THE UK COVID-19 INQUIRY

TRADES UNION CONGRESS:

WRITTEN OPENING FOR MODULE 6 ON THE SOCIAL CARE SECTOR

INTRODUCTION

1. This is the opening statement of the Trades Union Congress (**'the TUC'**) in Module 6 of the UK Covid-19 Inquiry. Over five million working people are members of the TUC's affiliated unions. TUC affiliated unions with a particular interest in Module 6 include UNISON, GMB, and Unite, each of which are general unions whose representation includes a substantial number of members across the social care sector. As a core participant in Module 6, 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. These submissions address: (a) the experience of care work in the pandemic; (b) structural issues affecting pandemic response, (c) supporting care workers and care safety in a pandemic, and (d) lessons to be learned.

3. Whereas we anticipate closing submissions having a greater focus on the decision making in the care sector, and the lessons to be learned, these opening submissions will focus particularly on giving voice to the experience of working in the care sector during the pandemic.

A. THE EXPERIENCE OF CARE WORK IN THE PANDEMIC

4. Front and centre of this module should be the experiences of those providing social care. The social care sector is, at its core, a social care workforce. Supporting that workforce is central to effective pandemic response and must be a focus of recommendations.

Witnessing suffering and death, and experiencing loss and grief

5. The tragic loss of life which occurred in the social care sector was a cause of significant trauma and grief for social care workers (**'SCWs'**). This is reflected in the survey responses and evidence received from SCWs by the TUC. A social care assistant in Scotland recalled that *'*[s]*taff were struggling to care for residents with the virus knowing they were not going to survive their symptoms and were possibly in pain'*.[1] Jacqueline Kitchen, a Wellbeing Co-ordinator who often covered care shifts, describes the experience of an outbreak at her care home in May of 2020 in which, at one point, 67 of 87 residents tested positive. The home lost 25 residents to Covid-19 in just three weeks. Ms Kitchen describes an occasion when five residents were at end-of-life simultaneously, and she was *'going between the rooms to check they were still breathing and were clean and comfortable, knowing each time when I left the room that next*

[1] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0014 para 67.

time I returned, they might have died'.[2] She says: *'my colleagues and I were devastated because we saw the residents as extended family, having cared for some of them for over nine years* […] *The normal process of grieving for residents was missing for staff, because it was not possible due to pandemic restrictions to attend their funerals. The last that we as care workers saw of the residents was as their body bags were zipped up and they were taken away from the care home.* [Because of the infection risk we] *were not able to hug the family members, who in many cases felt like our extended families'*.[3]

6. SCWs offered the best support they could to their service users, and the families of their service users, in novel and difficult circumstances. Ms Kitchen describes the death of a resident whose daughter was *'devastated that she couldn't hold his hand when he was dying. I sat with him on a Zoom call to his daughter and told his daughter to put her hand up to her screen, and I lifted his hand up to the screen of the iPad she was using. I said to his daughter that it was the closest thing to holding hands that I could do for her. It is a memory which has stayed with me, and which I will never forget'*.[4]

7. Similarly, Senga Walker, a Care Assistant in Scotland describes caring for residents with Covid-19 as *'a painful, defeating experience because no matter how ill they were, they could not be transferred to hospital, so there was little I could do for them other than sit with them and hold their hands. I am not a medic so I could not give them anything beyond company and making them comfortable. Family members would look through the windows outside their rooms, often when they were very unwell or dying. They were not allowed in because of the visiting restrictions. It was horrific'*.[5]

8. Another care sector worker told the TUC: *'Eventually residents caught it and it went through the home. It was very distressing looking after elderly residents who are actually dying, with blue lips and bulging eyes, trying their hardest to get air in their lungs and writhing around the bed in agony from aches and pains in joints and headaches. One of the worst parts for both staff and residents was knowing that no doctor or nurse will enter the building to administer anything to ease the pain, and them being unable to say goodbye to family. All we could do was be there for them. I had a shift where a resident was dying and she was in total distress as she knew she was dying and she could get no peace. Myself and the other member of night staff cried as there was nothing we could do except try to keep her comfortable. To watch a strong lady in her 90s die with no family or loved ones to hold their hand broke our hearts'*.[6]

Infection and deaths amongst care workers

9. The social care workforce bore a disproportionate burden in terms of infections, severe disease and death. At least 29% of social care staff were infected with Covid-19 during the first wave.[7] SCWs had a statistically higher mortality rate for deaths involving Covid-19 of *'at least 2 times larger in the social care workers compared to the population'*.[8] The risk was disproportionality higher amongst Black, Asian and Minority Ethnic SCWs.[9]

[2] INQ000614382_0008 para 29.
[3] INQ000614382_0008 paras 28-30.
[4] INQ000614382_0008 para 29.
[5] INQ000614383_0002 para 3.
[6] INQ000587381_0045-0046 para 97.1.
[7] INQ000613177_0022 para 45.
[8] INQ000553814_0033-0034 para 126.
[9] INQ000569768_0042-0043 paras 164-165.

10. These data are reflected in the experiences of the social care workforce, as reported to the TUC:

    10.1. A social care maintenance worker in the Yorkshire and Humberside region: *'People in charge working from home safe while I was working in infected rooms on Living wage. I ended up hospitalised with Covid then a week later Covid caused me to have a heart attack and have suffered from long Covid chronic fatigue syndrome ever since. It's ruined my life'*.[10]

    10.2. A care assistant in the North East: *'Staffing was a major problem as staff were obviously ill too. There was pressure from management to return to work after the obligatory ten days isolation, even if one was still unwell'*.[11]

    10.3. A carer in the East Midlands: *'I contracted Covid at the start of the pandemic from a client that had been discharged back into her home from a rehabilitation centre after being in hospital. She was not tested for Covid. Five carers who visited her all contracted Covid simultaneously'*.[12]

    10.4. A residential support officer in the Yorkshire and Humberside region: *'Staffing levels were horrendous due to staff contracting Covid-19'*.[13]

    10.5. A manager at a care home: *'*[e]*very day I sent staff home with symptoms of Covid'*.[14]

The experience of following guidance, and accessing PPE and tests

11. Workers in the social care sector reported difficulty accessing both quality PPE and Covid-19 tests. This resulted in inevitable negative impacts upon both infection prevention and control, and morale. Many care homes in the early months of the pandemic were entirely unsupported in terms of provision of and access to PPE, and numerous SCWs have recounted to the TUC how limited it was:

