Witness Name: Ian Trenholm
Statement No.: 2
Exhibits: IT/01 - IT/275
Dated: 25 August 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF IAN TRENHOLM

I, Ian Trenholm, Chief Executive of the Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA, will say as follows: -

1. I am employed by the Care Quality Commission (CQC) as Chief Executive, a post I have held since August 2018.

2. Prior to this I was Chief Executive of NHS Blood and Transplant from 2014, and previously Chief Operating Officer at the Department of Environment, Food and Rural Affairs (Defra). Prior roles have included Chief Executive of the Royal Borough of Windsor and Maidenhead and Strategic Director for Resources at Buckinghamshire County Council. I began my career as an Inspector in the Royal Hong Kong Police Force and then served with the Surrey Police for four years, before moving to the commercial sector.

3. I make this statement in response to the request dated 11 May 2023 made under Rule 9 of the Inquiry Rules 2006 (SI 2006/1838) from the UK Covid-19 Public Inquiry (the Inquiry). I adopt the abbreviations or acronyms deployed in the Rule 9 Request where appropriate. I am duly authorised to make this statement on behalf of CQC.

4. Save where it is stated otherwise, the contents of this statement are within my own knowledge. This statement is to the best of my knowledge and belief accurate and complete at the time of signing. Notwithstanding this, it is the case that CQC

continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality the additional material will of course be provided to the Inquiry and a supplementary statement will be made, if required.

5. This statement has been prepared following consultation with colleagues at CQC in order to provide as accurate an account as possible on behalf of CQC.

A. Role, functions and responsibilities of CQC

6. CQC was established on 1 April 2009 by the Health and Social Care Act 2008 (the 2008 Act) as the independent regulator of health and adult social care in England. CQC is an executive non-departmental public body, sponsored by the Department of Health and Social Care (DHSC), and accountable to Parliament through the Secretary of State for Health and Social Care.

7. Our functions, statutory duties and powers, which extend to England only, are set out principally in the 2008 Act[1], together with the Health and Social Care Act 2012, the Care Act 2014, the Health and Care Act 2022 and additional primary and secondary legislation. We are responsible for the registration, monitoring, inspection and regulation of services which fall within our regulatory remit. In addition, we have a duty, under the Mental Health Act 1983 (MHA), to monitor how services exercise their powers and discharge their duties when patients are detained in hospital, subject to community treatment orders or guardianship. We also monitor how the Mental Capacity Act 2005 (MCA) is being used by health and adult social care providers and how they use the Deprivation of Liberty Safeguards.

8. Our objectives when fulfilling these functions are set out in section 3 of the 2008 Act. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care

[1] As set out in Section 2 of the 2008 Act.

services to improve. We report on how care is being delivered in England in our annual *State of Care* report.

CQC's regulatory remit

9. Providers of 'regulated activities' must be registered with CQC[2]. These regulated activities are:

- personal care;
- accommodation for persons who require nursing or personal care;
- accommodation for persons who require treatment for substance misuse;
- treatment of disease, disorder or injury;
- assessment or medical treatment for persons detained under the 1983 Act;
- surgical procedures;
- diagnostic and screening procedures;
- management of supply of blood and blood derived products;
- transport services, triage and medical advice provided remotely;
- maternity and midwifery services;
- termination of pregnancies;
- services in slimming clinics;
- nursing care; and
- family planning services.

10. It is an offence to carry on a regulated activity without being registered, and we can prosecute those who do this. The 2008 Act gives CQC both civil and criminal enforcement powers to address issues of non-compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009, which registered persons are required to comply with.

[2] Set out in Section 10 of the 2008 Act, and defined in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

11. Although we adapted our approach during the pandemic, our statutory functions and objectives remained the same.

Healthwatch England

12. We host Healthwatch England (HWE), the consumer champion for health and social care to ensure the voices of people who use services are listened to and responded to, leading to improvements in service provision and commissioning. HWE was established under the Health and Social Care Act 2012 as a statutory committee of CQC and is funded through grant in aid. The Chair of HWE sits on CQC's Board. It is operationally independent but supported by our infrastructure.

National Guardian's Office

13. We also host the National Guardian's Office (NGO). The NGO and the role of the National Guardian were created in response to recommendations made in Sir Robert Francis KC's report 'Freedom to Speak Up' (2015). The office leads, trains and supports a network of Freedom to Speak Up Guardians in England and conducts case reviews of organisations when it appears that speaking up has not been handled according to best practice. The NGO is funded mainly by NHS England (NHSE), with CQC's contribution paid for by grant in aid. The NGO has operational independence to CQC but is supported by our infrastructure and, as part of CQC, has no separate legal status.

Governance of CQC

Board

14. CQC has a unitary Board, made up of Non-Executive and Executive members. The Chair and other Non-Executive Members are appointed by the Secretary of State. Legislation sets out requirements governing these arrangements, including Schedule 1 of the 2008 Act (as amended), the Care Act 2014 and the Care Quality Commission (Membership) Regulations 2015. The Board must have no fewer than six and no more than 14 members (not including the Chair) and retain a majority of non-executive members.

15. During the Specified Period (1 January 2020 - 24 February 2022), the Chair of the Board remained the same. One executive member of the Board left CQC, without their role being replaced. Three non-executive members concluded their terms, and four non-executive members were appointed by the Secretary of State. The composition of the Board therefore changed from six non-executive members (excluding the Chair) and six executive members to seven non-executive (excluding the Chair) and five executive members. For the first time, we also appointed an Associate non-executive during the Specified Period (with effect from January 2021).

16. During the Specified Period, the Board ordinarily met monthly (except August), in both private and public. However, in light of the pandemic, during the period from April 2020 to June 2020 the Board had additional weekly, one-hour Microsoft Teams calls.

17. The Board also has a number of established committees, which continued to meet during the Specified Period to provide the required assurance and advice to the Board on areas such as senior pay and succession planning, overseeing risks specific to the regulatory programme, the implementation of the transformation programme and risk management and internal control (with this latter audit committee including two independent members throughout the Specified Period).

18. The Board followed prevailing government guidelines on face-to-face gatherings during the Specified Period and therefore met remotely in the majority of cases.

Executive Team

19. Our Executive Team (ET) membership remained relatively stable, with one planned departure in March 2020 and one new appointment in post in August 2021. ET meets formally twice a month. There were additional meetings held as the need for these arose, including in April 2020 and in the period from November 2020 to January 2021.

20. In line with existing business continuity plans, in early March 2020 we established a Gold Command (Gold) and Silver Command (Silver) structure to provide strategic and operational leadership during an emergency. Gold was chaired by me, and Silver on rotation by a number of Deputy Chief Inspectors.

21. Gold met three times a week in March 2020, stepping down gradually to once a week for the remainder of 2020, and stepped up again to twice a week for January 2021. After early March 2021 it resumed meeting only for emergency business continuity purposes, but was briefly stood up again during December 2021 and January 2022, meeting six times. Silver met weekly in February 2020, increasing to daily in March and April, before gradually stepping down to once per week until January 2021, where it stepped up again to twice a week for that month.

22. Committees of ET continued to meet during the Specified Period, looking at areas such as: health, safety and welfare of colleagues; safeguarding and responding to concerns; financial, people and commercial resources; research and evaluation work; and the effective delivery of our strategic changes.

Corporate Governance Framework and CQC-DHSC Framework Agreement

23. We have a corporate governance framework which sets out the responsibilities and procedures that we use to make sure we govern our organisation to a high standard. This was refreshed in 2021, and again in 2022. In addition, a signed Framework Agreement is in place between CQC and DHSC. This sets out our governance, as well as accountability, management and financial responsibilities and reporting procedures. It includes the Accounting Officer's accountability responsibilities to Parliament. It was last reviewed in 2021. Both documents are available on our website (IT/01 [INQ000235429] and IT/02 [INQ000235453]).

Structure of CQC

24. In January 2020, CQC had six Directorates. The majority of people worked in specialist teams in one of the three inspection directorates: (1) hospitals (including ambulances and mental health); (2) primary medical services and integrated care

(including dentists, health and justice); and (3) adult social care (ASC). In addition, there were three further directorates: (4) Strategy and Intelligence; (5) Digital; and (6) Regulatory Customer and Corporate Operations (RCCO). In March 2020 the Strategy and Intelligence and Digital directorates were restructured and renamed as Engagement, Policy and Strategy, and Digital and Intelligence. After recruiting a team member to our new role of Executive Director of Operations, who joined us in August 2021, we began further restructuring to deliver our new regulatory approach. Regulatory Leadership teams were established, led by the Chief Inspectors with Directors heading up the different sectors within health and social care. Alongside Regulatory Leadership, we brought together our specialist sector teams into one Operations Group led by the Executive Director of Operations with Directors across four geographical networks: (1) London and the East of England; (2) Midlands; (3) North; and (4) South. These operate alongside National Operations and a central Hub. This has continued to evolve beyond the Specified Period, in line with our strategy outlined on our website (IT/03 [INQ000235465]).

Operational stance during the Specified Period

25. During the course of the pandemic we recognised that we had an important role to carry out in offering assurance to the public (and Government) around the safety and quality of services, but doing so wholly through on-site inspections was practically difficult during lockdowns. Our intent was always to balance the value to be gained from a full physical inspection with the risk posed by inspectors moving between services, alongside the recognition that every provider was operating an 'exceptional' service. We moved to a risk-based approach to our work.

26. Whilst information on the exact method of spread of the virus and the exact role that asymptomatic spread played was unclear at the start of the pandemic, we tried to avoid placing the public at risk by asking inspectors to physically move regularly between services.

27. I also had to take into account the need to minimise physical risk to my own team, especially in the early part of the pandemic with shortages of Personal Protective

Equipment (PPE) and uncertainty around how best to contain and manage the spread of the virus. The average age of my team is older than many others, as we actively recruit people who have experience of operating in leadership roles in healthcare and social care providers. This meant that a number of my team were themselves shielding; or were in a household with someone who was; or shared a household with a health or care worker.

28. Whilst we did continue to make physical visits to providers as part of this risk-based approach, we rapidly developed new assurance approaches which deliberately limited on-site activity. These approaches were, in the main, not designed to change the rating of the provider, but did examine specific aspects of the safety of services.

29. At different points in the pandemic we examined emergency care and created a remote monitoring approach to enable us to triage and follow up concerns, along with a rapid review process for examining infection prevention and control (IPC), offering an '8 ticks of assurance' (discussed in paragraph 183 below) to a number of care homes.

30. Our National Customer Service Centre (NCSC) remained open throughout the period. The NCSC supported both providers and the public in answering questions and recording concerns. During the period of the pandemic the number of concerns raised by the public increased by approximately 50% per annum, with comparable increases in reports from members of staff working for providers. In addition, we upgraded our digital contact channels to make them easier to use.

31. Taken together, the information from the public and members of staff gave us a picture of concerns as they arose, which in turn drove our risk-based approach to inspection. We were then able to provide an appropriate regulatory response, up to and including an on-site inspection. About half of our inspection activity during the pandemic was driven directly by information from the public or those who worked in services.

32. We were also able to identify and work with government on emerging concerns. Examples included inappropriate use of Do Not Attempt Resuscitation orders,

deployment of Covid-19 positive staff and the challenges of visiting care home residents and patients during a pandemic.

33. The overall aim was to contribute to sharing information and promote improvement in the exceptional circumstances the nation found itself in, rather than to continue to try and carry out our work using our traditional methods and approaches. We did take enforcement action where necessary, but we considered carefully the public interest before so doing.

34. We had a number of national capabilities. These included: inspectors based in the field across England with good local knowledge of both health and social care; a NCSC underpinned with technology which enabled the team easily to work remotely; and a modern, cloud-based technical architecture which could be rapidly deployed to support new services. We had long-standing relationships with charities and representative groups. Some colleagues had recent clinical experience, and all had a good understanding of the challenges of supporting vulnerable people.

35. We reinforced the message to care providers that they needed to keep their registration up to date and no derogations were given. This meant we had an up-to-date list of all providers, and the services they offered, at all times. This list changed daily and continued to be updated on our website each month. I have provided a witness statement in respect of this Care Directory list for Module 1. We always sought to prioritise the registration of providers who were adding capacity to the Covid-19 response. This included the registration of Nightingale Hospitals in a few days, and the creation of bespoke social care settings to support people with Covid-19.

36. Taken together we offered Government and our communities a range of support outside our normal remit. This included a small number of our teams returning to front line NHS work in ambulance services, Intensive Care Units (ICU), vaccination clinics and so on. A number of people were given daytime work flexibility to support local voluntary organisations in their community delivering food, etc.

37. We made a standing offer to Government to support the national response, wherever that did not conflict with our regulatory duty – which remained

paramount. Examples of support included using our knowledge of the sectors we regulate plus our technical infrastructure to contact providers. We provided these updates to providers each week, and, on occasion, more frequently, when new guidance was published. Immediately post Easter 2020 we ran a booking service to give priority access to social care staff to book a Covid-19 test. This service was stood down once the national booking portal was created.

38. We worked closely with a range of statutory partners such as DHSC, NHSE, NHS Digital and maintained contact with other regulators across the country. We were called upon to comment on guidance and documentation drafted by others, notably DHSC, NHSE and Public Health England (PHE).

39. We also assumed the role of commenting on the accessibility and plain English of information produced by Government to providers, particularly when information was required to be passed to social care providers. The lack of an equivalent body to NHSE in Social Care sometimes proved problematic and we found ourselves deployed in that role on occasion, alongside other liaison groups established to work with local government. Examples of this work are outlined later in this statement in answer to specific questions. We also used our provider representative networks to help ensure that changes in policy and approach were understood on the ground, and to gather intelligence to help inform government policy choices.

40. The legislative framework and powers we operated under remained unchanged during the Specified Period and we sought, as far as possible, to retain the same decision-making processes, albeit at times these needed to operate at a faster tempo.

41. Our legislation gives us specific duties and powers, and in some cases excludes us from some activity, the responsibility for which rests with others. The capabilities and expertise we have within our teams reflects those duties and powers. We always have worked with other agencies, and continued to do so during the pandemic, deferring to them in areas where they held primacy, or had particular expertise and powers. During the pandemic we accepted expert policy advice from

a range of other agencies, notably PHE and the National Institute for Health and Care Excellence (NICE), and incorporated this into our work.

B. CQC liaison and communication with the UK Government

UK Government meetings attended by CQC

42. The Inquiry has asked us to provide, for the Specified Period, a chronology setting out UK Government-led meetings attended by us for the purpose of informing the UK Government's response to the Covid-19 pandemic. In addition, we have been asked to set out details of any regular meetings that were set up between CQC and UK Government Ministers, advisers or senior civil servants to discuss core political and administrative decision-making relating to the response to Covid-19, and its impact on the health and social care sector in England.

43. The attached chronology (IT/04 [INQ000235485]) sets out the meetings that we attended with the UK Government during the Specified Period. The definition of "UK Government" provided to CQC by the Inquiry was "the Cabinet Office, the DHSC or any other UK Government departments". We have identified that we attended over 1,000 meetings with the UK Government where various issues relating to the UK Government's response to the Covid-19 pandemic were or may have been discussed.

44. The chronology was compiled following the manual review of the Microsoft Outlook calendars of the key CQC colleagues who were engaging with UK Government officials during the Specified Period. These colleagues, and the positions they held during the Specified Period, are as follows:

    a. Peter Wyman (Chair)
    b. Ian Trenholm (Chief Executive)
    c. Ted Baker (Chief Inspector of Hospitals)
    d. Kate Terroni (Chief Inspector of Adult Social Care)
    e. Rosie Benneyworth (Chief Inspector of Primary and Integrated Care)
    f. Mark Sutton (Chief Digital Officer)

g. Chris Day (Director of Engagement)
h. Joyce Frederick (Deputy Chief Inspector, Registration and Regulatory Assurance, then Director of Policy and Strategy from October 2021)
i. Rebecca Lloyd-Jones (Director of Governance and Legal Services)
j. Helen Louwrens (Director of Intelligence)
k. Stuart Dean (Director of Corporate Providers and Market Oversight) and
l. Debbie Ivanova (Deputy Chief Inspector).

