhouse staff, she was allowed a single FRSM/'blue mask' at the beginning of her shift. She had no one to ask for better protection. She had to **take** better PPE. When clinical staff received PPE training late,[40] outsourced workers like 'Witness 1' often received no training at all.[41]

42. Most outsourced workers were still operating without PPE up until the first lockdown in March 2020. In the months that followed, even where PPE was secured it was typically unsuitable, ill-fitting, or in short supply and insufficient to protect the whole workforce. Employers of outsourced staff typically did not provide PPE as a matter of urgency. There was an embedded

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[36] INQ000474276/32 § 78 and Evidence of Professor Beggs 11th September 2024 12:21 to 12:53
[37] Evidence of Alex Marshall 10th October 2024 PHT000000114/12 10:59:24, 11:07:55, 11:09:17, 11:13:00.
[38] Evidence of Matt Hancock 22nd November 2024: 11:48:49.
[39] Evidence of Alex Marshall: 10th October 2024: PHT000000114/13 P51 line 3
[40] See M3W2 INQ0004 7 4298/5
[41] Evidence of Alex Marshall: 10th October 2024: PHT000000114/13 P51 line 9

culture in which workers were considered replaceable combined with a lack of employer accountability and an outlook that put profit first. The result was that outsourced hospital workers were working with even less PPE than their woefully under-resourced NHS employed colleagues.

43. There were outsourced cleaners with little or no PPE working directly alongside in-house staff whose NHS employers had provided it. Some of those outsourced cleaners would then have to go on to their second jobs. Taxi drivers were tasked to provide free transportation for NHS workers to and from hospitals but were given no PPE at all. Member reports include migrant workers being de-prioritised for PPE distribution,[42] and denied access to FFP3 masks.[43] There were couriers, moving to and from cancer wards and pre-natal wards, responding to haemorrhages with bags of blood, who reported clinical staff completely covered up, like "spacemen"; the couriers did not even have so much as a mask. [44]

44. The Group has several examples of outsourced workers recognising the risk from Covid well in advance of their managers and pressing for PPE.[45] There are other examples of NHS employed migrant nurses flagging the need for PPE in the early stages.[46] Another area of commonality between migrant and outsourced staff, is that they were generally ignored by both NHS and private employers. When individuals tried to speak out, they were effectively silenced: "*people who did question what they were given were sometimes faced with punitive measures…called troublemakers… told they were scaring people… told that they shouldn't be speaking out and they were moved into places to keep them out of the way or sent into more dangerous situations…. a dynamic that was playing out for outsourced precarious migrant workers all over the UK*".[47]

45. This was a plainly a gaping hole in the 'Infection Prevention and Control' system. It would have been a significant failing in an outbreak where the dominant mode of transmission was fomite. With an airborne virus, it was potentially catastrophic. The under protected workers then had to return to their homes fully conscious of the risks of infecting their families. Kanlungan, UVW and IWGB all made efforts to source and distribute PPE amongst their members. Invariably they did so at a fraction of the cost that Government was paying to their suppliers.[48]

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[42] INQ000327667/6 & 7
[43] INQ000327661/11
[44] INQ000477577/17
[45] For example INQ000477577/11 §51 and INQ000327661/10
[46] INQ000477577/11§ 52
[47] Evidence of Alex Marshall: 10th October 2024: PHT000000114/13 P49 line 4
[48] INQ000477577/19

Disproportionate allocation to higher risk environments:

46. Migrant workers were disproportionately allocated to higher risk working environments.[49] A research paper "Nursing Narratives: Racism and the Pandemic", led by Sheffield Hallam University and co-conducted with Kanlungan, found that 44% of Filipinos surveyed felt that they had been unfairly delegated to high-risk or COVID-19 positive wards compared to their white peers.[50]

47. These workers, particularly new nurses or those on lower pay grades, were unable to protest these allocations for the same reason that they were given them in the first place; they were either afraid of, or threatened with, losing their employment visas if they raised complaints.[51] As pre-existing chronic understaffing was exacerbated by the pandemic, self-isolating Filipino staff found themselves being pressured to return to work before they were well enough to do so.[52]

48. Filipino nurses' inability to refuse unsafe allocations or orders to return to work led to pre-existing racist perceptions becoming entrenched. The idea that Filipino workers were "*docile, submissive and hard-working*"[53] became self-perpetuating as they could not refuse the demands increasingly made of them.

49. Migrant and outsourced workers were pressured into working in higher risk environments;[54] they were unable to say no because of the precarity of their employment and/or immigration status.

Risk assessments, testing and vaccination:

50. Risk assessments often did not happen at all. If they did, they were consistently late or inadequate.[55] In 'Witness 1's' case, neither her hospital managers nor her outsourced employers ever asked a single question about her welfare.[56] As far as she was aware "*there*

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[49] INQ000477577/11
[50] INQ000327661/10
[51] INQ000327667/7
[52] INQ000477577/21 § 94
[53] INQ000327667/3
[54] Alex Marshall: 10th October 2024: PHT000000114/13 P49 line 16
[55] Evidence of Alex Marshall: 10th October 2024: PHT000000114/14 P53 line 20
[56] INQ000474284/6 §18

were no checks or assessments of the hospital or of the outsourced company for compliance with health and safety regulations or IPC guidelines during the pandemic."[57]

51. Outsourced non-clinical staff were regularly in the lowest priority categories for testing and vaccination. There were reports of migrant workers being refused swab tests in the first wave of the pandemic, whilst white colleagues in the same hospital received them.[58] 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 led to outsourced workers without access to the programme working alongside vaccinated inhouse staff.[59]

Sick Pay:

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

53. The system of sick pay was so inadequate for outsourced workers that they had to *choose to go into work and risk their lives or stay at home* [and] … *face destitution*.[60] We heard directly from 'Witness 1', the powerful evidence that had she become symptomatic she would had to have continued working. "*I would have done so, because I had to survive*".[61]

54. A choice between continuing to work whilst unwell or facing prolonged periods without an income is inevitably a key driver in health inequalities. The implications for the precariously employed worker and the wider infection control issues are obvious.

55. The 'No-Recourse to Public Funds' conditions applied to visas put migrant staff in similar positions to outsourced colleagues in the event of sickness. Whilst their status as employed staff entitled them to NHS occupational sick pay; if the period of occupational sick pay is exceeded, for example in the event of Long Covid, there was no entitlement to assistance.

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[57] INQ000474284/5§15
[58] INQ000477577/12
[59] INQ000477577/27
[60] Evidence of Alex Marshall: 10th October 2024: PHT000000114/11 P42 line 3
[61] Evidence of 'Witness 1' 9th October 2024: PHT000000113/2 page 5 line 24

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

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

58. As nosocomial infection rates increased, employed staff who were able to comply with orders to self-isolate did so. 89% of NHS staff absences were reported to be Covid related.[62] Outsourced workers were expected to cover shortages. Some had to take on increased workloads and job variations without training or consultation. Security guards found themselves taking on patient facing roles by covering porter absences. Cleaners found themselves required to cover twice their usual workload in the same time period and reported that this prevented them from having time to disinfect themselves before moving between Covid and non-Covid wards.

59. Long hours of exposure and physical exertion are clear risk factors increasing the likelihood of catching and becoming ill from Covid[63] yet, just as migrant workers were in no position to complain, those who were precariously employed as non-clinical staff could not refuse additional shift work. As Witness 1 said in evidence "*I would start work 6, 7 o'clock in the evening and go until 4, 5 in the morning…usually for five days a week but sometimes even weekends…due to the situation… I didn't really want to work additional hours, but I felt pressured by the circumstances and didn't feel able to say no…I feared losing my job*".[64]

60. The risk implications for both the worker and the wider public are self-evident. An understaffed sector cannot be resilient. The root causes of understaffing have to be understood and addressed.

61. These workers knew that they were vulnerable. They knew that they were working with patients who were vulnerable.[65] Their under-protection and over exposure had implications beyond their own welfare. It heightened the risk to those around them. It was a major failing in the whole 'Infection Prevention and Control' process.

