THE UK COVID-19 INQUIRY

TRADES UNION CONGRESS:

WRITTEN OPENING FOR MODULE 7 ON TEST, TRACE AND ISOLATE

'I worked all through Covid myself, but some of my colleagues had to isolate, I asked them if they were still getting paid, they said no and if it happens again, next time they will come into work even if they tested positive and had no symptoms, because they couldn't afford to stay off'.

A residential care worker, April 2025

'I had covid seven times and was paid nothing. I got myself into so much debt'.

A residential care worker, April 2025

'Most of the workers here work for £9.36 per hour. Living from week to week just managing to pay their bills without much extra. If you live in a house on a single income or like myself where my wife and I both work in the same factory if either one of us was to be told to self-isolate or worse catch this virus we would suffer a great financial burden, as we could not manage to pay our weekly bills from Statutory Sick Pay for 10 days during isolation. Even before the pandemic, presenteeism was high'.

A food manufacturing worker, January 2021

'We had to test the kids in the hall with the Covid testing and I was always getting sneezed and coughed on and I hated that'.

A cover supervisor for secondary school and sixth form pupils, August 2024

'We didn't feel safe. I work in Early Years and during lockdown was supporting key workers' children. A large majority of these children were under five, so testing was not a requirement. There were occasions where these children were sent into school poorly (with Covid symptoms)'.

A midday supervisor in Early Years Education, August 2024

INTRODUCTION

1. This is the opening statement of the Trades Union Congress (**'the TUC'**) in Module 7 of the UK Covid-19 Inquiry. Over five million working people are members of the TUC's affiliated unions, and systems for testing, tracing and isolating (**'TTI'**) were key to the safety of all of those workers during the pandemic. As a core participant in Module 7, the TUC is working in partnership with TUC Cymru (formerly known as the Wales TUC), the Scottish TUC, and the Northern Ireland Committee of the Irish Congress of Trade Unions.

2. In Module 7, the TUC will seek to bring its experience and expertise to two key issues: (a) supporting those at work who need to self-isolate; and (b) systems for TTI within education settings.

3. The failure to provide adequate support, particularly financial support, to those needing to self-isolate was a failure of the response to Covid-19 and is a key area for the learning of lessons for the next pandemic. Effective TTI not only reduces fatality and illness rates, it does so in a way that enables society to continue operating while avoiding or reducing the harms associated with lockdowns. However, adherence rates in the pandemic were devastatingly low. As we observed at the first preliminary hearing in this module, *'Cabinet Office polling in January 2021 suggested that only 36% of people with symptoms were getting tested, and a SPI-B paper in September 2020 reported that 'current rates of full self-isolation are very low (<20%) based on self-report. They are particularly low among the youngest and the poorest'.*[1] *Furthermore, Senedd research in December 2020 suggested that less than a third of people in Wales were fully compliant when required to self-isolate.*[2] *This contrasts with evidence from South Korea and New York where compliance rates of 99% and 98%, respectively, were reported'.*[3] The further evidence in this module has confirmed that picture. A paper from the BMJ titled 'Adherence to the test, trace, and isolate system in the UK: results from 37 nationally representative surveys' demonstrates that, across the first waves of the pandemic, just one in five people with symptoms sought a Covid test, and only 43% stayed at home for 14 days.[1] A core difficulty was the lack of adequate financial support for self-isolation. The impact on those on lower incomes and in insecure work is inevitably greater, rendering more vulnerable those communities that suffer from pre-existing health inequalities.

4. Similarly, we focus on TTI in education settings because implementing effective non-pharmaceutical interventions in such settings, including TTI, is as important as it is challenging. It was also an area where there appeared to be very little pre-pandemic planning and poor, last-minute decision-making. This ultimately undermined the entire TTI system, created significant and unreasonable demands on education staff, and huge uncertainty for pupils. This exposed pupils' families and immediate contacts to infection risk, and ultimately resulted in predictable and manifest ill-effects in terms of community transmission and the R-rate.

5. We suggest, therefore, that these submissions address two areas where the failings during the Covid-19 pandemic were abject, but where carefully considered recommendations will significantly improve outcomes in the next pandemic.

A. SUPPORT FOR WORKERS TO ISOLATE

Context of structural inequalities

6. As Dr Jennifer Dixon DBE (The Health Foundation) sets out in her evidence:

> *'More socioeconomically advantaged people may have more resources supporting them to exercise their agency, and may have home and work circumstances that mean they are better able to isolate (such as being able to work from home or isolate without fear of loss of income, and have housing circumstances that allow them to stay away from others in the household)'.*[2]

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[1] INQ000228154, cited by Professor Anthony Costello: INQ000587298_0018 para 54.
[2] INQ000475185_0009 para 36.

