Witness Name: Karolina Gerlich

Statement No.: 1

Exhibits: 32

Dated: 3/21/2025

UK COVID-19 INQUIRY - MODULE 6

WITNESS STATEMENT OF KAROLINA GERLICH

ON BEHALF OF THE CARE WORKERS' CHARITY

In relation to the issues raised by the Rule 9 request dated 29th May 2024 in connection with Module 6, I, KAROLINA GERLICH will say as follows: -

Personal Details

1. I am making this statement in my capacity as the Chief Executive Officer (04.2021) and previously as Executive Director (03.2020-04.2021) of The Care Workers' Charity based on evidence received from care workers and other staff employed in adult social care who submitted applications for grant funding and mental health and wellbeing support relating to COVID-19 from the Charity and other anecdotal evidence received from these applicants relating to their experiences as supplied in their application forms. This witness statement relates to matters addressed by the Inquiry's Module 6. My evidence will relate to the period between 1 March 2020 and 28 June 2022.

2. This witness statement relates to the matters addressed by the Inquiry's Module 6, which is examining the impact of the pandemic on the publicly and privately funded adult social care sector in England, Scotland, Wales and Northern Ireland between the following dates.

The Care Workers' Charity

3. The Care Workers' Charity was founded in 2009, originally known as The Care Professionals Benevolent Fund, but later changed in agreement with trustees to The Care Workers' Charity. The objective of The Care Workers' Charity (CWC) was in supporting current and former care workers with one-off crisis grants. Due to a lack of funding, we now support currently employed care workers. The CWC supports care workers in England, Scotland, Wales and Northern Ireland. From 1 March 2025, The Care Workers' Charity was incorporated, and we trade as Care Workers Support (Company Number 15048761) and we work on Charity Commission number 1207208 from this date.

4. The Mission of the Charity is to advance the financial, professional and mental wellbeing of social care workers by making grants, signposting to resources and providing access to services.

5. The Care Workers' Charity (CWC) is funded by sponsors and supporter members who make annual donations to pay a set amount each year to enable the Charity to support care workers. The CWC also receives funds from Trusts and Foundations, this being a combination of funding restricted to grants or other criteria and other funding which can be used towards grants or core costs. The CWC is also funded by fundraising by individuals and organisations. Sponsors are organisations who supply into the social care sector, such as traders providing services (I.T., recruitment platforms etc) or items (furniture, equipment etc).

6. Supporters are organisations in the social care sector in the UK employing care workers and providing adult social care services. They pay a membership fee which is calculated on the number of staff they employ in their organisation, including all staff. In 2020 the CWC had 80 supporter members.

7. In addition the CWC is funded by an administration contribution made by organisations such as local authorities and social care providers who have Agreements with the CWC to administer and distribute grants to care workers to agreed criteria and with grant funding by these organisations to enable this activity.

The CWC Support for Care Workers between March 2020 and 28 June 2022

The COVID-19 emergency fund (2020-June 2022)

8. The number of grants awarded during this period was 4351 which amounted to £2,665,228.49 awarded.

9. The COVID-19 Emergency Fund was launched at the end of March 2020, with donations being received from Trusts and Foundations, individual fundraisers and grants from local authorities. At the beginning we were only able to award care workers a £500 grant for two weeks isolation, however as we surpassed fundraising targets we began to offer out a wider range of grants and by the end of 2020 were able to offer grants for: 1 week isolation, 2 weeks isolation, shielding, childcare costs incurred due to COVID-19, funeral costs, other grant costs (to contribute towards COVID-19 related emergency repairs. Our most popular grant was the two week isolation grant; over £1m was awarded for this particular circumstance.

10. During the period of 1 March 2020 and 28 June 2022 the CWC supported 4351 workers in the adult social care sector in the UK.

11. This table below shows a summary of the types of grants awarded, the total amount against each grant type and the number of grants awarded.

Grant type	Amount awarded	No of grants awarded
1 Week Isolation from Work	**£ 189,016.00**	**498**
12 week shielding	**£ 615,059.50**	**385**

2 Week Isolation from Work	**£**	**1,520,120.50**	**3061**
Car Repairs	**£**	**2,350.00**	**5**
Childcare Costs (up to £2,000)	**£**	**20,308.83**	**28**
Daily living costs	**£**	**50,385.00**	**89**
DRO/Bankruptcy fee	**£**	**1,680.00**	**3**
Funeral Costs up to £2,000	**£**	**127,287.15**	**80**
Home repairs	**£**	**1,800.00**	**3**
Household items/ white goods	**£**	**11,250.00**	**25**
Moving costs	**£**	**5,665.00**	**7**
Other Costs (up to £1,000. for example for emergency repairs, emergency appliance replacements, etc)	**£**	**74,367.99**	**110**
Preventing eviction	**£**	**40,998.52**	**50**
Travel expenses	**£**	**250.00**	**1**
Whitegoods	**£**	**4,690.00**	**6**
Total	**£**	**2,665,228.49**	**4351**

12. The table below shows a breakdown of staff roles and whether they are care providing or otherwise and the number of grants awarded against each category

Job role	No of awards
Administrative/Office staff not care-providing	16
Ancillary Staff not care-providing	24
Care Worker	1002
Managers and staff not care-providing	3
Managers and staff not care-providing	1
Other	72

Other Job Role directly involved in providing care	49
Registered Manager	23
Senior Care Worker	167
Supervisor	24
Blank*	2970
TOTAL	4351

13. The table below shows a breakdown of the gender of applicants awarded a grant

Gender	No of awards
Male	**576**
Female	**2455**
Transgender	**2**
Prefer not to say	**1**
Other	**1**
Blank *	**1316**
TOTAL	**4351**

14. This table shows the ethnicity of applicants awarded a grant

Ethnicity	No of awards
Asian/Asian British	331
Black/African/Caribbean/Black British	311
Middle Eastern	5
Mixed	67
Other Ethnic Group	35
Prefer Not to Say	32
White	2232
Blank*	1338
Total	**4351**

15. This table shows which region in the UK (Scotland, Northern Ireland, England and Wales) applicants live in and the number of grant awards made in each Region

Region	No of awards
East Midlands	172
East of England	214
London	209
North East England	297
North West England	453
Northern Ireland	3
Scotland	131
South East England	398
South West England	221
Wales	130
West Midlands	459
Yorkshire & The Humber	193
Blank*	1459
TOTAL	4351

***this question was not asked in the earlier version of the application forms**

Mental Health and wellbeing support for care workers

16. In 2020 we undertook a procurement process to find a suitable partner for our Mental Health Support Programme. We wanted to set up a programme to support care workers who were suffering from stress, PTSD, depression and bereavement and struggling as an impact of the COVID-19 pandemic. They could also be supported by the programme for other mental health wellbeing needs. The programme launched in February 2021, providing up to 10 sessions with a qualified therapist through an accredited mental health provider.

