Witness Name: Lucy Strong

Statement No.: 1

Exhibits: n/a

Dated: 30 April 2025

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF LUCY KATE STRONG

I, Lucy Strong, of Irrelevant & Sensitive I&S will say as follows: -

INTRODUCTION

1. I understand that the Inquiry wishes to receive evidence about the impact of the pandemic on care professionals like me. As a member of the National Association of Care and Support Workers ("**NACAS**") I was contacted about this opportunity by NACAS' representatives and I expressed an interest in providing evidence, as I wanted to share my experiences and I think there are changes that could be made to improve the care sector – including to help dealing with any future pandemics or other infectious diseases. I understand the Inquiry has now formally requested evidence from me, so this witness statement sets out my response to that request.

2. I understand that the Inquiry is interested in particular in the period March 2020 to June 2022 and so this statement focuses on that time period, although I also set out below some general background on my experiences before and since that period.

3. I have been a member of NACAS since January 2023, when I became self-employed and was researching training opportunities for people who are self-employed in the care sector.

OVERVIEW OF MY PERSONAL CIRCUMSTANCES AND BACKGROUND

4. I have worked in the care sector for 24 years, in a variety of roles. Before that I worked as a registered mental health nurse, having qualified with a professional registration in nursing from Bournemouth university in 1999. I decided to work in the care sector

because I was interested in caring for people and I was drawn to the more holistic role of a carer (in contrast to the more focused role I had as a mental health nurse).

5. I first started working in the care sector when I moved from Hampshire to I&S and decided to work in a local care home during the day and as a community home carer in the evenings, which I really enjoyed and found very fulfilling. This led me to decide that mental health practice was no longer for me and I wanted to work as a carer full time. Having previously undertaken a two-year national diploma in caring services at a further education college, I was already qualified to undertake this role – I didn't have to take any specific additional course or training, although different care organisations sometimes have specific training requirements and carers are typically expected to keep up to date through practical manual handling training and e-learning on topics such as current IPC measures. For example, I was offered and elected to enrol to obtain a Care Certificate, which covered 15 core standards of care, when I first joined the care agency I worked for during the pandemic. This was not strictly a requirement for me, but was mandatory for new social health and care support workers in England at that time.

6. At the beginning of the pandemic (March 2020) I was working as a paid domiciliary care worker for an agency in Lancashire and I stayed in that role until around July 2021. Then between July 2021 and January 2023, I worked in a supported living complex. Since then, I have worked as a self-employed carer. I explain my roles during the pandemic in more detail at paragraphs 7-10 and 33-35 below.

MY EXPERIENCES AS A PAID DOMICILIARY CARER FOR AN AGENCY DURING COVID-19

Background on my role and work as a paid domiciliary carer

7. As a domiciliary care worker I worked with about 8 to 10 clients of the agency I was employed by, carrying out shift work. For most clients I provided care on a one-on-one basis, although some clients, depending on their needs, required two carers to be working with them at the same time. For each client, there would have been around 5 to 8 carers working on rotation, although exactly which carers and how many were assigned to each client varied – for example, if one of the carers was off sick and cover needed to be provided.

8. Under my employment contract with the agency, during my 3-month probationary period I had no guaranteed hours. Then after that, I was guaranteed 15 hours of work a week (on average across a 12-week period) at £12 per hour, but I usually worked

much more than that. I was probably working a 25 to 30 hour week on average. I worked in shifts and was required to be flexible and available for shifts as and when they came up, so I didn't have reliable or sociable hours, which made it difficult to plan around my work. For example, I needed to be available throughout the days on which I was working, but I might only be offered 3 to 4 hours of work – whether in the morning, afternoon, or evening shift.

9. My day-to-day tasks mainly involved providing personal care, meal preparation, medication administration and promoting client safety and wellbeing at all times. As part of this I would also carry out welfare checks, which was important as some of the clients had dementia or physical conditions which they were managing.

10. My clients had a range of complex needs, such as dementia and heart problems, and were mostly aged 65 or over. Some lived with family members, whilst others lived alone. As a carer in this position I already had a higher risk than average of contracting infections, even before the pandemic.

