Care Quality Commission

The state of health care and adult social care in England 2021/22

State of Care

HC 724

Care Quality Commission

The state of health care and adult social care in England
2021/22

Presented to Parliament pursuant to section 83(4)(a) of the Health and Social Care Act 2008.

Ordered by the House of Commons to be printed on 20 October 2022.

HC 724

© Crown copyright 2022

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at www.gov.uk/official-documents.

Any enquiries about this publication should be sent to us at enquiries@cqc.org.uk

ISBN 978-1-5286-3701-5

E02803100 10/22

Printed on paper containing 75% recycled fibre content minimum

Printed in the UK by HH Associates Ltd. on behalf of the Controller of Her Majesty's Stationery Office.

Contents

	Foreword	4
	Summary	7
	Evidence used in this report	11
1.	**Gridlocked care**	15
	Introduction of integrated care systems	17
	The urgent care system	18
	Our urgent and emergency care reviews	22
2.	**Access to care**	26
	Waiting for care	27
	Accessing primary care	36
	Capacity and stability in adult social care	44
3.	**Inequalities in care**	52
	Deprivation	53
	Disability	54
	Ethnicity	55
	Accessible health and social care	56
	The importance of data	58
4.	**Areas of specific concern**	60
	Overall ratings	61
	Maternity care	61
	People with a learning disability and autistic people	65
	Children and young people's mental health	69
	Deprivation of Liberty Safeguards	72
	Other concerns	78
	Medicines safety – the role of pharmacy professionals	79
5.	**Workforce**	82
	Staff shortages	83
	Impact on care	89
	Impact on staff	91
	Tackling workforce issues	95
	Developing the workforce	97
6.	**Systems: challenges and opportunities**	102
	Integrated care systems and CQC's role	103
	Challenges for systems	104
	Keeping people well	111
	Appendix: Ratings charts	114
	References	129

Foreword

In 2022, the health and care system is gridlocked, unable to operate effectively. Most people are still receiving good care when they can access it – although this is less likely to be the case for people living in deprived areas, disabled people and people from ethnic minority groups. Too often, however, people just can't access the care they need. Capacity in adult social care has reduced and unmet need has increased. Only 2 in 5 people are able to leave hospital when they are ready to do so, contributing to record-breaking waits in emergency departments following a decision to admit, and dangerous ambulance handover delays.

What this gridlock means for people is that they are stuck – stuck in hospital because there isn't the social care support in place for them to leave, stuck in emergency departments waiting for a hospital bed to get the treatment they need, and stuck waiting for ambulances that don't arrive because those same ambulances are stuck outside hospitals waiting to transfer patients.

As part of a series of coordinated inspections across the urgent and emergency care pathway in 10 integrated care systems, CQC convened a group of 250 health and care leaders – they described the system they work in as one 'in crisis' and shared their fears that the risk of people coming to harm represents a worrying new status quo.

Health and care staff want to provide good safe care, but are struggling to do so in this gridlocked system. This is reflected in growing dissatisfaction with health and care services both by the public and by staff. More staff than ever before are leaving health and social care and providers are finding it increasingly challenging to recruit, resulting in alarmingly high vacancy rates that have a direct impact on people's care.

Without action now, staff retention will continue to decline across health and care, increasing pressure across the system and leading to worse outcomes for people. Services will be further stretched, and people will be at greater risk of harm as staff try to deal with the consequences of a lack of access to community services, including adult social care. This will be especially visible in areas of higher economic deprivation, where access to care outside hospitals is most under pressure. In addition to the increased risk of harm to people, more people will be forced out of the labour market – either through ill-health or as a consequence of supporting family members who need care.

Many of the challenges services are now facing are linked to historical underinvestment and lack of sustained recognition and reward for the social care workforce. The crucial role of social care is increasingly being recognised by healthcare leaders – with some taking action to jointly invest in and commission social care services with partners in local government, in recognition of the benefits for their whole local system. While there is no silver bullet, joining up these pockets of local innovation has the potential to help to unblock the gridlock.

Solutions to the problems that affect people's care can only come from long-term planning and investment, with local areas taking a whole system view that recognises the relationship between health and social care and addresses the root causes behind the immediate and obvious problems.
To understand what is driving performance, local leaders need to bring together data and information from providers and other local stakeholders, and agree success measures that are focused on people's overall experience of care, not limited to organisation or sector.

Better quality data and increased data sharing are critical not only to planning for people's care needs but to understanding and tackling inequalities in people's experience of and access to care. From our work across local areas, we know that the current recording of demographic data, especially on ethnicity and disability, is not good enough.

Workforce shortages across all sectors need to be addressed through innovative initiatives that look to the future and can be delivered at a local level. The focus should be on shaping more flexible workforce models that help local systems meet the needs of people – all people – who are in turn empowered to take a more active role in their own wellbeing.

In adult social care, where workforce shortages are particularly acute, this needs to be treated as a national problem with local solutions. The money announced by the government to help speed up the discharge of patients from hospital this winter when they are medically fit to leave, as well as helping to retain and recruit more care workers, is welcome – but there needs to be more focus on long-term planning and investment. With 165,000 vacancies in adult social care, there needs to be a real step change in thinking about how to attract and retain staff.

We are calling for funding and support for ICSs so they can own and deliver a properly funded workforce plan that recognises the adult social care workforce crisis as a national issue and offers staff better pay, rewards and training linked to career progression – a plan that encourages investment in long-term solutions rather than short-term sticking plasters.

In this year's report, we also highlight our concerns about specific service areas, in particular maternity services and those that care for people with a learning disability and autistic people – areas where our inspections continue to find issues with culture, leadership and a lack of genuine engagement with people who use services. In response to the national challenges faced by maternity services, we have begun a new maternity inspection programme, which aims to help services improve, both at local and national level. Next year, our ongoing programme of work focusing on services for people with a learning disability and autistic people will be extended to residential mental health settings.

We want to celebrate all the good care that is out there – and there is a great deal, from the GP practice in Manchester carrying out ward rounds in care homes, to the new initiatives introduced by the hospital in Newcastle upon Tyne that have improved people's access to and experience of cancer treatments, to the ICS in Cornwall using inclusive technology to help give people more control of the services they use.

However, the fact is that it is difficult for health and care staff to deliver good care in a system that is gridlocked. There are no quick fixes – but there are steps to be taken now that will help avoid further deterioration in people's access to and experience of care. By working together to address the issues that lie behind the gridlock, we can try to make sure that next year, more people can access good, safe health and social care – delivered by a better supported workforce who have more reason to be optimistic about the future.

Ian Trenholm
Chief Executive

Ian Dilks OBE
Chair

Summary

The health and social care system is gridlocked

Twelve months ago, we highlighted the risk of a tsunami of unmet need across all sectors, with increasing numbers of people unable to access care. We said that funding must be used to enable new ways of working that recognise the inter-connectedness of all health and care services, not just to prop up existing approaches.

Today, our health and care system is in gridlock and this is clearly having a huge negative impact on people's experiences of care.

People in need of urgent care are at increased risk of harm due to long delays in ambulance response times, waiting in ambulances outside hospitals and long waiting times for triage in emergency departments.

Large numbers of people are stuck in hospital longer than they need to be, due to a lack of available social care. And people's inability to access primary care services is exacerbating the high pressure on urgent and emergency care services.

At the heart of these problems are staff shortages and struggles to recruit and retain staff right across health and care.

One major survey shows the proportion of people satisfied with the NHS overall dropping from 53% to 36%. More people (41%) were dissatisfied with the NHS than satisfied. Another survey shows that the proportion of people who reported a good overall experience of their GP practice went down from 83% to 72%.

People are struggling to access care

The repercussions of the COVID-19 pandemic continue to be felt by individuals, families and care staff – people are still being affected by problems ranging from frustrations in accessing regular appointments to delays that stop people getting the life-saving treatment they need when they need it.

Many people are still waiting for the health and social care support and treatment they need, and many are waiting too long.

We commissioned a survey of more than 4,000 people aged 65 and over who had used health or social care services in the previous 6 months. Over 1 in 5 people (22%) said they were currently on a waiting list for healthcare services like diagnostic tests, mental health services, consultant appointments, an operation or a therapeutic service such as physiotherapy.

More than a third (37%) on a health waiting list did not feel well supported by health and care services. Two in 5 (41%) said their ability to carry out day-to-day activities had got worse while they were waiting.

There is variation across the country in waiting times for elective care and cancer treatment. People living in the worst performing areas were more than twice as likely to wait more than 18 weeks for treatment as people in the best performing areas.

In our community mental health survey 2021, only 2 in 5 respondents felt they had 'definitely' seen NHS mental health services enough for their needs in the last 12 months. This was the lowest score across the period from 2014 to 2021.

People are also struggling to access GP practices and NHS dental care. Worryingly, the GP Patient Survey showed that over a third of people didn't see or speak to anyone when they couldn't get an appointment at their GP practice, and more than 1 in 10 went to A&E. There has also been a significant reduction in the availability of NHS dental care, particularly for children and young people.

Around half a million people may be waiting either for an adult social care assessment, for care or a direct payment to begin, or for a review of their care. In the first 3 months of 2022, 2.2 million hours of homecare could not be delivered because of insufficient workforce capacity, leading to unmet and under-met needs. At the same time, care home profit margins are at their lowest level since our Market Oversight scheme began in 2015.

Inequalities pervade and persist

Inequality continues across large parts of health and social care. It is vital that everyone, inclusively, has good quality care, and equal access, experience and outcomes from health and social care services.

Health and social care providers need to do more to make their services accessible, especially to people with different communication needs.

Our survey of more than 4,000 older people who had used health and social care services in the last 6 months found that those living in the most deprived areas were more likely to report that they had a long-term condition, disability or illness, compared with those living in less deprived areas. They also tended to use fewer health services than average, although they did use them more frequently. We also found that disabled people were less likely than non-disabled people to describe the care and support they received for their health and wellbeing over the previous 6 months as good.

Furthermore, disabled people, those with a long-term health condition and people living in more deprived areas were less satisfied with being able to access services when they need them and in a way that suits them.

Wider inequalities issues include our finding that ethnic minority-led GP practices are more likely to care for populations with higher levels of socio-economic deprivation and poorer health – this increases the challenges they have around recruitment and funding.

The recording and use of demographic data by services generally needs to improve, to make sure data is complete, accurate, widely shared and used to bring about improvement.

Specific concerns

In 2021/22 we continued to focus on higher risk providers and where people were most at risk of receiving poor care.

Overall, when people have been able to actually access the care they need, we have been able to reassure people that the quality of care at the point of delivery is mostly good. Health and social care staff across the country are working relentlessly to ensure people are kept safe. At 31 July 2022:

- 83% of adult social care services were rated as good or outstanding.
- 96% of GP practices were rated as good or outstanding.
- 75% of NHS acute core services were rated as good or outstanding.
- 77% of all mental health core services (NHS and independent) were rated as good or outstanding.

But we have deep concerns about some types of care. The quality of maternity care is not good enough. Action to ensure all women have access to safe, effective and truly personalised maternity care has not been sufficiently prioritised to reduce risk and help prevent tragedies from occurring. Furthermore, women from ethnic minority groups continue to be at higher risk of dying in pregnancy and childbirth than White women, and more likely to be re-admitted to hospital after giving birth.

We are prioritising our operational and inspection resources to ensure we and others have an up-to-date and accurate view of the quality and safety of maternity services.

Also, the care for people with a learning disability and autistic people is still not good enough. Despite multiple reviews and reports, people continue to face huge inequalities when accessing and receiving health and social care. Our review of the care in hospital for people with a learning disability and autistic people will highlight how they are not being given the quality of care they have a right to expect.

Mental health services are struggling to meet the needs of children and young people. This increases the risk of their symptoms worsening and people reaching crisis point – and then being cared for in unsuitable environments.

Ongoing problems with the Deprivation of Liberty Safeguards process mean that some people are at risk of being unlawfully deprived of their liberty without the appropriate legal framework to protect them or their human rights.

Depleted workforce

Across all health and social care services, providers are struggling desperately to recruit and retain staff with the right skills and in the right numbers to meet the increasing needs of people in their care. Despite their efforts, in many cases providers are losing this battle, as staff are drawn to industries with higher pay and less stressful conditions.

Sickness, vacancy and turnover rates are having a deep impact. Continuing understaffing in the NHS poses a serious risk to staff and patient safety, both for routine and emergency care; and shortages in social care are even worse than they are in the NHS. Retention of staff is just as big a challenge as recruitment, one that in many cases is crucial to maintaining relationships between staff and patients. These relationships can be lost if there is a high turnover of staff or increased use of agency or bank staff.

More than 9 in 10 NHS leaders have warned of a social care workforce crisis in their area, which they expect to get worse this winter. Care homes have found it very difficult to attract and retain registered nurses. We have seen nurses moving to jobs with better pay and conditions in the NHS, and care homes that have had to stop providing nursing care.

In our workforce pressures survey, 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.

Only 43% of NHS staff said they could meet all the conflicting demands on their time at work. Ambulance staff continue to report high levels of stress.

Challenges and opportunities in local systems

This year, integrated care systems (ICSs) were formally established and the role of integrated care boards set out in legislation. This will bring with it a new role for CQC to review and assess each ICS, starting next year.

We have for several years been looking at the challenges for systems, particularly around inclusivity and planning in health and care services for residents.

From our own work looking at care within the emerging and newly formed systems, and from listening to people's experiences of care, we can point to some areas of focus for local systems as well as some tangible collaborations that are already making a difference in people's lives. Local partnerships are starting to make a positive difference – they must be focused on outcomes for people.

Understanding the health and care needs of local people is paramount for integrated care systems, and each one faces a different challenge in meeting those needs. Good leadership will be vital for local systems as they become established during challenging times for all services. All services working in a local health and social care system should be included in planning for healthier communities.

To maintain and develop the required workforce, as well as to plan for the future, providers and systems need to be clear about demands in the longer term, including the required workforce skillsets. A strong understanding of local community needs is required to ensure the right services, including preventative health measures and plans for improving health outcomes, are delivered.

Evidence used in this report

This report sets out the Care Quality Commission's (CQC's) assessment of the state of care in England in 2021/22.

We use data from our inspections and ratings, along with other information, including that from people who use services, their families and carers, to inform our judgements of the quality of care. The evidence used in this report includes national published data and reports, as well as evidence generated by CQC. Further detail relating to the evidence used in this report is provided below.

Our view of quality and safety has been informed by information people have shared with us through our Give Feedback on Care service, phone calls and social media.

- To understand access issues in general practice, we analysed a random sample of 410 comments received through Give Feedback on Care in October 2021. We reviewed a further 113 comments received between January and March 2022, to see whether issues identified in October 2021 and last year's State of Care report were still prevalent.

- In dentistry, we looked at a random sample of 127 submissions received between March and May 2022. We did this to understand how issues related to people's access to NHS dental services had changed since we reported on these issues in our publication COVID Insight 10: dental access during the pandemic, as well as last year's State of Care report.

- Our findings relating to the Deprivation of Liberty Safeguards (DoLS) are informed by details received through Give Feedback on Care. We analysed a sample of 310 comments submitted between April 2021 and March 2022 that spoke to people's experiences with DoLS. The sample was created using a keyword search method looking for terms such as 'DoLS' and 'liberty'.

We have drawn on findings of our published surveys to inform what we say about what people think of the NHS services that they use. Also, we have also drawn on data and insight from bespoke surveys that we commissioned.

To complement our own work and help us understand people's experiences of health and social care, we commissioned Ipsos to carry out a survey. Ipsos carried out telephone interviews between 17 May and 12 June 2022 with people aged 65 and over living in England who had used health or social care services in the previous 6 months. A total of 4,013 people completed the interview.

In the Ipsos survey, quotas were set by age, gender and integrated care system to ensure that interviews were conducted all over England. Responses were also monitored by ethnicity and social grade. The results were weighted by these 5 variables to ensure that the final results matched the population profile of people aged 65 and over living in England. A limitation of the methodology used is that some groups of people using social care services

are likely to be under-represented in the survey, namely people living in care homes and people with substantial or critical social care needs living in the community.

We commissioned Traverse to explore people's experiences of accessing GP services since the outbreak of the COVID-19 pandemic. They surveyed members of an online panel, targeting English adults who have tried, successfully or not, to access a GP service in the past 12 months. Emails were sent to panellists selected at random from the base sample. Quotas were set to ensure an adequate spread in terms of region, age, gender, ethnicity, socio-economic background, carer status and long-term conditions. The online survey was completed by a total of 2,087 people between 10 and 15 November 2021.

We commissioned PEP Health to conduct a longitudinal analysis of their data on 'patient experience' across England. PEP Health gathers, analyses and interprets patient feedback from across the web and combines it to create a patient experience score. Comments are analysed using custom Natural Language Processing models to identify the relevance of a comment, which topics are discussed – for example, the speed of treatment and clarity of communication – and the strength of sentiment for each of these topics.

PEP Health's data is gathered from a variety of sources with different user bases, resulting in diverse feedback. This data helps inform our picture of people's experience for this report, alongside survey and other data. However, the data will not capture the views of all people who use services, families and carers.

We have used the data and insight that we have gained through our routine monitoring of and engagement with providers, for example information collected through our provider information returns and our notifications data.

In this report, we draw specifically on vacancy, turnover and occupancy data returned by adult social care providers between 1 April 2021 and 31 August 2022.

We also include analysis of information shared with us up to 30 June 2022 through the adult social care workforce pressures survey. This was introduced in December 2021 to facilitate discussions around workforce challenges between our inspectors and adult social care providers. Surveys are completed when we carry out an inspection or other monitoring activities. As a result, for some services the survey has been completed more than once and all responses from the same provider have been included in this analysis.

This report provides an analysis of data submitted to us by providers in our Market Oversight scheme, as well as information and insight gained from our engagement with providers within the scheme. The scheme covers providers that have a large local or regional presence and which, if they were to fail, could disrupt continuity of care in a local authority area.

We have conducted quantitative analysis of our inspection ratings of more than 33,000 services and providers. Aggregated ratings for the main sectors and services we regulate are provided in the data appendix of this report. In March 2020, we paused routine inspections and focused our activity where there was a risk to people's safety. Since then we have continued to carry

out inspection activity where there were risks to people's safety or where it supported the health and care system's response to the pandemic. We have also begun carrying out inspections in low risk services to quality assure our risk identification process. To provide as contemporaneous a picture as possible, the ratings in the data appendix are as at 31 July 2022.

This year quantitative analysis of inspection ratings includes information on the proportion of services that are categorised as having 'insufficient evidence to rate'. This rating can be used when, on inspection, we have not been able to collect enough information to rate against one of the other ratings: outstanding, good, requires improvement or inadequate. Charts in our data appendix visualise the proportion of all active services with a current rating of outstanding, good, requires improvement or inadequate. The proportion of services where there was insufficient evidence to rate is provided in a note below the chart where applicable.

In our role as the independent regulator, we regularly publish our views on major quality issues in health and social care. This report includes data and insight from this work, including findings from the following reports:

- our provider collaboration review on the mental health care of children and young people during the pandemic
- our progress report on the use of restraint, seclusion and segregation in care services
- our report on safety, equity and engagement in maternity services
- the joint thematic inspection we supported with HM Inspectorate of Probation and other agencies of the criminal justice journey for individuals with mental health needs and disorders
- our CQC Insight 15: quality of ethnicity data recording for mental health services
- our programme of research to look at the impact and experiences of regulation on ethnic minority-led GP practices.

We have collected bespoke qualitative evidence to supplement our findings. Through this work, we have gathered views from our operations teams and subject matter experts on quality issues in particular sectors of health and social care and/or on particular aspects of our monitoring and regulatory approach, for example our monitoring of the DoLS. We are also informed by findings from our urgent and emergency care system inspection programme (published in system level inspection reports) and our internal evaluation of this programme.

We have used the data and insight that we have gained from our engagement with voluntary and community sector organisations, provider representatives, health and social care leaders, practitioners and people using services in health and social care.

This report is also informed by our wider horizon scanning activity. We have reviewed reports published by our stakeholders, drawn on national survey findings, and analysed publicly available datasets to supplement our understanding of the challenges facing health and social care today and the experiences of people using services. Where we have used data from other sources, these are referenced within the report.

Evidence in this report, alongside our Annual Report and Accounts, enables us to fulfil our legal duties to report on equality issues and on the operation of the DoLS.

Analytical findings have been corroborated, and in some cases supplemented, with expert input from our chief inspectors, colleagues in our Regulatory Leadership directorate, specialist advisers, analysts and subject matter experts to ensure that the report represents what we are seeing in our regulatory activity. Where we have used other data, we reference this in the report.

State of Care

1. Gridlocked care

Key points

- Our health and care system is in gridlock. People in need of urgent care are at increased risk of harm due to long delays in ambulance response times, waiting in ambulances outside hospitals and long waiting times for triage in emergency departments.
- Large numbers of people are stuck in hospital longer than they need to be, due to a lack of available social care.
- People's inability to access primary care services is exacerbating the high pressure on urgent and emergency care services.
- Staff shortages and struggles to recruit and retain staff are widespread throughout health and care.
- Public satisfaction with NHS health care and with social care has plummeted in 2021/22.

Twelve months ago, we highlighted the risk of a tsunami of unmet need across all sectors, with increasing numbers of people unable to access care. We said that funding must be used to enable new ways of working that recognise the inter-connectedness of all health and care services – not just to prop up existing approaches.

In the period since then, the public have shared their growing dissatisfaction with the health and care services that they need to rely on.

Results from the latest British Social Attitudes survey, published in March 2022, showed the proportion of people satisfied with the NHS overall dropping from 53% to 36%. More people (41%) were dissatisfied with the NHS than satisfied.[1]

Satisfaction with every type of service was down:

- GP services from 68% to 38% (the lowest since the survey began in 1983)
- inpatient services from 64% to 41%
- A&E services from 54% to 39%
- NHS dentistry services from 60% to 33% (again, the lowest since the survey started).

Only 15% of respondents were satisfied with social care services in 2021 and 50% were dissatisfied.

In the 2022 GP Patient Survey (719,137 surveys completed, based on fieldwork from January to April 2022), the proportion of people who reported a good overall experience of their GP practice went down from 83% to 72%. Worryingly, more than a third of people (34%) said they didn't speak to or see anyone when they couldn't get an appointment. Fewer patients with a mental health need felt their healthcare professional recognised their needs – down from 86% to 81%. More than a third of patients with a long-term condition said they didn't have enough support to manage their condition (up from 26% to 35%). And of all conditions, people with a learning disability, people with a mental health condition and autistic people had the lowest results for saying they received enough support (58%, 57% and 50% respectively).[2]

Our Community mental health survey 2021 showed that people consistently reported poor experiences of NHS community mental health services, with few positive results (based on feedback from 17,322 people who used NHS mental health services in England between 1 September 2020 and 30 November 2020). Many said that their mental health had deteriorated as a result of changes made to their care and treatment due to the pandemic. Across many areas of care, experience of using mental health services was at its lowest point since 2014.[3]

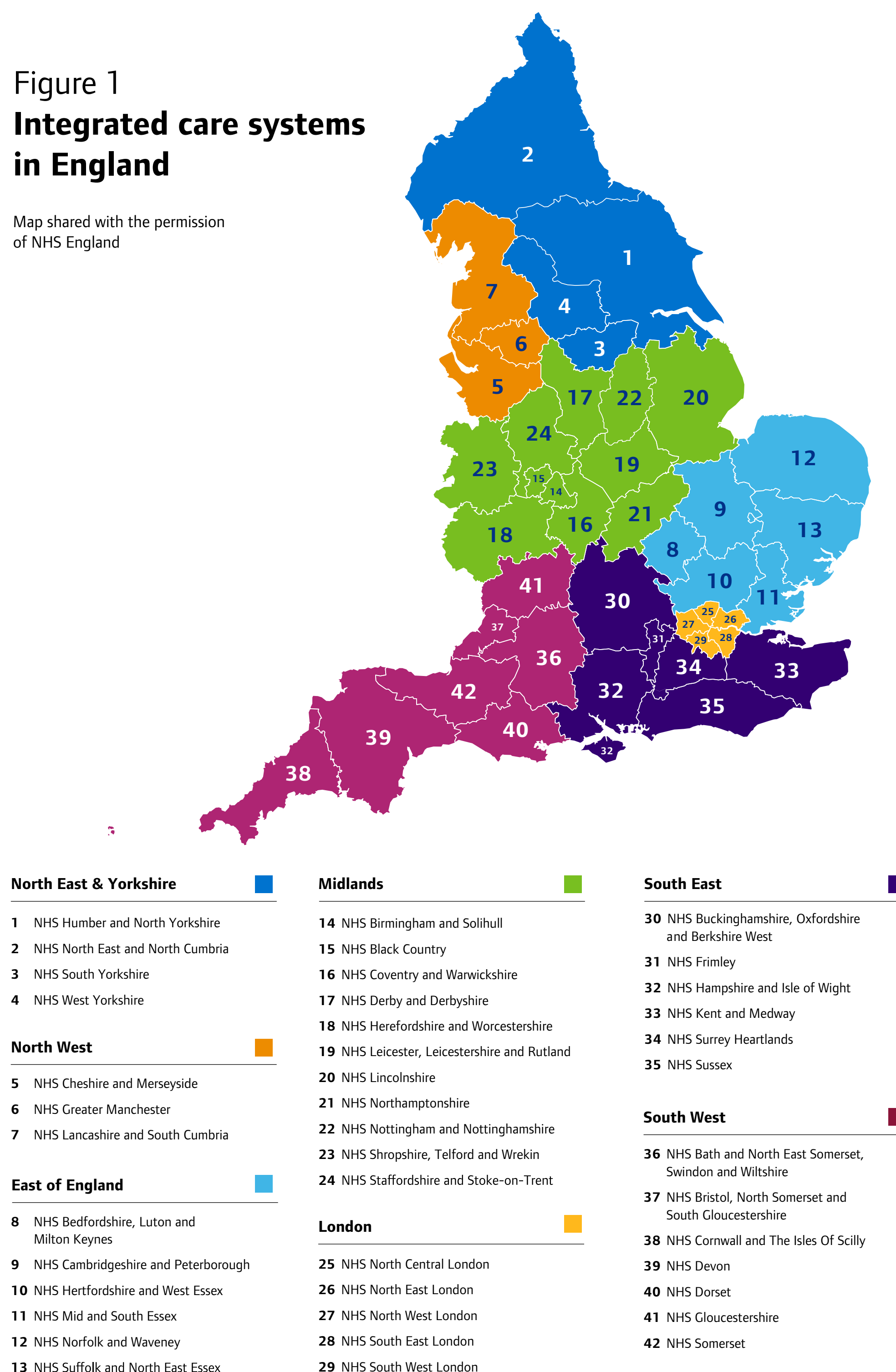
Our Adult inpatient survey 2021 (based on feedback from 62,235 people who were in hospital in November 2021) showed a decline of 4 percentage points in the number of people that had 'a very good experience' from 40% in 2020 to 36% in 2021.[4]

NHS staff have also aired their deep frustration. In the 2021 NHS Staff Survey (based on feedback from over 600,000 people working in the NHS between September and December 2021), the proportion of staff happy with the standard of care provided by their organisation declined from 74% to 68%. Only just over a quarter (27%) said there were enough staff in their organisation for them to do their job properly – down from 38%. In ambulance services, only 1 in 5 staff (20%) said this. For midwives, it was only 6%.[5]

Introduction of integrated care systems

Figure 1
Integrated care systems in England

Map shared with the permission of NHS England



North East & Yorkshire

1 NHS Humber and North Yorkshire
2 NHS North East and North Cumbria
3 NHS South Yorkshire
4 NHS West Yorkshire

North West

5 NHS Cheshire and Merseyside
6 NHS Greater Manchester
7 NHS Lancashire and South Cumbria

East of England

8 NHS Bedfordshire, Luton and Milton Keynes
9 NHS Cambridgeshire and Peterborough
10 NHS Hertfordshire and West Essex
11 NHS Mid and South Essex
12 NHS Norfolk and Waveney
13 NHS Suffolk and North East Essex

Midlands

14 NHS Birmingham and Solihull
15 NHS Black Country
16 NHS Coventry and Warwickshire
17 NHS Derby and Derbyshire
18 NHS Herefordshire and Worcestershire
19 NHS Leicester, Leicestershire and Rutland
20 NHS Lincolnshire
21 NHS Northamptonshire
22 NHS Nottingham and Nottinghamshire
23 NHS Shropshire, Telford and Wrekin
24 NHS Staffordshire and Stoke-on-Trent

London

25 NHS North Central London
26 NHS North East London
27 NHS North West London
28 NHS South East London
29 NHS South West London

South East

30 NHS Buckinghamshire, Oxfordshire and Berkshire West
31 NHS Frimley
32 NHS Hampshire and Isle of Wight
33 NHS Kent and Medway
34 NHS Surrey Heartlands
35 NHS Sussex

South West

36 NHS Bath and North East Somerset, Swindon and Wiltshire
37 NHS Bristol, North Somerset and South Gloucestershire
38 NHS Cornwall and The Isles Of Scilly
39 NHS Devon
40 NHS Dorset
41 NHS Gloucestershire
42 NHS Somerset

This period of deepening public disaffection with health and care coincides with the start of a fundamental change in the organisational structures that sit behind health and adult social care in England.

New integrated care systems (ICSs) in England formally took up their responsibilities in July 2022. There are 42 area-based ICSs, each covering a population of between 500,000 and 3 million people (figure 1).

The aim of ICSs is to deliver joined-up care that better meets the needs of local people. ICSs are partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, reducing inequalities and improving health across geographical areas.

The changes have been described as the biggest legislative overhaul of the NHS in a decade.[6] Overturning a longstanding approach in which the emphasis was on organisational autonomy, competition and the separation of commissioners and providers, ICSs will rely instead on collaboration and a focus on places and local populations as the driving forces for improvement.

Importantly, to really understand whether their work will make a difference, ICSs will need to use insights from local people on whether the care in their area is improving and giving them what they need.

The urgent care system

Packed emergency departments

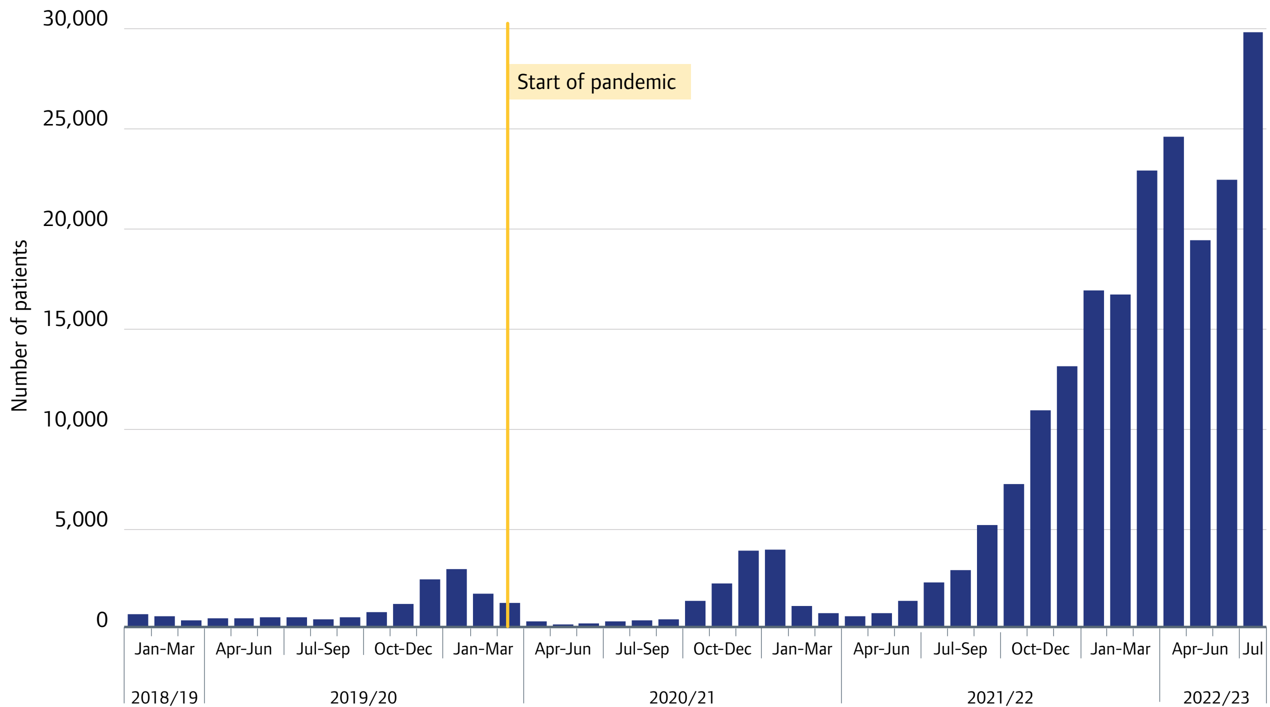
NHS England data shows that, in 2021/22, around 24.4 million people attended A&E – an increase of nearly 7 million on 2020/21 when the NHS was so fundamentally affected by the first waves of the pandemic.[7]

This increase has contributed to a domino effect on access to other services, including medical and elective care. People have experienced long delays in waiting to be triaged within emergency departments, as well as then being seen by a medical professional.

The proportion of people left waiting for more than 4 hours to be admitted, treated or discharged from A&E continues to grow. National performance estimates show that in 2021/22 over 5 million attendees waited more than 4 hours in A&E, compared with just over 3.5 million in 2019/20.

Across 2021/22, the estimated number of people waiting more than 12 hours to be admitted to a ward from A&E (after a decision to admit them) increased massively. The latest data for July 2022 shows this figure was nearly 65 times higher than it was 3 years before: 452 in July 2019 and 29,317 in July 2022 (figure 2).

Figure 2
Patients waiting 12 or more hours from decision to admit to admission, England, January 2019 to July 2022



Source: NHS England, A&E Attendances and Emergency Admissions

On top of this, NHS hospital providers have told us that people are presenting more acutely unwell, and are therefore more likely to be admitted. This is also reflected in steep increases in category 1 ambulance calls such as cardiac arrest, which are classified as life-threatening.

Queuing ambulances

The increases in attendances at emergency departments and waits to be admitted have had a huge knock-on effect on ambulance services. Long queues of ambulances waiting outside emergency departments to hand over their patients have become a regular sight.

