Witness Name: Mary Cridge
Statement No.: 2
Exhibits: MC2/01 – MC2/27
Dated: 11 June 2025

UK COVID-19 INQUIRY
MODULE 6

SUPPLEMENTARY WITNESS STATEMENT OF MARY CRIDGE

Introduction

I, Mary Cridge, Director of Adult Social Care for the Care Quality Commission, Citygate, Gallowgate, Newcastle upon Tyne NE1 4PA, will say as follows: -

1. I make this statement in order to clarify three matters to enable the Inquiry, and relevant witnesses and core participants, to better understand CQC's evidence ahead of the commencement of the Module 6 public hearings.

Visiting

2. In relation to the UK Government's Care Homes Visiting guidance, which my main statement [INQ000584245] deals with at pages 172 to 183, I wish to provide the following additional context.

3. Prior to the first national lockdown taking effect on 23 March 2020, concerns about the spread of Covid-19 cases and the impact of an outbreak in care homes were already under consideration by DHSC and care providers.

4. On 11 March 2020, draft guidance regarding home care and care homes was provided to CQC and other stakeholders by DHSC for comment (MC2/01 [INQ000235568]). At paragraph 5(g), the draft care home guidance (MC2/02 [INQ000235570]) stated that care home providers should discourage those with respiratory illness from visiting care homes as part of their normal everyday practice.

On 13 March 2020 CQC responded with comments on the draft guidance documents and invited DHSC to make the guidance about visiting care homes more explicit to address the scope for confusion as there were already a lot of concerns about care homes restricting visitors (MC2/03 [INQ000547941]).

5. On 13 March 2020, following these exchanges and input from other bodies, DHSC indicated that they were considering amending the guidance on visiting in care homes to advise that care home providers should request that anyone with suspected Covid-19 or who is generally unwell should not visit their care home (MC2/04 [INQ000547942]).

6. By 15 March 2020, as outlined in the section of my main statement regarding the suspension of routine inspection activity (pages 74 – 85), CQC and the Secretary of State for Health and Social Care had decided that there would need to be a change to routine inspections of care homes. As explained in paragraph 258 of my main statement, on 15 March 2020 Kate Terroni shared the wording of the draft letter that CQC was intending to send to providers to notify them of the decision, with ASC stakeholder colleagues. In the first iteration of the draft letter shared by Kate Terroni we stated that the current PHE guidance on visiting in care homes was that care homes should not close their doors to visitors and we indicated that we did not expect to see care homes closing their doors to visitors (MC2/05 [INQ000547943]). Some of the trade association members shared feedback with us regarding the issue of visiting as set out in the draft letter (MC1/118 [INQ000525012]), including the National Care Association, who advised that in the absence of definitive advice, many providers had already started to restrict visiting at their care homes. The National Care Forum shared detailed feedback on the topic of visiting. In relation to care home visiting they suggested that the letter as drafted may make many of the care homes that had already shut their homes to visitors feel that they were operating "outside of the regulatory advice". They suggested some alternative wording but ultimately advised that "it would be most helpful if [we] did not address this issue of visiting" in the letter as "the risk of keeping it in…implied that [we would] be actively taking a role in ensuring that PHE guidance [was] being followed". Given the changing government guidance on visiting, we agreed with this advice and removed the paragraph on care home visiting from the final letter sent to the ASC providers

pending further clarity from government about what the advice was at that stage (MC1/114 [INQ000235536]).

7. Sometime between 19 March and 30 March 2020, and without notice to CQC, the government guidance on visiting was changed from allowing care homes to make a decision on whether to allow visitors based on risk assessments, to advising that care home providers should stop all visits to residents from friends and family (MC2/06 INQ000547944]). This shift in advice was made without consultation with CQC and we only came to know of the change because our ASC queries panel was regularly checking for updates to government guidance.

8. On 1 April 2020 we notified DHSC, through the Sponsor Team and the Patient Safety Cell, of our concerns regarding not having been notified of the change to the visiting guidance, the fact that the date on the updated guidance had not been amended which created difficulties for providers to stay across the updates, and that the guidance was at odds with the NHSEI 'Advice on end of life care issued for hospitals' which stipulated that visitation by one person was permitted. We suggested that it should therefore be aligned urgently).

