THE UK COVID-19 INQUIRY

TRADES UNION CONGRESS:

WRITTEN CLOSING FOR MODULE 6 ON THE SOCIAL CARE SECTOR

INTRODUCTION

1. This is the closing 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) infection prevention and control; (B) regulatory intervention in the care sector; (C) vaccination of social care workers (**'SCWs'**); (D) movement of staff between care settings; (E) financial support for SCWs; (F) insecurity of work, including migrant workers and the issue of structural racism; (G) sectoral reform; and (H) a summary of lessons learned.

3. Whereas our opening submissions to this module focussed primarily on the impact of the pandemic upon those working in the care sector, these closing submissions will focus on the lessons to be learned. Many of the lessons flow directly from the harms caused to the social care workforce, and to those relying on its services.

A. INFECTION PREVENTION AND CONTROL

Training and guidance

4. The evidence in this module has demonstrated that the social care workforce did not benefit from the quality IPC training, guidance and resource which could have improved their safety significantly during the pandemic.[1] The position was particularly poor in respect of domiciliary

[1] [6/8/9 - 6/10/25]; [6/174/17 - 6/179/23].

care. Christina McAnea (the TUC) reflected in her evidence that the guidance as it applied to domiciliary care appeared to be *'made up on the hoof'* with no real thought.[2]

5. In closing submissions in Module 3 we suggested that health care workers should be empowered to implement IPC measures, and that there needs to be significant investment in training because a 'whole workforce' approach is required.[3] The position is the same in respect of the social care sector; and, in many senses, the requirement is *more* urgent due to the practical realities of a sector which includes over 18,000 employers in a largely unregulated market, rife with poor commissioning practices. The TUC considers that the workforce deserves, at the very least, the protection associated with adequate IPC training and resource.

6. The capacity to deliver quality IPC training and guidance in the social care sector will be greatly improved by some of the recommendations which have been endorsed by witnesses in Module 6, including: improved status and professionalisation of the workforce, the introduction of a register of care workers, greater tri-partite mechanisms of social partnership for the sector, and improved centralised oversight. At the moment, it is not possible, given the fragmentation in the sector, to deliver a robust system of training, and monitoring of compliance with IPC. The solution is therefore two-fold. There must be standardised training for the social care workforce, as well as teams of IPC experts responsible for producing high-quality guidance which is specific to the on-the-ground challenges which arise in diverse social care settings, and achieving this will require investment. However, there must also be the systems in place in the social care sector to disseminate guidance and monitor the delivery of standardised training. This requires reform of the kind which we address at paragraphs 68 to 78 below.

Planning and preparation

7. A recurring recommendation throughout the life of this Inquiry has been that far greater planning and preparation is required in respect of PPE – not just about how it is manufactured or procured, but also in respect of how it is distributed to the workers who need it. That recommendation is especially relevant in the context of Module 6. We have heard evidence during the module that distribution of PPE to social care settings was complicated by the lack of data held centrally on both providers of social care and the workforce itself. We have similarly heard evidence that the fragmentation in the sector, including in relation to the level of privatisation, made distribution of PPE much more difficult.[4] This evidence again reinforces the need for reform – in terms of systems, data and communication with the workforce. Without

[2] [6/194/16 - 6/195/18].
[3] INQ000532406/23-24 para 67.
[4] [6/175/4 - 6/177/3].

that reform, important recommendations in respect of planning and preparation will not have the intended impact.

8. As urged by Ms McAnea, there should be a central distribution system for social care, as there was for the NHS – and the system should be in place and functioning now.[5] Individual providers of PPE should be required to hold their own stocks of PPE, and planning needs to take account of how those stocks will be replenished in circumstances of emergency. It is clear from the evidence that, at the outset, there was a level of confusion regarding responsibility for sourcing PPE for the private sector.[6] As Ms McAnea set out: '[there] *was no proper system for distribution from any central resource. Some were resorting to trying to buy their own from different providers. Even in the union,* [...] *some of our branches were actually buying PPE from wherever they could get it to distribute to the members. And they were going to workplaces to give them PPE and give them masks and gowns* [...]'.[7] Plans should acknowledge that in the circumstances of a crisis, central and local government must be ready to step in to support all settings, including the private sector.

Level of PPE

9. Helen Whately (former Minister of State for Care) raised in her oral evidence an important question regarding the level of PPE which may be appropriate in a future pandemic of an airborne virus. She recalls asking on multiple occasions during the pandemic: *'is the PPE not working?'*.[8] Ms Whately reflected on research which shows that in intensive care, where higher levels of PPE were provided, transmission of Covid-19 was lower than in ordinary hospital wards.[9] This is an issue in common with Module 3, and we endorse the same recommendation as we did in that module:[10] FFP3 should be recommended for all staff likely to come into contact with the virus- where there appears to be more than negligible airborne transmission.

10. If higher levels of PPE were provided, with the appropriate fit-testing and training required to ensure effectiveness, this would likely reduce transmission and, in so doing, reduce the pressure on other issues which have dominated the evidence during Module 6, such as transmission associated with movement of staff between care settings, and vaccination as a condition of deployment.

[5] [6/175/7 - 6/177/5].
[6] [6/105/14 - 6/107/25].
[7] [6/175/20 - 6/176/3].
[8] [12/7/19-23].
[9] [12/80/1-24].
[10] INQ000532406/26 para 75.

Parity with the NHS

11. A key theme in our opening submissions was the impact upon the social care workforce of being secondary to the NHS in terms of priority for PPE. As Ms McAnea described in her oral evidence, care workers '*were always the last to be considered when it came to how you would distribute PPE'.*[11] As with the quality of the IPC guidance, supply of PPE was another issue where the domiciliary workforce was particularly disadvantaged. We commend to the Inquiry the words of Professor Rayner, who highlighted the need to '*recognise the professional kind of expertise of the social care sector as equal partners when decisions are being made* [...] *at a local level, a regional level and a national level'*.[12] She said: *'I suppose my ultimate message is that we need those decision makers to think about social care first. It's not Cinderella. It's not the handmaiden of the NHS. It's a vital public service that's the backbone of communities. And we forgot that then and we must never do that again*'.[13]

12. In relation to the delay in introducing face mask policies in social care compared to the NHS, Matt Hancock (former Secretary of State for Health and Social Care) stated during oral evidence that: *'it comes back to the very first thing we discussed, which is that in the NHS, we could just make this decision and get on with it. In the world of social care, we had to get cross-government agreement for a decision like this and it took a whole lot more effort* [...] *The NHS is a hierarchical organisation* [...] *And it was under a centralised system, emergency system, where if NHS England said something was policy, that's what people did'*.[14] This observation again, underlines the need for reform in order to create greater centralised oversight and improved social partnership, data collection and lines of communication within the social care sector; please see paragraphs 73 to 78 below regarding plans for a National Care Service.

B. REGULATORY INTERVENTION IN THE CARE SECTOR

A regulatory vacuum

13. A key question explored during public hearings in this module has been the decision by the CQC, Care Inspectorate Wales, Care Inspectorate Scotland and the RQIA, to take a step back from regulatory activity, including by pausing routine inspections.

14. The decision to adapt and change regulatory functions at the outset of the pandemic is not one which the TUC challenges – it is clear that regulators needed to respond dynamically to a crisis of scale. However, the evidence received by this module suggests that there was an overall

[11] [6/177/20-22].
[12] [4/119/10-19].
[13] [4/119/10-19].
[14] [3/126/2 - 3/127/16].

reduction in regulatory activity and support. We cited in our opening statement Natalie Magee of the Belfast Health and Social Care Trust who stated the '*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*',[15] the John's Campaign, Care Rights UK and the Patients Association, who explained '*We and those we supported felt that the CQC abdicated responsibility during the pandemic and that oversight and regulation were lacking*',[16] and Rachel Harvey of Care UK, who set out how '*Care UK did not get any support from the Care Quality Commission, Care Inspectorate or Care Inspectorate Wales. Regulatory inspections and usual provider meetings ceased and there was only very limited communication received from the regulators*'.[17] Indeed, Nadra Ahmed (National Care Association) stated in oral evidence that: '*the CQC went AWOL. There was no support for the sector. They were basically shutting down, although they were telling us that they would be around*'.[18] This is also reflected in the exchange between Peter Wyman of the CQC and Mr Hancock. Mr Hancock sent a text message to Mr Wyman on 16 March 2020: *'I need CQC to pull back more than they are currently planning on inspections & data collection. We are likely going to have people in hotels & it's important people do their best without worrying about box ticking'*. Mr Wyman responded: *'Have pulled right back on inspections - only where we believe abuse or serious harm may be happening. Data collection will be really light touch'*. Mr Hancock said in response: *'The data collection will remain a barrier to people doing things differently*.[19]

15. The TUC agrees with the submissions made in oral closing on behalf of the DPO and John's Campaign, Care Rights UK, and the Patients Association, that the decision pause routine inspections and significantly reduce in person inspections overall reduced opportunities to understand what was happening in the sector and to protect service users.