According to the Association of Ambulance Chief Executives (AACE), the volume of patient handovers taking more than 60 minutes has reached an unprecedented high level. In March 2021 there were 7,000 handovers taking over 60 minutes. In March 2022 there were more than 45,000.[8] Our analysis shows that this translates to more than 1 in 10 ambulance handovers taking over an hour in March 2022, when the standard is 15 minutes and no-one should have to wait more than 30 minutes.

AACE reported that the longest handover recorded was 23 hours, in March 2022.

Ambulances are not the best place to treat someone

Ambulance handover delays are a consistent risk to the quality and safety of patients' care. Although the care from ambulance crews during these waits tends to be good, ambulances are not the right locations to care for people once they have arrived at the emergency department. In some providers, paramedics care for patients in the ambulance, including if their condition deteriorates. The training for paramedics and emergency care assistants does not account for providing ongoing care. Providers mitigate this risk as far as possible, supporting ambulance staff to monitor patient's conditions using clinical tools such as the National Early Warning Scores (NEWS) tool.

'Every minute matters'

In the North West of England, we found out about good collaboration between hospital and ambulance services. The ambulance service's project, called 'Every minute matters', reduced preventable harm to patients by cutting the length of time people waited for a doctor when they got to hospital. It also freed up ambulances to respond to people calling 999.

Hospitals, commissioners and other stakeholders were involved. One part of the improvement initiative was an ambulance handover safety checklist – this triage tool helped to safely differentiate patients who need constant ambulance clinician monitoring from those who were left unattended. There was closer working between ambulance and hospital staff, and a reduction in ambulance handover delays.

Handover delays create a huge risk for people needing an ambulance

Another impact of handover delays is that ambulances cannot respond to emergencies in the community, resulting in delays to ambulance response times to 999 calls. The result is that people with urgent health conditions cannot always access the care they need, when they need it, resulting in serious injury and, in some cases, deaths.

We have also received consistent concerns about ambulance response times from care home providers. People in care homes should receive the same level of emergency care support as other people. 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 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.

In August 2022, Healthwatch commissioned a survey asking a representative sample of 2,036 people about urgent and emergency care services. While just over two-thirds of people who responded (68%) were confident they would receive high-quality care, treatment and support at an emergency department, the proportion who felt they would be seen in a reasonable time in an emergency department or that an ambulance would arrive in a reasonable time was closer to one-third (37% and 38% respectively).[9]

The survey also found that people over 55 were generally less confident that they would be seen or treated within a reasonable time, compared with people under 55.

Adult social care

There are large numbers of patients who are stuck in hospital longer than they need to be, due to a lack of available social care packages.

Commenting on NHS performance figures for July 2022, NHS Confederation highlighted that only 4 in 10 patients were able to leave hospital when they were ready to. They said that at that point there were almost 13,000 patients a day who spent more time in hospital than needed.[10]

This is due, to a large extent, to severe staff shortages in adult social care, resulting in homecare providers handing care packages back to the local authority and a reduction in hours of homecare. Workforce shortages have also contributed to a reduction in care home capacity, with a number of providers choosing to hold empty beds because they don't have the care workers to staff them.

In December 2021, we introduced our adult social care workforce survey. As at 30 June 2022, this survey had been completed over 5,500 times by our inspectors talking to providers. It explores with providers what impact workforce challenges and staffing shortages have had on the services they deliver to people. Of care home providers that reported workforce challenges in the survey (36%), 87% said they were experiencing challenges related to recruitment. Of homecare providers that reported workforce challenges (41%), this figure was 88%. This is reflected in vacancy rates in both care homes and homecare providers, which are more than 10%, and staff turnover rates in care homes in excess of 30%.

Importantly, it is not just the adult care sector that recognises the seriousness of the situation it faces. NHS Confederation said in July 2022 that the pressures on health and care services are driven strongly by the severe capacity challenges affecting social care. In its July 2022 survey of healthcare leaders (243 respondents), 99% agreed that there is a social care workforce crisis in their local area.[11]

It said that these pressures are affecting the ability of the whole health and care system to deliver care across community and acute settings. Almost three-quarters of healthcare leaders surveyed (73%) said a lack of adequate social care capacity is having a significant or very significant impact on their ability to tackle the elective care backlog. Over 80% said it is driving the demand for urgent care.

Our urgent and emergency care reviews

In the face of this emerging crisis, and recognising that local care systems need to find ways to cut through this gridlock, we carried out a programme of coordinated inspections of urgent and emergency care (UEC) services in 10 integrated care system areas. This enabled us to review the whole UEC pathway, rather than looking at providers in isolation.[12]

For this State of Care report, we reviewed the findings and themes from the first 5 areas:

- Cornwall and Isles of Scilly
- Gloucestershire
- Kent and Medway
- Norfolk and Waveney
- North East London.

The subsequent inspections were carried out in:

- Cambridgeshire and Peterborough
- Leicestershire and Rutland
- Cheshire and Merseyside
- Lancashire and South Cumbria
- West Yorkshire.

Overall findings from our reviews

It is clear that urgent and emergency care services across England have been – and continue to be – under immense pressure. Our inspections of systems found people facing long waits and overcrowding – putting them at risk of harm and of deterioration in their condition. At every point along this urgent care pathway, the risk to people is increasing.

Our reviews have highlighted many issues, often comprising multiple providers and complex pathways, which are not always well understood or communicated by those operating within them.

Flow of patients

Ambulance delays are a symptom of a systemic problem. Emergency departments have been struggling to get patients admitted to the right hospital wards, because those wards have been struggling to discharge people back into the community.

Hospital beds are occupied by people who don't need to be there and who would get more appropriate care elsewhere. Hospitals have seen a huge increase in the number of patients waiting on a trolley in the emergency department while they wait for a bed.

We heard from providers that this is due to lack of capacity in care settings in the community, such as adult social care settings.

Ambulance handover delays are generally caused by this poor flow through the acute hospital, and out into the community. Where ambulances cannot hand patients over to emergency departments quickly enough, their staff are having to wait outside and care for patients in the ambulance until they can be handed over.

Managing the flow of patients on care pathways is important for people who need care – the services involved must talk to one another. However, all 5 systems we saw had examples where people were unable to leave hospital and go home or move into community care.

At 4 of the 5 UEC systems, people who were medically fit to be discharged from hospital could not leave because there was insufficient social care capacity. People could not go home from hospital because there was no homecare support in place, or there was a lack of nursing or residential care beds.

Primary and community care challenges

In the systems we inspected, the high demands on urgent and emergency care services were exacerbated by people's inability to access primary care services as a first port of call. People had problems getting GP and dental appointments (including out-of-hours appointments), which was leading to people calling NHS 111 and being told to go to acute urgent services, or attending A&E directly.

NHS 111 was experiencing high call volumes, along with staff shortages. This caused delays in giving clinical advice, and high call abandonment rates may have led to people going to A&E instead. The lack of available GP and dental appointments meant that NHS 111 could not always appropriately signpost people to primary care, resulting in directing people to call 999 or to present at A&E.

In 3 systems, there was a lack of capacity for people needing community and mental health hospital services. We heard how people were either directed to, or chose to use, urgent and emergency care services when they could not access care another way.

Staffing problems

Problems with staffing levels, absences, recruitment and retention were found throughout system partners. These were limiting the ability of services to recover from the impact of the pandemic and affecting patient care.

All 5 UEC areas highlighted staffing problems, including issues in general practice, mental health care, dental care and adult social care. The causes ranged from stress and exhaustion to uncompetitive pay.

We look at workforce in detail later in this report.

Complex pathways

We found complex urgent care pathways across multiple providers. People's care pathways within and between services were complicated, and communication between providers was sometimes poor. Some people got inappropriate referrals

or had additional triage processes – this was resource-intensive and resulted in delays for actual care.

Although services were under great pressure, we have raised concerns that providers, local authorities and NHS trusts sometimes work in isolation – demonstrating a lack of good oversight of risk to patient care and safety. In one area we saw that local authorities, providers and NHS trusts were working separately to try to resolve system issues – this didn't solve their collective problems, but merely diverted them.

Sometimes mistakes were made where services were not working well together, but there was no learning because the providers were not sharing information. Among other problems, we found people's care pathways were not always well understood by everyone involved, increasing the risk of wrong referrals and additional triage. There were also delays in people's access to services because of a lack of collaboration and poor communication – different digital operating systems within services was a barrier.

Collaboration

Across the UEC systems, there was a pressing need for better communication and collaboration to alleviate pressures and reduce risks to patient safety. Although we found some examples of good communication and collaboration, this was generally at particular pressure points and did not take a wider overview of the patient pathway.

We found that systems working collaboratively across health and social care were able to manage issues more effectively than those that didn't. In addition, where we saw pathways that were streamlined and easy to understand, people were able to access more appropriate care more quickly.

With systems under severe pressure, better communication and collaboration can help. We saw examples of efforts to improve communication between services. In Cornwall, for example, hospital, mental health and community health trusts shared board members and a chief nurse. They also held system-wide discussions to try to address critical issues.

Better collaboration and integration

There are some local examples of collaboration to help people who need care, including a 24/7 clinical assessment centre in **Gloucestershire**. The centre involved GPs, advanced nurse practitioners, pharmacists and paramedics working to direct patients to the right services for them, and to avoid unnecessary hospital admissions.

Similarly, in **Kent and Medway** a GP practice employed a wide variety of health and care professionals and was working well with community services, which was alleviating pressure on ambulance and hospital services. Good use of technology was also improving the service, as this gave quick access to patient information for out-of-hours staff.

In our **Cornwall and Isles of Scilly** inspection, we found community nursing teams that were focused on avoiding hospital admissions and improving hospital discharges. Their work spanned health services and social care. In Cornwall, an 'emergency car' initiative meant that people could get help quickly, for example if a person had fallen in a care home. This was particularly useful where there may be a long wait for an ambulance, and meant the situation could be assessed to decide if an ambulance was needed.

In **Norfolk and Waveney**, people arriving at A&E could be assessed and directed to an on-site primary care service if they did not need hospital care. It was estimated that this meant a third of people avoided the emergency department.

Putting people first

When we completed our reviews, we brought system leaders together in a workshop to discuss the improvements needed across UEC pathways and, importantly, to identify improvements they could implement in their organisations to improve people's experiences of urgent and emergency care services.

The good practice highlighted through this workshop forms the basis for our new PEOPLE FIRST resource, focusing on systems, published in September 2022.[13]

Building on our Patient First resource developed in 2020, PEOPLE FIRST provides system leaders with helpful solutions that bridge the artificial divides between primary care, secondary care, community care and social care. It aims to support everyone to design person-centred urgent and emergency care services and to drive innovation across the system.

2. Access to care

Key points

- In our survey of people aged 65 and over who had recently used health or social care services, more than a third (37%) who said they were on a health waiting list did not feel well supported. Two in 5 (41%) said their ability to carry out day-to-day activities had got worse while they were waiting.
- There is variation across the country in waiting times for elective care and cancer treatment. People living in the worst performing areas were more than twice as likely to wait more than 18 weeks for treatment as people in the best performing areas.
- In our Community mental health survey 2021, 41% of all respondents reported feeling they had 'definitely' seen NHS mental health services often enough for their needs in the last 12 months. This was the lowest score across the period from 2014 to 2021.
- Over a third of people didn't see or speak to anyone when they couldn't get an appointment at their GP practice. More than 1 in 10 went to A&E.
- There has been a significant reduction in the availability of NHS dental care, particularly for children and young people.
- Around half a million people may be waiting either for an adult social care assessment, for care or a direct payment to begin, or for a review of their care. In the first 3 months of 2022, 2.2 million hours of homecare could not be delivered because of insufficient workforce capacity, leading to unmet and under-met needs.

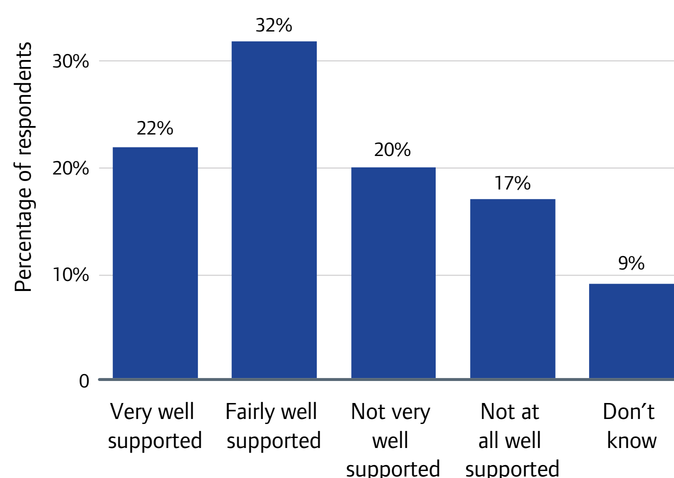
Waiting for care

The repercussions of the COVID-19 pandemic continue to be felt by individuals, families and care staff. After the initial prioritisation of urgent care, there was a gradual push to bring health and care systems back in line with pre-pandemic levels. That recovery continues, but people are still being affected by problems ranging from frustrations in accessing regular appointments to delays that stop people getting the life-saving treatment they need when they need it. Many people are still waiting for the health and social care support and treatment they need, and many are waiting too long.

We commissioned Ipsos to carry out, in May and June 2022, a representative telephone survey of more than 4,000 people aged 65 and over who had used health or social care services in the previous 6 months. Over 1 in 5 respondents (22%) said they were currently on a waiting list for healthcare services like diagnostic tests, mental health services, consultant appointments, an operation or a therapeutic service such as physiotherapy.[14]

We asked people whether they felt supported by health and social care services while they were on a waiting list for health services. Although just over half (53%) said they felt very or fairly well supported, more than a third (37%) did not (figure 3). As an estimate, this equates to around 800,000 older people in England who do not feel well supported while they are on a waiting list for healthcare services.

Figure 3
How supported do you feel by health and social care services while you are on a waiting list for health services?



Source: Ipsos/CQC

Base: All respondents aged 65 and over living in England who have used health or social care services over the last 6 months and are currently on a waiting list for health services (882, unweighted base). Survey conducted by telephone between 17 May and 12 June 2022.

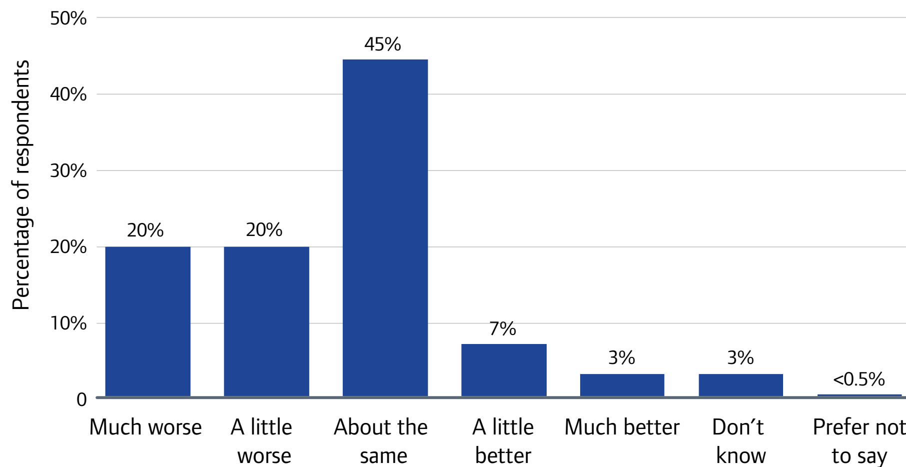
People were also asked how the condition for which they were on a waiting list had an impact on their ability to carry out day-to-day activities.

Two in 5 people on a waiting list for health services (41%) said that the impact of their condition on their ability to carry out day-to-day activities was worse than when they were first referred, while 1 in 10 (11%) said their ability to carry out activities was better (figure 4).

People who felt they were getting worse while waiting consistently reported poorer experiences of health and social care services compared with the average across the whole sample. For example, they were less likely to rate the care and support received for their health and wellbeing over the last 6 months as good (68% compared with 78% on average), and more likely than average to rate it as poor (21% compared with 11%).

Figure 4

Thinking about the condition you are on a waiting list for, what is its impact on your ability to carry out day-to-day activities in comparison with when you were first referred?



Source: Ipsos/CQC

Base: All respondents aged 65 and over living in England who have used health or social care services over the last 6 months and are currently on a waiting list for health services (882, unweighted base). Survey conducted by telephone between 17 May and 12 June 2022.

We asked people what information, activities or services would help them to manage their condition while they were waiting for health services. Leaving aside those who said they didn't need more help (39%), the most common answers were knowing where they were on the waiting list or how much longer they would have to wait (22%) and knowing that they were still on the list and had not been forgotten (14%).

Waiting for hospital treatment

The size and impact of people waiting for health services is explored at length in data and reports from commentators across the sector. NHS England data shows that the waiting list for planned elective NHS treatment has grown

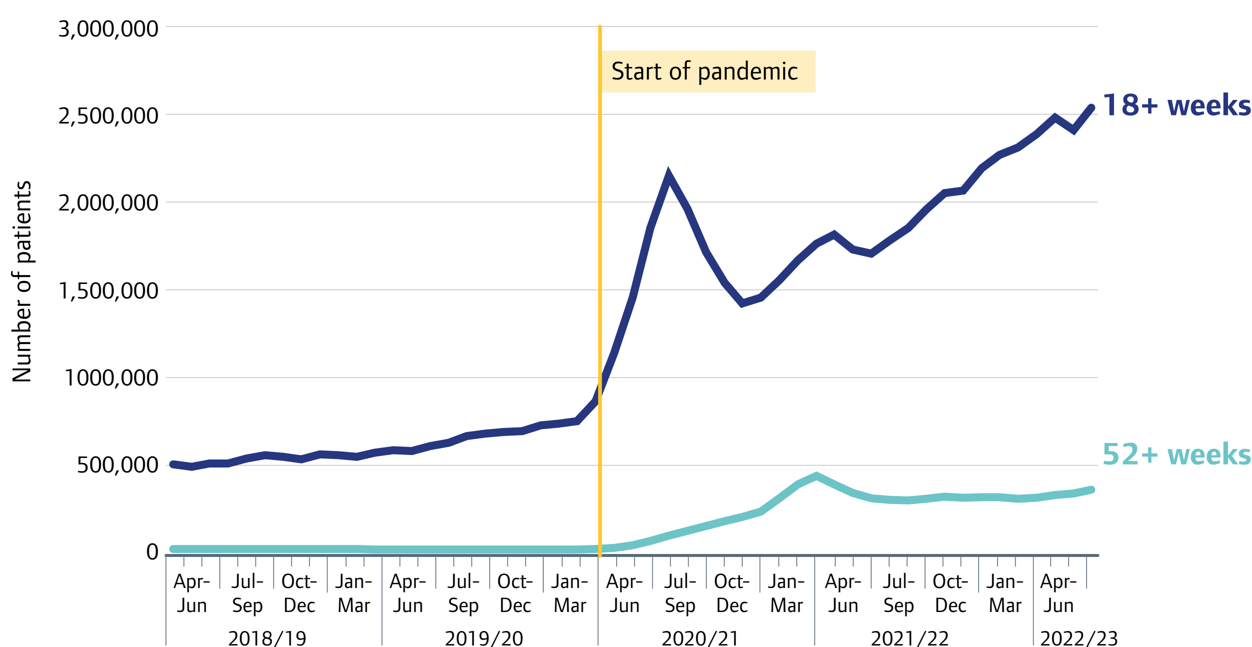
steadily since June 2020. In June 2022, there were more people than ever waiting for elective NHS care (6.7 million), which our analysis shows is an increase of over 50% since the pandemic began.[15]

The latest results from our Adult inpatient survey show that people are having to wait longer than they would like to for their treatment and care before being admitted to hospital. The results show a decline of 3 percentage points from the previous year in satisfaction with the length of time people were on a waiting list before their hospital admission (68% to 65%).[16]

In August 2022, the British Medical Association noted that waiting times were much longer than they were before the pandemic.[17] The NHS England data for June 2022 showed there were more than 350,000 people who had waited over a year for treatment – a figure that is over 220 times higher than it was before the pandemic. The number of people waiting more than 18 weeks for treatment was at its highest ever level at over 2.5 million (figure 5).

Figure 5

Patients waiting more than 18 and 52 weeks for consultant-led elective treatment, England, April 2018 to June 2022



Source: NHS England, Consultant-led Referral to Treatment Waiting Times.

In March 2022, the House of Commons Committee of Public Accounts noted wide variation across areas of the country in waiting times for elective care and cancer treatment.[18] People living in the worst performing areas were more than twice as likely to wait more than 18 weeks for treatment as people in the best performing areas. And the proportion of people waiting over a year for treatment in the worst performing areas was 12 times higher than in the best performing areas.

Healthwatch has conducted research on how NHS waiting lists have affected people.[19] Of the 2,500 people they spoke with between August and October 2021, nearly 1 in 10 (8%) said they had been waiting for more than 2 years to receive care. Treatments being cancelled was also a key concern. Healthwatch found that over the previous 18 months, 1 in 3 people (32%) had a procedure cancelled at least once; 15% had a procedure cancelled more than once.

"The first cancellation in July 2021, I was being wheeled down to surgery when they turned me around and took me back to the ward as no ICU bed available. They promised to do the surgery on 26 July 2021 and would make sure no one took my bed. I started a week in isolation at home prior to surgery, only to receive a phone call 3 days before the procedure that it was cancelled and couldn't give me another date. I have heard nothing since about another date."

Healthwatch research – November 2021

In addition, just 15% of the people Healthwatch engaged with said they had received interim support, such as pain relief, physiotherapy or mental health support, while they waited for their hospital treatment.

"My health and mobility is decreasing with every month that goes past. Without intervention I will be wheelchair-bound instead of me walking the dog every day. I will soon need help with personal care, cleaning etc, because my conditions have not been adequately monitored and treated for 18 months."

Healthwatch research – November 2021

Healthwatch followed this up with a survey in February 2022 of 1,000 adults on an NHS waiting list. It found that in the current hospital backlog, people from poorer households, people from ethnic minority groups, disabled people and women were more likely to have a worse experience of waiting for care. For example, it reported that:

- Almost twice as many people from poorer households (52%) who responded to their survey said long waits affected their mental health when compared with responses from more affluent households (28%).

- Over half of respondents from ethnic minority groups (57%) faced a delay to or cancellation of hospital treatment, compared with 42% of White British respondents.[20]

The government's Build Back Better plan in September 2021 promised to deal with the backlog by doubling its commitment in 2021/22 and spending £2 billion to start reducing the backlog, and then dedicating more than £8 billion over the subsequent 3 years to tackle it.[21]

In February 2022 NHS England set out an ambitious delivery plan for the NHS in England to be delivering 30% more elective activity than before the pandemic by 2024/25.[22] It set a timeline of milestones to tackle long waiting times, including ambitions that:

- By July 2022, no one would be waiting over 2 years.
- By March 2025, no one would be waiting over a year.

At the beginning of August 2022, the NHS chief executive praised NHS staff for "virtually eliminating" the 2-year waiting times – the first milestone in the delivery plan. Although there were more than 22,500 people who had been waiting 2 years or more for scans, checks, surgical procedures and other routine treatment at the start of the year, this had been reduced to 2,777, of whom 1,579 opted to defer treatment and 1,030 were very complex cases.[23]

The delivery plan also acknowledged the challenge of predicting how quickly elective services will recover, stating that waiting lists may only begin to fall from March 2024, in expectation that around half of the 8 million 'missing' patients who put off seeking NHS care during the pandemic come forward.

The British Medical Association has commented on these missing patients, referring to 'the hidden backlog' that is storing up greater problems for the future and likely to result in worsened conditions down the line, leading to greater demand on health services.[24]

Treating cancer patients at home in Newcastle

Some services are trying to overcome backlogs and cope with demand by expanding or being more flexible in the way they deliver care. As part of the NHS Long-Term Plan, Newcastle upon Tyne Hospitals NHS Foundation Trust has introduced 2 new initiatives.

Its day treatment cancer service previously ran 5 days a week in the Freeman Hospital's Northern Centre for Cancer Care. This managed emergency admissions and over 60 patients a day for chemotherapy treatment. Now it runs 7 days a week with an extra 400 appointments each month, supporting patients to receive treatment more quickly and with greater flexibility.

Combined with advances in cancer treatments, the service also gives some patients greater flexibility with appointments as they continue their day-to-day lives where possible.

Alongside this, the hospital has a new ambulatory care unit (ACU) that supports haematology and oncology patients regionally. ACUs assess, diagnose and treat patients, enabling them to go home the same day, without being admitted into hospital overnight.

This ACU has increased capacity across cancer services after implementing the CAR-T programme, an initiative also aimed to improve the experiences of those receiving treatment for cancer.

Patient care pathways have been designed to reduce inpatient bed days and unplanned admissions, and to support those patients who are eligible to receive care at home.

Patients who would usually need to be admitted an inpatient can be treated at home using new technology. This involves a programmed infusion pump that can deliver treatment twice a day at home, with only a short outpatient appointment needed to change pump cassettes. A remote system is used to monitor treatment delivery in real time, allowing the specialist team to troubleshoot without the need for patients to travel to hospital.

People cared for through this ambulatory care pathway have given positive feedback to the trust. The benefits have included better sleep, more quality time at home with family, and more involvement in decisions about care, as well as more comfortable surroundings and fewer delays. The trust is planning to further expand its ACU pathways.

During the pandemic, independent acute health providers supported NHS organisations to maintain some level of surgical procedures. These providers have also seen an increase in their self-pay and insurance-funded services since the impact of the pandemic has reduced.

This is reflected in figures from The Private Healthcare Information Network. From April to June 2019, 50,000 people opted to self-fund private treatment. For the corresponding months in 2021 (as the pandemic restrictions eased), 65,000 people chose this route. This indicates a rise of 30% in people paying for their own treatment between these 2 periods.[25]

Rising demand for mental health care

Last year, we raised concerns about the impact of the pandemic on people's mental health, and their ability to access the care and support they needed when they needed it. In our community mental health survey 2021, 41% of all respondents reported feeling they had 'definitely' seen NHS mental health services often enough for their needs in the last 12 months. This was the lowest score across the period from 2014 to 2021.[26]

The findings from a survey of over 5,000 people by the charity Mind, published in February 2022, suggest these access problems are likely to worsen as demand increases, with 1 in 4 adults surveyed (25%) who experienced a worsening of their mental health for the first time during the pandemic saying they were yet to have a first conversation about it.[27]

Not getting the right care at the right time can lead to people's symptoms worsening and people seeking support from emergency departments. This year, we continued to see increasing numbers of people with mental health needs attending emergency departments in crisis and need of support.

A lack of mental health beds has then led to people staying in acute hospitals for too long or being admitted to unsuitable settings. For example, at one trust we found that patients overstaying in acute mental health facilities was a regular occurrence, with the trust reporting over 20 12-hour A&E breaches in a single month that related to patients with mental health needs. While we recognise acute trusts often take action to meet patients' needs as best they can, these types of breaches mean that patients are not always receiving the right care and treatment when they need it.

Healthwatch carried out a review of feedback it received during 2021/22 about adult mental health services. This included analysing feedback from 581 adults as well as reviewing 28 local Healthwatch reports and one Healthwatch England report that represented the views of 4,054 people. The findings included:

- GPs vary in how well-equipped they are to support people with mental health issues, and people can struggle to get their GP to refer them for specialist mental health support.
- Waiting times are long at all stages of the mental health system.
- Crisis services are over-subscribed and therefore often inaccessible.
- Assessments can feel perfunctory and often do not lead to the outcome people want.
- Treatment often ends too early, before people feel they are ready, and without adequate follow-up support.

Through our work looking at the progress from our thematic review 'Out of sight – Who Cares?' [28], NHS England and NHS Improvement told us they are investing £2.3 billion of additional funding in mental health services by 2023/24 as part of the NHS Mental Health Implementation Plan. Some of the investment includes:

- almost £1 billion additional funding for new models of integrated primary and community services for adults with serious mental illness
- around £300 million in enhancing adult mental health crisis services, including a range of alternative crisis services in every part of the country
- all mental health crisis services to be 'open access', through 24-hour urgent mental health helplines, by 2024. This means that anyone can self-refer and there should be no exclusions. NHS England and NHS Improvement will share guidance on making reasonable adjustments for people with a learning disability and autistic people who call these lines
- ring-fenced investment in models such as crisis houses, sanctuaries and crisis cafes in all parts of the country.

While we welcome this additional funding, this needs to be supported by plans to ensure that there is a workforce to deliver these services.

Through our work this year, we have found that issues around workforce and staffing shortages remain the greatest challenge for the sector. Not having enough staff with the right skill mix can affect the safety of people who use services and have a negative effect on the quality of care they receive. As highlighted last year in our July 2021 insight report, issues with staff competence and training, and weak leadership and lack of oversight can increase the risk of closed cultures developing.

During our provider collaboration review on the mental health care of children and young people during the COVID-19 pandemic, we heard examples of systems taking steps to try and mitigate staffing shortages.[29] Other areas spoke about how they had 'upskilled' new and existing staff to try to meet demand and manage shortages.

However, the shortage of qualified mental health staff is an issue which requires a system-wide approach to ensure that there is a continual 'pipeline' of trained mental health professionals.

Waiting for social care

In our survey of more than 4,000 people aged 65 and over who had used health and social care services in the previous 6 months, 102 (3%, weighted base) people said that they were waiting for a care needs assessment from their local authority. Given the small sample size, the following results should be treated with caution. Of these 102 people, while more than half (57%) said they felt very or fairly well supported while they were waiting, over a third (36%) felt they were not very well or not at all well supported.

Two in 5 of those waiting for a care needs assessment (40%) said that their ability to carry out day-to-day activities was now worse than when the assessment was requested, while 15% said it was now better. These views are similar to those expressed by those in the same survey who reported being on a waiting list for health services.

We asked what information, activities or services would help to keep people safe while they wait for the needs assessment. Leaving aside those who said they didn't need anything else (31%), the most common answers were knowing when they will have the needs assessment (19%) and getting more information about how social care services work and how to access them (17%).

Survey findings from the Association of Directors of Adult Social Services (ADASS) indicated that, at the end of February 2022, around half a million people may be waiting either for an adult social care assessment, for care or a direct payment to start, or for a review of their care.[30] The report said that:

- In January and March 2022, more than 6 in 10 councils that responded (61%) said they were having to prioritise assessments and were only able to respond to people where abuse or neglect was highlighted, for hospital discharge or after a temporary period of residential care to support recovery and reablement.

- Between January and March 2022, a total of over 2.2 million hours of homecare could not be delivered because of insufficient workforce capacity. This figure is 7 times greater than it was in spring 2021 – an average of over 170,000 hours of homecare not being delivered each week, leading to unmet and under-met needs.

During our urgent and emergency care reviews we saw that reduced access to local authority assessment, and re-assessment when needs changed, caused delayed discharges from hospitals.

The impact of these issues is reflected in analysis published in September 2022 by Age UK for the Care and Support Alliance on the numbers of people who require assistance with one or more activities of daily living, like washing and eating. They estimate that 2.6 million people aged 50 and above are living with some form of unmet need for care in England.[31]

Waiting for a care assessment

Faizan supports his grandmother, Sharnaz who is in her 80s and lives in her own home. She is diabetic and has problems with mobility, so needs help with taking her medication and personal care, such as washing and dressing.

For several years, the family have supported Sharnaz by juggling informal care between them. But this is a big commitment, and Faizan feels guilty about not always being able to see her as much as he'd like, or to respond to her calls quickly enough because he is working or looking after his own children.

In summer 2021, because Sharnaz's care needs had increased, Faizan contacted his local council to request a needs assessment to provide more formal care. They soon called him back to take some details, so that they could arrange a visit.

A year on, and that assessment has still not taken place. Two visits have been postponed by the social care team. After the second postponement, Faizan called to investigate. A social worker explained that they were really struggling with demand and staffing issues, especially COVID-19 sickness absence, and were having to prioritise emergencies, such as people who have had a fall.

In the meantime, Sharnaz's needs have increased further, and she's become more anxious. Faizan thinks this has been made worse by the pandemic, because she feels isolated, so she doesn't have anyone to share her worries with, so they get bottled up.

The family have so far managed to meet Sharnaz's support needs through semi-formal arrangements with contacts in the local Pakistani community, but this is not sufficient in the long-term. Faizan can feel embarrassed because he doesn't want to over-burden friends and acquaintances. Also, Sharnaz can feel uncomfortable having some members of her community supporting her with more personal care, so has delayed having a bath until a family member has arrived.

Although Faizan understands the pressures that social care services are under, he is getting more and more anxious and keen to organise his grandmother's care in a professional, dignified way that keeps her safe and promotes her health and wellbeing.

Interview with a member of the public

Accessing primary care

The main interaction with health and social care services for many people is with their local GP practice or NHS dental practice. Good access to these services helps people to get care in the right place for their needs, and relieves pressure on other parts of the local health and care system.

Overall, people are less happy with primary care services than with other NHS services. In the 2021 British Social Attitudes Survey, people were most likely to be dissatisfied with NHS dental services – bottom out of all NHS services. Satisfaction with GP services was second to bottom. Responding to this survey, a joint report from the King's Fund and Nuffield Trust highlighted an "unprecedented" change. Satisfaction with GP services fell by 30 percentage points, from 68% of people reporting being satisfied in 2019 to only 38% in 2021. This is the lowest level recorded since the survey began in 1983. The numbers who were dissatisfied rose from 20% to 42%. Until 2018, GP services were always the highest rated in the survey.[32]

GP services

General practice is busier than ever – general practice appointments were the highest ever recorded during the winter of 2021/22. NHS Digital's experimental data shows that in June 2022, just under half (49%) of appointments were with a GP, while others were with nurses and various other healthcare professionals. Nearly two-thirds (65%) of appointments were recorded as face-to-face. Of all appointments, 44% happened the same day as booked, and nearly 3 in 10 people (29%) waited 8 days or longer for their appointment.[33]

In August 2022, the Royal College of GPs highlighted the hard work, dedication and resilience of GP teams, working in the face of intense workload and workforce challenges, to deliver timely, appropriate care for their patients; and how 26 million consultations to patients were delivered in July 2022, considerably more than in the corresponding month in 2019, before the pandemic.

The 2022 GP Patient Survey shows that people's overall experience of making an appointment worsened considerably, compared with 2021, with the percentage of respondents who said they had a good experience falling from 71% to 56%. Where people did not get an appointment, more than 4 in 10 (42%) said this was because they were not offered one, while over a quarter (28%) said this was because there weren't any appointments available for the time or day they wanted.[34]

More people overall have been trying to make appointments this year (71% compared with 63% last year). But the survey also shows that more people said they had avoided making appointments – over half (55%) compared with 42% last year. Previously, people said they didn't want to catch COVID-19 or burden the NHS – now they say they are not trying to make appointments because they find it too difficult.