9. On 2 April 2020, the government advice changed again when the 'Admission and Care of Residents during COVID-19 Incident in a Care Home' guidance was published which stipulated that family and friends should be advised not to visit care homes, except next of kin in exceptional situations such as end of life (MC1/438 [INQ000235334]). We escalated our concerns to the DHSC Sponsor Team again, on 3 April 2020, alerting them to the fact that the 'Covid-19 Guidance on Residential Care Provision' was now also at odds with the admissions guidance (MC2/07xx [INQ000547945]). The government advice remained unchanged in the May 2020 version of the Admission and Care of Residents in a Care Home during the Covid-19 Incident Guidance.

10. CQC's actions, contributions and engagement with stakeholders on the topic of government guidance regarding visiting in care homes from June 2020 to October 2021 is set out in my main statement at paragraphs 546 – 560.

11. Following the submission of my main statement, CQC has read the witness statement of Julia Jones on behalf of John's Campaign, Helen Wildbore on behalf of Care Rights UK and Rachel Power on behalf of the Patients Association [INQ000514104]. At paragraph 65 of the statement, the evidence of Care Rights UK regarding "Submissions made to Government bodies raising concerns" details four letters written to CQC [INQ000231915; INQ000231916; INQ000231917; INQ000231918] as examples of how they "repeatedly engaged in correspondence with key organisations and Government agencies" but only refers to one of our response letters, dated 7 July 2022 [INQ000499356]. The four letters, and CQC's responses, all touch on the issue of visiting in care homes and therefore we wish to provide some additional context and exhibit CQC's response letters in this section of my supplementary witness statement.

12. On 22 May 2020 [INQ000231915], 11 May 2021 [INQ000231916], 20 May 2022 [INQ000231917] and 1 August 2022 [INQ000231918] CQC received letters from the Relatives and Residents Association. In relation to the issue of visiting in care homes specifically, the Relatives and Residents Association raised concerns in their letters which, broadly, accused CQC of not doing enough to provide reassurance to the ASC sector when visiting in care homes was restricted, not taking a proactive role in monitoring compliance with the Government guidance on visiting, and needing to amend our own infection prevention and control guidance (as set out in the ASC IPC tool which is described in detail in my main statement as paragraphs 499 - 501) where it mentioned visiting.

13. CQC replied to each letter addressing the concerns raised and our responses are exhibited to this statement as follows:

    13.1. Letter dated 3 June 2020 (MC2/08 [INQ000547946]) in response to the Relatives and Residents Association letter dated 22 May 2020;

    13.2. Letter dated 20 May 2021 (MC2/09 [INQ000547947]) in response to the Relatives and Residents Association letter dated 11 May 2021; and

    13.3. Letter dated 7 July 2022 [INQ000499356] in response to the Relatives and Residents Association letter dated 20 May 2022.

14. These letters clarified how CQC was continuing to monitor and inspect, how we were sharing information and data within the sector and the support that we were providing. In our 20 May 2021 letter (MC2/09 [INQ000547947]) we also provided clarity on our role in relation to visiting in care homes which can be summarised as follows:

14.1. We do not have the power under legislation to compel care homes to inform us of any changes to their visiting status, or to require providers to report data on levels of visiting.

14.2. We had made it clear to providers throughout the pandemic that when thinking about visiting, they had the responsibility to put the individual at the centre of the decision and that all decisions needed to stay under review as circumstances changed.

14.3. We had been explicit that blanket bans were unacceptable and may trigger inspections.

14.4. We had signposted providers to good practice and resources to help them. This included the joint statement published by the Residents and Relatives Association, National Care Forum, Skills for Care and the Care Provider Alliance (which we endorsed). We also continually highlighted the 'Partners in Care' resources to support meaningful visits and information provided by the Care Provider Alliance.