Mental health support fund totals: 2021-2024

17. The number of applications approved in this period was 321 (data determined by searching for applicants who specifically mentioned COVID-19 as a reason for needing support with their mental health and those who applied for COVID-19 grants who mentioned similar) with Total spend equaling £131,950.

18. The amount of applications relating to COVID-19 was 18 with Total amount spent equaling £8,100.

19. The table below shows the number of applications received for mental health support by job role

Job role	No of Applications
Administrative/Office staff not care-providing	1
Care Worker	16
Other job role directly involved in providing care	2
Registered Manager	2
Senior Care Worker	1
Managers and Staff not providing care	2
Registered Manager	2
Supervisor	1

20. The tables below shows the gender, ethnicity and region of participants who took part in our pilot scheme providing mental health and wellbeing support

Gender	Number of applications
Female	13

Ethnicity	Number of applications
White	11
Black/African	2

Region	Number of

		applications
	Eastern England	1
	London	3
	North East England	1
	North West England	1
	South West England	2
	West Midlands	1
	Yorkshire & Humber	1

21. **The data provided above is exhibited as KG/01 – INQ000474937 and KG/02 – INQ000474938**

Local Authority collaboration with The Care Workers' Charity to support Care Workers

22. The CWC had regular engagement with local authorities. Solihull Council collaborated with the CWC in 2020 to support care workers during the pandemic. In April 2020 Solihull Council contacted the CWC with a view to working together to provide financial support for Care Workers (Exhibit KG/03 – INQ000542989]. The council provided funding and an administrative fee. The CWC set up the application form aligned to the agreed criteria, and opened the application process to Care Workers living or working in Solihull. To the end of 2020 68% of the grants awarded to Care Workers was payment for 2 weeks' isolation due to having or living with someone with COVID-19. The CWC and Solihull Council continued to review this support being given to Care Workers, ensuring that if different criteria for grant funding was needed, the conversations could continue and required changes implemented to the process.

23. The CWC continued working with Solihull Council and in March 2022 they signed an agreement with Oxfordshire County Council, focusing on supporting Care Workers who were in crisis. The crisis may be due to a range of circumstances including loss of income or replacement of white goods such as washing machines, both of which could be related to the impact of having had COVID-19, or to having to wash uniforms more frequently to avoid infection, The partnership came about when the CWC contacted local authorities in England with information about their work with Solihull with the aim of wanting to build on that success and to support Care Workers in other parts of England. In order to best support Care Workers, information about the availability of these grants was shared through the local care association in order for managers to be able to let their staff know.

Advocating for Care Workers during the pandemic

24. The Care Workers' Charity worked with and lobbied The Department of Health and Social Care, Trade organisations and professional organisations, Local Authorities, the Care Quality Commission and representatives of bodies of care providers. During meetings and discussions with these organisations the main concerns raised by the Charity were: Lack of mental health and wellbeing support for Care Workers suffering PTSD, stress or burnout [Exhibit KG/04 – INQ000542996].

25. A distinct lack of parity with NHS staff. Who at the time were able to access PPE, full sick pay and priority in social and organisational provision to school services as they were deemed to be key workers (until Care Workers were finally awarded this status); (Exhibit KG/05 - INQ000542996].

26. Lack of support to Care Workers who had lost income due to the requirement to work in only one care setting.

27. The CWC lobbied for a COVID-19 bonus for Care Workers, similar to the provisions provided in other parts of the UK (e.g., Wales and Northern Ireland). However, this was not implemented in England. (KG/013) The Scottish Government awarded a £500 bonus to Care Workers in November 2020; the Welsh Government awarded two bonuses to Care Workers (in May 2020 and March 2021) and in January 2021 the Northern Ireland Government announced £500 payments to Care Workers.

28. The CWC was involved in discussions with the UK Government, particularly the Department of Health and Social Care (DHSC). The CWC participated in the Workforce Advisory Group during the COVID-19 pandemic. Karolina Gerlich joined this group in 2019, while employed as Chief Executive of NACAS and has continued participation as a member of the group.

29. The charity also engaged with government bodies around key issues such as the lack of recognition for Care Workers as key workers and lobbied for improved access to Personal Protective Equipment (PPE) for Care Workers. (Exhibit KG/06 - INQ000542997].)

30. The CWC reached out to engage with the Care Quality Commission (CQC) during 2020. However, the CQC was largely inaccessible during the early stages of the pandemic, and the CWC found it difficult to have meaningful interactions.

31. The CWC participated in trade association meetings with the CQC, although these were limited.

32. The CWC had extensive interaction with representative bodies such as the National Care Forum, Care England, and the National Care Association. Discussions were focused on the wellbeing of Care Workers, the challenges faced by care providers, and the overall impact of COVID-19 on the care sector.

33. In the charity's meetings with representative bodies such as the National Care Forum and Care England, the CWC discussed the severe impact of staff turnover due to burnout, the financial hardships faced by care workers, and the overall neglect of the social care sector during the pandemic.

The Care Worker's Charity Impact Reports

CWC Impact Report 2020

34. The Care Workers' Charity Impact Report for 2020 highlights the significant support provided to care workers during a challenging year marked by the COVID-19 pandemic. 2,864 grants relating to Covid-19 were awarded, totalling £1,981,858. 39 funeral grants were awarded to

help pay for the funerals of care workers or their loved ones who had died of Covid-19. The report underscores the charity's role in providing financial and emotional support to care workers, raising awareness of their contributions, and adapting to the evolving needs during the pandemic. [Exhibit KG/07 - INQ000542983],

CWC Impact Report 2021

35. The Care Workers' Charity 2021 Impact Report describes a challenging year due to COVID-19, with significant impacts on care workers. The (CWC) saw a rise in applications for financial and mental health support, applications mentioned high levels of stress, depression and anxiety. In response the CWC launched mental health and wellbeing support in February 2021 to address these issues. The report describes the charity's role in raising the profile of the sector and of campaigning for parity of esteem between health and social care staff and for the wider public to have better understanding of the professionalism of care workers, rather than seeing them as exclusively supporting people with personal health tasks and that 'anyone can be a carer'. [Exhibit KG/08 - INQ000542984].

CWC Impact Report 2022

36. The 2022 Impact Report from the Care Workers' Charity describes a 74% increase in people applying for daily living costs grants due to the cost of living crisis and unprecedented increases in bills and food costs, compared to in 2021. It contrasts income from charitable donations and grants from 2021 with 2022, the latter amount raised being over half a million pounds less than the previous year. [Exhibit KG/09 - INQ000542985].

Pre-pandemic capacity of the adult social care sector in the UK.