More than 1 in 10 people (11%) who did not get an appointment at their GP practice said they went to A&E and just under 11% called NHS 111. However, over a third of respondents (34%) said they didn't see or speak to anyone. This is concerning as delayed or missed diagnosis could lead to worsening health and outcomes.

We found similar sentiment from an online survey we commissioned about people's access to a GP practice and their experiences in November 2021. The sample was 2,087 adults in England who had tried, successfully or not, to access a GP service in the previous 12 months. Where respondents did not get an appointment:

- 25% didn't see or speak to anyone.
- 25% decided to contact their practice at another time.
- 16% attempted to self-diagnose using an internet search.
- 10% went to A&E.

We collect information from people about all kinds of health and social care services – this often comes through our website and our Give Feedback on Care service. From this feedback, we can see that the experience of accessing GP care was frustrating for many people who contacted us.

From our analysis of a random sample of feedback received through Give Feedback on Care during October 2021 (410 comments), the most common issue for people was trying to book an appointment on the phone – nearly a third (31%) of the comments in our sample mentioned this. Over a fifth (22%) said there were no appointments available – and 18% felt the person they spoke to was a barrier to getting an appointment. Nearly 1 in 10 (9%) thought their GP was not addressing all their concerns or taking their symptoms seriously. These issues were also prevalent in a more recent random sample of Give Feedback on Care comments we reviewed (113 comments, January to March 2022).

In our November 2021 online survey about access to a GP practice, a third (34%) of people said it was 'not very easy' or 'not at all easy' to book their most recent appointment – and another 14% said they were unsuccessful. Regionally, people in the Midlands and East of England were more likely to report challenges in trying to get an appointment.

> *"Trying to get an appointment is near impossible every time… on more than one occasion I have had to use the NHS 111 service and accident and emergency as I can never speak to someone about my child. Any time I have received an appointment for my child, the doctors and staff always seem very dismissive. They are patronising and disregard information, making me feel belittled. Due to COVID we haven't been able to change surgery. I know I am not the only person who attends this practice to feel like this. It is unfair to have such a bad and unorganised medical practice running."*
>
> **Anonymous, through Give Feedback on Care**

> *"I have rung numerous times and have been in a queue for nearly one hour, with no answer. One time recently I went into the surgery, whilst still in the queue on my phone, and the phone wasn't even ringing in reception! I asked the receptionist why… they said it had been muted because they were busy… but there were no patients in the waiting room."*
>
> **Anonymous, through Give Feedback on Care**

The GP Patient Survey showed that people's overall experience of their GP practice has also deteriorated considerably in 2022, falling by more than 10 percentage points since last year. In 2022 just over 7 in 10 respondents (72%) described their overall experience of their GP practice as 'good'. This is the lowest level it has been in 5 years. The proportion of people describing their overall experience as 'very poor' more than doubled from 2.4% in 2021 to 5.6% in 2022.

Across the country, areas in the South West and West Midlands reported the best experience of their GP practices, while London, Essex, Kent and parts of central Midlands reported the worst experience. Inequalities in experiences are also apparent, with people from more deprived areas, disabled people, carers, people from Bangladeshi, Pakistani, and Gypsy or Irish Traveller backgrounds, people from Muslim and Sikh communities, people whose gender identity is different to their sex registered at birth, people who prefer to self-describe their gender identity or identify as non-binary, and gay, lesbian and bisexual people all reporting worse overall experiences.

Improved transparency

Shafi was unhappy with the service he was getting from his GP practice. He'd rung up several times to get appointments for his children, but they kept being pushed back, so they weren't being seen at the right time. He put a complaint into the practice.

As a result of the complaint, Shafi was seen by one of the practice partners, who explained simply how much pressure they'd been under during the pandemic. For example, the GP said he'd often been the only one working because of staff sickness.

Shafi found the GP's explanation to be very honest and open, and typified other conversations he'd had with health and care professionals over the pandemic. Despite the many terrible outcomes from COVID-19, he thinks the pandemic has broken down some barriers between professionals and people using health and care services, and created a culture of improved transparency and honesty.

Interview with a member of the public

In our online survey about access to a GP practice, we asked people to tell us whether their appointments met their health and care needs. Of the respondents, 42% said their needs were definitely met and the same percentage said they were partly met, while 15% said their needs were 'not at all' met by their appointments. More than half of the people who responded (58%) told us that they felt their access to GPs had worsened since the pandemic. This varied by region – for example, higher proportions of people in the North and the Midlands said it had worsened (59% and 61% respectively) and a lower proportion said the same in London (52%).

Dental services

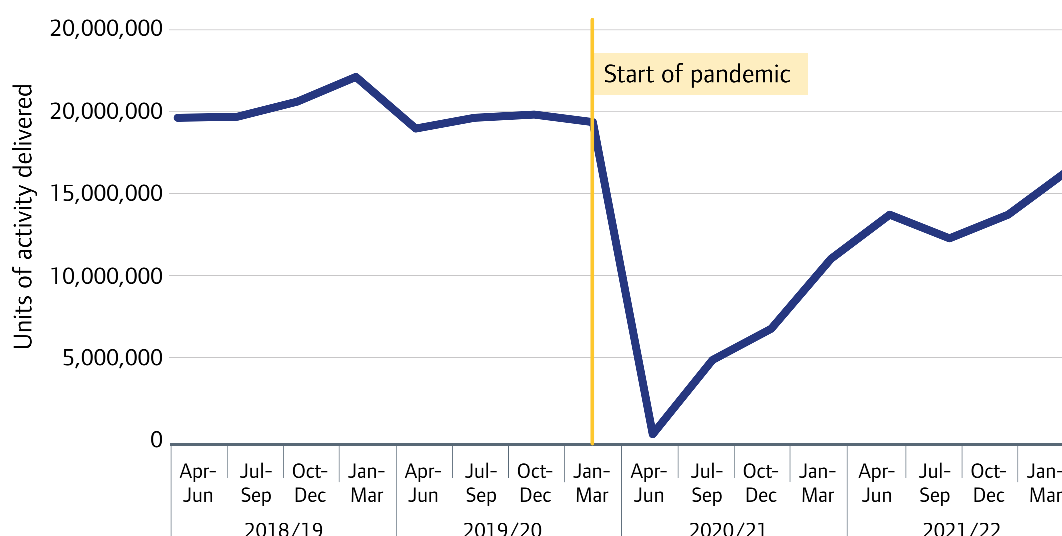
COVID-19 had a severe impact on dental services and there was a significant reduction in the number of treatments delivered for people.

Units of dental activity provide a measure of how much NHS dental treatment has been delivered (with more complicated courses of treatment being made up of more units). Data from NHS Digital for 2021/22 shows that the average quarterly units of NHS dental activity were nearly 30% lower than the average levels of activity in the 2 years before the pandemic, although activity was picking up towards the end of the year (figure 6).[35]

The data shows geographical variation. For example, London had the lowest figures up to the end of June 2022: only a third (33%) of adults had seen an NHS dentist in the previous 2 years and just 4 in 10 children (41%) had seen an NHS dentist in the previous year. In contrast, over 40% of adults in the North East and Yorkshire and half (50%) of children in the North West had seen an NHS dentist over the same respective periods.

The main shortfall in treatment was in 'Band 1', which covers routine check-ups and simple treatments. Band 2 and Band 3 treatments, which cover increasingly complex treatments, were also lower than pre-pandemic levels.

Figure 6
Total units of NHS dental activity, England, 2018/19 to 2021/22



Source: NHS Digital, NHS Dental Statistics for England.

The number of urgent treatments in 2021/22 was slightly higher than pre-pandemic levels.

In January 2022, NHS England announced a one-off £50 million fund to enable up to 350,000 additional dental appointments, for a limited time. This was split regionally – the priority was to treat children, people with a learning disability, autistic people, and people with severe mental health problems. The initiative aimed to catch up on missed dental appointments, with extra money for dentists delivering care outside core hours, such as early mornings and weekends.[36]

In a May 2022 report, the Association of Dental Groups said the funding was unlikely to recover the backlog of care or "shore up the finances of the many practices struggling to provide NHS services".[37]

From reviewing a random sample of comments from our Give Feedback on Care service about dental services (127 contacts, March to May 2022), we know that problems with booking NHS dental appointments continues to be a prominent theme. People reported being told there are no appointments available for days or sometimes months ahead. They have also told us about the frustration of appointments being cancelled with little warning or explanation.

"My children are registered with this dentist and have been unable to receive a check up, with the practice cancelling appointments several times with no reason given."

Anonymous, through Give Feedback on Care

"I am concerned that my children have not been seen by a dentist at this practice for over two years. This is in part due to COVID, but also because the practice keeps cancelling appointments. They typically say that this is down to them not having an NHS dentist available at the time booked and they advise that they will contact me to rearrange the appointment, but I never hear anything more. It is then up to me to chase another appointment, which invariably gets cancelled by them again. I fear for the state of my children's teeth as it has now been so long since they have had a check-up."

Anonymous, through Give Feedback on Care

There is distress for people who have not been able to get regular dental check-ups for extended periods. Some people told us they were left in pain or with worsening dental issues.

Some people told us they felt pressured to choose private dental care because they could not get NHS care. They noticed a lack of NHS appointments, while private appointments were available.

We also heard about people feeling unwelcome as NHS patients, particularly if they needed urgent treatment – and some said they were left in pain or discomfort because they chose not to pay for private treatment.

"I am a registered NHS patient at this practice… I attended for an urgent appointment due to a dental emergency… the dentist made no attempt to build rapport with me. Instead they moved quickly into upselling different private treatments. [I was] advised the procedure was very expensive… they said, because it was no longer covered under the NHS treatment offer. They were aggressively trying to sell the treatment and in no way made any effort to help. I ended the consultation after the first x-ray as I feared this treatment would begin to cost too much. I left the dental practice after paying a fee with no dental work completed and I now have severe pain."

Anonymous, through Give Feedback on Care

Other issues included being deregistered as an NHS patient at a dental practice without warning – some were told it was because they had not attended appointments during the pandemic. Some people told us how they struggled to get the care they needed through the NHS. In one example from feedback submitted in April 2022, we were told that a dentist told the patient that "none of the procedures are available on the NHS".

These experiences of trying to get NHS dental care are corroborated in other reports. The 2022 GP Patient Survey that ran between January and April 2022 found the number of people trying to get NHS dental care had continued on a downward trend (down to under 52% from 56% the previous year). In this survey, of the people who had tried to get an appointment over the past 2 years, more than 1 in 10 (12%) said they could not get an appointment because none were available. The same survey shows a continuation in the decline of people's experience of NHS dental care.

Healthwatch analysed data supplied by NHS Digital in December 2021. It found that 7 of the 42 integrated care systems reported having no practices taking on new adult NHS patients.[38]

In August 2022, the BBC published the results of an investigation that was supported by the British Dental Association (BDA) and in which the BDA expressed the feeling of crisis that dentists share alongside their patients. The BDA reports that it worked with the BBC, which identified 8,533 dental practices across the UK that were believed to hold NHS contracts. The BDA says that the BBC attempted to call them all and nearly 7,000 were contacted. Their survey shows:

- Across England, 9 out of 10 (91%) NHS dental practices were not accepting new adult patients (4,933 of 5,416). This was highest in the East Midlands (97%), South West, North West and Yorkshire and the Humber (98% respectively).
- Where English practices were not taking on adult patients, nearly a quarter (23%) said they had an open waiting list, while 16% said the wait time was a year or longer, or they were unable to say how long it would be.
- BBC researchers were unable to reach any practices who were accepting new adult NHS patients in over a third (37%) of the 152 local authorities in England.
- Across England, 8 out of 10 (79%) NHS dental practices were not accepting new child patients (4,293 of 5,416).[39]

In June 2019, we published Smiling matters, a report on the state of oral health in care homes. We plan to update on the findings from this report in the coming months.[40]

Prisons and secure settings

The main challenges to accessing health care for people in prisons and other secure settings during 2021/22 were mostly influenced by COVID-19-related restrictions.

COVID restrictions continued within secure settings beyond the timeframes seen in the community. Prisoners frequently missed appointments during the pandemic because the prison officers who were needed to collect and escort them to healthcare appointments were ill or testing positive. This shortage made it more difficult for dental patients because some prisons required a trained officer to wear full personal protective equipment and wait outside the dental room in case of an incident.

However, the pandemic sparked more innovative ways of working. Some of these were temporary due to restrictions but others are expected to continue and will improve patient access. There was improved cross-working between prison and healthcare staff as increased reliance was placed on working together to ensure prisoners received health care, and also improved working relationships between healthcare services in secure settings and local hospitals receiving patients for treatment.

The NHS Mental Health Secure Care Programme was established in 2016 to deliver the recommendations in the Five Year Forward View for Mental Health for care in the least restrictive setting, as close to home as possible and with a stronger focus on recovery. The programme aims to improve the experience and outcomes of people using secure mental health services, substantially reduce the number of people sent 'out of area' for care, and reduce the dependency on hospital beds through increased community provision.[41]

Between April and May 2021, CQC and other agencies supported HM Inspectorate of Probation in carrying out a joint thematic inspection. This followed the progress of people with mental health needs through the criminal justice system, from first contact with the police to release from prison.[42] Liaison and diversion services identify people who have mental health needs, a learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. These services can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care, or enable them to be diverted away from the criminal justice system into a more appropriate setting, if needed.

The review found that:

- There was significant inconsistency across the country in the provision and input from liaison and diversion services into court settings. We identified various reasons for this including commissioning arrangements, the capacity of providers, and the pandemic. This can affect information sharing and joint working with probation teams.

- Different areas use different operational systems, which can work well where the same providers deliver liaison and diversion as well as community mental health services, and when community and prison health providers use the same systems and share access. However, not having access to operational systems can be a barrier when different providers are commissioned, and different ones are in use. This can affect the timeliness and quality of information sharing with partners.

- Since the previous thematic review, there had been an improvement in staffing models, with a variety of different roles within liaison and diversion teams including social workers, learning disability nurses, psychologists and mental health nurses.

- The use of peer mentors was invaluable during the pandemic to maintain contact with patients, offer practical support, and encourage them to engage with services.

In February 2022, the Justice Select Committee published the government's response to its fifth report on mental health in prisons.[43] This noted that the Ministry of Justice, HM Prison and Probation Service, the Department of Health and Social Care and NHS England continue to work together to identify and meet the mental health needs of prisoners, as well as putting measures in place to ensure they can access treatment in the right place.

Capacity and stability in adult social care

Capacity

Adult social care plays a vital role in keeping people well – either in their own homes or in residential settings.

For a large part of 2021/22, care home visiting has been restricted. This has meant that people were often unable to visit services to decide whether they or their family member wished to become a resident. Restrictions also had an impact on residents' wellbeing, as family members were often not able to visit and some residents could only see family members through a window. This could be particularly hard for people who may not have been able to understand the reasons for the restrictions, including people with dementia, which can lead to feelings of isolation and confusion.

The impact of this on people living in these services and their loved ones cannot be underestimated. At times, these restrictions have been at odds with those imposed on most of society.

> The pandemic has disrupted the delivery of care within the service. The units and staff have for a large part been operated as self-contained units. All home activities such as external entertainers have been largely absent and visiting by family members severely restricted. Visits by the local school children have been stopped. This was normally a joyous occasion for our residents to interact with these children. Visits behind clear screens felt unnatural and although we utilise video calling, all this lacks the emotions of a proper visit with a hug. This has been very upsetting for all. Staff have been wonderful in maintaining personal interaction with residents. Incidents of self-isolation for residents have been particularly difficult and are contrary to the inclusive culture of our home. This is especially true for new admissions when we feel mixing with others and gaining familiarity within the wider home is most important.
>
> **Submission to CQC care home provider information return (April/May 2022)**

However, many care home staff have helped people to have regular contact with their relatives throughout the pandemic, and some providers have learned lessons from it for the future. When social restrictions ended, one provider continued to provide outreach support to people who had not always had the opportunity to engage in social activities and meet other people, due to the closure of many facilities. This helped to protect people from the risks of social isolation and enabled them to engage in the community. A family member told us, "Even when we had lockdown they had exercises on the computer and got in touch. [My family member] was so excited to see her friends and the staff, it was a way of keeping in touch."

Other access issues have been influenced by the pandemic. For example, people's choices about social care have been affected, with people staying at home longer rather than move into residential care. This increase in demand for homecare services, at a time when workforces are stretched, has led to large waiting lists. It has also led to delayed discharges from hospitals when there is no appropriate homecare available to facilitate a safe and person-centred discharge back home. In some cases, healthcare leaders are taking action to build more capacity in social care, to tackle unmet need in an area, and in recognition of the benefits for their whole local system. One example was the announcement by Northumbria Healthcare NHS Foundation Trust of its intention to provide home care services in North Tyneside and Northumberland.[44]

In July 2022, the Association of Directors of Adult Social Services signalled the rising demand for adult social care in its Spring Budget Survey 2022. Responses from 144 out of 152 councils, in May to June 2022, included:

- 78% of directors said more people are seeking support because of mental health issues.
- 67% said they are seeing more people because of domestic abuse and safeguarding concerns.
- 73% reported rising numbers of breakdowns of unpaid carer arrangements.[45]

Furthermore, directors said they are receiving more and more requests for support because of pressures elsewhere – for example, 82% reported increased referrals for people discharged from hospital.

In July 2022, Skills for Care reported a 50,000 fall in filled posts across the whole of adult social care between 2020/21 and 2021/22.[46] This reflects figures in a Nuffield Trust report in December 2021 suggesting that the reduction in staff "is fuelling an invisible care crisis in people's own homes with many unable to access the care they need, increasing care burdens on unpaid carers and impacting hospital discharges".[47]

Some areas have seen homecare providers handing care packages back to the local authority, as they are unable to fulfil their obligations to the people who use their services. One provider gave up 800 hours of care contracts due to insufficient numbers of staff and their inability to recruit.

We have seen a similar picture in other regions. Local authorities have told us they are concerned providers were handing back care contracts because they could not manage workforce shortages and demand.

However, we also continue to hear about local authorities that commission homecare in 15-minute blocks, which can lead to rushed or poor care. Some providers have refused to take up local authority contracts and only offer their service to people who pay for their own care. These providers tend to focus on 60-minute minimum care calls. They tend to have improved staff retention and recruitment (as they offer higher hourly rates) and overall satisfaction from people who use their service.

The pandemic also continued to have a significant impact on people's access to care homes during 2021/22.

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.

Workforce shortages and infection outbreaks have resulted in a reduction in care home capacity, which has been particularly acute in some regions. A number of registered providers have chosen to hold empty beds because they were unable to provide care workers to staff them.

Experimental data published by ONS using CQC's provider information returns shows that between March 2021 and February 2022, 77.8% of care home beds were occupied.[48]

More recent data from our provider information returns suggests occupancy is increasing, with figures for August 2022 up to 82.5%. However, this is still below the pre-pandemic occupancy rates of 84.7% captured in provider information returns between August 2019 and February 2020, and published by ONS.

Data from our register of adult social care services shows that it was not only care home occupancy that has been affected, as we have continued to see changes in the market. Between March 2021 and August 2022, there was a 2.4% reduction in the number of registered care homes (366 fewer locations). The South East had the biggest reduction in the number of care homes (96 fewer locations). However, proportionally the reduction was greatest in the South West (a reduction of 3.7%, amounting to 75 locations).

While the number of services has reduced, the total number of care home beds appears to have only reduced by 0.35% over this period, although this does amount to 1,611 fewer beds. The South West had the biggest reduction in care home beds, both proportionally and in number, with a reduction of 1.6%, amounting to 855 fewer beds. The South West therefore accounts for over half (53%) of the national loss in care home beds between March 2021 and August 2022.

There were particular challenges around assessment of people's needs before being admitted to a care home. Health and social care professionals were not always able or available to carry out needs assessments in people's own homes. Any assessments that did take place were focused on people with the highest care needs. This resulted in many people experiencing unmet needs.

Similarly, care home staff were unable to carry out face-to-face assessments and had to rely on either video technology, or the view of other healthcare professionals who were not familiar with the specific care home environment. This meant people were at risk of being admitted to services that were not able to meet their needs, either because of staff skill sets or lack of specific equipment. It also meant that people who were not digitally aware were unable to access these assessments.

> We want to get to know the residents before they come to the home. We typically discuss the placement with the resident, families, friends, social workers and any professionals who are involved in their care. We have unfortunately found that professionals and social workers are stretched for time and typically haven't met the resident. Families/friends struggle with highlighting some areas of their care. You don't get to know the resident in the same manner as you cannot sit with them and see their expressions or visibly see them walk. To ensure that we remain safe and can meet the needs of residents, we've been more cautious in our approach. We've kept all admissions to residents with no areas of concern and rejected admissions if there are potential concerns. We ensure that we talk to several professionals and family/friends where possible to ensure we have consistent, good quality information for the resident.
>
> **Submission to CQC care home provider information return (April/May 2022)**

Stability

In the section on workforce in this report, we highlight that providers are struggling to recruit and retain enough skilled staff, which is having a knock-on effect on access to care services and leading to unmet needs. In adult social care, which is predominantly private-sector based and dependent on profit, these challenges are also influencing the financial stability and sustainability of providers.

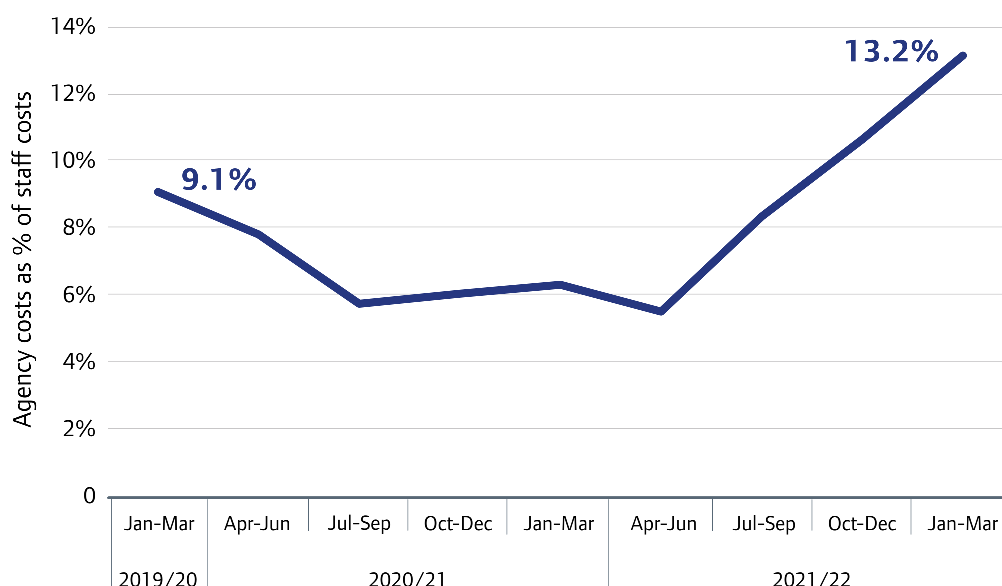
Data from our Market Oversight scheme gives insight into the state of the adult social care market. The scheme covers providers that have a large local or regional presence which, if they were to fail, could disrupt continuity of care in a local authority area.

For non-specialist care homes (principally those that care for older people), although staff costs decreased throughout 2021, reflecting a reduction in bed occupancy, they have started to rise in 2021/22, partly due to the need to pay more to recruit and retain staff. Between September 2021 and March 2022, staff costs as a percentage of turnover rose by 3.8 percentage points.

This will also be affected by increased use of agency staff. By the end of March 2022, agency staff costs made up 13.2% of total staff costs. This is 4 percentage points above what it was at the end of March 2020 (the start of the pandemic), and well over double what it accounted for at the end of June 2021, when there were restrictions on staff movement between care homes,

which included agency and bank staff (figure 7). The increasing cost of living is likely to have a further impact, which may result in more staff leaving care services for better-paid work.

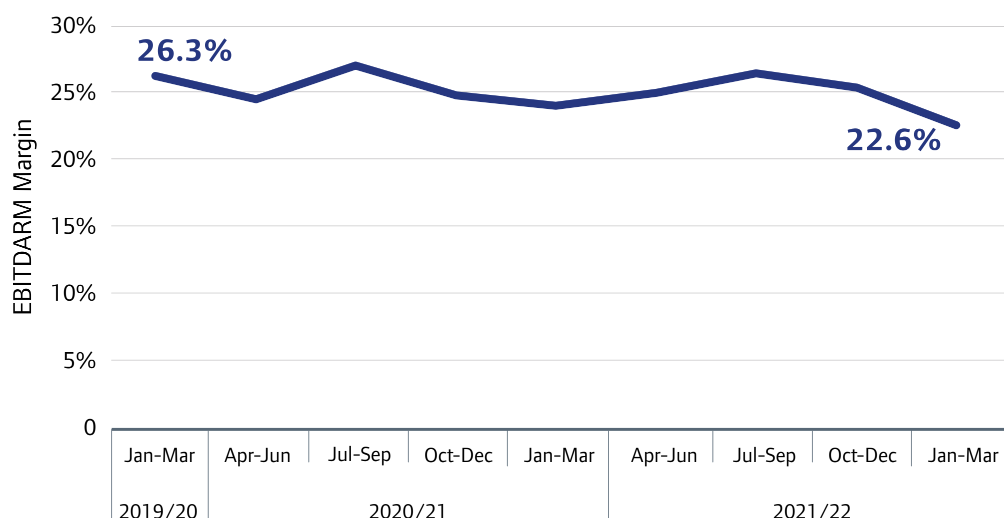
Figure 7
Quarterly agency staff costs in non-specialist care homes as a percentage of all staff costs, England, January 2020 to March 2022



Source: CQC Market Oversight data

Increasing staff and operating costs, and the lack of full recovery in care home occupancy, are having a significant reduction on profitability in non-specialist care homes. Profit margins (as calculated using 'EBITDARM', which is a high-level measure of profit that excludes key expenses such as rent, depreciation and interest charges) have fluctuated over the course of the pandemic, but at March 2022 were at their lowest levels since the pandemic began, and even since the Market Oversight scheme began in 2015 (figure 8).

Figure 8
Quarterly profitability (as measured by EBITDARM) in non-specialist care homes, England, January 2020 to March 2022



Source: CQC Market Oversight data

We can see a similar pattern of increasing costs and reducing profit margins in non-specialist homecare providers in the Market Oversight scheme.

As staffing costs increased, profit margins for homecare providers in the scheme started to fall after June 2021, decreasing from 15.3% to 13.2% at the end of March 2022.

The Homecare Association says that the minimum hourly rate for homecare services should be £23.20.[49]

However, the average national rate that commissioners pay for homecare is £18 an hour. Providers regularly state this has a negative impact on recruitment and retention, as well as their ability to appropriately reward their staff. Skills for Care and the Association of Directors of Adult Social Services recently organised a conference in the East Midlands (where the hourly rate ranges from £15.50 to £19.50 an hour). The event included presentations to homecare providers on how to advise their staff about accessing local foodbanks or claiming benefits to top up their wages.

Petrol and diesel prices have also had an impact on homecare staff who rely on a car to get them to their visits. Our adult social care workforce survey showed that, of the homecare services that provided information about retention challenges, nearly a quarter (23%) reported challenges related to the increased cost of petrol.

Some providers have told us they are having to increase fuel allowances to avoid losing staff to care homes and other sectors, but we also still see providers who do not pay for travel expenses or travel time, or who have not increased their pay to reflect the increase in these costs.

We are also hearing how the increasing cost of car ownership is not matched by increasing car allowance – and that some providers have put an annual ceiling on mileage which workers reached in 6 months, so they either leave or have to pay for their own mileage. In the South East, we heard of an unprecedented number of care worker resignations during May and June 2022, citing fuel costs (which peaked in June) as the reason for their decision.

Inflationary pressures are being felt in domestic households across the country, driven by cost increases in essentials such as food, electricity and gas. These soaring energy bills and food prices are also hitting care homes very hard.

The combination of increased wages to retain staff, increased running costs and the withdrawal of short-term government COVID-19 support, such as the infection control fund at the end of March 2022, have all increased the financial pressures on social care.

The Association of Directors of Adult Social Services, in its Spring Budget Survey 2022, reported that market instability is a major concern for directors, with 67% reporting that providers in their area had closed, ceased trading, or handed back local authority contracts. This is a significantly worse picture than last year and before the pandemic. It is also reflected by the fact that 64% of directors say they were concerned about their legal responsibilities in relation to market stability, and they believe the situation will get worse into next year.[50]

We are concerned that, if financial pressures continue, capacity in the adult social care market will be further constrained, and this will have knock-on implications for the NHS – all of which could make for a winter that is likely to be far tougher than anything experienced previously. If there is a repeat of the levels of COVID-19 community infection rates seen in previous winters, leading to increased staff sickness and care home lockdowns, these capacity challenges will only increase further.

"The impact of the increases in national living wage, fuel prices, insurance costs (more than doubled this year), employers national insurance, food etc is having an unprecedented impact on life at the care home, as profit is necessary to operate and reinvest. Savings will not last for ever.

For the last 2+ years the messages in the public media have been largely negative in terms of care home living. They have focused on the devastating impact COVID-19 has had. The upshot of COVID-19 for us is we shut down, we slowly had more and more empty beds, and now the threat is beginning to lift, we are seeing virtually no private enquiries, so we have been compelled to fill beds with local authority-funded people at a loss. At the time of writing this we have 6 empty beds out of 28 and zero private enquiries. The director writes an article in a free, local monthly magazine trying to be upbeat about residential care, but the message needs to be national.

Submission to CQC care home provider information return (April/May 2022)

Increased stability in social care is needed because it is also key in easing pressure on the NHS at both the front and back doors, by reducing emergency attendances and delayed discharges. This can support the development of new models for urgent and emergency care, in which people are less likely to be inappropriately funnelled towards emergency departments, and where primary care services are able to focus on those with multiple health conditions.

We welcome the government's 10-year reform programme of adult social care, set out in its People at the Heart of Care white paper, and the investment to reform social care.[51] However, providers have told us they are confused by the plans. And we note that organisations, such as the Local Government Association, have questioned whether the funding allocated will fully resource councils and providers in delivering the government's objectives.[52]

We therefore urge government and other stakeholders to continue to engage with people who use services, registered care providers, and their workforce to make sure that investment and reform work effectively to transform adult social care so that it can carry out its essential role of enhancing the day-to-day health, wellbeing and experiences of people using services in their community.

State of Care

3. Inequalities in care

Key points

- Health and social care providers need to do more to make their services accessible, especially to people with different communication needs.
- Our survey of people aged 65 and over who had recently used health or social care services found that older people living in the most deprived areas were more likely to report that they had a long-term condition, disability or illness, compared with those living in less deprived areas. They also tended to use fewer health services, although they did use them more frequently.
- Our survey also found that disabled people were less likely than non-disabled people to describe the care and support they received for their health and wellbeing over the previous 6 months as good.
- Ethnic minority-led GP practices are more likely to care for populations with higher levels of socio-economic deprivation and poorer health – this increases the challenges they have around recruitment and funding.
- The recording and use of demographic data by services generally needs to improve, to make sure data is complete, accurate, widely shared and used to bring about improvement.

Inequality continues to pervade and persist across health and social care. It is vital that everyone, inclusively, has good quality care, and equal access, experience and outcomes from health and social care services. It is also important that we focus on the quality of care for groups of people who face barriers in getting the care they need, and those most likely to have a poorer experience or outcomes. Not getting the care and treatment people need, in a way that meets their individual needs, is a breach of the Equality Act 2010 and puts people at risk of poorer health outcomes.

Deprivation

We commissioned a survey of more than 4,000 people aged 65 and over who had used health or social care services in the previous 6 months. The findings have painted a distinct picture of inequality.

In particular, we have seen how deprivation can affect people's health and access to health and care services.

Among those who had used services in the previous 6 months, people living in the most deprived areas were more likely to report that they had a long-term condition, disability or illness (70%), compared with the average for all survey respondents of 65%. Despite this, they tended to have used fewer health services over the last 6 months (58% had used 3 or more health services over the last 6 months, compared with 67% for those living in the least deprived areas).

Use of dentists was significantly lower for people living in the most deprived areas (43% compared with 65% of those living in the least deprived areas). This is supported by evidence from Healthwatch. In its 2020/21 annual report, 'Championing what matters to you', Healthwatch reported that people from lower income households were less likely to have visited an NHS dentist during the pandemic, more likely to have avoided treatment due to the cost, and less likely that they would see a dentist in the future.[53]

The British Dental Association reported a growing backlog for child tooth extractions, as the number of treatments in NHS hospitals more than halved during the pandemic. It also reported that children from the poorest areas are 3 times more likely to have extractions than those from the most affluent communities.[54]

Oral health is closely linked to a person's wider health, so poor access to dentistry is only likely to exacerbate other health inequalities.

From this evidence, we can infer that people from the most deprived areas are less likely to access preventative care, or receive care at an early stage when their condition may not be as serious. This was an issue we raised in our 2020/21 Mental Health Act annual report, which highlighted that people living in the most economically deprived areas face disadvantages in accessing mental health care and support when they need it. NHS Digital statistics for 2020/21, published in October 2021, showed that the most economically deprived areas had rates of detention more than three and a half times higher than the rate of detention in the least deprived areas.

Through our survey of more than 4,000 people aged 65 and over, we have also seen how some groups of people consistently report poorer experiences of care and support than others.

Overall, people aged 65 and over who have used health and social care services in the last 6 months were positive towards the care and support they have received for their health and wellbeing, with more than three-quarters (78%) describing their care and support as good, including around half saying it has been very good.

However, experiences were less positive in more deprived areas, with 76% in the most deprived areas saying their care and support has been good, compared with 80% in the least deprived areas.

