MODULE 6
OPENING SUBMISSIONS ON BEHALF OF
THE FRONTLINE MIGRANT HEALTH WORKERS GROUP

Introduction

1. These written opening submissions focus on the impact of the pandemic on workers in the care sector performing a range of social care tasks, often personal and intimate, for the vulnerable, elderly and disabled, in a range of environments including care homes, in the community and people's homes. In particular, these submissions throw light on the effect of the structural weaknesses and fragmented character of the care sector, the consequential disproportionate impact during the pandemic on migrant care workers, the lack of measures put in place to reduce that impact and the failure to consider their situation in the core-decision making process. They conclude with preliminary recommendations that we shall expand upon in closing.

The group

2. The Frontline Migrant Health Workers Group ("**the Group**") is a collective grouping of two trade unions, United Voices of the World ("**UVW**") and Independent Workers' Union of Great Britain ("**IWGB**"), and a consortium of community organisations, Kanlungan, which is a charity consisting of several Filipino and Southeast and East Asian grassroots community organisations. The Group exists for the purpose of participating in the Covid-19 Inquiry ("**the Inquiry**").

3. UVW organises predominantly low paid, migrant & precarious workers, many of whom worked on the frontline in care homes during the pandemic as carers, cleaners, porters and kitchen staff. IWGB also organises low paid migrant workers in under-represented sectors, including representing members who work in the adult care sector. They note that almost a quarter of the national care sector workforce are from ethnic minority backgrounds, with that figure rising to around 70% in London.[1]

[1] INQ000509517, p.18

4. Between 2021 and 2022 Kanlungan supported approximately 2,081 individuals, the majority of whom were in the UK on visas which are attached either to their work (such as domestic workers and health and social care workers) or attached to their spouse/partner. However, many are undocumented. In most instances, those who had become undocumented were lawfully admitted to the UK and had previously held valid visas. Such workers were relied upon to carry out vital work during the pandemic but went unrecognised. Their precarious status left them particularly vulnerable to exploitation; one of the Group's interviewees described her experience as working in "*an underground economy*" and an "*invisible world*".

5. In general terms the Group's members primarily fall into two broad categories:

Workers in care homes, performing non-nursing care and care assistant roles.

a. The majority of the Group's members worked in homes run by private providers, working at or around the (then) national living wage of £8.72 per hour. By virtue of being poorly paid, on zero hours contracts and/or having insecure and variable shift patterns, many such workers worked across multiple care homes, often having to take public transport to travel between shifts. The Group's members in this category are predominantly from ethnic minority and migrant backgrounds.

Domestic and/or domiciliary carers.

b. As stated by the International Labour Organisation domestic workers "*provide direct and indirect care services, and as such are key members of the care economy*"[2] Domestic workers performed these care services within one or more private households. They were typically engaged either via agencies or directly by the recipients of care or their families. Much of the domestic/domiciliary work done by Filipino individuals who are represented by Kanlungan was casualised and changeable, meaning that while on some days they provided direct care to elderly, disabled or unwell family members, on others they spent their time cleaning, cooking and looking after children. They were in effect required to undertake whatever role was asked of them by their employers.

[2] INQ000506979

c. For live-in domestic carers, their living space and workspace are the same. There was nowhere to go if a member of the household contracted Covid-19. On numerous occasions domestic carers were evicted from the household when they contracted the virus, rendering them both homeless and jobless. On the other hand, we have obtained testimony from workers who were confined to one room in their employers' home after contracting Covid-19. One of the most common themes reported to Kanlungan was not getting breaks or days-off for weeks or months at a time at the beginning of the pandemic.

d. These workers are employed in some of the most invisible areas of the care sector. Demand for such forms of care work arise through the lack of universal social care. As recognised by Dame Jenny Harries, this posed serious problems for governmental management of the sector: "s*ome informal or domiciliary carers would be 'sole traders' with essentially no relationship with DHSC and potentially unrecognised in the care system as a whole*".[3]

6. Whilst in some respects the two categories are distinct, there are a number of commonalities. They all performed vital work that kept vulnerable service users safe and cared for during the most difficult periods in their lives. In exchange, they were afforded low wages, poor working conditions and employment insecurity which left them vulnerable to exploitative employment practices and impeded their ability to self-isolate and adhere to measures aimed at limiting the spread of Covid.

