

The state of health care and adult social care in England 2020/21



Care Quality Commission

**The state of health care and
adult social care in England
2020/21**

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Foreword

Last year's State of Care was written as the country fearfully anticipated a second wave of COVID-19 infections and deaths. This year, the success of the vaccination programme has given hope that the virus can be contained – but alongside this hope is the recognition that COVID-19 will continue to cast a long shadow over all aspects of everyday life, in particular the health and care system.

The system has not collapsed – but the system is composed of individuals, both those who deliver and receive care, and the toll taken on many of these individuals has been heavy. As we approach winter, the workforce who face the challenges ahead are exhausted and depleted, which has implications for the quality of care. They cannot work any harder – they need support to work differently.

The impact on people who use health and social care services has been damaging: the man whose lung cancer went undiagnosed; the teenage girl whose mental health support was paused; the boy with a learning disability whose mother, also his advocate, wasn't allowed to visit him; the woman who contracted COVID-19 in late pregnancy.

Many of the underlying problems are not new – access to children and young people's mental health services, concerns about closed cultures in services for people with a learning disability or autistic people, and poorer experience and outcomes around childbirth for Black and minority ethnic women are all issues that pre-date COVID. But as we flagged last year, COVID-19 has exacerbated inequalities and continues to do so, meaning that people who were less likely to receive good care before and during the pandemic are in many cases the same groups disproportionately impacted by COVID-19.

People with a learning disability, for example, are significantly more at risk from COVID-19 – but our review of community care for people with a learning disability found that their physical health, including how COVID-19 may present, was not always considered. Our inspections of services for people with a learning disability or autistic people continue to find examples of care so poor that we need to take action to keep people safe.

To help address the multiple challenges faced by the care system, the government has now made a welcome £5.4 billion investment – it must be used to enable new ways of working that recognise the interdependency of all care settings, not just to prop up siloed approaches and plug demand in acute care. The £500 million committed to support the adult social care workforce has never been needed more, with rising vacancy rates as social care providers struggle to attract and retain staff. Monthly data from information submitted to CQC by providers of residential care shows their staff vacancy rate increasing steadily from 6.0% in April 2021 to 10.2% in September 2021. Some care homes whose attempts at recruitment have failed are now having to cancel their registration to provide nursing care, leaving residents looking for new homes in local areas that are already at, or close to, capacity.

If the funding for social care is to have any impact, there must be a sharp focus on developing a clearly defined career pathway for social care staff – linked to training and supported by consistent investment, 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 alternative is that the sector will continue to lose staff to the retail and hospitality industries. This will lead to reduced capacity and choice, and poorer quality care for the people who rely on social care – resulting in a ripple effect across the wider health and care system that risks becoming a tsunami of unmet need across all sectors, with increasing numbers of people unable to access care.

Increased stability in social care is the key not only to unlocking improved access and quality of care for the people who use it, but to easing pressure on the NHS by reducing emergency attendances and delayed discharges. There is short-term funding currently in place to help discharge patients who are no longer in need of hospital care but who may still require care services – this has improved patient flow and has made a crucial difference to the viability of some social care providers.

If this funding were to be committed to for a longer period, care providers could begin to make longer term investments in staffing and buildings to provide much-needed step-down care. They could also build more meaningful relationships with primary, secondary and community care services – as well with third sector organisations and with carers, who have too often been the missing pieces of the jigsaw.

In addition to a commitment to longer-term funding, there is a need for accelerated funding to be made available now to targeted areas that are particularly struggling with demand, in order to urgently increase capacity over winter.

As the number of people seeking emergency care continues to rise, leading to unacceptable waiting times for ambulances and in emergency departments, measures that improve capacity and patient flow are urgently needed. Close working between providers, commissioners and all other parts of the health and care system is essential to safely manage risk through the forthcoming winter.

We have seen some trusts and ambulance services work together to manage attendances at emergency departments in order to ease ambulance handover delays – an issue having significant impact on people’s care – and to free up ambulances and paramedics to go out and care for people in the community. And in primary care, some areas are creating patient access teams to triage, prioritise and assess requests for appointments, home visits and advice, bringing together paramedics, pharmacists, community nurses and third sector partners alongside GPs to ensure people get access to the right care quickly.