In the 2022 GP Patient Survey, there was a clear association between levels of deprivation and people's experience of GP practices. Sixty-eight per cent of people in the most deprived areas rated their experience as good, compared with 76% of people in the least deprived areas.[55]

Analysis by the Health Foundation in January 2022 also showed how GP services in more deprived areas of England perform less well on average on key quality measures. It highlights how, compared with more affluent areas, people in the most deprived areas face a 12-year gap in healthy life expectancy and are more likely to experience multiple health conditions – creating a greater need for GP services in deprived areas. The analysis referenced previous research (from 2020) showing that GP practices in poorer areas received about 7% less money per patient than less-deprived parts of the country, once the increased workload and health needs of patients in poorer areas were factored in.[56]

Findings from our monitoring and assessment of ambulance services suggest that people living in the most deprived areas may be more severely impacted by ambulance delays. Anecdotal evidence from our monitoring and assessment of ambulance services suggests that, traditionally, the ambulance service has fulfilled an informal role in helping people from deprived communities to navigate the health system (for example, GPs and urgent treatment centres) and therefore access the care they need, when they need it.

In June 2022, a report from the British Medical Association highlighted the need for change. It warned that, without wholescale reform of the social care system, people living in poorer areas of the country will see their health and wellbeing worsen in the coming years.[57]

Disability

In our survey of more than 4,000 people aged 65 and over, disabled people were less likely than non-disabled people to describe the care and support received for their health and wellbeing over the last 6 months as good (75% compared with 80%).

There appears to be a cumulative effect for some groups of people. For example, it was less common among disabled people living in the most deprived areas to rate the care and support received as very or fairly good than among disabled people living in affluent areas (72% compared with 79%).

Our survey also highlights the impact of the pandemic on people's use of activities that contribute to their health and wellbeing, such as exercise groups, clubs or religious institutions. Across all respondents, a fifth (20%) were participating less often than before the pandemic. However, this figure was higher for disabled people (26%, compared with 16% of non-disabled people).

We asked why these people were accessing groups or activity less often. Being too unwell to engage in activities was much more frequently mentioned by disabled people (32%, compared with 8% of non-disabled people).

In the 2022 GP Patient Survey, disabled people were less likely to describe their experience of their GP practice as good: 68% did so compared with 72% of all respondents to the survey.

Ethnicity

The COVID-19 pandemic has continued to have a disproportionate impact on people from some ethnic minority backgrounds. In August 2022, the Health Foundation reported that, in the Omicron variant wave, Bangladeshi and Pakistani men and women had mortality rates between 2 and 3 times higher than White British men and women. Mortality rates for Black Caribbean men and for women of Mixed ethnicity were also higher than for White British men and women respectively.[58]

A recent review into Ethnic Inequalities in Healthcare by the NHS Race and Health Observatory, published in February 2022, highlighted ongoing ethnic inequalities across a number of areas of focus including mental health care, maternal and neonatal health care, and the NHS workforce.[59] (We also discuss inequalities for women from ethnic minority groups in relation to maternity care in section 4 of this report.)

In our provider collaboration review on the mental health care of children and young people during the COVID-19 pandemic, we found a lack of long-term and cohesive strategic planning focusing on young people from ethnic minority groups.[60]

NHS Digital data for the number of people detained under the Mental Health Act (MHA) in 2020/21 showed that rates of detention for people from the Black or Black British group were over 4 times those of people from the White group. The rates of use for community treatment orders for people from the Black or Black British group were over 10 times the rate for people from the White group. We will discuss this in detail in our report on the monitoring of the MHA to be published later in 2022.[61]

Our survey of more than 4,000 people aged 65 and over who had used health or social care services recently shows that older people from ethnic minority backgrounds tend to use services less frequently (68% said they use them about once every 2 to 3 months or once in the last 6 months, compared with 58% of people from White British backgrounds).

In 2021/22, we carried out a programme of research to look at the impact and experiences of regulation on ethnic minority-led GP practices. Notably, we found that ethnic minority-led practices are more likely to serve

populations with higher levels of socio-economic deprivation and poorer health. This can affect the ability of a GP practice to achieve some national targets, and increase challenges around recruitment and funding.[62]

Ethnic minority-led practices were more likely to report they were single-handed – meaning they are operated by just one GP without other partners to offer support. This can present challenges around resourcing and capacity. GPs from ethnic minority backgrounds who participated in our research also cited a lack of leadership support from external bodies.

We commented how, as the first port of call and foundation of most people's health care, a huge expectation is placed on every practice team. However, we found that ethnic minority-led GP practices are often not operating on a level playing field in terms of where they work, and the support available to them.

Healthwatch reported in May 2021 that people from ethnic minority groups said they were less likely to be registered with an NHS dentist and more likely to struggle to access one when they needed to.[63]

Accessible health and social care

Getting care in the first place, and then experiencing the care itself isn't as easy for some people as others. In 2021/22, we carried out a review of the experiences of people with a learning disability and autistic people when in hospital. A full report of our review will be published in the autumn. Emerging findings suggest that some people don't get the reasonable adjustments that they regularly need, for example access to interpreters for different languages.

A February 2022 report from Healthwatch found that many NHS services are not supporting equal access to care for Deaf and Deafblind people. In particular, it noted that people had to rely on family and friends when they were not given communication support. This made them feel less independent and forced them to share sensitive health information with family members rather than a healthcare professional.[64]

We have also heard about a lack of reasonable adjustments for Deaf people when accessing primary care and emergency services.

Harriet's experiences of care

Harriet and her sister Jemima told us about the challenges that Harriet faces as a Deaf person trying to access health and care services. They also described Harriet's experiences as a Deaf mum to her hearing daughter, Jessie, who is 8 years old.

Harriet has faced ongoing problems with booking interpreters for GP appointments. She described having to wait weeks for an appointment with an interpreter, even in an emergency. As a result, most of the time Harriet doesn't have access to an interpreter and relies on communicating with her GP in writing in English. She described how this increases the risk of misinterpretation. Harriet described how British Sign Language (BSL) is a visual language so sometimes she can't read written letters as she doesn't know what some words mean.

While Harriet was able to get face-to-face appointments during the pandemic, she still faced issues in booking an interpreter. This situation was made worse because of the use of face masks. Harriet described how not having easy access to an interpreter affects many of her Deaf friends, as it puts them off from going to the GP at all.

Without access to interpreters, Harriet and Jemima told us that healthcare professionals often assume that Jemima will be able to interpret for them. However, Jemima told us, "I'm not a professional, qualified BSL interpreter. What if they give her the wrong tablet and it's my fault?".

She also worries about what will happen if she is not there to help.

Lack of access to interpreters has been a particular challenge for Harriet when accessing services for her daughter Jessie. In one instance, Jemima told us that Jessie had fallen unconscious and she had to call for an ambulance. When the ambulance arrived, the paramedics told Jemima that they did not have access to a BSL interpreter. As a result, the paramedics spoke to Jemima, not Harriet as Jessie's mum. Not only was this extremely upsetting for Harriet, but could be a confidentiality issue.

Interview with a member of the public

Providing accessible information and ways to communicate are legal requirements for health and care providers. In July 2022, Healthwatch published the findings from its Accessible Information Survey. This survey looked at 605 people's experiences of receiving accessible healthcare communication. Healthwatch found that 28% of respondents said they had been refused help when asking for support to understand information about their health care.[65]

Respondents also reported that the quality of communication from NHS and social care services had worsened over the last 2 years. Two-thirds (67%) felt that the way health and care services communicate with them had got worse or slightly worse over the course of the pandemic. Over a third (38%) said not having accessible information affected their mental health and wellbeing.

People need to be able to use health and care services in different ways that suit their own needs. In our survey of more than 4,000 people aged 65 and over who had used health or social care services recently, we asked about specific aspects of access to health and care services. Around two-thirds of respondents (65%) told us they were satisfied with being able to access services when they need them, with a quarter (24%) dissatisfied. People felt the same way about being able to access services in a way that suits them, with 66% satisfied and 23% dissatisfied.

However, this was not everyone's experience. Satisfaction with being able to access services when needed was lower among disabled people (61% satisfied compared with 68% for non-disabled people). Similarly, 60% of disabled people were satisfied with being able to access services in a way that suits them, compared with 70% of non-disabled people, and the same with the process of making appointments (48% compared with 58%).

As with other issues, positive experiences were less common among people living in deprived areas. Those living in the most deprived areas were less likely to be satisfied with being able to access services when they need them (61%, compared with 69% in the least deprived areas), and being able to access services in a way that suits them (63% compared with 68%).

Satisfaction was generally lower than average among Asian and Asian British people (noting the small base size of 40 who took part in our survey):

- 45% of these respondents were satisfied with their ability to access services when they need them.
- 47% were satisfied with their ability to access services in a way that suits them.
- 36% were satisfied with the process of making appointments.

These figures compared with 65%, 66% and 55% among White British people respectively.

The importance of data

We know that robust and reliable information is a fundamental tool in identifying, tackling and improving health inequality. Through our provider collaboration review on children and young people's mental health, we found a number of local health and care systems were using data proactively to identify and support children and young people with mental health needs who may face inequalities. In one area, we heard how system leaders then used this information to target their communication to areas where children and young people were potentially being missed.[66]

Another area we visited as part of our review told us how their analysis of data had shown that large proportions of children and young people from ethnic minority groups were missing appointments or not attending school during the pandemic. In response, they worked with community safety partnerships, schools and youth hostels to share information, targeting areas of high diversity and deprivation.

However, many of our publications over the last year have highlighted that, in many cases, the current recording of demographic data, for example on ethnicity and disability, is still not good enough.

For example, in our September 2021 report 'Safety, equity and engagement in maternity services', we highlighted the importance of collecting and reviewing data and called for services and systems to use the ethnicity data they collect to review safety outcomes for women from ethnic minority groups.[67]

In January 2022, our Insight publication shone a light on substantial concerns about the quality of data in many mental health datasets. This makes it more difficult for organisations to analyse and use data to address potential inequalities and check that services are meeting the needs of individual people.[68]

Most recently, early findings from our review on the experiences of people with a learning disability and autistic people in hospital have raised concerns around recording and flagging people's communication needs on electronic records. Not having access to information or sharing it with all staff can have a significant impact on people. Better recording of people's communication needs would also help to improve a provider's compliance with the Accessible Information Standard, especially when people are moving between services.

This is supported by the NHS Race and Observatory report Ethnic Inequalities in Healthcare, which recommended that work is needed to ensure recording of ethnicity is complete and accurate. It also highlighted the need to develop systems for routine data collection, particularly experiences of racism and discrimination.[69]

Similarly, in April 2022, findings from NHS Providers' race and health equality survey showed that nearly half of the trust leaders who responded (254 people in total) were concerned about the lack of access to data about health inequalities within trusts (49%) and across the health system (48%).[70]

The report highlighted that, despite these challenges, tackling inequalities is high on the list of providers' priorities. It described "high board-level commitment and strategic emphasis on tackling health inequalities", and a commitment to making action on health inequalities core business.

But it is not just about addressing inequality at the point of delivery. Leaders on the new integrated care boards (ICBs) have a key role in ensuring they take a systematic approach to addressing inequalities across the areas they manage.

As outlined in our strategy, we'll be continuing to check that the care provided in a local system is improving outcomes for people and reducing inequalities in their care. This includes looking at how services are working together within an integrated system, as well as how systems are performing as a whole.[71]

4. Areas of specific concern

Key points

- The quality of maternity care is not good enough. Action to ensure all women have access to safe, effective and truly personalised maternity care has not been sufficiently prioritised.
- Women from ethnic minority groups continue to be at higher risk of dying in pregnancy and childbirth than White women, and more likely to be re-admitted to hospital after giving birth.
- We are prioritising our operational and inspection resources to ensure we and others have an up-to-date and accurate view of the quality and safety of maternity services.
- The care for people with a learning disability and autistic people is still not good enough. Despite multiple reviews and reports, people continue to face huge inequalities when accessing and receiving health and social care.
- Our review of the care in hospital for people with a learning disability and autistic people will highlight how they are not being given the quality of care they have a right to expect.
- Mental health services are struggling to meet the needs of children and young people, increasing the risk of their symptoms worsening and reaching crisis point, and being cared for in unsuitable environments.
- Ongoing problems with the Deprivation of Liberty Safeguards process mean that some people are at risk of being unlawfully deprived of their liberty without the appropriate legal framework to protect them or their human rights.

Overall ratings

The whole of the 2021/22 year was spent under the continuing pressure created by the COVID-19 pandemic, and it will continue to have an impact for years to come. In 2021/22 we continued to focus on higher risk providers and where people were most at risk of receiving poor care.

Overall, when people have been able to access the care they need, we have been able to reassure people that the quality of care at the point of delivery is mostly good. As of 31 July 2022:

- 83% of adult social care services were rated as good or outstanding.
- 96% of GP practices were rated as good or outstanding.
- 75% of NHS acute core services were rated as good or outstanding.
- 77% of all mental health core services (NHS and independent) were rated as good or outstanding.

These figures are testament to the relentless hard work of health and social care staff across the country in ensuring people are kept safe and refusing to buckle under the enormous pressures that COVID-19 brought.

Similar to previous years, these headline figures can hide the dynamic picture underneath. When looking at overall ratings as of July 2022 compared with July 2021, forensic inpatient wards, child and adolescent mental health wards, and specialist community mental health services for children and young people all saw lower ratings overall.

Adult social care services saw a small increase in the number of ratings of requires improvement and inadequate across all 3 service types: residential homes, nursing homes and homecare. When we have identified problems on inspection these were often related to the leadership, management and oversight of the service, driven by staffing challenges. These challenges included the availability of experienced managers, staffing levels and staff burnout. They manifested themselves in poor person-centred care, and not meeting basic care needs (for example pressure area care, oral care and nutrition and hydration). We saw examples of exhausted staff responding inappropriately to challenges and an increase in the use of unauthorised or overly restrictive restraint.

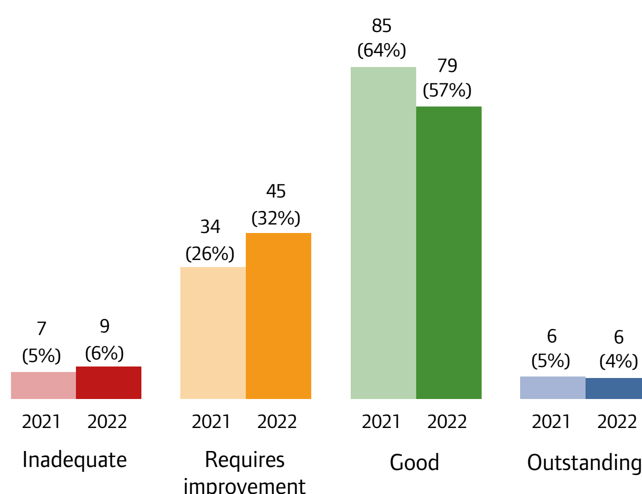
The ratings for urgent and emergency services in NHS acute hospitals are still unacceptably poor: more than half (54%, 109 services) were rated as requires improvement or inadequate as of 31 July 2022.

Maternity care

There have been a wide range of programme and policy initiatives in recent years to improve the quality and safety of maternity care in England. But, despite the greater national focus, the pace of progress has been too slow. Action to ensure all women have access to safe, effective and truly personalised maternity care has not been sufficiently prioritised to reduce risk and help prevent future tragedies from occurring.

In fact, our ratings as of 31 July 2022 show that the quality of maternity services is getting worse, with 6% of NHS services (9 out of 139) now rated as inadequate and 32% (45 services) rated as requires improvement. This means that the care in almost 2 out of every 5 maternity units is not good enough (figure 9).

Figure 9
Overall maternity core service ratings, England, July 2021 and July 2022



Source: CQC Ratings data, 31 July 2021 and 31 July 2022

Note: The ratings displayed are the latest rating for the maternity, maternity (inpatient services) and maternity (community services) and exclude maternity and gynaecology. Percentages may not add to 100 due to rounding.

The findings of recent reviews and reports – including our own report on Safety, equity and engagement in maternity services – show the same concerns emerging again and again.[72] The quality of staff training, poor working relationships between obstetric and midwifery teams, and a lack of robust risk assessment all continue to affect the safety of maternity services. These issues pose a barrier to good care, which is compounded when the voices of frontline staff and women using services are not listened to or acted on.

Furthermore there are some deeply embedded inequalities. Women from ethnic minority groups experience additional risks compared with White women that, without the right interventions, can lead to poor outcomes. For example, from our maternity report, we know that:

- Black women are 4 times more likely to die in pregnancy and childbirth than White women. For Asian women it is 2 times more.
- Mortality rates remain higher for Black or Black British babies and Asian or Asian British babies. This is also supported by more recent analysis from the Office for National Statistics (ONS) published in May 2021.[73]

In the report we also shared our analysis of Hospital Episode Statistics data for 2020. This showed that Black women had a significantly higher rate of re-admission in the 6-week postpartum period than women of other ethnicities.

We have updated this analysis to examine how re-admissions during the postpartum period changed in 2021.

Broadly, our new analysis shows that re-admission rates continued to increase throughout 2021. Where ethnicity was recorded, the data suggests that Black women still had significantly higher rates of re-admission than women of other ethnicities. Conversely, White women continued to have the lowest rates. The percentage difference between postpartum re-admission rates for Black women and White women also increased to 32% in 2021 compared with 30% in 2020 (102 re-admissions per 1,000 deliveries for Black women compared with 74 re-admissions per 1,000 deliveries for White women).

In May 2022, Birthrights published the findings of its year-long inquiry into racial injustice and human rights in UK maternity care, called 'Systemic racism, not broken bodies'. It said that participants in the review reported feeling unsafe, ignored and disbelieved, and had experienced racism by caregivers.[74]

This was echoed by the findings of a survey by Five X More, also published in May 2022. This looked at the experiences of maternity care of more than 1,300 women, who identified as Black or 'Black mixed' (defined in the report as Black Caribbean and White, Black African and White, or Other mixed), between 2016 and 2021. This found that 43% of women reported feeling discriminated against during their maternity care, with the most common reasons being race (51%), ethnicity (18%), age (17%) and class (7%). Women responding to the survey also similarly described feeling dismissed by caregivers and that genuine concerns were being ignored.[75]

Tiyanna's story

Tiyanna, a 22-year-old Black British woman, told us about her experiences of care when she gave birth to her first child.

Tiyanna told us that through previous research, as well as the experience of friends and family, she was aware of the higher risks to her as a Black woman. As a result, she did a lot of research to create a bespoke birthing plan for a home birth.

Despite initial concerns, Tiyanna said that her midwife supported her plans for a home birth. However, when Tiyanna's waters broke her partner phoned the midwifery team only to be told she would have to go into hospital because of the risk of infection.

Once in hospital, Tiyanna told us that she felt that she was labelled as a "problematic patient" because of trying to advocate for herself. Throughout the whole experience, Tiyanna was given little information and at every point felt that her wishes were being ignored.

Tiyanna is happy that her son is here and healthy, but she says that she sometimes cries and gets flashbacks about the procedures she went through at the hospital. While she understands the need for speed in the case of an emergency, she wants doctors to listen and communicate with people giving birth.

Interview with a member of the public

It is widely recognised that there is a severe shortage of midwives both nationally and globally. NHS England workforce statistics show the number of full-time equivalent (FTE) midwives fell by 633 between April 2021 and April 2022, the largest annual decrease since records began in 2009. The total number of midwives dropped further again, in May 2022, to 21,685.[76]

Services are finding it very difficult to recruit; and where one service is able to recruit, it has an impact on neighbouring services. We are seeing high turnover of senior midwives, leading to inconsistent leadership and difficulty in embedding a good culture.

In its July 2021 evaluation of the government's commitments for maternity services in England, the Health and Social Care Committee described continuing evidence of a shortfall in maternity staffing and said that urgent action was needed to address this.[77] This was supported by the recommendations of the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust, led by Donna Ockenden.[78] In a further report by the Health and Social Care Committee, on recruitment, training and retention in health and social care and published in July 2022, the committee again stressed the urgent need for a robust and funded maternity-wide workforce plan, to be delivered without further delay.[79]

The final Ockenden report in March 2022 also noted how many of the failures in care they found are not unique to that individual trust, and they identified 15 'immediate and essential actions' to improve care and safety that should be considered by all trusts in England providing maternity services.

We recently brought together maternity professionals from across England to discuss the challenges that they face. We held 2 separate sessions – one for frontline staff and another for senior leaders.

At the event, we heard first-hand how staff are working in exceptionally demanding circumstances. They described how staffing shortages and pressures, a drive to meet targets, and insufficient funding are all factors that are directly affecting their wellbeing and their ability to implement safety improvement programmes and ensure high-quality care. We heard that staff don't always feel they are working in a culture or environment where they are empowered to grow and learn – and that staff feeling safe and supported to speak up, alongside close, trusting and respectful multiprofessional teamwork, is crucial.

They said that different maternity professionals sometimes lack a common understanding of what 'good' maternity care looks like. A view shared by many staff was that ensuring the availability of training for multidisciplinary teams would be incredibly beneficial in supporting safety improvements, and in building stronger team relationships. Simulation scenario training for all professionals in the maternity team, more secondment opportunities to enable cross-system learning, and the introduction of a new national standard for team training and team building were all suggestions put forward.

There were also ideas about how to develop team skills and use the workforce more flexibly, by maximising the role of maternity support workers to increase capacity among more senior staff or those with specific expertise. Additionally, better support for students, such as bursaries and buddying schemes, was proposed as a way of improving staff retention.

What was apparent throughout the discussion was the overwhelming desire of all involved to provide the best care possible. Colleagues welcomed the various national initiatives that have been introduced to help strengthen safety, but felt that closer alignment between them would give services and staff a clearer direction and help focus their improvement efforts.

From summer 2022, we are prioritising our operations to ensure we and others have an up-to-date and accurate view of the quality and safety of maternity services nationally. Our inspection programme will focus on supporting improvements at both a local and national level.

Our ambition is to use what we learn from the programme as a whole, together with the insight from our event, to support frontline staff in delivering care. We are committed to doing all we can to accelerate safety improvements, facilitate wider learning across services, and influence action from national partner organisations where it is needed to alleviate the current challenges that staff face.

People with a learning disability and autistic people

Care for people with a learning disability and for autistic people is still not good enough. Despite multiple reviews and reports over decades, people continue to face huge inequalities when accessing and receiving health and social care.

Two years ago, our report 'Out of sight – Who cares?' shone a light on the consequences of people not getting the right care and support in the community when they need it. This, we highlighted, can lead to crisis point and admission to a mental health hospital.[80]

We also raised our concerns that while admission to hospital should be temporary, poor environments, lack of discharge planning and difficulties in finding suitable community placements were leading to people staying in hospital for years. We were particularly concerned that these hospitals were often far from people's friends, family and support networks, raising the risk of closed cultures developing.

A closed culture is a poor culture that can lead to harm, including human rights breaches such as abuse. In these services, people are more likely to be at risk of deliberate or unintentional harm. Closed cultures, and the possibility of breaches of human rights, may occur across a wide range of health and social care settings. However, we are particularly aware of the increased risk in services that care for people with a learning disability, for autistic people, and for people with a mental health condition.

The situation for people with a learning disability and autistic people has been exacerbated by the COVID-19 pandemic. For example, for a large part of the past year, visiting a service has been restricted. The impact of this on people living in these services and their loved ones cannot be underestimated.

Our Out of sight report made 17 recommendations for change. A review of the progress on these recommendations, published in March 2022, revealed that not enough progress has been made to address these. Of the 17 recommendations, we found that just 4 had been partially met and 13 had not been met.[81]

Although we were able to report that the number of people with a learning disability in hospital has halved since March 2015, we are concerned that there are still too many people in hospital. More worryingly, the number of autistic people in hospital has increased considerably over the same period.

A report from the House of Lords, published in October 2021, also raised concerns that since 2012, successive government targets to reduce the number of people with a learning disability and autistic people in hospital have not been achieved.[82]

Registering the right service

Our 2021 report Home for Good showed that there is a better way. Using the stories of 8 people with lived experience, we illustrated that bespoke homes in the community, that are tailored to meet people's individual needs, can transform people's lives.[83]

Diane's story

Diane, 38, who has a learning disability and a mental health need, spent 16 years living in secure hospital care and tried to take her own life many times.

"I felt like there was no hope," she says of her self-harm and attacks on staff. Driven by despair and frustration, Diane injured herself "to get away from the feelings and the thoughts".

A provider, working in partnership with the local authority and clinical commissioning group to develop services in response to Transforming Care, agreed to look at Diane's case. The provider had to review its approach to risk, convincing colleagues that working with adults with complex histories was safe and deliverable.

Support staff were trained to meet Diane's requirements. In addition to mandatory induction, they received training in Positive Behaviour Support, suicide avoidance, self-harm, mental health and autism.

Diane left the hospital 8 years ago and has never looked back. She lives in a supported living flat close to where she grew up. More confident and independent, Diane takes the bus on her own and, for the first time in years, visits her family alone.

"I feel like I've got a life now," says Diane of her experiences since leaving institutional care. "It feels better because it feels like someone cares about you…I'm thinking positive instead of negative."

Extract from Home for Good

As an organisation, we are committed to improving the quality of care in supported living across the country. A key part of this will be listening to the experiences of people who use services. We believe that they, their unpaid carers, families, friends and advocates are the best sources of evidence about their lived experiences of care and how good it is from their perspective.

In our strategy, we committed to improving how we encourage and enable people to engage with us and tell us about their experiences, particularly those most likely to have a poorer experience of care, or who have difficulty in accessing care.

While we are aware of the pressure on commissioners to provide for people moving on from hospital care, our role is to ensure that any new service meets statutory guidance and will provide the best possible care for a person with a learning disability.

However, a lack of commitment in some areas to following the 'Right support, right care, right culture' guidance, combined with local financial pressures, means that we are still seeing providers wanting to register services that do not meet good practice standards.[84] This includes, for example, registration requests for large-scale services, rather than small-scale ordinary housing. These large-scale services, often situated apart from local communities, can have a negative impact on the quality of outcomes for people living there.

A substantial proportion of applications we receive are refused based on inappropriate models of care or the applicant's poor understanding of how the model should be delivered. We have found that often providers do not recognise the importance of being part of the local community and the value attached to people feeling at home in their wider environment, leading a full life of their choosing.

Over the last year we have also taken more enforcement action against adult social care providers of services for people with a learning disability and autistic people. Types of enforcement action taken include cancelling providers' registrations, imposing conditions and restricting admissions.

We welcome the government's Building the Right Support Action Plan, published in July 2022. The plan builds on a broad range of existing evidence and work underway, including the objectives set out in the 2015 Building the Right Support national plan. It sets out the actions, which must be implemented immediately, to strengthen community support for people with a learning disability and autistic people, and reduce reliance on mental health inpatient care.[85]

Physical health care

It is not just about the quality of residential or supported living services. We continue to have concerns about the quality of physical health care for people with a learning disability and autistic people.

Our concerns are echoed in the findings of the 2021 Norfolk Safeguarding Adults Board Review into the deaths of Joanna, Jon and Ben at Cawston Park, and the LeDeR (Learning from Lives and Deaths of People with a Learning Disability and Autism) review into the death of Clive Treacey. Both of these reviews highlighted the devastating impact of people not receiving the physical health care they need while in mental health hospitals.[86,87]

This year, in response to recommendations in the multi-agency review into the death of Oliver McGowan, we carried out a review into the experiences of people with a learning disability and autistic people in acute hospitals. Early findings from our review, which will be publishing in the autumn, echo many that have come before – that when people with a learning disability and autistic people go to hospital, they are not being given the quality of care and treatment they have a right to expect. These include issues around:

- reasonable adjustments when accessing care
- listening to and involving people, their families and carers
- the knowledge and understanding of staff about inequalities that people with a learning disability or autistic people may experience
- the knowledge and skills of staff in caring for people with a learning disability and autistic people.

Workforce

Through our work, we have heard much praise for dedicated staff that have made a real difference for people. Competent well-trained staff, and an open, transparent and learning culture are essential for providers to be able to deliver good quality services for people in a person-centred way.

However, a June 2022 report from the Healthcare Safety Investigations Branch (HSIB) raised concerns about a shortage of learning disability nurses, with the number of people joining the profession each year matched by those leaving. The report highlights that this shortage could have an impact on the care of patients in secure units for people with a learning disability, and raises concerns about staff lacking the relevant knowledge and skills to understand the world from people's point of view and support them well.[88]

From 1 July 2022, there is a legal requirement for all CQC registered providers to ensure their staff receive training in how to interact with people with a learning disability and autistic people, at a level appropriate to their role. This applies to all health and care settings, including acute hospitals, and providers need to consider the training needs of staff who deliver care directly as well as ancillary and administrative staff, for example reception and call-handlers.[89]

To support this new requirement, the government will be rolling out the Oliver McGowan training package. Co-designed by autistic people, people with a learning disability, family, carers and subject matter experts, the training is intended to ensure that health and social care staff have the skills and knowledge to provide safe, compassionate and informed care.

Supported Living Improvement Coalition

Fundamental to the work we are doing to improve how we regulate services for people with a learning disability and autistic people is a focus on what it means to be a citizen. We want to understand how we can be ambitious for people receiving care and support, so they have more choice, independence and control over their lives and the care they receive.

With this in mind, we have set up the Supported Living Improvement Coalition. People with lived experience, their relatives and representatives are actively involved in the group so they can tell their stories to a range of organisations who can work with them to identify and embed the improvements that are needed.

Members of the coalition currently include people who use supported living services, advocacy groups, care providers, local authorities and housing developers. With leadership and support from across social care, together we aim to drive the improvements needed to change outcomes for people who access supported living.

The group has identified 5 areas of focus for their work:

- Staff must have the right knowledge, motivation and positive culture to support them and to support people to live their best lives.
- People should receive high-quality care and support that understands and meets their individual needs to allow them to be active members of their local community.
- There should be excellent, joined-up working where everyone understands their role.
- Person-centred housing and home options must be flexible and start with the individual.
- Regulation must have people's voice and that of their loved ones at heart, by listening well and being accessible.

Children and young people's mental health

Last year we shone a light on the impact of the pandemic on children and young people's mental health and the increase in demand for child and adolescent mental health services (CAMHS), particularly eating disorder services. We raised our concerns about providers' ability to meet this increasing need, and the risk of children ending up in inappropriate environments.[90]

This has been supported by the findings of our provider collaboration review on the mental health care of children and young people during the COVID-19 pandemic. Published in November 2021, we found:

- Services struggled to meet demand, increasing the risk of children and young people's symptoms worsening and reaching crisis point, and being cared for in unsuitable environments.
- While there were positive examples of systems working collaboratively together to ensure continued access to mental health support, there were some concerns around silo working.
- Communication – both between services and with families – was mixed, with some people not always aware of what support was available.

- The pandemic shone a light on, and exacerbated, health inequalities faced by some children and young people, in particular those living in deprived areas.
- Digital technology enabled services to adapt almost overnight, ensuring continuation of care. But we heard that this could lead to risks such as staff missing cues or issues that would have been picked up face-to-face.[91]

Joseph's story

Joseph, who is 10, has been diagnosed with depression and anxiety. Here, his mum Carla tells us about her experiences of accessing mental health support for Joseph.

Joseph's symptoms first started when he was 6 or 7. It began with him being a bit snappy, which I put down to behaviour. So I went on a parenting course to try and figure it out. But I knew it was something more. Joseph also started to complain of headaches – he would go really pale and then be sick.

When I took him to the GP, I suggested to the doctor that he might have depression and anxiety. But the GP wouldn't listen to me and told me he was too young.

I wasn't happy with the GP's response, so requested to see another doctor. The second GP was fantastic and gave us a referral for therapy and to see the team at the hospital.

Then the pandemic hit and everything slowed down. In total, Joseph has been on the waiting list for nearly 2 years. During this time my dad, his grandad, passed away – this has had a huge impact on Joseph's wellbeing as he and his grandad were really close.

While we've been waiting, the GP has given us some information by email and linked me in with our local Sure Start Centre. She has also emailed the school to get them involved. In addition to this, I have done a lot of my own research.

Now Joseph is older, he has recently been prescribed some medicine to help manage his symptoms, but we're still waiting to see a therapist.

Interview with a member of the public

In 2021/22, we have continued to see increases in demand for services, particularly eating disorder services. This is supported by data from the Mental Health Services Dataset (MHSDS), which shows that the number of children and young people starting treatment for an eating disorder increased following the onset of the pandemic, particularly the number of urgent cases.

The MHSDS data for January to March 2022 shows there were 249 urgent cases waiting to start treatment, an increase of 92% on the same period in the previous year. More than 8 out of 10 (86%) of these children and young people awaiting urgent treatment had waited longer than the 1-week target.

The number of children and young people waiting for routine treatment between January and March 2022 had increased by 21% over the same period in the previous year. Two-thirds (66%) of these 1,697 under-18s had been waiting longer than the 4-week target.[92]

Increased demand can mean that there is not always a bed available for all patients living in the local area who need one, so they might end up being placed 'out of area' or on acute paediatric wards.

Data from statutory notifications to CQC shows there were 249 admissions of under-18s to adult psychiatric wards over the course of 2021/22. This is a 30% increase on the 191 notifications that we received in 2020/21. The most common reason given (58% of admissions) was that the child needed to be admitted immediately for their safety. However, in over a quarter of cases (27%), the child was admitted to the adult ward because there was no alternative CAMHS inpatient or outreach service available.

In February 2022, NHS Confederation raised concerns that, without more action to respond to this growing demand, a generation of children and young people will face longer waits for their treatment and their mental health will deteriorate.[93]

A report by the Centre for Mental Health, published in July 2022, similarly warned that children's mental health services are buckling under pressure post-COVID. 'Heads Up: Rethinking mental health services for vulnerable young people' describes a growing crisis of mental health problems among children and young people in England, and highlights the increase in the regularity and extreme nature of mental health problems for many young people.[94]

Healthwatch carried out a review of the feedback it received during 2021/22 about children's mental health services. The findings included:

- Children and young people face long waiting times for diagnosis and treatment.
- Experiences of care are generally poor, with young people feeling like their symptoms are not taken seriously and increased demand on services limiting what support is available.
- People aren't always offered follow-up support once discharged from services, including discharge from inpatient services.
- Young people continue to face difficult transitions to adult services, often being cut off from support once they turn 18.
- Neurodivergent children, including children with autism and ADHD, struggle to access appropriate support for their mental health.