7. In particular, migrant workers are generally overrepresented in the lower paid jobs within the care sector, though the sector is ethnically diverse.[4] Their problems were compounded by their visa conditions and the Hostile Environment preventing them from leaving exploitative workplaces or seeking the assistance of public bodies and health providers.

8. Ultimately, the system of immigration control created an atmosphere of impunity for employers, who could afford to ignore safety standards in the knowledge that their workers were unable to leave or complain without risking a breach of their immigration conditions, placing them at risk of detention and removal. This had enormous public health implications: those who were best placed to identify what safety measures were needed were robbed of their ability to raise their concerns. Many domestic and undocumented workers were forced to stay in unsafe workplaces for fear of the alternative. The

[3] INQ000587394 para. 5.8,
[4] INQ000498610, p.101, chart 57, which shows that support and care workers have higher proportions of non-British workers. Note that Skills for Care do not analyse the sectoral overlap with domestic workers.

virus proliferated further as a result. The Group's overriding contention is that a workforce as important as this must never be left so unprotected again.

Structural issues and preparedness

9. The care sector was uniquely poorly placed to cope with the demands of the pandemic, as a result of years of underfunding. A decade of austerity prior to the pandemic had resulted in £7.7 billion in cuts being made to care budgets.[5] This underfunding led to a fragmented system of privatised providers that was ill-equipped to respond efficiently and coherently to the Covid emergency. A report from the Nuffield Trust dated November 2019 noted that the "*predominant approach used for buying services from providers incentivises organisations to provide a bare minimum of services and nothing more. Some 75% of councils report that these organisations have either closed or handed back contracts in the last 6 months, creating enormous disruption and discontinuity for those receiving care*".[6]

10. Just prior to the pandemic, underfunding had meant that providers were increasingly unable to meet the care needs of their local communities. Providers had to deal with the increasing demands of an ageing population with fewer resources.[7] The Nuffield Trust report from November 2019 added that the "*sector has high staff turnover and high vacancy rates with low pay, poor working conditions, unstable contracts (24% of the workforce are on zero-hours contracts) and the work is often perceived as low status. The organisations that provide care are already struggling to fill the posts needed just to deliver the level of service offered within our current system*".[8] These structural issues had three key implications for pandemic preparedness.

11. **First**, pay and conditions were poor across the sector. Despite there being significant demand for staff, funding constraints and decreasing profits maintained the pressure on wages (the average for those working in the private sector was around £8.79 an hour, which was around the national living wage, at the time, of £8.72,[9]) and labour conditions (around 35% of care workers were on zero-hours contracts,[10] with 56% of domiciliary carers on such contracts).[11] Whilst there is evidence that hourly

[5] INQ000514933, p.7
[6] INQ000553864, p.4
[7] INQ000506976
[8] INQ000553864, p.4
[9] INQ000509517, p.98
[10] INQ000509517, p.48
[11] INQ000509517, p.49

pay rates increased due to compliance with the National Living Wage, rates have been shown to be lower than those paid by most supermarkets.[12]

12. Crucially, there was a widespread lack of contractual sick pay, with a majority of care workers having to rely on statutory sick pay ("**SSP**") which in 2020 was set at a rate of £94.25 per week, i.e. well below the cost of living. Many domestic workers were unable to access SSP at all due to working in informal cash-in-hand or zero-hour arrangements. Consequently, many workers would have to work with multiple employers in order to survive. This rendered them more susceptible to contracting and spreading Covid-19, but also left them without readily identifiable "*employers*" who could be asked to put in place IPC measures or made accountable for breaches. Bella Ruiz, impact witness on behalf of UVW, recounted how staff members at the care home where they worked would come to work when sick without taking a Covid test. They simply could not afford to do otherwise:

> *"at this time [everyone] got very sick. Some people would say, "I feel sick, I don't know if it's Covid or not but I have to pay my bills"; "With Covid or not I have to come to work"; "I can't do the test, I don't care, I need to pay the bills, that's it". They would then infect residents and staff. On their part, management never said anything, they only said "if you feel sick, stay at home". That's all they said. They weren't really trying to find out if people were sick, they wanted us to work. They just said if you have Covid, please stay at home but they did nothing to make this possible."*

13. That care workers were amongst the lowest paid who without financial support might continue to work at risk rather than isolate for fear of loss of income is not only obvious but was specifically raised at least as early as 6 March 2020 in a meeting with the Secretary of State.[13]