We have also heard from trusts about the ways in which they are seeking to address the backlog of people waiting for NHS treatment, from patient-initiated follow-up to virtual outpatient clinics. As waiting lists for investigation and treatment lengthen, ensuring that they are managed well, fairly and safely will be increasingly crucial – closer collaboration with primary care services and third sector organisations will be vital to this.

Ultimately, however, new models for urgent and emergency care are needed in which people receive the care they need where and when they need it and are less likely to be inappropriately funnelled into emergency departments – and where primary care services are able to focus on those with complex co-morbidities, rather than patients who could be better treated in other settings and by other allied health professionals, such as community pharmacists.

In the medium to longer term, integrated care systems must set out plans for how social care and all parts of the health and care system work better together to respond to the needs of their local community. Success will involve making sure people get the right treatment in the right place at the right time, managing activity away from acute services where possible to where people can be better cared for. To make this happen, there needs to be more attention given to relationships and support outside the formal healthcare system, as well as to training and recruitment across all sectors.

Better, more coordinated care for people happens when local services work well as a system. During a series of provider collaboration reviews across England, we looked at how systems worked to understand their local populations and the way they prioritised people's needs. We saw how good collaboration made a difference in helping people access care, even during the pandemic – from the ambulance service who employed pharmacists in their 111 call centre to support prescription requests and keep people out of A&E, to the clinical commissioning group that expanded the provision of chemotherapy at home so that people could continue their treatment plans in a safer environment.

The challenge now is for every system to learn from these examples of innovation to ensure that their local population receives the care it needs, with leaders focused on delivering a transformation in the way that people access and experience care.

The future must be focused on outcomes for people – all people – who need care, supported by transformational changes to workforce, funding, commissioning and oversight. Rather than attempting a return to business as usual, we must grasp this opportunity to build something better – a health and care system that works for everyone.



Ian Trenholm
Chief Executive



Peter Wyman
Chair

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 2020/21.

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. Most of the analysis in this report is generated by CQC and is described in further detail below.

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 our provider collaboration reviews, and our reports on safety, equity and engagement in maternity services and 'do not attempt cardiopulmonary resuscitation' decisions during the pandemic. We have also drawn from our programme of COVID-19 Insight reports, in particular:

- COVID Insight 6: designated settings and care home capacity
- COVID Insight 7: hospital bed occupancy and designated settings
- COVID Insight 9: the impact of the pandemic on urgent and emergency care
- COVID Insight 10: dental access during the pandemic
- COVID Insight 12: infection prevention and control in NHS trusts
- COVID Insight 12: identifying and responding to closed cultures
- COVID Insight 13: recovery of NHS hospital services.

We have collected bespoke qualitative evidence to supplement our findings. Through this work, we have gathered data and insight from our inspection teams on quality issues within particular sectors of health and social care and/or on particular aspects of our monitoring and regulatory approach, for example our monitoring of the Deprivation of Liberty Safeguards.

We have conducted quantitative analysis of our inspection ratings of more than 32,000 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 2021.

This year quantitative analysis of inspection ratings includes information on the proportion of services rated as '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 – 'inadequate', 'requires

improvement', 'good' or 'outstanding'. Charts in our data appendix visualise the proportion of all active services with a current rating of 'inadequate', 'requires improvement', 'good' and 'outstanding'. The proportion of services rated 'insufficient evidence to rate' is provided in a note below the chart where applicable.

This report also provides an analysis of data submitted to CQC by providers in our Market Oversight scheme. This 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.

Our view of quality and safety has also been informed by our routine monitoring approach and engagement with providers, for example information collected through our provider information returns and our notifications data. In this report, we draw specifically on data and insight from our assessments of infection prevention and control in NHS trusts and in care homes, and our work with the Department of Health and Social Care, local authorities and individual care providers to provide assurance of safe and high-quality care in designated settings.

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.

We have used information people have shared with us through our Give Feedback on Care service, phone calls and social media to inform our views. We analysed a sample of 382 submissions received between April 2020 and December 2020 to understand issues related to how people access GP and dental services. The data was analysed to qualitatively explore nuances in the barriers and outcomes that people experience, and how these are interconnected. We have also used our surveys to inform what we say about what people think of the NHS healthcare services that they use.