In response to concerns around increasing demand, NHS England announced in July 2022 that 4,500 more NHS staff are working in children's mental health services. This is 40% more than before the pandemic. This includes the recruitment of psychological practitioners to specifically help young people aged 13 to 17 years-old with mental health problems such as severe depression, self-harm and more complex conditions. Support offered includes assessments, coping strategies and support in the community.[95]

Our progress report on the 'Out of sight' recommendations, published in March 2022, highlighted some positive developments. This includes nearly £1 billion of additional funding for children and young people's community, crisis and school services.[96] In addition, the Children's Commissioner has stated that children's mental health is one of her top priorities. In July 2022, she published 'A Head Start: Early support for children's mental health', which sets out 6 ambitions for early mental health support for children.[97]

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are an important part of the Mental Capacity Act (MCA) 2005 legislation. The DoLS can be used in care homes and hospitals of all types. Where someone who lacks capacity to consent is deprived of their liberty as part of their treatment and care, DoLS is a vital safeguard to ensure that such deprivation of liberty only occurs if necessary, proportionate and in their best interests. Many people who are made vulnerable by their circumstances are safeguarded by ensuring the proper use of the DoLS, including the right of appeal it confers.

The principles of the wider MCA run through the DoLS, including assessments to establish lack of capacity and ensuring arrangements are only as restrictive as they need to be.

The DoLS are due to be replaced by the Liberty Protection Safeguards (LPS). Introduced in the Mental Capacity (Amendment) Act 2019, the LPS have been designed to put the rights and wishes of those people subject to the LPS process at the centre of all decision-making on deprivation of liberty. At the time of writing the government is considering responses to its consultation on the MCA and LPS code of practice and relevant regulations, held between March and July 2022.

Ongoing concerns

In last year's State of Care, we highlighted continuing concerns around the DoLS process, and how these were exacerbated by the COVID-19 pandemic.[98] 2021/22 has been another incredibly challenging year for the system, including DoLS local authority teams. We are concerned ongoing problems with the process mean that some people are at risk of being unlawfully deprived of their liberty, with no safeguards, rights or protection in place.

In particular we have continuing concerns around:

- the knowledge and understanding of staff about the DoLS, and the quality of training
- poor quality Mental Capacity Act (MCA) assessments
- delays and backlogs in applications.

Through our monitoring activities, we have heard of continued staff shortages in providers and local authorities. In the adult social care sector in particular, we have seen a high number of experienced registered managers leaving. In some local authority areas this had created a knowledge gap, with less experienced managers lacking an understanding about the need to apply

for DoLS, particularly when previously granted authorisations had expired. Evidence from our monitoring and assessment activities has raised concerns that there had been an increase in restrictive practice where DoLS hadn't been applied for or authorised.

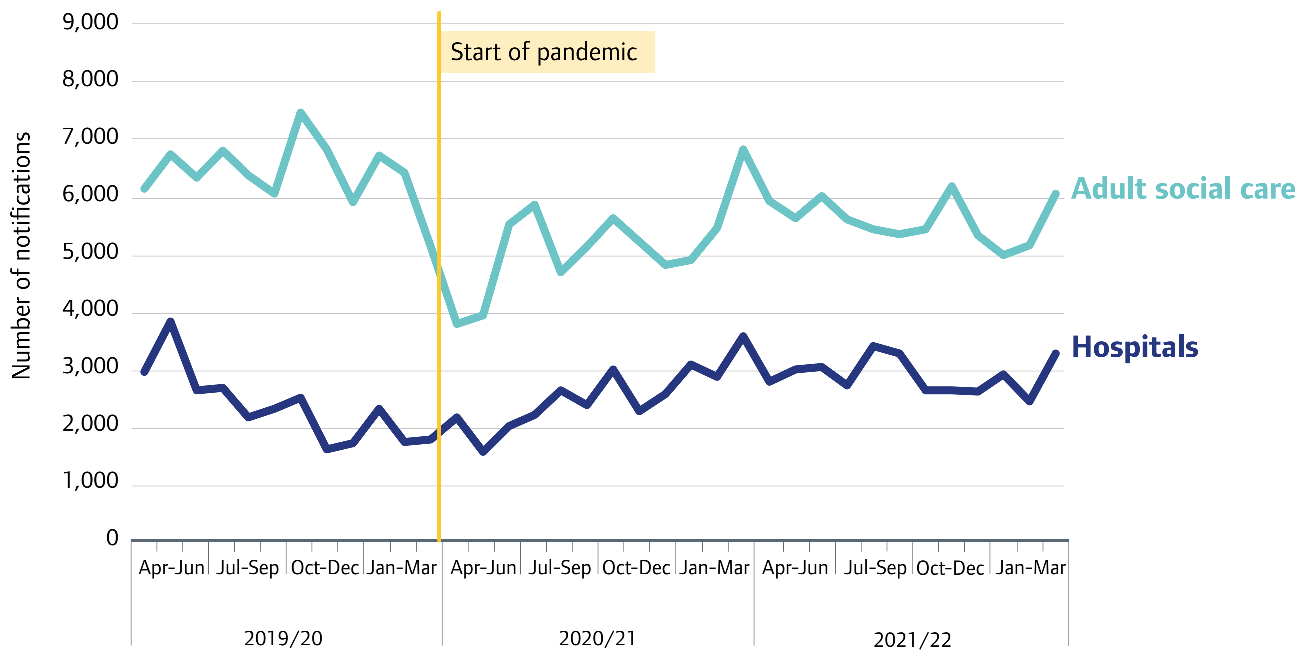
In mental health hospitals, we have seen how a lack of training means that staff still have difficulty in understanding the interface between the Mental Health Act (MHA), MCA and DoLS. In some cases, this meant that a DoLS application wasn't always considered when at times it should have been. There was also a misconception that if people were happy to be on a ward, then they could be classed as informal patients, without considering whether they had capacity to consent. As a result, we are concerned that people could be confined in hospital without the appropriate legal framework to protect them or their human rights.

Applications and waiting times

Providers must notify CQC without delay when the outcome of an application for a DoLS authorisation is known, including when an authorisation has not been granted.

Last year, we highlighted how DoLS notifications had been impacted by the pandemic, with numbers of notifications from adult social care services and hospitals reaching their lowest point in early 2020/21 before starting to recover. Since last year's report, we have identified some errors in the categorisation of our DoLS notifications data. The data has been updated (figure 10) and this has not affected the trends we have been seeing in adult social care, with figures rising back up this year, but still below 2019/20 levels. In hospitals, the data shows that notifications had been falling before the start of the pandemic but total counts have been higher in 2020/21 and 2021/22. This categorisation error has not affected the right regulatory action being carried out.

Figure 10
Deprivation of Liberty Safeguards notifications, England, 1 April 2019 to 31 March 2022



Source: CQC notifications

Note: this exclude notifications made through the court of protection and notifications from primary medical services.

The impact of the pandemic continues to be felt, with increasing waiting times and delays in assessments for DoLS applications. Data from NHS Digital shows that the proportion of standard applications completed within 21 days fell from 24% in 2020/21 to 20% in 2021/22. At the same time, the average length of time to complete applications rose to 153 days, compared with 148 days in the previous year.[99]

Members of our Expert Advisory Group told us that they have seen increasing waiting times for DoLS authorisations over the last year, as well as an increase in the use of urgent applications. This is supported by the NHS Digital data, which shows that the proportion of urgent DoLS applications rose from 54% in 2020/21 to 56% in 2021/22.

We heard how delays in DoLS authorisations leave provider staff feeling 'in limbo' about their legal authority to deprive people of their liberty where there are welfare concerns. Equally this leaves family, friends and staff unsure of how to raise concerns or make necessary decisions. The NHS Digital data shows that there were just over 124,000 DoLS applications not completed, that is where a formal decision whether to authorise a DoLS application has not been reached and recorded. This is an increase of 4% over the previous year.

Poor quality mental capacity assessments and unavailability of Best Interest Assessors (BIAs) have contributed to these delays. For example, in one instance we heard that BIAs from the local mental health trust, who had

previously been supporting with assessments, had been re-deployed during the pandemic and had not yet returned. Taken together, the issues are likely to have put at risk the upholding of people's human rights.

However, members of our Expert Advisory Group told us how BIAs have continued to work around difficulties to carry out their roles. This includes, for example, the use of remote assessments. We have also found evidence of local systems taking a hybrid approach to carrying out assessments.

Impact on people and carers

We looked at themes emerging from comments shared through our Give Feedback on Care service through our website between April 2021 and March 2022. There were 310 comments that were identified as being relevant to DoLS. Here, we are using the insights from our analysis of the comments to discuss what we are hearing from people's experience of the DoLS process.

It is important to note that some groups of people, including groups of people more likely to experience good care, may be less likely to contact us using Give Feedback on Care. As a result, the insights derived from our Give Feedback on Care analysis should be used as the start of a conversation around what is driving people's experience of care, but should not be seen as representative of the population.

A key theme emerging is around involvement. Some families told us they were involved in their loved ones' risk assessment and person-centred care planning, as well as being kept actively informed of incidents and progress.

However, the majority of families and friends told us they were unhappy with a lack of involvement in their loved one's care. They were also unhappy about the lack of information they receive around the DoLS process.

Where a person has a DoLS authorisation in place, family or close friends may sometimes be their Relative Person's Representative (RPR) and/or have power of attorney. They have a role in ensuring any decisions made are in the person's best interests. As a result, in some cases a lack of involvement has led to concerns about the safety of the person using the service. They described how this left them feeling suspicious, concerned, frustrated or angry and very often in distress themselves.

Naomi's story

My son, Joshua, is 22 years old and has been in residential school and college since before he was 18. Over the years, we have had to fight for everything for our son. As a result, I am familiar with many of the relevant laws and policies, and my husband and I are court appointed deputies for Joshua.

Our first experience of the DoLS was during the first COVID lockdown. I was phoned at home out of the blue by a total stranger (who I think was a doctor or psychiatrist), who asked to come to our home to see my son who was home since he could not cope in college. I did not catch who it was and they did not explain anything. I guessed that it might relate to DoLS and asked that question. I happened to know that DoLS does not relate to my home and so based on that, and that our son was shielding, I said that they could not come to our home.

It was very worrying and scary to get a call like that out of the blue and not know who these people are or what it was about. We have never had any communication from the local authority, clinical commissioning group or anyone about DoLS.

Joshua has been back in college since September 2021. Just before Christmas that year, he had an annual review, and shortly after we were told that a DoLS application was going to be made for Joshua. Because Joshua wasn't at home, we weren't contacted about this at the time and again were given no information – it was all kept very secret.

Out of the blue we were contacted by a stranger who told us they were a Best Interests Assessor (BIA) and would be assessing Joshua and writing a report. This was incredibly distressing because, as court appointed deputies, it is our responsibility to assess what's in Joshua's best interests. It was not clear why the BIA was involved or what their role was.

A DoLS authorisation has now been granted for Joshua. This affects every aspect of his life – everything from personal care and food, to which areas he can go in. We had to ask for the right to support Joshua so that we could fight for the things that make him happy, like being able to get off site.

Interview with a member of the public

As discussed in our section on Access to care, restrictions on visiting people in residential settings have had a big impact on some people using services and their families. We also heard how restrictions imposed by care homes and hospitals in response to the COVID-19 pandemic had exacerbated feelings of concern and suspicion. There were also concerns that some restrictions were still in place, even though those imposed by the government had been removed.

Restricting people's movements and their ability to see friends and family, without it being strictly necessary, can lead to them becoming isolated and suffering poor mental wellbeing, and potentially cause distress. In some instances that would have resulted in a reduction of people's social networks.

People also told us about concerns that individuals were being prevented from making their own choices in their day-to-day life, with little consideration of their wishes or capacity. For example, many family and staff members raised concerns about individuals being restricted from having access to their personal items, including money, cigarettes and alcohol.

While these types of restrictions may not automatically indicate a deprivation of liberty, it does raise concerns that the culture of some services may be overly restrictive, and not adhering to the wider principles of the Mental Capacity Act.

> *"The government has relaxed the rules around COVID [but]… I'm absolutely mortified about not being able to help my parent at a time they need us the most. They are vulnerable and NEED to see us. It feels like they are in prison and they/we have no rights… I am completely lost for words and feeling absolutely powerless."*
>
> **Anonymous, through Give Feedback on Care**

Many of the submissions we received through our Give Feedback on Care service raised concerns that, while applications were in progress, people may have been subject to unlawful deprivations of their liberty. For example, people told us that doors to services and rooms were regularly locked or people confined to their rooms, preventing them from leaving the service – for example to return home, to go outside for fresh air, and to go out into the community.

> *"I feel they are being deprived of their liberties illegally as they don't have a DoLS [authorisation] in place, they aren't asking for much, to be assisted to sit up in their bed and wheeled to the yard a few times a week."*
>
> **Anonymous, through Give Feedback on Care**

People told us that whether their experience of the DoLS process was positive or negative was often linked to a provider's staff understanding and/or awareness of whether a DoLS authorisation was in place.

Issues raised by people with lived experience included:

- DoLS applications not being person-centred
- applications only being made after a deprivation of liberty has occurred
- reviews of existing DoLS authorisations not being carried out at the right time, if at all.

Families and friends also told us about problems with a lack of care plans, missing information, and information not being recorded correctly. This could mean that staff may not have all the information they need, and could lead to people being cared for in unsafe conditions.

Other concerns

We continue to have concerns about some **baby scan services**. Women's understanding of the job title 'sonographer' may lead to them believing the keepsake scan is the same as a diagnostic scan that aims to detect abnormalities on the fetus. This, coupled with concerns about competency of some of these staff, has prompted us to carry out further joint work with the Society of Radiographers in 2022/23 to raise awareness among pregnant women.

In November 2021 we updated our published guide that aims to help women choose a baby scan service.[100] This was in response to concerns we found on inspections where staff in non-diagnostic services use the title of sonographer, which is not a protected title and does not assure the person is medically qualified in any way.

Independent cosmetic services have been of concern for some time and we continue to find evidence of poor services placing people at risk of harm. In response, we published a guide to support people in choosing good cosmetic surgery services. The guide focuses on consent and the importance of cooling-off periods, as well as which procedures need to be registered with CQC.[101]

We have seen a number of safety and quality issues in **non-emergency transport services** for secure and mental health patients. These relate to a number of key areas:

- unsafe recruitment practices
- failure to ensure vehicles and equipment are maintained and used safely
- failure to train staff to assess physical and medical needs before and during transport
- safeguarding and restraint
- failure to ensure subcontracted patient journeys are safe and high-quality.

Where we have found concerns, we have held those providers to account and have been clear where they must improve. We have also written to all independent ambulance providers, highlighting our concerns and pointing to regulatory requirements alongside appropriate good practice guidance for the sector.

Medicines safety – the role of pharmacy professionals

We know that people's physical and mental health outcomes improve when medicines are used in the best way. When medicines are not prescribed or administered correctly, they can cause harm. Medicines safety is an important aspect of our regulation of registered services. Pharmacy professionals offering specialist advice can help support staff and contribute towards better outcomes for people.

Adult social care

Pharmacy professionals are increasingly working directly with adult social care providers. While the consistency of service that pharmacy professionals offer is variable, we see that having a medicines expert available for advice benefits both staff and people receiving care. This includes improved frequency and quality of medicines reviews, monitoring of high-risk medicines, de-prescribing of unnecessary medicines, improved governance, and training for care staff.

Nationally we have seen an increase in the delegation of specialist medicines administration tasks to care staff. When managed effectively, delegating tasks can work well for people, helping to ensure they get their medicines correctly and on time. However, variation in the availability of training, supervision and access to support can mean that people don't get their medicines correctly.

Providers are increasingly using electronic systems to record and store information about medicines, for example electronic medicines administration records (eMAR). eMAR can offer benefits such as making it easier to identify missed doses. However, poor training, implementation and IT literacy of staff, and variable quality of equipment and software, can mean that people don't have their medicines administered as prescribed.

Ambulance services

During 2021 we reported on NHS hospital pharmacy services during the pandemic and the work of medication safety officers.[102, 103] In early 2022, our Medicines Optimisation team discussed medication safety with medicines leads in all NHS ambulance trusts.

Staffing, governance and roles
We heard there was significant variation in the scope of roles and responsibilities of pharmacy professionals working in ambulance trusts. Those leading on medicines optimisation told us they did not always have adequate time and support to carry out their role. Some services had better capacity in their medicines optimisation workforce than others. Where services lacked capacity, we heard that initiatives to improve medicines optimisation were placed on hold.

However, we did find examples of initiatives designed to improve people's outcomes, such as rapid access to ambulance staff trained in using medicines for the early treatment of sepsis. In one trust, public health registrars used data to help focus work on outreach and health inequalities, such as developing preventative initiatives to reduce harm for homeless people at risk of illicit drug overdose.

Transfer of care

When people move between services, poorly managed medicines processes can result in harm. We heard that joint agreements about roles and responsibilities when ambulance trusts transferred people between services was a problem. Increased wait times for transfer into acute services meant that people missed their regular medicines if ambulance staff were not authorised to administer them.

We heard about a "Green Bag Scheme" used across many different areas, whereby patients who are taken to hospital bring their medicines in an easily recognisable green bag. This helps to ensure people don't miss doses of their regularly prescribed medicines when they are being admitted to hospital. Further partnership working across geographical areas is needed to fully realise the benefits of this scheme, as there was variation in the processes adopted and outcomes in different areas.

Access to up-to-date medicines care records is equally as important as a supply of medicines. We were told that this could sometimes be a problem, especially when ambulance staff arrived to treat people at care services that used electronic records that were not easily accessible. We heard that this was a challenge for patients receiving medicines for care at the end of their life, as ambulance staff could not obtain information on the medicines that had been prescribed or administered.

Ambulance trusts and primary care

Ambulance trusts were aware of priorities and pressures in primary care. There was a perception of increased demand on emergency services, due to GPs not being able to access adult social care services during the pandemic.

Across the country we heard of situations when paramedics were deployed in primary care to support general practice. Trusts were positive about this activity, and viewed it as helping to reduce pressure on urgent care services as well as GPs. In some cases, these were pilots or projects, which means long-term sustainability was not assured. We also heard that prescribing by paramedics was sometimes made more challenging by IT problems. Concerns were raised about lack of clarity of governance and oversight arrangements for paramedics working in general practice.

Some ambulance trusts were able to use digital systems to refer people to community pharmacists or primary care network (PCN) pharmacists for a medication review. This ensured people received medicines safely and in line with their needs. It also helped reduce the inappropriate use of some medicines that can increase the risk of adverse effects associated with hospital re-admissions, such as falls.

Primary care

Within the primary care setting, the number of pharmacy professionals working in PCNs has increased. Pharmacy professionals in PCNs help to enhance workforce capacity and provide additional services to support people with their medicines. This includes providing effective medication review and ensuring safe reconciliation of medicines when people move between services. However, we have seen examples of pharmacy professionals not receiving appropriate support and working beyond their competence, with limited oversight of their activities. This has the potential to put people at risk.

The Centre for Pharmacy Postgraduate Education provides a learning pathway to support pharmacy professionals moving to PCN roles. Our Medicines Optimisation team has provided input to this learning pathway, introducing the role of regulation in primary care, to more than 1,200 learners in the past 18 months.

5. Workforce

Key points

- In many cases, providers are losing the battle to attract and retain enough staff.
- The persistent understaffing across health and social care poses a serious risk to the safety and wellbeing of people who use services.
- More than 9 in 10 NHS leaders have warned of a social care workforce crisis in their area, which they expect to get worse this winter.
- Care homes have found it very difficult to attract and retain registered nurses. We have seen nurses moving to jobs with better pay and conditions in the NHS, and care homes that have had to stop providing nursing care.
- 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.
- Only 43% of NHS staff said they could meet all the conflicting demands on their time at work. Ambulance staff continue to report high levels of stress.

Staff shortages

The pandemic brought into sharp focus how much people depend on the skills and extensive experience of a rich resource of health and social care staff. But across the breadth of health and social care services, providers are struggling desperately to recruit and retain staff with the right skills and in the right numbers to meet the increasing needs of people in their care. Despite their efforts, in many cases providers are losing this battle, as staff are drawn to industries with higher pay and less stressful conditions.

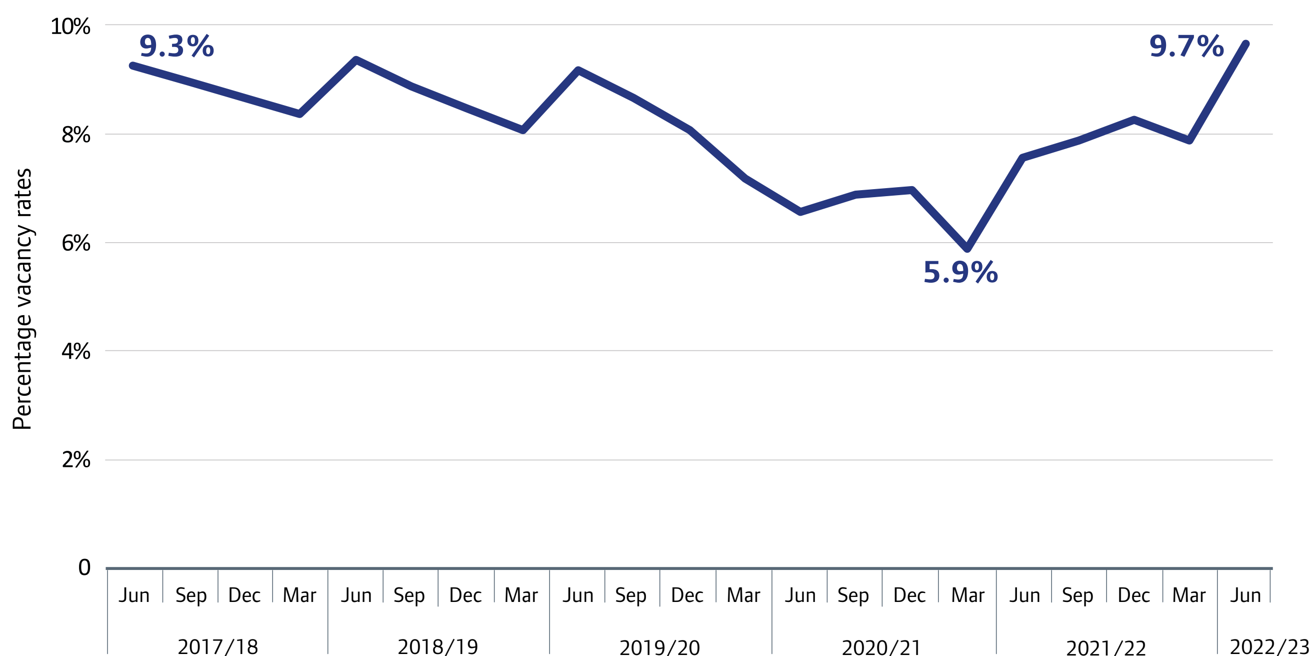
In a report to Parliament, the House of Commons Health and Social Care Committee said that NHS and social care services now face the greatest ever workforce crisis.[104] Sickness, vacancy and turnover rates are having a deep impact. In its report, the Committee went on to conclude that persistent understaffing in the NHS poses a serious risk to staff and patient safety, both for routine and emergency care; and that shortages in social care are even worse than they are in the NHS.

Retaining staff is just as big a challenge as recruitment – one that in many cases is crucial to maintaining relationships between staff and patients. These relationships can be lost if there is a high turnover of staff or increased use of agency or bank staff.

> *"Staff said that when unfamiliar staff were on the wards, patients felt they were less likely to trust new faces, which could increase the level of risk and put more strain on permanent staff."*
>
> **Extract from a 2022 CQC inspection report of a high secure hospital**

NHS vacancy statistics published by NHS Digital show that, while reported vacancy rates fell during the pandemic, they have risen over the past 12 months, with the overall vacancy rate for England now above pre-pandemic levels. At the end of June 2022 there were more than 132,000 vacant posts, which was a vacancy rate of 9.7% – two percentage points higher than 12 months before and the highest they have been for 5 years (figure 11).[105]

Figure 11
Total NHS workforce vacancy rates, England, June 2017 to June 2022



Source: NHS Digital, NHS vacancy statistics (experimental statistics)

In all regions, the mental health vacancy rate is higher than for acute healthcare services. For example, London has the highest mental health vacancy rate at 30 June 2022 at 16.0% and an acute vacancy rate of 11.9%.

While vacancy rates have fluctuated in all regions over the past 4 years, London has had the highest vacancy rate throughout most of the period (12.5% at 30 June 2022), with North East and Yorkshire consistently having the lowest (7.9% at 30 June 2022). However, the data does not show a consistent pattern across regions when looking by sector, with different regions experiencing workforce pressures to varying degrees in particular sectors. For example, the highest vacancy rate in the North East and Yorkshire is for the ambulance sector at 10.5%, which is now more than 4 percentage points higher than at June 2018. However, in London the lowest vacancy rate has consistently been in the ambulance sector (7.0% at 30 June 2022), with the highest vacancy rates seen in mental health care (16.0% at 30 June 2022) and community health care (14.8% at 30 June 2022).

There is a similar pattern to the overall NHS vacancy rate for both nursing and medical vacancies. However, the nursing vacancy rate is higher at 11.8% at the end of June 2022, representing almost 47,000 vacant nursing posts, the highest recorded number of nursing vacancies.

> *"The hospital did not have enough staff in the nursing team to keep patients safe at all times. There were 78 registered nurse vacancies, which represented a vacancy rate of 36%. Staff and patients told us staff shortages impacted on patient care. Patients did not always receive regular one-to-one sessions with their named nurse. Sports and leisure staff were regularly redirected to work on the wards. Patients and staff gave us numerous examples of the impact of staff shortages on access to the gym, recovery college and creative arts centre. Patients had their escorted leave or activities cancelled due to the hospital being short staffed."*
>
> **Extract from a 2022 CQC inspection report of a high secure hospital**

While data indicates that the NHS is on course to hit the government's headline target of an additional 50,000 full-time equivalent number of nurses in the NHS by March 2024, analysis by the King's Fund highlighted that:

- The supply of nurses into the NHS is not keeping pace with demand.
- Increasing the number of nurses is having no substantial impact on the number of vacancies or the shortfall of nurses in the NHS.
- There is wide regional variation in the scale of the challenge.[106]

In a March 2022 survey by NHS Providers, NHS leaders were asked which services or professions they were most concerned about in terms of workforce shortages. In the survey:

- Significant shortfalls in nursing staff, midwives and radiographers were mentioned most frequently.
- Shortages in psychiatry, community district nursing teams and ambulance call handlers were also frequently mentioned.[107]

Through our monitoring and assessment of services in prisons and other secure settings, we have seen a huge gap in the provision of nurses and psychologists.

Challenges around the recruitment and retention of adult social care staff have become particularly difficult over the past year. They are widely recognised as a major cause of the gridlock in the whole health and care system. NHS Confederation reported in July 2022 that, in a survey of NHS leaders, 99% of them agreed there is a social care workforce crisis in their area, which they expect to get worse this winter.[108]

Providers have told us that a key concern has 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.

Care homes have found it very difficult to attract and retain registered nurses. Through our regulatory activity, we have seen nurses moving to jobs with better pay and conditions in the NHS, and we heard about care homes that stopped providing nursing care. This meant that people either had to move to another care home or have their care transferred to community nursing teams.

In December 2021, we introduced our adult social care workforce survey. As at 30 June 2022, this survey had been completed over 5,500 times by our inspectors. It explores with care home and homecare providers the impact of workforce challenges and staffing shortages on the services they deliver to people. In the survey, 36% of care home providers and 41% of homecare providers said that workforce challenges have had a negative impact on the service they deliver.

For care home providers, of those that reported workforce challenges and went on to provide further information (2,820):

- 87% said they were experiencing challenges related to recruitment.
- 48% said they were experiencing challenges related to retention.

Two-thirds (66%) of care home providers that gave further information about their retention challenges said staff were leaving the sector.

For homecare providers, of those that reported workforce challenges and went on to provide further information (526):

- 88% said they were experiencing challenges related to recruitment.
- 41% said they were experiencing challenges related to retention.

Like care homes, two-thirds (65%) of homecare providers who gave further information about their retention challenges said staff were leaving the sector. Other challenges included pay and conditions (36%), staff burnout (28%) and increased cost of petrol (23%).

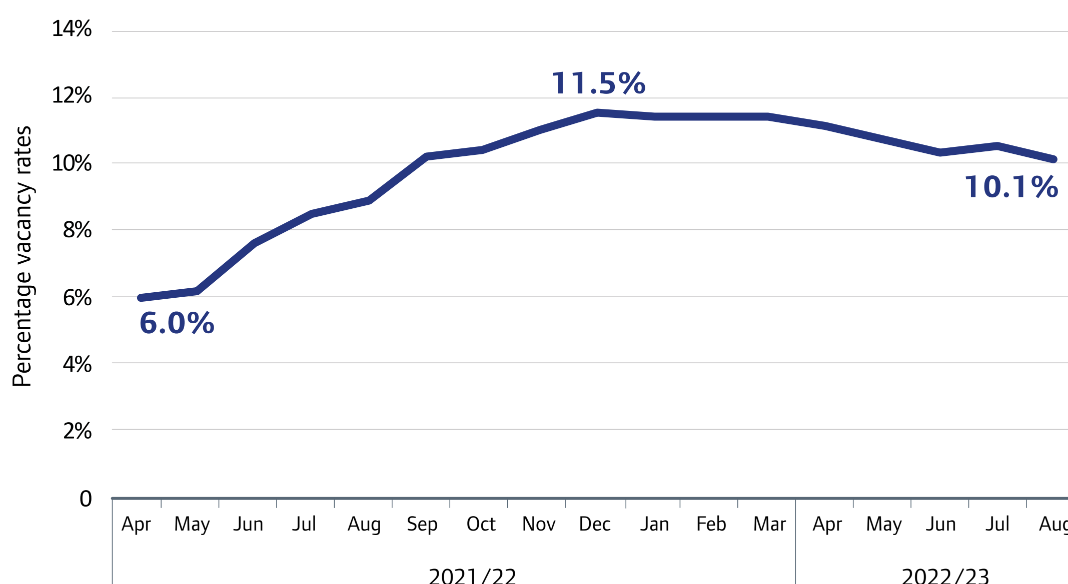
In terms of recruitment, as well as the sheer lack of applications, both care home and homecare providers reported challenges including candidates lacking necessary skills and experience and issues with pay and conditions.

> We are experiencing severe staff shortages and a recruitment crisis, and having to resort to using agency staff, since October 2021, for the first time in 30 years. We are competing with other industries which have sprung up everywhere around our local area and we note that potential recruits would prefer to work in that environment rather than working in a challenging environment such as social care and still get less pay for more responsibility. We found out that agencies are facing the same recruitment issues. The longer that this national crisis persists, staff and management face burn out, demoralisation and planning an exit out of social care.
>
> **Submission to CQC care home provider information return (April 2022)**

Recruitment and retention issues are also reflected in the vacancy and turnover data that we collect through our provider information return from care home providers. Across England, the vacancy rate increased from 6.0% in April 2021, peaking in December 2021 at 11.5%. It has been slowly falling since, but remains high at 10.1% at August 2022 (figure 12).

These vacancy rates are mirrored in Skills for Care data, with the vacancy rate across the adult social care sector estimated at 10.7% in 2021/22, compared with around 7% in the previous 2 years. Homecare services saw the highest vacancy rate for 2021/22 at 13.2%.[109] These high figures reflect a 50,000 fall in filled posts across the whole of adult social care, which is the first time a reduction has been recorded by Skills for Care since their records began in 2012/13.[110]

Figure 12
Care home staff vacancy rates, England, April 2021 to August 2022



Source: CQC Provider information returns

The turnover of care home staff, measured by the number of staff leaving in the previous 12 months, has also been high. Our provider information return data shows that, across England, the turnover rate increased from 26.5% in April 2021 to 38.2% in February 2022. It has since fallen but remains high at 34.8%, over 5 percentage points higher than 12 months previously.

Staffing at an inadequate care home

In August 2021 we inspected a residential care home that provides support to older people, including people with dementia. This inspection was prompted in part due to concerns received around staffing levels and risks to people.

Staffing levels at the service were not adequate. People were at risk of falling, harm from others and choking because staff were not given sufficient guidance to reduce the risk. This was particularly important because of the high use of agency staff. Medicines were not always managed safely, and people did not always receive their medicines as prescribed. Although safeguarding concerns had been reported and investigated, actions and lessons learned had not been implemented to ensure the concerns were fully addressed.

There was a poor culture at the service. Staff did not feel supported or listened to. Action plans to drive improvement at the service had not been updated and issues highlighted had not been actioned.

We rated the service as inadequate and issued a Warning Notice. We returned to the service in March 2022 and found the provider had worked with staff and the local authority to make improvements. Following this inspection, the service was rated as good.

Findings from a 2021 and 2022 CQC inspection report of a care home

To gauge current views on workforce challenges, we conducted a snap poll of providers in August 2022. Many adult social care providers who responded cited pay as having an impact on recruitment and retention issues – "People are not wanting to work in the care sector. Low pay and long hours".

Responses to our poll also reflected recruitment and retention challenges in primary care. Ninety per cent of GP practices who responded (217 of 241) and 92% of dental care providers who responded (88 of 96) agreed or completely agreed that they are currently struggling to recruit staff. Similarly, 71% of GP practices (170) and 59% dental providers (57) who responded said they are struggling to retain staff.

GP practices have been at the front end of efforts to tackle the pandemic, but there are concerns about the sustainability of the workforce. According to NHS Digital data, there has been a fall in the ratio of fully qualified GPs per 100,000 patients from 49.8 in June 2017 to 44.6 in June 2022.[111]

A Royal College of General Practitioners (RCGP) survey of over 1,200 of its members between March and April 2022 indicated that 42% of GPs plan to quit the profession within the next 5 years, with 10% in the next year and 19% in the next 2 years. The RCGP said that, even at the current level of GP training intake, there will be a net reduction in the GP workforce, further exacerbating workload pressures and affecting both patient safety and quality of care.[112]

We are seeing the difficulties with recruitment and retention, and the resulting workforce shortages, in our assessments of dental practices. There is a shortage of both dentists and dental nurses in the NHS. This is partly due to professionals moving into private practice.

The NHS Dental Statistics for England 2021/22 Annual Report shows that the number of dentists performing NHS activity during the year was below 2017/18 levels, and the number of dentists per 100,000 population fell from 44.1 in 2014/15 to 42.9 for 2021/22. Regionally this varied, with the number of dentists per 100,000 population highest in London (49.8) and lowest in the Midlands (42.0). Only the North West saw an increase compared with 2017/18.[113]

We have been told by dental providers that the international registration route to recruit overseas qualified professionals is slow, and delayed further during the pandemic because the examination used to register them was suspended.

