

IN THE UK COVID-19 PUBLIC INQUIRY

BEFORE BARONESS HEATHER HALLETT

In the matter of: The Public Inquiry to examine the Covid-19 Pandemic in the UK

**Care Quality Commission (CQC)
Written Closing Statement for Module 6**

These submissions include the submissions made orally on 31st July 2025.

1. The Care Quality Commission wishes to thank you, my Lady, and your team for the obvious care and attention paid to the important evidence heard in this Module and wish to assure the Inquiry that they too have followed the evidence attentively. CQC acknowledges the observations of many witnesses about the impact of decisions made during the pandemic and their varied experiences of CQC over that period.
2. It has become clear that a number of themes have emerged from the evidence.
3. The three referenced in oral submissions were:
 - 3.1. Pausing routine inspections;
 - 3.2. Guidance on the discharge of patients from hospitals to care homes; and
 - 3.3. Contingency planning and CQC's role in future pandemic preparedness.
4. In addition, in these written submissions CQC wishes to address the following topics:
 - 4.1. Care Home Visiting and the new fundamental standard of care created by Regulation 9A;
 - 4.2. How CQC did, and should, keep Government informed during a pandemic;
 - 4.3. CQC's role in tackling inappropriate DNACPR orders; and
 - 4.4. CQC's role in data collation.

Pausing routine inspections and what should happen in the future

Was it the right decision in the circumstances at the time?

5. It is important to note the qualitative difference between routine inspections and inspections prompted by intelligence regarding a risk of harm. To quote from Helen Whately's summary in her evidence on 17th July 2025, as "...a care home or care provider was only going to be inspected every so often, anyway, to do their rating as to whether they are good or requires improvement, or whatever, and it might make sense in the future, as it did in this, to de-prioritise doing those because those aren't triggered by a particular concern about the care home and everything is going to be different probably in the care setting during a pandemic anyway, so are you even going to get a fair sense of how you should be rating a care provider in that circumstance?" (Transcript of Module 6 Public Hearing on 17 July 2025 12/123/10-20). However, risk based inspections differ and are critical in ensuring safe care. These were never paused.
6. CQC would invite the Inquiry to conclude that at the time, in March 2020, as regards routine inspections, the competing interests were the need to ensure that the public received safe care, whilst not exposing the vulnerable in those care homes to the virus being introduced by an inspector crossing the threshold without adequate PPE, testing or vaccination. The clear mandate at that time to those not designated as 'frontline workers', as CQC inspectors were not, was to 'stay at home' because the risk of death to the vulnerable was too great and it was not known how long that threat would persist.
7. Amongst the many witnesses from whom this Module has heard, there was Ms Gillian Baranski from Care Inspectorate Wales whose evidence on this same point as the Welsh regulator was, it is suggested, powerful – *"the thought of our inspectors taking Covid into a care home, of which we were the regulators, and we know how vulnerable many of the people who live in our care homes are. That just seemed unacceptable."* (Transcript of Module 6 Public Hearing on 7 July 2025 5/152/10-14)
8. One might test the merit of the decision to pause routine inspections by imagining the criticisms that might now be faced by all regulators in this Inquiry, if they had continued their routine inspections without adequate PPE and could be traced, just as care worker movement has been, as one of the key sources that introduced Covid-19 into care homes.
9. This balance, in favour of a pause, was canvassed with and understood by relevant stakeholders and ultimately endorsed by Government. Indeed the Inquiry will recall the

very clear evidence from the then Secretary of State, Mr. Hancock, which was for “CQC to *pull back more than they [were] currently planning on inspections & data collection*” (Transcript of Module 6 Public Hearing on 2 July 2025 3/155/21-23) to reduce the administrative burden on providers of social care. He told the Inquiry that he considered the consequences of pausing inspections to be “*a balance, and that's the challenge.... often in policy, especially in these terrible times, we were taking actions in order to preserve life....you could read out any number of totally reasonable reports of people who found it deeply upsetting not to visit, not to be visited, and not to have a CQC inspection. The challenge is that on the other side, there were, in my view, greater risks of having taken the other decision so it's just a question of balance.*” (Transcript of Module 6 Public Hearing on 2 July 2025 3/161/5-22).

How did CQC maintain contact and regulation?