We have included, in this report, personal stories of accessing and receiving care over the last year. We conducted seven interviews to understand the quality of care that people using services and/or their family members have received from local health and social care services, and the barriers they have faced in getting the care and treatment they need.

This report is informed by our wider horizon scanning activity. We have reviewed reports published by our stakeholders, drawn on national survey findings, and have analysed publicly available datasets to supplement our understanding of the challenges facing health and social care today and the experiences of people using services.

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 Deprivation of Liberty Safeguards.

Analytical findings have been corroborated, and in some cases supplemented, with expert input from our chief inspectors, deputy chief inspectors, 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.



1. People's experiences of care

Key points

- The impact of the pandemic on many who use health and social care services has been intensely damaging. Many people have struggled to get the care they need, and there is also evidence that some people have not sought care and treatment as a result of COVID-19.
- We have previously highlighted the ongoing issues that people from some groups have faced in accessing and receiving high-quality care. Over the last year, the pandemic has further exposed and exacerbated these inequalities.
- People with a learning disability have faced increased challenges as a result of the pandemic.
- The need for mental health care has increased, with children and young people particularly badly affected.
- The strain on carers has intensified. Carers UK estimated in June 2020 that an additional 4.5 million people had become unpaid carers since the pandemic began.
- Health and social care staff are exhausted and the workforce is depleted. People across all professions, and carers and volunteers, have worked tirelessly to help those who needed care. The negative impact of working under this sustained pressure, including anxiety, stress and burnout, cannot be underestimated.
- Despite the widespread disruption caused by the pandemic, surveys have shown that, when people were able to access the care they needed, they were often positive about that care.

Impact of the pandemic

The COVID-19 pandemic has affected the lives of everyone in our society; for some its impact has been devastating.

Tragically, COVID-19 has resulted in the deaths of many people throughout the country. Every instance represents a life lost. And in many cases, the loss of a loved one has been made even harder for the relatives and friends of people in care homes and hospitals who were unable to be as near to them as they would have wished in their final days and weeks, due to COVID-19 restrictions. The emotional toll will also have been felt by the staff who have cared for and supported them, and who in many cases – particularly in adult social care – may have built up a relationship over years.

Both the people delivering care and the people needing and receiving care have had to grapple with the huge impact of the pandemic, and the restrictions needed to minimise the risk of COVID-19 infection. It has affected every aspect of health and care services.

Many people have had to wait longer to get the care they need, and for many these waits go on. The number of people in England waiting to start hospital treatment hit a new high in July 2021 – a total of 5.6 million. There were almost 300,000 people waiting more than 52 weeks to begin treatment.¹

Many of these people are waiting, often in pain, for hip and knee replacements and for other operations. Without the surgery they need, many people can be left unable to work or carry out everyday activities.

The number of people having long waits in ambulances at hospital emergency departments, due to pressures within the hospital, has been exceptionally high. In a survey of UK emergency departments in August 2021 by the Royal College of Emergency Medicine, half of respondents said they had been forced to hold patients outside in ambulances every day.² We reported in March 2021 how hospitals were trying hard to avoid overcrowding and maintain social distancing within the hospital, but this had had a knock-on effect on ambulance handover.³ An ambulance is not a suitable place for a patient to be waiting for treatment or waiting for a place on a ward to be found.

The pandemic has taken a toll on the health and wellbeing of older people. In July 2021, Age UK reported that 25% of all older people (around 4.0 million) were living with more physical pain since the start of the pandemic; 22% of older people (around 3.2 million) found it harder to remember things; 17% of older people (around 2.7 million) agreed they were less steady on their feet; and 36% of older people (around 5.8 million) said that they felt more anxious.⁴

In the same month, the Association of Directors of Adult Social Services released their Spring Survey 2021, reporting that almost 75,000 older and younger disabled people were waiting for assessments for care and support, with social care struggling to cope with people's needs arising from the pandemic. Furthermore, they reported that just under 160,000 people were waiting for annual care reviews, which are vital for each person who is waiting for care, support or safeguards.⁵

In feedback shared through our Give Feedback on Care service between April and December 2020, we have heard of people's frustrations about trying to access their GP practices. People told us that new systems to triage requests have been cumbersome and phone lines have seemed blocked. Some have told us they felt they had to advocate for themselves to get access to the care they were seeking, for instance chasing up referral requests, prescription requests or discussing with a receptionist why they need an appointment. At times people have felt their concerns or symptoms were not being taken seriously. Among those people who did see a GP, some told us that they could not see their preferred professional or were not offered a face-to-face appointment.