Impact of Covid-19 on me and my role as a domiciliary care worker

11. During the pandemic, my clients had less contact with family and friends, for example due to lockdown restrictions. This meant I had to take a more active role in managing their care and in reaching out to their family and support networks where necessary – for example, if I felt they needed additional care or support. I felt an increased sense of individual responsibility, because my clients' family members were not around as much to check in on them.

12. I was also extremely anxious about passing on Covid-19 to my clients and to my partner, who was in a high risk category due to type one diabetes and chronic kidney impairment. It is an awful feeling knowing that you might pass on an infection and that this might ultimately have fatal consequences.

13. Given these concerns and worries, I self-isolated more than was strictly required in an effort to protect my clients. For example, my partner would usually go out to do the food shopping rather than me; and I reduced my social contact with others to the bare minimum. This isolation, together with the stress and worry I was dealing with, had a severe emotional impact on me. However I took these additional steps because I believed that the protection of my clients was paramount.

14. My day-to-day tasks as a domiciliary carer broadly remained the same during this time, but the environment I was working in and the stress and anxieties that came with that made my role significantly more challenging.

Sick pay / financial support

15. Under the terms of my contract with the domiciliary care agency, I was only entitled to statutory sick pay on days on which I would normally have worked. This was the only pay I received while self-isolating after I contracted Covid-19 in around December 2020 and it was not sufficient to support myself and my partner.

16. I felt that I was in a very precarious situation at that time, as the agency could have laid me off or reduced my working hours if there was no longer enough work for me, or if they felt I wasn't up to the work. The agency I worked for was only required to give me one week's notice to terminate my employment. Under my contract I wasn't allowed to undertake any other paid employment without express approval from the agency, so I was fully reliant on this job to provide an income. This was particularly important as I was the sole earner in my household at the time – my partner was unable to work due to ongoing health problems.

17. Ultimately this lack of security and financial support led to me returning to work sooner than I would have done otherwise, when I was still struggling with symptoms of Covid-19 (see more on my experience of contracting Covid-19 at paragraphs 28-32 below).

18. Given care workers are at a high risk of contracting infections, I think they should be offered more financial protection while unwell, like NHS staff.

Infection and prevention control measures

19. The main infection and prevention control ("**IPC**") measures that I remember following while working as a domiciliary carer during the pandemic were: effective, regular handwashing practices, including washing hands before and after every client contact and using alcohol gel sanitiser as provided; social distancing measures; and full use of personal protective equipment ("**PPE**") (see further paragraphs 22-24 below). I remember having to ensure that I was using PPE appropriately, for example taking it off and disposing of it in the right way to avoid contamination.

20. Many clients faced additional challenges because of these IPC measures. For example, clients with hearing impairments found it more difficult to understand me when I was using a mask (as they could no longer lip read), as did some clients with dementia

(who were often more reliant on non-verbal cues). Clients with dementia also found it difficult to understand why these measures were needed and were not themselves always able to follow measures such as social distancing.

21. I do not recall whether any additional restrictions on rotating between clients were put in place, or whether team sizes (i.e. the number of carers who might provide care for each client) were reduced.

PPE

22. I felt that the agency I worked for was careful about the amount of PPE they provided and had a tendency to ration this, but I was still able to access the PPE that I felt I needed, once it was made available. However I think that PPE was provided too late after the onset of the pandemic, probably two to three months too late. For example, I remember that carers only started receiving surgical masks in around May 2020, so at least two months into the pandemic. I feel that carers were forgotten about and overlooked in that respect (and more generally), as the focus was more on NHS staff, even though carers too were exposed to increased risk of catching the virus – particularly from rotating around clients, as domiciliary carers. I also feel that the care sector was perhaps unprepared and reacted too slowly to the pandemic.

23. To be clear, I would have worn PPE, such as an apron and gloves, when providing care even before the pandemic. The main additional PPE that I wore after the onset of Covid-19 and during the pandemic was a surgical mask and a plastic visor which was ill-fitting and uncomfortable to wear.