7. However, a significant proportion of the UK population was not in this position. 3.7 million people were facing insecurity in work in the UK in 2021, either because their contract did not guarantee regular hours or income or because they were in low-paid self-employment. Insecure workers were almost ten times more likely than secure workers to not receive any sick pay.[3] As of 2020, two million employees were not eligible for sick pay.[4] As a result, an already vulnerable working population, which faces pre-existing health inequalities and is disproportionately Black, Asian and Minority Ethnic, and disabled, faced significant challenges in terms of adhering to self-isolation requirements. As Vaughan Gething observes in his evidence to this module:

> *'By advising people to self-isolate without clear advice on financial support we were essentially forcing them make, for what would be for many an impossible choice between their own, their family and their community's health and financial survival. It is important that we recognise the difficult position we put people in and address statutory sick pay much earlier in the event of a future pandemic'*.[5]

8. This had devastating impacts in terms of infections and fatalities in sectors where large proportions of workers faced work insecurity and socio-economic vulnerability. The cardinal example was in social care. The evidence of Professor Naomi Fulop (Covid-19 Bereaved Families for Justice) underlines the cost of this failure: *'I believe an effective TTIS programme could have played a crucial role in protecting my mother from contracting Covid-19. At the time, her domiciliary carers had inadequate access to testing and, even more concerningly, lacked the financial and practical support needed to isolate when necessary'*.[6] As Dr Dixon describes:

> *'Unlike NHS staff, social care workers were not guaranteed sick pay above the statutory requirement, and the prevalence of low wages and zero-hours contracts meant staff incomes were precarious. The prospect of losing earnings is likely to have been a barrier to staff getting tested and self-isolating if positive for COVID-19. Research evidence at the time found lower levels of infection among residents in care homes where staff received sick pay'*.[7]

9. That the lack of adequate financial support for self-isolation exacerbated pre-existing and structural inequalities is made clear in the evidence disclosed to this module. Indeed, Professor Martin McKee (London School of Hygiene and Tropical Medicine) outlines evidence of significantly lower rates of adherence to self-isolation requirements for those on lower incomes and the failure to properly understand and address this issue:

> *'Financial vulnerability exacerbated the problem; individuals earning less than £20,000 annually or with savings under £100 were three times less likely to self-isolate Exhibit MMK/48 [INQ000535952]. Compounding this, the UK provided only 29% Exhibit MMK/49 [INQ000280347] of wages through statutory sick pay, far below countries like Germany and Belgium, leaving many without adequate financial protection. An OECD review Exhibit! MMK/48 ~INQ000535952] highlighted the critical role of paid sick leave in supporting public health and economic stability during pandemics. All of this would have been clear if there had been serious engagement with those marginalised and disadvantaged communities'*.[8]

10. Lord Patrick Vallance (Chief Scientific Advisor) explains that SPI-B advised that barriers to self-isolation included financial impact associated with isolation, and highlighted in particular,

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[3] INQ000119085_0003-0004.
[4] INQ000119082_0002.
[5] INQ000575989_0102 para 382.
[6] INQ000587244_0004 para 17.
[7] INQ000475185_0012 para 54.
[8] INQ000475066_0032-0033 para 81.

'individuals in precarious and/or low paid employment without sick leave provision'.[9] This fact is recognised by former First Minister for Scotland Nicola Sturgeon, whose statement connects this barrier to the *'the increased risk BAME or disabled people face with regard to being on lower incomes'*.[10]

11. The advisory note by the Independent Pandemic Insights Group titled 'SPI-B insights on combined behavioural and social interventions' from March 2020, observed that the financial losses associated with self-isolation were often compounded by other financial challenges associated with the pandemic: *'For poorer families, loss of income and increased household bills (heating, electricity, food delivery etc) will occur concurrently with loss of social services provided through schools (free school meals, after school clubs etc)'*.[11] SPI-B recommended, in September 2020, that '*provision of financial support to safeguard incomes would likely have the single largest effect in achieving equitable self-isolation policies, in other words self-isolation that benefits the social groups with fewest material and other resources as well as those with the most'*.[12]

12. Similarly, Dr Robert Orford (Chief Scientific Advisor for Health for Wales) explained that inequalities in Covid-19 outcomes impacted upon: *'the same groups as historical inequalities in other risk factors and outcomes'*; *'occupations with lots of contacts, especially low paid occupations where people felt they could not afford to self-isolate'*; and key workers, who are disproportionately female and Black, Asian and Minority Ethnic.[13]

13. Improving adherence to self-isolation is an important aim of this module. However, a critical aim of this Inquiry must be to ameliorate the disproportionate impact of the pandemic on vulnerable and marginalised groups, including those of lower socio-economic status, in insecure work, and of Black Asian and Minority Ethnic background. Further to the evidence set out above, we say that work to address the issue of financial support for self-isolation and lack of adequate sick pay is a concrete step which can be taken to lessen the disproportionate impacts of any future pandemic.