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[62] INQ000231467
[63] INQ000474276/32 § 78
[64] Evidence of 'Witness 1' PHT000000113/1 page 2 line 3 onwards
[65] Evidence of Alex Marshall: 10th October 2024: PHT000000114/10 P39 line 15

62. These workers raised warnings on these issues, either individually or through organisations like Kanlungan and unions like UVW and IWGB. They were ignored. As Alex Marshall told the Inquiry, "*there was no point throughout the pandemic…where we thought that our employers or the state, the government were actually going the extra mile to think about how to protect us and keep us safe.*"[66]

Impact:

63. The impact on these workers was inevitable. Infection rates were higher[67], the incidence and severity of Long Covid was higher.[68] The mortality rates were truly shocking.

64. Up until 22 April 2020, 63% of the healthcare worker deaths were ethnic minority workers and of that 63%, **at least** 83% were migrants. 36% of those migrant deaths were workers from the Philippines. That was **by far** the highest national mortality rate for migrant health workers. [69]

65. The Office of National Statistics (ONS) occupational data from May 2020 flagged outsourced, gig economy, low-income occupations in the highest mortality categories. Inevitably they included the Group's healthcare worker members: healthcare assistants, care workers, cleaners, security guards and drivers.[70] The 3rd July 2020 Independent SAGE report added to the list with the inclusion of nurses and delivery jobs and the specific inclusion of hospital cleaners as being at increased risk of death.[71]

Data:

66. ONS data was considered the data gold standard by many of the witnesses.[72] Many of the reports referred to in the paragraphs below relied on it. Public Health England's (PHE) Fenton report relied on it.[73] PHE's later report "Disparities in risks and outcomes" also relied on it to count migrant deaths.[74] However, *"the ONS used a unique linked dataset that encompassed Census 2011 records and death registrations."*[75] Therefore, whilst it was incredibly valuable, **it did not include data on the deaths of any migrant worker who had arrived in the UK after 2011**.[76] Almost a decade's worth of migrant workers were not included in the mortality

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[66] Evidence of Alex Marshall: 10th October 2024: PHT000000114/11 P41 line 6
[67] INQ000352883/2
[68] Evidence of Alex Marshall: 10th October 2024: PHT000000114/13 P50 line 6
[69] Evidence of Professor Naqvi 10th October 2024: PHT000000114/34 P133 line 3
[70] References at INQ000069200 & INQ000235286
[71] INQ000215514/7
[72] For example: Sir Frank Atherton INQ000416178/34 § 94
[73] INQ000106482/6
[74] INQ000101218/54
[75] INQ000176357 P16
[76] INQ0000089742/21

rate assessments of most major studies. Bearing in mind the proliferation of migrant workers in outsourced and gig-economy occupations[77], it clearly follows that the deficiency extends to occupational mortality rates. **In all likelihood, the true picture of outsourced and migrant mortality would have been "significantly higher".**[78]

67. There are other deficiencies in data collection that impact on the Group's members and are particularly valuable because they give insight into the extent to which these workers were routinely overlooked. The ONS data on healthcare worker mortality included porters but did not include "domestic" workers. Despite constituting the largest national group of workers in the NHS behind British and Indian workers,[79] no official data was gathered on infection and mortality rates in Filipino workers. No official data was gathered in respect of migrant mortality rates generally.[80] Subcontracted staff were not represented in the NHS datasets.[81] The DHSC, **the Department** responsible for healthcare workers, did not even include[82] "domestic" workers like cleaners, in its data on healthcare worker mortality. These workers did not count enough to even be counted.

Foreseeability:

68. A key question for the Inquiry is whether any *unequal impact was foreseeable*.[83]

69. As a starting point, long before COVID-19, the scientific consensus accorded with a basic common-sense proposition: The poorer someone is, the more vulnerable they are to a pandemic such as this; the more likely they are to be infected and the more likely they are to die.

70. This basic proposition had been emphasised by the 1918 Spanish Flu pandemic almost a century before COVID. It was emphasised again in the 2009 H1N1 pandemic and re-emphasised in the seasonal flu **every single year**.[84]

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[77] INQ000106482/35
[78] Professor Naqvi PHT000000114/34 P136 line 12-14
[79] INQ000327667/3
[80] Professor Naqvi PHT000000114/34
[81] PHT000000114/29
[82] INQ000068863
[83] Introduction to the Module 3 List of Issues.
[84] See Bambra and Marmot report: INQ000195843: § 168-180: relying on various previous reports including Johnson, 2006, Crighton et al, 2007, Pearce et al, 2011, Tam et al,2014, Mamelund et al, 2021

71. Consistently with that, a 2008 report from the World Health Organisation's (WHO) *Global Commission on the Social Determinants of Health* concluded, unsurprisingly, that across the world *health inequalities are driven by socio-economic inequalities*.[85]

72. In response to that report, the UK Government commissioned its own review to consider how the WHO Commission's findings applied in England, and to make recommendations. That review, published in 2010,[86] contained the research of more than 80 health inequalities experts, led by Professor Sir Michael Marmot. It **informed Government** of the evidence on the causes of health inequalities and how to reduce them.

73. The review highlighted employment and working conditions as key social determinants of health inequality: *Being in good employment is protective of health. Good work is "**free of the core features of precariousness**, **such as lack of stability and high risk of job loss**, **lack of safety measures** (exposure to toxic substances, elevated risk of accidents) and the **absence of minimal standards of employment protection**". Conversely, **poor working conditions are characterised by low-pay, insecurity, few opportunities for advancement, and working in conditions that are harmful to health**… Insecure and poor-quality employment is also associated with increased risks of poor physical and mental health.*[87]

74. The 2010 review also highlighted the particular exposure and vulnerability of ethnic minority groups, in part because of the prevalence of ethnic minority workers in outsourced positions[88]. People from ethnic minority groups are *"more likely to be **in low-paid**, **poor quality jobs**, with few opportunities for advancement, **often working in conditions that are harmful to health**. Many are trapped in **a cycle of low-paid, poor-quality work**"*. It can only have been obvious that the 'Hostile Environment' policies, in the years after the 2010 review, would incrementally exacerbate the impact on migrant workers.

75. Ten years later, in February 2020, just as the pandemic was breaking in the UK, a follow up report "The Marmot Review 10 Years On" was published.[89] As with the first Marmot review, the Government was well aware of the findings.[90] It noted an increase in "*poor quality work*"[91] and the increased risk to the health of these workers, with "*several new types of poor-quality work*

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[85] INQ000195843 § 17.
[86] INQ000195843 § 22.
[87] INQ000195843/9 § 21.3
[88] INQ000195843 § 28.3 & 28.4
[89] INQ000195843/26
[90] INQ000176357/52: House of Commons Women and Equalities Committee Report
[91] INQ000195843/28

emerging, putting health equity at risk. ***From a health inequalities perspective, low paid, insecure and health-damaging work is not a desirable option.***[92] In essence, *"stalling life expectancy, increased regional and deprivation-based health inequalities,* ***and worsening health for the poorest in society***".[93]

76. As Professor Marmot stated in evidence to Module 1 of this Inquiry:[94] *"it is entirely predictable… the lower the socio-economic position, the greater the deprivation, the greater the consequences".*

77. Low paid workers, living in the most deprived areas, in multi-occupancy, low quality housing and packed into public transport are going to be hit hard. When their work is essential and exposed, in one of the most exposed sectors they are going to be hit harder still. When their work is made precarious by immigration conditions or a lack of contractual protection, they are going to be hit the hardest of all.

78. The impact was clearly "*predictable*". As Chris Whitty said: "*poverty is a risk factor for infections everywhere".*[95]

79. The extent of the foreseeability contextualises the Government's failures and informs the Inquiry's potential recommendations. **It is entirely foreseeable that, in the next pandemic, the impact on these categories of worker will be exactly the same again**.