10. CQC understands and accepts that to some providers and users of services, it would have felt different, as many things did during the pandemic. But CQC does not accept that it is a fair characterisation to say it ‘abandoned’ the adult social care sector, ‘went AWOL’ or that it withdrew oversight. From mid-March 2020 onwards, CQC gathered information to carry out its duties in the following ways:

10.1. Inspectors made proactive telephone calls to providers in their portfolios, prioritising those their experience suggested may be struggling more. This contact was designed to be supportive at the outset but was developed as part of the Emergency Support Framework from 1st May 2020 to become a more formal conversation to assess how a provider was coping. Where a provider was found to need support, further action from CQC was triggered including in-person inspections. Between 4th May and 29th October 2020, there were 11,935 ESF calls with care home providers within the ASC sector and an additional 6,281 to domiciliary care providers. Through ESF calls CQC identified that 301 care home providers needed support and, of those, 100 required an in-person inspection which took place within 6 months of the ESF call (of which 68 were between mid-March and mid-July 2020).

10.2. Intelligence was gathered from other sources as well (i) the Provider Collaboration Reviews which began in July 2020, (ii) the Give Feedback on Care form on the CQC website which received 138,000 comments between 1st March 2020 and 28th June 2022, and (iii) emails and telephone calls raising concerns including whistleblowing. All concerns were logged on CQC’s Customer Relationship Management system and reviewed by the National Customer Service Centre (NCSC). A total of 2.5 million enquiries were raised with CQC’s NCSC in that same period, of which 223,000 were

- Covid-19 related. This marked a 50% increase in contacts from the public and 55% increase from people working in services.
- 10.3. On 18 March 2020 CQC set up the internal Covid-19 ASC Response Panel to review and respond to questions from CQC colleagues as a result of the increase in queries being received in the ASC sector regarding Covid-19.
 - 10.4. In addition, IPC focussed inspections were undertaken in 300 care homes over August 2020 to supplement CQC's approach to the regulation of IPC in care homes and CQC was assured across all the IPC elements considered in those inspections in more than 90% of instances. A second phase of IPC inspections of an additional 500 locations took place between October and November 2020, and a total of 1200 IPC inspections were conducted by the end of January 2021.
11. In addition to the various intelligence gathering methods outlined above, during the pandemic CQC developed new assurance processes which used a risk-based approach to deliberately limit on-site inspection activity. The new assurance processes included:
- 11.1. The Transitional Regulatory Approach (TRA) which built on the work done through the development of the ESF and enhanced CQC's regulatory approach including by: 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 on-site inspections; taking a more dynamic and risk-based approach to inspections; strengthening the role of relationship management; and drawing a clearer link between monitoring activities and what CQC looks for on inspections. CQC developed a new app, the Transitional Monitoring Application (TMA) to facilitate operation of the TRA and undertook 396 TMA assessments in the ASC sector between 6 October 2020 and 12 July 2021. Through these assessments, CQC identified that "further regulatory activity" was required in respect of 28 care home providers and of those, 11 were inspected within a 6 month period following the TMA assessment.
 - 11.2. This then developed further from June 2021 when CQC expanded its monitoring approach to build capacity to inspect where higher risk was identified, including through Direct Monitoring Activity (DMA) calls. These were structured conversations with providers and an opportunity to explore any risks to care quality, the providers' actions in response to those risks, the process of sharing feedback and whether there was a need for further regulatory activity or enforcement action. CQC undertook 3642 DMA assessments in the ASC sector between 13 July 2021 and 28 June 2022. Through these assessments, CQC identified that "further regulatory

activity” was required in respect of approximately 164 care home providers and of those, 122 were inspected within a 6 month period.