The evidence in pre-existing modules on support for self-isolation

14. This is an issue which has been canvassed in previous modules, most notably in Module 2. It was a significant focus of our opening and closing submissions to that module.[14] In closing, we argued, in brief:

15. The context for the issue in the UK was inadequate levels of Statutory Sick Pay (**'SSP'**) – only £94.25 per week at the outset of the pandemic. Matthew Hancock (former Secretary of State for Health and Social Care) described the UK's SSP during oral evidence as *'far, far too low* [...] *far lower than the European average'*.[15]

16. That adequate financial support for sickness and self-isolation is required during a pandemic was known and recognised in academic literature prior to the pandemic, including in an article by Deputy Chief Medical Officer, Professor Sir Jonathan Van-Tam titled *'Influenza in long-term*

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[9] INQ000575986_0015 para 38.
[10] INQ000475142_0074 para 191.
[11] INQ000109111_0002 para 10.
[12] INQ000231034_0006.
[13] INQ000587247_0087 para 269.
[14] Please see: opening statement of the TUC in Module 2, paras 27-36 and closing statement of the TUC in Module 2, paras 30-75.
[15] Transcript [30/106/7-14].

care facilities' published in 2017. Inadequate levels of SSP have been described by a range of witnesses as being a clear and obvious challenge at the outset of the pandemic.

17. There were repeated warnings during the pandemic that low SSP and a lack of adequate financial support for self-isolation were undermining the TTI system. These warnings came from SAGE, SPI-B, scientific studies in care homes, politicians, unions, DHSC research, the Behavioural Insights Team, and Covid-O meeting briefings.

18. There was a powerful resistance within the Treasury, including from the then Chancellor to the Exchequer, to providing adequate funding for self-isolation support. It is clear that this arose, at least in part, from concern that any scheme to address the issue of financial support for self-isolation would *'concede the point that Statutory Sick Pay or other existing benefits are perceived to be inadequate'*.[16]

19. A theme which ran throughout government decision-making during the Covid-19 pandemic – of *'stick not carrot'*[17]and enforcement over incentives impacting upon the adequacy of the response to this issue. Lord Vallance's diaries demonstrate that he was concerned by, and critical of, this approach. Indeed, the emphasis on enforcement, fines and punishment undermines the TTI system itself, because, to many, it must have appeared safer to avoid the system entirely rather than seeking out a test or downloading an app intended to trace contacts. Indeed, Professor James Rubin (King's College London) explained: *'That's what we mean by focusing on support, enabling people to carry out the behaviours that they want to do, rather than trying to scare them into doing it. It was the first we wanted, not the latter'*.[18]

20. The schemes devised – in England, the Test and Trace Support Payment Scheme (**'TTSPS'**), the Adult Social Care Infection Control Fund and the Hardship Fund – were plagued by practical issues resulting from a lack of forethought, poor levels of awareness, and administrative issues (for further detail, see below at paragraphs 32 to 46).

21. It was evident that SSP and the devised schemes were inadequate and ineffective. Lord Vallance recorded the PM saying: *'we must have known this wasn't working - we have been pretending it has been whereas secretly we know it hasn't been'*.[19] Despite this action was never taken to fix the issue. As Professor Lucy Yardley (SPI-B) described in oral evidence to Module 2, in response to a question about whether the problems with financial support were ever resolved: *'Not at all. And it's something that we pointed out over and over again* [...] *before lockdown we pointed out that this would be a problem, and we continued to point it out throughout'*.[20]

22. There is a need for accessible sick pay provided at adequate levels in any future pandemic. The most suitable mechanism is via SSP. This would have been evident to Government. However, as was stated in an Equality Impact Assessment conducted in advance of the August 2020 TTSP scheme pilots, the scheme was separately administered *'To maintain the Government's current policy position on welfare benefits'*.[21] We cited in conclusion Mr Hancock's oral evidence to this Inquiry: *'the lesson for the future is that self-isolation payments, rapidly delivered, are a necessity when self-isolation or indeed mandatory isolation is required* [...] *a further lesson I would take for the future from this whole debate in government is that we*

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[16] INQ000203685_0006.
[17] INQ000273901_0637. *NB: document not yet cross-disclosed to Module 7.*
[18] Transcript [12/88/8-17].
[19] INQ000273901_0621.
[20] Transcript [12/140/23 – 12/141/4].
[21] INQ000203685_0008.

should have higher statutory sick pay'.[22] We set out below (at paragraphs 32 to 46) why we consider that Mr Hancock was right that both SSP and financial support for self-isolation must be addressed in advance of a future pandemic.

23. We ask that these submissions are read alongside paragraphs 30 to 75 of our closing submissions in Module 2. Given the limited length of public hearings in Module 7, we consider that this module must build on the evidence given on this issue in Module 2, otherwise there is a risk that the evidence will not advance this issue any further.

The questions which remain for this module

24. Numerous witnesses in this module have observed that financial support for self-isolation is important, or that it ought to be provided in a future pandemic. By way of example:

25. Professor Deenan Pillay (SAGE) summarised an Independent SAGE article thus: *'Isolation will not work unless people are supported to enable them to isolate. Self-isolation should be replaced by 'supported isolation' with assistance, if needed, with accommodation, domestic assistance and financial support up to £800'*.[23]

26. Professor Matthew Keeling OBE (SAGE): *'The other issue is the financial burden of isolation, especially for individuals on zero-hours contracts - many countries introduced payments or incentives for individuals to remain isolated'*.[24] And in respect of recommendations: *'Far greater incentives for compliance with isolation recommendations, or at least removal of the barriers for compliance'*.[25]

27. Professor Cristophe Fraser (SAGE): *'Recommendation: the UK should plan a system of financial and social support for quarantine, and plan to replace it if possible by a policy of regular testing'*.[26]