Silence and Inaction:

80. The State response was characterised by silence, inaction, wilful ignorance, tokenism, lip-service and disingenuity.

81. Pre-pandemic, National Risk Assessments apparently authored by the Department of Health and Social Care (DHSC), entirely excluded reference to any of this obvious risk.[96]

82. The Marmot and Bambra review of the entirety of Government contingency planning concluded[97] that "*Pre-existing health inequalities were only considered in a minimal way in… pandemic planning and then largely in relation only to age and clinical risk factors.* ***Wider***

[92] INQ000195843 § 55
[93] INQ000195843/23
[94] PHT000000004 P58
[95] Evidence of Sir Christopher Whitty: 26th September 2024 14:36: PHT000000107/40 P159 line 14
[96] INQ000195843/46 § 118-120
[97] INQ000195843 §146

issues of vulnerability (such as socio-economic status or ethnicity) were seldom considered in the UK. *"Overall… with some exceptions, the specialist structures concerned with risk management and civil emergency planning* ***did not properly consider societal, economic and health impacts in light of pre-existing inequalities. The UK Government and the devolved administrations and relevant public health bodies did not systematically or comprehensively assess pre-existing social and economic inequalities and the vulnerabilities of different groups during a pandemic in their planning or risk assessment processes.***[98]

83. In oral evidence, Professor Bambra firmed up this conclusion "*Yes, the risk registers pre-pandemic that we reviewed had very little by way of vulnerability other than clinical risk factors or age in some cases, and* ***there was certainly nothing in terms of, for example, minority ethnic groups, deprivation, other things which we know are major factors in the Covid pandemic****".*[99]

84. Two aspects of Professor Bambra's oral evidence set the scene:

    i. The disingenuity of DHSC evidence that inequalities impacts are "routinely assessed": "*In the documents that we have looked at… out of a whole body of work there was only one from 2011, so I don't think we could see that as routinely assessed in regards to the planning.*"[100]

    ii. The wilful ignorance of the impact on these workers, in the light of the clearly predictable risk: "*it would be quite difficult for* [Government] *to think about why* [people with health inequalities] *might be at risk when* ***they're not thinking about them at all.***"[101]

85. The evidence of the Group's members is entirely borne out by the key feature of this Inquiry's disclosure: **no one** appears to have given more than a cursory thought to protecting these workers.

86. As the pandemic ripped into the health system, it quickly became apparent that the predictable was coming to pass.

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[98] INQ000195843/64 § 149
[99] PHT000000004 P42
[100] PHT000000004 P52
[101] PHT000000004 P54

Risk factors and assessments:

87. In April 2020, NHS England certainly became aware that the mortality rate was extremely high in ethnic minority healthcare workers.[102] A report to the Chief Medical Officer (CMO), that is undated but from its context appears to be from March to May 2020, recognises that age, geography, **socio-economic factors and ethnicity** may all be directly or indirectly associated with increased risk of severe illness from Covid-19.[103] On 9th April 2020, the DHSC received media requests[104] to comment on reports that ethnic minority communities were being hit harder, and criticisms that Government was not being honest about the scale. By 12th April 2020 Chris Whitty (CMO) was referring to the known increase in death rates among ethnic minority healthcare workers.[105]

88. A DHSC email exchange on 19th April 2020 reiterates the recognition of increased death rates in ethnic minority HCWs, and specifically noted that DHSC analyses of hospital death rates do not include "domestics". [106] A conscious decision had been made to not even count the deaths amongst this group of workers.

89. On 20th April 2020 there was clear international recognition of high hospital infection rates and the increased risk to healthcare workers.[107] On the same day, it is clear that the DHSC were aware that outsourced staff were not being supplied with the same access to testing as their inhouse colleagues.[108]

90. On 22nd April 2020 the 'Health Service Journal', the publication for healthcare leaders, published an exclusive report on the data around ethnic minority healthcare worker deaths.[109] It reported that 71% of nurse and midwife deaths, 56% of healthcare support worker deaths and 94% of doctor and dentist deaths were from members of ethnic minority communities. It was this report, authored by Professors Cook and Lenane, that emphasised that at least 83% of these ethnic minority fatalities were **migrants** and firmly advised that **migration** be considered as a risk factor alongside ethnicity. In total, Professors Cook and Lenane reported that "*more than half those health and social care workers who have died were born outside the UK*" despite migrants constituting only *a reported 18% of NHS staff.*[110] The report also

[102] INQ000117760
[103] INQ000068989/2e
[104] INQ000068818
[105] INQ000068786
[106] INQ000068863
[107] INQ000068887
[108] INQ000068874
[109] INQ000352887
[110] See also INQ000106482/35 for confirmation of this figure.

noted "*a sense that the cases included many from the lower paid roles and those on the lower rungs of the hierarchy",* clearly flagging that socio-economic position was a risk factor.

91. It is noteworthy that the report also pointed to the lack of deaths in the best protected staff and called for *wider use of* [the] *rigorous PPE* worn by ICU staff. A later report from Professor Cook confirmed that infection rates were highest amongst nurses, junior doctors and house-keeping staff (i.e. cleaners, caterers and porters) and put that squarely down to the provision of less rigorous PPE.[111]

92. Also on 22nd April 2020, Professor Kevin Fenton (Regional Director of PHE London) wrote to the CMO[112] raising his "deep concern" and "*strong sense that COVID has simply covered worsening socio-economic inequalities in society*". On 28th April 2020 the British Medical Association (BMA) attended Downing Street raising the disproportionate rate of serious illness and deaths in ethnic minority practitioners, suggesting that all ethnic minority practitioners be issued with FFP3 masks, and pointing out that because the majority of doctors who had died were **migrant** there was a concern that they were being pressured into more frontline work.[113] It cannot have escaped Government's notice that if migrant doctors were being pressured into COVID wards, then those further down the professional hierarchy would be similarly exposed.

93. On 5th of May 2020, Public Health England produced a report[114] clearly concluding that ethnicity was an important factor in mortality rates. It listed all of the markers of social deprivation; occupation, population density, use of public transport, household composition and housing conditions, as potential contributors to the death rates. The data[115] was clear that the two most deprived quintiles of the population were "*significantly associated with increased odds of death"*. The report was marked 'Official Sensitive'.

94. On 7th May 2020, Ministers were made aware that health and social care workers were almost ten times more likely to test positive for COVID than the general population.[116] On the same day, the Office of National Statistics (ONS) released data[117] analysing the high risks of mortality in ethnic minority communities, flagging socio-economic deprivation as a contributor. Also on 7th May 2020, a report referred to as the "Goldacre paper" was published. It was clearly known to the DHSC, because it was referenced in internal emails.[118] It stated "*We have*

[111] INQ000352883/2
[112] INQ000068904
[113] INQ000117871
[114] INQ000069221
[115] INQ000069221/13 and 29
[116] INQ000069130
[117] Referenced in INQ000226458
[118] INQ000069524

quantified a range of clinical risk factors for death from COVID-19, some of which were not previously well characterised, in the largest cohort study conducted by any country to date. ***People from Asian and Black groups are at markedly increased risk of in-hospital death*** *from COVID-19…* ***Deprivation is also a major risk factor*** *with, again, little of the excess risk explained by co-morbidity or other risk factors.*"

95. Matt Hancock had read "Goldacre", he referred to it in his oral evidence, calling it "*excellent evidence*" and "*very good statistical work*".[119] It formed part of the knowledge he had, in April 2020 at the latest,[120] that migrant healthcare workers were dying at a significantly disproportionate rate; in his words "***it was absolutely crystal clear that this was a major problem*".**[121]

96. Mr. Hancock has asserted that he wanted "*risk factors… published so that those who were at risk of particularly acute effects of a COVID-19 infection were aware of this and could take precautions accordingly".*[122]

97. On 10th/11th May 2020 the government published its COVID recovery strategy titled "Our Plan to re-build". Two different versions of this document have been disclosed. The first[123] is an early draft (10th May 2020) and the second[124] (11th May 2020) appears to be the final published draft.

98. At page 38 of the first draft, when dealing with higher risk categories of the population, the report states "*It is clear the virus disproportionally effects men, older people, people who are overweight and people with some underlying health conditions*". There is no mention of ethnicity, migration, socio-economic disadvantage, or occupation. A reviewer of the draft has added a proposed amendment "*Start with older people (biggest risk). Maybe add ethnic minorities".* By the final draft[125] the sentence had been amended to correctly prioritise the risk to the elderly, but the suggested inclusion of ethnicity had been ignored. There had been no consideration at all of immigration status, deprivation or occupation.

