THE UK COVID-19 INQUIRY

MODULE 3: CLOSING SUBMISSION OF THE TRADES UNION CONGRESS

INTRODUCTION

1. This is the closing submission of the Trades Union Congress ('TUC') in Module 3 of the UK Covid-19 Inquiry. The TUC is working in partnership with TUC Cymru ('TUCC'), the Scottish TUC ('STUC'), and the Northern Ireland Committee of the Irish Congress of Trade Unions ('NIC-ICTU'). The STUC and NIC-ICTU are separate organisations, but with shared aims and values. The TUC's affiliated unions have approximately 900,000 healthcare workers ('HCWs') as members.

2. In Module 3, the Inquiry has received evidence from Sara Gorton (UNISON, on behalf of the TUC), Kevin Rowan (on behalf of the TUC), Adam Morgan (on behalf of TUCC), Roz Foyer (on behalf of the STUC), Gerry Murphy (on behalf of NIC-ICTU) and Gill Walton (on behalf of the Royal College of Midwives). The TUC has also submitted a statement setting out individual accounts from 34 healthcare workers and members of the TUC affiliated unions. Two members of affiliated unions, Mark Tilley (an Ambulance Technician at South East Coast Ambulance Service) and Carla Jones-Charles (Director of Midwifery at Walsall Healthcare NHS Trust), provided witness statements and, in the case of Mr Tilley, oral evidence.

3. The TUC, its affiliated unions, and its sister organisations aim, generally and in this Inquiry, to provide a voice for working people, and to shine a light on the outcomes of decision-making upon the experience, safety and well-being of those at work; in the context of this module, of healthcare workers. It also seeks to improve the position of HCWs in a future pandemic and, accordingly, a significant focus of this written submission is recommendations.

4. This submission addresses:

    a. The harms suffered by healthcare workers (paras 5-10).
    b. Inequality of impact and structural racism in healthcare (paras 11-26).
    c. HCWs and the collection of data (paras 27-32).

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d. The state of the UK's public healthcare systems, including staffing shortages and estates (paras 33-43).
e. Dynamic staffing responses to a pandemic, including nightingales, use of reserve workforces and volunteers, and redeployment (paras 44-55).
f. Precariousness faced by indirectly employed and migrant workforce (paras 56-66).
g. Infection prevention and control, including developing IPC guidance, training, ventilation and PPE (paras 67-82).
h. The regulatory response (paras 83-97).
i. Individual staff risk assessments (paras 98-101).
j. Vaccination as a condition of deployment (paras 102-108).
k. Support for HCWs, including mental health support and financial (paras 109-115).
l. Long covid, including return to work and occupational disease (paras 116-117).
m. Social partnership, improving current arrangements and break glass provisions (paras 118-122).

THE HARMS SUFFERED BY HEALTHCARE WORKERS

5. The terrible impact of the pandemic upon healthcare workers was foreseeable. It has been widely known, for over a decade, that the UK's public healthcare services were (and remain) stretched in terms of staffing and resource, and that the pandemic struck at a time when staff were already overworked and exhausted. The workforce suffered immeasurable loss, trauma, burnout, and moral injury. It has been important to hear workers explain, in their own words, the experience and the toll of working on the frontline. It has brought real weight and depth to the evidence received in this module.

6. We highlight some examples of the evidence given by the TUC and its affiliated unions and sister organisations as to impact:

   a. Mark Tilley (Ambulance Technician): '*I exposed* [my family] *to elements of risk that I could have avoided, and that's something that I live with, but I would be going home from work and having to strip off in the hallway so that I didn't go in in my uniform, to try and protect them. That plays on my mind. Turning up at people's houses where someone was unfortunately dead inside the front window or just on the pathway up to their property, and I've got out the vehicle and I would have normally gone over, started bouncing up and down on their chest, but we went and got our masks and suits on and all of that. That plays on my mind all the time*'.[1]

[1] Mark Tilley 1 October 2024 27/13-28/6-8.

b. Roz Foyer (STUC): '[Our members] *felt that, due to the staffing levels, the lack of resources, that they weren't -- you know, that added to their burn-out, the feeling that they weren't able to give the sort of public service that they would want to, to care for people. I think that the very nature of the role of care giving and healthcare workers, there's a lot of emotional investment involved, in fact it's very important, that human element is a very important aspect of care, and there was real frustrations coming through from staff that they weren't giving what -- you know, their feeling of a high standard of care because of the sheer lack of resources available and the burn-out that they were themselves experiencing'*.[2]

c. Sara Gorton (TUC): '[...] *by 2021, one in five health workers were telling us that they were seriously or very seriously considering leaving their job in the NHS. So* [the pandemic] *had a profound impact on those workers and in the ability of the NHS to recruit staff'*.[3]

d. Gill Walton (RCM): '*I believe that* [the pandemic] *had an impact on staff's ability to keep going, and to keep thinking about doing their best. I think staff told us that they just about managed to get through day by day. Some staff didn't and either left the profession, left their job or went on long-term sick, and on top of that of course Covid and Long Covid… So I would say that staff tried their very, very best and it had a personal toll on their health and their mental health. Which I think they are still recovering from, I don't think it is over...'*.[4]

e. An emergency medical technician working in the Ambulance Service: '*In the beginning there was a lot of uncertainty. It was terrifying. I cried every day driving to and from work, mostly in fear of taking Covid home to my parents and child and the risk of leaving my son without his mum. There was little to no PPE. We were asked to use it sparingly, we were asked to reuse items. Like most workplaces PPE supplies were unobtainable and we were using out of date stock or given two single use face-masks for a 12 hour shift. The sights were harrowing, taking people from their homes, leaving loved ones behind, knowing they would never see them again. We lost colleagues and friends*'.[5]

f. A palliative care nurse specialist: '*It was scary. We genuinely thought we might die and we all still got up every day and went back into a building and community where Covid was rife. I caught Covid from work in mid-2020 and it was severe. I wrote my will aged*

[2] Roz Foyer 16 September 2024 37/6-19.
[3] Sara Gorton 15 September 2024 147/24-148/4.
[4] Gill Walton 7 October 2024 137/18-138/5.
[5] INQ000474305_0002 para 4.

39. Yes, we had PPE but, just like everywhere, not enough initially. There was delayed mask fitting and rules that changed so often no one knew what we were doing. That level of trauma doesn't just go away. I thought from soldiers getting PTSD we knew so much more about how prolonged exposure to stress hormones can affect you. This has definitely been washed over. I defy anyone who worked in the environment to tell me they haven't been affected one way or another. The sad part is that we don't feel any more valued after all we went through. Recognise your workforce broke, are broken and will continue to be for a generation'.[6]

g. A domestic cleaner working at an NHS hospital: '*I was one of the first domestics to be in contact with Covid at the hospital, cleaning up after first Covid patient was brought in. I worked on A&E and then ITU cleaning all through pandemic. I was scared of taking Covid home. We wore the same PPE as nurses and it was hot and uncomfortable. Nobody knew what to do. It was horrible hearing people crying and saying they want to die and seeing so many young and old die. I used to come home after my shifts, go straight into the shower and cry from what I heard and saw. I didn't tell my wife what I saw for 6 months and I didn't see my family because I was scared of giving them the virus. I now sleep with a gum shield because I grind my teeth because of it, some smells still remind me of it, just the thought of what I saw still upsets me. We got no support after it, either financial or psychological. I was on the front line*'.[7]

7. There is a significant body of evidence to demonstrate that patient-facing HCWs faced a significantly higher infection risk than members of the public. One study estimated that 10 per cent of all Covid-19 infections in England were in patient-facing HCWs and resident-facing social care workers.[8] Another found that an estimated 24.4 per cent of HCWs had Covid-19 antibodies, compared with only in the 6 per cent estimated in the general population.[9] The risk of severe disease (defined as hospitalisation or death) was, similarly, higher for HCWs. As we set out in our written opening, a study found that, in comparison to non-essential workers, HCWs had a more than seven-fold greater risk of severe disease from Covid-19.[10] A tragic number of HCWs lost their lives. We do not have reliable data, but collated statistics from the Office for National Statistics ('ONS'), National Records of Scotland ('NRS') and Northern Ireland Statistics and Research Agency ('NISRA') suggests that the number is at over 900

[6] INQ000474305_0010-0011 para 28.
[7] INQ000474305_0016-0017 para 38.
[8] INQ000474282_0121 para 11.28.
[9] INQ000474282_0121 para 11.28.
[10] INQ000339466_0053.

HCW.[11] The mental health impact has also been immense. In January 2021 an RCP survey reported that 64 per cent of respondents felt tired or exhausted and 19 per cent had sought informal mental health support.[12]

8. The harms HCWs suffered were not evenly distributed amongst the workforce. Particular roles, such as porters, cleaners, nurses and healthcare assistants suffered disproportionate levels of infection.[13] Those on lower incomes fared poorly compared to counterparts on higher incomes, as did Black, Asian and minority ethnic workers.[14] Incidence of Long Covid was more common in women, those facing social deprivation and those who had pre-existing health conditions.[15]

9. It has been evident in the Module 3 evidence that, with adequate preparedness and resilience, the harms would have been significantly less. That underlines the need for pragmatic, forward-looking recommendations.

10. There is also a broader lesson to emerge from this module: the impact on HCWs is itself an important consideration in seeking to identify appropriate NPIs in a future pandemic, and in communicating the utility and importance of NPIs to the public. Arguments sceptical as to the value of more draconian NPIs (such as 'lockdowns') must confront not only the loss of life that may result from a failure to take decisive action, but also the impact on hundreds of thousands of HCWs in overwhelmed healthcare settings, forced to bear witness to such high levels of mortality in the most distressing of circumstances.

INEQUALITY OF IMPACT AND STRUCTURAL RACISM IN HEALTHCARE

11. There has been a tendency among witnesses in this module to demonstrate a willingness to acknowledge the disproportionate impact on grounds of race, but a reluctance to acknowledge the role of structural racism as a causative factor, let alone demonstrate the effort and will to address those causes. The Federation of Ethnic Minority Healthcare Organisations described the unequal impacts upon Black, Asian and minority ethnic workers as: *'the foreseeable results of systemic neglect, historical inequalities left unremedied, and a healthcare system deeply*

[11] 854 recorded in England and Wales, 54 in Scotland and 28 in Northern Ireland. See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14554deathsinvolvingcoronaviruscovid19amonghealthandsocialcareworkersthoseaged20to64yearsenglandandwalesdeathsregistered9march2020to31march2022; https://www.nrscotland.gov.uk/files/statistics/covid19/covid-deaths-22-monthly-data-week-37.xlsx; and https://www.nisra.gov.uk/publications/vital-statistics-user-requested-data (accessed 19 December 2024).
[12] INQ000396735_0025 para 77.
[13] INQ000474282_0121 para 11.37.3.
[14] INQ000474282_0121 para 11.37.1-2.
[15] INQ000421758_0032 para 87.

entrenched in structural and institutional racism, a pernicious form of discrimination that we must confront, however uncomfortable that confrontation may be'.[16] The TUC agrees.

12. Annually, NHS England produces the Workforce Race Equality Standard ('WRES') report which provides an overview of data relating to nine indicators, intended to capture the experience of Black, Asian and minority ethnic people working in the NHS.[17] The statistics are alarming. They demonstrate that, every year since the WRES started in 2016, Black, Asian and minority ethnic staff have suffered poorer experiences than white counterparts across a range of workplace issues. The WRES reports spell out the often hidden or ignored impacts of systemic and structural racism.