We have also seen that NHS hospital providers continue to review and use overseas recruitment, but this takes time before a person can start in their role. And adult social care providers have said they have been trying to source nursing staff from abroad – but this can be costly and involve a lot of re-training, with no guarantee the person will stay at the service once they have retrained and obtained their personal identification number in the UK.

Impact on care

Staffing shortages are reflected in the responses in the latest NHS staff survey, which indicate heavier demands on the workforce.[114]

Only 43% of staff in 2021 said they could meet all the conflicting demands on their time at work, which is a 5-year low.

Responses varied for staff in different occupation groups. Midwives had the lowest results – only 17% said they are able to meet all the conflicting demands on their time at work, compared with 28% in 2020, and only 7% said they never or rarely had unrealistic time pressures. More than half of midwives (52%) said they often think about leaving their organisation, with 71% saying they find their work emotionally exhausting and 63% saying they often feel burnt out because of work.

A Royal College of Nursing report in February 2022 declared that "dire shortages in the nursing workforce were compromising patient care even before the COVID-19 pandemic" and that this won't have improved given increases in demand.[115]

This is supported by our recent Adult inpatient survey findings, which show that only 55% of patients felt there were always enough nurses on duty to care for them in hospital. Additionally, 11% of patients responded that they 'never' felt there were enough nurses on duty during their hospital stay. This is an increase of 4 percentage points in one year. Similarly, the number of people that said they were always able to get enough help from staff to wash or keep themselves clean declined from 75% in 2020 to 70% in 2021. We can infer that shortages in the workforce are tangibly impacting on the quality of care being provided to people in a hospital setting.[116]

We have also seen challenges across a number of hospitals for patients with mental health needs because of a lack of specialist staff, as well as a lack of beds. This has meant, for example, that some have been admitted to acute services or unsuitable settings.

> *"Due to a shortage of registered mental health nurses, the service had a policy of cohorting patients assessed as requiring enhanced observations or one-to-one care in a bay. However, we saw cohorted bays were not always observed by staff. There was a risk to patients if they were assessed as requiring enhanced observations or one-to-one care and this was not provided in accordance with their assessed needs at all times."*
>
> **Extract from a 2022 CQC inspection report of an NHS trust**

During our inspections, we have seen the effect of staff shortages, such as a lack of midwife leaders causing inconsistent practice and difficulty in embedding a good culture.

In some cases, staff shortages can have a severe impact on people's human rights. For example, in some services in the North West there was an increase in restrictive practices, due to limited staff numbers. This included examples of staff removing frames from people when they sat down, so they were unable to get up and move around, and the locking of corridors and other areas of a service.

In a March 2022 survey, NHS Providers asked a range of executive directors about the impact of staff shortages on services and backlog recovery. The survey received 236 responses from 142 trusts and found that:

- 97% thought current shortages were having a serious and detrimental impact on services (60% strongly agreed, 37% agreed).
- 98% thought current shortages would slow down the care backlog recovery (68% strongly agreed, 30% agreed).[117]

Responses to the survey also indicated that, as consequences of staff shortages:

- The shortfall in radiographers was preventing progress towards developing community diagnostic hubs.
- Some services were being closed or reduced (including midwifery services).
- There were concerns that, in recruiting to midwifery roles, services would not be able to match the standards set out in the Ockenden report.
- Reliance on agency staff had increased.

GPs in England are also feeling the impact of demands on their time. In a 2021 survey of over 2,200 GPs, more than 8 out of 10 GPs reported experiencing considerable or high pressure from rising workloads (86%) and increased demands from patients (84%), with the latter growing since 2019.[118]

A report commissioned by the Association of Dental Groups pointed out that every time a dentist leaves the NHS and isn't replaced, approximately 2,000 patients could lose access to NHS care.[119]

In our adult social care workforce survey, completed more than 5,500 times with providers, 25% of care home and 26% of homecare providers said there has 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 have had a negative impact, this was higher with 42% of care homes and 43% of homecare providers saying people have experienced a delay.

In the survey, care homes that reported workforce challenges having a negative impact were asked how staffing shortages were having an impact on their ability to provide the previous level of service. Of those that provided information, a third (32%) said there had been a reduction in group and one-to-one activity sessions due to a lack of staff. Also, workforce pressures were 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.

> We have faced a lot of barriers in health and social care throughout the pandemic and these are still affecting the way that our service users live their lives. Staff morale has been low at times due to the implications on staffing and being burnt out, which has led to service users not always receiving the great quality of support they usually receive.
>
> **Submission to CQC care home provider information return (April 2022)**

Homecare providers that reported workforce challenges having a negative impact were also asked how staffing shortages were affecting their ability to provide the previous level of service. From those that provided information (525):

- 46% of services told us that they had not accepted any new packages of care.
- 38% said they were being selective about which packages of care to accept.
- 18% said they had handed back individual packages of care to the local authority and 3% told us they had terminated contracts with local authorities.

Impact on staff

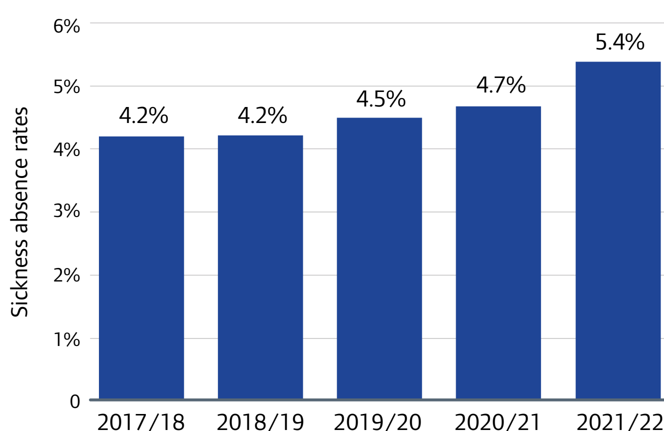
The pressure on health and social care workers can be seen in staff sickness data. Clearly these have been affected by COVID-19 infections, but compared with other areas of work, health and social care professionals will have felt the impact of the pandemic considerably, which has manifested itself in stress, burn-out and staff leaving the profession.

The sickness absence rate for all people in employment in the UK in 2021 was 2.2% – the highest it has been since 2010. Workers in caring, leisure and other service occupations had the highest rates, at 3.8%.[120]

These figures only tell part of the story. In our inspections of NHS hospitals last year, all trusts have reported significant issues due to short and long-term absences related to COVID-19.

According to NHS Digital statistics, NHS sickness absence in England rose to its highest level of 6.7% in January 2022, which is 1 percentage point higher than January 2021. The past 4 years have seen a steady increase in NHS sickness absence rates (figure 13).[121]

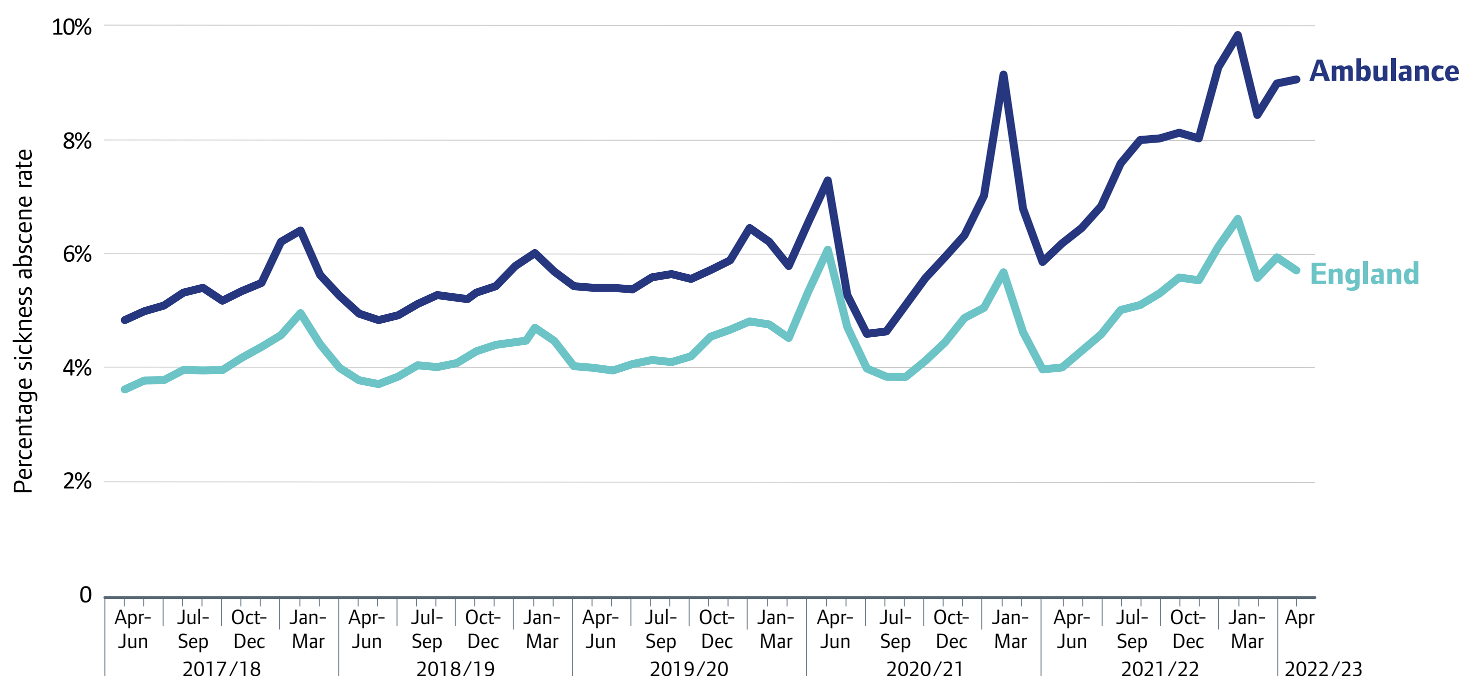
Figure 13
NHS sickness absence rates, England, 2017/18 to 2021/22



Source: NHS Digital, NHS sickness absence rates

Sickness rates for some groups are higher than others. They continue to be highest for staff within ambulance trusts, and were at their highest recorded level in 2021/22 averaging 8.1%. While sickness rates for ambulance trusts have always been higher, the gap appears to be widening. The April 2022 rate of 9.1% for ambulance trusts was 3.4 percentage points above the England average (figure 14).

Figure 14
Sickness absence rates, NHS ambulance services in England compared with all NHS services in England, April 2017 to April 2022



Source: NHS Digital, NHS sickness absence rates

Anxiety, stress, depression and other psychiatric illnesses are consistently the most reported reasons for sickness absence across all staff groups, accounting for more than 463,000 full-time equivalent days lost and 20.4% of all sickness absence in April 2022.

The impact of stress was shown in a December 2021 survey of 532 doctors released by the Medical Defence Union. Over a third of doctors said they felt sleep deprived on at least a weekly basis and over a quarter had been in a position where tiredness had had an impact on their ability to treat patients. Over 1 in 4 doctors responding (26%) said tiredness had affected their ability to safely care for patients, including almost 40 near misses and 7 cases in which a patient actually sustained harm.[122]

These findings are reflected in a 2022 survey of over 48,000 trainee doctors across the UK. Two-fifths of trainees who responded (39%) said that they felt burnt out to a high or very high degree because of their work. This is a 6 percentage point increase compared with the previous year.[123]

NHS Digital statistics show that, for some staff groups with the highest sickness rates, days lost as a result of psychiatric illnesses have risen notably:

- ambulance staff – days lost rose by 56% from 85,000 in 2020/21 to 132,000 in 2021/22
- midwives – days lost rose by 27% from 132,000 in 2020/21 to 167,000 in 2021/22.[124]

Experiences of staff at ambulance trusts are particularly concerning. They have consistently reported the poorest experiences of all trust types in every year of the NHS Staff Survey. The gap between ambulance trusts and the national average widened between 2020 and 2021 in many questions – most notably in areas such as whether there are enough staff to do the job properly, feeling unwell from work-related stress, thinking about leaving the organisation, and whether they had an appraisal or development review.

Ambulance services have been under sustained pressure, exacerbated by handover delays at emergency departments. While ambulance crews wait at emergency departments, they must continue to care for their patients. This can affect their ability to take breaks and finish their shifts on time.

Over the last year these pressures have, all too often, become business as usual for ambulance crews. In some NHS ambulance trusts we have inspected, staff have told us they have started their shift relieving a fellow paramedic waiting outside an emergency department, taking over caring for the patient in the back of the ambulance. Furthermore, while ambulance crews wait outside emergency departments they are, inevitably, aware that they are unable to respond to emergencies in the community. These pressures undoubtedly have an impact on the wellbeing and morale of crews.

It is not just ambulance crews who experience the impact of current service pressures. Staff in emergency operation centres also provide support over the telephone to patients and their loved ones while they wait for an ambulance to arrive. Due to delays, the support offered over the telephone has been particularly important, and undoubtedly more emotionally challenging for staff. As people are often waiting much longer than they expect due to delays, they may also be more likely to call operation centres many times for updates, further adding to the workload pressures. We have heard about, and witnessed on our inspections, the increase in abuse experienced by call handlers during this period.

In adult social care over the past year, the pandemic has caused significant challenges in terms of staff absence, either because of COVID-19 infection or the need to self-isolate. Average sickness rates, measured by the average number of days lost to sickness in the previous 12 months, vary by service type. According to Skills for Care data, as at July 2022, care homes with nursing had the highest sickness rates of 8.2 days, which is more than 3 days higher than before the pandemic (4.8 days). Although sickness rates for care homes without nursing (6.9 days) and homecare services (7.5 days) were lower, they were still above pre-pandemic levels.[125]

There is also regional variation. As at July 2022, average days lost to sickness varied from 4.8 days in the South East, which is slightly lower than its pre-pandemic rate (5.1 days), to 9.6 days in Eastern England, which is almost double the pre-pandemic rate (4.9 days).

Tackling workforce issues

We have seen how providers and staff are trying new ways to ease the pressures, at both a provider level and a system level.

Some initiatives have been short-term solutions to immediate workforce challenges, such as maintaining morale and wellbeing during the worst periods of the pandemic. These are creative and praiseworthy and have undoubtedly supported staff during particularly challenging times. Others, in areas like recruitment and retention, aim to drive longer-term changes.

> We were told about [a project] and later witnessed it in action. This was a volunteer scheme provided by furloughed [airline] staff. They had a seating area set aside at the Waterloo headquarters where they provided tea, coffee and magazines available free of charge. The [airline] staff used their training on how to communicate and deal with sensitive situations to offer [the ambulance service] employees the chance to talk with someone external to their own organisation. Some staff we spoke with had found this useful.
>
> **Extract from a 2022 CQC inspection report of an NHS ambulance trust**

Through our inspections of urgent and emergency care services, we have seen partnership work to address systemic issues, such as an increase in the use of multidisciplinary teams with more diverse skill mixes. For example, we saw NHS 111 services making additional use of midwives, mental health practitioners and pharmacists. By providing access to a wide range of healthcare professionals, they could give more appropriate clinical advice to people accessing NHS 111 and support local systems to keep people out of acute services.

Staff shortages are a problem in many of our recent mental health inspections reports. This is a particular issue in London due to increased costs of living and where staff have more of a choice of employment. We are seeing lots of innovative approaches, such as international recruitment, training and apprenticeships, and pay incentives being taken forward.

The trust turnover rate for the 12 months to September was 13.8%. Over the same period, the trust vacancy rate was 10.1% but, in some areas, this rose to 19%. The trust was finding it challenging to recruit to community health service nurses and mental health nurses, in line with other trusts nationally. In some local areas, the trust was reliant on locum consultants.

To address these challenges, the trust was looking at how bank or permanent posts within the trust could be made more appealing to local agency workers and developing new apprenticeship roles.

Thirty-six apprentices were in post at the time of our inspection, covering a range of roles including social work, pharmacy and allied health professionals. Work was also underway to look at how bank work for the trust could be developed into a career pipeline to make it an attractive option for agency staff to join the trust. The trust was also looking at improving learning and development opportunities for bank staff.

Extract from a 2022 CQC inspection report of an NHS trust

We have heard from adult social care providers in our Market Oversight scheme about initiatives to bolster recruitment and retention. These include:

- building better career pathways beyond the support worker role, so that staff see a future for themselves in social care. For example, implementing a nursing associate role that aims to bridge the gap between carers and nurses
- working with local universities on a nursing apprenticeship programme, to support staff to become qualified as registered nurses
- broadening their talent base and attracting new people into social care, by looking for the right behaviours and capability, rather than social care experience. Also, offering apprenticeship programmes for young people and school leavers, as a route into a care career
- striving to make clear the development opportunities, as well as other allowances and benefits, afforded by a career in care when placing recruitment adverts
- involving staff who have progressed from support workers to manager roles in recruitment activity, so they can tell their stories.

In primary care, one example of notable practice was a dental provider that had implemented a wellbeing policy and created personal holistic wellbeing action plans for each member of staff. These were regularly reviewed. The provider also organised weekly in-house meditation sessions for all staff, which were well received.

To support GP practices, a number of online primary care providers have been contracted to provide remote consultations for individual patients and have direct access to the GP clinical record. This is particularly helpful for areas where it is difficult to recruit permanent GPs.

On a larger scale, the Additional Roles Reimbursement Scheme (ARRS) was introduced in 2019 as a key part of the government's commitment to improve access to a GP practice. The scheme aims to support the recruitment of 26,000 additional staff into general practice by 2023/24, to create bespoke multidisciplinary teams. It appears to be on track to meet that target.[126] While the wider team working in general practice that ARRS will introduce is to be welcomed, there is a need to ensure that there are appropriate governance, oversight and supervision arrangements and that staff are not working beyond the scope of their competence.

Developing the workforce

More needs to be done to maintain and develop the workforce, especially in adult social care, with system-wide workforce planning a priority.

Valuing staff

The people who make up the health and social care workforce need to feel valued, rewarded and supported. Ensuring staff feel valued is important to retaining a diverse workforce with the right skill mix across health and care organisations.

In its Workforce Disability Equality Standard, NHS England identified a link between NHS trusts being rated as outstanding for our well-led question and showing evidence of being better employers for disabled staff.[127]

In the first year of the pandemic, we saw health organisations working together to rotate places of work. This not only helped workforce capacity issues, but also enabled staff to develop new skills. Continuing and developing this model would help to break down barriers and give staff a shared understanding of a person's journey through the health and social care system.

Through our provider collaboration review work, we found that training and upskilling of new and existing staff members was crucial to maintaining a workforce able to deliver high-quality care during the pandemic. We heard that, where staff had been redeployed to different services, their employers were keen to make use of their newly acquired skills on their return. This could benefit both the quality of care they deliver and their personal career prospects.

> We have invested in our learning and development team which has allowed us to upskill our staff and give them credited qualifications. We have made it so all support staff have opportunity to complete an NVQ L3 and complete on the job training and learning.
>
> **Submission to CQC care home provider information return (April 2022)**

We have heard how adult social care staff are now expected to perform a wider range of tasks than before the pandemic, many of which would have been carried out by health professionals. However, time for staff training isn't consistently factored into care costs. This means there is a 'triple whammy' for the provider:

- First, they have to pay for the training.
- Second, they have to pay the staff member to attend the training.
- Third, they have to pay someone else to cover their shift.

We also heard about problems for adult social care staff in accessing it:

- Workforce and capacity challenges meant it was often difficult for providers to release staff for training.
- Online training was not suitable for many staff.
- There were issues around assessing competence following online training.

Around 1.5 million people work in the adult social care sector in England, which is more than work in the NHS.[128] We need to champion the adult social care workforce and dispel once and for all the notion that it is low skilled work. The ability of staff to continue to work to a higher skill level will need investment in workforce development, higher overall levels of pay to increase the competitiveness of the market, and good terms and conditions to ensure employers can attract and retain the right people.

> The deputy manager was promoted to manager of another service, the senior at the service has been promoted to the deputy's post, and a support worker has just been promoted to the senior's post. This has shown that staff feel they have been given the skills and training to progress, and also the clients feel there is consistency and knowledge within the staff team (from promotions from within the team).
>
> **Submission to CQC care home provider information return (April 2022)**

The government has dedicated £500 million funding to support the recovery of the adult social care workforce.[129] This funding is welcomed, and urgently needed to attract and retain staff.

However, if the funding for social care is to have a long-lasting impact, it needs to tackle the systemic problems that all providers are faced with. Stronger workforce planning should make sure that social care is seen as an equal partner and that caring is seen as a respected and sustainable career. Workforce shortages need to be treated as a national issue with local solutions. We are calling for funding and support for ICSs so they can own and deliver a properly funded workforce plan that recognises the adult social care workforce crisis as a national issue and offers staff better pay, rewards and training linked to career progression – a plan that encourages investment in long-term solutions rather than short-term sticking plasters.

System-level change

Our urgent and emergency inspection programme has highlighted how increased strategic workforce planning across health and social care is needed. For example, we found that care homes across Gloucestershire were reporting significant spare capacity, which could be used to support patients to leave hospital in a timely way. However, staffing shortages in social care restricted system leaders’ ability to use this capacity. This shows how vital workforce planning at a system level is, and how all partners within health and care need to be involved.

Our data shows that workforce issues do not follow consistent patterns across the country, as seen in the NHS vacancy figures above, indicating that different areas have different challenges. As a further example, although figure 12 above shows that residential adult social care vacancy rates in England have been slowly reducing since March 2022, the South West and South East regions continued to rise (figure 15). The data also shows that vacancy rates vary regionally, with the South West having the highest rate for the quarter to June 2022 (13.1%) and London the lowest rate (9.0%).

To maintain and develop the workforce, and plan for the future, providers and systems need to review workforce demands for the longer term, including skill sets. A full understanding of the needs of the local community must be maintained to ensure services meet demand. This should include preventative health measures, as well as maintaining and improving health outcomes.

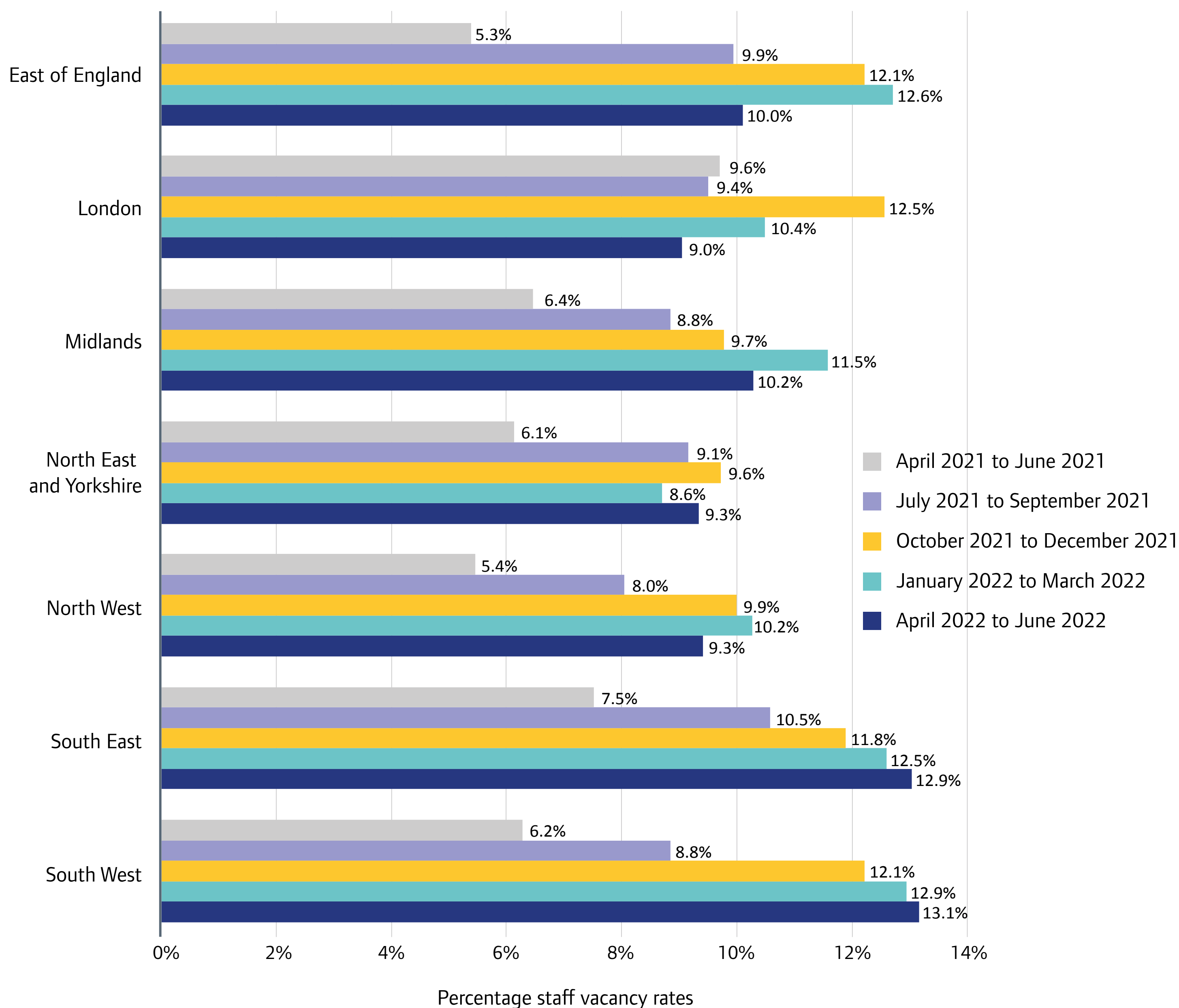
Strong, visible system leaders are important in ensuring that a local area has a sufficient staff with the right skills in the right places to support patients.

Integrated care systems (ICSs) will become increasingly important over the coming months and years, with significant responsibilities for planning services and managing NHS resources, and providing the basis for collaboration across health and care organisations. Crucially, ICSs have a key role in workforce planning.

A successful ICS will have plans in place to address national and system workforce priorities, using clinical and non-clinical skills effectively across an integrated pathway, with a focus on staff health and wellbeing.

An effective ICS will also be able to identify and prioritise training and learning needs for the people who care for their population, commissioning and coordinating training for all sectors.

Figure 15
Quarterly percentage staff vacancy rates by region for care homes, England, April 2021 to June 2022



Source: CQC Provider information returns

Note: regional breakdowns are calculated using quarterly aggregated data to ensure sufficient coverage.

Work at ICS level to tackle workforce issues

Birmingham and Solihull ICS

Increased partnership working began during the COVID-19 pandemic and providers worked together to ensure staff were moved to where the need was greatest, such as intensive care. This has continued – for example, prioritising the recruitment of orthopaedic staff to areas of greatest need. Also, the ICS has pledged to deliver a minimum of 100 entry-level job opportunities, each year for three years, for unemployed and young people from economically disadvantaged areas across the region. They will provide education and training, interview help and pastoral support for prospective job seekers, all of whom will be guaranteed an interview for entry-level jobs in both clinical and non-clinical settings – for example becoming a healthcare support worker, pharmacy assistant, porter, business administrator, receptionist or IT apprentice.

Lincolnshire ICS

Lincolnshire ICS now has a medical school to 'grow our own' doctors. This is due to the difficulties in recruiting and retaining medical staff within the system. However, this is relatively new and currently unable to demonstrate impact.

Shrewsbury, Telford and Wrekin ICS

Following feedback that overseas nurses have experienced racism, this ICS has been working with a local university to carry out research regarding rural racism and overseas nurses' experience. This research is still in progress.

Norfolk and Waveney Health and Care Partnership

INK (Indian Nurses in Kings Lynn) was a group that was accessible to all Indian nurses, irrespective of the organisation they worked for. This ensured people had support mechanisms in place, was able to signpost to other support providers as needed, and aided the retention of the workforce within the area.

6. Systems: challenges and opportunities

Key points

- Understanding the health and care needs of local people is paramount for integrated care systems, and each one faces a different challenge in meeting those needs.
- Good leadership will be vital for local systems as they become established during challenging times for all services.
- Local partnerships are starting to make a positive difference – they must be focused on outcomes for people.
- System-level planning should include all health and care services to address population needs and health and care inequalities, and do their best to keep people well.

In this section we consider the introduction of integrated care systems (ICSs) and the challenges for systems, particularly around inclusivity and planning and their importance for people living in their local areas.

From our own work looking at care within the emerging and newly established systems, and from listening to people's experiences of care, we can point to some areas of focus for local systems as well as some tangible collaborations that are already making a positive difference in people's lives. The areas for focus include:

- leadership in establishing collaborative local relationships
- ensuring all local services are included in planning how to keep people well
- understanding local population needs to improve planning and address inequalities.

Integrated care systems and CQC's role

When the Health and Care Act 2022 formally established integrated care boards (ICBs) to deliver system-wide strategic plans for the delivery of health and care services across local areas, it also provided a new role for CQC to review and assess the integrated care systems associated with each ICB. This will start in April 2023.

The introduction of ICSs instigates a change in the focus for our regulation and how we consider the quality of care, including how well systems are integrated to serve local people.

We already know about some factors that have an impact on the quality of care people receive, especially in what we see at individual service level. We need to better understand what affects people's experience of care, so we are transforming the way we work so we can do our best to ensure people receive safe and high-quality care.

We will be better equipped to shine a light on good or poor quality of care – and to understand the causes of poor care by looking at what's happening under the surface of local care systems. We have progressed to a position where we can start to realise two of our strategic ambitions:

- providing independent assurance to the public about the quality of care in their area
- tackling inequalities in health and care by pushing for equality of access, experiences and outcomes from health and social care services.

There are many challenges facing the leaders on the ICBs. From our previous work across local systems, we know that better outcomes are possible for people in places where system leaders work well together. We know this particularly from our work across different places and where we have looked at services for older people.[130,131] Also, we saw this in our November 2021 report about services for children and young people with mental health problems.[132]

Challenges for systems

Achieving integrated care is a new responsibility for all organisations charged with delivering health and social care services. Until now, services have operated in autonomous ways – for example, GP practices with their own financial arrangements, NHS trusts with their own workforces, or social care services operating across their own defined localities.

This has meant people do not always get high-quality care or a good experience when they use services – especially if they need multiple services.

While CQC's focus remains the quality and safety of services, and the experience of people when they get care, we will now also be looking at the leadership in ICSs and assessing how well services are integrated.

The inception of ICSs and their respective ICBs comes at a time when providers are reeling from the impacts of the pandemic, but they also face problems in health and social care that pre-date COVID-19.

In the mix of challenges for the new systems, reports have described how the country 'entered the pandemic in a vulnerable position'. In November 2021, the Health Foundation described "systemic weakness in the NHS and poor underlying health", pointing to a system with "fewer doctors, nurses, beds and scanners relative to European neighbours".[133] Nuffield Trust said in September 2022 that historical trends in key performance measures "paint a picture of a system already stretched beyond its limits before the pandemic, with access and waiting times in a gradual but steady decline".[134]

In August 2022, NHS England (NHSE) published guidance about the winter ahead, also detailing 6 metrics for accountability in the performance of ICSs.[135] They point out that its elective recovery plan is underpinned by the new approach to how organisations in the NHS work together. NHSE and ICBs will be monitoring:

- 111 call abandonment
- mean 999 call answering times
- Category 2 ambulance response times
- average hours lost to ambulance handover delays per day
- adult general and acute type 1 bed occupancy (adjusted for void beds)
- percentage of beds occupied by patients who no longer meet the criteria to reside.[136]

Understanding local needs – the ONS Health Index

A tool that is increasingly helping people to understand the needs of their local area is the ONS Health Index.

First introduced in 2020, the Health Index is a measure of the overall health of the nation. It uses a broad definition of health, including health outcomes, health-related behaviours and personal circumstances, and wider drivers of health. It provides a single value for health that can show how health changes over time, and it can also be broken down to focus on specific topics to show what is driving these changes.

It is organised around 3 broad areas:

- **Healthy People** – this includes areas such as life expectancy, physical health conditions like dementia, cancer and kidney disease, disability, personal wellbeing and mental health.
- **Healthy Lives** – including physiological risk factors such as obesity and hypertension, and behavioural risk factors such as drug misuse, smoking and healthy eating.
- **Healthy Places** – including local environmental factors such as pollution, noise and road traffic, and economic and working conditions such as child poverty and unemployment.

As well as showing how health in England changes over time, the Health Index provides measures of health for local authority areas and integrated care systems. This allows users to see the health of smaller geographical areas, and what is driving the changes relevant to that area. It also allows comparisons to be made between areas.

The Health Index release in March 2022, including an interactive tool, explores the changes in health between 2015 and 2019, and an update to 2020 will be published soon.

Understanding patient experience

Every local health and care system needs to listen to the needs of its local people and community, and each one will face a different challenge.

We commissioned PEP Health to conduct a longitudinal analysis of their data on 'patient experience' across England, nationally and regionally, and with a focus on urgent and emergency care (UEC) and maternity care.

PEP Health gathers, analyses and interprets patient comments on multiple healthcare settings every year and combines it to create a 'score' of patient experience. For this project, PEP Health gathered more than 1 million potential comments from social media and review sites for all NHS trusts and GP practices, from the start of 2018 up to the end of August 2022. More than 670,000 of these were relevant to the quality of care; 65,000 to urgent and emergency care; and more than 17,000 to maternity care. Sources used in the analysis included Care Opinion, Facebook, Google, NHS.uk and Twitter.

Their findings show that:

- Patient experience across England, as measured by PEP Health, has fluctuated significantly since 2018, with COVID-19 unsurprisingly having a large impact. It improved for each of the three categories analysed (overall quality, UEC and maternity) shortly after the introduction of the first COVID lockdown in early 2020. It then decreased from mid-2021, particularly for UEC; and it is now below pre-COVID levels.
- The overall trend was mirrored at a regional level. However, some regions saw a less significant decrease in patient experience and were less impacted by the pandemic than others. The South West and the North East regions consistently scored highest throughout the period.
- The decrease in patient experience was consistent at a more granular level, with a drop in score for all but one ICS from September 2021 to August 2022. There was variation in the size of the decrease.
- Patient experience for UEC scored higher overall than for non-UEC from 2018 to 2020, but UEC then scored lower in 2021 and 2022. All regions saw a similar trend in overall scores for UEC, with an uplift after the start of the first lockdown, and a significant drop between April 2021 and December 2021. The lowest scored regions have shown an improvement from mid-2022.
- The South West and North East regions have the highest UEC patient experience and have done so for most of the past four years. London currently has the lowest patient experience scores.
- All but one ICS saw declines in UEC scores between September 2021 and August 2022.
- Regional trends for maternity care were similar to those for care overall and for UEC, with the North East and South West regions having the highest patient experience.

