Low-paid workers in health and social care during COVID-19

Research for the Equality and Human Rights Commission

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Contents

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1. Introduction

This report presents research exploring the experiences of workers in health and social care during COVID-19 commissioned by the Equality and Human Rights Commission (EHRC) to support a statutory inquiry under Section 16 and Schedule 2 of the Equality Act 2006. The primary focus for the inquiry is health and adult social care across the UK because of the high rates of infection and death from COVID-19 in these sectors[1]. The research is based upon 44 interviews with largely Black and Ethnic Minority (BME) health and social care workers and four focus groups across Britain. The research aims to feed into evidence-based recommendations for action to tackle entrenched racial inequalities that have left BME workers concentrated in the lowest paid sectors and jobs and therefore most vulnerable when the pandemic arrived. The report consciously aims to reflect the experiences of health and social care workers and to privilege their voices.

2. Executive summary

- Structural inequalities

The participants in this research were frontline workers including NHS Healthcare Assistants, porters and security workers, and residential, home and personal care workers employed in the public, private and third sectors. Their experiences attest to the concentration of BME workers in particular jobs in the health and care sectors. All worked throughout COVID-19, although there was variation as to whether they were formally defined as 'key' or 'essential' workers. All were highly aware of being in the frontline in terms of risk, but also that there was reliance on them to provide personal care to vulnerable people.

- Contractual differentiation

Contractual differentiation was evident in the sample with participants describing a hierarchy of contracts resulting from the privatisation and contracting out of services by the NHS and local government. At the top were those directly employed on open-ended contracts with fixed hours, below them were agency workers and those on zero-hours contracts and at the bottom those with no contract, often live-in carers. Participants described a two or even three tier workforce within organisations, with differential contractual status, terms and conditions and employment rights that could reflect racialised hierarchies and migrant status. An increase in the engagement of agency workers during COVID-19 was noted, in some cases white British workers who had lost jobs or been furloughed, in others migrant workers. Where agency workers moved between different organisations and workplaces it was reported that they placed themselves, but also colleagues and service users, at risk.

[1] The inquiry's terms of references are available at: https://www.equalityhumanrights.com/en/inquiries-and-investigations/inquiry-racial-inequality-health-and-social-care-workplaces/terms

- Migration status

Migrant workers felt unable to shield or self-isolate when they or household members were symptomatic and were more wary of testing regimes and contact with the NHS for vaccination – key factors contributing to risk. Participants with uncertain migration status (undocumented or leave to remain) reported feeling reluctant to refuse work or to challenge unsafe conditions because of their dependence upon employers (particularly where workers provided live-in care). No recourse to public funds intensified vulnerability and locked some into debt that increased dependence on low paid work.

- Racism at work

Respondents cited both direct and indirect discrimination and racism at work including bullying, harassment and victimisation, which was rarely dealt with by employers. A range of micro aggressions from colleagues, managers and service users were described. Mistakes made at work led to differential disciplinary outcomes for BME and white workers. Filipino care workers reported COVID-related anti-Asian abuse from members of the public whilst travelling to work.

- Indirect discrimination

Indirect discrimination was evident in the overqualification of BME health and care workers, particularly migrants, for the work they were doing which did not reflect their professional experience or status. Linked to overqualification, BME participants reported few opportunities for promotion and that BME workers were not proportionately represented in senior and management positions. There were widespread perceptions of the informal preferential treatment of white workers.

- Race Equality Standard and equality policies

There was very limited awareness among BME workers in England of the NHS Workforce Race Equality Standard. Overall, many believed that organisational equality policies were rhetoric and not applicable to their experiences at work.

- Institutional racism?

Participants recognised that the disproportionate impact of COVID-19 on BME workers and communities was rooted in their position in the labour market. A number explicitly used the terms ‘institutional’ or ‘systemic racism’, while the words of others allude to collective rather than individualised experiences of unfair treatment. The role of government in defining migrant status clearly structured their experiences.

- COVID-19 and Risk

All participants described the pervasive risk of COVID-19 in the workplace and in getting to and from work. They concurred that effective social distancing was impossible in their work and some noted informal discrimination in the allocation of BME workers to high-risk areas. There were differences in the capacity of private and

public sector organisations to maintain COVID-safe environments with those working in in the former more likely to be exposed to risk, particularly with the decanting of COVID-19 patients from hospitals to care homes.

- COVID-19 risk assessments

It was evident that workers had different experiences of risk assessment, largely related to organisational relationships. Those directly employed by the NHS or local government, particularly in Scotland, had access to earlier, regular, and more meaningful risk assessment than those working for private contractors, agencies or in private care homes. There were also differences in the nature of risk assessment with the NHS and local authorities more likely to define ethnicity as a risk factor for directly employed workers. In care homes risk assessment focused on the needs of service users rather than the workforce. There was limited consultation and negotiation with workers on risk assessment and its practical application.

- Personal Protective Equipment

Most participants recounted that in the early stages of the pandemic they had inadequate access to appropriate PPE. Staff working directly for the NHS had earlier access to better PPE and received more support and guidance than those working in social care. Workers in all sectors reported infection and mortalities caused by inadequate access to PPE and/or poor practices.

- Sick pay and absence

Sick pay emerged as a major issue in the ability of workers to counter COVID-19 risk to themselves, their families and wider communities. Sectoral differences in access to occupational sick pay were evident. Dependence on Statutory Sick Pay (SSP) meant that health and social care workers in private care homes or working for private contractors could not afford to self-isolate or shield. Agency workers and those on zero-hours contracts generally had no access to sick pay. Inadequate sick pay encouraged attendance at work or a premature return to work and led to workers putting themselves, colleagues and service users at risk. There were no cases where parents in the sample had been allowed time-off or where arrangements had been made to deal with childcare and/or home-schooling in the pandemic, placing extra pressure on them.

- Work intensification

Most respondents reported work intensification. This was largely due to covering for workers off sick or self-isolating, but also because of the increased demands of COVID-19 risk measures and extra duties, including where managers were working from home. Public sector workers appeared to have more control over whether or not they accepted extra work, whereas many private sector workers said they had little choice.

- The under-valuation of care work

Those not directly employed by the NHS, particularly care workers, felt under-valued by the government and public. Whilst participants welcomed gestures of support such as bonuses, food, vouchers and clapping, many suggested that this support could take a more tangible form and address persistent and pervasive low pay.

3. Methods

The research is based upon four case studies involving 44 interviews with health and social care workers;

- A UK-wide case study based on interviews with 11 Filipino participants working in health and social care
- A case study of Health Trusts in Oxford based on interviews with nine porters and security workers, largely male
- A case study based on 11 interviews with residential care and home care workers in London
- A case study based on 11 interviews with homecare (or care at home) and care home workers from Wales and Scotland

The interviews were supplemented by four focus groups of health and social care workers;

- A UK-wide focus group of Filipino health and social care workers organised by Filipino community organisation, Kanlungan
- A Welsh BME focus group
- A BME focus group based in Leicester
- A white British focus group

The interviews were semi-structured allowing for exploration of the micro-processes that underpin racial and gender divisions of labour and variation in work arrangements under COVID-19. While interviews allowed participants to discuss sensitive matters, the focus groups encouraged interaction between similar groups of workers promoting discussion and teasing out variation, shared experiences, perceptions and views.

The geographic spread, including England, Scotland and Wales, captures the variations between national health and social care provision as well as the divergent responses to COVID-19 between countries. In comparison to England there are no internal markets in Scotland and Wales. In Scotland, Health and Social Care Partnerships are responsible for the delivery of adult social services. In Wales, local authorities are responsible for adult social services. Although there is devolved and stronger publicly funded and delivered health and social care sector in Scotland and

Wales, with a greater focus on the integration of health and social care, there is still private provision of social care commissioned by local authorities.

The interviews and focus groups aimed to capture change under COVID-19. Variation in experience by race was interrogated by the inclusion of different ethnicities, including white workers, in the sample. There was a focus on a range of occupations in health and social care. The interviews allowed detailed scrutiny of occupational locations, pay, hours and contractual status, but also how work is located within the wider household context and how, in the context of COVID-19, household arrangements impact upon work.

Respondents were identified through networks and contacts. The Filipino case study was facilitated by Kanlungan (meaning Shelter), a registered charity consisting of six Filipino community organisations working closely together for the welfare and interests of the Filipino community in the UK. The research took place under COVID-19 restrictions. Data was collected online using Microsoft Teams or Zoom, or in some cases (where respondents did not have access to computers) via mobile phones. It was coded and analysed using QSR NVIVO.

Interviews probing individual experiences of racism and wider discrimination needed utmost sensitivity. All interviewers were BME. A Participant Information Sheet provided full information on the research and the implications of participation; participants were free to withdraw at any time. Participation in interviews and focus groups was based on informed consent; all participants as well as the organisations that they work for are anonymised and have been given identifier codes with the key known only to the research team. Participants were assured that they would not be identifiable in the research or any publication arising from it. Interviews and focus groups were recorded with consent from participants and transcribed. Recordings and transcriptions were stored on password protected drives under GDPR regulations and only accessed by the researchers. The Filipino focus group and interviews were conducted by a Filipino researcher in Tagalog and translated into English. The research was approved by the University of Greenwich Research Ethics Committee. All respondents were offered a £25 gift card to acknowledge their time.

4. The Sample

Table 1 provides a breakdown of the 44 interviewees and their key characteristics. They were in a range of health and social care jobs, including homecare (domiciliary), residential care, live-in care and NHS Healthcare Assistants, security and porters. Over half (59%) of participants were female. There was a range of ages, most in their 40s or 50s, but approaching one quarter under 30 and four over 60. There was variation in migration status including four undocumented workers, and 19 with residency or leave to remain – over half had British citizenship (25).

A breadth of ethnicities and nationalities are represented, six participants were white and four of these white British – the sample was thus 86% BME. A range of public and private sector employers were represented. Approaching one third (30%) of participants were employed through agencies. Six (14%) reported that they were on

zero hours contracts (excluding agency workers who also may not have fixed hours), although they could still work regular and full-time hours. Four (9%) had no contract and half were on open-ended contracts with fixed hours. Just under one third (27%) worked part-time and in five cases hours were variable.

Table 1 – The Participants

Code	Ethnicity	Nationality	Gender	Job	Employer	Contractual status	Hours
Filipino national case study							
KX05	Asian - Filipino	Undocumented	Female	Live-in care worker	Private individual	No contract	Full-time
KX07	Asian - Filipino	UK	Male	Healthcare Assistant	NHS	Open-ended	Full-time
KX08	Asian - Filipino	Undocumented	Female	Live-in care worker	Private individual	No contract	Full-time
KX09	Asian - Filipino	Residency or leave to remain	Female	Live-in care worker	Private individual	No contract	Full-time
KX10	Asian - Filipino	UK	Male	Healthcare Assistant	NHS	Zero hours	Part-time
KX13	Asian - Filipino	Residency or leave to remain	Male	Residential care worker	Private Care Home	Open-ended	Full-time
KX14	Asian - Filipino	Undocumented	Female	Home Care worker	Agency		Full-time
KX15	Asian - Filipino	Undocumented	Female	Live in care worker	Private individual	No contract	Full-time
KX20	Asian - Filipino	UK	Female	Healthcare Assistant	Agency		Full-time
KX22	Asian - Filipino	Residency or leave to remain	Female	Residential care worker	Private care home	Open-ended	Part-time
KX23	Asian - Filipino	UK	Female	Healthcare Assistant	NHS	Open-ended	Part-time
London case study							
NL02	Black - Caribbean	UK	Female	Residential care worker	Local Authority	Open-ended	Full-time
NL07	Black - African	Residency or leave to remain	Female	Clinical Coordinator	NHS	Open-ended	Full-time
NL15	Black - Caribbean	UK	Male	Residential care worker	Private care home	Open-ended	Full-time
NL18	Black - African	Residency or leave to remain	Female	Home care worker	Agency		Variable
NL28	Asian - Pakistani	UK	Male	Home care worker	Agency		Part-time
NL31	White - Portuguese	Residency or leave to remain	Female	Homecare worker	Agency		Full-time
NX02	Black - African	UK	Female	Homecare worker	Charity	Zero hours	Full-time
NX07	Black - African	Residency or leave to remain	Male	Homecare worker	Agency		Variable

NX12	Black – African	Residency or-leave to remain	Female	Residential care worker	Multiple private	Open-ended	Part-time
NX13	Asian-Iranian	Residency or leave to remain	Male	Residential Care Worker	Local Authority	Open-ended	Part-Time
NX14	Black African	Residency or leave to remain	Female	Healthcare Assistant	Agency		Variable
NX15	Asian - Indian	Residency or leave to remain	Male	Homecare Worker	Agency	Zero hours	Variable
Oxford case study							
NO04	Black – African	UK	Male	Security Guard	Private contractor	Open-ended	Full-time
NO17	Asian – Pakistani	UK	Male	Porter	Agency		Full-time
NO21	Asian – other	Residency or leave to remain	Male	Security Guard	Private contractor	Open-ended	Full-time
NO22	Asian – Pakistani	UK	Male	Homecare worker	Agency		Part-time
NO27	Asian – East Timor	Residency or leave to remain	Male	Porter	Private contractor	Open-ended	Full-time
NO31	Black – African	UK	Male	Porter	NHS	Open-ended	Full-time
NO34	Black – African	UK	Male	Security Guard	Private contractor	Zero hours	Full-time
NW33	White British	UK	Female	Homecare worker	Private company	Zero hours	Variable
NX10	Asian – Nepalese	Residency or leave to remain	Male	Porter	Private contractor	Open-ended	Full-time
Scotland case study							
NS18	Black – African	Residency or leave to remain	Female	Residential care worker	Private care home	Open-ended	Part-time
NS20	Black - African	Residency or leave to remain	Female	Homecare worker	Local authority	Open-ended	Part-time
NS30	Black – African	UK	Female	Homecare worker	Local authority	Open-ended	Part-time
NS33	Black – African	Residency or leave to remain	Male	Residential care worker	Local authority	Open-ended	Full-time
NX01	Black – African	UK	Female	Residential care worker	Private care home	Zero hours	Part-time
Wales case study							
NW03	Asian - Indian	UK	Female	Residential care worker	Local authority	Open-ended	Part-time
NW08	Black - Caribbean	Residency or leave to remain	Male	Residential care worker	Private care home	Open-ended	Full-time
NW15	Mixed – Thai British	Residency or leave to remain	Female	Residential care worker	Private care home	Zero hours	Part-time
NW20	White British	UK	Female	Live-in care worker	Agency		Full-time

NX03	Black - African	UK	Female	Healthcare Assistant	Private care home	Open-ended	Full-time
NX05	White British	UK	Female	Live-in care worker	Agency		Full-time
NX16	White British	UK	Female	Live-in care worker	Agency		Full-time

There were some difficulties recruiting to the focus groups, largely in scheduling a time suitable for all participants to join online, this meant there was some drop-out. Table 2 shows participation. The Filipino and white focus groups were essentially defined in terms of ethnicity. The white focus group participants were female residential care workers. The Filipino focus group had two male participants and was a mix of Healthcare Assistants, residential and homecare workers, with one undocumented live-in carer. The Leicester focus group comprised a mix of male and female BME residential and homecare workers. The Welsh focus group had one male and were all residential care workers. Despite huge efforts it was not possible to recruit a Scottish focus group.