    11.1. A residential care worker in the South West: *'We struggled for basic gloves and aprons. We only received very basic face shields after part of the home was wiped out'*.[15]

    11.2. A residential care worker in the East Midlands: *'The PPE was poor and didn't do the job properly. Gloves kept tearing, aprons kept tearing and the masks were of poor quality'*.[16]

    11.3. A residential care worker in the North of England: *'The main issue for me personally is the real shortage of PPE, especially face masks. The staff had one mask for each day you worked. When you had a 12-hour shift, by the end your mask was no good, either the straps snapped or the lining inside came away, or both at the same time. With wearing the mask so long, little parts of the mask came away and you could breathe them in without realising you had. The masks were inferior and not fit for purpose'*.[17]

    11.4. A residential care worker in Wales: *'All these things appeared on Facebook, people making face masks. And I was literally driving around for these face masks. There's a lot of people were selling them, and I was literally going around and standing outside*

[10] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0012 para 59.
[11] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0013 para 61.
[12] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0019 para 85.
[13] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0015 para 70.
[14] INQ000587381_0055 para 97.11.
[15] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0002 para 6.
[16] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0003 para 7.
[17] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0003 para 11.

people's doors and you know, throwing the money through the door and they would throw the face mask back at me. Because we had nothing. And we had no sign of anything coming either…'.[18]

12. Others describe having access to PPE but lacking training and guidance on how to use it. A residential children's care worker in Wales recalls: *'we had no instructions for it. There was nobody coming in to support and say "right before today, we've gotta go through the proper way, procedure for putting it on." There's nothing, it was just there. You saw a mask. You saw some gloves and apron just got on to the best of your knowledge, but obviously there are ways and a certain sequence that you put these things on, so that was lacking'*.[19]

13. Poor access to PPE was a significant cause for anxiety, and workers report being infected with Covid-19 as a result. An ancillary worker in Scotland explained: '*There was no PPE at the beginning for quite some time.* [That] *had a huge impact on me and my family's physical and mental health as I caught Covid at the care home and took it home'*.[20]

14. These were not isolated experiences; a poll carried out by Survation on behalf of GMB in April 2020 found that fewer than half (47%) of all SCWs felt that they had been provided with adequate PPE to safely do their job.[21]

15. The evidence received by the TUC and its affiliated unions tallies with an Age UK report published in November 2020 which stated: *'We know from care workers' own testimonies that the lack of access to PPE has been particularly distressing for them. Some have told us how they were asked to reuse or make their own masks, and in one example take old bed sheets into their care home to be used as aprons. Carers who spoke to us felt forgotten and as if their lives and those of the people they look after were considered unimportant'*.[22]

16. Some workers describe having to source their own tests. For example, a family support officer in the North West described: *'Initially there were* [no tests] *available and it required driving over an hour to go and get a test. This was done in my own time and I was unable to claim the mileage'*.[23] Others describe difficulty persuading their employer to implement testing. For example, a support worker in the North West recalled: *'Management didn't set up testing until months after receiving the tests even though we as a team constantly kept asking to be tested'*.[24]

17. Rapidly changing, inconsistent, and difficult to access guidance compounded the stress and anxiety felt by the social care workforce, particularly in relation to PPE. A report from the Local Government Association in November 2023 noted that respondents *'consistently emphasised'* the confusing nature of the national guidance and found that three-fifths of respondents in England reported that the national IPC policies worked not very well or not at all well.[25]

18. Ms Walker explains that she found the guidance from government and from her employer to be confusing: *'it was like total panic with the rules changing all the time. You would be doing something one way, then the next day you would be told you could not do it that way anymore'*.[26] It was particularly confusing for Ms Walker because she worked for an English company, but

[18] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0002 para 4.
[19] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0002 para 5.
[20] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0003 para 10.
[21] INQ000525604_0011 para 31.
[22] INO000532614_006 para 4.
[23] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0007 para 32.
[24] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0008 para 35.
[25] INQ000400522_0060.
[26] INQ000614383_0002 para 4.

her care home was based in Scotland, which made it difficult to identify which rules and guidance applied.[27] Ms Kitchen describes the impact these difficulties had on staff: *'it created anxiety and a lack of faith in the guidance, especially amongst the staff who were trying to follow it. We would be making our best efforts to understand and follow a piece of guidance and would just have got to grips with it, when it would change to almost entirely contradict itself. It was hard to feel that our employer, or that the government, knew what was best'*.[28]

The impact of understaffing and absences

19. Due to the pre-existing staffing crisis, and the impact of workers needing to self-isolate and shield, enormous pressure was placed upon care sector workers to work additional shifts and to forego breaks and days off:

    19.1. A residential care worker at a local authority in Scotland: *'Staff quickly became exhausted, we carried out extra shifts, gave up days off to cover for staff, didn't even have our break times, so our residents didn't suffer as far as possible'*.[29]

    19.2. A community support worker in the North West: *'It was horrendous. I don't think I'll ever get over it. It was tough. People were leaving. So more work* [was] *left for the rest of us. Any annual leave was cancelled as they couldn't allow staff time off. It was mentally and physically exhausting. Words cannot express how I truly feel. I can't, and won't go through that again'*.[30]

    19.3. A supported living worker in the West Midlands: *'My manager would not approve annual leave holiday requests. When I would miss out on holiday days, they would not allow annual leave to roll over into the following year'*.[31]

20. Ms Kitchen described in her statement: *'I was working an average of 40 or 50 hours per week prior to the pandemic, but I often worked 60 or more hours during the pandemic just to cover staff shortages. This was made worse by the fact that we were not allowed to use agency staff at the time, who we would usually rely on when shortages arose. Agency workers were banned by our company because we did not know what other homes they had been to and whether they had been properly tested'*.[32] Indeed, Ms Kitchen explains that she was too tired to play with her granddaughter due to the hours she was working, which felt unfair on her granddaughter at the time, and she now feels that she missed out on quality time with her.[33] Similarly, Ms Walker described regularly working 70-hour weeks to cover understaffed shifts during the pandemic.[34]

Financial impacts

21. The burden of being overworked, traumatised and at risk of infection and severe disease was in many cases compounded by financial losses associated with working in the care sector during the pandemic.

