SIPTU

SIPTU SUBMISSION TO THE INDEPENDENT EVALUATION ON THE MANAGEMENT OF THE COVID-19 PANDEMIC IN IRELAND

September 2025

Fairness at Work and Justice in Society

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Fairness at Work and Justice in Society

Introduction

The Services Industrial Professional and Technical Union (SIPTU) is Ireland's largest trade union, representing a diverse membership across both jurisdictions on the island. Our members are employed in a wide array of sectors, including public, private, and community, each of which faced unique challenges during the COVID-19 Pandemic.

We welcome the opportunity to contribute to the Independent Evaluation's Public Consultation on the Management of the COVID-19 Pandemic in Ireland. As noted by the Economic and Social Research Institute (ESRI), "Working people took more risk than non-working people" during this crisis, underscoring the significant impact the pandemic has had on the workforce and our members.

The pandemic introduced unprecedented challenges for SIPTU members, with the degree of impact varying significantly depending on whether workers were classified as essential or were able to work remotely. This submission aims to illuminate the multifaceted effects of the pandemic, addressing critical areas such as health and safety measures, access to personal protective equipment (PPE), earnings and job security, levels of consultation with workplace representatives, and essential lessons for future preparedness.

Many of our members have endured significant disruptions, including job losses, reduced hours and alterations to their working conditions. The pandemic not only threatened economic stability but has also exacerbated longstanding issues surrounding workers' rights, highlighting the vital role that trade unions play in advocating for fair treatment at work and justice in society.

In this submission, we seek to provide a comprehensive overview of the diverse challenges faced by SIPTU members across various industries, including health, transport, energy, aviation, construction, manufacturing, public administration, and community services. The structure of our submission reflects the distinct experiences of our members, organised within SIPTU's five industrial divisions: the Health Division, the Transport, Energy, Aviation, and Construction Division, the Services Division, the Manufacturing Division and the Public Administration and Community Division. This approach ensures a nuanced understanding of the pandemic's impact across different sectors and sets the stage for further engagement with those running the Public Consultation on recovery and preparedness for the future.

Fairness at Work and Justice in Society

Chapter 1 - Impacts on and supports for Frontline Healthcare Workers

1. Executive Summary

This submission addresses the impact of the COVID-19 pandemic on healthcare workers in Ireland, with a focus on the effects of direct exposure to the virus, the psychological toll, workforce challenges and systemic pressures within the health system. It is informed by national data, independent research, and engagement with frontline workers.

Healthcare workers were central to Ireland's pandemic response. However, many experienced illness, burnout, and moral injury while working in high-risk conditions without adequate resources or supports. While short-term measures such as the Pandemic Special Recognition Payment were introduced, a more comprehensive and enduring policy framework is required to protect the workforce in the future.

The COVID-19 pandemic presented an unprecedented challenge to the Irish health service. From March 2020, healthcare workers at all levels were required to deliver services under extraordinary and challenging circumstances. The pandemic highlighted both the dedication of healthcare staff and the vulnerability of the health system when under strain. This submission recognises the seismic challenges faced by healthcare workers during the pandemic, both at great risk and personal cost to many within the service.

This submission focuses on the impact of COVID-19 exposure on healthcare workers and outlines key lessons and recommendations for future pandemic management. The submission references important research, data and articles which demonstrate a comprehensive overlook of the impact of the pandemic on healthcare workers at the height of the emergency from 2020 to 2022.

Our submission presents the results of a comprehensive survey conducted by the SIPTU Health Division in July 2025. The survey was distributed amongst our membership within the health service to understand their roles, work environments, experiences and perceptions during the COVID-19 pandemic. The survey aimed to capture a wide range of data, including workforce demographics, mental health impacts, workplace safety and the effectiveness of support systems. The result of our survey provides valuable insight into the challenges faced by healthcare workers during the pandemic and the measures taken or needed to address these challenges. The findings of our survey are intended to inform key stakeholders about the critical areas our members contend need attention to improve the well-being of patients and service users and the working conditions of healthcare workers. Our survey serves as a crucial resource for understanding the impact of the pandemic on the healthcare workforce and to support the development of effective strategies to support them in future public health emergencies.

This submission seeks to contribute to the independent evaluation of the COVID-19 pandemic management in Ireland. It focuses specifically on the treatment, conditions and support offered to healthcare workers represented by SIPTU Health Division, including support staff, healthcare assistants, psychiatric nurses, ambulance personnel, radiographers, radiation therapists and phlebotomists. These workers played a critical role on the frontline of the national response. The pandemic revealed both strengths and weaknesses in the preparedness, coordination and resourcing of the healthcare system. This submission also reflects on institutional responses of the Government, Department of Health, Department of Public Expenditure and Reform (DPER), the Health Service Executive (HSE), and trade unions, as well as the disparity in treatment between public services and private sector healthcare staff.

2. An introduction to SIPTU Health Division

As part of the Services, Industrial, Professional and Technical Union (SIPTU), the Health Division represents over 41,000 members employed in a wide range of roles throughout the public, private, voluntary and community health sectors.

Our membership spans the full breadth of the health workforce, including healthcare assistants, psychiatric nurses, ambulance personnel, radiographers, radiation therapists, phlebotomists, porters, social care workers, support staff, clerical and administrative workers, catering and household personnel. Members are employed in acute hospitals, mental health and intellectual disability services, primary and community care, residential and disability services and diagnostic and pre-hospital emergency care.

The SIPTU Health Division is a member of the Health Service National Joint Council which is the highest level of industrial relations within the public health service. Our division plays a central role in national and sectoral

negotiations with Government Departments, the HSE, and employer bodies. The SIPTU Health Division is also actively engaged in policy consultation processes and contributes constructively to the development of health and industrial relations policy within the health service.

Throughout the COVID-19 pandemic, the SIPTU Health Division provided critical representation for frontline healthcare workers. It worked collaboratively to address safety concerns, advocate for access to PPE for all staff on the frontline, secure appropriate redeployment protocols and achieve recognition measures for staff. The Health Division continues to advocate for sustainable safe staffing levels and ratios for all grades, support for those affected by Long COVID, mental health supports for healthcare workers and investment in safe, high-quality care environments and technology.

3. Key Stakeholders within this Submission

3.1. The Government of Ireland

While initial mobilisation efforts could be viewed to be swift by Government, including emergency legislation and public health campaigns, communication with frontline healthcare staff was inconsistent and often failed to address practical operational concerns. Effectively, the health service had to build policies, procedures and resources from the ground up to support and protect staff, patients and service users. The healthcare workforce often advised their trade union they felt exposed to the danger of the pandemic given there was little preparation or readiness to the possibility of a health emergency on this scale.

Given the seismic efforts and dedication made by the healthcare workforce and developments in other countries including the UK, trade unions called for recognition to be made by the Irish Government. A recognition scheme was introduced in 2022. It was known as the Pandemic Special Recognition Payment but was announced late in our opinion and was not as favourable as other European countries. The pandemic recognition payment was implemented unevenly within the public health service as it excluded many staff on technicalities or there was an inconsistency of application in locations. Equally, the second phase of the scheme used to recognise healthcare workers such as private nursing home staff or agency personnel within the public health system was administered through a third party, was elongated, there was no appeal mechanism and funding took too long to get to workers.

Access to vaccines for healthcare workers was rolled out as being prioritised for frontline healthcare workers, amongst other vulnerable groups in society, in the first instance. Many members reported the actual distribution of vaccines within the local health service as being inconsistent with the priority schedule published by the Department of Health and the HSE.

Trade unions have long campaigned for the recognition of Long COVID as an occupational disease. This would be consistent with other European countries within the EU. Alongside Greece, Ireland remains as an outlier within Europe in not designating Long COVID as an occupational disease. Trade unions have called for the introduction of an occupational health scheme to support healthcare workers who are suffering from medically confirmed Long COVID. The proposed scheme would be akin to other existing occupational schemes within the health service such as the Blood Borne Disease scheme (HIV, Hep C etc) and the MRSA scheme. Currently, there is a temporary scheme within the health service which has restricted access for staff due to date of infection. The temporary scheme is due to close on th[e] 31st December 2025 when all healthcare workers medically certified to be suffering from Long COVID will only have the normal public service sick leave scheme for support.

3.2. Department of Health

The Department of Health played a central role in setting public health strategy, alongside the HSE. There was a clear prioritisation of clinical over support roles in strategic planning. While this can be understood at one level, our members in non-clinical roles believed they could have contributed significant expertise and experience to strategic planning for the management of the pandemic. However, the Department and HSE failed to fully integrate key frontline personnel such as healthcare assistants, radiographers, radiation therapists, phlebotomists and similar roles into pandemic advisory and planning groups.

3.3. Department of Public Expenditure and Reform (DPER)

The Department of Public Expenditure and Reform adopted a rigid approach to funding and expenditure in response to the pandemic, particularly during early phases. They preferred a public sector wide approach to supports and policy decisions in answer to the pandemic. Our members believed this approach was often ineffective in the health service particularly in relation to the scope of supports for isolation periods or recovery from infection. The approach of 'one size fits all' was not appropriate as separate sectors of the public service faced different challenges. The health service was quite unique given the need for healthcare workers to go to work despite the lack of PPE, inadequate training in many instances, or the development of a vaccine.

3.4. Health Service Executive (HSE)

The HSE was responsible for fronting the healthcare response to the pandemic. The pandemic demonstrated how unprepared our health service was in dealing with the challenges on a major scale. Many of the policies which would be heavily relied on did not exist prior to the pandemic. As a result, significant work had to be taken to develop policies and procedures which were fit for purpose in the fight to protect the most vulnerable and those who provide care to them.
Some of the significant challenges presented included:

The need to deliver a rapid upscaling of ICU capacity and laboratory testing infrastructure.
Staff redeployment was required but implemented with challenges arising in many cases. Members raised concerns of minimal consultation at local level in many instances which created role mismatch and low morale issues for many workers.

Communication directed to staff from the HSE often struggled to get to the frontline or lacked clarity and consistency across services, sites and departments.

Mental health and wellbeing supports were introduced late and were under-utilised due to inadequate promotion and resources.

The lack of timely resource allocation for PPE undermined the capacity of the service. At the beginning, members advised their trade unions that PPE was often prioritised for clinical grades, there was improper fit testing or poor air ventilation was in place. Infrastructure had to be put in place to manage the distribution of mass supplies such as PPE. Once supply chains were secured, members informed their trade union of issues with delivery schedules, incorrect or inadequate quantities, or inferior quality of PPE in many instances.

Policies and procedures had to be developed to meet the challenges of COVID-19.

3.5 Trade Unions

SIPTU Health Division is a member of the National Joint Council within the health service. This is the national committee for industrial relations within the health service. National representatives from across the trade unions, employers, government departments and IBEC are present. It is chaired by the Director of the Workplace Relations Commission. In response to COVID, a national stakeholder group to facilitate the flow of information was developed with representatives of all trade unions and with the HSE and Department of Health. During the height of the pandemic, the forum met every week, or more often as needed.
Within this forum, the SIPTU Health Division:

Provided a critical voice in advocating for safe staffing levels for all grades, PPE, recognition payments, fair redeployment terms and supports for those infected during their work on the frontline of the health service.

Acted to support channels of communication between staff, the HSE and Department of Health during every stage of the pandemic.

Played an essential role in securing collective agreements to protect workers' rights during emergency redeployment and leave schemes.