In addition, the same review was conducted in relation to the calendars of the following colleagues: three Heads of Inspection, the Head of Adult Social Care Policy, a Head of Provider Analytics, the Head of Parliamentary Government and Stakeholder Engagement, a Government Engagement Manager and a Senior Government Engagement Officer.

45. We identified the meetings that, on the information available in the calendar entries, encompassed issues relating to the Covid-19 pandemic. Our role in these meetings and the topics of discussion were varied. Generally, our role in these meetings was to provide information to the UK Government as required. Our input typically entailed information regarding: (1) our role as regulator; (2) our approach to regulation and adaptions that we made to respond to the challenges of the pandemic; (3) our unique knowledge of the sectors we regulate; and (4) our insight into the particular pressures being faced by providers of these services. We drew the Government's attention to issues as they arose and sought to use our knowledge and understanding of the health and adult social care sectors to influence where appropriate.

46. The chronology does not include the details of the conversations that took place in the meetings that occurred during the Specified Period. To do so was not possible within the time limit set by the Inquiry for this response. However, if further details and information is required it will of course be provided to the Inquiry. In light of the above we have focused on providing the following information:

a. Column A – the date of the meeting;
b. Column B – the time of the meeting;

c. Column C – the title of the meeting invitation taken from the relevant Microsoft Outlook calendar entry;
d. Column D – additional information about the meeting, summarised from the calendar entry, if provided.
e. Column E – the sender of the meeting invitation;
f. Column F – whether the meeting was a regular meeting[3];
g. Column G – key external individuals (or their organisation) included in the list of invitees. The information in Column G is not intended to be an exhaustive list of invitees as it is not possible, from the meeting invite, to determine whether they in fact attended the meeting;
h. Column H – the names or roles of key CQC colleagues (as identified above) who received the meeting invite;
i. Column I – any documentation (such as minutes, agendas and slide packs) attached to the calendar entries, a sample of which (in relation to five meetings) are explained below and provided as exhibits. Any other documentation referred to in Column I, although not provided at this stage, will be provided to the Inquiry if required.

47. The information provided in Column C has been categorized by colour as follows:

a. The meetings which have been highlighted in light green ("Ministerial / Secretary of State meetings") are those meetings involving Secretaries of State and other Ministers of State. This category also includes Cabinet Committee Covid-19 Operations meetings, known as 'Covid-O' meetings. We have identified over 100 such meetings within the Specified Period.
b. The meetings which have been highlighted in yellow ("high level departmental meetings") are those attended predominantly by Directors or Deputy Directors at DHSC in relation to a range of Covid-19 matters relating to the health and social care sectors.
c. The meetings which have been highlighted in light blue ("cell calls") are those set up by DHSC's Quality, Patient Safety and Investigations

[3] For the purposes of this statement, we have defined a 'regular meeting' as where the meeting was set up as a recurring invite, or where repeated entries with the same meeting title appeared in calendars.

Directorate. These were held on a regular basis throughout the Specified Period and involved discussion of issues relating to patient safety in the context of the pandemic. The attendees to the cell calls were usually individuals from DHSC, NHS, and from arm's-length bodies including CQC, NHS Resolution and the Healthcare Safety Investigation Branch.

d. The meetings which have been highlighted in light grey ("T&F groups") are the Task and Finish group meetings, for example relating to Care Act "easements", the Adult Social Care (ASC) workforce, PPE and Covid-19 testing. These were set up by DHSC and were held regularly during the period which they ran for.

e. The meetings which have been highlighted in pink are the final 'other' category of meetings identified, which may have potential relevance but which do not fall into the previous four categories.

48. The Inquiry has asked us to provide details about what was discussed in the meetings listed in the chronology and to outline any advice or information we provided which informed the UK Government's response to Covid-19. In order to answer this question, taking into account the limitations outlined above, we have selected five meetings in the first year of the pandemic by way of example. These were meetings that were attended with Helen Whately MP in her capacity as Minister of State for Care which took place between May 2020 and October 2020 and where we prepared slide packs. A summary of the discussions that took place in these meetings are set out in paragraphs 54 to 58 below, including reference to the associated documentation.

49. The Inquiry has also asked that we provide a high-level overview of the role we played in key meetings with the UK Government relating to the UK Government's response to Covid-19.

50. We had regular meetings with the then Minister of State for Care, Helen Whately MP and subsequently Gillian Keegan MP (then Minister for Care and Mental Health). There were also meetings with Jo Churchill MP (then Parliamentary Under-Secretary: Minister for Vaccines and Public Health); Nadine Dorries MP (then Minister for Patient Safety, Suicide Prevention and Mental Health); and Maria Caulfield MP (Minister for Patient Safety and Primary Care).

51. We received a request very early on in the pandemic to meet with the Minister of State for Care, Helen Whately MP, who had just been appointed to this role. A series of key topics upon which we would brief the Minister were agreed. The key purpose of the meetings was for us to provide information and assurance, giving a brief overview of what we were doing at that point operationally. Although the agendas included key topics, new issues would be added as and when they arose, and the Minister would raise any concerns brought to her attention from constituents and stakeholders. In advance of these meetings, we would prepare a slide pack (examples are referenced in paragraphs 54 to 58 below). The slide pack prepared for these meetings would usually be shared in advance with DHSC in order for officials to brief the Minister and for the Minister to be sighted in advance of any discussion. In addition, a pre-meeting was held internally, prior to sharing these slides, to ensure the content was accurate and covered the key points we needed to raise at the time.

52. The meetings were often attended by Kate Terroni, our Chief Inspector of Adult Social Care; a Deputy Chief Inspector; a Head of Inspection; and a member of our Parliamentary, Government and Stakeholder Engagement (PGSE) team.

53. Minutes of these meetings were taken by DHSC, which were usually later shared with us. We took our own note for internal purposes, to give a brief overview of the discussion and any immediate actions required. As noted above, more detail on five such meetings is set out below, by way of example.

54. We prepared a slide pack for our meeting on 21 May 2020 with Helen Whately MP in relation to how we obtain assurance from ASC providers. The main topic for discussion was how, and from where, we collect data to help identify which services may need support, including the main areas of concern that we had identified. We set out how we were assured that care homes were safe after a Covid-19 outbreak, how this would be supported by the launch of our Emergency Support Framework (ESF), and how we would be assured that issues were dealt with quickly and appropriately. We suggested that support for a whole-systems approach from DHSC would be welcome in order to prevent a disconnect in some organisations (regionally and nationally) impacting on internal information sharing

and a potential risk of confusion and lost information due to the different approaches of local systems. (IT/05 [INQ000235496] and IT/06 [INQ000235508])

55. On 11 June 2020 we met with Helen Whately MP. We provided an update on assurance in ASC, including data from our ESF, inspection activity including our next phase of using targeted and focused inspections, and NHS Capacity Tracker red flags. The Minister raised an issue about our level of confidence that local authorities were following up on 'red flag' actions. We agreed that we would look back at assurance steps we had undertaken between March 2020 and June 2020 to provide detailed analysis of inputs (from trackers, whistleblowing, notifications, risk and so on), actions we had taken and outputs / follow-up (assurance that actions had been completed). (IT/07 [INQ000235509]; **Irrelevant & Sensitive** **Irrelevant & Sensitive** and IT/10 [INQ000235512])

56. When we met with Helen Whately MP on 23 July 2020 we provided an update from our ESF data in ASC including numbers of ESF assessments and on-site inspections, emerging themes that instigated inspections, our findings from those inspections and our planned actions. We also set out our IPC thematic review, which covered both our current approach and how we planned to build upon this in the short term. During the meeting we discussed the timeframes for responding to a concern raised to us, our pre-Covid processes and the difficulties in manually pulling together the data presented. Queries were raised regarding the relatively high level of issues found on inspection. We confirmed that a higher than average incidence of issues was likely given our process of targeting high-risk providers for inspection. We advised that we were considering a piece of work on corporate providers to improve transparency amongst them. The Minister also asked us to provide further information about our approach to winter planning. (IT/11 [INQ000235513] and IT/12 [INQ000235514])

57. On 14 September 2020 we met with Helen Whately MP. We provided an update on how we were identifying and taking action against poor IPC practice in ASC services and how we were sharing good practice with providers; how we were ensuring people were receiving safe care during the pandemic; setting out our new Home Care inspection pilot; and using intelligence to support inspectors' decision-

making as part of our Transitional Regulatory approach. We discussed the impact of delays on people in services getting Covid test results back, and what more could be done to improve IPC practices in care homes and the consequences for IPC failings, especially around care home staff wearing PPE. (IT/13 [INQ000235515] and IT/14 [INQ000235516])

58. When we met with Helen Whately MP on 1 October 2020 we provided updates on how we were responding to risk through our regulatory activity; how we were supporting the Winter Plan; our focus on IPC; and the IPC Accreditation/Assurance Scheme. The Minister asked if we had considered the merits of self-assessment for IPC and we responded that we ask providers to send us copies of audits and we expect them to do that as part of monthly assurance. We provided an update on our updated intelligence tool that allowed us to comment on actions taken post-inspection, and would be able to provide further information at our next scheduled meeting as well as more intelligence from recent inspections. (IT/15 [INQ000235517] and IT/16 [INQ000235518])

59. We also attended a number of high level meetings with Directors and Deputy Directors at DHSC on a range of Covid-19 matters touching on the health and adult social care sectors. These included meetings with Ed Scully - Director of Primary and Community Health Care, Michelle Dyson - Director General for Adult Social Care, Tom Surrey - Director of Adult Social Care, William Vineall - Director of NHS Quality, Safety Investigations and Lee McDonough, Director General Acute Care and Workforce. We also attended the Social Care Sector Covid-19 Support Taskforce meetings. With a range of other organisations, we were members of 'Task and Finish' groups with a focus on areas such as PPE, Covid-19 testing and Care Act 'easements', and of the National Adult Social Care (Covid-19) group (NACG).

60. As can be seen from the chronology, we were party to a large number of meetings with the UK Government (mainly DHSC) and a range of partners across the health and social care sectors throughout the Specified Period and can provide more detail on this should it be required.

Parliamentary Select Committees

61. The Inquiry has asked us to provide a list of any UK Parliament Select Committees to which we provided oral or written evidence relating to Covid-19. This is set out in exhibit IT/17 [INQ000235519] which lists the relevant written evidence and transcripts along with the links to the respective documents (column D). There are various instances where the documents are not linked through the list and these have been annexed to this statement as exhibits IT/18 [INQ000235520]; IT/19 [INQ000235521]; IT/20 [INQ000235522]; IT/21 [INQ000235523]; IT/22 [INQ000235524]; IT/23 [INQ000235525]; IT/24 [INQ000235526] and IT/25 [INQ000235527].

Significant written correspondence

62. The Inquiry has asked us to provide a list of significant written correspondence between us and UK Government departments, Ministers or senior civil servants relating to the UK Government's response to Covid-19 and core-political decision-making. This is set out in exhibit IT/26 [INQ000235528], highlighting some of the exhibits noted elsewhere in this statement. To compile this list we considered the correspondence identified during the process of collating all potentially relevant documentation to respond to this Rule 9 request. We have interpreted 'significant' as referring to those items of correspondence which may have impacted on the broader Government decision-making process. In contrast, correspondence that may have impacted only specific details of guidance or messaging has not been included in this list but may, where appropriate, be referenced elsewhere in this statement.

63. The Inquiry also asked us to outline whether we raised any concerns about the UK Government's decision-making, and any advice or representations we made to core political and administrative decision-makers in the UK Government, including any instances where such advice was not followed, concerning its response to Covid-19. This is referenced in exhibit IT/26 [INQ000235528] and in the relevant places throughout this statement.

Informal / private correspondence

64. In response to the Inquiry's request, I can confirm that we had very little informal and / or private correspondence with UK Government Departments, Ministers or senior civil servants relating to the UK Government's response to Covid-19. As requested, we have set out details below, noting that the Inquiry does not require disclosure of these informal communications at this stage.

65. We have limited our response to this question to refer to senior officials in UK Government departments and Ministers (most notably the then Secretary of State). For these purposes we have not included civil servants working in Executive Agencies, such as PHE. We contacted all current colleagues at Executive Director level, two Directors who are members of the Executive Team (the Director of Engagement and Director of Policy and Strategy), the three former Executive Director level colleagues who were in post during the pandemic (two Chief Inspectors and the Chief Operating Officer) and the former Chair. We requested confirmation of relevant information on either personal or work devices. We confirmed that all potentially relevant contact that may have been made needed to be made available. Any responses confirming that potentially relevant contact may have been made were followed up individually.

66. Colleagues have the option of following our 'bring your own device' policy or having a CQC-issued mobile phone. In relation to work phones, these were upgraded in an organisation-wide project starting in January 2022 and as a result of that upgrade text and / or WhatsApp messages on those phones are no longer accessible.

67. The small amount of informal and / or private correspondence that there was took place via text or WhatsApp and mainly related to arranging meetings or requests to look at an urgent email, with items of substance being shared via email. Any other discussions are set out below. No decisions were made in these exchanges.

68. As Chief Executive, I exchanged some messages with Lee McDonough (Director General, initially leading the Acute Care and Workforce team before then becoming Director General for the NHS Policy and Performance team) at DHSC.

As stated above, these were largely prompts to look at an email. There were a small number of other messages, as detailed below.

69. On 27 February 2020 Lee was able to confirm that there wasn't an intention to use emergency legislation to direct us to stop inspections, as we were already not carrying out routine inspections at locations dealing with Covid-19 outbreaks.

70. On 16 March 2020 Lee texted to say that the then Secretary of State was not happy with our interim proposals regarding cessation of inspections. This was followed up with an email from William Vineall (Director of NHS Quality, Safety, Investigations at DHSC) discussing letters to providers and clarity of messaging on the stopping of routine inspections. (These letters are referenced in paragraph 83 below.)

71. On 24 March 2020, Lee asked for the number of CQC colleagues who are clinicians to be redeployed to front line clinical roles. I was able to confirm that so far 10 clinical colleagues had been released from their CQC roles and we were working on ways to help people volunteer. This was repeated regarding the release of nurses on 8 January 2021, where I was able to confirm that we had released some people locally, some were signed up to administer vaccinations and had committed to releasing people to ICU and paramedics, but we didn't employ many registered nurses. There was a follow on exchange where Lee asked if we could try and show the overall amount of resource released back into the 'system'.

72. On 16 April 2020 I had emailed DHSC (Lee McDonough, William Vineall and Jennifer Benjamin, Deputy Director of the Quality, Patient Safety and Investigations Branch at DHSC) regarding a request we had received from Deloitte to provide wider assistance to the Covid-19 testing booking service (IT/27 [INQ000235529]). Lee texted me to ask me not to proceed at the moment, with an email to confirm that arrangements were being clarified and they would get back to us.

73. On 12 May 2020 I informed Lee that we would be publishing an update later that week (Thursday 14 May 2020), (IT/28 [INQ000235530]), following the release of

data to the BBC, in response to their request. This related to detailed data analysis that we were doing to understand the impact of Covid-19 on people with a learning disability or autism, which we later published on 2 June 2020 (as referenced in paragraph 234 below).

74. On 16 September 2020 I texted Lee to offer for us to carry out an audit of progress on Covid-19 testing of provider staff. This was not taken up.