14. Perhaps most unconscionably of all, this inadequate pre-pandemic position resulted in bad decisions taken during the pandemic in order to "*save face*": on 13 April 2020, minutes to the Covid-19 Strategy Ministerial Group state that a commitment to providing full-pay to care workers from day one of sickness would "*cause difficulty for the Government as it would be the first time the government acknowledged that Statutory Sick Pay (SSP) was not appropriate*".[14] The Vivaldi study subsequently

[12] INQ000518421
[13] See INQ000587394, para. 5.35, and INQ000049530.
[14] INQ000088629

proved this to have been a fatal decision, as empirical evidence of the link between a lack of adequate sick pay and the spread of the virus in care homes emerged during the summer of 2020.[15]

15. As a result, the government backtracked on this earlier decision over sick pay and used the "*Infection Control Fund*" to try and filter money down to the frontline. Instead of giving key workers a right to full pay, the government opted for a convoluted, overly-bureaucratic handout to care providers, via local authorities, using a reporting mechanism and conditionality to try and ensure the money reached key workers. But the evidence shows that monitoring and oversight were wholly inadequate: by 11 January 2021, a presentation to the Covid-O committee stated that only "*82% of respondents*" reported that they were using the fund to pay normal wages to staff isolating due to infection.[16] This self-reporting diverges from the experiences of the Group's members' experiences, as well that of the TUC's[17] and the Royal College of Nursing[18] which indicates that key workers were not getting the money they needed. As such, the government acknowledged early in the pandemic that statutory sick pay is inadequate, then failed to act on this for political reasons. They then backtracked on this after scientific advice demonstrated the importance of ensuring there were no financial penalties for being sick, but never went so far to legislate a right to full pay. This limited effort at ensuring our key workers had full pay when they sick then ended in England in March 2022,[19] leaving the care sector in the vulnerable state it started in. As our impact witness, Bella Ruiz stated to her employer when she was asked to wave for those people "*clapping for carers*", "*I don't need claps!"*[20]

16. Business leaders also promoted misplaced fears about the implications of sick pay: Melanie Weatherley MBE explains in her statement at para. 8.21 that "*providers were concerned that if sick pay was made available, staff would take time off even when they were well enough to be at work*".[21] Again, this hesitancy and business model that put profit ahead of public safety had deadly implications. It also made an assumption about a dedicated and profoundly conscientious workforce that was

[15] INQ000613177, and INQ000613177 para. 15
[16] INQ000325299, p.10
[17] INQ000525560, letter citing a survey of union members carried out between 3 April and 7 May 2021, of whom only 45% reported received full normal wages during isolation.
[18] INQ000614378, para. 31 and 32
[19] INQ000475131
[20] INQ000587716, p.6
[21] INQ000504053

unsupported by evidence but obtained traction because providers were being heard - unlike the care workers themselves.

17. **Second**, and flowing from the above lack of pay and benefits for the workforce, the sector relied heavily on migrant workers, whose position within the labour market is rendered precarious and vulnerable to exploitation by the system of immigration control. The inability of the sector to recruit and retain staff meant that understaffing remained stubborn.[22] In 2019, the UK government issued just under 23,000 Overseas Domestic Worker visas to workers temporarily accompanying their foreign national employers to the UK. About half of these six-month visas were issued to workers from the Philippines.[23] The government then developed the Health and Care Worker ("**HCW**") Visa which was launched in August 2020.[24] These workers were tied to their employer-sponsors and faced numerous barriers to obtaining fair working conditions.[25]

18. The sector also survived due to reliance on undocumented workers, often losing their status as a result of the expiry of their Overseas Domestic Worker visas which, since 2012, automatically expire after 6 months without the possibility of renewal.[26] These workers provided vital care work at the periphery of the formal system, in unregulated and under-regulated domiciliary contexts. Such workers were systematically disincentivised from accessing healthcare, as discussed further below.

19. **Third**, the sector was highly fragmented, decentralised and dependent on business models which proved to be highly ill-suited for managing a pandemic. This meant that the government's response to the pandemic was immediately hampered by the fact it had next to no direct contact or oversight with day-to-day business of care, with standards of Covid-compliance varying widely between workplaces.