13. As of March 2023, 26.4 per cent of the directly employed NHS workforce across England were of a Black, Asian or minority ethnic background – and that percentage is increasing.[18] In London, that percentage was 52.1 per cent, yet London NHS trusts had some of the highest levels of race disparity in term of career progression, the worst relative likelihood of Black, Asian and minority ethnic staff entering the formal disciplinary process, and highest race disparity in terms of board membership.[19] In relation to representation in senior roles, above pay Band 5 the percentage of staff who are Black, Asian or minority ethnic drops off sharply – at Band 9, only 11.2 per cent are Black, Asian or minority ethnic.[20] Among board members, 15.6 per cent (and only 10.8 per cent of executive board members) identify themselves as Black, Asian or minority ethnic.[21] At 76 per cent of trusts, white applicants are significantly more likely than Black, Asian or minority ethnic applicants to be appointed from shortlisting.[22] In 2022, a higher percentage of Black, Asian and minority ethnic staff (16.6 per cent) than white staff (6.7 per cent) experienced discrimination from other staff; a pattern that has been evident since at least 2015, and which was repeated in all regions across England.[23] The percentage of Black, Asian and minority ethnic staff who experienced discrimination from other staff increased markedly between 2019 and 2020 and has remained at an elevated level since then.[24] The 2023 WRES report reaches a damning conclusion: *'amongst nurses, midwives, and nursing assistants, the largest part of the NHS workforce, BME staff and staff from "other" white backgrounds have poorer experiences of working for the NHS than their white British*

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[16] Leslie Thomas 27 November 2024 108/2-8.
[17] See, for example: INQ000215511.
[18] See: https://www.england.nhs.uk/long-read/workforce-race-equality-standard-2023-data-analysis-report-for-nhs-trusts/#:~:text=Percentage%20and%20number%20of%20staff,to%20a%2061.5%25%20increase (accessed 19 December 2024).
[19] Ibid.
[20] Ibid.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Ibid.

colleagues. This inequality is most marked for black staff who feel the least equality of opportunity and are most likely to be victims of discrimination'.[25]

14. Similar statistics arise out of the WRES for Wales, which has reported for the first time in 2024, and found that: *'Black, Asian and minority ethnic staff are experiencing on a daily basis, discrimination and injustice'*;[26] Black, Asian and minority ethnic representation on boards is only 3.67 per cent;[27] and minoritized staff of all ethnicities are least likely to be appointed to posts after shortlisting.[28]

15. The structural racism that is evident in those figures aligns precisely with the first-hand evidence provided to this module, of: Black, Asian and minority ethnic staff feeling unable to raise issues around inadequate PPE out of fear of being disciplined, sacked or 'erased from the register';[29] feeling more threatened with being disciplined for wearing a mask when they supposedly should not;[30] having poorer access to PPE and being disproportionately redeployed to frontline, high risk roles;[31] being less likely to raise concerns, leading to poorer protections and greater redeployment.[32] Adam Morgan's (TUCC) evidence in this module explained: '*unions reported that BAME workers were being discriminated against in a number of ways, including being singled out for more dangerous or difficult work, having inadequate access to PPE, not being protected despite having underlying health conditions, being targeted when hours or jobs were being cut, and being racially abused by colleagues or customers'*.[33]

16. Professor Whitty suggested that the Covid-19 pandemic was: *'a wake up call, as if one were needed, that these problems exist within the health service…'*.[34] It clearly, however, has not been a wake up call, at least thus far.

17. It is striking that two consecutive health secretaries – Mr Hancock and Sir Sajid Javid – have both in their evidence espoused a policy of 'colour blindness': the idea that as long as everyone is treated equally, the potential disproportionate impacts of an action, policy, or system do not matter or will dissipate.[35] Sir Sajid, in response to a question about the disproportionate impact

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[25] Ibid.
[26] See: https://www.nhs.wales/sa/workforce-race-equality-standard/national-report-2024/#:~:text=The%20WRES%20is%20a%20dataset,where%20it%20needs%20to%20end, p.28 (accessed 19 December 2024).
[27] Ibid p.4.
[28] Ibid p.18.
[29] JS Bamrah 8 October 2024 21/7-24.
[30] JS Bamrah 8 October 2024 22/23-23/9.
[31] Habib Naqvi 10 October 2024 112/7-113/13.
[32] Philip Banfield 28 October 2024 120/4-10.
[33] INQ000400723_0013 para 43.
[34] Christopher Whitty 26 September 2024 183/2-4.
[35] Matt Hancock: *'My strong view is that racism was a problem and is best tackled by treating each individual as a person and being -- and treating the colour of their skin the same way as you would consider the colour of someone's eyes'*. 21 November 2024 149/9-12.

of a policy of vaccination as a condition of deployment stated that this did not impact upon his evaluation of the policy as an appropriate one because: *'I think all workers in the NHS should be treated equally regardless of their race'*.[36] The idea that a policy's blindness to disproportionate impact is either a means to addressing it, or even an excuse for disproportionate impact, is a facile approach. Public authorities are under a duty to take steps to advance equality of opportunity, which may include removing or reducing the disadvantage faced by persons with protected characteristics or taking steps to meet the specific needs of people with protected characteristics.[37] It appears that at a ministerial level there was a fundamental misunderstanding of this duty owed to Black, Asian and minority ethnic workers, and of the action required to eliminate systemic barriers. The fact that two Secretaries of State can preside over the health service, with such well-known problems of structural inequality, and not have been disavowed of this misapprehension, appears to be indicative of a deeper problem within the approach of the Department of Health and NHS England.

18. Witnesses in Module 3 have emphasised the scale and gravity of the disproportionate impacts faced by Black, Asian and minority ethnic people during the pandemic. The Inquiry has, quite properly, pressed for detail as to the actions which need to be taken. Answers have, on many occasions, been hesitant and devoid of substance. The complexity of the UK's public healthcare systems appears to perpetuate the issue – there is always another institution, department or individual to whom the responsibility may be passed, the end result being a lacuna of accountability, and a dire need for a whole system approach.

19. NHS England has assisted this module with corporate statements which extend over 1,346 pages of evidence. The statements say extraordinary little about the issue of systemic racism within the health service, beyond mention of the existence of the Equality Delivery System and staff networks catering to Black, Asian and minority ethnic staff. The statements outline steps taken to address the disproportionate impact of the pandemic, which, although important, do not address the underlying, systemic causes.

20. The deficiency has not been universal. Judith Paget, on behalf of NHS Wales, at least acknowledged the impact of staff facing systemic racism, explaining of the June 2020 report of the socio-economic subgroup, that it *'highlighted the entrenched inequalities experienced by ethnic minority people which were magnified by Covid-19'*; that *'Black, Asian and Ethnic Minority people were over-represented in some sectors of the NHS …'*; and that *'Black, Asian*

[36] Sajid Javid 25 November 2024 70/17-22.
[37] INQ000409898_0003-0004.

and Ethnic Minority members of staff [reported] *experiencing racism within the NHS and … feeling pressurised to work on Covid-19 wards and with a lack of PPE'*.[38]

21. Professor Whitty, in response to a question about risk assessing low-income health workers and those who were precariously employed in the health service during the pandemic, stated: *'I think what would have been actually more helpful is to make the employment of people less precarious during Covid. I think that solves the problem in a much more sensible and fundamental way'*.[39] The TUC agrees, and recommendations that address precarity of work in the UK's public healthcare systems and in so doing may reduce unequal impact for Black, Asian and minority ethnic workers, are addressed below at paragraphs 56 to 66.

22. For the 'wake-up call', as Professor Whitty describes it, to land, the report of this module is a crucial opportunity. The report's findings and recommendations are the mechanism through which this Inquiry may sound the alarm, and seek to ensure that Black, Asian and minority ethnic workers (and patients, and family members) do not suffer the injustice of repeated disproportionate impacts in future pandemics. All the recommendations we commend to the Inquiry seek to avoid or ameliorate disproportionate impacts in a future pandemic.

23. However, alongside those general recommendations there is a need for recommendations focused specifically on addressing structural racism. There is a need for recommendations which, in particular, prompt a shift from a practice of recording inequalities in health service, to removing it.

24. Whilst NHS England has taken steps in identifying and recording racial inequalities, it abrogates too much responsibility for taking action to the trusts as the employers. It needs to take a leadership role, to promote change and shared learning across the NHS. It should review the how the WRES operates in not just recording systemic inequalities, but as a driver for change. That might include an equivalent to the recently introduced Anti-Racist Wales Action Plan: that plan explains, *'Adopting an anti-racist approach requires us to look at the ways that racism is built into our policies, formal and informal rules and regulations and generally the ways in which we work'*.[40] NHS Scotland, too, has enacted anti-racism action plans.[41] The NHS in England, more broadly, needs to do more to explicitly identify and tackle the structural causes of the alarming statistics presented in the WRES. There needs to be greater accountability, particularly in respect of trusts in England. Trusts should be required

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[38] INQ000486014_0153 para 436.
[39] Christopher Whitty 26 September 2024 218/1-5.
[40] See: https://www.gov.wales/introduction-anti-racist-wales-html (accessed 19 December 2024).
[41] See: https://www.publications.scot.nhs.uk/files/dl-2024-23.pdf (accessed 19 December 2024).

to report progress on the NHS England Equality Diversity and Inclusion Plan,[42] to NHS England and progress reports should be independently evaluated, and publicly available so as to create a culture of accountability.

25. NHS England should review the mechanisms by which it addresses structural racism, with an aim of moving from simply recording it to removing it. That review may consider, by way of example:

    a. The work of the NHS Race and Health Observatory and, specifically, how it may be afforded higher profile and resource.

    b. Equality Diversity and Inclusion leads in trusts and health boards and, specifically, how they may be afforded better resourcing and greater capacity, and how greater centralised responsibility for this programme may be achieved, to ensure equality and diversity does not exist in silo.

    c. Equality Impact Assessments ('EIAs') and whether to introduce a legal requirement that they be publicly available in respect of each new policy or practice in England as they are in Wales and Scotland.

26. Indeed, a wider, four nations review of EIAs is required, to consider how they may be made more meaningful, primarily by ensuring that they reflect the reality of systemic racism within the healthcare systems. Research and policy work is required to establish how this could best be achieved – for example, in the US, proponents of 'Racial Equity Impact Assessments' suggest specific assessment is required in terms of systemic racism.

DATA ON THE IMPACTS ON HEALTHCARE WORKERS

27. The systematic and accurate collection, analysis and sharing of data, particularly in respect of the impact upon the healthcare workforce, is essential in terms of increasing visibility of the risks and disproportionate impacts and identifying steps which may be taken to protect healthcare workers and reduce transmission. Some of the most shocking evidence in this module has been the data which do not exist. For example, it is not known:

    a. How many HCWs died with Covid-19, nor how many of those workers were Black, Asian or minority ethnic.[43]

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[42] See: https://www.england.nhs.uk/long-read/nhs-equality-diversity-and-inclusion-improvement-plan/ (accessed 19 December 2024).
[43] Philip Banfield 28 October 2024 127/9-22; Susan Hopkins 18 September 2024 192/8-16; Rosemary Gallagher 4 November 2024 75/17-76/20; Aidan Dawson 5 November 2024 76/6-14; Jenny Harries 6 November 2024 158/6-159/2.

b. How many HCWs were infected with Covid-19, nor do we have a breakdown of those infections by healthcare worker role.[44]

c. How many HCWs have suffered with or are currently suffering with Long Covid, nor whether it disproportionately impacts Black, Asian or minority ethnic healthcare workers.[45]

d. Whether there is a link between repeated infection with Covid-19 and the incidence of Long Covid.[46]

28. Systems urgently need to be established now to collect this information in as-close-to-real-time as possible during a future pandemic, across the breadth of the healthcare workforce – private and public, and directly and indirectly employed by the NHS.

