Witness Name: Mary Cridge
Statement No.: 1
Exhibits: MC1/001 – MC1/568
Dated: 11 March 2025

UK COVID-19 INQUIRY

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 am employed by the Care Quality Commission (CQC) as Director of Adult Social Care, a post I have held since 1 July 2022.

2. Prior to this I was interim Deputy Chief Inspector (Adult Social Care, covering the Central Region) from 16 September 2019, and previously Head of Inspection (Hospitals) from 1 December 2013, Head of Regional Compliance from 1 April 2012, Regional Lead from 28 November 2011 and Compliance Manager from 17 May 2010. I worked as an Area Manager for the Healthcare Commission, one of CQC's predecessor organisations from 1 June 2005. I began my career as a civil servant in 1985 at the Department of Employment and from 1991 have worked in regulation in a number of organisations including the Office for Electricity Regulation and the Charity Commission.

3. I make this statement in response to the request dated 29 May 2024 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 current and former colleagues at CQC in order to provide as accurate an account as possible on behalf of CQC.

A. CQC's role, functions and aims

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 (ASC) in England. CQC is a 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, 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. Our responsibilities include the registration, monitoring, inspection, assessment 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 ASC providers and how they use the Deprivation of Liberty Safeguards (DoLS).

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 services to

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

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

10. The Health and Care Act 2022 (the 2022 Act) received Royal Assent on 28 April 2022 and added to the list of regulatory duties held by CQC. The changes brought in by the 2022 Act include CQC's review and assessment of Integrated Care Systems (ICSs) and regulation of certain Local Authority functions relating to ASC. These changes are explained in greater detail below in paragraphs 136 - 140.

CQC's regulatory remit

11. Providers of 'regulated activities' must be registered with CQC unless a specified exemption or exception applies[1]. The regulated activities are defined in detail below.

12. We have a wide set of powers that are designed to protect the public and hold registered providers to account. 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). Failure to comply without reasonable excuse is an offence.

13. 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, with which registered persons are required to comply.

14. We also have powers to undertake civil and criminal enforcement action against registered persons who fail to comply with a condition of their registration or the

[1] 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.

relevant Regulations[2], and those carrying on regulated activities without registration. CQC's civil enforcement powers as set out in the 2008 Act include powers to cancel or suspend a registered person's registration (sections 18 and 30 to 31), to impose, vary or remove conditions of registration in respect of a registered person (sections 12 (5), 15 (5), 30 and 31) or to serve a "warning notice" where the test set out in sections 29 is met. Criminal enforcement action can be taken, in response to breaches of certain regulations and sections of the 2008 Act, against any registered person, or against any unregistered person where they are carrying out regulated activities, or against a body corporate (and its representative) as defined under sections 91 and 92 of the 2008 Act. It can also be used against any person who obstructs us during an inspection and against registered or unregistered persons where they have made a false or misleading statement in any application to us. CQC's criminal enforcement powers include the power to issue simple cautions, fixed penalty notices and commence a prosecution. These powers are explained in greater detail in section F below.

15. We also have the power to conduct a special review of, or investigation into, the provision of NHS care; ASC services; the exercise of the functions of NHS England or an integrated care board; the exercise of the functions of English local authorities in arranging for the provision of ASC services; or the exercise of functions by English Health Authorities. Special reviews or investigations may be conducted at CQC's discretion (with the approval of the Secretary of State), or upon the request of the Secretary of State (section 48 of the 2008 Act). Between 1 March 2020 and 28 June 2022 ("the relevant period"), the only special reviews carried out by CQC under section 48 of the 2008 Act were:

    15.1. the review of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions during the Covid-19 pandemic in terms of which we published the 'Protect, respect, connect – decisions about living and dying well during

[2] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended by a) Health and Social Care Act 2008 (Registration and Regulated Activities (Amendment) Regulations 2005 and b) Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012) and Care Quality Commission (Registration) Regulations 2009 (as amended by a) Care Quality Commission (Registration) and (Additional Functions) and Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2012 and b) Care Quality Commission (Registration and Membership) (Amendment) Regulations 2012).

Covid-19' report in March 2021. This is explained in detail in Section J below; and

15.2. the review of the use of restraint, seclusion and segregation in services such as hospitals and care homes for people with a mental health condition, a learning disability or autistic people in terms of which we published the 'Out of sight – who cares?' report in October 2020. The Inquiry has confirmed that CQC's role in examining the use of restraint, seclusion and segregation is not within the scope of Module 6 therefore this is not explained in further detail in this statement.

16. 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"[3]. This includes co-operating with other public authorities in the United Kingdom.

17. CQC also has a duty, under the Care Act 2014, to carry out its Market Oversight role. The Market Oversight Scheme is a statutory scheme which came into effect in April 2015. Through this scheme CQC assesses the financial sustainability of ASC providers that local authorities would find difficult to replace if they were to become unable to carry on delivering a service. CQC's role is to monitor the relevant providers and to tell local authorities if services in their area are likely to stop owing to business failure. This allows for the local authorities to ensure that people using those services continue to receive care. CQC does not assess or monitor the financial sustainability of the ASC sector as a whole, only those providers which are part of the Scheme. The work of CQC's Market Oversight Team relevant to the outline of Scope of Module 6 is explained in greater detail in Sections K and N below.

18. We are responsible for regulating CQC registered health services provided to children to make sure they are safe, effective, compassionate and high-quality and we encourage services to improve. We also work in partnership with other inspectorates including Ofsted on a number of programmes to assess how well different agencies work together in a local area to provide services to help and protect children with specified needs or in response to a particular issue.

[3] Paragraph 2, Schedule 4 of the 2008 Act

Healthwatch England

19. We host Healthwatch England (HWE), which is the consumer champion for health and social care acting 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

20. 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.

21. The Care Quality Commission (Additional Functions) (Amendment) Regulations 2023 came into force on 28 November 2023. The regulations relate to clarifying the legal status of the NGO.

Maternity and Newborn Safety Investigation

22. On 1 October 2023, the functions of the Maternity and Newborn Safety Investigations (MNSI) programme were transferred to the CQC pursuant to the Care Quality Commission (Maternity and Newborn Safety Investigation Programme) Directions 2023. Prior to the transfer, the maternity investigations function was an additional function of the Healthcare Safety Investigation Branch (HSIB) under the NHS England (Healthcare Safety Investigation Branch) (Additional Investigatory Functions in respect of Maternity Cases) Directions 2022. Part 4 of the Health and Care Act 2022 established the Health Services Safety Investigations Body 'HSSIB'

to carry out the safety investigations functions previously discharged by HSIB. The maternity investigations function was then transferred to CQC as explained above.

B. Liaison and communication with Government and other stakeholders

23. The extent to which the CQC advised, collaborated with or otherwise worked with the following organisations during the relevant period, in response to the Covid-19 pandemic is set out below:
    - 23.1. Department of Health and Social Care;
    - 23.2. Department for Levelling Up, Housing and Communities;
    - 23.3. Local Government Association;
    - 23.4. Association of Directors of Adult Social Services;
    - 23.5. NHS England;
    - 23.6. Public Health England (now UKHSA) and, where applicable,
    - 23.7. Healthcare Improvement Scotland, the Regulation and Quality Improvement Authority and Healthcare Inspectorate Wales;
    - 23.8. any other key stakeholders not referred to above.

24. The extent to which CQC liaised with DHSC, predominantly, and other external stakeholders during the relevant period is illustrated by the attached chronology (MC1/01 [INQ000235485]), which sets out the meetings that we attended with the UK Government from March 2020 to February 2022 ("UK Government" includes for these purposes: the Cabinet Office, DHSC and other UK Government departments). The chronology was prepared to respond to the Inquiry's Rule 9 Request to CQC for Module 2 where the focus was on CQC's engagement with UK Government in the context of core decision-making during the pandemic. Whilst preparing the chronology, we identified that we attended over 1,000 meetings with the UK Government where various issues relating to the Covid-19 pandemic were or may have been discussed. The vast majority of these meetings were also attended by representatives from some of the other external stakeholders listed above.

25. 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 pandemic. These colleagues, and the positions they held during the relevant period, are as follows:

25.1. Peter Wyman (Chair)

25.2. Ian Trenholm (Chief Executive)

25.3. Ted Baker (Chief Inspector of Hospitals)

25.4. Kate Terroni (Chief Inspector of Adult Social Care)

25.5. Rosie Benneyworth (Chief Inspector of Primary Medical Services and Integrated Care)

25.6. Mark Sutton (Chief Digital Officer)

25.7. Chris Day (Director of Engagement)

25.8. Joyce Frederick (Deputy Chief Inspector, Registration and Regulatory Assurance, then Director of Policy and Strategy from October 2021)

25.9. Rebecca Lloyd-Jones (Director of Governance and Legal Services)

25.10. Helen Louwrens (Director of Intelligence)

25.11. Stuart Dean (Director of Corporate Providers and Market Oversight)

25.12. Debbie Ivanova (Deputy Chief Inspector).

26. In addition, the same review was conducted in relation to the calendars of the following colleagues:

26.1. three Heads of Inspection;

26.2. the Head of Adult Social Care Policy;

26.3. a Head of Provider Analytics;

26.4. the Head of Parliamentary Government and Stakeholder Engagement;

26.5. a Government Engagement Manager; and

26.6. a Senior Government Engagement Officer.

27. From the information available in the calendar entries, we identified the meetings that 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 as required. Our input typically entailed information regarding:

27.1. our role as regulator;

27.2. our approach to regulation and adaptions that we made to respond to the challenges of the pandemic;

27.3. our unique knowledge of the sectors we regulate; and

27.4. our insight into the particular pressures being faced by providers of these services.

28. We drew 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. Examples of the issues in respect of which we were liaising with the UK Government as well as the other organisations outlined in paragraph 23 above, which are relevant to Module 6, are explained in detail throughout this statement to answer specific questions.

29. Below is an explanation of the information set out in the chronology:

29.1. Column A – the date of the meeting;

29.2. Column B – the time of the meeting;

29.3. Column C – the title of the meeting invitation taken from the relevant Microsoft Outlook calendar entry;

29.4. Column D – additional information about the meeting, summarised from the calendar entry, if available;

29.5. Column E – the sender of the meeting invitation;

29.6. Column F – whether the meeting was a regular meeting. (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);

29.7. 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;

29.8. Column H – the names or roles of key CQC colleagues (as identified above) who received the meeting invite;

29.9. 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, can be provided to the Inquiry if required.

30. The information provided in Column C has been categorised by colour as follows:

30.1. 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 relevant period.

30.2. 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.

30.3. The meetings which have been highlighted in light blue ("cell calls") are those set up by DHSC's Quality, Patient Safety and Investigations Directorate. These were held on a regular basis throughout the relevant 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, NHSE, and from arm's-length bodies including CQC, NHS Resolution and the HSIB.

30.4. 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 ASC workforce, Personal Protective Equipment (PPE) and Covid-19 testing. These were set up by DHSC and were held regularly during the period which they ran for.

30.5. 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 outlined above.

31. 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).

32. As can be seen from the attached chronology, we liaised with DHSC on a wide range of Covid-19 related issues. The chronology does not include the details of the conversations that took place in the meetings listed as to do so was not possible within the time limit set by the Inquiry for responding to the Module 2 Rule 9 Request. Below is a summary of five of the meetings listed in the chronology, the details of which have been requested by the Inquiry. If further specific detail or information is required by the Inquiry we will of course endeavour to provide it where it is available.

33. Care Provider Roundtable meeting on 19 March 2020:

33.1. This was a teleconference with care home providers and stakeholders from the social care sector organized on behalf of the then Secretary of State for Housing, Communities and Local Government ("MHCLG"), Robert Jenrick MP. The list of invitees included Simon Clarke MP and Christopher Pincher MP (then Ministers of State at MHCLG), Helen Whately MP (then Minister for Care) and representatives from the following organisations and care home providers (MC1/001a [INQ000567464] MC1/001b [INQ000567465]):

33.1.1. Local Government Authority (LGA);

33.1.2. National Care Forum (NCF);

33.1.3. UK Homecare Association (UKHCA);

33.1.4. National Care Association (NCA);

33.1.5. Care England;

33.1.6. Association for Real Change (ARC);

33.1.7. Association of Directors of Adult Social Services (ADASS);

33.1.8. DHSC;

33.1.9. Department for Business, Energy and Industrial Strategy (now known as the Department for Energy Security and Net Zero, Department for Science, Innovation and Technology, and Department for Business and Trade);

33.1.10. CQC;

33.1.11. Barchester Healthcare Homes Limited;

33.1.12. Lifeways;

33.1.13. The Order of St John Care Trust;

33.1.14. City and County Healthcare Group Limited;

33.1.15. Choice Support; and

33.1.16. Community Integrated Care.

33.2. The meeting was set up to discuss how ASC stakeholders and the UK Government were responding to Covid-19. At the meeting the representatives from MHCLG and DHSC provided updates to the group as follows (MC1/001c [INQ000567484]):

33.2.1. Christopher Pincher MP wanted to hear what the challenges were that were being faced by providers and staff. He highlighted that there would be financial contributions being made by UK Government to help free up capacity in the NHS and to assist local councils. He also provided an update on the status and definition of "key workers" and guidance within the sector. He explained that he had already heard of some real concerns from care providers about getting local authorities to move quickly enough and to ensure that providers received the money they needed to operate.

33.2.2. Helen Whately MP acknowledged that the ASC sector felt "overlooked" and that UK Government would make sure that they highlighted the social care message to the media.

33.2.3. The MHCLG Finance Director provided an explanation to the group regarding the UK Government's financial contributions to Local Authorities confirming that this money was "aimed at ASC providers" and he asked the providers on the call to explain where the cost pressures were and what the key pressures on their businesses and workforces were. He also provided an update on the availability of PPE that was being supplied to care home providers.

33.3. Thereafter, the other attendees (providers and sector stakeholders) provided updates to the group regarding a variety of topics including financial pressures, workforce issues, PPE, contingency plans and sector assurance. Some of the key messages and issues raised by the other attendees were as follows:

33.3.1. Concerns regarding the financial sustainability of the sector due to increased costs associated with Covid-19 such as PPE costs, agency costs and regulatory costs.

33.3.2. Concerns regarding workforce costs and absenteeism following the minimum wage increase due to take effect in April 2020 and the increasing required use of agency staff. Several attendees called for the urgent testing of care sector workers.

33.3.3. The need for clear messaging, guidance and cooperation between Government, Local Government, providers and regulators. Some representatives mentioned the need for clear messaging from CQC on "what is acceptable". There were several mentions of "a lack of support from Local Authorities" and calls for guidance from Central Government to Local Authorities on how the extra money should be spent.

33.3.4. Concerns regarding hospital to care home discharge transfers and specifically the need for correct training and flexibility in the system to handle this. Questions were raised about whether providers had the equipment to deal with the discharges, whether those being discharged had been tested and whether there was sufficient capacity in the ASC sector to accommodate with the discharges.

33.4. Ian Trenholm and Kate Terroni provided an update on behalf of CQC, as recorded in the meeting note, highlighting the following:

33.4.1. CQC announced earlier in the year that we had frozen our fees but that if fees were to stop, Government would need to fund CQC.

33.4.2. CQC was aware of and keeping an eye on the issue of staffing ratios between agency and non-agency workers.

33.4.3. Whilst CQC paused routine inspections, we continued to provide support to the sector through our inspection teams via remote methods.

33.4.4. CQC continued to work on the registration of new services and with existing providers who may have to change their registrations.

33.4.5. CQC was working closely with Helen Whately MP to help influence where we could.

33.4.6. Ian Trenholm asked those on the call to stay close to their local CQC inspection colleagues and to provide feedback on what was happening on the ground to help shape understanding of the regional picture.

34. Call with Helen Whately MP on 1 April 2020:

34.1. The invitation for this call indicates that it was about "Monitoring social care" and was organized by Helen Whately MP. The list of attendees on the invitation included Ian Trenholm, Kate Terroni, Christopher Pincher MP and some representatives from DHSC's ASC team (MC1/001d [INQ000567466]).

34.2. CQC has been unable to locate the minutes or any notes from this call, however we have sought to summarise the correspondence which preceded the call in order to provide additional information regarding what it was about.

34.3. On 29 March 2020 Kate Terroni was copied into an email from Rosamund Roughton from DHSC (Director for Adult Social Care, then promoted to Director General) to Helen Whately MP's office regarding DHSC's proposed plan for securing care provider support for submitting information on a daily basis and how the information would be fed into local government (MC1/001e [INQ000567480]). Reference was made to a meeting held on 27 March 2020 held by DHSC attended by the main care provider bodies, LGA, ADASS and CQC to agree an approach. The proposed plan was for CQC to operate a daily situation report ("sit rep") on behalf of DHSC which would be fed by a number of data streams (including from providers, PHE and other sector bodies) and for any action to be taken in response to the daily sit rep by either local authorities, Local Resilience Forums, CQC or DHSC as necessary. Ms Roughton indicated that the approach would be set out in a diagram for the Minister for Care. She also indicated that the Minister for Care had asked to see the provisional data produced by PHE on prevalence in care homes which would be fed into the daily sit rep.

34.4. Following this email, the call to discuss "monitoring social care and data in social care" was scheduled for 1 April 2020 to be attended by representatives from DHSC and MHCLG, Christopher Pincher MP, Helen Whately MP and Kate Terroni and the "process map for data" was circulated to the invitees (MC1/001f [INQ000567473] MC1/001g [INQ000567474]).

34.5. This work relates to the setting up of the Domiciliary Care Agency Tracker which is explained in detail later on in Section G of this statement.

35. Meeting on 14 April 2020 regarding "Operationalising new policy on testing for care home residents":

35.1. This meeting was organized by DHSC to discuss the following two new policies (MC1/001h [INQ000567476]), a move to which was asked for by the CMO, and which were due to be announced the following day as part of the ASC Action Plan:

35.1.1. Testing all symptomatic residents in a care home; and

35.1.2. Testing all individuals before admission to a care home

35.2. In the meeting invitation, Rosamund Roughton indicated that until that point local PHE health protection teams had been undertaking some measure of testing in care homes but "it [was] clear that there [was] insufficient capacity to do this at the scale now asked" hence the need to "develop a different operational model to deliver this new ask".

35.3. Ahead of the meeting DHSC circulated an annotated agenda which provided additional information on the policies described above (MC1/001i [INQ000567482]).

35.4. Following the meeting, a note recording the discussion and actions was circulated by DHSC along with a Q&A document regarding testing in ASC (MC1/001j [INQ000567481] which I provided comments on and re-circulated on 16 April 2020 [MC1/001k [INQ000567483]).

36. Meeting on 27 April 2020 with HSIB regarding Social Care Patient safety risks:

36.1. This meeting was organized by HSIB to discuss Social Care patient safety risks. This was a brief meeting during which the representatives from HSIB set out their role and we explained the ASC patient safety risks that we had

identified in a paper prepared for DHSC which we circulated to HSIB following the meeting (MC1/001l [INQ000567469] and MC1/001m [INQ000567470]), and which are summarised as follows:

36.1.1. Over-arching:

36.1.1.1. Lack of understanding about scale and scope of ASC provision

36.1.1.2. Focus on NHS provision

36.1.1.3. Lack of support available to small and medium sized providers

36.1.1.4. Lack of visibility for people receiving care in their own homes (missed visits may not be easily picked up)

36.1.1.5. Increased risk of unchecked unsafe/abusive care and treatment (care homes have become closed environments)

36.1.1.6. Lack of visibility of self-funders

36.1.2. Assessment

36.1.2.1. People discharged from hospital to inappropriate settings

36.1.2.2. Access to assessments for people who are living in the community

36.1.2.3. Prioritisation of hospital discharges could reduce capacity for people living in the community

36.1.2.4. Pathways are residential rather than community focused

36.1.3. Care Delivery

36.1.3.1. Staffing: availability of staff (especially nurses); staff competencies to deliver care for older people outside of normal service 'profile'; lack of GP support (e.g. injections, complex dressings, catheterisations in care homes without nursing)

36.1.3.2. Supplies: food deliveries; access to PPE; access to and safe disposal of medical supplies; medicines.

36.1.3.3. Impact of isolation: unauthorized/more restrictive practices; escalation of behaviours which may

challenge the service; increase in people struggling to with mental health (staff and people in services).

36.1.4. Escalation/change in need

36.1.4.1. Decisions made about priority for care delivery (different threshold for meeting needs)

36.1.4.2. GP support to visit/assess in care service

36.1.4.3. Staff competence to meet changing needs

36.1.4.4. Lack of hospital beds for non-Covid 19 conditions

36.1.4.5. Certification of unexpected death in care homes

37. Meeting on 15 July 2020 of the Dementia Programme Board:

37.1. During the pandemic DHSC's Dementia Policy Team led a series of informal meetings of the Dementia Programme Board to exchange information and for the members to flag any important issues relating to the pandemic (MC1/001n [INQ000567471]).

37.2. This was the first of a series of these informal meetings to design a solution focused action plan to support people with dementia during the pandemic, attended by CQC (MC1/001o [INQ000567468]).

37.3. The working group produced the Dementia Covid-19 Action Plan 2020/21 which was submitted to Ministers on 7 October 2020. In addition to this the group prepared a paper on the "Wider Dementia Covid-19 Issues Identified not for the Action Plan 20/21" which set out the wider issues raised outside of the Action Plan and the actions being taken to address them. These were addressed through the Winter Plan, the proposed new dementia strategy and/or other vehicles for action (MC1/001p [INQ000567467]).

37.4. CQC was a member of the Dementia Programme Board and attended the Covid-19 related meetings providing brief updates on the relevant work being undertaken by CQC which had implications for dementia services. The most notable examples being CQC's review of DNACPR practices which is discussed in detail in Section J below.

38. With regard to CQC's engagement with the other stakeholders identified in paragraph 23 above, it is not possible to summarise all of the matters in respect of

which CQC advised, collaborated or otherwise worked with those bodies in this statement. Therefore, we have chosen to highlight what we consider to be the key workstreams/decisions/projects/groups as examples of instances where we advised, collaborated or otherwise worked with the external stakeholders listed above and which fall within the outline of the scope of Module 6.

ASC Trade Association meetings

39. Well before the start of the pandemic, CQC engaged with the key stakeholders in the ASC sector through the ASC Trade Association meetings which are led by CQC and attended by representatives of the following ASC Trade Association organisations including:

    39.1. Associated Retirement Community Operators (ARCO)
    39.2. Association for Real Change (ARCUK)
    39.3. Association of Mental Health Providers
    39.4. Care Provider Alliance (CPA)
    39.5. Care Association Alliance (CAA)
    39.6. Care England
    39.7. National Care Association (NCA)
    39.8. National Care Forum (NCF)
    39.9. National Housing Federation
    39.10. Registered Nursing Home Association
    39.11. Shared Lives
    39.12. United Kingdom Homecare Association (UKHCA)
    39.13. Voluntary Organisations Disability Group
    39.14. Outstanding Society
    39.15. National Association of Care and Support Workers (NACAS)
    39.16. Cornwall Partners in Care
    39.17. National Dignity Council
    39.18. The Care Workers Charity

40. The group met throughout the relevant period and continues to do so.

41. Before the pandemic, the meetings took place on a monthly basis, but between April and August 2020 the ASC Trade Associations group met bi-weekly. After August

2020 the meeting schedule returned to the monthly timetable. The meetings were chaired by one of our Deputy Chief Inspectors/Heads of Inspection for ASC and were attended by various CQC colleagues working in the ASC sector. The minutes for these meetings were prepared and shared by CQC and can be provided to the Inquiry if required.

42. The Trade Association meetings provided us with the opportunity to update the group about the work that we were doing in the ASC sector, and to listen to concerns, issues and provide feedback from the Trade Association organisations about what was going on in the ASC sector. The meetings that took place within the relevant period covered a very wide range of topics regarding Covid-19. An example of what was discussed is set out below.

43. A common theme of discussion at the ASC Trade Association group meetings during the pandemic was around the collection and use of data, particularly in relation to deaths in ASC services. At the meeting on 22 April 2020 CQC presented to the group about how this was being done (MC1/02 [INQ000525041]). The Voluntary Organisation Disability Group highlighted that their organisation had done some analysis around deaths and testing and were looking to see if there were any further opportunities for collaboration. CQC confirmed that it was important to get the data right, to understand what it was telling us and to be able to act upon that data.

44. In the meeting on 5 May 2020 there was a discussion regarding the publication of data by the Office of National Statistics (ONS) (MC1/03 [INQ000525040]). The National Care Forum raised queries about the figures and whether the data was showing a flattening of the death rates. CQC suggested that we would include someone in future meetings who could answer data-related questions. A CQC colleague from either our Intelligence or Analytics teams attended some of the subsequent Trade Association meetings as a result.

45. Throughout this statement, there are multiple references to additional relevant Trade Association group meetings. If further specific detail or information is required by the Inquiry in respect of these meetings we will of course endeavour to provide it where it is available.

Provider Issues Group

46. The National Adult Social Care & Covid-19 Social Care Provider Issues Group was a working group which met to discuss issues that arose during the pandemic that affected the adult social care sector and to share information. In addition to CQC, NHSEI and DHSC, the following organisations were members of the group:
    46.1. Local Government Association (LGA),
    46.2. Association of Directors of Adult Social Services (ADASS),
    46.3. Care Provider Alliance (CPA),
    46.4. Care Association Alliance (CAA),
    46.5. Think Local Act Personal (TLAP)

47. Initially CQC was included on an ad hoc basis but received a standing invitation to attend the meetings in late April 2020. The group met weekly for most of the relevant period and the meetings were co-chaired by Simon Williams (LGA) and Lisa Lenton (CPA). The invitations and minutes were circulated by the LGA. The group covered a wide range of topics with detailed minutes produced for those meetings (which can be made available to the Inquiry if required).

48. One of the issues regularly discussed at these meetings was Covid-19 testing. On 16 April 2020 CQC attended the meeting to update the group on our recent work in setting up the test booking system (MC1/04 [INQ000524962]). We discussed with the group a number of specific issues such as whether there was any prioritisation of certain workers (this was not part of CQC's system) and around getting people to testing centres, particularly those in low-paid roles and those in rural areas. We fed this information back to DHSC.

49. We provided a further update to the group on 21 April 2020 about our work with Deloitte on testing, and on the numbers of care staff who had been referred (MC1/05 [INQ000524964]). Concerns from Clinical Commissioning Groups (CCGs) and councils around the conflict between local and national initiatives were discussed and we confirmed that we were committed to working with partners on this issue. We answered questions from the group about timescales and asked the CPA to pull

together some proposals for how to change the system to reduce travel times to the testing centres.

National Adult Social Care Covid-19 Group (NACG)

50. In early February 2020, DHSC wrote to the members of the "EU Exit: National Steering Group (ASC)" (of which CQC had been a member) to invite them to a remote meeting to discuss the emerging situation around Covid-19, share information and updates and talk about communications to support the sector. An agenda was circulated for the meeting on 5 February 2020 and the group was named National Steering Group (Coronavirus) (MC1/06 [INQ000525009]). The steering group met weekly.

51. On 4 March 2020, following publication of the Government's plan for responding to Covid-19, DHSC wrote to the members of the National Steering Group (Coronavirus) to confirm that they would be setting up a formal Covid-19 steering group to replace the existing Social Care National Steering Group. This group was named the National Adult Social Care Covid-19 Group ('NACG') (MC1/07 [INQ000525076]).

52. The NACG was set up to advise on action being taken nationally and to support local authorities and providers in their response to the pandemic. It acted as a conduit for communication into the ASC sector and into Government, and brought together sector leaders to provide expertise as necessary.

53. The group was co-chaired by Rosamund Roughton from DHSC (Director for Adult Social Care, then promoted to Director General) and James Bullion (then President of Association of Directors of Adult Social Services (ADASS)). It was formed of representatives from:

    53.1. DHSC
    53.2. CQC
    53.3. LGA
    53.4. PHE
    53.5. Local Resilience Forums
    53.6. NHSE
    53.7. Ministry of Housing, Communities and Local Government (MHCLG)

53.8. Carers UK and

53.9. Representatives from the providers sector including from CPA, NCF and UKHCA

54. The group met weekly, although on occasion more frequently when necessary. DHSC circulated an agenda prior to the meeting, and subsequently circulated action logs and workstream updates to the group's members.

55. The NACG's Terms of Reference (MC1/08 [INQ000525000]) stipulated that the purpose of the group was:

55.1. To assess what additional guidance and support was needed for the ASC sector in light of the Government's plan for Covid-19 published on 3 March 2020.

55.2. To provide advice on specific areas including, but not limited to:

55.2.1. guidance to the sector in the event of a reasonable worst case scenario;

55.2.2. emergency legislation; and

55.2.3. financial implications for the sector.

55.3. To act as a channel of communications providing rapid insight from providers and commissioners, and to promulgate national guidance from Government.

56. There were also a number of sub-groups that were set up to provide insight and advice on specific areas that fed into the weekly NACG meetings. Following the call on 6 March 2020 it was suggested that there should be four strands of focus for the group:

56.1. Prioritisation & Ethics,

56.2. Financial Support,

56.3. Workforce, and

56.4. Communications.

57. On or about 16 March 2020 the Workforce Task & Finish Group involving CQC was set up as a sub-group of the NACG to respond to workforce related concerns raised by the sector in response to Covid-19 and to provide advice on maximising supply

and capacity of the social care workforce during a reasonable worst case scenario. The group would meet on an ad-hoc basis depending on need but it was expected to meet weekly (MC1/09 [INQ000525021]).

58. On or about 17 March 2020 an additional Task and Finish Group under the NACG was convened by the LGA, the Task and Finish Group on Adult Social Care SITREP, and CQC was invited to be a member (MC1/10 [INQ000525031]). This group met over a very short period and its purpose was to look at how to create proportionate and helpful reporting into central government about the status of the ASC sector. The initial email convening the group on 17 March 2020 made clear it was important that CQC and NHSE were involved to agree one single report if possible and to avoid duplication for councils and providers. The group included representatives from CQC, LGA, NHSE, DHSC and ADASS.

59. CQC's involvement in this group is described in detail in Section G below where the DCA Tracker is explained.

Covid ASC Working Group of Stakeholders

60. The Covid ASC Working Group of Stakeholders ('CAWGS') was formed in September 2021 and replaced the previous PPE & Testing Stakeholder Group (MC1/11xx [INQ000525046]). The purpose of the group was to bring together ongoing work regarding vaccines, PPE, testing, Infection Prevention and Control ("IPC"), visiting, admissions and homecare to provide a single touchpoint with the ASC sector on Government's Covid-19 response .

61. DHSC chaired the meetings and distributed the agendas and minutes. The meetings were attended by:
    - 61.1. CQC
    - 61.2. representatives of the trade associations (including ARCUK, UKHCA, NCF)
    - 61.3. representatives of some of the large provider groups
    - 61.4. ADASS
    - 61.5. PHE
    - 61.6. LGA
    - 61.7. NHSE

61.8. HM Treasury

61.9. Cabinet Office; and

61.10. Local government representatives.

62. The group met twice per month throughout the relevant period.

63. One of the key issues considered by the group was the response to the Omicron variant. In a meeting on 16 December 2021 the issue of blanket bans on visiting in care homes was discussed (MC1/12 [INQ000524938]). CQC's work regarding visiting in care homes is explained in greater detail later on in this statement in Section H.

64. The group was also involved in the development of an update to UKHSA's guidance 'Covid-19: how to work safely in adult social care settings (care homes and domiciliary care). On 17 December 2021 the group was invited to review the content and format of the proposed updated draft document (MC1/13 [INQ000524933]). A further draft was then circulated by UKHSA and we responded on 20 January 2022 with comments regarding the language in the document, PPE, exposure to Covid-19 and occupational health (MC1/14[INQ000524943]) and (MC1/15 [INQ000560883]).

Designated Premises/Settings Working Group

65. The Designated Premises Working Group (also referred to as the Designated Settings Working Group) was set up by DHSC in September 2020 and met fortnightly. The purpose of the group was to discuss issues relating to the provision and updating of guidance on designated settings and the rules around how Covid-19 was to be managed in such settings.

66. The meetings were attended by CQC along with Care England, NCF, NCA, DLUHC, NHSE, ADASS, PHE and representatives from local government.

67. In a meeting on 20 November 2020 we provided an update to the group on our pilot program of inspections of designated settings (MC1/16 [INQ000524916]). This work is described in greater detail below in Section K.

68. On 24 February 2021 we jointly hosted a shared experiences and learning event with CPA, LGA, NHSEI and ADASS (MC1/17 [INQ000524996]). This brought together people who were already running a designated setting, and those who were contemplating doing so, to share experiences and learning. There was also discussion regarding the experiences of providers working with CQC.

Finding and Keeping Workers Group

69. The Finding and Keeping Workers Group was set up by Skills for Care in order to examine practical solutions for staffing issues in ASC in England. The meetings commenced in August 2021 and occurred monthly. The group included representatives from CQC, Skills for Care, TLAP, NCF, LGA, DHSC and carers employment groups.

70. In a meeting on 6 September 2021 DHSC noted that the ASC sector was facing a number of immediate pressures, in particular workforce capacity. It was also noted that CQC was reviewing best practice in relation to addressing workforce capacity in conjunction with local authorities (MC1/18 [INQ000524925). In the meeting it was noted that retention of staff was an issue, particularly in relation to the retention of registered managers. The representative from Walnut Care reiterated this concern indicating that recruitment agencies were reporting staff shortages "and that retention of Registered Managers [was] a real concern".

71. A registered manager is responsible for ensuring that the care service they oversee is in compliance with all CQC regulations. This includes making sure that all staff are properly trained and that the facility is adequately equipped and staffed to meet the needs of its residents or clients. The registered manager therefore needs to have a good understanding of CQC regulations and guidelines as well as an understanding of the care needs of those they serve.

72. On their website Skills for Care describe the importance of registered managers in the ASC sector on the basis that they play a vital role in ensuring the highest quality of care for people drawing on support and in supporting their team to be happy and effective in their roles. They also report that from their data they have seen that staff

turnover rates are lower when an experienced registered manager is in post, and services with a stable registered manager in place also have better CQC ratings.

73. As explained later on in this statement, the pandemic brought the challenges around recruitment and retention of ASC staff into sharp focus. In our State of Care Report 2021/2022 (MC1/556 [INQ000398569]) we reported on the workforce related challenges necessitated by the pandemic and noted that providers had told us that a key concern had been staff moving out of the sector to take up jobs in other industries. For example, areas with high levels of tourism or expensive housing can be particularly badly affected, with cleaning and catering staff leaving as well as care workers. The government decision to make vaccination a condition of deployment also had a significant impact on the care home workforce.

74. The results of our adult social care workforce survey (described in detail in Section N below) showed the impact of workforce challenges and staffing shortages in general on the services they deliver to people, with 36% of care home providers and 41% of homecare providers saying that workforce challenges had a negative impact on the service they delivered. Additionally 25% of care home and 26% of homecare providers said there had been a delay in accessing health and care services for people (for example, GPs, mental health care and speech and language therapy). For those that said that workforce challenges had a negative impact, this was higher with 42% of care homes and 43% of homecare providers saying people had experienced a delay. Workforce pressures were also clearly having an impact on access to care homes, with over a quarter of services telling us that they had made an active decision not to admit any new residents. Whilst CQC has not conducted any analysis regarding the impact of the retention of registered managers specifically, the results outlined above are applicable to all members of the ASC workforce.

Social Care Taskforce and the Workforce Advisory Group

75. The Social Care Sector Covid-19 Support Taskforce ('the Taskforce') was set up in June 2020 to support the delivery of the Government's support packages for the ASC sector, the Social Care Action Plan and the Care Home Support Package. CQC's involvement in the Taskforce is set out in detail later on in this statement in Section G.

76. On 3 July 2020 CQC was invited to join the Workforce Advisory Group which was one of eight advisory sub-groups of the Taskforce. The Workforce Advisory Group was co-chaired by Professor Vic Rayner (Chief Executive Officer, National Care Forum) and Colin Angel (Policy, Practice & Innovation Director, UK Homecare Association. CQC was represented by an ASC Head of Inspection and the other members included:

76.1. UKHCA

76.2. NHSE

76.3. ADASS

76.4. Unison

76.5. The Deputy Chief Nursing Officer

76.6. Careworkers' Charity

76.7. National Co-production Advisory Group

76.8. Care England

76.9. Shared Lives Plus

76.10. NCF

76.11. PHE

76.12. Skills for Care

76.13. LGA

76.14. Care Association Alliance.

77. The Workforce Advisory Group's aims included:

77.1. the consideration of what should change for the frontline workforce;

77.2. ensuring the sector had the staff they needed;

77.3. the security and wellbeing of staff; and

77.4. organising the workforce.

78. The group produced a final report for the Taskforce in August 2020.

Task and Finish Group: Covid-19 Operational Guidance

79. In early March 2020 DHSC set up the 'Covid-19: Operational Guidance' Task and Finish Group (MC119 [INQ000525030]). Its aim was to ensure the care sector was prepared in its response to the pandemic, and to work closely with national partners

to help co-ordinate advice and support, by supporting the decision-making process through the scoping of operational guidance for the sector. The invitation for CQC to attend this group came from the Chief Social Worker for Adults. This Task and Finish group included representatives from LGA, the British Association of Social Workers, the Royal College of Occupational Therapists, ADASS and DHSC.

80. In advance of the first group meeting, a draft version of DHSC's Adult Social Care Ethical Framework was circulated (MC120x [INQ000525024]). The aim of the framework was for use before and during a pandemic by planners and strategic policy makers at national, regional and local level. Following DHSC's invitation for feedback and comments on the Ethical Framework, we confirmed that we agreed with the comments of NCF that Kate Terroni had shared during the group's meeting concerning the need for equality of approach with self-funders (MC1/21[INQ000525022] MC1/22 [INQ000525023] MC1/23 [INQ000235335]).

81. We provided our final comments on the draft Ethical Framework, raising some concerns about whether it addressed the issues CQC was likely to face in determining our tolerance and thresholds to act, as well as raising the relevance of human rights across a number of the principles in the framework (MC1/24 [INQ000235336]). However, at this point the document had already been passed to the Prime Minister's Office for final approval and we were advised that further amendment would be difficult (MC1/25 [INQ000525028]). The framework was subsequently published on 19 March 2020.

Engagement with the systems regulators for the four nations

82. As stated above, CQC is the independent regulator of health and social care services in England. Health Improvement Scotland (HIS) is the national healthcare improvement organisation for Scotland. Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. The Care Inspectorate (CI) is the independent regulator of social care and social work services in Scotland. Care Inspectorate Wales is the independent regulator of social care and childcare in Wales. The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland.

Chief Executive Calls

83. As part of the working relationship between the regulators for the four nations, there are fortnightly calls that take place which are attended by the Chief Executives of:
    83.1. CQC;
    83.2. The Health Information and Quality Authority;
    83.3. HIS;
    83.4. CI; and
    83.5. HIW.

84. The group meets regularly, mostly monthly but sometimes fortnightly when necessary. During the relevant period Ian Trenholm attended the meetings as CQC's Chief Executive unless he was unable to do so, in which case a Chief Inspector from CQC would usually deputise.

85. The purpose of the meetings during the pandemic was to meet regularly to share experiences and discuss areas of commonality within the respective health and care sectors.

86. In March 2020 the group planned to hold a Collaborative Development workshop in person, but this was cancelled and instead a teleconference was held on 12 March 2020 (MC126 [INQ000524882]). The invites and agendas were initially circulated by CI, and the agendas generally included an update from each regulator in relation to their response to the pandemic. Ian Trenholm chaired these meetings on two occasions, as detailed below.

87. In December 2020 it was agreed that a seminar would be organised in order to take account of the experiences of health and social care regulators during the pandemic, along with an articulation of the learning arising from those experiences (MC1/27 [INQ000524889]) (MC1/28 [INQ000524890]) (MC1/29 [INQ000524891]). The seminar was held virtually on 21 January 2021 and each regulator was able to invite up to two senior officers from their respective Government departments to participate. William Vineall (Director of NHS Quality, Safety and Investigations at

DHSC) attended alongside Ian Trenholm on behalf of CQC. The seminar was entitled 'British Isles and Ireland Health and Social Care Regulators' Forum.'

88. The forum noted that for the health and social care sectors, particularly care home settings, the past 10 months had been among the most personally and professionally challenging any of the members had to deal with. The forum reflected on individual and joint learning from Covid-19, based on the key issues members of the forum faced over the course of the pandemic, and discussed the issues likely to persist for regulators in the new Covid-19 world. Forum members discussed the responses to a questionnaire they were sent in September 2020 to establish key issues and challenges health and social care regulators faced during the pandemic and what they thought would be expected of them in the future. From the responses to the questionnaire, four main pillars of common themes were identified:
    88.1. Effective engagement, information sharing and communication;
    88.2. Regulation and the future of care;
    88.3. Stakeholder/partner coordination: a more integrated approach; and
    88.4. Key enablers.

89. A forum member delivered a presentation at the seminar on each of these pillars to provide the opportunity for further discussion as a group.

90. Following the seminar a feedback report and a letter dated 2 February 2021 signed by the Chief Executives of all of the named organisations in para 83 above was circulated to the government attendees (MC1/30 [INQ000198546]) (MC1/31 [INQ000198545]). The letter indicated that the pandemic had highlighted the critical role that regulators play in the social care sector. It further stated that it was clear through the discussions that the pandemic had necessitated closer working than ever before between the regulators and government colleagues, as well as new and closer working relationships with other public bodies and the wider care sector. It was stressed that the pandemic had shone a light on the social care sector like never before and that the forum had been extremely helpful throughout the pandemic in discussing issues of commonality and navigating a course through the many challenges faced. The forum confirmed that it was keen to continue to work with

government colleagues and identified some common areas that it intended to work with governments on including, but not limited to:

90.1. Retaining the co-production that has been necessary and successful during the pandemic – noting the need to balance this with the regulator's role in providing independent assurance;

90.2. The benefits of market oversight;

90.3. Legislative review;

90.4. Review of enforcement powers;

90.5. Future models of care and redesign of care homes; and

90.6. The importance of being digitally enabled – both internal (as an organisation and external (providers)

91. The letter confirmed that there was a shared intention to continue to meet regularly and build on the learning and the valuable work that had already taken place.

92. On 5 April 2022 CQC chaired a meeting of the group (MC1/32 [INQ000524893]). Each regulator provided an update on Covid-19. Ian Trenholm provided an update for England and told the group that long ambulance waiting times were an issue and that visiting in care homes remained a problem. Ian Trenholm explained that CQC had followed up on the visiting concerns and that there were a small number of cases where visiting concerns were cited together with evidence of other issues to support enforcement action (this topic is covered in detail in Section H below). Representatives from Scotland, Wales and the Republic of Ireland also provided an update and there was a general discussion on masks and testing for social care and the spring booster programme.

93. On 13 June 2022 CQC also chaired a meeting of the group (MC133x [INQ000524885]). Each country provided an update on Covid-19. Ian Trenholm told the group that:

93.1. From a market oversight perspective we were seeing care homes struggle to recruit staff and capacity being reduced

93.2. This issue was being blamed on regulation

93.3. CQC was not reducing standards/expectations on safety, so care homes were reducing beds to manage staffing shortfalls

93.4. The creation of 42 new integrated care systems was underway

93.5. Further information on CQC's Market Oversight function would be provided to the group and the possibility of CQC's Director of Market Oversight to attend a future meeting would be explored.

Cross Regulators Meeting

94. On 4 March 2020 CQC held a cross regulators meeting with devolved administrations, including the RQIA, CI, HIW, Care Inspectorate Wales, and HIS. The purpose of the meeting was to ensure that the regulators were as coordinated as possible in their response to the Covid-19 pandemic and to ensure that there was a forum to discuss and share challenges.

95. In the meeting CQC provided an overview of our preparedness and noted that CQC had been having internal discussions around what our role was in the context of the Covid-19 pandemic. We told the group that we had seen evidence of an increased demand for NHS 111 services; were keen to maintain our regulatory integrity but respond in a pragmatic and appropriate way; had offered support to NHSE and PHE by seconding staff; were looking at the capacity of our National Customer Service Centre (NCSC) and whether we could offer support to PHE's call centre; expected an increase in safeguarding issues; and were considering our regulatory response, and a reduced inspection framework should Covid-19 prevail for a significant length of time. We also discussed CQC's set of principles and decision-making tool, our internal and external communications work, and our focus on technology, to allow staff to work flexibly and whether NCSC could be run remotely.

96. RQIA, CI, HIS, HIW and Care Inspectorate Wales also provided an overview of their preparedness in the context of the Covid-19 pandemic.

97. The outcome of the meeting was that we agreed to share information across all six regulators. CQC agreed to share our principles and decision trees and all regulators agreed to share communications and any other information that they considered may be useful to the other regulators. CQC prepared the minutes for the meeting and circulated these via email on 4 March 2020 (MC1/34 [INQ000524900]).

The European Partnership for Supervisory Organisations in Health and Services and Social Care

98. The European Partnership for Supervisory Organisations in Health and Services and Social Care (EPSO) is a forum which brings together supervisors and regulators of health services and social care across Europe and beyond, including England and the devolved administrations in the UK. Its aim is to improve the quality of health care and social care and to connect supervisory and regulatory organisations to improve exchange of ideas, information and good practice. Meetings and agendas were organised by a small secretariat team. The EPSO initially held weekly EPSO Covid-19 Taskforce tele-meetings from April 2020 during the relevant period. These meetings were then reduced to monthly meetings. The EPSO distributed agendas and minutes for the meetings. Representatives from supervisory organisations across Europe and beyond were invited to the meetings, including CQC, HIS, RQIA and HIW. The EPSO introduced "Monthly Taskforce" meetings in March 2022, different to the Covid-19 Taskforce meetings, as the scope of the EPSO Taskforce Covid-19 meetings changed over time and were no longer limited to purely Covid-19 related topics.

99. At the Covid-19 Taskforce meetings the group discussed each nation's updates on their Covid-19 response, DNACPR issues, the Delta variant, vaccination programmes and international research projects, one of which included looking at infection rates and deaths in nursing homes.

100. On 7 April 2021 CQC, HIS and HIW attended a EPSO Covid-19 Taskforce weekly tele-meeting to share information and provide updates (MC1/35 [INQ000525008]). At this meeting CQC provided an update to the group regarding DNACPR. We explained that we had found that there was no national approach to DNACPR in adult social care and that organisations were taking different approaches. We further explained that CQC's overall recommendation in its report regarding DNACPR was that DNACPR decisions needed to be recognised as wide conversations about long term care planning and end of life care and that a consistent national support was needed. CQC agreed to share the report with the group and the group agreed to

revisit this after continuing with the tele-meeting. Our work in relation to DNACPR is explained in detail in Section J below.

101. On 6 October 2021 CQC and HIS also attended a EPSO Covid-19 Taskforce monthly tele-meeting. CQC provided a further update to the group regarding compulsory vaccination of staff in England. We explained that from November 2021 all health and care staff that are working in England needed to be vaccinated and that a consultation had been published by the Government on (9 September 2021) providing that vaccination for all staff working in healthcare settings would be required for Covid-19 vaccinations and flu vaccinations. We explained that this had caused some controversy regarding the policing of vaccination of health care and social staff and because England had staff shortage issues (MC1/36 [INQ000525007]).

Health and Social Care Accreditation Forum

102. The Health and Social Care Accreditation Forum (HaSCAF) is an established network of organisations which aims to share experience, good practice and new ideas around the methodology for programmes, covering issues such as developing healthcare quality standards, implementation of standards within healthcare organisations, assessment by peer review and exploration of the peer review techniques to include the recruitment, training, monitoring and evaluation of peer reviewers and the mechanisms for awards of accredited status to organisations.

103. CQC is an 'observer' of the HaSCAF and HIS is a member of HaSCAF. HaSCAF held meetings on a quarterly basis throughout the relevant period.

104. On 16 June 2020 The HaSCAF held a meeting attended by representatives from CQC, HIS, CHKS, United Kingdom Accreditation Service, Royal College of Anaesthetists, WMQRS, British Standards Institution and Royal College of Psychiatrists as well as Jan Mackereth-Hill, Quality Improvement Consultant specialising in Healthcare Accreditation, to discuss the group's experience of the Covid-19 pandemic and how the group was coping with the pandemic (MC1/36 [INQ000525039]). CQC and HIS provided an update regarding the carrying on of

assessments and inspections throughout the Covid-19 pandemic. CQC explained that routine inspections had been suspended and that inspections were only taking place on a risk basis and that CQC had carried out some-risk based assessments. We also informed the group that a lot of CQC staff were on secondment to support the delivery of healthcare. HIS explained that it had recommenced limited assessments in care homes and that it had changed the way that it worked looking at remote assessments and use of technology.

C. Pre-pandemic structure and capacity

105. 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 good and outstanding care as well as identifying potential problems within the system.

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

107. In order to provide an overview of the state of the Care Sector in England at the start of the pandemic, we have summarised the relevant information from the State of Care Reports for 2018/19 and 2019/20 below.

State of Care 2018/19

108. The report was published on 14 October 2019 (MC1/38 [INQ000502393]) and Part 2 (pages 33 – 44) provides a description of the state of the adult social care sector for 2019. The key issues in adult social care for 2019 were identified as follows:
    108.1. Funding pressures
    108.2. Workforce challenges
    108.3. Access to services

108.4. Local services working together

108.5. Innovation and technology

109. The report also includes graphs depicting the following:

109.1. Figure 2.1: The overall ratings of each type of service in the ASC sector for 2018 and 2019

109.2. Figure 2.2: The overall ratings of ASC services broken down by region for 2018 and 2019;

109.3. Figure 2.3: The numbers of care home beds per 100 000 people aged 85 and over per region for 2014 to 2019;

109.4. Figure 2.4: The types of funding in care homes broken down by region for 2019;

109.5. Figure 2.5: The change in the numbers of residential care homes, nursing homes and domiciliary care services in England between 2014 and 2019;

109.6. Figure 2.6: The change in numbers of residential care homes, nursing homes and domiciliary care services in London between 2014 and 2019; and

109.7. Figure 2.7: The numbers of ASC staff turnover by job role for 2014 to 2019

State of Care 2019/20

110. The report was published on 15 October 2020 (MC1/39 [INQINQ000235495]) and specifically reported on the quality of care before the pandemic. The key points from this section were as follows:

110.1. The care that people received in 2019/20 was mostly of good quality and in relation to the ASC sector specifically, 80% of services were rated as "good" and 5% as "outstanding" which was broadly the same as the previous year.

110.2. While quality was largely maintained compared with the previous year, there was no improvement overall.

110.3. Before the arrival of the coronavirus pandemic, we remained concerned about a number of issues:

110.3.1. the poorer quality of care that is harder to plan for;

110.3.2. the need for care to be delivered in a more joined-up way;

110.3.3. the continued fragility of adult social care provision;

110.3.4. the struggles of the poorest services to make any improvement;

110.3.5. significant gaps in access to good quality care, especially mental health care; and

110.3.6. persistent inequalities in some aspects of care.

111. The ratings charts for the ASC sector are shown in the Appendix to the report from page 92 – 93 and depict the following:

111.1. Figure A1: The overall ratings for ASC services for 2019 and 2020;

111.2. Figure A2: The overall ratings for ASC services against each of the 5 key questions for 2019 and 2020;

111.3. Figure A3: The overall ratings for ASC services broken down by service type for 2019 and 2020;

111.4. Figure A4: The overall ratings of ASC services broken down by region for 2019 and 2020;

112. In relation to the overall state of the ASC sector, the 2019/20 State of Care Report highlighted that the funding model continued to drive instability in this sector, and we pointed to an urgent need for Parliament and government to make this a priority.