20. The consequences of privatisation and fragmentation of the care sector are highlighted in the witness statement of Dame Jenny Harries: "*central government has little direct ownership of, or day-to-day formal accountability for ASC…One consequence is that while there are systems and controls in place for the quality of the service provision, the formal responsibility for management of the residential setting in a crisis, as with other businesses, lies predominantly with the business itself. This*

[22] INQ000551236 on the "*crisis of recruitment and retention*", e.g. at page 11, and the vacancy rate being "*the highest of any major industry and more than three times higher than the national average*".
[23] INQ000509513
[24] INQ000551236, p.12-13
[25] INQ000551236, p.19-39.
[26] INQ000509515 (see in particular for overview and implications for modern slavery)

fundamentally reduces the levers immediately available to government to direct and influence the ASC sector's response at pace". She goes on to express the opinion that whilst "*[i]t is an entirely political decision what the state wishes to take responsibility for at any particular timepoint and/or routinely… it is reasonable to reflect on the vulnerability of the ASC sector to serious external stressors which has been highlighted by the pandemic, as well as the difficulties in building resilience in a fragmented system consisting of many private providers. In my view the division of responsibility and the ownership of risks in respect of ASC as between providers, local government and central government needs to be given proper consideration. Similarly, those stressors, in particular the availability of and support for workforce, which is so critical for ASC delivery, are driven and enabled by many different inter-departmental decision in government*". Her conclusions are stark: "*I am not of the view, even in light of our experiences in 2020 and 2021, that the division of responsibility has been properly considered or resolved….Until such clarity on their respective responsibilities is achieved, it is likely that both providers' and Government's planning for the next crisis will be inadequate*".[27]

21. Professor Laura Shallcross's government funded work showed that the odds of infection and large outbreaks were "*significantly higher*" in care and nursing homes which were for profit.[28] This should be unsurprising given that the business model of the for-profit care sector depends on larger facilities (typically 60-99 beds) and high occupancy rates,[29] which is in notable contrast to the scientific advice that low occupancy and staff-patient ratios were required for managing the virus.[30]

22. The Group wishes to highlight in particular the failure to appreciate the sheer number of domiciliary workers within the sector. Against this backdrop of a highly dysfunctional system that depended on downward pressure on wages and inflating care costs, the natural consequence was that private domiciliary arrangements arose at the periphery of the system. For many workers within our Group, the distinction between being a domestic worker and carer is inherently blurry. These domiciliary carers worked pursuant to casualised, cash-in-hand arrangements. Whilst some were recruited to work as carers, others were recruited as domestic workers, with the expectation that cooking, cleaning and related chores would be their core duties, but were then required to provide the full range of adult

[27] INQ000587394_0059, paras. 9.1-9.3.
[28] INQ000544929, p.1, 5
[29] INQ000643493 p.52 exhibit 12
[30] INQ000544928, p.6-7

care.[31] In a roundtable with members of Kanlungan, we heard from frontline workers who, after being employed as a domestic worker, found themselves caring for sick and/or elderly clients; having to bathe and feed, give and record their medications, and check on them every few hours throughout the night. Whilst some had rewarding relationships with these individuals, the workers often had irregular migration status, which exposed them to exploitation in the form poor wages, no/few days off, and verbal abuse from their employers, such as racist comments and threats of physical harm.

23. These casual employers were able to dismiss such workers summarily or to impose a "*no work, no pay*" rule upon them. Complaining or trying to seek changes within that unregulated workplace environment was accordingly extremely risky for care workers, especially if workers risked breaching their immigration conditions if they lost their job. For live-in domestic carers, their living space and their workspace are the same, and they accordingly had nowhere to go if a member of the household contracted Covid-19.

The public health implications of structural unpreparedness

24. The exploitative employment and immigration law frameworks that existed pre-pandemic contributed heavily to the spread of Covid-19. The more precarious a worker's employment was, the less able they were to keep themselves or those they cared for safe and well. This was due to a constellation of factors inherent in such a fragmented and un/under-regulated sector resulting in the inability of workers to raise concerns with employers, to take action collectively and even to seek NHS care for themselves. The Group wishes to highlight the following points in particular.

The structure of immigration control

25. A "*no recourse to public funds*" or NRPF condition attached to a visa or residence permit is one which prevents a migrant from claiming mainstream benefits, tax credits and housing assistance. This includes, for example, free childcare or disability support in the event of a long-term condition, such as Long Covid. Many care workers are migrants on visas which are contingent on their continued employment with a specific licensed employer because they have been sponsored by social care providers. A great many others are undocumented. The upshot is this: many migrant workers were unable to seek medical assistance if they were unwell. Their inability to claim mainstream benefits

[31] INQ000614375 para. 12 explains how such duties formed part of the usual expectation of a domestic worker's role

plunged them further into poverty during desperate times, making them more likely to have to work across multiple workplaces, take public transport or live in crowded accommodation.