99. On the same day, the ONS published its findings on high-risk occupations.[126] Cleaners, security guards, nursing assistants, care workers, hospital porters, kitchen catering assistants and taxi drivers were among the occupations with the highest mortality rates. The Government

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[119] Evidence of Matt Hancock 21st November 2024 15:53:16
[120] Evidence of Matt Hancock 21st November 2024 14:27:16
[121] Evidence of Matt Hancock 21st November 2024 14:27:54
[122] INQ000421858/42 § 171 see also INQ000421858/42 § 171
[123] INQ000069181
[124] INQ000069192
[125] INQ000069192/40
[126] References at INQ000069200 & INQ000235286

knew that this material was awaited.[127] It would not have been difficult to discover its delivery date and inform the public accordingly.

100. As a result of their exclusion from "Our Plan to Re-build" none of these factors were highlighted for the "risk-based targeting of protection measures" that the document emphasised. The document was signed off by the then Prime Minister, Boris Johnson. We do not know the extent to which the DHSC was involved in its drafting and thereby also responsible for obscuring these risk factors. We raised questions on this issue in our Rule 10 submissions, but unfortunately the questions were not asked. We do know that Matt Hancock was involved in implementing the "Plan"[128] and was invited to contribute to the second chapter of the document that was published in July 2020.[129]

101. In any event the DHSC **was involved** in the publication of NHS Employers' risk-reduction framework on 28th May 2020. The *risk assessment tool*[130] was designed *to help NHS organisations to enhance their existing risk assessment processes, particularly for at risk and vulnerable groups.*[131] Importantly, **this risk reduction framework was based entirely on the data published by Professors Cook and Lenane a month before**.[132] For the first time it included ethnicity as a risk factor for healthcare employers to consider. However, despite the clear emphasis in the Cook and Lenane data, the framework made **no mention at all** of the fact that the vast majority of ethnic minority healthcare worker deaths were **migrants** and the indications were that they were predominantly the **lowest paid**.

102. NHS England sent the risk reduction framework to NHS Trusts on 24th June 2020.[133] By this time, PHE had published their (2nd June 2020[134]) report "Disparities in risks and outcomes". [135] The report flagged that "*When compared to previous years, we also found a particularly high increase in all cause deaths* ***among those born outside the UK and Ireland****; those in a range of caring occupations including* ***social care and nursing auxiliaries and assistants****; those who drive passengers in road vehicles for a living including* ***taxi and minicab drivers****…; those working as* ***security guards*** *and related occupations; and those in* ***care homes****".*[136] The report emphasised that "*migration is a factor that impacts on people's*

[127] INQ000069221/18
[128] INQ000232194/98-99, 102
[129] INQ000232194/116
[130] INQ000223041
[131] INQ000472172/91 § 322
[132] See INQ000223041/8 reference [3]
[133] INQ000051089
[134] For date see INQ000176357/26 footnote 156
[135] INQ000399820
[136] INQ000399820/4

health" and noted that the pandemic all cause death rate was **3.4 times higher** than previously for migrants from "*South East Asia, which includes Malaysia, the Philippines and Vietnam".*[137]

103. The report was "crystal clear" that (a) occupations with the highest infection and mortality rates were those with the highest exposure and the lowest pay and (b) migrants had "*significantly higher"* mortality rates.[138]

104. These two key features of the Cook and Lenane data, relied on by those who created the risk reduction framework, and repeated by PHE's own findings, somehow did not find their way into the "Official" NHS risk assessments.[139]

105. Matt Hancock's assertion that information was published so that "*the public could see the people who may be at greater risk"*[140] was simply not accurate. There is not a single example of risk assessments taking into account immigration status or the socio-economic deprivation that flows from precarious employment.

106. Importantly, the risk reduction framework was targeted at NHS "staff".[141] The DHSC state that it was sent to NHS trusts reminding them of their legal duty to protect the health, safety and welfare of **their employees** i.e. "staff".[142] The letter to Trusts on 24th June 2020[143] focused on NHS inhouse staff, emphasising instructions to distribute information via the NHS staff intranet or at all-staff briefings. Outsourced workers, not direct employees of the NHS, were not included. This is one of many disclosed documents[144] aimed at "staff" that demonstrate the extent to which outsourced healthcare workers were, on the face of it, overlooked.

107. When Sir Christopher Wormald, then Permanent Secretary at the DHSC, was asked the extent to which the framework was sent to subcontracted employers of hospital workers to ensure that outsourced staff had the same level of protection as their NHS staff colleagues, his answer was that he did not know.[145] He also did not know the extent to which the framework was sent to private hospitals who were caring for NHS patients.[146] The lack of knowledge is entirely consistent with the overall lack of consideration for outsourced workers. Sir

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[137] INQ000399820/54
[138] INQ000399820/55
[139] INQ000051089/1
[140] Evidence of Matt Hancock 21st November 2024 14:26:40
[141] INQ000223041/1
[142] INQ000472172/9191 § 323
[143] INQ000051089
[144] For example: INQ000192661, INQ000192711, INQ000068547, INQ000068552, INQ000069540, INQ000249084, INQ000069000, INQ000069109.
[145] Evidence of Sir Christopher Wormald 12th November 13:51:09
[146] Evidence of Sir Christopher Wormald 12th November 13:51:32

Christopher told us that he would "*go away and check*". His reply, a month later,[147] highlighted the lack of consideration by shifting the responsibility downwards to the NHS, and Amanda Pritchard's acceptance that "*on reflection… we should have been explicitly clearer that that needed to apply to outsourced staff*".

108. When Alex Marshall was negotiating with employers on behalf of IWGB couriers who were clinically vulnerable, but not enough to have received shielding letters[148], trying to ensure they had a sick pay that they could live on and not risk their lives at work, he was hamstrung by Government's wilful ignorance and refusal to publicly acknowledge the risk factors. The fact that they were clinically vulnerable, precariously employed and in some cases migrant, put them at significant risk. But employers conducted risk assessments on the basis of the risks that Government informed them of.[149] If the Health and Safety Executive (HSE) took action against errant employers at all, it only did so on the basis of those same risks.

109. The response of the HSE throughout the pandemic has been criticised, for a myriad of reasons, as wholly unsatisfactory.[150] It is a regulator that in reality is little more than a paper tiger. Again, given the wholesale cuts to its funding this is unsurprising.

110. In a report by the Institute of Employment Rights titled "HSE and Covid at work: a case of regulatory failure" it is noted that HSE funding has been significantly reduced in the last decade with a reduction, in real terms (when inflation adjusted) of 58% between 2009 and 2020. It is apparent that these cuts have affected staffing numbers with a fall of full-time staff by 36% and frontline staff, including inspectors, declining by 35%[151]. The HSE is responsible for regulating approximately 5.5 million duty-holders. In a six-month period in 2020, during the pandemic, the number of HSE inspectors conducting spot check visits declined by 40% compared to the previous year[152]. In the ten-year period preceding the pandemic the number of workplaces investigated by an inspector fell by 70%. In twenty years, the number of prosecutions has fallen by 91%.[153]

111. For 'limb b' workers[154] such as medical couriers, who due to the nature of their work are not eligible for inhouse employment, the HSE is their baseline employment protection.

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[147] Statement 13th December 2024 INQ000474738/5
[148] INQ000327662 § 45
[149] FMHWG Statement INQ000477577/10 § 47
[150] See for example INQ000477577/18 § 82
[151] INQ000103571/34-35
[152] INQ000103571/36
[153] INQ000477577/37
[154] INQ000477577/18 § 81

Government was supposed to lead and guide, instead it obfuscated and obscured. In doing so it catastrophically failed the healthcare workforce.

Tokenism and Immigration:

112. Government knew of the impact, not simply on ethnic minorities, but particularly on migrants. Matt Hancock accepts that he was aware in at least the spring of 2020, "long before"[155] the PHE findings in June, that migrant healthcare workers were suffering disproportionately high infection and mortality rates.[156]

113. In the light of that knowledge, Mr. Hancock was asked four times what specific steps he took to protect these workers. Putting aside his stock answer about introducing lockdown, all he could identify was "*encouraging the NHS to introduce a Chief People Officer for the first time, who as it happened… was from a migrant background*".[157] It is noteworthy that that same Chief People Officer sent the 24th June 2020 risk assessment letter to NHS Trusts,[158] excluding migration as a risk factor, directly in the face of the evidence.