75. On 22 January 2021 Lee alerted me to an issue raised that day with the then Secretary of State, regarding ongoing inspection activity, in a meeting with the Shelford Group (an issue also raised with our then Chair, Peter Wyman, as noted in paragraph 90 below). This Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England. I was able to confirm that we had not conducted any routine inspections at these (or other) trusts in recent months, unless there was specific risk identified. I noted that we may have had discussions with NHS trusts, including if this was in relation to our Provider Collaboration Reviews (PCRs), but that we had paused PCRs before Christmas and had made public statements that we would not be resuming them imminently.

76. On 8 February 2021 I texted Lee to confirm that I had seen a note about a proposal to mandate vaccinations and make this a condition of CQC registration. I asked for a conversation, which Lee agreed to.

77. On 18 March 2021 I sent a text to Lee referencing speculation around a proposal for mandating Covid-19 vaccination for social care, but not NHS, workers. I also mentioned that there was to be a Public Accounts Committee hearing on 19 April on adult social care, which may be critical of DHSC on the adult social care aspect of their responsibilities, and that I had notified Michelle Dyson's team. This hearing was scheduled following the National Audit Office report *'The adult social care market in England'* published on 25 March 2021. It was a hearing that I later attended.

78. Peter Wyman, then Chair of CQC, also had brief WhatsApp exchanges with Lee.

79. On 9 June 2020, Peter had an exchange with Lee to offer a pre-meet before a meeting he had with the Minister at DHSC (Nadine Dorries MP) on 11 June. Lee replied that they should try to have a chat before-hand and she would come back to him with a time.

80. On 20 July 2020, following a meeting that morning with the then Secretary of State, the Rt Hon Matt Hancock MP, Peter asked if there was anything he needed to do, noting that he was meeting with me that afternoon. Lee continued "We do need to get a bit more pace and join up on maternity as am worried about all that". This was not specifically related to the Covid-19 pandemic. She noted that Mr Hancock had mentioned to her after the meeting that they needed to follow up with Peter on "the 1 page letter to the system". She also noted that the Secretary of State's speech was likely to be on 30 July. Peter responded that Mr Hancock had just texted him about this, and confirmed he had committed to sending Mr Hancock information, but noted that a one page letter was not how we had ever communicated with providers. That evening, Peter sent a message to confirm that he had just emailed Lee "a couple of short documents which I hope will meet Matt's expectations" and asked Lee to let him know what she thought. (The content of this email is also referenced in paragraph 86 below.) The documents attached were: (1) a copy of an internal intranet article I had shared with the organisation on 13 July 2020 (IT/29 [INQ000235531]); and (2) a letter dated 16 July 2020 sent in my name to all registered providers (IT/30 [INQ000235532]; IT/31 [INQ000235533] and IT/32 [INQ000235534]). This letter set out the aims of our PCR work, namely to identify themes and learning that can be used to inform winter and subsequent spikes of Covid-19, and to help providers / local health and care system leaders to plan / work together more effectively.

81. Although not directly 'relating to the UK Government's response to Covid-19', on 28 September 2020 Peter messaged Lee to note the most relevant page of our strategy briefing paper for Mr Hancock, ahead of the meeting with him the next day. Lee picked up the message that evening and wasn't sure what had been shared with Mr Hancock. The next day, 29 September 2020, Peter confirmed that his message the previous day had only been to avoid time spent reading more than was necessary, especially as the meeting was "to make sure he's comfortable

with the big themes". Lee asked when our *State of Care* report (detailed in paragraph 291ff below) was to be published and Peter confirmed it was due to be laid in Parliament on 15 October 2020 and the scheduled media coverage would be the next day.

82. Peter also had some text and WhatsApp exchanges with the Rt Hon Matt Hancock MP. These are set out below.

83. On 16 March 2020, Peter sent a text to Mr Hancock in which he suggested that, if there was a consideration for those aged over 70 to self-isolate for the summer, there be some consideration given to an exemption for those who work, noting his personal preference not to be leading CQC exclusively from home whilst our colleagues worked normally. Mr Hancock replied that he needed CQC "to pull back more than they are currently planning on inspections & data collection" and that "we are likely going to have people in hotels & it's important people do their best without worrying about box ticking". In response, Peter noted that inspections were scaled back and would only be taking place where abuse or serious harm may be occurring, and that data collection requests were intended to be light touch and focused on social care, where existing data was less than for other sectors. Mr Hancock replied to note he had made amendments to the letter. Mr Hancock also noted that "the data collection will remain a barrier to people doing things differently", to which Peter replied to confirm that this was not the intention. This exchange, and that referred to in paragraph 70 above, was in reference to two letters, one for healthcare providers and one for adult social care providers, which we sent out on 16 March 2020, entitled 'immediate cessation of routine CQC inspections' (IT/33 [INQ000235535] and IT/34 [INQ000235536]).

84. On 26 May 2020 Peter sent a text to Mr Hancock thanking him for his letter to CQC of 21 May 2020 (IT/35 [INQ000235537]).

85. On 20 July 2020 Peter confirmed the following to Mr Hancock:

"Firstly we are significantly reducing the regulatory burden by a) changing the approach to inspections and b) reducing the burdensome data gathering and

talked about both in our public board [meeting] last week. I've also spoken to about 30 Trusts in the past two or three weeks and also Chris Hopson [then Chief Executive] at [NHS] Providers. Similar conversations are taking place with Martin Marshall [then Chair of the Royal College of GPs]. I should just add that we are not a standard setter; we look to make sure what others say is required is what actually happens. So actually most of the freedom to act as they think fit comes from the professions themselves and of course we support this, and Ted Baker and others are making this clear." Mr Hancock wanted examples to point to in a speech he was giving on 30 July.

86. On 21 July 2020 Peter referenced the documents he had sent Lee McDonough (noted in paragraph 80 above), which included a letter from me to all registered providers (IT/31 [INQ000235533]). Peter noted that the letter "explains the Provider Collaboration Reviews but I think the context and tone give you what you want [for the speech] in that it fully recognizes and celebrates the innovative practices adopted over the past few months". Peter had also sent Lee my intranet article dated 13 July 2020 setting out how we were developing our new approach (IT/29 [INQ000235531]). Peter noted that in my communication with colleagues I was impressing the need to work and think differently.

87. Also on 21 July 2020, Peter sent Mr Hancock a message inviting him to a guest slot on the weekly internal all-colleague calls, and, on 6 November 2020, thanking him for the video that he had provided for this purpose, which had been shown during the all-colleague virtual conference the day before.

88. On 18 August 2020, Peter noted that Mr Hancock had been asked, when giving a speech at the Policy Exchange that day, why CQC inspectors were allowed to enter care homes without having undertaken Covid-19 tests. Peter stated that CQC had requested regular testing for inspectors but had been told by Dame Ruth May, Chief Nursing Officer for England, that they didn't meet the requirements as they did not have close contact with residents, and confirming that staff with symptoms continue to follow national guidance. We did not contest this.

89. On 6 November 2020, Mr Hancock stated that we needed "to speed up the validation of isolation sites in social care – else we end up with delayed discharges". Peter replied to note that we were providing validation within 24 hours of being advised of selected locations and had approved 772 beds (with a further 709 beds in community hospitals and other settings that didn't need further CQC approval), but that only 97 local authorities had provided us with potential locations. Peter continued: "If greater capacity is required (as it obviously is) we need all local authorities to designate appropriate places particularly in those parts of the country under greatest pressure; we are committed to doing our bit in the agreed timeframe in whatever numbers are supplied."

90. A further exchange took place on 22 January 2021, when Mr Hancock had heard in a meeting with the Shelford Group (as referenced in text exchanges between Lee McDonough and me at paragraph 75 above) that it may be the case that routine inspections of hospitals (which at Mr Hancock referred to as "visits or meetings") were still taking place. Peter confirmed that routine inspections (of hospitals and other locations) were not taking place, other than where a high level of concern had been identified. Peter confirmed shortly afterwards that he had spoken with Ted Baker, then Chief Inspector of Hospitals, who had confirmed that routine inspections were not being undertaken. Peter offered to speak to Trust Chairs to resolve any remaining issues, to which Mr Hancock replied that he thought it would be valuable for him to check in with the Shelford Group. Peter replied to note that Ted had a meeting with them in the coming weeks and would check things out then, and noted that Lord David Prior and he had a meeting the day before with about 20 Trust Chairs, including some from the Shelford Group, and nothing was flagged

91. Kate Terroni, then Chief Inspector of Adult Social Care, had calls and texts on her work phone with a small number of senior civil servants at DHSC: Ros Roughton (Director for Adult Social Care, then promoted to Director General); her successor as Director General for Adult Social Care, Michelle Dyson; Tom Surrey (Director - Adult Social Care - Quality); and, later in the Specified Period, Claire Armstrong (Director – Adult Social Care Delivery and Covid-19 response).

92. Kate spoke frequently with Ros during April/May 2020 about communicating with the social care sector and our role as the regulator. Topics included the Insights products we made public in May 2020, which highlighted the significant challenge social care providers were facing in relation to accessing PPE and testing. Texts were to arrange calls. Kate spoke occasionally with Michelle and Tom from September 2020 to February 2022. Kate spoke with Michelle about topics relating to Covid positive staff still working in care homes, after our sharing of data with DHSC about this emerging issue. Following this, a joint statement was issued by DHSC, PHE, CQC and the Association of Directors of Public Health, as detailed in paragraph 195 below.

93. Rosie Benneyworth, then Chief Inspector of Primary Medical Services and Integrated Care, also had very little contact of this sort. Rosie had WhatsApp communication with Ed Scully (Director of Primary and Community Health Care) on 30 November 2021. She asked if she could speak to him regarding a discussion she had with NHSE in which they asked CQC to step down routine inspections of GP practices. Rosie and Ed set up a call for the morning of 30 November 2021 and they had no further communication. Rosie also had a brief text message conversation with Jo Churchill MP (Minister for Primary Care) following a meeting of GP leaders.

Advice to the UK Government regarding the identification of at risk and vulnerable groups

94. The Inquiry has asked us to identify, in the context of the UK Government's response to Covid-19, if the UK Government sought or received advice from us on the identification of at-risk and vulnerable groups.

95. We continued to provide written and oral evidence to Parliamentary Select Committees during this period, including in relation to concerns about at-risk and vulnerable groups in the context of the UK Government response to Covid19.

96. We provided written evidence to: (1) the Women and Equalities Committee (May and August 2020); (2) the Joint Committee on Human Rights (June and July 2020, and March, May and November 2021); (3) the Health and Social Care Committee

and Science and Technology Committee joint inquiry (November 2020); and (4) the Health and Social Care Committee (October 2021), highlighting concerns and vulnerabilities during the pandemic.

97. We also gave oral evidence to a number of committees during this period, some of which touched particular at-risk or vulnerable groups, such as the Joint Committee on Human Rights (May 2020 and April 2021) and the Women and Equalities Committee (July 2020).

98. These appearances related to a number of specific groups, including: older people and people with dementia; people in care homes; children and young people with Special Educational Needs and Disability; people with learning disabilities, autism and spectrum disorder; people with mental health issues and people detained under the Mental Health Act; people from Black, Asian and Minority Ethnic (BAME) communities (patients and care staff); and LGBT people.

99. The concerns identified ranged from increased death rates in Black, Asian and Minority Ethnic communities, human rights of people detained under the Mental Health Act, closed cultures, restricted access to routine care for people in care homes, and the increasing backlog of people waiting for services from Gender Identity Clinics.

100. As part of our ongoing engagement with DHSC, we also raised concerns regarding vulnerable groups during some of these meetings. For example, in early June 2020 we highlighted that we would be increasing targeted and focused inspections prioritising areas such as closed cultures; and in early July 2020 we shared concerns developed through our public Insight work around the need to resume on-site inspections in settings caring for people with learning disabilities and autism and mental health services. (IT/36 [INQ000235538])

101. More generally we continued to raise awareness that as the Government's response to the pandemic for social care was focused on care homes, that this could exclude some people. For example, as regards the availability of testing for Covid-19, those who use supported living services (with care often delivered by CQC-registered home care providers), including those with learning disabilities

and autistic people. We supported DHSC and later Deloitte through the summer of 2020 to expand testing to supported living and extra care services.

102. In January 2022 we highlighted concerns around reduced access to community mental health services during the pandemic potentially having contributed to an increase in the number of people being detained under the Mental Health Act.

103. We also contributed to a letter from the National Prevention Mechanism to the Rt Hon Sir Robert Buckland MP in March 2020 setting out concerns regarding the impact of Covid-19 on detained people such as those subject to Deprivation of Liberty Safeguards (both in terms of health and human rights violations) and on children in residential special schools (IT/37 [INQ000235539]).

104. As is covered in greater detail in Section E below, we were keen to better understand the impact of Covid-19 on specific groups through analysis of the data already being submitted to us about deaths and which was already being published as part of the Office for National Statistics (ONS) reports. With the support of ONS, we completed a targeted analysis to better understand the impact of Covid-19 on people with learning disabilities using the data submitted to us by care homes and published by ONS. The findings were published on 2 June 2020. Similarly, on 17 June 2020 we published data on deaths in care home settings broken down by ethnicity to better understand the impact of Covid-19 on people from different ethnic groups (IT/204 [INQ000235422] and IT/243 [INQ000235472].

105. As discussed in more detail in paragraphs 182ff below, IPC was already a feature of our comprehensive inspection methodology, but in August 2020 we developed a bespoke IPC tool with input from PHE. This was designed to help support best practice in care homes and to give the public an up-to-date view of IPC practice within that setting.

106. This tool, from its first version, described for inspectors what good practice looked like, including specific consideration of high-risk groups such as clinically vulnerable people and people from Black, Asian and Minority Ethic communities, covering both people using services and staff. The tool prompted inspectors to consider actions needed to be taken or already taken to reduce the impact of

Covid-19 on those disproportionately at-risk and included links to relevant guidance focused on the impact of Covid-19 on Black, Asian and Minority Ethic Groups, supporting autistic people, people with learning disabilities, and people with dementia. The mandatory questions included in the tool used to gather intelligence and to allow for swift reporting specifically asked:

"Has the service adequately taken measures to protect clinically vulnerable groups and those at higher risk because of their protected characteristics (BAME, physical and learning disabilities)?"

107. Responses received from Government to our comments and engagement on concerns took a number of different forms. This could be a simple acknowledgement of our comments for consideration, or more specific responses on points we had raised. The following are a few examples to illustrate this (it is not intended as an exhaustive list).

108. For example, in March 2020 DHSC requested input into the draft *Covid-19: Ethical Framework for adult social care* (also referenced in paragraphs 156-157 below). Our comments included emphasising the importance of the human rights aspects of the policy, and taking account of where people may experience psychological harm because of a change in their routine during this period, such as some autistic people. Whilst, due to timescales for approvals, these were not incorporated into this publication, DHSC agreed with the value of our comments and that they would be built into future communications and responses around this Framework. DHSC also offered further discussion and consideration of how best this input could be incorporated into future guidance around the Coronavirus Bill, such as on Care Act Easements.

109. Similarly, in March 2020 we provided comments on the impact of Covid-19 on those detained under the Mental Capacity Act and on the Deprivation of Liberty Safeguards process (IT/38 [INQ000235540] and IT/39 [INQ000235541]). DHSC were grateful for comments, and we continued to provide comment on draft guidance documents in these areas.

110. Also, in May 2020 we raised concerns with DHSC, via email and in relevant meetings, regarding access to testing for learning disability and mental health services where people using these services were under the age of 65, and the associated risks this presented (IT/40 [INQ000235542]). Our concerns, alongside those of other stakeholders, contributed to DHSC's decision to roll out the testing to learning disability and other services. We also worked with Deloitte, sharing information and supporting the development of their Frequently Asked Question (FAQ) document, to help these services access testing.