14.5. We had spoken to providers via our inspection teams to understand their approach to visiting, to ensure they were aware of the latest guidance, and to emphasise that all decisions needed to stay under review as circumstances changed.

14.6. We had gathered information from residents, relatives and loved ones about their experience of how visits were being facilitated. Our assessments also included consideration of local factors such as vaccination rates, numbers of positive cases, and infection prevention and control measures.

14.7. We had been clear with providers that if something changed and they were no longer able to follow government guidance, they should speak to their CQC inspector as soon as possible.

14.8. We had recommended that care home providers should be transparent about their approach to visiting with families and residents through

publication on their website where appropriate or other forms of communication.

14.9. We had encouraged providers to complete the capacity tracker on care home visiting and used the information providers were submitting through the capacity tracker on care home visiting to inform our monitoring of services and to prioritise inspections.

14.10. We had undertaken 1282 inspections of care homes, and taken action in 5% of those where we had concerns about visiting arrangements since the introduction of the updated government guidance on visiting on 8 March 2021.

14.11. We had taken action in every case where concerns were raised with us about 37 potential blanket bans, including following up with providers, inspecting, raising safeguarding alerts where appropriate, and following up with the local authorities.

14.12. We had ensured all of our care home inspections included a mandatory question on visiting.

15. In our response dated 7 July 2022 [INQ000499356] we signposted the Relatives and Residents Association to our position on care home visiting as set out on our website (MC2/10 [INQ000547948]). We also confirmed that our expectation remained that care homes should follow government guidance, which at that time was to ensure that visiting was unrestricted and that we would follow up in instances where we were made aware that this may not be happening. We also indicated that our ASC IPC tool was being revised and updated and thanked them for their feedback.

Suspension of routine inspection activity: Prioritising the health, safety, and wellbeing of our staff and reducing the risk they were exposed to (the third key operating principle)

16. Further to paragraph 221 of my main statement where it is explained that the decision to suspend routine inspections was considered necessary on the basis of the three key operational principles, I would like to clarify the following matters.

17. The first two key operating principles were: that our focus would be on ensuring the public received safe care by responding where we believed risk was the highest and where we could make a difference; and to support providers at a challenging time

by reducing what we asked of them wherever we could without compromising people's safety, and by ensuring that we were not contributing to the risk of spreading infection. The third key operating principle was the prioritisation of the health, safety, and wellbeing our or staff and the intention to reduce the risk that they were exposed to.

18. When the decision was made to pause routine inspections from 16 March 2020, one of the major factors that CQC was contemplating was how to balance the importance of conducting in person inspections against the risks posed to our own staff and to others if we continued to meet and mix with providers and vulnerable people at site inspections. As an employer, we have a duty of care to our own staff and CQC did not want to put our employees, or anyone that we came into contact with, at any greater risk than they already were. As an indicator of numbers of staff to consider, staff lists held by CQC indicate that on 31 March 2020 there were 627 inspectors in the ASC sector. It is important to note that a number of CQC inspectors were themselves shielding; or were in a household with someone who was shielding; or shared a household with a health or care worker. It has not been possible to obtain the specific data to know how many of our inspection colleagues were unable to cross the threshold due to shielding for themselves and/or their loved ones but there were a number who were not able to carry out physical inspections for these reasons.

19. At this time, access to PPE, testing and vaccinations was as much an issue for CQC as it was for the rest of the country. The challenges we faced in securing PPE supplies, together with accessing testing and vaccinations, had a significant impact on our ability to conduct inspections and on the morale of our inspection teams. Despite the challenges we were facing to secure access to PPE, testing and vaccinations we were widely criticised by the sector as providers were genuinely concerned that inspectors could be bringing or spreading infection in their services. This, in turn, had a negative impact on the relationships between our inspectors and providers which was most obvious when our inspectors visited care services. We made an effort to inform and update the ASC sector, through our bulletins and various other communications, of the challenges we were facing to secure access to PPE, testing and vaccinations so that they were aware of any developments that may have impacted the providers and/or the people using services.