114. The chief concern that Government had about migrant healthcare workers, was not how to protect them, but how to get more of them.

115. The austerity led understaffing of the NHS came home to roost with the onset of the pandemic. The conflict between the Government's need to fill the gaps with migrant workers and their desire to hide the reality of understaffing is exemplified by an internal DHSC email exchange[159]. The desperation was such that the DHSC had chartered a private plane to bring in 250 nurses from India. The plan was abandoned because "*nursing staff shortages have not been the main focus of the media… given how angry people are about the health system; the optics might not be good*".[160]

116. The Government actively sought to dramatically increase the cohort of migrant nurses, with particular reference to the Philippines, from September 2019 onwards.[161] The DHSC, under Hancock and Javid, continued to focus on that recruitment.

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[155] Evidence of Matt Hancock 21st November 2024 14:27:16
[156] Evidence of Matt Hancock 22nd November 2024 10:54:53
[157] Evidence of Matt Hancock 22nd November 2024 10:58:24
[158] INQ000051089
[159] INQ000193433
[160] INQ000193433
[161] INQ000479043/31 §142 and 34 §148

117. The July 2020 NHS "People Plan"[162] noted the need to increase international recruitment.[163] In the same month the Government introduced the new Health and Care visa.[164] The new visa was 50% cheaper[165] to apply for than the previous (Tier 2) system. It also exempted migrant health and social care workers from having to pay the Immigration Health Surcharge (IHS).

118. The IHS had been introduced as part of the 'Hostile Environment', apparently to *"ensure that* [migrants] *contribute to the NHS"*.[166] Of course, migrant healthcare workers already "contributed" to the NHS, firstly by working for it and secondly by paying for it via National Insurance contributions, like any other worker. The surcharge had always been indefensible, a tax on migrants as part of the 'Hostile Environment' narrative. The removal of the surcharge was pitched as an "exemption"[167] as a tribute to the sacrifices that migrant health workers were making.[168] In fact, the exemption only applied to surcharge paid after the 31st of March 2020[169] and it was not agreed in Government until late July 2020.[170] The refunding of 'unsponsored' health care workers, such as outsourced cleaners, who had paid between those dates, did not begin until April 2021.[171] None of the migrant workers who had previously been working and dying on the front line were exempted. At best, the removal of the surcharge was an example of tokenism.

119. The real motivation for the removal of migration charges is clear from the July 2020 NHS People Plan. It made it "*quicker, cheaper and easier*" to recruit migrant healthcare workers.[172] It did not make it safer. It is no surprise that Matt Hancock did not refer to this when asked about specific steps taken to protect these workers.

120. On 3rd July 2020, the Independent SAGE group submitted a report to Government.[173] Authored by Sir David King, the former Chief Scientific Advisor, the report highlighted the particular dangers of 'Hostile Environment' policies limiting access to healthcare, in the context of a pandemic. The report specifically identified 'No Recourse to Public Funds' conditions as exacerbating "precarity and destitution" and called for their removal.[174] However, 'NRPF' conditions remained attached to every new Health and Care Worker visa. Further, despite

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[162] INQ000292624
[163] INQ000292624/43
[164] INQ00292624/44
[165] INQ000292624/44
[166] INQ000421858/39-40§ 161
[167] INQ000421858/39-40 § 161
[168] INQ000421858/39-40 § 160-161
[169] INQ000478900
[170] INQ000478900
[171] INQ000478899/3 § 6
[172] INQ000292624/44
[173] INQ000215514
[174] INQ000215514/15

Matt Hancock's acceptance that the precarious immigration status of migrant healthcare workers made them more vulnerable to employer pressure to work in higher risk environments than their non-migrant colleagues,[175] the visas remained conditional on continued employment by the sponsoring employer.

121. The "*quicker, cheaper*" visas ensured that migrant health workers continued to arrive. In 2022-23 a total of 57% of new adult nursing joiners were recruited from overseas.[176] In 2016, 4.1% of NHS staff were of Asian nationalities, by 2022 that figure had risen to 7.2%.[177]

122. At no stage were any of these new migrant workers warned that their status made them significantly more likely to become infected and die. In the second wave of the pandemic Southeast Asian nationalities continued to suffer the same high rates of both infection and mortality.[178]

123. It is of the utmost concern that the DHSC endorsed the obscuring of migration as a mortality risk factor at exactly the same time that they endorsed the exponential recruitment of more migrant healthcare workers.

124. It cannot come as any surprise to read these, depressingly astute, words from a Filipino nurse who has left the UK since the pandemic: *'They look at* overseas *workers* as *commodities, whom they buy through recruitment from other countries to get to their land* to *work* as *their* slaves. *We are nothing but a disposable commodity'*.[179]

Outsourced and non-clinical workers:

125. The 3rd July 2020 Independent SAGE report to Government[180] flagged socio-economic disadvantage, overcrowded, multi-generational housing conditions and occupation as major risks. The occupations that were specifically emphasised as having "*increased...risk of exposure, infection and death*" were "*transport and delivery jobs, health care assistants, hospital cleaners, social care workers, taxi drivers, security guards, and… nursing and medical jobs*". The report raised concerns that "*some of these occupations have been the last to receive supplies of personal protective equipment*" and that racial inequalities had led to ethnic minority healthcare workers having "difficulty" acquiring PPE. It noted the higher mortality rates

[175] Evidence of Matt Hancock 22nd November 2024 10:58:01
[176] INQ000292664/49 NHS Long term workforce plan
[177] INQ000195843/80
[178] The Technical Report INQ000177534/93
[179] INQ000327661/14
[180] INQ000215514

in ethnic minority health workers and that mortality rates in deprived areas were twice that of the least deprived. The report noted how critical Statutory Sick Pay was to ensure self-isolation and shielding the vulnerable. It was clear that SSP was too low for working families to live on and that many low pay/zero-hour workers and migrants were not eligible for it. There was a clear emphasis on occupations that are regularly outsourced within the healthcare workforce.

126. With that in mind, there has been a notable reluctance on the part of the DHSC to explain how they defined "frontline" workers. The DHSC corporate witness statement[181], with contributions from three Departmental Director Generals, carefully avoided answering the question when it was directly asked by the Inquiry.[182]

127. In oral evidence, Sir Christopher Wormald was also reluctant to give a straight answer to the simple question "*How did the DHSC define the frontline?"*[183]. His eventual answer was: "*NHS employees. People who were working as employees of the NHS who would normally be in the NHS pension scheme*."[184] The answer is illuminating because it explains the entire pandemic experience of the Group's outsourced members, none of whom were employees of the NHS or beneficiaries of its pension scheme. Despite working on the frontline, they were not considered (by the Government) to be "frontline".

128. The definition explains why Sir Christopher did not know if the risk reduction framework was sent to subcontracted employers of hospital workers to ensure that outsourced staff had the same level of protection as their inhouse colleagues. It explains why the 24th June 2020 letter to NHS Trusts, about risk assessments, only included their directly employed "*staff*". It also explains why subcontracted staff were not represented in the NHS datasets.[185]

129. The lack of consideration extended all the way down the line: Professors Shin and Warne were unaware if NHS staff testing was extended to outsourced workers. When asked whether any 'Infection Prevention and Control' consideration was given to a lack of sick pay disincentivising testing, the answer was that they believed some steps were taken to prevent that, but they could not say what they were.[186]

130. As regards outsourced workers in particular, Dr Jones acknowledged that whilst frontline clinical staff may have understood IPC measures, there was "*little evidence of other*

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[181] INQ000389241
[182] INQ000389241/47
[183] Sir Christopher Wormald evidence 12/11/24 13:46:49
[184] Sir Christopher Wormald evidence 12/11/24 13:47:59
[185] PHT000000114/29 P114 line 9
[186] Evidence of Dr. Shin and Warner 19th September 2024 P189 line 15 to P190 line 15

staff or workers being prepared or supported for pandemic incidents". Further, "*the management of health risk amongst contract staff in catering and other services was not consistently under the control of those overseeing the control of the spread*".[187]

131. Recognition, from Dame Jenny Harries[188] and Professor Stephen Powis[189], that risk assessment and IPC measures should not be applied inconsistently across the employed and outsourced NHS workforce is appreciated. However, the fact is that they were. The only safe way to ensure equality of treatment is to guarantee equality of employment.