113. To provide an overview of the state of the Care Sector in England at the start of the pandemic, with reference to staffing levels, bed capacity and the number providers registered with the CQC we have extracted the relevant data as at 1 January 2020 which is set out below.

114. Care homes and domiciliary care providers registered with CQC

114.1. The number of adult care homes registered with CQC was 15,525.

114.2. The number of registered domiciliary care providers was 9,415.

115. In terms of bed capacity, we are able to confirm the total number of beds each provider has indicated they are able to accommodate when they register with CQC. This number represents the 'max service users' that registered providers are able to accommodate however this does not necessarily give an indication of available bed capacity because capacity might be impacted by other factors such as staffing ratios. Providers are expected to confirm these numbers in their Provider Information Returns (PIRs) which must be submitted to CQC annually, but can be submitted

more regularly if the provider wishes to notify us of relevant changes throughout the year. PIRs are explained in greater detail in Section E below.

115.1. As at 1 January 2020 the 'max service users' number for registered care homes was 456,806.

116. In the PIRs, registered providers are required to provide information regarding staffing numbers. Specifically, they are asked to confirm the following:

116.1. How many people are directly employed and deliver regulated activities at the service as part of their daily duties

116.2. How many staff have left the service in the past 12 months;

116.3. How many staff vacancies the service has;

116.4. How many full-time equivalent posts the provider employs;

116.5. How many hours of care have agency staff provided in the past 28 days

117. As stated above, we collect PIR data from all adult social care providers annually, but this is a staggered process with only a sample of providers submitting returns in any given month. In January 2020 there were 1,098 PIR submissions received from registered ASC providers, indicating that there were 36,152 people directly employed and delivering regulated activities as part of their daily duties. This can be considered a statistically valid sample size to estimate national figures.

D. Regulated activities, Registration and Notification

Regulated Activities

118. The regulated activities are detailed in Schedule 1 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and are as follows:

118.1. personal care;

118.2. accommodation for persons who require nursing or personal care;

118.3. accommodation for persons who require treatment for substance misuse;

118.4. treatment of disease, disorder or injury (TDDI);

118.5. assessment or medical treatment for persons detained under the 1983 Act;

118.6. surgical procedures;

118.7. diagnostic and screening procedures;

118.8. management of supply of blood and blood derived products;

118.9. transport services, triage and medical advice provided remotely;

118.10. maternity and midwifery services;

118.11. termination of pregnancies;

118.12. services in slimming clinics;

118.13. nursing care; and

118.14. family planning services.

119. The regulated activities which specifically relate to ASC, are explained in detail below:

119.1. Personal care[4]:

119.1.1. involves providing personal care for people who are unable to provide it for themselves because of old age, illness or disability. The personal care must be provided in the place where those people who need it are living at the time when the care is provided.

119.1.2. For example, this includes personal care provided through:

119.1.2.1. domiciliary care agencies/homecare;

119.1.2.2. extra care housing;

119.1.2.3. Shared Lives schemes; and

119.1.2.4. Supported living.

119.2. Accommodation for persons who require nursing or personal care:

119.2.1. Where residential accommodation is provided together with nursing care or personal care as a single package meaning that the person using the service cannot choose to receive personal

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[4] Personal care is defined in Regulation 2 (Interpretation) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and covers:

- Physical assistance given to a person in connection with:
  - eating or drinking (including the administration of parenteral nutrition)
  - toileting (including in relation to menstruation)
  - washing or bathing
  - dressing
  - oral care
  - the care of skin, hair and nails (except for nail care provided by a chiropodist or podiatrist)
- Prompting and supervising a person to do any of the types of personal care listed above, where that person is unable to make a decision for themselves about performing such an activity without being prompted and supervised.

care from another provider while they are living in the accommodation. In the same way, to receive the accommodation, they are required to receive their personal care from one specified provider.

119.2.2. For example: nursing or personal care delivered in a care home setting

119.3. TDDI:

119.3.1. This activity covers a treatment that is:

119.3.1.1. Provided by or under the supervision of a defined list of healthcare professionals or by a multi-disciplinary team that includes a listed health professional, or

119.3.1.2. Provided by or under the supervision of a social worker where the treatment is for mental disorder, or by a multi-disciplinary team that includes a social worker where the treatment is for a mental disorder, and is

119.3.1.3. For a disease, disorder or injury.

119.3.2. Treatment of a disease, disorder or injury covers a wide range of treatments including examples such as:

119.3.2.1. Emergency treatment

119.3.2.2. Ongoing treatment for long-term conditions;

119.3.2.3. Treatment for a physical or mental health condition or learning disability;

119.3.2.4. Giving vaccinations or immunisation;

119.3.2.5. palliative care

119.3.3. This regulated activity applies to the treatment of disease, disorder or injury in any setting, for example:

119.3.3.1. Hospices;

119.3.3.2. Community services; and

119.3.3.3. Care homes

119.4. Nursing care:

119.4.1. This regulated activity covers nursing care where it is not part of another regulated activity. It covers any service that is provided by a registered nurse and involves:

119.4.1.1. Providing care; or

119.4.1.2. Planning, supervising or delegating the provision of care.

119.4.2. This regulated activity normally covers services that do not constitute treatment, for example health visiting may include vaccination, which is included in the activity of TDDI, or may include a test that is included in Diagnostics and screening procedures.

120. The types of services within the remit of CQC's ASC Directorate and some examples of services that fit within each category are as follows:

120.1. Care home with nursing:

120.1.1. A care home is a place where personal care and accommodation are provided together. People may live in the service for short or long periods. For many people, it is their sole place of residence and so it becomes their home, although they do not legally own or rent it. Both the care that people receive and the premises are regulated. In addition, qualified nursing care is provided, to ensure that the full needs of the person using the service are met.

120.1.2. Examples of services that fit under this category include:

120.1.2.1. Nursing home

120.1.2.2. Convalescent home with nursing

120.1.2.3. Respite care with nursing

120.1.2.4. Mental health crisis house with nursing

120.2. Care home without nursing:

120.2.1. Examples of services that fit under this category include:

120.2.1.1. Residential home

120.2.1.2. Rest home

120.2.1.3. Convalescent home

120.2.1.4. Respite care

120.2.1.5. Mental health crisis house

120.2.1.6. Therapeutic communities.

120.3. Domiciliary care services (including those provided for children):

120.3.1. These services provide personal care for people living in their own homes. The needs of people using the services may vary greatly, but packages of care are designed to meet individual circumstances. The person is visited at various times of the day or, in some cases, care is provided over a full 24-hour period. Where care is provided intermittently throughout the day, the person may live independently of any continuous support or care between the visits.

120.3.2. Examples of services that fit under this category include:

120.3.2.1. Domiciliary care agency

120.4. Extra care housing services:

120.4.1. These services cover many different arrangements. Usually, they consist of purpose-built accommodation in which varying amounts of care and support can be offered, and where some services and facilities are shared. The care that people receive is regulated by CQC, but the accommodation is not.

120.5. Shared lives services (formerly known as Adult Placement):

120.5.1. Shared Lives is care and/or support provided by individuals, couples and families who have been approved and trained for that role by the service registered with CQC. Care and/or support may also be provided either within or outside of the home of the carer as well as kinship support to people living in their own homes. It is the service that is regulated, not the individual accommodation that is owned or rented by private residents.

120.6. Specialist college services:

120.6.1. These services provide education, care, and training in independence for young people with a learning disability and/or physical disability. The colleges are first and foremost educational establishments and are regulated by Ofsted. CQC regulates the personal care and accommodation that a college provides where 10% or more of the students require personal care.

120.7. Supported living services:

120.7.1. These services involve a person living in their own home and receiving care and/or support in order to promote their independence. The care they receive is regulated by CQC, but the accommodation is not. The support that people receive is continuous and is tailored to their individual needs. It aims to enable the person to be as autonomous and independent as possible, and usually involves social support rather than medical care.

Registration

121. Any person (individual, partnership or organisation) who carries out a regulated activity in England must be registered with CQC. To be registered, an application must be made to CQC providing details about the applicant, the regulated activities applied for, and the places at which, or from which, they will be carried out. It is an offence to carry on a regulated activity without being registered, unless a relevant exception or exemption applies.

122. Providers can apply to us to be registered to carry out one or more regulated activities. Sometimes registration for one regulated activity will remove the need to register for another. In the context of ASC, a provider will not need to apply for:
    122.1. Nursing care where it is part of another regulated activity such as TDDI; or
    122.2. Personal care where it is delivered as part of:
        122.2.1. Accommodation for persons who require nursing or personal care;
        122.2.2. Accommodation for persons who require treatment for substance misuse; or
        122.2.3. TDDI.

123. However, wherever nursing care or personal care is provided in its own right, then the provider may need to register for it as a regulated activity, even if the provider is registered for other regulated activities.

124. For example, where a provider is registered for Accommodation for Persons who Require Nursing or Personal Care in respect of a residential care home, but they

also provide care to people in their home (called a domiciliary or homecare service), the provider must also register for the regulated activity of Personal Care because the domiciliary or homecare service involves personal care that is separate to the care home service.

125. The Quick reference guide to regulated activities by type of service: Guidance for providers (MC1/40 [INQ000398691]) provides guidance to providers around how regulated activities and services may link together, but it is for the provider to determine which regulated activities it carries on and therefore which activities it requires registration for. When CQC decides whether to grant or refuse an application for registration of a service provider we must apply the test set out in section 12 of the 2008 Act. This provides that we must be satisfied that the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009, and any other enactment which appears to us to be relevant, are being and will continue to be complied with in relation to the regulated activity for the application to be granted, otherwise we must refuse it.

126. The Scope of Registration Guide: March 2015 guidance (exhibit MC1/41 [INQ000524947]) outlining CQC's scope of registration was in place throughout the relevant period until May 2022 when an updated version was published (exhibit MC1/42 [INQ000525035]). The May 2022 version is still in place.

127. We have the power to grant an application for registration subject to conditions and the power to impose, vary or remove conditions on the registration. In some cases, registration of a provider is subject to a registered manager condition (section 13 HSCA 2008). The Care Quality Commission (Registration) Regulations 2009 set out the circumstances in which a service must have a registered manager as a condition of its registration.

128. These are:

    128.1. Any service provider that is an organisation, whether corporate (for example, a company) or unincorporated (for example, a partnership or a charity), must have a registered manager for every regulated activity that it

carries on, unless it is a health service body. Health service bodies such as English NHS trusts do not need to have a registered manager unless we impose a condition on their registration that requires one. Others, including independent organisations that work under contract to the NHS, must always have a registered manager.

128.2. If the service provider is an individual, they do not need to have a registered manager unless they are not a fit person[5] to manage the regulated activity, or they do not intend to be in day-to-day charge of how the regulated activity is provided.

129. When we register NHS trusts that provide the regulated activity of accommodation for persons who require nursing or personal care in a care home, we will use our discretion and may impose a condition to have a registered manager. This is because we consider the role of a manager who is in day-to-day charge of these services to be fundamental to providing positive outcomes for people who use the service.

130. In deciding whether to grant or refuse an application for a registered manager, CQC must apply the test in section 15 of the 2008 Act, which is the same as that set out in section 12. We also have the power to grant a manager's application for registration subject to conditions and the power to impose, vary or remove conditions on the registration.

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[5] Regulation 7 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: The intention of this regulation is to ensure that people who use services have their needs met because the regulated activity is managed by an appropriate person. This is because providers who comply with the regulations will have a registered manager who:

Is of good character;
Is able to properly perform tasks that are intrinsic to their role;
Has the necessary qualifications, competence, skills and experience to manage the regulated activity; and
Has supplied them with documents that confirm their suitability.

CQC cannot prosecute for a breach of this regulation or any of its parts but we can take regulatory action.
CQC must refuse registration if providers cannot satisfy us that they can and will continue to comply with this regulation.

131. At the point of registration we are required to issue a certificate of registration. This sets out the regulated activities that the provider is permitted to carry on, and the locations at which the provider may carry on the regulated activities in a locations condition which forms part of the conditions of registration. There are other conditions that may be placed on the registration of providers, some routine and some not, depending on the type of provider and the type of service being operated.

132. Registered persons, that is providers or their associated registered managers, may apply to us to vary or remove any conditions on their registration (other than a Registered Manager condition); or to cancel their registration; or for the cancellation of, or the variation of, the period of any suspension of their registration as set out in section 19 of the 2008 Act. However, there are several exceptions to when this is permissible.

133. As part of CQC's contingency planning at the start of the pandemic, we acknowledged the need to ensure that our registration operations were aligned with the evolving situation. To help us respond to the spread of Covid-19, we therefore adapted our methodology and approach to registration to apply a specific response, where required, to Covid-19 related applications and to ensure the continued delivery of registration activities.

134. In March 2020 we began drafting the "Covid-19 Registration Principles and Decision-Making Tool" to be used to ensure that we had a framework through which to consistently assess risk, identify escalation measures and the actions needed in response to registration issues in the context of the changing Covid-19 situation. The tool sought to do this by:
    134.1. setting out how we would risk assess an application if we needed to minimise the completion of site visits; and
    134.2. setting out how an application for a Covid-19 related service should be assessed; and
    134.3. setting out what temporary Covid-19 registration arrangements may apply to both Covid-19 and routine registration applications and how these would be recorded and managed.

135. Initially, specific queries regarding registration from providers were dealt with by the Query Handling Group. However, in March 2020 we formed a dedicated Registration Covid-19 Advisory Panel to provide advice to colleagues regarding questions from providers about supporting the national response to Covid-19 and any implications on their registration, as well as ensuring consistent decision making on applications. The panel's first meeting was on 20 March 2020 and it continued to meet on Mondays and Fridays and ad-hoc as necessary during the early stages of the pandemic. The panel's Terms of Reference; the "Covid-19 Registration Principles and Decision-Making Tool" and the Registration Covid-19 Panel Supporting Guidance are attached as (MC1/43 [INQ000398702])

136. On 25 March 2020 we wrote to the Secretary of State for Health and Social Care to formally update him on the improvements that we made to our registration activity to ensure support was given to those working to respond to the pandemic (MC1/44 [INQ000525080).

Changes to registration and/or regulation duties and powers through legislative amendments during and post pandemic

Changes to "Regulated Activity"

137. The definition of regulated activity as set out in Schedule 1 of the 2014 Regulations did not change during the relevant period. A change was made to the specified "general exemptions" in Schedule 2 to exempt Covid-19 testing from being a regulated activity.

138. Schedule 2 was amended by the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) (No. 2) Regulations 2020 to include paragraph 12 as a general exception as follows:

12. Any activity which—

(a) is carried on for the purpose of testing for the presence of severe acute respiratory syndrome coronavirus ("SARS-CoV-2") in an individual, or for the presence of antibodies to SARS-CoV-2, or

(b) is carried on for the purpose of processing, analysing or reporting the results of a test for the presence of SARS-CoV-2 in an individual, or for the presence of antibodies to SARS-CoV-2.

139. In September 2020 CQC colleagues had discussions internally, and with relevant stakeholders, about the best way to take forward DHSC's proposed Covid-19 testing programme as part of their 'Project Moonshot' (the UK Government programme to introduce rapid mass testing for Covid-19 in England).

140. Initial discussions canvassed the possibility of CQC having a prominent accreditation and assurance role for registration and inspection of non-NHS testing providers, for example by registering all emerging providers, and once registered inspecting, and potentially rating, services so that the Government could issue a list of assured providers. We shared our view that CQC's regulatory role would not fit the accreditation model being proposed. It was felt that this could be an obstacle in terms of providing timely assurance considering the number of providers who would be involved. It was agreed that the UK Accreditation Service (UKAS) was a better organisation for undertaking provider accreditation.

141. We also flagged, with reference to testing falling within the scope of our regulations, that taking an exemption approach to the CQC regulated activities had precedent under similar Covid-19 emergency regulations from earlier in the year (Safeguarding Vulnerable Groups Act 2006 (Regulated Activities) (Coronavirus) Order 2020): This order, pursuant to Article 2, provided for the activity of 'removal of saliva or mucus from the mouth or nose of an individual where that is done for the purpose of testing an individual for coronavirus' to not be treated as a regulated activity within the meaning of the Act).

142. We met with DHSC, KPMG, the MHRA, and UKAS on 18 and 22 September 2020 and agreed on the way forward.

143. The discussion with DHSC regarding amendments to legislation to exempt Covid-19 tests themselves from being a regulated activity and thereby removing the requirement for registration continued into October 2020. Our legal and registration

colleagues attended several meetings with DHSC and provided some views. (MC1/45 [INQ000235380])

144. 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 (MC1/46 [INQ000398788]). This meant that any testing activity in relation to Covid-19 was taken out of scope of CQC registration. Regulation 6 of The Health Protection (Coronavirus, Testing Requirements and Standards) (England) Regulations 2020 instead required all private coronavirus test providers to become accredited by UKAS.

The Health and Social Care Act 2022

145. As stated in paragraph 10 above, the Health and Care Act 2022 (the "2022 Act") which received Royal Assent on 28 April 2022 introduced new regulatory duties for CQC as set out below. Sections 31 and 163 of the 2022 Act added the review and assessment of Integrated Care Systems (ICSs) and the regulation of certain Local Authority functions relating to ASC to the list of regulatory duties held by CQC.

146. ICSs are local partnerships that bring health and care organisations together to develop shared plans and joined-up services. They were legally established on 1 July 2022 and build on partnerships that were already in place across England. ICSs are formed by NHS organisations and upper-tier local councils in the respective area and also include the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing. The NHS organisations and upper-tier local authorities in each ICS run a joint committee called an integrated care partnership (ICP). Each ICP must develop a long-term strategy to improve health and social care services and people's health and wellbeing in the area. Integrated care boards (ICBs) are NHS organisations responsible for planning health services for their local population. There is one ICB in each ICS area. They manage the NHS budget and work with local providers of NHS services to agree a joint five-year plan which outlines how the NHS will contribute to the ICP's integrated care strategy.

147. Section 31 of the 2022 Act (which came into force on 1 April 2023) amended section 46 of the 2008 Act by inserting a new section 46B requiring CQC to:

147.1. conduct reviews of:

147.1.1. the provision of relevant health care, and ASC, within the area of each ICB; and

147.1.2. the exercise of the functions of the board, its partner local authorities and registered service providers in relation to the provision of that care with the area of each ICB

147.2. assess the functioning of system for the provision of relevant health care, and ASC, within the area of each ICB, taking into account (in particular) how the ICB, its partner local authorities and registered service providers work together; and

147.3. publish a report of the assessment.

148. Section 163 of the 2022 Act (which also came into force on 1 April 2023) amended section 46 of the 2008 Act by inserting a new section 46A requiring CQC to:

148.1. conduct reviews of the exercise of regulated care functions by English local authorities (specifically reviewing the delivery of their adult ASC duties under Part 1 of the Care Act 2014);

148.2. assess the performance of those authorities following each review; and

148.3. publish a report of the assessment.

149. CQC is responsible for determining the indicators of quality for the assessments and the methods, period and frequency of ICS and local authority reviews with Secretary of State approval. The Secretary of State is responsible for setting the priorities and objectives of ICS and local authority reviews. We have currently paused our assessments of integrated care systems (ICS) in agreement with DHSC.

Amendments to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Vaccine as a condition of deployment ("VCOD")

150. On 4 March 2020 we attended a meeting with DHSC at which emergency legislation for mandatory flu vaccinations was discussed. Following the meeting DHSC sought views on how we could help in a scenario where vaccination became a mandatory

legal requirement for health and care workers. We confirmed our position in relation to specific points raised and confirmed this in an email.

151. In June 2020, DHSC approached us again asking for advice and support around mandatory vaccinations. On 16 June 2020 Ian Trenholm wrote to DHSC indicating that it was not clear what CQC was being asked to do in relation to the mandatory vaccination provisions in the draft emergency legislation. Ian Trenholm indicated that we were supportive of widespread vaccinations but that we needed to know more about what was required and intended. In a call between Lee McDonough and Ian Trenholm on 16 June 2020, Lee McDonough confirmed that the mandatory vaccination policy was not happening (MC1/47 [INQ000235339).

152. In March 2021, DHSC confirmed that the mandating of Covid-19 vaccination in older people's care homes would be proceeding and asked for some discussion to ensure that CQC's role could be accurately reflected in policy from DHSC (MC1/48 [INQ000235340]). On 22 March 2021, we confirmed that, in relation to proposals for 'older adult' care homes, our legislation does not draw a distinction between different categories of social care based on age, nor does it confer different enforcement powers in respect of different regulated sectors. We advised that further thought would be needed around potential evidence to confirm vaccination and that the impact of the policy on CQC enforcement would depend on what legislative changes were made.

153. On 23 March 2021, at the request of DHSC, we provided a paper on CQC's regulatory role in relation to mandatory vaccination for inclusion in the submission to the Secretary of State along with some further comments on the DHSC proposals (MC1/49 [INQ000235343]); MC1/50 [INQ000235346] and (MC1/51 [INQ000235347]).

154. On 26 March 2021 DHSC approached us for input on the proposed additions to the Infection Prevention and Control Code of Practice and we provided comments (MC1/52 [INQ000235348] and MC1/53 [INQ000235349]).

155. In May 2021, at the request of DHSC, we confirmed our view that all CQC-registered care homes should be included in scope, along with all visiting professionals

(MC1/54 [INQ000524909]). At this stage, we also advised of the need to amend either Regulation 17 or Schedule 3 to the 2014 Regulations to ensure 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.

156. In June 2021 DHSC invited us to comment on further additions to the Code of Practice on the Prevention and Control of Infections and Related Guidance. 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 the updated Code of Practice proposals.

157. On 22 July 2021 the Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021 introduced amendments to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of which a requirement was created for all care home workers, and anyone entering a care home, to provide evidence that they have met certain vaccination requirements unless they fall into exempt groups. The amendment took effect from 11 November 2021.

158. In September 2021, DHSC asked for our comments on a submission regarding medical exemptions for vaccination as a condition of deployment in care homes. We responded to confirm our concerns and that the position was quite unhelpful – both from a regulatory perspective, and more importantly, for providers (MC1/55 [INQ000235353]).

159. 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 and we provided some very limited comments to suggest further clarification of context may be helpful (MC1/56 [INQ000235592]).

160. From 11 November 2021 we began inspecting care homes by reference to criteria set by regulation 12(3) of the Regulations during site inspections, including the IPC inspections (which are explained in greater detail in Section G below). Our registration assessment and inspection processes for care home providers and

managers were updated and internal guidance was also issued in relation to the vaccination status of CQC colleagues required to cross the threshold of care homes.

161. On 14 December 2021 Parliament agreed the Health and Social Care Act (2008) (Regulated Activities) (Amendment) (Coronavirus) (No.2) Regulations 2021, which extended vaccination as a condition of deployment beyond residential care settings to any other CQC regulated activity in health and social care, subject to certain exemptions and conditions. The amendment was due to take effect from 1 April 2022 as there was a 12-week grace period to allow people sufficient time to be vaccinated.

162. In summary, the effect of the amendments was that all providers registered with CQC would have to ensure that anyone they employed or engaged to carry out direct and face-to-face CQC regulated activities met the vaccination requirements as set out in the operational guidance (MC1/57 [INQ000525114). The employed/engaged person must have been able to prove that they met one of the following:
    162.1. Satisfied the vaccination requirements;
    162.2. Were exempt from vaccination; or
    162.3. Were covered by other exceptions.

163. In December 2021, DHSC asked for views on the operational guidance for the extension of the vaccination as a condition of deployment regulations and some comments were provided from a legal and operational perspective, along with some guidance on preferred language and phrasing to be used to ensure clarity and consistency (MC1/58 [INQ000235356] and MC1/59 [INQ000112095]. The operational guidance was published by DHSC on 20 January 2022 (MC1/60 [INQ000524932).

164. On 20 December 2021 we published an article on our website regarding our role in relation to vaccination as a condition of deployment in health and social care settings (MC1/61 [INQ000525115]). In the article we indicated that from 1 April 2022, Covid-19 vaccinations would be a requirement for staff providing face-to-face care in healthcare and those social care settings not covered by the existing legislation. We stated that we would use our existing assessment approach and enforcement policy when the new regulations came into force.

165. On 1 February 2022 we were notified of the Government's intention to revoke the regulations making vaccines a condition of deployment for health and social care staff. Following this announcement we drafted a guidance to provide for decision making in this context whilst the public consultation took place (MC1/62 [INQ000524920]) The regulations were revoked on 15 March 2022 and we published an update on our website on 18 March 2022 in response indicating that "*each location found to be in breach of regulation 12(3) will have their inspection report reviewed in respect of these changes. We will assess whether the location's rating has been affected by this removal and take necessary action to ensure our assessment of a service meets applicable regulations. We will be treating each location individually and assessing the particular circumstances.*" (MC1/63 [INQ000397421).

Regulation 9A: Visiting and accompanying in care homes, hospitals and hospices

166. Regulation 9A of the Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2023 introduced a new fundamental standard of care with effect from 6 April 2024. This regulation applies to all providers delivering a regulated activity in a care home, hospital or hospice (with exemptions for certain regulated activities such as personal care and substance misuse treatment) with the aim of ensuring that:
    166.1. People staying in a care home, hospital or hospice can receive visits from people they want to see;
    166.2. People living in a care home are not discouraged from taking visits outside the home; and
    166.3. People attending appointments in a hospital or hospice, that do not require an overnight stay, can be accompanied by a family member, friend or advocate if they want someone with them.

167. Whilst a breach of Regulation 9A is not a criminal offence, CQC can take regulatory action, including civil enforcement, if a provider is failing in this area. CQC must refuse registration if a provider cannot show that they can and will comply with this regulation.

Notifications

168. Registered providers and/or registered managers are required to submit notifications to us about certain incidents, events or changes that affect a service, or the people using it (MC1/64 [INQ000525016). These are called 'statutory notifications'.

169. The statutory notification framework is set out in regulations 12, 14-18, and 20-22 of the Care Quality Commission (Registration) Regulations 2009. The regulations also state the timescales within which we must be notified, and these vary depending on the type of notification. CQC uses information from statutory notifications to:
    169.1. be aware of what is happening in a service;
    169.2. identify issues of concern;
    169.3. inform whether we need to take regulatory action; and
    169.4. monitor trends across health and care.

170. The relevant changes, events and incidents can be split into two categories:
    170.1. <u>Events and incidents</u>
        170.1.1. Absence of a registered individual for 28 days or more (regulation 14)
        170.1.2. Allegations of abuse (safeguarding) (regulation 18(2))
        170.1.3. Children and young people in adult psychiatric units (regulation 18(2)(h))
        170.1.4. Death of a detained mental health patient (regulation 17)
        170.1.5. Death of a person using the service (regulation 16)
        170.1.6. Death of a registered provider (and plans for the service) (regulation 21)
        170.1.7. Events that stop a service running safely and properly (regulation 18(2)(g))
        170.1.8. Liquidator or trustee's plans for a service (regulation 22)
        170.1.9. Outcome of an application to deprive a person of their liberty (DoLS) (regulation 18(2))
        170.1.10. Police involvement in an incident (regulation 18(2))
        170.1.11. Return of a registered individual after an absence of 28 days or more (regulation 14)
        170.1.12. Serious injury to a person using the service (regulation 18(2)(b))

170.1.13. Unauthorised absence (regulation 17)

170.2. Changes to registered details

170.2.1. Change contact details (regulation 15)

170.2.2. Change of an individual's name (regulation 15)

170.2.3. Changes to your statement of purpose (regulation 12(3))

170.2.4. Insolvency (regulation 15)

170.2.5. Nominated individuals, officers and directors (regulation 15)

170.2.6. Provider stopping regulated activities (regulation 15)

170.2.7. Provider's name and address (regulation 15)

170.2.8. Registered manager for an activity (regulation 15)

171. Regulation 25 of the Care Quality Commission (Registration) Regulations 2009 states that it is an offence not to notify CQC when a relevant change, event or incident has happened, specifically in relation to regulations 12 and 14 to 20. Failure to notify under regulation 21 (death of a registered provider) is not in and of itself an offence, however, in this event, the service will no longer be registered and it is an offence to operate as an unregistered provider.

172. The information that must be provided to CQC varies depending on the type of notification being submitted. We hold a range of forms to enable providers to submit statutory notifications to us and there is a specific form for each different type of notification.

173. The form for submitting a statutory notification where there is abuse or allegations of abuse concerning a person who uses the service is exhibited as an example to demonstrate what information must be contained in the notification (MC1/65 [INQ000524979]).

174. During the relevant period, the statutory notification forms were submitted manually to a central CQC mailbox or by post. NHS bodies (only) were able to submit some notifications through the NHS Commissioning Body's National Reporting and Learning System (NRLS) but this did not apply to providers of ASC, independent healthcare, primary dental care and private ambulance services.

Changes to Notification Requirements

175. Providers are required by law to notify us of the death of a person accessing their service under Regulation 16 of the Care Quality Commission (Registration) Regulations 2009. We ask for a range of demographic information about the person who died, using a structured reporting form (SN16).

176. We did not waive any notification requirements during the relevant period. In Spring 2020 we amended the scope of the information collected as part of Regulation 16 notifications to collect additional information regarding the relevance of Covid-19 to the death.

177. 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.

178. 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 within our Customer Relationship Manager System (CRM) to enable us to analyse it (this is described in detail in Section M below). At this time, we also used a new specified field in CRM to record place of death information for analysis purposes. The new information regarding Covid-19 deaths was included in our daily Sitrep Reports to DHSC from 27 April 2020 (MC1/66 [INQ000235392]) and MC1/67 [INQ000235393]).

E. Inspection activity

CQC's ASC Directorate

179. The ASC Directorate covers the following services:

179.1. Residential care homes and nursing care homes;

179.2. home care;

179.3. specialist colleges;

179.4. extra care;

179.5. personal care provided in supported living settings; and

179.6. Shared Lives 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).

180. As at January 2020, before the pandemic, the ASC Directorate was led by a Chief Inspector of ASC and a senior leadership team comprised of three sector specific Deputy Chief Inspectors, and a Director of Corporate Providers and Market Oversight.

181. Delivery of CQC's regulatory activity (monitoring, inspecting and regulating) in the ASC Directorate was led by the three Deputy Chief Inspectors across the following four regions, which align with the NHSE/I regions:

181.1. North[6];

181.2. Central[7];

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[6] The North region encompasses:

North East and Yorkshire

1. Cumbria and the North East
2. West Yorkshire and Harrogate
3. Humber, Coast and Vale
4. South Yorkshire and Bassetlaw

North West

1. Lancashire and South Cumbria
2. Greater Manchester
3. Cheshire and Merseyside

[7] The Central region encompasses:

Midlands

1. Staffordshire and Stoke on Trent
2. Shropshire and Telford and Wrekin
3. Derbyshire
4. Lincolnshire
5. Nottinghamshire
6. Leicester, Leicestershire and Rutland
7. The Black Country
8. Birmingham and Solihull
9. Coventry and Warwickshire
10. Herefordshire and Worcestershire
11. Northamptonshire

181.3. London[8]; and

181.4. South[9].

182. The Deputy Chief Inspectors were supported by ten sector specific Heads of Inspection who took responsibility for regulatory activity in a particular geographic area within the region (e.g. South West; South East etc.). The Heads of Inspection line managed an average of eight inspection teams each. These inspection teams carried out regulatory activity within one or more of the local authority footprints (number of inspection teams dependent on the size of the local authority area). The inspection teams were led by an Inspection Manager and comprised an average of eight Inspectors.

East of England

1. Cambridgeshire and Peterborough
2. Norfolk and Waveney
3. Suffolk and North East Essex
4. Bedfordshire, Luton and Milton Keynes
5. Hertfordshire and West Essex
6. Mid and South Essex

[8] The London region encompasses:

London

1. North West London
2. Central London
3. East London
4. South East London
5. South West London

[9] The South region encompasses:

South East

1. Kent and Medway
2. Sussex and East Surrey
3. Frimley Health and Care
4. Surrey Heartlands
5. Buckinghamshire, Oxfordshire and Berkshire West
6. Hampshire and Isle of Wight

South West

1. Cornwall and the Isles of Scilly
2. Devon
3. Somerset
4. Bristol, North Somerset and South Gloucestershire
5. Bath and North East Somerset, Swindon and Wiltshire
6. Dorset
7. Gloucestershire

183. The Director of Corporate Providers and Market Oversight was supported by two Heads of Market Oversight and the Head of Corporate Providers who, in turn, were supported by Market Oversight Managers and Corporate Provider Relationship Managers. The Director of Corporate Providers and Market Oversight was primarily responsible for ensuring the CQC's Market Oversight responsibilities were fulfilled by leading the engagement with corporate providers on quality and financial issues.

184. These roles are depicted in the organogram exhibited as (MC1/68 [INQ000525117]).

CQC's pre-pandemic inspection regime

185. At the start of the Covid-19 pandemic, our operational teams were organised into the following three overarching directorates covering the specific service types we regulate: Primary Medical Services, Hospitals and Adult Social Care. Below is a summary of the CQC's pre-pandemic inspection regime insofar as it relates to the ASC sector.

186. Our pre-pandemic inspection model can broadly be described across three main phases (set out below) and these were largely similar across all the sectors and service types regulated by us. Detailed guidance on the inspection model as it applied to ASC services can be found in the provider guidance provided alongside this summary (MC1/69 [INQ000525118]).

187. Generally, monitoring and inspection of ASC services was carried out through a series of stages as follows:
    187.1. The information pack stage: collection and consideration of information used for monitoring, inspection and rating.
    187.2. Planning stage: the planning of inspections.
    187.3. Inspection stage: announced or unannounced inspections.
    187.4. Reporting stage: publication of inspection reports.

188. Sometimes the monitoring and inspections of services occurred on an ad hoc basis outside of the four stages listed above.

189. The pre-pandemic Assessment Framework set out the Key Lines of Enquiry (KLOEs), related prompts and ratings characteristics for inspectors of ASC services, and applied to all ASC services. (MC1/70 [INQ000524911]) The KLOEs help our inspectors to answer the five key question: is the service safe, effective, caring, responsive and well-led and we still rely on these five questions for our current assessment framework.

190. The three broad phases of the pre-pandemic inspection model were: monitoring and information sharing; inspection; and after inspection. Each is outlined below.

Pre-pandemic Inspections: (1) Monitoring and Information Sharing

191. This involved the review of information we had on a service collected through various ways and means. The exact information reviewed varied depending on service type.

192. "CQC Insight" was a tool that collated the information we held about a service into one place and analysed it. This helped us to decide what, where and when to inspect and provided analysis to support the evidence in our inspection reports. It was used to monitor quality of care and we had specific insight tools for the different health and care sectors which aimed to: incorporate data indicators that aligned to our key lines of enquiry for the relevant sector; brought together information from people who use services, knowledge from our inspectors and data from our partners; indicated where the risk to the quality of care provided was greatest; monitored change over time for each of the measures; and pointed to services where the quality may have been improving.

193. Our inspectors would check CQC Insight regularly. If it suggested that the quality of care in a service had improved or worsened, we may have followed this up between inspections or asked providers to give us further information to explain the reasons for the change.

194. CQC Insight gave inspectors:
    194.1. Facts and figures: contextual and descriptive information about services including registration details;
    194.2. Ratings: current and historical ratings indicating performance over time;

194.3. Registered manager information: a history of the registered managers at a service and their length of absence where applicable;

194.4. Performance monitoring indicators: information about a service's performance compared with comparable services based on a range of different data sources.

195. CQC Insight for ASC services analysed information from a range of sources including statutory notifications, safeguarding incidents and staffing information, as well as information we received from people who use services, the public and other external data sources such as Skills for Care and Food Hygiene Rating Scores.

196. As outlined above our PIR allowed social care providers to submit up-to-date information about the quality of care being delivered by their service to CQC every year. The PIR collects information at location level from the provider and is requested under Regulation 17(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The PIR is essentially a questionnaire about a service that providers are required to complete annually. Its purpose is to help identify areas to explore in more detail as part of our continuous monitoring of a service and ahead of a site visit. There are four ASC PIRs:

196.1. Residential;

196.2. Community;

196.3. Specialist Colleges; and

196.4. Shared Lives Schemes

197. The PIRs are requested on the anniversary of the provider's first site visit date. The requirement for providers to submit a PIR was, however, suspended on 15 April 2020. Requests for PIRs recommenced for ASC providers on 10 March 2021 (MC1/71 [INQ000524946). In order to reduce the burden on providers and to avoid duplication of information being collected elsewhere, the number of questions was reduced. Submissions in the first month were voluntary, ahead of the full launch in April 2021.

198. PIR information was reviewed and analysed before it was passed to inspectors as part of the regular updates they received about the services they inspected. We

asked providers to tell us how they ensured that their services were safe, effective, caring, responsive, and well-led (the KLOEs); and how they planned to sustain continuous improvement. Providers could update their PIR at any time and were obliged do so annually otherwise their rating for the Well-led key question would be no better than "requires improvement" at the next inspection.

199. Our relationships with providers, local and national organisations and the public helped CQC to gain insight into people's experiences of care, how services were performing and any local issues. We used the information that we received from them to decide when and where to inspect.

200. We encouraged people who use services, their carers, relatives and members of the public to share their experiences with us through our website, helpline or CQC's social media channels. People could also share their experiences through our national "Tell us about your care" partner charities.

201. We also shared information with and received information from a range of local and national groups such as: local health and social care professionals; local Healthwatch; overview and scrutiny committees; independent complaints advocacy groups; voluntary and community sector organisations and Shared Lives Panels. We also worked with Parliamentarians; schools; police, fire services and local medical committees; coroners; environmental health teams and the Office of the Public Guardian.

202. Our work with providers has always been central to our approach to inspections. A relationship owner was allocated to each service provider, in most cases this would have been a local CQC inspector though in some cases it may have been an inspection manager or head of inspection. These relationship owners developed a consistent understanding of the service and were responsible for day-to-day communication and information sharing with the provider. Relationship owners would have carried out inspections unless they were unavailable. Those providers within Market Oversight had a corporate provider relationship manager and a strategic lead (either a Deputy Chief Inspector or a Head of Inspection, depending on the provider) allocated to them.

Pre-pandemic Inspections: (2) Inspection

203. Before the pandemic, the below frequency principles were the primary trigger for inspections:

    203.1. Services rated as good and outstanding: normally inspected within 30 months of the publication of the last comprehensive inspection report.

    203.2. Services rated as requires improvement: normally inspected within 12 months of the publication of the last comprehensive inspection report.

    203.3. Services rated as inadequate: normally inspected within 6 months of the publication of the last comprehensive inspection report.

    203.4. Newly registered services and those no longer dormant: the first comprehensive inspection would normally be scheduled between 6 to 12 months from the date of registration.

204. The above timescales are maximum time periods in which we would normally conduct an inspection, but services may have been inspected at any time. Where we received information of risk or concern through the monitoring and information sharing phase a comprehensive inspection could be conducted sooner than originally scheduled or a focused inspection could be carried out instead.

205. ASC inspection teams were led by an ASC CQC inspector. They would often include an Expert by Experience who is a person with personal experience of care or who has experience of caring for someone else. Their role was to assist the inspector by providing feedback on what was discovered during an inspection and to help the inspector to make their judgements. The size of an inspection team was based on the individual requirements and circumstances of the inspection and due regard was always given to the size and complexity of the service, levels of risk, and whether enforcement action was being taken or was anticipated. Sometimes inspection teams might also have been supported by Specialist Advisors who are team members with specific skills such as dementia specialists, pharmacy inspectors or interpreters.

206. The different types of inspections were as follows:

    206.1. Comprehensive inspections:

206.1.1. An in-depth and holistic view was taken across the whole service.

206.1.2. Inspectors looked at all five key questions to consider if the service was safe, effective, caring, responsive and well-led. A rating of either outstanding, good, requires improvement or inadequate was given for each key question, as well as an overall rating for the service.

206.1.3. These were carried out:

206.1.3.1. within the timescales set out above; or

206.1.3.2. where there was a risk to the safety or wellbeing of people who use the service, or there had been a significant deterioration in the quality of the service; or

206.1.3.3. where there was a substantial improvement in quality that could increase the overall rating.

206.1.4. These were usually unannounced, although there were circumstances where the provider was notified of the inspection in advance (for example, we may have contacted a small residential service within 48 hours of the start of the inspection to check that people were home, or given up to a week's notice to very complicated community services where careful planning was needed).

206.2. Focused inspections:

206.2.1. These were more targeted than comprehensive inspections and were conducted in response to specific information received or to follow up on findings from a previous inspection.

206.2.2. We did not necessarily look at all five key questions however we would always look at the well-led key question, plus any other key question that was relevant to the information that triggered the inspection

206.2.3. Focused inspections could be converted into comprehensive inspections if the scope needed to be broadened.

206.2.4. These were structured according to the reason why they needed to be conducted which may have included:

206.2.4.1. Risks or concerns raised

206.2.4.2. Timing, evidence or engagement required

206.2.4.3. Resources entailed, including use of Experts by Experience and/or Special Advisors.

206.2.5. They were smaller in scale than a comprehensive inspection

206.2.6. They broadly followed the same process as a comprehensive inspection

206.2.7. They could have resulted in a change to the overall rating of a service at any time by using key question ratings from the focused inspection as well as the remaining key question ratings from the last comprehensive inspection.

206.2.8. Focused inspections were normally unannounced.

206.3. Combined inspections:

206.3.1. These were aimed at those providers who delivered services across the health and social care sectors (for example, mental health, community health and care homes).

206.3.2. Where possible, we aligned the inspection process.

206.3.3. Each service was inspected by a specialist inspector.

206.3.4. The report and the ratings of each type of service were provided in a comparable way by using a combination of the different inspection approaches. Overall ratings were aggregated from the ratings for all of the services of that provider that were inspected.

207. Below is an explanation of how we inspected the different ASC services:

207.1. Residential services

207.1.1. Comprehensive inspections: the inspector reviewed the information we held about the service and contacted relevant stakeholders and professionals for their feedback before carrying out an inspection site visit. During the site visit, the inspector spoke with people using the service, their visitors, the staff, volunteers and visiting professionals to assess all of the key questions. They also reviewed relevant records and

inspected the layout, safety, cleanliness and suitability of the premises, facilities and equipment.

207.1.2. Focused inspections: broadly followed the same process and used the same methods as a comprehensive inspection, but focused on one or more specific key questions (always including the well-led question) rather than all of them.

207.2. Community services

207.2.1. Comprehensive inspections: the inspector reviewed the information held by CQC about the service and contacted the people who use the service, care staff, relevant stakeholders and professionals for their feedback. This was done by telephone, through questionnaires, or by visiting them in person. The inspector also visited the service's office and reviewed relevant records.

207.2.2. Focused inspections: broadly followed the same process and used the same methods as a comprehensive inspection, but focused on one or more specific key questions (always including the well-led question) rather than all of them.

208. During all inspections CQC would check:

208.1. Whether services worked in a person-centred way to meet the needs of people from all equality groups;

208.2. Whether services were meeting the Accessible Information Standard[10];

208.3. How leaders and managers were promoting equality, diversity and human rights in their service, including for their staff; and

208.4. Whether people from different groups had equal access to care pathways and all parts of the service.

[10] From 1 August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

209. The report, drafted by the lead inspector, contained a description of the good and outstanding practice found, as well as any concerns we may have had. The report included the findings in relation to the key questions that were inspected and what this meant for the people who use the service.

210. The reports typically included:
    210.1. Contextual information about the service and the inspection;
    210.2. A description of the inspection team's findings;
    210.3. Ratings for each key question inspected and the overall rating given;
    210.4. Evidence about any breaches of the regulations, the action we told the provider to take, and any enforcement activity that CQC may have taken;
    210.5. Recommendations made to the provider about improvements to their service; and
    210.6. A summary section for the provider to share with each person using their service, their family and carers, and staff.

211. The first draft of the report was sent to the provider who had 10 working days to conduct factual accuracy checks where they were able to challenge the accuracy of the evidence that the inspection team had used to reach the findings and decide the ratings. Before the report was published, CQC conducted a quality assurance check of each report by peer review.

212. The report and ratings were then published on our website. The characteristics for ratings are included in the Key lines of enquiry, prompts and ratings characteristics for ASC services document (MC1/70 [INQ000524911]) and the provider guidance for each sector details the process for aggregating ratings. It was, and remains, a legal requirement for providers to display their ratings, although there are a small number of services that we did not have the duty to rate (for example dentists).

213. If the inspection identified regulatory breaches, further regulatory action may have been taken following the inspection, as appropriate. These processes are explained in detail elsewhere in this statement.

Care Home Inspections

214. CQC has prepared two tables to demonstrate the number of care home inspections carried out in the years 2019 to 2023, and to show a breakdown per year of the number of care homes assessed as "outstanding"; "good"; "requires improvement" and "inadequate". These tables have been prepared specifically for use in this statement.

215. The table below sets out the number of care homes inspected in the years 2019, 2020, 2021, 2022 and 2023. In total, CQC carried out 27 272 care home inspections across the 5 year period:

Number of Care Home Inspections per year 2019-2023

Year	Number of Inspections
2019	8155
2020	4793
2021	5448
2022	5580
2023	3296
Grand total	**27272**

216. The table below shows a breakdown of the numbers of care homes in each ratings category by year for 2019, 2020, 2021, 2022, 2023 and 2024. The total numbers of inspections per year in this table are different to the numbers in the table above as there are several instances where an inspection may have taken place in one year but the report (and the rating) is only published in the following year. We have also included figures for 2024 as these inspections took place in 2023. The grand total for the table below is 27,269 inspections which is 3 less than the total number of inspections in the table above. At the time that the data depicted in the table below was collected (2 July 2024), 3 inspection reports had not yet been published.

Outcome of Care Home Inspections by year 2019-2024

Rating	2019	2020	2021	2022	2023	2024	Grand Total
Outstanding	226	139	20	20	46	8	459
Good	4516	1911	1249	1622	1826	112	11236
Requires Improvement	2024	1214	1269	1444	1260	136	7347
Inadequate	331	289	374	391	332	78	1795

Insufficient evidence to rate		1	3	3			7
Inspected but not rated	10	1560	2775	1975	95	10	6425
Grand Total	**7107**	**5114**	**5690**	**5455**	**3559**	**344**	**27269**

Suspension of routine inspection activity

CQC's rationale

217. Before the pandemic we had already considered pausing some routine inspection activity, albeit only for short periods (MC1/72 [INQ000398815). In January 2018 we paused routine inspections of NHS Acute services, GP practices, and Urgent Care services in response to increased pressure on the health and care system driven in part by a rise in respiratory illness and flu and conducted risk based inspections.

218. At the start of the pandemic, prior to suspending routine inspections, we cancelled a number of routine inspections and directed our activity at areas which we considered to have the most risk. We considered that there were some environments (such as social care settings, domiciliary care, closed mental health wards, and elderly care wards in hospitals) which presented inherently more risk in terms of opportunities for people to suffer unseen harm and that they would therefore need to be monitored carefully (MC1/73 [INQ000466432]). The cancellations were based on daily assessments of risk within the relevant sector and were personally overseen by the three Chief Inspectors.

219. During the pandemic we recognised that we had an important role to play in offering assurance to the public (and Government) around the safety and quality of services, but that doing so wholly through on-site inspections was practically difficult during lockdowns. We were also actively working to develop an interim targeted methodology for inspections, with internal workshops held on 9 and 10 March 2020 attended by over seventy colleagues from across all directorates at CQC looking at how to ensure we could continue to deliver our purpose during the pandemic.

220. On 13 March 2020 we took the decision, in consultation with relevant stakeholders and with the approval of the then Secretary of State for Health and Social Care, as

set out below, to move from conducting routine inspections to focusing on more responsive and targeted ways of supporting providers to keep people safe. This decision took effect from Monday 16 March 2020.

221. The decision to initially redirect our inspection activity, and then to move away from conducting routine inspections was considered necessary on the basis of our continuing assessment of three key operational principles. Firstly, that our focus would be on ensuring the public received safe care by responding where we believed risk was highest and where we could make a difference. Secondly, 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 the infection. And thirdly, to prioritise the health, safety, and wellbeing of our staff and reduce the risk they were exposed to [MC1/74 INQ000398816].

222. 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. 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.

223. The effect of the decision to pause routine inspections was that all routine inspections were stopped, with the intention that they would not return in their then form during the peak of the pandemic. In so doing we aimed to support providers to keep people safe, whilst continuing to provide Government, decision-makers, and local and national partners with an accurate picture of pressures being faced on the ground to inform national response and planning.

224. Whilst we did continue to inspect 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 rather to examine specific aspects of the safety of services.

Inspectors were still able to extend an inspection so that a rating could be changed if they identified risks that warranted such action to be taken. These revised approaches are described in greater detail later in this statement.

225. We took a flexible and proportionate approach to deciding which inspections would take place. It was important for us to continue to regulate, and where appropriate inspect, to provide assurance to the public and to Government, as well as continuing to be a route for intelligence from the sector into Government and other key stakeholders.

226. Our National Customer Service Centre (NCSC) remained open throughout the relevant period. The NCSC supported both providers and the public in answering questions and recording concerns. During 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.

227. Taken together, the information from the public, members of staff, local health and care professionals and providers 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.

228. We were also able to identify and work with Government on emerging concerns. Examples included inappropriate use of DNACPR orders, deployment of Covid-19 positive staff and the challenges of visiting care home residents and patients during a pandemic.

229. Our overall aim was to contribute to sharing information 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. Following the pandemic, we did not return to a programme of routine frequency-based inspections. Our post-pandemic new regulatory approach is set out in detail later in this statement.

External input into the decision to pause routine inspections

230. Throughout the pandemic we continued to engage with our key stakeholders, on how we could best adapt our approach to inspections to meet the needs of the rapidly changing situation. In terms of direct engagement with Government or any non-Governmental bodies on the decision to suspend or adapt our routine inspection activity, this was predominantly with DHSC. As our sponsor department they were kept informed of any proposed changes to our approach to inspections and regulation, and ultimately the Secretary of State approved the decision to suspend routine inspection activity as referenced above and explained below. Below is a summary of the external input into the decision to suspend routine inspection activity.

231. In the early stages of the pandemic, specifically in the healthcare sector, there was mounting pressure from Government, external organisations and the public for CQC to suspend routine inspections.

232. On 13 February 2020 Ian Trenholm wrote to then Chief Executive of NHSE, Simon Stevens, and then Chief Executive of Public Health England, Duncan Selbie, offering CQC's support to both organisations and indicated that we were reviewing "*our inspection activity on a daily basis with a view to minimising the impact we may have [had] on the health and social care system, whilst at the same time making sure we [could] provide assurance to the public that services [were] safe.*" (MC1/75xx [INQ000524973])

233. On 14 February 2020 we were invited by our DHSC colleagues to join a discussion with "*sector stakeholders (LGA; ADASS)*" "*about how best DHSC [could] support the [ASC] sector in its potential response to a coronavirus worst case scenario*" which "*could potentially include a discussion about the CQC regulatory regime, and potential 'easements' that may [have been] necessary.*" (MC1/76INQ00052043]). Colleagues from DHSC; LGA; ADASS; GLD and CQC's Head of Provider Engagement; Head of Parliamentary Government and Stakeholder Engagement; Deputy Chief Inspector of ASC and a Government Engagement Manager were invited to attend the meeting (MC1/77 [INQ000524994] and MC1/78 [INQ000525048]). We have been unable to locate any minutes or notes from this

meeting and those who attended on behalf of CQC, and who are currently employed by CQC, have not been able to recall the content of any discussions which took place at the meeting.