- 11.3. From September 2020 to December 2020 CQC conducted a pilot programme of remote inspections of Domiciliary Care Agency (“DCA”) services and extra care services without visiting the location/site focussing on the Safe and Well-Led Key Lines of Enquiry (“KLOEs”). These inspections involved the use of technology, including video calling, Teams, the secure file transfer portal and other methods to engage with people using the service, their supporters and the providers. If concerns were identified, consideration was given as to whether to conduct an on-site inspection. Some of the key takeaways of the pilot were that CQC demonstrated an ability to carry out robust, evidence-based inspections using the pilot methodology without visiting the offices of the locations and to gather feedback from people using the services and their supporters in an effective and extensive manner.
- 11.4. The pandemic reinforced the importance of CQC’s Closed Cultures Project, started prior to the pandemic. Between May and July 2021, as part of this project, CQC proactively reviewed the information held on services which were considered to be at risk of developing closed cultures, to improve the understanding of, and how CQC identified, the risks associated with closed cultures which was particularly relevant in the context of the pandemic. This included the review of whistleblowing concerns, feedback about quality of care from people using services, their carers and provider staff, and notifications received from service providers. Where a closed culture was identified, CQC took appropriate action which included conducting focused inspections, using civil enforcement powers, and relocating people to other care services where necessary. The Closed Cultures Project led to the launch of CQC’s closed culture risk indicator dashboard in late 2021 which has since been embedded into CQC’s regulatory process.
- 11.5. During the pandemic CQC continued to use its civil and criminal enforcement powers where appropriate and developed an amended framework for enforcement decision making which provided for the impact of the exceptional circumstances arising from the pandemic to be considered. The following numbers of enforcement cases were taken in the relevant period: 3,298 in 2020, 4,511 in 2021 and 6,048 in 2022.

Matters arising out of oral evidence heard about CQC inspections

12. CQC heard the evidence of Christina McAnea on 8 July 2025 on behalf of the Trades Union Congress in response to CTI’s question regarding whether the regulatory inspection

regime adopted during the pandemic had an impact on care home workers. Ms McAnea suggested that *“if CQC were going in and looking at homes...and seen there was inadequate PPE, you'd have hoped they would have actually done something about that...If they were able to see that there were high levels of infections in particular care homes, then couldn't questions have been asked about that? And somebody sent in to assist the care home with looking at infection control, and that didn't -- none of that was happening, you know, because there was nobody going in to do the [inspections] or pick up on any of these particular issues”* (Transcript of Module 6 Public Hearing on 8 July 2025 6/196/20 - 6/197/8). Paragraphs 10 and 11 above demonstrate that CQC maintained its oversight where risk of harm to service users or staff arose. Though the methodology changed, it does not mean that lack of PPE or poor IPC was being ignored. The matters referenced by Ms. McAnea were being picked up and acted upon throughout the pandemic via the various intelligence gathering methods and assurance processes set out in CQC's evidence to the Inquiry, including at paragraphs 498 to 503 of statement INQ000584245 (pages 157-159) which reference the specific IPC inspections taking place and the ASC IPC tool that CQC used from the summer of 2020, and summarised above. Indeed, when the Designated Setting Scheme began in Autumn 2020, CQC assessed each location through an IPC inspection and with 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 (paragraph 687 INQ000584245/229).

13. In her evidence, Dr. Jane Townson, Chief Executive of the Homecare Association stated that she and her organisation had challenged CQC *“and said: if television crews -- the BBC worked with us early in the pandemic using smartphones to interview people drawing on services and care workers in people's own homes -- if the BBC can do that, why can't the Care Quality Commission? And they did say, well, fair point. And went off and did a pilot that there were about four times more volunteers for than they had slots for. But having done that, they then didn't follow it up. And still to this day, we don't know why.”* (Transcript of Module 6 Public Hearing on 14 July 2025 9/10/16-25). By this evidence, CQC understands that the Homecare Association sought to question before the Inquiry whether more should have been done to consult with the end users of domiciliary care during the pandemic. It should be noted that CQC does not have powers to inspect people's own homes as a matter of routine: domiciliary care providers are usually inspected by reference to the office base, which continued through the use of remote methods during the relevant period as explained above. Though CQC has not found records of these matters being raised during meetings with the Homecare Association at the time, in fact CQC did use the pandemic as an opportunity to pilot greater engagement with service users by remote

methods. These remote methods are still used today as part of CQC's inspection methodology and have in fact led to a widening of the means of evidence gathering than had been routinely available pre-pandemic.

14. Whilst there may not have been the same 'sights, sounds and even smells' available, there was a sound body of intelligence to understand, prioritise and target risk. CQC used this, together with the adapted regulatory assurance processes, to maintain adequate oversight during the pandemic.