132. Importantly the DHSC definition explains why the Group's outsourced members report so frequently that they did not have the same level of protection as inhouse staff, be it PPE or access to testing.[190]

133. Finally, it explains why the Group's outsourced members reported a two-tier approach to vaccination. Public Health England's list of categories for the first phase of vaccination, as late as April 2021, prioritised "frontline health workers" as second in line, after care workers.[191] From the perspective of the DHSC and NHS England that did not include outsourced workers.

134. On PHE's prioritisation list, a 49-year-old outsourced cleaner, who was traveling to hospital on public transport, earning minimum wage and living in a multi-occupancy flat in the most deprived area in the country would have been in category 10, the lowest category for prioritisation. To contextualise that, a 29-year-old stockbroker, working online in the garden of their stately home, would have been in the same category. A 50-year-old stockbroker would have been prioritised above the cleaner.

135. Matt Hancock was absolutely right when he said that non-clinical workers were "often overlooked."[192] Similarly, his assertion that it "*wasn't always the natural inclination of NHS employers"* to take account of outsourced workers,[193] is also accurate and is a welcome (but insufficient) recognition and confirmation of the accounts that the Group's members have given.

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[187] INQ000273913/55
[188] Evidence of Dame Jenny Harries 6th November 2024 15:39 – 15:44
[189] Evidence of Professor Sir Stephen Powis 7th November 2024 15:41 – 15:42
[190] INQ000068874
[191] INQ000302492
[192] Evidence of Matt Hancock 21st November 2024 10:54:58
[193] Evidence of Matt Hancock 22nd November 2024 10:59:45

136. However, when asked what practical steps he, as Minister for Health, had taken to protect these vulnerable workers, the best that he could muster was his "support"[194] for the National Living Wage (NLW). Apart from being misnomered and based on a minimum income standard rather than on the cost of living, the NLW was introduced four years prior to the pandemic (when Mr. Hancock was a minister without portfolio). When the prevarication is stripped away, the answer to the question is, quite simply, that he did nothing. Mr. Hancock's protestations of "worry"[195] and "care"[196] and self-description as "*a big champion of the workforce*"[197] are entirely inadequate.

137. Further, the assertion that it "*wasn't always the natural inclination of NHS employers*" to take account of outsourced workers,[198] is one of many examples of Government attempting to shift accountability downwards.[199] It does not address the reality that it was Government policy of underfunding that led to the proliferation of outsourced healthcare workers in the first place. It conveniently ignores the fact that the Department that he was heading (a) did not consider the precariously employed in their pre-pandemic national risk assessments[200], (b) did not include outsourced workers in their own internal definition of "frontline" healthcare workers[201] and (c) did not count any non-clinical workers (outsourced or otherwise) in their count of healthcare worker deaths.[202] Even UK legislation specifically aimed at the protection of workers and in force at the height of the pandemic did not properly extend to 'limb b' workers.[203]

138. Throughout the module the evidence has pointed to a lack of accountability, a culture of blame shifting and a health system that is structured in such a way that responsibility is impossible to pin down. That was encapsulated by CTI's very pertinent question to Alex Marshall: "*If you are an outsourced worker or a migrant worker who do you complain to*?"[204] Within the UK health system, even responsibility has been outsourced.

Post Pandemic:

139. Nothing has changed in the aftermath of the pandemic.

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[194] Evidence of Matt Hancock 22nd November 2024 10:59:21
[195] Evidence of Matt Hancock 22nd November 2024 10:55:11
[196] Evidence of Matt Hancock 22nd November 2024 10:54:53
[197] Evidence of Matt Hancock 21st November 2024 15:53:30
[198] Evidence of Matt Hancock 22nd November 2024 10:59:45
[199] For example: Evidence of Matt Hancock 21st November 2024 14:14:00 onwards and 15:55:41
[200] As above
[201] As above
[202] As above
[203] INQ000203417
[204] Evidence of Alex Marshall: 10th October 2024: PHT000000114/12 P46 line 8

140. The Government's final report on progress to address COVID inequalities, published on 3rd December 2021, was designed to historically whitewash the Government's state of knowledge and excuse their lack of action to protect frontline, low income, precariously employed workers.

141. Referring to "***the latest analysis***"[205] it stated "*We **now** know… the main factors behind the higher risk of COVID-19 infection for ethnic minority groups include occupation (particularly for those in frontline roles, such as NHS workers), living… in multigenerational households, and living in densely populated urban areas with poor air quality and higher levels of deprivation*"[206]

142. The report notes the lack of official data on migrant death rates[207], as if that gap was not apparent and resolvable in the early stages of the pandemic. It then uses the gap of "official" data, that Government itself officiated over, to suggest that immigration status could account for some "residual" risk. It was readily apparent at the outset, as Matt Hancock has confirmed, that migrant mortality was "significantly higher".

143. One of the greatest values of this Inquiry is that it permanently captures the truth about the timing and state of knowledge and shields it from these attempts to bend the narrative and adjust the "optics".

144. Sir Sajid Javid was the Health Minister at the time that this final Government report was published. In his statement to the Inquiry[208] he referenced the PHE paper "Disparities in Risks and Outcomes"[209] that had highlighted the "significantly higher" mortality rates amongst migrants as early as June 2020.[210] Interestingly he was not able to pinpoint the timing of his awareness of "*the particularly high increase in all cause deaths among those in a range of caring occupations including social care and nursing auxiliaries and assistants and the particular vulnerability and high mortality rates of migrants in the pandemic*".[211] He noted a "*general awareness*" and becoming "*more and more aware*" as a result of his personal "*inquisitiveness*".

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[205] INQ000302496/21
[206] INQ000302496/4
[207] INQ000302496/24
[208] INQ000485736/22 § 53
[209] INQ000399820
[210] INQ000399820/55
[211] Evidence of Sir Sajid Javid 25th November 2024 16:04:36

145. Sir Sajid rightly acknowledged that migrant workers are "*a very, very important part of our health and social care system*" and added that "*had we not had the level of support that we did from such workers things would have been a lot more challenging and difficult than they already were*".[212] He also accepted that the pandemic exacerbated pre-existing health and social deprivation inequalities.[213]

146. However, his own White Paper titled "Health Disparities: Levelling up health"[214] made very little reference to migrants at all. The primary suggestion, in keeping with the narrative of the 'Hostile Environment' and wholly dismissive of the sacrifices that migrant workers made, was that they should be screened for infectious diseases on entry to the country.[215] That derisory consideration was revealing of the U.K. institutional position.

147. In September 2021, shortly after becoming Health Minister, Sir Sajid requested a "rapid strategic review of ethnic minority health disparities". His contribution to understanding the drivers of these disparities was that he "*specifically*" requested a review of "*the impacts of consanguineous marriages*".[216] Entirely ignoring the wealth of evidence from Marmot, Independent SAGE, PHE and countless others, he sought to suggest that marrying cousins was a root cause of inequality.

148. Consistently, the Chapter of the White Paper that addressed Employment[217] purports to recognise the health benefits of being in good work but makes no reference to addressing the issues arising from precarious employment, for example zero-hours contracts and outsourced employment or more exposed occupations.

149. Overall, the White paper proposals for addressing health inequalities, repeated in his oral evidence, focused entirely on obesity, smoking, alcohol and drug use.[218] In doing so it continued the Government emphasis on shifting accountability downwards, placing the blame for inequality squarely on the shoulders of those suffering from it.