[27] INQ000614383_0002 para 5.
[28] INQ000614382_0002 para 5.
[29] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0032 para 136.
[30] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0035 para 147.
[31] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0034 para 144.
[32] INQ000614382_0009 para 33.
[33] INQ000614382_0009 para 35.
[34] INQ000614383_0001 para 2.

22. Many SCWs lost wages as a result of self-isolation and struggled financially as a result. A residential worker in the West Midlands said: *'I live on a small amount of wages each month to cover basic items. I couldn't afford* [on sick pay] *to pay my rent and council tax. I ended up in debt'*.[35] A carer in the East Midlands described: *'The government were offering £500 help to workers off with Covid. I applied for this but was told I was not eligible as when working my income was too high to qualify. Therefore I had no funds for my mortgage, bills, nor groceries for the entire 10 days. As well as being extremely poorly I could not afford food!'*.[36] A care assistant in the North West explained: *'I tested positive and despite being fit and healthy, I felt very poorly but the fear of the virus was far worse than the physical symptoms. Also, I had to have two weeks off from work, unpaid which was very stressful as I am a single mother to a disabled adult and any little savings I had quickly vanished'*.[37]

23. Despite the Adult Social Care Infection Control Fund (**'ASCICF'**), many SCWs were not paid full wages when required to self-isolate. For example, an employee of a not-for-profit in the North of England was told *'that there was a certain amount of money allocated to each company so once it was used up staff needing to isolate lost out financially'*.[38] A SCW in the North West explained: *'There seemed to be confusion [about sick pay] so we didn't get it. Staff complained but got nothing and because of this staff still came in if they were sick'*.[39] Others found that their employers were reluctant to or refused to pay them from the ASCICF: *'Work told me I didn't qualify for payment but I knew I did. I continued to push for my payment and they finally did pay me but still managed not to pay the full amount'*.[40] Indeed, a UNISON survey carried out in July 2020 found that more than half (52%) of its members were being paid less than £100 a week – with one in 12 (8%) being paid nothing at all – when they needed to shield or self-isolate.[41]

24. The result was that many workers were attending work even when they were ill, or should have been self-isolating, because they could not afford to lose wages. In some cases, this was because SCWs did not have company sick pay, so were reliant on SSP (if they qualified for it). A care worker in the West Midlands said: *'We didn't get paid if we had Covid.* […] *people that needed the money to survive were tempted to come to work even knowing they had covid because they had bills to pay'*.[42] In other cases, SCWs were only paid their contracted hours when self-isolating, which could potentially amount to a significant drop in earnings. A SCW in Wales explained: *'People were going to work with COVID because they couldn't afford not to... Care workers can't survive on their basic contract pay. It's why everybody works ridiculous hours. And of course, you live according to what you're getting, don't you? So all of a sudden you're going from 60 hours a week down to a basic 35-hour contract on minimum wage'*.[43] Indeed, a GMB survey carried out in July 2020 showed that 81% of respondents across the UK would be forced into work if they became ill on SSP.[44]

25. For some workers, income was reduced as a result of being unable to undertake the same volume of work as prior to the pandemic. For example, a hospice worker in the South East explained: *'Most of our patients were frightened of us carrying covid which had an impact on*

[35] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0026 para 110.
[36] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0027 para 116.
[37] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0018 para 84.
[38] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0025 para 106.
[39] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0026 para 111.
[40] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0025 para 107.
[41] INQ000339425_0001 para 1 and INQ000339425_0002 para 7.
[42] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0024 para 101.
[43] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0023 para 98.
[44] INQ000587381_0025 para 53.

our workload, which resulted in all of us losing a great amount of income as we only got paid for the patients we visited'.[45]

Movement of staff between care homes

26. On 15 May 2020, the Government announced the Care Home Support Package which recommended that care homes restrict staff working in more than one care home. This package was supported by the ASCICF. [46]

27. For many SCWs, it was not possible to comply with this policy. Pressure from employers to continue to work in multiple settings was a key feature. A care worker in a children's residential home in Scotland explained: *'They made us work between multiple care homes while on shift and refused to listen to concerns, telling me "Get on with it, it is your job"'.*[47] Similarly, in the case of domiciliary workers, visiting multiple sites in a day is part of their job. A homecare worker for a private company in the East of England visited a minimum of 10 service users per day, but *'No boundaries were expected by my employer* [we were] *just expected to carry on as normal'.*[48]

28. Financial pressures similarly meant that many SCWs did not feel able to constrain their work to one setting. A cook in a private residential care home in the North West of England explains: '*I was employed to manage the three kitchens and missing work meant I was not going to have enough money to pay my bills'*.[49] A local authority family solutions worker in the South East of England faced similar difficulties and continued to work across multiple sites due to financial pressure: *'I cannot afford to lose work and cannot afford to reduce my hours so continued to work with families even when I knew I was at risk'.*[50] Consequently, workers were often forced to choose between ensuring regular income and balancing the risk to themselves and their families by working across multiple sites. A care home worker for a local authority in Wales recalls: *'Initially, I was reluctant to put my wife at risk, as she has many health issues, but I was told by my senior manager that if I refused to work, I would not be paid, which obviously was a stressor'.* [51]

The impact of the vaccination as a condition of deployment policy

29. The vaccination as a condition of deployment (**'VCOD'**) policy, which was introduced in July 2021 and enforced from November 2021, required workers in adult social care residential settings to be fully vaccinated. As Christina McAnea, Rachel Harrison and Dominic Hook (TUC) explain: *'When introduced, mandatory vaccination became a huge distraction to a sector that needed to concentrate on persuasion and reassurance. It exacerbated staffing shortages and lowered workforce moral at the worst possible time'*.[52]

30. Workers describe the vaccine mandate as being '*pressurised*', '*forced*' and '*like blackmail*'.[53] This damaged already waning morale and reduced trust between workers, their employers and government. A residential care worker in the Yorkshire and Humberside region said: *'It felt like*