37. Between 2014 and 2019 the Care Workers' Charity awarded 915 grants to care workers and others working in adult social care in the UK as follows:
    a. No of grants: 915
    b. Amount awarded: £360,582

38. This could have been significantly more but during that time the CWC was much smaller, not on the public radar and as such did not have the funds or fundraising capacity it had from 2020 onwards.

39. According to Skills for Care, from their report "Skills for Care The State of the Adult Social Care Sector and Workforce 2020 V2", (data between April 2019 to March 2020) the average Care Worker employed in the independent sector in England was aged 44, female and British, and earned around £16,900 (FTE), with a permanent contract. The split between full and part time positions for this job role is 50/50. [Exhibit KG/10 – INQ000542979].

40. Their report shows that 51% of Care Workers were working part time, with 24% of them on zero-hours contracts.

41. 42% of the domiciliary care workforce were employed on zero-hours contracts. This proportion was even higher for Care Workers in domiciliary care services (56%) with many of these Care Workers living in a financially precarious state if they did not have fixed weekly hours or work and with their pay fluctuating from week to week. As a result they did not have a financial cushion to protect themselves if they had unexpected bills to pay.

42. A lack of finances, low pay and challenging work conditions meant the pre-pandemic workforce capacity of the adult social care sector was already of concern. There was a lack of awareness of the work of Care Workers and the provision of adult social care among the general public; if they had no experience of a member of their family drawing on social care their opinions were coloured by what they read and saw in the media. Recruitment has

always been a challenge for the sector, despite strategies and initiatives developed to increase the number of care workers.

43. The Association of Directors of Adult Social Services (ADASS) Budget Survey 2019 states "There is a great deal of excellent care and support from a whole range of people: care staff, personal assistants, family members, communities, social workers. That is tribute to the immense commitment and going over the odds by those involved. But the market is fragile and failing in some parts of the country. 72 directors say they have seen home care providers closing or ceasing to trade in the last six months and 38 directors had contracts handed back by home care providers. [Exhibit KG/11 - INQ000574133].

44. Despite raising fees to providers, fees do not match what providers say they need to be sustainable. Directors' biggest concern about the impact of savings made or planned is the prospect of providers facing financial difficulty and quality challenges. 79% of directors are concerned about their ability to meet the statutory duty to ensure market sustainability within existing budgets".[Exhibit KG/11 - INQ000574133].

45. The Office for National Statistics, "Average Household Income UK, Financial year ending 2020 (provisional)" report stated that in the financial year ending (FYE) 2020, the period leading up to the implementation of measures against the coronavirus (COVID-19), average household disposable income for all households (after taxes and benefits) was £30,800 – up 2.3% (£700) compared with FYE 2019, after accounting for inflation [Exhibit KG/12 – INQ000542987].

46. The Low Pay Commission Report in 2022 states " Care England thought staff turnover of 28.5 per cent was driven by low pay and disparity with terms and conditions in other parts of the economy, especially the NHS. 'Care workers in the independent sector earn on average around £3,500 less than similar roles in the NHS'. The report adds "Both employers and workers described a social care workforce on the brink of burnout. Care England told us the pandemic saw considerable and continuing pressure on care home workers: 'people are taking a step back, and they're starting to realise what they've been through … And there aren't the mechanisms to support people like there are in other sectors like the NHS for example". [Exhibit KG/13 - INQ000542981]

47. "Skills for Care's The State of the adult social care sector and workforce 2020" covered data collected between April 2019 to March 2020. ([Exhibit KG/10 – INQ000542979].
. Their statistics included:

    a. Around a quarter of the workforce were recorded as being employed on a zero-hours contract with domiciliary care services having the highest proportion of workers [Exhibit KG/10 – INQ000542979, page 9]. employed on zero-hours contracts (42%), especially among care workers (56%).

    b. Care workers had one of the highest turnover rates at 38.1% The staff turnover rate of directly employed staff working in the adult social care sector was 30.4% in 2019/20. This equates to approximately 430,000 people leaving their jobs over the course of the year. However, most of these leavers don't leave the sector. Around 67% of jobs were recruited from other roles within the sector.

    c. There was an average of 4.7 sickness days taken annually per worker in 2019/2020, this for all social care staff, not specific to care workers.

    d. The age distribution of the adult social care workforce was older than the economically active population (27% of adult social care workers were aged 55 and

over compared to 20% of the economically active population) [Exhibit KG/10 – INQ000542979, page 10].

e. Around 21% of workers identified as being of an ethnicity that was black, Asian, mixed, or minority ethnic (BAME) [Exhibit KG/10 – INQ000542979, page 10].

Issues affecting the social care sector's ability to respond to the pandemic

48. High staff turnover, low pay, an older workforce and over 20% of the workers identifying as being of BAME ethnicity impacted on the sector's ability to respond to the pandemic. Some providers struggled to source and provide PPE to their staff, increasing uncertainty and anxiety among Care Workers which would have impacted on the already high staff turnover. As a result, some care providers would have struggled to meet needs and take on new care packages – the knock on effect increasing delayed discharge from hospital and putting the NHS under pressure.

49. Migrant workers, many of whom are essential to the adult social care workforce, were particularly disadvantaged during the pandemic.

50. There was no workforce strategy for the sector, with key commitments not being followed up to enhance career development, tackle retention and recruitment challenges. There was a need to develop sector leadership in order to improve the pay and working conditions for the staff working in adult social care.

51. One of the major hindrances was the lack of professionalisation and registration for Care Workers. Unlike NHS staff, Care Workers were not able to present ID cards to access priority services such as skipping queues in supermarkets. This affected their ability to procure necessary supplies for themselves and those they cared for, further complicating their roles during the pandemic.

52. An Age UK report in November 2020 "Time to bring our care workers in from the cold" [Exhibit KG/14 - INQ000532614, page 6 para 4] states "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". And then include the testimony above. Care Worker who received a grant from CWC stated "*I've been very ill with covid, and could not go in. As I work in care I could not go back as I tested positive [for* COVID-19*] for 10 days. I then went back for three days and got very ill. I had a very bad chest infection, bordering on pneumonia, which was caused by the covid virus. I do not get paid, so this grant is amazing."* [Exhibit KG/15 - INQ000474939].

53. Many Care Workers were employed on zero-hours contracts with no access to full sick pay. This forced them into a difficult situation where they had to choose between going to work while symptomatic (without access to testing) or staying home without income. The lack of financial support led to significant economic hardship for Care Workers, exacerbating the strain on the sector as many were unable to isolate when necessary. "*For the two weeks that I had to isolate, I was only entitled to SSP of £92 a week, which barely covered rent, never mind anything else. With this grant, I can actually now go food shopping and not have to rely on food banks*". Care Worker who received a grant from the CWC. [Exhibit KG/15 - INQ000474939].