20. Before the pandemic, CQC's inspectors did not routinely use PPE during inspections but if a specific situation required it the approach was that the provider would supply our inspector with appropriate PPE. Early on in the pandemic, this approach became difficult to manage and it became clear that we would need to procure PPE for our staff if they were going to conduct site inspections.

21. From April 2020 we began engaging with DHSC regarding obtaining support with procuring PPE so that we did not have to use the PPE of providers. We also devised a Covid-19 Inspection and Registration Visit Risk Assessment Tool for our inspection colleagues to use to determine whether a visit in person was necessary, and if so to mitigate any risks prior to each site visit/inspection (MC2/11 [INQ000547949]). In relation to PPE, it stated that PPE requirements must be assessed and agreed prior to any visit. This tool was accompanied by PPE guidance which provided clarity regarding the use of PPE once the decision to inspect or visit had been confirmed and stated that "If you are unable to source the relevant PPE, the inspection/visit must not go ahead" (MC2/12 [INQ000547950]). In this way, CQC sought to continue its important inspection work whilst seeking to avoid the risk of spreading infection and protect our own staff.

22. Between April and September 2020, stocks of PPE were held in our Newcastle office and would be couriered to staff as required but this was expensive and sometimes very slow. From September 2020 onwards, staff were able to order PPE through our stationery provider, Banner.

23. In relation to access to testing, CQC staff had the same access to testing as members of the general population for most of 2020. During the early months of the pandemic, testing was largely limited to key workers and those who presented with Covid-19 symptoms, and asymptomatic testing for non-essential workers was not widely available. At the start of the pandemic, in line with the government guidance "Critical workers and vulnerable children who can access schools or educational settings" published on 20 March 2020, CQC made the decision not to identify staff as key workers to avoid placing pressure on schools and because we were able to support people to work flexibly from home and accommodate childcare. This decision was made following careful consideration of the government guidance in

relation to the activities that CQC was undertaking at that time (which was shortly after we had paused routine inspections), applying the following principles:

23.1. It was clear from the guidance that regardless of key worker status there was a request that if you could, you should keep your children safe at home.

23.2. It was not explicit that our work and roles fell squarely in the definitions of the frontline activities of delivering health and social care for the country.

23.3. It was of absolute importance that spaces in schools were available and prioritised for those frontline workers in the health and social care system and the other vital roles to keep the country safe.

24. On that basis, CQC did not consider that the organisation, as a whole, met the definition of key worker. However, our leadership was mindful that some roles could have fallen within the description of "urgent Covid-19 related activities" and therefore kept this under review as our regulatory activity developed over the next few weeks.

25. From June 2020 we started to receive a stream of queries from our staff, and from providers, regarding whether our staff should be tested before conducting inspections. In early June 2020 CQC began engaging with DHSC and the Association of Directors of Adult Social Services (ADASS) on the issue of whether CQC inspection staff should be tested prior to, and after, visiting health and social care services as there was no applicable government guidance. We also reached out to the regulators in the devolved nations to see what their approach was to staff testing (MC2/13 [INQ000547951]) and MC2/14 [INQ000547952]).

26. From 15 June 2020, all CQC employees were identified as key workers. This was the result of a decision made by CQC's executive team as we were starting to resume some of our inspection activity. This meant that anyone who was displaying symptoms of Covid-19, and anyone living with them, was entitled to receive a test. By this time, DHSC had not reached a conclusion regarding whether our staff should be tested prior to, or after, inspections. In line with national guidance, consultation with other regulators and with DHSC's approval, we therefore decided not to introduce testing before or after an inspection and to rely instead upon the proper use of PPE until DHSC provided a further steer.

27. In early July 2020 CQC decided that inspection staff should do a Covid-19 test before visiting services. The decision was based on the feedback received from colleagues in CQC and discussions with key stakeholders such as providers, the trade associations, DHSC and other regulators. During July 2020 Ian Trenholm was involved in ongoing discussions with DHSC regarding the practical arrangements surrounding asymptomatic testing for CQC inspectors (MC2/15 [INQ000547953]). CQC was intending to connect into the NHS testing regime for peripatetic workers so that the testing of our inspectors was consistent with what was happening elsewhere and so that there was no risk of a provider turning an inspector away because they had not had a test in the way other NHS workers had. There was some confusion created as DHSC's ASC Testing team had indicated that CQC inspectors may not be permitted to use the government portal to access asymptomatic tests (MC2/16 [INQ000547954]).