16. Dr Jane Townson OBE (Homecare Association) highlighted the impact this had upon inspection backlogs, and therefore safety: *'Reduced oversight of service quality due to suspended CQC inspections added to risks for people drawing on services' and that 'By June 2024, 23% of homecare locations remained unassessed, while 37% had ratings that were 4-8 years old*'.[20] She also highlighted that the impact was not equal between residential and homecare settings: *'During the pandemic, the CQC prioritised residential care at the expense of homecare. CQC inspectors stopped visiting homecare services, though did make phone calls to registered*

[15] INQ000586007/82 para 387.
[16] INQ000514104/97 para 250.
[17] INQ000569775/10 para 53.
[18] [13/164/8-10].
[19] INQ000419147/2.
[20] INQ000587670/102 para 427 and /111 para 469.

managers' and that the CQC appears *'to lack resource or the will to perform their roles effectively'*.[21]

17. Significant weight was placed by the regulators during public hearings upon the fact that some of the regulators, including the CQC, continued to inspect in response to concerns raised by staff or members of the public. However, we say that is not sufficient. With visits by family and friends significantly restricted, and an insecure workforce, who are in usual circumstances not empowered to report their concerns, and during the pandemic were under significant additional pressure, it is unlikely that issues would have been reported with any level of consistency. Furthermore, the evidence demonstrates that inspections in response to concerns raised by the CQC, at least, were small in number: just 50 inspections between 16 March 2020 to July 2020.[22] As Paul Featherstone (the National Association of Care and Support Workers) explained: *'if they are going to cut back on inspections, that, to me, is a detrimental step. There should have been more, not less'*.[23]

18. We say that the evidence suggests that there was a failure to dynamically adapt regulatory activity to respond to the challenges posed by the pandemic. Instead of adapting, the regulators stepped back from their responsibilities. A regulatory vacuum was created in social care – as a result, central government knew very little about what was happening inside the sector. Minutes from a meeting Ms Whately conducted with the CQC in July 2020 note: *'it is likely we will see an increase in the number of services that haven't been able to cope during the pandemic- and therefore a spike of these cases being unveiled in the next few weeks'*.[24] The minutes record Ms Whately's 'extreme concern'.[25]

Focus on risk

19. We have highlighted in a number of other modules that, at the outset of the pandemic, there was a failure of the HSE to pivot towards the sectors and areas of work presenting the most risk as a result of the pandemic. The unfortunate evidence is that the CQC did, initially, adapt their regulatory regime in a pragmatic, risk focussed way. Before routine inspections were cancelled in their entirety, Mary Cridge (the CQC) explains that the CQC *'cancelled a number of routine inspections and directed our activity at areas which we considered to have the most risk'*.[26] The CQC chose to focus resource on high risk environments including social- and domiciliary care settings, which, she says, '*presented inherently more risk in terms of opportunities for people to*

[21] INQ000587670/36 para 120 and /37 para 126.
[22] INQ000518408.
[23] [17/147/13-15].
[24] INQ000609960/2-3.
[25] INQ000609960/2-3.
[26] INQ000584245/74 para 218.

suffer unseen harm'.[27] This appears an entirely logical approach: but one which was abandoned when routine inspections ceased.

20. Ms Whately, in her evidence, emphasised the importance of continuing risk-based inspections.[28] We agree – but we suggest that these cannot only be in response to specific concerns raised for the reasons we outline at paragraph 17 above. Targeted inspections focussed on the most risky settings – as the CQC originally planned – are where we suggest the capacity and resource during a pandemic should be directed. Any pause to routine inspections should be as limited as possible given the risk of creating unsafe backlogs, as highlighted by Dr Townson. Where risk-based inspections are pursued, there should not be a significant dropping-off of the level of inspections. The aim should always be to continue to inspect at the same as or higher frequency than during non-pandemic times, whilst recognising that the purpose and form of those inspections will likely need to adapt. The TUC is clear that, in the circumstances of a pandemic, where risk is inevitably higher, regulators should step forwards, not back.

21. The HSE has a limited focus on the social care sector in non-pandemic times. However, the HSE is highly skilled in inspecting and supporting sectors where there is a high level of risk, and in investigating and conducting inspections in response to identified incidents or concerns. We have heard evidence in this module that, after the pandemic, the CQC has undergone transformation (plans which were opposed by the joint trade unions at the CQC), which it now regards as a '*failed transformation'*.[29] The TUC would suggest that there should be a greater level of flexibility and co-working between regulators, such that the HSE can step into sectors which are identified as high risk during a pandemic. As we suggested in Module 3,[30] the HSE should be ready to pivot its regulatory oversight towards sectors which it ordinarily has a more limited role in. The TUC considers that responsibility of regulators, and how they can work together to identify and respond to risk during a pandemic, would benefit from urgent consideration and review.

Continued in-person inspections

22. Both in his text messages to Mr Wyman and during oral evidence in Module 6, Mr Hancock described routine regulatory inspections as 'box ticking'.[31] There appears to have been a fundamental misunderstanding by Mr Hancock of the importance of routine in-person inspections. It is clear from the evidence that Ms Whately recognised the grave risks associated with reducing in person inspection activity. Similarly, Ms Cridge stated in evidence that she does

[27] INQ000584245/74 para 218.
[28] [12/122/23 - 12/124/17].
[29] [5/32/17 - 5/33/3].
[30] INQ000532406/31-32 para 93.
[31] [3/154/15-23].

not recognise the description of inspections as just box-ticking exercises of little or no merit.[32] We suggest that a key finding to arise out of this module should be the importance of maintaining in person inspection activity wherever possible.

23. Ms Cridge emphasises in her supplementary statement the importance of in person inspections: *'CQC recognises that on site inspections are an integral part of regulation and that, in the event of a future pandemic, strenuous efforts should be made to protect the ability to carry out on site inspections as much as is practically possible. On site inspections, together with other forms of regulatory activity, play a vital role in assuring the safety and quality of services for the adult social care sector'*.[33]

24. There will always be a balance to strike between the risk of transmission into care settings which could potentially result from a visit from an inspector, and the risk arising from failing to adequately inspect and regulate. We suggest that this balance was not struck during the Covid-19 pandemic. Ms Cridge set out in her supplementary statement that the *'CQC did not want to put our employees, or anyone that we came into contact with, at any greater risk than they already were'*.[34] We suggest that there was too strong a focus on the potential risk of transmission – leading to regulators and central government overlooking the importance of inspections in maintaining safety in care settings.

25. Ms Cridge accepted in oral evidence that, had the CQC had the same stocks of PPE and testing as the health services, a different decision could have been made in respect of pausing routine inspections.[35] Indeed, when inspections did resume, UNISON heard from its members that inspectors were often having to fight for appropriate PPE, access to testing and access to the vaccination programme in much the same way as the social care workforce. It is the TUC's position that individual inspectors made significant efforts to safely inspect care settings in difficult circumstances, even as the wider regulatory regime stepped back – but that they were failed by the lack of planning and preparation which also failed many SCWs.