3.6 Health Surveillance Protection Centre

The Health Protection Surveillance Centre (HPSC) is Ireland's specialist service for the surveillance of communicable diseases. The HPSC is part of the HSE and strives to protect and improve the health of the Irish population by providing timely information and independent advice, and by carrying out disease surveillance, epidemiological investigation and related research and training. The HPSC has six main areas of responsibility: surveillance, operational support, training, research, policy advice and public information.[1]

3.7 The World Health Organisation

The World Health Organisation is the United Nations agency that connects nations, partners and people to promote health across the world. They direct and

[1]Accessed via https://www.hpsc.ie/abouthpsc/

coordinate the world's response to health emergencies.[2]

3.8 The Organisation for Economic Co-operation and Development (OECD)

The OECD is an intergovernmental organisation which was founded in 1961 to advise governments on how to deliver better policies for better lives. This organisation informs policies and creates global standards through multi-stakeholder collaboration and peer learning. The Council has more than 300 committees which work with the Secretariat to determine the output of the OECD.[3]

4.The Frontline Workforce: Critical Roles and Exposure During the Pandemic

During the pandemic, Ireland's healthcare system depended heavily on a wide range of frontline healthcare workers. The SIPTU Health Division represents the widest range of healthcare workers within acute and community care and across both public and private services. Our members employed in support, care staff, nursing, health professionals and pre-hospital emergency care:

- Delivered care under extreme and prolonged physical and psychological stress.
- Had high levels of exposure to infection, particularly in the early stages of the pandemic when PPE shortages were acute or virtually non-existent.
- Were required to adapt to new or rapidly changing protocols with limited consultation, preparation or training.
- Often worked excessive hours at short notice due to workforce shortages and high patient dependency.
- Faced prolonged separation from their families due to infection control, demand from within the system and social restrictions.
- Despite their critical role, the experience of many frontline healthcare workers was marked by systemic pressure, stress, delays in recognition and inconsistent support structures.

5. The Impact of COVID-19 Exposure on Healthcare Workers in Ireland

The COVID-19 pandemic presented one of the most significant public health crises in the history of the Irish State. In a paper published by the OECD in March 2023, the authors argue the pandemic "highlighted significant weaknesses in the public health system, affecting its resources as well as its organisation" and the Irish healthcare system pre-COVID-19 as "a legacy of the procyclicality of health spending, such as the cuts after 2008 and of weak capital investment in health infrastructure up to the 1990s, the existing capacity constraints included understaffing, outdated hospital infrastructure, low numbers of hospital beds associated with inpatient bed occupancy rates well above international safety standards and, finally, weak ICU facilities."[4] At the centre of the national response were healthcare workers (HCWs), who continued to deliver care under conditions of immense pressure, personal risk, and uncertainty. The cumulative effect of this exposure, both physical and psychological, remains evident across the Irish health system. While certain short-term supports have been introduced, there remains a critical need for a long-term, coordinated government response that recognises the contribution of healthcare workers and addresses the lasting impact of the pandemic on this essential workforce. The OECD published a report entitled 'Ireland: Country Health Profile 2023' in December 2023. Within their report the OECD confirm "The COVID-19 pandemic has proved to be the most significant disruption to health systems in recent decades." [5]

This submission outlines the impact of COVID-19 exposure on Ireland's healthcare workers and provides recommendations to support recovery, resilience, and preparedness for the future.

5.1 COVID-19 Infections Among Healthcare Workers in Ireland

Healthcare workers in Ireland were disproportionately affected by COVID-19 infection during all phases of the pandemic. According to data from the Annual Report of the Epidemiology of COVID-19 in Ireland 2021-2022, which was prepared by the Health Protection Surveillance Centre

[2] Accessed vis https://www.who.int/about
[3] Accessed via https://www.oecd.org/en/about.html
[4] Accessed via http[s]://one.oecd.org/document/ECO/WKP(2023)3/en/pdf
[5] Accessed via https://www.oecd.org/en/publications/irela[n]d-country-health-profile-2023_3abe906b-en.html

(HPSC), 84,091 healthcare workers (HCWs) had tested positive for COVID-19. They reported there was a total of 4,839 COVID-19 outbreaks associated with health and care settings in 2021 and 2022.[6] In the early waves of the pandemic, healthcare workers made up to 32.5% of all confirmed cases nationally, reflecting their exposure in clinical settings and the initial shortfall in protective measures. The Health Protection Surveillance Centre (HPSC) also reported for the early stages of the pandemic that:

Over half (53%) of HCWs affected were nurses and healthcare assistants (HCAs) and this corresponded to over 1 in 2 of HCWs diagnosed with COVID-19.

The majority (76%) of HCWs affected were female due to the gender balance within the health service.[7]
In a recent study published by the HPSC in June 2024, it concluded *"Hospital HCWs have an ongoing high exposure risk to SARS-CoV-2 and are a high-risk population for SARS-CoV-2 infection, despite high rates of COVID-19 vaccination and prior infection."*[8]

The risk was especially pronounced in acute hospital settings, emergency departments and residential care facilities, where staff were required to provide care in environments with limited ventilation, high patient turnover, high dependency rates and, in the early stages of the pandemic, insufficient access to Personal Protective Equipment (PPE). International comparisons reinforce the scale of the risk: the World Health Organization (WHO) estimates that between 80,000 and 180,000 healthcare workers globally may have died from COVID-19 between January 2020 and May 2021.[9]

Although improvements were made in PPE supply chains and infection prevention protocols, the delay in securing sufficient levels of early protection left many workers exposed to the disease, resulting in illness, absence from work, and, in some cases, death.

5.2 Psychological and Emotional Impact

In addition to the physical risks, the psychological toll on healthcare workers has been profound and well documented. Healthcare workers experienced sustained levels of trauma, moral distress, and burnout. Many staff were redeployed into unfamiliar roles or worked extended shifts under crisis conditions, while witnessing high patient mortality and the knowledge that many patients or service users were without the physical contact with family. This left many healthcare workers fearing for their own safety and that of their families. The fear of bringing the disease home and infecting loved ones was an ever-present worry of the healthcare workforce.

A 2021 HSE Staff Survey found that:

- 55% of respondents believed their level of stress affected their work.
- 48% of respondents believed the source of their stress was work-related.
- Half of respondents felt there had been a negative change in their workplace culture since the pandemic began.[10]

Furthermore, a study published in Occupational Medicine (2022) had surveyed Irish hospital staff during the pandemic and found high prevalence of post-traumatic stress symptoms, particularly among nurses, healthcare assistants, and support staff.[11] These outcomes are consistent with broader research. Within the Official Journal of the Irish Medical Organisation dated 19th December 2024, it noted burnout was present in 70% of respondents to their survey and stated 'it is clearly evident that the mental health of healthcare workers worldwide has been severely impacted by COVID-19, leading to widespread burnout.'[12] The World Health Organisation (WHO) reported in 2021 that the levels of stress, anxiety and depression amongst healthcare workers was demonstrative of a 'pandemic within a pandemic'. They argued 'healthcare workers showed many mental disorders, such as, anxiety, depression and insomnia. Moreover, healthcare workers reported having worse mental health disorders than before the pandemic started.'[13]

Psychosocial risks (PSR) refer to the design and management of work and its social and organisational context that have the potential to cause harm to workers. While psychological support services were made available

[6] Accessed via www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/surveillance/covid-19annualreports/COVID-19%20Annual%20Report%202021-2022_Final_v6.0.pdf
[7] Accessed via www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/surveillance/covid-19annualreports/First%20year%20of%20the%20COVID-19%20pandemic%20in%20Ireland.pdf
[8] Accessed via www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/research/precise/PRECISE%205_report_FINAL.pdf
[9] Accessed via www.who.int/news/item/20-10-2021-health-and-care-worker-deaths-during-covid-19
[10] Accessed via https://assets.hse.ie/media/documents/2021_Your_opinion_counts_staff_survey_results.pdf
[11] Accessed via https://academic.oup.com/occmed/article/74/1/3/7610099
[12] Accessed via https://imj.ie/wp-content/uploads/2024/12/The-Prevalence-of-Burnout-in-Healthcare-Workers-Presenting-to-Occupational-Health.pdf
[13] Accessed via https://www.who.int/news/item/05-10-2022-world-failing-in—our-duty-of-care—to-protect-mental-health-and-wellbeing-of-health-and-care-workers—finds-report-on-impact-of-covid-19

through the HSE's Employee Assistance Programme (EAP), many staff reported difficulties accessing these services in a timely or confidential manner, particularly during peak pandemic periods. In research entitled 'A Scoping Review of Psychosocial Risks to Health Workers during the Covid-19 Pandemic', published in March 2021[14], the authors cited:

The pandemic had caused significant disruption to the overall wellbeing in the working and social life of healthcare workers. A higher prevalence of anxiety, stress and depression are observed among healthcare workers Identified three categories of risk factors that associate with PPE: anxiety related with the risk of infection due to the lack of PPE; anxiety and physical discomfort related to use of routines and protocols; and practice disruptions and moral dilemmas. Redeployment to the front-line and the need for adjustment created anxiety due to fear of infection; and psychological stress due to sense of inadequacy in the new role.

The effect of Moral Injury – the pressure of managing scarce resources or services and having to take difficult decisions in the provision of care.

There is a strong case for investing in a permanent and well-resourced mental health strategy for healthcare workers across the Irish system. At the time of drafting this submission, it is noted with regret the HSE Occupational Health Department appears to have withdrawn the self-referral service which had been available to staff. This service was invaluable to staff who felt they needed the support of the Occupational Health Department in a confidential manner, and provided access to support which did not have to be instigated by their line manager.

5.3 Long COVID and Ongoing Health Effects

A substantial number of healthcare workers who contracted COVID-19 continue to experience persistent symptoms months and even years later. This condition is recognised as Long COVID. While Irish-specific data remains limited, The Society of Occupational Medicine (SOM) in the United Kingdom found that 33.6% of healthcare workers who contracted COVID-19 experienced symptoms lasting more than 12 weeks.[15] The World Health Organisation (WHO) reports the symptoms of Long COVID include fatigue, brain fog, breathlessness, muscle or joint pain and impaired sleep.[16] The OECD reported in December 2023, "COVID-19 has led to a significant number of individuals experiencing a wide range of long-lasting and often debilitating symptoms following SARS-CoV-2 infection which are unexplained by an alternative diagnosis. This constellation of symptoms is known as long COVID." Furthermore, the OECD cites research which found that over 12 % of individuals who had contracted COVID-19 reported experiencing symptoms compatible with a Long COVID diagnosis at three months post-infection.[17]

Irish trade unions, including SIPTU, have raised concerns about the lack of structured supports for healthcare workers experiencing Long COVID. While the HSE Occupational Health Service has provided guidance to managers and clinicians, there is no statutory entitlement to protected leave or income support for healthcare workers who cannot return to work or must reduce their hours due to post-COVID health conditions.

This gap has significant implications for workforce retention, service continuity, and the personal and professional impact on the affected staff themselves. We argue Government must consider the development of a dedicated Long COVID occupational health and recovery framework for healthcare staff who continue to struggle with recovery from the disease.