[45] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0022 para 94.
[46] INQ000587746_0035 para 153.
[47] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0022 para 97.
[48] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0022 para 95.
[49] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0021 para 89.
[50] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0021 para 90.
[51] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0021 para 92.
[52] INQ000587381_0028 para 63.
[53] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0027 paras 117 and 118.

the government was giving the care sector another kick in the teeth'.[54] A residential care worker in the North of England described: *'It felt like a betrayal, like we were useless, and incapable of keeping the people we support safe'*.[55]

31. SCWs also note that colleagues being dismissed who refused to get the vaccine worsened already difficult staffing pressures. For example, a residential care worker in the East of England explained: *'We lost a few good workers who chose not to be vaccinated which meant we had to work short staffed and in turn this created a lot of pressure on those that remained'*.[56] A healthcare support worker recalled: *'It made a lot of my colleagues leave their positions which put extra strain on the service at an already challenging time. We had to work longer hours without much time off to see our families'*.[57]

32. Ms Walker was dismissed due to her refusal to be vaccinated. She describes: *'I have lost my job which I loved and dedicated myself to for over 17 years. That care home was the job where I have been happiest, and it has been dire ever since. I worked there for 21 years, and I stayed throughout three different companies owning the care home. That the pandemic meant I was forced out of my job continues to hurt me to this day. I feel that my life has been ruined by what happened with the mandatory vaccination policy, and losing my job'*.[58]

33. A support worker told the TUC: *'When the vaccine was announced, I was really concerned because I researched it and found out it could cause blood clots. I have a family history of blood clots and members of my family have died as a result. When the vaccine became mandatory for people in my profession, I was dismayed.* […] *I was dismissed because of my refusal to have the vaccine. I had a breakdown. Luckily, I had my family around me but I had to leave work for three months because I was so depressed. I lost a lot of weight and it was a really dark period for me'*.[59]

The experience of working in the 'Cinderella service'

34. As in the TUC's opening statement to Module 1: *'The Inquiry will see a powerful theme emerge, which we say underpins the forementioned challenges: that the Government has repeatedly undervalued and de-prioritised the social care sector, to the extent that it has become widely known as the 'Cinderella service'*.[60] That theme played out during the Covid-19 pandemic. PPE was an area where the contrast was particularly strong. Both domiciliary care and care homes experienced extensive challenges in sourcing PPE. Between 20 March and 31 July 2020, only 14% of nationally distributed PPE items were distributed to social care providers which accounted for only 10% of what was needed by social care. In contrast, 80% of NHS PPE needs were met.[61]

35. The lack of parity between the NHS and social care sector in respect of PPE is reflected in the survey responses provided to the TUC which include:

[54] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0030 para 128.
[55] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0030 para 130.
[56] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0028 para 119.
[57] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0029 para 124.
[58] INQ000614383_0007 para 29.
[59] INQ000587381_0053-0054 para 97.7.
[60] Page 10, para 36.
[61] INQ000509894_0021, para 8.4.1.

35.1. *'There was no guidance with what we should be wearing. We all knew the NHS had shields and visors and were wearing PPE from head to toe. All we had were gloves and aprons'*.[62]

35.2. '*we were told by paramedics who came in their space suits that our PPE was insufficient'*.[63]

35.3. *'As we were private, nobody would issue us with PPE, the NHS were the priority'*.[64]

36. An adult social care inspector in the North West witnessed during inspections: *'Care homes had insufficient gloves, aprons and visors at the start because they were all going to the NHS. Social care was a complete afterthought which is disgusting'*.[65]

37. It was not only PPE which this affected; it was felt that the undervaluing of the social care sector permeated government announcements, guidance and support available to workers, and the response of the public to the pandemic. Professor Dame Jenny Harries (UKHSA) correctly noted *'a perception amongst care staff and organisations that they were not being recognised and this was something reinforced by them not being mentioned in press statements, Ministerial announcements or even public expressions of thanks. Often the focus was on the NHS and there was a risk of minimising the contribution of the ASC sector'*.[66]

Impacts on wellbeing and mental health

38. The combined effects of witnessing the suffering and deaths of service users and the personal risk to health, against the myriad of challenges in working conditions, resulted in SCWs suffering significant impacts on their mental health. Survey respondents described *'the most stressful period of work I have ever experienced'*, *'extreme stress'*, being *'stressed with the constant worry of coming into contact with staff or the general public'*, a *'terrible stressful experience'*, an *'extremely stressful, depressing, anxious time'*, and that *'stress was horrific'*.[67]

39. Exhaustion and burn out were a significant theme in the survey responses received by the TUC. A care home manager in the North of England described that the pandemic: *'led to me having burn out and work-related stress, which triggered my depression that is normally managed well'*.[68] A community support worker in the North West explained: *'It was mentally and physically exhausting* […] *I can't, and won't go through that again'*.[69]

40. Ms Kitchen explained that she moved away from direct provision of care as a result of her experiences: *'My colleagues and I were experiencing burn out and constant exhaustion, as well as grief and trauma from our experiences caring for residents who had Covid-19.* […] *Towards the end of the pandemic, two of the staff in the kitchen left and I went to work full time in the kitchen as I found that felt easier and safer. I recognise now that the impact of what happened through Covid-19 was a big part of my decision to move away from offering direct care. I have not done a care shift since* […] *I still struggle with the memories of the residents. It affected me*

[62] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0005 para 19.
[63] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0006 para 25.
[64] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0006 para 27.
[65] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0014 para 65.
[66] INQ000587394_0031 para 5.51. See similarly, evidence of Melanie Weatherley MBE (Care Association Alliance), INQ000504053_0013-0014, para 4.13 and evidence of Cathryn Lee (Alzheimer's Society), INQ000498137_0017, para 5.15.
[67] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0032-0034.
[68] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0033 para 143.
[69] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0035 para 147.

deeply'.[70] Similarly, a care home manager in Northern Ireland described leaving their role: *'Working during Covid was one of the worst experiences in my career, so horrendous I left working in care'*.[71]