15. Further to queries raised during the evidence of Mary Cridge, CQC can confirm that the frequency of routine inspections is not set in legislation but is for CQC to outline. CQC's powers in relation to inspections are set out in the Health and Social Care Act 2008; section 46(4)(a) directs that:

"The Commission must prepare a statement-

(a) setting out the frequency with which reviews under this section are to be conducted and the period to which they are to relate."

Paragraph 203 of INQ000584245 (page 68) sets out that the pre-pandemic expectation was that 'good' and 'outstanding' services were inspected within 30 months of the last comprehensive inspection report; those 'requiring improvement' within 12 months and those rated as 'inadequate' within 6 months.

In a future pandemic, what should happen to inspections?

16. For the future, however, lessons have been learned and as the Inquiry is aware there is currently ongoing change within CQC. Whilst it will always be for Government to determine how best to protect public health depending on a future pandemic's transmission route, CQC recognises that there would need to be the widest toolkit available to enable regulation to continue. This should include a robust registration system and broad intelligence gathering methods but CQC is committed to the recommendation made a paragraph 44 of the supplementary statement of Mary Cridge (INQ000587795/13-14), to recognise the importance of on-site inspections, and ensure the ability to continue to conduct them in a future pandemic.

Discharge from hospitals to care homes and the future of guidance drafting

To what extent, if any, were CQC involved in drafting the 19/3/20 hospital discharge guidance which did not require testing?

17. CQC did not draft the 'Covid-19 Hospital Discharge Service Requirements' that DHSC issued on 19th March 2020. When DHSC sought CQC's agreement to suspend the requirement for trusted assessment before a patient was discharged from hospital, CQC refused to agree. Mary Cridge explained to the Inquiry on 7th July 2025 that this was because CQC "*will always put safety first ...and that the trusted assessors must take account of the legal responsibilities of the social care providers ...[who] must ask themselves, can they care for this person safely?*" (Transcript of Module 6 Public Hearing on 7 July 2025 5/67/6-13). CQC's only engagement in the drafting of the full document was to ensure that the content of Annex C, 'the Trusted Assessor guidance', remained as unaltered as possible, changing only to require that the NHS employ and use more trusted assessors.

How should guidance of this kind be created in a future pandemic?

18. CQC recognises the observations of many witnesses in Module 6 that the presence of the voices of representatives with extensive knowledge and experience of the adult social care sector 'in the room' or 'around the table' within Government was lacking at the outset of the pandemic. This was much improved when the role of Director General of Adult Social Care commenced and when David Pearson was appointed to lead the Social Care Sector Covid-19 Support Taskforce in June 2020.

19. CQC's position in relation to guidance, was stated clearly by Mary Cridge in her oral evidence to the Inquiry when she explained that "*our current powers on guidance are confined to guidance about compliance and how to meet the fundamental standards. It doesn't go wider than that. We think government are the best placed to provide guidance in a pandemic. What we need is guidance that is relevant to social care and is not health sector guidance adjusted for social care. It's a very diverse sector...with lots of different sized providers. The best way to really good guidance is to have that genuinely co-produced with those who provide services, those who receive services, and the various experts interms of infection prevention and control.....CQC has a role in that, perhaps even as a lead facilitator.....but I think CQC providing.....guidance about guidance,don't think that's a healthy state...it's the road to confusion for providers.*" (Transcript of Module 6 Public Hearing on 7 July 2025 5/56/15 - 5/57/8)

20. This was particularly acute in the context of the hospital discharge guidance which, as Joanna Killian from the Local Government Association told the Inquiry, went through 11 iterations. CQC attempted to keep track of the Government issued guidance and disseminated it with prompts to where changes could be found. It is suggested that further guidance would only have caused providers confusion about whether to follow that from CQC or that from DHSC. CQC have made recommendations for how co-production could operate at paragraph 53 of Mary Cridge's supplementary statement (INQ000587795/15-16).
21. Further, unlike the Regulation and Quality Improvement Authority in Northern Ireland (RQIA), whose focus is on quality improvement through support and advice, CQC's statutory function is to inspect and regulate and thus to give any single provider detailed guidance may raise conflict issues during inspection. Instead, CQC's focus is on signposting providers to the widely available guidance and support. It should be noted that the quality standards against which CQC regulate are underpinned by the Human Rights Act 1998 and apply to all regardless of age, thus, in this way, older people in care homes do have quality rights.