5.4. Workforce Challenges

The pandemic exposed and intensified pre-existing workforce challenges in Ireland's health system. Staff shortages, excessive workloads, and underinvestment in health infrastructure made it difficult to maintain safe staffing levels during COVID-19 surges. This resulted in many healthcare workers being called upon to work double shifts, cancel leave, or provide care outside their normal scope of practice. Staff were also caught in the moral conundrum of loyalty to their family versus the pressure to attend work as difficulty accessing transport, childcare issues and periods of isolation were not uncommon. The failure of the healthcare system to identify safe staffing levels for most grades is unacceptable and must be addressed.

The ongoing and unrelenting pressure on healthcare workers has continued beyond the acute phase of the pandemic. Persistent recruitment and retention challenges, and a growing waiting list backlog have left the system

[14] Accessed via www.mdpi.com/1660-4601/18/5/2453
[15] Accessed via www.som.org.uk/sites/som.org.uk/fil[es]/LC%20CHECK%20SOM%20Webinar%20B%20Dempsey.pdf
[16] Accessed via www.who.int/news-room/fact-she[et]s/detail/post-covid-19-condition-(long-covid)
[17] Accessed via https://www.oecd.org/en/publications/irela[nd]-country-health-profile-2023_3abe906b-en.html
[18] Accessed via https://insightsimaging.springeropen.com/articles/10.1186/s13244-020-00910-6

operating at unsustainable demands for service. If unaddressed, these conditions risk triggering further attrition in an already stretched workforce.

5.5. Recognition and Government Response

The Irish Government's decision to introduce a Pandemic Special Recognition Payment in 2022 was an acknowledgement of the sacrifices made by healthcare workers. However, the scheme's implementation highlighted challenges around equity and inclusion. Many grades and services were not automatically included in the initial rollout of the scheme, despite having worked alongside HSE employed colleagues under the same conditions. This submission notes the public health system is not always the provider of care in the first instance and is very often the purchaser of care on behalf of the state. The rules of the recognition scheme were published by the Department of Public Expenditure and Reform and were not negotiable as the trade unions were informed the scheme was 'a cabinet decision'. Services which played an important role in the fight against COVID-19 such as the Irish Blood Transfusion Service and the National Virus Reference Laboratory were specifically excluded from the Pandemic Special Recognition Payment Scheme despite providing key laboratory capacity to the HSE when it was needed at the outset of the pandemic or maintaining blood supply throughout the crisis.

Additionally, the recognition payment was a one-off gesture that does not reflect the continuing needs of staff dealing with the long-term effects of COVID-19. There remains a strong case for ongoing recognition and support, including leave entitlements, recovery programmes, and guaranteed access to psychological and occupational health services close to the point of demand.

It is essential we safeguard the health, dignity, and sustainability of Ireland's healthcare workforce. To do so, we argue the following actions are needed:

- The need to establish a statutory entitlement to support healthcare workers living with Long COVID, including rehabilitation programmes, and income support.
- Fund and expand mental health supports for healthcare workers, including access to on-site psychological services, well-being and trauma-informed care.
- Mandate minimum safe staffing levels across all grades in acute, community, pre-emergency and residential services to prevent burnout and ensure service resilience.
- Strengthen Occupational Health Services with enhanced capacity to provide early intervention, surveillance, and return-to-work supports for healthcare workers.
- Ensure equitable recognition of all healthcare workers in a reward scheme, including agency, outsourced, seconded and private healthcare staff who are involved in any future public health response.

The experience of COVID-19 has left a profound mark on Ireland's healthcare workforce. Healthcare workers went beyond their duty to protect public health, often at great personal cost. The Government has a responsibility to honour that contribution not only through symbolic gestures but through enduring longer term support structures. A sustainable, resilient, and protected workforce is essential to the future of Irish healthcare. It is required to support the integrity of any future public health emergency response and to protect those who step forward on all our behalf to care for the most vulnerable in our society.

6. SIPTU Health Division Survey 2025

In support of this submission, the SIPTU Health Division conducted a survey amongst its membership in July 2025 to ascertain the opinions of healthcare workers with the management of the COVID-19 pandemic and the impact on healthcare workers. The SIPTU Health Division received 1,589 responses to our survey.

The confidential survey was conducted to gather healthcare workers' experiences during the COVID-19 pandemic. It aimed to inform advocacy for improved working conditions, safety, mental health support, and recognition of healthcare workers on the frontline of the pandemic response.

The survey examined:

- Diverse healthcare roles and settings: It collected data on professional roles, healthcare settings, years of service, and whether workers were employed in public or private sectors.
- Focused on mental health and personal impact: The survey asked about mental health effects from work-

related stress, availability and use of mental health supports during and after the pandemic, and concerns about transmitting COVID-19 to family of healthcare workers. It also explored views on the need for long-term mental health supports.

- Work conditions and safety measures: The survey addressed the issue of staffing shortages, overtime, work-life balance, PPE availability and adequacy, safety guidance, training, and health and safety resources. Communication, culture, and recognition issues: The survey investigated internal communication effectiveness within the health service, union support, staff involvement in safety and staffing decisions, workplace culture changes, and perceptions of government recognition, including views on Long COVID as an occupational disease and ongoing support needs.

- Learnings: The survey asked what learnings should be derived from the experience of the pandemic to ensure healthcare workers are protected for the future.
  The comprehensive survey results present insights from healthcare workers regarding their professional roles, work settings, experiences, and perceptions during the COVID-19 pandemic. It highlights the challenges faced by healthcare workers at the coal face of the fight against this deadly disease, the availability and effectiveness of mental health supports and, workplace safety.

This survey emphasises the need for a policy to ensure supply of adequate PPE when needed, improved communication, and government recognition of occupational health issues such as Long COVID. The data reflect varied experiences across roles and settings, highlighting ongoing challenges and areas for improvement in healthcare workforce support during and after the pandemic.

6.1 Professional Roles and Workplace Environment

Most respondents to our survey identified as Healthcare Assistants (51.30%), followed by Support Staff such as porters and catering assistants (15.26%), Health Professionals, such as nurses, radiographers, radiation therapists or phlebotomists (10.36%), and Other Care Staff (5.59%). There were smaller proportions in Admin/Clerical and Agency roles.

Regarding healthcare settings, most participants worked in Acute Hospitals (29.02%) and Intellectual Disability Services (25.64%), Community Healthcare Organisations (16.14%), Nursing Homes (10.52%), Mental Health Services (4.72%), and Primary Care (2.68%) was also represented. Other settings accounted for 11.29% of respondents.

6.2 Experience and Employment Sector

Most respondents had extensive experience, with 62.09% working more than 10 years in the health service. Those with 6–10 years and 1–5 years of experience made up 23.42% and 14.24%, respectively, while less than 1 year was reported by 0.25%.

Most respondents (82.91%) worked in the public health service, while 17.09% were employed in the private healthcare sector.

6.3 Mental Health and Support Systems

More than half (54.62%) reported that their mental health suffered due to work-related stress or trauma during the pandemic, with 6.70% using available supports and 27.19% not using them despite availability. Notably, 27.95% indicated no supports were available, and 38.16% were unsure about what mental health supports were available in their workplace during the pandemic.

The survey asked what mental health supports were currently available in the workplace for healthcare workers: 10.50% of respondent used them, 44.53% did not use available supports, 6.17% reported there were no supports, and 38.80% were uncertain about what supports were available locally.

Regarding effectiveness of mental health supports, only 4.42% rating them as excellent, 24.47% stated they were adequate, and 35.81% believed they were poor.

6.4 Workplace Concerns and Conditions

The survey queried if healthcare workers worried about transmitting the COVID-19 pandemic to family members during the pandemic due to their work in the health service. 77.38% said yes frequently, 14.07% said occasionally, while 4.06% said rarely and 4.50% said no.

Healthcare workers were asked if long term supports for mental health and post-pandemic trauma are required for healthcare workers. A substantial 74.18% said yes, they are essential. Only 5.20% felt existing supports were sufficient, and 10.41% were unsure. 10.22% responded to say they believed such supports were only necessary for certain staff groups.

Workforce challenges included frequent short staffing (63.96%), occasional short staffing (24.11%), while 5.27% stated they never experienced short staffing during the crisis.

44.23% of respondents confirmed they were regularly asked during the pandemic to commit to additional working hours through overtime, longer shifts or cancellation of leave, with 32.07% saying this happened occasionally. This demonstrates a significant burden on an already struggling workforce to cope with the growing demand for service.

Only 26.87% felt their employer adequately protected their work-life balance during the pandemic, whereas 51.84% believed they did not.

6.5 Personal Protective Equipment (PPE) and Safety

36.20% of respondents said they felt exposed to higher risk of infection due to the lack of personal protective equipment (PPE) during the pandemic. 58.16% said they did not.

Healthcare workers were asked if PPE was consistently available in their workplace in the early stages of the pandemic. 38.04% said yes, always and 37.59% said most of the time. 4.18% said never.

Improvement in PPE availability in later stages of the pandemic was reported by 87.85%, while 12.15% saw no improvement.

Safety guidance and infection control advice were considered readily available and up to date within the workplace by 62.44% of respondents, with 23.92% disagreeing and 13.64% saying they were not sure.

Training on updated infection control was received by 66.94%, while 25.13% did not receive training, and 7.93% were unsure.

6.6 Health and Safety and Communication

Health and Safety resources were viewed as adequately resourced by 35.41% of respondents, 41.81% said they were not and 22.78% were unsure.

Trade union workplace communication during the pandemic was rated as very helpful or somewhat helpful by 48.50% of respondents or not helpful by 10.69%. A significant 22.85% stated they did not receive any union communication during the pandemic.

47.18% of respondents stated their voice, or the voice of their colleagues, was not heard when decisions were being made on safety and staffing issues. 33.23% felt their voice was heard sometimes, and 5.83% were unsure. This supports the concerns expressed by many grades represented by SIPTU that their experience on the frontline was not taken into account by policy decision makers who predominantly focused on medical and nursing personnel for input.

6.7 Staff Voice and Workplace Culture

About 58.16% felt the culture in their workplace or service deteriorated due to the pandemic to some extent, and 30.03% saw no major change. In contrast, 4.95% felt it had improved.

6.8 Government Recognition and Support

Only 15.98% believed the Government appropriately recognised the efforts of healthcare workers during the pandemic, while 74.64% believed they did not.

An overwhelming 81.80% supported the call for the formal recognition of Long COVID by Government as an occupational disease for healthcare workers.

Similarly, 88.40% of respondents believed the government must do more to support healthcare workers suffering from COVID-19 or Long COVID symptoms.

6.9 Lessons to be learned

Our survey asked for feedback on key lessons to be learned on how the health service supports staff during future public health emergencies. A distinct pattern of issues was identified from the extensive response to our survey. Having examined the information received, a summary of key themes and quotes from the survey are as follows:

Adequate Support for Staff

"Look after staff who are most exposed during a pandemic i.e. medical staff, Gardaí and other frontline services including retail staff!"

"Staff really need support for their mental health. It was a lonely time for some having to live away from home."

"Support to frontline staff, better communication and understanding for pressure and stress."

Mental Health and Well-being

"Staffs mental health has seriously deteriorated since this ordeal. The health service should have more support in place."

"Protect mental health: Provide counselling, peer support, and time to recover."

"Treat long covid sufferers with respect and not constantly putting us under pressure when it comes to not extending the covid payment. It is the HSE that has made my mental health a lot worse."

Communication Issues

"Better clarity of communication, say one thing in the morning and by lunch it has changed."

"They should at all times be upfront with their work force. Communication is the key."

"Communication with staff needs to improve by 1 million percent, we lived by the grapevine."