41. A homecare worker in Scotland also described the lasting impact of the pandemic on them: *'Working during the pandemic was terrifying! As a home carer I visited up to 18 different houses a day… The homes we visited consistently broke the rules. On one of my visits there were five different households visiting my client. When I called the office I was told to just get on with it, that it wasn't my business that the rules were being broken. The streets were empty it was terrifying! It was also stressful thinking I might pass on Covid to a client and they die. We had no support as all managers worked from home and didn't answer calls when we needed them. We got no emotional support during or after the pandemic. These feelings of being a lamb to the slaughter will never leave me'*.[72]

42. These survey responses reflect the general picture across the sector. A GMB survey of 1,200 SCWs carried out between December 2020 and January 2021 found that 75% reported that their work during the pandemic had had a serious negative impact on their mental health.[73] A UNISON survey in November 2021 of over 1,600 SCWs found that: *'67% of staff were thinking of leaving social care, with the most common reason being burnout, stress and mental health and wellbeing'*.[74]

43. It is clear that many SCWs will continue to experience ill mental health as a result of their experiences during the pandemic. Andrew Knight (Care UK) notes in his witness statement that: *'The impact of the pandemic on Care UK's workforce cannot be underestimated. Care UK colleagues have recounted experiences consistent with varying degrees of post-traumatic stress following the pandemic. Care UK understands this to be a delayed reaction to the trauma experienced, the higher than ever number of resident deaths and the challenging circumstances in which they continued to work'*.[75]

B. THE STRUCTURAL ISSUES AFFECTING PANDEMIC RESPONSE

Fragmentation

44. In Module 1, the TUC described a complex interconnected diagram said to depict the UK's pandemic preparedness structures as *'more like a bowl of spaghetti than a clear and coordinated framework'*.[76] If it were possible to depict the social care sector in a diagram, it would be similarly labyrinthine in appearance. And the abject lack of data on the sector is such that it would, in any event, be incomplete.

45. In February 2021, the Department for Health and Social Care set out that the social care workforce is comprised of *'around 1.5 million people working across 38,000 settings'*.[77] However, as Matt Hancock confirmed in Module 1, at the outset of the pandemic the Department

[70] INQ000614382_0009 paras 34, 36 and 37.
[71] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0034 para 146.
[72] Supplementary witness Statement of Kate Bell to Module 6, INQ000587821_0013 para 62.
[73] INQ000525594.
[74] INQ000587381_0035 para 84.
[75] INQ000569774_0013 para 6.2.
[76] Sam Jacobs 13 June 2023 135/20-24.
[77] INQ000058216_0036.

of Health and Social Care did not know how many care homes were operating in the UK, let alone have a list of all of the providers of social care.[78]

46. As the King's Fund have explained: '*adult social care is mind-blowingly complex* [...] *It has a hugely tangled mix of public and private funding, of fees and of top-up charges, and of what is known as 'self-funding'* […] *It is an equally tangled mix of mainly private but also some public provision'*.[79] Concrete reform is long awaited in the sector: *'There have been four independent reviews, five consultations and seven government policy papers focused on social care in the last 20 years without a meaningful change to the system'*.[80]

47. Fragmentation hamstrung the response of the sector to the pandemic. A rapid, co-ordinated response was not possible in circumstances that the responsible department did not know the settings or workers it needed to consider and to communicate with. Greater insight into the sector and better data *'could have made the difference between rapid, effective responses and the high rates of infection and mortality that have been the hallmark of covid-19'*.[81] Furthermore, the fragmentation in the sector has long undermined the capacity for greater unity and co-ordination between the health and social care sectors – a report from the National Audit Office in 2020 set out that successive efforts to integrate the two sectors have come to nothing, and the sector entered the pandemic with meaningful integration *'still to occur'*.[82]

Poor capacity and resilience, and insecurity of work

48. As we heard in Module 1, the social care sector came into the pandemic in a poor state in terms of capacity and resilience. A report from the Local Government Association in 2023 found: *'Councils reported considerable difficulties in the adult social care sector prior to the pandemic. Over a fifth of respondents said that the capacity and/or resilience of the adult social care sector in their area were not very good or not good at all, whilst 95 per cent of these cited workforce recruitment difficulties, 93 per cent cited funding pressures, and 93 per cent cited a rising demand for adult social care services'*.[83]

49. A core and significant issue was (and remains) the understaffing crisis – the sector came into the pandemic with around 120,000 vacancies and high staff turnover.[84] As the King's Fund sets out, understaffing undermines the provision and quality of care: '*The vacancy rate is an important indicator of providers' capacity to deliver social care services. Staffing also affects quality: higher staff-to-bed ratios in care homes correlate with higher Care Quality Commission (COC) ratings'*.[85] Similarly, a report in 2019 from Incisive Health found that a lack of specialist SCWs was limiting the provision of social care – finding, for example, that in Devon there were cases of care homes reducing their bed capacity due to understaffing.[86]

50. As ADASS has highlighted, the understaffing crisis is primarily an issue of underfunding – '*there is only so much that can be achieved by other initiatives when the social care workforce is amongst the lowest paid in the economy'*.[87] Indeed, Matt Hancock set out in a letter in 2020 that: *'we must not lose sight of the long term issues around pay and financial reward in the*

[78] Matt Hancock 27 June 2023 46/23-24.
[79] INQ000498620_0008.
[80] INQ000502188_0003.
[81] INQ000051030_0001.
[82] INQ000114319_0006.
[83] INQ000400522_0005.
[84] INQ000106404_0003.
[85] INQ000498616_0027.
[86] INQ000502188_0005.
[87] INQ000080753_0006.

social care sector, including how they relate to recruitment, retention, and building the workforce needed to deliver on the Government's promise to fix the social care system'.[88]

51. Despite significant issues with understaffing, the sector has received very little attention from the Department for Health and Social Care. As both the National Audit Office and Incisive Health have highlighted: '*it is hard to identify tangible activities the Department has taken to support a sustainable social care workforce. In fact, the Draft health and care workforce strategy for England to 2027 1 published in March 2018, contained only six pages on social care out of 142. Social care has no equivalent to Health Education England with a statutory duty to direct training and workforce planning, and the Department does not have the ability to set pay rates and conditions for social care workers, as it does for NHS workers'*.[89] The understaffing crisis in the sector has worsened with very little practical implementation or change for several decades.