Consultation and advice in relation to non-pharmaceutical interventions (NPIs)

111. The Inquiry has asked us to confirm if, and if so the extent to which, we were consulted by the UK Government regarding any decisions to impose non-pharmaceutical interventions (NPIs) during the Specified Period. We were consulted by UK Government departments / bodies in relation to NPIs in only a limited capacity. The nature of such consultation generally involved the relevant Government department (usually DHSC) requesting comments and/or feedback from us on pre-prepared documents. We have identified the following areas in which we were asked to comment on Government guidance.

Care home visiting

112. We were approached by DHSC for comment in relation to *Guidance on care home visiting* (published on 22 July 2020). We responded with some limited comments regarding the public accessibility of the guidance and policies (IT/41 [INQ000235543]).

113. DHSC subsequently developed an annex to this guidance looking at visits out of care homes and approached us for comments on the draft guidance. We responded with our suggestion that a person-centred approach be taken (noting that care homes were people's homes and those individuals should be part of the decision-making process) and that consideration should be given to the legal position concerning restrictions of liberty (IT/42 [INQ000235544]; IT/43 [INQ000235547] and IT/44 [INQ000235548]).

114. In February 2021, DHSC approached us for comment on updated draft guidance. We responded to confirm that we considered that the guidance was clear, respected people's wishes and enabled choice whilst mitigating risk. We provided some very limited comments regarding the content (IT/45 [INQ000235549] and IT/46 [INQ000235551]). Discussions were held with DHSC regarding allowing nominated essential care givers in care homes. This entailed a change to care home visiting guidance in March 2021 to enable one key visitor per resident to provide significant support and reduce strain on care staff.

115. Throughout mid-2021, CQC regularly attended DHSC-arranged meetings regarding care home visiting with stakeholders.

116. In October 2021, a further iteration of visiting guidance was provided by DHSC for comment. We suggested that the guidance could be simplified and provided limited comments (IT/47 [INQ000235552] and IT/48 [INQ000235553]).

Designated settings

117. In September 2020, DHSC approached us regarding the implementation of a new system of formal designation of Covid-safe isolation facilities, in support of the Adult Social Care Winter Plan published by DHSC. We provided some headline points on what we could deliver within our existing regulatory framework and comments on proposed guidance (IT/49 [INQ000235554]). DHSC involved us in these discussions from the outset and we developed the scheme, with input from DHSC when required.

118. Although our regulatory framework did not make it possible to provide a formal designation, we agreed to a combination of a rapid registration and IPC inspection, with the outcomes published. We did this to offer public assurance around the safety of a designated setting. Using our IPC toolkit (with some amendment) we could give assurances that services were able to use IPC methods with the aim of reducing the risk of onwards transmission of Covid-19 and had separate geographical areas within care homes.

119. In November 2020, DHSC provided a draft FAQ document on Designated Settings requirements and a draft of the guidance for us to comment on. We provided comments by return to clarify points in relation to our position and involvement in the scheme (IT/50 [INQ000235555]).

120. I attended a meeting on 10 January 2021 with Lee McDonough, DHSC Director General, where the concept of care hotels was discussed. After the meeting I followed up in writing, particularly suggesting that the policy shouldn't be "over design[ed] at the centre" (IT/51 [INQ000235556]).

121. Following this, on 15 January 2021 we were asked by DHSC to review a proposal created by NHSE entitled *Care Hotels' approach: using hotel spaces to improve patient flow from hospital*. We provided a range of comments including that any interim arrangement is rarely the best thing for a person leaving hospital; that the proposal assumes people will agree to this approach and there is a risk that people may choose to wait in hospital; that workforce capacity would be needed to manage such a programme; that safeguarding was paramount; and that a joined-up approach was needed. Other comments covered people's discharge from hospital in more detail. (IT/52 [INQ000235558])

122. On 18 January 2021 we also commented on a draft letter from Matthew Winn, Director of Community Health, NHS England and NHS Improvement to CCG Accountable Officers, Local Authority Directors of Adult Social Care and System discharge leads providing comments to help ensure clarity (IT/53 [INQ000235559] and IT/54 [INQ000235560]). The letter was published on 20 January 2021.

123. The issue of Care Hotels was also raised in a briefing to the Minister for Care on 21 January 2021 in the context of the work we were doing with DHSC to establish new arrangements to provide indemnity cover for care homes operating designated settings (IT/55 [INQ000235561]). In this model of care, the hotel provided 'normal' services, i.e. accommodation, meals, cleaning, laundry etc and a Domiciliary Care Agency (DCA) provided any personal care the individual required. This provision by the DCA generally didn't need any changes to their CQC registration as the DCA was operating within its normal scope.

124. Further proposed guidance was provided by DHSC in March and April 2021, to which we provided limited comments (IT/56 [INQ000235562]).

125. In late August 2021, DHSC approached us regarding options for the continuation of designated settings with further flexibility. We responded with comments on all proposed options (IT/57 [INQ000235563]. DHSC approached us regarding their updated Designated Settings guidance in October and November 2021 and colleagues provided some limited comments on the draft (IT/58 [INQ000235565]; IT/59 [INQ000235566] and IT/60 [INQ000235567]).

Discharge from hospitals

126. We were asked by DHSC to co-sign a revision to the Hospital Discharge Service Requirements guidance (post-publication of the original version on 19 March 2020). We asked that the guidance consider whether a care home would be in a position to safely accommodate a returning resident; to ensure that care providers had a way to challenge individual decisions where this could not be done; and to involve providers and trade associations in the revision of the guidance. A revised version of the guidance was subsequently published on 2 April 2020, including criteria that needed to be in place before people could be discharged to care homes. This is detailed in paragraphs 146ff below.

C. Public health communications and public confidence

CQC's role in the development of public health messaging

127. The Inquiry has asked that we provide a high-level description of the role we played, if any, in the development of the UK Government's public health messaging over the course of Covid-19. Throughout the Specified Period, we were corresponding and meeting with the UK Government representatives almost daily and a lot of the engagement was in relation to the development of the UK Government's public health messaging delivered in the form of public guidance, in so far as it related to CQC's regulatory functions. We, along with other

organisations and stakeholders, were regularly asked by DHSC to provide advice or to comment on public guidance and did so where we were able to.

128. In addition to the provision of advice and / or comments to the UK Government regarding their public guidance, there were limited instances where we used our own communication channels to providers and the public (such as our website) to draw attention to new Government policies / guidance as well as changes to existing Government policies / guidance. This is covered elsewhere in the statement, notably paragraphs 288ff below.

CQC advice / briefings to Government on public health messaging, including written correspondence

129. The Inquiry has asked us to explain whether we provided advice or briefings to the UK Government on its public health communications and messaging relevant to the health and social care sector in England, and details of any written correspondence between us and UK Government relating to the UK Government's public health communications and messaging relevant to the health and social care sector in England. In addition to those instances outlined elsewhere in the statement, we also provided comments/advice to the UK Government on the following issues relating to the UK Government's public health guidance relevant to the health and social care sector in England.

Domiciliary care and home care

130. On 12 March 2020 DHSC asked us to provide comments on two guidance documents regarding "preparing for more widespread transmission", one for care homes and the other for home care (IT/61 [INQ000235568]; IT/62 [INQ000235569] and IT/63 [INQ000235570]). We responded on 13 March 2020 with general editorial comments across both documents. In respect of the care homes document, we specifically provided comments related to deprivation of liberty and suggested that the guidance should provide for the potential impact on mental health. In the home care document we made suggestions relating to acknowledging the Shared Lives care schemes which provide for an approved

carer to be matched with someone with learning disabilities, mental health problems or other needs that make it harder for them to live on their own (IT/64 [INQ000235571]).

131. On 17 April 2020 DHSC asked us to comment on the draft Home Care guidance, which was jointly drafted by NHSE/NHSI and DHSC (IT/65 [INQ000235572]). The guidance was made up of three documents, outlined below:

    a. an overarching Q&A on domiciliary care;
    b. specific guidance on shielding vulnerable individuals and staff cohorting; and
    c. specific guidance on PPE.

    The PPE guidance was not shared for comment.

132. On 20 April 2020 we provided comments relating to general editorial amendments, also noting that "both documents [i.e. a. and b. above] seem unclear on scope" as they seemed to be intended to cover domiciliary care agencies and supported living services without being clear about whether the guidance was also intended to cover other providers of regulated personal care services such as extra care housing, live-in domiciliary care and Shared Lives schemes. (IT/65 [INQ000235572])

133. On 20 April 2020 DHSC followed up and asked us to provide input on the issue of the necessary assessments required by providers in the context of decisions to discharge patients from hospital as outlined in the Home Care Guidance, indicating that "Without clear guidance from CQC, it is difficult for providers to feel assured" that they can meet the necessary legal requirements for any discharge assessment decisions". This area was, however, covered in the NHS's Discharge to Assess Guidance and, in almost identical form, on our website as a standalone piece (IT/65 [INQ000235572])

134. On 10 August 2021, we were asked by DHSC to review the Home Care guidance as they were undertaking a "complete refresh of the provisions" (IT/66

[INQ000235573]). Our main comments related to several inconsistencies in the language including suggesting that all references to 'patients' be replaced with 'people'.

135. On 17 and 27 April 2020 PHE published the *Covid-19: how to work safely in care homes guidance* for those working in care homes, providing information on 'how to work safely during this period of sustained transmission of Covid-19', and the *Covid-19: how to work safely in domiciliary care in England guidance* to provide information on the use of PPE for those working in domiciliary care. These guidance documents were developed and monitored in consultation with DHSC and the PPE Task and Finish group which represented the ASC sector, and of which some of our employees were members. In April 2021 the PPE Task and Finish Group began working on updates to the *How to Work Safely (HTWS)* guidance documents and provided us with the opportunity to comment on the updated versions of the HTWS in care homes guidance. On 26 April 2021 we provided comments and suggestions on the updated draft guidance document in the form of general editorial amendments regarding improving the clarity of the guidance (IT/67 [INQ000235574] and IT/68 [INQ000235575]).

ASC Winter Plans, ASC Task Force Report

136. To prepare for winter pressures on health and social care services, DHSC publishes annual winter plans outlining its intentions to support the health and social care services during the upcoming winter period. During the Specified Period DHSC asked us to contribute to the annual adult social care winter plans which we did through comments and drafting especially in relation to our operational and regulatory activity during the winter months.

2020 Winter Plan

137. On 11 June 2020 Kate Terroni was invited by Sir David Pearson to join the Social Care Sector Covid-19 Support Task Force, which he chaired (IT/69 [INQ000235577] and IT/70 [INQ000235578]). The Task Force was set up in June 2020 to "ensure the delivery of two packages of support that the Government [had]

put in place for the care sector, the Social Care Action Plan and the Care Home Support Package". Kate regularly joined the meetings, providing insight into our ongoing work, what we were seeing from a regulatory perspective, including on IPC, and to discuss how the sector could be supported.

138. In August 2020, we fed into two draft versions of the Task Force's report to the Minister of State for Care, commenting on testing, flu vaccinations, workforce, funding, discharge / admission to care homes, our regulatory approach, capacity, use of data, staff movement and good practice (IT/71 [INQ000235579]; IT/72 [INQ000235580]; IT/73 [INQ000235581]; IT/74 [INQ000235582]; IT/75 [INQ000235583]; IT/76 [INQ000235584]; IT/77 [INQ000235585]; IT/78 [INQ000235586]; IT/79 [INQ000235587 and IT/80 [INQ000235588]).

139. Between July and September 2020 we fed into several iterations of DHSC's *Adult Social Care: our Covid-19 winter plan 2020 to 2021 Policy Paper* (the 2020 ASC winter plan) which was published on 18 September 2020. Our contributions to the 2020 ASC winter plan focused mainly on our operational activity and our ongoing assurance on operational delivery over winter (IT/81 [INQ000235589]; IT/82 [INQ000235590]; IT/83 [INQ000235591]; IT/84 [INQ000235293]; IT/85 [INQ000235294]; IT/86 [INQ000235295]; IT/87 [INQ000235296]; IT/88 [INQ000235298]; IT/89 [INQ000235299]; IT/90 [INQ000235300]; IT/91 [INQ000235301]; IT/92 [INQ000235302]; IT/93 [INQ000235303]; IT/94 [INQ000235304]; IT/95 [INQ000235305] and IT/96 [INQ000235307]).

140. On 18 September 2020 the Task Force report was published alongside the 2020 ASC winter plan. This was accompanied by a letter from Helen Whately MP to system commissioners launching the 2020 ASC winter plan, "which [built] upon the excellent work of David Pearson's Adult Social Care Covid-19 Taskforce". (IT/97 [INQ000235308]; IT/98 [INQ000235309]; IT/99 [INQ000235310]; IT/100 [INQ000235311] and IT/101 **[INQ000058216]**)

141. In November 2020 DHSC reached out to us seeking our comments on DHSC's public messaging for Care Home Providers (IT/102 [INQ000235313] and IT/103 [INQ000235314]) around its policy to supply vitamin D supplements to vulnerable

people in Care Homes during the winter months. We supported DHSC's policy, provided some editorial comments on the public messaging document and raised some concerns about classifying the provision of the supplements as "homely remedies" on the basis that it may cause some concern with providers. Often the standard operating procedures for homely remedies in care homes are time limited and our view was that this supplementation of Vitamin D would need to be ongoing (IT/104 [INQ000235315]).

2021 Winter Plan

142. In February 2021 the Social Care Sector Covid-19 Support Taskforce was commissioned to conduct an independent review of the 2020 ASC winter plan and its implementation. On 5 May 2021 DHSC wrote to us indicating that the Minister for Care had asked "for the CQC section to be strengthened further" in the Taskforce's draft report for the independent review (IT/105 [INQ000235316]). CQC's section in the draft report for the independent review outlined the support measures we had put in place during the early stages of the pandemic. The Minister for Care requested clarification from us regarding the means that we used to continue monitoring the ASC sector. On 6 May 2021 we responded to DHSC setting out the means used to carry out its routine monitoring activities during the pandemic (IT/105 [INQ000235316]).

143. Between July and October 2021 we worked with DHSC in developing DHSC's *Adult Social Care: COVID-19 winter plan 2021 to 2022* (the 2021 ASC winter plan) which was published on 3 November 2021. Again, the comments provided by us focused on our operational approach and activity in the ASC sector. We specifically made changes to align the plan with our new regulatory approach and strategy adopted during the early stages of the pandemic (IT/106 [INQ000235317]; IT107 [INQ000235318] and IT/108 [INQ000235319]).

144. The independent report of the Social Care Sector Covid-19 Support Taskforce *Adult social care in England (COVID-19): a review of the 2020 to 2021 winter plan and subsequent actions – what more should be done?* (IT/109 [INQ000235320])

was also published on 3 November 2021 and included 33 recommendations, which the UK Government had responded to as part of the 2021 ASC winter plan.

2022 Winter Plan

145. Between July and September 2022, at the request of DHSC, we provided contributions to DHSC's Policy Paper *Our support for adult social care this winter* (the 2022 ASC winter plan) which was published on 9 January 2023 (IT/110 [INQ000235321]). The 2022 ASC winter plan was a much more simplified plan and looked at system pressures more broadly during the winter season. Our contributions to the 2022 ASC winter plan focused mainly on the messaging around our regulatory model and how the model enables us to provide national support to the ASC sector. This goes beyond the Specified Period and therefore the supporting correspondence is not annexed, but can be provided to the Inquiry if necessary.

Accessibility / clarity of public health messaging

146. The Inquiry also asked us about any concerns about the accessibility or clarity of the UK Government's public health communications relevant to the health and social care sector in England. Concerns were raised in relation to the following areas:

Admissions to Care Homes

147. Following the publication of the original Government guidance on *Hospital Discharge Service Requirements* on 19 March 2020 [IT/111 [INQ000087450]), DHSC contacted us on 25 March 2020 inviting us to co-sign amended guidance that had been written in collaboration across DHSC, PHE and the NHS. Our objective was to ensure that proper attention was given to the voice of care providers, and that any revised guidance was clear that providers should be involved in decisions about how they managed the care needs of any returning residents, while being ever mindful of the increasing pressure on hospital capacity. At this point in the pandemic there were issues with PPE supply, Covid testing was

not widely available and asymptomatic transmission was not well understood (IT/112 [INQ000235323] and IT/113 [INQ000235324])

148. We raised concerns with DHSC about this guidance. At this point providers had not been appropriately engaged in shaping this directive guidance, and it did not reflect an understanding of the pressures care home providers were facing in dealing with the spread of the coronavirus.