28. Dr Dixon (The Health Foundation): *'People needed to be supported to isolate at home and be confident that they would be no worse off for having to done so. It was clear at the time that isolation compliance was higher where people had access to social, practical, and economic support'*.[27]

29. Richard Foggo (Scottish Government): *'The key finding of that report, that reflects my view is: "a significant package of practical and financial support for people self-isolating, where needed, to minimise the impact of self-isolation requirements on people in low-income households and older people* [...]*'*.[28]

30. Professor Christina Pagel (SAGE): '*This suggests that key ways to improve test seeking are better communication (both of symptoms, and the availability of tests for those with no symptoms), ease of access to tests, and supporting people to isolate if they test positive. [...] financial support for isolation did not improve much during the pandemic (the £500 isolation payment was low and hard to access [CP/062 - INQ00057391 O])'*.[29]

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[22] Transcript [30/110/4-11].
[23] INQ000475152_0010 para 35(e), summarising INQ000474857_0001.
[24] INQ000475144_0013 para 28(iii).
[25] INQ000475144_0017 para 38(iv).
[26] INQ000475153_0052 para 137.
[27] INQ000475185_0008 paras 34-35.
[28] INQ000475184_0039 para 136.
[29] INQ000575988_0013 paras 33-34.

31. We agree. But we say that is not enough. That was made clear by Modules 2, 2a, 2b and 2c. What this module must address is: (i) the adequacy of the schemes which were devised; and (ii) a clear set of recommendations on what must be achieved to prepare for a future pandemic, to ensure that the financial support offered to workers to self-isolate is adequate and substantially improves adherence with the requirements.

32. A range of evidence in this module highlights practical issues with the schemes which were devised. For example:

33. Dr Dixon has explained in her witness statement that: *'the UK's sick pay regime was unusually frugal by international standards, and government support payments for people self-isolating were limited and subject to eligibility tests. Surveys at the time, for example those conducted as part of the CORSAIR study, made clear that substantial proportions of people felt unable or unwilling to follow self-isolation guidance. [JD-7/03b - INQ000475176]. The failure to join up testing and broader policy, including with respect to financial and practical support to self-isolate, materially hampered the overall effectiveness of NHSTT'*.[30]

34. Mr Gething has outlined steps which needed to be taken during the pandemic: *'We agreed the package of financial and non-financial support for those required to self-isolate should be reviewed for the potential to make it more generous and easier to access'*.[31]

35. Professor Pagel explained: *'[…] financial support for isolation did not improve much during the pandemic (the £500 isolation payment was low and hard to access [CP/062 - INQ00057391 O])'*.[32] And: *'Sick pay equivalent to 80%-100% of full salary was offered to cases and contacts isolating in many countries such as Portugal, Slovenia, Germany and Sweden [CP/105 - INQ000573904]. Other countries provided generous one-off payments or other financial support not based on salary such as Australia, Singapore, South Korea or Taiwan [CP/106 - INQ000573894]. Practical support, often in the form of home visits, grocery shopping and/or accommodation outside the home, was also offered by many countries, including Denmark, Norway, South Korea, Taiwan, France and the Netherlands [CP/106 - INQ000573894]. However, there was no financial support offered by the government in England to those isolating until 28 September 2020, when a £500 one-off payment was brought in for those on both low incomes and benefits. The new payment was introduced alongside new financial penalties for not self-isolating if you tested positive for Covid-19 or were a contact [CP/107 - INQ000573982]. Support payments were retrospective and had to be applied for'*.[33]

36. The TUC's report, 'Sick Pay that Works', highlighted the inadequacies of the TTSPS in practice. Freedom of information requests revealed that 70% of applications were being rejected by local authorities. There was both a mandatory and discretionary scheme, and only 10% or fewer of applications under the discretionary scheme were being granted. As the TUC stated, '*Our findings shows that the scheme is failing to financially support workers who have been required to self-isolate. This is for two reasons: the eligibility criteria for the main payment means that many workers miss out; and the lack of funding for the discretionary scheme means most applicants are rejected*'.[34] This was similarly highlighted by Mr Steve Rotheram in a letter to Rishi Sunak in February 2021, with Mr Rotheram stating that '*Two-thirds of the applications from those who have applied for financial support to self-isolate and stay at home have been*

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[30] INQ000475185_0017 para 70.
[31] INQ000575989_0081 para 289.
[32] INQ000575988_0013 paras 33-34.
[33] INQ00057598813_0031 para 82.
[34] INQ000119082_0011.

rejected'.[35] TUC surveys in June 2021 found that only one in five people even knew about the scheme, with the level of awareness even worse amongst those in low-paid and insecure work.[36]

37. A DHSC paper for Covid-O entitled 'Improving adherence to self-isolation' set out that:[37]

    (a) The application process for the TTSPS was *'too complex'* because individuals were required to find out which local authority they lived in, locate the forms on the website and complete the forms, including providing evidence such as pay slips and bank statements.

    (b) The eligibility criteria exclude some people who face hardship, including those who earn slightly above the income threshold for means tested benefits.