29. Professor Bamrah suggested that there should be a legal requirement upon government to ensure that data on HCWs is collated, including on the number of deaths, infections, the roles, age, sex, ethnicity, and where they live(d).[47] The TUC agrees. The primary task should lie with the employer, although it may be appropriate for the employee to have some role in terms of reporting or recording some aspects of this data, such as instances of infection. Work should be done to review how such a system may function, and that work should involve consulting employers, employees and representative bodies.

30. There should be a body responsible for processing this data and providing it to the relevant organisations, including the Health and Safety Executive ('HSE') and the national offices responsible for records and statistics (the ONS, NRS and NISRA).

31. The ONS, NRS and NISRA should be responsible for comparing the data provided by employers against their own data drawn from death certificates, in order to identify and address any discrepancies.

32. Whilst we consider that there should be reporting of deaths and other data around the impact on HCWs via employers into a single body responsible for collating the data, we further consider that improvements should be made to the national statistics offices' methods of recording HCW deaths:

[44] INQ000474282_0114 paras 11.27-11.29.
[45] See: Rachael Evans 29 October 2024 142/25-143/21; Rosemary Gallagher 4 November 2024 108/1-8; Stephen Powis 7 November 2024 169/4-16; Amanda Pritchard 11 November 2024 172/21-173/12; Vaughan Gething 20 November 2024 55/13-24; and Eluned Morgan 20 November 2024 178/11-23.
[46] INQ000421758_0033 para 94.
[47] JS Bamrah 8 October 2024 12/3-13/7.

a. Work should be done to review and improve consistency between the ONS, NRS and NISRA. All three should use the same coding for categories of HCW – that which is presently used by ONS and NRS.[48]

b. The statistics on how many HCWs have died from a particular virus should include all ages (presently it is only 20-64), given many workers do not retire at 64 (or as in the Covid-19 pandemic may return to healthcare work temporarily due to the need to surge capacity) and older age may well be a risk factor in a future pandemic.

c. Rather than simply recording 'retired' in brackets after the occupation, death certificates should specifically record whether someone was actively engaged in their occupation at the time of their death. This should be added to the series of changes presently being made to death certificates. The statistics on HCW deaths collected by the national records offices should not include death certificates where the person is marked as not have been actively engaged in their occupation at the time of their death.

THE STATE OF THE UK'S PUBLIC HEALTHCARE SYSTEMS

33. The poor and stretched state of the UK's public healthcare systems is acknowledged by all witnesses and in public discourse. The report on Module 3 must lay bare both the impact of the state of the healthcare systems on pandemic response and, significantly, the reality that reform to its capacity and infrastructure is fundamental to more effective pandemic response in future.

34. In particular, this module has shone a light on the grave challenges which arose as a result of the staffing crisis in the public healthcare systems, limited supplies of equipment and, in very many cases, the outdated healthcare estate. Stephen Mathieu, for example, described that: *'occupancy rates in intensive treatment units already ran higher than the Society's original recommendation of around 70%* [and that] *the UK entered the pandemic with just 7.3 critical care beds per 100,000 people, less than half the average in OECD EU nations'*.[49] His words echo those of Sally Davies in Module 1, who described the UK as 'bottom of the table' compared with other similar countries in terms of *'number of doctors, number of nurses, number of beds, number of ITUs, number of respirators* [and number of] *ventilators'*.[50] We have seen in this module how those pressures, already at crisis point, came to bear *in extreme*

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[48] See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/14554deathsinvolvingcoronaviruscovid19amonghealthandsocialcareworkersthoseaged20to64yearsenglandandwalesdeathsregistered9march2020to31march2022 (accessed 19 December 2024).

[49] INQ000472300_0054 para 127.

[50] Sally Davies 20 June 2023 151/7-11.

during the pandemic. Professor Kevin Fong's evidence will likely be at the forefront of the minds of those drafting the Module 3 report, as it is indelibly etched in the memories of many who watched it. He explained that the ICU staff he supported: *'told me that their ICU was full, that they were overflowing with patients, that they were running out of staff, that they were running out of basic consumable items'*.[51] Resilience and capacity is crucial not only to effective pandemic response, but also to the ability of the health service to maintain or return to effective healthcare during a pandemic, and after its end.

35. Sir Stephen Powis correctly described the necessity of a *'sustained capital investment programme to bring NHS estate up to date to make sure it's fit for purpose across all range of health settings'*. He also described the necessity for increases in staffing levels and a need to *'double the number of medical school places, increase the number of nurses, increase the number of GPs, simply having more staff and relying on less agency staff for instance will make the NHS more resilient'*; and in relation to data and IT infrastructure, *'having systems that can talk to each other, that can automatically generate the data'*.[52]

36. Mr Hancock was dismissive of the notion that recommendations on healthcare capacity cross the Rubicon into the political realm, out of reach of a public inquiry.[53] Sir Sajid Javid was not dissimilar in urging ambition upon the inquiry.[54] Whether to accept a recommendation is a political decision, but it is the duty of the Inquiry to make recommendations where they are necessary. The confines upon the Inquiry are not set by its instincts on what is too political, but by the Inquiry's terms of reference. The Inquiry's terms of reference require it to consider *'initial capacity and the ability to increase capacity, and resilience'*, and also to *'identify the lessons to be learned…'*. It is the Inquiry's duty to fulfil those terms of reference. The Inquiry is required to examine questions of capacity, and to learn lessons. The Covid-19 Bereaved Families for Justice UK were correct to observe that: *'An Inquiry is under a duty to consider all matters within its terms of reference and to make appropriate findings and recommendations. If public resourcing and funding is at the heart of those matters then inquiries not only can, but must address issues concerning the allocation of public funds: R (Smith) v Asst Dep Coroner for Oxfordshire [2011] 1 AC 1, at [127]'*.[55]

[51] Kevin Fong 26 September 2024 3/19-21.
[52] Stephen Powis 7 November 2024 193/4-195/4.
[53] Matt Hancock 21 November 2024 186/11-16.
[54] Sajid Javid 25 November 2024 100/22-101/15.
[55] INQ000502158_0001 para 2.

37. In fact, recommendations that steer clear of this issue risk being counter-productive: they would give a false impression that resolving some of the narrower issues can surmount the fundamental problems of capacity and staffing. The reality is they cannot.

38. It is of course not for this Inquiry to say *how many beds* or *what precise number of nurses* are needed – but the Inquiry must be forthright in: pointing out a lack of resource where it finds one; saying that something must be done; and providing practical suggestions as to the process which may be followed in addressing the problem.

Staffing shortages

39. In respect of staffing shortages, the emphasis must be upon increasing standing capacity, resilience and flexibility within the substantive workforce. Any mechanisms to supplement that workforce, such as use of volunteers or the military, partnerships with the private sector or a reserve workforce, must be secondary to a focus upon: reducing vacancies; ensuring enough staff are presently being trained and recruited to meet future need; and retaining existing staff.

40. The staffing problem can only be resolved with long-term action. The National Audit Office's modelling suggests that the NHS in England presently has a workforce shortfall of approximately 150,000 full-time equivalent staff.[56] NHS England projects a shortfall of 260,000 – 360,000 by 2036/37. This means that over the next 12 years, the NHS workforce will need to increase by 65 to 72 per cent. The 2023 NHS Long Term Workforce Plan[57] is an important step in the right direction. However, the TUC is concerned that it lacks teeth; it does not direct individual trusts what they need to do to meet the targets. There is also a concern that the Long Term Workforce Plan focusses too strongly on the registered workforce, taking insufficient account of non-clinical support and management staff. Moreover, the Plan pays lip service to retention but does not provide concrete plans in term of pay, reward, banding, structure and progression – elements crucial to ensuring that existing staff stay. In terms of culture, the plan does not speak to the dire statistics in staff surveys about bullying and discrimination. There is urgent need for greater top-down strategy, which provides real direction, support and resource to trusts to ensure that the staffing crisis across the *full* NHS workforce is addressed.

41. Estimated vacancies in NHS Wales are at 5,684: a vacancy rate of 5.8 per cent.[58] The workforce strategy in Wales, 'A healthier Wales: long term plan for health and social care', is

[56] See: https://www.nao.org.uk/reports/nhs-englands-modelling-for-the-long-term-workforce-plan/ (accessed 19 December 2024).
[57] See: https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/ (accessed 19 December 2024).
[58] See: https://www.gov.wales/nhs-vacancy-statistics-30-june-2024-official-statistics-development-html - as of June 2024 (accessed 19 December 2024).

a ground up strategy which involves health boards identifying the number of staff they project will be required in three years' time. Although the plan speaks of a 'long term vision', the commitments and actions *'focus on the short term, and on what we will do over the next three years'*.[59] Centrally, the figures the health boards project are collated, and a recommendation is made to government. This has the benefit of being informed by local need, but a longer-term strategy and set of actions is required beyond the three-year window currently addressed by the plan. The TUC's understanding is that there is presently no independent verification of these figures and considers this would be a helpful step. Furthermore, greater vision and investment is urgently needed to overcome the workforce shortages which have accumulated and persistent issues with retention.[60]

Estates

42. Recommendations also need to address the aging healthcare estate, including the need for more single occupancy rooms, larger corridors, modern oxygen pipelines and efficient ventilation of buildings and ambulances. In this respect, we draw attention to two passages of evidence given during oral hearings:

    a. Dr Shin: *'It would be really important to review and improve the NHS estate, particularly in ventilation and isolation capacity* […] *if the legacy inadequacies of our NHS estate across the country* [are not] *improved, we will face the next emergency with the same difficulties that we encountered this Covid pandemic'*.

    b. Sir Stephen Powis: *'Clearly much of the estate and the NHS in England is much older than it needs to be and that has a whole host of consequences.* […] *I know you will have heard how we had difficulty piping oxygen through to certain ward settings in older estate where the plumbing, the piping simply could not take the volumes of oxygen going through it. We talked about the issues of single rooms versus more open wards where infection spreads more easily.* […] *we could talk about the problems of ventilating spaces adequately. So that means capital investment in hospitals and also in other healthcare settings'*.

43. The TUC would endorse a recommendation that an independent review of the existing public healthcare estate takes place with a view to determining the steps and capital investment

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[59] See: https://www.gov.wales/sites/default/files/publications/2021-09/a-healthier-wales-our-plan-for-health-and-social-care.pdf, p.15 (accessed 19 December 2024).

[60] See, for example: Stephen Mathieu 9 October 2024 144/25-145/9 and Vaughan Gething 20 November 2024 19/12-20.

required to make improvements, such that the UK's health services would fare better in a future pandemic.