28. On 22 July 2020 Ian Trenholm wrote to Professor Jane Cummings, Director of Testing in DHSC's Adult Social Care Team, stating that he was "keen to access testing for [CQC inspectors] asap, or at the very least understand when the wider policy position on this subject [would] be agreed" and setting out the reasons why CQC thought that regular asymptomatic testing was appropriate for our inspectors (MC2/17 [INQ000547955]). On 10 August 2020 Professor Cummings responded to say that she had discussed the matter with both the CMO and the deputy CMO who agreed that "CQC inspectors [did] not meet the criteria for regular weekly asymptomatic testing" as "CQC inspectors are not required to undertake "hands on" close personal contact with residents" and they therefore did not "currently meet the criteria" (MC2/18 [INQ000547956]) .

29. In CQC's Provider Bulletin published on 14 August 2020 (MC2/19 [INQ000547957]) we provided an update to the ASC sector regarding Covid-19 testing for CQC inspectors where we confirmed that DHSC had indicated that CQC inspectors did not meet the criteria for weekly asymptomatic testing.

30. On 26 August 2020 the National Care Forum wrote an "Open letter to Matt Hancock, Secretary of State for Health and Social Care and Helen Whately, Minister for Care" with the subject line "CQC inspectors must have regular routine testing when they conduct on-site inspections" (MC2/20 [INQ000547958]).

31. On 21 September 2020 Care England sent a briefing paper to the Secretary of State, in direct response to our 14 August 2020 Provider Bulletin, wherein they raised concerns about the issue of no regular testing for CQC inspectors (MC2/21 [INQ000547959]).

32. On 21 September 2020 Ian Trenholm followed up with Professor Cummings highlighting some key changes to our work and checking to see if the government policy had changed, or whether CQC's inspection teams could access weekly testing (MC2/22 [INQ000547960]).

33. On 23 October 2020 the issue was discussed at the end of the "MS(C) Covid-O Pre-Brief, and subsequent discussion with Professor Jane Cummings on CQC Inspector Testing" meeting by Professor Cummings, David Pearson, Kate Terroni and Ian Trenholm (MC2/23 [INQ000547961]). Professor Cummings confirmed that the National Prioritisation Board had agreed the day before to test visiting professionals and as such she "would like to commence inspector testing in tier 3 locations" as she had been "inundated with requests for CQC testing from stakeholders." The decision to offer regular asymptomatic testing to CQC inspectors was confirmed in an email from Professor Cummings to Ian Trenholm on 27 November 2020 (MC2/24 INQ000547962]) which was a welcome development for CQC.

34. From early December 2020 CQC's inspection teams were enrolled in a national programme of weekly polymerase chain reaction ("PCR") testing and CQC policy was updated such that anyone forming part of a CQC inspection who crossed the threshold should be tested. From March 2021, following updated government guidance, our inspectors began taking lateral flow tests ("LFTs") on the morning of all inspections as an additional measure to the weekly PCR tests.

35. Although CQC inspectors were classed as 'key workers' from June 2020, they were not classed as 'frontline' health and care workers and so were not in the first tranche of vaccinations offered to those in the front line and others in the adult care sector such as older residents and care home staff. On 13 January 2021 Ian Trenholm wrote to Nadhim Zahawi MP, Minister for Covid Vaccine Deployment, asking for CQC inspectors to be included in the priority group for vaccination (MC2/25

[INQ000547963]). On 2 February 2021 Minister Zahawi responded indicating that vaccinations would not be offered to CQC inspectors (MC2/26 [INQ000547964]). On 5 May 2021 Minister Zahawi wrote to Ian Trenholm again, in response to his 13 January 2021 letter, providing information regarding the government's vaccination policy (MC2/27 [INQ000547965]). It was not until May 2021 when the majority of our inspection colleagues were able to access vaccinations. Before then, where local authorities and health trusts were able to make provision for their local inspection team to be vaccinated, CQC encouraged staff to take that opportunity. By June 2021, there was explicit reference by government to the fact that everyone who worked in a care home should be fully vaccinated.