Table 2 – Focus Groups

Focus Group	Participants
Welsh BME	5
Leicester BME/mixed	6
Filipino	6
White	2

5. Findings

Section 1 of the findings draws on the testimonies of the participants to show how race, ethnicity and migrant status, and racism, structures the experiences of health and social care workers. Section 2 focusses on the impact of COVID-19 on their work and how existing racialised experiences of health and social care work were reflected in disproportionate outcomes for BME communities.

Section 1 – Racialised Experiences of Health and Social Care Work

5.1 Occupational segregation

Depending on where they lived and worked, a number of respondents alluded to the racial or ethnic (as well as gendered) segregation of the labour market and concentration of BME workers in health and social care. As one BME homecare worker put it:

> *'You don't have an option, that's why most of my colleagues always tell me, "when we don't have an option we just go for care work", most of the people usually are black in the care sector, I don't know why. Because it's a local job*

> *and many people don't like to do it, you know'. (NX01: Black – African, UK, Female, Residential care worker, Private care home, Zero hours contract)*

A London care home worker said that his workforce largely comprised African women. A hospital porter noted specific concentrations by nationality, so cleaners tended to come from East Timor, catering workers were largely Asian and there had been a high proportion of Polish porters, who had subsequently been replaced by Spanish and Nepalese. In Scotland, a care worker employed by a local authority outlined how she was the only BME worker employed by the council despite there being a sizable BME community locally and large numbers being employed in private care homes:

> '*I can say it's really unbalanced. It's certainly unbalanced on the level of ethnicity. So since I started working there a few years ago, I can say I've never seen any African working there...this is an area where we've got quite a lot of different ethnic minorities. But where I am, there's quite a lot of ethnic imbalance. I know people who applied there, I know a lot of my friends, some people from African origin, Caribbean, who applied there, they always say "how did you get the job?" I was like "hmm, yeah, I don't know, sometimes – I don't know. I don't know how I got the job but I got the job, I had to push and push and why?" Why is there an imbalance, there is no equality about it? Why are we in care homes? Why are we not in the same local authority, why is that?' (NS30: Black – African, UK, Female, Home care worker, Local authority, Open-ended contract)*

The concentration of BME workers in particular occupations in health and social care is evident throughout the report and is reflected on in terms of the impact of COVID-19 and exposure to risk in Section 2.

5.2 Contractual differentiation – the privatisation of health and social care

As Table 1 shows the sample is characterised by contractual differentiation with a hierarchy of contracts – at the top were those directly employed on open-ended contracts and fixed hours, then agency workers and those on zero-hours contracts and at the bottom those with no contract, often live-in carers. Contractual differentiation was the result of the privatisation and contracting out of services by the NHS and local government.

Over one in ten of the sample were on zero hours contracts (excluding agency workers) and had no guaranteed hours, although in some cases those on such contracts were expected to work regular hours and some felt they were permanent. A homecare worker from London described the prevalence of zero-hours work that for him was essentially working without a contract, but also racialised:

> *'They always give us zero-hour contracts, that is a fact. We are working zero-hour contracts, what are they going to change? There's nothing to change because I would not even call that a contract because you are on zero-hours'. (NX07: Black – African, Residency or leave to remain, Male, Home care worker, Agency, Zero hours contract)*

In NHS Trusts the continual tendering of services and survival of 'legacy contracts' had led to two or three tier workforces with differential contractual status, terms and conditions and employment rights. Porters in NHS Trusts described a 'three tier'

workforce, defined by contract and one illustrated the issues of having a workforce with different contracts and different employers and its impact on workers:

> *'So that's why there is lots of miscommunication because it's not the same company who look after the same thing. So that's why from my point of view, that's the reason there is lots of miscommunication, misinformation, inequality. So if it was only run by the NHS everyone would have the same bonus, equality, pay, sick leave, but it's run differently and the contract is different. Even though you are working doing the same job, it's still the payment and all the things – when you have a contract you have certain facilities, you get certain benefits. And for some people you are working in the same job but you are not getting the benefits. So there is lots of difference which affects the portering department because there is a feeling we are doing the same job but he is getting paid more, I'm getting less. Why should I work more? And basically because of those kind of feelings there is not proper organised, or proper teamwork because of those reasons'*. *(NX10: Asian - Nepal, Residency or leave to remain, Male, Porter, Private contractor, Open-ended contract)*

Participants reflected on agency workers' lack of employment rights, a porter directly employed by the NHS reflected on the conditions for agency porters, described as 'agency donkeys', who work at a flat hourly rate with no bonuses or premia:

> *'Well in short basically I have security, the employment law will apply, will work in my favour because they would have to prove this and that, I have more rights than the agency employees. The agency employees have rights but they don't know them and neither do the management team. They just treat them like chattel. They can decide that tomorrow we don't want this one, and don't send him here, and that's it'. (NO31: Black – African, UK, Male, Porter, NHS, Open-ended contract)*

Another Oxford porter highlighted the lack of security for agency workers:

> *'They've got more agency workers and again, it's unfairly treated because they are not getting better terms and conditions. Terms and conditions are absolutely scrapped to answer you. I think they get less pay, I believe also agency workers have now been working for so many years they have not even been given a safe contract. They still wake up in a morning and they don't know if they can have a job the next day or not because it's just agency. Because agency workers, and PFI (public finance initiative) company can just make a phone call the next morning and say, "we don't need you anymore" '*. (NO22: Asian – Pakistani, UK, Male, Porter, Private contractor, Open-ended contract)

These hierarchies based on contractual status are in some cases are racialised and participants highlighted how different ethnicities seemed to have differing capacities to negotiate these hierarchies and progress to more secure work. They outlined how favouritism and ethnic discrimination could lead to BME staff being trapped in insecure forms of work such as agency, bank, or zero contract work whilst white staff seemed to more easily be able to access more secure contractual statuses associated with working for the NHS or Local Authorities. A support worker in London discussed how

over the last decade she had observed how white colleagues had been much more likely to secure permanent posts:

> *'Ethnicity plays a big role. So in my position I've worked as a bank staff for over 10 years but there are people from a different ethnicity who have come within a year or two they are already permanent. So they are already permanent but for some you are just bank. Although they claim the treatment is the same, but obviously there's no job security. If I look at most of the people we work with, there's no white who is bank, they come and they get a permanent job'.* (NX02: Black – African, UK, Female, Residential care worker, Charity, Zero hours contract)

A similar point was made by the Oxford Porter cited above, who suggested that contractual status could reflect access to nationally or ethnically defined networks:

> *'I'll give you one case in point. There was a young boy who came in as an agency worker, young man. And he got talking to his English colleague – he was English - and within a flash he suddenly got an NHS contract which no one else was getting. And it doesn't happen across the board, no it doesn't normally happen that way at all'. (NO31: Black – African, UK, Male, Porter, NHS, Open-ended contract)*

Similarly, participants discussed how BME workers were overrepresented in insecure private sector employment and underrepresented in more desirable public sector roles. In the Welsh focus group a participant reflected on contractual hierarchies that defied qualification:

> *'But BAME, they're provided with casual relief contracts. However, they're more qualified than say, some colleagues who are from different backgrounds, and they've been given permanent contracts. That doesn't make sense to me'. (WAF01: Welsh focus group, predominantly female BME residential care workers)*

In addition to variation in employment rights, participants discussed a range of differential treatment in the workplace, including in the allocation of work by white managers through 'favouritism' based on race and ethnicity. One porter commented on the different treatment of agency and directly employed workers and the allocation of agency workers to the busiest departments, for example Accident and Emergency or to more unpleasant work, for example to deal with dead bodies. The specific risk faced by agency workers under COVID-19 is discussed in Section 2. The porter cited above also felt that there was discrimination in the allocation of overtime and shifts with premia, with white British workers given preference:

> *'That's another area now of favouritism and corruption because everybody knows that the wages of porters is so low that they can't survive if they've got family and children, whether the children be here or East Timorese or Spain or wherever. They can't survive on that wage without overtime. So, overtime has become a big issue and then obviously because of that demand, they will always show favouritism and corruption. Because the English are not very concerned about that; what they would tend to do is try and get them into the more lucrative portion of the work which would be the weekends, including nights. So basically, if I work Friday Saturday and Sunday night, do 12-hour*

> *shifts, I will probably take home about £600 or whatever it is a week. That's one group, that one is a lot of English getting into it that way. Others they will also have fixed, maybe a couple of hours a day but it's not necessarily on ethnic lines but I think it will also be your relationship with the supervisors. And it will also depend on how long you've been working for the NHS. So, it's pretty variable but the main recipients of the overtime are basically those people who are prepared to play up I suppose to the manager or supervisor and so forth'. (NO31: Black – African, UK, Male, Porter, NHS, Open-ended contract)*

As is evident in Section 2, contractual differentiation had implications under COVID-19 with workers on agency and zero hours contracts, or without contracts, particularly vulnerable to exposure and their lack of entitlement to sick pay crucial.

5.3 Migrant Status

A proportion of care workers in the sample had uncertain migration status leading to dependence on low paid informal work with no employment rights. Issues with visas meant a number of migrants were working as live-in carers with no contractual status. One communicated the pressure of supporting her family in the Philippines, but in addition she had given birth in the UK and with no recourse to public funds had to pay back the medical bill charged by the NHS:

> *'Because of my undocumented status, even if job offers are low salaried, I have no choice but to accept it or have no work. You are not paid hourly rates. It's like back home. It's better to have a job and an income because I have family in the Philippines who need my support. I have two children back home. So, I have no choice even if the salary offer is low. Especially in these times. When I gave birth, the NHS charged me to pay a lot. That is one of my worries, so I need to accept even low-salaried job offers because I am making monthly payments towards this very big bill. That is why I am afraid to get sick because I might need to be treated in hospital again and incur a huge bill. It is very stressful'. (KX08: Asian – Filipino, Undocumented, Female, Live-in care worker for private individual, No contract)*

Another Filipino respondent commented on the requirement for migrant nurses to pay a surcharge to access the NHS that they were employed in, but also hospital parking fees:

> *'Just to add, here in Leicester, there are a lot of new nurses. Most of them arrived last December before COVID. So they were already deployed during COVID. At the same time, they were asked to pay the health surcharge. I think it should be suspended, especially for migrants, and the other surcharges being asked by the government. The nurses and the healthcare workers in the NHS are already doing a lot of help. It should be halted. We need to have a united voice, or a campaign for them to discontinue it. The nurses and the healthcare workers are already beat up from working, then they're going to be beaten up from these fees?' (KF01 Filipino focus group, male and female Healthcare Assistants, residential and homecare workers, live-in carer)*

The specific vulnerability of migrant workers to COVID-19 is discussed in Section 5.8.