STAFFING: DYNAMIC RESPONSES TO A PANDEMIC

44. Even with better standing capacity in the substantive workforce, there will in a crisis of scale be an important role for surge capacity, particularly in areas such as critical care.[61]

Nightingales

45. We invite scepticism as to whether the Nightingale model, of large, temporary field hospitals divorced from existing infrastructure, is the best way to achieve surged capacity. There has been no credible explanation as to how the 10,000 additional bed capacity created in England would have been staffed at a time when capacity within existing hospitals had already been stretched to its limit. Even after tens of witnesses and thousands of documents, there is no clear idea as to where trained clinicians were going to come from, or how tens of thousands of volunteers would be trained and operationalised. There has been passing reference to training military staff, or even airline staff. Amanda Pritchard, for example, stated: *'So for London, for example, we had made plans to train airline staff, who were at that time available and keen to help, to be part of that volunteer workforce'*.[62] There has been no explanation offered regarding the 6,000 beds which were created outside of London. A document produced by NHS England, dated 28 March 2020, states that for every 500 beds, 3514 medical and nursing staff would be required, as well as 615 'other non-clinical staff'.[63] At maximum capacity, the Nightingales would have required over 80,000 additional staff – which appears incredible given Amanda Pritchard's evidence that the Nightingales would only be required once staffing ratios in hospitals had already reached 6:1 (six trained critical care staff to one patient).[64]

46. The reality appears to be that it was a project driven by politicians, who, at least at the time that the Nightingales were commissioned, misunderstood the limiting factor as being one of physical beds rather than staff. Later, as Sir Sajid Javid confirmed in evidence, it became *'well known'* that there were not enough staff to run the field hospitals and 'Nightingale hubs' were pursued instead.[65] Sir Sajid provided evidence that the Inquiry will likely wish to evaluate, which suggests that the Nightingales were, in essence, a vanity project devised because the then Prime Minister was *'insistent on the idea of Nightingale hospitals despite the workforce*

[61] See, for example, Stephen Powis 7 November 2024 195/5-24.
[62] Amanda Pritchard 11 November 2024 125/25-126/3.
[63] INQ000109220_0013.
[64] Amanda Pritchard 11 November 2024 124/10-17.
[65] Sajid Javid 25 November 2024 50/4-22.

problems having been explained to him' and was *'keen on resurrecting the original form of Nightingale hospitals'* even after it was clear that they were *'not effective'*.[66]

47. Ultimately, as the Inquiry has uncovered, the seven Nightingale hospitals in England were constructed, run and decommissioned at a total cost of £358,457,185.[67] Across Waves 1 and 2, the hospitals treated a combined 388 Covid-19 patients.[68] The position was similar in Wales and Scotland, where Nightingale hospitals were constructed but, in Wales saw a small number of patients, and in Scotland saw no Covid-19 patients due to practical issues around IPC.[69]

48. The TUC seeks a recommendation that 'Nightingale' style temporary hospitals should only be used subject to a realistic assessment of whether there will be staff available to operate them, including assessment of the knock-on impact on staffing at existing hospitals. Unless standing staffing levels in critical care units are substantially increased, such hospitals are unlikely to be of any significant utility. Expanding capacity within existing hospitals is likely to be more effective. In the first instance, it would be sensible to consider the construction of additional wards and units, comparable to the 'Nightingale hubs' constructed in the second wave. Consideration should also be given to establishing infrastructure which can be utilised after the pandemic – so as to avoid the circumstance in future where public healthcare systems construct temporary estate at exorbitant cost, which cannot be used beyond the crisis.

Volunteers and the NHS reserve workforce

49. There has been some discussion in the evidence as to the use of volunteers and/or a reserve NHS workforce to assist with surge capacity during a pandemic, as planned by the NHS. The TUC is not opposed to any such plans in principle, but such plans must not become a distraction from the critical, central task of ensuring safe staffing levels within the much-depleted substantive workforce. The TUC further notes that any such plans must not be pursued before a cost-benefit analysis is conducted – the NHS has a poor track record of converting potential 'volunteers' into boots on the ground. Effective operationalisation of medical volunteers is a complex task and careful thought should first be given to whether efforts would be better placed on recruitment drives to train and hire permanent staff.

[66] INQ000485736_0047 para 102e and _0062 para 135.
[67] INQ000474444.
[68] INQ000474444.
[69] INQ000489425_0001; Humza Yousaf 19 November 2024 175/11-176/1; and INQ000469991_0003 para 26.

Redeployment

50. Redeployment may be a necessary feature of surge capacity. It is evident that widespread redeployment is fraught with difficulty, and that there was inappropriate redeployment during the pandemic. As one physiotherapist told the TUC:

> *'The process of redeployment for physiotherapy staff was chaotic and took no account of clinicians' experience or substantive role.* […] *Whilst in my redeployed role no one contacted me to find out how well I was functioning.* […] *I had had no acute ward experience for many years* [...] *I heard reliable accounts of redeployed* […] *professionals administering injections when not qualified to do so, and other situations where* [they] *acted beyond their competence. I was asked to do things clinically which were outside my professional competence but I refused'*.[70]

51. Gill Walton (RCM) gave evidence that redeployment of midwives away from their roles within a service identified as essential was impacting upon the delivery of maternity services. As a result, NHS England were asked on a number of occasions to make clear that midwives should not be redeployed.[71] Matt Stringer (Disabilities Charities Consortium) explained that capacity issues in healthcare settings and the pandemic itself put enormous strain on staffing, which meant that many learning disability nurses were redeployed, sometimes leaving no specialist service at all for learning disabled patients, drawing a potential link between redeployment and the mortality statistics during the pandemic for persons with learning disabilities.[72]

52. Redeployment is most successful where adequate numbers of trained staff are not diluted to unsafe levels and have time to train, support and supervise redeployed staff – thus it is more likely to be successful where lower levels of redeployment are required, which will naturally be achieved by addressing the significant vacancies in key specialisms such as critical care. This is made clear by the evidence given by Dr Stephen Mathieu.[73]

53. Where redeployment does need to take place, the recommendation commended to the Inquiry is that: (1) pandemic planning includes plans for training, oversight and HR and occupational mental health support to both redeployed staff and staff overseeing redeployed staff; (2) staff who are redeployed are appropriately consulted, risk assessed, and trained (including as to the support available to them) before being redeployed.

54. Given the evidence in this module that Black, Asian and minority ethnic staff were disproportionately redeployed into frontline roles, it is critical that this metric is tracked during

[70] INQ000474305_0014 para 36.
[71] Gill Walton 7 October 2024 107/17-108/5.
[72] Matt Stringer 10 October 2024 100/6-22 and 102/1-14.
[73] Stephen Mathieu 9 October 2024 134/21-136/25.

a pandemic. Furthermore, risk assessments upon redeployment must take account of any evidenced risks associated with ethnicity.

55. It is important, and should feature in recommendations, that redeployment, including processes for risk assessment, training and oversight, should form part of pandemic planning.

THE PRECARIOUS NHS WORKFORCE

56. During any pandemic, precarious work is a driver of transmission of the disease – infection prevention and control ('IPC') relies on workers who are trained and empowered to follow safe systems of work, who are able and feel confident to sound the alarm where those systems are not working, and who do not fear being penalised (financially or otherwise) where they are required to self-isolate. That is the basis for Professor Whitty's observations that: *'what would have been actually more helpful is to make the employment of people less precarious during Covid. …that solves the problem in a much more sensible and fundamental way'*.[74] These submissions identify a number of practical recommendations which would reduce the dangers of precarious work during a pandemic, focused on two groups within the NHS workforce who face especially precarious working terms and conditions: the indirectly employed workforce, and the migrant workforce (which overlap, but warrant distinct consideration).

The indirectly employed workforce

57. A significant, growing, and more vulnerable section of the workforce is not directly or permanently employed. The indirectly employed workforce encompasses a range of employment circumstances – including clinical locum, bank and agency staff who provide cover for individual shifts or are allocated to a trust or ward for a fixed period, outsourced workers who provide services within a healthcare setting but are employed by a non-NHS organisation contracted by the trust, and staff employed to work in GP practices as employees of the business. These healthcare workers are an important and growing group within the NHS. Anecdotally, it is acknowledged that this group is disproportionately Black, Asian and minority ethnic as compared to the general population, and more likely to be in low pay; both features were identified as risk factors during the Covid-19 pandemic and are likely to remain so in future pandemics. Indirectly employed staff, especially agency and outsourced workers, are more likely to have poor or no sick pay provision. As Sara Gorton explained:

> *'It was much harder for ministers and system leaders to exert an influence over those services which existed beyond their direct control. While the NHS remains a public organisation, in recent years, more and more outsourcing has occurred. In the case of cleaners, security staff, and porters, this has largely been about trying to cut costs at the*

[74] Christopher Whitty 26 September 2024 218/1-5.

expense of the workforce. Black workers are disproportionately represented among these occupational groups. Over time, pay and terms and conditions, including sick pay and pension provision, fall far behind what the same workforce would receive if they worked for the NHS in-house'.[75]

58. Anecdotally, indirectly employed workers are more likely to face pressure, bullying and/or harassment from employers[76] who face less scrutiny and regulation than trusts and health boards – and find it more difficult to make a complaint about this behaviour when it arises. Alex Marshall explained that outsourced workers are told to complain to the company which engages them, but that they do not typically have union membership to support them in making such a complaint and, very often, their complaints are not responded to.[77] As Professor Bamrah described, agency and locum staff were more likely to be redeployed into frontline roles and likely to have poorer access to PPE *'because hospitals would not provide it'*.[78]

59. They are also less likely to be members of unions[79] and unions have less direct reach into outsourced companies and agencies in order to ensure agreements made at the Social Partnership Forum level are being implemented on the ground. As Ms Gorton explained, this *'two-tier arrangement made it harder to ensure that activities such as risk assessments for Black workers were taking place in these parts of the system'*.[80] Further, agreements that UNISON reached for directly employed NHS staff covering full pay for Covid sickness and self-isolation, or for staff required to shield and unable to work from home, *'proved very difficult to enforce for staff who were either outsourced, worked in primary care, or worked via bank or agency arrangements'*.[81]

60. The recommendations of this Inquiry, and pandemic planning and response, must consider the full workforce. It is not enough to ensure that NHS trusts, NHS England and the Department of Health and Social Care (and devolved counterparts) have oversight of and responsibility for the directly employed workforce. This is a significant limitation on the efficacy of measures intended to respond to a pandemic and is a key driver of unequal impact within the workforce.

61. Indirectly employed workers are not accounted for in the workforce plans or race equality strategies prepared by NHS England. As Amanda Pritchard accepted in oral evidence, *'we don't hold any data on staff who are employed by third-party outsourced providers'*.[82] As a

[75] INQ000471985_0025 para 84.
[76] See, for example: INQ000477577_0011-0013 paras 52-58 and _0030-0033 para 133.
[77] Alex Marshall 10 October 2024 47/11-23.
[78] JS Bamrah 8 October 2024 32/19-33/2 and 33/3-15.
[79] JS Bamrah 8 October 2024 60/9-61/1.
[80] INQ000471985_0025 para 84.
[81] INQ000471985_0025 para 86.
[82] Amanda Pritchard 11 November 2024 188/21-22.

result, so much is not known, therefore, about the indirectly employed workforce, including the percentage of each category of indirectly employed worker who is Black, Asian or minority ethnic.