149. We highlighted that necessary consideration needed to be taken as to occasions when a care home may not be in a position to safely accommodate a returning or new resident. In our view, the original guidance proposed by Government, and subsequent early draft additions put to us by DHSC, left providers with little or no power to challenge individual decisions if they felt an admission of an individual from a hospital back to their care setting would not support the best interests of the person or could put them or others at risk. (For instance, if staff in the care home did not have adequate PPE, or if the setting itself wasn't able to safely accommodate individuals who needed to isolate.) In order to provide safe care, providers would benefit from being informed if a person had any reason to undertake a Covid-19 test or was showing any symptoms while in hospital, to allow them to make decisions accordingly.

150. In discussion with DHSC, we worked to update the guidance with our amendments and recommendations, reflecting our ongoing conversations with providers about the evolving environments care homes were operating in, while at all times being mindful and sympathetic to the acute pressures being put upon hospitals and their capacity.

151. We also highlighted the need to involve trade associations and linked bodies, to ensure they were sighted and their views reflected. DHSC supported this by convening a call with provider bodies, and we also contacted a leading provider trade association (the Care Provider Alliance, CPA) to ensure they were brought into the conversation. On 26 March 2020, DHSC contacted us again with a revised version of the guidance, which was sent to provider bodies and trade associations in parallel (IT/114 [INQ000235325]; IT/115 [INQ000235326]; IT/116 [INQ000235327] and IT/117 [INQ000235328]).

152. We only put our name to the guidance once we had assurances that it would offer providers the power to make their own informed decisions. By exercising our influence through the drafting process, we helped to ensure providers had a say in the discharge and admissions process, and therefore had the power to make decisions that put the needs of the individual first (IT/118 [INQ000235329]; IT/119 [INQ000235330]; IT/120 [INQ000235331]; IT/121 [INQ000235332] and IT/122 [INQ000235333]).

153. The final version of the guidance, dated 2 April 2020 (IT/123 [INQ000235334]), stated that people could only be discharged to care homes if certain criteria were in place:

    a) that information from the discharging hospital included the data and results of any Covid-19 test, the date and onset of the symptoms, and a care plan for discharge from isolation;
    b) that the care home had the ability to isolate symptomatic patients; and
    c) that care staff had adequate PPE.

154. If these elements were not in place, we were clear with providers that they would be able to refuse an admission. We also wrote to providers to reiterate the duty on them to continue assessing how they were keeping people safe despite Covid pressures, and the need to clearly understand and uphold the rights of the individual at all times.

155. Some care home managers contacted us to ask whether we would support their decision not to admit a patient with Covid-19 based on the absence of one of these elements and we confirmed that we would do so.

Ethical Framework

156. We first received this draft on 11 March 2020, following discussions with the National Adult Social Care Covid-19 Group (NACG) that morning and a 'task and finish' NACG sub-group call the day before, Although the turnaround time was too tight to provide detailed comments at this stage, Kate Terroni was able to join the NACG call and shared concerns about the need for equality of approach for self-

funders (IT/124 [INQ000235335]). On receipt of a further draft on 17 March 2020, we responded to suggest that the Framework use a human rights approach, to help manage difficult ethical tensions. As part of this, we advised it should adopt the least restrictive option that will achieve a legitimate aim – such as keeping people free from infection – and urged DHSC to consider the aim of any decision, ensuring actions were proportionate and to avoid any blanket restrictions. (IT/125 [INQ000235336])

157. We also suggested that it was important to minimise psychological harm, as well as physical harm, including a review of care plans to put in place alternatives for people using a service to maintain contact with their loved ones whilst observing social distancing requirements and the impact of a change of routine on some vulnerable people. Unfortunately, our comments were not included in the publication on 19 March 2020 on this occasion, recognising the pace and volume of work taking place at this time.

Testing in Adult Social Care (ASC)

158. We raised concerns that incorrect information was being given about our role in testing. Because we had up to date contact details and the technology and contact centre functions necessary, we operated a booking service for social care workers to book a Covid-19 PCR (polymerase chain reaction) test at one of the public testing centres around the country. [IT/125a - INQ000225978] Despite our messaging, there was a level of misunderstanding, with some people contacting us with queries or issues that were best directed at DHSC to be resolved, having thought that we had overall responsibility for the wider planning and rollout of national testing. This was not the case – it remained the responsibility of Government and not CQC.

159. By the time the 'Gov Portal' self-referral site was online we were able to conclude our contribution to this process, having facilitated the booking of testing for over 40,000 ASC staff. Through a linked process, we also successfully piloted a programme of arranging home testing kits to be delivered to identified care homes so that they could administer tests to symptomatic residents themselves. Along with helping social care staff return to work where it was safe to do so, this process

also enabled us to provide Government, the NHS, Local Authorities and others with accurate, and therefore valuable, trend data on rates of infection and positive cases - who, where and when - helping them in their work to build an understanding of how the virus was spreading locally and nationally.

D. The public health and coronavirus legislation and regulations

Advice or briefings to Government regarding legislation and regulations proposed and enacted

160. The Inquiry has asked us for any advice or briefings we prepared and provided to the UK Government concerning the public health and coronavirus legislation and regulations that were proposed and enacted.

Easements

161. In March 2020, we commented on some draft clauses of the Emergency Coronavirus Bill in relation to what is referred to as the Care Act 2014 (CA 2014) 'easements'. Where some "duties" were set out in CA 2014 to meet eligible needs, they were to be replaced instead with a "power" to meet these needs. This was for the duration of the emergency period and subject to safeguards to avoid any breaches to the European Convention on Human Rights. Other legal provisions relating to the provision of care and support remained in place, including "duties" under the MCA 2005. In commenting, we made the point that there should be a stronger narrative in the guidance on the overriding message about prioritising saving lives. We highlighted the need to consider Deprivation of Liberty Safeguards and safeguarding (IT/126 [INQ000235337]).

162. Via our website, we shared the Local Authorities who 'switched on' the easements, to help people understand how and where they were being used. We discussed with our local Heads of Inspection any impact we were observing with the quality of care received within those areas and this was fed back where appropriate.

163. There was no change to our regulatory remit: it remained an offence to provide a 'regulated activity' in England without being registered to do so. There was no change to the requirement that we could not grant registration unless satisfied that

the provider or manager was able to meet the requirements of the regulations. However, we did offer some flexibility to providers. We committed to prioritising and fast-tracking applications from providers to vary their registration to increase bed numbers. Although we require submission of a Disclosure and Barring Service (DBS) check upon application for registration to consider any convictions, legal warnings, reprimands or cautions, in March 2020, there was revised guidance from the DBS which explained how providers could, for the duration of the emergency period, satisfy regulatory requirements in a revised way. We took this into account when assessing compliance with the regulations.

164. In June 2020, DHSC requested advice in relation to whether proposed changes in Wales mirrored those made in England. We responded to confirm that the proposals went further than those in England, particularly with regard to registration requirements, with the caveat that we were not sighted on the detail (IT/127 [INQ000235338]).

Mandatory vaccination[4] - care homes

165. In March 2020 we attended a meeting with DHSC at which mandatory flu vaccinations were discussed. DHSC sought views on how we could help in a scenario where vaccination became a mandatory legal requirement for health and care workers, such as requiring information through our inspection approach. DHSC stated their intention that forthcoming emergency legislation would address any lack of power for CQC to take action on this. The Government Legal Department (GLD) also approached our legal team for specific input into draft clauses on vaccinations proposed by the Office of the Parliamentary Counsel (OPC).

[4] Amendment to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; The Care Home Regulations 2021; The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021; Code of Practice on Infection and Prevention Control issued under s.21 of the Health and Social Care Act 2008.

166. We confirmed our position in relation to specific points raised, drew attention to existing offences in the legislation which could warrant enforcement action and referred to the need for guidance on the meaning of 'reasonable steps'.

167. In June 2020, DHSC further asked us for advice and support around mandatory vaccinations. I confirmed to DHSC that we were supportive of widespread vaccinations but that we were unsighted on the detail of the proposal and could not agree to enforce mandatory vaccinations (IT/128 [INQ000235339]). It was confirmed that this was not the intention.

168. In March 2021, DHSC confirmed that the mandation of Covid vaccination in older people's care homes would be proceeding. We were asked to comment specifically in relation to definitions to be used; evidence of vaccination; potential repercussions for providers and CQC enforcement; and inspections post-policy change.

169. We highlighted issues around proposals for such a duty to apply to 'older adult' care homes (rather than all those registered with CQC) and how implementation would be monitored or enforced. At this stage, without having sight of the proposed legislative changes, we were not able to comment in any detail and confirmed we would need to review proposals once this was made available (IT/129 [INQ000235340]).

170. When meeting with DHSC and with the Minister for Social Care, we noted that we were disappointed that the proposals would not cover health as well as social care and highlighted the inequality of approach. We also noted that we were wary as to the reaction of the ASC sector to this announcement and the need to avoid unintended consequences (such as exacerbating workforce challenges) (IT/130 [INQ000235341] and IT/131 [INQ000235342]).

171. DHSC subsequently provided their draft consultation document and invited comment, particularly on our role, enforcement and inspection. We provided comments as requested along with some more general reflections and clarification that in instances where Regulation 12 (the requirement to assess risk and prevent

the spread of infection) is breached we will consider enforcement action (IT/132 [INQ000235343] and IT/133 [INQ000235346]). We were also asked to comment on additions to the Code of Practice on the Prevention and Control of Infections and Related Guidance, which we did, including in relation to the proposed definition of 'care homes' (IT/134 [INQ000235347]).

172. When DHSC circulated the consultation document for final review we responded with general comments, in particular reiterating that there is no definition of 'older adult care homes' (as proposed for the legislation) and the difficulties this might pose. We also noted the need to identify which visiting professionals were to be included in the scope. DHSC asked us for further input into a definition of 'older adult care homes'.

173. In May 2021, we confirmed our preference that all registered care homes be included in scope. We subsequently suggested that, with some caveats, a definition of 'accommodation for people who require nursing or personal care', may be feasible, but still highlighted the inequality of this approach. We also commented on potential issues with allowing entry to visiting professionals (IT/135 [INQ000235348] and IT/136 [INQ000235349]).

174. At this stage, we also advised of the need to amend either Regulation 17 or Schedule 3 to the 2014 Regulations[5] to impose a duty to retain information about vaccination status, with a corresponding ability to do so under GDPR, in order to have something to check against when inspecting.

175. At DHSC's request, we submitted further comments in relation to a submission to Ministers. We noted that the guidance was now planned to be applicable to all CQC-registered care homes, as we had suggested (although note that we had previously expressed disappointment in the inequality of approach in not also applying this to health referenced in paragraph 170 above). We also noted that visiting professionals would be within scope and reiterated potential challenges around holding providers responsible for the vaccination status of visitors. We

[5] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

recommended the need for a clear and consistent method for demonstrating vaccination status and the need for clear guidance for providers. We set out our current civil and criminal enforcement powers, including the legislative basis, and the methods for our decision-making (IT/137 [INQ000235350]).

176. In June 2021 DHSC invited us to comment on further additions to the Code of Practice. We did so in relation to some use of language and phrasing; the practice for retention of evidence; and inspection expectations. We provided further comments, on request, on the updated version in relation to visiting professionals. In July 2021, DHSC requested our comments on proposals for an Impact Statement to be tabled to members of Parliament explaining the regulations; and comments on updated Code of Practice proposals, both of which were provided (IT/138 [INQ000235351] and IT/139 [INQ000235352]).

177. In September 2021, DHSC asked for our comments on medical exemptions for vaccination where vaccination was a condition of deployment in care homes. We responded to confirm our concerns (addressed further below at paragraph 206) and our suggestions to include clear guidance around implementation and timelines. On request, we provided further general comments and queries around the proposed text IT/140 [INQ000235353] and IT/141 [INQ000235354] - IT/142 [INQ000235355]).

178. In December 2021, DHSC asked for views on operational guidance and some limited comments were provided from a legal and operational perspective (IT/143 [INQ000235356] and IT/144 [INQ000112095]). We subsequently provided some broader comments on an updated draft in late December (IT/145 [INQ000235358] and IT/146 [INQ000235359]) and early January (2022) (IT/147 [INQ000235360] and IT/148 [INQ000235362]). Our main comments were regarding the language and phrasing used to ensure consistency and ease of understanding.

Vaccination policy in NHS

179. In July 2021, DHSC requested comments in relation to the practicalities of mandatory vaccinations applying in hospital settings. We explained at a high level

the main differences in approach and some of the difficulties this might present, particularly from an enforcement point of view. We suggested that we could offer further advice if DHSC had a more clearly defined scope of their current thinking available for review (IT/149 [INQ000235363]).

180. Following a meeting at DHSC's request, further advice was offered on draft scope options. We highlighted potential difficulties with the approach and suggested a settings-based approach with a suitable list of caveats / exemptions. We also set out our expectations in relation to enforcement and explained that these would be dependent on the precise amendments (IT/150 [INQ000235364]). We were then asked to comment on the draft policy, giving some limited comments on possible enforcement options, where proportionate, and general comments such as distinguishing between flu and covid vaccinations (IT/151 [INQ000235365]).

181. In August 2021, we were asked to comment on some additions to the Code of Practice in relation to mandatory vaccinations in healthcare settings. We provided some limited and general comments on this and a draft consultation document (IT/152 [INQ000235366] and IT/153 [INQ000235367]).

182. In November 2021, DHSC asked for our input to establish an agreed position on activities to be considered 'in' and 'out' of scope of the regulations when referring to 'provision of the regulated activity' in relation to vaccinations. They suggested various scenarios along with the proposal for the scenario to be included or exclude and we provided some very limited comments to suggest further clarification of context may be helpful (IT/154 [INQ000235592]).

Infection Prevention and Control (IPC)

183. IPC was already a feature of our comprehensive inspection methodology, but in August 2020 we developed a bespoke IPC tool with input from PHE. Using this IPC tool we looked at how well people using a service were kept safe from the spread of infection, using a pre-agreed list of areas that we would assess on every care home inspection regardless of the original trigger for inspection. This '8 ticks of assurance' list, the outcomes of which we published on our website, covered:

visitors; shielding; admission; use of PPE; testing; premises; staffing; and policies. It was designed to help support best practice in care homes and to give the public an up-to-date view of IPC practice within that setting.

184. In September 2020, following a meeting with the Minister of State for Care and in response to a request from DHSC, we provided a note to DHSC setting out our current approach to IPC in care homes (IT/155 [INQ000235368] and IT/156 [INQ000235369]). This included our focus; gaining assurances; enforcement action (including the relevant legislative powers and their limitations); and planned communications. There had been a suggestion from the Minister that it might be appropriate for us to issue on-the-spot fines, so we explained in the note that this would not be within our powers.

185. In October 2020 we updated our approach to inspect automatically any care home where we had received credible information about IPC problems, regardless of the rating of the service. Previously, automatic inspection on receipt of a concerning information would only apply to those services we had rated Requires Improvement or Inadequate.

186. The amendment to the Code of Practice on Infection Prevention and Control, and its associated guidance, was issued by the then Secretary of State under section 21 of the 2008 Act. Providers were required to have regard to this Code of Practice when complying with obligations under Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff movement

187. In October 2020, DHSC requested our input on a developing a 'staff movement' policy. This was to require providers not to use staff who were attending more than one care setting, and to keep records to demonstrate their compliance on inspection (IT/157 [INQ000235370] and IT/158 [INQ000235372]).