234. On 27 February 2020 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, was able to confirm to Ian Trenholm directly 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.

235. On 3 March 2020 we met with DHSC colleagues on a number of points (MC1/79 [INQ000398834). We updated them on our revised regulatory response, including moving towards a risk-based approach, and there was agreement in principle for us to suspend inspections or undertake them differently during DHSC's 'Reasonable Worst Case Scenario' period. We also confirmed to DHSC that we had developed a decision making framework for use by our inspection teams to be followed alongside national guidance (MC1/80 [INQ000466472]). Similarly between 4 and 6 March 2020 we engaged with DHSC to confirm the governance processes by which a decision to suspend routine inspection activity would be formally agreed with the Government (MC1/81 [INQ000398835]).

236. At the meeting of the Coronavirus National Steering Group for Adult Social Care on 4 March 2020 CQC's approach to inspections was discussed and it was noted that "*Providers are worried that CQC attitude to inspections. A Statement would be helpful, CQC use 3 principles to inform decisions about inspections so that CQC is focussing where there is a known risk and can make a difference. Comms are going out to providers today and is being shared with CPA in advance.*" (MC1/82 [INQ000524939] and MC1/83 [INQ000524940])

237. As agreed, on 4 March 2020 we wrote to every registered care provider in England setting out how we were intending to respond to Covid-19 and how we planned to approach future decisions relating to it (MC1/84 [INQ000525034]). In this update we indicated that:

"*We will still be carrying out inspections, but inspection managers will be reviewing inspection plans on an ongoing basis to make sure our activity is aligned with the very latest position. Most inspections will continue as planned in the short term, we will keep the position under review and may decide to postpone an inspection, perhaps with relatively short notice. We will take a pragmatic and flexible approach to how and when we regulate as and when this situation develops and we commit to continuing conversations with providers and their representative organisations.*"

238. On 4 March 2020 CQC set up a Regulatory Response Operational Working Group to develop an action plan for responding to the situation if the virus outbreak changed. The purpose of the operational working group included identifying "*a pared back approach towards inspection and other regulatory activity during the period of crisis*" (MC1/85 [INQ000524949).

239. On 9 March 2020 we met with the then Minister of State for Care Helen Whatley MP to provide an update on our approach. She enquired about the impact of the pandemic on our inspection programme and we confirmed our view that continuing with the targeted inspection programme was important for providing assurance both to the public and to DHSC. We also highlighted that we were already in the process of developing a more targeted and intelligence-led inspection programme (MC1/86 [INQ000524878]).

240. On 11 March 2020, at the Chief Nursing Officer's summit event in Birmingham, Simon Stevens called for CQC inspections to be suspended, stating that "*There will be a small number of cases where it would be sensible to continue for safety related reasons… but the bulk of their routine inspection programmes is clearly going to need to be suspended and many of the staff who are working as inspections need to come back and help with clinical practice*". This was reported on by the Health Service Journal (HSJ) in an article dated 11 March 2020 exhibited as MC1/87 [INQ000525119].

241. At the Trade Association Meeting on 11 March 2020, Debbie Ivanova, Deputy Chief Inspector provided an update to the group regarding CQC's response to the evolving coronavirus situation confirming that "*this [was] a fast-moving situation which may involve us changing what we do and how we do it*". She also provided an update on

our inspection methodology indicating that "*we will still be carrying out inspections, but inspection managers will be reviewing inspection plans on an ongoing basis*" and that CQC would provide regular updates on this (MC1/88 [INQ000524950]; MC1/89 [INQ000524948]).

242. On 11 March 2020 Ian Trenholm responded on behalf of CQC to the comments made by Simon Stevens (MC1/90 [INQ000398836]) indicating that:

"*CQC inspection and regulation activity will continue. However, we will be adapting our standard inspection approach – adopting a targeted risk based approach to direct our efforts at areas of specific safety concern – this means that planned inspections of services may well be postponed. Clinically qualified CQC special advisors are already being supported to return to the frontline to help with the wider national response.*

We are very conscious of balancing the need for public reassurance with our impact on health and social care providers and will be focused on working with providers to ensure that they are supported to keep people safe while the health and care system faces a period of considerable pressure. As the regulator with unique oversight of the NHS and social care, we will maintain our role in keeping patients and service users safe as people continue to access care in difficult circumstances, provide assurance to Government and Parliament that health and social care services are safe, and ensure that patient safety is being monitored during the period of the COVID-19 outbreak."

243. On 11 March 2020 during a debate in the House of Commons, then shadow Secretary of State for Health and Social Care Jonathan Ashworth MP asked the then Secretary of State the following question "*The NHS has suggested suspending Care Quality Commission inspections for now. What is his view on that?*". Mr Hancock responded stating that "*The CQC has already published a statement today, saying that it is relaxing some of its requirements and taking into consideration the impact of coronavirus, and I welcome that. It is, of course, independent.*" (MC1/91 [INQ000525120]).

244. On 11 March 2020 the NHS Confederation wrote to Ian Trenholm "*to ask for a temporary suspension of all planned CQC inspections*" (MC1/92 [INQ000398840]).

245. On 12 March 2020 during a Parliamentary debate in the House of Lords, Baroness Thornton MP stated:

"*We need to do all we can to support NHS and social care staff, so may I specifically ask about care homes? The NHS Confederation has called for the suspension of Care Quality Commission inspections. Care homes face huge challenges protecting their frail, elderly residents, and chronic staff shortages will be exacerbated by absences if staff contract the virus or need self-isolation. Does the Minister agree, given the circumstances, that the NHS Confederation's request to suspend those inspections and scale them back is sensible?*" (MC1/93 [INQ000525121)

246. Lord Bethell MP responded indicating that:

"*I assure the House that we are listening to all those organisations that have concerns about inspection regimes and meeting legal requirements when physical resources and resources of people and time are under huge pressure. We hear their concerns loud and clear and will be making realistic provisions about those inspections and legal requirements.*" (MC1/93 [INQ000525121])

247. On 11 March 2020 we responded to a request received from DHSC for an urgent briefing on our approach during Covid-19, as well as providing a draft letter addressed to the then Secretary of State for Health and Social Care (MC1/95 [INQ000525123; MC1/96 [INQ000398838] and MC1/97 [INQ000524983]). In these we set out our risk-based approach. We noted that the developing targeted inspection methodology (which would later become the Emergency Support Framework) would enable us to provide assurance during the pandemic whilst minimising any burden on providers. We also noted that we did not expect to be taking significant enforcement action during the pandemic as, in the main, it would not pass the public interest test. The letter was sent to Rt Hon Matt Hancock MP by Ian Trenholm on 12 March 2020 (MC1/98 [INQ000525082]).

248. We received feedback from other stakeholders, including the Royal College of Emergency Medicine, who expressed concerns around continuing inspections of emergency departments (MC1/99 [INQ000399820]) and the BMA who urged CQC "*to immediately halt all routine inspections of GP practices for the foreseeable*

future." (MC1/100 [INQ000398839]). We also engaged with Ofsted on our joint approach to inspections of Special Educational Needs and Disability inspections.

249. On 13 March 2020 Kate Terroni met with Helen Whately to update her on our plans regarding regulation of the ASC sector in response to the pandemic. In this meeting Ms Terroni confirmed to the then Minister that we would still be carrying out inspections in the short term but that we would keep the position under review, taking a pragmatic and flexible approach to how and when we regulate. Ms Terroni also updated her on the development of our interim methodology (MC1/101 [INQ000524897]).

250. On 13 March 2020, as a follow up to the discussions which took place at the Trade Association meeting on 11 March 2020, we sent an email to our Trade Association colleagues providing an update on the development of our interim methodology and requesting any feedback or reflections (MC1/102 [INQ000525049).

251. On 13 March 2020 Ian Trenholm responded to the letters received from the RCGP and the BMA over the preceding days which touched on our ongoing inspection activity, and to the letter from the NHS Confederation (MC1/103 [INQ000398841]; MC1/104 [INQ000398842]; MC1/105 [INQ000398823]). In his response he stated our view of the essential function of regulation, outlined the ways in which we were already adapting our approach to inspections, and summarised the approach we were taking to developing our new methodology.

252. On 13 March 2020 Ian Trenholm also wrote to the Rt Hon Jeremy Hunt MP, Chair of the Health and Social Care Select Committee (MC1/74 [INQ000398816]); the Rt Hon Jon Ashworth MP, Shadow Secretary of State for Health and Social Care (MC1/106 [INQ000524895]) and the Rt Hon Munira Wilson MP Liberal Democrat Spokesperson for Health and Social Care (MC1/107 [INQ000524898) wherein he set out our revised approach to inspections as follows:

> "*Inspect: <u>Planned activity (with sector variation) will need to be cancelled</u> during the outbreak, and this has already begun:*

o The decision to cancel is based on an assessment of risk and the sector. This decision-making process is personally overseen by the three Chief Inspectors daily.

o We have written to providers and told them what we are doing and explained we will be adopting a pragmatic approach to inspection.

*o **We are developing an interim targeted methodology** which will enable us to provide assurance of the safety and risk during the outbreak, and for a period of approximately 6 months afterwards. This revised methodology will shift the emphasis from inspection to a broader regulatory approach which can be delivered remotely if necessary. The methodology is being developed as a purely digital 'app' product, at pace, in conjunction with 70 of our inspection team and Microsoft. We hope to have a product being live tested during week commencing 16th March, hopefully ready for deployment at the end of that week. This should enable us to provide some assurance around the areas of concern, by topic and geography, even if in extreme cases, the work has to be done remotely and over the phone.*

o Full inspections rely on the use of Specialist Advisors (SpA), many of whom are clinicians. They are increasingly telling us they are needed in their home medical setting, which in turn has caused some cancellation of inspection.

o We don't expect to be taking significant enforcement action during the outbreak. However, if we receive information about an incident of serious harm or abuse, for example, then we would fulfil our role to keep people safe."

253. Whilst we engaged with a number of stakeholders around our approach to inspections, as set out above, the decision to pause routine inspections was taken by CQC's Gold Command group on the basis of our assessment of how to best respond to the pandemic's impact on our inspection programme and broader regulatory approach. The board was notified of the decision to pause routine inspections on 16 March 2020 (MC1/108 [INQ000398832). We also notified all staff and colleagues of the decision on 16 March 2020 (MC1/109 [INQ000398833]).

254. We took the decision to stop all routine inspection activity and move to risk-based assessments as of Monday 16 March 2020 at a meeting of our Gold Command group on Friday 13 March 2020 (MC1/110 [INQ000398843]). Jennifer Benjamin, Deputy Director of the Quality, Patient Safety and Investigations Branch at DHSC attended this Gold Command call and it was agreed on the call that we would share with DHSC our planned communications with the sector around this. This would be communicated to senior colleagues and Members of Parliament later that day and to providers, the wider organisation and the public on 16 March 2020.

255. On 16 March 2020 Lee McDonough texted Ian Trenholm to say that the then Secretary of State Matt Hancock was not happy with our interim proposals regarding cessation of inspections and that he had asked William Vineall to follow up with him "on specifics" (MC1/111 [INQ000419146]).

256. Our understanding of Mr Hancock's unhappiness was that he wanted CQC to do more than what he thought was planned in terms of our plans to pull back on planned inspections temporarily. On 16 March 2020 Mr Hancock sent a message to Peter Wyman stating that he needed CQC "*to pull back more than they are currently planning on inspections & data collection*" (MC1/112 [INQ000419147]). In response, Mr Wyman clarified CQC's intended approach noting that CQC had "*pulled right back on inspections*" and that they would only be taking place "*where we believe abuse or serious harm may be happening*". Mr Wyman also asked Mr Hancock whether he had seen the letter that we were intending to send to providers on 16 March 2020 regarding the pausing of routine inspections. Mr Hancock then replied to note he had seen and made amendments to the letter.

257. This exchange, and that referred to in paragraph 256 above, related 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' (MC1/113 [INQ000235535] and MC1/114 [INQ000235536]). The draft letters were shared with DHSC on 15 March 2020 who provided their comments and feedback and instructed us not to send the letters until the necessary clearance had been obtained (MC1/115 [INQ000466430]).

258. Kate Terroni also shared the wording of the draft letter with colleagues from NCF; TLAP; CPA; UKHCA; Care England; NCA; ADASS and LGA on 15 March 2020 and asked that they provide any comments before it was sent out (MC1/116 [INQ000524999 and MC1/117 [INQ000525019]). The feedback received from the stakeholder organisations was considered and, where appropriate, incorporated into the draft before it was sent (MC1/118 [INQ000525012]).

259. The final letters were sent to the then Secretary of State on 16 March 2020 and we received confirmation of his approval based on his revisions to the letters later that afternoon. (MC1/119 [INQ000466433)

Continued Monitoring of Risk: Risk Monitoring Tools (ESF/TMA/DMA)

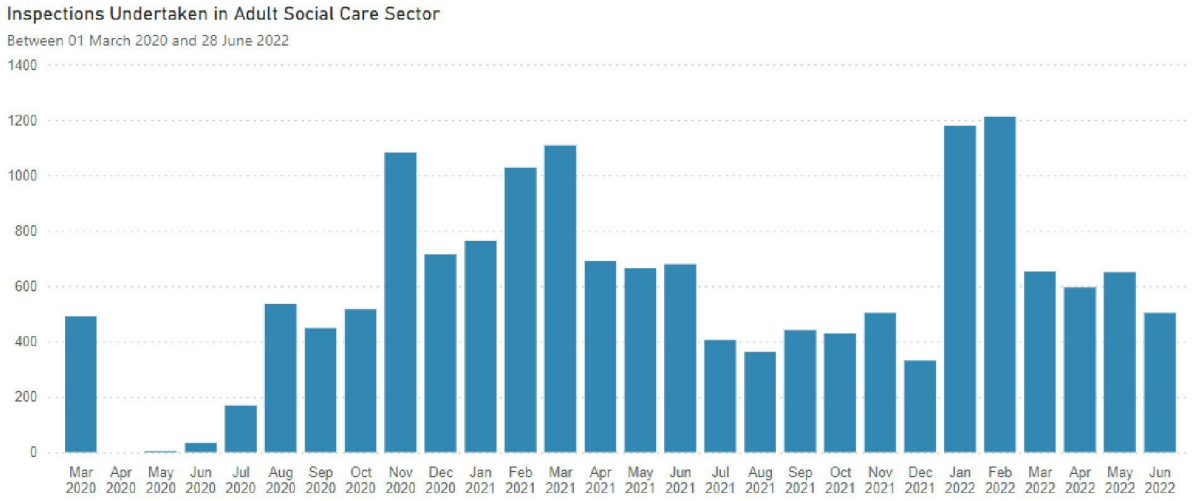
260. CQC's inspection activity in the Adult Social Care Sector, Hospitals Sector and Primary Medical Services Sector during the relevant period is demonstrated in the graphs shown on exhibit MC1/120 [INQ000470224]. These graphs were prepared specifically for use as an exhibit to CQC's statement in respect of Module 3 of this Inquiry and show how many inspections were undertaken in each of named sectors during the relevant period. The graph for the ASC sector has been pasted into this statement below. When reading and analysing the graphs, the following should be noted:

    260.1. Inspections in larger institutions such as hospitals can take more than a month to complete, and the volume of work required for each inspection of a larger institution is greater per inspection when compared to the volume of work involved in conducting an inspection in a small care home. Therefore, the numbers of inspections per sector should not be treated as an indicator of increased focus in one sector over another.

    260.2. The Primary Medical Services (PMS) graph does not include Oral Health Services (P1 services omitted[11]) as these services are not within the scope of Modules 3 or 6.

[11] CQC uses codes to identify/categorise the services, known as 'Primary Inspection Categories', which we regulate. For example, 'P2' is 'General Practice'. 'P1' refers to 'Oral Health/Dental' services and these have been excluded from the PMS graph.

260.3. Once a provider is registered, an Organisation ID (also known as a 'CRM ID') is assigned for each location included in the registration certificate. All inspections are linked to a 'CRM ID'/Organisation ID and where there is no ID this is considered an erroneous record. We have run a blanket check for the inspections included in the graphs and found that there were no blank CRM IDs for the relevant period.



261. We had already begun to review our approach to regulation and our inspection methodology prior to the pandemic in order to make better use of intelligence to target inspection activity where it was most valuable (MC1/121 [INQ000398847]). From early on in the pandemic, both prior to and following the suspension of routine inspection activity, we utilised a responsive and increasingly intelligence-led and risk-based approach to inspection activity to ensure patient safety and the proportionality of inspections. We rapidly developed new tools and methods for continuing to deliver on our purpose of ensuring safe care in difficult and changing circumstances and there were a number of adaptations to our approach during the course of the pandemic. The most relevant tools which were developed during the pandemic, in terms of the scope of Module 6 are as follows:

261.1. Emergency Support Framework (ESF);

261.2. Transitional Monitoring Activity and Application (TMA); and

261.3. Monitoring Approach 2021/22 and the Direct Monitoring Activity (DMA)

262. Each of these tools is explained in detail below.

Emergency Support Framework (ESF)

263. Following the suspension of routine inspection activity in the three sectors as outlined above, we continued to fulfil our regulatory purpose by embarking on a series of rapid changes and new ways of working. CQC deployed a number of alternative methods of regulating which revolved around the use of remote means to monitor, assess and/or inspect providers. We continued to inspect in response to risk and concerns raised where we considered appropriate, with services remaining the subject of close monitoring, using a range of intelligence sources and tools (MC1/122 [INQ000398848]).

264. One such monitoring tool was the Emergency Support Framework (ESF), a software application designed for inspectors to be able to review their portfolio and prioritise according to a risk model that indicated which services were the most at risk, leading to a structured phone conversation between the registered manager and the inspector ("ESF call"). The ESF call was intended to be supportive and predominantly focused on gaining assurance that the provider was managing Covid-19 related risks adequately.

265. The ESF process followed a series of six steps, as follows (MC1/123 [INQ000469883]; MC1/124 [INQ000469884]; MC1/125 [INQ000398851]):

    265.1. The ESF tool provided inspectors with a list of locations, usually based on locations normally within their portfolio. Each location or core service (depending on sector and directorate) was assigned:

        265.1.1. A risk level which was automatically calculated from data and intelligence held in our records. The four risk levels were “very high”, “high”, “medium” and “low”; and

        265.1.2. A priority ranking.

    265.2. Inspectors used the risk level, priority ranking and their own knowledge of services to make judgments about the order in which they made ESF calls.

    265.3. The ESF call took place.

265.4. The information discussed during the ESF call was recorded in the ESF tool.

265.5. The information from the ESF call was assessed to provide an assessment outcome based on the answers given against the framework questions. The tool recorded whether the service was 'Managing' or 'Needs Support'.

265.6. The ESF tool produced a 'Summary Record' in a standard format setting out the answers to the ESF questions and the inspector's overall summary. A copy of the Summary Record was sent to the provider.

ESF Process

Step one: Risk Level and Priority Ranking

266. For step one of the ESF process, the risk level was calculated using existing information held in our systems from sources such as notifications, current ratings, enforcement activity, whistleblowing activity and the length of time since our last inspection. The specific criteria used to model the probability of risk in a service provider varied by sector, with different risk models used for NHS GPs, prisons, independent doctors, urgent care services, and dentists, as well as independent health providers of dialysis, ambulances, standalone services for people with a learning disability and/ or autism and both residential ASC services, and community ASC services.

267. To demonstrate the criteria used to model the probability of risk, the ESF risk model guidance applicable to adult social care residential services (care homes with and without nursing) is set out below. This risk model used historic data collected between April 2014 and March 2020 from approximately 45 000 inspections to predict risk ratings. The model also included data from a wide range of sources in respect of over 80 variables including:

267.1. Registration: regulated activities, location ownership type, local service user age, location maximum service user number, provider size, provider registration change count, whether the service is a nursing or residential home.

267.2. Notifications and Enquiries: safeguarding incidents, complaints, Deprivation of Liberty safeguarding notifications, injuries, deaths (including unexpected deaths), whistleblowing etc.

267.3. Registered Manager: Whether a registered manager was needed/not needed, registered manager days absent in 12 months prior to last inspection, registered manager yearly absenteeism rate over lifetime of location.

267.4. Local and Demographic Indicators: CCG complications with diabetes, local authority indicators, region in which service is located, unemployment rates, Adult Social Care Outcomes Framework (ASCOF) indicators relating to adults with learning disabilities, percentage of resident population over 85, postcode population size.

267.5. Other: history of "Inadequate"/"Requires Improvement" rating, length of time location open in days, Food Standards scores.

268. The model was trained so that it produced a probability score indicating whether a location's rating was "Requires Improvement"/"Inadequate". The probability score ranged from 0 to 1, the higher the score the more likely the service would be to get a "Requires Improvement"/"Inadequate" rating.

269. The model assigned risk scores to each indicator in terms of which data was collected. The higher the number, the higher the indicative risk. The model provided an overall combined risk and probability risk percentage and an associated risk level which was measurable across services.

270. The model used the following 15 risk measures, each one having been chosen because it provided us with a quantifiable indication of risk:

270.1. Whether the service had a registered manager;

270.2. Current overall rating;

270.3. Months since rating published or month since registration (if the service had not yet received a rating);

270.4. Rating change;

270.5. Safe rating; Effective rating; Caring rating; Responsive rating; and Well-led rating;

270.6. Number of complaints in past 12 months;

270.7. Number of whistleblowing reports in past 12 months;

270.8. Regulatory status (in breach or compliant);

270.9. Count of red and amber ASC Insight flags;

270.10. Count of notifications in past 12 months;

270.11. PIR Score calculated via the average of PIR Indicator Scores (these scores included PIR questions such as, but not limited to: people at risk of malnutrition or dehydration, staffing numbers and staff training)

271. The above measures were then multiplied by the combined impact score (impact score 1 and impact score 2 multiplied) to create 15 risk scores which accounted for the number of service user bands and the number of people that use the service. This data was collated from the latest PIR or from Registered Services information if PIR data was not available.

272. The combined risk score was calculated by adding the risk scores for each service and dividing them by the highest possible maximum risk score for that service (i.e. the number of indicators multiplied by the highest possible combined impact score and multiplied by the number of indicators that information was available for). The combined risk score was then used to determine the overall level of risk as follows:

272.1. 0% - 14%: risk level "low"

272.2. 15% - 28%: risk level "medium"

272.3. 29% - 50%: risk level "high"

272.4. 51% and above: risk level "very high"

273. We tested the model's outputs against historic data and in the beginning of the pandemic we set a threshold score of 0.7 to identify services that we recommended needed further review as part of the interim regulatory response to Covid-19.

274. The high level risk model methodologies underpinning each of the intelligence risk models for the different services within the respective sectors are set out in exhibit (MC1/126 [INQ000524966]).

Steps Two, Three and Four: ESF calls

275. ESF calls were not inspections, but supportive conversations with providers about the challenges they were experiencing at that time. The ESF calls were normally 1:1 conversations but if the service managers wished to invite other colleagues to join the calls they were welcome to do so.

276. The ESF calls were structured conversations which covered four assessment areas and followed a framework of fifteen standard questions as follows (MC1/127 [INQ000398852]):

276.1. Safe care and treatment (Regulation 12)

276.1.1. Had risks related to infection prevention and control, including in relation to COVID-19, been assessed and managed?

276.1.2. Were there sufficient quantities of the right equipment to help the provider manage the impact of COVID-19?

276.1.3. Was the environment suitable to containing an outbreak?

276.1.4. Were systems clear and accessible to staff, service users and any visitors to the service?

276.1.5. Were medicines managed effectively?

276.1.6. Had the management of risk been affected by COVID-19?

276.2. Staffing arrangements (Regulation 12, 17 and 18)

276.2.1. Were there enough suitable staff to provide safe care and treatment[12] in a dignified and respectful way during the Covid-19 pandemic?

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[12] Regulation 12(1): Care and treatment must be provided in a safe way for service users.

CQC Guidance on Regulation 12(1):

- Providers must provide care and treatment in a safe way. In particular, this includes the areas listed in 12(2) (a) – (i). However, 12(2) is not exhaustive and providers must demonstrate that they have done everything reasonably practicable to provide safe care and treatment.
- Providers should consult nationally recognised guidance about delivering safe care and treatment and implement this as appropriate.

12(2) without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include–
12(2)(a) assessing the risks to the health and safety of service users of receiving the care or treatment;
12(2)(b) doing all that is reasonably practicable to mitigate any such risks;
12(2)(c) ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;
12(2)(d) ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;
12(2)(e) ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and used in a safe way;

276.2.2. Were there realistic and workable plans for managing staffing levels if the pandemic leads to shortfalls and emergencies?

276.3. Protection from abuse and protection of human rights (Regulation 13)

276.3.1. Were people using the service being protected from abuse, neglect and discrimination?

276.3.2. Had the provider been able to properly manage any safeguarding incidents or concerns during the pandemic?

276.4. Assurance processes, quality monitoring and business risk management (Regulation 17)

276.4.1. Had the provider been able to take action to protect the health, safety and wellbeing of staff?

276.4.2. Had the provider been able to implement effective systems to monitor and react to the overall quality and safety of care?

276.4.3. Is the provider able to support staff to raise concerns during the pandemic?

276.4.4. Had care and treatment provided to people being sufficiently recorded during the Covid-19 pandemic?

276.4.5. Had the provider been able to work effectively with system partners when care and treatment is commissioned, shared or transferred?

277. There were sector specific guidance documents for exploring the ESF questions with the different services. The guidance documents included the standard ESF questions as well as sector specific and shared support prompts and links to

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12(2)(f) where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;
12(2)(g) the proper and safe management of medicines;
12(2)(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;
12(2)(i) where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

CQC Guidance on compliance with Regulations 12(2)(a) – (i) found at https://www.cqc.org.uk/guidance-providers/regulations/regulation-12-safe-care-treatment

potential sources of support for passing onto the providers (similar to the KLOE prompts explained earlier in this statement). The prompts in the sector specific guidance documents were intended to help the inspectors frame the conversations but they were not treated as a checklist. The inspectors were expected to focus on what was important for each individual service and to discuss additional risks and issues as needed in order to fully understand the service's situation. The specific guidance document outlining the discussion questions for adult social care services is exhibited as MC1/128 [INQ000524955].

278. Inspectors used the risk levels, ESF priority rankings and their own knowledge of the services to make judgments about the order in which to make their ESF calls and prioritised those services with the highest levels of risk.

Steps Five and Six: Deciding the assessment outcome and the Summary Record

279. The outcome of an ESF call did not lead to a change in the provider's rating but would inform the ongoing assessments of the provider in relation to the level of risk present and the appropriate next steps. The ESF was used alongside other intelligence (see paragraph 283). Following the ESF call, and once the information from the ESF call had been recorded in the ESF tool, the inspector was required to complete the assessment. The ESF would automatically provide an assessment outcome of either 'Managing' or 'Needs Support' based on the answers given against the questions asked in the ESF call. The inspector may have chosen to over-rule this assessment based on what they already knew about a service.

280. ESF calls were not inspections but a targeted or focused inspection could be considered by way of exception where we had serious concerns. Examples of when an inspection might be appropriate included where there were serious concerns relating to:

280.1. Abuse;

280.2. Breaches of human rights;

280.3. Neglect;

280.4. Standards of care and treatment; and/or

280.5. Lack of engagement and refusal to engage.

281. Where we had serious concerns about actual or possible avoidable significant harm, abuse, and breaches of human rights we assessed the risks involved using a separate process. Between May and July 2020 the "decision to assess process" (MC1/129 [INQ000398492]) was used to guide decisions to undertake focused or targeted inspections in instances where we had serious concerns. The decision to assess process was premised on the fact that during the Covid-19 pandemic there were heightened risks across all providers but that the option of inspection was not readily available and therefore should be reserved for the most serious cases.

282. The decision to assess process followed three steps:

282.1. Ongoing monitoring: Existing processes for ongoing monitoring continued to apply except in relation to reviewing intelligence products such as Insight (a dashboard of data created by our Intelligence team for each provider which was used to support and inform our pre-pandemic approach to inspections).

282.2. Reviewing inherent risk: Consideration of the extent of inherent risk and the likelihood that any inherent risk was a potential risk to safety (i.e do the risks make the threat to safety more "remote", "possible" or "probable"?). The "indications of elevated risk" were categorised under the following four headings:

282.2.1. Indications of a closed culture;

282.2.2. Inherent risk of service type or population;

282.2.3. Weak or inconsistent leadership; and

282.2.4. Provider track record against regulations.

282.3. Decide which ESF assessments to prioritise: The Risk Tool indicated a risk level (low, medium, high, very high) and therefore determined an assessment priority. However, the inspector may have chosen to over-rule this assessment based on what they already knew about a service. In making prioritisation decisions, inspectors considered the following:

282.3.1. Their review of the inherent risk of each provider (from step 2 above);

282.3.2. Any recent incidents of information which had come to light; and

282.3.3. Anything else they knew about the provider which could influence risk.

283. If we received intelligence or information of serious concern at Step 1, a shortened process would be triggered in terms of which:

283.1. Review of the intelligence or information of concern (in place of stage 2 above): The impact of the concern was considered and weighed against the likelihood that the concern was a potential risk to safety to determine the level of seriousness.

283.2. In cases of extreme risk, the inspector could skip the ESF assessment (step 3 above) and move directly to scheduling a management review meeting ("MRM").

283.3. Responding to extreme risk: A MRM would be held to decide the appropriate next steps such as conducting a targeted or focused inspection.

284. The decision to assess process document explained that while the specific justification for an inspection was decided on case by case basis, there were three broad principles that would apply when deciding whether to inspect and where one of these was suspected or evident, an urgent MRM would be triggered to decide the best course of action. These three broad principles were:

284.1. Lack of response: For example, the provider was not responsive to contact. All attempts to contact the provider including Covid-19 specific routes such as the ASC provider survey had failed. This could indicate a complete failure of care.

284.2. Abuse or willful neglect: For example, if CQC received reports of abuse or wilful neglect of people using the service.

284.3. Provider unable to cope: For example, following the completion of the Covid-19 assessment process, CQC had reason to believe that the provider was not coping and was unable to manage risk.

285. The decision to assess document (MC1/129 [INQ000398492]) was replaced with the 'Principles and Triggers for crossing the threshold during lockdown easing' document in July 2020 (MC1/130 [INQ000398850]). This set out a high-level description of what governed our decisions to remotely assess and/or inspect providers during the pandemic and reflected the current approach at that time, as the nation was coming out of the first lockdown. It was agreed that the following ten

principles would guide the decision to conduct an on-site assessment and/or inspection:

285.1. We would increase the use of on-site assessments and inspections as the prevalence of Covid-19 decreased;

285.2. We would not return to "previous business as usual (e.g. inspection frequencies)";

285.3. We would minimise additional burdens on providers at that time recognising the pressure placed on them due to the pandemic;

285.4. We would continue to put people who use services at the centre of what we were doing, taking necessary action to protect them and gathering their views where this was appropriate;

285.5. We would assess only the aspects of care that we needed to, being clear on the scope of our assessment and proportionate to the risk presented;

285.6. Where activity could take place remotely, it would;

285.7. Site visits would only take place when essential and time on site would be kept to a minimum;

285.8. We would take all necessary precautions to safeguard our staff, people who use services, providers and their staff from infection control and prevention risks;

285.9. We would aim for cross-sector consistency and collaboration where possible;

285.10. We would re-establish a programme of regular, planned inspections with a methodology adapted for Covid-19 as soon as it was safe to do so.

286. The "triggers" page clarified that:

"*Inspectors will continue to use all existing sources of information and our standard risk assessment processes to come to their decisions about the risk level of each provider and therefore what the appropriate regulatory action should be. The key change is that we can now cross the threshold where services exhibit a level of risk lower than "extreme".*

The information we use to inform risk will vary slightly be sector, but may include: Risk tool and ESF conversations; Whistleblowing; Safeguarding; 'Give Feedback on Care'; Inspection history; Enforcement activity; Notifications (including deaths

and serious injury); Information from other organisations (e.g. LA, CCG, Coroner); indicators of closed culture; inherent risks of particular service types and groups of people receiving care; Insight dashboards; Complaints etc.

Options for regulatory action include:
Crossing the threshold; desk-based assessment; continued/increased monitoring; phone calls; sharing and discussions with other agencies; requesting evidence and assurances from the provider; enforcement etc."

Roll-Out, Operation and Implementation of the ESF

287. On 20 April 2020, in advance of the roll out of the ESF for all sectors, we provided an internal update to CQC inspection teams and colleagues which confirmed that the ESF was being finalised, and that the guidance shared would support colleagues to make decisions about assessments and inspections during the pandemic (MC1/131 [INQ000469888]). Three Deputy Chief Inspectors (one per sector) were named as leads on how the ESF process would be applied in their respective sectors.

288. On 1 May 2020 we published an article on our website officially launching the ESF and indicating that it would be rolled out across all sectors but that it was initially being used with ASC providers (MC1/132 [INQ000469889) and (MC1/133 [INQ000466428]). From 4 May 2020 we began rolling out the ESF: initially in Adult Social Care, then: GPs (18 May 2020); Health and Justice services (29 May 2020); Independent Learning Disability and Autism services, Independent Dialysis services and Independent Ambulance services (5 June 2020); and Independent Doctors and Slimming Clinics (8 June 2020).

289. On 17 June 2020 we published an article on our website regarding "why raising concerns about care [was] more important than ever" for regulation during the pandemic. We stated that while routine inspections had been paused, we had continued to inspect in response to risk concerns raised and that services had remained subject to close monitoring using a range of intelligence sources, including the ESF (MC1/122 [INQ000398848]). In the article we indicated that the ESF tool

would be adapted as the pandemic evolved and the impact on the health and social care systems changed.

290. It was in this context that the move from using the "decision to assess" process to the "Principles and Triggers for crossing the threshold during lockdown easing" process as explained above was made. The evolution of the ESF process and tool is reflected in the three versions of the "Guidance: The Covid-19 Emergency Support Framework" documents exhibited at paragraph 265 above.

ESF statistics

291. CQC has prepared a table to demonstrate the number of ESF calls made between 4 May 2020 and 29 October 2020, broken down to show how many of those calls were with ASC providers and broken down further to show how many of those calls were with care home providers. This table has been prepared specifically for use in this statement.

Number of ESF Calls made between 4 May 2020 and 29 October 2020

	Number of Emergency Support Framework Calls
Total ESF calls across all sectors	**20,014**
ESF calls with providers of ASC services	18,216
ESF calls with care home providers within ASC	11,935

292. During the period of operation of the ESF Tool, the software system where the ESF calls were recorded had no direct link to our CRM System. Therefore, we cannot say with certainty that a particular inspection has been undertaken as a result of, or was triggered by, an ESF call.

293. During the relevant period we identified, through ESF calls, that approximately 301 care home providers needed support. Of those care homes that were identified as needing support, 100 were inspected within a 6-month period following their ESF conversation. If the details of these inspections are required by the Inquiry we will of course provide them where available.

294. In order to provide an overview of some of the issues that were identified during the inspections of care homes, which may have followed an ESF call, we have selected one of the briefings which we prepared for the meetings with the Minister of State for Care that took place between May 2020 and October 2020 as set out below.

295. In the briefing prepared for our meeting with the Minister on 23 July 2020 (MC1/134 [INQ000525011]), we set out the key themes that had instigated the 68 inspections undertaken in the ASC sector between 17 March 2020 and 14 July 2020 as follows:
    295.1. Lack of a manager, change in manager during Covid-19 or a new manager;
    295.2. Closed cultures;
    295.3. Failure of staff to respond appropriately following an incident;
    295.4. Staff competence to assess and support people safely;
    295.5. Poor management of IPC;
    295.6. Administration of medication;
    295.7. Failure to identify and respond appropriately to changes in people's health needs;
    295.8. Failure to manage end-of-life care needs;
    295.9. Inappropriate use of restraint;
    295.10. Extremely poor, unsafe care; and
    295.11. Risks not addressed in services that were lined up for First Tier Tribunal (FTT) prior to lockdown.

296. Of the 68 inspections completed between 17 March 2020 and 14 July 2020, we analysed a sample of 38 inspections and reported the most common "initial reason" for inspection was where there were safeguarding concerns (39.47%). The most common theme to come out of the sample of 38 inspections was lack of oversight/poor governance (67.57%) and we reported that where there was a lack of oversight/poor governance this impacted on safety, service delivery and practice around IPC. The most commonly breached obligations in the Health and Social Care Act 2008 Act (Regulated Activities) Regulations 2014 were Regulations 12 (Safe Care and Treatment) and 17 (Good Governance). We also reported on our planned actions, with the most common being plans to work with partners (27.03%).

Transitional Monitoring Activity and Application (TMA) (implemented as part of the Transitional Regulatory Approach (TRA))

297. With the risks relating to Covid-19 still present, we continued to adapt our existing methodologies to work within this environment, whilst being clear that our focus would continue to be on services where we had concerns about care and taking appropriate action as necessary. Rather than returning to a fixed timetable of inspections we continued to balance the need to hear people's experiences and accurately assess quality where risk was identified against minimising the risk of spreading the virus and not adding unnecessary pressure to the health and care system. On-site inspections were a valuable tool and we continued to use them proportionately.

298. Our Transitional Regulatory Approach (TRA) built on the work done through the development of the ESF to include: consideration of more areas where quality needed to improve; and targeting safety, people's access to services, and leadership.

299. The TRA developed our regulatory approach in a number of ways, including: making greater and better use of monitoring, intelligence and data to maintain an accurate view of quality; piloting new ways of gathering information outside of physical inspections; taking a more dynamic and risk-based approach to inspection frequencies; strengthening the role of relationship management; and drawing a clearer link between monitoring activity and what we look for on inspection.

300. We made use of a range of information sources to support our monitoring, including the work undertaken as part of our Provider Collaboration Reviews (PCRs), and information gathered through our routine ongoing monitoring. The PCRs are described in detail below. As well as information on individual services, we also used information that we held about local systems, building on the work as part of the PCRs to understand where there are barriers to good care and to target our activity to help break these down.

301. The TRA was a cross-sector structured risk-based approach for gathering and recording intelligence which was used to support us in assessing risk (MC1/135

[INQ000398849] and MC1/136 [INQ000398493]). New general and sector-specific guidance was developed to assist inspection colleagues with decision making under the TRA. We also developed a new application, the Transitional Monitoring Application (TMA), built using Microsoft Dynamics using the learning gained from the ESF and IPC Apps to facilitate the operation of the TRA (MC1/137 [INQ000525010]; MC1/138 [INQ000398495]; MC1/139 [INQ000525072]; MC1/140 [INQ000524905]).

302. We launched and rolled out our TRA in stages, starting with ASC and Dentistry on 6 October 2020 (MC1/135 [INQ000398849]). We continued to iterate this process on the basis of feedback (MC1/141 [INQ000398494]).

303. The focus of the TRA and TMA was to expand the content of the questions used in the ESF and was based on a streamlined set of our KLOEs to focus on issues that were broader than Covid-19.

304. The TMA was built on the lessons we had learned through the ESF as a more comprehensive digital application tool to support the roll out and iteration of the TRA. This offered structured questions and prompts in the same manner as the ESF, and used further sources of intelligence and improved modelling to produce risk prioritisation scores to help inspectors corroborate their own assessments of the safety of services. The TMA also provided a consistent place to store monitoring information and offered a consistent cross-sector method of monitoring (MC1/136 [INQ000398493] and MC1/138 [INQ000398495]).

305. We engaged with key stakeholders during the development of the TMA to assist with the formulation and testing of the questions and prompts. The experiences of those receiving care, their families and carers continued to be central to our approach to monitoring. In this process of engagement we worked with CQC's Experts by Experience, Healthwatch England, and other organisations that help us capture the voices of people who use services.

306. After a review of the monitoring information and using the streamlined set of KLOEs, we made a judgement. If we were confident that our review indicated that there weren't any risks to people who used the service then we would take no further action at that point, and let providers know the outcome.

307. Where the outcome of our monitoring activity led to us inspecting a service, we used our existing inspection methodologies, adapted to work with the environment we were in. This meant that across all the health and care sectors we regulate, we would still look at any or all the KLOEs on inspection, to ensure people were receiving safe, high-quality care. However, as our inspections were more targeted and focused around areas of risk, we did not always cover all aspects of our five key questions and our KLOEs. As a result, our inspections did not always lead to a change in rating for a service.

308. A five-point scoring system was used to assess risk from very low to very high. This took into consideration the inspector's professional judgement of the risks across the topics covered by the engagement conversation, as well as the provider's awareness of the risks and issues, and their track record and capacity to recognise, respond to, and learn from relevant events. Scores of 'very high' or 'high' in any KLOE meant that there were serious risks or issues and the TMA prompted a further regulatory response to be initiated. Where a service was banded as 'very high priority' they received an on-site inspection, and those banded as 'high priority' were triaged to identify if an inspection was appropriate.

309. Where 'high' or 'very high' risk was identified the process was signed off by an Inspection Manager, and where there were concerns about actual or avoidable potential harm, abuse, and breaches of human rights, and an MRM was held to decide the next step, for example inspection or enforcement processes.

310. Where we needed to carry out a regulatory response such as enforcement, we used existing CQC processes in line with the sector scheme of delegation and the MRM to consider this .

311. TMA engagement calls were undertaken by consent. In the event that a provider refused to engage with a TMA call, a MRM was held to determine how best to respond, including whether it was appropriate to request relevant information under section 64 of the 2008 Act.

312. Improving on the ESF, the new TMA also helped to identify improved practice and changes in the quality of care. We also undertook our own evaluation of the TMA in early 2021 (March/April 2021) with colleagues from across the organisation identifying positive feedback as well as areas for learning and improvement.

TMA Statistics

313. CQC has prepared a table to demonstrate the number of TMA assessments undertaken in the ASC sector between 6 October 2020 and 12 July 2021, broken down by year and broken down further to show how many of those assessments were in respect of care home providers. We switched from using the TMA application to using the DMA assessment system on 13 July 2021 but we continued to use the TMA methodology and application in respect of any assessments started prior to the switch. Therefore the numbers shown in the table below extend into 2022. This table has been prepared specifically for use in this statement.

Number of TMA Assessments undertaken between 6 October 2020 and 12 July 2021

Year	Number of TMA assessments in adult social care	Number of TMA assessments in care homes
2020	152	71
2021	233	126
2022	11	5
Total	**396**	**202**

314. It is not possible to provide an indication of the TMA assessment ratings for each of the assessments detailed in the table above as it is likely that the risk scores have since been overwritten with updated information.

315. For the same reasons as those set out above in respect of the integration of the ESF Tool and CQC's CRM System, we cannot say with certainty that a particular inspection has been undertaken as a result of, or was triggered by, a TMA assessment.

316. During the relevant period we identified, through TMA assessments, that "further regulatory activity" was required in respect of approximately 28 care home providers.

As explained above, whilst we cannot say with certainty the instances where an inspection was the "further regulatory activity" undertaken following a TMA assessment, we have identified that 11 of the 28 care home providers were inspected within a 6-month period following the TMA assessment. If the details of these inspections are required by the Inquiry we will of course provide them where available.

Monitoring Approach 2021/22 and the Direct Monitoring Activity (June 2021-)

317. From June 2021 we began to introduce our expanded monitoring approach to improve how we monitor services and to build capacity to inspect where higher risk is identified (MC1/142 [INQ000398501]). This included a new process to prioritise services for regulatory activity using the data we held, and placing them into three separate Regulatory Activity Bands, as well as the introduction of Direct Monitoring Activity (DMA) calls. Banding applied to most service types which we regulate. This was not applied to NHS Trusts due to the well-established relationship management already in place, and the focused risk work undertaken for high-priority areas such as IPC, and Urgent and Emergency Care.

318. DMA calls were structured conversations with providers and were an opportunity to explore any risks to service quality and the trusts actions in response to those risks, the process of sharing feedback, and whether there was a need for further regulatory activity or enforcement processes.

319. From July 2021, we did a monthly review of the information we held on most of the services we regulated to help us to prioritise our activity (MC1/143 [INQ000398502]). This involved publishing a statement on our website for lower risk (band one) services which indicated to providers and the public that we had not found any evidence that told us we need to re-assess the rating or quality of care at that time. Although these statements were refreshed monthly, we continued to monitor services and took urgent action if we received information about a serious risk.

320. Where our review indicated that there may be higher risk (band two) we undertook additional checks such as gathering people's experiences of care and contacting the

provider for a call (otherwise known as Direct Monitoring Activity) or to request evidence. If, following the necessary monitoring activity, we were satisfactorily assured the service would be eligible to have a public statement published in the next monthly information review. If not, we would record this information to inform any future monitoring. For services where we consider there to be very high risk (band three) we would prioritise these services for an inspection.

321. Risk was categorised in accordance with the scales set out in the guidance exhibited at paragraph 317 above. In general, the occurrence or demonstration of a high probability of major harm was classified as very high risk; whilst an indication that major harm is possible, moderate harm is probable, or disproportionate restrictions of liberty or breaches of human rights were probable are indications of high risk. The relevant definitions are set out in the guidance referenced above.

322. If, following further monitoring activity such as a DMA call, further action was required, colleagues would undertake an MRM as needed. Where any KLOE was scored as 'very high' we would hold an MRM with system partners such as the police and the local authority within 24 hours of this being identified. For 'high risk' classifications we would arrange an MRM to plan next steps within two working days.

323. In August 2021 we shared an update with providers and the public on the changes we were making to how we would assess quality and update ratings going forwards (MC1/144 [INQ000398503]). These changes were designed to help us work towards our ambition to be a more dynamic, proportionate and flexible regulator in line with our new strategy from 2021. Following the introduction of our new regulatory approach as outlined below, we no longer use the DMA.

DMA Statistics

324. CQC has prepared a table to demonstrate the number of DMA assessments undertaken in the ASC sector between 13 July 2021 and 28 June 2022, broken down by year and broken down further to show how many of those assessments were in respect of care home providers. This table has been prepared specifically for use in this statement.

Number of DMA Assessments undertaken between 13 July 2021 and 28 June 2022

Year	DMA assessments in adult social care	DMA assessments in care homes
2021	923	667
2022	2719	1728
Total	**3642**	**2395**

325. It is not possible to provide an indication of the DMA assessment bands for each of the assessments detailed in the table above as it is likely that the risk scores have since been overwritten with updated information.

326. For the same reasons as those set out above in respect of the integration of the ESF Tool and CQC's CRM System, we cannot say with certainty that a particular inspection has been undertaken as a result of, or was triggered by, a DMA assessment.

327. During the relevant period we identified, through DMA assessments, that "further regulatory activity" was required in respect of approximately 164 care home providers. As explained above, whilst we cannot say with certainty the instances where an inspection was the "further regulatory activity" undertaken following a DMA assessment, we have identified that 122 of the 164 care home providers were inspected within a 6-month period following the DMA assessment. If the details of these inspections are required by the Inquiry we will of course provide them where available.

Continued Monitoring of Risk: Specific Examples in ASC

328. In response to the Inquiry's specific questions set out in the Rule 9 Request we have provided examples throughout this statement of some of the instances where we adapted our regulatory response to continue monitoring and ensure safety throughout the pandemic. These examples include our work in relation to criminal enforcement activity; Infection Prevention and Control; visiting in care homes; CQC's Insight Reports; DNACPR; discharge of patients from hospitals to care homes; testing of adult social care workers and care home residents; deaths within adult social care as well as the various reviews, lessons learned exercises and State of Care Reports. Below are some additional examples of where we adapted our

regulatory approach and where we focused on specific services during the pandemic to continue monitoring and ensure safety which have not been covered elsewhere.

Covid-19 ASC Response Panel

329. On 18 March 2020 we set up the Covid-19 ASC Response Panel ("the Response Panel") to review and respond to questions from CQC colleagues regarding Covid-19. The Terms of Reference of the Response Panel (MC1/145 [INQ000525059]) stated that the purpose of the panel was to:
    329.1. Ensure that we were applying the three principles we had set out as part of our response to Covid-19 (set out in paragraph 212 above) in a consistent way;
    329.2. Ensure we were responding to Covid-19 related queries in a prompt and consistent way;
    329.3. Ensure that any deviation from usual methodology that we made when responding to Covid-19 related queries was applied and documented consistently;
    329.4. Ensure that we were recording any potential risks that would need addressing after the Covid-19 pandemic was resolved; and
    329.5. Support colleagues to confidently respond to queries from providers, the public and partner agencies.

330. The Response Panel was responsible for providing advice and guidance on issues relating to Covid-19 in ASC settings; promoting consistency in our approach and decision making by:
    330.1. Offering guidance and advice on queries that CQC colleagues were receiving from existing providers, partner agencies and the public relating to Covid-19 within ASC services;
    330.2. Focusing on queries that were not covered by existing guidance;
    330.3. Offering guidance and advice on queries from internal colleagues regarding the regulatory view of providers responses to Covid-19;
    330.4. Identifying and recording common themes and issues and circulating these internally to colleagues regularly, and externally through our engagement with Government and other key stakeholders;

330.5. Ensuring that CQC was effectively disseminating and communicating responses to queries both internally and externally.

331. The Panel comprised of representatives from the ASC Directorate, together with Policy and Engagement colleagues with support from legal colleagues when required and met twice daily, initially, on Teams. A mailbox was set up for receiving queries as well as a page on Yammer (a social networking platform designed for communication and collaboration within organisations – this is a closed platform and only employees within the corporate domain have access) for colleagues to post questions. The full log of questions including the responses ("the ASC Response Panel log") as well as a FAQ document was made available to colleagues so that the messaging from CQC was consistent. The FAQ document and some of our responses were also published on our website.

332. Between its formation on 18 March 2020 and the end of September 2020, the Response Panel responded to 1,651 Covid-19 related queries. Throughout the pandemic the purpose of the Response Panel evolved as CQC took on further responsibilities, such as answering questions relating to our inspections and supporting our Implementation colleagues in responding to queries around the TRA/TMA (a description of which is set out in paragraphs 297 to 312 above). Therefore from 30 September 2020 the Response Panel changed its name to the ASC Transitional Response Panel to better reflect its operation and to take account of its much broader purpose and increased involvement in CQC's transitional approach to regulation (MC1/146 [INQ000524953]). The Yammer page was decommissioned at the end of December 2020 and the panel meetings were reduced to twice a week from 4 January 2021. The frequency of the panel meetings was gradually reduced over the course of the relevant period as determined by need, the last entry on the ASC Response Panel log is dated 24 May 2022.

Domiciliary Care Agency inspections in ASC

333. In July 2020 our ASC Senior Leadership Team committed to undertake a Regulatory Assessment of every ASC location (registered prior to 1 June 2020) between 1 April

2020 and 31 March 2021. As at July 2020, the proposed Regulatory Assessments were intended to take the following forms:

333.1. ESF monitoring calls;

333.2. Inspections;

333.3. IPC thematic reviews; and

333.4. Use of the "new transitional methodology" to be introduced towards the end of 2020.

334. At that time, our routine inspections remained suspended but as the "*risk from Covid-19 decrease[d]*" we planned to increase our inspection activity using targeted and focused inspections (MC1/147 [INQ000525056]). The criteria for onsite inspections was a follows:

334.1. Priority 1: where people using services may be at immediate risk

334.2. Priority 2: where people using services may be at risk from known regulatory breaches

334.3. Priority 3: All remaining services without recent regulatory action

335. As part of "Priority 3" we planned to undertake a programme of IPC themed reviews to commence from 1 August 2020. This work is explained in greater detail later on in this statement. We also planned to conduct a pilot of inspections of Domiciliary Care Agency ("DCA") services and extra care services remotely without visiting the location/site between September and November 2020.