62. It is more difficult to ensure that the indirectly employed workforce is appropriately and consistently risk assessed, and that actions and recommendations are followed up on (see paragraphs 98 to 101 below). Professor Simon Ball accepted in oral evidence that risk assessments ought to be done by the line manager in the workplace regardless of employment status.[83]

63. It is the policy position of the TUC that outsourcing is a product of short-termism - a solution aimed at reducing costs which, ultimately, results in poor working conditions arising for which trusts, health boards and centralised management are absolved of responsibility. Between 2008 and 2010 in Wales, Scotland and Northern Ireland, all cleaning services (and, in Scotland, catering services) were brought back in-house, with the key argument being improved IPC associated with in-house services.[84] It was found, and emerging evidence continues to support, that incidence of MRSA and other common nosocomially acquired infections is higher in hospitals where cleaning services are outsourced.[85] The benefits extend beyond improved IPC – the EHRC noted in its 2022 report on the treatment of lower-paid ethnic minority workers: *'We uncovered examples of outsourced NHS services being brought back in-house in England. We came across one trust that was bringing cleaning and catering back in-house to boost workforce equality and support staff from ethnic minority groups'*.[86] The TUC would strongly endorse a recommendation that options for increasing in-sourcing, or bringing outsourced services back in-house, are urgently explored. This important step would further Professor Whitty's objective of making work less precarious during a pandemic.

64. In addition, there are three critical steps which must occur in advance of a future pandemic:

    a. Steps need to be taken to gain greater visibility of the indirectly employed workforce at a local and centralised level. Trusts and health boards should be obligated to collect from agencies and outsourced workers the same workforce information held about directly employed workers. That information should be collated by trusts in England and shared with NHS England alongside the data around the directly employed workforce. There

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[83] Simon Ball 7 November 2024 172/6-173/10.
[84] See: https://www.epsu.org/article/uk-hospital-cleaning-brought-house-scotland-wales-n-ireland (accessed 19 December 2024).
[85] See: https://www.sciencedirect.com/science/article/pii/S0277953616306864 (accessed 19 December 2024).
[86] INQ000136934_0045.

should be central records kept of contracts for provision of services, with central recording of the staff engaged and the number of hours each is required to work.

b. The indirect workforce, once visible, must be included in: workforce planning, WRES reports, the NHS England Equality Diversity and Inclusion Plan, the NHS Wales Anti-Racist Action Plan and other measures of workforce safety and equality; staff surveys; and pandemic planning. Specifically, clear plans must be in place to ensure that the indirectly employed workforce receives IPC training, PPE, risk assessments and updates in IPC guidance and that there is clear oversight of this by each trust or health board.

c. Work needs to be completed to ensure that mechanisms of social partnership reach the indirect workforce. This will be improved by the recommendations we make in respect of social partnership at the local level, as set out below. However, thought should be given to how trusts can reach into external organisations and banks to ensure, for example, if sick pay for indirectly employed workers is agreed by the NHS, it is being implemented.

The migrant workforce

65. The migrant workforce face additional layers of precariousness due, in the main, to conditions of work attached to their visas and their employers' role in their legal status in the UK. Alex Marshall described the experience of those on precarious visas where work is tied to visa status, meaning if they do make a complaint or seek additional layers of protection, they can find themselves fired, with only two months to try and find alternative work – he described this as *'the risks of pushing back'*.[87] Similarly, Rosemary Gallagher explained the difficult circumstances faced by migrant nurses, including facing cultural challenges, new ways of working, disproportionate risk from Covid-19 and financial detriment from having no recourse to public funds, all combined to *'not give them confidence around how they would be listened to and how their concerns would be taken seriously'*.[88]

66. As a result, the migrant workforce is less likely to feel able to raise concerns, demand risk assessments, PPE and IPC training, and is more likely to fall into presenteeism when they should be self-isolating. A significant proportion of migrant workers identify as Black, Asian or minority ethnic and so faced additional risk in the Covid-19 pandemic in addition to the barriers associated with structural racism. The TUC proposes the following recommendations:

[87] Alex Marshall 10 October 2024 58/5-11.
[88] Rosemary Gallagher 4 November 2024 102/11-103/1.

a. There should be an automatic presumption that visas get extended in any future pandemic in order to remove uncertainty for migrant workers and protect the UK healthcare workforce.

b. Widen and extend the visa extension scheme in any future pandemic. The use of automatic free visa extensions during the pandemic was welcome but should be broadened in a future pandemic to cover the whole of the NHS workforce so that the least well-paid healthcare workers are also covered.

c. Visa sponsorship should be decoupled from individual employers as a way of removing the ability of unscrupulous employers to use the threat of deportation against migrant workers. The visa sponsor could be a government department or NHS England. This would reduce the fear often experienced by migrant workers as a result of individual employers holding the power of dismissal and deportation over them.

d. The independent review by Wendy Williams, 'Windrush Lessons Learned Review', made the following recommendation ('Recommendation 9): *'The Home Secretary should introduce a Migrants' Commissioner* [who] *would have a responsibility to engage with migrants and communities, and be an advocate for individuals as a means of identifying any systemic concerns'*.[89] We commend this recommendation to the Inquiry in terms of the benefit it would bring in any future pandemic. The Migrants Commissioner should both be involved in pandemic planning and play an important role in the currency of a crisis in identifying any issues specific to migrants and bringing them to the attention of decision-makers.

INFECTION PREVENTION AND CONTROL

67. Professor Sir Michael McBride stated in his evidence that HCWs should be empowered to implement IPC measures and that there needs to be significant investment in IPC teams and training because – although IPC is traditionally the preserve of nurses – it should be *'everyone's responsibility'*.[90] The TUC commend Professor McBride's recommendation to the Inquiry and emphasise that IPC must be a comprehensive, whole workforce approach which extends IPC measures and training to all roles, and the indirect as well as direct workforce. There should be greater status and resource for IPC teams within healthcare settings and

[89] See: https://assets.publishing.service.gov.uk/media/5e7dd650e90e0706f7d69cc1/6.5577_HO_Windrush_Lessons_Learned_Review_LoResFinal.pdf, p.16 (accessed 19 December 2024).
[90] Michael McBride 24 September 2024 206/11-19.

continuity of the teams developed during the Covid-19 pandemic, which will be more effective than attempting to rapidly expand IPC teams at the outset of a pandemic.

Developing guidance

68. Understanding of and trust in IPC guidance by HCWs is critical to ensuring that guidance is followed, and workforce morale is maintained. Frequently changing advice for which the rationale was not always evident, and which varied between the four nations of the UK, was often a source of anxiety for healthcare workers. Professor Susan Hopkins, for example, agreed that changes to guidance at short notice and on a Friday evening created a degree of fear and upset.[91] Dr Shin gave evidence that the numerous iterations created confusion.[92]

69. The IPC experts, Professor Gould, Dr Warne and Dr Shin, recommended that in the event of the next pandemic which is novel and for which there is not an evidence base, IPC guidance should be developed by a panel of stakeholders, which includes technical experts, practitioners, lay representatives and people from professional bodies, and that there should be stakeholder engagement at the outset of the process for developing IPC guidance.[93] That is a recommendation which the TUC endorses; it will provide greater transparency around who the decision-makers are, and the evidence base for their decisions, which in turn is likely to improve trust in the guidance, and consistency across the four nations. The TUC further would endorse the inclusion of health and safety experts within the forum, to ensure that IPC and health and safety controls are joined-up and benefit from sharing of expertise.

Training

70. The IPC experts highlighted evidence that domestic services staff, porters and healthcare assistants had higher rates of infection compared with other HCW roles.[94] These are, of course, also roles with high proportions of agency and outsourced workers. The Inquiry heard from a domestic services staff member - M3/W1 (Frontline Migrant HCWs Group) - who explained that they did not *'have any feeling of safety but had to go ahead and do things'* in the workplace due to a lack of PPE and a lack of training on PPE.[95] Professor Whitty's evidence cut to the central issue. He said:

> *'I think the level of training for people who are not patient facing in one sense but actually are in reality is often much lower than would be optimal. And I think ensuring that there is a minimum level of training –* […] *being a porter is a difficult job physically. You are also close to patients a lot. For example, people who are providing meals are close to patients*

[91] Susan Hopkins 18 September 2024 131/21-132/20.
[92] Gee Yen Shin 19 September 2024 93/16-94/7.
[93] Dinah Gould 19 September 2024 54/5-21 and 87/16-89/7.
[94] Ben Warne 19 September 2024 161/3-21.
[95] M3/W1 9 October 2024 5/25-7/12.

a lot. And I think they are not trained in PPE to the same level [and] *they see a lot of people in quite close succession. So there's a training element'*.

71. The IPC experts recommended that there be standard training on IPC for healthcare assistants.[96] The TUC endorses this recommendation and would suggest that it be expanded to include more healthcare roles, such as porters, caterers and cleaners. Further, IPC training should be delivered by the trust itself or by a competent body, not by external, sub-contracted organisations, to ensure consistency and quality of training. The training offered should include consideration of language and possible need for translation and/or interpretation, especially for those in outsourced and agency roles. As the evidence of M3/W1 demonstrates, whereby interpretation was required, there are workers within the UK's public healthcare services who do not speak fluent English.

Ventilation

72. Ventilation is critical in any pandemic with more than negligible airborne transmission. As Professor Susan Hopkins, in her evidence, stated: *'one of the biggest things we can do to reduce respiratory infections* [...] *is to improve ventilation in healthcare'*.[97] This is an issue which flows from the age and quality of the estate (see paragraph 42 above). There were also specific issues which arose in relation to ambulances' ventilation, air conditioning and related mechanical faults.[98] There should be a review of the adequacy of ventilation in hospitals which serves to identify a standard for ventilation in new hospitals, and identify achievable improvements in the existing estate, potentially involving air filtration. Ambulances should also be included in any review.

73. Where it is not possible or too costly to improve ventilation, particularly in old estate, or whilst works to improve ventilation are outstanding, sufficient resourcing and oversight needs to be in place to ensure that HEPA filters are available and utilised. A review of the guidance which exists in each of the four nations – both in terms of pre-pandemic guidance and that which arose out of the pandemic appears appropriate. Ms Amanda Pritchard committed during oral evidence to ensuring that the Health Technical Memoranda ('HTM') is clear that the guidance on use of HEPA filters is mandatory and part and parcel of the HTM, and to confirm what is being done to improve access to HEPA filters.[99] The former has been addressed by a further statement from Sir Stephen Powis,[100] but more could be done to ensure practical arrangements are in place to promote the use of HEPA air filters. Professor Beggs is right to

[96] Dinah Gould 19 September 2024 114/14-16.
[97] Susan Hopkins 18 September 2024 94/15-18.
[98] Mark Tilley 1 October 2024 15/13-16/23. See also: INQ000472383 and INQ000281189_004 para 13.
[99] Amanda Pritchard 11 November 2024 152/3-153/25.
[100] INQ000474664_0009-0013 paras 32-47.

observe that portable air filtration devices are 'low hanging fruit'[101] in that they represent a straightforward, relatively low-cost solution to improving air quality in clinical settings.