150. As Professors Marmot and Bambra have made clear *"People are not poor because they make poor choices and the poor health of the poor does not result from poor choices. Rather, it is poverty that leads to unhealthy choices and the poor health of those lower down*

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[212] Evidence of Sir Sajid Javid 25th November 2024 16:04:16
[213] Evidence of Sir Sajid Javid 25th November 2024 14:44:12
[214] INQ000468609
[215] INQ000468609/86
[216] INQ000309454/2 § 10
[217] INQ000468609/77
[218] Evidence of Sir Sajid Javid 25th November 15:13:40

the social hierarchy results from the restricted range of options available to those on low incomes, as well as the direct health impacts associated with the stresses and poor conditions which result from poverty. As an illustration, the poor diet of people in poverty is, very largely, the result of poverty not poor choices. So, tackling health inequalities involves tackling social inequalities".[219]

151. The Race and Health Observatory, established in 2021, is focused on tackling ethnic and racial inequalities within the healthcare system.[220] But even their reports have a distinct lack of consideration for the immigration status of the workforce. That was perhaps best illustrated by Professor Naqvi's lack of awareness of the deficiencies of the ONS data on which the Observatory's reports are primarily based.[221]

152. Lord Darzi, reliant as he was on reports from the Race and Health Observatory,[222] makes no reference to the impact of immigration status or precarious employment within the healthcare workforce.

153. It is undeniably clear that if there were another pandemic tomorrow, the low paid, precariously employed and migrant healthcare workers would continue to die at the same significantly higher, disproportionate rates.

Impact on the system:

154. We have focused the bulk of our written submissions on the impact on the healthcare workers themselves. Inevitably the impact is much wider. In keeping with the key worker and caring nature of their occupations, the Group's members were continuously conscious, not just of the impact on themselves and their families but on the patients in the hospitals they worked in and the wider community:

"A lot of these workers were making basic demands… these were frontline workers who had been doing a job and knew they were going to be particularly vulnerable, and they were asking for things to be implemented that would protect them, that would protect their families. Also, we knew that we were going into places where there were incredibly vulnerable people. We're talking about cancer wards, we're talking about antenatal wards, we're talking about old people's homes, and we were just asking for things to be put in place to ensure that we weren't spreading the virus more than you know it was already clearly spreading like wildfire."[223]

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[219] INQ000195843 § 19.
[220] PHT000000114/26 P104 line 24
[221] PHT000000114/34 P133 line 9 to P134 line 24
[222] INQ000474367/73
[223] Evidence of Alex Marshall 10th October 2024 PHT000000114/10 P39 line 15

"There's a huge responsibility on the workers. We knew that every single day you're coming into contact with people who are unwell, who are sick, who are vulnerable, and you know we were carrying specimens of Covid to and from these places. We were going into crowded lifts. We were going in and out of wards. And we knew we could be superspreaders if we weren't given sufficient protections in order to try and mitigate against that."[224]

"We've seen the situation of cleaners… couriers and nurses who were given secondary access to PPE despite the fact that they were not only going into incredibly dangerous places but also were then going into loads of different rooms and loads of different hospitals so had the potential to be superspreaders".[225]

155. At a most basic level, it is fundamentally unwise from a public health perspective to have any section of the healthcare workforce unprotected. The impact is amplified when unprotected workers have to move within and between different hospital settings. Unprotected workers simply become vectors. The two-tier system is an 'Infection Prevention and Control' issue.

156. The Chief Medical officers have raised specific 'Infection Prevention and Control' concerns around the issue of Statutory Sick Pay. They were conscious that workers with precarious finances could continue to work when ill. Sir Frank Atherton noted that "*People's access to statutory sick pay was limited sometimes according to their socio-economic status and their race, their origins."*[226] Sir Chris Whitty "*worried throughout the pandemic… people who were not on permanently employed…who were not paid sick pay fully were more likely to come into work when they had symptoms and therefore spread disease around."*[227] Both noted that this issue required careful consideration in advance of the next pandemic. But those in Government who could have alleviated that risk did nothing of significance to address it.

157. Outsourced contracts result in reduction in service quality which also impacts directly on the hospitals themselves. From the perspective of a pandemic, outsourced cleaning is the most obvious example. Private providers reduced staffing levels and limited the terms of cleaning contracts. Poor terms and conditions result in a rapid turnover of workers, who are either unable or unwilling to work so hard for so little. "*Wherever services were contracted out, the most dedicated and experienced cleaning staff, who often had been the staff best able to communicate with and support anxious patients, and supplement the level of care nurses could provide, were stripped out".* Outsourced, *"under-paid and over-worked staff* [were]

[224] Evidence of Alex Marshall 10th October 2024 PHT000000114/10 P40 line 8
[225] Evidence of Alex Marshall 10th October 2024 10:59:24, 11:07:55
[226] Evidence of Sir Frank Atherton 30th September 2024 15:08
[227] PHT000000107/46 Evidence of Sir Chris Whitty 26th September 2024 15:14:56

required to work strictly to the specification in the contract and [were] *no longer employed by the NHS or accountable to the ward sister or matron. Tasks that were not in the* [contract] *specification, or which could no longer be done in the reduced hours of work, wound up being done by nursing staff or others – or not done at all".*[228]

158. The impact on hospitals was inevitable. The shifting of residual cleaning responsibility onto nursing staff further de-moralised an already overburdened nursing profession as well as consequentially lowering the amount of patient care offered. "*Clinical staff found they had no managerial control over contractors' staff*"[229]. From the perspective of 'Infection Prevention and Control', outsourced cleaning contracts were disastrous. Pre-pandemic there were clear indications that "*Plunging hygiene standards… created ideal conditions for the spread of… MRSA and other hospital-borne infections.*"[230]

159. The dominant route of Covid-19 infection was airborne.[231] However, bearing in mind that, "*large amounts of SARS-CoV-2 can survive on inanimate surfaces for several hours*"[232] and that the next virus outbreak may have a greater rate of surface/fomite transmission (whether by contact or droplet infection); it was and is grotesquely irresponsible to wilfully undermine the frontline of infection control, and the workers who maintain it. Outsourced healthcare workers are a false economy.

160. Other Core Participants have raised concerns about the financial viability of outsourced contracts. The British Medical Association have called for "*Greater transparency around private sector spending"* noting it *"is essential to avoid the misuse of taxpayers' money, yet we saw outsourcing being carried out with minimal oversight or governance. Deals were struck without adequate scrutiny and as a result, taxpayers' money poured out of the Treasury at a time when the NHS was struggling to cope and in desperate need of investment."*[233]

161. A report from the TUC notes: *"The impact of private sector involvement on quality has also been questioned. For instance, research by the Association of Public Service Excellence (APSE)'" looked at over fifty examples of where local authorities had brought services back in house delivering benefits including greater accountability, enhanced performance, more flexibility and increased public satisfaction".*[234]

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[228] INQ000474329/10 "Forty Years of Failure"
[229] INQ000474329/4 "Forty Years of Failure"
[230] INQ000474329/10 "Forty Years of Failure"
[231] INQ000474276/8
[232] INQ000474276/38 § 94
[233] INQ000098545/9
[234] INQ000103543/32

162. The extent of the benefit of bringing outsourced workers back in house was demonstrated by the success of campaigns organised by UVW. Just before the pandemic, in January 2020, at the end of a three month long industrial dispute, Imperial NHS Trust brought all hotel/domestic services inhouse for a two-month trial period. A year later the arrangement was made permanent. A report to the Trust's board noted "*The in-house approach has also allowed more flexibility in responding to Covid challenges, such as increased cleaning frequency recommended by Public Health England. Since the last report, the service has been maintained and flexed to meet demands faced as part of the evolving response to the pandemic".*[235] Other Trusts have taken the same course, citing support for equality[236], quality improvements, flexibility in response and financial advantage.[237]

163. The June 2022 Equality and Human Rights Commission report[238] on the treatment of lower-paid ethnic minority workers, noted that outsourced employment led to "*workplace hierarchies, with those employed directly on open-ended contracts and fixed hours having better terms, conditions and pay than agency workers and those on zero-hours contracts or employed by private companies".*[239] In the section on "Actions to improve working conditions", the report noted "*examples of outsourced NHS services being brought back in house*". The Chief Executive of one Trust is quoted as saying "*This is absolutely the right time to welcome these teams back to the NHS family".*[240]

164. Ending the two-tier system creates a safer working environment and better health outcomes for the general public.

Inquiry Recommendations sought by the Group:

165. When Alex Marshall gave evidence, the focus of CTI's questioning on recommendations was on what the Group proposed to make sure their *voices can be heard* in the future.[241] To be meaningful, the Inquiry's recommendations must go much further than that. There is no point in voices being heard if they are not listened to. The same principle applies to the gathering of data. Full data gives improved visibility, and data such as that detailed in paragraphs 66-67 above must be gathered. But if it is not acted on it is valueless. If nothing is done to actually address the root causes of health inequality, outsourced and migrant healthcare workers are going to die at significantly disproportionate levels, again. As the CMO reflected in the "Covid-19 Technical Report": *The pandemic has reinforced the*

[235] INQ000474329/15 "Forty Years of Failure"
[236] INQ000136934/45 Equality and Human Rights Commission report
[237] INQ000474329/16 "Forty Years of Failure"
[238] INQ000136934
[239] INQ000136934/43
[240] INQ000136934/45
[241] PHT0000000114/14 P54 line 24 to P55 line 19

message seen in many previous pandemics that those already marginalised, socio-economically disadvantaged and suffering poorer health outcomes are likely to be at increased risk during a pandemic".[242] Improved data and louder voices in the next pandemic will simply repeat that message.