5.4 Over-qualification and lack of promotion opportunities

Closely related to migration status, a number of respondents noted that they or others were educationally over-qualified for the job they were doing but excluded from better paid sectors and occupations. A number of those working in social care had nursing qualifications from their country of origin. One nurse from India had tried to register with the National Nursing and Midwifery Council, but had found the accreditation procedure too complicated and, having no support to navigate the system, had given up and was working as a residential care worker:

> *'I've got 24 years' experience in nursing and I'm working as a carer and they are saying that they've got a shortage, shortage, shortage. And bringing more workers from different countries, why can't they use the workers from this country? Those who are qualified. Everybody is working as carers, there is no choice. You come here to this country and you can't say to anybody you are a carer. I can't tell anyone in my house or in my place in India I am a carer here, they will kill me'. (NW03: Asian – Indian, UK, Female, Residential care worker, Local authority, Open-ended contract)*

A Filipino respondent was challenged when he applied for a Healthcare Assistant role because he did not have GCSEs in English and Maths:

> *'I funded myself to take a Master's here in the UK. So, I told them, "is GCSE higher than my Master's?" They became dumbfounded. They said, they still want the GCSE, "fine", I told them. So, I decided that I could retrain as an OT [occupational therapist]. So, I am in training now for my OT'. (KX07: Asian – Filipino, UK, Male, Healthcare Assistant, NHS, Open-ended contract)*

Overall respondents reflected the view of an African residential care worker that '*it doesn't matter what qualification I have, the white person is priority, why?".* She recalled working with a male from Cameroon who had two Master's degrees, but could only get a support worker job, which he had to take to sustain his family. She went on to explain that she had more qualifications than a senior white staff member and suggested that this tendency underpinned wider occupational segregation:

> *'Sometimes my senior who asked me, "can you show me the computer, how to do this? I don't know how to do that". Tell me do you understand inequality? But she is my senior because she is white. She's got less qualifications than I do so this is what is happening. So, they are covering it up with other things, this is actually the stuff they need to look into and see why we are not giving people of colour better opportunities. We are pushing them into care and not put them at the front. We're pushing them to be security, we're pushing them to work in the supermarket'. (NS20: Black - African, Residency or leave to remain, Female, Residential care worker, Local authority, Open-ended contract)*

Participants faced assumptions that BME workers were uneducated and unqualified; a Filipino live-in care worker reflected on her employer's attitude:

> *"The way she looks at [people from the] Philippines, [as if] we are like slaves. That's the thing I told her, "we are not slaves here. If you are educated, I am*

> *educated. I have a Masters too".'* *(KX15: Asian – Filipino, Undocumented, Female, Live in care worker for private individual, No contract)*

Respondents perceived few opportunities for promotion and where there were opportunities reported discrimination. A residential bank worker for a charity was asked about possibilities for promotion:

> *'There are those ones who are kind of favoured. It depends on how well you get on with your bosses, that is all. Ethnicity plays a big role. So in my position I've worked as a bank staff for over ten years, but there are people from a different ethnicity who have come within a year or two they are already permanent. So they are already permanent, but for some you are just bank. Although they claim the treatment is the same, but obviously there's no job security. If I look at most of the people we work with, there's no white who is bank, they come and they get a permanent job. To me it's very normal that I don't even think about it anymore. The majority are black although the management is white and then most of the staff are black'.* *(NX02: Black – African, UK, Female, Residential care worker, Charity, Zero hours contract)*

An NHS porter described how agency porters were moving into Healthcare Assistant roles as there were no promotion possibilities for them and, because of demand created by Covid, these roles gave them more secure contracts:

> *'It provides the security, that will be in the case of those people who are agency workers. But then you also have people who are on contracts who still joined as nursing assistants because they are looking for an upgrade. Because, as a porter, there's no room for promotion really, neither is there much room for the domestics, or as a cleaner. Then of course you get the usual thing that happens, the usual corrupt practices which has resulted in a lot of Polish people occupying roles at mid-level which will be the supervisory, manager assistant roles, especially in domestic and catering. They are now represented in that bracket'.* *(NO31: Black – African, UK, Male, Porter, NHS, Open-ended contract)*

The respondent alluded to the role of ethnically defined networks that have been facilitated by privatisation, where recruitment and promotion have been removed from formal organisational processes and equal opportunities policies and practices – here it was perceived that Polish workers had unequal access to supervisory roles.

BME care workers in Scotland noted the ethnically segregated nature of their workplace with BME workers delivering frontline care whilst their managers, supervisors and care coordinators were all white. NHS Porters and Security Guards in Oxford similarly reflected that their managers and supervisors were mostly white British referring to a preference for white British staff. The White focus group provided testimony that the lack of diversity on boards and in management groups was a major issue, linking directly and indirectly to the poor pay, terms and conditions experienced by BME social care workers. One argued

> *'We have a super-diverse staff team working within diverse multi-ethnic communities but the make-up of the management structure and board lacks inclusion, there's no lived experience from those feeling entitled to make a*

decision about a project that they have no personal experience of...these are affluent middle class people on the board'. (WHF01: White focus group – female residential care workers)

5.5 Racism at work

While the testimonies of workers above point to direct and indirect discrimination, participants also reported experiences of racial harassment in the workplace. In terms of everyday racism, a range of micro aggressions and bullying from colleagues, managers and service users were communicated. A relief support worker in a care home for young people with learning disabilities related:

'There seems to be a lot of hate towards immigrants and I'm an immigrant and they know I'm an immigrant. And they will openly say things that are offensive. So, I'd say the more that they start to show their true colours and how they actually feel about people like me, it's like I don't really like that mindset at all. It does make me feel a bit uncomfortable at times and I do tend to spend less time bonding with them because I don't want to. And maybe they don't want to with me either, I don't know'. (NW15: Thai British, Residency or leave to remain, Female, Residential care worker, Private care home, Zero hours contract)

One reported being fired from her job as a live-in carer, due to discrimination on the grounds of race:

'I thought your son doesn't like me because of my colour. At the end of the day, Mr X did not have a choice, the son's decision was followed. I lost my job. I was just given a week's salary. I really cried. He said, "can she speak English?" I answered back, "what English do you want? I am an educated person. I read and write. I speak English well." I really told their son. I told him. I had to defend myself. He told me that I was the only Filipino that he met that can speak English'. (KX14: Asian – Filipino, Undocumented, Female, Home Care worker, Agency, Zero Hours contract)

A respondent who had worked as a care coordinator in the NHS described racism from her manager, who was related to someone in senior management making it impossible to complain, she then compared this to her move to working in a vaccination centre:

'So I receive the respect here, I receive the equality here. I think, to put it in plain terms, in my old NHS role, it's a case of being reminded that you're black, whereas with my role now and my manager now I feel very equal, I feel there's no limitation, I don't put a doubt on myself that I'm going through this because of my skin, or I'm being treated like this because of my skin'. (NL07: Black – African, Residency or leave to remain, Female, Clinical Coordinator, NHS, Open-ended contract)

An agency worker discussed the racism of a service user:

'Actually there was a service user – I don't really know if she doesn't want a black to come in or she was just actually nasty. But I went in with her and another staff and she was like "negro!" – insulting. The staff said it was her lifestyle, she doesn't want to be touched. I think it's because of her problem, I

> *don't know in her normal circumstances she wouldn't be like that'. (NX14: Black-African, Residency or leave to remain, Female, Healthcare Assistant)*

When asked if her manager or colleagues were supportive, she was equivocal; *'Well sometimes, they can't do much, I guess'.*

Along with others, a worker in a care home identified that that the consequences of errors were different for BME and white staff (sometimes referred to as the racialisation of mistakes):

> '*We as black people are doing our job, but we get more targeted for criticism, for fault finding. But how do you start to support each other when you find that one person is making a mistake, not a serious mistake, maybe for example you forget you charged the service user. Everybody does it. When it's a white person that makes that mistake, nobody says anything but when it's a black person then you find people go into a report and it's just a minor mistake. Because for me when I'm doing my work and I find anybody makes a mistake, I will call the person and say "oh, you forgot to do that, go and do that". That's what I do but if I'm the one then there will be a report and they will be telling each other'. (NS20: Black - African, Residency or leave to remain, Female, Residential care worker, Local authority, Open-ended contract)*

Participants from various locations held a similar viewpoint that BME members of staff tend to face greater criticism and reproach for any mistakes made. Another residential care worker of Thai heritage reflected:

> *'I think that I'm given a lot of more harder jobs to do, I don't know why that is. But I seem to be getting the brunt of things and there's a lot more scrutiny and criticism towards me than the other colleagues. And it's like one rule for them and a different rule for me'. (NW15: Thai British, Residency or leave to remain, Female, Residential care worker, Private care home, Zero hours contract)*

When asked if it was due to age, ethnicity or because she was fairly new, she said she thought it was all of these.

One Filipina participant highlighted how she had been blamed for mistakes made in her care home because she felt that managers held discriminatory stereotypes about Filipinos being passive and less likely to resist accusations of misconduct and easier to use as scapegoats to take the blame for other people's mistakes or even systemic failings.

> *'I've been accused twice in one nursing home, she said, "Oh I am disappointed with you." I said, "Why? What have I done?" So, and so you know that already, that the daughter of this particular resident complain all the time. Because it happened that in that home, they divided into groups, and that particular service user is in my group. I am not a senior carer but I am the oldest one, I am the one in there since it opened. They said "oh they will report us to the CQC (Care Quality Commission) blah blah blah," And I said, "Okay, she is in my group, but I don't see her all the time, I did not feed her.And I said, "so why you keep on blaming on me, this is the second time you've said you blame me I said. And I am disappointed as well because you did not do your work first, find out who*

> *did it, and you are blaming me again. I don't want to be used as a scapegoat'. (KX20: Asian – Filipino, UK, Female, Healthcare Assistant, Agency, Zero hours)*

The racialisation of mistakes maps onto the contractual hierarchy outlined above; agency workers have fewer employment rights and were dismissed for minor infringements whereas an NHS worker has access to some form of disciplinary procedure:

> *'They were treated about differently than normal NHS workers. I'll give you one good example. Again, say there was a complaint from the department, some minor, minor complaint and it was an NHS worker. And one was employed by the NHS and one was agency, they would just not look into the complaint or do something about it, all they would do is simple and easy and say "ok it's agency worker let's sack him", make a phone call and say," look, we no longer need you"". With the NHS worker, for example, there's a policy and procedure to follow, but with the agency worker it's just a click of the fingers and say, "we don't need you", simple as that. You make a mistake, you go, you go'. That's one example. As I said, agency workers are not treated the same as other workers'. (NO22: Asian – Pakistani, UK, Male, Porter, Private contractor, Open-ended contract)*

5.6 Policies and Practices – the Race Equality Standard

There was very limited awareness among BME workers in England of the NHS Workforce Race Equality Standard or equality policies and practices in general. Many believed that organisational equality policies were rhetoric and not applicable to their experiences at work. NHS Porters or Security Guards noted that Equality and Diversity training was often online and this gave them the impression that it was minimal and 'tickbox'. Workplace equality measures were seen as ineffective paper policies with little direct or positive impact on their day to day working lives:

> *'They say it in the writing, but the reality is something else'. (NX01: Black – African, UK, Female, Residential care worker, Private care home, Zero hours contract)*

Similarly, for a BME care worker in the private sector;

> '*It is said more than it's done'. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

Although one respondent suggested that BME workers needed to understand their rights and have the confidence to stand up for themselves at work, overall, there was little evidence that participants felt able to challenge racism or discrimination, particularly where they had no contractual status and there were no formal procedures available to them. In two cases where workers were directly employed by local authorities they had access to such channels and had challenged discrimination on the grounds of race:

> *'I've experienced discrimination at work and outside of work but mainly at work. At the present moment as I speak to you, I'm involved with the tribunal for discrimination as well as employment appeal tribunal. And I've had three tribunal hearings and one scheduled'. (NS33: Black – African, Residency or leave to remain, Male, Residential care worker, Local authority, Open-ended contract)*

Another support worker who was one of only two BME members of staff in a Scottish local authority run residential care setting had been verbally and physically assaulted and bullied by another member of staff with no consequences for the perpetrator. She had raised a grievance:

> *'I was bullied by this same person in an activity when I was doing an activity with service users. All the white people there, I was the only black person and everybody saw what she did. Nobody spoke up for me. So basically I am on my own. And these are the things I have raised a grievance against and I'm waiting for them and if they don't get back to me within three months I will lodge this into an employment tribunal. Because I've gone through this for three years and I've had enough. And I am not going to keep quiet and I'm going to stand up not for myself but for other people that lots of times have been frustrated'.* *(NS20: Black - African, Residency or leave to remain, Female, Residential care worker, Local authority, Open-ended contract)*

Section 2 – Work under COVID-19

5.7 On the Frontline

All but one research participant had worked throughout COVID-19. The exception was a bank agency care home worker on zero hours, had been furloughed for a year initially on 80% pay and subsequently 60%, she was anticipating job losses on her return to work. A homecare supervisor recounted that workers had to sign a standard protocol that they agreed to work during COVID-19, but commented '*Well, people will sign because they still need to be having a job'*. There was variation in the extent to which participants were formally defined as a key or essential worker, particularly in the case of live-in carers. Security workers and porters were not sure if they were considered to be essential workers even though they had been working throughout in hospitals. Respondents reported that there had been an increase in agency workers during Covid, often migrant workers, but also an influx of those who had lost jobs or were on furlough including white British.

Everyone interviewed were acutely aware that they were in the frontline in terms of exposure to COVID-19. Across all sectors almost all participants described the pervasive risk in the workplace, as a residential care worker from Wales put it:

> *'When you work in an environment like this, there is so much going on you just don't know when next it's your turn or you might come in contact with someone. So the concern is nobody wants to get sick and everybody wants to carry on with the job, but don't want to get ill because they don't know if they're on the line or how well they may pass under if they do contract the Covid. The concern is everyone is being cautious not to get sick'.* *(NW08: Black – Caribbean, Residency or leave to remain, Male, Residential care worker, Private care home, Open-ended contract)*

The nature of care work and proximity to service users and the public meant effective social distancing was impossible, as for a residential care worker:

> *'There was no social distancing introduced, how can you introduce social distance in a care setting? You can't have social distancing in a care setting'.* (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract).