26. Even where medical and other services were accessible, many workers felt unable to attend them due to the distrust generated by the hostile environment, and in particular the reporting obligations on public services to the Home Office. Of those who were interviewed as part of the "*A chance to feel safe*" report who were infected by Covid-19, one in four were too scared to ask the NHS for help in case it affected their immigration status in the future.[32] The Hostile Environment's objective, of warding undocumented migrants away from using NHS services, succeeded. This inevitably resulted in the death and serious illness of many migrants during the pandemic.

27. One member of Kanlungan, a domiciliary carer described the reluctance of undocumented migrants to get vaccinated and the deadly consequences of such hesitancy:

> *"They were scared that if they went to the GP, they would get arrested, brought to a detention centre and deported. When free vaccination became available, domiciliary care workers with irregular status opted out not to be vaccinated and bought their own PPE for everyday use. At some point, I sent a message to a lady who was a previous member of FDWA to tell her that she could get a free vaccine. I found out after that she had died alone in her flat before being able to get the vaccine. Because domiciliary workers without legal status were not able to present a vaccination card, they were required to provide a negative test result every day before going to work. They had to spend £10 on testing kits every day. I told them "you are going to spend a lot of money", but they said that it was better than getting the free vaccine and running the risk of getting reported to the authorities and being deported".*

28. A further contributor to the proliferation of the disease within the sector was the imposition of strict restrictions on the HCW Visa. The sponsored worker could only work full-time for the employer stipulated in that visa (they could perform part-time work, volunteering or studying outside of this, provided they remained with that primary employer for their full-time work).[33] They had no resource to public funds, and no ability to change employer without an application to the SSHD (paying the relevant fee). If they were dismissed or resigned, they would have just 60 days to find a new sponsor

[32] INQ000235265
[33] INQ000551236

before becoming an overstayer and thereby becoming subject to the Hostile Environment. The right to withdraw was effectively nullified in this context. This led to the inevitable consequence that workers with unscrupulous or exploitative employers were left with no choice but to remain with them, even if this put themselves or recipients of care in danger.

29. Despite their immense contributions and sacrifice, once the pandemic subsided, migrant care workers did not receive the recognition they deserved. Instead, in April 2025, the government raised the minimum salary floor on the HCW Visa, and in May 2025 announced sweeping restrictions on the ability of care homes to recruit from abroad.

Safety standards

PPE

30. There were clearly significant PPE distribution problems at the outset of the pandemic, owing in large part to the fragmentation and decentralisation of the sector.[34] The contrast with the NHS was stark. Guidance and training on PPE was also too slow, and enforcement was weak. Both UVW and Kanlungan worked with individuals who were forced to make their own makeshift PPE due to the failure of their employers to provide them with it.[35] At a North London care home, UVW member workers took to making their own masks by laminating pieces of plastic, and then tying elastic that they took from their leggings to fix the plastic around their heads.[36] When they were eventually provided with masks, they were given one single-use surgical facemask for each 12-hour shift. Kanlungan reports that many employers of domestic carers simply refused to provide PPE, or were unable to source it.

31. When PPE did become available, each member of the Group noted disparities in who was given access to it: outsourced and agency workers would not be provided PPE by their direct employers, whereas employed staff would, and domestic carers would often have no recognisable employer from whom to request PPE provision – as many of the households they work in do not see themselves as employers with "normal" responsibilities towards their worker. The law at the outset of the pandemic provided that while an employer was obliged to provide PPE to employees, they were not obliged to provide it

[34] INQ000145895, p.13, "*key finding*" §19.
[35] INQ000506993
[36] INQ000587638

to "*limb b*" workers, such as agency staff and other outsourced workers (see *R (Independent Workers' Union of Great Britain v Secretary of State for Work and Pensions and another* [2020] EWHC 3039 (QB) (Admin)). This was a very significant failing in light of the preponderance of "*limb b"* workers within the sector.

Infection prevention and control

32. UVW members faced problems with training and guidance on IPC. A significant problem was poor communication in respect of outsourced workers providing cleaning services. In the latter case, workplaces were issuing instructions but were communicating with the outsourced employers rather than with the staff who were directly engaged in frontline work. Furthermore, many domiciliary carers, who provided essential care functions in private households, simply had no recognisable "*employer*" from whom they could expect training or guidance: they were required to work things out for themselves. This meant that Covid-compliance in these unregulated workplaces was hugely variable and often non-existent. These problems were compounded in the case of undocumented care workers, who could not even turn to government services for assistance.