54. The care sector was already facing staffing shortages before the pandemic. The lack of support during the crisis, combined with increased burnout and financial strain, worsened the situation. "*Throughout the COVID-19 Crisis, I have not felt supported in my role as a Care*

Worker and felt like I was being interrogated about being ill and punished for catching COVID-19." Care Worker who received a grant from the CWC. [Exhibit KG/15 - INQ000474939].

55. The Skills for Care report "The State of the adult social care sector and workforce 2022" shows many Care Workers left the sector after the pandemic subsided, leading to an even higher turnover. Care Workers had one of the highest turnover rates in adult social care at 36.1% in 2021/22, up from 34.4% in 2020/21. [Exhibit KG/16 - INQ000542998, page 20].

56. Managers and long-term care staff, in particular, were deeply affected, with many quitting due to the overwhelming challenges and lack of recognition. The Care Quality Commission State of Care 2019/2020 report states "We heard that care staff had to suddenly cope with a whole range of new tasks and take on aspects of care that they had never had to do before. The lowest paid staff had an enormous burden put on them. They had to care for large numbers of people faced with a new and complicated illness, understand complex guidance, and often be the only one to be with the person as they died, sometimes relaying families' messages of comfort to the dying person. [Exhibit KG/17 - INQ000542999].

57. This also contributed to a significant number of Care Workers leaving the profession, which in turn affected the sector's ability to maintain adequate staffing levels during the pandemic.

58. Care Workers experienced severe financial difficulties due to the lack of adequate sick pay and rising costs, including fuel prices. This added strain reduced their ability to attend work or maintain consistent support for the people in their care, further affecting the sector's response to the pandemic. "W*hen I was really poorly and my husband was as well, we were both off work for 7 weeks and both tested positive for Covid 19 together, working at the same care home.*" Care Worker who received a CWC grant. [Exhibit KG/15 - INQ000474939].

The impact of the pandemic on care workers

59. Many Care Workers were put at risk due to inadequate access to PPE, especially during the early stages of the pandemic. The absence of proper protective equipment meant that Care Workers were more exposed to the virus than they should have been. Many Care Workers contracted COVID-19, and some had to leave the sector or reduce their hours due to the long-term effects on their health. "I had a lady on my floor who was very unwell. Myself and a colleague were assisting her when she started coughing. Both of us were open to infection from the droplets from her coughing as the only PPE we were allowed to wear were our aprons and gloves. There were a number of residents tested and confirmed positive to have Covid 19. Once it was confirmed we were allowed to wear the masks but this was too late for a number of staff including myself." – Care Worker who received a grant from the CWC. [Exhibit KG/18 - INQ000474940].

60. Care Workers faced extreme mental health challenges, primarily due to the sheer number of deaths in care settings. They were working in environments with frequent loss of life, with little to no opportunity for debriefing or mental health support. Unlike other sectors, social care did not have systems in place to help Care Workers cope with the emotional toll of losing residents with whom they had developed strong, personal relationships. This resulted in many Care Workers experiencing burnout, anxiety, and depression, leading some to leave the profession. "Earlier this year I was in a really dark place. I was struggling with work because of the changes due to covid-19 and would often find myself in or close to tears. I felt so alone and like nobody cared". [Exhibit KG/19 - INQ000474757].

61. The increased absence of Care Workers due to illness or isolation further strained the sector, leaving those still working overwhelmed. The high number of deaths within care settings, especially in the early phases of the pandemic, severely affected the mental wellbeing of both staff and remaining residents. Care Workers had to manage not only their personal grief but

also the distress of the residents who lost fellow residents and were isolated from their families.

62. Many Care Workers reported feeling unsupported and forgotten during the pandemic. The intense workload, coupled with the mental strain of witnessing so many deaths, led to significant burnout. Many Care Workers ultimately left the profession after enduring months of gruelling conditions. Managers and experienced care staff, in particular, held on through the worst of the pandemic but resigned once the immediate crisis subsided, contributing to the sector's high turnover rate.

63. There was a widespread sense of abandonment among Care Workers, particularly due to the lack of recognition from the government. While NHS workers received public praise and special provisions, social care workers felt dismissed and unsupported. This was compounded by the failure to provide full sick pay or a COVID bonus, which had a direct impact on workers' wellbeing, as many felt their contributions during the pandemic went unappreciated.

64. The pandemic also deeply affected the personal lives of Care Workers. Many Care Workers sacrificed time with their families, with some choosing to live at their workplace to reduce the risk of spreading COVID-19 to their loved ones. This separation took a significant emotional toll, impacting not just the workers but also their families and relationships.

65. Female Care Workers, who made up the majority of the workforce, were disproportionately affected, particularly as they often had additional caregiving responsibilities at home.

66. The 2019/2020 Edition of the Care Quality Commission 'State of Care Report' quoted Skills for Care's data showing the vulnerability of adult social care staff: data from Skills for Care showed that a quarter of staff (340,000 people) were aged 55 or over, and 1.4% (18,500) of staff were aged 70 or over. Data collected by Skills for Care showed that 7.5% of working days were lost to sickness (including self-isolation and shielding) up to August 2020 during the COVID-19 period, compared with 2.7% pre-COVID-19. The report continues, saying " In hospitals and care homes, staff worked long hours in difficult circumstances to care for people who were very sick with COVID-19 and, despite their efforts to protect people, tragically they saw many of those they cared for die. Some staff also had to deal with the loss of colleagues to COVID. . [Exhibit KG/17 - INQ000542999].

Lack Of Mental Health Support For Care Workers

67. The pandemic took a heavy toll on the mental and physical health of Care Workers. Many reported burnout, anxiety, depression, and a sense of being unsupported and forgotten during the crisis when they applied to the CWC for mental health and wellbeing support. "*I'm really glad there is support like this for Care Workers especially during such difficulties with the pandemic we all are facing. Thank you." From a Care Worker who accessed the CWC support .*

68. The lack of mental health support for Care Workers was a major oversight in the management of the pandemic. Care Workers were exposed to high levels of trauma, particularly in care homes where they witnessed multiple deaths and experienced significant emotional strain. Despite this, there were no formal systems of debriefing or psychological support in place, leading to widespread mental health challenges among the workforce.

69. It took a substantial emotional toll on care staff, concerned as they were not only for the wellbeing of their patients and residents but also for their own families and loved ones, as they worked to understand the nature of the disease and protect people to the best of their ability.

70. COVID-19 Issue 3 briefing from the Care Quality Commission (Financial viability and stability in the adult social care sector - Care Quality Commission (cqc.org.uk)) stated "We also said that some providers were struggling with the costs of ensuring they had enough personal protective equipment. These have continued to be themes in some of the discussions our inspectors have been having with providers through our emergency support framework". [Exhibit KG/20 - INQ000542988].