52. Low pay, coupled with other features of insecure work, contribute to the vacancies and turn over in the sector. Research from Skills for Care suggests that the following five factors are key to retaining adult social care staff:

> *'• Being paid more than the minimum wage • Not being on a zero-hours contract • Being able to work full time • Being able to access training • Having a relevant qualification. Where none of these factors apply, care workers are more than twice as likely to leave their jobs than when all five factors apply - a 48.7% turnover rate compared with 20.6%'*.[90]

53. However, zero-hours contracts are common in the sector: in 2019, Skills for Care found that around a quarter of the workforce were recorded as being on zero-hours contracts, with that figure being even higher (43%) within domiciliary care services, especially amongst SCWs, for whom it was 58%.[91] In the same report, Skills for Care found that around half of direct care-providing adult social care staff did not hold a relevant qualification.[92]

54. Another significant feature of insecure work in the sector relates to the reliance of it upon migrant workers. As a result of the understaffing crisis in the sector, employers have invested in international recruitment to meet demand. In 2019, approximately 16 per cent of the workforce had a nationality other than British (with 8 per cent having an EU nationality and 9 per cent having a non-EU nationality).[93] For migrant workers, the features of insecure work described above are often reinforced by exclusionary migration policies, hostile social environments[94] and additional layers of insecurity created by employers' roles in relation to the migration status of their employees; issues that are highlighted by the Frontline Migrant Health Workers Group.[95]

55. The social care sector therefore entered the pandemic with significant vacancies, high reliance on agency staff and migrant workers engaged on poor working terms and conditions, and on a wider workforce which is underpaid, undervalued, and overworked. Those features lead not only to economic vulnerability; they are well recognised determinants of health and health inequality.

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[88] INQ000051125_0001.
[89] INQ000502188_0017.
[90] INQ000498610_0004.
[91] INQ000103564_0009.
[92] INQ000103564_0013.
[93] INQ000103564_0010.
[94] INQ000049319_0001.
[95] INQ000474919_0011 para 28.

Structural racism

56. Research conducted by Skills for Care in 2020 similarly found that the major challenge cited by respondents was *'racism from and within organisations, management and peers, we well as racism from service users'*.[96] One feature of structural racism is that Black, Asian and Minority Ethnic workers in the social care sector face disproportionate levels of bullying, harassment and discrimination. UNISON conducted a survey in 2021 of Black, Asian and Minority Ethnic members in social care which found that almost half (46 per cent) of respondents had experienced racism or discrimination in the past year.[97]

57. Despite strong representation of Black, Asian and Minority Ethnic workers in the social care sector as a whole, Black, Asian and Minority Ethnic workers are typically overrepresented within lower-paid and insecure roles, without good representation at management level. As Tricia Pereira (FEMHO) set out in her witness statement: *'Although 32% of the adult social care workforce are from Black, Asian or Minority Ethnic backgrounds [TP/01 - INQ000572390], the leadership and managerial levels remain overwhelmingly white. This imbalance in leadership has had long-standing consequences on policy and decision-making'*.[98] Skills for Care reports that in 2024, 38 per cent of SCWs were Black, Asian or Minority Ethnic, whereas only 19 per cent of senior management roles were occupied by Black, Asian or Minority Ethnic workers.[99] This was a key concern reported in the research by Skills for Care in 2020[100] and is reflected in a response received to UNISON's survey: *'All the managers are white, the support workers are Black. It's absurd during training or meetings because the divide is obvious. There's not a single Black member in management'*.[101]

58. The DHSC Covid-19 Taskforce BAME Advisory Group reported in 2020 that Black, Asian and Minority Ethnic workers were more likely to report poor access to PPE and to experience unfair treatment because of their ethnicity.[102] The survey by UNISON also found that 40 per cent of Black, Asian and Minority Ethnic workers had not felt able to report concerns regarding infection control and safety with their managers or employers. Similarly, a report from the First Minister's BAME COVID-19 Advisory Group in Wales noted that Black, Asian and Minority Ethnic workers may face bullying and microaggression regarding PPE availability.[103]

Consequences

59. As Christina McAnea, Rachel Harrison and Dominic Hook (TUC) explain:

> *'The weaknesses of the care sector were well known before the pandemic hit. Anyone with even a passing knowledge of the sector should have realised that it needed an urgent, nationally coordinated interventionist approach to ensure the safety of care recipients and care workers. Instead, the Government's lack of understanding of the sector led to its inaction and then, when it did act, several damaging and ineffective interventions, which were inadequate, light-touch or outright punitive towards care workers'*.[104]

[96] INQ000542991_0001.
[97] INQ000339477_0007 para 2.9.
[98] INQ000587395_0005 para 15.
[99] INQ000572390_0081 Table 9.
[100] INQ000542991_0001.
[101] INQ000339477_0007 para 2.9.
[102] INQ000543049_0067 para 306.
[103] INQ000082919_0016.
[104] INQ000587381_0003.

60. The consequences for the workforce, as detailed above, were profound. The impacts upon recruitment and retention are still being felt and will continue to impact the sector and those in receipt of social care for many years. Moreover, the loss of life, both in the workforce and amongst those in receipt of social care, is a tragic and direct consequence of the structural inadequacies. The Joint Intelligence Organisation and Foreign & Commonwealth Office in a report on the impact of Covid-19 in the care home sector found that deaths of care home residents from non-Covid-19 causes likely increased due to shortfalls in medical care and the pre-existing staff shortages which were exacerbated by the Covid-19 pandemic.[105] The findings and recommendations in this module must not shy away from the dire circumstances which the social care sector found itself at the outset of the pandemic, nor the necessity for significant and wholesale reform.

C. SUPPORTING CARE WORKERS AND ENSURING SAFETY IN CARE SETTINGS

61. We seek to identify some of the key issues which warrant focus during public hearings in Module 6, and upon which recommendations flowing from this module – particularly in relation to the position of those who work in the care sector – ought to focus.

IPC controls including guidance and PPE

62. Poor access to adequate and effective IPC controls, including PPE and testing, and rapidly changing guidance, as is set out at paragraphs 11 to 18 above, had a dual negative impact upon the workforce: increased transmission of Covid-19 in the social care sector; and elevated levels of stress, anxiety and burnout.