Reflection and Recommendations

36. Further to the Inquiry's request for any recommendations that CQC would invite the Chair to consider in order to improve the response of the Adult Social Care Sector and its regulatory oversight in the event of a future pandemic, I would like to make the following observations based upon reflections in the following key areas.:
    - 36.1. Movement of people between care settings;
    - 36.2. Inspections;
    - 36.3. Visiting in care homes;
    - 36.4. Co-production and co-ordination of communication; and
    - 36.5. Funding

Movement of people between care settings

37. It is recognised that the key decisions relating to the discharge of people from hospitals into care homes is a matter that the Inquiry will scrutinise very carefully.

38. During the pandemic providers articulated a perception that they had little or no power to challenge discharge decisions if they felt an admission of an individual from a hospital to their care setting would not support the best interests of the person or could put them or others at risk.

39. The aim in any future pandemic should be the safe discharge, transfer and admission of people between care settings. Key to such safe movement will include testing, Infection Prevention Control (IPC), effective vaccination, together with the

ability of the accepting service to meet the individuals' needs, co-ordination of integrated care, clear guidance and policy, and data sharing.

40. Possible recommendation:

40.1. That care providers maintain, and are supported in, their ability to refuse to admit a person where they are not satisfied that there are adequate measures in place to enable the individual's needs to be safety met without increasing risk to other people.

40.2. That social care providers should be seen as equal partners in the delivery of safe care and treatment, and be given equal access to IPC measures including testing, PPE and vaccinations.

Inspections

41. CQC recognises that on site inspections are an integral part of regulation and that, in the event of a future pandemic, strenuous efforts should be made to protect the ability to carry out on site inspections as much as is practically possible.

42. On site inspections, together with other forms of regulatory activity, play a vital role in assuring the safety and quality of services for the adult social care sector. But it should be recognised that on-site inspections cannot safely take place in a pandemic if they increase risk to those in the care settings and the inspectors themselves.

43. CQC's statutory powers are detailed in the 2008 Act and include powers of entry and inspection (sections 60 to 63) and powers to require information and documentation (sections 64 and 65). The 2008 Act also gives CQC a general power to "do anything which appears to it to be necessary or expedient for the purposes of, or in connection with, the exercise of its functions". Our responsibilities include the registration, monitoring, inspection, assessment and regulation of services which fall within our regulatory remit. During the pandemic CQC was able to demonstrate that our existing regulatory methodologies could be adapted and used flexibly in changing and challenging circumstances.

44. Possible recommendations:

44.1. To ensure inspectors are treated as 'key workers' at the outset of a future pandemic with priority access to testing, PPE, vaccinations and IPC training; and

44.2. To recognise the importance of on site inspections, and ensure the ability to conduct on site inspections to allow CQC, as the regulator, to be able to continue to assure the safety and quality of service provision in the ASC sector.

Visiting

45. The rights and wishes of those using adult social care services must remain a focus at all times. During the pandemic, the rules about visiting in care settings caused suffering and harm both to people using care services and their loved ones.

46. Significant steps have already been taken to address this concern including the introduction of a new fundamental standard in Regulation 9A which places a requirement on providers to allow users to receive visits or be accompanied unless there are exceptional circumstances. It is noted that adherence to this regulation will always require balancing with the fundamental standard of safety which is about preventing people from receiving unsafe care or treatment or being put at risk of harm that could be avoided. The difficulties in balancing the quality of life interests of people using services (which, during the pandemic, were not always aligned) with the need to reduce the risk of infection were demonstrated during the Covid-19 pandemic.

47. Possible recommendation:

47.1. That the introduction of Regulation 9A is seen as a lever to ensure that the ability to continue visiting those in care settings is maintained throughout any future pandemic.