71. In December 2020 Skills for Care issued a report "Investigating the issues facing the BAME workforce and the impact of COVID-19" the issues facing the BAME workforce. They stated "during the COVID-19 pandemic, people – both workers and those cared for – from BAME backgrounds have been disproportionately more likely to become ill or die. BAME workers were also more likely to report a lack of access to PPE and to experience unfair treatment because of their ethnicity. Respondents to their survey said they were anxious about the increased risks faced by BAME staff in relation to COVID-19, and often felt that they were not being sufficiently protected at work. Mental health issues were also a concern, linked to the frustration and resentment of experiencing racism and anxiety about the COVID-19 risk. [Exhibit KG/21 - INQ000542991].

72. In June 2021 Social Care Institute for Excellence (SCIE) issued a report "Challenges and solutions: commissioning social care during COVID-19 – SCIE" [KG/22 - INQ000542990]. The following is contained in the report:

    a. Death rates amongst Care Workers are double the general population – with higher risks still for black, Asian and minority ethnic workers and for men.

    b. Poor terms and conditions for Care Workers added to the spread of the virus. Many don't have contractual sick pay, 25 per cent are on zero-hours contracts working multiple shifts across sites and simply cannot afford to take time off.

    c. Recruitment and retention are ongoing concerns. Skills for Care estimated that vacancy rates across the sector were 10.3% in May 2022 having risen from 6% in March 2021.

    d. Turnover which decreased early in the pandemic is back above pre-pandemic levels at over 30 per cent and higher in some areas.

    e. Skills for Care also point to sickness rates increasing during COVID-19 and the number of workers leaving or ill due to burn-out.

    f. Recruitment and retention is a major concern especially given higher pay and shortages in other competing sectors. New immigration and Brexit rules have added more pressure (visas are currently only available for professional and more senior roles). Concerns about the loss of workers due compulsory vaccinations has led to the requirement being suspended.

    g. Staff vacancies in care homes rose from 6% in April 2021 to 11.5% in December 2021 with the National Care Forum reporting even higher rates in the not-for-profit sector. New waves of COVID-19 caused additional pressures. Lack of staff plus COVID-19 related absence and infection rates in homes, resulted in many care homes not accepting new referrals in December 2021. This had a significant impact on hospital discharges.

    h. Community-based services have also faced issues with staff sickness, absence, costs, PPE and loss of business. The lack of regular testing for people receiving social care, home care workers, unpaid carers and personal assistants will have accelerated transmission across a range of settings. [Exhibit KG/22 - INQ000542990.

    Issues affecting social care workforce retention

73. The most significant issue affecting workforce retention was the burnout experienced by care workers during the pandemic. Many care workers reported feeling unsupported and overwhelmed by the emotional and physical toll of working through the pandemic. After working through the worst phases of COVID-19, many experienced burnout, with some leaving the sector altogether. Care Worker who received a grant from the CWC stated "*I was working extra hours with staff unable to work due to sickness. There was an eerie atmosphere in the home, the uncertainty of what was going to happen next. I have to admit I did have a little cry in one of the rooms, frightened of catching the virus and taking it home, my husband has occupational asthma and gets very poorly.*" . [Exhibit KG/18 - INQ000474940].

74. In particular, Care Managers and experienced workers were heavily affected. Many of these individuals held on as long as possible, often through personal sacrifice, but once the crisis subsided, they resigned in large numbers. This created a void in the sector, as these were highly skilled and irreplaceable staff with years of experience. Their departure further exacerbated the existing staffing shortages.

75. Even before the pandemic, the care sector was dealing with a high number of vacancies. The crisis only worsened the problem, as the already stretched workforce struggled to cope with increased demand and the health risks posed by COVID-19. The sector's inability to quickly fill these vacancies led to severe workforce capacity issues, making it difficult to respond effectively to the pandemic.

76. Recruiting new staff during the pandemic was a significant challenge. The combination of low pay, high health risks, and the lack of recognition for Care Workers made the role unattractive to potential recruits. Care Workers were often paid low wages, had little job security (especially those on zero-hours contracts), and were not provided with full sick pay or adequate financial support. These factors created barriers to attracting new talent to the sector.

77. The financial issues faced by Care Workers during the pandemic further contributed to the workforce retention problem. Many Care Workers were forced to choose between working while sick or losing income due to a lack of full sick pay provisions. For Care Workers on zero-hours contracts, this decision was particularly difficult, leading to increased job insecurity and further strain on retention.

78. The overlap of the pandemic with rising fuel prices and other cost-of-living pressures made it even harder for care workers to remain in their roles. Some workers reported being unable to afford the cost of fuel to get to work, further reducing workforce capacity. "*I was worried I didn't have enough money for petrol to be able to get to our clients in need, the stress and anxiety and tears as I didn't want to leave my clients without care.*" Care Worker who received a grant from the CWC. [Exhibit KG/15 - INQ000474939].

79. The UK Government's failure to implement meaningful incentives for Care Workers during the pandemic had a direct impact on workforce capacity. While other UK nations such as Wales and Northern Ireland provided Care Workers with a COVID bonus, Care Workers in England were not similarly compensated. This lack of recognition contributed to a widespread feeling of neglect and further disincentivised individuals from staying in or joining the sector.

80. Additionally, the government's handling of policies such as vaccination as a condition of deployment created further workforce challenges. The singling out of the social care sector for mandatory vaccinations, without equivalent requirements in other sectors, led to many Care Workers leaving the profession, reducing the available workforce further.

Financial issues experienced by Care Workers as a consequence of working within the social care sector during the pandemic

81. The report by the Institute of Employment Studies "Potential Impact of Covid-19 Government Policy on the Adult Social Care Workforce" [Exhibit KG/23 - INQ000542992] states the following:
    a. "one of the most pressing financial issues was the absence of full sick pay for care workers. Many Care Workers were employed on zero-hours contracts, which meant they did not receive any income beyond statutory sick pay if they were ill or needed to self-isolate. This forced workers to make difficult choices between going to work while sick (potentially spreading COVID-19) or staying home without pay, resulting in financial hardship".
82. The loss of income during periods of illness had catastrophic consequences for Care Workers, many of whom were on low pay. Losing two weeks' wages could lead to workers being unable to pay for basic necessities, such as food or rent. This situation was especially difficult for workers who were already living pay-to-pay.

83. Due to the lack of sick pay and other financial protections, many Care Workers fell into debt during the pandemic. The need to take time off due to illness or to care for loved ones led to significant income loss, which pushed many workers into arrears on their bills or forced them to borrow money. This long-term financial instability added to the overall strain faced by care workers during the pandemic. In his Testimony NR said he had to turn to friends to support him, working on 'minimum wage means there is no room to manoeuvre, you don't have the ability to save up reserves and it's very difficult' [Exhibit KG/24 - INQ000474941].