PPE

74. There has been significant time devoted during public hearings to the question of whether FFP3 masks provide a greater level of protection against an airborne disease in real world clinical environments, compared to fluid resistant surgical masks ('FRSM'). Perhaps the best real-world evidence as to the efficacy of FFP3 came from Professor Banfield, who noted that after Addenbrooke's hospital implemented FFP3 for all staff, a sharp decrease in the infection rate in the hospital was recorded.[102] This has been reported by a team at the University of Cambridge.[103] Furthermore, a number of witnesses explain that infection rates were higher on non-Covid wards compared with ICU – a critical difference being that those on ICU had fit-tested FFP3 masks which they were trained to use. Dr Suntharalingam gave the following evidence: *'Numerically, intensive care was arguably better than some other areas. Also due to decisions that FFP3 was used universally and that wasn't the case elsewhere in the hospital. And arguably should be'*.[104] Similarly the evidence from organisations such as the Royal College of Anaesthetists, the Faculty of Intensive Care Medicine and the Association of Anaesthetists that anaesthetists and intensivists were comparatively well protected from infection and severe disease as compared to those on general wards, supports the point that the RPE offered to anaesthetists and intensivists ought to have been offered more widely.[105] The Long Covid experts, Professors Brightling and Evans, recorded that *'people working in intensive care units were less likely to be have been infected'*.[106] We see clear logic in the line of questioning pursued by CTI with Dr Lisa Ritchie:

> *'if it was the case that those using higher performing PPE were dying at lower rates and were infected at lower rates, did that not indicate that, in fact, it was necessary to spread the use of higher performing RPE and PPE more widely among other areas?'*.[107]

75. The evidence in favour of FFP3 providing a higher level of protection in an airborne pandemic is strong – FFP3 should be recommended for all staff likely to come into contact with the virus in a future pandemic where there appears to be more than negligible airborne transmission.

[101] Clive Beggs 11 September 2024 175/25-176/12.
[102] Philip Banfield 28 October 2024 135/20-24.
[103] See: https://www.cam.ac.uk/research/news/upgrading-ppe-for-staff-working-on-covid-19-wards-cut-hospital-acquired-infections-dramatically (accessed 18 December 2024).
[104] Ganesh Suntharalingam 9 October 2024 73/20-25.
[105] INQ000389244_0056-0057 paras 291-292.
[106] INQ000421758_0033 para 94.
[107] Lisa Ritchie 16 September 2024 121/14-123/18.

76. Where a virus is airborne, peripatetic workers, who are required to move through a range of settings, clinical and non-clinical, such as porters and cleaners, are at greater risk due to the increased likelihood of their being in a space with high concentrations of aerosols. Dr Warne explained that part of the role of a porter is to *'move between different clinical areas with patients* […] *and we know that staff that move between clinical areas, from other studies, are at higher risk of acquiring Covid'*.[108] Professor Gould confirmed that movement around the hospital and contact with visitors may have contributed to higher infection rates.[109] On that basis, we seek a recommendation that, where airborne transmission may account for a more than negligible proportion of transmission, peripatetic workers should receive PPE at that same level as those roles which involve direct patient contact.

77. In respect of the availability of PPE, it is clear that significant issues were encountered in respect of the distribution of PPE between healthcare settings, and within individual large settings including hospitals. For example, Professor Sir Gregor Smith explained that some of the difficulties were at the ends of the supply chain, with difficulties getting PPE in sufficient numbers to those delivering care.[110] Sir Chris Wormald explained that difficulties arose in relation to distributing PPE within the country once received, which led to circumstances where *'we were* […] *very close to the wire'* and *'caused huge worry and concern to many healthcare workers'*.[111]

78. There appears to be a risk that the important learning from this Inquiry as regards to distribution and storage of PPE may be lost over time if safeguards are not put in place to avoid repetition of the challenges faced. In that regard, we seek a recommendation that there be a regulatory role, ideally on the part of the HSE, to be involved in non-pandemic times in ensuring that healthcare settings have appropriate stockpiles of PPE and plans in place for the purchasing and of PPE, receipt of deliveries and distribution of PPE within the physical setting.

79. It is also clear that greater numbers of trained fit-testers were required.[112] We consider that the HSE should have regulatory responsibility in non-pandemic times for checking that clinical settings have sufficient numbers of staff are trained to undertake fit-testing to enable all members of staff to be fit-tested rapidly where required at the outset (and at regular intervals) in a future pandemic.

[108] Ben Warne 19 September 2024 175/7-176/12.
[109] Dinah Gould 19 September 2024 175/7-176/12.
[110] Gregor Smith 25 September 2024 111/21-112/2.
[111] Chris Wormald 12 November 2024 20/9-19. See, similarly, Jeane Freeman 19 November 2024 33/18-34/4.
[112] Susan Hopkins 18 September 2024 201/9-18.

80. A number of witnesses have supported the proposal that worker preference be taken into account in the selection of PPE. For example, Professor Susan Hopkins stated that workers should also be enabled to judge their own personal risk level better, with regular fit testing and a range of masks being available to them – she described this as *'an enabling situation with FFP3s, rather than mandating'*.[113] Professor Chris Whitty, similarly, suggested that the correct approach would be to *'it is sensible to say to people, "Our advice is professionally we don't think this will make a difference, but if you feel this is important for your particular situation, this is available for you"* […] *I would give people choice within reason'*.[114]

81. The TUC supports the points made, in particular, by Roz Foyer (STUC), who stated that *'ultimately I think we would have wanted to see workers' voices being given a primary consideration in that, and if it was felt to be required then it should have been provided'*, and of Fiona McQueen (CNO for Scotland), who stated that It was better to give people as much support as possible and not *'worth arguing about whether it was FRSM or FFP3'*.[115] However, a worker-led approach to PPE must not involve an abrogation of minimum standards, and that the appropriate level of PPE for a worker must be identified during a formal risk assessment with an appropriately qualified person. Such an approach would not create a risk of some workers choosing not to wear PPE at all, when it is necessary (cf. Lisa Ritchie's suggestion):[116] the intention is to enable workers to adopt a higher standard of protection than the minimum required level, where they wish to do so.

The current state of the guidance

82. An open letter has been sent to the Module 3 Inquiry team by the Long Covid Group, and others, seeking an urgent interim report to address the need for the National Infection Prevention and Control Manual and the HTM Guidelines to be reviewed and updated, particularly in respect of the need to address the risks of airborne transmission from Covid-19 and other airborne disease. That is supported by the TUC.

[113] Susan Hopkins 18 September 2024 95/8-19.
[114] Christopher Whitty 26 September 2024 143/24-144/22.
[115] Roz Foyer 16 September 2024 55/7-12 and Fiona McQueen 17 September 2024 183/15-184/4.
[116] Lisa Ritchie 16 September 2024 165/6-24.

THE REGULATORY RESPONSE

RIDDOR reporting

83. Is clear from the witness evidence[117] and the data that widespread underreporting took place in the healthcare sector. Professor Phillip Banfield stated: *'we did a survey of over 600 people with Long Covid and a large proportion of them said that they had asked for their Covid to be reported under the RIDDOR's reporting mechanism and it had been declined'*.[118] The HSE disclosed data as to levels of RIDDOR reporting in NHS trusts between May 2021 and February 2022 which shows that between 16 May 2021 and 19 February 2022, out of the 98 NHS employers analysed, 51 had made three or fewer RIDDOR occupational Covid-19 disease reports, in total for infections and fatalities.[119]

84. A key reason for widespread underreporting was the guidance issued by the HSE. The guidance required both a written diagnosis from a medical practitioner (which was relaxed at the end of May 2020 to include the results of a laboratory test) and an assessment by the responsible person that there was reasonable evidence that an occupational exposure was the likely cause of the Covid-19 infection leading to the occurrence of disease or the death. The guidance provided a non-exhaustive list of factors which could be taken into account.[120] The guidance was both *onerous* in requiring a written diagnosis and, later, a laboratory test result, and *vague* in that the responsible person is given wide discretion to decide what factors to take into account and how to interpret key words such as 'likely'. The bizarre circumstance arose in which the HSE provided guidance that, even in a healthcare setting, it was most likely that Covid-19 was contracted in the community rather than the workplace,[121] whereas it is known that nosocomial infections were highly prevalent and HCWs faced a substantially increased risk of infection than the general public.

85. The HSE's interim report on the impact of Covid-19 stated in relation to RIDDOR guidance:

> *'There have been criticisms of HSE in how this has been interpreted alleging that an exclusive rather than inclusive approach will significantly under-estimate the true toll of COVID19- related effects, thereby missing opportunities to learn lessons. There is an implied view in the criticisms that HSE would be able to follow up every such report'*.[122]

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[117] See, for example: Kevin Rowan 16 September 2024 13/3-5; Philip Banfield 28 October 2024 147/16-148/3; Adam Morgan witness statement INQ000400723_0030 para 106; Rosemary Gallagher 4 November 2024 83/11-23.
[118] Philip Banfield 28 October 2024 147/16-148/3.
[119] INQ000269831 Table 1.
[120] INQ000269884_0002-0003.
[121] INQ000475580_0051 para 133.
[122] INQ000269707_0026 para 5.4.15.

The TUC has, of course, made such criticisms, including in its report titled '*RIDDOR, Covid and underreporting*'.[123] However, the TUC is firmly of the view that the HSE need not individually investigate each report – as it does not in non-pandemic times – but should collate and analyse the data to inform its inspection activity.

86. As a result of widespread underreporting, the HSE did not have the insight into the healthcare sector in order to direct its regime of proactive inspection or identify systemic issues. Kevin Rowan (TUC) explained:

> *'what RIDDOR does is it gathers data about risk beyond the workplace level, because it's a report to the Health and Safety Executive* […] *I think that would have informed or should have informed that healthcare settings, with the emergence of the pandemic, then became a high-risk sector. So the intelligence would provide evidence of risk, gathering that intelligence in a systemic way would identify sectoral risks. That would then inform the Health and Safety Executive's enforcement strategy'*.[124]

87. In respect of RIDDOR reporting, the TUC proposes a recommendation that, in a pandemic, all deaths of workers infected with (or suspected to be infected with, if prior to testing being widely available) the disease should automatically meet the threshold for being reported. This would ensure that all deaths are promptly and formally recorded and can be investigated where necessary.

88. Infections should be reported to the HSE via RIDDOR where they meet the threshold of *'reasonable evidence'*.[125] In a pandemic where healthcare workers face a substantially higher risk of infection, it should be assumed that an infection will meet the reporting criteria absent positive evidence to suggest that the infection was *not* acquired at work. The guidance should be formulated to require an inclusive, rather than an exclusive approach – and certainly should not be formulated to discourage reporting.

89. RIDDOR reports should be expanded to include ethnicity,[126] as well as age and gender.

Capacity and resource

90. In February 2022, Prospect published a report entitled 'HSE under pressure: A perfect storm'.[127] That report set out concerning figures relating to the decreased funding available to the HSE and the impact that has had upon the HSE's capacity to carry out inspections and other investigations. The report notes that, since 2010, HSE has experienced cuts to its core

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[123] INQ000119177.
[124] Kevin Rowan 16 September 2024 9/5-10/24.
[125] See: https://www.hse.gov.uk/riddor/coronavirus/disease-due-to-exposure-to-biological-agent.htm (accessed 19 December 2024.
[126] See: Kevin Rowan 16 September 2024 18/24-19/9.
[127] INQ000327687.