24. Despite wearing PPE ourselves as carers, it did not appear to be expected that clients should wear PPE. For example, clients did not typically wear masks, even when unwell, and I believe I caught Covid-19 from a client who was unwell but not wearing a face covering. It was often not practical for clients to wear PPE anyway, for example while I was helping them to shower; and for some the use of a mask seemed to exacerbate their breathing difficulties.

Visiting restrictions

25. I do not remember specific visiting restrictions being put in place for visitors to those I cared for, although I expect visitors were generally supposed to follow the Government's lockdown restrictions.

26. In my experience, family members of clients still visited throughout the pandemic and there was not much that I felt domiciliary carers could do to stop that. I could have informed management at the agency, but I am not sure they would or could have done anything. At times I remember feeling that some clients' family members were travelling too far and that this was unnecessarily exposing me and other domiciliary carers to an even greater risk of catching Covid-19, particularly given the clients were being well looked after. However I do recognise and understand family members' desire to visit, particularly when those I was caring for were very unwell or in end of life care. For example, I remember a client who died a few months after contracting Covid-19 and whose son understandably instigated more visits in those final few months.

Testing

27. I remember that tests were initially made available to me by the agency, at the agency's offices. After seeking clarification on the testing policy from a colleague from the time, I was reminded that we were told to test ourselves if we had symptoms of the virus before going to work, but that we were not otherwise required to test ourselves on a regular or ongoing basis. It was not always practical to keep returning to the office, so I obtained additional tests as needed from a local chemist.

MY EXPERIENCE OF CONTRACTING COVID-19 AND THE LONG-TERM IMPACT

28. I contracted Covid-19 in around late December 2020 or early January 2021, I believe from a client who I was working with at the time and who had Covid. Very sadly, this client passed away a few months later.

29. I was very seriously impacted by Covid-19, both during the initial period after I caught it and on a long-term basis. When I first caught it my symptoms included palpitations, shortness of breath, specific aches and pains, tiredness, and loss of taste and smell. I self-isolated for a period of 10 days, but then returned to work before I was ready for the reasons explained at paragraphs 16-17 above. At this time I was still suffering from extreme tiredness/exhaustion and shortness of breath, and I had not regained my sense of smell and taste. I ended up having naps in between shifts so I could carry on working despite my symptoms.

30. I was also suffering from anxiety at the time, which I believe was linked to the ongoing effects of Covid-19 and the stress of trying to work in the pandemic environment whilst I was still unwell. I found myself waking up with bruises from gripping my legs at night, and I was getting heart palpitations, heart burn and chest tightness. I was also having

memory problems, and I still find it difficult to remember precise details of events from that time period.

31. My struggle with these symptoms persisted for several months. I had no previous health conditions, so I believe all my symptoms were related to Covid-19. In June/July 2021 I ended up seeing my GP about these long-term symptoms, as I was worried about this having a lasting impact on me. The GP carried out some tests and I was offered a referral to a long Covid-19 clinic, but I did not want to take that up at the time as I felt I was starting to see small improvements in my symptoms and others probably needed the support more.

32. Ultimately, I decided I could not go on working as a domiciliary carer in these circumstances and this led to me changing jobs in August 2021 to work in a supported living context instead. I cover my experiences working in a supported living context during the pandemic at paragraphs 33-40 below.

MY EXPERIENCES WORKING IN A SUPPORTED LIVING CONTEXT DURING THE PANDEMIC

Background on my work in a supported living context during the pandemic

33. As explained above, I worked in a supported living complex from August 2021 to January 2023.

34. The supported living complex housed around 35 homeowners who were generally over 70 years old, each with their own flat and with a communal dining hall for all residents. When I first worked there, I was told that meals used to be taken up to each individual flat during the height of lockdown measures, to avoid everyone congregating in one place; but when restrictions were lifted, meals were typically only taken up to individual flats if homeowners informed staff of their Covid-positive status and chose to self-isolate. Each resident could live independently in their flat, but with personal care provided according to their needs, an alarm call system and staff available on call 24 hours a day. Some residents chose to have care input, whilst others did not – the majority were very independent. Therefore as well as providing personal care to those who needed it, I also had cleaning duties and worked in the restaurant.