84. The pandemic overlapped with rising fuel prices and other cost-of-living increases, which further impacted Care Workers' financial situations. Many Care Workers reported to the CWC to being unable to afford the increased cost of fuel required to travel to work, particularly in cases where they worked in community care roles that required driving between clients' homes. Some Care Workers were unable to attend work because of these costs, further impacting their income.

85. Despite lobbying efforts by The Care Workers' Charity and other organisations, the UK Government did not provide sufficient financial support to Care Workers. Unlike in other UK nations (such as Wales and Northern Ireland) Care Workers in England did not receive any special financial compensation for their critical role during the pandemic.

86. For many Care Workers, the financial hardships experienced during the pandemic had lasting consequences. Workers who had to take time off due to illness or isolation found themselves behind on bills or in debt, with limited opportunities to recover financially due to their low wages and lack of job security. This long-term financial strain contributed to the high turnover and burnout seen in the sector after the worst of the pandemic had passed. In his Testimony NR describes being off work for 2 weeks and six weeks on NR felt very weak, had a cough and was breathless. Having survived on SSP during this time he was scared and anxious, worrying if he will be able to return to care work [Exhibit KG/24 - INQ000474941].

Infection Prevention and Control ('IPC')

87. The Test and Trace scheme – lack of support by employers in raising awareness of the scheme and helping their social care employees to apply.

88. Lack of childcare from family members who previously looked after their children. These informal carers were now either shielding, vulnerable or scared that the Care Worker would bring COVID-19 into their homes.

89. Lack of testing kits for Care Workers.

90. Increased demand to avoid contamination – Care Workers needing to purchase white goods in order to wash their uniforms more often.

91. Care Workers restricted to working in one care setting (where previously they may have had jobs in more than one, such as across two or more care homes, or a mixture of jobs in domiciliary care and care home.

92. Services being merged or travel to new services meant an increase in travel costs for some care workers.

93. Death of Care Workers or their close family members.

94. Lack of pay if they needed to look after family members who had contracted COVID-19.

Key decisions made by the UK Government and Devolved Administrations

95. One of the major concerns for the CWC was the significant reduction in the care sector workforce capacity due to shielding requirements. Many Care Workers had to shield because of their own health vulnerabilities or due to the risk of exposing vulnerable family members. This reduced the available workforce at a time when the demand for care services was increasing.

96. The absence of these workers created additional strain on the remaining workforce, leading to burnout and further staff shortages as Care Workers struggled to cover for their colleagues. The lack of government guidance on how to manage this reduction in workforce capacity exacerbated the challenges faced by care providers.

97. Many Care Workers who were forced to shield received little to no financial support. The absence of full sick pay meant that those shielding were left without adequate income to sustain themselves during the pandemic. This not only caused financial hardship for the workers but also contributed to the wider issue of workforce retention, as many shielded workers did not return to the sector after the pandemic due to the financial insecurity they experienced.

98. The CWC noted that the government did not put in place sufficient plans or support mechanisms to manage the workforce capacity issues caused by shielding. There was little coordination or guidance on how care providers should address the significant workforce shortages caused by shielding requirements, leaving many providers in crisis as they struggled to maintain care services with reduced staff.

99. The decision to mandate vaccination as a condition of deployment for social care workers, but not for other sectors (including the NHS), was one of the most controversial government policies. The CWC had major concerns about this policy, as it singled out the social care sector for mandatory vaccinations, leading to feelings of discrimination and frustration among Care Workers. [Exhibit KG/25 - INQ000325334].

100. Many Care Workers felt that they were being unfairly targeted, especially when other frontline workers were not subject to the same requirements. This policy led to a significant number of care workers leaving the profession, further exacerbating the workforce shortages in an already strained sector. This had a catastrophic impact on workforce capacity and retention, with providers struggling to fill the gaps left by departing workers.

101. The timing and rollout of the policy were also problematic. It was introduced during a period of severe workforce strain, and the lack of adequate planning or consultation with the sector left care providers unprepared for the sudden loss of staff. The CWC was concerned that the policy had been implemented without proper consideration of the long-term effects on workforce capacity. [Exhibit KG/026 - INQ000542993].

102. Even after the policy was reversed, the damage had already been done. Many workers who left due to the mandate did not return, leaving the sector with a lasting recruitment and retention problem. The policy also contributed to a wider sense of distrust and disillusionment among Care Workers, who felt that the government did not value their contributions or consider the impact of such policies on their livelihoods.

The management of the pandemic in adult social care

103. An Age UK report in November 2020 "Time to bring our care workers in from the cold" (page 6 para 3) states "The NHS was considered a higher priority, receiving state acquired PPE ahead of care services. For many providers, the sheer cost of privately sourced PPE prevented them from being able to obtain adequate amounts for their staff. Some reports suggested that the cost of PPE had gone up twelve fold since the start of the pandemic, with the cost of gloves up by 30%, aprons by 166% and masks by 1000%x. These sky high costs continue to be a serious threat to the financial viability of many care providers". Testimony (pg 7) from NR: There has not been enough PPE - like our lives and that of my family don't matter". [Exhibit KG/14 - INQ000532614].

104. The government did not classify social care workers as key workers at the same time as NHS staff, which delayed their access to priority shopping hours and PPE. This delay created significant hardships for care workers who were already dealing with high levels of stress and risk.

105. One of the most pressing issues was the inconsistency and lack of clarity in government guidance. Care providers received conflicting advice from different agencies, including Public Health England, local authorities, and the Care Quality Commission (CQC).[Exhibit KG/027 – INQ000543007].

106. These guidelines were often issued late on Fridays, leaving providers scrambling over the weekend to interpret and implement them. The constant changes and unclear messaging made it difficult for care providers to stay compliant while managing the immediate needs of their staff and residents.

107. The management of PPE supplies was poorly handled, with the NHS being prioritised over social care. Many care providers struggled to source adequate PPE, especially in the early stages of the pandemic. This placed both Care Workers and residents at significant risk.

108. Home care workers and personal assistants, who worked outside of larger care settings, were particularly disadvantaged in accessing PPE. This failure to provide equal protection across the sector further marginalised these essential workers.

109. One of the most damaging aspects of the pandemic management was the decision to discharge patients from hospitals into care homes without adequate testing to confirm that they were COVID-free. This decision directly contributed to the rapid spread of the virus in care homes, leading to devastating loss of life. [Exhibit KG/028 – INQ000543002].

110. Care homes were put in an impossible position, often under pressure to accept hospital discharges, even when it was clear that this would put their residents and staff at risk. This mismanagement not only increased the death toll in care settings but also created mistrust between care providers and the government.