63. This is an area which evidently needs improvement in advance of a future pandemic, and which pandemic planning must take greater account of. However, effective support for IPC controls and PPE, across the sector, will inevitably be limited if the sector remains similarly fragmented. As recognised in the Module 1 Report: *'The Inquiry also heard that there were severe staff shortages and that a significant amount of the hospital infrastructure was not fit for purpose. England's social care sector faced similar issues. This combination of factors had a directly negative impact on infection control measures'*.[106]

Financial support

64. As at paragraphs 21 to 25 above, the pandemic had significant financial impacts for care sector workers, most prominently in terms of lost wages as a result of being required to self-isolate. The ASCICF was introduced in May 2020 and was paid to employers in two tranches. A pre-requisite of the funding was that 75% of the grant must be allocated to specific measures, but these measures were relatively broad and included paying staff full wages whilst required to isolate, ensuring staff only work in one care home, supporting recruitment of additional staff, cohorting staff, limiting use of public transport, and providing accommodation to staff.[107] This left significant discretion to employers, and there was little to no monitoring of whether funds were actually reaching the staff they were intended to support.

[105] INQ000109395_0002.
[106] Module 1 Report, page 122.
[107] See: https://www.gov.uk/government/publications/adult-social-care-infection-control-fund/about-the-adult-social-care-infection-control-fund.

65. Christina McAnea, Rachel Harrison and Dominic Hook (TUC) explained that the ASCICF *'transferred large amounts of public money to independent care providers without achieving its central objective of paying care workers full and normal wages for periods of self-isolation. The sector paid a heavy price for this failure'*.[108] We adopt our closing submissions on the topic in Module 2, which set out that: only 25% of employers were paying staff who needed to self-isolate their full wages in October 2020, five months after the scheme was introduced; some homes had refused to sign up to the ASCICF because they feared setting a precedent of paying full sick pay beyond the pandemic; and that DHSC did not have the ability to check whether care home staff who tested positive in the weekly testing programme were being paid their full wages.[109]

66. In a future pandemic, adequate funding must be provided, or presenteeism will persist, with inevitable impacts upon IPC and the vulnerability of the workforce. The deficiencies of the ASCICF will not be capable of being avoided without a less fragmented sector, with greater centralised knowledge, strategy and oversight.

Regulation

67. The CQC, Care Inspectorate Wales, Care Inspectorate (Scotland), and the RQIA ceased almost all inspections of care settings during the first wave of the pandemic. This left the sector without important regulatory intervention at a time when guidance was complex and changing rapidly, when risk had increased dramatically in care settings to both recipients of care and the workforce, and when the evidence suggests that breaches of health and safety protections were commonplace. For a precarious, low paid workforce external intervention in health and safety standards is particularly key. The following witness evidence to this module sets out the negative impacts of the inspectorates' changes to working patterns and inspection regimes:

68. Natalie Magee (The Belfast Health and Social Care Trust): *'The Trust was not consulted on the decision to stand down regulatory inspections.* […] *absence of onsite visits from Trust staff and RQIA created significant challenges with maintaining oversight of the quality and safety of care in care homes and the early identification of risk, particularly during the first wave of the pandemic'*.[110]

69. Paul Featherstone (The National Association of Care and Support Workers): *'The oversight role of the inspection regimes was less effective without routine in-person monitoring of care homes, particularly where effective IPC practices within care homes were paramount to the safety of the residents'*.[111]

70. Julia Jones, Helen Wildbore and Rachel Power (John's Campaign, Care Rights UK and the Patients Association): *'We and those we supported felt that the CQC abdicated responsibility during the pandemic and that oversight and regulation were lacking.* […] *We were disappointed at the failure to recognise that oversight and regulation were more important than ever and felt that once again those needing care were abandoned in the name of infection control (i.e. because there were some risks in carrying out inspections, they were abandoned altogether)'*.[112]

71. Rachel Harvey (Care UK): '*Care UK did not get any support from the Care Quality Commission, Care Inspectorate or Care Inspectorate Wales. Regulatory inspections and usual provider*

[108] INQ000587381_0003 para 5.
[109] TUC closing submissions in Module 2, paras 58-61.
[110] INQ000586007_0082 para 387.
[111] INQ000569768_0042 para 160.
[112] INQ000514104_0097 para 250.

meetings ceased and there was only very limited communication received from the regulators, often just the onward circulation of DHSC guidance'.[113]

72. The HSE is the primary workforce regulator in the adult social care sector as is set out in the memorandum of understanding between the HSE and CQC.[114] Prior to the pandemic, as with the health care sector, the HSE played a minor role in carrying out inspection activity in the social care sector. As we set out in submissions to Module 3, the inspection regime of the HSE is targeted according to risk and inspections typically target high risk sectors and activities where the risks are least well-controlled.[115] In non-pandemic times, this means that the HSE's focus of inspection activity is typically upon sectors such as manufacturing and recycling. The social care sector, like the health care sector, is not generally considered 'high risk' because of higher levels of compliance with health and safety laws and frameworks typically mean that the risks are comparatively well-controlled.[116] There is no issue with this approach in principle. However, in the pandemic it quickly became clear that the social care workforce was at significantly increased risk due to the level of hospitalisations, transmission and outbreaks in the sector. In those circumstances, the TUC considers that the HSE ought to have pivoted its focus to include the social care sector, substantially increasing its proactive inspection regime. As Kevin Rowan explained in oral evidence in Module 3:

> *'I think this was especially evident when we were hearing about failings around protective equipment, any logical assessment would identify that relatively early as a potentially high-risk environment, and that should have, in my view, led to a review of the Health and Safety Executive's regulatory priorities. It's a very effective organisation in high-risk sectors. What my concern is that it didn't pivot to treat the healthcare sector as a high-risk sector'*.[117]

We say that the same ought to have occurred in respect of the social care sector, particularly taking into account the vulnerability and precarity of its workforce. Indeed, in respect of the low level of inspections in the healthcare sector during the pandemic, Richard Brunt (HSE) accepted in Module 3 that learning would need to be taken into account in a future pandemic.[118]

73. Ultimately, there was a dearth in the social care sector, of regulation, inspection and the support which consistent intervention from a regulator can offer. As at paragraphs 11 to 18 above, SCWs in many cases had poor access to basic IPC controls and faced barriers in respect of accessing and interpreting the guidance; greater support and intervention by the regulator, including by way of inspections, ought to have been in place in order to make record of and act upon unsafe working conditions.