2nd April 2020 Admissions Guidance

22. CQC's role in the drafting of this document was to ensure it was changed to allow providers to decline to accept admission of an individual if they were not satisfied that they could safely care for the patient being discharged and their other residents. When CQC first received the draft Admissions Guidance from DHSC on 25 March 2020 with a request to co-brand it, CQC indicated that it would "*struggle to get behind*" the guidance as the tone was "*slightly accusatory and out of line with the supportive role [that CQC was] seeking to play with providers, particularly social care providers who did not have access to the same national infrastructure and resources as the NHS.*" (INQ000235324/1). Only once the draft was amended to ensure that providers had the power to make decisions that put the needs of the individual first were CQC prepared to allow their logo to appear on the guidance.
23. As was made plain during the oral evidence of Mary Cridge, CQC considers co-production involving all stakeholders remains the best way to draft guidance of this nature.

Contingency planning and CQC's role in future pandemic preparedness

Is it part of CQC's current role to ensure every provider has an adequate pandemic plan?

24. At present, the regulations by which CQC must exercise their oversight do not require a provider or the local authority to hold a pandemic plan. What was required in 2020, and which remains the position today, is that when a 'care home' registers with CQC, they are told they 'may' be asked to supply some 'additional documents' which 'depending on the type of service you plan to provide' may include 'a business continuity plan' and an 'emergency plan'. To date 'emergency plan' has not been defined to include pandemic plans.

Whose role is that currently?

25. It was clarified during CTI's careful questioning of Joanna Killian from the Local Government Association on 28th July 2025, that the aim of a pandemic plan differs from that of a business continuity plan and a business contingency plan. Miss. Killian's evidence was that it falls to national Government to define the threats to the nation which could range from flu pandemics to cyber attacks. It then falls to the Local Resilience Forum, under the Civil Contingencies Act 2004, to make sure that the local authorities within their footprint are ready to respond to a national emergency. Where the emergency involves public health then it is the responsibility of the Director of Public Health in that local authority to have plans in place (Transcript of Module 6 Public Hearing on 28 July 2025 17/10/24 – 17/13/5). A business continuity plan provides for the mechanisms to make sure that the business can continue to operate in the event of a threat materialising (e.g. a cyber attack, or similar threat, such as a flood). Contingency plans are understood to sit below a business continuity plan, as a specific response to an identified risk.

26. It is with this evidence in mind, that the recollection of Helen Whately should be viewed when she was referred to INQ000327767/2 which included a WhatsApp message dated 3rd March 2020 stating, in relation to an Essex local authority contingency plan, that "*providers are required by CQC to have plans in place to provide safe care in the event of a pandemic.*" She suggested that she would expect CQC to be the natural organisation to oversee plans held both by providers and now local authorities given CQC's new regulatory duties brought in by the Health and Care Act 2022 (Transcript of Module 6 Public Hearing on 17 July 2025 12/15/8-10).

27. CQC is not qualified to assess what amounts to an 'adequate' pandemic plan for a care provider or a local authority. Indeed, CQC's oversight of local authorities is limited to the duties under Part 1 of the Care Act 2014. It is expected, however, that setting the criteria for adequate pandemic plans will be part of the Government's current work, referenced in this Module by Michelle Dyson as the 'Pandemic Preparedness Strategy', to tackle the 5 different potential transmission routes of a future pandemic. CQC can confirm it is one of the organisations which has been invited to be 'around the table' in this planning work and stands ready to play whatever part is deemed necessary as a result of that process and this Inquiry's recommendations.
28. CQC submits that the determination of what constitutes an adequate pandemic plan requires input and oversight from the ASC system, and the health system, as a whole. This was canvassed by Mary Cridge in her oral evidence to the Inquiry when she said "*I think it would be wrong to consider providers as islands who should each in their own way produce their own pandemic guidance. It's the system. So it's -- you couldn't have a care home plan that didn't take account of what the GP -- the GPs who served that care home, what their plans are. So I think a system-level plan, with the local authority as a key player in that, is the way to go.*" (Transcript of Module 6 Public Hearing on 7 July 2025 5/57/25 - 5/58/7).
29. The importance of ensuring a system-wide approach to pandemic planning was clearly demonstrated by the evidence of Julie Parkinson, on behalf of National Association of Care and Support Workers, on 8 July 2025 when she described the difficulties that care workers had in accessing medical care and treatment for their clients during the pandemic with reference to GP wait times. She explained that "*[it] was so difficult. It really was. The GP service...were in disarray...So it was very, very difficult to get doctors' attention. We were recommended to use 111 service and that doesn't work in domiciliary care because you've got to stay with the person that needs the help to answer the questions. It just doesn't work. So we had problems getting appointments, getting doctors to come and visit people who were bedbound and can't go anywhere.*" (Transcript of Module 6 Public Hearing on 8 July 2025 6/7/14-25).
30. To the extent that the Inquiry is giving consideration to whether CQC would be the appropriate body to take responsibility for checking the adequacy of pandemic plans held by providers in the future, then it should be noted that internal changes may be required to ensure the requisite methodology and skillset was available to do this. Changes to CQC's methodology would also require DHSC approval. As regards any role CQC might