111. Despite the crucial role Care Workers played during the pandemic, the government failed to provide adequate financial support to those in the sector. Care workers did not

receive full sick pay, forcing many to work while ill or to suffer significant financial hardship when self-isolating.

A summary of CWC's views and concerns about:

112. The introduction of key-worker status for care workers was significantly delayed. Unlike NHS workers, Care Workers were not granted the same priority when the pandemic began, resulting in difficulties accessing essential services such as priority shopping hours and personal protective equipment (PPE). This delay in recognition severely hindered their ability to fulfil their critical roles during the pandemic.

113. When key-worker status was eventually introduced, its implementation was inadequate. Unlike NHS staff, Care Workers did not have access to a unified identification system that would allow them to easily prove their key-worker status, making it difficult for them to access the benefits available to key workers. For instance, Care Workers often could not bypass queues in shops or access other priority services, leading to unnecessary challenges in both their personal and professional lives.

114. The CWC was particularly concerned with the inconsistent approach to key-worker status across the UK. In regions such as Northern Ireland and Wales, Care Workers were treated more favourably than in England, where the lack of cohesive government planning left many without proper recognition or support for a prolonged period.

115. One of the most significant concerns raised by the CWC was the absence of a COVID bonus for care workers in England. [Exhibit KG/06 INQ000542997] as was the case in other parts of the UK. This underscored the government's failure to fully acknowledge the vital role Care Workers played in responding to the pandemic. Many Care Workers were already earning low wages, and the absence of additional financial support exacerbated the economic challenges they faced during this demanding period.

116. A further critical concern was the absence of full sick pay for Care Workers. Most Care Workers, particularly those on zero-hours contracts, were only entitled to statutory sick pay, which was insufficient to cover their living costs if they were required to isolate or became ill.

117. The CWC repeatedly requested additional government funding to provide sick pay grants to care workers, but these requests were denied. The absence of this crucial financial support led to significant financial hardship for many Care Workers and further contributed to the decline in workforce morale and retention.

Lack of other support from the UK Government and Devolved Administrations for care workers.

Mental health support (sub heading)

118. The UK Government and the Devolved Administrations failed to provide adequate mental health support to Care Workers, despite the immense emotional and psychological strain they endured during the pandemic.

119. The CWC noted that the absence of formal mental health support contributed to burnout and the high turnover of staff. Many Care Workers left the sector after feeling unsupported during the most challenging periods of the pandemic.

Personal Protective Equipment

120. While personal protective equipment (PPE) was prioritised for NHS staff, social care workers struggled to access sufficient protective equipment, especially in the early stages of the pandemic.

121. Moreover, the system for accessing PPE was not designed with social care workers in mind, particularly for those working as personal assistants or in smaller home care settings, leaving many vulnerable and inadequately protected for extended periods.

Funding for care workers

122. Lack of financial support to Care Workers who contracted COVID-19; lack of funding during shielding including those Care Workers deemed particularly vulnerable to the virus. This was apparent given the number of Care Workers who applied to the CWC for financial support during the pandemic and could evidence that they were only eligible for SSP from their employers, or to minimum sick pay if they contracted the virus [Exhibit KG/22 – INQ000542990].

123. The CWC requested government funding for care worker grants, particularly to help workers with the financial burdens caused by the pandemic, but these requests were refused. This lack of financial support left many Care Workers struggling to cover basic living expenses, exacerbating the financial challenges they faced.

124. The Care Workers' Charity applied to the UK Government for funding to provide sick pay grants to care workers during the pandemic, but these requests were declined. As a consequence, many financially vulnerable Care Workers, lacking sufficient sick pay, were unable to isolate or shield when necessary.

Vaccination as a condition of employment

125. The CWC also expressed deep concern over the government's decision to introduce vaccination as a condition of deployment specifically for care workers. This policy singled out social care staff, creating a sense of inequity, particularly as NHS workers were not subject to the same requirement at the outset.

126. This policy led to a significant number of care workers leaving the sector, further exacerbating workforce capacity issues. Although the government eventually reversed the policy, the damage to the workforce had already been done, leaving numerous vacancies unfilled and contributing to the ongoing recruitment crisis in the care sector.

127. Beyond the immediate response to the pandemic, the UK Government's long-term neglect of systemic issues in social care has worsened the challenges faced by Care Workers. The pandemic exposed the sector's pre-existing fragility, including low pay, poor working conditions, and a lack of professional recognition. [Exhibit KG/13 - INQ000542981].

128. The CWC continues to advocate for better pay, the professionalisation of Care Workers, and a more sustainable workforce strategy, as these issues remain insufficiently addressed by the government, even after the worst of the pandemic has subsided.

Infection prevention and control ('IPC')

129. Lack of availability of PPE for care workers, particularly personal assistants and those on zero-hour contracts. [Exhibit KG/ 29 -INQ000542995].

130. Lack of information regarding Test and Trace and the Infection Control Fund and how care workers could access and information regarding any impact this may have on benefits they were receiving [Exhibit KG/22 – INQ000542990].

131. The Infection Control Fund was launched in May 2020 with the first fund closing at the end of October that year. The final fund closed in June 2021. A Health Foundation Report "How is COVID-19 impacting people working in adult social care? in January 2021 stated" Social care workers faced among the highest mortality rates by occupation during the first phase of the pandemic and sickness absence rates more than doubled between February and October 2020. To an extent, care work – which often demands close personal contact –

carries increased risk of COVID-19 exposure. Staff are also at higher risk of getting the virus and of dying from it because they are older and more ethnically diverse than the general population – a quarter are aged 55 and older and 21% are from black and minority ethnic backgrounds. And the government was slow to implement policies (for example to ensure staff had access to enough PPE and comprehensive testing) to protect the sector. [Exhibit KG/030 – INQ000231639].

Working conditions impacting Care Workers' ability to self-isolate and/or shield:

132. A significant proportion of Care Workers were employed on zero-hour contracts, which resulted in job insecurity and made it exceedingly difficult for workers to self-isolate or shield during the pandemic. These contracts did not guarantee regular hours or income, meaning that Care Workers were often hesitant to take time off when required to isolate, as they faced the risk of losing their income entirely.

133. For many Care Workers on zero-hour contracts, missing work equated to receiving no pay at all, leaving them financially vulnerable. This situation led to instances where Care Workers continued to work despite displaying symptoms of illness or having potential exposure to COVID-19, thereby increasing the risk of transmission within care settings.

134. The absence of standardised employment protections for Care Workers further hindered their ability to shield or self-isolate. Those employed on temporary or agency contracts experienced even less security than those on permanent contracts, heightening the risk of financial hardship if they opted to stay home when ill or at risk.