C. VACCINATION OF WORKERS

Vaccine confidence

26. Sir Sajid Javid (former Secretary of State for Health and Social Care) has stated in evidence that it is important to build vaccine confidence during non-pandemic times, given the difficulty of doing so during a crisis. Sir Sajid said in his statement to this module: *'I do think that the*

[32] [5/7/1-16].
[33] INQ000587795/13 paras 41-42.
[34] INQ000587795/7 para 18.
[35] [5/12/8 - 5/13/18].

education process regarding the value of vaccinations is something that should be happening in 'peace time' and should be led by people in the community. Vaccine uptake may have been higher and more widespread if we had started several years earlier and won the confidence of the public'.[36] This appears an entirely sensible suggestion. However, it is also true that during a pandemic it will be necessary to share information about the specific vaccine workers are being asked to take. Accounts and survey data collected by the TUC suggest that many care workers who had *general confidence* in vaccines, and, for example, happily took the flu vaccine each year, did not have confidence in the Covid-19 vaccines. This was due to: concerns about the speed at which the vaccines were developed and the adverse reactions suffered by some; and due in part to the general climate of anxiety and lack of confidence in leadership and government which pervaded the experience of Covid-19 for many care workers.

27. However, it is clear from the survey data that mechanisms for sharing information about vaccines and providing support to care workers were not in place or were ineffective. In a survey of over one-thousand six-hundred care workers, 58% said that they did not feel they were given enough information and support by their employers regarding the Covid-19 vaccines.[37] Witness evidence provided to this module from TUC witnesses who were subject to the VCOD policy supports those findings.[38] Jacqueline Kitchen, a care worker who felt she had no choice but to get the vaccine, told the TUC that she was worried because a local radio presenter had died from an adverse reaction and because some of her colleagues had to have time off work with bad reactions. She said: *'I feel that more information could have been shared with workers in the care sector in order to put people at ease. Some limited information was provided to me by my employer, but it was really just a leaflet which listed out the ingredients of the vaccine.* [...] *I do not recall consultations or information sessions being offered to me or to my colleagues to reassure us'*.[39] Similarly, Senga Walker, a care worker who refused to get the vaccine for fear of an adverse reaction, having suffered adverse reactions to vaccinations previously, said she was not offered any support to help her decide whether the vaccine would be safe for her and was just told by her employer that she must get the vaccine or she would lose her job.[40]

28. This lack of information and support likely impacted unequally upon Black, Asian and Minority Ethnic workers. Higher levels of hesitancy amongst some minority ethnic groups can be linked to concerns about the number of minority ethnic people included in clinical trials, and fears stemming from historical unethical research.[41] These concerns are amenable to resolution through the provision of information and culturally competent engagement.

[36] INQ000587755/74 para 190.
[37] INQ000587934/4.
[38] INQ000614382/5 and INQ000614383/3.
[39] INQ000614382/5.
[40] INQ000614383/3.
[41] INQ000315604/10-11 para 17.

29. On being asked about the survey statistics demonstrating that 58% of SCWs did not feel that they were given enough information and support regarding the Covid-19 vaccines, Sir Sajid confirmed his prior evidence that the *'fact that the NHS is a centralised state body* [meant] *it was easier* […] *for* [vaccine] *hesitation to be addressed'*.[42] He endorsed the need to develop centralised mechanisms for communicating with care workers. Ms Whately similarly stated that despite there being a programme designed to address fears about vaccination, because there was no register of care workers there was no way of knowing whether this information reached care workers.[43] Ms Whately considered that registration of care professionals would assist, and noted that greater unionisation of the workforce *'would* [provide] *a channel of communication'*.[44]

30. The TUC suggests that recommendations which would appropriately support vaccine confidence and dissemination of information about vaccines to SCWs in a future pandemic include: registration of the workforce; improved mechanisms of social partnership in the social care sector; and work to develop improved mechanisms of communication between central government and the workforce.

Vaccination as a condition of deployment

Impact on the workforce

31. The TUC holds serious concerns about the impact which mandating the Covid-19 vaccination had upon vaccine confidence during the pandemic – and considers that mandating it in circumstances where workers were not adequately informed and supported was especially detrimental. If another pandemic strikes and the response relies on high rates of vaccination, the TUC is concerned that the handling of the VCOD policy during the Covid-19 pandemic may have detrimental effects upon vaccine uptake by SCWs and their communities – unless important work is done now to re-build confidence.

32. The TUC has received through surveys significant evidence from care sector workers that it had that impact. Workers describe the vaccine mandate as being *'pressurised'*, *'forced'* and *'like blackmail'*.[45] 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'*.[46]

33. Prof Dame Jenny Harries (former Deputy Chief Medical Officer for England) has expressed concern that pursuit of the VCOD policy may impact upon trust and confidence in vaccines more generally, and in turn upon vaccine uptake in the future: *'on 15 February 2021, I provided my*

[42] INQ000474381/61 and [9/106/23 - 9/107/24].
[43] [12/192/1 - 12/193/15].
[44] [12/192/16 - 12/192/23
[45] INQ000587821/27 paras 117-118.
[46] INQ000587821/30 para 130.

further views to DHSC with respect to mandating vaccination for care home workers [...] *The challenges were* [...] *importantly the potential decrease in trust and uptake of vaccination more widely, particularly in a critical carer workforce, many of whom were from ethnic minority heritage. This included the potential for staff to feel stigmatised, and of a potential longer term detrimental impact of worsening health inequalities if vaccination rates subsequently reduced'*.[47]

34. Similarly, Joanna Killian (the Local Government Association) has highlighted the low levels of support for VCOD policies from the care sector and noted that there was '*a consistent message from stakeholders that encouragement and support were better than threats of being sacked ("no jab. no job") in increasing take up'*.[48] Ms Killian set out that the LGA cautioned at the time that the approach proposed could entrench vaccine hesitancy, and notes that subsequent evidence suggests that this risk did indeed transpire as a result of VCOD policies.[49] She also records a negative impact as a result of the policy in terms of exacerbation of health inequalities.[50]

35. The TUC considers that further research is required to confirm whether that risk of damage to longer-term vaccine confidence, highlighted by Jenny Harries, has transpired.

36. Mr Hancock was directed during questioning to Covid-O meeting minutes estimating that 19,000 people lost their jobs as a result of VCOD.[51] In response, he stated that this was not a *'material number'* in the context of the normal turnover of a workforce of 2.5 million people.[52] The TUC disagrees. In a sector where workforce capacity was in crisis at the outset of the pandemic as a result of over 100,000 vacancies by the DHSC's own estimations,[53] this number is material and significant – a fifth of total vacancies at the outset of the pandemic and the same target recruitment figure which central government hoped to achieve through costly recruitment campaigns during the pandemic. As Ms McAnea set out in oral evidence, going into the pandemic, the sector was dealing with the legacy issues including high vacancy rates and high turnover of staff.[54] Sir Sajid also acknowledged that the social care system was under severe stress, particularly around workforce capacity pre-pandemic, and that it was known that VCOD had the potential to contribute to workforce pressures.[55] Moreover, the figure in the Covid-O meeting minutes only reflects direct losses i.e. those who left because they were not vaccinated by the deadline – and does not reflect the potential for long-term upwards pressure on workforce

[47] INQ000587394/49 para 5.99.
[48] INQ000587382/166-168 para 594.
[49] INQ000587382/166-168 para 594.
[50] INQ000587382/166-168 para 594.
[51] INQ000091577/6.
[52] [3/232/17 - 3/233/9].
[53] INQ000325232.
[54] [6/164/10-24].
[55] [9/51/9-25] and [9/66/24 - 9/67/8].

turnover, as a result of damaged trust and confidence between SCWs, government and their employers.

37. Mr Hancock's blasé discussion of the loss of 19,000 skilled SCW belies an attitude which is commonplace within central government: that SCWs are dispensable and can easily be replaced. This attitude is a problem in itself, which urgently needs addressing if capacity issues in the workforce are to be overcome.