336. As part of the pilot we proposed to carry out around 60 inspections of locations ('locations' in the context of a DCA refers to the office from which the care was organized, we would not visit people in their own homes where the care was actually delivered), who volunteered to participate, where we would interact virtually with staff and people who receive services directly rather than conducting site visits. We wanted to ascertain whether the use of virtual inspection methods was an effective way of inspecting homecare services and whether it would help to reduce the burden on providers in terms of coping with the pressures of Covid-19. In the context of the pandemic, we also hoped that this approach would allow us to inspect more locations that we may otherwise not have visited due to risks associated with the spread of the Covid-19 virus (MC1/148 [INQ000525057]).

337. The scope of the DCA pilot inspections was to look at the Safe and Well-led KLOEs in their entirety, and additionally, the following specific questions under the Effective, Caring and Responsive KLOEs:

337.1. How do you ensure consent to care and treatment is always sought in line with legislation and guidance?

337.2. How does the service ensure that people are treated with kindness, respect and compassion, and that they are given emotional support when needed?

337.3. How does the service support people to express their views and be actively involved in making decisions about their care, support and treatment as far as possible?

337.4. How do people receive personalized care that is responsive to their needs? and

337.5. How are people supported at the end of their life to have a comfortable, dignified and pain-free death (for services that provide end of life care)?

338. If, as part of the inspection, concerns were identified, consideration was given as to whether to conduct a standard inspection that included a site visit.

339. The locations inspected were nominated by inspection teams, providers themselves and/or UKHCA and participation in the pilot was by consent. The locations inspected were selected by the project team, based on the following criteria (MC1/149 [INQ000525090]):

339.1. Locations must have been rated "good" or "outstanding" at their last inspection;

339.2. An equal selection of locations based on size (number of people they supported);

339.3. Locations with no current concerns from the inspection team;

339.4. Locations with a registered manager in post; and

339.5. Locations with the service type(s) DCA and extra care housing only.

340. There was an equal spread of locations in each of the four CQC regions (North, South, Central, London).

341. The inspections largely followed our methodology in use at the time, with the key difference being that documents were reviewed virtually and the site visit element to the location's office was not undertaken. Inspections teams used technology including video calling, Teams, the secure file transfer portal and other methods to engage with people using the service and the providers.

342. The inspections provided a rating for the key questions outlined above and the inspection reports were completed using a slightly adapted template to confirm that the inspection had been completed without crossing the threshold. The draft inspection reports were quality assured to make sure that the evidence included in the reports was comparable to the evidence used for standard inspection reports.

343. The inspectors had access to additional resource in the form of Experts by Experience ("ExE"), NCSC and the Medicines Optimisation Team. ExEs covered 47 of the inspections, with a total of 34 ExEs supporting inspectors with calls to people who use services. For the larger services with over 150 people, the inspectors had support from NCSC to contact people who used services and the Medicines Optimisation Team supported 27 of the inspections to provide inspectors with support around medicines.

344. As of December 2020, none of the pilot inspections had resulted in a change in overall rating which was not surprising given that any concerns/regulatory breaches identified meant inspections teams reverted to usual onsite inspections. Of the pilot locations that had some form of inspection, 19% were removed from the pilot process due to concerns or an indicated decline in rating.

345. On 2 November 2020 we reported on the progress of the pilot inspection programme to the Regulatory Transition Programme Board (MC1/150 [INQ000524968]). In November 2020 we also compiled an evaluation report on the DCA pilot inspections which was presented to the ASC Directorate Improvement Board and SLT on 12 January 2021 The key findings of the evaluation included:

    345.1. We were able to carry out robust, evidence-based inspections using the pilot methodology and without visiting the offices of those locations included in the pilot;

345.2. We were able to gather feedback from people using services and their supporters in an effective and extensive way using the pilot methodology. The same applied to members of staff working for home care agencies;

345.3. There was little (if any) time saved through carrying out inspections virtually. The evidence suggested that this was primarily because potential time saving from reduced travel/time onsite was offset by additional time required to manage and review evidence digitally;

345.4. How efficient and time effective virtual inspections are depended on a number of factors, most significantly, the file sharing methods used and how "digitally enabled" providers were. We also found that, across all sectors, inspectors were often unsure about how much evidence was "enough". It was suggested that this needed to be addressed as CQC developed its future approach (although this was not an objective considered as part of the pilot).

346. The board was asked to consider the findings of the evaluation report and specifically to consider whether remote inspections of home care agencies be incorporated into CQC's future regulatory approach. The following recommendations were made to the ASC Directorate Improvement Board:

346.1. Pending the outcome of CQC's consultation on changes to the definition of "inspection" as set out in the 2008 Act as part of the 2021-26 Strategy consultation, we should continue to develop our approach with a view to incorporating an inspection methodology similar to the pilot approach into our 'tool kit' for inspecting care at home services;

346.2. If the roll-out of the virtual approach is agreed, inspection teams can choose to apply the approach to locations:

346.2.1. rated as "outstanding", "good" or "requires improvement" overall;

346.2.2. with existing or new breaches not above "requirement notice" level;

346.2.3. with the service types of DCA and extra care housing; and

346.2.4. that are "digitally enabled".

346.3. The ASC Directorate Improvement Board provided a view on whether to continue/expand the pilot or await consultation

347. In November 2021, following the successful pilot and our public consultation[13], the inspection using remote technology ("IURT") approach for home care services was introduced as part of the home care inspection toolkit. We published a handbook for inspectors to assist with carrying out IURTs wherein it was stated that these inspections are "Performance Reviews and assessments" as set out in our duties under Section 46 of the 2008 Act.

348. Part of the development of our regulatory approach included undertaking IPC focused inspections from August 2020, these are described in greater detail later on in this statement where we directly address the rationale and methodology for IPC inspections as well as how the ESF was used for these inspections.

Closed Cultures Inspections

349. In 2019 the BBC Panorama programme uncovered abuse and mistreatment of people with learning disabilities and/or autism at Whorlton Hall, an independent hospital in County Durham. Following the programme, CQC commissioned an independent review by Professor Glynis Murphy into CQC's regulation of Whorlton Hall between 2015 and 2019. Professor Murphy produced two reports, the first in March 2020 and the second in December 2020. In response to the recommendations made by Professor Murphy, CQC embarked on the 'closed cultures' project to inform and amend our regulatory approach.

350. Shortly before the first report by Professor Murphy was published, a report from David Noble QSO, commissioned by CQC, was also published specifically addressing how we dealt with concerns raised by a former CQC inspector in relation to the regulation of Whorlton Hall. This report also featured a number of recommendations for CQC which informed the closed cultures project.

[13] Between January 26 and 23 March 2021 we ran a formal public consultation to hear views on our proposals for some specific changes for more flexible and responsive regulation which built on our learning from our regulation during the Covid-19 pandemic. The findings were published in an update on our website at https://www.cqc.org.uk/about-us/our-strategy-plans/responding-our-consultation-changes-more-flexible-responsive-regulation

351. Some of the work around closed cultures was already in train prior to the project receiving dedicated resourcing at the end of 2019, and this was carried forward by CQC to address the recommendations contained in the relevant reports.

352. The closed cultures project set out to:

352.1. Improve our approach to regulation for people with learning disabilities and/or autistic people; and

352.2. Improve our approach to regulation at locations where closed cultures are more likely.

353. The closed cultures project was predominantly structured around the following workstreams:

353.1. Policy: the development of new methods, approaches, and means for improving the organisational approach to regulating services and minimizing the risk of closed cultures developing.

353.2. Engagement: ensuring that there was input from people with lived experience of closed cultures, and organisations who represent such people. This workstream also entailed the involvement and awareness of internal colleagues into the project, as well as managing the relationships with targeted and interested stakeholders.

353.3. Intelligence: delivering improvements to data and intelligence that CQC holds, and how it is used, to monitor and detect risk in services at risk of developing closed cultures.

353.4. Evaluation: clarifying how the activities for each workstream contributed to the aims of the overall programme.

353.5. Surveillance: looking at CQC's use of its surveillance powers including looking at our use of surveillance and how we use surveillance by others, including providers and families.

354. CQC defines a "closed culture" as 'a poor culture that can lead to harm, including human rights breaches, such as abuse'. Soon after the project commenced, the Covid-19 pandemic hit and severely affected the people at the heart of this work. The pandemic reinforced the need for the project as closed cultures became more of a risk than ever.

355. In furtherance of the closed cultures project aims, in June 2020, we released new guidance for CQC colleagues about "*Identifying and responding to closed cultures*" (MC1/151 [INQ000524881]) and training in "*Closed Cultures: Understanding closed cultures and protecting people's human rights during Covid-19*" was rolled out to all operational colleagues.

356. In October 2020 our *Right support, right care, right culture* guidance was published as an update to the earlier Registering the right support guidance. Training on the updated guidance was also delivered to managers and they were asked to cascade it to their teams. This is explained in greater detail later on in this statement.

357. In April 2021 the development of the Quality of Life tool was completed and the tool was piloted on the learning disability and autism pilot inspections. The Out of Sight implementation team was formed to drive forward the *Out of Sight – who cares?* Report, which reiterated the closed cultures work on improving our regulatory approach for providers of services for autistic people, and people with a learning disability and/or mental health condition. The Quality of Life Tool was published on CQC's website in October 2021. This is also explained in greater detail later on in this statement.

358. In May 2021 the *Identifying and responding to closed cultures* guidance was updated for CQC colleagues (MC1/152 [INQ000524978]) and a similar version was also produced for providers . We also published a brief guide for operational CQC colleagues regarding: *Surveillance, Private Information, Open Source and Telephone Recordings* guidance .

359. We described the work that CQC was undertaking in relation to identifying and responding to closed cultures in our Covid Insight Report Issue 12 published in July 2021 (MC1/153 [INQ000835481). In the report we acknowledged that the risk of the development of closed cultures within services had been exacerbated during the pandemic, with more services becoming closed environments due to a lack of visitors, and the potential impacts of staffing and management pressures. To improve our understanding of, and how we identified, the risks associated with closed cultures, we began proactively reviewing the information we held on services

which we considered to be at risk of developing a closed culture. This included reviewing whistleblowing concerns, feedback about quality of care from people using services and their carers and staff, and notifications received from service providers.

360. Where we identified services as having a closed culture, we took appropriate action which ranged from initiating focused inspections, using our civil enforcement powers to issue urgent notices to restrict admissions, placing services into special measures and, where necessary, ensuring people were relocated to other care services. In these instances, we worked with the local authority in assisting to find suitable alternative accommodation.

361. In cases where we had concerns about a service, but where we did not find evidence of a closed culture on inspection, we continued to monitor them as part of our ongoing regulation.

362. The findings published in our Covid Insight Report Issue 12, were based on a sample of 29 inspections where we found evidence of closed cultures. These inspections included services in both the mental health and ASC sectors. In the report we described some of the common features of services where we found evidence of closed cultures as:

    362.1. Incidents of abuse and restrictive practice
    362.2. Issues with staff competence and training
    362.3. Cover-up culture
    362.4. Lack of leadership and management oversight
    362.5. Poor quality care
    362.6. Poor quality reporting

363. The intelligence closed culture risk indicator dashboard was launched in late 2021. This is a bespoke dashboard for closed cultures and services that care for people with a learning disability and or autistic people that is monitored regularly for risk and informs enforcement action. Within this we have developed risk indicators for closed cultures and factors that increase the likelihood of a service developing a closed culture. This has been embedded into our regulatory process (MC1/154 [INQ000525062]).

364. In October 2021 the Department of Health and Social Care's Research and Development Committee approved CQC's proposal to commission the first stages of research into 'Understanding and detecting abuse in residential care settings for people with a learning disability and/or autistic people'. This proposal followed a recommendation made by Professor Murphy in her second report regarding a literature review of international research evidence in relation to the detection and prevention of abuse in services for adults with a learning disability and autistic people. [MC1/155 [INQ000525063]); MC1/156 [INQ000524971]

365. In November 2021 our Research and Evaluation Team completed an evaluation of the closed cultures project some of the key findings in the report included: (MC1/157 [INQ000524976])

365.1. CQC colleagues clearly view this work as fundamental to what we do.

365.2. There is a good level of awareness of closed cultures across the organisation. Our survey showed over 70% of colleagues agreed that their team has a good understanding and awareness of closed cultures risk.

365.3. Operational colleagues have increasing confidence about identifying and preventing closed cultures.

365.4. We saw that taking action in response to cases is a serious undertaking, requiring persistence and diligence from operational colleagues.

365.5. CQC colleagues often referred to 'gut feelings' around the risk of a closed culture. Colleagues would base these views on their experience, training and knowledge of the service. This was not always something they could report and act on.

365.6. CQC colleagues were clear that it is vital to cross the threshold of services to identify closed cultures.

365.7. Pilots of specific tools to help colleagues get a greater understanding of people's experiences have been well-received. For example, the evaluation of the Talking Mats pilot[14] found that colleagues felt the mats helped people share their views and experiences of care. A significant proportion of

[14] Talking Mats is a communication and interactive tool developed by CQC which uses specially designed symbols to supports people with communication difficulties to express their views and feelings

colleagues said they identified concerns about a person's wellbeing or their care using the mats.

366. The report also made recommendations to ensure that the work continued beyond the life of the project, including:
    366.1. Continuing to increase understanding and awareness by ensuring that we apply our learning and tools to other service types, as we know closed cultures can exist in any kind of service.
    366.2. Reframing how we look at cultures to widen the relevance across operations.
    366.3. Giving colleagues extra information and support where needed. This includes helping colleagues with the use of communication tools and supporting colleagues to use their professional instinct effectively.
    366.4. Continuing to build on intelligence work by evaluating, monitoring and iterating the roll out of the intelligence dashboard.
    366.5. Making sure the closed cultures message and outputs continue through other key projects.

367. In the written evidence submitted by CQC to the Joint Committee on Human Rights' Inquiry into protecting human rights in care settings on 5 November 2021, we described the work done by CQC to improve our regulation of services for people with a learning disability and autistic people, specifically outlining the work done around closed cultures (MC1/158 [INQ000525077]). In our State of Care Report for 2020/2021 (MC1/159 [INQ000235497]), we reported on 'Risks of closed cultures' which describes the work done by CQC as outlined above. We also presented an update on this work to the Public Board on 19 January 2022 (MC1/160 [INQ000525006]) Public Board Paper January 2022 and we published an update on our website on 8 August 2022 (MC1/161 [INQ000525091]).

CQC's roles and responsibilities in relation to Safeguarding

368. The legal framework governing the safeguarding of children is explained in statutory guidance, Working together to Safeguard Children (2023) and for adults is derived from the provisions found in the Care Act 2014. The overarching objective for both

frameworks is to enable children and adults to live a life free from abuse or neglect. This cannot be achieved by any single agency and every organisation and person who comes into contact with a child or adult has a responsibility and a role to play to help keep them safe. The CQC Safeguarding statement sets out what safeguarding means for us, what our roles and responsibilities are (and are not), and why safeguarding is important to us (MC1/162 [INQ000525092]).

369. Safeguarding is a key priority for CQC and people who use services are at the heart of what we do. Our work to help safeguard children and adults reflects both our focus on human rights and the requirement within the 2008 Act to have regard to the need to protect and promote the rights of people who use health and social care services. Regulated providers of health and social care services all have a key role in safeguarding children and adults in their care who may be at risk of abuse and neglect. We monitor how well providers are doing this by assessing the quality and safety of care they provide.

370. The CQC Safeguarding Policy explains our processes and arrangements in relation to safeguarding practice to assure CQC's Board that we are protecting the people using health and social care services from harm effectively (MC1/163 [INQ000525093]).

371. CQC's primary responsibilities for safeguarding are set out below and are explained in more detail in the Safeguarding Statement and the Safeguarding Policy:
    371.1. Making sure providers have the right systems and processes in place to ensure children and adults are protected from abuse, improper treatment and neglect.
    371.2. Working with other inspectorates (Ofsted, HM Inspectorate of Probation, HM Inspectorate of Constabulary, HM Inspectorate of Prisons and NHSEI) to review how health, education, police, probation and prison services work in partnership to help and protect children and young people and adults from significant harm.
    371.3. Holding providers to account, securing improvements and taking enforcement action where we need to.

371.4. Responding to information received from all sources, including from the public, staff working in services, health and care providers and other stakeholders.

371.5. Using intelligent monitoring, where we collect and analyse information about services, to assess the risks to people using services and taking regulatory action to mitigate risks to people using services.

371.6. Working with local partners such as Local Healthwatch, local authorities, the police and ICSs to share information about safeguarding.

372. CQC is not responsible for conducting safeguarding investigations or enquiries as this is for the relevant Local Authority or the police to do. However, where appropriate, we work with colleagues from Local Authorities, NHSE, Integrated Care Systems and the police by sharing information and intelligence to help them conduct their investigations or enquiries.

373. As set out in Section D above, when determining whether to register new service providers, we assess whether the providers will meet the relevant requirements for registration as set out in Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009. These regulations include our expectations that providers will carry on high-quality regulated activities by implementing effective safeguarding policies and systems to protect people using the service. During registration, safeguarding evidence will be gathered at the assessment stage to determine whether or not a provider can satisfy us as to their compliance should registration be granted.

374. Our Insight model monitors information we receive about safeguarding to assess risks to adults and children using services, to make sure the right people act at the right time to help keep them safe and to inform our inspections. It enables us to act promptly where we identify high levels of risk to people using services. When we receive information of concern about safeguarding our priority is to make sure that the right people are aware so that they can take the right steps to remove any immediate risk of harm to the individuals. This could be the local authority, the police, or the provider. We add the information to what we already know about the service and consider whether the overall level of risk means that we should bring forward an

inspection or conduct a focused inspection to look at a specific aspect of the service. Where risks are low, we will make sure we take the issue into account in planning the next inspection. Providers have a legal responsibility to notify us about all abuse and/or harm caused to children and adults using regulated services or incidents which place them at risk of harm. Notifications include details of whether or not the local safeguarding authority has been informed and what action has been taken.

375. As explained in Section N below, all concerns raised to CQC's NCSC are logged, triaged and forwarded onto the relevant relationship owner within 24 hours of receipt. This may include safeguarding information from members of the public, other statutory bodies, information from whistleblowers and complaints from patients detained under the MHA 1983. NCSC also make safeguarding referrals to the Local Authority Safeguarding Team. We respond to concerns where we suspect abuse or neglect.

376. In respect of our approach to inspection, safeguarding sits in the "Is the service safe?" key question. Information about safeguarding or safeguarding concerns may emerge in responses to any of the five KLOEs and their related prompts. We aim to act promptly on any safeguarding issues we discover during inspections, raising them with the provider and, if necessary, referring safeguarding issues to the local authority and the police, where appropriate, to make sure action is taken to keep children and adults safe. We speak with people using services, their carers and families as a key part of our inspections so we can understand what their experience of care is like and to identify any safeguarding issues. We also speak with staff and managers in care services to understand what they do to keep people safe.

377. We hold providers to account by taking regulatory action to ensure that they rectify any shortfalls in their arrangements to safeguard children and adults, and that they maintain improvements. This includes requiring providers to produce action plans, taking enforcement action to remedy breaches of fundamental standards, and taking action against unregistered providers. We publish our findings about safeguarding in our inspection reports.

378. During the pandemic we did not change our approach to safeguarding.

379. We have not included the details of any reports of recipients of care being abused during the pandemic (whether by another recipient of care or by staff) because to do so was not possible within the timescales set by the Inquiry for responding to the Module 6 Rule 9 Request. If further specific detail or information is required by the Inquiry we will of course endeavour to provide it where it is available.

Provider Collaboration Reviews

380. To help providers of health and social care services learn from the experience of responding to Covid-19 around the country, CQC carried out rapid reviews of how providers were working collaboratively in local areas between July 2020 and November 2021. These Provider Collaboration Reviews (PCRs) looked at how health and social care providers were working together across Integrated Care Systems (ICS) or Sustainability and Transformation Partnerships (STPs) with the aim of helping providers learn from each other's experience of responding to the pandemic (MC1/164 [INQ000398504]; MC1/165 [INQ000398505]; MC1/166 [INQ000398506]; MC1/167 [INQ00039507; MC1/168 [INQ000398508]; MC1/169 [INQ000398509]). Our powers for this work fell within section 58 of the 2008 Act, which relates to publication of information, and is ancillary to our powers in Chapter 2 of the 2008 Act.

381. This built on work we had previously undertaken with a series of 26 Local System Reviews (LSRs) through 2017 and 2018, under the Secretary of State's section 48 powers (MC1/170 [INQ000398510; MC1/171 [INQ000398511]; MC1/172 [INQ000398512]; MC1/173 [INQ000398513]; MC1/174 [INQ000398514). We looked specifically at how people move between health and social care, including delayed transfers of care, with a particular focus on people over 65 years old. The LSRs did not include mental health services or specialist commissioning but, through case tracking, looked at the experiences of people living with dementia as they move through the system. The LSRs also included commissioning across the interface of health and social care and an assessment of the governance in place for the management of resources. We published our findings for individual local areas and

overall, in our 2018 Beyond Barriers: How older people move between health and social care in England report (MC1/175 [INQ000398515]).

382. In carrying out the PCRs, we looked at data and information held by CQC to inform and undertake conversations, focus groups and workshops with providers structured around the KLOEs; and gathered views from people who used services using the Healthwatch network. We also surveyed system partners, gathered statistical and engagement data relating to published reports, and reviewed literature relating to regulatory approaches in systems.

383. The PCRs covered five topics in phases and the findings were published on our website. The key findings of the PCRs, relevant to the Scope of Module 6, are summarised below.

Care for older people (September 2020) (MC1/176 [INQ000235474]

384. The first phase looked to understand how care providers had collaborated to improve care for older people, who were most at risk of Covid-19. The review focused on the interface between health and social care for people aged 65 and over. In both the health and care systems we carried out a deep dive review of a local authority area and then fed this information back to the ICS or STP leads. To get a comprehensive picture, we engaged with a wide variety of organisations locally, including primary care networks, local medical committees, adult social care providers, directors of social services, NHS trusts and independent hospitals, urgent care providers, NHS 111, community care providers, integrated care teams, urgent dental services, local Healthwatch and other organisations that represent those who use services, their families and carers.

385. We published our findings in the Covid-19 Insight Report Issue 4 and the State of Care Report for 2019/2020.

386. We found that:

386.1. Understanding local population needs, including cultural differences, was especially important.

386.2. The quality of existing relationships between local providers played a major role in the coordination and delivery of joined-up health and social care services that meet the needs of the local population.

386.3. There was an increased focus on shared planning and system wide governance, but pre-existing plans may not have been fit for purpose to cope with Covid-19.

386.4. Staff across health and social care worked above and beyond their roles – we spoke to dedicated, passionate staff, committed to supporting everyone including people aged 65 and over.

386.5. There was a range of initiatives to ensure the safety and wellbeing of staff working both on the front line and in support services.

386.6. The move to digital working accelerated and impacted on access to services, and more generally digital solutions supported data-sharing and communication between health and social care partners and within health and social care organisations.

Urgent and emergency care (March 2021) (MC1/177 [INQ000398516]

387. The second phase looked at urgent and emergency care (UEC) in 8 areas of England in October 2020 to understand whether people were getting the right care at the right time and in the right place, and how collaboration across local areas had made a difference. UEC covers a wide range of services that people turn to when they need immediate help, including NHS 111, GP out-of-hours services, urgent treatment centres, urgent dental services, accident and emergency, ambulance services and pharmacies.

388. We published our findings in the Covid-19 Insight Report Issue 9 and the State of Care Report for 2020/2021.

389. The findings relevant to the scope of Module 6, as presented in the PCR report were as follows:

389.1. Ensuring access

389.1.1. Urgent and emergency services collaborated in a variety of ways to maintain access to services, although access to the right UEC care was sometimes difficult for people.

389.1.2. The pandemic served as a catalyst for change – pathways were often evolved at pace with positive impact.

389.1.3. There were adult social care and health care services that tried to reduce Covid-19 risks and the need for urgent and emergency care services through enhanced support and training in care homes.

389.2. Tackling inequalities

389.2.1. There was variation between local systems in the level of focus and action on health inequalities, linked to pre-COVID oversight and planning maturity around population needs.

389.2.2. The pandemic exposed where some systems lacked the full understanding of inequalities across their population groups.

389.3. Governance and shared planning

389.3.1. There was extra support for social care providers in some places, to ensure residents received appropriate urgent care. Clinicians were aligned with care homes, sometimes through a primary care network. Equipment was provided to support remote consultations.

389.3.2. There was also some poor collaboration. Many adult social care providers felt uninformed, not supported or unincluded by GPs and NHS trusts, particularly around coordination of the discharge of people from hospitals to care homes or into people's own homes.

389.3.3. Some adult social care providers told us that no measures were in place to ensure support from UEC providers for vulnerable people. Sometimes, support for people shielding was led by the adult social care service where people lived. Some home care services relied on NHS 111, while some care homes were supported by a GP and could also get rapid response via a special designated 111 service.

389.3.4. Limited national guidance and support from the system early in the pandemic, creating pressure on providers to source PPE (later improved with access to NHS portals).

389.3.5. Hospital discharge processes into care homes: due to a lack of testing there was pressure to accept people into care homes. There was a suggestion that this had since improved, with patients only being discharged following a negative test result.

389.4. Safety and staff skills

389.4.1. Providers created new collaborative relationships, sometimes sharing staff or helping ensure services were adequately staffed. Staff have been flexible and risen to many challenges. But exhaustion and burnout were concerns everywhere, especially with the impact of winter.

389.4.2. We saw little evidence of widespread shared strategies, at a whole-system level, for managing anticipated increased demand for UEC services this winter. Some interviewees from oversight bodies felt that it was not within their remit to set up cross-system staffing strategies (for example across the health and care systems). We heard that overlapping geographical footprints and general complexity within the health and social care systems were barriers to this happening. Geographically-isolated trusts were also less likely to be able to share staff.

389.4.3. Easy access to enough and appropriate PPE had been a problem for some providers at the beginning of the pandemic, particularly for staff at adult social care services, but was mostly no longer an issue. PPE was shared across systems too – hospitals helped adult social care providers to get supplies nearer the beginning of the pandemic.

389.5. Use of technology

389.5.1. Technology increased and changed the way people were encouraged to access UEC, although some systems were more advanced than others in their approaches to equality of access.

389.5.2. Many people benefitted from the quick responses of primary care to offer virtual access. Rapid technology advancements were seen to significantly improve transfers of care.

389.5.3. Where electronic patient records were shared across all sectors, we heard of a positive and timely impact for people accessing

care. In adult social care, people using services and their families (if they had the rights) were able to see aspects of their care records, including visit times for home care agencies, and other information such as prescription and medication records – they were helped to be aware if issues were arising, proactively supporting that person to reduce the risk of them experiencing a crisis.

Cancer care services and pathways (July 2021) (MC1/178 [INQ000398517]

390. Phase 3 looked at cancer care in 8 areas of England in March and April 2021 to understand whether people were getting the right care at the right time and in the right place, and how collaboration across local areas had made a difference. Cancer care is provided by a wide range of services, including NHS hospitals, GPs, adult social care, hospices, 111, GP out-of-hours services and community pharmacies.

391. We reported on some of our findings in the Covid-19 Insight Report Issue 10 and in the State of Care Report for 2020/2021.

392. The overall learning and the common challenges found from the review, relevant to the scope of Module 6, were as follows:
    392.1. There was recognition that adult social care providers were not always sufficiently involved in the local systems planning and strategies.
    392.2. Planning and strategy considerations for adult social care within cancer services was one of the prevalent challenges – one of the local systems recognised the need for adult social care providers to have "a clearer and stronger voice in the system".

Services for people who live with a learning disability in the community (July 2021) (MC1/179 [INQ000398518]]

393. The fourth phase looked at the care and support for people with a learning disability in 7 areas of England in March 2021. We reported on some of our findings in the Covid-19 Insight Report Issue 11 and the State of Care Report for 2020/2021.

394. The findings relevant to the scope of Module 6, as presented in the PCR report were as follows:

394.1. Access to care during the pandemic

394.1.1. Access to services – including day services, respite services and health services (GPs, dental, mental health) – was disrupted during the pandemic. This was distressing for people and led to a deterioration in the health of some people. It also led to some people displaying distressed behaviour.

394.1.2. Local areas had prioritised people with a learning disability for vaccination.

394.2. Information and support

394.2.1. A lack of clear national guidance that took account of the needs of people with a learning disability caused confusion and increased anxiety for them and their families/carers.

394.2.2. People's experiences of care and support varied during the pandemic. How well services were meeting people's needs was often down to individual relationships.

394.2.3. Generally, people felt well informed about the pandemic and why they could not see friends and family, and how to stay safe. A range of communication techniques and strategies, such as easy reads, had been used to help keep people informed and reduce anxieties.

394.2.4. We continued to find issues with care planning and transition planning. This meant that there was the risk that people were not receiving the right care and support that met their needs, when they needed it.

394.3. Use of digital technology

394.3.1. The increased use of technology and virtual consultations helped to improve some people's access to care and support as they removed the barriers imposed by travelling to appointments, particularly cost and time.

394.3.2. However, there were challenges. Not everyone had access to or felt comfortable using digital technology. It also made it more difficult for health and social care professionals to pick up subtle

clues in relation to mental health and wellbeing, and led to increased safeguarding concerns.

394.3.3. Systems recognised the need for flexibility and creativity around options for both virtual and face-to-face support. This needs to be built into any future planning around the use of digital technology.

394.4. How systems worked together

394.4.1. Some systems we looked at had a clear plan for the delivery of services for people with a learning disability and had made changes in response to the pandemic. However, services were often planned by providers themselves or were a result of collaborative arrangements between providers.

394.4.2. Communication and collaboration greatly affected how well systems worked together. While there were a number of examples of providers and organisations collaborating and sharing information, this was not always taking place at a strategic level.

394.4.3. Some systems had started to plan around health inequalities for people with a learning disability, but this was not consistent.

394.4.4. While LeDeR reviews had taken place in all of the systems that took part, progress in completion, learning and awareness from these reviews were in varying stages.

Mental Health care for children and young people (November 2021) (MC1/180 [INQ000398519).

395. This report looked at mental health care of children and young people in 7 areas of England in June and July 2021 and is not relevant to the scope of Module 6.

396. We took the decision to pause the ongoing fieldwork element of these reviews twice due to pressures on the system caused by the pandemic. Once in November 2020 until early January 2021 and again in January 2021 to March 2021 (MC1/181 [INQ000398520]; MC1/182 [INQ000398521]).

397. We also undertook internal evaluation work around what had worked well and what could be improved upon in the PCRs to inform future iterations of work to review local health and care systems (MC1/168 [INQ000398508]).

CQC's New Regulatory Strategy

398. In January 2020, CQC had six Directorates:
    398.1. hospitals (including ambulances and mental health);
    398.2. primary medical services and integrated care (including dentists, health and justice);
    398.3. adult social care (ASC).
    398.4. Strategy and Intelligence;
    398.5. Digital; and
    398.6. Regulatory Customer and Corporate Operations (RCCO).

399. 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. Our strategy is outlined on our website (MC1/183 [INQ000235465]).

400. In early 2021 we undertook a public consultation on our new strategy and on changes for more flexible and responsive regulation (MC1/184 [INQ000398522]). We took our experience of regulation both prior to and during the Covid-19 pandemic into account in developing this new approach. Our strategy was built on four themes: people and communities; smarter regulation; safety through learning; and accelerating improvement. To support a more flexible and responsive regulation we proposed a number of changes to our approach including moving away from comprehensive on-site inspections as the main way of assessing quality in services and instead using wider sources of evidence, tools and techniques to assess quality (MC1/185 [INQ000398523]).

401. On 24 March 2021 we wrote to registered providers to update on our regulatory approach (MC1/164 [INQ000398504]. In the letter we outlined a series of specific approaches to the different sectors we regulate. Since suspending routine inspection activity we had continued to undertake inspection activity where there were serious risks to people's safety or where it supported the health and care system's response to the pandemic. This was with the intention of taking an active role in encouraging and supporting system-wide recovery and beginning to roll out our future approach to regulation based on recent consultations.

402. We were clear that, utilising the tools we had developed over the preceding year, we would continue to respond to risk, but also that following on from the public consultations we would be seeking to deliver change and improvement across CQC in line with our ambition to regulate in a more dynamic and flexible way.

403. In May 2021 CQC published its new strategy setting out our ambition to regulate in a smarter way. The strategy was launched on 27 May 2021 making clear our ambitions and commencing joint working with people who use services, health and social care providers and professionals and other partners to develop our future regulatory approach (MC1/186 [INQ000398525]). Over the summer and autumn of 2021 we continued to develop how we would implement this strategy and how this would change our approach to regulation.

Winter 2021/22

404. We wrote again to providers on 10 December 2021 to update on the regulatory approach we would take over the winter months, taking account of the increased pressure on the health and care system, particularly compounded by the emerging Covid-19 variants (MC1/187 [INQ000398524]). We emphasised that we would not be returning to routine frequency-based inspections during this period but would continue taking our risk-based approach. We would also be continuing our ongoing monitoring of services and adapting our approach to specific sectors.

405. On 13 December 2021 we provided a further update that, in response to new data on the spread of the Omicron variant, we would be postponing on-site inspection

activity in acute hospitals, ambulance services and general practice for the next three weeks with immediate effect (except in cases where we have evidence of risk to life, or the immediate risk of serious harm to people) but that we would continue risk-based inspection activity in other sectors, including ASC (MC1/188 [INQ398526]). We continued risk-based inspection activity in adult social care, mental health, independent health and dentists. On 21 December 2021, aware of circumstances where re-rating services can support providers to deliver more capacity across the system and address wider pressures that they were facing, we proactively wrote to every Director of Social Services in England to inform them that we would seek to prioritise our regulatory activity if they believed a re-rating would open up capacity (MC1/189 [INQ000398527]).

Changes in 2022

406. On 27 January 2022 we wrote to providers to further update them on changes to our regulatory approach which would take effect from 1 February 2022 (MC1/190 [INQ000398528]). In light of the situation, including the easing of Covid-19 restrictions across the UK, we had reviewed our approach and in addition to ongoing monitoring, we planned to inspect in three situations:
    406.1. Firstly, where there was evidence of risk of harm (across all sectors) including those inspections previously postponed.
    406.2. Secondly, where we could support increasing capacity in the system.
    406.3. And thirdly, where focusing on urgent and emergency care would help us to understand the pressures, where local or national support was needed, and where we could share good practice to drive improvement.

407. Following a period of engagement with providers, people who use services and stakeholders, we published an update on our website in July 2022 sharing information about our developing work on our new approach to regulation and the Single Assessment Framework (SAF) (MC1/191 [INQ000398529] and (MC1/192 [INQ000398530]).

408. Whilst quality ratings and the five key questions have remained central to our approach to regulation, we replaced the KLOEs and prompts with new 'quality

statements'. Our assessments across all types of services at all levels are now based on the Single Assessment Framework which is currently under review.

409. The SAF was introduced in November 2023. In May 2024 Dr Penny Dash was asked by DHSC to conduct a review into the operational effectiveness of CQC (The Dash Review). This was a pre-planned assessment which is part of the Cabinet Office Review Programme (COPBRP), which aims to periodically review the governance, accountability, efficacy, and efficiency of existing arm's length bodies, including in response to significant changes in approach. Amongst other things, the purpose of the review was to examine the suitability of CQC's SAF methodology. On 26 July 2024 the interim findings of the Dash review were published and the final report was published on 15 October 2024. The conclusions of the final report were summarised around ten topics, with seven key recommendations. These recommendations focus on operational performance, rebuilding expertise, reviewing the SAF to ensure it is fit for purpose, clarifying ratings, local authority assessments, Integrated Care Systems (ICS) assessments and the sponsor relationship with DHSC. CQC has also commissioned Professor Sir Mike Richards to undertake a review of the SAF to address concerns identified in the interim report of the Dash Review. Findings from his first part of the review were also published on 15 October 2024. CQC published a response to the final report of the Dash Review and the Review of the SAF by Sir Mike Richards on 15 October 2024, accepting all high-level recommendations. On 2 December 2024, Sir Julian Hartley joined CQC as our new Chief Executive. He has set out the immediate actions that CQC's Executive Team are leading on which involve urgent work that will get CQC back to delivering effective regulation. Central to this work we will be looking at how our culture needs to change, and how we re-centre our purpose, values and ways of working under what will be known as 'the CQC Way'. We will be co-creating the CQC Way with providers, the public and wider stakeholders.

F. Enforcement Activity

410. Enforcement is one of the core components of the operating model that CQC uses to achieve our purpose and perform our role. We use our enforcement powers to promote our statutory objective of protecting and promoting the health, safety and welfare of people who use health and social care services.

411. CQC is the primary enforcement body at a national level in England for ensuring that people using health and adult social care services receive safe care of the right quality. We have a wide range of enforcement powers and we can take enforcement action against anyone who provides regulated activities without registration. We can also take enforcement action against registered persons who breach either:
    411.1. conditions of their registration; and/or
    411.2. relevant sections of:
        411.2.1. the 2008 Act
        411.2.2. The Care Quality Commission (Registration) Regulations 2009
        411.2.3. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
        411.2.4. Other legislation that is relevant to achieving registration requirements.

412. Where breaches of regulations do not constitute a criminal offence, we can enforce the standards using our civil enforcement powers which are explained in greater detail below. Failure to comply with the steps required when we use our civil enforcement powers is a criminal offence and therefore may result in a prosecution. The breaches that constitute criminal offences are explained in greater detail below.

413. Our Enforcement Policy sets out the principles and approach we will follow when using our enforcement powers under the 2008 Act, as amended by the Care Act 2014, and is intended to be a general guide to good practice when carrying out or considering carrying out enforcement action. During the relevant period we used the 2015 version of our Enforcement Policy (dated February 2015, effective from 1 April 2015) (MC1/192a [INQ000567478]), which was replaced with the current Enforcement Policy on 21 November 2023.

414. The 2015 Enforcement Policy operated alongside the following other key guidance documents:
    414.1. Our enforcement decision tree for selecting appropriate enforcement powers, (explained in greater detail below);

414.2. Our provider handbooks that described our approach to inspecting, regulating and, where applicable, rating each of our care sectors, referenced above in Section E; and

414.3. Our guidance for providers on meeting the regulations, referenced above in Sections D and E.

415. As set out in our 2015 Enforcement Policy, we have two primary purposes when using our enforcement powers:

415.1. To protect people who use regulated services from harm and the risk of harm, and to ensure they receive health and social care services of an appropriate standard; and

415.2. To hold providers and individuals to account for failures in how the service is provided.

416. When a service falls below the required standards, we will consider both purposes.

417. In addition, the 2015 Enforcement Policy sets out the five principles which guide our enforcement decision making as follows:

417.1. Being on the side of people who use regulated services;

417.2. Integrating enforcement into our regulatory model;

417.3. Proportionality;

417.4. Consistency; and

417.5. Transparency

418. We updated our Enforcement Policy in 2023 to bring it in line with our new regulatory approach and the new version took effect from 21 November 2023 (MC1/192b [INQ000567485). The changes include, but are not limited to, removing principle (ii); 'integrating enforcement into our regulatory model' referred to above, as this requirement is no longer relevant. Therefore the current Enforcement Policy refers to the remaining four principles referred to above to guide the use of our enforcement powers.

419. The 'Enforcement Decision Tree' is at the core of how we apply our Enforcement Policy. This describes the process that guides how CQC makes decisions on the

use and selection of appropriate enforcement powers to ensure consistency and proportionality. During the relevant period we were using the 2017 version of the Enforcement Decision Tree (MC1/192c **[INQ000543916]**. We updated our Enforcement Decision Tree in 2023 to bring it in line with the amended Enforcement Policy 2023 (MC1/192d [INQ000567486]).

420. The enforcement decision tree sets out a four-stage decision-making process which we use to select the appropriate enforcement power. Below is a high-level summary of the process:

420.1. Initial assessment:

420.1.1. before commencing enforcement action, the first stage is to consider the case at a MRM. In the overwhelming majority of cases, the MRM will be followed up through standard direct checks such as a focused inspection. Urgent cases may proceed directly to evidence collection for potential urgent action or prosecution.

420.2. Legal and evidential review:

420.2.1. At this stage we check that the evidence we hold demonstrates a breach of the regulations or relevant requirements. We also ensure that we take account of our statutory guidance and any other relevant legislation. The purpose of this stage is to check that the evidence is sufficient to enable us to proceed to take enforcement action, and that the initial logging and registering of evidence has been done correctly.

420.3. Selection of the appropriate enforcement action:

420.3.1. Stage 3A looks at the seriousness of the concern and the facts that gave rise to it. It does not take account of other incidents that may have taken place nor the provider's response to them. It is an assessment of the likelihood of the concern happening again, and if it were to happen again, the impact it would have on the people using the service.

420.3.2. Stage 3B takes account of other incidents that may have taken place relating to the provider and their response. It requires inspectors to consider whether there is sufficient evidence of

systemic failings in the quality of care and/or management which may result in recurrent issues. The outcome of assessment at stage 3B can result in an increase or decrease to the severity of the enforcement action we decide to take, as well as determining whether we need to hold a provider and/or individual to account through criminal sanctions.

420.4. Final review:

420.4.1. The final decision about which enforcement action to take is made at an MRM meeting where CQC's sector enforcement priorities are considered. These are the priorities set by CQC's Board and agreed in our business plan. They set expectations for our overall approach to enforcement, providing a transparent message to the sectors as well as to our inspectors. Consideration of these priorities could result in a change to the type or severity of the planned enforcement action. At the final review stage we also check that the recommendation is in line with the enforcement policy and that the decision-making process has been followed properly.

421. There are three enforcement actions that we use in order to require a provider to protect people who use regulated services from harm and the risk of harm, and to ensure that the services they receive are of an appropriate standard. These are:

421.1. Requirement Notices (now known as Action Plan requests)

421.1.1. Where a registered person is in breach of a regulation or has poor ability to maintain compliance with the regulations, but the people using the service are not at immediate risk of harm, we may use our power to require a report from the provider by serving a Requirement Notice. The response from the provider must show how they will comply with their legal obligations and must explain the action they are taking or propose to take to do so. Failure to send us a report in the timescales set out in the Requirement Notice is an offence and could lead to us using other enforcement powers.

421.2. Warning Notices

421.2.1. Warning Notices notify a registered person that we consider they are not meeting a condition of their registration, a requirement in the 2008 Act, a regulation, or any other legal requirement that we think is relevant. We cannot issue Warning Notices against unregistered persons. We can serve Warning Notices about past failures or about a continuing breach of a legal requirement. If a registered person does not comply with the Warning Notice we will consider further enforcement action under civil or criminal law. The regulations allow us to publish Warning Notices as long as registered persons are given the opportunity in advance to make representations about the proposed publication.

421.3. Section 29A Warning Notices

421.3.1. Section 29A of the 2008 Act make provision for Warning Notices that are addressed to NHS Trusts or foundation trusts. We may issue such a notice where we find that an NHS trust requires significant improvement.

CQC's Civil Enforcement Powers

422. We use the following civil enforcement powers to force a provider to protect people who use services from harm and the risk of harm, and to ensure that they receive services of an appropriate standard:

422.1. Impose, vary or remove conditions of registration;

422.2. Suspend a registration;

422.3. Cancel a registration;

422.4. Urgent procedures; and

422.5. Special measures – a time limited approach ensures inadequate care does not continue and co-ordination with other oversight bodies.

423. A high-level explanation of each of these powers is provided below.

Impose, vary or remove conditions of registration

424. As explained in Section D above, registered persons may have conditions attached to their registration. Imposing, varying or removing conditions of registration is a

flexible enforcement process that we can use in a variety of different ways to ensure that providers comply with their legal obligations.

425. For example, we may use a condition to stop a regulated activity at one location but allow the provider to continue providing services at its other locations. This allows us to remove the condition if, and when, the concern has been addressed. We can apply conditions at whole-provider level and/or at certain targeted geographic locations.

426. We can also use conditions to require a registered person to take some action where further improvement is necessary. We design and communicate these conditions so that they explain what we require to be achieved but leave the provider to decide exactly how that will be delivered. We will not define precisely how a provider should operate or manage its service. It should be the provider's choice to decide precisely how to operate its business, provided it complied with all relevant legal requirements.

427. We will consider imposing conditions on the provider's registration if we assess that by imposing a condition it is likely to result in the provider addressing the matters of concern within an acceptable timescale.

Suspend registration

428. We can suspend the registration of a registered person for a specified period of time. This period can also be extended if necessary. This power allows us to compel the provider to address a specific concern within a fixed period, for example, to hire new staff.

429. This power is rarely used as suspension affects all of the locations where the registered person carries on or manages the relevant regulated activity. We will therefore pay particular attention to the likely outcomes of suspending registration before taking this action. If a provider carries on providing a regulated activity following suspension, we may prosecute this as a criminal offence.

430. We will consider suspending a provider's registration if we assess that suspension is reasonably necessary to prevent the breaches of the provider's legal requirements

but that the provider will be able to provide a lawful service at an identifiable time in the future.

Cancellation of registration

431. One of our most powerful civil enforcement powers is to cancel a registration. As with suspension, this will affect all of the locations where the provider carries on or manages the relevant regulated activity. Cancellation normally follows considerable efforts to get the registered person to meet the legal requirements. However, where appropriate we will use the cancellation process without following other processes first.

432. If a provider carries on providing a regulated activity following cancellation, we may prosecute this as a criminal offence.

433. We will consider the cancellation of a registration if we assess that the registered person does not have the capability or the capacity to substantially comply with regulations, or is likely to fail to do so.

Urgent procedures

434. In certain circumstances we can use our powers to impose, vary or remove conditions or suspend a registration on an urgent basis with immediate effect. Section 31 Health and Social Care Act 2008 states that we can use urgent procedures where the evidence demonstrates that unless there is an urgent use or amendment of conditions, or urgent suspension of registration, a person will or may be exposed to harm.

435. Under section 30 of the Health and Social Care Act 2008, we can apply to a magistrate for an order to immediately cancel a registration. We can apply for these orders if not cancelling the registration would pose a serious, immediate risk to a person's life, health or wellbeing.

436. Providers are entitled to appeal against the use of these urgent powers, but this does not prevent the conditions, suspension or cancellation from taking effect immediately.

437. Urgent procedures are an important part of our enforcement powers so that we can act quickly to protect people using a registered service. We expect urgent procedures to be a significant element of our enforcement activity and we will also consider criminal sanctions in serious cases.

Special measures

438. Special measures are an administrative framework which helps CQC to manage providers who are failing to comply with their legal requirements and require a higher than usual level of regulatory supervision. For these providers, special measures assist us to deliver our statutory functions.

439. Part of any special measures regime is the effective use of enforcement powers to ensure that improvements are made to the standard of care provided by the registered provider. A provider that is operating under special measures may also be working under the close supervision of another oversight body. Where appropriate, we will work closely with relevant oversight bodies to ensure that the registered provider makes improvements to the standards of service provision.

CQC's Criminal Enforcement Powers

440. Failure to comply with the steps required when we use certain civil enforcement powers is a criminal offence and may result in a prosecution. Some of the regulations have offences attached, and as part of our enforcement action, CQC is able to bring prosecutions if these regulations are breached. CQC is able to bring prosecutions for breaches of the following regulations.

    440.1. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

    440.2. The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015

    440.3. The Care Quality Commission (Registration) Regulations 2009

441. The Enforcement Policy provides lists of the specific regulations in respect of which a prosecution may be brought directly if the offences listed in the regulations are breached; and the regulations in respect of which further qualification is required before CQC can prosecute (which are that the breach results in people who use services being exposed to avoidable harm or significant risk of such harm occurring or suffering a loss of money or property as a result of theft, misuse or misappropriation).

442. CQC can use a variety of methods to hold providers and individuals to account for failures in how the service is provided. Our criminal powers include using:
    442.1. Simple cautions;
    442.2. Penalty notice; or
    442.3. Prosecutions

443. Each of these methods is briefly described below.

Simple Caution

444. A simple caution ensures that there is a formal record of an offence when a person has admitted to it but is not prosecuted. There is no obligation on a provider to accept a caution and, where the offer of a caution is refused, we will consider prosecution. We will consider using a simple caution when:
    444.1. we have evidence of an offence and that evidence is sufficient that we would be able to bring criminal prosecution;
    444.2. although we could prosecute, we consider that achieving improvements without initiating lengthy and costly proceedings is a realistic alternative and is more proportionate than proceeding with prosecution;
    444.3. the provider has demonstrated to us that they will be able to put these improvements in place within a reasonable timescale;
    444.4. the Code for Crown Prosecutors indicates that this option would be appropriate; and
    444.5. the offence has an insubstantial impact on people using the service.

Fixed Penalty Notices

445. Our power to issue Fixed Penalty Notices (FPNs) is set out in sections 86 and 87 of the 2008 Act, and in Regulation 28 and Schedule 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. A FPN requires a provider or individual to pay a specified amount of money to CQC, which is then passed on to the Secretary of State for Health and Social Care. Paying a FPN enables a registered person to avoid a potential prosecution for an offence. It is only appropriate to issue a FPN where CQC would have been entitled to prosecute.

446. We have the discretion over whether to serve a FPN as an alternative to a prosecution. There is no obligation on a registered person to pay the sum under a FPN and, if a registered person decides not to pay the penalty, we will consider using other enforcement powers. The failure to pay sums under a FPN will normally lead to a prosecution.

447. We will consider using the power to issue a FPN when:
    447.1. we have evidence of an offence and that evidence is sufficient to bring a criminal prosecution;
    447.2. although we could prosecute, we consider that achieving improvements without initiating potentially lengthy and costly proceedings is a realistic alternative and is more proportionate than proceeding with prosecution; and
    447.3. the offence has an insubstantial impact on the people using the service.

Prosecutions

448. Prosecution can be used to
    448.1. hold a registered person to account for breaches of prosecutable fundamental standards (those regulations with prosecutable clauses that specifically relate to harm or the risk of harm), or for failing to comply with conditions of registration;

448.2. enforce the offence of carrying on a service without registration (in which case we may prosecute the person who appears to be carrying it on);

448.3. ensure accountability for any person who obstructs us during an inspection, or any person who makes a false or misleading statement in an application to be registered with us.

449. Where appropriate, we may prosecute at the same time as taking other enforcement action, for example alongside urgent procedures. We may also prosecute more than one offence at the same time. There may be occasions where, even if the above criteria are satisfied, we will decide to serve a Warning Notice as an alternative to immediate prosecution. However, we will generally prosecute providers where there are serious, multiple or persistent breaches of the fundamental standards (those regulations with prosecutable clauses that specifically relate to harm or the risk of harm) without issuing a Warning Notice first. Failure to make the improvements set out in a Warning Notice is likely to lead to a prosecution.

450. Although we are not required by law to publish details of all criminal law procedures that we undertake, we have a general power to publish this type of information and will normally do so. We must publish information about any offence for which a registered person has been convicted.