We will be exploring this data and analysis in more detail in the coming months.

Good leadership is vital

When we have visited some local areas – systems in their infancies, or before they assumed their formal ICS existence – we have found varying degrees of success in the way services were collaborating to improve people's experience of care.[137] There is some consensus around this, and the various challenges identified for ICSs' leadership, among independent reports for government and policy experts, including a report by Baroness Cavendish.[138]

The first annual report by the NHS Confederation's ICS Network has assessed the progress of ICSs and is based on the views of system leaders.[139] They say one of the biggest strengths so far is that 90% of system leaders believe they have been able to improve joint working. However, they warn there is a risk that, without enough time and space, they will not be able to deliver the radical changes to health and care services that the pandemic has demonstrated are needed.

Among the challenges, they say that further support is needed to help systems achieve the ambition of systems contributing to local social and economic development. Also:

- Primary care leaders highlighted that in many areas there is uncertainty about how the experiences and insights of those leading primary care services at neighbourhood level inform system-level planning and strategy.
- System leaders feel the biggest obstacle preventing further progress is national workforce shortages – 3 out of 4 said this was the top priority.

In an independent report for government by General Sir Gordon Messenger and Dame Linda Pollard, some of the immediate tasks for systems' leadership are laid out for those looking to build a collaborative and inclusive future.[140]

Looking across health and social care, the report described "institutional inadequacy in the way that leadership and management is trained, developed and valued". It echoes some of our own findings from recent years, particularly the importance of collaborative behaviours.[141]

We have often reported about the importance and impact of good leadership at service provider level and its link to better outcomes for people who need care. The Messenger and Pollard report stressed the importance for systems to show "collaborative leadership, broader cross-sector awareness and understanding".[142]

The importance of local partnerships

CQC has an important role to play in assessing and supporting providers and systems to improve. We will assess the way multiple health and social care providers work in partnership locally, checking that their focus is on improved experiences and outcomes for people.

The King's Fund, for example, says it is important to measure and assess the right things – it points to CQC's role to "evaluate whether the objectives of ICSs – better integration, population health, and prevention – are being met".[143]

In a briefing published by NHS Providers in August 2022, we can see examples of provider collaboratives that are developing across England and their reported benefits.[144] These collaboratives are partnership arrangements bringing together two or more trusts to maximise economies of scale and improve care for their local populations. NHS Providers points out that NHS England has required all trusts providing acute and/or mental health services, including specialist trusts, to join at least one provider collaborative from July 2022.

NHS Providers points to "unanswered questions and risks for trust boards to navigate" when exploring the opportunities of collaboration at scale. However, they say that trust leaders across all sectors see "potential to improve care and services through driving standardisation, addressing unwarranted variation, bolstering service resilience, identifying approaches to better support people experiencing inequalities, and developing innovative ways of working with other local partners such as social care providers and primary care services".

From what we have seen in our recent local reviews of urgent and emergency care in local areas – and in previous provider collaboration reviews – the quality of pre-existing relationships between local providers plays a key role in the coordination and delivery of joined-up health and social care services that meet the needs of the local population.[145]

Baroness Cavendish's February 2022 report points out that the pandemic "prompted a level of positive collaboration", a view supported by the NHS Confederation in June 2022. However, the Cavendish report goes on to say, "The NHS showed little comprehension of the care sector or its needs… linkages between NHSE and local authorities proved to be virtually non-existent." She adds that the "lack of parity between the NHS and social care became stark".

We know that many good local partnerships are making a tangible difference in people's lives. For example, a homecare service that worked closely with district nurses, a GP and other care professionals made a positive change for a person who lived for years with serious skin problems. Their collaboration, sharing care plans and offering consistency of care, led to an improvement in the person's skin so that they had many months with no further concerns. The homecare providers' relationship with their health and social care colleagues was also cemented for the long term.

Some good collaboration was sparked by the pandemic and we know from previous provider collaboration reviews that solid partnerships were founded this way. In some cases, the collaborative approach has continued – in some local areas, we know how system partners met twice a week with a focus on care home needs, including infection control, medicines management and access to GPs. This was effective at managing risks and partners also spread their staff where they were needed most.

'ICS in your pocket'

In Cornwall, an integrated care system (ICS) is using technology to help people take control of the services they use. They are working towards a 'patient portal', following the 2021 launch of their 'patient hub'.[146] The hub helps residents keep track of all their hospital outpatient appointment information – all in one place and accessible on a smartphone, tablet or computer.

Following stakeholder consultations, the ICS's plans are part of a four-year digital strategy. The strategy is clear that digital transformation must be planned plan around inclusion, otherwise there is a risk of increasing inequality of access. The ICS points out that "digital exclusion aligns closely with social exclusion and wider determinants of health".

Part of their plan is to introduce an 'ICS in your pocket', to transform people's care pathways. This would be a facility to book and manage appointments, communicate with care staff and get health and wellbeing information. It could empower residents to manage their own care, in and out of hospital, with the potential to improve their experience, as well as supporting the ICS's vision of "supporting people to help themselves and each other".

The Birmingham and Solihull ICS has increased partnership working, also using 'mutual aid' within the system. Beginning during the pandemic, providers worked to ensure staff were moved where the need was greatest, such as intensive care. The partnership has developed further and now includes recruitment campaigns and making sure people are appointed where greatest need is identified.

Across the Herefordshire and Worcestershire ICS, there is a system-wide approach to bank and agency staff – this has helped by setting a pay cap, which means providers are not outbidding one another for new recruits. We know about a similar project involving mental health services in parts of London and Essex.

Some providers are working together to directly address the risks people may face because of current delays in patient handover between services. In the south west, they wanted to reduce the risks for people who might have to remain sitting or lying down, often in an ambulance, while waiting for a possible hospital admission. When a delay like this happens, pressure injuries can develop within an hour or injury is very likely within 4 to 6 hours. Ambulance trolleys were not designed for long waits.

South Western Ambulance Service NHS Foundation Trust's clinical team has worked with hospitals' tissue viability specialists across the region to reduce these risks. Their pressure ulcer guideline was updated with an extra focus on care during patient handover delays and a specialised type of mattress was identified that would reduce the risk of ulcers – it helps with pressure redistribution and the mattresses are already stored and used at 4 hospitals, with another 3 hospitals lined up. At another 3 hospitals, arrangements have been made to reduce risks by transferring patients to hospital trolleys if there are extended waits.

Planning and inclusivity

All services working in a local health and social care system should be included in planning for healthier communities. To maintain and develop the required workforce, as well as to plan for the future, providers and systems need to be clear about demands in the longer term, including the required workforce skillsets. A strong understanding of local community needs is needed to ensure the right services, including preventative health measures and plans for improving health outcomes.

In the first year of the pandemic, we saw organisations working together and often rotating some employees' workplaces. This helped with capacity issues, but it also upskilled some staff. Continuing and developing this model would also help to break down barriers and gain a shared understanding of people's journeys through the health and social care system.

Recognising the importance of effective social care in a local system, one NHS trust is aiming to help to resolve unmet demand by growing its own homecare provision. Northumbria Healthcare NHS Foundation Trust is an established hospital and community services provider that says it intends to recruit people to 250 jobs – it plans to "use its expertise to help support the care sector in Northumberland and North Tyneside".[147]

The plan aims to enable the region's hospitals to cope with demand from new patients by moving on those patients in hospital who no longer need to be there.

There is a need to expand training and education for new health and social care staff, so that the future workforce has a good awareness and understanding about system plans and new models of care. This will help to change mindsets and ensure professionals focus on people's care pathways, considering preventative health measures to achieve better health outcomes.

There are different challenges for different sectors to achieve more local inclusivity. With services coming together, a King's Fund analysis in December 2021 points out that there are challenges – for example, "language, spending power, metrics culture and leadership style".[148] The King's Fund points out that adult social care services have "vital experience and understanding" and how to involve them will differ across ICSs. It adds that social care shouldn't "undersell itself" and notes that "social care and local government have strong history of mobilising assets around the needs of the individual and tackling inequalities".

The analysis highlights that inclusivity will recognise "who does what best in the system", pointing out at that social care must be "on the agenda, not just in the room". This observation was also clear from some of the provider collaboration reviews we carried out in 2020 and 2021, with the potential for partnerships relying on an understanding about collective responsibility around system challenges.

A May 2022 report points to the importance of helping people to stay well for longer. Dr Claire Fuller's Next steps for integrating primary care: Fuller Stocktake report notes that "improving the experience of accessing primary care is essential" and adds that too often most of the effort "is focused on treating people who have already become sick".[149] Reporting on the role of primary care in the new ICSs, Dr Fuller says there needs to be a "sense of urgency around

providing proactive care and improving outcomes" for people. The report adds that this is "only achievable if we work in partnership" to address inequalities, "taking action to address the wider determinants of health".

Keeping people well

We have previously reported on examples of good local planning.[150] They are usually examples where services are working hard to address specific localised issues, rather than whole-system planning that is more strategic and considers wider population needs and inequalities.

Working well together

In Greater Manchester, we have seen how a GP practice is collaborating effectively with a local care home and improving outcomes for people by proactively engaging with residents about their health.

The Barrington Medical Centre in Altrincham not only sees the care home residents who are registered with the practice, but also those registered with other GP practices.

It started when a GP decided there had to be a better way of working that would suit the practice and the care home residents. Previously, the home called out GPs when a resident was poorly. Many times, they found the home could have dealt with the health issue. However, the visiting GP would often be asked to see other residents while visiting, or the GP might realise another resident needed attention.

A problem was no continuation of care – visits were reactive and sometimes unnecessary.

The GP partners agreed that a weekly session at the home by one dedicated partner might work better. Now, a GP visits the home weekly for a session where they see residents who staff may be worried about. The GP now does their own ward rounds, reviewing and talking to every resident to check on their health.

These proactive visits have discovered residents with urinary tract infections, depression, or early onset dementia. They are helping to keep people well – and out of hospital.

There are multidisciplinary meetings, involving residents' families, their own GPs (if not affiliated to the practice), community nursing and tissue viability nurses. They also involve others who might care for residents – for example, at the end of people's lives. This has helped to identify health concerns before they might have become too difficult to manage.

The GP also reviews people's medicines. For example, we heard that some patients with dementia had tended to be prescribed antidepressant medicines – the practice said this wasn't always good practice. We were told that people's medication was reviewed and where appropriate they were taken off some medicines. We also heard how the GP has helped improve the quality of life for some people by reducing the number of different medications they use, and sometimes prescribing better pain management.

The care home has the GP's mobile telephone number for emergencies, but the GP has also trained clinical and non-clinical staff at the home to identify illnesses and understand what requires urgent or non-urgent attention. We heard that outcomes for residents and their families had greatly improved with the collaboration.

The Fuller Stocktake report cites positive examples where primary care is part of integrated neighbourhood teams that are trying to improve access for same-day urgent care, recognising that the "current system is not fit for purpose" and that workforce gaps must be confronted. Dr Fuller adds that "a new care model will not magic-away our workforce challenges".

We have also focused on the importance of systems understanding the needs of their local populations, so they can plan better.[151] There are NHS working groups called 'Maternity voices partnerships' (MVPs) and in our review of safety, equity and engagement in maternity services we found some positive examples of targeted engagement with local communities:

- One service was participating in a local maternity system survey, looking at cultural safety in working with women from ethnic minority groups.
- One MVP was working with the local maternity system to recruit diversity champions to build links with local communities.
- Another service, supported by their MVP, was holding weekly focus groups to better understand the issues faced by women from ethnic minority groups.[152]

The focus of our provider collaboration reviews on health inequalities encouraged some systems to think about how they could address these issues in their area.[153] Some systems were not as far along in their thinking as others and our focus had helped systems to consider inequalities as a key topic.

From our survey of more than 4,000 people aged 65 and over who had used health or social care services in the previous 6 months, we know that people in more deprived areas tended to be less positive about their care, as were disabled people and those with long-term mental health conditions. These groups were also less likely than average to be satisfied with being able to access services when they needed them and in a way that suited them.

There is a role for systems in promoting better health. Just over half of the people surveyed who had used health and social care services in the last 6 months (52%) told us they had also accessed the groups or organised activities contributing to their health and wellbeing that they were asked about. It suggests that many do not access such groups or organised activities – or they are unaware that they may exist.

Social networks were important – the survey showed about 4 in 5 people who had used health and social care services found it easy to get help from a close family member (86%) and friends and neighbours (80%) if they needed it. Those most likely to need help, for example due to a disability or being on a waiting list for health services or a care needs assessment, found

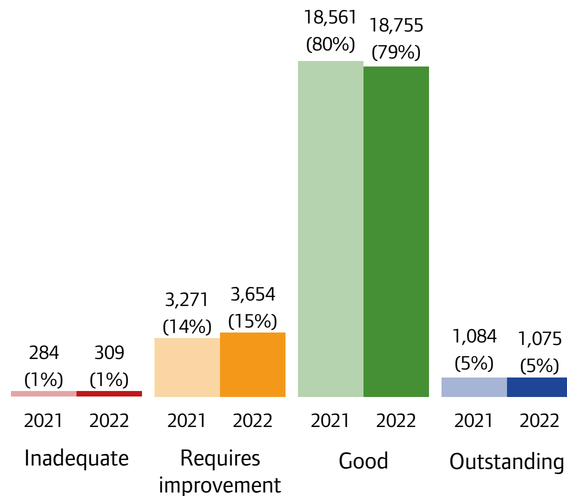
it comparatively harder to get help from a close family member, friends or neighbours. People with greater needs but weaker support networks might be helped through a systemic approach that involves the voluntary sector.

Better understanding of local populations might help address inequalities. For example, the survey showed people who find it difficult to get support from friends and family were slightly less positive about some aspects of services they get, such as whether their care and support needs have been met over the last 6 months. This group was also more likely to live in deprived areas (24% do, compared with 17% among those who find it easy to get help from a close family member, friend or neighbour) and be disabled (71% of them are, compared with 58% among people who find it easy to get help from a close family member). This suggests there is a risk of exacerbating health inequalities because these groups have slightly worse experiences of services and less developed social networks.

Many people are on hospital waiting lists, so there is a coordination role for local systems in making sure people feel supported and reassured while waiting for treatment. From our survey, we know that a significant proportion (37%) do not feel well supported while on a health waiting list, and for 40% of those on a health waiting list, their ability to carry out day-to-day activities is getting worse while waiting.

Appendix: Ratings charts

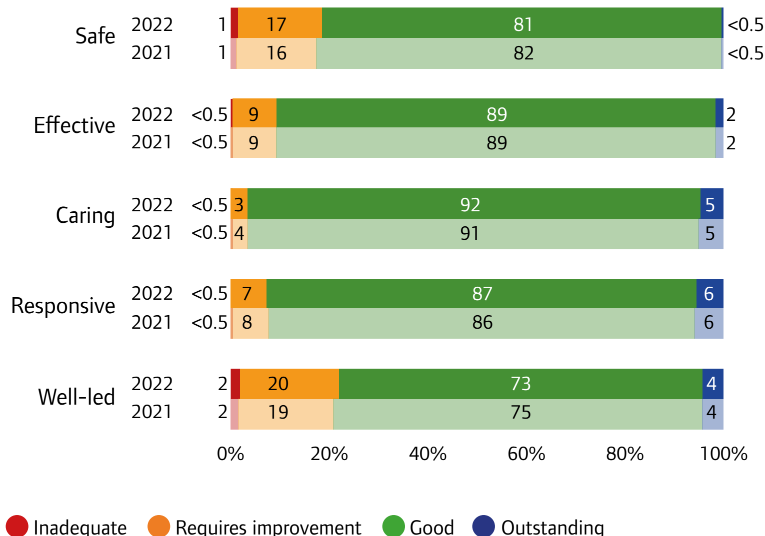
Figure A1
Adult social care, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 20221

Note: The 2022 ratings also included 12 'insufficient evidence to rate' overall ratings, which represented 0.05% of the total ratings (including 'insufficient evidence to rate').

Figure A2
Adult social care, key question ratings, 2021 and 2022

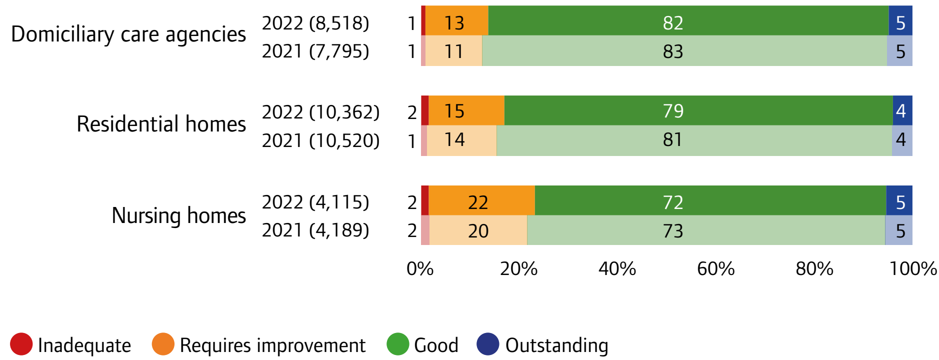


Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.03% for safe, effective, caring and well-led, and 0.04% for responsive. Percentages may not add to 100 due to rounding.

Figure A3

Adult social care, overall ratings by service type, 2021 and 2022

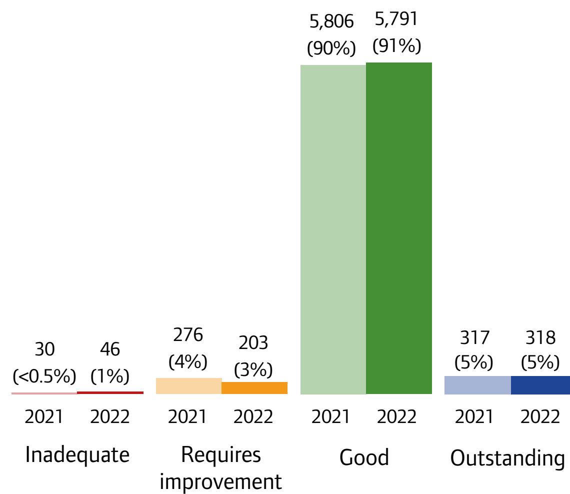


Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 1 insufficient evidence to rate' overall ratings for nursing home, 3 for residential homes and 8 for DCAs which represented 0.02%, 0.03% and 0.09% of the total ratings (including insufficient evidence to rate') respectively. Numbers in brackets denotes the number of rated locations. Percentages may not add to 100 due to rounding.

Figure A4

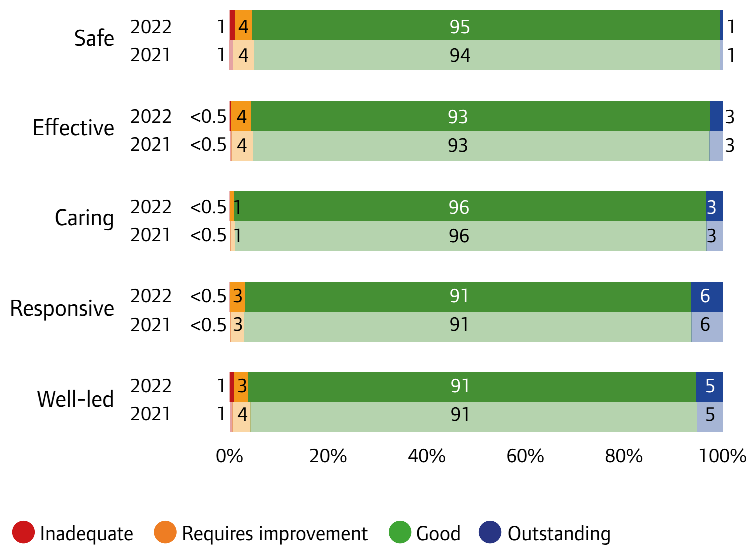
GP practices, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 1 'insufficient evidence to rate' overall rating, which represented 0.02% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding.

Figure A5
GP practices, key question ratings, 2021 and 2022

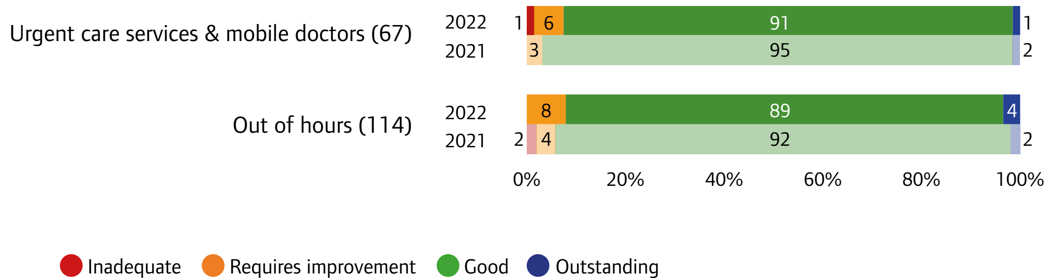


Inadequate · Requires improvement · Good · Outstanding

Source: CQC ratings data, 31 July 2021 and 31 July 2022

Notes: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.02% for safe, 0.03% for caring, effective and responsive. Percentages may not add to 100 due to rounding.

Figure A6
Other primary medical services, overall ratings, 2021 and 2022

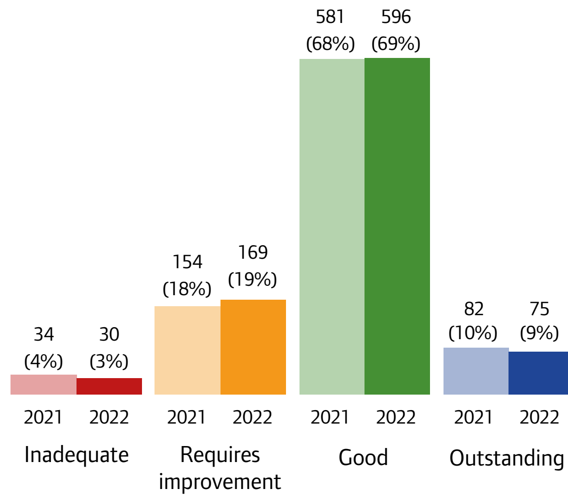


Inadequate · Requires improvement · Good · Outstanding

Source: CCQC ratings data, 31 July 2021 and 31 July 2022

Notes: No locations had 'Insufficient evidence to rate'. Numbers in brackets denotes the number of rated locations.

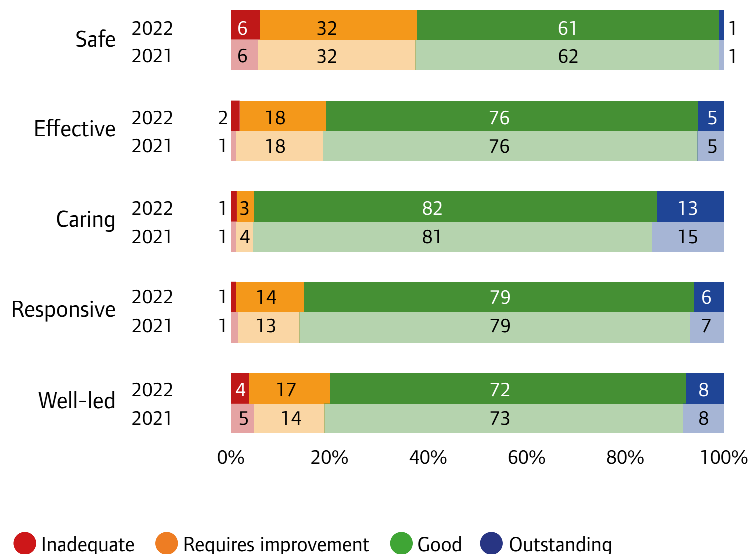
Figure A7
All NHS and independent mental health core services, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 2 'insufficient evidence to rate' overall ratings, which represented 0.2% of the total ratings (including 'insufficient evidence to rate). Percentages may not add to 100 due to rounding.

Figure A8
All NHS and independent mental health core services, key question ratings, 2021 and 2022

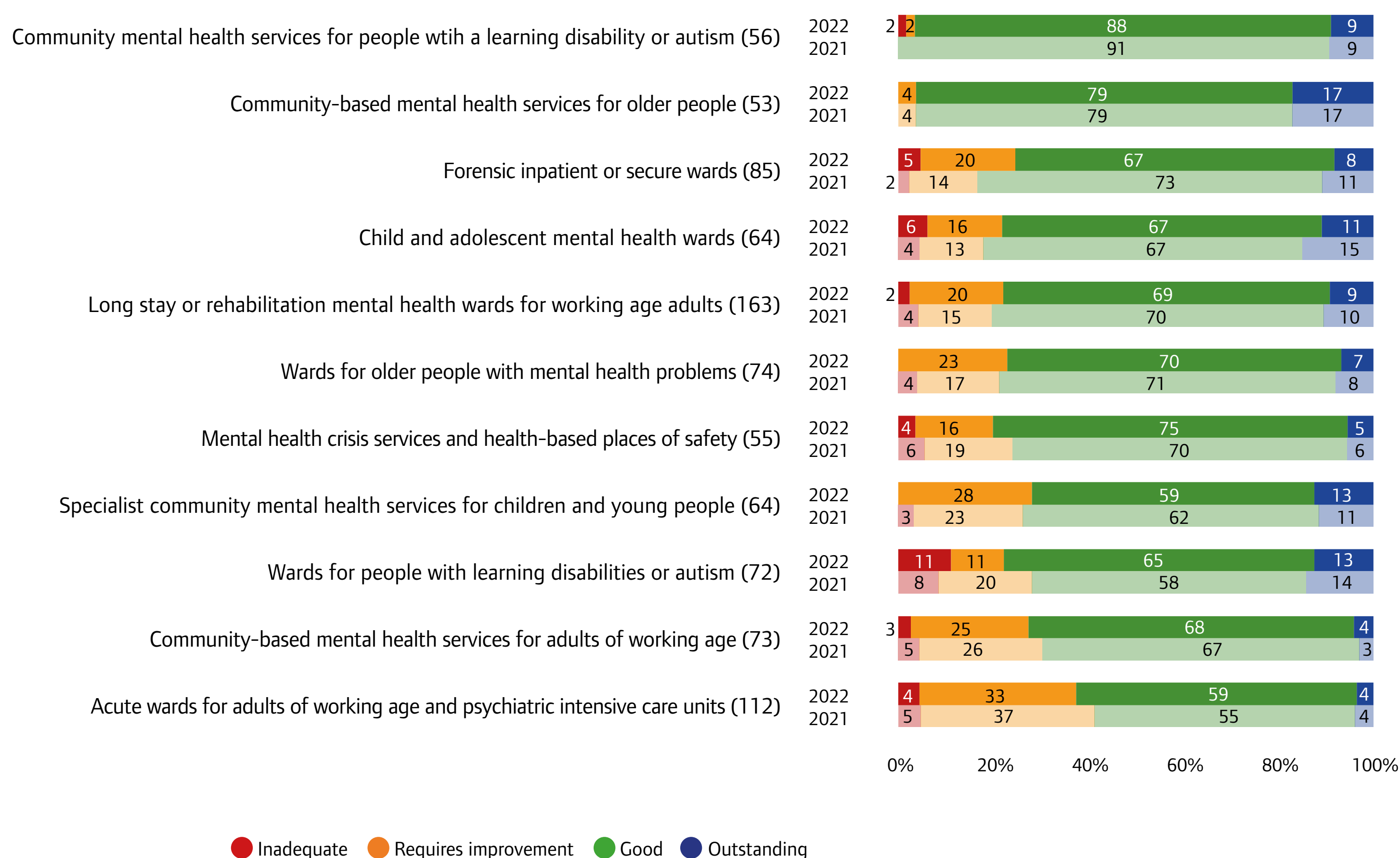


Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.3% for safe, effective and caring, 0.5% for well-led and 0.7% responsive. Percentages may not add to 100 due to rounding.

Figure A9

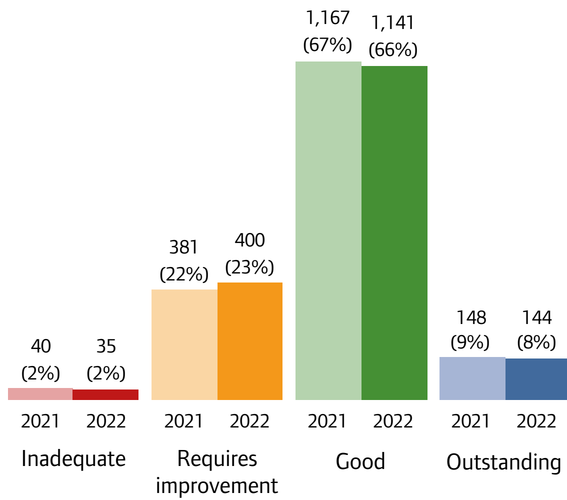
NHS and independent mental health core services, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 2 'insufficient evidence to rate' overall ratings, which (including 'insufficient evidence to rate') represented the following proportions of the total core service ratings: 1% for 'acute wards for adults of working age and psychiatric intensive care units' and 2% for 'community mental health services for people with a learning disability or autism'. Numbers in brackets denotes the number of rated locations. Percentages may not add to 100 due to rounding.

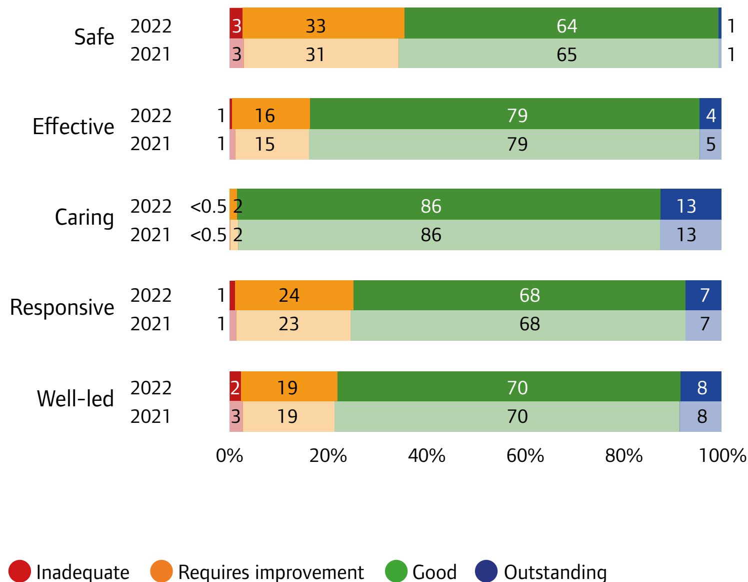
Figure A10
NHS acute core services, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 4 'insufficient evidence to rate' overall ratings, which represented 0.2% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding.

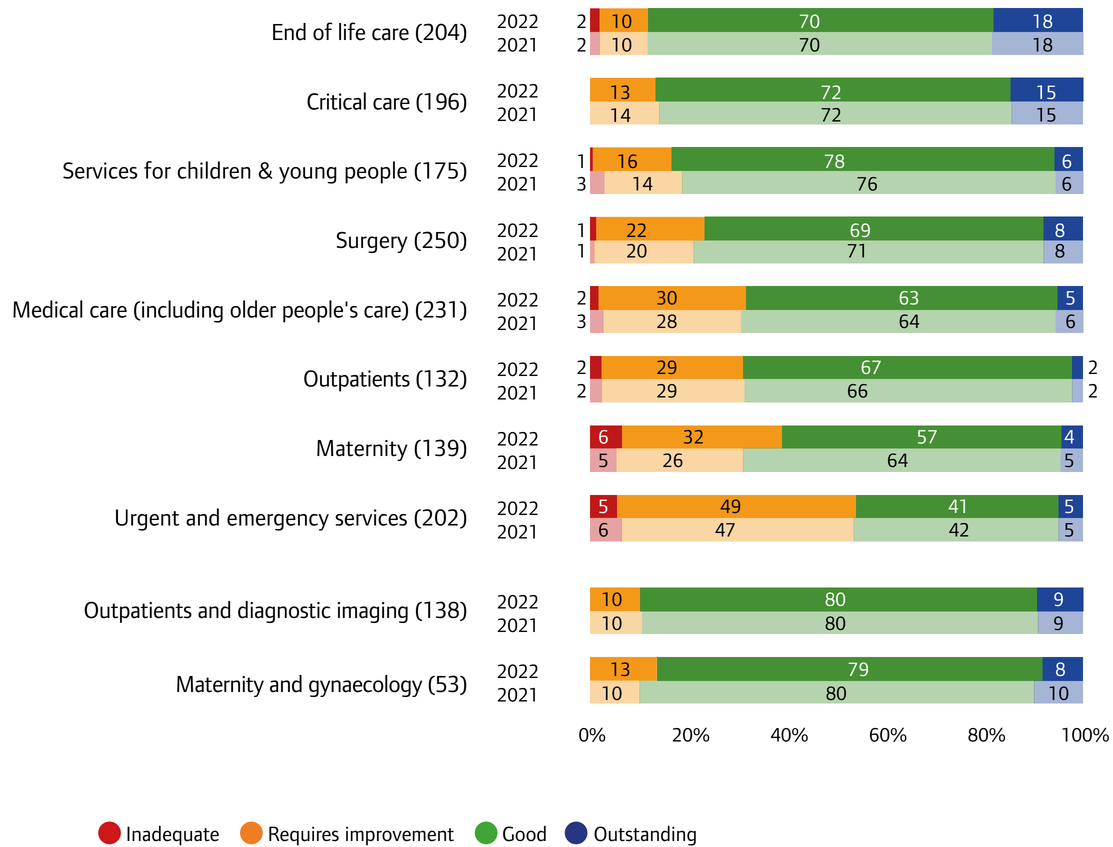
Figure A11
NHS acute core services, key question ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.2% for safe, responsive and well-led, 0.4% for caring and 10.1% for effective. Percentages may not add to 100 due to rounding.