Efficacy of VCOD compared to other methods

38. A study by Public Health England found that: '*making COVID-19 vaccination a condition of deployment may not result in increased willingness to get the COVID-19 vaccination, with most care home employees in this study favouring leaving their job rather than getting vaccinated. At a time when many of the workers already had negative experiences of care work during the pandemic due to perceived negative judgment from others and a perceived lack of support facing care home employees, policies that require vaccination as a condition of deployment were not positively received*'.[56] Participants in the study cited concerns over the efficacy of the vaccine, side effects, and speed of vaccine development. The study concluded: *'these barriers could be addressed by facilitating open, honest, and nonjudgmental communication about the vaccine. Specifically, information provided to care home employees should include the benefits and risks associated with getting the COVID-19 vaccine, and employers should facilitate open and non-judgmental discussions where care home employees have the opportunity to discuss their reasons for not getting the vaccine*'.[57]

39. Similarly, advice provided to the Welsh Government suggested that alternatives to VCOD included increased targeted media and social media coverage, identifying homes that fall under SAGE minimum thresholds and speaking to those homes to ascertain how to improve take-up rates, working with faith leaders and community groups to understand cultural barriers, and offering mobile mop-up services to care homes where staff have faced logistical barriers to getting vaccinated.[58]

40. The TUC considers it highly likely based on the available evidence that VCOD policies are not as effective in driving up vaccine rates amongst workers as the other methods mentioned above, especially when co-designed with unions and the workforce, used in combination with each other, and deployed through social partnership routes. We suggest that more research (potentially involving analysis of international comparators) is required to reliably establish the

[56] INQ000606878/1.
[57] INQ000606878/25.
[58] INQ000492845/8.

efficacy of the VCOD policies deployed during the Covid-19 pandemic, compared with other methods.

41. Ms Whately has suggested that we need a discussion, as a society, about when mandating vaccination is appropriate, and expressed feeling 'uncomfortable' about mandating a new vaccine for SCWs.[59] The TUC agrees, but considers that such a discussion, in order to effective, requires further research as set out above – both in terms of the potential risks and harms associated with VCOD policies, and the efficacy of VCOD policies as compared to methods involving information sharing, consultation, engagement via community leaders, and practical support.

D. MOVEMENT OF STAFF BETWEEN CARE SETTINGS

The impact of the rhetoric around movement of staff between care settings

42. We address first the impact of the rhetoric around staff being the main source of transmission into care homes. This message was uncomfortable for many SCWs – especially for those who were required as a result of either their job description or their terms and conditions to move between care settings, including domiciliary care workers, workers with more than one employment role in two or more care settings, and workers employed by a company with more than one home.

43. Reflecting on an entry in Mr Hancock's 'Pandemic Diaries' which stated that *'the vast majority of infections were brought in from the wider community, mainly by staff*', Paul Featherstone (NACAS) has explained that these comments were hurtful to SCWs and were *'an attempt to distract from the UK government's disastrous discharge policy and inaction to address the risks to the care sector'*.[60] The TUC agrees. We highlighted in Module 2 the inaction of the UK government in addressing the risk of transmission between care settings.[61] It is a refrain which Mr Hancock has repeated on numerous occasions, including in front of this Inquiry. We consider it was a convenient scapegoat for the dire levels of transmission in care homes. It is, however, not a proposition which is supported by the evidence. As Professor Laura Shallcross MBE has explained: as a result of limited testing data from the early stages of the pandemic, it is not possible to identify which of the identified potential routes of transmission was 'dominant'.[62] We invite the Inquiry to reach a finding to that effect.

[59] INQ000587788/113-114 paras 49-53.
[60] INQ000569768/43 para. 167.
[61] TUC written opening submissions in Module 2, para 37.
[62] INQ000613177/9 para 18 and /18-20 paras 39-40.

Addressing the transmission associated with movement of staff between care settings

44. The TUC is clear, however, that movement of staff between care settings was evidently a driver of transmission. The 'Easter six' study found in terms of transmission that: *'Of importance was the fact that while symptomatic staff were self-isolating, they were being replaced by bank staff who moved between care homes'*.[63] Similarly, the conclusions of the Vivaldi study included that: *'*[w]*orking across multiple sites is a strong risk factor for infection in staff'* and *'*[r]*egular use of bank staff is an important risk factor for infection in residents and staff'*.[64]

45. The TUC's position is that it simply was not practical or possible to entirely ban movement of staff between care settings, and that this was known during the pandemic. A paper from Simon Ridley, the Cabinet Secretariat in May 2020 set out: *'DHSC are concerned about the practical implications of a mandatory route. Stakeholders from across the sector highlight the nature of the care workforce and the need to balance adequate staffing levels with measures to prevent transmission of the virus. There is concern that rigidly enforced restrictions may compromise the ability of providers to safely staff homes, as well as impact on the size of the overall workforce. A significant proportion of the workforce are on zero-hours contracts and so are not obligated to come into work if they are faced with restrictions that prevent them working enough hours and impacting their earnings'*.[65]

46. In oral evidence, Mr Hancock stated that he would ban staff movement between care homes in good times as well as pandemics because communicable diseases kill people in care homes all of the time. In defence of this position, Mr Hancock stated that he did not agree that there would not be enough care staff to provide good quality care if staff movement was restricted, because they had reduced staff movement by 90% over the summer and that had not had that consequence, so the final 10% was not going to make a difference.[66] There are, however, two issues with his reliance on this statistic: (1) as a mere matter of logic, it appears highly likely that the 10% of workers who were not reported as having ceased movement were the proportion of SCWs who really could not cease movement and for whom serious capacity issues would have arisen had they ceased movement; (2) the statistic was self-reported by providers, and thus not independently verified in any way.

47. Where we do agree with Mr Hancock is in relation to his questioning in oral evidence around the purpose served by insecure terms and conditions for SCWs: *'But why should we have care home workers on zero-hours contracts anyway? Don't people in care homes deserve highly*

[63] INQ000587394_0034 para 5.62.
[64] INQ000069921/7 and /11.
[65] INQ000198084/2.
[66] [3/107/9 - 3/110/15].

professional, highly organised support with the staff who are in reliable employment? [...] *we should have been more ambitious for the care we give to the most vulnerable in society'*.[67]

48. We similarly commend to the Inquiry the analysis of Vaughan Gething MS (former Minister for Health and Social Services): '[Movement of staff] *is a real problem and a real factor. People going into care homes are what changed the nature of Covid in care homes. And, you know, staff are one of the factors. That's not a criticism of staff, who made extraordinary sacrifices, but if you've got people working between three care homes, then it's much more likely to be a factor* [...] *I don't think it is as simple as just rejigging employment* [...] *what you need to do is you need to do something about sick pay and you need to do something about terms and conditions within the sector more generally. If you work in three different care homes, it almost certainly isn't because you love working in three different settings. It's about how you make your wages up to be able to feed your family and put a roof over your head. If the pay in care homes doesn't mean you can do that in a single employment, people will work more than one job'*.[68] It is not an accident that working in multiple locations, for many SCWs, is the only way to make ends meet; it is the result of decades of government policy which has sought to fragment and cheapen an essential public service.

49. Another barrier to effectively reducing movement of staff was the treasury resistance to providing it through a reliable and effective mechanism such as furlough. Indeed, Ms Whately confirmed in her witness statement that it was the rejection of providing funding through the furlough scheme which led to her abandoning plans to mandate a restriction on staff movement: *'HM Treasury rejected the proposals to compensate staff through the furlough scheme but said that they would consider extending the Infection Control Fund — or creating a new compensation scheme — to support the regulations.* [...] *I responded the next day saying I did not want to go ahead without furlough payments being made (reflecting the fact that this was not an option without HMT approval)'*.[69] The underlying reason is set out in the advice Ms Whately received on this decision, which referred to the difficulty of proceeding with regulations to restrict movement of staff without *'a robust compensation mechanism'*.[70]

50. Ms Whately was asked during oral evidence whether there should be legislation and/or funding to address the issue of movement of staff between care homes. She responded that there needs to be a plan by which you can halt staff movement, but that the greatest challenge is that a greater supply of staff is required, and it must be possible to make up for the lost income. She emphasised the importance of building up the workforce in peacetime '*making it worthwhile working in care so that people would pursue a career in care',* pointing to the assessment of

[67] [3/111/20 - 3/112/1].
[68] [10/39/17 - 10/40/13].
[69] INQ000587788/43 para 167.
[70] INQ000328026/4.

local authorities to ensure they are commissioning care in a way that means care providers '*are employing staff on proper contracts, with decent hours and decent pay and sick pay'*.[71] The TUC agrees entirely with this position. So many of the issues which constrained the response of the social care sector during the pandemic cannot be effectively resolved without important work to improve capacity within the workforce, and, necessarily, the status and terms and conditions of SCWs during peacetime. These issues cannot suddenly be resolved on the eve of a pandemic, and action is urgently needed to address them.