    (c) The discretionary scheme has led to a 'post code lottery' due to the variable criteria introduced by local authorities in respect of eligibility for discretionary payments.

    (d) Administering the schemes was highly resource intensive for local authorities, exacerbating existing resource pressures.

38. As Dr Dixon's evidence emphasises, lack of financial support does not only impact upon isolation adherence, but upon the decision to test in the first place: *'The prospect of losing earnings is likely to have been a barrier to staff getting tested and self-isolating if positive for COVID-19'*.[38] This is emphasised by Nicola Boyle of Scottish Covid Bereaved: *'Financial and practical support for those required to isolate was non-existent for most of our members, who had to provide support to loved ones off their own accord. It is understood that those in low-income jobs and/or with low job security often felt that they had no option but to attend work and would ignore testing and isolation rules in order to provide for their families'*.[39]

39. Furthermore, evidence from a mass testing trial using Lateral Flow Devices ('**LFDs**') in Liverpool in November 2020 demonstrates the strength of the connection between deprivation and access to testing: *'Overall, 43% of Liverpool residents without symptoms had an LFD test between 6 November 2020 and 31 January 2021. When analysed by deprivation, 32% of those in the most deprived areas had an LFD test compared to 53% in the least deprived areas'*.[40] Professor Pagel linked these findings to concerns regarding financial losses associated with isolation: *'Given the legal requirement to isolate if positive (and fines for not doing so [CP/061 - INQ000573927]), lack of financial ability to isolate might prompt people not to find out if they are positive'*.[41] As a result, a failure to put in place adequate financial support does not only affect isolation adherence, but has the capacity to undermine the entire TTI system.

40. On that basis, we say that really careful thought is required during Module 7 as to: (i) the *amount* of financial support; and (ii) the *mechanism* for its delivery.

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[35] INQ000180840_0054.
[36] INQ000192241.
[37] INQ000566269_0009.
[38] INQ000475185_0012 para 54.
[39] INQ000587320_0021 para 104.
[40] INQ000575988_0013 paras 33-34.
[41] INQ000575988_0013 paras 33-34.

The lessons to be learned

Amount of sick pay

41. It is not enough simply to provide some financial support as an 'incentive'. Workers need to feel confident that isolating will not lead to difficulties in paying their bills or putting food on the table. As Professor Costello notes in his statement, this was not addressed in the pandemic by UK SSP provision:

> '*The UK spent a paltry £54 million in 2020/21, and just £72 million in 2021/22, the lowest rate among OECD countries. Sick pay rates were under £96 per week unless you were one of the two million people who earned less than £120 a week, in which case you received nothing. The same report showed that in Canada or New Zealand in 2020, people were paid the equivalent of £287 or £308 a week respectively. As a result, compliance with self-isolation in England was dismal. Across the first waves, just one in five with symptoms sought a Covid test, and only 43% stayed at home for 14 days. This policy failure of inadequate financial support for isolation, absolutely critical to break transmission and maintain infection control, was never raised in public fora by our senior government advisers*'.[42]

42. Similarly, this issue was not adequately addressed by the payments made by the TTSPS, nor by its equivalents in the devolved nations. In October 2020, Independent SAGE stated: '*Government should make isolation financially feasible for all cases and contacts. This was not provided until September 28, since when £500 has been provided to properly isolate for 14 days, or £7.14 per hour, substantially below minimum wage and hard to access (and many remain ineligible). For five million workers in the gig economy, this provides little incentive. We recommend £800 as a minimum.*'[43] A subsequent paper from Independent SAGE, in March 2021, went further, highlighting: '*The government should make isolation financially feasible for all cases and contacts. One idea would be to provide a lump sum based on a living wage (£9.50 per hour, £10.85 in London) at the start, with a final incentive payment if the case/contact completes 14 days without breaking isolation as measured by an app monitoring the GPS signal. The current £500 sum, for which most people have their application rejected, is wholly inadequate and a disincentive to isolate. A minimum sum should be 14 days x £70 or £980*'.[44]

43. Even where full sick pay was available (whether as a result of the workers' usual terms and conditions, or the Adult Social Care Infection Prevention and Control Fund), it was most commonly based on the employee's contracted hours. In the care sector, for example this may mean that a worker contracted to work 24 hours who ordinarily worked 50 or 60 hours, would nonetheless see a significant drop in income during periods of self-isolation.

44. We say that the answer is simple. Workers – especially those on low and moderate incomes – should not be worse off as a result of being required to self-isolate. Bills, including mortgages, rent, food and repayments of loans, do not decrease simply because one is self-isolating. Without full sick pay, most people will not be in a stable enough financial position to self-isolate.

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[42] INQ000587298_0018 paras 54-56.
[43] INQ000145926_0007 para 31.
[44] INQ000535912_0006 para 9.

Mechanism for financial support

45. We say that the mechanism used to pay SSP is the best mechanism for delivery of any pandemic-specific financial support for self-isolation, for the following reasons:

    (a) **Awareness**. A fundamental issue with the schemes devised during the pandemic was that so few people who were eligible knew that the schemes existed and that they were eligible. SSP, because it exists in non-pandemic times, and does not require the worker to seek out the application, does not suffer from the same issues.