Recognition and Fairness

"Doctors and nurses are not the only people who worked through this. Porters, kitchen staff, cleaners, admin, IT staff got no recognition."

"The €1000 subsidy was unfairly distributed, causing a divide in staff teams."

"I have worked in a HSE lab since 2007. I caught COVID-19 and developed Long Covid. I missed out on the special paid sick leave for HSE employees by about two weeks."

"The IBTS clinic staff were not paid any covid payment despite the fact that we provided front line service throughout the pandemic, operating in the beginning of covid without the IBTS providing us with any PPE. The donors were not required to wear masks initially, despite working in a clinical setting blood donor clinical staff did not allowances or remuneration in respect to covid pay as did many other public sector services who were not dealing directly with the public or working in a clinical setting."

"Employees should have free access to psychological support and should be understood when experiencing burnout. Every healthcare worker, regardless of whether they work in the public or private sector, should be guaranteed free medical check-ups once a year."

PPE and Resources

"Have PPE readily available, listen to staff re safety concerns."
"They didn't give us PPE at the start when we requested."

"I felt I was constantly put at risk working without PPE with people with COVID while colleagues in the city had PPE…"

"As a shop steward, I had to write to management to supply masks and ppe gear, they eventually handed out one washable mask and five disposable masks. Disgraceful."

Workplace Policies

"Make sure that PPE is available to all staff members who work in the building and not just some."

"Offering the COVID jab was done in a questionable fashion, and staff were pressured."

Work-Life Balance

"Support for staff with dependents at home."

"Extremely difficult and stressful time trying to manage work and childcare."

"We must always be prepared. adequate PPE etc. We personally struggled with lack of childcare during COVID as both my husband and I are healthcare workers. Schools and crèche closed but we were expected to still work. Management couldn't care less."

The direct quotes listed above from our survey highlight the recurring concerns of our members about the need for effective communication, mental health supports, fairness, recognition and resource allocation during the pandemic.

7. Key Issues Identified at National Level

7.1 PPE Shortages and Risk Exposure

Early failures to secure adequate PPE disproportionately affected support staff.

Supply chains within the HSE were developed with significant challenges arising. Upon the roll out of distribution channels, errors within packaging of orders or delays in delivery were commonplace.

7.2 Mental Health Impact

Prolonged trauma, grief, and moral injury among healthcare workers remains a significant challenge due to under resourcing and capacity.

A national post-crisis mental health programme for healthcare staff must be implemented.

Recognition of the impact of Long COVID on healthcare workers as an occupational disease must be achieved. This will deliver long term support for the affected workers within the workforce.

7.3 Inequity Between Public Services and Private Healthcare Staff

Many healthcare workers in different settings of the health service were excluded from State support or recognition schemes.

Disparities in pay, sick leave, and recognition payments deepened frustration and created divisions amongst the workforces.

Healthcare workers in the private sector argued they met the challenge of the pandemic when the doors of many facilities were opened to the public service.

Equally, many private nursing homes struggled to provide for the needs of their residents with the same challenges of the public sector, but without many of the supports.

7.4 Lack of Staff Voice in Decision-Making

Staff and their representative bodies were often excluded from policy development forums. Many of the policy supports were implemented across the public sector, at the apparent direction of the Department of Public Expenditure and Reform, rather than being specifically designed to support the health service.

Many grades on the frontline who had gained significant experience were under-represented or non-existent in sharing information or shaping strategy.

7.5 Inconsistent Application of Protocols

Infection control and testing protocols were frequently amended with little lead time and poor communication channels, creating operational confusion on the frontline of the health service. In a study entitled *"Early experiences of radiographers in Ireland during the COVID-19 crisis.",* the authors cited the importance of clear effective communication channels by stating *'Clear communication regarding changing protocols and importantly patients' infectious status are essential to safeguard healthcare workers and to minimise unnecessary anxiety and distress. Attention is required to staff mental health including the identification of burnout symptoms to prevent long-term negative consequences of the pandemic on radiography services.*[18]

7.6 Inadequate Workforce Planning

The healthcare system was under-resourced pre-COVID. Surge demands and high levels of infection of healthcare workers arising from the pandemic highlighted long-standing weaknesses in staffing, the absence of recognised safe staffing levels for all grades and adequate resourcing across all levels of the health service.

8. Key Recommendations

8.1 Integrated Pandemic Preparedness Plans

- Ensure all healthcare roles (clinical, health and social care and support) are represented in future emergency planning structures.
- Maintain national PPE stockpiles and protocols for urgent distribution prioritised by exposure risk.
- Ensure adequate capacity exists for critical care and testing infrastructure to expand service delivery as needed.

8.2 Staff Wellbeing and Support

- Implement a long-term national mental health strategy for healthcare workers.
- Provide peer support programmes post-crisis.
- Recognise Long COVID as an occupational disease within the health service with appropriate long-term support for those affected.

8.3 Equity in Treatment and Recognition of Frontline Healthcare Workers

Ensure that public and private sector healthcare staff receive equal access to State support measures when called upon for service on the frontline during national emergencies.

[18]Accessed via https://insightsimaging.springeropen.com/articles/10.1186/s13244-020-00910-6

Design recognition schemes that are inclusive and recognise the role played by stakeholders from all sides of the health service. Such schemes should be administered transparently and promptly.

8.4 Improved Communication Channels

- Develop a national taskforce which includes all key stakeholders including national trade union representatives.
- Develop consistent national communication channels to all levels of staff including frontline staff, with localised implementation and feedback mechanisms.
- Acknowledge the healthcare workforce is a team approach and there are many grades working on the front line from medical, nursing, health and social care professionals, care assistants and support staff.

8.5 Investment in the Workforce

Fund and implement sustained increases in staffing levels across all health professions, including radiographers, radiation therapists, support staff, paramedics, and healthcare assistants.

- Develop safe staffing levels for all grades within the health service.
- Prioritise permanent contracts to improve retention and morale.
- Commit to offer permanent employment to all healthcare professional university graduates to promote the retention of the graduates within our healthcare system.
  Reduce the need for agency within the workforce and promote a policy of conversion to directly employed public health services.
- Implement rostering to recognise the need for a fair work/life balance.

8.6 Oversight and Evaluation

Create mechanisms for assessment of emergency response impacts on healthcare workers. Such mechanisms should include participation from all key stakeholders including national representatives from trade unions within the health service.

Support research into the long-term occupational health outcomes of frontline staff.

9. Preparing for Future Challenges

Ireland's response to the COVID-19 pandemic saw significant dedication by its frontline healthcare workers. However, the system supporting them was frequently deemed to be unable to provide the necessary supports when needed. The opportunity now exists to learn from these failings and be better prepared for the future. It is essential we build a more resilient, fair, and responsive healthcare system that respects and values all who serve within it.

We argue an independent evaluation must recognise both the contribution of these workers and the structural shortcomings that limited their protection during the pandemic. Future preparedness will depend not only on logistics and protocols, but on recognising where the system fell short previously and by ensuring healthcare workers are properly resourced and supported going forward.

Some of the significant issues which must be addressed in any future model must include:

9.1 Health and Safety Capacity in Workplaces

At the onset of the COVID-19 pandemic, most healthcare workplaces, in both public and private settings, were under-resourced in terms of dedicated health and safety (H&S) capacity. Healthcare facilities did not have robust pandemic preparedness plans at local levels. Updating risk assessments was often slow to reflect the airborne nature of COVID-19, effective communication channels remained problematic and many frontline workers reported a lack of access locally to timely and practical guidance.

As the pandemic progressed, there was an improvement in awareness and provision of H&S structures. However, these changes were often ad hoc and varied significantly by location and employer. Future readiness for similar challenges remains uncertain. Without adequate investment in a sustained H&S infrastructure, including Infection Prevention and Control (IPC) officers, ventilation improvements, and continuous risk assessment capacity, our members fear many facilities would likely again be inadequately prepared.

9.2 Role and Capacity of the Health and Safety Authority (HSA)

During the pandemic, the Health and Safety Authority had a limited role within healthcare settings, with primary oversight falling to the HSE or employers themselves. The HSA was not sufficiently resourced or mandated to carry out active, on-the-ground inspections in many hospitals or care settings, in the public or private sectors.

Trade union health and safety representatives often lacked training, protected time, access to specialist advice or direct lines of engagement with the HSA. There is a strong view that the HSA needs additional resources, such as inspectors, expanded statutory powers and a dedicated connection to the health service to provide meaningful oversight and support in future crises.

9.3 PPE Preparedness and Evolution

The early phase of the pandemic was marked by critical shortages of PPE, especially for staff who often felt they were not categorised as high-risk (e.g., catering, household, porters or other support staff). Reuse of PPE was reported in multiple settings, and guidance often appeared driven by availability or supply rather than safety protocols. Fit testing for respiratory protective equipment (e.g., FFP2/FFP3 masks) was inconsistent or absent across the system.

Over time, a reliable steady delivery of PPE was attained, the National PPE Distribution Framework improved coordination, and the situation stabilised. However, in many instances supply remained uneven, with some private healthcare providers struggling to maintain access. In addition, our union continued to receive concerns from members due to challenges accessing quality PPE for non-clinical but frontline staff such as support grades.

Future readiness would benefit from:

- A national PPE stockpile strategy
- Ongoing procurement contracts to secure supply of quality products
- Adequate local fit-testing capacity
- Clear allocation protocols for all exposed staff categories
- A quality fit for purpose order and dispatch system

9.4 Impact on Earnings and Employment Security

While public service healthcare workers had their core pay maintained, many:

- Lost out on unsocial hours/overtime due to reconfiguration of services
- Were redeployed in ways that reduced their earnings
- Incurred increased commuting and accommodation costs due to infection control protocols

In the private and agency sectors, the situation was often worse as:
There was a lack of adequate sick pay and other supports in many parts of the private sector. This suggests a need for greater alignment of policy initiatives with the public sector during an emergency crisis.

9.5 Sufficiency of Supports from Government and Employers

Government supports were often slow to be introduced, reactive, inequitable, and poorly communicated:

- The Pandemic Recognition Payment was seen as divisive amongst the healthcare workforce and was poorly administered in many instances. The second phase of the scheme was administered through a third party and was too slow in administering funds to those identified for payment. The scheme also excluded many categories of workers who contributed to the fight against COVID-19 on the frontline of the health service and led to resentment in some parts of the health service.
- Access to childcare, accommodation, mental health services, and transport was inconsistently provided across the country. This added to the mental distress of healthcare workers as they struggled to meet the demands of their professional and personal responsibilities.
- Employer-level supports also varied widely. In some cases, managers were flexible and supportive to their staff. In others, redeployment was imposed without adequate consultation. Equally, demands for additional commitments, such as additional working hours, were high and wellbeing supports were minimal.

9.6 Level of Consultation with Worker Representatives

In the early stages of the pandemic, decisions were largely top-down, particularly concerning redeployment, leave, and infection control protocols. This left many staff without a voice during a period of profound personal risk and workplace upheaval. The Department of Public Expenditure and Reform regularly updated guidance documents for the management of absence caused by infection during the pandemic. The guidance was designed to be public sector wide, and it was non-negotiable for individual sectors, such as health, to depart from it.

Trade unions pushed for structured engagement and were eventually recognised through national forums such as the HSE COVID-19 Stakeholder Forum. This group met weekly or more often as deemed necessary. The forum was welcomed by the trade unions as a positive step in recognising the need for worker voice in the management of the response to the COVID-19 national emergency.