Many care providers have turned to a more remote or digital model of care, often by telephone or sometimes using online/video, as a way of continuing to keep services running or available. This has undoubtedly been beneficial for many people, particularly for those who would otherwise struggle to visit a service in person, those for whom travelling to an in-person appointment creates extra health anxiety, and those who value the flexibility, for example if they just need a quick check-in or update with their care professional.

But remote care has not worked for everyone. In June 2021, Healthwatch published research exploring how and why certain groups are more likely to experience digital exclusion – including older people, disabled people, families on low incomes, and those whose first language isn't English. They found that there can be various reasons for digital exclusion, including digital skill level, affordability of technology, disabilities and language barriers. Not knowing how to seek alternatives to remote booking systems and appointments can also make people more reliant on families and carers, impact the quality of care they receive or impact their ability to access services altogether.⁶

In their 2021 report on the importance of choice in remote mental health services, Mind highlighted that, for many, mental health services providing help and support by phone or online has been a lifeline – but also that for some it made their mental health worse.⁷

An awful consequence of the pandemic, particularly during its height, has been the separation of families and carers from their loved ones. Whether this has been partners being restricted from regular visiting in care homes or family members being unable to sit with their relatives in hospital, the way it has affected people – through increased worry, stress and loneliness – has been deeply felt. Although the measures that have caused this separation were introduced to keep people safe, this does not reduce the impact on people's wellbeing – both for those using health and care services as well as those who love and care for them.

The pandemic has also impacted how and when people may decide to access the care they need. There is some evidence that some people have not sought care and treatment due to fear of infection or out of a desire not to burden the health and social care system.

Findings from the 2021 GP patient survey (based on fieldwork conducted between January and March 2021) showed that 52% of people who had responded to the survey had had an appointment in the previous six months – this was down from around 70% in 2020.⁸

In adult social care, we have heard how feelings of uncertainty, anxiety and fear over safety, as well as restrictions on visiting, may have led to families choosing not to send relatives into care homes or take up home-care services. This means that people need to rely more on family and friends. Carers UK have reported how unpaid carers have increased the amount of care they have given loved ones – by October 2020, 81% of unpaid carers said that they were providing more care since the start of the pandemic.⁹

Some people were afraid to visit clinical settings for their cancer care because of COVID-19. Some people continued their care but without the various support groups they normally relied on for emotional wellbeing. Families were often unable to be with people who were having cancer treatments. We heard that families struggled when they were not able to support each other during these difficult times.

However, despite the widespread disruption and challenges caused by the pandemic, surveys have shown that, when people were able to access the care they needed, they were often positive about that care.

In the 2021 GP patient survey, a high proportion of people continued to say that they had a good experience of their GP practice: 83% in 2021, similar to the results across the previous three years. Satisfaction rates for appointment times were improved: 67% compared with 63% in 2020. Nearly nine in 10 respondents to the survey said their healthcare professional was good at listening to them (89%), giving them enough time (89%), and treating them with care and concern (88%).

Findings from the 2020 urgent and emergency care survey (based on feedback from people who attended a type 1 or type 3 service in September 2020) showed that a third of people (33%) who had attended a type 1 department (a major emergency department) and 44% of people who had visited a type 3 department (typically a minor injury unit or walk-in centre) said their overall experience was ‘very good’, rating it 10 out of 10 – an increase from 2018, when the survey was last carried out. Seventy-five per cent of those who responded to the 2020 adult inpatient survey rated their experience positively (based on feedback from people who received care in November 2020).¹⁰

Most people surveyed in both the urgent and emergency care and adult inpatient surveys had positive interactions with hospital staff, including doctors and nurses. Across both surveys, the majority of patients reported that they had trust and confidence in the doctors and nurses involved in their care and were treated with dignity and respect.