E. FINANCIAL SUPPORT FOR CARE WORKERS

51. It was inevitable, from the outset of the pandemic, that workers – especially those on low incomes – would need financial support to ensure that they would be able to self-isolate. This issue was acute in social care, where many workers are paid at (or, in the case of domiciliary care workers and migrant workers in particular, *below*) minimum wage, and where zero hours contracts and insecure terms and conditions are rife. Mr Hancock recognised this stark reality during oral evidence in Module 6: '*in this country, sick pay is absurdly low, and many people find it difficult not to go to work because of the ridiculously low levels of sick pay, and that leads to disease spreading in the workplace* [...] *Many people are paid hourly, and if you don't do the hours because you're ill, you don't get paid'*.[72]

The issues with the ICF

52. We have addressed in detail in other modules the issues which arose with the schemes set up to provide support to workers on low incomes, such as, in England, the Test and Trace Support Payment Scheme.[73] For the social care sector, the primary mechanism of providing pay for SCWs required to self-isolate was the Adult Social Care Infection Control Fund (**'ICF**').

53. The evidence in this module has demonstrated what quickly became apparent to unions during the pandemic[74] – the ICF was not fit for purpose. This has been illustrated by the TUC through survey responses published in Kate Bell's Module 6 statement on behalf of the TUC.[75] One SCW 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'*.[76] Another explained that '[t]*here seemed to be confusion [about sick pay] so we didn't get it. Staff complained but got nothing*

[71] [12/100/21 - 12/101/9].
[72] [3/44/17 - 3/45/5].
[73] See for example INQ000399530/17-25 paras 46-75.
[74] INQ000119058; INQ000119060; INQ000119061; INQ000119062; INQ000119063; INQ000119064; INQ000119066; INQ000119068; INQ000119070; INQ000119060; INQ000119072; INQ000119073; INQ000119075; INQ000119076; INQ000119077; INQ000119078; INQ000525620.
[75] INQ000587821.
[76] INQ000587821/25 para 106.

and because of this staff still came in if they were sick'.[77] A third said their employer *'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'*.[78]

54. Evidence disclosed by the TUC to this Inquiry demonstrates 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.[79]

55. Dr Townson set out in her statement that the extent to which funds from the Infection Control Fund reached domiciliary care providers was inconsistent and varied significantly by region and provider type.[80] The ICF placed significant burden for distributing the funds upon individual local authorities who were already beyond capacity during the pandemic.

56. It was known within central government that the scheme which was devised was ineffective. Minutes of a Covid-19 Operations Committee Meeting in December 2020 state: '*The ICF was designed to support* [the restriction of movement of staff between care homes] *policy but its weak processes meant that funding was not reaching those who needed it most. The furlough was a well tested mechanism for ensuring that funding reached under-represented groups and was fair* [...] *the Department for Health and Social care knew the ICF was being used to cover some elements of staffing costs* [...] *but it was less clear whether it was being used to compensate staff so that they do not work with another employer*'.[81] That is also made clear from the evidence (referred to above) which demonstrates that Ms Whately declined to implement mandatory restrictions on movement of staff between care homes when it became clear that the Treasury would not allow reimbursement of SCWs for lost wages to be made via the CJRS, as opposed to the ICF.[82] Ms Whately stated in oral evidence that she did give clear instructions to care home providers at the time, but that it is evident subsequently that payment was not happening. She explained that one of the challenges was obtaining the data that would tell them down to a care provider level where use of the funds for paying sick pay was not occurring.[83] Mr Hancock accepted in evidence that he was aware that the issue of flow of the

[77] INQ000587821/26 para 111.
[78] INQ000587821/25 para 107.
[79] INQ000119062/1 and INQ000119075/2-3.
[80] INQ000587670/62 para 237 and /86 paras 361-365.
[81] INQ000091133/5.
[82] INQ000587788/43 para 167 and INQ000328026/4.
[83] [12/87/23 - 12/88/10].

funds from Treasury to MHCLG to councils to providers and then to staff had '*drop-off at every point*', which he described as an issue of governance.[84]

57. It appears that this was due, in part, to lack of planning and preparation prior to the pandemic regarding the inevitable need for such a scheme. Ms Whately described in her statement: *'My aim was to get the money to providers as soon as possible, while making sure there was leverage to ensure it was spent on the measures we had specified in the letter to Local Authorities. I therefore asked the policy team to explore options for a formula to help local authorities pass the funding onto care providers without delay*. [...] *The disadvantage was that local authorities would lose much of their leverage to ensure the money was spent by providers on the things we thought make the biggest difference'*.[85] As a result, a scheme was devised which ensured funds reached providers rapidly, but as a result – financial support in many cases never reached the SCWs it was intended to support.

58. Ms Whately described the issues as stemming from the fact that the ICF was a novel approach, because there was not an existing way to pay providers directly, which meant they had to go through local authorities and rely on them to do a level of due diligence.[86] She noted that local authorities and care providers themselves were complaining that the process was too bureaucratic, with too much reporting – but, reflecting on the issues, Ms Whately stated that, if anything, more reporting is needed to know that the money is being spent as intended.[87]

59. The fact that the ICF was a lump payment to providers intended to cover a range of issues gave too much discretion to employers and made reporting overly complex. As Ms McAnea explained: *'there was a sufficiently high number of providers who had a very poor attitude towards their staff* [...] *I sat through many meetings* [where the tone was] *"We don't want to pay you sick pay because it will set a precedent, people will think they're entitled to sick pay afterwards" or "We don't want to pay sick pay because they'll all basically be, you know, taking advantage of it and going off sick even where they're not sick because suddenly we're going to pay them"* [...] *it was the culture of these are people you can't trust, these are low-paid workers, you can't trust them.'*[88] She explained that '*what we were asking for was that it be mandatory, that it be used for sick pay*'.[89] This is a key lesson learned in respect of any future pandemic.

Statutory sick pay

60. Mr Hancock stated in evidence that he has formed a view that SSP should be higher. He said: *'the implication of the question is that there should be better Statutory Sick Pay. I strongly*

[84] [3/235/20 - 3/237/15].
[85] INQ000587788/82-83 para 330.
[86] [12/179/16 - 12/180/7].
[87] [12/183/9-14].
[88] [6/207/19 - 6/208/9].
[89] [6/209/1-2].

agree. I can't think of reasons not to, other than the direct cost of it. The direct cost, in my mind, is massively outweighed, in normal times, let alone in a pandemic, by the benefits of such a policy'.[90] That is a point which the TUC and its affiliated unions were making at the time, and which the TUC continues to support. We have detailed in submissions to previous modules the reasons, demonstrated by evidence disclosed to this Inquiry, that SSP was not used as the mechanism for financial support for self-isolation, such as the risk of setting a precedent beyond the pandemic or somehow 'incentivising' workers to take unnecessary time off work.[91] We detailed in closing submissions in Module 7 why these reasons are not sound.[92]

F. INSECURITY OF WORK

61. In the background of many of the issues addressed during Module 6 public hearings has been the insecurity of work for many SCWs. Terms and conditions in the sector are generally very poor. As Ms McAnea explained in evidence, social care is one of the worst paying sectors, with some of the worst conditions – and SCWs understandably compare themselves to the NHS workforce.[93] Jeane Freeman noted in her oral evidence that the adult social care sector is disadvantaged in the terms and remuneration to staff and the absence of clear career progression; she explained that the '[f]u*ndamental problem is the terms and conditions*'.[94]

62. The features of insecure work in social care are especially pronounced within domiciliary care. Workers have to travel from home to home, but many are not paid, or not adequately paid, for travel time between care visits. Pay for overnight sleep-in shifts is usually below minimum wage.[95] As Dr Townson set out, workers are paid by the minute – she described this as a 'national disgrace'.[96] Dr Townson also highlighted the industry practices which have created such insecure work – and if a person goes into hospital, the councils and NHS stop paying the provider.[97] This all trickles down to the workforce, who receive unacceptably low pay: 43% are on zero-hour contracts, ordinarily with no company sick pay.[98]

63. Beyond the poor terms and conditions SCWs are subjected to, there are other features of the workforce itself which contribute to insecurity and limit the agency of SCWs to negotiate with their employers, call out unsafe practices and demand better terms and conditions. These features were aptly summarised by Sir Sajid:

[90] [3/221/7-12].
[91] See, for example, INQ000399530/10-16 paras 30-42.
[92] TUC written closing submissions in Module 7, paras 12-15.
[93] [6/172/13 - 6/173/3].
[94] [14/42/7-8].
[95] INQ000587381/2 para 3.
[96] [9/28/5-8].
[97] [9/28/9-21].
[98] INQ000103564/9.