We strongly believe where local union structures existed, better consultation outcomes and clearer communication channels were evident.

9.7 Other Impacts on Workers

Workers across healthcare roles experienced a wide range of secondary impacts:

- **Mental and Emotional Strain on the Healthcare Workforce:** Healthcare workers suffered an exposure to the death of patients, service users or even fellow colleagues. They also suffered from trauma and a sustained isolation from family with high levels of uncertainty.
- **Burnout and Staff Exiting the Service:** A significant number of experienced workers have cited exhaustion and lack of institutional support as factors in their consideration to leave the service, their profession or reduce their hours of work post-pandemic.
- **Training and Career Development Derailed:** Many staff missed out on professional development due to service restrictions, redeployment or redirected funding from training and career progression opportunities.
- **Physical Health:** Long COVID has affected a subset of healthcare workers, yet structured supports and recognition (e.g., occupational illness status) remain lacking or limited.

10. Conclusion

The COVID-19 pandemic exposed systemic weaknesses in workplace health and safety, the preparedness of our health service, and the ability to respond equitably across a fragmented healthcare system. Due to their commitment to their patients and service users, all healthcare workers rose to meet this unprecedented challenge with great risk to their own personal safety, often with insufficient protection or recognition.

A future-proofed healthcare system must learn from these lessons by embedding safe staffing levels for all grades, providing stronger health and safety infrastructure, improving consultation mechanisms, fairer employment protections, and proactive investment in workforce wellbeing and pandemic preparedness.

Chapter 2 - Impacts on and Supports for Workers in the Transport, Energy, Aviation and Construction Sectors

Health and Safety of workers and whether there was adequate Health and Safety capacity in workplaces to deal with the COVID-19 Pandemic. Did this change during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence.

Construction

It is viewed there was adequate health and safety capacity in workplaces to deal with the COVID-19 Pandemic within the Construction Sector. The Sector was one of few who had active working sites and services (such as Roadstone) throughout the pandemic. High priority projects reopened on a phased basis, these included social housing, the new children's hospital and Tara Mines. While these were difficult times, health and safety did not present any significant issues. Measures changed on a weekly basis in line with advice from the Health and Safety Authority (HSA) and NEPHET. In the event of a similar occurrence, lessons can and should be learned from the past.

Energy

Most companies had the capacity to deal adequately with the COVID-19 Pandemic with the introduction of a crewing model that remained in place during the crisis. This involved crews being rostered together and not changed, with no interchangeability between crews, mainly in the ESB, Uisce Éireann and Gas Networks Ireland.

Aviation

Despite a dramatic drop in earnings workers in the aviation sector continued to work during the pandemic thus ensuring that the vital and essential medical and PPE supplies were able to enter the country. There were hundreds of jobs lost due to the dramatic and speedy decline in air travel. The companies did their best to provide PPE and provided a mix of face shield and masks and updated their PPE to the best in class as soon as it became available. However, stocks of PPE should be kept on site for immediate use in case of other pandemics.

Transport

Public Transport and the Port and Docks sector remained open for almost the entirety of the COVID-19 lockdowns and restrictions. Initially all operators struggled to source adequate supplies of PPE and essential medical equipment. This was due to the enormous demand across the economy. Once the initial shortages were resolved all necessary supplies were available. Shifts and rosters were altered in most companies and public transport vehicles were sectioned off to ensure social distancing guidelines were followed. In the event of any similar pandemic, all operators are highly equipped to deal with it.

Does the Health and Safety Authority (HSA) have the capacity to support representatives in a pandemic?

Construction

It was felt Health and Safety staff/inspectors worked from home during the pandemic. Where an issue arose this was dealt with by the appointed health and safety representative appointed by management. The representative would contact the appropriate union official to seek advice and implement appropriate action.

Energy

The HSA has the capacity to support representatives in such a scenario in the future through lessons learned during the pandemic surrounding the supply of adequate PPE. In some energy sector employments the companies did not utilise rosters to optimum effect so that crews were not interchanging regularly with each other. In some employments the employees were afraid to raise these issues with the management as they may not get called for work at all if they raised concerns.

Aviation

Comments from the aviation sector committee members include:

"It was not made clear that there would be tax repercussions to receiving the EWSS/TWSS when full pay was reinstated. Some staff had bills in the thousands."

"We later received tax bills, as tax was not or was incorrectly applied which hit hard as it came during the emergence from COVID-19."

Dublin and Cork Airports availed of the TWSS scheme. In applying the 20% reduction in time on 26th April, 2020, the below decisions were taken which resulted in employees being treated differently.

(a) Employees not in TWSS -
20% reduction to GROSS pay and employee remained outside TWSS.
(b) Employees not in TWSS -
20% reduction to GROSS pay and brought into TWSS where applicable.
(c) Employees in the TWSS -
20% reduction to Average Revenue Net Weekly Pay.

Group "C" were treated inequitably and for SIPTU this equated to approximately 709 members.

Following representation by SIPTU, daa agreed to the correct treatment. All employees received 80% gross pay from fortnight 11 to 18, subject to a maximum of their ARNWP. In order to make this correction and to manage cashflows due to the prolonged impact of the COVID-19 pandemic on the business the amounts due to our members were paid out as follows:

Over five Fortnights
To offset money owed to employees against money owed to daa arising from the planned TWSS reconciliation (149 employees; €36k). Engage employees with outstanding EAP, Bridging and overpayment balances

Shannon Airport also availed of the TWSS scheme which resulted in the inequitable treatment of some members as set out in the above daa example. This matter was dealt with through the Workplace Relations Commission with a resolution coming from the process on 4th February, 2025. This proposal, which was accepted by our members, saw payment of a €1000 tax free voucher to all airport employees whether affected by the loss of earnings or not.

Transport

There was little if any direct dealings between the SIPTU Transport Sector and the HSA regarding the COVID-19 Pandemic except for members raising individual concerns. This was mainly at the outset and owing to the fact the Transport Workers, by and large, continued to provide services and have direct face to face interactions with passengers. While some SIPTU safety reps did raise general issues with the HSA, it was felt that the level of support improved as people grew experienced in dealing with common issues.

Issues that arose with the level of preparedness of the provision of appropriate PPE and whether this changed during the course of the Pandemic. What would be the likely state of readiness in the event of a similar occurrence?

Construction

There were few issues or significant problems during this time in relation to the provision of PPE. The Pandemic

presented many challenges, and the situation was quite fluid. Measures were put in place on a rolling basis as issues arose. As for what would be the likely state of readiness in the event of a similar occurrence, a full review should be carried out of all sectors to identify what could be achieved.

Energy

Most companies were caught off guard in relation to the supply of adequate PPE, at the start of the pandemic a shortage was evident. This improved very quickly and in the event of another outbreak companies would be in a state of greater readiness.

Aviation

Responses from the aviation sector committee members include:

"In daa security at the beginning of the pandemic ASU staff were instructed not to wear masks because it would 'frighten the passengers!' Then there was a complete backtrack on that when it became obvious, we had to be protected too. Our company has become so customer care driven I have no doubt their needs would come first. I don't trust the company to have a plan in place judging by experience."

"I don't know about the capacity of the HSA as we only heard updates through the company, media or our SIPTU Organisers. We did refer to the website and advice from previous pandemics to help our cases at the very beginning and were able to refer to COVID-19 advice on the HSA and HSE websites. I think a portal for reps would have been helpful for the more obscure cases we encountered and for generic advice and best practices for employees."

"I would like to think so. I would also like to trust in them to have taken responsibility for any errors in the way things were handled and put in place corrective measures in case of any future issues of this kind."

"We initially had push back from management when we asked were staff allowed to wear masks when it was not a requirement, but other countries were doing so. They said they would frighten passengers. It then went to the extreme that everyone had to wear masks, no exemptions. We struggled with a few particular cases as some members said they could not work with a mask on, so we agreed on face shields. To credit the company, both masks and shields were provided in abundance, cleaning and sanitisation crews were set up, hand sanitiser was placed at strategic locations around the buildings, screens were put up in close contact areas and we very quickly had free testing on site and staff could avail of this whenever we wanted."

"I think the fact we have been through it recently means people will remember how things were done and what worked well. I think if the removed screens and sanitiser stands were not kept then that would be a mistake as having them in storage is easier than trying to get them made in the event of another pandemic."

Transport

As public transport services continued during all levels of lockdown, albeit with reduced from time to time. No operator was able to meet the initial demands for face coverings, gloves, hand sanitiser etc. This improved greatly after the initial onset. As guidelines were updated, the operators and staff quickly adapted to the changes needed so much so that deep cleaning and sanitizing of vehicles occurred on a daily basis. This helped alleviate the initial fears of most staff. This experience would no doubt place all in a better state of preparedness for any future similar occurrence.

The impact on earnings and employment security for workers during the pandemic.

Construction

The COVID Payment and Temporary Wage Support Scheme (TWSS) had an impact on members within the Construction Sector. COVID Payment, while it was welcomed, fell short of the average weekly wage whereas TWSS presented challenges for workers post pandemic, e.g. Revenue seeking monies. Since the COVID-19 Pandemic, many workers within the construction sector have chosen to find work in areas.

Energy

There was no impact on wages in the Energy Sector as most were considered as emergency workers and no jobs were affected.

Aviation

The submission to the Joint Oireachtas Committee on Transport and Communications Networks (check this is the

right Committee) put some context around how impactful the pandemic had been on the industry and on those members that we represented in the sector.

- According to the CSO, the passengers handled by the main Irish airports dropped by 74.5% from January to September 2020, a drop in absolute terms from 29,512,46 to 7,534,363. Given this includes what was a busy January and February 2020 comparing quarter three of that year gave a more realistic example of the devasting impact, with 2019 recording 11,597,270 passengers in the four-month period while the same four months in 2020 saw only 1,453,486 passengers use our main airports.
- When the pandemic struck and the extent of the impact became known, SIPTU's focus quickly switched to protecting incomes in the short term as best we could and seeking to ensure that the response to this crisis would be different to the 2010 financial crisis.
- Despite the best efforts of all involved there were huge sacrifices made by aviation workers, some were placed on lay off, some left their employment on a voluntary basis, and almost all suffered some drop in their working hours and pay, ranging from 20% to 70% in some instances. Many workers in some of the ground handling companies lost their jobs.
- In the daa the vast majority of the 3,500 workers suffered a 20% reduction in hours of work and pay.
- As part of new ways of working agreements in Dublin Airport with daa and as a means of allowing more members to leave on a voluntary redundancy scheme 180 unionised cleaning jobs were contracted out to the private sector.
- In Aer Lingus, workers in ground operations earnings fluctuated from 30% to 50% to 60%. Workers in Dublin were working 60% of their contractual hours for several months, while Aer Lingus workers in Cork were only working 30% of their normal hours. In Shannon a majority of workers had been laid off. Management were clear that this was not as a result of the consequence of poor wage supports.
- In Ireland West Airport Knock approx. 35 fixed term workers did not have their contracts renewed and were made redundant. Approximately 10 more workers were made redundant, and the remaining workers were placed on temporary layoff from the 14th of November 2020 until their return in July 2021 where they returned to work on 80% of contracted working hours and in September 2021 returned to 100%.
- Government supports assisted workers through the TWSS and latterly the EWSS and the PUP payment for those who were laid off or let go.
- Despite these supports and some funding directly to the airports there was no doubt that the aviation sector and the workers in the industry needed additional supports beyond the generic economy wide supports that were offered at that time.
- To this end SIPTU and our colleagues in the Congress of Trade Unions engaged with Government and various Oireachtas Committees to seek additional supports to keep aviation workers afloat.