Health inequalities further exposed

We have previously highlighted the ongoing issues that people from particular groups face in accessing and receiving high-quality care.¹¹

Over the last year, the pandemic has both further exposed and exacerbated these inequalities.¹² Public Health England data shows that inequalities in COVID-19 case rates became evident early in the pandemic and persisted. At the end of June 2021, cumulative age-standardised case rates were higher in more deprived areas than less deprived ones, and highest among people from the Asian ethnic group – particularly people from the Pakistani and Bangladeshi groups.¹³

At the end of May 2021, the cumulative age-standardised mortality rate in the most deprived areas in England was 2.4 times the rate in the least deprived areas. The mortality rates in people from the Black and Asian groups were more than double the rate in people from the White group.

This inequality in terms of ethnicity also applied to health and care staff. The Health and Social Care Select Committee reported on workforce burnout and resilience in the NHS and social care, and heard evidence that staff from Black and minority ethnic backgrounds were disproportionately affected by COVID-19 compared with staff from White backgrounds, in relation to both deaths and other work-related challenges.¹⁴ In April 2020, BMJ reported findings that two-thirds of healthcare workers who had died from COVID-19 were from a minority ethnic background.¹⁵ The NHS Staff Survey 2020 found that 47% of staff that reported working on a COVID-specific ward were from Black and minority ethnic backgrounds, while 31% were White. Among those staff who reported working from home, 29% were from Black and minority ethnic backgrounds, while 38% were White.¹⁶

Feedback in the urgent and emergency care and adult inpatient surveys show that some differences in patients' experiences of hospital treatment have endured. People with dementia or Alzheimer's disease, and those with mental health conditions, continued to report consistently poorer experiences of acute care when admitted to hospital. Those with pre-existing mental health issues also had poorer experiences across the board when using emergency departments. These differences have been found in previous acute patient surveys and cover many areas that are essential to good patient experience: being treated with dignity and respect, having confidence and trust in doctors and nurses, being given appropriate emotional reassurance, and being able to access help when needed while in hospital.

Over the last year, we have been looking at how local systems are working together to address inequalities, as part of our provider collaboration reviews.¹⁷ Most systems had some understanding that inequalities in health and social care existed in their areas before the pandemic, as well as how they had worsened or changed due to the pandemic.

But tackling inequalities was often not a main priority for systems, or strategies to identify and tackle health inequalities were not yet well established.

Issues included poor accessibility of information and guidance in different languages during the pandemic for some people, variation in service provision and access to services, and a lack of understanding of how people's individual characteristics affected the care they needed – for example, the specific needs of people with a learning disability from Black and minority ethnic groups.

The pandemic has led to an increase in remote or digital care in many sectors. While this has worked for some people, our provider collaboration reviews highlighted how this could prevent some people from accessing the care and support they needed because they did not have access to or feel comfortable using digital technology.

Inequalities have also been exposed through the vaccination programme. As at 31 August 2021, NHS England vaccination data showed that the percentage of people vaccinated in the 18 and over, and 50 and over age categories was lower among all minority ethnic groups compared with the White-British and White-Irish population.¹⁸

Vaccine confidence and uptake among Black ethnic groups has also been recognised as a particular concern.¹⁹ As at 31 August 2021, among those aged 50 and over, people from Black ethnic groups had the lowest vaccination rates in England, with 68% of Black or Black British-Caribbean, 74% of Black or Black British-African, and 71% of Black or Black British-Any other Black background having received at least one dose. This is compared with 96% of people from the White-British group.²⁰ As highlighted by the King's Fund, lower vaccine uptake among Black and minority ethnic groups could further perpetuate health inequalities.²¹

Variances in vaccine uptake have also been seen in relation to levels of deprivation. Public Health England reported that, at the end of June 2021, 95% of those living in the least deprived areas had received both doses compared with 87% in the most deprived areas.²²

Providers and representatives from the voluntary and community sector have told us that recovery needs to focus on addressing health inequalities, particularly those that were amplified by the pandemic. However, there were some concerns that a focus on waiting list backlogs for elective care will put the emphasis on clearing these at pace, instead of on where the need is greatest.