    (b) **Administrative burden.** The schemes devised during the pandemic placed enormous administrative burden on over-worked and under-resourced local authorities. There was also a significant administrative burden placed upon individual workers to make find and submit the complex applications. By contrast, processing SSP is part of the usual work of an employer and is a familiar system. Some of the additional burden, appropriately, we say, would fall upon central government.

    (c) **Immediacy.** Evidence demonstrates that workers often had to wait significant periods of time before receiving payments from the TTSPS. Payments via SSP are not retrospectively determined, nor subject to undefined delay. Rather SSP payments are paid in the same way as wages, and at the same time.

    (d) **Confidence.** Because SSP payments are made in non-pandemic times and are not subject to complex eligibility criteria, workers can have confidence that they will be eligible and that their pay will be received on time, in the usual way.

    (e) **Culture.** Because SSP is so low in the UK, there is a culture – particularly amongst those in insecure work and for whom SSP is the only sick pay they may receive – that one turns up to work however unwell they are feeling. A pandemic arriving and an ill-advertised government scheme being introduced is unlikely to reverse these entrenched cultures and behaviours. Workers in countries with healthy SSP schemes have better attitudes to assessing whether one is safe to attend the workplace.

46. For SSP to work, there are issues which must be improved in advance of a pandemic:

    (a) It should be available to all workers – approximately two million workers are currently not eligible. The lower earnings threshold should be removed.

    (b) The prohibitive three-day wait for payment should be removed.

    (c) The level of SSP in non-pandemic times should be increased to a liveable rate.

B. TTI WITHIN EDUCATION SETTINGS

47. Any strategy in a future pandemic for the TTI system will have to include a strategy for education settings. The imperative to limit restrictions on school attendance is a powerful one, but unrestricted school attendance can be a powerful vector for transmission. Important questions arise as to the extent to which TTI is a core NPI in respect of education settings and, if so, how it is implemented.

48. We are uncertain as to where in the Inquiry's modular approach this issue of NPIs in schools, including TTI, is to be grappled with. It was given some, superficial consideration in Module 2, but, in large part, was put over to future modules. Module 8 is focused heavily on the impact of the pandemic on children and young people, and it does not appear that it will include and detailed or sufficient analysis of NPIs (including TTI) in education settings. There is some

witness evidence thus far disclosed in Module 7 which grapples with the issues, but not in the detail which appears essential. The TUC is concerned that this is a critical issue which may fall between modules. Further, the Inquiry has indicated that a draft statement was provided by the Department of Education on 18 October 2024,[45] but it has not yet been disclosed to Core Participants. The evidence on this issue will therefore need to develop during public hearings.

49. In education settings in particular, there was a dire lack of pre-pandemic planning in respect of the TTI system. During the pandemic, this failure was compounded by a lack of social partnership with education unions, who were in a position to provide advice to ensure that the TTI system would be as effective as possible on the ground, and by a failure or refusal to acknowledge at an early stage in the pandemic the contribution which children mixing in education settings made to community transmission and the R-rate.[46] As is set out by Deepti Gurdasani et al. in 'Covid-19 in the UK: policy on children and schools':

> *'The enormous educational and social benefits to children from attending school, particularly those vulnerable at home,' and the initial belief that covid-19 was a mild and inconsequential disease in children led the UK governments to reopen schools as soon as possible after the initial closures. However, reopening was not accompanied by a comprehensive package of measures to protect children returning to school'*.[47]

50. Susan Acland Hood's statement on behalf of the Department for Education in Module 2 noted that a PHE paper in June 2020 stated: *'the strongest evidence of an outbreak was related to the number of new infections identified in children and working-aged people'*.[48] Similarly, the statement records that in September 2020 a paper by the Task and Finish Group on Higher Education/Further Education warned that *'there was a significant risk that Higher Education could amplify national and local transmission rates'* and that it was '*highly likely that there would be significant outbreaks associated with HE and asymptomatic transmission might make these harder to detect'*.[49] Despite these warning signs, education settings returned without sufficient TTI systems, including mass asymptomatic testing of workers and pupils/students.

51. There were significant limitations in terms of access to and availability of testing for education workers, pupils and students in September 2020 before schools returned for the Autumn term. As the report from the UK Parliament Public Accounts Committee titled 'COVID-19: Test, track and trace (part 1)' set out in March 2021:

> *'We found that NHST&T was still struggling to consistently match supply and demand for its test and trace services. In September 2020, NHST&T significantly underestimated the increase in demand for testing, when schools and universities returned. Laboratories processing community swab tests were unable to keep up with demand, leading to large backlogs, limits on the number of tests available, longer turnaround times and some people having to travel hundreds of miles to get a test'*.[50]

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[45] Module 7 – Update to Core Participants, February 2025, page 5.
[46] Draft statement of Kate Bell to Module 7, paras 36-37; para 85. *NB: despite providing a draft of our statement to the Module 7 team on 15 January 2025, we have not yet received a response from the Inquiry and, as such, our statement remains in draft format.* In respect of the evidence of the impact on community transmission, see, for example: INQ000075546_0011-0012; and INQ000350502_0021-0022.
[47] INQ000573888_0001.
[48] INQ000146054_0061 para 16.3.2.
[49] INQ000146054_0061 para 17.1.4.
[50] INQ000573909_0001.