Vaccination as a condition of deployment

74. Significant worker testimony, as at paragraphs 29 to 33 above, demonstrates the managing effects of the VCOD policy upon the workforce, both in terms of trust and morale, and in terms of the understaffing crisis and retention of the workforce. As Professor Heidi Larson, the Inquiry's expert on vaccine hesitancy, set out in evidence in Module 4: *'there's quite a bit of*

[113] INQ000569775_0010 para 53.
[114] INQ000101585_0002 paras 5-7.
[115] INQ000347822_0021 para 85. Please also see TUC closing submissions in Module 3 at paras 92-97.
[116] INQ000474291_0003 para 9 and Kevin Rowan 16 September 2024 14/15-15/14.
[117] Kevin Rowan 16 September 2024 14/15-15/14.
[118] Richard Brunt 12 September 2024 123/6-20.

evidence that these requirements, in the short-term, increased uptake, but in the long-term was a trust breaker'.[119]

75. As we set out in our closing submissions to Module 3:

> *'Proponents of the policy say that the risk benefit analysis falls in favour of the policy because the issue is one of saving lives.*[120] *But that misses the point. Increasing vaccination uptake in the healthcare workforce is critical – but this can be achieved through methods of provision of information and access, support and encouragement. The TUC considers that it can be achieved as, if not more, effectively (in terms of impact on vaccination rates amongst workers) and with less damage to relationships, trust and confidence by deploying other methods.* […] *It should be a measure of last resort, balanced against the results of consultation and a risk-benefit analysis which takes into account factors such as the characteristics of the virus, the efficacy of the vaccine against transmission, and the stage of the pandemic. The same over-zealous 'stick before carrot' approach criticised in the TUC's closing statement in Module 2,*[121] *also impacted upon the decision to introduce VCOD, despite the strong evidence provided against the policy in the government consultation'*.[122]

Movement of staff between care homes

76. Movement of staff between care homes introduces significant infection risk. The conclusions of the Vivaldi study included that: *'*[w]*orking across multiple sites is a strong risk factor for infection in staff'*;[123] and *'*[r]*egular use of bank staff is an important risk factor for infection in residents and staff'*.[124] The Vivaldi study showed that homes were more than twice as likely to have had an outbreak if there was staff movement compared with those with none.[125] Similarly, a study of care homes in London found that Covid-19 positivity was significantly higher among staff working across different care homes than those who were working in one care home.[126]

77. A significant proportion of the movement of staff in the sector is caused by the understaffing crisis and the related reliance on agency and bank workers. Similarly, the poor terms and conditions in the sector have meant that many workers have more than one job in order to work a full week and make ends meet. A report of the Covid-19 International Comparators Joint Unit of the Joint Intelligence Organisation concluded: *'Long-term staffing shortages (exacerbated by Covid-19) and low pay in the care sector have created conditions that likely increase transmission of the disease into and between care homes'*.[127]

78. The pressure to reduce movement of staff between care homes created damaging and unsustainable working conditions for care sector workers. As is addressed in a Cabinet Office C-19 Task Force presentation titled 'Care Homes Outbreak Fieldwork' in November 2020: *'all 'No outbreak' homes reported a stringent approach to use of agency staff and were not used. Safe staffing levels were maintained through staff incentives (e.g. increasing hourly wage), staff good will, block booking and over recruiting. For example, some were paying a £25 bonus to*

[119] Heidi Larson 16 January 2025 160/19-21.
[120] See, for example, Matt Hancock 22 November 2024 4/18-5/15 and Sajid Javid 25 November 2024 69/11-70/8. Please also see TUC closing submissions in Module 3 at paras 102 to 111.
[121] INQ000399530_0016-0017 paras 43-45.
[122] INQ000339444.
[123] INQ000069921_0007.
[124] INQ000069921_0011.
[125] INQ000103863_0005.
[126] INQ000223914_0002.
[127] INQ000109395_0002.

take more shifts or managers were stepping in to provide cover'.[128] For many care settings, it was only through relying on staff working unsustainable hours and suffering burn out that it was possible to forgo agency workers. For many others, restricting movement of staff simply was not possible.

79. It is true that much was done during the pandemic to try to seek to reduce movement of staff between care homes. That is set out in detail in the statements and disclosure which have been provided by the DHSC to this module. The truth of the matter is that these efforts came too late. In the currency of a pandemic, it was too late to fix the structural issues which have created the dire understaffing crisis in the sector. Similarly, there were no plans in place for those who need to move between settings, such as domiciliary care workers and district nurses. Domiciliary care workers have reported that a single service user might be visited by three different workers in a single day, and that plans could and should have been put in place to ensure that their care was delivered by one person, potentially utilising split shifts. These issues were compounded by the inadequately monitored ASCICF, which placed large funds in the hands of employers, gave significant discretion to employers in respect of how those funds were spent, and involved no independent monitoring of whether the funds were reaching the staff who needed them.[129]

80. The solution in advance of a future pandemic must be three-fold: the understaffing crisis *must* be addressed if meaningful progress is to be made on this issue; there must be adequate financial remuneration in place for those who are nonetheless affected by being asked or required to cease working in more than one home; and pre-pandemic planning must create pragmatic solutions and increased IPC for those who need to more between care settings.

D. THE LESSONS TO BE LEARNED

81. Though this Inquiry cannot itself resolve the structural problems within the care sector, nor spell out a detailed plan as to how a coherent social care sector may be achieved, neither can it ignore the issue. A core recommendation for a centralised oversight and strategy over the care sector would be an entirely unsurprising recommendation (indeed, it would be the latest in a line of reports) but it should be repeated, in the hope that it gives impetus for reform. Many of the deficiencies in the pandemic response cannot be avoided without this fundamental reform, and the Inquiry should say so. Of course, it should also consider what narrower lessons can be learned. This is addressed in the TUC's witness statement,[130] and it will be a focus of closing submissions in this module.

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[128] INQ000059003_0004.
[129] INQ000587381_0003 para 5; _0021 para 44; and 0023-0026 paras 50-58.
[130] INQ000587381_0039-0044 paras 94-96.