Increased challenges for people with a learning disability

In our learning disability provider collaboration review (PCR), we looked in depth at the care and support for people with a learning disability living in the community.²³

Many of the issues that emerged from our review are not new. In a lot of cases, the pandemic simply served to shine a light on the pre-existing challenges, gaps and poor-quality care.

But it also posed increased risks. For example, we know that people with a learning disability have an increased risk of respiratory illnesses and a higher prevalence of asthma, among other health concerns. Among other factors, these can make them more vulnerable to COVID-19.

Figures published during the pandemic suggested that, between January 2020 and 20 November 2020, the risk of death involving COVID-19 for people with a learning disability was greater for both men and women even when adjusting for a range of personal and household characteristics.²⁴ Between 10 April 2020 and 31 March 2021, we identified notifications of the deaths of at least 1,633 people with a learning disability or autistic people, from services identified as caring for people with a learning disability or autistic people. This was 3% higher than the 1,581 deaths notified in the comparable period in 2019/20. Of these 1,633 people, 486 were identified by the provider as deaths involving either suspected or confirmed COVID-19.²⁵

In our PCR, we found that the physical healthcare needs of people, including how COVID-19 may present in people with a learning disability, were not always taken in account by systems.

Some systems we looked at had a clear plan for the delivery of services for people with a learning disability and had made changes in response to the pandemic. But people still faced difficulties in accessing services – including day services, education placements, respite care and health services (GPs, dental, mental health). This caused people distress and, in some cases, led to a deterioration in people's health. It also led to some people expressing their distress in ways that affected others living with them. For example, we heard that the loss of routine due to school and respite care being stopped caused distress for one child, and this led to them expressing this in way that others found difficult. The child's parent also believed that the disruption caused their epilepsy to become less well controlled, and meant the child needed hospital treatment.

Research from the University of Bristol, which looked at the deaths of 206 people with a learning disability from COVID-19 between March and June 2020, also found that access to care could be problematic. In particular, their report highlighted issues around the responsiveness of NHS 111, access to COVID-19 tests, and access to specialist learning disability nurses.²⁶

In our learning disability PCR, we also found issues with care planning and transition planning between child and adult services for people with a learning disability. In the majority of areas, we heard that either it was not present or it was weak. Some areas told us that there were no existing transition planning pathways. Not planning and coordinating the care of people with a learning disability when moving between child and adult services can mean that they do not always get the right care and support that meets their needs. As we recommended in our 2020 report 'Out of sight – who cares', there needs to be a clear focus on support during transition periods between services and from childhood to adulthood.²⁷

Not only did COVID-19 serve to highlight these issues, but the pandemic had made transitions even harder because of a lack of effective assessments and not being able to meet new providers and care organisations. Organisations across local areas need to work together to ensure that transition planning is made a priority for improvement.

Despite these challenges, people with a learning disability generally felt well informed about the pandemic and why they could not see friends and family,

and how to stay safe. A range of communication techniques and strategies, such as easy reads, had been used to help keep people informed and reduce anxieties.

To try and prevent or minimise disruption to services, providers and voluntary sector organisations increasingly turned to digital technology. This improved collaboration between services, and gave people with a learning disability who had access to digital devices, and the skills to use them, access a broader range of activities, social groups and educational tools and resources.

However, not everyone had access to or felt comfortable using digital technology. Some people with a learning disability were able to adapt to virtual communication methods, but others could not. It also made it more difficult for health and social care professionals to pick up subtle clues about mental health and wellbeing, and led to increased safeguarding concerns.