451. We are required to carry out all investigations of criminal offences in accordance with the Police and Criminal Evidence Act 1984 (PACE) principles and Codes of Practice. Where another regulator has the power to prosecute, we will coordinate our activity with them at an early stage to ensure the right action is taken, to avoid inconsistency, and to ensure that any proceedings taken are for the most appropriate offence. Where we successfully prosecute, the court will decide on the penalty to be imposed and we must publish information about any offence for which a registered person has been convicted. The court may impose a prison sentence as well as, or instead of, a fine following conviction for carrying on a regulated activity without being registered.

452. We will consider using our powers to prosecute where:

452.1. the breach of legislation is assessed by us to be serious and there are multiple or persistent breaches; or

452.2. we have sufficient evidence so there is a realistic prospect of conviction; or

452.3. we assess that it is in the public interest for us to use our powers of prosecution.

453. In making decisions about whether to prosecute, we will be guided by the Code for Crown Prosecutors.

Enforcement activity during the pandemic

454. Prior to the pandemic, under CQC's Scheme of Delegation, decisions on civil and criminal enforcement matters were, in the main, delegated to colleagues at Head of Inspection level in ASC and PMS, and Deputy Chief Inspector level in the Hospitals sector.

455. On 16 March 2020, in light of the increasing pressures faced by providers across all services as a result of the pandemic, and in order to avoid creating both unnecessary burdens and cross infection risks for providers, we took the decision that all new enforcement activity going forward would need to be authorised by Chief Inspectors. This decision was made at the Gold Command meeting on 16 March 2020 at which William Vineall was present.

456. In order to support enforcement decision-making we established National Civil Enforcement Panels for each sector to consider all 'in flight' and new civil enforcement action and we developed the 'Covid-19 – Enforcement Principles and Decision-Making Framework' (MC1/192e [INQ000567475]) for the National Enforcement Panels to use when making enforcement related decisions.

457. At first the framework applied only to civil enforcement and applied to all "in-flight" and new civil enforcement action including Warning Notices; imposition, variation or removal of conditions; suspension; cancellation and urgent procedures.

458. The framework outlined the following three principles intended to underpin our regulatory approach to enforcement during the pandemic:

458.1. We will focus our activities on ensuring people receive safe care by responding where we believe risk is highest and where we can make a difference;

458.2. We will support providers in this challenging time by reducing what we ask of them wherever we can without compromising people's safety and by ensuring we are not contributing to the risk or spread of infection; and

458.3. We will manage the health, safety and wellbeing of our staff and reduce the risk they are exposed to.

459. Under the framework, the following approach applied:

459.1. The statutory thresholds for taking civil enforcement activity remained the same;

459.2. The Enforcement Handbook and Decision Tree remained the first points of reference for enforcement;

459.3. Each case would be considered individually to take account of the impact of the exceptional circumstances arising from the pandemic on each service; and

459.4. We would be especially mindful of risks to people in particular settings, for example, in hospitals, prisons, and settings with closed cultures.

460. The framework also provided for the following revised Covid-19 Enforcement Decision-Making Steps (also recorded in the "interim Covid-19 Enforcement Decision Tree") to be carried out by the local team during a Regulatory Review MRM as follows:

460.1. Apply the decision tree where appropriate and review the recommendations.

460.2. Consider whether the breaches and failures that led to our action/proposed action, present ongoing risks to the fundamental safety of people using the service, focusing on breaches of regulations 12 (safety); 13 (safeguarding); 14 (nutrition and hydration); and 17 (Good governance) of the Regulated Activities Regulations 2014.

460.3. Consider whether any Covid-19 related emergency guidance relevant to the failures impact on the proportionality of the civil enforcement action being taken/proposed.

460.4. Consider whether any existing or new information (for example from the provider, NHS trusts, NHS England, NHS Improvement, Local Authorities and CCGs) changed our assessment of the risks to people's safety and the appropriateness of continuing the in-flight or proposed civil enforcement action.

460.5. Consider the impact of our planned enforcement action on people using the service in context of the Covid-19 pandemic, taking into account in particular the availability of alternatives if the service is closed.

460.6. Consider what the impact of our planned enforcement action would be on the wider local system, taking into account any available analyses from Commissioners.

460.7. Consider whether, and what, alternative civil enforcement action would be more appropriate at this time, in the context of the exceptional risks to people and systems arising from the Covid-19 pandemic.

461. Inspectors were required to submit a completed "Covid19 civil enforcement panel referral form" to the National Civil Enforcement Panel which contained the Covid-19 Enforcement Decision Tree template (MC1/192f [INQ000567472]). The form was used to record the recommendation made by the local inspection team, the Civil Enforcement Panel and the final decision made by the Chief Inspector.

462. The Terms of Reference for the National Civil Enforcement Panels were outlined in the framework as follows:

462.1. Panel purpose: To have oversight of enforcement activity and a record of all our enforcement decisions which will support both consistency and feed into the COVID-19 Interim Regulatory Response Group. A referral should be made to Civil Enforcement Panel to facilitate support at the start of any potential civil enforcement decision.

462.2. Panel procedure:

462.2.1. The Civil Enforcement Panel will adhere to a documented Civil Enforcement Panel procedure that has been signed off via the governance route. The Civil Enforcement Panel procedure will be reviewed on an ongoing basis as we develop our approach through the COVID-19 situation.

462.2.2. The panel will review the referral and recommendation made at the MRM or by the Representations Team.

462.2.3. The panel will decide whether they agree or do not agree with the recommended enforcement decision.

462.2.4. The panel will check to see if the inspection team have applied the seven Covid-19 Enforcement Decision-Making Steps in each case

462.2.5. The panel will make a decision regarding the appropriate response and recommendation for each referral.

462.2.6. The panel will escalate their recommendation supported by a rationale to the Chief Inspector for the Directorate for the formal decision to be made and authorised.

463. In April 2020 the framework was revised to encompass criminal enforcement activity (MC1/192g [INQ000567477]). Proposed criminal cases continued to be reviewed by the existing Criminal Case Assessment and Progression Panel ("CCAPP"), a multidisciplinary panel including colleagues from Heads of Inspection (DCI for hospitals), Enforcement and Legal. The CCAPP decides whether to close or pause existing enforcement procedures, or whether newly identified cases meet the threshold to proceed to formal investigation.

464. The National Civil Enforcement Panels remained in place until 25 June 2020 when they were stood down as the pandemic started to ease following which approval of enforcement decisions was delegated away from Chief Inspectors and back to Heads of Inspection (as per the standard Scheme of Delegation).

465. The Framework was withdrawn in October 2020 when some lockdown restrictions were eased and it was believed the worst of the pandemic was over and we reverted back to our standard approach. The updated seven-step interim Covid-19 Enforcement Decision Tree (set out above) remained in place but was withdrawn and re-introduced a few times throughout the relevant period as the spread of Covid-19 eased and spread. Each time it was withdrawn we reverted to using the standard Decision Tree template. The interim Covid-19 Decision Tree was withdrawn for the

last time on 5 May 2022 when CQC reverted to using the standard template until the current Decision Tree replaced it in 2023 as explained above.

Enforcement cases brought by CQC during the pandemic

466. The table exhibited as (MC1/192h [INQ000567487]) has been prepared specifically for use in this statement and provides the numbers of civil and criminal enforcement cases the CQC brought in relation to ASC services in 2019, 2020, 2021, 2022 and 2023 respectively, broken down into the number of:

466.1. Civil enforcement activity:

466.1.1. cancellation of registration;

466.1.2. imposition of conditions;

466.1.3. refusal of registration;

466.1.4. registration agreed with conditions;

466.1.5. removal of conditions;

466.1.6. variation of conditions; and

466.1.7. urgent procedures

466.2. Criminal enforcement activity:

466.2.1. cautions;

466.2.2. fixed penalty notices; and

466.2.3. prosecutions

466.3. Requirement Notices

466.4. Warning Notices

467. The table includes the cases brought in relation to both care homes and home care/domiciliary care services.

G. Infection prevention and control ("IPC")

Overview of CQC's monitoring of IPC in the ASC Sector

468. All providers of services that we regulate need to ensure that they have effective IPC measures in place in order to meet the requirements under Regulations 12 (relating to safe care and treatment) and 15 (relating to premises and equipment) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

469. The *Health and Social Care Act 2008: Code of Practice on the prevention and control of infections* (IPC Code of Practice) and related guidance sets out what registered providers in England should do to ensure compliance with Regulation 12(2)(h) of the regulations. This includes 'assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated'. The IPC Code of Practice sets out the 10 compliance criteria against which registered providers will be judged. CQC uses the IPC Code of Practice and related guidance when judging compliance. The 2015 version of the IPC Code of Practice and its associated guidance were amended on 13 December 2022 to reflect the structural changes that took effect in the NHS from 1 July 2022 and the role of IPC (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance. The new document takes account of changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic.

470. In the first few months of the pandemic, issues and concerns to do with IPC were the most common feedback we received through the GFC portal. During the pandemic we recognised, as regulator, that a focus on effective IPC measures was more important than ever to ensure that providers could keep people safe. IPC was already a feature of our comprehensive inspection methodology, but as a result of the pandemic we undertook a range of activities focusing directly on IPC across the health and social care sectors. The IPC activities undertaken in the ASC sector are set out below.

IPC Guidance

471. In April 2020 there were growing concerns regarding the extent of IPC measures in both hospitals and care home settings as a lot of the focus at the start of the pandemic had been around the availability of and access to PPE only. We were concerned, especially in relation to ASC settings, that there was a gap in the wider IPC guidance generally beyond PPE.

472. On 15 April 2020 DHSC published *COVID-19: our action plan for adult social care* which detailed how the government intended to support the ASC sector in England throughout the coronavirus outbreak. The plan had four pillars:

472.1. Reducing the spread of infection in care homes;

472.2. Supporting the workforce both to provide high quality care, and to cope with the practical and emotional demands of caring during the pandemic;

472.3. Supporting independence, end of life care and responding to individual needs; and

472.4. Supporting the organisations that provide care.

473. On 15 April 2020 Kate Terroni updated providers on how CQC had contributed to the plan, how we intended to help deliver it and that we would continue to support the ASC sector (MC1/193 [INQ000525094]).

474. On 19 April 2020 colleagues from PHE approached CQC requesting our support in relation to managing the risk of Covid-19 spreading into care homes which had not yet had any infections, and in trying to limit the spread within those where there were confirmed cases (MC1/194 [INQ000524970] and MC1/195 [INQ000524969]). It was our view that we could support by helping to ensure that appropriate IPC measures were in place and being implemented effectively. On 21 April 2020 we wrote to PHE to enquire whether they had developed any IPC guidance for ASC settings and, if so, to share it with us as it was not clear which guidance was applicable to the sector at the time. We confirmed that CQC were already supporting NHSEI with the development of IPC guidance in the hospital setting (MC1/195 [INQ000524969]), implying that we would be willing to do the same in respect of any guidance in the ASC sector.

475. Throughout this period our staff were directing providers and Trade Association colleagues to the "Infection Prevention and Control" page on the Skills for Care website which had helpful resources for the ASC sector.

476. On 20 April 2020, our Chief Inspector of Hospitals, Ted Baker, attended a meeting with colleagues from DHSC, the Cabinet Office and NHSE/I to discuss the development of nosocomial Covid-19 infections. It was agreed that CQC would monitor the uptake and implementation of the nosocomial infection guidance in hospital settings . After the meeting, Ted Baker indicated to DHSC that the guidance for care homes would need to be tailored to meet the needs of the ASC sector and this was confirmed by William Vineall to the attendees of the meeting on 21 April 2020 (MC1/197 [INQ000524977]).

477. On 20 April 2020, an internal cross-directorate IPC Task and Finish Group was set up to provide information and support to enable inspectors to make safe judgments on IPC. The IPC Task & Finish Group reported into the Regulatory Oversight Group and led on creating better awareness of IPC for all of our staff through the development of internal guidance, learning and training.

478. On 20 May 2020 a range of IPC learning in the form of videos, risk assessment checklists and additional guidance was created and shared internally. The intention behind this learning was to provide all colleagues with a baseline understanding of Covid-19 and how to prevent and control the spread; for regulatory colleagues to understand the actions they needed to take to keep public, providers and themselves safe when on a site visit; and for regulatory colleagues to be able to make consistent assessments around providers use of IPC measures during the pandemic.

479. On 5 June 2020 Kate Terroni attended the "Secretary of State – Coronavirus Adult Social Care meeting" where DHSC presented their "10 point plan" *Next Steps for the Care Sector and the New Normal*. As part of the conversation about delivery of the care home support package outlined in the plan, CQC was asked to draft an offer of how we could contribute through the monitoring of care home infection control measures (MC1/198 [INQ000525025]). Initially, DHSC suggested that our offer should be to audit care home IPC measures within 48 hours of the care home experiencing an outbreak. The intention was that this would provide insight and support to the care home provider, and the Local Authority would be asked to follow up to support implementation of the policy. Following internal discussions, we suggested to DHSC that CQC's involvement should rather be framed as follows: "*providers [should] audit their care home infection control measures within 48 hours of a new outbreak, in collaboration with the local health protection teams and send a copy to CQC. This will provide support and insight to the care home provider and the information will be used to guide CQC's response.*"

480. DHSC accepted the revised wording as outlined above.

<u>CQC's Involvement in the Social Care Sector Covid-19 Support Task Force</u>

481. 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 (MC1/199 [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*". In his conversation with Kate Terroni on 11 June 2020, Sir David Pearson indicated that one of the issues that he was interested in was about how CQC's inspection activity could be targeted to look at whether care homes had effective infection control measures in place.

482. Kate Terroni regularly joined the Social Care Sector Covid-19 Support Task Force 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.

483. On 12 June 2020 colleagues from CQC met with the then Minister of State for Care Helen Whately MP and colleagues from DHSC to discuss ongoing assurance in the ASC sector. One of the questions asked by the Minister was what CQC could do to reassure her that care homes were complying with IPC measures. Kate Terroni highlighted the discussion she had with Sir David Pearson and Ros Roughton about CQC's assurances around IPC in care homes. The Minister suggested that the work on IPC needed to go "*beyond inspection*" and it was suggested by Tom Surrey (Director of Adult Social Care, DHSC) that we should consider "*more infection control inspections, or revised KLOEs*". CQC agreed to discuss what more could be done on IPC assurance in care homes and how we might best capture this in the future. (MC1/200 [INQ000524915]).

484. On 26 June 2020 Kate Terroni sent CQC's proposal on *Infection prevention and control in care homes: The Social Care Taskforce and the role of CQC* (MC1/201 [INQ000525027]) to Sir David Pearson and Ros Roughton (MC1/202 [INQ000525026]).

485. In the proposal, CQC's approach to the regulation of IPC in care homes was outlined as well as the intended short-term plans as summarised below:

485.1. Continuing to check that providers were implementing the ten criteria set out in the IPC Code of Practice and related guidance through monitoring and inspection, taking enforcement action where necessary. Lower the threshold for inspection visits from the previous "extreme risk" that was in place at the height of the pandemic with the intention of doing increasingly more inspections during which IPC practice would always be assessed.

485.2. Conduct PCRs to understand how health and social care providers worked together across areas during the pandemic, covering various topics including IPC.

485.3. Develop a revised approach to inspection that would form part of our transition to more regular inspections following the pandemic, which would include IPC as a core part of our regulatory methodology.

485.4. In August 2020, inspect a sample of 300 care homes where we have no concerns about risk, including where outbreaks have not occurred, to understand how IPC measures may have had a positive influence. A minimum of 3,500 homes to be inspected by March 2021. The initial findings from all inspections (including any sampling) to be reported in our September 2020 Covid Insight Report, with a larger set of findings being published in the November 2020 edition.

485.5. Consider continuing the use of this approach as part of an ongoing focus on IPC over the year.

486. In the proposal we also set out the limitations of CQC's intended short-term plans highlighting that in order to truly understand the IPC preparedness of care homes and of the system in which they operate, we would need to carry out detailed analysis of national and local health and care systems which could be done through Local System Reviews ('LSRs') (as had been done previously by CQC for our work described in the 'Beyond Barriers' report). However, it was noted that we would be unable to initiate LSRs without being formally commissioned by the Secretary of State for Health under Section 48 of the 2008 Act, or through a change to the Act itself. In the proposal we indicated that CQC had been in discussion with DHSC for a number of months on how this could be accommodated in the forthcoming health bill.

487. On 28 June 2020 Sir David Pearson responded to Kate Terroni seeking clarity on some of the content of the proposal (MC1/203 [INQ000525020]). On 29 June 202 Kate Terroni responded to Sir David Pearson clarifying the intended plans relating to the IPC focused care home inspections and provided further information about some of the issues regarding the proposed LSRs.

488. On 2 and 3 July 2020 Kate Terroni spoke to Sir David Pearson regarding CQC's intended plans for the regulation of IPC in care homes (MC1/204 [INQ000525018]).

489. In August 2020, we fed into two draft versions of the ASC Covid-19 Support 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 (MC1/205 [INQ000235579]; MC1/206 [INQ000235584]; MC1/207 [INQ000235585]; MC1/208 [INQ000235586]; MC1/209 [INQ000235587] and MC1/210 [INQ000235588]

490. 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 (MC1/211 [INQ000235589]; MC1/212 [INQ000235590]; MC1/213 [INQ000235591]; MC1/214 [INQ000235293; MC1/215 [INQ000235294]; MC1/216 [INQ000235295]; MC1/217 [INQ000235296]; MC1/218 [INQ000235298]; MC1/219 [INQ000235299] MC1/220 [INQINQ000235300]; MC1/221 [INQ000235301]; MC1/222 [INQ000235302]; MC1/223 [INQ000235303]; MC1/224 [INQ000235304]; MC1/225 [INQ000235305] and MC1/226 [INQ000235307]).

491. On 18 September 2020 the ASC Covid-19 Support 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". (MC1/227 [INQ000235308]; MC1/228 [INQ000235309]; MC1/229 [INQ000235310]; MC1/230 [INQ000235311] and MC1/231 **[INQ000058216]**

492. 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 (MC1/232 [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.

493. 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 (MC1/233 [INQ000235574] and MC1/234 [INQ000235575]). We also contributed to the further development of the HTWS guidance documents in December 2021 through our involvement in the Covid-19 ASC Working Group of Stakeholders (MC1/13 [INQ000524933] and MC1/235 [INQ000524934])

494. 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 (MC1/236 [INQ000235317]; MC1/237 [INQ000235318] and MC1/238 [INQ000235319]).

495. 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?* (MC1/239 **[INQ000279947]**) 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.

496. Between January and March 2022 we attended meetings of and engaged with the ASC IPC Guidance Working Group, "*a regular working group to guide return to BAU work*" led by DHSC with its initial focus being to ensure that the sector had accurate and up to date IPC guidance available to guide day to day operations (MC1/240 [INQ000524931] and MC1/241 [INQ000524930]).

497. 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 (MC1/242 [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 went beyond the relevant period and therefore the supporting correspondence is not annexed, but can be provided to the Inquiry if necessary.

IPC Inspections in the ASC sector

498. In July 2020 CQC established the IPC in Care Homes Project Delivery Group ("Project Delivery Group"), an internal group to oversee the planning and delivery of the IPC in care homes work, with lines of accountability back to the Board and the Executive Team. The Project Delivery Group was led by Senior ASC colleagues, with representatives across Engagement, Intelligence, Operations, Project Management, Strategy & Policy, and Digital and usually met weekly. The group was governed by Terms of Reference which set out the roles and responsibilities, success measures, accountability structure and its members (MC1/243 [INQ000524901]).

499. One of the first pieces of work produced by the Project Delivery Group was the development of the "ASC Inspection Information Gathering Tool: Infection Prevention and Control" ("the ASC IPC tool") (MC1/244 [INQ000524914]) to be used by inspectors to gather relevant information on IPC practices during inspections. The ASC IPC tool was an observational methodology designed to help inspectors focus on IPC issues during inspections of care homes, whilst making effective use of time

on site. The ASC IPC tool was effectively a set of questions in a form to be completed on all types of inspections for care homes where a site visit was conducted. The form comprised a series of eight questions, set out below, with prompts and guidance for the inspector on "what good looks like" and the information gathered was submitted via a checkbox:

499.1. Are all types of visitors prevented from catching and spreading infection?

499.2. Are shielding and social distancing rules complied with?

499.3. Are people admitted into the service safely?

499.4. Does the service use PPE effectively to safeguard staff and people using services?

499.5. Is there adequate access and take up of testing for staff and people using services?

499.6. Do the layout of premises, use of space and hygiene practice promote safety?

499.7. Do staff training, practices and deployment show the service can prevent and/or manage outbreaks?

499.8. Is the IPC policy up-to-date and implemented effectively to prevent and control infection?

500. At the end of the form there was a further set of mandatory questions that required yes or no answers regarding implementation of IPC measures in care homes, as follows:

500.1. Does the service have sufficient and adequate supply of PPE that meets current demand and foreseen outbreaks?

500.2. Are staff using PPE correctly and in accordance with current guidance?

500.3. Has the service received external PPE training during the pandemic sourced from a Mutual Aid trainer or of similar equivalence?

500.4. Does the service know where to go for advice should there be an outbreak which authorities and what their role and responsibilities are?

500.5. Is the service participating in the testing program that is currently provided for residents and staff members?

500.6. Do staff in the service understand the principles of isolation, cohorting and zoning appropriately?

500.7. Has the service implemented isolation, cohorting and zoning appropriately?

500.8. 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)?

501. Guidance was produced to support inspectors with using the ASC Inspection Tool. (MC1/245 [INQ000524907]]); (MC1/246 [INQ000524935]); (MC1/247 [INQ000525067]); (MC1/248 [INQ000524906]) (MC1/249 [INQ000524954]).

502. At the ASC Trade Association Group meeting on 3 July 2020, CQC provided an update on IPC in care homes. We indicated that we had started a piece of work to look at a thematic review on IPC in terms of which we would share the findings in two Independent Voice pieces, a cross sector one at the end of summer 2020 and one in autumn focusing on care homes (MC1/250 [INQ000524951]).

503. At the ASC Trade Association meeting on 31 July 2020, CQC presented an update on the work being undertaken regarding IPC specifically in response to the request by the Social Care Taskforce that CQC look at the preparedness of care homes in relation to IPC. As part of CQC's "next steps" for IPC in care homes, we presented our plans for a "thematic review to look at the safety of care homes in relation to IPC" (MC1/251 [INQ000524913]). The thematic review would be based on the inspections of a sample of 300 care homes across the country using the ASC IPC tool to gather information on their experiences and preparedness for what lay ahead in terms of a second wave of Covid-19 and the upcoming winter pressures, starting on 1 August 2020. We notified the group that we would prepare a brief high-level overview report in September 2020 and a more detailed report in November 2020 (MC1/252 [INQ000524998]).

504. On 14 September 2020 we met with the then Minister of State for Care Helen Whately MP and colleagues from DHSC. At this meeting CQC presented a briefing outlining the work being undertaken in the ASC sector (MC1/253 [INQ000524883]), including how CQC were:

504.1. Identifying and taking action against poor IPC; and

504.2. Understanding and sharing good practice with providers on IPC.

505. We provided an overview of the interim findings from the IPC focused inspections, and some case study examples demonstrating how CQC addressed IPC-related issues in the care sector.

506. On 16 September 2020 we wrote to DHSC attaching a comprehensive overview of CQC's approach to the regulation of IPC in care homes up to that point for sharing with the Minister (MC1/254 [INQ000524912] and MC1/255 [INQ000235369]), including highlighting the following:

506.1. We conducted over 800 ASC inspections since May 2020, including 301 services inspected as part of the IPC sample. The majority were found to be managing IPC well, but in some services, where we had serious concerns we undertook a range of regulatory action, including to propose to cancel the registration in the most serious case. The details and nature of these concerns are discussed in greater detail in paragraph 508 and Section N below.

506.2. We produced the ASC IPC tool which helped inspectors collate relevant information to provide assurance that a care home has appropriate IPC measures in place. This tool references good practice guidance and is used in all risk-based inspections. The Care Provider Alliance (CPA) have used our tool to create a helpful toolkit for providers to help them audit their practice and make sure their IPC is effective.

506.3. We were also conscious that IPC practice in many care homes is very good. In order to understand how IPC practice may have been a positive influence in reducing the number and impact of outbreaks, during August we carried out a thematic review of IPC practice in 301 care homes. These were selected as either good practice examples, or services which seemed to be doing well in difficult circumstances as per the following criteria:

506.3.1. Care homes that have not had an outbreak of COVID-19 despite high levels of the virus in the local authority area;

506.3.2. Care homes that have had outbreaks but no deaths from the disease; and

506.3.3. Care homes that have had an outbreak but who now appear to have it under control.

506.4. We intended to publish the information we gathered during these inspections (both risk based and thematic) in a CQC Insight report, the first one containing the initial findings to be published on 16 September 2020. This is set out in paragraph 508 and Section N below.

507. In the overview document we also outlined how we gained assurance on IPC through the CQC Insight and ESF tools; the action we took against poor IPC including both civil and criminal enforcement and details on how CQC decided on the appropriate action to take. We also shared the draft wording of the statement to be published in our provider bulletin to all registered social care providers setting out our IPC work in the care sector.

508. In our provider bulletin dated 17 September 2020 (MC1/256 [INQ000524967]), we provided an update regarding IPC referring to our latest Covid-19 Insight Report Issue 4 dated 15 September 2020 (MC1/176 [INQ000235474) which outlined the interim findings of the IPC focused inspections as follows:

508.1. We reported on the findings of the 300 IPC inspections carried out in care homes in August 2020:

508.1.1. Very few of these services turned out not to be managing well and requiring a fuller inspection.

508.1.2. Across the 300 inspections, we've had more than 90% assurance across all the elements we were looking at.

508.1.3. Feedback from the initial inspections has identified good practice examples

508.2. We reported on the findings collected during the 59 high-risk inspections of care homes undertaken during the first half of August 2020 specifically in response to concerns about safety and quality, or to feedback from staff or people using services and their families:

508.2.1. Safe admission: We were assured in more than four-fifths of care homes in our risk-based inspections that the homes were following the guidance in relation to safe admissions.

508.2.2. IPC for visitors: We were assured in four-fifths of care homes in our risk-based inspections that all types of visitors were prevented from catching and spreading infection.

508.2.3. IPC policy: We found the lowest level of assurance (59%) against the question, "Is your IPC policy up-to-date and implemented effectively to prevent and control infection?".

508.2.4. Effective use of PPE: The second lowest area of assurance in these risk-based inspections (69%) was whether services used PPE effectively to safeguard staff and people using services.

509. Following the publication of the 2020 ASC winter plan, we made some improvements to the ASC IPC tool to help us with collection of data with input from colleagues from key stakeholders including DHSC and ADASS (MC1/257 [INQ000524937]).

510. 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 concerning information would only apply to those services we had rated Requires Improvement or Inadequate.

511. On 1 October 2020 we met with the Minister and colleagues from DHSC and provided an update on our work including in relation to our approach to IPC in ASC (MC1/258 [INQ000525013]). We indicated that we would be starting our second phase of IPC inspections on 5 October 2020 in terms of which we planned to inspect 500 locations by the end of November. We also confirmed that the ASC IPC tool was being revised in consultation with external stakeholders for roll out later in October 2020 and showed a mock-up of how the IPC inspection results would be published on our website (MC1/259 [INQ000524952])

512. On 9 October 2020 we published an article on our website outlining CQC's plans to monitor IPC over winter (MC1/260 [INQ000525095]). In the article we confirmed that we had published over 400 inspection reports from the recent ASC IPC inspections, providing an overview of our findings, and indicated that we had committed to another 500 care homes IPC inspections by the end of November 2020.

513. At the next meeting with the Minister on 16 October 2020 we shared our findings from the 600 plus IPC inspections in ASC, as part of the IPC thematic work and risk-based inspections which included an IPC review and confirmed our intention to carry out a further 500 IPC inspections by the end of November 2020 (MC1/261

[INQ000524888] and MC1/262 [INQ000524886]). We continued to report on the numbers of IPC inspections and findings at the monthly Ministerial meetings.

514. From early November 2020 we began providing daily reports to our DHSC, MHCLG, NHSE and the Cabinet Office colleagues detailing the numbers of scheduled IPC inspections, the numbers of IPC inspections undertaken and an overview of the findings. Some examples of this are exhibited as (MC1/263 [INQ000525045]); (MC1/264 [INQ000525044]); (MC1/265 [INQ000524984]) (MC1/266 [INQ000524985]) (MC1/267 [INQ000524986]); (MC1/268 [INQ000524997]) (MC1/269 [INQ000235454]) (MC1/270 [INQ000235456]) MC1/271 [INQ000235457]; MC1/272 [INQ000235459]; MC1/273 [INQ000235460] and MC1/274 [INQ000235461]). The information from these updates was also used to inform Covid O meetings and ministerial briefings as appropriate. 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.

515. On 17 November 2020 we published the final report on the IPC care home inspections conducted between 1 August and 4 September 2020 "How we managed IPC during coronavirus pandemic 2020" (MC1/275 [INQ000524910]). The report is summarised below:

    515.1. During August 2020 we carried out a special programme of IPC inspections in 301 care homes selected as potential examples of where IPC was being done well.

    515.2. We also reviewed IPC in 139 "risk-based" inspections between 1 August and 4 September 2020, which were carried out in response to concerns about safety and quality. During these inspections we reviewed how well staff and people living in care homes were protected by IPC measures, looking at assurance overall across eight questions (as explained above).

    515.3. Across the 440 inspections, we found a high level of assurance in the eight questions.

    515.4. At 288 of the 440 services visited (65%), inspectors were assured in all eight of the IPC questions.

    515.5. Effective use of PPE and having up-to-date policies in place were the two areas with the most gaps in assurance.

515.6. Wherever inspectors encountered poor IPC practice, they escalated this at the time with the manager of the service and signposted to the available guidance. In a few cases an inspector returned to complete a comprehensive inspection or pursued regulatory action.

515.7. As expected, the care homes selected as potential good IPC practice examples generally demonstrated higher levels of assurance across the eight questions than those where we carried out risk-based inspections.

516. On 5 January 2021 DHSC requested that CQC increase the number of IPC inspections being carried out and asked that we prepare a proposal outlining how CQC could meet this request (MC1/276 [INQ000524908]). We responded on the same day setting out our plan to undertake an additional 300 inspections on top of the 900 that we had committed to undertaking by the end of January 2021, bringing the total to 1,200. These inspections would be a mix of risk based, IPC/outbreak inspections. We also indicated that we would continue to prioritise inspections of designated settings and of services that had not yet had an IPC assessment and that all care home inspections would continue to have an IPC assessment regardless for the reason for the inspection. In the response we raised concerns about the impact that the new lockdown would have on our resourcing and suggested that where colleagues were unable to physically undertake an inspection, they would continue to undertake TMA assessments. We also suggested that we would be finalising plans to potentially move some PMS inspector staff over to support the efforts in the ASC sector.

517. In early January 2021, following the request for CQC to increase the number of ASC IPC inspections, we amended the internal IPC ASC Guidance for inspectors to include sufficient detail to support inspectors with varying degrees of experience, especially those who had not carried out an IPC inspection before or inspection colleagues from the PMS sector who were being brought in to take on some of the additional inspections (MC1/277 [INQ000525058]). The guidance was further amended at various points in 2021 to bring it in line with best practice .

518. On 11 January 2021 Peter Wyman and Ian Trenholm wrote a letter to the Rt Hon Matt Hancock MP to provide an update on CQC's regulatory approach including the ongoing work around ASC IPC inspections (MC1/278 [INQ000524887]).

519. On 15 January 2021, following a request by colleagues from DHSC, we provided input into the DHSC report for the Prime Minister covering "Increased infection control inspections by the Care Quality Commission, and the repurposing of resources to this end" (MC1/279 [INQ000524919]; MC1/280 [INQ000524918]).

IPC Specific Guidance used in ESF Conversations

520. As described above, the ESF calls were structured conversations which covered four assessment areas and followed a framework of fifteen standard questions, grouped under the headings "safe care and treatment"; "staffing arrangements"; "protection from abuse and protection of human rights" and "assurance processes, quality monitoring and business risk management". The first question under "safe care and treatment" related specifically to IPC and asked "Had risks related to infection prevention and control, including in relation to COVID-19, been assessed and managed?"

521. The ASC sector guidance document for exploring the ESF questions "Support with answering the ESF questions – Adult social care services" was included as "Appendix 1" to the ESF Guidance from April 2020 (MC1/123 [INQ000469883]). The relevant prompts for the IPC related question are set out as follows:
    521.1. Were there existing infection prevention and control arrangements?
    521.2. Have the arrangements been reviewed and amended in response to the pandemic?

522. The guidance document also included potential sources of evidence for each of the prompts, to be assessed by inspectors where necessary. The potential sources of evidence for the IPC prompts are as follows:
    522.1. Infection prevention and control policies and procedures, including any additional Covid-19 specific material;
    522.2. IPC audits;
    522.3. Cleaning schedules; and
    522.4. Staffing understanding of IPC.

523. As explained earlier in this statement, the ESF guidance was updated regularly throughout the relevant period in accordance with feedback and experience. The May 2020 version of the "Support with ESF answering the ESF questions – Adult Social Care Services" guidance (MC1/281 [INQ000525070]) had the following updated prompts for the IPC related question:

523.1. How do you keep up to date with current IPC guidance/practices?

523.2. Have your existing IPC arrangements been reviewed and amended in response to the pandemic – have you needed to make any changes?

523.3. How are changes in guidance and processes being communicated to staff?

523.4. How is COVID-19-related training being provided?

524. The potential sources of evidence were also updated to include a full list of Government guidance on IPC and a link for providers to find their local health protection team.

525. In June 2020 the "Support with ESF answering the ESF questions – Adult Social Care Services" guidance was updated again with the following changes made to question 4 "How is COVID-19 *and other IPC-related* training and support being provided?" [my emphasis added] and a new question 5 "*How are the particular IPC risks to BAME (Black, Asian and Minority Ethnic) people being assessed and managed?"* (MC1/282 [INQ000525071]).

PPE Portal

526. In the early stages of the pandemic, the Government launched the PPE Portal and invited providers to register to use the Portal. As the PPE Portal was intended to deliver direct to end users, providers were required to register with a unique email address to use the Portal. CQC shared the contact details of registered providers with DHSC, which they used to notify the providers to register on the Portal. In the invitations to register there was an indication for the provider to change their contact details with us in the normal manner if incorrect. Throughout the pandemic we received many enquiries from providers regarding issues with access to the Portal. Where providers needed to change the email address linked to the Portal, we advised them to do so via the Covid-19DailyUpdateCQC@cqc.org.uk mailbox which was monitored by ASC colleagues.

527. Other than to provide the contact list to DHSC, CQC had no other involvement in the operation of the Portal.

The Domiciliary Care Agency ("DCA") Tracker

Background/rationale which led to the creation of the DCA Tracker

528. In early March 2020, as part of our Covid-19 regulatory response, we began developing a survey tool to allow us to collect and analyse Covid-19 specific information from providers. At first, the intention was for this to be rolled out to all providers asking some very specific, simple to answer, questions such as "How many of your service users are being impacted by Covid-19?"; "How many of your staff are being impacted by Covid-19?"; "Are you experiencing any shortages of essential supplies or medicine?"; and "Are there any Covid-19 related issues you are experiencing that you'd like to feedback?". We went about considering how to define the challenges being faced by all providers, what data collection processes already existed, what new information we would need, and how we could begin to source it.

529. At the meeting with the Minister for Care on 13 March 2020, which is referred to above in relation to the decision to pause routine inspections, we discussed our early thinking about developing an application to maintain oversight of the impact of Covid-19 on the social care sector including through collecting information on things like numbers of staff and vacancy rates (MC1/101 [INQ000524897]).

530. On 15 March 2020 we were copied into correspondence between colleagues from DHSC and ADASS regarding the development of a "sit rep of some sort" for the monitoring of the ASC sector during the pandemic. It was proposed by DHSC that "*with CQC standing down inspections, there may be scope for the CQC regional teams to help with this*". On 16 March 2020 we responded to DHSC and ADASS indicating our willingness to support, outlining the data that we could provide and the limitations of that data (MC1/283 [INQ000235388]).

531. On 17 March 2020 we were copied into correspondence with colleagues from DHSC, LGA, NHSE and ADASS regarding ways of reporting on the status of ASC to central government during the pandemic. It was suggested by LGA that both CQC and

NHSE should be involved in this work and that "*one single report*" would be preferable, if possible, to "*avoid duplication for councils and providers*". It was proposed that this work would be covered by "*an additional task and finish group under NACG*" and that a scoping meeting would take place the next day "*in view of the pace at which this [was] moving*" (MC1/284 [INQ000524993]).

532. On 18 March 2020 LGA circulated an email to CQC, ADASS and DHSC outlining some potential "Sitrep options" and confirming that it had been agreed in the meeting earlier that day that:

> "*the four key fields to collect are customer morbidity…, staff shortages, capacity for new customers, and practice needs for things like PPE.*
> *the principles for whatever system we use are providers only having to do one return, it being available now or very soon, it being safe to use in terms of provider sharing support needs, and it being of practical use for providers and commissioners.*"

533. In the email each of the proposed options presented were set out, including how the required information would be collected as well as the pros and cons of each option, as discussed at the meeting. In respect of CQC's involvement specifically, one option was labelled "*POSSIBLE CQC collection*" and it was noted that "*CQC were already wondering whether to develop their own collection especially around morbidity/staffing/practical help (but not capacity)*". In terms of this option it was noted that it would collect "*some but not all of what we need so providers would need to input elsewhere on capacity*". In terms of the NHS Capacity Tracker, it was noted that "*it doesn't currently touch home care*". In the email chain, a conversation followed regarding the suitability of each option (MC1/285 [INQ000524992]).

534. Following this, there were several conversations that CQC was included in with key stakeholders such as DHSC, LGA, ADASS, NHSE, UKHCA regarding the best option for the collection of Covid-19 related data from homecare providers. (MC1/286 (INQ000524995]; MC1/287 [INQ000524991]; MC1/288 [INQ000525002]; MC1/289 [INQ000525001]; MC1/290 [INQ000525015]; MC1/291 [INQ000525014]).

535. On 30 March 2020 CQC, DHSC and NHSE/I issued a joint statement to key ASC sector stakeholders including UKHCA, ADASS, LGA, PHE, ARC UK, NCF and

Carers UK on Covid-19 related data collection across the ASC sector. In the statement it was noted that the NHS Capacity Tracker was only collecting data from care homes leaving a gap in the national picture of the rest of the ASC sector. The statement confirmed that, in response, DHSC were partnering with CQC to "*create a regular data collection on Covid-19 related pressures from the rest of the adult social care sector.*" (MC1/292 [INQ000525032]). It was explained that CQC would gather information on capacity, staffing and supply issues through a simple online survey tool, which would be tested to ensure that it added "*no unnecessary burden on providers*". The statement indicated that the information would then be combined with data gathered by the NHS Capacity Tracker and other data sources, and shared across organisations who could help to mobilise necessary support. There was also confirmation that the information would "*not be used to drive any regulatory enforcement activity*". It was noted that CQC were building a pilot to test with providers in the first week of April 2020 ahead of rolling it out and there was a request that the organisations provide their support to encourage the highest possible response rate from providers "*whether they are asked to complete the NHS Capacity Tracker or the CQC tool*".

536. With the support of DHSC, we worked with Microsoft and KMPG to develop 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 ADASS, LGA and DHSC.

537. An overview of the survey was also included in DHSC's *COVID-19: our action plan for adult social care* published on 15 April 2020 and Kate Terroni's update to ASC providers published on the same day, as explained in para 473 above.

538. On 17 April 2020 we issued a joint letter to all registered providers of adult social care together with the CPA, DHSC and NHSE/I regarding the rollout of the DCA Tracker (MC1/293 [INQ000235452]). In the letter we confirmed that:
    538.1. Residential and nursing homes should complete only the NHS Capacity Tracker;
    538.2. Homecare/domiciliary care providers should complete CQC's 'Update CQC on the impact of Covid' online form (from 13 April 2020). This would be

rolled out to Shared Lives services, Extra Care and Supporting Living services in due course; and

538.3. The small number of providers of both homecare and residential and/or nursing homes should complete both data collections.

539. The DCA Tracker was rolled out to the providers of Shared Lives schemes, Supported Living services and Extra Care Housing in June 2020.

The data collected by the DCA Tracker

540. 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. The format of the survey was through an online form which asked a series of questions, as set out below. Screenshots of the earliest version of the form are attached as exhibit (MC1/294 [INQ000525084]):

540.1. How many people are using your service today?

540.2. At the moment, how many people using your service have a confirmed diagnosis of coronavirus?

540.3. At the moment, how many people using your service have a suspected case of coronavirus?

540.4. How many staff in your organisation deliver care to people? This includes staff who are currently unable to work because they have coronavirus, are self-isolating or have care commitments.

540.5. How many staff who deliver care to people are not working because of coronavirus? This includes staff who are self-isolating or have care commitments.

540.6. What is your current stock of personal protective equipment (PPE)? By personal protective equipment (PPE), we mean:

540.6.1. Aprons

540.6.2. Gloves

540.6.3. Fluid repellent surgical masks

540.6.4. Eye protection, if used

540.7. Can you provide any extra care hours?

540.8. How many extra care hours do you think you can provide per week?

540.9. If your organisation is experiencing any other coronavirus related issues please use this space to tell us (e.g. needs you cannot meet, shortages etc.). Do not use this form to raise urgent issues. Please use your normal channels to do this.

541. From early May 2020, the data was made available to our inspectors to use as part of the ESF process. 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. We also shared the data weekly with Ministers, NHSE and MHCLG to support national planning and reported it in our Covid Insight Reports.

DCA Tracker and NHS Capacity Tracker

542. On 7 September 2020 Kate Terroni received an email from DHSC regarding a Ministerial request regarding the integration of the data collected by the DCA Tracker with the care home data collected via the NHS Capacity Tracker (MC1/295 [INQ000525083]).

543. On 8 September 2020 Kate Terroni met with DHSC's Deputy Director, Social Care Analysis to discuss moving the DCA Tracker into the NHS Capacity Tracker to allow for the homecare data to be published alongside the care home data and for all of the data to be included in the Social Care Taskforce Dashboard, Covid-19 SitReps etc. The proposal was for DHSC to work with CQC with the aim of retaining the questions as far as possible, and to ensure a seamless changeover for providers. On 16 September 2020 we shared the DCA questions with DHSC including an up-to-date screenshot of the DCA Tracker form.

544. On 23 September 2020 Kate Terroni presented a paper to CQC's Gold Command regarding "Considerations for the future of the home care survey" in terms of which approval was sought for Gold Command to make a decision on whether CQC would support DGSC's proposal to move the DCA Tracker to the NHS Capacity Tracker. In

the paper it was suggested that "*the benefit of doing this is that providers and commissioners need to access only one platform to input and get access to data, there can be more alignment between the tracker for community care and care homes, and the governance for changes can be simplified*." The paper listed key reasons for supporting the proposal and some concerns about the proposal, indicating that "*DHSC are aware of our concerns and have said that as a starting point and to phase it, there will be no change in questions for some time and CQC will be part of the governance of how the trackers are developed and shared and used*." (MC1/296 [INQ000525088]). Gold Command approved the proposal for the transition and we began engaging with key ASC sector stakeholders and with DHSC throughout October and November 2020 to move this forward (MC1/297 [INQ000525087]; MC1/298 [INQ000525086]); MC1/299 [INQ000525085]).

545. On 24 November 2020 we published an update to providers on behalf of DHSC regarding the imminent transfer of the DCA Tracker from CQC to the NHS Capacity Tracker (MC1/269 [INQ000235454]). The transfer took place on 30 November 2020, when the data from our tool was moved into a new Home Care section of the NHS Capacity Tracker. This meant providers across all sectors only needed to use one system.

H. Care Home Visiting

Visiting guidance

546. On 12 June 2020 we were approached by DHSC for comment in relation to the updated draft Care Homes Visiting guidance. CQC colleagues provided comments on the draft updated guidance including regarding the role of Local Authorities in enforcing visiting policies within care homes and communicating with families and others about visiting decisions, as well as offering some minor grammatical suggestions (MC1/300 [INQ000524941])(MC1/301[INQ000560882]).

547. On 10 July 2020, DHSC approached us again for comment in relation to a further amended version of their guidance on care home visiting. We responded with some limited comments regarding the public accessibility of the guidance and policies

(MC1/302[INQ000235543]) and the updated guidance was published on 22 July 2020 (MC1/303 [INQ000525042]).

548. DHSC subsequently developed an annex to this guidance looking at visits out of care homes. On 24 August 2020, they approached us for comments on the updated 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 (MC1/304[INQ000235544]); MC1/305[INQ000235547]) and MC1/306[INQ000235548]). In addition, we included links to our good practice guidance on managing risks and person-centred care.

549. In our internal Cross-Engagement Insight Report dated 9 October 2020 (MC1/307 [INQ000398774]) we reported that we were hearing concerns from public stakeholders about care homes going back into lockdown and residents being unable to see their families and loved ones, with Rights for Residents, Alzheimers Society, National Care Forum, Age UK all expressing concern about the mental health of residents in care homes who were unable to see their families, particularly those with dementia. We also reported that the calls for clear guidance on visiting were continuing, with Age UK and NCF calling for decisions around visitation to be based on individual risk assessments, not blanket assessments of risk.

550. On 3 November 2020 we attended a roundtable meeting set up by DHSC, with the Deputy Chief Medical Officer and colleagues from LGA, PHE, ADASS and the Association of Directors of Public Health (ADPH) to discuss the Care Homes visiting guidance following the Government's lockdown announcement (MC1/308 [INQ000524922]). At this meeting, we supported the approach of having personalised plans for residents and avoiding blanket policies on visiting.

551. On 16 December 2020, Kate Terroni met with DHSC colleagues and the Minister of State for Care who enquired about CQC's position on care homes that had blanket bans (MC1/309 [INQ000525047]). We highlighted that we were treating blanket bans as a risk indicator for a closed culture. We clarified that where we heard about issues relating to visiting, we would investigate and that if there were additional concerns, we would likely undertake an inspection. The Minister approved this approach. We

also confirmed that we intended to issue communications with CPA after Christmas highlighting that blanket bans on visiting were not acceptable and that we would be speaking to ADASS to see if they would be willing to jointly sign the messaging.

552. Through early 2021, we continued to hear instances of care home providers issuing blanket bans on visiting in their services. An internal CQC bulletin message to all ASC colleagues advised of the "*need to assess this as a risk factor with the potential of a closed culture, therefore triggering an inspection*" (MC1/310 [INQ000524936]).

553. On 15 February 2021, in response to comments made publicly by Age UK regarding blanket bans on visiting in care homes, we included the following statement from Kate Terroni in our ASC provider bulletin outlining CQC's view on the issue (MC1/311 [INQ000524945]):

"*We recognise that many people will have had a terrible time, being unable to visit and spend important time with their loved ones for many months, and how this has had a significant impact on mental health and well-being of people in care services and their families. When thinking about visiting, for those entering care homes and those leaving to visit other places, providers must start with a focus on the individual and how their needs will be met. Blanket bans, where there is no active outbreak, are unacceptable and people should follow Government guidelines, give sufficient weight to local risks and advice from their Director of Public Health as well as giving consideration to the home environment. The individual must be at the centre of the decision. All decisions need to stay under review as circumstances change. Where CQC are aware of blanket visiting bans in homes with no outbreaks, this may trigger an inspection.*

The majority of providers are continuing to do extraordinary work, even when faced with workforce shortages, increased testing and the roll out of a national vaccination program. However, we are aware that in some places blanket decisions are continuing to be made against government guidance. Where decisions are being made, whether that is for visiting, testing or vaccination, the focus must always be on the individual needs of the person.

Person centred care has never been more important and recognising that part of people's identity and wellbeing comes from their relationships is critical. Meeting

people's holistic needs means an individualised approach. The distress caused by not having important relationships well maintained can be as devastating to mental health as when physical health is not attended to – both need to be a priority."

554. On 25 February 2021 we published an article on our website "Rights of individual must be paramount when deciding visiting plans" echoing Kate Terroni's statement and clarifying CQC's position on the importance of visiting. (MC1/312 [INQ000525096]).

555. On 23 February 2021, DHSC approached us for comment on updated draft guidance. On 24 February 2021, we provided some very limited comments regarding the content and responded to confirm that we considered that the guidance was clear, respected people's wishes and enabled choice whilst mitigating risk (MC1/316 [INQ000235549]) and (MC1/317 [INQ000235551). Discussions were held with DHSC regarding allowing nominated essential care givers in care homes. This entailed a change to the care home visiting guidance on 8 March 2021 to allow one key visitor per resident to enable further support and reduce strain on care staff.

556. On 12 March 2021, we received a letter addressed to Peter Wyman, then Chair of CQC, from Rt Hon Harriet Harman MP in her capacity as Chair of the Joint Committee on Human Rights, requesting information from CQC following the Government's most recent guidance on care home visiting (MC1/318 [INQ000235467]). The letter stated that "*as the guidance does not currently have statutory force, it is vital that the Care Quality Commission fulfils its responsibility for promoting compliance within the care home sector*" and requested that CQC provide the following:

    556.1. how many care homes were fully complying with the new guidance and how many were not;

    556.2. of those complying with the guidance, how many care homes were allowing visits, and how many were not allowing visits;

    556.3. how many care homes had introduced more restrictive visiting procedures since the introduction of the new guidance;

    556.4. the number of complains CQC had received about visits, including

556.4.1. where visits had not been allowed at all;

556.4.2. where visits had been permitted, but in a way which was unsatisfactory or not in accordance with the guidance;

556.4.3. where complaints had been resolved in the complainants' favour; and

556.4.4. where complaints had not been resolved

556.5. an explanation of how CQC will fulfil its responsibility for promoting compliance within the sector over the coming weeks, including the specific measures we had put in place to urgently address the complaints we received.

557. On 23 March 2021, we responded to the Rt Hon Harriet Harman MP (MC1/319 [INQ000235468). In the letter we confirmed our view regarding the importance of person-centred care and referencing Kate Terroni's statement outlined above. In response to the requests made by Ms Harman in her letter, we clarified our role and confirmed that we were not able to provide data on how many care homes were complying with the new guidance as this was not data that we were collecting. We indicated that where we were made aware of concerns that blanket bans on visiting may be in place, we were following up with providers and initiating inspections, as appropriate. We outlined the steps that we would consider taking to address visitation concerns as follows:

557.1. We enhanced our approach when inspecting care homes to include a mandatory question on whether the service is 'facilitating visits to people living at the home in accordance with current guidance'. The findings from these inspections are published on each care home's individual page on our website.

557.2. We were not able to take up formal complaints because we do not have powers under our legislation to investigate or resolve them. Our role was to bring together a range of information to form a picture of how well a particular service cares for all the people who use it. We valued all the information that was shared with us and used this to help us to decide where, when and what specific areas of a service to inspect.

557.3. We asked people to raise concerns first with the provider, but if they were unhappy about the matter not being resolved then they should let us know.