'It was also recognised throughout my time as Secretary of State that the workforce within adult social care would have protected characteristics, in that the majority of the adult social care workforce (whether paid or unpaid) are female, may have disabilities themselves, often have additional caring responsibilities at home, earn little money, and are disproportionately from minority ethnic communities, with large numbers of migrant workers'.[99]

64. The Inquiry has heard in other modules that Black, Asian and Minority Ethnic workers are less likely to complain about lack of PPE, to demand a risk assessment or to push managers to implement the recommendations which flow from a risk assessment. It is a function of structural racism that Black, Asian and Minority Ethnic workers have less agency and feel less able to speak out in the workplace.[100]

65. Similarly, we know that migrant workers are more vulnerable to exploitation because their position within the UK is less stable, and migrant workers commonly fear the impact which loss of employment may have upon their migration status.[101]

66. Plainly, SCWs suffer as a result of poor terms and conditions and insecure work. But it is also the service users, and the sector itself, which suffers as a result. These features of the workforce played out throughout the pandemic. For example:

    a. Workforce capacity was poor, due to high levels of vacancies and high turnover of staff, which were exacerbated by Covid-19 related absences.[102] Those working in the sector were often exhausted and overworked, and many left the sector – leaving those who remained under ever-increasing strain.[103]

    b. SCWs experienced poor access to PPE or were told to use PPE in ways which did not appear safe (for example, using a single FRSM for a full shift), but due to the insecurity of their work, were not in a strong position to challenge this.[104]

    c. Many care workers did not receive full sick pay as part of their terms and conditions, and as a result were more likely to attend the workplace even when experiencing symptoms.[105] Even when the ICF was introduced, many SCWs were still not paid by their employers.[106]

[99] INQ000587755/16 para 42.
[100] INQ000525596.
[101] INQ000339435; INQ000339436; INQ000339437; INQ000339438; INQ000049319.
[102] INQ000325232/1; [3/52/12 - 3/53/5]; INQ000587381/2 para 3; INQ000103564; INQ000103565.
[103] INQ000525595.
[104] INQ000525604; INQ000119097; INQ000581726; INQ000525605; INQ000525608; INQ000587381/45-46 para 97.1, /47 para 97.2, /50 para 97.4 and /52-53 para. 97.6.
[105] INQ000339425; INQ000525548; INQ000339477; INQ000525550; INQ000068455; [14/42/9-19].
[106] [12/87/4 - 12/89/1]; INQ000119075; [6/207/2 - 6/209/19]; INQ000525553; INQ000581721; INQ000525555; INQ000525556; INQ0005255571.

d. Transmission of the virus was higher in care homes where SCWs moved between care settings – and that a key reason for SCWs having more than one role in the care sector was poor terms and conditions.[107]

e. Many SCWs did not have access to private transport, and found travelling to undertake Covid-19 tests or to get vaccinated more difficult, and were forced to travel to work on public transport.

67. Conversely, we know that improving capacity in the SCW is tied to improved terms and conditions and tackling insecurity of work. As we set out in our written opening statement,[108] research by Skills for Care shows that the following five factors are key to retention of SCWs:

a. Being paid more than the minimum wage.

b. Not being on a zero-hours contract.

c. Being able to work full time.

d. Being able to access training.

e. Having a relevant qualification.

Improving quality of work in the sector will not only benefit SCWs, but the sector as a whole – and is essential if the sector is to enter a future pandemic with improved capacity and resilience.

G. REFORM AND THE NATIONAL CARE SERVICE

The urgent need for wholesale reform

68. There is so much overlapping between the severe workforce shortages faced by the sector and the urgent need for: improved status for the workforce, centralised co-ordination across the sector, and long-awaited reform. In this module, more than any other the TUC has been a Core Participant in, the issues are interdependent, and it is clear that, for any one recommendation to be effective, a host of other recommendations must also be implemented.

69. The call for reform has been virtually universal amongst those witnesses who have given oral evidence in this module – everyone from Mr Hancock to Cathryn Williams (Association of Directors of Adult Social Services) to Sir Sajid has endorsed it.[109] Albert Heaney (Chief Social Care Officer for Wales) refers in his witness statement to the issues facing the social care sector in Wales, which include stretched services; an undervalued, poorly remunerated workforce with recruitment and retention issues; fragmentation leading to data challenges; and lack of

[107] INQ000587381/30 para 68; [17/99/5 - 17/101/10].
[108] INQ000498610/4 para 52.
[109] [3/2/12-13]; [15/96/10 - 15/97/3]; INQ000587755/26-27 para 57.

progression and development opportunities. We consider that the issues he identified are universal across the social care sectors in the UK. We agree with Mr Heaney that *'reform is necessary and is a much-needed part of the solution'*.[110]

70. Discussion of reform has been a key feature of public hearings in this module, and it is a feature which we say this Inquiry cannot overlook, and which the report to this module must acknowledge. The TUC agrees with the point made in closing on behalf of Covid Bereaved Families for Justice UK, that the findings and recommendations to flow from this module can, and should, inform and support the work of the Casey review, but that they should not await it.[111] The work to improve resilience and to plan and prepare for a pandemic in respect of the social care sector is urgent, and must start as soon as possible.

71. As we acknowledged in oral closing, we agree with the National Association of Care and Support Workers and a number of other Core Participants who made similar points, that affordability is a matter for those implementing the Inquiry's recommendations; but that improved capacity and resilience will inevitably lead to long-term cost savings. We also say that the cost of implementing siloed recommendations which do not on their own address the overwhelming issues around fragmentation and capacity would be money wasted. We commend to the Inquiry the words of Professor Stephen Barclay, who said that *'the way to make sure* [something] *really happens is to say: right, we're going to resource it'*.[112]

72. We say though that reform must not focus primarily on care homes, but on the sector as a whole. We have heard throughout the evidence in the module the theme that domiciliary care was the underdog in a sector already secondary in terms of focus, status and resource to the NHS. In closing submissions, Dr Townson spoke powerfully of the efficient, revolutionary home care provided in other countries such as Italy and South Korea.[113] We should strive for to be an example of excellent homecare in the UK, and redesign our domiciliary care systems. Such reform has the potential to empower service users to remain in their homes, and would significantly relieve pressure on care homes and the NHS. We would urge the Inquiry to produce a set of recommendations specific to reform in the domiciliary care sector.

The National Care Service

73. The TUC has long called for a National Care Service and, following this module, considers it will be a crucial step in improving resilience, and the capability to respond to any future civil emergencies affecting the care sector.

[110] INQ000532383/65-66 para 162.
[111] [19/144/3-6].
[112] [19/27/19-20].
[113] [20/56/5-20].

74. Currently, most adult social care is arranged by councils and delivered via private and independent companies, with very little in the way of national standards. Central government does not have the powers or responsibilities for social care in the way it does for the NHS, so it often goes unnoticed, until people and their families need the service. A National Care Service would change this. There would be national standards for the way care workers, care recipients and family carers are treated, under a single national brand. Councils would still have an important role to play, but the commissioning of care would need to adhere to new national standards.

75. Indeed, Jeane Freeman's (former Cabinet Secretary for Health and Sport, Scotland) evidence to this module makes clear that she considered pursuing a National Care Service in Scotland was the right approach in order *'to move from a competitive market to collaboration and ethical approaches to commissioning and procurement to help embed fair work principles and improve the consistency of services'*.[114] The TUC agrees, as long as the reform is appropriately resourced, and work to address terms and conditions in the sector received immediate attention; rather than being placed on the backburner yet again.

76. Evidence in this module has underlined how difficult it is to achieve the most basic of policy positions or operational activities in the social care sector as a result of its structure and fragmentation. The creation of a National Care Service, as set out above, would simplify the structure, clarify responsibilities and create clearer channels of communication. It would make many of the other recommendations likely to flow from this module, such as a register of care workers, easier to achieve and more effective in practice.