For most categories of staff physical contact was an integral part of their duties, a number discussed their fears of catching COVID-19 from service users and several believed that they had done so. One respondent contracted COVID-19 following an outbreak in the care home where he worked and was hospitalised, his partner also contracted it and he reported that two colleagues had died and one had passed the virus to her husband who had subsequently died. A private care home worker explained how she voiced her fears to her manager about a particular patient not being properly isolated and that she, unlike nurses, did not have proper PPE:

> *'There is one resident in there. I said, "why are there staff [being mixed], you know," so I questioned them, even the manager, "Is he Covid positive?" I asked. "No, he is negative." So, the nurse had the shield, and she has a gown, "But how about me? I don't have the protection". And I spent almost 30-45 minutes with this gentleman who is "Covid negative". I gave him a shower, but then I found out on Christmas Eve that the resident was positive, I had a feeling that I knew then that he was positive when I looked after him. Because nobody wants to work in that unit during that time, so I have to. I have to work in that area'. (KX20: Asian – Filipino, UK, Female, Healthcare Assistant, Agency, Zero hours)*

There seemed to be significant differences in the approaches of organisations and the capacity of individuals to manage risks in the workplace. In NHS and local authority establishments there was greater emphasis on segregating staff most at risk from COVID-19 from those engaged in high-risk duties, although this was not always the case when it came to shared staff spaces:

> *'That's the problem because, you cannot control the actions of others. So, for example, you're in isolation, you are shielding, but your colleagues still go to Covid positive patients and you see each other in the staff room. or you see each other in the nurses' station. Well of course, the chance is you would still get the virus. You still see each other constantly. They are working, and they are also entering the Covid positive areas'. (KX07: Asian – Filipino, UK, Male, Healthcare Assistant, NHS, Open-ended contract)*

Homecare and residential care workers additionally had to manage the families of their clients:

> *'The family obviously still want to visit and we were having to say "no, you can't visit your relative, not at the moment". A couple of times a family member has actually come in when they were told not to. You can only go so far and say they're not allowed in. And you know that they're going to be at risk to you and the client and if I became ill who would look after the client? That's the problem'. (NX05: White British, UK, Female, Live-in care worker, Agency, Zero hours contract)*

A care supervisor in the private residential sector said that hospitals were discharging patients too early with homecare companies prioritising income by taking on extra

clients, but also that social services insisted that homecare provision had to be in place. He questioned such exposure and recalled a conversation with his manager about refusing to accept hospital patients who may by symptomatic:

> *'And he said, "Oh, we cannot do that we have to meet the demands of the service". So I asked him a question; "so ostensibly you can meet the demands of the service, but at the same time you're compromising the health of staff, their wellbeing is being compromised - because there is no balance there?" The risk is there but you can't just say I'm not gonna take them, I say to myself there is a little bit more risk in this'. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

Other residential care workers also raised concerns about their lack of control over a process that exposed workers and other service users to risk and had tragic consequences in a council run home:

> *'For care workers during the pandemic, it was a really, really scary time. And I think we wasn't supported enough or they didn't know what to do. The first time I was on duty, there was one man who diagnosed with COVID-19, he went to the hospital. And five days after he came back. I said to the ambulance, man, "I'm not gonna take him because he only was away for five days, so he hasn't done the 14 days, currently, as the guideline said, I have 14 other patient here who are vulnerable, so I'm not gonna take him". And the ambulance said, I can't refuse somebody" And I call the person who's on call who didn't answer. And then I call the senior manager and leave her a message. And in the morning, when she comes, she said, "oh, what you did is so wrong. You should have let him in". So, I said, to her, "do you have this morning, extra staff to work one to one with him?" She said, "why do we need extra staff?", I said, "if you don't have extra staff to work with that man with Covid, you're going to be spreading Covid. And anyone that has it here you're going to responsible. And if I go into his room and give him personal care, and I go to room two and give her personal care, I will be a spreader", You know, in that unit there that man died and about three more people died'. (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract)*

A care home worker emphasised the particular risks faced by those delivering personal care, which she felt went unrecognised:

> *'We are the ones giving more care to the patients or residents. Carers are more at risk, then nurses because the carers they are the ones giving more care. Nurses are giving medicine and the injection, but the whole personal care is coming under the carers so they are more so at risk I would say. Of course nurses are giving medicine and injections, but the body care, like the personal care bath and shower whatever and everything is done by the carers. So they are the most risk'. (NW03: Asian – Indian, UK, Female, Residential care worker, Local authority, Open-ended contract)*

BME agency workers brought in to cover for staff off sick were particularly vulnerable and being on zero hours could face the loss of work if they challenged managers over risk, as discussed by a local authority care home worker

> *'They bring a lot of new people, from agency they came there to work. There was people coming from agencies, it's poor people, mostly from Eastern Europe, Africa. They don't have any protection given to them, nothing, and some of them didn't tell them that there is Covid in these homes. They just tell them go work there and they come and don't know if anybody has the Covid or not. I remember one time, in the morning – I worked in the night and finished 8 o'clock in the morning. I remember one morning, there was agency staff because the face was new and they didn't have any masks or something, and were just arguing, they didn't know there was Covid here, the agency didn't tell them. They are zero hours contract, and they were very frightened. For example, if some Covid patient is there and they ask for the PPE if it's Covid and they [managers] can say "it doesn't matter, do it". If they say "no" then next time they don't give them their shift because they are on zero contract. They pressure them and force them, not seriously but mentally'. (NX13 Asian-Iranian, residency or leave to remain, Male, residential Care Worker, Local Authority, open-ended contract)*

The Welsh focus group discussed the specific risk for agency workers, but also the risk they presented in moving between care settings:

> '*Because we were having basically agency staff every day. And these agencies, they go to different places, not only in our company, but they go through to different, different places. And then they are just there and they're not tested, you know, because they're not part of the company staff, they are not tested. And also, because we were doing all the work. But when you have agency, for example, they come in and they don't know the company, they don't know the service user, they are basically there for a day or two or three days. So you as a permanent staff, are responsible to train the agency, like mentor them and also make sure the service user and yourself are safe'. (WAF01: Welsh focus group, predominantly female BME residential care workers)*

Many of the respondents cited travel as a concern during the pandemic, including exposure to risk on public transport, the expense of using taxis and hospital parking charges. There was some support for NHS workers in the form of hospital parking fee waivers during the first wave of the pandemic, but frustration that this was for a limited period only. Many, however, did not have their own vehicles and so relied on public transport to get to work as discussed by the Leicester focus group with some participants of the view that the employer could have provided more support:

> *G: 'Most of the staff then came in by public transport so the biggest worry was to catch the disease coming to work and spreading it in the home, because the home has 60 residents. Most of the staff were really frightened, we had, for the day shift five people for 60 residents.*
>
> *E: 'We had to fight with the owner of the home to have private transport. Because we noticed that some of the other care homes were providing transport, taxis – and also most of the private companies in general were receiving support from the government. But we couldn't understand why the owner of the home didn't want to provide us private transport to come to work*

> *in a safe way, so we are not spreading the virus in the home. And also, for us for not catching the virus in public transport'. (LFG01: Leicester focus group - male and female BME residential and homecare workers)*

Agency workers, in particular, were sometimes unable to find work locally and so had to pay for long distance travel, as with an agency healthcare worker:

> *'By April, although they have given me [some work], I cannot drive, I don't have a car. They gave me work located in long distances. Because, I think most of the staff, they do not like to travel, even if they have a car, even if it's far. So, they gave it to me. I have to take two or three bus rides. So, I said, "it's not worth it for me to travel that far, because I still have to use the bus. I have to pass it up". They couldn't give anything [else], so I had to'. (KX20: Asian – Filipino, UK, Female, Healthcare Assistant, Agency, Zero hours)*

Two vulnerable workers felt that in the context of not being able to shield they had to leave their employment in order to protect themselves or their families. For an Asian local authority worker in Wales:

> '*I came to a decision to leave on the basis that this whole anxiety around me visiting and potentially putting my mother at risk and my loved ones at risk - I didn't want to be a carrier'. (WAF01: Welsh focus group, predominantly female BME residential care workers).*

Similarly for a private care home worker:

> *'I had previously worked in another care home for over three years. I stopped, I resigned at that time, I think it was on the 15th of May, because at that time, COVID cases were on the increase. My GP told me that I was vulnerable since I have asthma. Although my GP did not tell me to resign, I decided to do it anyway because I wanted to make sure nothing bad would happen to me. This was during the start of COVID and I was really afraid'. (KX22: Asian – Filipino, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

5.8 Migrant status and risk

Under COVID-19 migrant status is a key factor contributing to risk – promoting dependence on employers (particularly where workers provide live-in care) along with reluctance to refuse work or challenge unsafe conditions. A number of Filipino respondents were also subject to COVID-related anti-Asian abuse from members of the public whilst travelling to work. Migrant workers pointed out that they needed to maintain their work hours during the pandemic because their visas were contingent on them being in active employment:

> *'I should also say that the Council has the COVID risk assessment available online for any individual and other staff who were shielding if we are not allowed to go to the other COVID wards. I have not done the risk assessment and frankly because as I said, I started my work in September, I didn't want to rock the boat in the beginning. I just wanted to do my work because I was so new and while there was a COVID risk assessment, I was aware at the same time that I needed to be renewing my visa. So, I didn't want to be seen as if I wanted*

> *to create a problem. But that was my own decision, nothing to do with management, it was my own personal choice'. (NS33: Black – African, Residency or leave to remain, Male, Residential care worker, Local authority, Open-ended contract)*

The Leicester focus group referred to the added financial pressures of maintaining caring responsibilities via remittances for family members living outside the UK:

> *'I know the socioeconomic status of people who are first time immigrants is very different from somebody who was born in the country on many, many levels. And when you get such opportunities because of other obligations back home and obligations here, you feel pushed to do it and take a risk, even if it costs your life in the process'. (LFG01: Leicester focus group - male and female BME residential and homecare workers)*

A hospital security indicated the increased vulnerability of BME agency staff to racism during COVID-19 particularly because of fears of job loss:

> *'I'll tell you something right, the people that are saying this manager is racist are the people from the agency. They're not going to come forward because they're scared to lose their job and they stay quiet. Because that's the honest truth basically, why should someone who's come from another country to work in low paid jobs, speak up, gets attacked, and look for another job which you might not even find during the pandemic. They're not going to take the risk of losing their job to speak up, when they've got money to send home back to their family. That's the whole point of why they're here for, to earn money, even if it's peanuts they can put food on the table for their family in their country, basically. You know, it's just the way it is'. (NO04: Black – African, UK, Male, Security Guard, Private contractor, Open-ended contract)*

Migrant workers felt unable to shield or self-isolate when symptomatic and were wary of testing regimes and contact with the NHS for vaccination. One residential care worker reported concerns about access to the vaccine:

> *'The gap that we're finding now is that people who are immigrant cannot book a vaccine. Because if you're an immigrant, you don't know the NHS, you don't have an NHS number, without our NHS number, you cannot book a Covid vaccine. That's our next obstacle, they did say, they're going to make it available for immigrant or non-immigrant. If it's available for immigrant or non-immigrant, why do you need to have your NHS number when you're booking? I know it's to identify people or booking, I can't book for people who haven't got NHS numbers, it won't allow you to book'. (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract)*

Live-in carers who do not have residency or whose residency depended on employers, may have little control over social contact with the families of their 'employer', especially when living arrangements changed under COVID-19:

> *'One of her kids, his house is on mortgage and when the lockdown hit, the house was foreclosed. That's why they also asked me if it's okay with me if he'd move in here. Because also this son of hers is recently divorced. I said to myself, what's my right to refuse and tell them I don't want him moving in here.*

> *I don't have that right. So, I told them, "it's up to you" '. (KX05: Asian – Filipino, Undocumented, Female, Live-in care worker for private individual, No contract)*

Another live-in carer was, however, able to resist the demands of families in the knowledge that they were totally dependent on her care:

> *'The daughter-in-law and her grandson had COVID. They live ten minutes away from the house. When they had the virus, what I did was, I did not allow anyone going to the house. Even the son always insisted, "Oh well, I am alright. I am negative." No, I don't care. I don't care if you are negative or not, but your household is [COVID] positive. If you don't care about [your family], how about me? You don't respect my decision, so be it. But I am going to leave if that happens, because nobody will look after her*'. *(KX15: Asian – Filipino, Undocumented, Female, Live in care worker for private individual, No contract)*

5.9 Work Intensification

Across most sectors workers described the intensification of work under COVID-19, the exception was NHS porters and security guards because fewer patients were attending hospital appointments. Other workers were covering for staff who were sick, isolating or shielding and were picking up extra and longer shifts. One Healthcare Assistant stated that 90% of staff on her ward had contracted COVID-19. Staff in care homes experienced high numbers of cases and absences due to staff isolating or shielding and one residential care worker said that 80% of staff had been infected:

> *'It was the second wave that just caught everybody. Almost all the residents. I think, out of 50 something residents we have, is only two [did not catch COVID]. Out of the 70 staff we have I think we have like four staff that didn't have COVID, quite a huge amount of staff'. (NX12: Black – African, Residency or leave to remain, Female, Residential care worker, Multiple private employers, Open-ended contracts)*

Similarly, a Healthcare Assistant reported the impact on staff in the second wave at the beginning of 2021:

> *'It really is on shortage. Because last time, two weeks ago, we had six permanent staff, who all developed symptoms - two tested positive. Instead of their having five staffs - three nurses, and two HCAs - there's no more, there's no more [left]. It really is short, really short, everywhere, everywhere. Especially in our hospital, short, really short'. (KX07: Asian – Filipino, UK, Male, Healthcare Assistant, NHS, Open-ended contract)*

Higher staff to patient ratios meant more work and the Leicester focus group participants agreed that everyone was having to do more with less. A residential worker in London considered that the workload had increased by 25-30%.