188. This was originally proposed as a change to Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Our comments included noting

the practical issues, for example that as we did not have a presence in every care home in England we could only rely on our usual monitoring approach (including assessing information from the public, people using services, their families and staff). We were clear that any breach would not necessarily mean civil enforcement action (in line with our regular enforcement approach) but a proportionate, consistent judgement would be made based on an assessment of the available evidence (IT/159 [INQ000235373] and IT/160 [INQ000235375]).

189. In November 2020, we set out our response to the consultation on changes to Regulation 18 (IT/161 [INQ000235376]). We continued to have concerns around the impact the proposed changes in the Regulations would have on some of the poorest paid workers and how the Government would ensure they were sufficiently compensated to avoid detrimental impact, noting the ongoing recruitment challenges faced by providers.

190. We noted complications that would occur for providers of services for people with learning disabilities / autism / Acquired Brain Injury (ABI) who may have a mix of residential and supported living settings, with little practical difference in how these are operated and staffed, but under the proposals would be required to draw a distinction and segregate staff accordingly. We also set out insight and thoughts on potential implications received from providers and trade bodies, including under-staffing in the provision of care for people who may have complex needs, and the financial and wellbeing impact on carers having their work limited in this way.

191. The decision to change Regulation 18 was not taken forward and DHSC confirmed that instead stronger guidance would be issued. In January 2021, DHSC requested comments on the guidance. We suggested issuing supportive guidance rather than formal requirements along with some suggested phrasing around our involvement in monitoring and inspection (IT/162 [INQ000235377]).

192. As with IPC, we updated our approach to inspect automatically any care home where we had received credible information about problems in relation to staff movement, regardless of the rating of the service.

193. During the Specified Period the issue of care sector staff continuing to work despite being Covid-19 positive was a concern which featured across a number of Government policy areas. This was for a number of reasons, including the regulation of sick pay. The Minister of State for Care, Helen Whately MP, was concerned about this issue and considered a range of approaches to attempt to mitigate the consequences, including suggesting that referrals be made to the police.

194. We were keen to be supportive of providers and people working in social care settings and to ensure the proportionality of actions, noting the impact on care staff.

195. In January 2021, we reviewed and agreed to the publication of a joint statement with DHSC and other organisations (IT/163 [INQ000235378]), making clear that it was unacceptable for staff who had tested positive for Covid to continue working. We sought to provide some context for DHSC from our regulatory perspective and findings from our IPC approach.

196. We commented on a number of related government guidance documents referenced elsewhere within this statement, largely confirming our role and how our IPC approach picked up issues relating to Covid positive staff continuing to work.

197. We developed a reporting system, used both internally and to provide assurance to the Minister for Care. Our reporting system focused on three categories:

    a) Where staff deliberately withheld their Covid positive status from their employer (and when told, the employer took appropriate disciplinary action);
    b) A local system decision, based on risk analysis, where certain staff were allowed to keep working while asymptomatic due to specialist care capacity requirements and the lack of alternatives; and
    c) Where a provider and their staff colluded to intentionally keep a positive test quiet – there were only a very small number of these instances.

198. It became clear that there were complications around how the national guidance was being implemented locally and regionally which led to mixed responses about how to manage the situation. We didn't support care workers being referred to the police as we were finding many nuances in the cases we encountered.

199. At the regular meetings with the Minister, we shared the data collected in this context and reassured the Minister that the data indicated that this was not a significant issue. In May 2021, in response to a proposed letter from the Minister requesting further action from CQC, we provided a draft response setting out our regulatory perspective and findings from our IPC approach: that the joint statement published earlier in the year had been effective and that the scale of this issue was minute (equating to approximately 0.013% of providers). We confirmed that, in our view, appropriate action had already been taken and explained this. We reiterated our position and the limited scope within which we could carry out any further action (IT/164 [INQ000235379]).

Registration exemption for testing

200. In October 2020, DHSC approached CQC regarding further amendments legislation to exempt Covid tests themselves from being a regulated activity and therefore removing the requirement for registration. Legal and registration colleagues attended several meetings with DHSC and provided some views. (IT/165 [INQ000235380] and IT/166 [INQ000235381])

201. On 15 December 2020, the law changed and testing was exempted as a regulated activity under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This meant that any testing activity in relation to Covid-19 was taken out of scope of CQC registration. The new Coronavirus, Testing Requirements and Standards (England) Regulations 2020 instead required all private coronavirus test providers to become accredited by the United Kingdom Accreditation Service (UKAS).

Concerns raised with the UK Government about legislation / regulations / guidance proposed and enacted

202. The Inquiry has asked whether we raised any concerns with the UK Government about the scope of the legislation, regulations or guidance proposed and enacted in response to Covid-19. Concerns raised regarding the scope of legislation, regulations or guidance were limited and in direct response to UK Government (generally DHSC) requests for comment in relation to proposed drafts. The following paragraphs provide some examples.

203. Further to our input into the guidance regarding admissions to care homes (detailed above), DHSC again requested our input into updated guidance drafts in May 2020. Along with some specific comments on the document itself, we also raised general concerns regarding how realistic the proposals were, particularly with regards to settings with people living with dementia or people with limited mental capacity, as well as the need to consider increased costs given the need for increased staffing levels and PPE IT/167 [INQ000235382] and IT/168 [INQ000235383]).

204. When asked to comment in relation to mandating vaccines in 'older adult care homes', we highlighted that the legislation within which we operate does not draw distinctions based on age and that a simpler approach would be to include all registered care homes. In addition to raising the issue of inequality of approach between health and social care settings (detailed above at paragraphs 169-173) we also raised the issue of inequality in this approach as a concern. During ongoing discussions, these concerns were reiterated and examples of problems outlined. Ultimately the guidance brought all care homes into scope.

205. We raised and reiterated potential challenges around the scope of the definition of a 'visiting professional' to be used. We also highlighted issues with holding a registered provider responsible for ensuring the vaccination status of a visiting professional, in terms of practicality, from an enforcement point of view, and in relation to the risk of negative impact on the health of people using the service.

206. When asked to comment in relation to proposals for temporary exemptions for vaccination we explained that the position was quite unhelpful – both from a

regulatory perspective, and more importantly, for providers. We noted that these proposals would have a significant impact on care home staff, and particularly registered managers, already under immense pressure. We suggested that an alternative option would be delaying the enforcement date, to mitigate risk and avoid confusion, but recognised that this was not a preferred option. We highlighted a 'real risk' in terms of timeframes for communications and that clear guidance would be essential (IT/140 [INQ000235353]).

E. Collection and dissemination of data between UK Government and health and social care sectors

207. During the Specified Period we took the lead or became involved with gathering, analysing and sharing data and intelligence to help build local and national oversight of how providers, across health and social care, were being impacted by Covid-19 on a day-to-day basis. The Inquiry has asked about the extent of our role in the collection and dissemination of data between the UK Government, the NHS and the health and care sectors (including the Office for National Statistics) in respect of the Covid-19 pandemic. The section below sets out some of the key areas in which we played a role, together with some of the key dates of communications or interactions with relevant external stakeholders.

Data about numbers of deaths

208. As the regulator of health and adult social care in England, we received a wide range of data and information directly from providers and the public. Statutory notifications are the most routine and structured data we received from providers, in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. Providers of health and adult social care services are required to inform us when certain events happened. All statutory notifications follow the same approach.

209. Such events include, but are not limited to, allegations of abuse[6], death of a person using the service[7], death of a patient detained under the Mental Health Act[8], and serious injury to a person using the service[9].

210. In particular, Regulations 16 and 17 provide that we are to be notified by service providers registered with us when the death of a person using a service occurred when either of the following happens:

- the person died while a regulated activity was being provided; or
- the death may have been a result of the regulated activity or how it was provided.

211. Notifications about deaths must be sent to us 'without delay' (defined in our ASC Guidance for providers on notifications as meaning as soon as can be reasonably achieved). Providers send their notifications directly to us, other than when the exemption provided in Regulation 16(2) is applied. This exemption provides that for certain notifiable deaths that occur in an NHS registered service, providers are not required to inform us directly if they had already reported this death to NHSE as a patient safety event. Providers use the designated forms on our website to make such notifications.

212. ASC providers who notify us of a death are required to tell us of deaths of those who use their service regardless of where the death occurred, including when in hospital. This means that a death of a care resident reported by a residential care provider may also have been reported by an NHS hospital to NHSE.

213. Prior to March 2020, when a notification of this kind was received, our NCSC colleagues would input some of the information contained within the form into specified fields within our Customer Relationship Manager System (CRM). This information was then used for analysis purposes. However, the form contained information other than that which was required for the specified fields in CRM, for

[6] Regulation 18(2)
[7] Regulation 16
[8] Regulation 17
[9] Regulation 18(2)

example, details about place of death. Accordingly, the completed form was saved as an attachment to the record so that it could be viewed in its entirety by relevant inspectors for the service. At that time we did not analyse or report on place of death data as there was not a specified field within CRM.

214. In March 2020, we agreed to re-open data sharing channels with DHSC that had been previously established and utilised for a limited period in 2019 to share summary notification data by Local Authority to support EU Exit preparedness and response activity. We agreed to use this channel to facilitate sharing information related to ASC notifications being received by us. We have highlighted some of the significant interactions below to provide the context for the approach taken.

215. On 3 March 2020, we met with DHSC to discuss what information would be useful and how it could be shared.

216. After various email communications discussing timing and frequency of data sharing, we started providing data to DHSC on 23 March 2020 (IT/169 [INQ000235385]; IT/170 [INQ000235386]; IT/171 [INQ000235387]; IT/172 [INQ000235388] and IT/173 [INQ000235389]). The data was provided on working days initially and covered the number of notifications received for Care Homes (Nursing), Care Homes (Residential) and Domiciliary Care Services, summarised to Local Authority level, for the following statutory notifications (SN):

- SN16 – Death of a service user
- SN18 – Other incidents (including serious injury, abuse or allegation of abuse, events that prevent or threaten to prevent the carrying on of a regulated activity safely)

A copy of the data file shared is attached as (IT/174 [INQ000235390]).

217. On 25 March 2020, additional data was added to include:

- Total number of registerable services registered
- Total number of registered services submitting notifications
- SN17 – Mental Health Act Deaths

An example of the updated data set dated 29 March 2020 is attached as exhibit (IT/175 [INQ000235391]).

218. Daily situational report (sitrep) files were shared with DHSC, via a separate DHExchange, an area created by DHSC for exchange and sharing of information, on working days from 23 March to 17 April 2020. The regularity of the data sharing was increased to include Sundays from 18 April 2020. This continued until April 2022.

219. We understand that DHSC used this data to develop a Stata CQC notifications tracker (an automated reporting tool on DHSC Exchange). The first version was uploaded on 7 April 2020.

220. When receiving death notifications during February and March 2020, colleagues in the NCSC reviewed free-text information contained within the forms to identify whether the death involved Covid-19 or not. However, testing was not yet widely available, making deaths attributed to Covid-19 hard to confirm.

221. Our SN16 notification form was updated on 9 April 2020, and from 10 April 2020 providers were informed that when making a notification they should use the revised form to notify us if the death of an individual under their care was as a result of confirmed or suspected Covid-19 infection. This information was then recorded in CRM to enable us to analyse it. At this time, we also used a new specified field in CRM to record place of death information for analysis purposes. The new information related to Covid deaths was included in our daily sitrep reports to DHSC from 27 April 2020 (IT/176 [INQ000235392] and IT/177 [INQ000235393]).

222. On 10 April 2020 our then Chief Inspector of ASC Kate Terroni attended a meeting with the Minister for Care, Helen Whately MP and others from DHSC where they discussed making this data available publicly. An email confirming actions to be taken forward from that meeting is exhibited at (IT/178 [INQ000235394] and IT/179 [INQ000235395]).

223. Noting that the number of deaths reported to us was increasing, we collectively felt that this data should be made visible publicly but that it needed to be done in a way that did not add confusion. At that time, the main data in the public domain on Covid deaths were the NHSE data on Covid deaths, which were being reported daily. There was some overlap with our death notifications reported by ASC providers. The Office of National Statistics (ONS) were also working towards publishing data on Covid death registrations at this time.

224. Conversations took place from 10 – 13 April 2020 between DHSC, ONS, PHE and us (IT/180 [INQ000235396]) to understand the data that the different organisations held or were planning to produce. We were keen to validate the large increase in death notifications being received and believed that comparing with what ONS held through official death certifications was the best means of validation.

225. Through these conversations and some early analysis, we became increasingly confident that our daily death notifications could potentially present an early indication of what ONS official deaths reporting would show a few weeks later. Death registration data is often incomplete for some time after a death pending registration and completion of a death certificate.

226. A meeting was held on 14 April 2020 attended by representatives from DHSC, PHE and NHSE focused on development of a new measure of Covid deaths that would become the headline figure and would include community deaths and deaths in hospital. Given the evolving discussions on publishing data from our death notifications, we joined the call and there was a brief discussion of the options available to publish our death notifications data. The emerging consensus was that rather than a standalone measure being published by us, the data should be published as part of a more rounded description of what was going on. Actions arising from the meeting required us to link up with ONS on their data publication. Details of actions agreed were shared after the meeting by email (IT/181 [INQ000235397]).

227. Later on 14 April 2020 we shared our proposal with ONS for the publishing of the deaths notifications as part of the ONS weekly bulletin. ONS were receptive to our proposal, and we agreed to work towards inclusion of our data in the ONS weekly

bulletin from 28 April 2020 (IT/182 [INQ000235398] and IT/183 [INQ000235399]). This timeline allowed us sufficient time to: (1) validate that our data was a sufficiently good indicator of the ONS official deaths registration; (2) create a clear description of what the data was and was not; (3) align on the format for presenting this effectively; (4) carry out checks to remove any duplicate records; and (5) to ensure we engaged the Office for Statistics Regulation (OSR) sufficiently to publish this data in line with their code of practice.

228. On 16 April 2023 ONS provided us with the daily counts of death certificates from 1 February 2020, enabling us to validate that counts of death notifications were sufficiently similar. Having undertaken a provisional comparison we felt confident that our data could be used as a leading indicator for the deaths that ONS would later record as official deaths from death certificates (IT/184 [INQ000235400] and IT/185 [INQ000235401]). With ONS's support, we produced a transparency statement detailing how the data is captured, what we would do with it, and how it compared to other similar data sources (IT/186 [INQ000235402] and IT/187 [INQ000235403]).

229. On 26 April 2020 we shared the first set of tables on the number of deaths of care home residents for 10-24 April 2020 with ONS (IT/188 [INQ000235404] and IT/189 [INQ000235406]).

230. A data access agreement for sharing the daily data with DHSC was signed by DHSC on 19 May 2020 (IT/190 [INQ000235407]).

231. From 28 April 2020, death notifications received by us were released by ONS (IT/191 [INQ000235408]; IT/192 [INQ000235409]; IT/193 [INQ000235410]; IT/194 [INQ000235411]; IT/195 [INQ000235412]; IT/196 [INQ000235413]; IT/197 [INQ000235414] and IT/198 [INQ000235415]).

232. Data was reported by ONS on a weekly basis every Tuesday. This included CQC deaths data where we had been notified of the death by 4pm on the previous Friday. We provided weekly deaths in 4 views:

- Total deaths
- Deaths reported as involving Covid-19

- Deaths by Local Authority
- Deaths by place of occurrence.

233. Weekly reporting to ONS evolved over the Specified Period but remained in place. Our data has also been included in the following publications made by ONS:

    - Deaths involving Covid-19 in the care sector, England and Wales, released on 15 May 2020 (IT/199 [INQ000235416])
    - Deaths in the Care Sector, England and Wales 2020, released on 2 December 2021 (IT/200 [INQ000235417])
    - Deaths of care home residents, England and Wales 2021, released on 22 November 2022 (IT/201 [INQ000235418]).