77. It would also be a powerful way to address the lack of parity between the NHS and social care sector, and would enable the setting of employment standards – both of which would be essential in addressing the workforce crisis which was exacerbated by Covid-19 and which hamstrung many of the attempts to halt transmission in the sector.

78. Covid Bereaved Families for Justice UK set out in oral closing submissions that: *'The current UK Government has committed to a national care service and the Inquiry should state its unequivocal support for this policy commitment and the urgency of it'*.[115] The TUC firmly agrees. Reform has been recommended and promised in respect of the social care sector on numerous occasions over the past 30 years, and true reform has never come to fruition. Momentum and support for the reform which would transform the sector and its ability to respond effectively to the pandemic is critical, and we ask that the report to this module does just that.

[114] INQ000606530/98 para 349.
[115] [19/147/18-22].

H. LESSONS LEARNED, A SUMMARY

79. Below, we summarise the lessons which the TUC considers flow from Module 6 in respect of SCWs.

80. **Register of Care Workers**. One of the recommendations which has received almost universal support in this module has been the creation of a register of care workers in England. Notably, Ms Cridge, Ms McAnea, Ms Whately and Dr Townson spoke convincingly of the anticipated benefits.[116] We agree with Ms Cridge that such a development *'would acknowledge* [SCWs] *as a profession. And along with a register would come a clear educational offer, and it* […] *would raise the status and recognise the incredible skills and role of care workers'*.[117] We further agree with Ms Cridge that work to develop plans for such a register should be co-produced with the sector;[118] it should involve consultation with care workers. In order to be effective and meets its aims, we consider that such a register should be mandatory and should apply to care workers in care homes and domiciliary care workers – but it should be introduced in such a way that it does not penalise care workers financially, or otherwise. Dr Townson highlighted the challenges created during the pandemic as a result of the lack of register, including in respect of providing PPE, ensuring access to testing, and confirming vaccination eligibility and status.[119] Helen Whately reflected on the utility in respect of disseminating training.[120] The TUC considers that a mandatory register of all care workers, potentially linked to a Royal College of Care, would facilitate many of the other recommendations likely to flow from this module.

81. **Social partnership**. A key distinguishing feature between social care and the NHS during the pandemic was the structures of social partnership. As Ms McAnea set out in oral evidence, there was no overall social care forum for partnership engagement with the UK government, only a series of different groups set up to deal with specific issues, which ceased to function after the pandemic.[121] The TUC agrees with Ms McAnea that a standing group would have made a significant difference during the pandemic in terms of being able to address issues and communicate decisions much more quickly.[122] In many cases, it was the pace of operational decision-making and activity in the social care sector which lagged behind the NHS, and the lack of mechanisms for social partnership was a key cause. The NHS Partnership Forum is often attended by DHSC ministers and is seen an important forum where discussion leads to action by government; an equivalent in the social care sector should receive the same status and resourcing. In addition to setting up and ensuring the consistent functioning of standing

[116] [5/58/22 - 5/59/14]; [6/191/10 - 6/192/9]; [9/43/23 - 9/44/7]; [12/137/21 - 12/138/22].
[117] [5/58/23 - 5/59/3].
[118] [5/59/7-9].
[119] [9/15/15-24].
[120] [12/138/7-14].
[121] [6/168/4 - 6/169/3].
[122] [6/169/7-19].

social partnership fora, the TUC would commend to the Inquiry the creation of health and safety committees, consisting of DHSC, UKHSA, care employers and unions, at national and local levels to provide consultation machinery for the care sector. As the TUC sets out in its joint witness statement:

> *'At UK/national level this should operate on a tripartite basis, consisting of DHSC, UKHSA, care employers and unions. Regionally, Local Authorities (or Local Resilience Forums) should play the co-ordinating role. These bodies should work to set policies and procedures; work with HSE and other expert bodies to produce up-to-date guidance on control measures; and monitor the key metrics, including worker and care recipient infections and deaths, sickness absence and self-isolation rates, PPE supply levels and usage, and vaccination uptake rates. In Wales, this should bring in Public Health Wales as well as Local Authorities, HSE and devolved and non-devolved government'*.[123]

82. **Workforce capacity**. The Inquiry has received significant evidence on the impacts of understaffing in the sector. The impacts in terms of burnout, trauma and wellbeing were set out in detail in our written opening. But this issue was a double-edged sword; a lack of capacity in the workforce also hamstrung efforts to address key issues during the pandemic, such as movement of staff between care settings. In order to protect SCWs in a future pandemic, and to retain flexibility to implement a range of NPIs and absorb inevitable knocks to capacity due to illness, the workforce shortfall in the sector must be addressed. The TUC considers that there is an urgent need to introduce a workforce plan which includes both short- and long-term actions, and takes into account the need for improved working terms and conditions and greater diversity in leadership roles.

83. **Terms and conditions**. As is detailed at paragraphs 61 to 67 above, poor terms and conditions hampered the response to the pandemic in the care sector, and constrained the ability of SCWs to raise concerns about safety at work. Improved terms and conditions are also the key to improving retention of skilled staff, as set out above. The TUC considers that urgent work is required to recognise, professionalise, standardise and improve working terms and conditions. This includes improving pay, reducing or eliminating zero hours contracts, improving sick pay, and creating opportunities for formal qualifications linked to career progression. A recommendation which has been explored during public hearings and which the TUC would support is the introduction of a real carers' wage.

84. **Data.** The Inquiry has received striking evidence during this module, and in previous, as to the lack of data held by central and local government in respect of the social care sector. We have heard that there is very little visibility of private providers of care, of SCWs themselves, and of their service users. This created consistent barriers in respect of managing the response to the pandemic in the social care sector. The Inquiry ought to be prescriptive about the data sets

[123] INQ000587381/43 para 96.16.

which should be created and managed going forwards; there must be a much more substantial dataset in relation to care providers/employers and the social care workforce. The TUC further considers that urgent work should be undertaken to maintain and update the systems which were created during the pandemic to ensure that important learning is not lost. Critically, systems should be in place to monitor transmission in the care sector, infections and deaths in SCWs and outbreaks in individual care homes and domiciliary care providers. A disproportionate impact upon Black, Asian and Minority Ethnic people was recorded during the pandemic, and we know that the care workforce is disproportionately Black, Asian and Minority Ethnic compared with the general population.[124] In order to identify any disproportionate impacts on any racial or ethnic group in a future pandemic, and to ensure that we have the workforce data to be able to assess risks and put in place mitigations, it is essential that action is taken now to improve visibility of ethnicity in existing datasets, including on death certificates, in RIDDOR reports and in data on infections and deaths. These matters were addressed in detail in our closing submissions in Module 3[125] and we consider that the same principles apply equally in respect of the social care sector.

85. **Communication**. Closely connected to the lack of data on the sector were the challenges faced in communicating with SCWs, which similarly affected all aspects of pandemic response including the dissemination of: PPE, IPC training and guidance, and information about vaccines.[126] The TUC considers that work is required now to create a platform for central and local government to communicate with SCWs, to ensure that in a future pandemic, the provision of key information does not rely upon providers/employers passing it on. This work would likely fit within the same stream of work to create a register of care workers, and potentially to establish a Royal College of Care and should be co-produced with SCWs.

86. **Financial support for self-isolation**. We say that the lesson is that SCWs should not suffer any financial detriment as a result of complying with any requirement to self-isolate or quarantine. Given the issues identified with the ICF, it is clear that work must be done now to ensure that there is a reliable system for distributing financial support, which includes ringfenced funds for sick pay, and which is independently monitored. The TUC considers that the most effective way to overcome the issues which plagued the ICF (and, indeed, the Test and Trace Support Payment Scheme) is to use a system which ordinarily operates in non-pandemic times, and to ensure there is effective, independent reporting on the extent to which those funds are reaching workers. SSP, accompanied by an appropriate rebate scheme to mitigate burden on

[124] INQ000572390.
[125] INQ000532406/11 para 29.
[126] [9/95/16-25]; [17/190/15 - 17/193/15].

employers, is one such potential mechanism which the TUC would support. Regardless of the vehicle used, the outcome must be:

a. The funds must be specific to sick pay, or otherwise clearly ringfenced.
b. The scheme should be centrally administered to reduce burden on local authorities and simplify data collection.
c. Reporting on provision of the funds to SCWs must occur at provider level, and the use of the funds must be independently monitored.
d. There must opportunities for SCWs to anonymously report non-payment to a body with oversight of the scheme.
e. The scheme must be mandatory, with clear and consistently enforced consequences for failing to pay SCWs in full for periods of self-isolation.