33. The Group's members also noted that management were, disturbingly, often keen to avoid testing or checking for symptoms too closely, in order to avoid having to send workers home because they faced severe understaffing issues and the need to use relatively expensive agency workers.

Risks while at work

Sick pay

34. The obvious and foreseeable consequence of a widespread lack of contractual sick pay in the sector was that workers would be forced to attend work while potentially having Covid-19 in order to subsist. Wages at or around the national living wage meant that many workers had to work full time hours just to make ends meet - without the possibility of top up payments through 'in work' welfare benefits. When the threat of SSP loomed with bills to pay and mouths to feed, many faced the impossible choice between risking spreading the virus and falling into destitution. The upshot was that some workers,

understandably prioritising their families and survival, were forced to opt for the former.[37] Even those who remained healthy lived in constant fear of falling sick.

35. The government were plainly aware of this situation at the outset of the pandemic. As early as 3 March 2020, Matt Hancock MP expressed support for the proposal that SSP should be available from day 1 of Covid-related absences, noting that this "*only solves half the problem*".[38] Proposals followed to introduce contractual (or similar) sick pay provision for care workers:

> *"We expect local authorities to fund social care providers in a way that means that means employers can continue to pay their workers their full wages for up to [X weeks of sickness or isolation during the pandemic]. Where local authorities face particularly disproportionate costs of doing this, the Government will meet the costs centrally. [POLICY NOT AGREED WITH MINISTERS] And there this is not happening we want to know, and will work with those representing care workers to ensure there is a way that staff can flag if they are not receiving the support to which they are entitled."*[39]

36. As described above, the government felt that this would be an admission that SSP was "*inadequate*" and so it did not take the bold action that was plainly required.[40] This concern over saving face cost many lives, as the virus inevitably spread through care homes where workers were forced into work despite fearing that they had the virus. For workers who cared deeply about the care recipients and colleagues, this was a devastating position to be put in.

37. Domestic workers were in even more of a difficult situation, given that many of them worked pursuant to casualised employment not entitling them even to SSP. Many found the Self-Employment Income Support Scheme inaccessible due to having started trading after 6 April 2019. Pursuant to the "*no work, no pay*" arrangements detailed by many of the Group's interviewees, such workers could also be dismissed without notice. Camila, a domestic worker interviewed by the Group, lost her job when she contracted Covid-19 for the second time in January 2021. Although she had worked for her elderly employer conscientiously for five years and they had a close relationship, she was dismissed without notice or care for her health and wellbeing.

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[37] INQ000551236, "*being sick for too long was simply not an option*", p.29
[38] INQ000102709
[39] INQ000088388, para. 2.27
[40] INQ000088629

Unfair and/or discriminatory treatment

38. The Group notes that inadequate staffing levels had the effect that management often pressured workers to return to work before they were well enough. This had a disproportionate effect on members whose visa was tied to their job, as they reasonably feared they would lose their jobs and visa status, thus becoming subject to the hostile environment, if they refused their managers' requests. Perhaps more alarmingly, many of the Group's migrant workers reported being disproportionately allocated to high-risk areas, being asked to undertake work that their British colleagues would refuse to do. It would appear that employers were conscious of the reduced ability of migrant workers to take decisive action against their employers, and used this to force them into the riskier situations. We note that coercion is also cited in the Federation of Ethnic Minority Healthcare Organisations' witness statement,[41] citing research from Sheffield Hallam University on "*racism and the pandemic*", which also found that "*Black and Brown staff's frequent allocation to more risky spaces impacted them massively during the pandemic*".[42]

<u>Conditions outside of work raising risk of infection</u>

Movement between care settings

39. Inadequate pay, insecure contracts, and the proliferation of peripatetic agency work meant that care workers often worked across a number of workplaces. This meant that care workers frequently travelled between workplaces on public transport, and unwittingly carried the virus from one workplace to another. As explained by the Nuffield Trust: "*policies to limit movement of staff introduced in September 2020 did not adequately take account of the nature of domiciliary care, high levels of staff vacancies and the fact that, as a largely low-paid sector, many staff often work more than one job*" [INQ000506975].