52. In respect of implementing testing of pupils and students, Kate Bell (TUC) sets out in her evidence to Module 7 that education staff (and particularly staff in state primary and secondary schools) bore the overwhelming burden of effectively running TTI in the education sector in the absence of Government or local authority leadership.[51] The evidence shows that decision-makers recognised the value in implementing an asymptomatic testing regime, similar to that carried out in Germany, as early as June 2020.[52] However, when a scheme was devised in December 2020, not only was it delayed, but it relied significantly upon education settings planning, administering, disposing of, and recording the results of the tests – the paper from the Secretary of State for Education, titled 'Asymptomatic Testing in Schools, Colleges and Universities From January 2021' sets out:

> *'our core proposition will require asymptomatic test sites to be set up in every secondary school and college until self-administered tests become available at scale - likely to be at the end of January. This will require clear information provided to local authorities, schools and colleges in the coming days enable them to plan how to establish this. It will also require NHS Test and Trace to provide test kits, PPE, training and advice to all secondary schools and colleges on the workforce required and DfE to provide an advice line, guidance and support with implementation and delivery in the New Year* [...] *We propose to make materials and tests available to schools and colleges and strongly encourage them to deliver a testing programme'*.[53]

53. The communication to secondary schools of the plan to introduce mass asymptomatic testing occurred on the last day of term in 2020[54] and represented a significant challenge for services which were already overburdened. It was a last-minute request to public sector workers who were not trained or specialist in delivering testing regimes, in contrast, for example, to those running the pilot schemes in universities.[55] A significant burden fell upon support workers, who had already been exposed to additional risk and significant workload burdens as a result of attendance restrictions in schools and their roles in delivering education and supervision to the children of key workers.

54. That is not to undermine the importance – where asymptomatic spread is or may be occurring – of establishing mass asymptomatic testing regimes for education workers, pupils and students. Evidence showed in April 2020 that a significant proportion of transmission, especially amongst those under 20 years of age, was asymptomatic.[56] Indeed, TUC affiliated unions called for asymptomatic testing of workers, pupils and students – for example, NEU sent a letter to the Department for Education requesting this in September 2020.[57] The December 2020 paper from the Secretary of State for Education makes clear the benefits:

> *'The benefits of asymptomatic testing in schools, colleges and universities are: a. Public health - finding those with the virus and isolating them quickly to break chains of transmission of the virus among high prevalence and highly mobile groups. b. Educational - serial testing of contacts to bolster school attendance and ensure schools remain open to all year groups. This is particularly critical as it is unlikely that children or young people will be vaccinated against COVID-19 in the foreseeable future; and a. Economic - in the short term, minimising self-isolation of pupils allows parents and carers to be economically active;*

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[51] Draft statement of Kate Bell to Module 7 para 5.
[52] INQ000069655_0001.
[53] INQ000075484_0006 para 13.
[54] Draft statement of Kate Bell to Module 7 para 96.
[55] INQ000575985_ 0028-0029 para 4.6.2.
[56] INQ000573954_0007.
[57] Draft statement of Kate Bell to Module 7 para 93.

in the longer term, keeping schools open is key to developing the skills of our future workforce'.[58]

The TUC is supportive of establishing systems to test asymptomatic pupils and students, but considers that in a future pandemic government must not *'effectively pass*[…] *all the responsibility to schools and school staff'*, who are not healthcare providers and must retain the capacity to perform their primary task of delivering education to children in the challenging circumstances of a pandemic.[59]

55. The failure to plan and to use social partnership mechanisms to involve education workers in decision-making was made clear by the plethora of practical issues which arose with TTI systems in schools. For example:

    (a) There was often not adequate supply of tests distributed to schools, meaning that some pupils and students were without tests, and there was often not sufficient supplies left in schools to enable testing of children who became symptomatic during the school day.

    (b) Disposal of the tests after use in schools often fell to support staff, but clear guidance, facilities and PPE for disposal were not in place, putting support staff at additional unnecessary risk.

    (c) When contact tracing apps were deployed, education workers and especially teaching staff were instructed not to use the app on the basis that staff shortages would have been too significant if all education workers were complying with contact tracing isolation requirements. This placed education workers in an uncomfortable position.

    (d) Members of the armed forces being used to administer testing in schools was suggested, but it was unclear to education staff whether the practical ramifications, such as the need for DBS checks, had been thoroughly considered. Ultimately, this proposal was not implemented.

    (e) As was the case in other sectors, outsourced staff such as cleaners and catering staff were often not provided with full sick pay, undermining the TTI system in schools.

    The TUC considers that these examples of practical challenges and points of concern and confusion in respect of the TTI system in schools underline the need for pre-pandemic planning and for effective mechanisms of social partnership.