Transport

As previously advised, most if not all transport workers continued to work during the COVID-19 pandemic so IT had negligible impact on their basic payments. However, all operators ceased any non-essential overtime, which did impact workers regular earnings.

One section that did shut down was the School Bus Services, but agreement was reached that workers in this section were paid their normal weekly wages during the pandemic. It is our understanding that the Department of Education financed this directly.

Were the levels of support provided to workers by the Government and/or employers during the Pandemic sufficient?

Construction

Just like point No, 4, the levels of support provided to workers by the government and/or employers presented many challenges by way of a reduced weekly wage. However, other Sectors of employment may have benefited by COVID-19 payment and TWSS payments (part-time employees in the Service Sector).

Energy

The level of support was good for workers provided by the government, but very few in the Energy sector availed of it. Bord na Móna was an example of a semi-state body using state support in the energy sector.

Aviation

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daa New Ways of Working Agreements

SIPTU and daa entered into lengthy and constructive consultation which resulted in approximately 24 separate New Ways of Working Agreements for our members in the various sections at Dublin and Cork Airports. In these discussions, SIPTU sought to avoid the need for compulsory redundancies, wholesale lay-offs and not to change basic pay and shift rates of pay. Instead, daa and SIPTU sought to address right-sizing on a voluntary basis combined with changes to our existing ways of working which would bring longer term sustainable value to the business.

The guiding principles of these agreements included:

1. Swift engagement and implementation of new ways of working (even if under protest) with acceptance that the changes put forward by management are the minimum required to right size our business in a sustainable fashion.
2. Acceptance that changes to working hours and mandatory annual leave made to-date have been reasonable and justified in the circumstances.
3. Acceptance that changes are continuing unless and until different changes are agreed in the future.
4. In the short-term, we must be responsive to the challenges posed by COVID-19 on our operations and do what is required to keep our operations running as best we can.
5. As base pay and shift rates are not changing unions will accept that no pay increases will be considered until April 2022 at the earliest (when results for 2021 will be confirmed) and that grading, equalisation or other retrospective cost increasing claims will not be made in relation to the period from 1st March 2020 to 31st March 2022.
6. DAA recognises the right of the unions to process pay claims post 31st March 2022 and both parties accept that it is everyone's interests to promote industrial harmony during this period.
7. Any claims will need to be viewed against the circumstances at that time including whether any of the three roadmap conditions have not been met.
8. No gainshare or PRP payments will be paid in April 2021 in respect of 2020, but they will apply in April 2022 in relation to targets set for 2021.
9. Existing staff may be in receipt of RDA's based on current shift patterns. If new ways of working leads to a change in rosters daa confirms that such RDA payments will not be reduced and treated on a red-circled basis.
10. If staff are required to work more nights and weekends as part of the new rosters, they will receive the appropriate payments related to their existing agreements.
11. Winter Operations – staff currently in receipt of winter operations payments (such as those in respect of gritting) will continue to receive these in line with current agreements. As Winter operations are part of

new roles and ways of working no additional payments will be made to staff that have not previously received them, however, this will be considered as part of any future discussions on pay.

12. Nothing in this agreement changes the dispute processes contained in existing agreements related to different groups or in different locations. Each side will strive to ensure all matters are addressed to a conclusion in house with working under protest (individual or collective) for all those issues that are not capable of agreement. Each side are committed to reviewing these processes following implementation of new ways of working when the period of this crisis has passed.
13. Each side accepts that maximum advantage must be taken of technology in the new environment and full cooperation will be provided with it and associated processes.
14. Likewise, sanitisation of workplaces must now be accepted as a normal part of working together with back to work protocols and PPE as determined by management following risk assessments. This will be accepted by each side.
15. As part of management's right to manage, management will determine the resourcing required in each area and at each time following appropriate consultation in line with our agreements.

The structures and make up of teams remain matters for determination by management following consultation.

Transport

The financial support for workers, from Government, was good and was put in place in a timely manner but thankfully transport sector workers did not need to avail of such support on a collective basis.

The level of consultation that took place with worker representatives and was this sufficient and did it change over the course of the pandemic

Construction

Since companies appointed COVID-19 Representatives, consultation and information was by way of toolbox talks and similar. Online mandatory workplace inductions were in place, SIPTU did share on site experiences/best practice with various Construction companies. Larger sites implemented on-site COVID-19 testing throughout the latter stages of the pandemic. Given the situation was quite fluid and changed on a day-to-day basis, Lead Health and Safety Representatives engaged with management on the following:

- Appropriate PPE
- Ensuring Social Distancing measures were adhered.
- Sanitising Stations/Clean Up areas were provided.
- Heavy foot fall areas identified and regularly sanitised.
- Staggered breaks implemented.
- Segregated breakrooms/cleaning stations/changing rooms and toilet facilities were available.

Energy

Consultation was particularly good throughout the companies in the energy sector with the Unions being briefed on a weekly basis on the ongoing situation, updated on additional and more quality driven PPE.

Aviation

Responses from aviation sector committee members include:

"I think we were lucky in the sense we had open conversations with the CEO about issues staff were facing at the start of the pandemic. Management readily listened to problems regarding childcare, ill and at-risk relatives and personal issues. Accommodations were made and all absences regarding COVID-19 were covered and not held against the person. Later most staff were put onto the TWSS pay scheme. The company applied through the government, and it applied to all eligible staff."

Transport

The experience across transport differed from employer to employer. The CIÉ Group met with worker representatives at the beginning of lockdown and while not every measure was introduced smoothly at first, things did improve as the group learned and got to grips with the necessary plans needed.

Outside the CIÉ Group planned consultation was sporadic at best and the bulk of this was initiated in the first instance by the workers and their representatives. Thankfully, the sector was able to utilise the learnings and planning within CIÉ group to seek similar measures within the other transport operators and across the port and docks. As experience grew in these sectors, consultation, and measures taken vastly improved.

Other ways in which workers were impacted?

Construction

While this is difficult to quantify, workers were impacted by health issues, both physical and mental . Some members suffered with anxiety and simply could not attend work during the pandemic. One other factor is Long COVID which has presented many challenges since the onset of COVID-19. Workers were required to travel from site to site found it difficult due to travel restrictions and restricted due to reduced passenger volumes on public transport services. Workers also had to constantly remain mindful of the impact on family members who were vulnerable to infection and such. Workers also suffered financial difficulty during the pandemic.

Energy

Some companies did not handle the pandemic well at all, we had key issues within Bord Na Móna, where initially social distancing was a non-occurrence, but over time this improved. Some of our members who worked from home felt isolated and lonely as they missed working as a group in offices.

Aviation

Workers in Aviation were affected by the speed in which their employments were effectively shut down and for extended periods they did not know if their employments would last. Large numbers of workers had financial commitments, and the COVID-19 pandemic really affected their mental wellbeing.

Transport

One of the biggest impacts on transport workers during the pandemic was the potential exposure to the virus due to day-to-day passenger interaction. This was significantly heightened by the small minority of intending passengers who refused to comply with guidelines and our members were expected to police and deal with these situations. This placed significant stress on some workers.

Chapter 3 - Impact on and Supports for Workers in the Services Sector

Health and Safety of workers and whether there was adequate Health and Safety capacity in workplaces to deal with the COVID-19 Pandemic. Did this change during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence.

Arts, Culture Print Media and Sport

In many instances in the ACPMS sector improvements occurred as the pandemic dragged on. For example, when film and TV production resumed in the independent sector, there were COVID officer roles specifically appointed on each shoot. Regular testing was also carried out. In other employments, such as RTÉ and TG4, where the work could be done remotely it was. Equally where shifts were in place in employments they were kept in bubbles. From consultations with local representatives the situation helped improve the HandS capacity as people became more aware of the situation. However, I do think from talking to members that the lapse of time since the pandemic has seen the situation regress somewhat and if a similar event was to happen in the future it would take a body of work to get back to that level.

Contract Services

Health and safety capacity for contract services workers was non-existent. For example, contract cleaners in health care settings, such as hospitals, with patient facing duties, including in covid wards, initially were only given a basic mask and apron. This did improve during the course of the pandemic. There is a sense that there would be a state of readiness in such settings if this were to occur again.

Hospitality and Finance

In my experience most employers did take the advice and their obligations seriously and did update as it unfolded. I found a mixed level of engagement when it came to workers being engaged but again many employers embraced the help and involvement of reps and officials. I do believe the experience was so intense that most employments I had to deal with would be ready to regroup and put a plan back in to place due to the overall COVID experience. I would say the fear of being exposed/ reputational damage was likely a motivation for some employers to stay on top of things.

Does the Health and Safety Authority have the capacity to support representatives in a pandemic

Arts, Culture Print Media and Sport

There is a belied that it would, however, it would need to be maintained with regular planning and for modules of training for H&S reps to be delivered regularly.

Contract Services

We would hope that given the catastrophe that was the COVID-19 Pandemic that the HSA would be adequately resourced and funded to ensure this.

Hospitality and Finance

I find the HSA like a lot of similar agencies have finetuned their frontline services to send issues through a “procedure”/route to weed out the volume which is understandable. I didn’t encounter a situation where we were thwarted by a lack of action. However, I can only imagine there is a lack of resources to follow up on physical visits etc. I do have to say their online written articles and documents are extremely helpful for reps and officials alike.

Issues that arose with the level of preparedness of the provision of appropriate PPE and whether this changed during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence?

Arts, Culture Print Media and Sport

I had no reports of issues with provision of PPE as many of the sections stopped work. When they returned there had been enough of a lapse in time for adequate PPE to be provided. I do believe though that those stocks would be depleted and not kept on hand given the lack of time which would be an issue in the event of a similar occurrence.

Contract Services

Health and safety capacity for contract services workers was non-existent. For example, contract cleaners in health care settings, such as hospitals, with patient facing duties, including in covid wards, initially were only given a basic mask and apron. This did improve during the course of the pandemic. There is a sense that there would be a state of readiness in such settings if this were to occur again.

Hospitality and Finance

Initially we would have received calls in relation to worries over PPE, but I can say most employers did step up to the mark in line with everyone who was depending on PPE/safety measures generally like signage etc. The overall COVID experience and planning that was put in place would lend me to feel there would be readiness if a similar event occurred. I have to add that this is much down to our input as both officials and our people on the ground.

The impact on earnings and employment security for workers during the pandemic

Arts, Culture Print Media and Sport

Many of the members in the sector would have moved to the PUP as they were not working. I don't believe that earnings in employments who kept working were affected substantially. There is a large element of freelance or short-term work in the ACPMS sector so it is not simple to say security of employment was affected in those instances as they would have picked up work as things opened up again.

Contract Services

The Contract Catering Sector was decimated overnight. There was widespread dramatic contraction of the sector because of the pandemic, with our members being redeployed, put on short time, part time, and with big numbers being placed on temporary layoff and being made redundant.

These Job losses by way of redundancies, did not return, as catering in establishments have been either reduced dramatically, or have been discontinued altogether.