Figure A12
NHS acute core services, overall ratings, 2021 and 2022

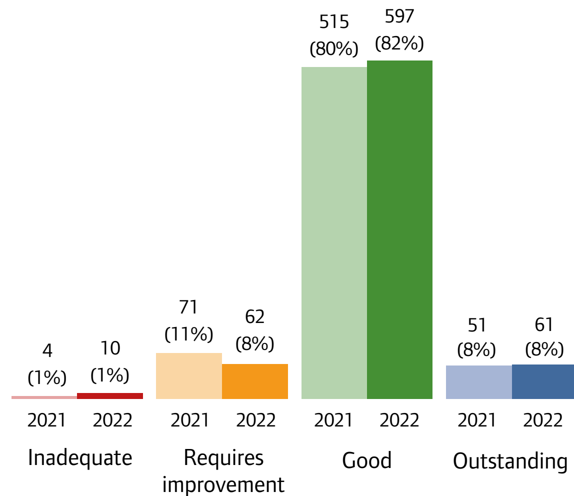


Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 4 'insufficient evidence to rate' overall ratings, which (including 'insufficient evidence to rate') represented the following proportions of the total core service ratings: 0.5% for 'end-of -life care' and 'urgent and emergency services', 1% for 'outpatients and diagnostic imaging' and 2% for 'maternity and gynaecology'. Percentages may not add to 100 due to rounding. Maternity ratings include the latest rating for the maternity, maternity (inpatient services) or maternity (community services) core service.

Figure A13

Independent health acute (non specialist) core services, overall ratings, 2021 and 2022

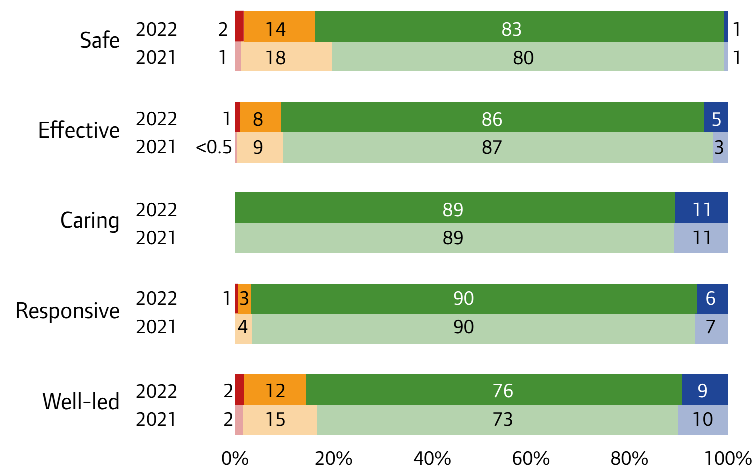


Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 12 'insufficient evidence to rate' overall ratings, which represented 2% of the total ratings (including 'insufficient evidence to rate. Percentages may not add to 100 due to rounding.

Figure A14

Independent health acute (non specialist) core services, key question ratings, 2021 and 2022



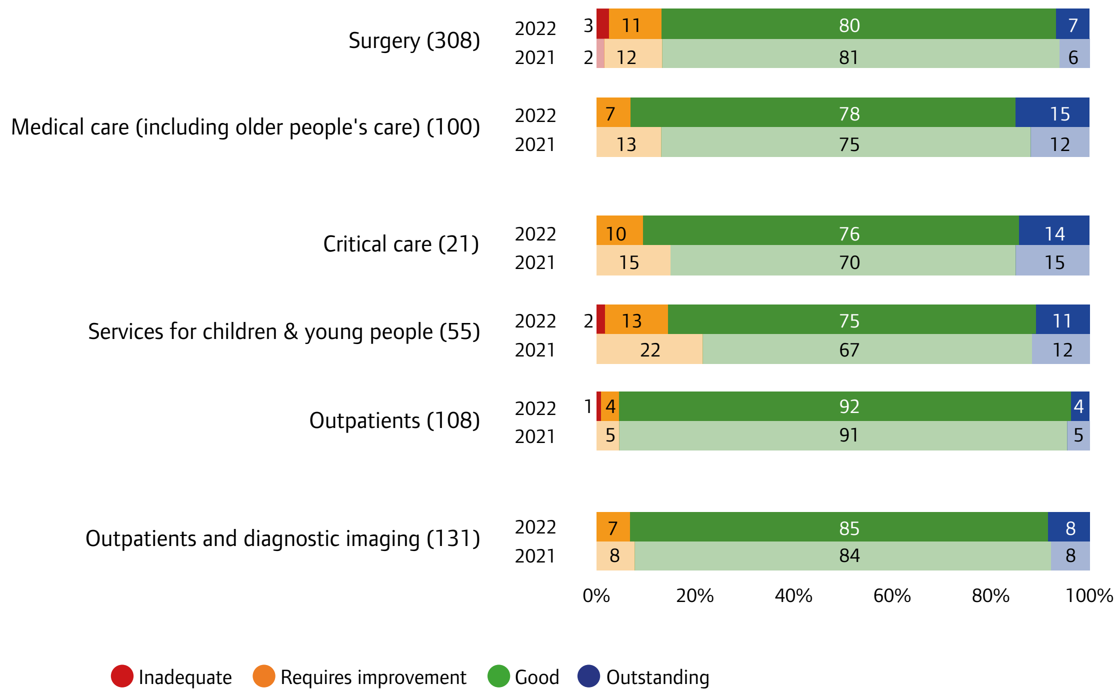
Inadequate   Requires improvement   Good   Outstanding

Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 1% for safe and well-led, 2% for responsive, 6% for caring and 21% for effective. Percentages may not add to 100 due to rounding.

Figure A15

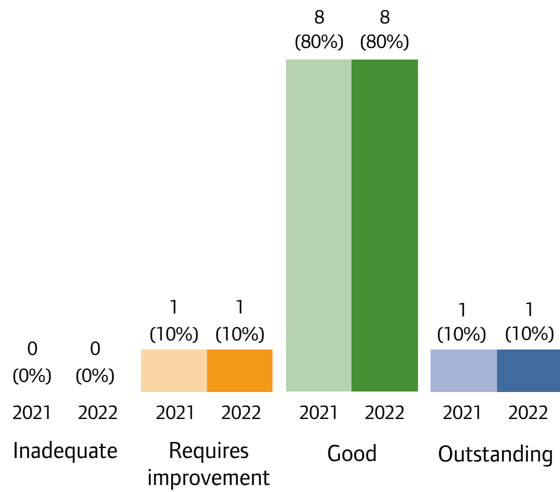
Independent health acute hospital (non specialist), core service ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 12 'insufficient evidence to rate' overall ratings, which (including 'insufficient evidence to rate') represented the following proportions of the total core service ratings: 5% for 'critical care' and 'medical care (including older people's care)', 8% for 'services for children and young people', and 0.3% for 'surgery'. Numbers in brackets denotes the number of rated locations. Percentages may not add to 100 due to rounding.

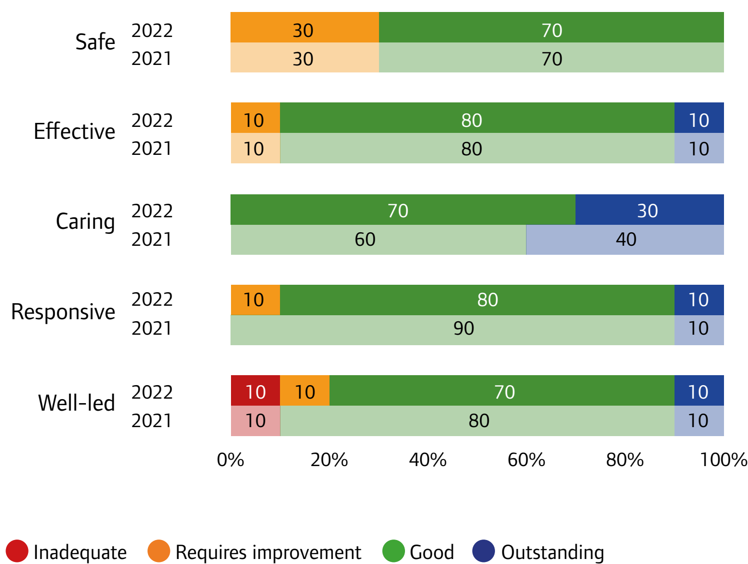
Figure A16
NHS ambulance trusts, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: No locations had 'Insufficient evidence to rate'.

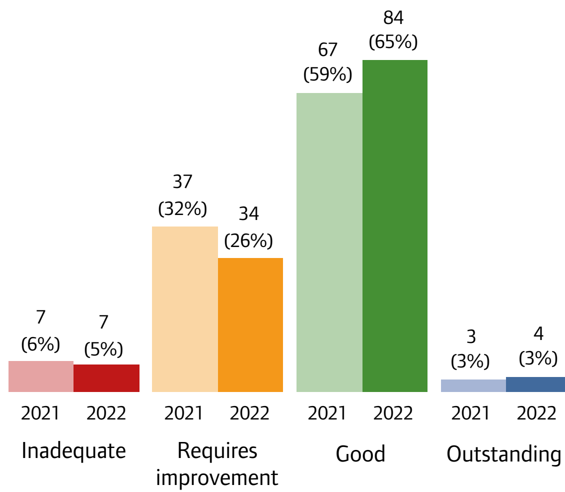
Figure A17
NHS ambulance trusts, key question ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: No locations had 'Insufficient evidence to rate'.

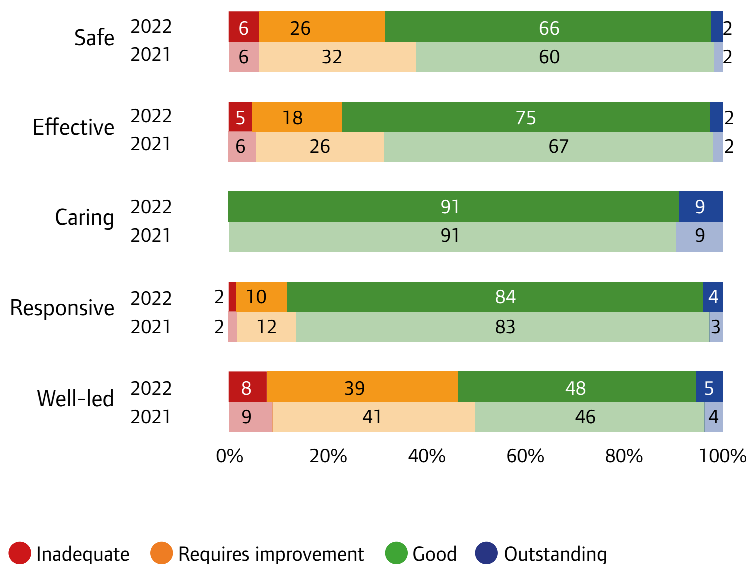
Figure A18
Independent ambulance locations, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 1 'insufficient evidence to rate' overall ratings, which represented 1% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding.

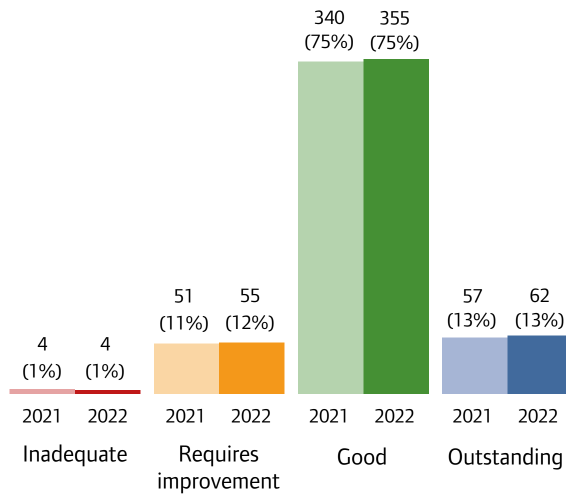
Figure A19
Independent ambulance locations, key question ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 1% for safe and well-led, 2% for responsive, 3% for effective, and 40% for caring. Percentages may not add to 100 due to rounding.

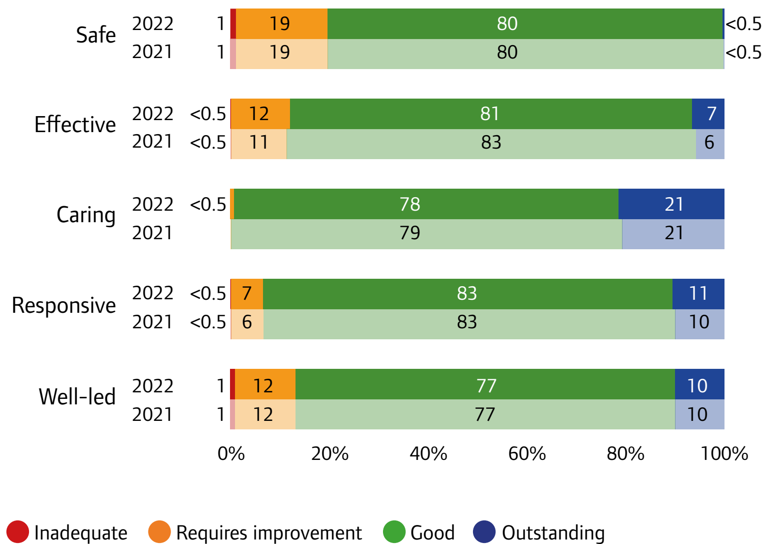
Figure A20
Community health core services in all settings, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2021 ratings also included 6 'insufficient evidence to rate' overall ratings, which represented 0.2% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding.

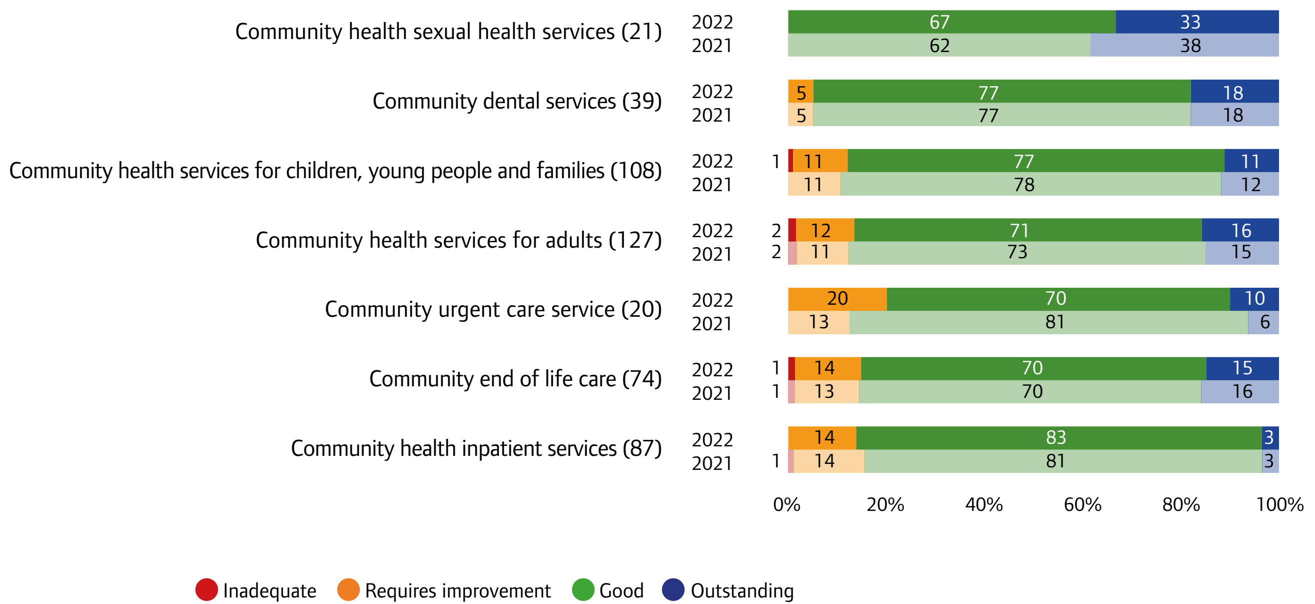
Figure A21
Community health core services in all settings, key question ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.2% for safe, responsive and well-led, and 0.4% for effective and caring. Percentages may not add to 100 due to rounding.

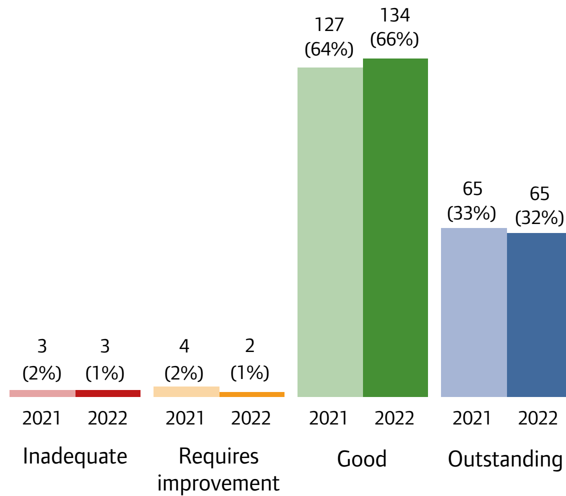
Figure A22
Community health core services, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: The 2022 ratings also included 1 'insufficient evidence to rate' overall ratings, which (including 'insufficient evidence to rate') represented the following proportions of the total core service ratings: 1% for 'community health inpatient services'. Numbers in brackets denotes the number of rated locations. Percentages may not add to 100 due to rounding.

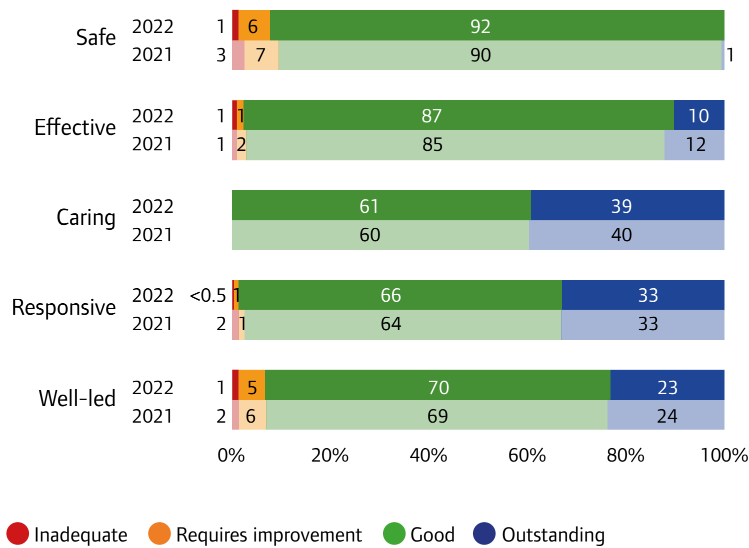
Figure A23
Hospices, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: No locations had 'Insufficient evidence to rate'. Percentages may not add to 100 due to rounding.

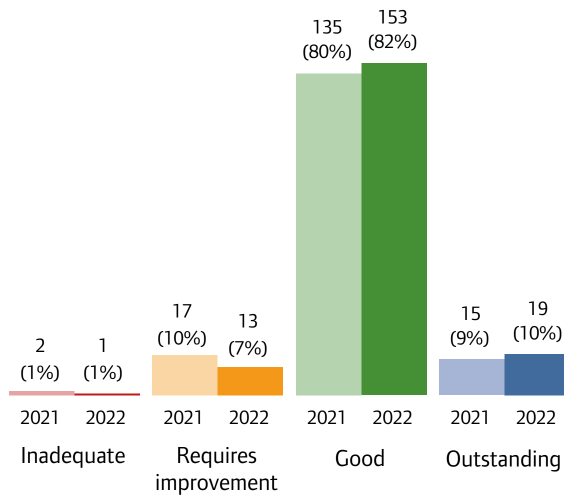
Figure A24
Hospices, key question ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: No locations had 'Insufficient evidence to rate' Percentages may not add to 100 due to rounding.

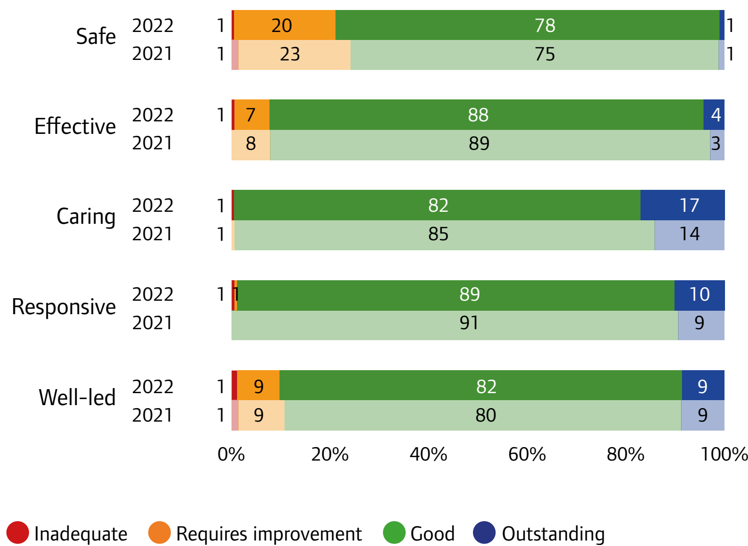
Figure A25
Substance misuse services, overall ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: No locations had 'Insufficient evidence to rate'.

Figure A26
Substance misuse services, key question ratings, 2021 and 2022



Source: CQC ratings data, 31 July 2021 and 31 July 2022

Note: No locations had 'Insufficient evidence to rate'. Percentages may not add to 100 due to rounding.

References

1. The King's Fund, Public satisfaction with the NHS and social care in 2021: Results from the British Social Attitudes survey, March 2022
2. NHS England, GP Patient Survey 2022 National Report, July 2022
3. Care Quality Commission, Community mental health survey 2021, December 2021
4. Care Quality Commission, Adult inpatient survey 2021, September 2021
5. NHS England, NHS Staff Survey 2021 National Results, March 2022
6. The Health Foundation, Integrated care systems: what do they look like?, June 2022
7. NHS England, A&E Attendances and Emergency Admissions, June 2022
8. Association of Ambulance Chief Executives, National Ambulance Data, April 2022
9. Healthwatch, What are people's experiences of urgent and emergency care?, September 2022
10. NHS Confederation, 'NHS making huge progress on long waits, but too many patients stuck in hospital due to capacity crunch in social care', August 2022
11. NHS Confederation, System on a cliff edge: addressing challenges in social care capacity, July 2022
12. Care Quality Commission, Urgent and emergency care system wide inspections, August 2022
13. Care Quality Commission, PEOPLE FIRST, September 2022
14. Ipsos/CQC, 4,000 voices, October 2022
15. NHS England, Consultant-led Referral to Treatment Waiting Times Data 2022-23, July 2022
16. Care Quality Commission, Adult inpatient survey 2021, September 2022
17. British Medical Association, NHS backlog data analysis, August 2022
18. UK Parliament, NHS backlogs and waiting times in England, March 2022
19. Healthwatch, 'Waiting lists are inevitable. It's how we manage them that matters', November 2021
20. Healthwatch, 'We need to focus on inequalities to address NHS waiting list', June 2022
21. UK Government, Build Back Better: Our Plan for Health and Social Care, September 2021
22. NHS England, Delivery plan for tackling the COVID-19 backlog of elective care, February 2022

23. NHS England, ‘NHS marks milestone in recovery plan as longest waits virtually eliminated’, August 2022
24. British Medical Association, NHS backlog data analysis, August 2022
25. The Private Healthcare Information Network, ‘More people self-funding routine operations as NHS waiting lists reach record levels’, October 2021
26. Care Quality Commission, Community mental health survey 2021, December 2021
27. Mind, A million UK adults who had problems with their mental health for the first time during the pandemic have not spoken to anyone about it, February 2022
28. Care Quality Commission, Restraint, segregation and seclusion review: Progress report, March 2022
29. Care Quality Commission, Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic, November 2021
30. Association of Directors of Adult Social Services, Waiting for Care Report, May 2022
31. Age UK, ‘Incoming PM needs to act fast, says Care and Support Alliance, as new analysis finds 2.6m aged 50+ now have some unmet need for social care’, September 2022
32. The King’s Fund and Nuffield Trust, Public satisfaction with the NHS and social care in 2021 Results from the British Social Attitudes Survey, March 2022
33. NHS Digital, Appointments in General Practice, June 2022
34. NHS England, GP Patient Survey 2022 National Report, July 2022
35. NHS Digital, NHS Dental Statistics for England, 2021-22, Annual Report, August 2022
36. NHS England, Hundreds of thousands more dental appointments to help recovery of services, January 2022
37. Association of Dental Groups, England’s Dental Deserts: The urgent need to “level up” access to dentistry, May 2022
38. Healthwatch, Recovery of NHS dental care too slow to help thousands left in pain, December 2021
39. British Dental Association, NHS dentistry at a tipping point, as BBC reveal true extent of access crisis, August 2022
40. Care Quality Commission, Smiling matters: oral health care in care homes, June 2019
41. NHS England, Mental Health Secure Care Programme
42. His Majesty’s Inspectorate of Constabulary and Fire & Rescue Services, A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders, November 2021

43. UK Parliament, Mental health in prison: Government Response to the Committee's Fifth Report, February 2022
44. Home Care Insight, 'Northumbria NHS Trust to establish home care provision and create up to 250 jobs', January 2022
45. Association of Directors of Adult Social Services, Spring Budget Survey 2022, July 2022
46. Skills for Care, The size and structure of the adult social care sector and workforce in England, July 2022
47. Nuffield Trust, 'Invisible crisis in home care unfolding as social care sector loses up to 50,000 staff in lead up to winter months', December 2021
48. Office for National Statistics, Care homes and estimating the self-funding population, England, May 2022
49. Homecare Association, Minimum Price for Homecare 2022-2023, December 2021
50. Association of Directors of Adult Social Services, ADASS Spring Budget Survey 2022, July 2022
51. DHSC, People at the Heart of Care: adult social care reform, December 2021
52. Local Government Association, 'LGA responds to government guidance on the Fair Cost of Care', March 2022
53. Healthwatch England, Championing what matters to you: Healthwatch England Annual Report 2020–21, February 2022
54. British Dental Association, England: Ministers must act on child tooth extractions backlog, May 2022
55. NHS England, GP Patient Survey 2022, July 2022
56. The Health Foundation, Tackling the inverse care law: Analysis of policies to improve general practice in deprived areas since 1990, January 2022
57. British Medical Association, BMA warns of social care crisis as current system is 'deeply flawed' and in need of 'urgent reform', June 2022
58. The Health Foundation, The continuing impact of COVID-19 on health and inequalities, A year on from our COVID-19 impact inquiry, August 2022
59. NHS Race and Health Observatory, Ethnic Inequalities in Healthcare: A Rapid Evidence Review, February 2022
60. Care Quality Commission, Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic, November 2021
61. NHS Digital, Mental Health Act Statistics, Annual Figures 2017-18: Summary Report, October 2021

62. Care Quality Commission, Ethnic minority-led GP practices: impact and experience of CQC regulation, January 2022
63. Healthwatch England, Dentistry during COVID-19 insight briefing, May 2021
64. Healthwatch England, The Accessible Information Standard: Findings from our evidence review, February 2022
65. Healthwatch England, Accessible Information Survey Findings, July 2022
66. Care Quality Commission, Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic, November 2021
67. Care Quality Commission, Safety, equity and engagement in maternity services, September 2021
68. Care Quality Commission, CQC Insight: Issue 15, January 2022
69. NHS Race and Health Observatory, Ethnic Inequalities in Healthcare: A Rapid Evidence Review, February 2022
70. NHS Providers, United against health inequalities: a commitment to lasting change, April 2022
71. Care Quality Commission, The world of health and social care is changing. So are we, May 2021
72. Care Quality Commission, Safety, equity and engagement in maternity services, September 2021
73. Office for National Statistics, Births and infant mortality by ethnicity in England and Wales: 2007 to 2019, May 2021
74. Birthrights, Inquiry into racial injustice in maternity care - Birthrights, May 2022
75. Five X More, The Black Maternity Experiences Report, May 2022
76. NHS Digital, NHS workforce Statistics - May 2022, August 2022
77. Health and Social Care Committee, The safety of maternity services in England, July 2021
78. Department of Health and Social Care, Final report of the Ockenden review, Findings, conclusions and essential actions from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, March 2022
79. Health and Social Care Committee, Workforce: recruitment, training and retention in health and social care, Third Report of Session 2022–23, July 2022
80. Care Quality Commission, Out of sight – who cares?: Restraint, segregation and seclusion review, October 2020
81. Care Quality Commission, Restraint, segregation and seclusion review: Progress report, March 2022

82. House of Lords Library, Community care for people with learning disabilities and/or autism, October 2021
83. Care Quality Commission, Home For Good: Successful community support for people with a learning disability, a mental health need and autistic people, July 2021
84. Care Quality Commission, Right support, right care, right culture: How CQC regulates providers supporting autistic people and people with a learning disability, June 2022
85. Department of Health and Social Care, Building the right support for people with a learning disability and autistic people, July 2022
86. Norfolk Safeguarding Adults Board, Safeguarding Adults Review: Joanna, Jon and Ben, September 2021
87. NHS England, Clive Treacey: Independent Review, December 2021
88. Healthcare Safety Investigation Branch, Medicine omissions in learning disability secure units, June 2022
89. Care Quality Commission, All CQC-registered providers to ensure their staff receive training on interacting with people with a learning disability and autistic people, July 2022
90. Care Quality Commission, The state of health care and adult social care in England 2020/21, October 2021
91. Care Quality Commission, Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic, November 2021
92. NHS England, Children and Young People with an Eating Disorder Waiting Times, August 2022
93. NHS Confederation, Mental healthcare recovery plan urgently needed to tackle 'second pandemic', February 2022
94. Centre for Mental Health, Commission on Young Lives warns that children's mental health services are buckling under pressure post-Covid, July 2022
95. NHS England, NHS boosts children's mental health workforce by 40%, July 2022
96. Care Quality Commission, Restraint, segregation and seclusion review: Progress report, March 2022
97. Children's Commissioner, A Head Start: Early support for children's mental health, July 2022
98. Care Quality Commission, The state of health care and adult social care in England 2020/21, October 2021
99. NHS Digital, Mental Capacity Act 2005, Deprivation of Liberty Safeguards, 2021-22, August 2022
100. Care Quality Commission, Choosing a baby scanning service, October 2022

101. Care Quality Commission, Choosing cosmetic surgery, July 2021
102. Care Quality Commission, COVID-19 Insight 9: Safe and effective use of medicines in NHS trusts, March 2021
103. Care Quality Commission, CQC Insight 14: Medicines safety in NHS trusts, November 2021
104. UK Parliament, Workforce: recruitment, training and retention in health and social care, July 2022
105. NHS Digital, NHS Vacancy Statistics England April 2015 – June 2022 Experimental Statistics, September 2022
106. The King's Fund, Is the NHS on track to recruit 50,000 more nurses?, April 2022
107. NHS Providers, Workforce planning survey 2022, March 2022
108. NHS Confederation, System on a cliff edge: addressing challenges in social care capacity, July 2022
109. Skills for Care, Vacancy information – monthly tracking, July 2022
110. Skills for Care, The size and structure of the adult social care sector and workforce in England, July 2022
111. NHS Digital, General Practice Workforce, June 2022
112. Royal College of General Practitioners, Royal College of General Practitioners survey, June 2022
113. NHS Digital, NHS Dental Statistics for England, 2021-22, Annual Report, August 2022
114. NHS England and NHS Improvement, NHS Staff Survey 2021, March 2022
115. Royal College of Nursing, Staffing for Safe and Effective Care: State of the nation's labour nursing market 2022, February 2022
116. Care Quality Commission, Adult inpatient survey 2021, September 2022
117. NHS Providers, Workforce planning survey 2022, March 2022
118. NIHR Policy Research Unit in Health and Social Care Systems and Commissioning, Eleventh National GP Worklife Survey 2021, April 2022
119. Association of Dental Groups, England's Dental Deserts: The urgent need to "level up" access to dentistry, May 2022
120. Office for National Statistics, Sickness absence in the UK labour market: 2021, April 2022
121. NHS Digital, NHS Sickness Absence Rates Provisional Statistics, April 2022
122. Medical Defence Union, 'Sleep deprived doctors concerned about patient safety', January 2022
123. General Medical Council, National training survey 2022, July 2022

124. NHS Digital, NHS Sickness Absence Rates, January 2022 to March 2022, and Annual Summary 2009 to 2022, Provisional Statistics, July 2022
125. Skills for Care, Average days lost due to sickness – monthly tracking, July 2022
126. NHS England and NHS Improvement, General practice contract arrangements in 2022/23, March 2022
127. NHS England, Workforce Disability Equality Standard: 2021 data analysis report for NHS trusts and foundation trusts, May 2022
128. Skills for Care, The size and structure of the adult social care sector and workforce in England, July 2022
129. Department of Health and Social Care, Our plan for patients, September 2022
130. Care Quality Commission, Local system reviews
131. Care Quality Commission, Provider collaboration reviews
132. Care Quality Commission, Provider collaboration review: Mental health care of children and young people during the COVID-19 pandemic, November 2021
133. The Health Foundation, 'The UK entered the pandemic in a vulnerable position with both systemic weaknesses in the NHS and poor underlying health', November 2021
134. Nuffield Trust, How much is Covid-19 to blame for growing NHS waiting times?, September 2022
135. NHS England, Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter, August 2022
136. NHS England, NHS publishes electives recovery plan to boost capacity and give power to patients, February 2022
137. Care Quality Commission, Provider collaboration reviews
138. UK Government, Social care: Independent report by Baroness Cavendish, February 2022
139. NHS Confederation, The state of integrated care systems 2021/22, February 2022
140. UK Government, Health and social care review: leadership for a collaborative and inclusive future, June 2022
141. Care Quality Commission, State of Care 2020/21, October 2021
142. UK Government, Health and social care review: leadership for a collaborative and inclusive future, June 2022
143. The King's Fund, Integrated care systems and social care: the opportunities and challenges, December 2021
144. NHS Providers, Realising the benefits of provider collaboratives, August 2022

145. Care Quality Commission, Collaboration in urgent and emergency care, March 2021
146. Cornwall and Isles of Scilly Integrated Care System
147. Northumbria Health NHS Foundation Trust, 'Jobs boost as Northumbria Healthcare confirms intention to provide care services', January 2022
148. The King's Fund, Integrated care systems and social care: the opportunities and challenges, December 2021
149. NHS England, Next Steps for integrating primary care: Fuller Stocktake report, May 2022
150. Care Quality Commission, Provider collaboration reviews
151. Care Quality Commission, The world of health and social care is changing. So are we, May 2021
152. Care Quality Commission, Safety, equity and engagement in maternity services, September 2021
153. Care Quality Commission, Provider collaboration reviews

How to contact us

Call us on 03000 616161
Email us at enquiries@cqc.org.uk
Look at our website www.cqc.org.uk

Write to us at
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter @CareQualityComm
#stateofcare

Read the summary and download this report in other formats at www.cqc.org.uk/stateofcare

Please contact us if you would like this report in another language or format.

CQC-478-050-102022

E02803100

978-1-5286-3701-5