When we were made aware of concerns related to visiting, we made contact with the registered manager to explain our position, which was that:

557.3.1. they should review any blanket bans as they were not in line with government policy or our expectations;

557.3.2. as this was a human rights issue, all agencies involved had a duty to weigh-up those separate rights and how they applied to each individual;

557.3.3. we expected them to follow best practice, which was person-centred care and included consideration of how each individual's holistic needs should be met, and

557.3.4. we expected them to give us a clear plan as to how they were moving from their current position, without delay

557.4. We also told providers that each time we were notified of a blanket ban, we would look at the individual service and its circumstances, and we would ask the following questions which could lead to an inspection and or appropriate enforcement action being taken if evidence was found to support the concerns:

557.4.1. Did that tell us that there could be a closed culture developing from the closed environment? What else did we know about the service? Was this an early indicator of risk and therefore did we need to inspect?

557.4.2. Did this suggest that people's individual needs were not being properly recognized?

558. In late March 2021, we were again approached by DHSC for comments on updated guidance on care home visiting. On 30 March 2021, we responded with some limited comments on the draft (MC1/320 [INQ000524987]; MC1/321 [INQ000560887]).

559. Throughout mid-2021, CQC regularly attended DHSC-arranged meetings regarding care home visiting with stakeholders. We shared with DHSC concerns we were hearing from providers about the risk averse nature of the guidance (MC1/322 [INQ000525097]).

560. On 18 October 2021, a further iteration of visiting guidance was provided by DHSC for comment. On 21 October 2021, we responded to suggest that the guidance could be simplified and provided limited comments, including that there should be an individual approach for each resident based on a risk assessment for them specifically (MC1/323 [INQ000235552]) and MC1/324 [INQ000235553]).

Care home visiting concerns

561. In order to keep track of the concerns around visiting in care homes that we were receiving we developed the Care Home Visiting Concerns Form ("the Concerns Form") in late February 2021 (MC1/325 [INQ000560888]). The Concerns Form was completed internally and allowed us to view relevant information in one central location in order to assess the number of concerns raised and the number of services involved.

562. The questions on the Concerns From included (but were not limited to):

562.1. How were we made aware of the concerns? (Select all that apply.)

562.1.1. Inspection

562.1.2. Contact from person using a service

562.1.3. Contact from a relative, advocate or other supporter of person using a service

562.1.4. Whistleblower

562.1.5. Direct Monitoring Approach (DMA)

562.1.6. Capacity Tracker

562.1.7. Information shared by a system partner (e.g. local authority)

562.1.8. Other

562.2. Dare of information of concern received;

562.3. What concerns did the information relate to: (Select all that apply.)

562.3.1. A blanket ban on any visiting (no outbreak or unknown if outbreak)

562.3.2. A blanket ban on any visiting (where there was an outbreak)

562.3.3. Concern provider was not following government guidance around visits to ensure they are safe (e.g. with regard to PPE or lateral flow tests)

562.3.4. Concern provider was not facilitating virtual contact with friends, relatives or others (e.g. video calls)

562.3.5. Concern provider not facilitating indoor 'named visitor' visiting

562.3.6. Concern provider not facilitating essential care giver visits

562.3.7. Concern provider not facilitating window, outdoor and screened visits

562.3.8. Concern provider not facilitating exceptional circumstance (e.g. end of life) visits

562.3.9. Visiting Out

562.3.10. Other

562.4. What did we do in response to the information of concern? (Select all that apply.)

562.4.1. Held a Management Review Meeting

562.4.2. Planned an inspection

562.4.3. Raised concerns with provider and/or registered manager

562.4.4. Raised concerns with system partners (e.g. local authority)

562.4.5. Contacted person raising the concerns

562.4.6. Contacted relatives

562.4.7. Planned direct monitoring approach (DMA)

562.4.8. Raised a safeguarding alert

562.4.9. Other

562.5. What was the outcome of the action taken (in relation to concerns around visiting)? (Select all that apply.)

562.5.1. Received adequate assurances that provider was acting reasonably/proportionately and in accordance with government guidance

562.5.2. Provider took action to change visiting practices

562.5.3. System partner (e.g. local authority) took action to ensure visiting practices changed

562.5.4. Escalated concerns regarding system approach to facilitation of visits

562.5.5. Provider was acting on advice of Director of Public Health, local authority or other public body

562.5.6. Historical concern already addressed by provider

562.5.7. Awaiting inspection

562.5.8. Escalated to Corporate Provider Team

562.5.9. Other

562.6. For providers with more than one location, did the information reviewed suggest a provider-led decision on blanket bans/restrictions?

562.6.1. Yes

562.6.2. No

562.6.3. Unknown

563. On 1 March 2021, the Concerns Form was circulated internally, along with accompanying guidance ahead of its launch on 8 March 2021 (MC1/326 [INQ000525037]] (MC1/327 [INQ000525038]). The internal correspondence explained that the Concerns Form should be completed on occasions when we were informed of or identified concerns regarding a care home's approach to supporting visiting including:

563.1. Information of concern relating to 'blanket' restrictions on visiting;

563.2. Concerns relating to the provider not following current guidance around facilitating visits; and/or

563.3. Other information of concern relating to visiting, such as concerns around the safety of any arrangements.

564. The internal correspondence also set out the suggested regulatory responses/steps to be taken by inspectors on being made aware of concerns relating to visiting, including:

564.1. To make contact with the Registered Manager/Provider to explain CQC's position, which was:

564.1.1. that they should review any blanket bans as they were not in line with government policy or our expectations

564.1.2. that this was a human rights issue and consideration should be given as to how separate rights applied were weighed and applied in individual circumstances

564.1.3. that we expected best practice to be followed i.e. person-centred care and a consideration of how each individual's holistic needs should be met

564.1.4. that we expected, without delay, a clear plan from them for moving away from their current position.

564.2. To inform the Registered Manager/Provider that on being notified of a blanket ban we would consider the individual service/circumstances in the following way:

564.2.1. Whether a closed culture could be developing from the closed environment? What else did we know about the service? Was the visiting ban an early indicator of risk and therefore do we need to inspect?

564.2.2. Whether the visiting ban suggested that people's individual needs were not being properly recognised?

565. When the Concerns Form was completed, the raw data would be deposited into a spreadsheet. This can be made available to the Inquiry if required.From here, it was used in the Care Home Visiting Concerns Power BI report. This gave a graphical representation of the types of concerns that were being raised, the action that was taken in response and the outcome of that action. It could also be used to break down the information by geographical area for ease of reference. Full details of concerns were listed on the 'Details' tab and could also be filtered. A screenshot of the front page of the Power BI report is exhibited (MC1/328 [INQ000525099]). The full report can be made available to the Inquiry if required.

566. It is important to note that there were other ways in which it could be recorded that a service was potentially restricting visiting. For example, on 16 March 2021, an additional mandatory question regarding the facilitation of visiting was added to the ASC IPC Information Gathering Tool: "Is the service facilitating visits to people living at the home in accordance with current guidance?" (MC1/329 [INQ000524957]). Our website was updated accordingly and providers were informed via the provider bulletin.

567. The information collected from the use of the ASC IPC tool could only be collected where an inspection was being completed, whilst the Concerns Form data was collected where a concern was reported from any source. Steps were taken internally

to ensure that reports of concerns were cross-referenced between the ASC IPC tool and the Concerns Form to avoid duplication.

568. The data collected was used internally to review and inform the action taken by CQC. For example, some of the information on visiting triggered inspections and the outcomes of the inspections were collated and tracked in a spreadsheet. This spreadsheet can be made available to the Inquiry if required. Other actions taken included raising the concerns with/meeting with the registered manager/provider or contacting the local authority.

569. The data also informed our responses and feedback on the versions of guidance shared by DHSC for comment and our response to the Joint Committee of Human Rights letter (as detailed above). It was used to report back to stakeholders such as the Trade Associations; to inform our discussions with DHSC and the Minister; and to satisfy specific requests from DHSC.

570. The data also informed our letter dated 14 January 2022 to Matthew Style, Director General for NHS Policy and Performance, to set out our concerns regarding instances where Directors of Public Health (DPH) had offered advice to providers or local areas which went beyond the government guidance. In the letter we stated that there may have been circumstances that meant that this might have been the most appropriate action but we did not have a picture of when this was the case and why, meaning that it was more difficult for CQC to take the right regulatory action at the time. We suggested to DHSC that they be informed when DPH had directed care homes to put in place restrictions that conflicted with the government guidance and for this information to be shared with CQC to "help us to better respond to concerns raised about visiting rights in health and social care" (MC1/330 [INQ000235469).

571. On 21 April 2021, we provided information regarding our handling of visiting concerns to DHSC in response to a specific request from the Minister of State for Care (MC1/331 [INQ000524927]), stating as follows:

"*CQC has provided mechanisms for people to feedback on visiting concerns – there have only been 27 queries raised and none were genuine blanket bans (the majority*

were miscommunication between the care homes and the visitors; or a lack of understanding around visits being restricted in the case of an outbreak). CQC has advised these care homes to provide clearer communication and avoid mixed messages."

572. This data was also used to inform Kate Terroni's appearance before the Joint Committee on Human Rights on 21 April 2021. On 13 May 2021, we provided an update to the Minister of State of Care on the issue with a general overview and with a case study of a visiting concern (MC1/332 [INQ000524904]).

573. Throughout the pandemic, the Concerns Form spreadsheet was updated to provide for additional analysis. For example, on 16 May 2022, all heads of inspection were requested to input additional information into the spreadsheet in order to inform further analysis for DHSC (MC1/333 [INQ000525036]).

574. On 5 January 2022, new internal guidance was issued regarding the recording of inspections which had been triggered by visiting concerns (MC1/334 [INQ000524929]). This categorisation gave us the ability to identify and retrieve data within the system about the number of inspections that were triggered by a specific factor such as visiting concerns.

575. In January 2022, we set up a new cross-directorate panel to oversee our regulatory response where visiting concerns were identified in regulated care settings through the data collected by the Concerns Form or otherwise (MC1/335 [INQ000524958] (MC1/336 [INQ000524959]). The first sitting took place on 13 January 2022. The panel ensured that the approach taken in response to visiting concerns and any resulting breaches or enforcement action, was thoroughly reviewed, appropriate and proportionate. It offered a cross-directorate approach by:
    575.1. Reviewing cases and providing advice and guidance,
    575.2. Reviewing regulatory and enforcement decision making,
    575.3. Recommending alternative/additional Regulatory and Enforcement action
    575.4. Providing oversight and data regarding these cases.

I. CQC's Insight Reports

576. During the relevant 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.

577. 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 during 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 from our collection of numeric data on issues such as death rates and numbers of inspections. 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.

578. We determined the themes and content of these reports which evolved over time and sometimes differed from report to report. 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.

579. The reports were principally published on our website and highlighted to the health and care sector through our Provider Bulletins and they were shared with national bodies such as NHSE. 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. A number of the relevant Covid Insight Report Issues are referenced throughout this statement.

580. We published 15 Covid Insight Reports in total, briefly described below:

580.1. Issue 1 published 19 May 2020 (MC1/337 [INQ000235471)

580.1.1. This issue focused on adult social care, reviewing data on outbreaks, deaths and availability of PPE, and highlighted the impact of Covid-19 on staff wellbeing and the financial viability of adult social care services.

580.2. Issue 2 published 15 June 2020 (MC1/338 [INQ000235472]);

580.2.1. This issue looked at collaboration across systems in response to Covid-19; the care of people from different groups and how this was managed; and the changes in GP and online primary care services.

580.3. Issue 3 published 13 July 2020 (MC1/339 [INQ000235473);

580.3.1. This issue looked at the importance of collaboration among providers and other organisations; the issues and concerns that prompted us to carry out a number of inspections in recent months; the financial impact of Covid-19 on adult social care services; and the challenges faced by providers in caring for people detained under the Mental Health Act or subject to a deprivation of liberty.

580.4. Issue 4 published 15 September 2020 (MC1/176 [INQ000235474)

580.4.1. This issue looked at good practice in infection, prevention and control in three key settings (acute hospital trusts, care homes and GP surgeries) and introduced our provider collaboration reviews.

580.5. Issue 5 published 17 November 2020 (MC1/340 [INQ000235462);

580.5.1. This issue looked more specifically at infection, prevention and control in care homes and presented the key findings from a survey of hospital inpatients to understand their experiences during the early stage of the pandemic.

580.6. Issue 6 published 15 December 2020 (MC1/341 [INQ000235475])

580.6.1. This issue looked at designated settings and care home capacity as well as some good practice examples from Phase 2 of our provider collaboration reviews, on urgent and emergency care.

580.7. Issue 7 published 20 January 2021 (MC1/342 [INQ000235476)

580.7.1. This issue looked at the increase in hospital bed occupancy compared with the potential capacity of beds in designated settings as well as some further exploration of the data on deaths in adult social care, in terms of learning disability and ethnicity.

580.8. Issue 8 published 20 February 2021 (MC1/343 [INQ000235477)

580.8.1. This issue looked at the evidence to date regarding winter pressures for urgent and emergency care services during the pandemic and the action taken by CQC to provide constructive support.

580.9. Issue 9 published 23 March 2021 (MC1/344 [INQ000235478])

580.9.1. This issue looked at the impact of the pandemic on urgent and emergency care services and pharmacy services in NHS trusts.

580.10. Issue 10 published 18 May 2021 (MC1/345 [INQ000235479])

580.10.1. This issue looked at the impact of the pandemic on access to dental services, and shared examples of the innovative ways that local services collaborated to care for people with cancer, or suspected cancer.

580.11. Issue 11 published 22 June 2021 (MC1/346 [INQ000235480])

580.11.1. This issue looked ahead at some of the areas to be covered in our Phase 4 provider collaboration review (subsequently published on 21 July 2021) of how services across local areas in England worked together for people with a learning disability during the COVID-19 pandemic.

580.12. Issue 12 published 21 July 2021 (MC1/153 [INQ000235481])

580.12.1. This issue looked at data on death notifications involving COVID-19 received from individual care homes; inspections of acute NHS services monitoring inspection prevention and control; highlighted what we had learned about how risks can build into a closed culture.

580.13. Issue 13 published 20 September 2021 (MC1/347 [INQ000235482])

580.13.1. This issue looked at how NHS trusts were planning for people's care while tackling the backlog caused by Covid-19 and their assessment of challenges. It also looked at how they were considering people's care in a fair and equal way.

580.14. Issue 14 published 16 November 2021 (MC1/348 [INQ000235483])

580.14.1. This issue looked at our review of medication safety in 95% of England's NHS trusts, focusing on the role of medication safety officers.

580.15. Issue 15 published 18 January 2022 (MC1/349 [INQ000235484])

580.15.1. This issue looked at data on staff vacancies in care homes (further to the State of Care report 2020/21), and the quality of ethnicity data recording for mental health services.

581. The below information is provided in direct response to the Inquiry's Rule 9 Request to CQC for Module 6.

Issue 1 (INQ000235471)

582. Issue 1 published on 1 May 2020 referenced 'The Impact on Care Providers and Staff'. In this issue we reported how the availability of PPE was "still a big concern". We included data collected from the DCA Tracker, referred to as the Domiciliary Care Agency Survey (page 13), and indicated that in domiciliary care, "of those agencies that responded to the CQC tracker from 2 – 8 May [2020], 6% of agencies in London had only enough PPE to last two days or less; 28% of agencies in London and the North West had only enough PPE to last up to a week."

583. We also reported that there had been instances where the wrong PPE items had been delivered or where the quality of the equipment provided was poor. In the report we set out that our inspectors had been contacting providers to support them to keep people safe, and that we had been working with local authorities to try and ensure that providers received the PPE supplies that they needed.

584. At page 13 of Issue 1, the report states "Our inspectors have even arranged loans of PPE from other providers to cover immediate need." In these instances, CQC staff acted as the conduit/intermediary party in the arrangements of loans of PPE from one care home to another. Other steps taken included talking to care homes and homecare providers to find out where stock levels were low, then contacting local authorities to try to arrange the necessary supplies.

585. For other enquiries that came centrally through the Covid-19 ASC Response Panel ("the Response Panel"), we shared contact information for the dedicated 'National Supply Distribution Line' and pointed to guidance on the Public Health England website on the use of PPE. If a provider was unable to obtain PPE through their usual supply lines or those suggested by DHSC, they were encouraged to speak to their local authority or Local Resilience Forum, to discuss arrangements for coordination at a local level.

586. There is no specific record available to confirm the number of times nor the time period over which these arrangements were made. Queries sent to the Response Panel regarding PPE were mainly received during the first few months of the pandemic. This is borne out in the Response Panel log, which demonstrates that of the 257 enquiries tagged as relating to 'PPE' made between March 2020 and March 2022, more than half of these were received between March and June 2020, with the bulk being received in March and April 2020. It is important to note that these numbers do not reflect the total number of 'PPE' queries CQC colleagues received from service providers during the pandemic. The full log outlining all of the enquiries received and answers provided was made accessible to everyone in CQC, and colleagues were encouraged to check the log for similar queries before sending a new one through to the Panel in case it had been answered previously. It is therefore possible that additional 'PPE' related queries were received and responded to by CQC colleagues in addition to those recorded on the Response Panel log.

587. We also reported on "Financial concerns for adult social care" under "The Impact on Care Providers and Staff" section of the report (page 17). In this section we described how the pandemic was "having a significant impact on the financial viability of adult social care services", which was already fragile as reported in our Market Oversight report to the CQC Board in March 2020. On page 17 of Issue 1 we set out some of the financial struggles that the ASC sector was facing as a result of the pandemic and indicated that "...we [had] heard concerns over insurance companies informing providers that, if they knowingly take COVID-19 positive patients, they are in breach of their insurance."

588. In order to address these concerns, as is set out below, CQC raised the issue with DHSC directly and at daily NHS-led stand-up calls for national/regional health and care bodies. We also flagged this issue with regional incident centres to instigate intervention from partner agencies.

589. On 28 October 2020, we met with DHSC specifically to discuss the provider insurance issues (MC1/350 [INQ000524923]). We also raised our concerns intermittently with DHSC as they arose (MC1/351 [INQ000524921]; MC1/352 [INQ000524926]) and responded to requests for information from DHSC (MC1/353 [INQ000524924]).

590. Where enquiries regarding insurance came centrally through the Response Panel, we advised providers that these concerns were being shared and highlighted with DHSC. We confirmed that the matter was being looked at across government and DHSC were working with providers and insurers to understand the breadth and severity of the issue.

591. On 11 March 2021, we participated in Exercise Guardian (MC1/354 [INQ000060256]). This was a tabletop-style virtual exercise to support ongoing work to prepare for and respond to the risk that a large, specialist health and social care provider in England would be unable to provide its services due to a lack of affordable or available insurance cover. It was developed and delivered for NHS England & NHS Improvement and DHSC, with the report produced by PHE's Emergency Response Department.

592. CQC worked with providers to assist, where possible (MC1/355 [INQ000524928]). For example, on 24 March 2021 CQC were made aware of an instance in which the insurance cover of a service expired at midnight and the provider could not get the insurance policy renewed because the service was rated inadequate. Through liaison with the provider and local authority, it was established that the insurers required evidence of improvement from CQC as the regulator in order to make a decision regarding renewal of the policy. That evidence could only be provided by CQC following an inspection. CQC prioritised the need to inspect as soon as possible and to expedite the writing of the inspection report. The inspection was

carried out over 26 March 2021 and 30 March 2021. Written feedback was subsequently sent to the provider to confirm that previous breaches had been rectified and the quality of care had improved. This was shared with the insurers to provide assurance about the provider's quality of care. On 31 March 2021, the provider confirmed that their renewed insurance cover was to start the next day.

Issue 3 (INQ000235473)

593. One of the topics highlighted in Covid Insight Report Issue 3, published on 15 July 2020, was how CQC was responding to feedback about care services and the "importance of hearing about concerns about the care people receive" during the pandemic.

594. In the report we described the various ways that CQC was responding to concerns, including how our contact centre automatically allocated calls from care workers who had concerns about the safety or quality of care to an inspector or senior member of the team to investigate for quick investigation/resolution. We also referenced the article 'Regulating during COVID-19 - why raising concerns about care is more important than ever', published on our website on 17 June 2020 (MC1/122 [INQ000398848]) which described the increase in calls to CQC's national contact centre from staff raising concerns about care, many of which related to issues with PPE, infection control and the challenges posed by social distancing.

595. The 17 June 2020 article outlines with some specificity the numbers of concerns, the nature of those concerns and the respective sources as follows:

595.1. Between 2 March 2020 and 31 May 2020 we received 2,612 calls from adult social care staff raising concerns, compared to 1,685 for the same period in 2019 – a 55% increase;

595.1.1. many of the calls (26%) related to lack of PPE or other infection control products;

595.1.2. Thirty-two percent of calls included concerns about how infection control or social distancing was being practiced at the service they worked in; and

595.1.3. 4% of calls referred to quality of care being impacted by Covid-19.

595.2. There had also been an increase in calls about, or from, people detained under the Mental Health Act, often expressing distress or confusion about why people are more likely to be confined to their rooms rather than being able to move around freely. Of the eight mental health services we had inspected between pausing routine inspections and the publication of the article, five have been as a direct result of concerns raised with us by staff or members of the public.

595.3. In Adult Social Care specifically, 17 inspections had been conducted since the pausing of routine inspections on 16 March 2020, of which 11 were as result of concerns raised by staff or members of the public. The remainder were in response to notifications from providers or information from key stakeholders.

596. On page 11 of the Covid Insight Report Issue 3, we stated that "We [had] carried out 50 inspections in adult social care services since 16 March [2020]; 24 of these were as a result of concerns raised by staff or members of the public, and the remainder were in response to concerns we identified through our Emergency Support Framework, notifications from the provider or information from key stakeholders." This information was an updated version of the information contained in the 17 June 2020 article as set out above

597. In terms of the nature of concerns being raised which led to the inspections outlined above, we indicated that they included:

597.1. Indications of closed cultures;

597.2. Reports of poor IPC; and

597.3. Reports of poor management of:

597.3.1. falls;

597.3.2. wound and pressure area care;

597.3.3. medicines; and

597.3.4. appropriate incident response.

598. Although there is no way for CQC to definitively state where each concern came from and the exact nature of each concern without going through the various inspection records from the relevant period, below is a summary of some of the main

concerns we received during the period covered in Covid Insight Report Issue 3, categorised with reference to where they were most likely to have come from:

598.1. Public

598.1.1. failure of staff to respond appropriately following an incident i.e. 999 calls/GP and/or a lack of oversight/insight by the registered provider;

598.1.2. lack of staff competence to assess and support people safely, for example, with manual handling;

598.1.3. poor management of IPC – in both environments with outbreaks of Covid-19 and also with no active cases of Covid-19, leading to the absence of or inappropriate use of PPE;

598.1.4. medication concerns e.g. service users may be receiving more medicines than required to manage behaviours rather than pain; wound treatments not being provided in a timely manner to reduce pain;

598.1.5. failure to identify and respond appropriately to changes in people's health needs;

598.1.6. failure to manage end-of-life care needs;

598.1.7. inappropriate use of restraint

598.1.8. poor, unsafe care including concerns around falls management; nutrition and hydration; health care and medical needs; wound and pressure area care; dignity and respect;

598.1.9. absence of clinical oversight or governance.

598.2. Staff

598.2.1. lack of PPE or other infection control products

598.2.2. concerns about infection control or social distancing practices in their service

598.2.3. quality and safety of care in their service

598.3. ESF/notifications from the provider/information from key stakeholders

598.3.1. lack of a manager or a change in manager during the pandemic impacting on safety, service delivery and practice around infection control;

598.3.2. indications of a closed culture at a location or instances in which information could not be ascertained to assure that people were safe in a service

598.3.3. risks not addressed in services that were identified prior to lockdown – through our monitoring of a location we were not able to gain assurance and we have subsequently had to go in and inspect.

599. In the report we indicated that in response to some of the more serious concerns received we had taken urgent action to protect people using services where appropriate, including by "stopping new admissions and on rare occasions closing services". Again, without reference to the various inspection records from the relevant period, we are unable to definitively state the number of care homes in respect of which CQC imposed conditions to restrict admissions or the number of care homes in terms of which CQC cancelled registrations or removed a location or registered activity from their registration. It has not been possible to review the inspections reports and affiliated documents within the time limit set by the Inquiry for responding to the Module 6 Rule 9 Request. If further specific detail or information is required by the Inquiry we will of course endeavour to provide it where it is available.

Issue 4 (INQ000235474)

600. In Covid Insight Report Issue 4, published on 15 September 2020, we highlighted some of the learning and insights about good IPC practice in three key settings: acute hospital trusts, care homes and GP surgeries.

601. In relation to IPC policies in care homes specifically, outlined on page 13 of the report, we described our findings from the 59 high-risk inspections of care homes undertaken during the first half of August 2020 where IPC was assessed. We reported that the lowest level of assurance (59%) found was in respect of the question "is your IPC policy up-to-date and implemented effectively to prevent and control infection?" and described the various indicators for this. One of the indicators for this was "examples of care homes that lacked risk assessments for people from Black and minority ethnic groups and others who were at higher risk due to the

pandemic, as well as for staff members" and examples where the risk assessments for these groups had been undertaken but had not been actioned.

602. We have been able to search for mentions of "risk assessments" in the source report containing the inspectors notes from the 440 IPC inspections undertaken in care homes between 1 August 2020 and 4 September 2020, and have found that:
    602.1. 13 services did not make sure they had an up-to-date individual risk assessment for everyone using the service;
    602.2. 6 services had undertaken risk assessments, but they did not take account of the specific risks to people from Black and minority ethnic groups;
    602.3. 33 services had either not conducted risk assessments for their staff, or the risk assessments conducted did not take account of the specific risks to people from Black or minority ethnic groups;
    602.4. there was no evidence to suggest that the absence of a risk assessment for people who used services or staff was because they were from Black or minority ethnic groups.

603. Generally, the actions taken by our inspection colleagues in response to these types of concerns included:
    603.1. discussing the issue with the registered manager of the provider;
    603.2. signposting the registered manager to best practice guidance; and/or
    603.3. gaining assurance that risk assessments would be put in place or updated.

604. Throughout the pandemic we continued to monitor the quality and implementation of IPC policies including the proper use of risk assessments through ASC IPC tool, which is described in detail at paragraph 452 of this statement. Question 8 of the ASC IPC tool asks "Is the IPC policy up to date and implemented effectively to prevent and control infection?" and the prompts for this question include:
    604.1. Are infection risks to people thoroughly assessed, reviewed and managed?
    604.2. What action has been taken to consider and reduce any impact to people and staff who may be disproportionately at risk of transmissible community infections?

604.3. How does the provider support people using the service to have access to recommended vaccinations?

604.4. What changes have been made following the most recent IPC audit?

604.5. What contingency planning is in place to address possible infection outbreaks and winter pressures?

605. Under Question 8 of the ASC IPC Tool, the inspector is also signposted to the PHE guidance 'Understanding the impact of Covid-19 on BAME groups' and question 9 of the additional mandatory questions in the ASC IPC Tool asks specifically "Has the service adequately taken measures to protect clinically vulnerable groups and those at higher risk because of their protected characteristics (ethnic minority background, physical and learning disabilities)?". The ASC IPC tool was also published on our website in order for providers to be able to use it themselves as part of their audit processes.

J. Do not attempt cardiopulmonary resuscitation (DNACPR) report

'Protect, respect, connect: Decisions about living and dying well during COVID-19' [INQ000235492]

606. In March 2021, we published a thematic report entitled 'Protect, respect, connect: Decisions about living and dying well during COVID-19' (MC1/356 [INQ000235492]). Our report provides findings and recommendations arising from our review, undertaken pursuant to a request by the Rt Hon Nadine Dorries MP in her capacity as Minister of State for Patient Safety, Suicide Prevention and Mental Health in terms of section 48 of the 2008 Act and commissioned by DHSC in October 2020. The review was conducted between November 2020 and January 2021 and looked at how DNACPR decisions were being made in the context of advance care planning across all types of health and care sectors, including care homes, primary care settings and hospitals. As requested, we have set out below a timeline of our key interactions with DHSC and others, together with an explanation of the approach taken and findings reached.

607. We welcomed the request from the Minister for this review as DNACPR had been an area of concern for us for some time. Shortly before the Covid-19 pandemic there

had been widespread concerns that, as part of advance care planning, DNACPR decisions were being made without involving people, their families and/or carers and that blanket decisions were being applied to groups of people.

608. In November 2019 DHSC contacted CQC seeking contribution to the Minister of State for Care's response to the 2018 Learning Disabilities Mortality Review (LeDeR) annual Report, published in May 2019, specifically regarding the recommendation that CQC conduct a review of "Do Not Attempt CPR Orders and Treatment Escalation Personal Plans" relating to people with learning disabilities (MC1/357 [INQ000466450]). On 23 January 2020 CQC provided the requested update to DHSC indicating that:

"CQC acknowledges the importance of the findings of the 2018 LeDeR annual report published in May 2019 – and welcomed the recommendation made for CQC around reviewing provider's DNACPR orders and Treatment Escalation Personal Plans (TEPP) for people with learning disabilities during inspection. CQC's current inspection approach prompts inspectors to review records relevant to a person's care and treatment, including DNACPR and TEPP's where applicable. Where shortfalls in the quality and safety of care are identified, CQC will take appropriate regulatory action to encourage and ensure action is taken by providers to meet the requirements of legislation and improve care. CQC is reviewing its current relevant inspector guidance with a view to updating and expanding the guidance available, and promoting its particular importance for people with a learning disability. CQC Action: By October 2020" (MC1/358 [INQ000466451]).

609. This work was put on hold until the work on the Section 48 review was completed in case there was learning from the review that needed to be incorporated into any revised guidance.

610. In March 2020 we became aware of concerns (raised via the National Care Forum) around DNACPRs and advance care planning. On 27 March 2020 Richard Kelly (Deputy Director for Adult Social Care: Covid-19 Policy at DHSC) notified CQC of a "really worrying local case" where GPs were "*telling local care homes to put all residents on DNARs*". The issue had been reported to DHSC by the National Care Forum on 26 March 2020. DHSC approached CQC for assistance with getting the

correct messaging out to the relevant providers and GP practices (MC1/359 [INQ000466452]).

611. On 27 March 2020 NHSEI also alerted CQC, RCGP and GPC to the issue and indicated that an agreed position needed to be reached and communicated urgently (MC1/360 [INQ000466453]; MC1/361 [INQ000466454]).

612. It was important that appropriate messaging was sent to GP practices and care providers urgently and so, on 30 March 2020, we issued a joint statement, together with the BMA, CPA (representing its members) and the RCGP, to adult social care providers and GP practices stating the importance of advance care planning based on the needs of the individual (MC1/362 [INQ000235489]). It sought to remind all providers that it was unacceptable for advance care plans, with or without DNACPR, to be applied to groups of people of any description. The joint statement was also endorsed by NHSEI who were unable to authorise the use of their logo by the publication date but indicated that they were happy for CQC "*to publish with the logos you get, we will then share/cascade if that's ok*" (MC1/363 [INQ000398629]).

613. Additionally, from March 2020 to September 2020, we had seen an increase in GFC submissions 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. As detailed in pages 8-10 of our interim report (referred to below) we were also aware of other organisations' concerns around the use of DNACPR orders during the early stages of the pandemic, summarised as follows:

    613.1. During early lockdown, Healthwatch received some reports of providers seeking to apply DNACPR forms to patients without sufficient discussion or explanation with the individuals and their families.

    613.2. A survey by Learning Disability England in late April 2020 found that, while two-thirds of the organisations replying did not report an increase in DNACPRs for the people they supported, some organisations said that DNACPR decisions had been made either for groups of people or for

individuals without consultation with them, their loved ones or the people who support them.

613.3. A survey of care home nurses and managers by The Queen's Nursing Institute in May and June 2020, found that 16 out of 163 respondents reported negative changes to DNACPR arrangements. Changes included 'blanket DNACPR' decisions being made or decisions about resuscitation status being taken by others (GPs, hospital staff or clinical commissioning groups) without discussion with residents, families or care home staff.

613.4. In data published in July 2020, almost 10% of people using services or families who responded to their call for evidence told the British Institute of Human Rights that they had experienced pressure or use of DNACPR orders. 34% of people working in health and/or social care said they were under pressure to put DNACPRs in place without involving the person. In addition, 71% of advocacy organisations and campaigners said they experienced DNACPR orders put in place or pressure to make them without the person being involved in the decision.

613.5. In September 2020, the parliamentary Joint Committee on Human Rights reported that they had "*received deeply troubling evidence from numerous sources that during the COVID19 pandemic DNACPR notices have been applied in a blanket fashion to some categories of person by some care providers, without any involvement of the individuals or their families…. (it is) discriminatory and contrary to both the ECHR and the Equality Act 2010 to apply DNACPR notices in a blanket manner to groups on the basis of a particular type of impairment, such as a learning disability; or on the grounds of age alone. …*"

613.6. In data published in October 2020, Compassion in Dying, a national charity that supports people to prepare for the end of life, said that it received many calls and enquiries about CPR and DNACPR. It called for new national guidance for the public on DNACPR and in a survey it commissioned found that more than half of people do not understand DNACPR orders.

613.7. In their interviews with relatives, care home managers, advocacy organisations and legal representatives, Amnesty found examples of the inappropriate or unlawful use of DNACPR forms – including blanket DNACPR, their inappropriate individual use and recommendations for use

– by GPs CCGs, hospitals and care homes. They also found that staff incorrectly interpreting DNACPR prevented people getting access to hospital care and treatment. Amnesty also highlighted that health and social care staff reported pressure during the pandemic to put DNACPRs in place without consultation.

614. We saw this review as an opportunity to accelerate best practice around treatment escalation plans, advance care planning and personalised care planning. In carrying out this review we had two primary aims: to investigate the scale of this issue to understand why it was happening; and to use our evidence to make actionable recommendations that would begin to deliver real change. To carry out this review effectively and meaningfully, we knew we would need a multi-faceted approach that could bring in the views of stakeholders as well as capturing the voices of those who were receiving care, or their families and loved ones.

615. On 29 September 2020, Rosie Benneyworth (Chief Inspector of Primary Medical Services) and Ian Trenholm met with William Vineall regarding a proposed review to be conducted under section 48 of the 2008 Act. During the meeting we were informed that an announcement would be made in the House of Lords the following day (MC1/364 [INQ000398622].

616. On 1 October 2020, a question was raised by Baroness Browning in the House of Lords asking the Government what assessment they had made of the use of Do Not Resuscitate notices in hospitals and nursing homes since March 2020. Lord Bethell (Parliamentary Under-Secretary of State, DHSC) stated that the Minister for Patient Safety and Mental Health would be writing to CQC requesting that we investigate and report on DNACPR issues. (MC1/365 [INQ000339272]).

617. On 6 October 2020, we had an initial meeting with DHSC colleagues to discuss the proposed review in more depth. The meeting was attended by representatives from DHSC's Health Ethics team and their CQC Sponsorship team. DHSC advised that the reason for the review had arisen due to multiple reports of blanket DNACPR decisions being issued. It had coincided with Parliament returning and heightened interest in both the House of Commons and House of Lords on this issue. DHSC

also advised that it had received a pre-action protocol letter looking to instigate a judicial review. We indicated that we could expand the scope of the review requested to also look for examples where DNACPRs were being used in a good way. DHSC asked us to provide some options and timescales, and to share our work undertaken up to that point on the issue together with an engagement plan so that terms of reference could then be agreed. (MC1/366 [INQ000398624]).

618. 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 special review, under section 48 of the 2008 Act, of DNACPR decisions taken during the pandemic in the context of advance care planning. The letter referenced concerns around the blanket application of DNACPR decisions and that DHSC was committed to ensuring that DNACPR policy and best practice guidance was understood and followed. We were asked to look at 'all key sectors', including care homes, primary care and hospitals, exploring implementation of best practice DNACPR guidance. The special review was to start with immediate effect. (MC1/367 [INQ000235490])

619. We met again with DHSC on 9 October 2020 where we introduced the options and remit for the thematic review and discussed approaching it through both a person-centred approach and online information gathering; and assured them that we would be mindful of local Covid-19 escalation levels when planning face to face activity. We discussed the cost of undertaking the review and timescales for the delivery of the interim and final reports. It was agreed that CQC would formally respond to the Minister's letter of 7 October 2020 (including our proposed approach and budget requirement), and DHSC would share with us a list of MPs and Peers who had expressed an interest in the topic and a list of Parliamentary Questions raised on the topic since September 2020. (MC1/368 [INQ000398627])

620. On 23 October 2020 Ian Trenholm wrote to Ms Dorries responding to her letter of 7 October 2020 setting out our intended scope and approach and timelines for the review as well as the estimated delivery costs (MC1/369 [INQ000466455] and MC1/370 [INQ000466456]).

621. On 29 October 2020 Ian Trenholm wrote to Ms Dorries again to provide an update on the estimated cost of the review (MC1/371 [INQ000466457] and MC1/372 [INQ000466458]).

622. On 2 November 2020 Ian Trenholm received Ms Dorries' response to his letters of 23 and 29 October 2020 wherein she confirmed that DHSC was content with the timing, approach and costs relating to the review (MC1/373 [INQ000466459]).

623. As a result of our interactions with DHSC in October 2020, we immediately began conversations with key partners, including Disability Rights UK, Compassion in Dying, Mencap, the BMA, RCGP and the CPA, among others. Although the review was our responsibility, we wanted to give our stakeholders the opportunity to help us shape it, taking into consideration the questions they wanted to ask. We undertook a series of scoping meetings with several key partners. Stakeholders welcomed the review and demonstrated strong support for our work.

624. All aspects of our review were guided by our assessment framework, which was developed in consultation with these stakeholders. We focused on assessment of the following areas:

624.1. Putting people at the centre: How were providers and systems putting people at the centre of their care in approaches to DNACPR decisions to protect human rights, protect people from discrimination and meet people's individual needs? What were people's experiences from the start of the pandemic?

624.2. Shared vision, values, governance and leadership: How did providers and the system work in partnership to influence and agree a shared approach for the use of DNACPR decisions to protect human rights, give equal access to care and treatment and prevent avoidable deaths? What were the enablers and barriers for the appropriate use of DNACPR?

624.3. Workforce capacity and capability: How were providers and the system working together to ensure that clinicians, professionals and workers involved in the use of DNACPR had the right knowledge, skills and tools to deliver personalised approaches to DNACPR in line with the relevant

legislation, and how were staff and people supported to raise concerns in order to improve care?

625. The methodology used included:

625.1. Review of literature, guidance and evidence: We wanted to understand what was already known about the use of DNACPR before the pandemic and what impact the use of DNACPR had on people's experiences during the pandemic. This included understanding best practice in approaches to thinking about future care and treatment if a person was to become seriously ill or approaching the end of their life.

625.2. Engagement with external stakeholders and experts: To ensure that the views of interested parties, and in particular the views of people affected by the use of DNACPR during the pandemic, influenced and shaped the scope of the review from the outset, we held initial conversations with nearly 50 stakeholders who had a specific interest in the scope of the review. These included organisations that represented or advocated on behalf of the public, family carers, care providers, and care professionals. Many of these organisations and individuals continued to provide their expertise and insight through our Expert Advisory Group which influenced the scope, approach and the recommendations in our final report.

625.3. Bespoke information collections: To help us understand the scale of the issue, we sent a voluntary information request to around 25,000 adult social care providers (including care homes, nursing homes, domiciliary care agencies, supported living schemes, Shared Lives facilities and extra care housing). While acknowledging that responsibility for making DNACPR decisions did not predominantly rest with adult social care providers, we asked them a range of questions to understand their views of the experiences of people in these settings. We asked about the number of inappropriate DNACPR decisions put in place from 17 March 2020, what made them inappropriate and if they remained on people's records at the point of submission of the information request. With the support of voluntary sector partners, we ran surveys to ask people who used the services and their families and carers about their experiences of DNACPR decisions during the pandemic. We made sure that some communities who needed

support in sharing their experiences through this survey were enabled to do so.

625.4. Fieldwork activities: We carried out fieldwork to explore how primary, secondary, social care and system partners worked together in an area including the impact of commissioning arrangements. We identified seven CCG areas as case studies for our review. These covered a cross-section of geographical areas and a mix of demographics so that the lessons learned would be of value to people in health and social care across the country. We focused activity at a CCG level, the level at which clinical services are planned and delivered and where population health management was used to target interventions to particular groups, in partnership with NHS organisations and local government.

626. Wherever it was possible and appropriate to do so, our fieldwork was completed virtually which also involved:

626.1. Retrospectively tracking people's journeys through care: To gain an understanding of people's experiences of care and how decisions about their care and treatment were made and communicated, we carried out an in-depth review of seven people's experiences. This involved reviewing the relevant care records and, wherever possible, speaking to the person experiencing care and their families and a range of relevant health and care professionals.

626.2. Sampling DNACPR records: We reviewed the DNACPR records of 166 people affected during the pandemic allowing us to consider a larger number of people's cases. We accessed care records through a range of care settings (acute, mental health hospitals, care homes and GP services).

626.3. Information from local advocacy groups: We spoke with local advocacy organisations that had engaged with the public and providers over the use of DNACPR decisions to share our emerging findings, ask for their feedback on these, and their thoughts on recommendations.

626.4. Interviews and focus groups with frontline staff: We held 156 interviews and focus groups with clinicians, professionals and workers from different roles and organisations involved in providing care, which included the use of

DNACPR decisions, to understand practice, challenges and enablers for best practice.

626.5. Interviews with commissioners and members of the wider system: We spoke with commissioners and system leaders to explore practice across the system, collaboration and how oversight arrangements ensure best practice in DNACPR decisions.

627. Throughout November 2020 we regularly met and corresponded with DHSC colleagues to discuss and provide updates regarding the review. The timetable for the sharing of the interim and final reports with DHSC and the publication of the final report was agreed with DHSC on 19 November 2020 (MC1/374 [INQ000466460]). The draft interim report was shared with DHSC colleagues, including the CQC Sponsorship Team, on 20 November 2020 (MC1375 [INQ000466461] and MC1/376 [INQ000466462]). DHSC provided their comments on the draft interim report to CQC on 24 November 2020 (MC1/377 [INQ000466463] and MC1/378 [INQ000466464]).

628. We sent the interim report to Nadine Dorries and our DHSC colleagues along with a cover letter on 30 November 2020 (MC1/379 [INQ000466465]; MC1/380 [INQ000466466]; MC1/381 [INQ000466467]).

629. The final copy of the interim report was sent to DHSC on 2 December 2020 (MC1/382 [INQ000466468]) and it was published on our website on 3 December 2020 (MC1/383 [INQ000235491]). On 4 December 2020 Minister Dorries' Private Secretary confirmed that she had reviewed and noted the interim report (MC1/384 [INQ000466469]).

630. We published our final report on 18 March 2021 (MC1/356 [INQ000235492]). When concluding our review we found that there needed to be a focus on three key areas:

630.1. Information, training and support

630.1.1. We found that the quality of people's experiences was greatly impacted by having the time and information they needed to talk about what care and support they wanted. People's experiences of DNACPR decisions varied.

630.1.2. We made it clear in our conclusions that best practice requires that every DNACPR decision must take account of each person's individual circumstances or wishes. While most providers we spoke with were unaware of DNACPR decisions being applied to groups of people, we heard evidence from people, their families and carers that there had been 'blanket' DNACPR decisions in place.

630.1.3. We found also that the training and support that staff received to hold these conversations was a key factor in whether they were held in a person-centred way that met people's needs and protected their human rights. Where people using services and health and care staff were not fully informed about advance care planning or given the opportunity to discuss DNACPR decisions in a person-centred way, there was a clear risk of inappropriate decision making and a risk of unsafe care or treatment. This also gave rise to concerns that people's human rights and rights under the Equality Act 2010 had not been considered or were at risk of being breached.

630.2. A consistent national approach to advance care planning

630.2.1. Our findings highlighted the need for a consistent national approach to advance care planning and DNACPR decisions, and a consistent use of accessible language, communication and guidance to enable shared understanding and information sharing among commissioners, providers and the public.

630.2.2. Across all the areas that we looked at, there were many types of advance care planning in use.

630.2.3. This lack of consistency and the problems this causes could affect the quality of care received by the person and result in missed opportunities to support them in the right way at the right time.

630.2.4. We found that the way in which health and care professionals talked about advance care planning and DNACPR decisions also varied.

630.2.5. Every area we looked at had taken steps to make sure that providers were aware of the importance of taking a person-centred approach to DNACPR decisions and advance care planning. However, we found that providers had to cope with a huge amount of guidance about all aspects of the pandemic that lacked clarity and changed rapidly, leading to confusion.

630.3. Improved oversight and assurance

630.3.1. We determined that there was an urgent need for regional health and care systems, including providers, clinical commissioning groups and patient representative bodies, to improve how they assure themselves that people are experiencing personalised, compassionate care in relation to DNACPR decisions.

630.3.2. Most providers and health and care professionals told us that the individuals, their families, carers or advocates were involved in conversations about their care, including DNACPR decisions. However, poor record keeping and lack of audits meant that we could not always be assured that the individuals were being involved in conversations about DNACPR decisions, or that these were being made on individual assessments. Once DNACPR decisions were in place, it varied whether providers and local systems reviewed them. We were also concerned about whether local areas had oversight of training and support for health and care professionals to ensure they were making sound clinical decisions that were person-centred and protected people's human rights.

631. We knew it was important to keep up momentum and use our findings to make recommendations that could encourage real systemic change. Focusing on the above mentioned three key areas we recommended that:

631.1. Recommendation one: a new Ministerial Oversight Group (MOG) be set up to take an in depth look at the issues raised in our report. The group, which should include partners in health, social care, local government and voluntary and community services, should be responsible for overseeing the delivery and required changes suggested by the recommendations of

this report. DHSC was identified as the lead department responsible for this.

631.2. Recommendation two: providers ensure that people and/or their representatives are included in compassionate, caring conversations about DNACPR decisions as part of advance planning. This includes making reasonable adjustments for disabled people to remove any information or communication barriers and ensuring that clinicians, professionals and workers have the necessary time to engage with people properly.

631.3. Recommendation three: health and social care systems consider diversity, inequality and mental capacity factors when planning care for the local population in partnership with local communities, including voluntary and community services. Integrated care systems were identified as the lead bodies responsible bodies for this.

631.4. Recommendation four: there are clear and consistent training, standards, guidance and tools for the current and future workforce. This needs to be in line with a national, unified approach to DNACPR decision making. Providers also need to ensure that there are training and development opportunities available for all health and care professionals. Health Education England, Skills for Care and Providers were assigned as the lead organisations for this.

631.5. Recommendation five: there is a consistent national approach to advance care planning and positive promotion of advance care planning and DNACPR decisions, as well as a more general focus on living and dying well. In addition, we recommended that there should be more widely publicised and accessible information available via a national campaign in partnership with the voluntary sector and advocacy services. DHSC and NHSEI were identified as the lead bodies responsible for this.

631.6. Recommendation six: system partners across health and social care work together with voluntary sector organisations, advocacy services and individuals to establish and assure a national unified approach to policy, guidance and tools that support the positive implementation of DNACPR decisions. DHSC was identified as the lead department for this.

631.7. Recommendation seven: the system ensures that there is digital compatibility between providers enabling them to share real-time updates

and information between professionals, services and sectors. NHSX (from 2019 to Feb 2022, NHSX 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 integrated care systems were assigned as the lead organisations/bodies for this.

631.8. Recommendation eight: there are comprehensive records of the decisions and conversations regarding individuals' care that support them to move around the system well. This requires providers to ensure proper standards of documentation and record keeping and sharing of information around the system.

631.9. Recommendation nine: integrated care systems need to be able to monitor and assure themselves of the quality and safety of DNACPR decisions. To do this, there needs to be a consistent dataset and insight metrics across local areas.

631.10. Recommendation ten: providers ensure that all workers understand how to speak up, feel confident to speak up and are supported and listened to when they speak up. To do this, providers must follow national guidance to foster positive learning cultures and ensure consistency and clarity of speaking up arrangements across the patient pathway. The National Guardian's Office was assigned as the lead organisation for this.

631.11. Recommendation eleven: CQC must continue to seek assurance that people are at the centre of personalised, high-quality and safe experiences when it comes to DNACPR decisions, in a way that protects their human rights. To do this, we will ensure a continued focus on DNACPR decisions through our monitoring, assessment and inspection of all health and adult social care providers. CQC is the lead responsible organisation for this recommendation.

Overview of feedback received in relation to the recommendations of the report

632. The communication channels established with partners across the health, social care, community and voluntary sectors early in the review gave us the opportunity to gather feedback on the findings and recommendations in the final report. Prior to publication we met with representatives from organisations within the sectors to

share the details of the recommendations and as appropriate seek comment thereon.

633. A series of virtual meetings were held in February and March 2021 and provided a platform for us to share our findings and recommendations and to gather feedback from organisations, including but not limited to: Resuscitation Council; Compassion in Dying; RCGP; National Care Forum; ADASS; Local Government Association; Mencap and Care England.

634. The feedback gathered during these sessions was largely positive and supportive. The partners we spoke to were keen to ensure that the messaging emphasised the importance of advanced care planning in its entirety, involved people in discussions about their care and that it should be a whole system approach. The decision to designate lead responsible bodies was welcomed as was the proposal to set up the MOG. Partners expressed some caution around the potential for headlines around this to be misconstrued. At publication we made it clear that although we found a worrying picture of poor involvement, record keeping, and a lack of oversight and scrutiny of those decisions, more work was needed to support health and care clinicians, professionals and workers in holding conversations about DNACPR decisions as part of a holistic approach to advance care planning. Additionally, the feedback received encouraged us to emphasise that when done in the right way these conversations can be a positive experience for all involved. It also highlighted the need to capitalise on the momentum gained to ensure that conversations about advance care planning and DNACPR decisions are high on everyone's agenda.

635. Details of the draft recommendations were also shared with the lead organisations/bodies in February and March 2021 including NHSE (MC1/385 [INQ000398630] and MC1/386 [INQ000398631] and MC1/387 [INQ000398632]), Skills for Care (MC1/388 [INQ000398633]), Health Education England (MC1/389 [INQ000398634]), NGO (MC1/390 [INQ000398636]) and DHSC (MC1/391 [INQ000398637] and (MC1/392 [INQ000398649]). Comments and feedback around these were received either in writing or during discussions with the organisations concerned. Again, these discussions and the feedback enabled us to ensure that the appropriate organisations were identified as the lead bodies responsible for the

recommendations and that the wording used clearly conveyed the appropriate messaging prior to publication.

636. Specifically, our discussions with NHSE and DHSC helped us to ensure that the lead bodies responsible for recommendations 6, 7 and 8 (as summarised above) were appropriately designated in the final report. The recommendations as set out in the report published on 18 March 2021 were accepted by all lead bodies.

637. We also met with Nadine Dorries MP and Lord Bethell on 16 March 2021 to discuss the report's findings and recommendations. During this meeting we were able to explain the importance of this piece of work and how it had led to broader conversations encouraging good practice in end-of-life care planning and ensuring that these conversations happen. We were able to provide reassurance around concerns about blanket usage, which in part led to the review, and emphasise the need for training and awareness across all sectors including the public. We discussed the role of the then proposed MOG and our willingness to be part of that.

638. Following publication of the report we continued to engage with interested parties concerning the report. Some examples include a presentation at a Parliamentary engagement event on 24 March 2021 and a webinar aimed at bringing together CCGs on 22 April 2021.

639. Following publication of the final report we also wrote to each of the NHS CCG's involved in the review in May 2022 to thank them for their support and co-operation and to provide some additional detail from the fieldwork completed in their local area. An example of one of the letters sent is attached. (MC1/393 [INQ000398639]).