87. Moreover, the TUC considers that work could be done in non-pandemic times to encourage and motivate care providers to provide full company sick pay as standard; education around the benefits of offering this, including in relation to IPC and avoiding outbreaks of infectious disease, may help to improve terms and conditions in the sector.

88. **Improved cohesion and co-working between the social care sector and the NHS**. Ms Whately in her oral evidence pointed to the relationship between the social care and the NHS, querying why NHS leaders did not appear to consider the impact on the care sector of certain decisions, such as those relating to discharges.[127] The implementation of a National Care Service would simplify the structures in the care sector and in so doing make co-working and cohesion between the two sectors easier and more effective. In the shorter term, the TUC considers that it would be helpful to put social care and trade union seats on Integrated Care Boards and Healthcare Boards. As the joint TUC statement sets out:

> *'ICBs and Healthcare Boards are mainly an NHS function, with the aim of joining up care leads to better outcomes for people. Trade unions are not given a seat on these boards, nor is a representative of the local social care provision. These boards therefore have a significant blind spot to both workers' safety and the impact on the care systems locally. If both these seats were recommended on ICBs, it would have held up accountability to those decision-makers in the pandemic. In late 2024, the regulations were amended to include worker representation on Wales Regional Partnership Boards'*.[128]

89. **Mental health.** Significant evidence about the impact of the pandemic upon SCWs' mental health and wellbeing has been recorded during this module. However, mental health support in the care sector was variable, and entirely dependent upon the employer.[129] The TUC commends to the Inquiry a recommendation that there be a joint mental health workforce plan with the NHS. Given the linked nature of the services and the common challenges facing

[127] [12/167/17 - 12/168/8].
[128] INQ000587381/40 para 96.2.
[129] INQ000587821/13 para 62.

healthcare workers and SCWs, the TUC considers that a joint mental health workforce plan would enable both sectors to support their workers most effectively, and would continue to promote parity between the two workforces.

90. **Structural racism.** As is set out above, structural racism contributes to insecurity of work for Black, Asian and Minority Ethnic workers, who are overrepresented in the care workforce. To empower Black, Asian and Minority Ethnic workers to be able to negotiate improved working terms and conditions, seek risk assessments and ensure the recommendations are enforced, and to call out unsafe workplace practices, it is essential that structural racism is addressed in the social care sector. Steps must be taken to improve diversity in leadership roles and to address bullying, harassment and discrimination. A significant challenge is the lack of data on structural racism in the care sector. Skills for Care collects survey data, and a number of unions regularly collect survey data, which we cited in our opening submissions[130] - but more comprehensive datasets are required in order to implement any workforce action plan to address structural racism. Skills for Care has driven work to implement a Workforce Race Equality Standard in the care sector and has been successful in deploying the WRES across local authority providers of care. Data from the Social Care WRES 2024 report highlights concerning statistics; for example, SCW from minoritised background are 37% more likely to face formal disciplinary action and 48% less likely to be appointed from shortlist.[131] However, a first critical step in putting in place a plan to address these structural barriers is to implement the WRES across the entire social care sector.

91. **Migrant workers**. As is set out above, insecurity of work was a key barrier to SCWs raising concerns and challenging unsafe practices during the pandemic. To address the particular vulnerability of migrant workers, the TUC commends the following recommendations:

    a. There should be an automatic presumption that visas are extended in any future pandemic, to remove uncertainty for migrant workers.

    b. Consideration should be given to granting Indefinite Leave to Remain to migrant care workers in any future pandemic. This would mitigate the administrative complexity of managing complicated immigration rules, would provide greater security for the workforce, and would benefit essential services.

    c. No health or care worker should have to pay the Immigration Health Surcharge, and any scheme to reimburse the surcharge should be less cumbersome, and more prompt, than the current system.

[130] TUC written opening submissions in Module 6, para 57.
[131] https://www.skillsforcare.org.uk/Support-for-leaders-and-managers/Supporting-a-diverse-workforce/Social-Care-Workforce-Race-Equality-Standard/Social-Care-Workforce-Race-Equality-Standard.aspx

d. The system of No Recourse to Public Funds should be suspended. It left many migrant families destitute, including those of migrant workers in the NHS and social care.

e. The visa exemption scheme should be widened in any future pandemic. The use of automatic free visa extensions during the pandemic was welcome, but should be broadened in a future pandemic to cover the whole of the NHS and social care workforce so that the least well-paid workers are also covered.

f. Visa sponsorship should be decoupled from individual employers as a way of removing the ability of unscrupulous employers to use the threat of deportation against migrant workers. The visa sponsor could be a government department. This would reduce the fear often experienced by migrant workers as a result of individual employers holding the power of dismissal and deportation over them.

92. **Movement of staff between care homes**. Having heard the evidence on this issue, we stand by what we said in opening as to the appropriate recommendations to flow from this issue. We said: *'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'*.[132]

93. **Vaccination**. SCWs should be prioritised for vaccination in a future pandemic where there is evidence of increased risk to service users and/or to staff, including of increased risk of transmission. Work should be undertaken now to improve vaccine confidence in advance of a future pandemic, and to improve channels of communication to SCWs to ensure that key messaging around vaccination actually *reaches* them. Those channels should include union representatives and community leaders. Research should be done now to understand more about the VCOD policies introduced during the pandemic; to understand the risks, harms, and benefits comparative to other methods of increasing vaccination in the workforce. Policies which mandate vaccination as a condition of deployment should be avoided; it appears clear that VCOD can impede vaccination efforts, and that the costs outweigh any benefits.

94. **Infection Prevention and Control**. Investment in training SCWs in IPC and developing IPC leads and teams within the social care sector needs to be done now *before* the next pandemic strikes. Clear plans should be in place in advance of a future pandemic in relation to how PPE will be procured and distributed, a central distribution system should be created for the social care sector, and care providers and agencies should be required to hold local stockpiles. FFP3 should be recommended for all staff likely to come into contact with the virus- where there

[132] TUC written opening submissions in Module 6, para 80.

appears to be more than negligible airborne transmission; relevant training and fit testing should be occurring now and at regular intervals so that SCWs are prepared for any future pandemic. SCWs should have priority access to testing on the same basis as the NHS. As we suggested in Module 3,[133] a national risk assessment tool should be created and implemented now, which can readily be adapted in a future pandemic as epidemiological evidence emerges.

95. **Regulation, oversight and inspection**.

a. To ensure that in person inspections can safely continue in any future pandemic, we say that: regulatory bodies should be required to hold stocks of PPE; inspectors should be recognised as keyworkers from the outset of a pandemic; and that they should be prioritised for access to PPE; IPC training; testing; and vaccines.

b. A national whistleblowing hotline should be established now and should be used during pandemic and non-pandemic times, to ensure familiarity and effectiveness of the system. The whistle blowing hotline should specifically facilitate the raising of concerns by BAME and migrant workers; and it should be possible to raise concerns anonymously. Data from the hotline should be visible to the Department for Health and Social Care and the relevant regulators.

c. Local authorities should be empowered to improve IPC in the private sector. As was set out in the TUC joint statement: *'During the pandemic, because Local Authorities are well adapted to conducting risk assessments, access to PPE and health and safety measures were quickly put in place for local authority workers, while private providers were often ill-equipped to do this. Residents and the workforce would be provided safer environments if local authorities were able to take a greater role in improving IPC measures and standards in the private care home sector'*.[134]

d. In accordance with the IIAC recommendation, Covid-19 should be prescribed as an occupational disease, and a compensation scheme should be created. We set this requirement out in closing submissions in Module 3,[135] and we consider that this logic applies equally in respect of the social care sector.

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[133] INQ000532406/33-34 para 100.
[134] INQ000587381/42 para 96.12.
[135] INQ000532406/39 para 117.