Respondents related how one worker after another would go down with the virus and some in private care homes were pressurised to come into work to cover for absent colleagues, sometimes because of the extra cost to the employer of paying for agency staff. A residential care worker discussed this at the Leicester focus group:

> *'The management was putting pressure on staff to do those long hours because they were always trying to avoid recruiting staff from the agency'. (ELFG01: Leicester focus group - male and female BME residential and homecare workers)*

Another also described the pressure she felt under:

> '*My work with a care home was part time work during the COVID-19 period, I was working 16 hours and sometimes, I do extra a little bit, when they're short of staff and they call you, because at the time 80% of the staff were infected. So we were left with a few, few staff. So sometimes they can call you with "oh, please it's only agencies that we have, please can you come in and be the only staff"' (NX12: Black – African, Residency or leave to remain, Female, Residential care worker, Multiple private employers, Open-ended contracts)*

A security guard working for a private contractor said he and his colleagues had been pressurised not to take annual leave in order to cover for absent staff:

> *'Because of the COVID, they didn't give us paid leave. They are saying "you can take this holiday next year. It's quite difficult to find other agency guys, and that's why you can't take a holiday this year. You can take this holiday next year", they are saying like that because of COVID-19'. (NO21: Asian – other, Residency or leave to remain, Male, Security Guard, Private contractor, Open-ended contract)*

In contrast in the public sector a Scottish local council worker felt that she could refuse work:

> *'We've got work phones, but they'll phone you on your personal phone. …they will be phoning "can you come to work?" But for me, they know I just tell them when I want to work, if I haven't told them I need to come to work, they shouldn't phone me because I'm busy with my studies. But they will still phone me and be sending emails and everything as well for people to come because people are phoning in sick for COVID reasons. So there's a shortage of staff so the demand to care is going high'.* (NS30: Black – African, UK, Female, Home care worker, Local authority, Open-ended contract)

A number of live-in carers, generally undocumented workers, reported being confined in their 'employer's' home. One undocumented worker (referred to as a TNT or Tago Nang Tago, in English, 'always hiding') caring for a 99 year old man and his 70 year old daughter, had not had any days off during COVID-19 and the inability to go out intensified her experience of work:

> '*Of course It's hard for a TNT to find a job so I just stay patiently, and I do whatever I can, try to get along with them, the family and the two patients, praying all the time for them. And so, I manage. Then here comes the COVID, what I called it double hardship of job, but I thank that I managed it. I want to say is double hard work because you have to stay 24 hours 7 days a week no going out, so it's very stressful and I'm so stressed and I experience a lot of body ache'. (KX09: Asian – Filipino, Residency or leave to remain, Female, Live-in care worker for private individual, No contract)*

In addition to extra time spent at work, participants experienced some reorganisation of work and additional duties. An undocumented live-in carer said that she had been asked to take on cleaning when her employer's cleaner could not work during the pandemic. She felt that because of the personal relationship with her employer, who gave her gifts, she could not complain.

There were additional administrative duties because of the use of PPE, new safety procedures and associated paperwork and record-keeping. A recurring theme was that because managers were working from home or were unwell, junior staff took on extra duties for which they may not have been trained resulting in risks for staff and service users. As one residential care worker in London put it:

> '*It has become more intense and the requests they have now put in a lot more requirements for us to meet, and a lot more paperwork than what it really should be. They want you to have a watch on people, just to see if somebody washed their hands'. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

In residential homes staff related that they had to take on extra cleaning duties, temperature screenings and PPE counts, but also that there were increased tensions between residents because they could not go out, leading to incidents that then had to be recorded. Increased workloads meant they were unable to take breaks:

> *I barely have any breaks. I eat my food as I go along. There's not really a time where I can just sit down and have a break without someone coming up to me five times asking something. "will you come and do this?" "Something's happened in the living room, they're arguing". There's not really a time where I can actually have a break to myself'. (NW15: Thai British, Residency or leave to remain, Female, Residential care worker, Private care home, Zero hours contract)*

One residential worker commented that additional duties impacted on the quality of care. A NHS Healthcare Assistant described how new tasks related to PPE and COVID-19 prevention had led to work becoming more intense:

> *'The work is really non-stop. This COVID, it's hard because, of course we'd have to double time, we have to wash our hands, and we have to constantly change your clothes, your gloves. And we constantly wipe our face shield. And we are all sweaty. What do you do? Because when you cater to individuals, one round, one bay, you'd have to change gear every step of the way. So, it's hard. Especially the time. It really shows that the time is not enough. There's not enough staff, and there's not enough time'. (KX23: Asian – Filipino, UK, Female, Healthcare Assistant, NHS, Open-ended contract)*

Another agency residential care worker described the experience of working in a mask all day:

> *'Even the so-called mask at times is not really easy because it's so disturbing because you will have it 12 hours. I will start feeling hot and I had to run somewhere and remove it to have some refreshment, if not, it will start choking me if I take it so long. And it's not really easy, like start work eight o'clock and before you move from your home, you put it on on the way. Just calculate it like*

> *you have it 14 hours the whole thing, so it's not really easy. You breathe in, you breathe out, you breathe in. So you're doing all those things to save your life and save others'. (NL18: Black – African, Residency or leave to remain, Female, Home care worker, Agency, Zero hours contract)*

5.10 Absence and Sick Pay

The capacity of workers to self-isolate if they or household members are symptomatic is clearly crucial to containing the spread of COVID-19. However, evidence suggests sickness absence was an issue in some workplaces. A residential care worker reported that there had been disciplinaries arising from sickness in her organisation:

> *'A lot of people who feel unsafe, they were deemed absent from work. Well, they're going through the [disciplinary] procedure. And they're making it like confidential so they so they're not allowed to share it with other staff member and all that'. (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract)*

In contrast a directly employed NHS porter said that, as in some other sectors, potentially punitive sickness absence procedures had been suspended to encourage workers to stay away when symptomatic. One homecare worker recounted that those testing positive faced a disciplinary if they attended work and another agency worker that workers were required to have proof of vaccination or could not work. A porter working for a private contractor in the NHS had to test every two weeks and self-isolate for ten days if positive. However, he also said porters felt under pressure to return to work:

> *'We feel like they push because they say "ok you come to work and we'll see how you feel". How can I get up and go to work and I feel sick? I feel like "oh you push me. I'm sick"'. (NO27: Asian – East Timor, Residency or leave to remain, Male, Porter, Private contractor, Open-ended contract)*

Existing studies on COVID-19 have highlighted the importance of sick pay in allowing for self-isolation and controlling its spread. In this research sectoral differences in access to occupational sick pay were evident. Dependence on Statutory Sick Pay (SSP) meant that health and social care workers in private care homes or working for private contractors could not afford to self-isolate or shield. Agency workers and those on zero-hours contracts generally had no access to sick pay. Inadequate sick pay encouraged attendance at or premature return to work and led to workers putting themselves and colleagues at risk. Sick pay thus emerged as a major issue in the ability of workers to counter COVID-risk to themselves, their families and wider communities.

One residential care worker who contracted COVID-19 took time off on full pay and in a care home for young adults another participant reported those contracting Covid at work were paid while off sick. All white participants had access to some form of sick pay, although again mostly SSP, and this tended to reflect their contractual relationships. One white focus group participant working for a charity got occupational sick pay, but also ten days compassionate leave that workers had used during COVID-19.

A NHS porter noted that agency and outsourced workers doing the same job as those directly employed by the NHS did not receive sick pay. When one on a zero-hours contract, but working 60 hours per week, had to shield because his partner had Covid he survived on SSP. His colleagues who were still on NHS contracts were entitled to occupational sick pay:

> *'There is no support, there is no support, there is no support. So, I'm talking to you now, it affected my wages and it affected me paying for my rent, but the Government does nothing about those aspects. They want people to isolate, once they come in contact or somebody of your household has Covid, but they didn't do nothing concerning their wages. Like me staying at home for that ten days, that has drastically halved my wages into two. So how am I going to live? How am I going to survive? And that has really put a deep hole in our household. The Government does not do anything about that. It's really, really bad'. (NO34: Black – African, UK, Male, Security Guard, Private contractor, Zero hours contract)*

Overall respondents depended on SSP, but struggled to survive - a worker in a private care home also found it hard to stay away from work:

> *'It affected me financially because my job was my source of income so being off for six weeks really,, really, really literally affected my wages and literally even pulled my life upside down at that point because I wasn't able to pay my bills. And it took me a lot of extra shifts, extra extra work to be able to get myself financially back as well'. (NS18: Black – African, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

A white live-in carer working for an agency also reported that she had to take four weeks off because of stress, but could not survive financially and had to return to work. Workers on zero hours contracts ('pay as you work') generally do not have sufficient contractual hours to qualify for even SSP:

> *'So when the children had gotten sick, when they developed symptoms, and because the advice then is, to shield. To isolate. So there. I did self-isolation. The only issue was, the issue was our finances. Because, I had no, I'm only, pay-as-you-work. We all live, we just live on my wife's income because I'm not entitled for anything. Even, even I contacted Universal Credit. They said that I need to contact, I need to contact my employer. However, my employer said that HR, they told me that I'm not entitled for sick pay. because the number of hours that I work is not sufficient to cover the entitlement for statutory sick pay. So that's it. Nothing, I don't have income. I didn't have any income for like, good three months. Because we were just in a rotating shift. Because when my wife got sick. We both got COVID at the same time. She got it first, then I got sick two weeks after. So of course I also did shielding. So after that I have no work. At least my wife still got sick pay, I don't have sick pay'. (KX10: Asian – Filipino, UK, Male, Healthcare Assistant, NHS, Zero hours contract)*

Inadequate sick pay encouraged people to continue to work when they were symptomatic:

> *'I felt pressure to come back to work because I was losing money which I know will definitely affect me, which it did affect me. I'm not the only one, it's going to affect a lot of people and because of that, most people that are supposed to self-isolate, they are not going to do that'. (NO34: Black – African, UK, Male, Security Guard, Private contractor, Zero hours contract)*

One NHS healthcare assistant told how her husband was an agency worker in the same hospital with no access to sick pay, but also communicated a harrowing story of a white agency (bank) worker who died on return to work:

> *'Like my husband, he's in the bank. No work, no pay. That's the difference. But if you're in the NHS, and you've been made permanent, you're a full-time worker, you can if you are sick, you still have pay. The problem is for those who, for those working in the bank. There was one white who died recently, because she works as a bank. She did not work for six months, but, because she's in the bank, she has no income. When she came back, she did not know that someone had COVID, she has a COVID patient and apparently, she was nervous. Then she got COVID. She did not get lucky. So that's the difference if you really have no money, you'd have to take risks if that's your only source of income'. (KX23: Asian – Filipino, UK, Female, Healthcare Assistant, NHS, Open-ended contract)*

Even those with occupational sick pay felt that their entitlement was threatened. A participant in the Leicester focus group outlined how managers used threats of financial sanctions to pressure her not to isolate:

> *'I tested positive twice. The second time what I received from the management is threatening, saying to me that "if you go positive again, you're not going to receive any payment". For them that was to pay me because I have to be isolated for 14 days. So that's the kind of pressure that we are receiving every single day during the Covid situation'. (ELFG01: Leicester focus group - male and female BME residential and homecare workers)*

These sorts of pressures led workers to use other entitlements, for example the Welsh focus group discussed cases where workers had taken annual leave to cover periods when they were sick or isolating or felt at risk.

However, a local authority care home worker who was entitled to occupational sick pay when he was hospitalised with COVID-19 reported that during recovery his manager pressurised him to produce a sickness certificate:

> *'And they asked me for the sick note. I said "look, for the sick note I have to go to the surgery, the surgery they won't let anybody go there. The second thing, if you want to know if I'm sick or not, come here and you can see, or you can contact the hospital". Anyway I had some briefings from the hospital about my situation with the Covid, because I was in a bad situation. And they said "no, you should at least bring it, just fax it to me or scan it, send it" - in other words "we cannot pay". And I was so angry and said "look, when I'm sick, I'm sick and I cannot do this thing" I just called them and said "look, I cannot walk and you've just forced me to bring certificates. Give me more time, if I don't bring it*

ok, don't pay" '. (NX13 Asian-Iranian, residency or leave to remain, Male, residential Care Worker, Local Authority, open-ended contract)

5.11 Caring responsibilities

There were no cases where workers reported being allowed time-off or where arrangements were made with managers to deal with childcare and home-schooling during the pandemic. One third of the participants stated that they had to balance work and caring responsibilities, including home-schooling. One residential care worker who worked nights home-schooled her children by day. An NHS Healthcare Assistant related that he had to work on Saturdays and Sundays because of the lack of childcare. As a residential care worker based in Scotland put it:

> *'Now you have to do your job and at the same time the teacher has to check what the children are doing, if they are doing well or not. So, you have to learn academic skills now. Everybody, because everything is not the same anymore. There is a lot of pressure at every level in the life. You are working and doing everything around your children'. (NX01: Black – African, UK, Female, Residential care worker, Private care home, Zero hours contract)*

Some expressed worry about the academic performance of their children and blamed themselves for not having the time to monitor the home learning situation, as for one local authority residential care worker:

> *'That was a big disadvantage for him and his education, because I get an email from his school that he attend 65% of his class, 65% this child had 100% attendance during Covid. And the time that I was working, he attained 65% of this class, which meant when I gone to work, he wasn't online studying. So, that was one of my big disappointments with myself during the pandemic, that he wasn't able to get the full benefit of his education during that time. Oh, I was so shattered when I come home, I would just go to sleep, sometimes I wouldn't even eat. You're so tired from all of this extra protection, extra mask everything. I just think it drains away from you'. (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract)*

A participant who worked as a live-in carer for an elderly lady spoke about the challenge of balancing two full-time caring roles, as she took her young baby to work:

> *'Baby sits in her rocking chair. I just leave her there sitting. What is important is she sees me. …I bring her inside the bathroom. She also comes with me to the toilet. She just watches us. As long as she sees me, she behaves herself. Even when we wake up in the morning, we go downstairs, I start cleaning and she just sits in her rocking chair. She is just quiet. Then I start to vacuum and clean-up. We have not made any day off arrangements. Anytime that my baby and I want to go out for some fresh air, we go walking in the park. We just need to ask permission'. (KX08: Asian – Filipino, Undocumented, Female, Live-in care worker for private individual, No contract)*

Other respondents spoke about the need to keep earning to support their families but also expressed deep fears about contracting COVID-19 and infecting their vulnerable family members, as for a Filipino residential care worker:

> '*In those three months, it was really difficult because I am supporting my parents. Especially my father, he is very sickly and frail, and he takes antibiotics all the time. He recently got sick and his condition worsened in 2020. What if I catch Covid? I saw how my child suffered and how bad it could get. She is only 20 years old and she caught Covid. What about if I catch it and I have asthma? So, I was really scared to go back to work. But I fought against it and convinced myself I could do it. So, I applied for work again. And I was accepted'. (KX22: Asian – Filipino, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

5.12 COVID-19 Risk Assessment

It was evident that workers had very different experiences of employer risk assessment, largely related to organisational relationships. There was a tendency in all sectors for first risk assessments to be introduced well into the pandemic and this was particularly clear in the private sector. In some cases, risk assessments were seen as reactive rather than proactive.