Co-production and co-ordination of communication within the ASC sector

48. During the pandemic the decisions, advice and guidance about how the adult social care sector should operate were made and formulated at pace. Key stakeholders were not always afforded the opportunity to be fully involved in these processes, making them difficult to understand, follow and implement. The pressure that this placed on the sector cannot be underestimated.

49. As the independent regulator of health and adult social care in England, we are sponsored by the Department of Health and accountable to Parliament through the Secretary of State for Health and Social Care. This means that we are in a unique position as the only organisation to have oversight of the healthcare and adult social care sectors as well as local and central government. We can use this unique position to advise on, and contribute to, any proposed policy areas by highlighting the potential risks and benefits from both perspectives.

50. It is the role of government to issue clear, coherent advice and guidance about how the adult social care sector should operate in a pandemic. It is not our role, as regulator, to interpret or issue guidance about government guidance. CQC understands firsthand the value and importance of being involved in the co-production of advice and guidance for the sector. We recognise that without suitable strategies and structures in place to facilitate co-production there is a risk that the advice or guidance will not be effective at meeting intended outcomes. This has potential to re-enforce a perception that government does not understand the adult social care sector.

51. In the context of the adult social care specifically, CQC understands the disparate and diverse nature of the sector. We effectively hold a comprehensive address book of all registered services and as such CQC can be used to channel government advice and guidance into the sector. We can also provide vital feedback to government to ensure that the diverse voices of the adult social care sector are heard.

52. In order for government advice and guidance to operate effectively at a national and local level there needs to be a proper infrastructure in place for it to be issued. During the pandemic we demonstrated that CQC's sector knowledge and regular communications with registered persons can play a valuable role in signposting and flagging the key parts of relevant government advice and guidance, as well as highlighting changes to it.

53. Possible recommendation:

53.1. The development of a strategy which recognises the value of co-production and works on the assumption that co-production will take place,

53.2. The development of a structure to bring together key sector stakeholders in a timely manner in order to provide meaningful input,

53.3. That a clear and simple infrastructure is identified to allow effective and timely communication of government advice and guidance to the adult social care sector at national and local level, and

53.4. That our unique position as regulator is recognised and used to disseminate government advice and guidance as well as to receive feedback and facilitate the co-production of guidance.

Funding

54. To the extent that further funding would be required to execute any of these actions, then CQC requests that consideration be given to an additional recommendation that funding be increased to permit the necessary work to be done to prepare for a future pandemic in a way that promotes parity between the healthcare and adult social care sectors.

Shared reflections

55. CQC would like to take the opportunity to observe that the list of lessons learned and reflections set out by the Care Inspectorate (Wales) at paragraph 305 of their statement are matters that also sensibly apply to the regulation of the adult social care sector in England. They are summarised as:

55.1. The importance of a rights-based approach to ensure people receiving health and social care, and their families or advocates, are involved in decision making with decisions taken on an individual basis and in the best interests of the person.

55.2. Recognising, and minimising as far as possible, the impact of not being able to see family and friends has on the mental health and well-being of many people.

55.3. The importance of co-ordinated communication for successful hospital discharge, recognising family members and providers are partners in care for many people.

55.4. The importance of having a co-ordinated communication strategy to minimise duplication and ensure messages are shared with the right people at the right time.

55.5. Ensuring health and social care staff have access to testing with timely turnaround of results; sufficient PPE (personal protective equipment) with clarity about its use; access to infection prevention and control training and support, including support networks for managers and care workers.

55.6. The importance of continuity of staffing to help mitigate the risk of agency staff transmitting the virus if they are working across different services.

55.7. The interdependence of the health and social care sector recognising providers of social care services should be treated as equal partners in care and people working in the social care sector should have parity of esteem and terms and conditions as those working in the NHS.

55.8. The value of working co-productively with all partners to bring together a wide range of knowledge and stakeholders to address complex issues and achieve the best outcomes for people.

55.9. Working with and sharing information with partners is key to achieving improvements in care services.

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: 11 June 2025