Accommodation

40. Due to low wages and the Hostile Environment policies, many care workers live with other care workers in very overcrowded accommodation [Exhibit MHW/26 INQ000506980, BBC report on conditions of undocumented workers, drawing on Kanlungan's work in the sector]. This inevitably

[41] INQ000587395, para. 24
[42] INQ000643494, p.9

rendered such people more likely to catch and spread the virus within (and outside of) care homes. Further, the landlords which were willing to accommodate undocumented care workers were few and far between, meaning that workers who did find appropriate accommodation often invited other undocumented workers to live with them. This created clusters of undocumented migrants all occupying the same, small spaces, often in deprived parts of London, where NHS services were most overwhelmed and underfunded.

Access to healthcare and vaccination

41. Undocumented workers and those with limited immigration leave subject to conditions were not initially able to access the vaccine as they were excluded from NHS primary care. As recognised in the expert report for module 4, entitled "*Vaccine hesitancy and confidence during the Covid-19 pandemic*" by Prof. Heidi J. Larson, *"Although Covid-19 treatment and vaccinations were exempted from the charging provisions, ['Hostile Environment' policies which aim to make life difficult for migrants living in the UK have] fostered a pervasive sense of mistrust and suspicion toward the NHS which intensified during the pandemic because the sharing of data from the NHS to the Home Office presented as a serious risk and fear of perceived or actual immigration consequences, thereby acting as a disincentive and causing many to avoid accessing the vaccine or therapeutics".*[43]

42. Thousands of these workers carrying out vital frontline care work with vulnerable people were accordingly unable to minimise the risk of contracting and spreading Covid-19 as a result of an immigration system designed to disincentivise migrant access. The subsequent exemption of the charging regime was narrow, belated and did not exempt charges for complications arising from Covid-19 or for Long-Covid.

43. Moreover, as set out above, there was a well-founded, widespread and persistent belief among migrant workers that GP surgeries and hospitals reported individuals to the Home Office. Indeed, no firewall or mechanism was ever implemented to stop data-sharing practices during the pandemic. No other patient group, other than migrants, are subject to their data routinely being shared by the DHSC for non-clinical purposes. The Government provided links to explanatory information (which changed frequently) failed to translate into multiple key languages such Tagalog/Filipino.[44] Hence, even after

[43] INQ000474623, p.14
[44] INQ000327678

vaccine access became widespread, many undocumented workers reported being too scared to engage with the NHS at all, and as such refused to take the vaccine.

Government decision-making

44. We welcome the Inquiry's focus in this module on the decision to discharge untested patients from hospitals to care homes. Notwithstanding the scientific consensus expressed by advisers to the government,[45] the Group wishes to highlight the context to such a decision: As the Nuffield Trust's Leonora Merry and Sally Gainsbury wrote, "*austerity was a contributing factor to declining resilience in the NHS in the years leading up to the pandemic, hampering its ability to manage the shock of Covid*".[46]

45. There was also a systemic underappreciation of the care sector vis-à-vis the NHS. Due to a "*sneaky accountancy trick that redefined "health" spending as "NHS" spending from 2015*", while NHS spending was "*ringfenced*" (i.e. flatlining) during austerity, health and social care budgets were cut.[47] As explained by the Nuffield Trust: "*Adult social care voices were not sufficiently embedded in decision-making structures. This rendered social care largely invisible in the early stages of the response. While all eyes and efforts were focused on the National Health Service (NHS), social care representatives struggled to raise the profile of the sector, despite its vast scale and critical role in the pandemic*".[48]

46. Whilst it appears that subsequent enquiry suggests the precarity of the labour force may have had more to do with virulence in care homes than the discharge decision,[49] the chaos of the situation on the ground cannot neatly be explained without understanding the legacy of austerity. Around 25,000 people were discharged from NHS hospitals in England to care between 17 March and 15 April 2020. Around 5,900 care homes in England (38% of the total) reported an outbreak of Covid-19 between 9 March and 17 May.[50] As Kanlungan reported, care workers regularly told them that they felt like the "*dumping ground*".