Those directly employed by the NHS or local government, particularly in Scotland, had access to earlier, regular, and more meaningful risk assessment than those working for private contractors, agencies or in private care homes. Most had been risk-assessed and some were given the option to transfer to 'non-COVID-19' wards or other relatively safe areas such as reception. As the disproportionate impact of the virus on BME communities emerged, ethnicity was included as a risk factor in a number of NHS and local authority risk assessments, as a Healthcare Assistant described:

> *'There was a high, high number of the BAME community that died. So, they become so cautious when it comes to people of colour, the number of people in the BAME community dying. They tried to protect them, their ethnic staff. It was on the second wave - September right? That was September? Yes. They did risk assessments, and risk assessments became prevalent'.* (KX10: Asian – Filipino, UK, Male, Healthcare Assistant, NHS, Zero hours contract)

A local authority residential care worker in Scotland also recounted the focus on ethnicity as risk by December 2020 as part of a meaningful risk assessment:

> *'My employers sent me a Covid risk assessment and they are aware of the risks associated with black and Asian minority ethnic persons. In December they gave me a Covid risk assessment which I completed. And when I completed my risk assessment my Covid risk was 70, which meant that I was at high risk. So I am not put in those other units where we have got Covid patients'. (NS33: Black – African, Residency or leave to remain, Male, Residential care worker, Local authority, Open-ended contract)*

One NHS worker reported that management had sent out an email stating, '*If you do feel like you're at risk because you fall under the BAME category, make sure you highlight it or you talk about it with your manager' (NL07: Black – African, Residency or leave to remain, Female, Clinical Coordinator, NHS, Open-ended contract),* which appeared to place the onus on workers themselves.

While public sector employers were more likely to define ethnicity as a risk factor for workers, in private care homes risk assessment focused on the needs of service users rather than workforce. Within the residential care home sector there were differences in practices around risk assessments, but most participants working in private care homes tended to discuss COVID-19 testing and PPE rather than any formal risk assessment process in relation to staff safety. There were no reports of ethnicity being considered as a risk factor. In the Leicester focus group, some blamed the lack of engagement with risk assessment on the private care system:

> *'In the care sector, most of the private owners, they always do stuff to save money for themselves. Because they don't really think about staff or they don't really think sometimes about the residents'.* (XLFG01: Leicester focus group - male and female BME residential and homecare workers)

For homecare workers the approach was similar to that in care homes - risk assessment focused on protecting the service user and consisted of little more than a COVID-19 test and instructions to not allow relatives into the home. Where risk assessments had taken place, many participants saw them as poorly managed or as a tick box exercise, as for a respondent in a private care home:

> *'Well risk assessment - paperwork was sent out for people to sign but I just believe it's a standard protocol that they follow, it's ok sign this and once you sign it you are saying that you agree. Well people will sign because they still need to be having a job'. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

Those working for outsourced contractors in the NHS or local authorities appeared to be less aware of any risk assessment by their employers. In some cases they reported that they did not have NHS email addresses so were unable to access information circulated by the Trust. One porter said he got occasional emails from the contractor reminding them of government guidelines, but that senior managers did not come on-site and workers had very little contact with them:

> *'We are always the last to get the information. Even our management doesn't get informed because they don't have NHS email ID as well. But with us, there are always miscommunications like before. When the ward became a red zone – red zone is Covid infected, no one told the portering department because with the red zone we need to be careful. And we had a few incidents, a porter went inside just with the normal mask because that was a red zone area, it means high risk of infection. So those kind of things, late information happens a lot, a lot, a lot'. (NX10: Asian - Nepal, Residency or leave to remain, Male, Porter, Private contractor, Open-ended contract)*

This can be compared with a directly employed worker at the same hospital

> *'My manager has done several risk assessments with me, especially with the extra one because I'm ethnic minority which Occupational Health or the Trust they should be doing more because they think the minorities are more high risk than others. So yes, mine was done, but I believe this has been done not with*

> *PFI [public finance initiative] companies'.* (NO22: Asian – Pakistani, UK, Male, Porter, Private contractor, Open-ended contract)

As mentioned above there was heightened risk for agency workers moving between different jobs in the health and social care sector during the pandemic and also for those in the workplaces they were going into. Movement between jobs was reflected by participants in the Leicester focus group, but they had different experiences of risk assessment:

> *G: 'When I was working for the agency, when COVID started, although they put measures to help, it was in a children's care home. There was very little awareness really, apart from temperature checks and stuff like that. I remember the first incident was, I worked on a Sunday and on the Tuesday, I was told that somebody had tested positive for COVID. And I had to go then and get tested for my other job. So, it's just the half-heartedness – I do not know whether they could have done it any better. But that was how it was right in the beginning'.* (GLFG01: Leicester focus group - male and female BME residential and homecare workers)

> S: '*I remember when one in my day job workplace tested positive, the agency I work for were so cautious that they let me not work for at least three weeks. Because they wanted to be certain that I wouldn't spread it by any chance I had got the virus. So that's my experience'. (SLFG01: Leicester focus group - male and female BME residential and homecare workers)*

Overall, several participants stated that the risk assessments were undermined by a lack of clear guidance and support around how to engage with the results of the assessment. A number felt there was no clear information on the circumstances in which they should shield, particularly the case for those with caring responsibilities. There was little evidence of consultation or negotiation on risk assessment and practical outcomes, although respondents in the NHS and local authority may have been unaware of trade union involvement.

5.13 Access to Personal Protective Equipment (PPE)

Most participants reported that in the early stages of the pandemic they had inadequate access to appropriate PPE and some said this had resulted in infections and mortalities, particularly in care homes. One care worker in Leicester related:

> '*I work in a residential home and we lost loads because of the COVID. The information was delayed, PPE was delayed. It was awful. To be fair it's been now more structured than it was when it started'. (LLFG01: Leicester focus group)*

The inadequacy of early PPE was widely expressed. A participant in the Filipino focus group stated:

> *'The government mandated that we needed PPEs, Personal Protective Equipment. However, our company was a bit delayed during the first phase of COVID. The PPEs that were given to us were common products and won't offer sufficient protection from COVID. Thin aprons, and the usual gloves -- those were the ones used. They were delayed. After a few weeks or a few months, that's the only time when the PPEs suited for COVID protection arrived. That*

> *was my first experience'. (KF01 Filipino focus group, male and female Healthcare Assistants, residential and homecare workers, live-in carer)*

However, even within the NHS one Healthcare Assistant suggested that in the middle of the second wave they still did not have access to adequate PPE:

> *'We don't have enough PPE, we only have masks and gloves. But the, you know the coat, the multi-resistant one, we wear full gown. Do we still have that there? I think not'. (KX23: Asian – Filipino, UK, Female, Healthcare Assistant, NHS, Open-ended contract)*

Live-in carers were less likely to use PPE as, in theory, they and their service users were isolating so these workers were less exposed to risk. However, they were not always able to resist demands by service users' families to visit.

There were suggestions that within the NHS nursing staff had better access to PPE thank other staff. There was a debate about whether porters needed PPE level 2, as nurses were supplied with, or whether they only needed PPE level 1. An agency Healthcare Assistant compared her PPE to that of nurses, even those working for agencies:

> *'Then the nurse said, "Oh, it's not fair that I'm the only one going there." And I said, "you have the gowns and everything, and I don't have. I just have the mask, and the apron." So, the nurse had the shield, and she has a gown, probably that, because she's from the agency, and probably they provided that for her. So, I did not ask "But how about me? I don't have the protection" '. (KX20: Asian – Filipino, UK, Female, Healthcare Assistant, Agency, Zero hours)*

Overall staff working directly for the NHS appeared to have earlier access to better PPE and to have received greater support and guidance than those working in other sectors. A number of respondents in social care or working for agencies or NHS contractors highlighted disparities with the NHS, as a residential care worker reflected:

> *'We were working with little or less PPE. While NHS was up with good gowns, with goggles with the right masks. We in the care home, we just use a paper or a waterproof bag to cover ourselves. Just the £1 Chinese mask, no goggles. Sometimes our managers too, I don't think they are well trained. And they said, "oh, you people will make the residents be afraid, how can you wear masks to somebody's room". And we the staff, we have to explain to them that this is not a matter of the residents, is a matter of us protecting them and protecting ourselves. So, it was difficult at first, even for us to, to wear face masks until the government made it a guideline and I think that is why they spread the whole thing in the in the care homes'. (NX12: Black – African, Residency or leave to remain, Female, Residential care worker, Multiple private employers, Open-ended contracts)*

As in the case of risk assessment there was confusion about who was responsible for PPE for agency or outsourced staff, leading to differential exposure to risk in the same organisations. Some agencies appear to have taken responsibility for providing PPE for their workers:

> *'Don't worry, they told me. I told them that they have to provide me with the PPE. Because the caring homes don't provide you with everything, with the elderly around. And the agency agreed. So, I am well provided for. My [regular] supplies arrived yesterday'. (KX14: Asian – Filipino, Undocumented, Female, Home Care worker, Agency, Zero Hours contract)*

In contrast, porters and security guards working for contractors for an NHS Trust said PPE was only forthcoming after the deaths of two Filipino colleagues and argued that the contractor initially tried to pass on responsibility for providing PPE onto the NHS:

> *'They didn't meet their duty of care at all at the beginning. They were telling us the Trust should be providing PPE. You provide a contract, right, with the trust managers, it's your 100% right to keep us safe in the workplace. You don't point the finger at the trust, if you point the finger at the trust, tell them to give us PPE, or we're not going to do the jobs. As soon as the porter passed away, that's when you started to see the PPE coming'. (NO04: Black – African, UK, Male, Security Guard, Private contractor, Open-ended contract)*

While a directly employed porter stated, '*the PPE is always available, there was never any issue or shortage (NO31: Black – African, UK, Male, Porter, NHS, Open-ended contract),* a porter employed by a contractor had little access to PPE either from the employer or the Trust:

> *'My employer's just giving us face masks and the other things we buy ourselves, [from the] supermarket or Boots. Yeah, we buy the gloves and the visors, sanitiser and visors we buy ourselves as well'. (NO21: Asian – other, Residency or leave to remain, Male, Security Guard, Private contractor, Open-ended contract)*

Other participants also provided their own PPE, an additional expense for poorly paid workers and likely to be of questionable quality. This was even the case for a care worker employed by a Scottish local authority:

> *'So, it got to a time where people bought their own PPE because it's not the bosses going to see this patient, it's you seeing the patient. So, I bought mine, I bought everything, gloves, apron, shoes and everything. We had gloves and the ones for the shoes, but we didn't have the goggles when it started. So, most people bought the googles and the hand sanitiser, and took them home. And the soap as well'. (NS30: Black – African, UK, Female, Home care worker, Local authority, Open-ended contract)*

Others had to improvise PPE from available materials, as in a care home:

> *'We had to toilet one of the kids and there was no PPE. It was just me and three other staff and two kids with special needs. And we had to use a bag, there was no PPE at that time. And that particular day we didn't have enough of it, because we didn't have gloves especially. I said ok let me risk it and then I put on a polybag in my hand to do the changing. If anything had happened to me at that point, I didn't have an apron on, it was just a polythene bag I used to do the changing. Because I felt the kid needed that and I had to risk it and do it'.* (ALFG01: Leicester focus group - male and female BME residential and homecare workers)

A number of participants believed that they or colleagues had caught COVID-19 in the workplace due to lack of adequate PPE, as for the colleague of a Filipino NHS Healthcare Assistant:

> *'It's not really effective if you only wore masks. Because, we had another Filipino staff who had done shielding, last January, that Filipino filed for a dayshift. So, after three days, they had COVID'.* (KX23: Asian – Filipino, UK, Female, Healthcare Assistant, NHS, Open-ended contract)

The Leicester focus group discussed how even where PPE was available poor communication resulted in confusion about appropriate use, as a care worker stated:

> *'There's not been any clear communication in terms of PPE and what's been put in place and things like that. Everything is coming in dribs and drabs'. (XLFG01: Leicester focus group - male and female BME residential and homecare workers)*