Grant-in-aid funding of around 45 per cent in cash terms.[128] Further, 'All inspector' numbers (regardless of grade role or division) have fallen from a total figure of 1,651 in 2003, to 1,187 in 2010, to the current figure of 974 (a 41 per cent reduction over 20 years).[129] Prior to 2010, annual inspection totals reported by HSE were more than 25,000 (more than 41,000 in 2006-07), but proactive inspections are currently being delivered at around 16,000 to 17,000 per year'.[130]

91. A recommendation is required as to the adequate resourcing and staffing of the HSE, who are the primary workforce regulator in the healthcare sector as is set out in the memorandum of understanding between the HSE and Care Quality Commission.[131] The HSE must be adequately resourced and staffed in order to be able to provide effective regulation in the healthcare sector, particularly when increased risk in the sector requires an elevated level of activity (as below).

Inspection activity

92. The inspection regime of the HSE is targeted according to risk. As Richard Brunt (HSE) set out in his witness statement:

> *'Inspections are carried out for the purposes of targeting high risk sectors/ activities, for benchmarking, following an incident and responding to local intelligence* […] *When planning inspections, HSE target's those sectors and activities with the most serious risks and where the risks are least well-controlled'*.[132]

93. In non-pandemic times, this means that the HSE's focus of inspection activity is typically upon sectors such as manufacturing and recycling. The healthcare sector is not generally considered 'high risk' because higher levels of compliance with health and safety laws and frameworks typically mean that the risks are comparatively well-controlled.[133] There is no issue with this approach in principle. However, the pandemic struck, and it became clear very quickly that HCWs were at significantly increased risk due to the level of hospitalisations – indeed, analysis showed later in the pandemic that HCWs were at a sevenfold risk of severe disease (categorised as hospitalisation or death).[134] In those circumstances, the TUC considers that the HSE ought to have focussed on the healthcare sector, substantially increasing its proactive inspection regime. As Mr Rowan explained in oral evidence:

[128] INQ000327687_0003.
[129] INQ000327687_0008.
[130] INQ000327687_0011.
[131] INQ000101585_0002 paras 5-7.
[132] INQ000347822_0021 para 85.
[133] See: Kevin Rowan Second witness statement INQ000474291_0003 para 9; and Kevin Rowan 16 September 2024 14/15-15/14.
[134] INQ000339466_0053.

'I think this was especially evident when we were hearing about failings around protective equipment, any logical assessment would identify that relatively early as a potentially high-risk environment, and that should have, in my view, led to a review of the Health and Safety Executive's regulatory priorities. It's a very effective organisation in high-risk sectors. What my concern is that it didn't pivot to treat the healthcare sector as a high-risk sector'.[135]

94. The evidence disclosed to this Inquiry demonstrates that there was no change at the outset of the pandemic (or at any point during it) in order to increase inspection activity in the healthcare sector. Mr Brunt's witness statement explains that in the three years prior to the pandemic the number of HSE inspections in healthcare settings was 55, 161 and 95[136] and goes on to explain that, during the pandemic, the number of HSE inspections in healthcare settings for 2020/21 financial year was 81, and for the 2021/22 financial year was 134.[137] HSE inspections during the pandemic therefore remained broadly consistent with the years immediately prior.

95. Furthermore, Mr Brunt's statement sets out the regime of spot checks carried out by HSE during the pandemic. He explains: *'The selection of data for HSE spot checks initially followed the sectors covered by HSE's enforcement authority. HSE targeted high-risk sectors such as waste and recycling, metal fabrication and manufacturing'*.[138] The statistics are set out: the HSE conducted a total of 404,629 spot checks and spot inspections during the life of this regime.[139] Of those over 400,000 spot checks and spot inspections, 483 were carried out in healthcare settings – only 0.12 per cent of the total number of spot checks.[140] There was a failure by the HSE to recognise the enormously increased risk in the healthcare sector and – critically – to do something about it.

96. Concerns of regulation increasing the burden on healthcare settings in a pandemic[141] are misplaced. The HSE is well able, in the face of a novel virus, to work collaboratively with healthcare settings. To stay away from healthcare settings when they are at their most dangerous is to unacceptably forsake healthcare workers.

97. We seek the following recommendations:

    a. The HSE should maintain a level of activity and training in the healthcare sector, such that it has the institutional knowledge and dynamism to be able to pivot towards the healthcare sector when required.

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135 Kevin Rowan 16 September 2024 14/15-15/14.
136 INQ000347822_0021 para 87.
137 INQ000347822_0023 para 92.
138 INQ000347822_0045 para 186.
139 INQ000347822_0048 para 207.
140 INQ000347822_0048 para 209.
141 INQ000474225_0045 para 143 and Michael McBride 24 September 2024 118/5-25.

b. At the outset of a pandemic and at intervals throughout, the HSE should review the level of risk in all sectors including the healthcare sector and should adjust its inspection regime accordingly. If a pandemic involves significant hospital admissions, it should be assumed (in the absence of positive evidence to the contrary) that risk is likely to be higher for HCWs.

c. Staff of the HSE should be identified as essential workers from the outset of a pandemic and provided with the necessary support and PPE to enable inspectors and other staff to continue to carry out the HSE's inspection regime safely.

INDIVIDUAL STAFF RISK ASSESSMENTS

98. Professor McBride explained in oral evidence that: *'the ethical principle of reciprocity* [means] *that if you have a healthcare worker who is putting themselves in harm's way and is at greater risk, that that greater risk should inform decisions about how they work, where they work* […] *and the employer has responsibility* [to protect them from that risk]'.[142] That aim of the employer executing their duty to protect workers at higher risk is the backbone of the risk assessment. Individual risk assessments are, of course, a requirement of health and safety law in any event. However, the pandemic revealed weaknesses in how individual risk assessments are carried out in the healthcare sector. A number of targeted recommendations are required to ensure that risk assessments function effectively in a future pandemic.

99. Professor Whitty, in respect of assessing risk, stated that: *'what I think we were trying to avoid is a situation where every single person was assessed on completely different risks and we ended up in an extremely difficult situation to actually provide realistic and achievable guidance, when it would be much better for all to optimise the outlooks for everybody'*.[143] Whilst the TUC takes no issue with that basic principle – the first and primary objective should be to reduce risks for all workers, risk assessments are a vital tool in steering the most vulnerable away from the highest risk situations. The TUC agrees with Professor Whitty, however, that it is essential to ensure all workers are assessed on the same risks and that the guidance, training and execution of the risk assessment process is practical and achievable.

100. On that basis, it is suggested that the solution is to use a national, or four nations, risk assessment tool. That tool can allocate 'points' to reflect factors contributing to risk, such as age, ethnicity, comorbidities or weight. The tool can then provide simple advice as to the steps to be taken, such as redeployment away from the frontline, or a review of the PPE available to the worker. A national tool of this nature – the All Wales COVID-19 Workforce Risk

[142] Michael McBride 24 September 2024 179/12-18.
[143] Chris Whitty 26 September 2024 179/19-24.

Assessment Tool – was deployed in Wales and should be followed in future.[144] The recommendation ought to be that a template tool is generated and agreed in advance of any future pandemic, with a 'menu' of options which can be updated to reflect the epidemiological data as it develops. Adoption of a national tool would be beneficial in terms of ensuring that those who are indirectly employed are risk assessed on a consistent basis and would make it easier to account for increased risk associated with specific ethnic groups.

101. We would further note that a risk assessment tool is only effective if the recommendations are followed. Professor Banfield gave evidence that Black, Asian and minority ethnic staff are less likely to request an individual risk assessment or feel able to ensure that recommendations are implemented.[145] The following recommendations would bolster the implementation of actions identified in risk assessments:

a. Trusts ought to be responsible for retaining copies of risk assessment documentation for all staff, *including indirectly employed staff working in the trust.*

b. NHS England, or an independent body, ought to be responsible for dip sampling risk assessments in each trust (and ensuring that the recommendations arising from assessments are implemented (including for indirectly employed staff).

c. There should further be a review of risk assessment processes to identify whether improvements can be made to improve outcomes for Black, Asian and minority ethnic staff, particularly in terms of ensuring recommendations are acted upon.

VACCINATION AS A CONDITION OF DEPLOYMENT ('VCOD')

102. Powerful evidence, highlighted in our written opening, has underlined the damaging effect of the pursuit of VCOD in the NHS.[146] Proponents of the policy say that the risk benefit analysis falls in favour of the policy because the issue is one of saving lives.[147] But that misses the point. Increasing vaccination uptake in the healthcare workforce is critical – but this *can* be achieved through methods of provision of information and access, support and encouragement. The TUC considers that it can be achieved *as, if not more, effectively* (in terms of impact on vaccination rates amongst workers) and with *less damage to relationships, trust and confidence* by deploying other methods.

[144] INQ000222875.
[145] Philip Banfield 28 October 2024 139/10-17.
[146] INQ000472879_0007-0008 paras 33-37; INQ000477436_0009 para 24; INQ000471161_0012 para 57; INQ000477351_0015 para 65; INQ000474214_0012-0013 paras 2.32-2.38; and INQ000477597_0020 para 66.
[147] See, for example, Matt Hancock 22 November 2024 4/18-5/15. See also: Sajid Javid 25 November 2024 69/11-70/8.

103. Indeed, Professor Simon Ball gave evidence that providing information, encouragement and support was effective within the Queen Elizabeth Hospital in Birmingham, and confirmed that once the government dropped the policy, the Queen Elizabeth Hospital reverted to the approach of encouragement alone.[148] Pursuit of the plan involved a failure to listen to representative bodies who were, from an early stage, explaining to government that methods of providing support, information and encouragement would be equally if not more effective.[149]

104. Such an approach would be in keeping with the UK's vaccination strategy. The UK Health Security Agency's 'Green Book', '*Immunisation against infectious disease*' states:

> *'It is a legal and ethical principle that valid consent just be obtained before starting personal care, treatment or investigations. This reflects the rights of individuals to decide what happens to their own bodies and consent is a fundamental principle of good healthcare and professional practice.* […] *For consent to immunisation to the valid, it must be given freely, voluntarily and without coercion'*.[150]

To push HCWs to get the vaccine against their personal judgement by way of a threat of redeployment or, more likely, unemployment was in breach of the UK's strategy on vaccination and has been damaging in terms of trust and confidence between workers, HR personnel, and employers and government.[151] It caused further damage to HCWs who had put their own health and wellbeing on the line in order to provide care during the pandemic.