have in assessing Local Authority pandemic preparedness, legislative change and/or Secretary of State approval may be required as CQC's oversight powers are presently limited to those under Part 1 of the Care Act 2014.

31. The below matters are the topics not addressed in oral closing submissions.

Visiting and the new Regulation 9A fundamental standard of care

32. As was acknowledged by the Chair at the end of the Module 6 hearings, it is in relation to the rules restricting visiting in care homes that some of the most impactful personal accounts of suffering and distress have emerged. It is also a topic which evoked opposing viewpoints even from those with relatives affected by the visiting restrictions. The clearest indication of the tension that prevailed was touched on by Mr. Hancock in his evidence where he referenced that there were opposing judicial review claims brought regarding DHSC's decisions on visiting by those in favour of reducing the restrictions on visiting and by those in favour of maintaining the restrictions to prevent anyone being granted greater access to care homes which might have contributed to the transmission of the virus (Transcript of Module 6 Public Hearing on 2 July 2025 3/24/6-17).

33. CQC's awareness of the risks around visiting, was present in the context of considering the potential risk of transmission where an inspector crossed the threshold. The feedback from the provider trade associations to CQC's letter announcing a pause to routine inspections (INQ000525012) demonstrates that there was a need to address concerns about the risk that an inspector would bring in the virus if there did need to be an in-person inspection by CQC. Indeed INQ000525624/1 refers to concerns regarding a risk that CQC inspectors would become 'super spreaders' and were not part of the routine asymptomatic testing programme.

Changing guidance

34. CQC was not involved in drafting the visiting guidance which changed frequently but, as is demonstrated by INQ000547944, CQC alerted DHSC when an inconsistency with other guidance issued by DHSC was noticed. As explained by Mary Cridge in her evidence, CQC's role was not to issue its own guidance on allowing visiting where it did not have the knowledge and information to do so, but to signpost providers to the DHSC issued guidance and any changes.

How will CQC help to ensure that visiting is allowed in a future pandemic?

35. As set out in paragraphs 45 to 47 of the supplementary statement of Mary Cridge (INQ000587795/14), significant steps have been taken to address the harm caused by the visiting rules during the pandemic, including the introduction of a new fundamental standard of care in Regulation 9A which places a requirement on providers to support individuals to receive visits, take visits outside the home or be accompanied by someone when attending appointments unless there are exceptional circumstances.

How CQC did, and should, keep Government informed during a pandemic?

36. CQC considers that by virtue of its oversight role within the diverse and disparate ASC sector, it was, and would remain, essential for CQC to be involved in keeping Government informed and assisting in the necessary consultation around the drafting of applicable sector guidance. CQC submits that during the pandemic, it was considered to be a key contributor in keeping DHSC and other stakeholders sufficiently informed. INQ000609960 is an example which shows that Ros Roughton, in her capacity as Director General of Adult Social Care, considered that the information and feedback provided by CQC through weekly calls helped shape DHSC's policy response to the pandemic. In future, CQC would urge that no less engagement with government take place.