234. On 14 May 2020, we published an update regarding our intended work regarding the impact of Covid-19 on autistic people and people with learning disabilities (referenced in paragraph 73 above). Following a request from the BBC we released figures to show a provisional number of deaths reported across all settings where autistic people and/or people with a learning disability lived for a defined period (10 April – 8 May). We wanted to better understand the impact of Covid-19 on specific groups through analysis of the data already being submitted about deaths and which was already being published as part of the ONS reports, so whilst sharing these initial provisional numbers we explained how we would undertake further detailed analysis to develop a more accurate understanding (IT/28 [INQ000235530]).

235. With the support of ONS, we completed a targeted analysis to better understand the impact of Covid-19 on people with learning disabilities using the data submitted to us by care homes and published by ONS. This analysis looked at all deaths notified to us between 10 April and 15 May 2020 from providers registered with us who were providing care to people with a learning disability and / or autism. The findings were published on 2 June 2020 (IT/202 [INQ000235420]).

236. On 22 May 2020, we shared the first location level report and historical data set (it was set at Local Authority level prior to this) with DHSC. The time frame used was

1 March to 20 May 2020. This was also shared via the DHExchange secure portal. An example report is attached at exhibit (IT/203 [INQ000235421]).

237. On 17 June 2020, we published data on deaths in care home settings broken down by ethnicity. Supported by ONS, targeted work was completed to analyse the impact of Covid-19 on different ethnic groups in care settings. The data published included death notifications in adult social care settings from 10 April -15 May 2020 (and the equivalent period in 2019). The data indicated a disproportionate number of deaths among people from Black, Asian and Minority Ethnic groups. (IT/204 [INQ000235422])

238. During the specified period we also shared death data information on request with other key system partners or external stakeholders, for example:

239. On 9 April 2020, an individual in the Housing and Planning Statistics team in the Ministry of Housing, Communities and Local Government (MHCLG) (now known as the Department for Levelling Up, Housing and Communities) sought access to deaths in care homes data via DHSC. DHSC granted access to the DHExchange portal - email confirming agreement is exhibited at (IT/205 [INQ000235423]).

240. On 5 July 2021, following receipt of a signed Information Sharing Agreement, access for PHE to the DHExchange portal was confirmed (IT/206 [INQ000235424]).

241. The data was also made available on request via the DHExchange portal to universities and researchers where the request was deemed to be in the public interest. The data was shared with researchers and data scientists pursuant to the Information Sharing Agreement. Some examples include, a member of the Government's scientific pandemic influenza modelling subgroup (SPI-M) which informed SAGE (Scientific Advisory Group on Emergencies) (IT/207 [INQ000235425]), a data scientist (IT/208 [INQ000235426]) and a Senior Lecturer in Health Policy and Economics (IT/209 [INQ000235427]). At the request of DHSC, we also agreed that access could be granted to the Vivaldi Care Home Study research team (IT/210 [INQ000235428]).

242. We went on to release publicly the death data in July 2021 on our website in a dashboard format for the period 10 April 2020 to 31 March 2021 (IT/211 [INQ000235430]).

243. We used this data internally also to:

- understand regional variations and pressure points, so our Inspectors could prioritise contact with those providers who were in greatest need of advice and support; and
- understand if there was any correlation between the number of Covid-19 related deaths and the quality of care being delivered in a setting, so we could act accordingly.

244. The daily reports to DHSC evolved over time. For example, in November 2020 we added place of death to the location level report at DHSC's request. In December 2020 we amended the categorised services of the local level report in the main data set necessitating sharing of revised data with DHSC. In May 2021 we identified some minor errors in the data capture processing which required rectification. Although these errors did not materially impact the overall insights provided by the data, nevertheless detailed corrections were shared with DHSC and ONS (IT/212 [INQ000235431] - IT/213 [INQ000235432]).

245. Discussions started with DHSC in early September 2021 about the addition of our location level reporting to their new platform for data sharing, Azure Blob store platform for EDGE (Environment for Data Gathering and Engineering). An additional data sharing agreement covering this method of sharing was completed on 10 September (IT/214 [INQ000235433] and IT/215 [INQ000235434]).

246. Following a request from DHSC, received on 17 March 2022 (IT/216 [INQ000235435]), our sharing of this data with DHSC was amended to weekly, on Wednesdays, from 23 April 2022.

247. During the specified period we also received a number of ad hoc queries and requests for death notification data from several external organisations including DHSC, Local Authorities, voluntary organisations, ONS and National Audit Office.

The Data Requests log attached as IT/217 [INQ000235436] sets out the summary of requests and queries received.

Home Care Tracker

248. Prior to the start of the pandemic the NHS utilised a Capacity Tracker online tool (established in 2019 by North England Commissioning Service - NECS) for NHS services, enabling these providers to share vacancy and other critical information easily and quickly. At that time there was no such tool or national oversight of ASC service provision, either for care homes or home care/domiciliary care (services who provide care for people in their own homes).

249. In early March 2020, our Covid-19 response structure worked to define the challenges for all providers, considered what data collection processes already existed, what new information we would need, and how we could begin to source it.

250. Recognising the need for collaboration across the health and social care interface, but wishing to avoid placing an increased demand on providers (particularly avoiding duplication of requests) we sought to engage with NHSE in the knowledge that some NHS Covid-related emergency data collections were already taking place. Unfortunately, the data requested was unable to be shared due to its confidential nature (IT/218 [INQ000235437]; IT/219 [INQ000235438]; IT/220 [INQ000235439]; IT/221 [INQ000235440]; IT/222 [INQ000235441]; IT/223 [INQ000235442] ;IT/224 [INQ000235443] and IT/225 [INQ000235444]).

251. Meanwhile, NHSE proceeded with plans they had to develop their existing Capacity Tracker online tool, expanding it to capture data from care homes on Covid-19 specific issues, such as levels of PPE, positioning it as a national tool for reporting Covid-19 related information from the sector.

252. After engagement with key partners, and in order to support and fill the gap relating to the homecare sector, we decided to take a lead in collecting the equivalent data collection of domiciliary care, for a short-term period. With the support of DHSC we sought to create our own method of collecting relevant data from this sector.

Working with Microsoft and KMPG we developed an online survey, which became known as the Domiciliary Care Agency Tracker (DCA Tracker). The survey asked providers to share with us details of the issues they faced so that local, regional and national support could be mobilised. We tested our question set with key partners such as the Association of Directors of Adults Social Services (ADASS), the Local Government Association (LGA) and DHSC.

253. On 13 April 2020, our pilot DCA Tracker was launched to all Domiciliary Care providers as an online survey, with Shared Lives, Supported Living and Extra Care Housing following in June 2020. Through the daily survey we gained information on topics such as staff sickness and Covid-19 related absences, available capacity within the service, admissions status, levels of PPE and testing kits.

254. On 17 April 2020, we rolled out use of the DCA and issued a joint letter together with DHSC, NHSE and NHS Improvement (NHSI) and the CPA, to all ASC providers, updating on data collection and making it clear exactly what providers were expected to complete (IT/226 [INQ000235452]).

255. As well as using the data internally to guide how and where we prioritised support, from early May 2020 we shared information daily using the DHExchange workspace. Access to this workspace was given to key partners such as DHSC, NHSE regional cells, Local Authorities (via LGA), Clinical Commissioning Groups and Local Resilience Forums, and weekly with Ministers, NHSE national and MHCLG to support national planning.

256. The DCA Tracker and NHS Capacity Tracker ran concurrently until 30 November 2020, when the data from our tool was moved into a new Home Care section of the NHS Capacity Tracker – meaning providers across **all** sectors only needed to use one system. We supported DHSC with communication around this which included targeted messaging to home care providers on 24 November 2020 (IT/227 [INQ000235454]).

Market Oversight

257. The Care Act 2014 (CA 2014) places a statutory duty on CQC to assess the financial sustainability of potentially 'difficult to replace' ASC providers. Our Market Oversight scheme aims to do this by providing local authorities with advance notice of the likely cessation of one or more regulated care service as a result of their likely business failure. The number of provider groups within the scope of the Market Oversight Scheme varies but typically is around 60 and represents about a quarter of ASC provision in England. Some of the groups operate in other parts of the United Kingdom.

258. This advance notification is designed to assist local authorities in discharging their obligations under section 48 of CA 2014 to ensure temporary continuity of care for all people using an impacted service. In the first half of 2020, we noted that a large number of providers began to change their statement of purpose and change their capacity through the Covid-19 Registration Framework. As reported in our *State of Care* report 2020/21, this was in part due to care homes having to cancel their registration to provide nursing care because their attempts at recruitment failed. At the same time, many providers saw a reduction in people using their services.

259. Whilst our registration service was swiftly managing the change in registration process and handling applications at pace, we considered that it was vital that a process was put in place to offer a 'real-time' view of the changing nature of occupancy within care homes for older people. It quickly became apparent to us through our provider engagement generally that this was a gap not being covered or in-train with any of our system partners.

260. Meanwhile colleagues in our Market Oversight team decided to use their existing relationships with ASC providers in our Market Oversight Provider Scheme to begin collecting data on occupancy levels within care homes for older people or care hours of home care providers. They used this to build a picture of how, at a consolidated level, Market Oversight Providers were being affected by the pandemic. Utilising information from various sources, namely (1) information that we were already routinely gathering from providers; (2) data from our DCA Tracker; and (3) the responses to an initial and then, from November 2020, weekly occupancy surveys, we were able to develop a relatively good data set which

enabled us to track occupancy on a weekly basis. The survey sought information about financial occupancy, short term Covid-19 block contracts, admissions and occupancy projections.

261. We analysed the results to prepare qualitative narratives of the data for internal use to feed into individual provider risk analysis. The additional occupancy data was used to supplement the analysis we had already been providing prior to the pandemic. The consolidated trending and analysis of this Occupancy data was also shared with Market Oversight Providers (providers saw their own data mapped against average figures and a subset of providers based on percentage of private funding), DHSC and Treasury and to inform briefing slides prepared for Ministerial meetings. We produced quarterly consolidated analysis which included this information in October 2020, February 2021 and May 2021. This analysis was used:

- to form our own internal understanding of occupancy trending and risk relative to the performance of providers;
- on an ad-hoc, anonymised basis with providers who participated in the survey;
- in various Covid update reports to DHSC / ministers;
- to underpin numbers in DHSC Provider Viability Advisory Group (PVAG) reporting and discussion; and
- at a high level in quarterly consolidated data reports presented internally as part of quarterly governance process, externally to DHSC, other government and industry stakeholders, providing a high level view on the status of occupancy recovery.

262. During the Specified Period, Market Oversight colleagues attended meetings hosted by DHSC that covered emerging developments in market oversight as well as general trends. Dates and times of these meetings are included in the chronology at exhibit [IT/04 [INQ000235485]), These meetings were agile in the sense that the agenda covered emerging developments as well as general trends. A formal agenda would not ordinarily be prepared and minutes typically not taken. Also, bed data would only have been one aspect of a more general discussion.

263. These meetings were replaced in July 2021 by the PVAG, again hosted by DHSC. When appropriate and relevant verbal updates were provided on the challenges to the sector with reference sometimes potentially being made to occupied beds data collection.

264. Similarly, this type of qualitative data was discussed in meetings the team had with ADASS, Cabinet and Treasury colleagues as set out in the chronology exhibited at (IT/04 [INQ000235485]). These meetings were also agile in nature, formal agendas and minutes were not produced and bed data may not have always been discussed.

265. The team also provided expert input into wider government projects; including the McKinsey report commissioned by DHSC on *Covid-19 impact and response* (IT/228 [INQ000235455]).

Designated Settings and IPC Inspection Data

266. From 4 November 2020, we provided a CQC Designated Setting and IPC report to DHSC, MHCLG, NHSE and the Cabinet Office on the number of assured designated locations three times per week (IT/229 [INQ000235456] - IT/230 [INQ000235457]; IT/231 [INQ000235459]; IT/232 [INQ000235460] and IT/233 [INQ000235461]). The information from these updates was also used to inform Covid O meetings and ministerial briefings as appropriate.

267. We also developed and launched a dashboard for the data being collected about designated settings and the IPC inspections we were undertaking, enabling the Cabinet Office and DHSC to access it directly from the end of November 2020.

268. In November 2020, as part of our Covid-19 Insight: Issue 5 report we included a section reporting on how care homes managed IPC during the pandemic in 2020. This report sought to explore in more detail the results of IPC inspections undertaken in August and September 2020 (IT/234 [INQ000235462]).

269. From the end of February 2021, we reverted to weekly sharing of these reports with DHSC (IT/235 [INQ000235463]).

270. We updated our public messaging around this in April 2021, and key data in May 2021, taking the opportunity to highlight the fact that many providers were seeking to remove their designated settings status due to a reduction in demand (IT/236 [INQ000235464]).

Care Home Visiting Concerns

271. Early in 2021, we began collecting data related to care home visiting concerns. We developed an online Care Home Visiting Concerns Form to track information about this. Where there was evidence to suggest a care home was restricting or banning visits this information would be recorded and shared via our dashboard on an ad-hoc basis with DHSC and was included in ministerial briefings, as appropriate an example is exhibited at (IT/237 [INQ000235466]).

272. The information gathered on this was also used, as appropriate, to inform briefings, respond to queries and to provide updates. Some examples include:

- Our response of 23 March 2021 to a letter of 12 March 2021 from the Rt Hon Harriet Harman MP in her capacity as Chair of the Joint Committee on Human Rights, in which we explained our role in assessing concerns and our regulatory response in relation to care home visits (IT/238 [INQ000235467] and IT/239 [INQ000235468]).
- A letter to Matthew Style, Director General for NHS Policy and Performance Group and Michelle Dyson, Director General for ASC at DHSC on 14 January 2022 to set out our concerns around departures from DHSC's guidance by Directors of Public Health on visiting at that time (IT/240 [INQ000235469]).

Regulation 12(3) Breaches Breakdown

273. We also briefly collected data to highlight instances where Regulation 12(3)[10] was breached (staff not vaccinated) from November 2021 until February 2022, when the Government guidance changed. This information was used to inform ministerial briefings, as appropriate. An example is exhibited at (IT/241 [INQ000235470]).

CQC Publications

274. In addition to our regulatory function, part of our role was to use the insight we gained from providers and those receiving care to speak with our independent voice, reporting on areas of concern across the health and care landscape, ensuring representation for those we monitor, and where necessary, challenging policies and cultures that we believed may impact on the quality and safety of care. To achieve this we regularly carried out research and used our data and intelligence to produce public reports, such as our annual *State of Care* product, which offered sector insight and learning for partners and the public alike.

275. We also used our unique position within the health and social care landscape to carry out thematic reviews on areas and disciplines where we had particular concern, at times at the request of DHSC, but otherwise as a result of information we were gaining through inspections, whistleblowing or feedback from stakeholders or those who were receiving care.

i. **COVID Insight Reports**

276. During the Specified Period, we identified that it would be beneficial for us to collate and share the data and insights we were gathering from several different sources with providers and system partners at a national and local level.

[10] Regulation 12(3) of Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as amended by the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 and The Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No.2) Regulations 2022.

277. We decided to do this through our monthly Covid Insight Reports, designed so that we could share a contextualised and data-driven narrative about what was happening across health and social care, in light of the pandemic. We included information from internal sources including regulatory data, submissions to our 'Give Feedback on Care' portal, responses to surveys undertaken and themes and trends from website activity. We had both 'soft' information from our ongoing contact with providers looking at the problems they faced and 'hard' information on death rates from our collection of notifications data. We also included data from various external sources in this report such as ONS, PHE and NHSE. We started publishing these on our website in May 2020 and continued until January 2022 (IT/242 [INQ000235471]; IT/243 [INQ000235472]; IT/244 [INQ000235473]; IT/245 [INQ000235474]; IT/234 [INQ000235462]; IT/246 [INQ000235475]; IT/247 [INQ000235476]; IT/248 [INQ000235477]; IT/249 [INQ000235478]; IT/250 [INQ000235479]; IT/251 [INQ000235480]; IT/252 [INQ000235481]; IT/253 [INQ000235482]; IT/254 [INQ000235483] and IT/255 [INQ000235484]).