Hospitality and Finance

Initially we were snowed under with queries in relation to concerns over job security. Essential services such as Credit Unions who used hubs and kept things moving and most paid their people even though hours were reduced. We had laundries who supplied hospitals with linen, scrubs etc. However, there were lay-offs, as the more commercial non-essential areas of this sector were hit badly. Financial services used remote working to keep going so there was limited impact here. Hotels took a major hit during longer lock down periods. A number of these workers moved to essential services like retail to take up employment. There were also ironies of people who went on to COVID payments not losing out, but it really just exposed the lower paid employments like the hotels and restaurants.

Were the levels of support provided to workers by the Government and/or employers during the pandemic sufficient?

Arts, Culture Print Media and Sport

Anecdotally the members who availed of PUP struggled with the reduction in pay. I believe the support should have been greater in coming in line with actual earnings.

Contract Services

By and large the supports were adequate but also vital in the bigger scheme of things.

Hospitality and Finance

I certainly did not receive too many complaints about the level of payment. Again, to the point above, lower paid workers were not seeing the hit as much as those in higher paid sectors. Financial sector saw pay being maintained.

The level of consultation that took place with worker representatives and was this sufficient and did it change over the course of the pandemic

Arts, Culture Print Media and Sport

It was a mixed level of consultation, some workplaces it was high and in a lot it was negligible. It did improve as the pandemic wore-on, but it could have been better.

Contract Services

Despite the chaos and the difficulties, particularly with the restrictions the union did continue to represent members' interests right across the contract services sector. Most of this was carried out remotely with sector bargaining on security and cleaning on Employment Regulation Orders (ERO's) being agreed through the respective Joint labour Committees (JLC's).

Hospitality and Finance

I did encounter a small level of reticence from some employers but over-all it developed into a more structured/agreed approach.

Other ways in which workers were impacted

Arts, Culture Print Media and Sport

The impact has come more in the post pandemic era. For example, members in the live performance areas are now seeing different patterns of work as attendances at live events now vary compared to the pre-pandemic period and this requires shows at different times. Equally in areas such as cinemas it has resulted in changes in workloads as employers look to work with less staff.

Contract Services

Significant numbers of catering workers have never really returned to the sector post pandemic. As contact cleaners and private security workers essentially worked right through the pandemic some have reported after affects both physiological and physical mainly by way of long covid.

Hospitality and Finance

There were issues around mental and physical health. There was genuine fear because there was a lot that was unknown about the virus. There was also fear generated by the economic impact. The only positive I could see was where employers retained levels of income during the period. Also, those who served communities and kept the show on the road were marked out in some cases.
My overall comment is that the vast majority of our members I dealt with did what all decent citizens did and helped their families, colleagues and society in general.

Chapter 4 - Impact on and Supports for Workers in the Manufacturing Sector

Health and Safety of workers and whether there was adequate Health and Safety capacity in workplaces to deal with the COVID-19 Pandemic. Did this change during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence.

Across Manufacturing in Ireland there was a mixed experience in terms of adequate health and safety capacity in the workplaces, while all sectors experienced the difficulties in the early stages of the pandemic with access to masks etc there was a divergence thereafter. Large multinationals in the pharmaceutical and medical devices sector were better equipped to put in place health and safety measures than other environments that are not necessary already set up to as straightforwardly implement measures.

Pharmaceuticals, Chemicals Medical Devices Sector

As previously mentioned, beyond the initial shortage in PPE, there was the health and safety capacity within this sector to due to it being a well-resourced, well organised and highly regulated sector. While lessons can be learned from the COVID experience there would be a degree of confidence that the state of readiness would be on a solid footing.

Agriculture, Ingredients, Food and Drink Sector

There was mixed experience within the sector in terms of the health and safety capacity to deal with the pandemic, industries like the dinks and dairy sector proved much more successful in dealing with the pandemic than the meat industry. It is beyond doubt that the meat processing industry contains unrivalled vectors for the transmission of COVID-19 or other such viruses, this caused thousands of meat plant workers to be infected in many clusters. These vectors include proximity working, bottlenecks in canteens and toilets, noise pollution causing workers to shout to communicate and which creates droplets circulated through the industrial air cooling systems and relatively low wages causing workers to car pool, share accommodation and in many cases share rooms within that accommodation. It is notable that circa 90% of workers in the industry did not have sick pay, forcing vulnerable workers to go to work, even if they are feeling unwell with possible COVID-19 symptoms.

The likely state of readiness is debatable in the industry, while the introduction of statutory sick pay, albeit stalled in terms of increasing days, is welcome the underlying factors of the work environment and low pay remain.

Electronics, Engineering, Industrial Production Sector

This sector is varied in terms of its make-up, ranging from large multinational in high tech industries such as Apple to small indigenous production facilities. The capacity to deal with the pandemic mirrored the size and resources available to the business, there were issues similar but not identical to the meat processing industry in terms of work environment and in organised sites, sick pay schemes are more prominent. The state of readiness is mixed with larger more advance firms being at a higher state of readiness and those with established Union structures being better equipped.

Does the Health and Safety Authority have the capacity to support representatives in a pandemic

Across the three sectors but related to the meat processing industry we have concerns of the Health and Safety Authority has the capacity to support representatives in such a scenario. In low paid industries with a significant amount of migrant workers there is undoubtably a fear factor in raising issues related to health and safety and this was apparent during the pandemic. The remedy to this is to have HSA inspections of sites and unannounced HSA inspections. SIPTU was particularly unhappy with the number of unannounced visits and it is not clear if this capacity has been increased within the HSA.

Issues that arose with the level of preparedness of the provision of appropriate PPE and whether this changed during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence?

Pharmaceuticals, Chemicals Medical Devices Sector

Beyond the initial shortage of PPE experienced nationwide there were not many issues in this Sector, many of these factories operate in clean room environments with significant PPE worn as a matter of course and therefore the likely state of readiness is not a significant concern.

Agriculture, Ingredients, Food and Drink Sector

The meat processing industry was caught of guard and the nature of the industry, work environment, low pay, inadequate sick pay schemes remain the case. There is very low confidence that the current state of readiness would be much better than the situation that arose in 2020.

Electronics, Engineering, Industrial Production Sector

There were issues with the initial shortage of PPE but this improved over the course of the pandemic, there is a mixed level of confidence in the Sector as to current state of readiness, while workers and employers will undoubtedly learn from the experience, there are still concerns in relation to the environment in some factories such as lack of space and facilities.

The impact on earnings and employment security for workers during the pandemic

Across the three sectors there was little direct impact on wages as most were considered essential workers and continued to work for the duration of the pandemic, there were a number of employers that availed of the wage subsidy schemes, the tax implications in relation to these schemes proved problematic.

The most widespread and significant impact on earnings was in relation to sick pay, the pandemic highlighted the scandal of a lack of statutory sick pay and this resulted in a loss of earnings for many workers and worryingly workers being left the option of no income or going to work against NPHET advice. The partial introduction of statutory sick pay will not alleviate these issues if we find ourselves in a similar situation.

The better paid sectors such as pharmaceuticals and high end electronics did not experience any loss of earnings as a result of reduced work or illness due to collectively bargained sick pay schemes.

Were the levels of support provided to workers by the Government and/or employers during the pandemic sufficient?

As previously advised many companies continued to operate under full production and therefore did not access the most significant Government supports available, for those that did the supports for workers were positive but the taxation issue that arose from the wage subsidy schemes has proved problematic. The most significant impact of Government supports, or lack of, was in terms of the lack of statutory sick pay. The enhanced COVID Illness Benefit did mitigate this to some extent.

The level of consultation that took place with worker representatives and was this sufficient and did it change over the course of the pandemic

The level of consultation varied across the sectors, the better organised employments in the three sectors seen a high level of engagement, this took the form of:

- Weekly briefings on developments
- Utilizing the lead COVID representative.
- Working together to ensure social distancing
- Providing clean up areas and time to do so
- Implementation of staggered breaks.
- Regular updates and consultation on quality PPE.

In low paid sectors such as the meat industry, in many plants there was little consultation that was sporadic at best, there was a distinct lack of transparency and a feeling that production above people was the mantra.

Other ways in which workers were impacted

Almost all of our 35,000 members in Manufacturing had to change shift patterns to ensure that workers worked in teams and limit the risk of cross contamination. While necessary, this had a significant impact on members in terms of childcare where they were the sole career of their partner was also an essential worker. The experience in managing this and reaching accommodations within the health guidelines was mixed.

As previously advised thousands of workers contracted the virus with the Meat Processing Industry being particular impacted. The reasons for this have been already covered and a worrying element of this is that it was predictable as the experiences suffered by fellow meat processing and abattoir workers in the United States, Canada and across Europe.

This resulted in thousands of people becoming ill and many suffering long covid which continues to present challenges to those workers.

Chapter 5 - Impact on and Supports for Workers in the Public Administration and Community Sectors

SIPTU's Public Administration and Community Division represents over 30,000 workers employed across Local Authorities, Education, State Agencies, and the Community and Voluntary Sector. Our members were at the forefront of the national response to COVID-19 and played critical roles in maintaining essential public services during the pandemic.

As the seriousness of COVID-19 became increasingly apparent in early 2020, the Union proactively engaged with management across the public sector — in particular within Local Authorities and emergency services — to develop contingency arrangements. In February 2020, Dublin Fire Brigade (DFB) management advised the Union that preparations were underway for potentially up to 20,000 fatalities in Ireland, in line with emerging projections based on the situation in Italy and across Europe. The union responded by seeking urgent engagement to both protect frontline workers and maintain essential services in the event of widespread infection among staff.

On 28th March 2020, following the Taoiseach's announcement of a nationwide lockdown, the Local Government Management Agency (LGMA) issued a Critical Services list for Local Authorities. This clarified which services would continue fully, which would operate on a reduced or emergency basis, and how remote working should be used wherever possible.

The COVID-19 pandemic had a profound impact on SIPTU Community Sector members working in care services, including those in the Irish Wheelchair Association, Enable Ireland, and other organisations across the Community Sector. Workers in homeless shelters also rose to the occasion, ensuring that vital services continued for those most in need this despite the fact that they would on regular occasions put their own personal health at risk.

Members in the Community Sector of SIPTU were called upon to maintain essential services, including daily visits from Personal Assistants, Home Helps, Drivers, and other frontline workers. For many of the clients, these visits were their only source of contact and support during lockdown, a fact which has never been properly acknowledged.

Despite the immense challenges to their own personal safety, our members remained at the forefront, ensuring that no client was forgotten. Special identification badges and letters of permission were issued to enable workers to pass through Garda checkpoints during travel restrictions and carry out their duties.

In the State Related Sector, many members such as those working in the Agriculture Sector, were deemed essential workers and worked throughout the pandemic, while many workers in administration services were sent home, many of whom worked remotely during the lockdown.

SIPTU, representing the ICTU Education Committee, played a central role in addressing the challenges faced by the Higher and Further Education sector during the COVID-19 pandemic. As the largest union in the Department of Further and Higher Education, Research, Innovation and Science (DFHERIS), SIPTU engaged with stakeholders to ensure that public health guidance, staff welfare, and educational continuity were prioritised throughout the crisis.

Health and Safety of workers and whether there was adequate Health and Safety capacity in workplaces to deal with the Covid-19 Pandemic. Did this change during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence.

At the outset of the pandemic, the state agencies and authorities were critically underprepared in relation to workplace health and safety. Despite SIPTU raising concerns in late 2019 and early 2020, there was minimal evidence of risk assessments or contingency planning by employers until the national lockdown was announced in March 2020.