CQC's role in tackling inappropriate DNACPR orders

37. The Inquiry has heard much evidence about how the issue of inappropriate blanket DNACPR orders was dealt with during the pandemic. CQC acted quickly, and worked together with partner bodies, to disseminate messaging which was clear that no such orders must be issued. The review work conducted by CQC, and the eleven recommendations made in the 'Protect, respect, connect: Decisions about living and dying well during COVID-19' report led to various improvements in relation to advance care planning, including the Government's Universal Principles for Advance Care Planning published in March 2022. As was explained by Mary Cridge, and confirmed by Michelle Dyson in her evidence, DNACPR assessment is part of CQC's current assessment framework.

38. The recommendations in CQC's final report, summarised at paragraph 631 of INQ000584245 (pages 206-208), set out who is to be responsible for record keeping and oversight of providers' records in this context. It should be noted that both CQC's interim

and final DNACPR reports focussed on England and did not include Northern Ireland or other parts of the UK.

CQC's role in data collation

Death data

39. CQC plays an important role in the collection of data within the ASC sector through the statutory notifications process. During the pandemic it was recognised by DHSC, and other key Government stakeholders, that CQC's death notifications data was a good lead indicator of the numbers of Covid-19 related deaths within the ASC sector. CQC shared this data with the Government and worked with ONS to ensure that it was properly validated so that it could be included in the ONS weekly bulletin published during the pandemic. From 9 April 2020 providers were informed that when making a death notification they should include whether the death was as a result of confirmed or suspected Covid-19 and, by 28 April 2020, ONS was including this data in its weekly release.

40. It should be noted that death data was not, and is not, routinely published at location level. CQC's view is that ratings and assurance statements provide the best view of the quality and safety of care in a location. The position is similar in respect of publishing information about how many people were or are discharged into care homes that have a rating of 'inadequate'. CQC's focus, derived from statute, is on the registered provider who carries the obligation to meet the needs of the individual. Therefore CQC does not hold information about the individuals who are either provided care by Local Authority commissioning or who pay privately for care in residential home settings, save in rare cases. It should be noted that Local Authorities pay close attention to the ratings of services that they commission and the vast majority have a policy of only commissioning from services rated as 'Good'.

Care worker register

41. CQC supports the keeping of a register of social care workers and understands how this might promote and benefit the professionalism of these workers. Given that CQC's role, at present, is to regulate the providers as opposed to those the providers choose to employ, CQC would not be best placed to maintain the register and CQC recognises that that the Inquiry heard evidence and submissions from other organisations who could fulfil this role.

Capacity tracking

42. CQC also helped with the collation of other critical Covid-19 related information and data during the pandemic. The NHS Capacity Tracker tracked information within residential and nursing care homes about morbidity, staff shortages, bed capacity and equipment shortages. Similar information was then tracked in the Domiciliary Care sector using the DCA tracker established by CQC. By September 2020, DHSC requested the information from these two tools be integrated and it was this data collectively which ultimately led to the dashboard relied upon extensively by Government to track trends on a daily basis during the pandemic.

CQC's Recommendations

43. For ease of reference, CQC repeats here the recommendations it has made in evidence:

Movement of people between care settings:

1. That care providers maintain, and are supported in, their ability to refuse to admit a person where they are not satisfied that there are adequate measures in place to enable the individual's needs to be safely met without increasing risk to other people.
2. That social care providers should be seen as equal partners in the delivery of safe care and treatment, and be given equal access to IPC measures including testing, PPE and vaccinations.

Inspections:

1. To ensure inspectors are treated as 'key workers' at the outset of a future pandemic with priority access to testing, PPE, vaccinations and IPC training;
2. To recognise the importance of on-site inspections, and ensure the ability to conduct on-site inspections to allow CQC, as the regulator, to be able to continue to assure the safety and quality of service provision in the ASC sector.

Visiting in care homes:

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

Co-production and co-ordination of communication:

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

2. The development of a structure to bring together key sector stakeholders in a timely manner in order to provide meaningful input,
3. That a clear and simple infrastructure is identified to allow effective and timely communication of government advice and guidance to the adult social care sector at national and local level, and
4. That our unique position as regulator is recognised and used to disseminate government advice and guidance as well as to receive feedback and facilitate the co-production of guidance.

Funding:

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

Kate Wilkinson K.C.
On behalf of the Care Quality Commission

5th September 2025