278. We determined the themes and content of these reports. Prior to finalisation and publication we sighted DHSC on the content, in line with our information sharing agreement, giving them the opportunity to review each report and provide us with any comments in advance of publication. In this way we continued to operate as an independent organisation whilst maintaining our accountability to Parliament and ensuring DHSC had the opportunity to consider any steps the government might choose to take in response to our reports to support their response to the pandemic.

279. We generally shared the draft on the Monday of the week prior to planned publication seeking comments by Friday, with engagement by email to confirm any amendments made or explanations for not making changes.

280. In advance of publication of the first report on 19 May 2020 we were asked to meet with the then Secretary of State, the Rt Hon Matt Hancock MP, to discuss the decision to produce and publish this report. We used this opportunity to explain the reasons for generating the report and how we considered it could assist the

health and care sector. We met with DHSC colleagues thereafter to agree an approach for future reports (IT/256 [INQ000235486] and IT/257 [INQ000235487]).

281. The reports were principally published on our website and highlighted to the health and care sector through our Provider Bulletins. The content and format of the reports slightly evolved over time when we incorporated statistical analysis, local and national context, findings from thematic reviews and learning across a number of key aspects of the sector's Covid-19 response.

ii. Covid Inpatient Survey

282. One of the regular data collections we make is the NHS National Patient Survey program. There are five surveys in this program each running annually or bi-annually. In August 2020, we commissioned a one-off Covid inpatient survey to capture the experiences of patients discharged from hospital during April and May 2020. We focused our questioning on those admitted with confirmed or suspected Covid-19, as well as those admitted for unrelated reasons. Evidence and learning from the survey was shared in a report published in November 2020. This report was published on our website (IT/258 [INQ000235488]).

iii. DNACPR Thematic Review

283. On 30 March 2020, we issued a joint statement, together with the British Medical Association (BMA), CPA and the Royal College of General Practitioners (RCGPs), to ASC providers and GPs stating the importance of advance care planning based on the needs of the individual (IT/259 [INQ000235489]).

284. From March to September 2020, we saw an increase in the number of submissions to our online Give Feedback on Care facility that related to DNACPR. The majority of this feedback raised concerns about DNACPR orders that had been put in place without consulting with the person or their family. Often the evidence we received was about an individual, but there were some examples where DNACPR orders were placed on numerous people routinely. We were also aware of publications

by other stakeholders highlighting this as a potential issue (set out in interim report).

285. On 7 October 2020, the Rt Hon Nadine Dorries MP wrote to us in her capacity as Minister of State for Patient Safety, Suicide Prevention and Mental Health, to request that we conduct a review, under section 48 of the Health and Social Care Act 2008, of DNACPR decisions taken during the pandemic in the context of advance care planning (IT/260 [INQ000235490]). The letter referenced concerns around the blanket application of DNACPR decisions. We were asked to look at 'all key sectors', including care homes, primary care and hospitals. Work started immediately to scope the issue and methodology to be used with key partners such as Disability Rights UK, Compassion in Dying, the BMA, GCGPs and CPA, among others. These stakeholders welcomed the review and demonstrated strong support for our work in this area.

286. In November 2020 we published our interim report, prior to starting the field work elements of our review (IT/261 [INQ000235491]). Our final report was then published on 18 March 2021 (IT/262 [INQ000235492]). Based on our findings we recommended that a new Ministerial Oversight Group be set up to look in depth at the issues raised in our report. The group we proposed included partners in health, social care, local government and voluntary and community services and was to be responsible for overseeing the delivery and required changes of the recommendations of the report.

287. The report made 10 recommendations and identified lead responsible bodies which included DHSC, NHSE, NHSX (from 2019 to Feb 2022, the NHSX unit had responsibility for setting national policy and developing best practice for National Health Service technology, digital and data, including data sharing and transparency - it is now part of NHSE's Transformational Directorate) and NHSI, amongst others. The report recommended that a Ministerial Oversight Group be set up to look in depth at the issues raised within. The Ministerial Oversight Group (MOG), led by DHSC and which included health and social care partners, local government, voluntary and community services in addition to ourselves, held its

first meeting on 8 June 2021. The MOG met quarterly throughout the remainder of the specified period.

iv. Provider Bulletins

288. Provider Bulletins are one of the ways we share messages and information with registered providers and professionals working in ASC services. Before the start of the pandemic we produced a monthly bulletin. However, from 13 March 2020 and for much of the Specified Period we issued them on a weekly basis with the aim of sharing the latest guidance on Covid-19 and our approach during this period.

289. We used these bulletins to convey key messages and highlight changes in practice and guidance. Subscribers or recipients of these provider bulletins are usually registered managers, nominated individuals and others in registered organisations in addition to anyone who signed up via our website to receive specific bulletins or news items.

290. A very small amount of bulletin content would have been shared with DHSC in advance for comment/approval where it related to joint statements / communications. On occasion we included DHSC messaging on their behalf, making it clear it was entirely DHSC content. Some examples are exhibited in (IT/263 [INQ000235493] and IT/264 [INQ000235494]). We continue to issue our own monthly Provider Bulletins.

v. State of Care Reports

291. The *State of Health and Adult Social Care in England Annual Report* (known as *State of Care*) is a statutory report that CQC is legally required to publish each year for Parliament. It objectively outlines the findings from our inspections of health and social care providers across England, highlighting any concerns we have and identifying potential problems within the system. During the specified period we published reports on 15 October 2020 and 21 October 2021 (IT/265 [INQ000235495] and IT/266 [INQ000235497]).

292. In each of these reports we used data and insights from a variety of internal and external sources. The reports were designed to add weight to our regulation of all services and to speak on behalf of people using services. It served to provide a view from our perspective of health and care, information and evidence to aid understanding, and, we hope, to shape the debate around how services need to change and improve.

293. The Inquiry asked us to consider if the systems for the collection and dissemination of data between the UK Government, the NHS and the health and care sectors worked effectively, and any recommendations for improving such processes.

294. We continue to engage with DHSC, NHSE, NHS Digital and other national partners on the Data Alliance Board (DAB), referenced below. This group aims to enable an efficient approach to the use and development of information about care services across national bodies. We are keen to continue to work with DAB partners to develop a more efficient and streamlined approach to collection and sharing of data about services, aiming to minimise the effort of information collections on providers of care. There remain opportunities to improve sharing of information across the member bodies of the alliance, which could include:

- the creation of a cross-system data catalogue documenting all datasets collected by each national body from systems, commissioners and providers of health and social care;
- a set of principles to be adopted by all Alliance members – including publication of transparency statements for each data collection;
- a review of processes for accessing data from partner bodies of the Data Alliance –including an opportunity to develop 'umbrella' data sharing agreements rather than data sharing agreements focused on each individual dataset.

295. The Inquiry has asked us to outline concerns or issues which we raised with the UK Government about the relationship between and operation of systems for the collection and dissemination of data between the care sector, the UK Government

and the NHS. During the specified period we wrote to UK Government in reference to the importance of data sharing and collaboration as set out below.

296. On 3 April 2020, we wrote to the Director of Adult Social Care at DHSC, Ros Roughton, to highlight messages from conversations we had had with representatives of ASC providers. A copy of this letter is attached at Exhibit (IT/267 [INQ000235498] and IT/268 [INQ000235499]). In sending this letter we wanted to convey a clear message around the importance of data provision and sharing.

297. We set out in that letter how we could use our existing expertise to create an overview of the multiple data sources that were capable of measuring the impact of COVID-19 on ASC providers and people using services. We set out our ambition to help to reduce the burden on providers. In this letter we sought authority and/or assistance from DHSC to:

- develop our information gathering approach and analysis with stakeholders;
- co-ordinate with respective analyst teams concerning the daily sitrep data feeds; and
- ensure clear communication regarding our agreed role to NHSE, PHE and other system stakeholders in health and social care.

298. On 15 May 2020, our former Chief Inspector of Hospitals, Professor Ted Baker, sent a letter to Amanda Pritchard, Chief Operating Officer, NHS England/NHS Improvement and Professor Stephen Powis, National Medical Director, NHS England/NHS Improvement. Within the letter we referenced national data and information sharing, noting that there had been at that point positive engagement between respective data and analytics teams.

299. We also noted that single points of contact had been established regionally to enable attendance at relevant cell meetings and to obtain relevant data sets and assurance mechanisms where required. In this letter we expressed the importance of continuing to build on this collaboration and information sharing at a regional

level and that the learning from this regional work should be taken to the National Quality Board. A copy of the letter is attached as exhibit (IT/269 [INQ000235501]).

300. On 29 June 2020, our Chief Inspectors Professor Ted Baker, Kate Terroni and Dr Rosie Benneyworth wrote to the then Secretary of State, Rt Hon Matt Hancock MP, seeking support with commissioning a programme of local system reviews and legislative change. In the letter we emphasised the need for collaboration across the organisational boundaries of health and social care sector, system working and oversight (IT/270 [INQ000235502]). A response was received on 21 July 2020 that confirmed that officials had been asked to continue to work with us on this (IT/271 [INQ000235503]).

301. On 29 July 2020, I wrote to the then Secretary of State by email referencing his letter of 21 July explaining we had been having discussions with key system partners such as the Nursing and Midwifery Council (NMC), General Medical Council (GMC), ADASS, NHSE/NHSI and NHSX about how we could work together to better manage information flows across health and care. In that email I proposed the creation of a health and social care 'Data Alliance' (IT/272 [INQ000235504]). The then Secretary of State responded later that day confirming support in principle for this idea (IT/273 [INQ000235505]).

302. Throughout August and September 2020 discussions around the development of a Data Alliance continued with key system partners and DHSC, resulting in the creation of the Data Alliance Partnership Charter and Board with NHSX, NHSE, CQC, NIHP, NHCD, DHSC, LGA/ADASS. The first meeting of the Data Alliance Board was held on 28 October 2020 and continued throughout the Specified Period.

303. As explained in my Witness Statement of 12 July 2023 submitted to the UK Covid-19 Inquiry in respect of Module 1, on 25 June 2021, I wrote to the Permanent Secretary concerning statements made in an Evening Standard article on 23 June 2021. I set out that a list of all adult social care providers within our scope of regulation, including all care homes registered to care for older people (the Care Directory), is publicly available on our website and is updated monthly. I also

confirmed that we did not receive a specific request for a list of care homes registered to care for older people. However, as the latest list had been published on 2 March 2020, in line with our monthly reporting, on 26 March 2020 we provided DHSC with a bespoke update of the Care Directory to ensure the information was as up-to-date as possible.

304. On 5 July 2021 I received a response from Michelle Dyson, Director General, Adult Social Care, on behalf of the Permanent Secretary.

305. On 27 January 2022, we wrote to the then Secretary of State for Health and Social Care, the Rt Hon Sajid Javid MP to offer support improving discharge from acute settings and the management of flow of people across the health and social care system (IT/274 [INQ000235506]). We set out how we could do that by:

- building capacity in ASC;
- giving DHSC regular access to our insight and information; and
- supporting local system collaboration.

F. Lessons Learned

306. The Inquiry has asked us to consider if we can identify lessons we learned as an organisation from our experience of the UK Government's decision-making in relation to the response to Covid-19, and any recommendations that might improve the Government's response to a future pandemic. As an organisation we did not undertake a formal lessons learned review to reflect on our experience of UK Government's decision-making in relation to the response to Covid-19. We have however undertaken internal reviews on issues that related directly to our governance and performance.

307. Any lessons learned must be taken in the context of a very fast moving uncertain situation that none of those involved had ever experienced previously. However, reflecting on the challenges we faced during the specified period three themes emerge:

Decision making

308. The model of decision making throughout the pandemic within Government was the same as the normal civil servant / minister relationship, with the majority of decisions referred to ministers and the result that they, and the senior civil servants supporting them, became overwhelmed. This meant decisions were rushed and little time appeared to be spent on longer term recovery planning, or fully considering the ramifications of the larger decisions.

309. As the tempo of work increased, and it became clear that the management of and response to Covid was a long-term activity, there could have been a conscious shift from 'crisis mode' to 'campaign mode' in order to move to a more sustainable way of operating.

310. Civil servants and others within arm's-length bodies could have then stepped in to make day to day decisions with lower delegation levels, especially for operational decisions. This in turn could free up ministers to be considering the longer term and more strategic decisions, planning for recovery, and discharging their public leadership role with the benefit of time to prepare more effectively.

311. Such a shift in decision making would need to contain clear triggers and thresholds for moving between crisis and campaign mode and back to normal running.

Data Sharing

312. Repeatedly there were challenges to sharing data between different agencies and with private sector operators (in health and social care). There were undoubtedly elements of over caution on some occasions but greater clarity on the ability to share data between credible providers for a positive purpose would be helpful.

313. Whilst structures such as the Data Alliance we have been working on with national partners are helpful on a day-to-day basis, a pre-set 'campaign mode' data sharing exemption, triggered through a democratic process, would mean that everyone

could feel they have appropriate legal cover to openly share data with each other provided it is for a reasonable intent.

National coordination of social care services

314. The NHS has for some time been coordinated by NHSE which meant that public healthcare, and the interplay with private healthcare providers offering surge capacity, was done by one organisation. This arrangement frees up local healthcare leaders to deal with the day-to-day operation of their organisation. During the pandemic the value of this single national franchise approach was evident as the NHS was able to talk with one voice to Government, using a common language and set of objectives.

315. No such central coordination of providers exists in social care. Local Authorities are expected to manage operators in their area. The market in England consists of around 14,000 different providers, some of whom are owner operators on one site, others are multi-site corporations. Most operators are privately owned, some are not for profit, and some are owned by overseas investors using complex corporate structures. The proportion of care purchased privately compared with that provided by councils varies from around 20% to 50% depending on the part of the country.

316. The pandemic improved the brand image of social care overall and raised its importance and profile with the public, with most probably now seeing it as part of the *national infrastructure*. In reality, it remains a very disparate and variable *marketplace*.

317. There were times during the pandemic when we took on some elements of the NHSE equivalent role for social care such as delivering the booking service for Covid testing, and communicating changes in national policy. However, combining this role with that of regulation would lead to problems in the longer term.

318. There is a need to consider how government better coordinates its work with social care so that is it managed in a much more structured way, that retains market agility but can be brought together more quickly in the event of a future pandemic.

319. The Inquiry also asked, if at all, we undertook any lessons learned review in relation to our input into the UK's decision-making in connection with the response to Covid-19. We have highlighted below some of the reviews commissioned during the Specified Period which reflected at a high level on our approach and decisions which contain some, albeit limited, reference to our interactions with the UK Government and / or other stakeholders.

Covid-19 Chronology and immediate lessons

320. In 2020, we decided to carry out an internal review of our organisational decision making and response to the Covid-19 pandemic through 2020 and into Spring 2021. This review was designed to capture organisational memory and a timeline of the key activities and processes we created, paused, ceased or changed to support our, and indeed the nation's, response to the pandemic.

321. By beginning to pull together an overview of these activities, and any initial learning, we hoped to develop an engagement brief to support senior leaders when called upon to discuss our operations throughout 2020-21, and contribute to our operational response to future waves of Covid. A draft of this report was completed in November 2021 and shared with the Executive Team. A copy of this draft report is attached (IT/275 [INQ000235507]).

Statement of Truth

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

Signed:

Personal Data

Dated: 25th August 2023