640. One key recommendation from the final report was the formation of the MOG, to oversee the delivery of the recommendations. The MOG, led by DHSC together with health and social care partners, local government, voluntary and community services and CQC, was set up in May 2021 and began to meet quarterly from June 2021. The main aim of the MOG was to ensure that conversations about end-of-life care sat firmly on the agenda across the health and care systems. Our former Chief

Inspector of Primary Medical Services, Rosie Benneyworth, sat on the MOG, by invitation of Nadine Dorries MP (MC1/394 [INQ000398640]).

641. The MOG's terms of reference confirmed that it would oversee the delivery of our recommendations on DNACPR decisions (MC1/395 [INQ000339339]). The terms of reference confirmed that the group would bring together key bodies responsible for delivering the recommendations and would also report on the progress of ongoing workstreams and make decisions where necessary. The MOG was set up initially for one year with a plan that its role and membership would be reviewed by the Minister responsible for the work thereafter.

642. The MOG held its first meeting on 8 June 2021 and met quarterly throughout the remainder of the relevant period: on 20 October 2021, 9 February 2022 and 17 May 2022. Updates were provided by the lead bodies during each of these meetings.

643. The summary notes were published on the MOG gov.uk page and briefly captured the status of some of the recommendations as reported by some of the lead bodies up to that point in time. Copies of the summary notes were also distributed after the meetings (MC1/396 [INQ000398642]; MC1/397 [INQ000398643]; MC1/398 [INQ000398644] and MC1/399 [INQ000398645]).

644. In advance of the meeting of 17 May 2022, a summary of progress document was circulated to MOG members together with a more detailed updated report combining each of the lead bodies updates. These documents were shared with MOG members only. These documents represent the latest updates that we are aware of. (MC1/400 [INQ000398647, MC1/401 [INQ000398648], MC1/402 [INQ000398638] and MC1/403 [INQ000339340]).

645. We were the lead body responsible for Recommendation 11 (as summarised above). Details of the update we provided to that meeting are set out in our internal briefing note attached (MC1/404 [INQ000398651]). In summary, we explained how we had ensured continued focus on DNACPR through our strategic priorities of People and Communities, Safety Through Learning and Accelerating Improvement. We set out the actions taken internally to ensure end-of-life care was included in our new single

assessment framework and the work undertaken with providers. We also set out details of concerns being raised with us at that time and our continued focus in this area.

646. A working group sat below the MOG, this was set up to undertake the work required to implement the recommendations. The working group met quarterly between August 2021 and April 2022. We were represented on this group by one of our Inspection Managers. Copies of the readouts from meetings 2 and 3 of the working group meetings are attached as (MC1/405 [INQ000398652] and MC1/406 [INQ000466429]).

647. The last meetings of the working group and the MOG that we were invited to and attended were held in April and May 2022 respectively. The last update received in January 2023 from DHSC indicated that a ministerial steer was awaited on whether to extend the MOG beyond the initial 12 month period set out in the terms of reference. DHSC agreed to keep us informed but no communication has since been received.

648. Although we have not been asked for any updates since the last MOG meeting, we continue to monitor our own compliance with the matters related to Recommendation 11 and the closely aligned recommendations from the Joint Committee on Human Right's Report of 13 July 2022 'Protecting human rights in care settings'. Internal quarterly updates are provided by our relevant Directorate lead to our Board and Senior Leadership team. The internal update provided in September 2023 indicated that a number of actions linked to these recommendations have been implemented. Specifically, the update noted the following items of delivery:
    - 648.1. Internal Cross-Directorate End of Life Working set up and has provided internal learning on expectations of DNACPR;
    - 648.2. Guidance for inspectors to identify risks and protect people was issued in September 2021;
    - 648.3. DNACPR searches are now part of routine PMS inspection clinical searches;
    - 648.4. DNACPR evidence gathering is part of SAF assessments across all relevant sectors;

648.5. CQC's joint statement with BMA, Care Providers Alliance and RCGP around individualised care planning was published in April 2021; and CQC's GP Mythbuster regarding DNACPR was also published in Aug 2021. These Mythbusters are documents published on our website which aim to clear up some common myths about our inspections of GP services, independent doctors and clinics and out-of-hours services and share agreed guidance to best practice.

649. Since the publication of the report, and as noted above, CQC has strengthened its expectations of providers in this context by having a focus on end-of-life care planning and the clear need for a person-centred approach. This has specifically been provided for via the Planning for the Future Quality Statement under the "Responsive" KLOE under the SAF (MC1/407 [INQ000525101]). Under the SAF, the quality statements that accompany the 5 key questions are the commitments that providers, commissioners and system leaders should live up to. Expressed as "we statement", they show what is needed to deliver high-quality, person-centred care. The Planning for the Future Quality Statement states "*We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life*" and its aim is to help ensure that:

649.1. People are supported to make informed choices about their care and plan their future care while they have capacity to do so.

649.2. People who may be approaching the end of their life are identified (including those with protected characteristics under the Equality Act and people whose circumstances may make them vulnerable). This information is shared with other services and staff.

649.3. People's decisions and what matters to them are delivered through personalised care plans that are shared with others who may need to be informed.

649.4. When people want to express their wishes about cardiopulmonary resuscitation, they are supported to do so and are able to change their mind if they wish.

649.5. When any treatment is changed or withdrawn, professionals communicate and manage this openly and sensitively so that people have a comfortable and dignified death.

649.6. When people's future care preferences are for greater independence and fewer care interventions that are likely to benefit them, professionals work together to support them to achieve their goals.

650. On 14 March 2024 the Parliamentary and Health Service Ombudsman (PHSO) published a report "End of life care: improving 'do not attempt CPR' conversations for everyone" calling for urgent improvements to the process and communication surrounding DNACPR (MC1/408 [INQ000525102]). In the report PHSO made an overarching recommendation calling for "all outstanding recommendations in our Protect, respect, connect – decisions about living and dying well during Covid-19 to be implemented (recommendation 5) and identified two recommendations for CQC, under recommendation 3 (Regulation), as follows:

650.1. The CQC should update cross-sector guidance underpinning regulations to include planning for health inequalities in end-of-life care; and

650.2. The CQC should make sure that assessment of providers' compliance with standards of good practice around DNACPR is strengthened in its regulation of all services, with a particular focus on improvement in secondary care services.

651. On 10 April and 10 May 2024 we submitted our responses to the report via DHSC, indicating that we supported the recommendations and that we would be reviewing the findings with our regulatory approach (MC1/409 [INQ000525103]). We also noted as follows:

651.1. We are planning to include health inequalities across all cross-sector guidance and have quality statements that focus on this. DNACPR assessment is part of our quality statements for Planning for the Future under our caring key question and Equity of Experience and Outcomes under our responsive key question. We will assess DNACPR when we use these quality statements in our SAF. We may also look at DNACPR in specific services, for example, when we assess end of life care in a hospital and we look at DNACPR practice in the clinical searches in our assessment of GPs. We have also published our Human Rights Approach to regulation (MC1/410 [INQ000525104]) in December 2023, which makes specific

reference to consultation around DNACPR decisions (MC1/411 [INQ000525105]).

651.2. We have already strengthened our approach to regulation of DNACPR based on the recommendations in our 'Protect, respect connect – decisions about living and dying well during COVID-19'. We will be developing this further for our assessment of integrated care systems. We would look at DNACPR in our assessments of ICSs if risks were identified, if we were reviewing a pathway of care, or if this were identified as a priority from the Secretary of State.

651.3. We support the call for the recommendations for this report to be implemented and would value DHSC support in doing so.

652. It remains CQC's view that DNACPR decisions need to be recognised as part of wider conversations about advance care planning and end of life care, and these decisions need to be made in a way that protects people's human rights. This will go a long way in terms of readiness for a future pandemic.

K. Discharge of patients from hospital to care homes

CQC's Involvement in Government decision to discharge patients from hospital

653. Below is a summary of CQC's involvement in the high-level decision-making to discharge patients from hospital.

654. In March 2020 we became aware of the evolving situation and growing national concern that hospitals would soon reach capacity. We knew that if patients were to be discharged back into care settings the process would need to be managed in a robust and considered manner, with checks in place to ensure that vulnerable people were kept safe and that providers were able to cope.

655. On 16 March 2020 DHSC wrote to CQC and NHSEI indicating that the Trusted Assessor Guidance needed to be updated to align with NHSEI's new policy on hospital discharge that was due to be published later that week, specifically "*to amend the Trusted Assessor regime to enable very rapid hospital discharge to care homes, with acute staff acting as trusted assessors.*" (MC1/412 [INQ000398655]).

656. 'Trusted Assessor' schemes are a national initiative driven by the NHS designed to reduce delays when people are ready for discharge from hospital and to promote safe and timely discharges from NHS Trusts to adult social care services. The schemes are based on providers adopting assessments carried out by suitably qualified Trusted Assessors working under a formal, written agreement. Trusted Assessors must have the qualifications, skills, knowledge and experience needed to carry out health and social care assessments, and to formulate plans of care on behalf of adult social care providers. Providers must be confident that Trusted Assessors understand the needs their service can meet, and that the discharges to their service they arrange will be appropriate. Trusted Assessor accountability and employment arrangements vary. They can work for local provider organisations, hospital trusts, or under collaborative arrangements. Specific employment and accountability arrangements must be set out in Trusted Assessor agreements.

657. Before the pandemic, the Trusted Assessor Guidance which we produced together with NHS England, set out how Trusted Assessor agreements should be set up to meet people's needs and legal requirements and included guidance on what should happen when adult social care services have concerns that inappropriate discharges are being made. This guidance was published on our website and is annexed as (MC1/413 [INQ 000398659]).

658. On 16 March 2020 NHSEI advised CQC that insofar as the then current Trusted Assessor Guidance provided that "*the assessor must be someone who understands the needs of the individual they are assessing and the capability/capacity of the care home to receive and support their needs*", it would still apply. However, they advised that "*we will need more Trusted Assessors and quickly... to ensure we can respond to the planned changes in a way that supports the aims of the changes*" and asked for our assistance in amending the wording of the guidance to provide for this (MC1/414 [INQ000398660]). We were asked by DHSC to specifically provide "*a simple statement...making the following points*" (MC1/415 [INQ000398662]):

"1. Complete support for the principles in the new hospital discharge guidance and the Discharge to Assess model (D2A)

2. Advise all hospitals to develop trusted assessor regimes for every care home in their area, based on the D2A model

3. Aim is to support hospitals and care homes in the safe transfer of existing care home residents and new residents who need nursing/residential support but not acute hospital care, whilst D2A is current

4. Emphasising need for community based support, such as the EHCH framework, to support care homes

5. Status of existing trusted assessor guidelines during this period: suspended/ supplanted by this"

659. On 16 March 2020 Kate Terroni was copied into an email thread involving Ros Roughton, DHSC Director for Adult Social Care; Deputy Chief Medical Officer Jenny Harries; Matthew Winn, Chief Executive of the Cambridgeshire Community Services NHS Trust and Senior responsible officer across Bedfordshire and Luton for community health and integrated discharge; and others regarding discharge into care homes (MC1/416 [INQ000398661). Kate provided the following advice in relation to the approach regarding "*allowing patients to be discharged into care homes who are symptomatic of Covid-19*":

"the approach would depend on the position of the home and how its staffing is affected by covid-19. You might consider keeping 'clean' and 'infected' locations separate to ensure people aren't unnecessarily being placed in services where there is currently no other known people with the virus. It would be good if attention can still be paid to the ratings of services and that inadequate services are avoided where possible.

Important questions to ask/discussion to have in pre-discharge conversations between providers/commissioners to help assess suitability of provider/location:

- *Additional financial impact on providers*
- *How robust are the systems to prevent, detect and control the spread of infections? Consider availability of suitable PPE etc.*
- *Are there enough medicines for people at the service?*
- *Are there plans in place to ensure consistent access to and supply of medicines going forward?*
- *Has the provider taken steps to ensure the environment is as conducive as possible to containing an outbreak?*

• *Are there enough suitably skilled staff available to meet people's care or treatment needs whilst maintaining their dignity and respect?*

• *How robust are staffing contingency planning arrangements in relation to an outbreak of COVID-19?*

• *Are steps in place to manage existing risks to people?*

• *Are there systems and process in place to assess and manage new and emerging risks?*

These questions are in line with CQC's revised assessment framework."

660. On 16 March 2020 ADASS and Care England were also brought into the conversation for their views on the draft Hospital Discharge Service Requirements Guidance (MC1/415 [INQ000398662] and MC1/417 [INQ000398663]). ADASS raised two concerns regarding the draft guidance, indicating that it "*only look[ed] at discharge and unless you look at capacity of the whole system – including primary, community health care, social care and the inevitable additional needs if unpaid family carers cannot function then there is serious potential to make things worse not better*"; and that it "*is ostensibly a 'systems' message – though actually it reads as a directive from NHSE to social care. Social care is part of the system[.] It hasn't been co-produced... communication in this form is likely to cause chaos which is the absolute last thing we need right now for local systems.*" (MC1/417 [INQ000398663]). The draft Hospital Discharge Service Requirements Guidance was shared with CQC by NHSEI on 17 March 2020 (MC1/419 [INQ000398665]; MC1/418 [INQ000398664]).

661. On 17 March 2020 we provided comments and suggested amendments to the draft Trusted Assessor Guidance (MC1/420 [INQ000398668] and MC1/421 [INQ000560885]). On the same day, ADASS, Care England and the National Care Forum were brought into the conversation regarding the amendments to the Trusted Assessor Guidance (MC1/422 [INQ000398670]) and provided their comments regarding the draft MC1/423 [INQ000398672]).

662. On 18 March 2020 we provided the marked-up version of the amended Trusted Assessor Guidance to ADASS and clarified our role and position in relation to the

amendments made to the guidance (MC1/424 [INQ000398673] and MC1/424a [INQ000543915].

663. On 18 March 2020 we received NHSEI's letter, sent the previous day to all NHS trusts and foundation trusts, CCGs, GP practices, Primary Care Networks and providers of community health services, informing them of the NHS's next steps on its response to the pandemic (MC1/425 [INQ000398677]; MC1/426 [INQ 000087317]). The letter set out the measures required of the NHS to redirect staff and resources, including:

663.1. Freeing up *"30,000 (or more) of the English NHS's 100,000 general and acute beds"* by*:*

...

a. "Urgently discharg[ing] all hospital inpatients who are medically fit to leave..."

664. On 18 March 2020 Kate Terroni met with NHSEI to discuss the new Hospital Discharge Service Requirements Guidance and specifically the issue of the quality of care homes (MC1/427 [INQ000398680]; MC1/428 [INQ000235327]). In the briefing note prepared for this meeting, it was noted that NHSEI were seeking confirmation "*that hospitals shouldn't be discharging patients to care homes which [were] 'inadequate' and want[ed] to know if there [was] something they should include in their guidance*". CQC's position was that "*The person's needs and safety must be at the heart of all decision making. Providers should only enter into Trusted Assessor agreements if they are confident that referrals will be appropriate and based on sound knowledge of their service and the needs it can meet. It is highly unlikely that services rated inadequate will be appropriate and these should be avoided wherever possible*."

665. It was CQC's view that service providers rated as 'inadequate' should be avoided as they would present a greater risk to people in need of being admitted into care homes. It is important to note that CQC would not be involved in a service provider's decision/refusal to admit a patient from hospital. Our role in influencing such decisions may be indirect, for example where we have used our civil enforcement powers to impose, vary, or remove conditions of the providers' registration or where

we have suspended/cancelled registration such that the care home provider is unable to admit a patient who has been discharged from hospital. CQC is not able to comment on whether any patients were discharged to care homes rated as 'inadequate' as this data is not routinely recorded and is therefore not easily determinable.

666. On 19 March 2020 DHSC wrote to CQC indicating that they were intending to publish the Hospital Discharge Service Requirements Guidance which included "*CQC's annex on trusted assessors*" later that day and asked for CQC to supply a logo to attach to the Trusted Assessors Guidance (MC1/429 [INQ000398682]).

667. On 21 March 2020 Sir Robert Francis KC, then Chair of Healthwatch England and a member of CQC's board, wrote to CQC's then Chair, Peter Wyman, raising his concerns regarding the "*ethical dilemma*" associated with the "*admission of untested hospital patients*" into care homes following the publication of the Hospital Discharge Service Requirements Guidance (MC1/430 [INQ000398683]). Mr Wyman forwarded Sir Robert's email to Kate Terroni and Ian Trenholm on 22 March 2020, summarising the thread as follows:

> "*The central point is that there still isn't enough guidance, in my view anyway, for care home managers/owners, who are mainly using their own judgement as to what to do. While this may seem reasonable the fact that different homes are making very different rules for visiting, admissions, re-admissions and so on in circumstances that aren't obviously different suggests more guidance (from DHSC) might be helpful.*"

668. On 23 March 2020 Kate Terroni responded to Peter Wyman indicating that she had discussed the issue with Ros Roughton, DHSC on 22 March 2020 and that there was a "*system conversation*" taking place on 23 March 2020 "*about the impending Discharge to Assess plans and the increasing pressure care homes are likely to come under from hospitals to accept patients with little opportunity to assess themselves and for whom may have a covid-19 diagnosis*." Kate Terroni confirmed that CQC had been involved with revising our Trusted Assessor Guidance but that "*to date, the Discharge to Assess revisions ha[d] been Dept led*." Kate Terroni also indicated that the Trade Associations, ADASS and Local Authorities had all

expressed concerns about how the hospital discharge policy would be implemented. Finally, Kate Terroni confirmed that DHSC agreed that there was a need for specific advice from PHE about Care Homes accepting people either with a positive Covid-19 diagnosis or having had Covid-19 and that CQC would "*write a short guidance to care homes*" on this (MC1/430 [INQ000398683]).

669. Following the publication of the original Government guidance on Hospital Discharge Service Requirements on 19 March 2020 (MC1/431 [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 (MC1/432 [INQ000235324]).

670. 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.

671. 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.

672. 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.

673. 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 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 (MC1/433 [INQ000235325]; MC1/434 [INQ000235326]; MC1/428 [INQ000235327]).

674. We only put our name to the guidance, on 27 March 2020, 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 MC1/435 [INQ000235331]; MC1/436 [INQ000235332]; MC1/437 [INQ000235333]).

675. The final version of the guidance, dated 2 April 2020 (MC1/438 **[INQ000325255]**, stated that people could only be discharged to care homes if certain criteria were in place:

675.1. 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;

675.2. that the care home had the ability to isolate symptomatic patients; and

675.3. that care staff had adequate PPE.

676. 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.

677. On 20 April 2020 DHSC 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 (MC1/439 [INQ000235572]).

678. 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 (MC1/440 [INQ000235382]; MC1/441 [INQ000235383]).

679. The Inquiry has asked CQC whether in our view we should have published our own discharge guidance for care homes during the pandemic. CQC's view is that, as regulator, this would not have been appropriate for us to do as it was the role of DHSC to publish guidance. It is also CQC's view that our engagement with Government, specifically DHSC, through the provision of comments and input as outlined above was appropriate in the circumstances.

680. The Inquiry has also asked CQC to comment on whether the discharge of patients to care home could be better managed in the event of a future pandemic. CQC's view is that consideration of the following factors is important in respect of the management of discharging patients from hospital in the event of a future pandemic: better guidance based on engagement with providers and people who use services, their families or carers; provision for full testing and disclosure of testing outcomes; the availability of alternative facilities (for example Nightingale hospitals) established early; carrying out IPC assessments and identification of care homes with sufficient resources as early as possible; and ensuring support with staffing and access to PPE for care homes as early as possible.

Impact of discharge decisions

681. Some care home managers contacted us to ask whether we would support their decision not to accept a patient with Covid-19 based on the absence of one of these elements. There was anxiety among some care home providers as they were feeling pressured by hospital discharge teams to accept admissions and they felt that, without our support, they were made to feel obliged to accept admissions. There is no specific record available to confirm the number of these enquiries however the ASC Response Panel log demonstrates that there were 85 enquires tagged as relating to "Admission and discharge" made between March 2020 and March 2022. It is important to note that these numbers do not reflect the total number of enquiries received from providers regarding decisions/refusals to admit patients. Below are a few examples of queries received from providers regarding pressure to admit patients, and CQC's advice:

681.1. On 23 March 2020 we received a query from a registered manager of a care home where a service user had tested positive for Covid-19 but was not presenting any symptoms and the hospital had assessed the person as fit for discharge. As CQC cannot instruct a provider to accept an admission, we encouraged the Registered Manager to liaise with their support system, working cooperatively, to provide the best outcome for the service user and their local communities and to make decisions in line with the applicable guidance at the time (https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements)

681.2. On 2 April 2020 a Community Interest Company alerted us to multiple concerns raised by providers regarding being able to refuse admissions where they were not provided with the patient's Covid-19 test results on discharge or enough PPE to isolate the patient if necessary. We encouraged a dialogue between the service provider and the hospital's discharge team, so to understand the service user's needs, alongside that of others who may work or reside within the service. We emphasised that providers should be referred to the government's hospital discharge guidance dated 19 March 2020 and highlighted that the Government were updating their guidance regularly.

681.3. On 25 May 2020 we received a query from a provider indicating that they viewed some of their actions taken relating to admissions (e.g. signing contract amendments to accept positive tested people) to be extremely high risk. The provider was seeking clarity from CQC regarding our role in supporting them to reject these actions at a time of extreme pressure. We explained that it is ultimately the provider's decision as to who they accept or refuse to accept, into their services. In line with the fundamental standards set out in the relevant Regulations, it would be the provider's responsibility to carry out a pre-admission risk assessment for each person that they potentially may admit to their service, before making a decision about whether to admit them or not. We emphasised that, during the pandemic, CQC would encourage all care providers to support the health and social care systems as much as possible but that we would not interfere with or attempt to influence a provider's admission processes or criteria. We confirmed that CQC's responsibility is to oversee that regulated activity is being carried out in a way that meets the fundamental standards of the law. We indicated that in a very small number of cases, where care homes had told us that a patient's positive Covid-19 status was known to the hospital but not disclosed at the point of discharge, we were considering whether the hospital breached regulations.

682. Below are a few additional examples of queries received and the advice we provided demonstrating the physical/mental/safety impact of the discharge decisions on both recipients of care and those providing care as recorded on the ASC Response Panel log between March 2020 and March 2022:

682.1. On 18 March 2020 we received a query from a provider in relation to a service user being discharged from hospital with a positive Covid-19 diagnosis. The service user was also living with dementia and there was concern that they would not understand the need for isolation, with a risk of them becoming agitated or distressed. On 25 March 2020 we responded to the provider emphasising that people who use health and social care services need to be at the heart of the care they receive. We advised the provider to consider how they could adapt to manage the needs of the individual while managing the risks of infection posed to other service users

and staff. We encouraged the provider to also consider the person's capacity to consent and take the least restrictive approach available.

682.2. On 26 March 2020 we were notified by a provider that a service user in extra-care housing had been admitted to hospital with suspected Covid-19 but then tested negative. The provider was concerned that the hospital environment was one where the service user could have been infected and queried whether staff should carry on as normal or step up their PPE precautions. On 27 March 2020 we responded to the provider recommending that they follow the current guidance from PHE, and if still unsure should consider seeking further advice from a relevant source, such as their local health protection team.

682.3. On 2 June 2020 we received a query from a provider who indicated that they were having issues with hospital accident and emergency departments and whether they were testing people prior to discharging them back to their care homes. We responded the same day advising that it was ultimately the provider's decision who to admit, or refuse, into their service. It would be their responsibility to carry out a risk assessment for each person they may potentially admit, and any wider risks that admission to the service may pose. This could include adoption of social distancing measures to minimise the risk of unknown transmission to others.

683. 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 on our website (MC1/442 [INQ000235488]). The survey received feedback from 10 336 people who had received inpatient care in an NHS hospital and were discharged between 1 April and 30 May 2020. Patients with a Covid-19 diagnosis reported consistently poorer experiences than people who did not have the virus. The greatest differences in people's experiences were during discharge and knowing what would happen next with their care after leaving hospital. Discharge and care after leaving hospital were

the most problematic aspects of care. People who were discharged to a care home after their hospital stay were less positive about the information they received before leaving hospital and their involvement in discharge arrangements, than those who went home or to stay with family and friends. They were least likely to say they knew what would happen next with their care, that they were given sufficient information about new medicines or who they should contact about any concerns after leaving hospital.

684. During the relevant period we did not specifically monitor the financial impact of discharge decisions on recipients and providers of care. However, between April and October 2020 our Market Oversight Team prepared a series of ad hoc Market Oversight Covid-19 Update reports which were shared with DHSC, the Minister for Care and other key stakeholders. The focus of these reports was on the impact of the pandemic on care home occupancy which was monitored alongside ongoing cost pressures and the impact of government support measures on the sector.

685. Below is a summary of some of the findings included in the Market Oversight Covid-19 Update reports which demonstrate the financial impact of the pandemic on those providers of care who were included in the Market Oversight Scheme:

685.1. In the report dated 21 April 2020 (MC1/443 [INQ000525029]) we provided an overview on the impact of Covid-19 on the financial stability of those included in our Market Oversight portfolio. We indicated that occupancy in care homes had seen some initial boost owing to NHS discharges and block contracting activity but that the number of deaths were outstripping admissions leading to a typical occupancy reduction of c.1% per week.

685.2. In the report dated 20 May 2020 (MC1/444 [INQ000525033]) we provided an update on the impact of Covid-19 on care home occupancy, indicating that occupancy had declined 6.4% in April 2020 and was projected to decline a further 10.6% between 1 May and 30 June 2020. This was driven by excess deaths and a historic low in LA, CCG and private pay admissions. We indicated that the occupancy impact of Covid-19 would put post residential care providers in a loss making position while they sought to fill vacant beds, and this was before a consideration of other additional

costs (eg PPE etc) incurred as a result of Covid-19 which were not fully funded.

685.3. In our report dated 29 June 2020 (MC1/445 [INQ000525073]) we reported that overall, Market Oversight care home occupancy had stabilised in June 2020 at c. 82% (down 7% on pre-Covid-19 rates) for low private pay providers however high private pay providers had seen a larger 10% decrease as a result of depressed admissions and were forecasting a further reduction in June 2020. We also reported that engagement with local authorities had improved since May 2020 but future financial support was uncertain and was not expected to fully compensate care home providers for ongoing exceptional costs due to Covid-19.

685.4. In the report dated 15 September 2020 (MC1/446 [INQ000525074]) we stated care home occupancy had increased by 0.5% through June and July 2020 but that occupancy recovery was negatively impacted by the termination of short-term discharge bed contracts, which may have reduced occupancy as much as 2.3% with a greater impact on higher private pay providers who were unable to replace these beds with self-pay.

685.5. In our report dated October 2020 (MC1/447 [INQ000525075]) we stated that care home occupancy had increased by 0.3% between July and September 2020 but that occupancy recovery was negatively impacted by the end of short-term block bed contracts and occupancy guarantees, with a greater impact on low private pay providers. We also commented that further analysis of corresponding death data from April to September 2020 showed a greater impact for providers with larger homes and a correlation between the first wave of Covid-19 and subsequent death rates. Likely factors for this included ongoing IPC challenges (particularly in larger homes which may have had increased footfall), decreased demand in response to Covid-19 deaths and a dependency on block contracts and occupancy guarantees ending.

Designated Settings

686. 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 2020 ASC Winter Plan. In the 2020 ASC winter plan, the government committed to deliver

with CQC a scheme for designating settings for people who were discharged from hospital with a Covid-19 positive test and who would be moving or going back into a care home setting. We provided some headline points on what we could deliver within our existing regulatory framework and comments on proposed guidance (MC1/448 [INQ000235554]). DHSC involved us in these discussions from the outset and we developed the scheme, with input from DHSC when required.

687. Through the scheme, the government asked local authorities to speak to local care providers and find suitable locations for people to be safely discharged to. Once these were identified, we assessed each location with an IPC inspection and a specific focus on a service's ability to zone COVID-19 positive residents, and care for them with a dedicated workforce and high levels of ventilation.

688. 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 (MC1/449 [INQ000524917]) (MC1/450 [INQ000235555]).

689. 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 assureddesignated locations three times per week as described above in relation to the ASC IPC inspections. From the end of February 2021, we reverted to weekly sharing of these reports with DHSC (MC1/451 [INQ000235463]).

690. In our Covid-19 Insight Report Issue 6 (MC1/341 [INQ000235475]) published on 15 December 2020, we reported on the findings and good practice from our IPC inspections in care homes for August and September 2020 and the 500 additional IPC inspections carried out in October and November 2020, which had increasingly included inspections of designated settings locations. In the report we also included data on the ratio of beds in designated settings to 100 care home beds, the ratio of beds in designated settings to 100,000 people over 65 and the ratio of beds in designated settings to the average infection rate per 100,000 people tested for Covid-19. The data showed that there was wide variation between regions in terms of the numbers of designated beds per 100 care home beds and a similar level of variation between the number of designated beds per 100,000 people over 65 in

each region. The variation was somewhat reduced when comparing the provision of designated beds against the average regional rate of infection in the population.

691. In our Covid-19 Insight Report Issue 7 (MC1/342 [INQ000235476]) published on 20 January 2021, we reported on how the increase in Covid-19 hospital admissions compared with the overall capacity of beds in designated settings in each region of England. We indicated that as levels of infection continued to increase, it was more likely that, for those who had tested positive, hospitals would need to access the capacity created by the designated setting scheme.

692. Ian Trenholm attended a meeting on 10 January 2021 with Lee McDonough, DHSC Director General, where the concept of care hotels was discussed. After the meeting Mr Trenholm followed up in writing, particularly suggesting that the policy shouldn't be "*over design[ed] at the centre*" (MC1/452 [INQ000235556]).

693. 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. (MC1/452 [INQ000235556]) and (MC1/453 [INQ000524896]).

694. On 18 January 2021 we also commented on a draft letter from Matthew Winn, Director of Community Health, NHSE to CCG Accountable Officers, Local Authority Directors of Adult Social Care and System discharge leads providing comments to help ensure clarity (MC1/454 [INQ000235560] and MC1/455 [INQ000560881]). The letter was published on 20 January 2021.

695. 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 (MC1/456 [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.

696. Further proposed guidance was provided by DHSC in March and April 2021, to which we provided limited comments (MC1/457 [INQ000235562]).

697. In April 2021 we updated our public messaging about our Designated Settings work, taking the opportunity to highlight the fact that many providers were seeking to remove their designated settings status due to a reduction in demand (MC1/458 [INQ000235464]).

698. 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 (MC1/459 [INQ000235563]; (MC1/460 [INQ000235565]. DHSC approached us regarding their updated Designated Settings guidance in October and November 2021 and colleagues provided some limited comments on the draft MC1/461 [INQ000235566] and MC1/462 [INQ000235567]).

699. In our State of Care Report for 2020/2021 (MC1/159 [INQ000235497]), in relation to the "flexibility" of the health and social care sectors to respond to the pandemic, we reported on the discharging of patients focusing on the "discharge to assess" process, and our designated settings work.

L. Testing

700. On 2 April 2020 the Health Secretary set out the Government's 5 pillar plan to increase testing to 100,000 a day across the UK. Professor John Newton, the Director of Health Improvement for PHE, was appointed to help deliver the new plan and bring together industry, universities, NHS and government behind the new testing targets. DHSC's "Scaling up our testing programmes" plan was published on 4 April 2020.

701. On 3 April 2020 Ian Trenholm wrote to Professor John Newton indicating that CQC's contact centre, direct communications channels to all registered providers, survey capabilities, staff and connections into the health and social care sectors were "at [his] disposal" and he should not hesitate to ask if he needed any help from CQC with testing (MC1/463 [INQ000524884]).

702. On 9 April 2020 CQC wrote to DHSC indicating that we had been approached by Deloitte to support their work on testing of staff in health and social care (MC1/464 [INQ000524892]) and that they had asked us to do the following:

"1. Talk to trade associations and 'soft land' the idea of social care staff who are showing symptoms and off wok self-isolating being offered drive through testing. We are doing this tonight.

2. They have capacity over the weekend and asked us to coordinate with providers to fill that capacity

3. This involves a call and return spreadsheet process. We propose to badge this as a test process and look for larger providers within a short drive from each of the centres

4. We will do this by standing up a service in our National Customer Services Centre from tomorrow over the weekend."

703. In the email Ian Trenholm was seeking confirmation from DHSC that they were happy for CQC to do this and to check that Deloitte was acting on their behalf when they made the request. DHSC confirmed that this was correct but that we should await "proper instructions".

704. On 9 April 2020 Deloitte shared their draft outline of the process for identifying and inviting key workers for testing which entailed (MC1/465 [INQ000524980]; MC1/466 **[INQ000560886]** MC1/467 [INQ000524982]):

704.1. Telephoning self-isolating keyworkers and assessing their eligibility to attend the test centre – employers / referring entities must ensure that only the right person/people are invited for tests

704.2. Sending everyone being invited for a test the standardised email with the details they need, and to capture key personal details required for the test

704.3. Collecting the personal data of everyone being tested in the correct template

704.4. Sending the spreadsheet containing essential details back to the Co-ordination Lead for upload to the National Testing Centre secure ShareFile by 11:59pm the day before testing (or earlier, at the Co-Ordination Lead's request).

705. On 10 April 2020 we attended a meeting with colleagues from DHSC and Deloitte to discuss the plan for testing of care workers and home care residents and it was agreed that our role would be to coordinate/identify relevant care workers for testing via regional testing centres. This was put to the Minister for Care Helen Whately at a meeting later that day and she was "very supportive" of the proposed approach (MC1/468 [INQ000525017]).

706. On 11 April 2020 we met with KPMG to discuss and plan how we were going to undertake the task of assisting with the facilitation of the booking of tests for social care workers (MC1/469 [INQ000525050]). KPMG assisted us with the creation of a new solution to enable us to send a survey email to providers which included a link to a survey where the provider would be asked to select their preferred testing centre to book a test slot at one of the testing centres around the UK. They also assisted us by creating a form so that NCSC colleagues could take a booking over the phone. On completion of the form, it would trigger the survey email to be sent.

707. Our role was specifically to support the logistics of providers requesting a slot for staff to be tested. Individuals could only be tested if they have a pre-booked appointment at a drive through testing site and therefore these need to be allocated in advance. The plan for the automated process was as follows:

707.1. We would write to providers to share the booking link which was an online form.

707.2. Tests were being used to help get key workers who were isolating back to work and were focussed on eligible care staff in three key areas:

707.2.1. Care staff self-isolating because they were symptomatic.

707.2.2. Care staff self-isolating because an adult (over 18) in their household was symptomatic, but the staff member was not. In

this instance only the adult household member(s) of the care staff were eligible to go to a test centre to receive a Covid-19 test.

707.2.3. Care staff self-isolating because a child (under 18) in their household member was symptomatic, but the staff member was not. In this instance, only the under 18 household member of the care staff was eligible to come to a test centre to receive a Covid-19 test.

707.3. The providers would receive an automated email from us and they could use the "Book Test" button to book COVID-19 tests for one of more of their staff members.

707.4. To book the test providers needed to complete a simple form for each recipient using the link provided. All fields were mandatory and the tests were scheduled on a first-come, first-served basis.

707.5. Once booked, the staff members would be contacted with instructions about how to access their test and they would need to take Photo ID with them. A valid email address had to be provided in order for us to send a confirmation email with the details of the appointment.

707.6. The staff member would then drive to the centre; if they couldn't drive they would need to arrange for a household member to drive them through the test site and sit in the passenger seat behind the driver.

708. While this was being worked on by KPMG, we proceeded to conduct the process manually. Between Friday 10 April 2020 (Good Friday) and continuing over the Easter Weekend, CQC manually sent out 4775 emails to providers which resulted in 499 referrals being completed by Sunday 12 April 2020. An example of the template email sent to providers manually is exhibited as (MC1/470 [INQ000525068]).

709. On 13 April 2020 we rolled out the digital booking process across providers. An example of the template email containing the automatic booking link is exhibited as (MC1/471 [INQ000525069]).

710. During the first week of operation we were reporting the daily figures of how many emails had been sent and how many referrals had been booked to Deloitte who, in turn, provided a daily update to key stakeholders including DHSC, ADASS and PHE

regarding how many providers we had contacted and how many referrals had been booked (MC1/472 [INQ000525052]).

711. Our role in the facilitation of testing for ASC workers was also set out in DHSC's *COVID-19: our action plan for adult social care* published on 15 April 2020.

712. On 16 April 2020 Ian Trenholm 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 by extending it to all NHS staff and all other key workers including the Police (MC1/473 [INQ000235529]). Mr McDonough texted Ian Trenholm to ask him not to proceed at the moment, with an email to confirm that arrangements were being clarified and they would get back to us. We received the instructions to proceed with this later on 16 April 2020 (MC1/474 [INQ000524899]).

713. On 17 April 2020 we wrote to our ASC stakeholder colleagues including Care England, UKHCA and NCF to provide an update on our work supporting increasing access to testing for ASC staff. In the update we indicated that by the end of the week (week ending 19 April 2020) we would have contacted all 30,000 ASC providers that were registered with us to offer tests if they were not already accessing them via other local arrangements. We also included a copy of the email that was being sent to providers for their information. We stated that we were also supporting the expansion of testing to all key workers. In the email we also confirmed that we were working on a pilot of home testing which would start in the ASC sector and that we would keep them updated as the plans for this were still being finalised (MC1/475 [INQ000525003]; MC1/476 [INQ000525004]; MC1/477 [INQ000525005]).

714. On 20 April 2020 we published an article on our website outlining the work that we had been doing in this context (MC1/478 [INQ000525106]). We confirmed that on behalf of DHSC we had been contacting ASC providers to book appointments for their staff to be tested for Covid-19 and that since 10 April 2020 24,950 locations had been contacted and 12,422 appointments had been booked for staff.

715. By the time the 'Gov Portal' self-referral site was online on 24 April 2020 we were able to conclude our contribution to this process, having facilitated the booking of testing for over 40,000 ASC staff. On 30 April 2020 we wrote to Rt Hon Matt Hancock MP confirming our contribution to this process and that at the request of DHSC we had transitioned the work to the new Government portal for booking tests (MC1/479 [INQ000525081]). On 21 May 2020 we received a response to the letter from Rt Hon Matt Hancock MP in which he stated as follows (MC1/480 [INQ000235537]):

"*I want to write to thank you and all the staff at Care Quality Commission (CQC) for the exemplary work that you have undertaken to protect the safety of staff and patients across the health and social care system during the COVID-19 pandemic. The pragmatism and flexibility your organisation has shown, in appropriately altering your approach to regulation, in releasing staff back to support our frontline efforts and in directly supporting action for example in care homes has played a significant part in our response to the pandemic and I am grateful for your ongoing support. Your work to facilitate access to testing in the adult social care workforce greatly increased the rate of expansion in the demand and uptake for tests, allowing social care staff who were self-isolating to return to work to care for their patients, and to identify those who may need medical support earlier. I am delighted that you have now received the necessary assurances from Kristen McLeod and Professor John Newton that the NHS will be taking responsibility for this programme going forward, but please be in no doubt that the CQC's work to facilitate this is greatly appreciated given the essential role that testing has as we move toward the next stages of our response to COVID-19.*"

716. In total, across all sectors, there were 34,335 referrals made between 10 April 2020 and 26 April 2020. CQC does not hold data on the number of workers tested.

Home testing kits for ASC workers

717. On 17 April 2020, as part of "Pillar 2 of the National C19 testing programme", DHSC published the "Home Delivery Programme Pilot" in terms of which frontline workers were provided Covid-19 test kits for home testing (MC1/481 [INQ000525054]). In respect of this programme, we assisted DHSC by providing them with a list of those individuals who had tried to book a test through the automated booking process that we were facilitating but who had indicated that they could not drive or did not have

access to a vehicle. As part of the pilot we also shared the details of staff from Barchester Healthcare Homes Limited so that an email could be sent to these staff members on 20 April 2020 to sign up to the system and order their kits. This system was not administered by CQC.

718. From 21 April 2020 the care home testing pilot was rolled out in terms of which our role was to respond to requests from care homes for testing kits, and to liaise with a third party to enable the kit to be couriered to the care home. We did not have a role in the return of the test kit to the laboratories or in relation to the test results themselves. The approach to this pilot was defined by DHSC and PHE and, on their behalf, led by Deloitte. This pilot involved the testing of residents who were symptomatic; it did not involve testing of whole care home communities, including those who are asymptomatic .

Home testing kits for Care Home residents

719. From 19 April 2020, at the request of Deloitte (on behalf of DHSC), we assisted with a pilot programme which entailed the facilitation of sending home testing kits to 17 care homes for the purposes of testing residents. The initial 17 care homes involved in the pilot were Barchester Healthcare Limited nursing care homes. Our role was to write to the registered managers of the care homes and ask whether or not they had residents presenting with covid-19 symptoms and, if so, how many. If over 10, PHE would manage the case. If below 10, then CQC would capture and send the address details to Deloitte on a daily basis to organise the delivery of packs of 10 test kits the following day. The ordering of test kits was done through a form that was developed by KPMG. The care home would register the test online and then administer the test as required. The results would be returned to the registered manager to share with the service user. The guidance that was sent to the care homes involved in the pilot is exhibited as (MC1/482 [INQ000524974]; MC1/483 [INQ000524975] and MC1/484 [INQ000525051]) and a copy of the template emails sent to the care homes involved in the pilot are exhibited as (MC1/485 [INQ000525055] and MC1/486 [INQ000525053]).

720. From 22 April 2020 the pilot was expanded beyond the initial 17 nursing homes. Our involvement in this project ended on 11 May 2020 when the Government's portal

which allowed care homes to book tests online was finalised. By 11 May 2020 we had sent an invitation email to all nursing homes registered with CQC.

M. Deaths within ASC

721. As explained briefly in Section D of this statement, registered managers are required to submit statutory notifications to us about a death of a person using the service under Regulations 16 and 17 of the Care Quality Commission (Registration) Regulations 2009 when:
    721.1. the person died while a regulated activity was being provided (Regulation 16); or
    721.2. the death may have been a result of the regulated activity or how it was provided (Regulation 16); or
    721.3. the person who died was liable to be detained by the registered person either under the Mental Health Act 1983; or pursuant to an order or direction made under another enactment (which applies in relation to England), where that detention takes effect as if the order or direction were made pursuant to the provisions of the 1983 Act (Regulation 17).

722. 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.

723. Providers use the designated forms on our website to make death notifications, either by completing an online version through the CQC provider portal or by completing a Word document version and emailing it to the designated email address. The form for notification of a death under Regulation 16 is called Form SN16.

724. The compulsory fields to be completed on form SN16 are as follows:
    724.1. Provider details
        724.1.1. CQC provider ID; and

724.1.2. Name of provider.

724.2. Registered location details

724.2.1. CQC location ID; and

724.2.2. Name and address of location.

724.3. Details of person completing the form

724.3.1. Name and job title;

724.3.2. Date of submission; and

724.3.3. Contact details for person completing the form.

724.4. Details of person who died

724.4.1. Unique identifier;

724.4.2. Date began to use service;

724.4.3. Whether the person was receiving end of life or palliative care; and

724.4.4. Date of birth.

724.5. About the death

724.5.1. Cause of death;

724.5.2. Date, time and place of death; and

724.5.3. Whether the person died as a result of confirmed or suspected coronavirus (added 10 April 2020).

724.6. Circumstances prior to death

724.6.1. Whether the person died within 30 days of surgery;

724.6.2. Whether the person died during or within 30 days of the use of restraint;

724.6.3. Whether the death was the expected outcome of an illness or physical condition;

724.6.4. Whether the death is subject to a formal investigation; and

724.6.5. Whether the death is within 12 months of a termination of a pregnancy.

724.7. Circumstances around the death

724.7.1. Circumstances leading up to the death;

724.7.2. How the person died;

724.7.3. Who was present;

724.7.4. When the person was last seen by the provider/member of staff;

724.7.5. Any recent risk assessments; and

724.7.6. Details of other notifications submitted about the person in the last 3 months because of a serious incident; police involvement; or an allegation of abuse.

724.8. Whether it is a 'notifiable safety incident' under the 'duty of candour' (pursuant to Regulation 20 of the Regulated Activities Regulations 2014)

724.8.1. The duty of candour requires registered providers and/or managers to act in an open and transparent way with people receiving care or treatment from them.

724.8.2. A notifiable safety incident is an incident which:

724.8.3. Was unintended or unexpected;

724.8.4. Occurred during the provision of an activity regulated by CQC; or

724.8.5. In the reasonable opinion of a healthcare professional, already has, or might, result in death, or severe or moderate harm to the person receiving care.

725. Where an unexpected death has occurred, additional information must be provided regarding:

725.1. Details of the last individual in providing care to the person who died;

725.2. Any concerns relating to medicines e.g. drug overdose, missed dose, wrong drug given; and

725.3. Any concerns relating to the use of medical devices.

726. The following optional information regarding the person who has died can also be provided on the form:

726.1. Gender;

726.2. Sexual orientation;

726.3. Religion;

726.4. Ethnicity; and

726.5. Disability, impairment or long-term health condition, including a learning disability, autistic spectrum conditions or mental ill health.

727. ASC providers are required to tell us of deaths of those who use their service regardless of where the death occurred, including when in hospital if the person died

while a regulated activity was being provided or their death was as a result of a regulated activity. This means that a death of a resident reported by a residential care provider may also have been reported by an NHS hospital to NHSE.

728. The Care Quality Commission (Registration) Regulations 2009 require that notifications about deaths must be sent to us 'without delay' so that we can take urgent follow-up action where needed. As set out in our Statutory Notifications Guidance for ASC providers (MC1/64 [INQ000525016]), 'without delay' means 'as soon as can be reasonably achieved'. Due to this requirement, death notifications are usually sent to us before the official death certification. As a result, the information submitted is often subjective or speculative as to the cause of death. It may or may not correspond to a medical diagnosis or test result and may or may not be reflected in the official death certificate.

729. There is also a degree of subjectivity in deciding whether a notification is required for a death that occurs after the person has left the service, for example, if a care home resident is transferred to hospital and dies there. The requirement to notify depends upon an assessment of whether or not that death may have been a result of the regulated activity. This can result in the death being reported by both the hospital and care home, by only one, or by neither.

730. CQC receives death notifications for the purpose of carrying out our regulatory functions in relation to individual registered providers. The purpose of notifications is not to monitor mortality or to create mortality statistics.

731. 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 CRM. This information was then used for analysis purposes. However, CRM did not include specified fields for all of the information captured within the form, for example, details about the place of death were not specifically captured. The completed form was saved as an attachment to the record so that it could be viewed in its entirety by relevant inspectors but this meant that not all of the data captured by the form could be accessed with ease. At that time we therefore did not analyse or report on place of death data.

732. Whilst it is a statutory requirement for registered providers to inform us of a death of a person using their service, it is not a statutory requirement for providers to fill in all fields in the notifications form, nor to use the most up-to-date version of the form. For example, providers may use a 'desktop saved' older version of the form and therefore information can be missed this way. At the start of the pandemic this impacted on the quality and coverage of data received by CQC, and consequently, our ability to report on Covid-19 related deaths.

733. Due to the limitations of the systems in place, we created internal processes to work around these so that we were able to use the data in the most appropriate way. As is explained in Section D above, 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. This was also a resource intensive task and data quality issues continued to stem from this approach as a result of the manual process.

734. 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 these channels to facilitate the sharing of information related to ASC notifications that we were receiving. We have highlighted some of the significant interactions below to provide the context for the approach taken.

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

736. After various email communications discussing timing and frequency of data sharing, we started providing data to DHSC on 23 March 2020 (MC1/487 [INQ000235387]; MC1/283 [INQ00235388]; MC1/489 [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):

736.1. SN16 – Death of a service user; and

736.2. 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).

737. A copy of the data file shared is attached as (MC1/490 [INQ000235390).

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

738.1. Total number of registerable services registered;

738.2. Total number of registered services submitting notifications; and

738.3. SN17 – Mental Health Act deaths.

739. Between 23 March and 17 April 2020 daily situational report (sitrep) files were shared with DHSC via DHExchange, a separate area created by DHSC for exchange and sharing of information. Initially the data was only shared on weekdays however from Sunday 18 April 2020 the regularity of the data sharing was increased to include Sundays. This continued until April 2022.

740. 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 (MC1/491 [INQ000525089]).

741. As explained in Section D above, on 9 April 2020 we notified providers that when making a notification they should use our amended SN16 form which included provision for information regarding whether the death of an individual under their care was as a result of confirmed or suspected Covid-19 infection (MC1/492 [INQ000560884]). 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 was included in our daily sitrep reports to DHSC from 27 April 2020.

742. On 10 April 2020 Kate Terroni attended a meeting with the Minister for Care, Helen Whately MP and others from DHSC where they discussed making this data publicly available (MC1/493 [INQ000235395 and MC1/494 [INQ000235396]). Acknowledging that the number of deaths being reported to CQC was increasing, we collectively felt that this data should be made visible publicly. DHSC indicated that in normal times it might have been best for CQC to publish its own series of data, but with the potential for confusion and the need to maintain confidence in statistics, the various collections of data needed careful joint handling. At that time, the main Covid-19 deaths data in the public domain was being published by NHSE and, as explained above, there was the potential for overlap with the death notifications being reported to us by ASC providers where the death occurred in hospital. The Office of National Statistics (ONS) was also working towards publishing data on Covid-19 deaths at this time.

743. Between 10 and 13 April 2020 we participated in conversations regarding these issues with colleagues from DHSC, ONS and PHE to understand what data each organisation held and what they were planning to publish/share (MC1/494 [INQ000235396). We were keen to try and validate the large increase in death notifications being received and believed that comparing our data with what ONS held through official death certifications was the best way of doing so.

744. Through these conversations and some early analysis, we became increasingly confident that our daily death notifications could potentially present an early indication of the numbers of official deaths that ONS would report a few weeks later.

745. On 14 April 2020 we attended a meeting with representatives from DHSC, PHE and NHSE where the development of a new measure of Covid deaths that would become the headline figure and would include community deaths and deaths in hospital was discussed. During the meeting there was a brief discussion regarding the options available in terms of the publication of 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 the actions agreed were shared after the meeting by email (MC1/495 [INQ000235397]).

746. On 14 April 2020 we shared our proposal with ONS for the publishing of the death notifications data 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 (MC1/496 [INQ000235398] and MC1/497 [INQ000235399]). This timeline allowed us sufficient time to:
    746.1. validate that our data was a sufficiently good indicator of the ONS official deaths data;
    746.2. create a clear description of what the data was and was not;
    746.3. align on the format for presenting this effectively;
    746.4. carry out checks to remove any duplicate records; and
    746.5. to ensure we engaged the Office for Statistics Regulation (OSR) sufficiently to publish this data in line with their code of practice.

747. On 16 April 2020 ONS provided us with the daily counts of death certificates from 1 February 2020, enabling us to validate that our numbers 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 (MC1/498 [INQ000235400]] and MC1/499 [INQ000235401]). With ONS's support, we produced a transparency statement detailing how the data was captured, what we would do with it, and how it compared to other similar data sources (MC1/500 [INQ000235402] and MC1/501 [INQ000235403).

748. On 26 April 2020 we shared the first set of tables on the number of deaths of care home residents for 10 to 24 April 2020 with ONS (MC1/502 [INQ000235404 and MC1/503 [INQ000235406]).

749. A data access agreement for sharing the daily data with DHSC was signed by DHSC on 19 May 2020 (MC1/504 [INQ000235407].