105. Mr Hancock's emphatic declaration that VCOD should be introduced for HCWs as soon as a vaccine is available in a future pandemic is misconceived. It should be a measure of last resort, balanced against the results of consultation and a risk-benefit analysis which takes into account factors such as the characteristics of the virus, the efficacy of the vaccine against transmission, and the stage of the pandemic. The same over-zealous 'stick before carrot' approach criticised in the TUC's closing statement in Module 2,[152] also impacted upon the decision to introduce VCOD, despite the strong evidence provided against the policy in the government consultation.[153] Those in Welsh Government listened to representative bodies and were clear from the outset that VCOD would not be introduced – it stated in July 2021: *'Employers should be aware that vaccination is not a mandatory requirement. Public trust in*

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[148] Simon Ball 7 November 2024 42/2-21.
[149] INQ000391169; INQ000401270_0036 para 134; INQ000410862_0022-0023 paras 88-90; INQ0003967352_0034 para 113; INQ000232054; IN0000232055; INQ000292480_0036 paras 134-135; INQ000471985_0045-0046 paras 147-149.
[150] See https://www.gov.uk/government/publications/consent-the-green-book-chapter-2, p.1 (accessed 19 December 2024).
[151] INQ000477436_0009 para 24; INQ000472879_0007-0008 paras 33-37; INQ000471161_0012 para 57; INQ000477351_0016 paras 69; and INQ000474214_0012-0013 paras 2.32-2.38.
[152] INQ000399530_0016-0017 paras 43-45.
[153] INQ000339444.

vaccination is very important and it is the view of the Welsh Government that people should not feel forced into vaccination'.[154]

106. It is clear from the data disclosed to this module that in the Covid-19 pandemic, Black, Pakistani and Bangladeshi groups had lower uptake of the vaccine.[155] Studies, including those outlined by Dr Habib Naqvi, found that higher levels of hesitancy amongst some minority ethnic groups can be linked to concerns about the number of minority ethnic people included in clinical trials, and fears stemming from historical unethical research.[156] It appears a matter of common sense that such concerns are most appropriately addressed through the provision of information and support, and through engagement with community leaders. Indeed, Matt Hancock gave evidence in respect of previous vaccination schemes:

> *'one of the things we found was most effective in increasing vaccination rates amongst people from black, Asian and minority ethnic communities was to ensure that those doing the vaccinating and organising the vaccinating were also from those communities, to help people feel safe.* […] *all the work that Minister Zahawi led in the vaccine rollout to increase uptake amongst BAME communities could equally be applied within health and care settings'*.[157]

107. It appears oxymoronic that Mr Hancock was able to appreciate that methods of engagement and encourage were, on the one hand, *'most effective'* for the general public, but on the other hand, espoused a policy of mandating vaccination for the healthcare workforce as a matter of first resort. To simply mandate vaccination is to fail to reckon with the underlying causes of hesitancy or concern – and risks exacerbating them.

108. There are powerful arguments of principle against imposing vaccine as a condition of employment at all. Even if those are rejected, the balance of value and cost of such a policy will be influenced by factors set out above. We suggest that any recommendation as to VCOD should also await the end of Module 6, given the relevance of the issue to the social care workforce and the cross-cutting nature of this issue.

SUPPORT FOR HEALTHCARE WORKERS

Mental health support

109. Professor Whitty identified that in terms of reducing the mental health impact of a pandemic, staffing levels make a difference;[158] so much of the trauma and moral injury suffered by HCWs during the Covid-19 pandemic was as a result of feeling unable to provide the level of care

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[154] See: https://www.gov.wales/covid-19-vaccinations-guidance-employers (accessed 19 December 2024).
[155] INQ000315604_0010 para 16; INQ000302490; and INQ000302491.
[156] INQ000315604_0010-0011 para 17.
[157] Matt Hancock 21 November 2024 154/21-155/16.
[158] Christopher Whitty 26 September 2024 184/1-19.

they expected and were trained to provide.[159] If staffing levels and resourcing can be improved within the public healthcare systems in the UK in advance of another pandemic, the mental health toll for workers will be ameliorated.

110. However, it is unlikely that mental health impacts can be avoided in a novel pandemic, even with better resourcing. Not only are mental health impacts damaging for the individual, but they are a major driver of capacity issues. Dame Ruth May highlighted that *'even before the pandemic, mental health related sickness was the largest cause of absence in the nursing workforce'*.[160] It is clearly an issue which deserves far greater attention in advance of another pandemic or other crisis in the healthcare system, not least due to the trauma staff are experiencing *now* in respect of the Covid-19 pandemic.

111. We seek recommendations that:

    a. Mental health support be a recognised and prioritised part of pandemic planning.

    b. Greater mental health support should urgently receive significant investment and focus.

    c. The emphasis should be upon formal, robust support delivered by occupational health teams – whilst the peer support scheme delivered by Professor Fong is commendable, the onus of providing support should lie with employers, rather than workers.

Financial remuneration

112. As Sara Gorton has explained, HCWs faced unexpected costs during the Covid-19 pandemic, some associated with homeworking, some with purchasing equipment such as PPE which should have been provided by their employers and some in respect of loss of overtime opportunities or higher travel costs associated with redeployment.[161] This rubbed salt into the wounds of workers who were already forced to bear the brunt of the pandemic. The TUC seeks a recommendation that tripartite arrangements in each of the four nations, such as the Social Partnership Forum in England, be required to consider at the outset of a pandemic possible areas for financial detriment and to put in place safeguards to ensure that either these costs do not arise or to enable workers to rapidly claim back any costs via their employer.

113. In respect of sick pay, all HCWs in the public healthcare systems must be offered full sick pay when they need to self-isolate or recover from symptoms associated with infection; this is a basic matter of IPC.[162] In the NHS, full sick pay was available for the majority of workers, but

[159] See, for example, Charlotte Summers 9 October 2024 66/21-68/12 and Kevin Fong 26 September 2024 20/6-21/2.
[160] INQ000479043_0040 para 180.
[161] INQ000471985_0039 para 127.
[162] See INQ000399530.

those who were indirectly employed in many circumstances missed out. Professor Whitty explained in his oral evidence to this module:

> *'I worried throughout the pandemic as to whether we were dealing with the financial situation of people who were not on an employed basis. Permanently employed basis was optimal. We know from the care sector, for example, where the data is clearer, that people who were not paid sick pay fully were more likely to come into work when they had symptoms, and therefore spread disease around. So I think there are a set of issues around this that we need to look at quite carefully in advance of the next emergency, it doesn't have to be a pandemic'*.[163]

For that reason, as is set out at paragraph 57 above, more must be done to ensure all workers have the security of full sick pay to enable them to self-isolate.

114. For HCWs who were clinically vulnerable or who had clinically vulnerable ('CV') members of their household, there were also often significant financial detriments. Cathy Finnis explained in her statement to this module that many CV people working in high-risk situations could not access Statutory Sick Pay, and that family carers of shielded people were not shielded, leaving the approach to their employment circumstances up to individual employers. [164]

115. Where HCWs cannot work because they are clinically vulnerable or feel unable to attend their workplace in person due to the need to safeguard or provide care to a clinically vulnerable member of their household, financial support should be in place to ensure HCWs are not penalised for taking steps to protect the most vulnerable from the higher risks associated with healthcare settings.

LONG COVID

Return to work

116. In respect of returning to work in the NHS after suffering Long Covid, the experts, Professors Brightling and Evans, noted that the NHS adopts very fixed, rigid phase returns which are counterproductive in the context of Long Covid, which varies greatly in terms of presentation and recovery between individuals, and where fatigue requires a carefully planned, flexible plan for return.[165] Professor Evans pointed out that in the context of the public healthcare sector, where staff typically are very keen to return and are likely to do so sooner than is necessary of their own accord, this approach is unhelpful and puts staff at risk.[166] The TUC endorses the experts' recommendation of greater flexibility in phased returns for Long Covid and considers that, in a future pandemic, we must be alive to the need to listen to the worker and their own

[163] Christopher Whitty 26 September 2024 181/8-16.
[164] INQ000409574_0035 paras 65 and 85. See also: Catherine Finnis 8 October 2024 90/6-91/2.
[165] Rachael Evans 29 October 2024 118/7-17.
[166] Rachael Evans 29 October 2024 117/21-25.

account of their symptoms before data and clinical knowledge about how to treat the specific long-term sequelae develops.

Occupational disease

117. Mr Rowan explained in his statement that *'for many workers, carrying out their job puts them at greater risk of exposure to Covid-19'*.[167] That risk, for HCWs, is especially high. On that basis, the Industrial Injuries Advisory Council ('IIAC') concluded in November 2022 that Covid-19 should be prescribed as an occupational disease for frontline healthcare workers. The TUC endorses that IIAC's recommendation to this Inquiry, and further suggests that a bespoke compensation scheme should be created in respect of Covid-19, which could be similar in many respects to the scheme designed to deal with mesothelioma.[168]

SOCIAL PARTNERSHIP

Improving current arrangements

118. Tripartite engagement between government, employers and workforce representatives was a real strength of the response in the healthcare sector in England, particularly as compared to the social care sector. However, social partnership within the NHS in England, in particular, needs reinforcing. The Social Partnership Forum should be a forum for policy development and obtaining intelligence from those on the ground and should not be principally a mechanism for messaging and implementation. Sara Gorton explained that social partnership *'works best when people listen and then take action'* rather than being told retrospectively about decisions which had been made.[169] She drew upon the example of the VCOD policy as an example of when *'unions had been advising a particular course of action would be detrimental to a good vaccination campaign'* but the policy was pursued nonetheless.[170]

119. Below the national level, stronger and clearer structures are required to ensure that: the decisions made at a national level are enforced locally; issues which arise at a workforce level can be raised locally where the employer is not sufficiently responsive; and information gained at a local level, such as through risk assessments, feeds into the work of the SPF.

Temporary Covid-19 Terms and Provisions

120. The Inquiry has heard evidence about the difficulty which arose in identifying and negotiating appropriate and safe terms and conditions for the workforce during a pandemic.[171] In her

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[167] INQ000397188_0023 para 80.
[168] See: https://www.gov.uk/diffuse-mesothelioma-payment (accessed 19 December 2024).
[169] Sara Gorton 12 September 2024 166/6-167/1.
[170] Sara Gorton 12 September 2024 166/6-167/1.
[171] INQ000471985_0008-0009 paras 25-30. See also: Sara Gorton 12 September 2024 140/18-142/12.

statement, Ms Gorton sets out the process followed by the NHS Staff Council and, later, the Covid-19 Terms and Conditions Group to develop a set of temporary terms and conditions which would allow the workforce to continue to attend work safely and to bolster IPC.[172]

121. An important part of this Inquiry's work is to ensure that learning from the Covid-19 pandemic is not lost and may inform our approach in a future similar crisis. One area in which significant positive work was achieved was these temporary terms and conditions, which expanded and adapted as the state of epidemiological evidence developed during the pandemic. We seek to avoid this learning and groundwork being lost. We consider that these temporary terms and conditions should be adopted as permanent, 'break glass provisions' which are maintained 'off the books', so to speak, and can be triggered at the outset of a pandemic. These provisions form a 'menu' of terms and conditions which may assist during a future pandemic and can readily be tailored, as they were during the Covid-19 pandemic, according to the emerging evidence about the disease. For example, there are terms and conditions about full sick pay being provided to healthcare workers which can be triggered wherever the transmissibility of a virus requires policies on self-isolation.

122. The TUC seeks recommendations: that the temporary terms and conditions are adopted as 'break glass provisions', such that they can be utilised in a future pandemic; and that these terms and conditions ae reviewed annually to ensure they remain up to date with employment laws and standards, in addition to reviews on a more regular basis during the currency of any future pandemic.

CONCLUSION

123. The TUC has been grateful for the opportunity to contribute to Module 3 of this Inquiry. The Inquiry, as is the case for broader society, owes it to the healthcare workers who paid such a high price in the pandemic to learn the necessary lessons so that the healthcare response in the next pandemic is transformed for the better.

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20 December 2024

[172] INQ000471985_0007 para 22, _0008 paras 25-26, _0011 para 37 and _0025 paras 85-86.