In comparison a private care home worker in Scotland commented:

> *'I would say because of COVID we normally use it and we were told to – there was a training on just to see how it's properly worn, and how it should be used and disposed. So, I think everyone had to complete their training and I think that was it. And we were given a lot of PPE to use'. (NS18: Black – African, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

5.14 The undervaluation of care work

Exposure to risk and the intensification of work under COVID-19 exacerbated feelings that care work is undervalued. Care workers highlighted the emotional, psychological and physically demanding nature of the role during the pandemic. One respondent emphasised the lack of choice in continuing to work under risk, but also the low pay endemic amongst health and care workers, she also queried her private care employer's business model which pays her £9 an hour on a zero-hours contract:

> *'We don't have any choice. Those people are vulnerable and they need our help and we are out there putting ourselves at risk to help them and support them. But for what? For low pay wages. We are out there, especially in this COVID pandemic, we are putting ourselves at risk, our family at risk, everybody at risk for a low pay salary, for a minimum wage for most of those in the company. So you are told that if you catch it, for what? And what are you going to live on, your family, for what? For a minimum wage? Just because we don't have a choice, we have to go and work to survive. The company receives £70 for each service user but the worker gets £9 an hour, why can't we be paid more?' (NX01: Black – African, UK, Female, Residential care worker, Private care home, Zero hours contract)*

An agency homecare worker who was also an international student also highlighted low pay:

> *'The main thing is the pay, they should increase the pay. Because you know, I've got £8.24 there is not enough. Because I'm a student and if you've got an*

> *experience they should increase the pay, after experience and experience. Because if you have five years' experience, three years' experience then that's not enough'. (NX15: Asian-Indian, Residency or leave to remain, Male, Homecare worker, Agency)*

In one case residential care home workers had received a temporary bonus covering eight months of the pandemic and also got free food; but the payment was seen *'to encourage us to do more work' (NW03: Asian – Indian, UK, Female, Residential care worker, Local authority, Open-ended contract).* An NHS healthcare assistant also reported getting food donations and she also valued a NHS rainbow badge given to staff from management to acknowledge their work. Participants welcomed gestures of support from the public and government such as bonuses, vouchers and clapping. However, a number suggested that these public displays of appreciation should take a more tangible form in terms of pay. This was reflected in the Filipino focus group:

N: 'For me, instead of clapping, just turn these into salary (laughs)

S: Instead of clapping…

N: Yes, just raise the salaries instead of the applause (laughs). It's not just the NHS workers, or the nurses -- healthcare workers, every one of them. If you see it, what was the ratio of those who died, how many health workers died here because of COVID? It's almost everyone! What percentage was that? It was a lot!

And this is what they just want to give? Claps?

E: In the NHS, there's the clapping, right?

J: Sometimes I think that I might be better off working in Aldi because the salary is higher in Aldi'. (KF01 Filipino focus group, male and female Healthcare Assistants, residential and homecare workers, live-in carer)

While in Wales and Scotland social care workers had received a £500 bonus and other workers received one-off payments to acknowledge their role during COVID-19, others noted that despite being obliged to undertake extra work there was no additional payment, and it was some years since workers had received pay rises:

> *'A lot of staff were also complaining because I think we didn't have a pay rise. And apparently, we were told to do a lot of extra shifts because there were no staff. And most staff didn't want to do any extra because they were not getting paid, they were still getting the same pay for it. So, I think that actually affected the [care] home as well because at this point there was no staff at all. And I would say the management didn't really encourage staff, they were not really supportive from the beginning. And I think it's affected all homes as well because we lost a lot of residents and that was really difficult as well'.* (NS18: Black – African, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)

Lack of recognition was intimately related to low pay in the health and social care sector. A number had multiple jobs in order to survive financially. In the Welsh focus group, a male residential care worker discussed the legacy of the removal of bonuses or overtime premia for extra hours:

> *'Actually, working time it's gone, gone up quite high. I do my voluntary extra hours. So, my 50 hours. So last year, in June, we had organisational restructuring, which involves removing any kind of extra hour bonuses, saying that this was unfair on certain members of staff, who did not do the extra hours and they were not getting extra money. But that's kind of the point of the bonus pay. So, if you do the extra, get the bonus, if you don't do the extra don't get the bonus. Yeah, they were saying that this was unfair. Now when we needed the extra money, because we were at the risk of going into self-isolation, we were not given [it], so they took it away, they say it's an organisational restructuring. That that was not a wise step at all'. (WAF01: Welsh focus group, predominantly female BME residential care workers)*

Some NHS workers felt that they were valued by the public, employers, government and service users and a respondent working in a vaccination centre felt highly appreciated, with members of the public returning after their jab to bring gifts. However, those not directly employed by the NHS, particularly care workers, felt under-valued as a residential care worker from London asserted:

> '*In England, the only key workers they valued was the care workers from the NHS, because we do almost the same thing, or even worse than what the NHS was doing, but everybody's focus was on the NHS. They clapped for the NHS, and they never clapped for the care homes. They were talking about the lack of equipment. And nobody talked about lack of equipment in the care homes'. (NX12: Black – African, Residency or leave to remain, Female, Residential care worker, Multiple private employers, Open-ended contracts)*

This absence of recognition by the public and government was felt acutely by some home care workers many of whom felt that they had made great sacrifices in order to protect their service users, as one white Welsh live-in carer put it:

> *'I'd like the Government to give us more recognition in our job role, we are very much the forgotten workers through this pandemic. We've never been mentioned, they've never acknowledged what we've quietly been doing in the background. And it annoys carers because we've lost very, very few to COVID from looking after the elderly in their own homes to the amount who actually they lost in nursing homes. Now the good side of carers has never been mentioned and that we find very annoying that we've protected the elderly and hopefully we're coming out of this looking really good, but we're never acknowledged'. (NX05: White British, UK, Female, Live-in care worker, Agency, Zero hours contract)*

A hospital security worker felt that senior managers did not acknowledge the impact that the death of workers had on their colleagues:

> *'Like even when them two Filipino porters passed away, as far as I know, no director from the board team, from the NHS side, didn't even come down to speak to us. They didn't even write a card to the porters, "thanks for your help". It was all basically "speak to the private company". To me, the way I see it, we're in hospital grounds, like, even if we're a private company, the Trust should still treat us all the same whether you're agency, private company. we're in their*

> *grounds, we're basically running the hospital for them to get their bonuses'. (NO04: Black – African, UK, Male, Security Guard, Private contractor, Open-ended contract)*

Some linked employers' lack of appreciation for their work during COVID-19 to the wider differential treatment of BME workers, as for a residential care worker in Scotland:

> *'They don't appreciate, but if it's a Scottish person that does that, they will appreciate. But I don't know how to say this if it's discrimination or no regard for people of colour, there is no appreciation. Instead you find people feeling intimidated because maybe black people are supposed to be seen as stupid'. (NS18: Black – African, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

5.15 COVID-19, Stress and Mental health

Many participants discussed the toll that the pandemic has had on their mental health due to social isolation, fear of infection, the death and illness of colleagues and service users, wearing PPE and being expected to undertake new and challenging roles. As a residential care worker in Scotland put it:

> *'Some people have mental issues and they don't even know. Psychologically we are not well, psychologically and physically to be working every day, and going to work during this pandemic. But there is nothing, we are just carrying on and then just provided with equipment and that's all. We are suffering mentally and physically every day because it's not easy at all. But they have not changed, they are doing nothing at all'. (NX01: Black – African, UK, Female, Residential care worker, Private care home, Zero hours contract)*

Live-in care workers were particularly isolated and a white British participant expressed the feelings of isolation and stress that confinement caused:

> *'The isolation for us because we've not been allowed to go out at all. Also wearing PPE all the time in somebody's home can get very tiring. And also, the stress of trying to keep the person you're looking after calm in such frightening times'. (NX05: White British, UK, Female, Live-in care worker, Agency, Zero hours contract)*

Workers reported being exhausted by the intensification of work and the stress involved with being on the frontline, for example for one agency worker:

> *'I worked in two homes…at that time and I did not get ill! Even though they think I am ill, but probably it's because of exhaustion as well, I've been working hard during that time, almost six days or seven days a week. So, I worked in two homes and then I catch COVID! I am still off sick. I am still recuperating'. (KX20: Asian – Filipino, UK, Female, Healthcare Assistant, Agency, Zero hours contract)*

Some participants expressed frustration that despite the pandemic putting huge pressures on workers very little direct support was being offered to them to help maintain their wellbeing. One respondent noted that the occupational health team were working from home. An exception was in the NHS where a care coordinator said there was a health and wellbeing coach who provided therapy sessions. An porter

working for a contractor, said that there was a mental health first aider, as well as an employee assistance programme offering support in managing finances. Elsewhere support was contracted out to agencies, with web links to services. Workers were offered Zoom calls or online mindfulness or mental health support or external telephone counselling. Few participants said they actually used these services with some preferring external support, but others found them difficult to access:

> *'They offered us and I tried to access it but there was a lot you had to go through. There were websites and links, I tried, but there were a lot of questions you had to answer. So, I did not pursue it because I was still ok. I'll do it later when I really need it'. (KX22: Asian – Filipino, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

A residential care worker said a Women in Action group designed to support mental health had helped her when she had COVID-19, another participant had arranged his own private counselling. One respondent stated she would have preferred a team counselling session where she and colleagues 'could unload' rather than free food.

A number of informants discussed the racialised notions of resilience that they felt managers might invoke to justify the allocation of extra or risky duties. One African Caribbean residential worker felt she was characterised as resilient rather as necessarily adopting a coping strategy.

> *'I just think sometime in the UK, they see us Afro Caribbean people as really hard and resilient. And we could cope with it. And they don't know sometimes, that is the only way people think they can cope, they put up this front to say they're coping'. (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract)*

Similarly, Filipino participants discussed how they were seen as being resilient and reliable and could be called on to step in during times of crisis, but also that these characteristics were part of their own identity:

> *'Because us Filipinos, right, we work. I know that there is a doctor in the hospital, the doctor said that they need nurses, but they only needed like eight [nurses]. They said, "it's enough even if they were to be given only two Filipinos, that is enough. I think, that if given two Filipinos, they can surely do this". A "lazy" Filipino healthcare worker – that is rare'. (KX13: Asian – Filipino, Residency or leave to remain, Male, Residential care worker at private Care Home, Open-ended contract)*

There is a complex interaction between management characterisations of migrant groups as hardworking and their own self-image and assertion of their worth. These may reinforce each other and meant that, in this case, Filipino workers might be more likely to put themselves forward for overtime, but also respond to management pressure, as discussed in the Filipino focus group:

> *M: 'There are people who do not want to work overtime, we Filipinos like going to work overtime. I mean, you get scared that nobody wants to work overtime. At times they will make you feel guilty, like it bugs your conscience,*

> *that's the experience'. (KF01 Filipino focus group, male and female Healthcare Assistants, residential and homecare workers, live-in carer)*

> *E: 'For me, we do have COVID patients where we work. So staff members get ill too, even the white staff members get ill. So they will be off sick. We Filipinos, we really are diligent and hardworking, we'll just do the overtime work. You'll do the work. You volunteer yourself. At times it's short-staffed so they really urge you to do extra work'. (KF01 Filipino focus group, male and female Healthcare Assistants, residential and homecare workers, live-in carer)*

5.16 Support – Employers, Communities and Trade Unions

Relationships with individual managers influenced participants' experience of working through COVID-19. A residential care worker in Wales described her manager as:

> *'Really supportive. She used to phone me nearly every day – it wasn't only me, it was like I'd say out of the 40 staff, only five were negative, 35 tested positive. So, she was trying her best to phone nearly everybody there to see how you are and everything like that'. (NX03: Black – African, UK, Female, Healthcare Assistant, Private care home, Open-ended contract)*

An agency worker felt she had been put at risk by her organisation, but described her relationship with her line manager as 'brilliant'. However, others suggested that they had received very little support and migrant workers spoke about feelings of isolation and a lack of support from line managers with work-related issues that they faced:

> *'We are always, no matter how you see it, no matter what level we get to, if you're not born in this country you are always seen as a visitor, as an outsider. So, people look at it that way and they don't want to get too involved'. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

Similarly, a Filipino care worker felt unsupported in the workplace:

> *'I know no one will back me up, I will not say anything, because I know that they will not believe me. I've had many experiences that if you are Filipino, they will not listen to you. They will listen to English white men more often'.* (KX20: Asian – Filipino, UK, Female, Healthcare Assistant, Agency, Zero hours)

Agency workers face may feel particularly isolated with no chance to build work relationships, as one agency Healthcare Assistant stated:

> *'You are not part of the staff. So most of the work shift, you will not be familiar with everything that is being done. So sometimes you will feel like I don't know – not really in the team, you know. Sometimes you feel that you're not in the team so there is that problem, here sometimes you feel like you are excluded from your colleagues'. (NX14: Black African, Residency or leave to remain, Female, Healthcare Assistant, Agency)*

She did report that from time to time her manager sent her supporting messages. However, another residential care worker indicated there was a blurred line between management support and informal pressure to return to work:

> *'He is the top manager. For example, today is Friday, by Sunday he will ask how you are doing again. He will call you. He asks how you are and lastly reminds you of when you are back to work or after 10 days when and if you can go back to work again. Are you able? If not just let us know'. (KX22: Asian – Filipino, Residency or leave to remain, Female, Residential care worker, Private care home, Open-ended contract)*

White participants appeared to be more positive about their relationships with managers, particularly appreciating informal flexibility. The white focus group reported that managers had introduced a WhatsApp group that proved to be very useful in providing support during the pandemic, although one participant wanted more support:

> *'More support, really, I think for everybody. I have felt quite isolated and quite disconnected. Sometimes if I, if I have issues for the clients, it's more difficult to contact the management because I know that they're really, really busier than ever, and trying to cover visits and trying to get everybody their PPE and everything. They did start up a WhatsApp group that was quite helpful. So, they did start up a WhatsApp group for carers, so carers could share things. And that was one way of helping us to feel a bit more connected. But that didn't come in until maybe a few months ago.' (WHF01: White focus group – female residential care workers)*

Lacking support in the workplace BME workers often looked to their communities for support. and said that they received support from charities and community groups such as Kanlungan, but also churches, women's support group, and food hubs. A Filipino live-in carer was provided with food by her employer, but recounted:

> *'I joined but I am also attending a church here in (London suburb) and that is a charity church I think so, because they are also receiving a lot of calls, of supplies, like vegetables or foods and sometimes they give it to me they bring it here, but I said, you need to give to those with more children or our community Filipinos who need because I have supply here from my employer, so I stop them from giving it to me'.* (KX09: Asian – Filipino, Residency or leave to remain, Female, Live-in care worker for private individual, No contract)

There was some discussion of trade unions as organisations that could represent the interests of workers over health and safety during COVID-19. A porter working for a Private Finance Initiative (PFI) company reported that UNISON had intervened when workers had been threatened with disciplinary action for going sick during the pandemic:

> *'That's been stopped because the union, myself and my convenor made the complaint to the Trust regarding the PFI companies saying that this is not going on because people are off due to COVID 19 or somebody who is positive in their homes. And they have to adhere to Government guidelines, 10 days you have to isolate yourself, that is not your fault and that should be not counted as your sickness triggers. So that's been stopped. I think sickness is the most important point. I think that was the most, sickness, and UNISON have given more support to members, making sure they're ok and their families are ok. And then we have advised our members if they see anything that's not right, they*

> *should report it to us, so they're aware that we are here for them to help them. We will do them the best that we can for them'. (NO22: Asian – Pakistani, UK, Male, Porter, Private contractor, Open-ended contract)*

Another respondent was aware of the potential for union support through her sister's experience:

> *"A lot of people are in UNISON, my sister, who is a nurse, she was told the same thing that she's not entitled to furlough. When she went to her union, the union said, "no, that's wrong. You can take furlough if you feel unsafe", and the union advocated for her. And it was through the union, she was offered furlough'. (NL02: Black – Caribbean, UK, Female, Residential care worker, Local Authority, Open-ended contract).*

A residential care worker was taking a case under the Equality Act on the grounds of discrimination against a former employer and had not found the trade union supportive, he also suggests the constraints that migrant status has on raising grievances.

> '*But once they dismissed me, because of a tribunal proceeding and my complaint in terms of equality rights and human rights, I feel it's important for me to take this further to the tribunal. I contacted the UNISON colleague and UNISON said they couldn't see that I had a case. But I put that aside and then I looked for another full-time job because I needed to renew my visa, I needed a full-time job. And I would add as well the important point about immigration here. Some of the issues that contributed to discrimination and my dismissal at work are to do with whistle blowing and health and safety issues. But the trouble is sometimes someone with a limited immigration status, black people will tend to ignore those issues because they are worried about their immigration status. But because of my faith, I couldn't ignore that so I pursued this thing by whistle blowing because of my faith I couldn't ignore certain things. But I know that some black people who ignore some serious issues because they fear that getting involved in this they will lose your job, and losing your job means you lose your immigration status'. (NS33: Black – African, Residency or leave to remain, Male, Residential care worker, Local authority, Open-ended contract)*

Engagement with trade unions varied by employer and contractual status, with NHS and local authority workers more aware of union representatives, possibly because of this there was more discussion in the white focus group. One respondent suggested his employer was reluctant to allow trade union representation over individual issues.

> *'So they try to block you before you can bring in people who understand what is needed to be done. This is why I said there needs to be a revolution in what the care industry is about and the managers need to be accountable for things like equality, bullying policy. They have it but they don't follow it. They need to be held more accountable'. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

An NHS porter felt that unions should be more effective in representing agency workers. A white homecare worker testified to the absence of trade unions in private homecare companies:

> '*We're not allowed, this is the problem, when you work within a private care company, there's no trade union you can join. There isn't the same protection, because you're a zero-hours contract'. (NW33: White British, UK, Female, Home care worker, Private company, Zero hours contract)*

The white focus group discussed the perception that those working in third sector care homes did not enjoy the same benefits from union representation as those working in local authority, or even private, care homes. It highlighted the role of the union in connecting workers, but also in restructuring and redundancies arising from COVID-19 as one participant from a strongly unionised public sector workplace put it:

> *'Everybody was completely disconnected. The only way that we were speaking to each other if you weren't directly in a team with somebody, was through a union meeting. And you can only have a certain amount of those within the time, because that's all you're allowed to have. So, we were really, like the union became the only place that we even knew what was happening with the restructuring. You know, I mean, there was people who were offered to take redundancy, and they were told that they were the ones that they wanted to keep. So, like there was loads of stuff that like, I mean, half of that you don't know if it's hearsay, or you don't know if it's real, but all you see is that the structure has changed and that there was no consultation'. (WHF01: White focus group – female residential care workers)*

The immediacy of restructuring shifted the focus from health and safety, also due to the absence of union health and safety reps in the workplace.

5.17 The disproportionate impact of COVID-19

The interviews explored participants' perceptions of the disproportionate COVID-19 deaths in BME communities. Participants discussed a range of apparent factors including a lack of vitamin D and underlying health issues. Some mentioned mistrust of the government and health professions due to historical factors and consequent avoidance of engaging with the state:

> *'I think one is because first thing is mistrust. Black and Asian minority ethnic don't trust the powers that be and there is not enough reflection of them at the top with any sort of power as such or any sort of authority. So that is the first bit of it. And then secondly, because over the years if you look at history, they have used our nation, our ethnicity to test … So people are very wary, and in times past they have used them and not told them anything, so people are now saying, "I don't want to be in it because I don't want to be the first people they use as a guinea pig to test out your product on, to see if it will work or not" '. (NL15: Black – Caribbean, UK, Male, Residential care worker, Private care home, Open-ended contract)*

However, most respondents raised social, but more importantly, labour market factors. The social factors included poor education and a digital divide, but also inadequate

communication of health information and disinformation on social media. One participant proposed that it was not just about the health of the BME population, but also about their treatment, suggesting that health services may not take symptoms seriously enough. Above all in terms of the labour market there was an emphasis on the predominance of BME workers in frontline and risky jobs as the main cause of the high levels of COVID-19 in BME communities as a NHS porter put it:

> *'Healthcare assistants who have direct contact with the patients or homecare, the nurses who go into homes and support the patients, I think they're more affected because they have a more direct contact with the patients and using transport'. (NO22: Asian – Pakistani, UK, Male, Porter, Private contractor, Open-ended contract)*

His colleague in security was more explicit:

> *'The reason is, this country is run by foreigners, that's why it is, that's the truth. Whether you're Asian British, Black British, if you're working in wards, it's mainly ethnic people running the show, nurses, HCAs, even the doctors, so obviously because they are front line they will be affected'. (NO04: Black – African, UK, Male, Security Guard, Private contractor, Open-ended contract)*

An agency homecare worker alluded to sectoral and occupational segregation:

> 'the majority of us, the black and the Asian minority, we are in the healthcare sector, So we are more exposed and key workers during this COVID, many people worked from home, but as a key worker you can't work from home. So yes, we are more exposed'. *(NX14: Black African, Residency or leave to remain, Female, Healthcare Assistant, Agency)*

A residential care worker in Wales also identified labour market segregation as underlying the exposure of BME workers to the virus:

> *'The reason is I think most of them work in this industry and have been exposed to various things. Most of the things that mostly people could find is only a care job or some other job, cleaning or some other industry. They are more exposed I would say to the elements, always on the frontline doing the things that maybe other people are not interested in doing. I think one of the biggest reasons, if you look at the numbers of the people in that sector, it's from that origin. That's why the numbers are high because more of the people are open to the things like that, the frontline and other care duties. This is why you find these people are more affected, because they are the ones more in that job'. (NW08: Black – Caribbean, Residency or leave to remain, Male, Residential care worker, Private care home, Open-ended contract)*

A security guard working for a private contractor reinforced the role of occupational segregation and that BME staff were less able to resist demands to undertake risky work and suggested that self-isolation without pay did not encourage risk avoidance:

> *'I think because we are less privileged, I just give you a few examples. I was self-isolating for 10 days, no payment, and when they say the black and Asian minority ethnic community are more affected, how are they affected? Because*

> *we, the black Asian and the black community, we are at more risk because what somebody else cannot do, they want us to do it and we never say "no" because we just want to work, because we like working, we're living, and we're working. So that's why they always say "oh we are more affected". Why we would not be more affected, when the job that we are supposed to be doing equally, they always leave those types of jobs to us so why would we not be more affected?' (NO34: Black – African, UK, Male, Security Guard, Private contractor, Zero hours contract)*

The role of migration status and financial dependency were invoked in the Leicester focus group, summed up by one participant:

> '*There's a money issue there - where you come from, your parents...back home you've got them and you need the money. You come here on a work visa, you are not a British citizen. you have to fight to get your pay, because you've got debt ahead of you to pay. So that's why a lot of Black people, who are not born here, had to go in. And that is why we went, we risked ourselves so much and it affected us. That is most of the main reason why this went on and we have been affected'. (LFG01: Leicester focus group - male and female BME residential and homecare workers)*

A residential care worker emphasised the interplay of race and class in the workplace and how it structures BME workers' experiences of COVID-19 in the workplace:

> *'Because we're more working class, we're more than likely going to be essential workers and have to do – you know, the rich people they work from home and stuff, but we still have to go out and make a living for ourselves because of maybe not such a good background in education. And obviously because we're people of colour we're disadvantaged right from the start anyway. There's that. And I also feel like in things like the hospital where mostly black and Asian minority ethnic will be put on harder COVID wards and things like that, there is systemic racism going on'. (NW15: Thai British, Residency or leave to remain, Female, Residential care worker, Private care home, Zero hours contract)*

5.18 Institutional racism?

A number of respondents identified and articulated systemic and institutional racism, as a residential worker asserted:

> *'I know that we're already disadvantaged by socio economics and things like that anyway. Yes, there is obviously a disproportionality with the amount of black and ethnic minority people that have died of COVID compared to white people. And obviously because we're people of colour we're disadvantaged right from the start anyway. There's that. And I also feel like in things like the hospital where mostly black and Asian minority ethnic will be put on harder COVID wards and things like that, there is systemic racism going on. And I feel like people of colour also are being, getting rid of by loads of different employers and stuff. We're more likely to be sacked over a white person anyway'. (NW15: Thai British, Residency or leave to remain, Female, Residential care worker, Private care home, Zero hours contract)*

A participant in the all-white focus group working for a charity also pointed out that the discrimination experienced by BME workers is due to institutional racism and a lack of diversity in management:

> *'I think, ultimately, that problem is because we've completely white management completely white, like, we've got the institutional racism in an organisation that fights for equalities and provides services to African communities and Chinese communities. I don't even know how to articulate it, because there's so much depth to the barriers - colonised services, colonised structures'.. (WHF01: White focus group – female residential care workers)*

Finally, a BME NHS security guard asserted:

> *'But we still know in workplaces you will still have systematic racism by giving, making some people and some groups of people to be more privileged. There is racism everywhere we go to, everywhere. This privilege and the systemic racial discrimination was happening long before COVID-19 and will continue after COVID-19 disappears'. (NO34: Black – African, UK, Male, Security Guard, Private contractor, Zero hours contract)*

6. Conclusions

The research outlined in this report provides an insight into and a rich understanding of the experience of workers in the health and care sectors before and during the pandemic. Many participants are clear that sectoral and occupational segregation on the basis of race and migration status goes some way to explain the disproportionate impact of COVID-19 on BME workers and communities. The concentration of BME workers in particular jobs is despite their qualifications and there are limited promotion prospects with a disproportionately BME workforce managed by white British managers. Cutting across this is migration status with undocumented migrants experiencing extreme vulnerability and reluctant to refuse work that puts them at risk because of their status. The words of the health and social care workers involved in this study powerfully convey experiences of direct and indirect racism at work, with limited recourse to justice. Equality policies were often seen as empty rhetoric that did not reflect experiences in the workplace.

The research participants had worked throughout the pandemic on the frontline and were exposed to extreme risk of infection. A number had experienced the deaths of colleagues as well as service users. The sample shows the extent of contractual differentiation in health and social care with differential access to employment rights. BME and migrant workers were often denied the employment benefits granted to those directly employed by the organisations for which they worked. Crucially in a pandemic, many had no or limited access to sick pay or the right to self-isolate. Differential contracts mean disparities in terms of access to PPE and risk assessment, while the sample as a whole experienced work intensification. Participants overwhelmingly concurred that care work is under-valued in terms of pay and recognition. Health and care workers did not generally feel appreciated for their essential work during a pandemic and wanted tangible reward and recognition rather than gestures.

The articulation of collective experiences points to wider structures and institutional mechanisms reflecting national and organisational policies, particularly on migration status. Some respondents defined their experiences in terms of systemic and institutional racism. The cumulative pattern of experience exposed by a global pandemic points to entrenched inequalities and failure at the organisational and institutional level. The labour market locations of the sample indicate that care work in the UK is racialised and gendered and the testimonies suggest that this was seen as linked to the societal value placed on it.