[45] INQ000587394 para. 5.27-28
[46] INQ000506989, p.2
[47] INQ000506989, p.2-3
[48] INQ000506975, p.4
[49] INQ000587394 para. 5.27-28
[50] INQ000087234, p.6

Regulation

47. The mandate of the CQC is a substantial one. As set out in the Dash report, there "*has been an increase in the number of [adult] social care locations that CQC has the power to assess and rate over the last 5 years, with the total number increasing from around 28,500 in 2019 to around 29,300 in 2024 - a 14% increase. This is largely driven by an increase in domiciliary care providers, increasing from around 9,700 in 2019 to around 13,600 in 2024*".[51] With the outbreak of Covid-19 and the suspension of routine inspections in 2020, the number of inspections in 2020 fell by 59.5%. According to the Group's interviewees, the result was that carers "*felt like they were on their own*" with no support to promote safe practice for themselves and service users.

48. The CQC stated that although routine inspections would be suspended, they would continue to carry out inspections where there were allegations of harm, such as abuse (see the CQC's letter to adult social care providers on 16 March 2020).[52] However, the CQC's focus appears to have been on reports of harm to service users rather than staff and reaffirms the vulnerability of the Group's ability to advocate for and protect the rights of particularly vulnerable workers. The lack of oversight during the pandemic created an accountability gap that was exploited by unscrupulous employers. Whilst CQC regulatory action has dwindled, the Gangmasters and Labour Abuse Authority has reported a marked increase of severe exploitation within the care sector.[53] In addition, due to the fact that the CQC did not (and does not) regulate care provided to private individuals where those private individuals have engaged the carer (as opposed to the carer having been introduced or provided via a care provider), a key area of the adult care sector was wholly unregulated during the pandemic.

Conclusion and recommendations

49. The impacts of Covid-19 on those in the care sector reflected, and deepened, pre-existing structural inequality. Migrant and insecure workers were disproportionately affected by poor outcomes despite performing the most vital frontline services. Systemic issues that were readily identifiable before the pandemic gave rise to deep unfairness during it. This had deadly public health implications that worsened the spread of the virus and made everyone less safe.

[51] INQ000551241
[52] INQ000551248
[53] INQ000551242

50. The Group asks for recognition of these key observations through the Inquiry's focus on these less-discussed parts of the sector. It is important that this Inquiry asks why these categories of worker were so comprehensively ignored and exposed; and we ask Counsel to the Inquiry for focused questioning on the lack of consideration. An understanding and acknowledgement of the root causes is the first step to ensuring that it is not repeated.

51. The Group also seeks recommendations that could help address these fundamental problems so that such mistakes are not made again. They are set out in detail at §181 of its Rule 9 Witness Statement. We focus here on the following in particular:

    a. Urgently review the system of sick pay in the UK. Under the new government, SSP will soon be available from day one of illness. But in sectors like care where wages hover at around the minimum wage, statutory rates are simply too low. Workers are forced to choose between falling into poverty and debt or working while sick. This inevitably results in longer-term sickness implications and worse absences, both in terms of physical and mental health.

    b. Remove fees for in-country visa variation applications to move place of work or employer, thereby allowing workers to challenge exploitative conditions or to leave workplaces where they exist and easily switch to other employment in the sector. Again, given how low wages are in this sector, payment of extortionate fees to pay for a new visa application is a luxury many cannot afford. The result is the impunity of employers engaging in exploitative practices, whose lack of accountability results in poor standards being replicated in a race to the bottom.

    c. Urgently review the 'Hostile Environment' approach to immigration control. Warding undocumented workers away from public services has negative ramifications for everyone. Trust in health professionals is paramount to ensuring that people take appropriate steps to stop the spread of disease, and ensuring that misinformation is quashed. Individuals must be able to report abuse and wrongdoing without worrying about their own job security and consequent ability to remain in the country. In particular, we ask the Inquiry to recommend: (i) implementation of a "*firewall*" which prevents data-sharing between public bodies contacted for assistance and the Home Office; (ii) end the criminalisation of working while

undocumented; and (iii) support safe reporting pathways to work inspectorates, immigration enforcement and police.

d. Acknowledge, understand and address the clear adverse implications of such an insecure and exploited workforce for the success or failure of pandemic protections for the most vulnerable both in care homes and the community. Business models dependent on artificially cheap and insecure labour have no place in a resilient care sector. By extension, without universal access to social care, exploitative and unsafe business practices will emerge.

e. Acknowledge the vital work of migrant workers during the pandemic. They were disproportionately affected by the virus, and disproportionately affected by the follow-on implications, including Long Covid, poverty, insecurity and poor mental health. A workforce as important as this must never be left so unprotected again. In the current context of governmental action aimed at restricting the rights of the migrant workforce in the care sector, this inquiry provides a vital opportunity to present the role of migrant workers in this country with fairness and clarity.

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