750. From 28 April 2020, death notifications received by us were released by ONS (MC1/505 [INQ000235408]; MC1/506 [INQ000235409]; MC1/507 [INQ000235410]; MC1/508 [INQ000235411]; MC1/509 [INQ000235412]; MC1/510 [INQ000235413]; MC1/511 [INQ000235414] and MC1/512 [INQ000235415]).

751. 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:

751.1. Total deaths;

751.2. Deaths reported as involving Covid-19;

751.3. Deaths by Local Authority; and

751.4. Deaths by place of occurrence.

752. Our weekly reporting to ONS continued to evolve over the relevant period and our data has also been included in the following publications made by ONS:

752.1. Deaths involving Covid-19 in the care sector, England and Wales, released on 15 May 2020 (MC1/513 [INQ000235416]);

752.2. Deaths in the Care Sector, England and Wales 2020, released on 2 December 2021 (MC1/514 [INQ000235417]); and

752.3. Deaths of care home residents, England and Wales 2021, released on 22 November 2022 (MC1/515 [INQ000235418].

753. In addition to the data sharing arrangements in place with DHSC and ONS, we also shared death data information on request with key system partners or external stakeholders, for example:

753.1. 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 and was granted access to deaths in care homes data via DHSC (MC1/516 [INQ000235423]).

753.2. On 5 July 2021, following receipt of a signed Information Sharing Agreement, access for PHE to the DHExchange portal was confirmed (MC1/517 [INQ000235424]).

753.3. 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. For example, a member of the Government's scientific pandemic influenza modelling subgroup (SPI-M) which informed the Scientific Advisory Group on Emergencies (MC1/518 [INQ000235425]), a data scientist (MC1/519[INQ000235426]) and a Senior Lecturer in Health Policy and Economics (MC1/520 [INQ000235427]). At the request of DHSC, we also agreed that access could be granted to the Vivaldi Care Home Study research team (MC1/521 [INQ000235428]).

754. We also used this data internally, including to:

754.1. 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

754.2. 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.

755. 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, we nevertheless shared the detailed corrections with DHSC and ONS (MC1/522 [INQ000235431] and MC1/523 [INQ000235432]).

756. 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 (MC1/524 [INQ000235433] and MC1/525 [INQ000235434]).

757. Following a request from DHSC, received on 17 March 2022 (MC1/526 [INQ000235435]), our sharing of this data with DHSC was amended to weekly, on Wednesdays, from 23 April 2022.

758. During the relevant 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 MC1/527 [INQ000235436] sets out the summary of requests and queries received.

Publication of data on deaths of people with a learning disability

759. On 29 April 2020, following the submission of a briefing on CQC's approach to Closed Cultures during the pandemic provided to the JCHR on 27 April 2020, Dr Kevin Cleary (Deputy Chief Inspector of Hospitals and the lead for mental health at CQC) was invited to give evidence at a select committee evidence session at the Joint Committee on Human Rights on taking place on 18 May 2020. The focus of the session was the human rights implications of Covid-19, specifically regarding young people with learning disabilities and/or autism in closed environments (MC1/528 [INQ000524990]).

760. On 16 April 2020 we received a request for information from the BBC about the deaths of those who have a learning disability (MC1/528a [INQ000525107]). It was identified that, although we asked registered persons to tell us about protected characteristics under the "Additional Information about the User" section in the relevant notifications forms (SN16, SN17 and SN18) there was no system on CRM for capturing this information that enabled us to extract and report on it. We noted that our inability to capture the deaths or injuries of service users with disabilities made it difficult for us to monitor and report on the impact of Covid-19 on these specific population groups.

761. On 5 May 2020, Liz Kendall MP, in her capacity as Shadow Minister for Social Care, wrote to Helen Whately MP regarding the impact of Covid-19 on people with learning disabilities (MC1/529 [INQ000525108]). In the letter she stated that it was "*essential that the Department of Health and Social Care does everything possible to minimise*

the impact of Covid-19 on people with learning disabilities" and "*the first step towards achieving this is publishing regular data on the number of people with learning disabilities who have been infected with an died from the virus*". On 7 May 2020, Rt Hon Harriet Harman MP, Chair of the Joint Committee on Human Rights, wrote to Rt Hon Matt Hancock MP to express concern about the lack of transparency over the number of those with learning disabilities and/or autism who had contracted and died from Covid-19 (MC1/530 [INQ000525078]).

762. It was clear that this was becoming a clear area of focus for Government, stakeholders and the public. On 6 May 2020, in correspondence with DHSC regarding the ONS death data publications, we indicated that we were undertaking work to conduct additional analysis of the data to understand the impact of Covid-19 on learning disability services and set out the intended process for doing this. We advised that, following the extraction of data, the analysis would be likely to commence in the week beginning 18 May 2020 (MC1/531 [INQ000524965]).

763. On 14 May 2020, we published an update regarding our intended work on understanding the impact of Covid-19 on autistic people and people with learning disabilities (MC1/532 [INQ000235530]). We confirmed that we had started to do further work on the care home death data being published by ONS which included analysis of all available data on confirmed and suspected Covid-19 deaths (as published by ONS) and mapping this against records which indicated whether someone was autistic or had a learning disability. We confirmed that this would form part of our reporting moving forward and that this would was a priority for us.

764. In the article we stated that in response to the request from BBC, we had released figures to show that during the period 10 April to 8 May 2020, the provisional number of deaths reported across all settings where autistic people and/or people with a learning disability may live was 3,765 (compared to 1370 in the same period of 2019), but that this "absolutely [did] not reflect the number of deaths of autistic people and/or people with a learning disability, which could be as much as 40 times smaller than this figure once the data on deaths of people who receive other types of care from these providers is separated out". We confirmed that the analysis would entail separating the data on deaths of people with a learning disability and/or autism from

the data on deaths of people receiving other forms of care so that we could understand and report on what the actual figures were and whether or not these were in line with deaths within the wider population.

765. On 19 May 2020, we received a Judicial Review pre-action protocol letter sent on behalf Every Death Counts, who describe themselves on their website as "four individuals who are acting as figure heads for a wider group of interested citizens who believe that every death matters and should be counted" (MC1/533 [INQ000524956]. In the letter we were listed as a proposed defendant, alongside NHSE, the Secretary of State for Health and Social Care, NHS Digital and the UK Statistics Authority in respect of a proposed claim for a judicial review of the alleged failure by the proposed defendants to mandate the collection of and to publish accurate and reliable data on the deaths of people with learning disabilities and autistic people from Covid-19, on the grounds that these failures were 'irrational' and/or 'discriminatory'.

766. On their website, https://www.crowdjustice.com/case/every-death-counts/ the proposed claimants published a detailed timeline and updates regarding the proposed judicial review application, including copies of both of the pre-action protocol letters referenced in this section.

767. On 27 May 2020 we responded to the pre-action protocol (MC1/534 [INQ000524902]; MC1/535 [INQ000524903]) clarifying that we considered that we had properly discharged our statutory duties and did not consider that we had in any way acted unlawfully. In our response we provided detailed clarification of the duty on providers under Regulation 16, the forms of notification to CQC and publication of data by CQC and the publication of CQC figures. Our response is briefly summarised below:

    767.1. Duty to notify deaths under Regulation 16

        767.1.1. Beyond the requirement that the death notification provided to CQC "must include a description of the circumstances of the death", there is no further enforceable requirement that notifications must be submitted using any particular form. Similarly, CQC cannot compel a registered person to include

additional information about the deceased (eg whether they had a learning disability).

767.2. Forms of notification to CQC and publication of data by CQC

767.2.1. While we encourage providers to include information beyond the legal requirement when they submit a notification, through the inclusion of additional questions on the form, providers are not compelled to do this and therefore any data for specific groups of people, such as those with a learning disability, will be at best indicative and not give a complete and accurate picture.

767.3. Publication of CQC figures

767.3.1. We considered that the soon to be published further information would address the potential claimants' immediate concerns. In addition to publishing further data we confirmed that we were looking at how we might continue to contribute to the availability of improved data.

768. On 2 June we published an article on our website "CQC publishes data on deaths of people with a learning disability" (MC1/536 [INQ000235420]). The article explained that between 10 April 2020 and 15 May 2020 we completed a targeted piece of analysis, supported by ONS, to better understand the impact of Covid-19 on people with a learning disability and autistic people specifically focusing on how the number of deaths during the period compared to the number of deaths in 2019. The analysis looked at all deaths notified to CQC in the period from providers registered with CQC who provided care to people with a learning disability and/or autism (including providers of adult social care, independent hospitals and in the community), and where the person who died was indicated to have a learning disability on the death notification form. The results of the analysis can be summarised as follows:

768.1. Between 10 April and 15 May 2020, the number of deaths of people with a learning disability and/or autism who were receiving care from services which provide support for people with a learning disability and/or autism was 386.

768.2. For the same period in 2019, the number of deaths in the sector was 165 people, therefore indicating a 134% increase in the number of death notifications for people with a learning disability and/or autism in 2020.

768.3. Of the 386 people who died in the sector between 10 April and 15 May 2020, 206 deaths were as a result of suspected and/or confirmed Covid-19 as notified by the provider.

768.4. Overall, in 2020 the number of care home 'beds' registered with CQC to provide specialist learning disability and/or autism care, excluding care to older people or those with dementia, was 30,912. In 2019 that figure was 32,217.

769. We were clear that, despite the work undertaken to date, and the fact that this data was the most accurate we were able to produce at that point, it had a number of limitations in that:

769.1. It was not mandatory for providers to tell us if someone had a learning disability when submitting a death notification.

769.2. We could not extract detailed data, including whether or not the person who died had a learning disability, from a small number (around 4%) of the forms we included in this analysis due to the way the information was provided to us – i.e. illegible handwritten forms.

769.3. Despite removing a large number of duplicates from this data, we could not guarantee that every duplicate had been removed.

769.4. It did not account for those detained under the Mental Health Act (this was published separately).

770. On 9 June 2020, we received a second pre-action protocol letter from the same proposed claimants (MC1/537 [INQ000524963]) which we responded to on 22 June 2020 (MC1/538 [INQ000525079]) wherein we set out:

770.1. The steps we had taken including the analysis of data published on 2 June 2020.

770.2. Confirmation that we were looking at how we could make improvements to our notification processes and materials in order to capture and share better quality data going forward.

770.3. An invitation to the proposed claimants to engage constructively with us as part of our stakeholder engagement exercise relating to the improvement of notifications and the data provided.

770.4. Our view that it would be a disproportionate and inappropriate to routinely rely upon the use of our statutory power to require documents and information from registered persons in order to obtain data about a person who has died.

771. We continued to routinely monitor and collect this data and included it in our Covid-19 Insight Reports as described below:

771.1. Insight Report Issue 2 published 15 June 2020 (MC1/338 [INQ000235472])

771.1.1. We set out the data (as published on 2 June 2020) and stated that we were working to improve the data set that underpinned the information provided.

771.2. Insight Report Issue 5 published 17 November 2020 (MC1/340 [INQ000235462])

771.2.1. We set out the data analysis for the period 10 April to 30 September 2020.

771.3. Insight Report Issue 6 published 15 December 2020 (MC1/341 [INQ000235475])

771.3.1. We set out the data for the period 10 April to 16 November 2020.

771.4. Insight Report Issue 7 published 20 January 2021 (MC1/342 [INQ000235476])

771.4.1. We carried out further analysis on the data in an effort to improve the understanding of these issues.

771.5. Insight Report Issue 12 published 21 July 2021 (MC1/153 [INQ000235481])

771.5.1. We extended the reporting period to 31 March 2021.

N. Other matters

Concerns raised to CQC during the pandemic

How concerns were raised to CQC

772. During the relevant period we received concerns in several ways. Concerns could be raised with us by members of the public or by someone working for a health or social care service via the 'contact us' section of our website (MC1/539 [INQ000398720]). Members of the public could also raise concerns about care

through our Give Feedback on Care (GFC) form, accessible via our website (MC1/540 [INQ000398721]). GFC was, and still is, our priority channel through which we collect information from the public about their experiences of health and adult social care. The feedback we receive can be from any member of the public, from people working in services, people receiving care, or their relatives or advocates. Members of the public can also email or contact us if they are unable to complete the GFC form. We had, and continue to have, routine processes in place to ensure that individual GFCs and enquiries were/are reviewed by our National Customer Service Centre (NCSC) and operational teams. There was, and continued to be, also whistleblowing guidance in place for providers and individuals who work for providers on our website to enable them to make us aware of any concerns. (MC1/541 [INQ000398722] and MC1/542 [INQ000398723])

CQC Processes for handling concerns

773. During the relevant period CQC's process for people raising concerns about a service was as follows (as set out in the internal and external guidance):
    773.1. All concerns were directed via NCSC whether received via email, via the "Share your experience" form or by phone call, or otherwise;
    773.2. NCSC then logged this on CQC's CRM system, triaged it according to its level of priority and the nature of the concern (i.e. whistleblowing information from a staff member, a safeguarding concern, and/or a concern raised by a patient or member of the public – which is termed a complaint rather than whistleblowing);
    773.3. NCSC forwarded this information on to the relationship owner for the relevant provider.

774. CQC's internal guidance *Handling concerns raised by workers of providers registered with CQC* (MC1/543 [INQ000524972]) outlines the steps that may be taken when we receive concerns:
    774.1. Use the information to decide whether to urgently inspect or bring forward a planning inspection;
    774.2. Raise the issue directly with the provider (bearing in mind the need for confidentiality);

774.3. Make a safeguarding alert to the local authority;

774.4. Notify another regulator or official body if appropriate for them to look at the information as opposed to or as well as CQC;

774.5. Notifying the police if necessary.

775. How we act depends on what we are told, and how serious the matter is.

CQC's handling of concerns during the pandemic

776. From 1 March 2020 to 28 June 2022, we received approximately 138,000 comments through GFC, and 2.5 million enquiries were made to NCSC. When an enquiry was processed by NCSC a 'True/False' field referred to as a 'CovidFlag' could be applied by the operator. The field 'CovidFlag' was a 'Y/N' checkbox which was used to indicate whether the enquiry related to Covid-19. This was also used to indicate whether the service user in question had Covid-19 at the time of writing the enquiry. Approximately 223,000 enquiries, 9.1% of the total, were flagged 'True' for the field 'CovidFlag' during this period. We did not consistently use any other tags to differentiate types or themes of Covid-19 related enquiries.

777. We used qualitative analysis methods to explore people's experiences to inform topics of focus for State of Care. Examples of qualitative analysis for State of Care include the following: GFC responses specific to the health and social care workforce between 1 April 2022 and 31 March 2023; GFC responses specific to the National Maternity Inspection Programme and peoples experiences of maternity services; analysis of notes from group discussions of the Supported Living Improvement Coalition (collected August to December 2022), additional question notes from inspections (collected May and June 2022), and transcripts from interviews and focus groups with Coalition partners; analysis led by clinical fellows to explore what good workforce wellbeing looked like and what we could do to improve this. During the pandemic we still had old technology systems in place, and any analysis beyond an individual provider required significant manual work and could not be relied upon for policy making. We have subsequently made significant investment into the way we organise and process data and can now offer insights in a much faster and more comprehensive way.

778. We have developed a project to address this, with methodologies and tools to enable routine analysis of the GFC data through the application of data science techniques with qualitative analysis methods. Successful delivery of this project will contribute to our strategic aim to become driven by people's experiences of care by: enabling the provision of regular insight from GFC to senior leaders across our organisation to support their decision making; providing insights from GFC to inform prioritisation of our activity for operational teams; providing insights about specific, high priority issues and topics; improving responsiveness to queries about specific issues in services; reducing the length of time spent preparing relevant data for analysis; and providing insight from people's experiences available at area or service level.

779. While it is not currently possible to perform new analysis of concerns received during the relevant period, we will highlight later in this statement where this has been undertaken in relation to some specific areas that the Inquiry has asked us to address.

780. In addition to the formal mechanisms discussed above, during the relevant period, we engaged and communicated with a wide range of stakeholders as part of our day-to-day functions and as part of our response to Covid-19 to receive and raise concerns relevant to our work.

781. Below is a summary of how concerns about the following issues were raised to or by CQC, and how they were handled by CQC:
    781.1. PPE including lack of, use, misuse and re-use of PPE and adherence or otherwise to PPE guidelines;
    781.2. IPC including adherence or otherwise to IPC guidelines;
    781.3. Outbreaks of Covid-19 in care homes;
    781.4. GPs refusing or limiting visits to those in receipt of adult social care; and
    781.5. Inappropriate triaging of those in receipt of adult social care (for example an inappropriate refusal to take an unwell recipient to hospital, increased delays in paramedics attending care homes).

PPE and IPC

782. During the relevant period, we received concerns relating to IPC and PPE in adult social care via channels including NCSC and GFC as well as from providers and

local authorities. These concerns were published by us during the relevant period in the form of high-level summaries relating to IPC and PPE in some of our Covid Insight Reports and State of Care Reports. Additionally, our internal Cross-Engagement Insight Reports included some anecdotal references to concerns about various IPC and PPE issues that we were alerted to via our NCSC and GFC channels.

783. Whilst we have not undertaken analysis of individual IPC related concerns received via GFC and NCSC for the duration of the relevant period, some qualitative analysis of information from complaints, GFC and whistleblowing data for the period 2 March 2020 to 2 August 2020 was performed for internal use. This analysis was completed by the Local Qualitative Analysis Team (LQAT) in support of an internal working group called the Covid-19 Emerging Issues Group. The team consisted of various colleagues from our Intelligence Team at the time.

784. In April 2020 the LQAT developed a coding framework which was designed to monitor the incoming queries relating to Covid-19. Two senior analysts completed a thematic analysis of a sample of GFC enquiries relating to Covid-19 to develop an inductive (data-driven) coding framework and associated guidance materials. The framework was then applied to Covid-19 related queries on an ongoing basis. The resulting framework was designed to only code data or data segments which referred to Covid-19.

785. Colleagues within LQAT, as well as colleagues from other teams in Intelligence, were trained to apply the coding framework to Covid-19 related enquiries. The framework was used to monitor data received by CQC from multiple sources on an ongoing basis. Incoming enquiries were coded manually by colleagues and as this was a manual process with, at times ambiguous data, we put in place several quality assurance measures to ensure accurate coding, meaning consistency across coders as well as coding that reflected the content of enquiries correctly.

786. This ongoing analysis fed into a Power BI dashboard which was refreshed weekly. The dashboard gave a top-level overview of frequency of codes as well as a regional and sector breakdown of the data to give an idea of the key issues around managing Covid-19 in the system. It was also possible to further filter the code frequencies for

individual locations. The coding framework consisted of 14 codes, which were grouped into 6 higher-level codes as outlined below (MC1/544 [INQ000398754]).

787. These higher-level codes included: "Infection Control"; "Management Approach"; "Being Informed"; "Attitudes and Concerns"; "Access to Services"; and "Other". Each of these codes/themes contained more detailed sub-codes related to various issues as follows:

787.1. The code "Infection Control" was of particular significance because it contained analysis of the data related to two subcategories:

787.1.1. Availability of infection control: Availability of hand sanitiser/soap/washing facilities; Personal Protective Equipment (PPE), including clothing; availability of tests (staff, patient, relatives.

787.1.2. Infection and control practice: How hygiene/infection control is practiced within service; cleaning facilities, wearing PPE (if PPE is available), movement of staff between wards/services/people's homes, (self-)isolation of people with suspected symptoms (NOT staff, movement of people using the service within and outside of the service.

787.2. The code "Being Informed (Information/guidance/leadership/training)" reflected the information received about: training in how to prevent coronavirus spreading, e.g. training in use of PPE, training infection control.

788. The report can be filtered to show the number and percentage of Covid-19 related enquiries received with information for each code. The report can be further filtered to show the number of concerns and percentages by sector (ASC, Hospitals, PMS), by source type (complaint, complaint about provider, GFC, whistleblower), and by week, beginning from 2 March 2020 to 27 July 2020. The report also provides the number of IPC related tags applied to concerns we received by CQC region and NHSE region, which can again be further broken down into sector, source type and date. We divide England into regions for management and oversight purposes, that we apply across our work. These are: East; East Midlands; London; North East; North West; South East; South West; West Midlands; Yorkshire and Humberside. Our regional groups do not exactly align with those used by NHSE for the purposes

of their own work. NHSE regions are: Midlands; North East and Yorkshire; South East; North West; East of England; London; and South West.

789. The individual enquiry details from our CRM system relating to availability of IPC products and infection control practice for the data contained in this report, including the free-text box description of the enquiry, can also be found in the Power BI report where they exist, by searching through the location ID numbers.

790. We shared information from this report with DHSC regularly from June 2020. The report was last updated on 7 August 2020. This was due to the fact that the number of enquires being received had started to reduce substantially by this point MC1/545 [INQ000525109].

791. Our Covid Insight Reports published during the relevant period also featured information about concerns raised to by us relating to IPC and PPE in adult social care services. They were designed so that we could share a contextualised and data-driven narrative about what was happening across health and social care during the pandemic.

792. We determined the themes, content, and format of these reports which evolved over time and sometimes differed from report to report. We published 15 in total. More detail on 6 of the Covid Insight Reports which refer to IPC concerns is set out below by way of example.

    792.1. Issue 1 published on 1 May 2020 referenced 'The Impact on Care Providers and Staff'. In this issue we reported how PPE availability was still a big concern, specifically in domiciliary care where only 6% of agencies in London had enough PPE to last two days or less. We also reported how access to testing was key to reducing infection and saving lives, stating a key consideration in this regard had been to improve the availability of testing for frontline social care and primary care staff. We also outlined how the pandemic was putting financial pressure on the ASC sector, noting that some providers were struggling financially with the cost of PPE, including having to pay inflated costs to source what they desperately needed.

(MC1/337 [INQ000235471]). This issue is described in greater detail in Section I above.

792.2. Issue 2 published on 15 June 2020 focused on how providers were working across systems in response to the pandemic. From our conversations with providers, we reported that one of the barriers to collaboration that stakeholders had faced was the need to share resources, including PPE, fairly and in a timely way. (MC1/338 [INQ000235472])

792.3. Issue 3 published on 15 July 2020 highlighted our news item published on our website on 17 June 2020 about the increase in NCSC calls from providers raising concerns about care, many of which related to issues with PPE and infection control. We also described the initial findings of the 50 inspections carried out in ASC services between March 2020 and July 2020 where we had inspected in response to reports of poor IPC (MC1/339 [INQ000235473]; MC1/122 [INQ000398848]). This issue is described in greater detail in Section I above.

792.4. Issue 4 published on 15 September 2020 focused on IPC for care homes as one of its key themes. This issue is described in greater detail in Sections G and I above. (MC1/176 [INQ000235474])

792.5. Issue 5 published on 18 November 2020 provided a summary of IPC in care homes, providing insight on the findings from our IPC inspections in care homes including on the effective use of PPE specifically. (MC1/340 [INQ000235462])

792.6. Issue 6 published on 15 December 2020 provided a summary of the IPC inspections that took place in October and November 2020 which had increasingly included inspections of designated settings (MC1/341 [INQ000235475]). This is described in greater detail in section K above.

793. During the relevant period we stood up Cross-Sector Regional Escalation Groups situated across the country. These internal groups were set up by the Deputy Chief Inspectors (DCIs) through their understanding of risks, allocating a Manager to each region working collectively cross-sector. The groups offered real-time intelligence on issues from providers at a local level, helping to build a picture of trends and risk. Information gathered here was shared with system partners, such as DHSC and

Local Authorities, for national support and to help make decisions at a local level. The groups reported into a National Escalation Group.

794. During the relevant period we also produced Covid-19 Cross-Engagement Insight Reports which were shared internally. Twenty-two issues were produced from April 2020 to March 2022.

795. The reports were contributed to by a collaboration of colleagues from across our Transformation teams and Engagement Directorate. Monthly meetings were held with CQC employees by the Director of Engagement as a means of keeping them informed of the plans for the upcoming reports and any initial insights and key themes noted from liaison and engagement with different stakeholders.

796. These internal teams (Transformation, Public Engagement, Provider Engagement, Internal Engagement, and Parliamentary Governance and Stakeholder Engagement) collated insight from their engagement activity in the form of meetings, reports, action notes, survey results, focus group notes and webinar notes. The contents of the reports vary depending on the engagement activities undertaken and information received during the period. These included concerns received from a wide range of stakeholders, on a wide range of Covid-19 related themes.

797. The reports were not published or shared externally. The information in the reports was used by Engagement colleagues to inform discussions and briefings with key external stakeholders and internal colleagues. Key themes and insights from the reports were also brought to our Gold Command meetings at times. Engagement teams also used the findings throughout their wider engagement work to evidence any concerns we wished to raise externally, to show how we had listened to and engaged with external stakeholders, and to help us respond to feedback and concerns.

798. Some examples of the Covid-19 Cross-Engagement Insight Reports which featured information related to IPC and PPE concerns in ASC settings are included below:

798.1. Issues 1 to 6 released between 8 April and 20 May 2020 reported on access to and availability of PPE as a recurring concern from people who use

services (MC1/546 [INQ000398755]; MC1/547 [INQ000398756]; MC1/548 [INQ000398757]; MC1/549 [INQ000398759]; MC1/550 [INQ000398760]; MC1/551 [INQ000398761].

798.2. A lack of consistent guidance on IPC and use of PPE was also a common theme across audiences and was reported in later issues including Issues 12, 14 and 15 released between 30 June 2020 and 14 August 2020 (MC1/552 [INQ000398762]; MC1/553 [INQ000398763]; MC1/554 [INQ000398764].

799. Concerns that were noted on social media channels were tagged by an internal system and reviewed by NCSC colleagues and communicated to Engagement colleagues. These social media concerns tags were reported to our Executive Team, included in the Cross-Engagement Covid-19 Insight Reports and were communicated at Regional Escalation Groups by CQC.

800. In 2021 Engagement colleagues started to produce quarterly Cross Engagement Insight Reports. The first quarterly issue released on 28 May 2021 for the period January to May 2021 noted IPC as a barrier for the public, providers, and stakeholders. Providers were concerned about access to PPE, and the public shared concerns about access to services due to infection risk. (MC1/555 [INQ000398765])

801. These considerations are echoed and summarised in the State of Care Reports produced during the relevant period, which included IPC as a consistent theme as set out below:

State of Care Report for 2019/2020 (MC1/39 [INQ000235495])

802. In the section covering the impact of the Covid-19 pandemic on IPC we reported that:

802.1. During August 2020, we carried out a special programme of IPC inspections in 301 care homes selected as potential examples of where IPC was being done well. We were encouraged by the findings, with more than 90% assurance across all the elements we were looking at, and plenty of good practice examples.

802.2. We also reviewed IPC in 139 care home inspections that we carried out in high-risk services from 1 August to 4 September 2020. During these inspections, we reviewed how well staff and people living in care homes were protected by IPC measures, looking at assurance overall and across eight key areas. We were mostly assured by the approaches those care homes had taken. The main areas that needed to improve were around having out-of-date IPC policies and not using PPE in the most effective way.

802.3. We saw an increase in calls to our national contact centre from health and social care staff raising concerns about care. The biggest increase came from staff in the adult social care sector where there was a 55% increase in the number of calls made for the period 2 March 2020 to 31 May 2020 compared to the same period in 2019.

802.4. We also saw an increase in information sharing from people using services, their relatives, and staff, including through our GFOC service. IPC was the most common theme from the feedback received through our GFOC service, appearing in 44% of enquiries.

State of Care Report for 2020/2021 (MC1/159 [INQ000235497])

803. In our 2020/2021 State of Care Report we reported on the findings of the IPC inspections undertaken in hospitals and care homes for the 2020/2021 period as follows:

803.1. Care homes: Our report on 'How care homes managed infection prevention and control during the coronavirus pandemic 2020' published in November 2020 was based on a programme of 440 care home inspections in August and September 2020 that looked at IPC assurance across eight questions and found that most of the providers demonstrated that they had faced the challenges of the pandemic well. This is discussed in greater detail in Section G above.

<u>Outbreaks of Covid-19 in care homes</u>

804. During the relevant period enquiries and concerns regarding Covid-19 outbreaks in adult social care settings were received and recorded as described above.

805. We did not undertake any quantitative or qualitive analysis of the data received via the routes described above in relation to the issue Covid-19 outbreaks during the relevant period. Further, it has not been possible to perform any retrospective analysis of the data for this specific subject when preparing this statement because we did not have the relevant tags in place within our CRM, the system used by our NCSC operators at the time, and due to the limitations of our current system.

806. Whilst we have not undertaken analysis of individual outbreak related concerns for the duration of the relevant period, below is a summary of the nature of those concerns as recorded in the various internal and external insight reports, and the State of Care Reports.

807. In our Covid-19 Insight Reports we included high-level analysis of PHE's data on outbreaks of Covid-19 in care homes. The analysis included a heatmap showing the percentages of all care homes in each local authority that had an outbreak of Covid-19, as confirmed by PHE. We split the local authorities into five equal groups, and ranked them from the lowest fifth to the highest in terms of outbreak numbers. We confirmed that care homes were only counted once, when they first experienced an outbreak. We provided a breakdown of the number of outbreaks broken down by sector and by region. We also included a graph depicting the percentages of outbreaks in care homes in each region, as assigned by PHE, and a graph showing the new weekly care home outbreaks as a rate per 1000 care homes broken down by region as assigned by PHE's methodology. We included this data in Covid-19 Insight Report Issues 1; 2 and 3. Thereafter we began reporting on the prevalence of Covid-19 in homecare agencies and providing data on Covid-19 related deaths. (MC1/337 [INQ000235471]); (MC1/338 [INQ000235472]) and (MC1/339 [INQ000235473]).

808. From the Regional Escalation Groups we were hearing that there were a lot of concerns around lack of testing leading to outbreaks in care homes and deaths occurring due to this (MC1/546 [INQ000398755]). The Regional Escalation groups were also reporting that there were clusters of Covid-19 outbreaks and related deaths in certain regions as a recurring theme throughout the pandemic (MC1/552 [INQ000398762] and MC1/553 [INQ000398763]).

809. In our State of Care Report for 2021/2022 (MC1/556 [INQ000398569]), in relation to the capacity and stability in adult social care, we reported that when care homes had outbreaks of Covid-19, many were unable to admit people for prolonged periods. In some areas this had a very significant impact on hospital discharges and transfers of care. We also reported that workforce shortages and infection outbreaks had resulted in a reduction in care home capacity, which had been particularly acute in some regions.

810. In terms of the handling of these concerns, as part of our ASC IPC inspection program, we looked at assurance across eight questions as set out in detail in Section G above, including looking at whether:

    810.1. Staff were properly trained to deal with outbreaks and the proper procedures were in place;

    810.2. Shielding and social distancing were being done correctly; and

    810.3. Layout of premises, use of space and hygiene practice promoted safety.

<u>GPs refusing or limiting visits to those in receipt of adult social care</u>

811. In January 2021, we issued an internal report based on a review of access to Primary Medical Services between April and December 2020 ("2021 PMS Access Review"). The 2021 PMS Access Review provided insights into people's experiences of access to these services shared with us through GFC, phone calls, and our social media channels. The report was for internal use only and was not shared externally. (MC1/557 [INQ000398771])

812. The 2021 PMS Access Review set out the findings of our qualitative analysis of a random sample of the concerns we had received during the review period. In the report we were able to highlight 'access to services' as a common topic amongst GFC submissions. We were also able to provide examples of access issues, together with a summary of the common themes and barriers associated with access. The 2021 PMS Access Review also provided an overview of the outcomes associated with poor access (where this was included in comments received and/or conversations we had) and referred to the personal impact this had. The data analysed as part of this review was limited to the experiences and concerns of those

who had submitted comments to us through the channels mentioned above. As a result, it is stipulated that "*This report cannot comment as to whether PMS access issues are prominent/have increased within the general population, as the analysis presented here has only considered the experiences of those who submitted comments through the previously mentioned data sources.*"

813. One of the common themes associated with access covered in the 2021 PMS Access Review was "mode of appointment" in respect of which some people had told us how the type of appointment they received was not appropriate. These concerns mainly related to telephone calls and online/email consultations. We also indicated that we had heard from people living at home and staff of care homes that had been refused home visits. In these cases people often had barriers that stopped them from physically attending an appointment. One of the reasons we had heard for no home visits was 'GPs refusing to come out to patients homes' and 'using Covid as an excuse.'

814. In November 2021, we commissioned research and consultancy company Traverse Ltd to carry out a survey of the experiences of adults in England who had tried, successfully or not, to access GP services during the pandemic. The survey, which comprised 28 questions, was completed between 1 and 15 November 2020 and covered the experiences of 2087 adults in England who had tried, successfully or not, to access a GP service in the past 12 months. It was conducted using an online survey administered to members of the YouGov Plc UK panel of 1,000,000+ individuals who had agreed to take part in surveys. (MC1/558 [INQ000398772])

815. Some of the themes and findings of our 2021 PMS Access Review and the Traverse GP Access Report are also featured in our State of Care Report for 2021/2022. (MC1/159 [INQ000235497]) as follows:

    815.1. Of the 2,087 adults who responded to the Traverse GP Access survey and who did not get a GP appointment in the previous 12 months:

        815.1.1. 25% didn't see or speak to anyone.

        815.1.2. 25% decided to contact their practice at another time.

        815.1.3. 16% attempted to self-diagnose using an internet search.

        815.1.4. 10% went to A&E

815.2. In our analysis of feedback received via our GFC service, phone calls and social media between April and December 2020, we found that many people who contacted CQC about access to GP services told us about their inability to make an appointment. People described finding it difficult to figure out the best or 'correct' way to contact practices. When calling by phone, people told us they were often on hold or in a queue for a long time. Some people found that, when they did make a telephone appointment, the doctor did not call them during the allotted time or at all, and they had to go through the booking process again.

816. Between 2 March 2020 and 2 August 2020 our internal Covid-19 Emerging Issues Group also analysed qualitative data from complaints, GFC and whistleblowing concerns in relation to access to services and produced a report. The report provides a summary of the concerns received regarding 'access to services (systems)' and the numbers of Covid-19 related enquiries with information pertaining to 'access to treatment/care (other conditions)' and 'access to treatment/care for coronavirus'. The data can be filtered by sector, by source type (complaint, complaint about provider, GFC, whistleblower), and by week. The report also provides the number of access to services/system related tags applied to concerns we received by CQC region and NHSE region, which can again be further broken down into sector, source type and date. (MC1/544 [INQ000398754])

817. In our first Covid-19 Insight Report we described instances where there were good examples of collaboration between care providers, including between GPs and care home providers. We indicated that we had heard many examples of care homes being aligned to GP practices to support better care planning, to ensure that care homes were visited regularly, that they had a good supply of basic diagnostic equipment and were confident to use it (MC1/337 [INQ000235471]).

818. In October 2021 we developed an inspection methodology with a particular focus on access to GP services (MC1/559 [INQ000391358]) . Between November and December 2021 CQC carried out 38 inspections with a specific focus on the management of access in GP practices.

819. The access inspections focused on the responsive key question (KLOE R3 - Access to Treatment) to consider how appointment systems were being operated. This enabled us to identify and highlight good areas of practice and to support a broader understanding of access issues. The inspections were triggered in response to risks and/or concerns identified through a targeted intelligence review and from information received via existing routes such as GFC, whistleblowing and/or complaints or from information shared with us by CCG/ICS teams as part of their plans to improve access. The access inspections were undertaken as a standalone activity but were not intended to replace other inspections. The inspections were usually unannounced and focused on access and were guided by a series of specific questions and prompts as follows:

819.1. Do people have timely access to appointments/treatment and was action taken to minimize the length of time people waited for care, treatment or advice?

819.2. Does the practice provide a range of appointment types to suit different needs?

819.3. Can people make appointments in a way which meets their needs?

819.4. Are there systems in place to support people who face communication barriers to access treatment?

819.5. Do people with the most urgent needs have their care and treatment prioritised?

819.6. Is there information available to support people to understand how to access services?

819.7. Are there enough staff to provide appointments and prevent staff from working excessive hours?

819.8. Are there systems in place to monitor the quality of access and make improvements? From January 2022 the access inspection questions and prompts were incorporated into our existing inspection framework to enable us to ensure that we continued to have a comprehensive view of access, in conjunction with other aspects of general practice.

820. From January 2022 the access inspection questions and prompts were incorporated into our existing inspection framework to enable us to ensure that we continued to

have a comprehensive view of access, in conjunction with other aspects of general practice.

Inappropriate triaging of those in receipt of adult social care

821. We did not undertake any quantitative or qualitive analysis of the data received via the routes described above in relation to inappropriate triaging of those in receipt of adult social care during the relevant period. Further, it has not been possible to perform any retrospective analysis of the data for this specific subject when preparing this statement because we did not have the relevant tags in place within our CRM, the system used by our NCSC operators at the time, and due to the limitations of our current system.

822. Whilst we have not undertaken analysis of these concerns for the duration of the relevant period, below is a summary of the nature of those concerns and our handling of them as recorded in the State of Care Reports.

823. On 14 August 2020 we published an article on our website regarding "Access to hospital care and treatment for older and disabled people living in care homes and in the community during the pandemic" (MC1/560 [INQ000525110]). The purpose of the article was to convey to providers that it was vitally important that older and disabled people living in care homes and in the community could access hospital care and treatment for Covid-19 and other conditions when they needed it during the pandemic.

824. Earlier in the pandemic there were widely reported instances regarding potential discrimination in access to acute care, through triage/care pathways/decision making tools that some trusts were using to avoid admitting people from care homes or disabled and older people more generally. Our view was that whilst these "admissions avoidance" protocols may have been appropriate in certain situations, for example, where they were used to avoid admitting people who wanted to stay at home/in their care home or where appropriate care could be provided there, any use in a discriminatory way was unacceptable.

825. In the article we made it clear that if providers were putting in place local guidelines or decision-making protocols on access to care and treatment, these should always ensure that clinical decisions and pathways were not discriminatory and enabled equal access to hospital care and treatment for everyone. We stated that providers should communicate these guidelines and any changes quickly and widely and ensure that their staff understood and applied them correctly.

826. From September 2020 the article was included as a guide for inspectors using the TMA (and then the DMA) for independent ambulance services; ambulance patient and transport services; ambulance emergency operation centres; NHS ambulance emergency and urgent care services and NHS Trusts from September 2020 in relation to the overarching question "Do services take account of the particular needs and choices of different people?".

827. In our State of Care Report for 2020/2021 [MC1/159 [INQ000235497]) we reported that as the number of people seeking emergency care continued to rise in the early stages of the pandemic, this had led to unacceptable waiting times for ambulances.

828. In our State of Care Report for 2021/2022 (MC1/556 [INQ000398569]) we reported that the health and social care system had become gridlocked due to the pressures of the pandemic, and this was clearly having a hugely negative impact on people's experiences of care. A notable effect of this was that people in need of urgent care were placed at an increased risk of harm due to long delays in ambulance response times. We reported that we had also received consistent concerns about ambulance response times from care home providers. In one case, a person with a fractured hip was not classed as 'urgent' as they were deemed to be in a place of safety. Care home staff were told not to move the person and were only able to offer them paracetamol for pain relief. Despite a number of calls to the ambulance service, they lay on the floor for over 8 hours before the ambulance attended and transported them to hospital. CQC's response to the Coroner's Prevention of Future Death Report for this case was published with the Inquest documents and it notes that we were continually monitoring the regional ambulance picture, through ongoing engagement, performance reports and internal meetings. We indicated that we had been made aware of the impact of response times due to the delays caused by handovers at hospitals but that we expected the registered persons at the care home

in question to take on board and implement the relevant government guidance, which we had kept them informed of and signposted them to through regular engagement calls (MC1/561 [INQ000525111]).

829. In our State of Care Report we described how, in response to the greater issue of the entire health and social care sector having become gridlocked, we undertook a programme of coordinated inspections of urgent and emergency care (UEC) services in 10 integrated care systems to review the whole UEC pathway. We found that UEC services across England were under immense pressure due to issues with the flow of patients, ambulance delays, primary and community care challenges, staffing problems, complexity of pathways and a lack of collaboration across sectors and services. When we completed our reviews, we brought system leaders together in a workshop to discuss the improvements needed across UEC pathways. This formed the basis of our PEOPLE FIRST resource published in September 2022, which built on our Patient First resource developed in 2020.

Surveys conducted by the CQC about the impact of the pandemic on providers of ASC

830. The Inquiry has asked us to provide, for the relevant period, a list and short summary of surveys conducted by CQC about the impact of the pandemic on providers of care. It is important to note that during the pandemic CQC recognised that ASC providers were under a lot of pressure and, as such, surveys were limited so as not increase the workload or burden on providers. We also relied on the sharing of results from surveys conducted by other stakeholders and organisations, as outlined in our State of Care Reports, to monitor and report on the impact of the pandemic on providers of care. In addition, as part of our annual State of Care reports, we also utilised the surveys and reports of other organisations to guide and support our findings.

831. In addition to the DCA Tracker, explained in detail in Section G above, the most relevant surveys conducted by CQC about the impact of Covid-19 on providers of care were as follows:
    831.1. CitizenLab surveys;
    831.2. Adult Social Care Workforce Survey

831.3. Annual Provider Survey;

831.4. DNACPR;

831.5. Market Oversight Provider surveys.

CitizenLab surveys:

832. On 17 June 2020 CQC's Research and Evaluation team, supported by the Provider Engagement team, launched concurrent surveys seeking provider feedback in order to gather feedback to improve the support we were giving to providers. The surveys were conducted on CitizenLab (a digital public engagement platform) and ran concurrently from 17 June 2020 to 1 July 2020. The details of the surveys are outlined below:

832.1. Feedback on CQC's response to the pandemic (MC1/562 [INQ000525061]): The survey sought provider feedback on CQC's response to the pandemic and asked the following questions:

832.1.1. Whether the changes CQC made to the way we regulated during the pandemic had a positive impact

832.1.2. Whether CQC had been clear about the changes made to the way we regulate during the pandemic

832.1.3. Whether the providers understood why CQC had made the changes they had

832.1.4. Whether CQC were doing the right thing in response to the pandemic

832.1.5. Whether the changes CQC made to the way we regulated during the pandemic reduced the burden on providers

832.1.6. Whether CQC responded quickly to the pandemic and the needs of providers

832.2. Ensuring Safe, Effective and High-Quality Care during the pandemic (MC1/563 [INQ000525065]): The survey sought provider feedback on whether CQC ensured people were receiving safe, effective and high-quality care during the pandemic, and whether CQC effectively monitored risk with the aim of improving the support we were giving to providers and asked the following questions:

832.2.1. Was CQC able to ensure that people were receiving safe, effective and high-quality care during the pandemic?

832.2.2. Was CQC able to effectively monitor, and identify risk to people who used services during the pandemic

832.3. Understanding of the ESF (MC1/564 [INQ000525060]): The survey sought provider feedback on their understanding of the ESF and asked the following questions:

832.3.1. What was your understanding of the purpose of the ESF?

832.3.2. From your understanding of the ESF, do you think it is the right approach for CQC to be taking during the pandemic?

832.3.3. What approach do you think CQC should be taking during this time?

832.3.4. What benefits do you think the ESF might offer?

832.3.5. What are the limitations of the ESF?

833. In October 2020, a further CitizenLab survey was launched seeking provider feedback on whether CQC was a supportive regulator during the pandemic (MC1/565 [INQ000525064]). The survey ran from 7 October 2020 to 26 October 2020. The survey asked whether CQC succeeded in becoming a supportive regulator during the pandemic and asked providers to outline supportive/unsupportive behaviours displayed by CQC as well as indicating whether CQC could do to be more supportive.

834. On 25 March 2021 CQC's Research and Evaluation Team launched another Citizenlab survey in order to capture providers' opinions on the TRA. The survey was sent to providers via our regular provider bulletins and ran until 13 April 2021(MC1/566 [INQ000525066]). Provider reflections of CQC's TRA. The survey asked the following questions:

834.1. Are you confident in your understanding of CQC's transitional regulatory approach?

834.2. From your understanding of CQC's transitional regulatory approach, do you think it is the right approach for CQC to be taking?

834.3. Do you feel that the approach is an effective way to assess changes in quality of care?

834.4. Do you feel that the approach is able to effectively consider voices of people who use services and their relatives and people who work within services?

Adult social care workforce survey – December 2021

835. During the week commencing 13 December 2021 we launched the Adult Social Care Workforce survey tool. This provided inspectors with structured questions and prompts to help understand the workforce challenges at a location level as well as capture the actions that providers were taking to mitigate risks to the quality of care people were receiving. It was used on all ASC inspections (both care homes and care at home services) as well as on DMA calls. The tool was used to explore with providers what impact workforce challenges and staffing shortages were having on the services that they delivered to people.

836. The survey was completed more than once for some services and all responses from the same provider were included in the analysis. As at 30 June 2022, the survey was completed over 5,500 times by inspectors talking to providers.

837. The analysis of the information gathered was presented in CQC's State of Care report 2021/22 (MC1/556 [INQ000398569] . Key workforce challenges reported by both care home and homecare providers were related to recruitment and retention. 36% of care home providers and 41% of homecare providers said that workforce challenges have had a negative impact on the service they deliver. Of the providers who reported workforce pressures having a negative impact, 87% of care home providers and 88% of homecare providers told us they were experiencing recruitment challenges. Over a quarter of care homes that reported workforce pressures told us they were actively not admitting any new residents.

DNACPR Survey

838. As detailed in Section J above, on 7 October 2020 CQC was commissioned by the Rt Hon Nadine Dorries MP in her capacity as Minister of State for Patient Safety, Suicide Prevention and Mental Health to conduct a section 48 review of DNACPR decisions taken during the pandemic in the context of advance care planning.

839. As part of this review and to help us understand the scale of the issue, we sent a voluntary information request to around 25,000 adult social care providers (including care homes, nursing homes, domiciliary care agencies, supported living schemes,

Shared Lives facilities and extra care housing). While acknowledging that responsibility for making DNACPR decisions did not predominantly rest with adult social care providers, we asked them a range of questions to understand their views of the experiences of people in these settings.

840. We asked about the number of inappropriate DNACPR decisions put in place from 17 March 2020, what made them inappropriate and if they remained on people's records at the point of submission of the information request.

841. We analysed 2,048 responses, which were received from 7 December 2020 to 21 December 2020. It was a relatively low response rate (we received 2,171 responses our of approximately 25,000 providers and 2,048 were analysed due to data quality issues); however, it did allow us to capture the lived experiences of those who have had a DNACPR decision, or their families/carers.

842. In addition to the surveys, CQC held 156 interviews and focus groups with clinicians, professionals and workers from different roles and organisations involved in providing care, which included the use of DNACPR decisions, to understand practice, challenges and enablers for best practice. We also spoke with commissioners and system leaders to explore practice across the system, collaboration and how oversight arrangements ensure best practice in DNACPR decisions

843. The provider survey, focus groups and interviews were considered together with other review processes as described in Section J and the findings published in the "Protect, respect, connect – decisions about living and dying well during COVID-19: CQC's review of 'do not attempt cardiopulmonary resuscitation' decisions during the COVID-19 pandemic" report on 18 March 2021 (MC1/356 [INQ000235492]).

Annual Provider Survey

844. The Annual Provider Survey is part of CQC's programme of Annual Strategy surveys which are carried out to track what providers and stakeholders think about the way we regulate. We use the results to help measure the progress of our strategy.

845. Between 2018 and 2020 the Provider Survey asked a representative sample of providers about their experiences of CQC regulation. From 2021 the Provider Survey has asked all providers about their experiences of how well we are delivering our strategy.

846. The 2020 Annual Provider survey was carried out in October 2020 and focused on experiences of regulation during the pandemic. This included factual questions, for example "During the pandemic have you contacted CQC?" as well as opinion-based questions, for example "During the pandemic the information I received from CQC was useful to my service (Yes / No)".

847. 31,077 providers were invited to complete the survey, and 30.5% of these submitted responses. The results are published on our website and presented both collectively and broken down by sector (Adult Social Care; Hospitals; and Primary Medical Services) (MC1/567 [INQ000525112]).

The Market Oversight Provider Surveys

848. As explained in Section A of this statement, the Market Oversight Team collects and monitors information about a provider's finances and combine this with the information we already collect about quality of care. They use this to assess the level of risk to the provider's financial sustainability. As explained in Section K above, during the pandemic, the team continued to engage with providers, monitor financial risks and share intelligence as needed.

849. The team was amongst the first to report on the occupancy impact of Covid-19 on care home providers and they continued to monitor this alongside ongoing cost pressures and the impact of government support measures on the sector. The team also provided expert input into wider government projects including the McKinsey report commissioned by DHSC on Covid-19 impact and response.

850. It was noted in the first half of 2020 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.

851. 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. 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.

852. 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. These reports are discussed in greater detail in Section K above.

853. We also produced quarterly consolidated analysis which included this information. This analysis was used:

853.1. to form our own internal understanding of occupancy trending and risk relative to the performance of providers;

853.2. on an ad-hoc, anonymised basis with providers who participated in the survey;

853.3. in various Covid-19 update reports to DHSC/Government;

853.4. to underpin numbers in DHSC's Provider Viability Advisory Group (PVAG) reporting and discussion; and

853.5. 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.

O. Lessons learned and recommendations

854. The Inquiry has asked us to provide, for the relevant period, a chronological list of any internal or external reviews, State of Care Reports, lessons learned exercises or similar, produced or commissioned by us and which relate to any of the matters in the Provisional Outline of Scope for Module 6. In addition, we have been asked to include a summary of the conclusions and recommendations of any such reviews, reports or exercises, and whether any recommendations made as a result have been implemented.

855. The attached chronological list ("the list") (MC1/568 [INQ000560889]) sets out the reviews, reports and exercises completed together with details of the findings reached and recommendations made (as appropriate) where these can be drawn from the document itself and any supporting information. The list comprises 74 entries that have some potential relevance to the Provisional Outline of Scope for Module 6.

856. The list was compiled with reference to the similar list provided in Module 3. The Module 3 list was produced following the manual review of publications on our website as well as the work undertaken by our internal teams and directorates which was reported to the Board, the Executive Team, and the Gold and Silver Command Committees. To compile the list for Module 6, we have intentionally omitted all reviews, reports or exercises that were solely focused on matters that relate to Healthcare and Primary Care on the basis that these have already been considered during Module 3 and do not fall within the Scope of Module 6. Following further manual review of work undertaken by our internal teams and directorates, any

review, report or exercise focused on matters relating to Social Care (intentionally omitted from the Module 3 list) were included.

857. Column C of the list indicates whether the review, report or exercise was internal or external. In respect of the external reviews, reports and exercises Column C also indicates whether they were conducted upon the request of the Secretary of State in terms of section 48 of the Health and Social Care Act 2008. We have also included details of any recommendations (Column H) and implementation activity undertaken to date (Column J) where it has been possible to do so.

858. The Inquiry has asked CQC to comment on any areas of the response to the pandemic that we consider went well or were successful in how the ASC sector responded during the relevant period. Our brief views are that, on the whole, the profile of the ASC sector was successfully raised during the pandemic and that the health and social care system achieved a degree of integration beyond what it generally seemed able to deliver. It is difficult to come to any conclusions about the extent to which this spirit of co-operation persists but it is our view that when CQC commences the assessments of ICSs, we ought to be better placed to offer an independent view on this.

859. In respect of the actions and work undertaken by CQC during the pandemic, it is our view that we contributed positively to the ability of the ASC sector to handle the pandemic as has been highlighted throughout this detailed statement.

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 March 2025