135. The vast majority of Care Workers did not have access to full sick pay, particularly those employed on zero-hour contracts. Instead, they were often limited to statutory sick pay (SSP), which was substantially lower than their regular earnings. SSP was insufficient to cover basic living expenses, such as rent, utilities, and food, especially for those already on low wages.

136. The inadequacy of sick pay provisions compelled many Care Workers to continue working while unwell, as they could not afford the loss of income that would result from staying home to isolate. This situation not only jeopardised their own health but also the health of their colleagues and the vulnerable individuals in their care. Many Care Workers were forced to make the difficult choice between financial survival and safeguarding their own health and the health of others.

Inequalities in the impact of the pandemic and discrimination experienced by workers of protected characteristic groups

137. The care workforce is predominantly comprised of women, who were disproportionately affected by the pandemic. Many female Care Workers had additional caregiving responsibilities at home, such as looking after children or elderly relatives. The pandemic exacerbated existing gender inequalities, with women disproportionately bearing the burden of both professional and personal caregiving responsibilities, often with limited support.

138. Migrant workers, many of whom are essential to the adult social care workforce, were particularly disadvantaged during the pandemic. Workers with no recourse to public funds (NRPF) were unable to access financial support from the government, rendering them entirely dependent on their income from employment. This lack of a safety net made it nearly impossible for these workers to take time off to isolate or shield, as they had no financial means to support themselves in the absence of work.

139. These workers were disproportionately affected by the pandemic due to their financial vulnerability and limited access to benefits. The CWC observed that migrant workers, who

already face systemic challenges such as discrimination and lower job security, were placed in an even more precarious position during the pandemic. NR describes in his Testimony "I have not been able to claim benefits as I'm self employed and have just changed to self employed 3 months ago and not entitled to anything. I have had to struggle with the wage I've had left over" [Exhibit KG/31 - INQ000474942].

140. The pandemic also exposed broader racial and ethnic disparities within the care workforce. Workers from minority ethnic backgrounds were more likely to be employed in lower-paid, precarious roles within the care sector, and were disproportionately impacted by the health risks associated with COVID-19. Many of these workers faced higher levels of exposure to the virus, and the financial insecurity resulting from inadequate sick pay and job protections further hindered their ability to shield or self-isolate.

141. The lack of access to sufficient financial and employment support exacerbated pre-existing inequalities. For example, Care Workers with NRPF were excluded from government relief schemes, such as furlough, and were unable to access universal credit or other benefits. This exclusion left them more vulnerable to both financial hardship and the health risks associated with working throughout the pandemic.

Other concerns or issues

142. One of the CWC's longstanding concerns, which was further exacerbated by the pandemic, is the absence of professionalisation and regulation within the social care workforce. Unlike NHS staff, Care Workers do not have a formal registration system, which results in a lack of professional recognition, structured career development, and access to standardised benefits, such as identification cards. This deficiency had a significant impact during the pandemic, as care workers were not prioritised for essential services such as personal protective equipment (PPE) and priority shopping, thereby impairing their ability to perform their roles effectively.

143. A further concern is that, despite being at the frontline during the pandemic, Care Workers were not adequately represented in government decision-making processes. The social care sector's perspectives were frequently overlooked in favour of the NHS, and this lack of representation led to the formulation of policies that failed to fully address the needs and challenges faced by the sector.

Recommendations.

144. The CWC recommends that the Chair advocate for the professionalisation and registration of the care workforce to include a professional body. By establishing a formal registration system for Care Workers, akin to that which exists for NHS staff, Care Workers would receive the recognition and status they rightfully deserve. This would also facilitate improved access to essential services during emergencies, such as prioritisation for personal protective equipment (PPE) and access to critical supplies.

145. The introduction of comprehensive sick pay provisions for all Care Workers should be a key recommendation. The absence of sufficient financial support during the pandemic led to Care Workers continuing to work while ill, thereby placing themselves and others at significant risk. Providing full sick pay would promote better health practices and ensure that Care Workers are not forced to choose between safeguarding their health and maintaining their financial stability.

146. To review funding for the adult social care sector system with a view to increasing the funding year on year.

147. The Chair should further recommend the implementation of formal mental health support services for Care Workers. The pandemic underscored the severe emotional strain

placed on those working in social care, with many Care Workers experiencing burnout, anxiety, and depression. A national framework for mental health support within the sector is essential to addressing these issues and to ensuring the long-term retention of staff.

148. The CWC strongly recommends that future government strategies for pandemic or emergency response accord equal priority to the social care sector, alongside the NHS. The failure to do so during the COVID-19 pandemic had dire consequences for Care Workers and those in their care. Proper recognition of the social care sector's integral role within the broader health system is critical for future preparedness.

Positive responses by the social care sector during the pandemic

149. One of the indisputable successes during the pandemic was the resilience and dedication exhibited by Care Workers across the United Kingdom. Despite encountering significant challenges, such as the lack of personal protective equipment (PPE), low wages, and the emotional toll of caring for vulnerable individuals during a global health emergency, Care Workers continued to deliver essential services under exceptionally difficult circumstances.

150. Many Care Workers made considerable personal sacrifices, including residing within care homes or the homes of clients to minimise the risk of transmitting COVID-19 to their own families. This commitment undoubtedly saved numerous lives, although it was not widely recognised by either the government or the general public.

151. Care providers demonstrated the ability to swiftly adapt to the evolving demands of the pandemic. This included the implementation of infection control measures, the creation of isolation areas, and the reorganisation of staffing arrangements to cover for those workers who were either unwell or shielding. These efforts were instrumental in mitigating the spread of the virus within care settings, despite the significant challenges faced by the sector.

Inequalities which affected care workers during the pandemic

152. The Equality and Human Rights Commission Report "Experiences from health an social care: the treatment of lower-paid ethnic minority workers, June 2022) [Exhibit KG/32 – INQ000543006] states the following:

a. Workers on casual, zero-hours contracts are not guaranteed any regular work. Resolution Foundation's analysis of the Labour Force Survey (2017–2019) suggests one in 10 frontline Care Workers are on zero-hours contracts. This is much higher than the one in 40 of the working population as a whole.

b. In adult social care, our evidence suggests that workers often are unaware of their rights and entitlements. This was the case particularly for homecare workers. There were various reasons for this. Sometimes it was due to remote, 'hands off' management of workers – particularly in the case of commissioned-out roles. Unclear payslips and language barriers for migrant workers increased this lack of awareness.

c. In England, data produced for our inquiry by Skills for Care identified that ethnic minority care workers in the independent care sector were more likely to be on zero-hours contracts than their White British colleagues. This was the case particularly for homecare workers in the independent sector, in which 71% of ethnic minority workers were on zero-hours contracts compared with 59% of White British workers in March 2020. As with other racial disparities in outcomes, the causes of this difference are likely to be complex and multifaceted.

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

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Date: 3/21/2025