When the National Public Health Emergency Team (NPHET) published its 'Return to Work Safely' protocols, the Union welcomed the move as a necessary step toward creating safer workplaces. However, there was an inconsistent and often inadequate application of these protocols across the Local Authority sector.

SIPTU raised the matter with local management across several Local Authorities, but the responses were unsatisfactory and ineffective, with many employers either delaying implementation or applying the guidelines in a piecemeal fashion. This forced the Union to escalate the issue directly to the Minister for Housing, Local Government and Heritage, requesting that the Department instruct Local Authorities to apply the protocols consistently and in full compliance with public health guidance.

This episode underscored a broader issue: the absence of central enforcement mechanisms or accountability structures to ensure uniform health and safety standards across public sector employers. In a future pandemic scenario, the lack of such a mechanism could once again expose workers to unnecessary risks.

In the Education Sector, SIPTU emphasised that no reopening of institutions should occur without updated public health advice. Key developments included:

- The Chief Medical Officer (CMO) and the Health Protection Surveillance Centre (HPSC) reviewed and approved institutional plans.
- Written advice was issued regarding social distancing and mitigation measures.
- Institutions were required to adhere strictly to evolving public health guidelines.

SIPTU raised concerns about inconsistent application of safety protocols across Education Sector institutions. Specific issues included:

- Attempts to reduce social distancing from 2m to 1m without proper justification.
- The need for clear, centralised guidance from the Minister for Further and Higher Education.
- Ensuring that no institution prioritised commercial interests over staff and student safety.

The transition to remote and blended learning was a necessary response to the pandemic. SIPTU highlighted the following concerns:

- Increased workload for staff delivering blended learning.
- The need for consultation and negotiation regarding continued use of remote learning.
- Recognition that many staff continued working on-site or remotely under difficult conditions.

SIPTU called for additional staffing and resources to support safe and effective delivery of academic programmes. Key demands included:

- Proper resourcing for remote work and blended learning environments.
- Safe workloads and adequate staffing levels across all roles.

Does the Health and Safety Authority have the capacity to support representatives in a pandemic

The HSA was largely absent from the Local Authority, Community and State Agency sectors during the pandemic. There was:

Little or no visible inspection, enforcement, or guidance specific to frontline public sector workplaces.

Little or no meaningful engagement with COVID-19 Safety Representatives, who had been formally nominated through agreed protocols.

No clear communication strategy or support provided to union representatives raising safety concerns.

This apparent lack of capacity and coordination significantly undermined confidence in the HSA's ability to fulfil its role during a crisis. It is our position that the HSA did not have the resources, mandate, or visibility required to support workplace representatives during COVID-19, and without investment and reform, would be similarly unprepared for future pandemics.

Issues that arose with the level of preparedness of the provision of appropriate PPE and whether this changed during the course of the pandemic. What would be the likely state of readiness in the event of a similar occurrence?

The provision of PPE was initially inadequate and inconsistent across public sector employers. For example:

- Firefighters and other frontline staff reported early PPE supplies to be substandard or inappropriate for their work environment.
- National-level engagements were necessary to secure higher-quality PPE for workers in essential services.
- In several cases, union intervention was required to escalate concerns about supply and quality, particularly in the Fire, Rescue and Ambulance Services.

While supply chains eventually stabilised, this process took several months, during which time workers remained vulnerable. The absence of centralised procurement coordination or pre-existing stockpiles left frontline workers exposed.

In a future pandemic, resilience in PPE supply must be prioritised. This includes:

- Establishing national PPE reserves.
- Developing domestic procurement capacity.
- Ensuring that emergency services have access to PPE suited to their specific operational needs.

In the Community Sector, despite the immense challenges to their own personal safety, our members remained at the forefront, ensuring that no client was forgotten. Special identification badges and letters of permission were issued to enable workers to pass through Garda checkpoints during travel restrictions and carry out their duties.

Access to PPE quickly became a pressing issue due to the high demand for surgical masks, gloves, and face shields, like all frontline workers the community sector workers were adversely affected by the lack of proper protective equipment.

The impact on earnings and employment security for workers during the pandemic

Workers across the Local Authority, Community and State Agency sectors experienced varying impacts on earnings and job security:

- Most SIPTU members were deemed essential workers and remained on-site throughout the pandemic.
- Some workers, deemed non-essential, were temporarily cocooned at home under evolving public health guidance.
- SIPTU successfully negotiated COVID leave payments for affected members across various grades, including Fulltime and Retained firefighters, outdoor workers, and administrative staff.
- In general, public sector employment was more secure than in the private sector, but these protections were secured through strong union engagement.

As a result of the extreme measures workers went through to carry out their duties and responsibilities, the Government, through the HSE, introduced a Special Pandemic Recognition Payment for frontline workers who had direct contact with vulnerable individuals during the pandemic. However, many of our in the Community Sector members—despite meeting the eligibility criteria—were denied the payment. This caused significant distress, especially given the unwavering commitment they had shown.

The criteria for the recognition payment included:
- Public service health and ambulance workers.
- Those seconded or assigned to the HSE (e.g. Defence Forces staff at testing centres).
- Supernumerary students required to train in clinical settings.

- Staff in private nursing homes and hospices affected by COVID-19.

The payment was to be tax-free and pro-rata for part-time staff. Unfortunately, many eligible members were excluded by KOSI Co., the company appointed to distribute payments on behalf of the HSE. KOSI Co. determined that certain SIPTU members were not considered "frontline workers," despite evidence and repeated appeals to rectify this. The HSE needs to once and for all review this policy and award all frontline/essential workers the same respect and dignity as every other frontline worker that had to go above and beyond all the cause of duty during this difficult time.

The level of consultation that took place with worker representatives and was this sufficient and did it change over the course of the pandemic

SIPTU engaged in regular, structured consultation with employers at both national and local levels throughout the pandemic. In the local government sector, the Local Authority National Council (LANC) comprised of Union and Management representatives, agreed formal agreements on key measures such as the nomination of COVID Reps and raised issues regarding the application of the Return to Work Safely protocols.

SIPTU engaged in regular, structured consultation with employers at both national and local levels throughout the pandemic:

- The LANC process formalised agreements on issues such as COVID Reps and protocols for safe return to work.
- National consultation at the LANC took place via online meetings, which enabled continuity of engagement even at the height of restrictions.
- While consultation improved over time, the initial stages of the pandemic were marked by a lack of preparedness and urgency on the employer side.

However, the effectiveness of local consultation varied considerably across the sector. In particular, when NPHET issued national Return to Work Safely guidance, SIPTU encountered widespread inconsistency in its implementation by Local Authorities. Despite our efforts to raise concerns at local level, management responses were inconsistent and often dismissive, failing to meet the standard expected under public health guidelines.

This necessitated direct intervention by the Union at ministerial level, calling for the Department to issue clear instructions to Local Authorities to enforce uniform adherence to national return-to-work protocols. This step was both necessary and indicative of the challenges in achieving coherent consultation at local levels, even during a national emergency.

In the Education Sector, SIPTU was appointed as one of three staff nominees to the DFHERIS COVID-19 Steering Group. The group met fortnightly to:

- Ensure compliance with public health advice.
- Gather feedback from stakeholders on the impact of the pandemic.
- Provide strategic guidance to the sector.

Also, in the Education Sector, clear communication and adherence to industrial relations processes were essential. SIPTU insisted on:

- Transparent and consistent communication from institutions and government.
- Maintenance of normal IR processes throughout the pandemic.
- Coordinated guidance from the Minister to ensure uniform institutional response.

Other ways in which workers were impacted

The pandemic impacted SIPTU members in many additional ways:

- Redeployment pressures included attempts to move Local Authority workers into Health Sector roles without adequate training, which the union successfully resisted on safety grounds.
- Contingency planning was needed to maintain emergency operations (e.g. backup call centres for 999 services).
- Mental health strain and long working hours were common among emergency and frontline workers.
- The Community Call initiative saw Local Authority staff take on new roles in supporting vulnerable communities, a testament to their adaptability and commitment.

- The shift to online meetings and remote work introduced lasting changes, though access to remote working remains unequal across roles and grades.

SIPTU also represents workers in the Primary and Secondary School sectors. Concerns included:

- Classification of high-risk individuals and inconsistent assessments by Medmark.
- Local resolution of issues through pragmatic approaches by schools.

In addition, many members, such as those in the Community and Voluntary Sectors and Fire and Rescue services, were required to be vaccinated against COVID-19 in order to continue working on the frontline. Some chose not to take the vaccine for personal or medical reasons, resulting in them being unable to work and, in many cases, having to rely on the Pandemic Unemployment Payment (PUP).

Throughout the pandemic, members were expected to stay informed by following updates from the Health Protection Surveillance Centre (HPSC) and daily briefings from Chief Medical Officer. They also had to take regular antigen tests to reduce the risk of transmitting the virus to vulnerable clients.

Despite these enormous pressures, our members demonstrated unwavering dedication to their clients and their roles. That commitment continues today, just as strong as during the height of the crisis.

Conclusions and Recommendations

The pandemic revealed both strengths and vulnerabilities in the Public and Community Sector response. While workers showed extraordinary resilience and commitment, they were too often left without sufficient protection or support. Key learnings include:

Health and Safety and Preparedness

Health and Safety systems in the public and Community Sectors must be professionalised, resourced, and made crisis-ready.

The Health and Safety Authority (HSA) must be reformed and resourced to ensure it can engage meaningfully with public sector workplaces, including supporting and monitoring the role of worker-appointed COVID Reps.

Centralised PPE procurement and stockpiling mechanisms must be established, with ongoing assessments of sector-specific needs (e.g. Fire Services).

There must be a clearly defined and resourced mechanism for future pandemic planning, with regular sector-specific readiness reviews.

Governance and Accountability

The inconsistent application of national health guidance (e.g. Return to Work Safely protocols) across Local Authorities was unacceptable and placed workers at unnecessary risk.

There must be clear accountability structures and enforcement mechanisms to ensure that all public sector employers implement national public health directives in a uniform and timely manner.

In future public health emergencies, the Department responsible for sectoral oversight must have a statutory obligation to issue binding directions to ensure compliance with public health guidelines across all relevant agencies and employers.

Worker Representation and Consultation

Social dialogue — including the role of trade unions and worker representatives — must be institutionalised as part of Ireland's emergency response framework.

Formal consultation channels must be maintained and enhanced, ensuring that unions are not forced to escalate basic compliance issues to ministerial level in order to protect workers.

The nomination and role of Lead Worker Representatives should be retained and adapted for any future public health crises, with training and authority backed by both employers and national safety agencies.

Workplace Modernisation and Equity

The shift to remote and blended working introduced significant and lasting changes in work arrangements. Future frameworks must ensure fair and equitable access to these arrangements across all grades and roles.

Resources must be provided to address digital exclusion, workplace stress, and isolation, particularly in sectors and roles where in-person work remains the norm.

The COVID-19 pandemic exposed both strengths and vulnerabilities in the Higher Education sector. SIPTU recommends:

- Continued adherence to public health guidance in all institutional planning.
- Institutionalised consultation with unions on remote learning and workplace safety.
- Adequate resourcing and staffing to support blended learning and remote work.
- Clear accountability and enforcement mechanisms for public health compliance.

SIPTU is committed to continuing its engagement with government, employers, and stakeholders to ensure that the hard-won lessons of COVID-19 are not lost, and that the Public and Community sectors are better equipped to protect workers and deliver for the public in any future emergency.

Fairness at Work and Justice in Society

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