56. It appears from the evidence in this module that the lack of planning not only impacted upon the practical implementation of the TTI system, but also upon the scientific underpinning of the testing regime in schools:

    'Testing in school children has been introduced without evaluation. Although 'pilots' of testing in schools have been undertaken, opportunities to evaluate the accuracy of the test in children have been missed. Thus we have no data on the accuracy of the test in school aged children, and even the findings of the University testing of students has not been released by the DHSC. Now that we see it performing in unexpected ways it is essential that proper evaluations are undertaken and all data and reports are made publicly available'.[60]

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[58] INQ000075484_0001 para 1.
[59] Draft statement of Kate Bell to Module 7 para 96.
[60] INQ000575030_0002.

57. Distinct challenges arise in deploying TTI systems in SEN settings. This was the experience of members of TUC affiliated unions, and is evidenced in the disclosure to Module 7:

58. A report in January 2021 to the Secretary of State on asymptomatic testing in schools stated: *'Rough estimates suggest between 10,000-20,000 children and young people have SEND and many of these will be unable to self-swab as per the mass testing guidance'*.[61]

59. As an NHS Test and Trace paper from May 2021 sets out: *'A significant proportion of* [children with special education needs and disabilities] *are unable to be effectively tested using existing testing methods available, either due to challenges carrying out a nasal, nasopharyngeal or oropharyngeal swab, or due to the workforce needed to supervise LFDs'*.[62]

60. By the time of the July - September 2021 delivery plan, the government was still seeking capability to administer tests for children with special educational needs: *'continue to develop our national capability to provide saliva-based testing using Direct LAMP for vulnerable groups, such children with special education needs and disabilities, or prison populations'*.[63]

61. In the Covid-19 pandemic, members of TUC affiliated unions working in SEN settings found that there was often not sufficient or adequate guidance and training for TTI in these settings. This likely: contributed to the disproportionate impact of the pandemic on disabled people including disproportionate levels of closures and attendance restrictions in SEN settings; and exposed education workers in these settings to additional risk.

62. Finally, in all settings, but especially in education settings where there are children, TTI is an important part of the picture, but it must be teamed with other infection control measures. Children are less able to monitor their own symptoms and recognise the need to undertake a test or to isolate, and they are typically in close and frequent physical contact with others. To make spaces safe for children and the adults supporting them, the TTI system must be reinforced by measures such as effective ventilation. The TUC agrees with Professor Fraser: *'TTIQ is very challenging in schools due to the way in which children mix. The most effective ways of controlling infections in schools that minimise disruption to education are cohorting, air-cleaning for respiratory infections, outdoor learning and regular, possibly daily testing'*.[64]

The lessons to be learned

63. The TUC considers that the following lessons arise from the Covid-19 pandemic and ought to be considered by the Inquiry for recommendations flowing from Module 7:

    (a) Systems for testing, tracing and isolating education workers, pupils and students should be developed in social partnership with unions and other representative bodies to ensure that the system will work on the ground.

    (b) Adaptable systems for testing, tracing and isolating in education settings must be developed and planned for *in advance* of a future pandemic to ensure that the plans are considered and may be put into place at an early stage in the pandemic. This should involve appropriate levels of training and information sharing to education workers, students, pupils and parents to ensure that the systems can be rapidly deployed.

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[61] INQ000075582_0007 para 35.
[62] INQ000534469_0004-0005.
[63] INQ000520785_0011.
[64] INQ000475153_0052 para 138.

(c) Education settings should only be fully open when a properly functioning TTI system, including mass tests for workers, pupils and students, is established. This would protect health; counteract upward pressure on the R-rate; and avoid the circumstances where education provision was significantly disrupted during the pandemic by the failure to recognise the risk of transmission in education settings. With appropriate pre-pandemic planning, this need not represent a significant disruption to education provision.

(d) Workers, pupils and students should undertake testing at home, if possible, or in a testing centre/medical setting before going to an education setting. They should not be tested in education settings where they may have already spread the virus.

(e) In any pandemic, education workers must have prompt and effective access to testing – especially where the virus is known to or may be transmitted by pupils and students.

(f) Education sector workers should not hold primary responsibility for deploying TTI schemes in educational settings. It is accepted that there may be a co-ordinating or supervisory role for education settings – particularly in respect of contact tracing – but the primary function should rest with public health bodies. Where tests need to be administered to children, they should be self-administered or administered by parents at home, or by healthcare professionals.

(g) Any persons administering tests to children must be appropriately trained in administering the specific test being deployed. Wherever possible, tests administered by trained clinicians should be favoured.

(h) There should be distinct guidance and planning for TTI systems in SEN settings, due to the distinct challenges which arise.

(i) Where a virus is known to or may transmit asymptomatically, there should be promptly deployed, reliable systems for asymptomatic testing of education workers, pupils and students.

(j) TTI systems in education settings should be reinforced by appropriate access to PPE for education sector workers. Given the challenges in implementing TTI systems in schools, and the likelihood that a future pandemic will involve a level of airborne transmission, work should be done now to improve ventilation in education settings, including by installing HEPA filters as standard.

SAM JACOBS
RUBY PEACOCK
NATALIE LUCAS
Doughty Street Chambers

GERARD STILLIARD
HARRY THOMPSON
Thompsons Solicitors

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