166. As the Chair remarked at the end of Module 1 of this Inquiry: "*Money spent on systems for our protection is vital and will be vastly outweighed by the cost of not doing so."*[243] Under-investment, underfunding and understaffing in the NHS are the background to the issues raised by the Group's members. Clearly, from the wider perspective these are all areas that must be addressed.

167. However, the specific recommendations that the Group seeks are more focused. The basis for them is endorsed by Sir Chris Whitty. "*If we are serious about trying to tackle health inequalities between pandemics there is no way you are going to be able to do it when the pandemics occur. Part of our preparation is to reduce the vulnerability of the people we already know are vulnerable…*[244] In his words "*what would have been actually more helpful is to make the employment of people less precarious…* ***reducing economic precariousness is one of my strong recommendations to my successors***".[245]

168. The call for reduction of vulnerability and precarity at a societal level is consistent with the recommendations of the Marmot reports that pre-dated the pandemic (2010 and February 2020), the Independent SAGE[246] report (July 2020) and many others. In the words of the House of Commons Women and Equalities Committee report from 8th December 2020: *"Many reviews and reports have put forward recommendations to tackle health inequalities. Now is the time for action and Government should finally act on these recommendations.* ***The Government should prioritise implementing the entirety of the recommendations in the 'Marmot Review 10 years on' so that health inequalities are not further entrenched by the pandemic***".[247][original emphasis].

169. Those recommendations that are particularly pertinent to these submissions are

a) Creation of "*fair employment and good work for all"*[248]

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[242] INQ000177534/97
[243] Module 1 Report P2
[244] Evidence of Sir Chris Whitty 26th September 2024 PHT0000000107//45 P177 line 20
[245] Evidence of Sir Chris Whitty 26th September PHT000000107/55 P218 lines 1-13
[246] INQ000215514
[247] INQ000176357/50
[248] Marmot 2020 and the House of Commons Women and Equalities Committee INQ000176357/54

b) Reduction of "*conditionalities and sanctions in benefit entitlement and welfare payments*"[249] the removal of "*barriers for migrants accessing essential benefits*" including the '*No Recourse to Public Funds condition*'.[250]

c) Reduction of "*in-work poverty by increasing the National Living Wage, achieving a minimum income for healthy living for those in work*"[251]

d) Reduction of "*the high levels of poor-quality work and precarious employment*"[252] that "*increase the risk of exposure to disease and illness*"[253] and

e) "*Increase the amount and eligibility for statutory sickness pay.*"[254]

170. There is a strong argument (that the Group endorse), from a public health perspective, for recommendations from the Inquiry that encompass all of the above, across society as a whole. Policies that reinforce fundamental inequalities across society plainly weaken the resilience of society as a whole in the event of pandemic.

171. The Group understands the Inquiry's concern about an inability to "*change society.*"[255] However, key aspects of this module are the impact on healthcare workers and the foreseeability of any unequal impact. **Recommendations to reduce the vulnerability and precarity of the healthcare workforce and prevent the predictable from recurring are very much within the Inquiry's remit.**

172. The immediate application of the above recommendations **to the healthcare workforce** must be a realistic and achievable starting point.

173. Lord Darzi's recommendation to re-engage and re-empower healthcare workers[256] and the DHSC's recommendations to *"address health inequalities within the workforce"*[257] and ensure "*equitable and inclusive workplace environments*"[258] are all worthy and laudable. But none of those aims can be achieved whilst a two-tier healthcare workforce continues to exist.

174. This two-tier system of healthcare workers is the most blatant inequality of all. It is unequal by its very definition. To have a system whereby workers are more exposed than

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[249] Marmot 2020 and the House of Commons Women and Equalities Committee INQ000176357/54
[250] Independent SAGE July 2020 INQ000215514/15
[251] Marmot 2020 and the House of Commons Women and Equalities Committee INQ000176357/54
[252] Marmot 2020 and the House of Commons Women and Equalities Committee INQ000176357/54
[253] Independent SAGE July 2020 INQ000215514/18
[254] Independent SAGE July 2020 INQ000215514/15
[255] PHT000000114/12 P47 lines 4-8 Chair's comment during Alex Marshall's evidence.
[256] INQ000474367/133
[257] *INQ000471097/12*
[258] INQ000471097/16

others in the same hospitals, doing the same jobs, because of their employment contracts or immigration status, is a fundamental injustice.

175. As Alex Marshall pointed out, it is also a public health issue that *contributes to a crisis rather than helping with efficiencies or savings.*[259] Exposing these workers exposes their families, the wider community and their patients.

1: End of outsourcing of hospital workers

176. The primary recommendation that the Group seeks is for an end to this two-tier system of healthcare workers. There can be no place for precarious employment in the workforce that is required to protect every other workforce.

177. Outsourced hospital workers must be brought in house. Healthcare workers must be employed by the hospitals they work in. It is the only practical way of ensuring fair and equitable working conditions and effectively limiting their exposure to disease, protecting both workers and patients alike.

2: Real living wage:

178. The 'National Living Wage' is calculated on a percentage of median earnings and is a minimum standard at which a worker can exist. All healthcare workers must be paid at least a real living wage based on the actual cost of living. A *minimum income for healthy living* must be a fundamental requirement for workers who are tasked with protecting the health of the wider public. The Group alongside the trade union movement call for a minimum wage of £15 per hour.

3: Real living sick pay:

179. All healthcare workers must be paid a real living sick pay, based on the actual cost of living. It is plainly fundamentally unacceptable to have workers in a hospital setting forced by the risk of destitution into a situation where, as Chris Whitty said, they *"were more likely to come into work when they had symptoms and therefore spread disease around."*[260]

4: Effective HSE:

[259] *PHT000000114/12*
[260] Sir Chris Whitty 26th September 2024 15:14:56

180. Additionally, self-employed and 'limb b' health workers (whose work such as couriering, is incapable of being brought inhouse, because of the geographic spread of the work involved) must enjoy the additional protection of a re-funded and re-staffed Health and Safety Executive with genuine powers to hold profiteering employers to account.

5: Removal of 'No Recourse to Public Funds" conditions and barriers to changing employment for migrant healthcare workers:

181. Migrant healthcare workers must enjoy the same protections as their non-migrant colleagues. These are essential workers, filling gaps in a system that would otherwise not be filled. They bring their education, experience and labour to the UK, and risk their lives to help save lives. It is fundamentally unjust and exploitative for their continued presence to be dependent on conditions that put them at increased risk. As the proportion of migrant health workers increases, it is inevitable that if mortality rates will be even more elevated if nothing is done. Health and Care Worker visas must be reviewed. 'No Recourse to Public Funds' conditions and the barriers to changing employers must be removed.

Conclusion:

182. Within the healthcare system, precarious employment has to end now. The healthcare workforce protects all of us. They must be protected in return.

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Piers Marquis (Doughty Street Chambers)

Annabel Timan (Doughty Street Chambers)

Helen Mowatt (Public Interest Law Centre)

Paul Heron (Public Interest Law Centre)

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