35. Under my contract, I worked on average about 22 hours a week, although occasionally I would do overtime, if additional cover was needed and I felt able to do so. My pay was about £250 to £300 less per month on average than it had been as a domiciliary carer, but my hours were more regular and did not involve evening work (compared to

the irregular shift patterns that I had to deal with in my previous role) and this suited me better.

Infection and prevention control measures

36. I do not recall wearing a mask routinely unless I was in contact with homeowners who were known to be Covid-positive, but PPE was worn as standard practice during personal care.

PPE

37. I do not remember the specifics, but I expect I probably wore a mask, along with an apron and gloves, while carrying out my care duties at the supported living complex. This PPE would have been provided by my employer. I do not recall any particular difficulties with supply of PPE at that time.

Testing

38. To begin with we were tested for Covid-19 in the office at the supported living complex every morning before each shift, so we could not go ahead with the shift or have any contact with clients unless we had a negative test. Then when restrictions were lifted, I would test for Covid-19 at home on a weekly basis and send my result into the office via email.

Sick pay

39. In the height of Covid-19 restrictions, I believe we received full pay while we had a Covid-positive status and were off work as a result, but this changed to being paid only statutory sick pay when restrictions were lifted and we were not required to self-isolate (although as far as I'm aware, all staff did continue to self-isolate when they were Covid-positive as a precaution).

Visiting restrictions

40. I do not remember there being particular visiting restrictions in place for those living at the supported living complex, beyond the restrictions placed on any other households in the country at the time.

VACCINATION AS A CONDITION OF DEPLOYMENT

41. I received my first dose of the Covid-19 vaccination on 22 January 2021, although I had already contracted Covid-19 a few weeks before that. I probably would have had to

wait even longer for the vaccine, but I was volunteering at a vaccination clinic at a local library at the time, so I was offered it sooner there.

42. I am not particularly pro-vaccine myself and I did not feel that it was right to require vaccination as a condition of deployment – I personally felt pressured to have the vaccine as a result. However ultimately I decided to have the vaccine because I wanted to protect my clients, which was my priority, and I thought my clients would feel safer and more reassured if care staff were vaccinated.

LONG-TERM IMPACT OF THE COVID-19 PANDEMIC

43. As explained above, Covid-19 had a significant long-term impact on my health and ultimately led me to change jobs.

44. In terms of other long-term impacts, I feel more worried now about what I am exposed to during my work. In my view, carers are at a high risk contracting not just Covid-19, but also other diseases or infections that clients might have.

OTHER COMMENTS

45. Whilst I have now recovered from Covid-19 physically, I would never choose to work for a care agency again. I do not think that agency carers have the same level of protection when they fall ill through their work as compared to NHS workers, for example; and nor is there sufficient financial support to help them through a period of illness. This means you are under more pressure to work through ill health. Coupled with relatively poor pay, this is not a good combination.

46. I also think that agency work often does not allow for any work life balance. Some agency work involves zero-hour contracts, for example, where carers have to be flexible and make themselves available in case of work but are given no guarantees as to how much work (and therefore pay) they will actually be given. This was the case for me to an extent when I worked as a domiciliary carer for an agency, although at least I had minimum 15 hours of work guaranteed.

47. Since January 2023 I have been working as a self-employed carer. Although arguably I have less financial protection being self-employed, I have the flexibility to obtain more work when I want or need it, whether that is in the care sector or not. Also I have a far better wage as a self-employed carer, so I have more money to fall back on if I become unwell. When working for a care agency, in my experience your wage is much less and you have little or no security of employment or sick pay. At least now I am self-

employed, I feel I have more control over my circumstances. I also have sufficient work as a self-employed carer, which I think is because care agencies typically charge too much – often more than clients can afford. They also typically take up to 50% of the amount charged to clients, or whatever figure they deem fit, rather than that money going to the carers actually providing care.

48. As a general comment, based on my experiences I feel that carers need more protection – both for future pandemics and generally – and it would be better if the care sector becomes more State-managed and carers are salaried, like the NHS, rather than being increasingly in the hands of the private sector.

Statement of Truth

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: Personal Data

Dated: 30/4/25