Providers and systems will need to understand and manage the impact of the pandemic on people with a learning disability, including children and young people, and the long-term effects of service disruption. This includes ensuring that any health inequalities and specific needs relating to protected characteristics such as ethnicity, age and gender are part of a system-wide strategy. In line with recommendation two in the 2020 annual report of the Learning Disabilities Mortalities Review (LeDeR) programme, systems need to act to reduce disparities and ensure that people are able to remain in their communities and lead their best lives.²⁸

We are carrying out a year-long programme of work to transform the way we regulate services for people with a learning disability and autistic people. Following the recommendations of the independent review by Professor Glynis Murphy and from our report, *Out of sight – who cares?*, we have improved our inspection methodology to focus on the culture of services and on identifying where people living in hospitals and care services may be at a greater risk of poor quality of life.²⁹

Where services have a good culture and staff are engaged, we have seen people leading their best lives. However, we have found:

- that getting the right staff with the right skills has become increasingly difficult during the pandemic, resulting in people's needs not always being well met by staff who respect and value them
- cultures where restrictive practice is frequently used – people are observed and followed rather than interacted with and given opportunities to develop skills and a meaningful life
- that some people have become stuck in services and not able to move on to a community place
- some people moving into care services during the pandemic without good planning and support, which has stopped them settling in – this is distressing for them and disruptive to others

- fewer face-to-face visits from families, commissioners, professionals and providers has made it more difficult to identify when closed cultures could be developing
- that quality assurance systems, which check that good care happens around the clock, supported by every member of staff, have never been more important.

Closed culture put people at risk of abuse

When people moved into the service, there had been a lack of assessment to consider the adaptations needed to meet their needs. When people became distressed this was reflected in their behaviour, but the registered manager failed to re-assess the environment.

There was a negative closed culture at the service, which placed people at risk of psychological abuse. Two people had no curtains in their bedrooms. This infringed on people's dignity.

Staff used negative derogatory language when speaking with or describing people. People were told their behaviours were 'silly' and incident reports stated people were 'whinging' and 'having paddies'.

Restrictions had been placed on people that were not the least restrictive option and had not been reviewed. The kitchen door had a lock on it, which meant people were unable to access the kitchen freely.

Incident reports detailed that people were told to stay in their rooms until 'calm' following and during incidents. The registered manager had not considered if this was the least restrictive action.

There had been a complete lack of oversight and governance from the registered manager and the provider.

Rising demand for mental health care

The impact of the pandemic on people's mental health is well recognised. The Centre for Mental Health has estimated that up to 10 million people, including 1.5 million children, are likely to need new or additional mental health support as a direct result of the crisis.³⁰

Over the last year, Mind and Rethink Mental Illness have reported an increase in demand for their services.^{31,32} For example, in the 12 months since the first national lockdown was announced, Rethink reported a 175% increase in demand for advice and information on their website.

But the pandemic has not affected everyone equally, with some people more at risk of developing mental health problems due to their social and economic circumstances. Research published by the Mental Health Foundation in July 2020 highlighted that among those disproportionately affected by COVID-19 were young adults, older people, people with pre-existing mental health problems, people with long-term conditions, single parents, transgender

people, those unemployed or in insecure employment, those from Black and minority ethnic backgrounds, and women.³³

Through our Give Feedback on Care service between April and December 2020, we heard that when some people sought help for their mental health from primary care services, they reported issues including feeling ignored by the GP or not having their symptoms taken seriously. People with mental health needs also felt that they could not get a referral to a specialist from their GP because of a lack of capacity in community mental health services.

Not being able to access the right care and support when it is needed increases the risk of individuals' mental health deteriorating. This is a long-standing challenge, which has been exacerbated by the increased demand on mental health services due to COVID-19.

Our inspection teams have raised concerns about people being admitted to mental health services with more severe mental ill-health. They have also told us about people presenting in emergency departments and acute trusts struggling to find appropriate places for them due to a lack of suitable provision.

Through our provider collaboration reviews, we have heard of many examples where systems and providers have recognised the increasing demand and put in place adaptations to meet this need. For example, to reduce attendance at emergency departments, we heard of pathways being redesigned so that people with acute mental health needs were diverted to a more appropriate setting. Front door screening at hospitals aimed to ensure that people were either directed to the right place in the building or were directed to a different service or a different place. Systems also told us about new phonelines that had been set up during the pandemic, including 24/7 mental health crisis lines, to improve access. However, our inspectors have expressed concern that solutions put in place to address challenges with support and access would disappear after the pandemic has subsided, even though the issues remain.

As with other areas of health care, we saw that the increased use of digital technology had a positive impact for some people. This included for example, the use of online mental wellbeing apps. Video calling was also beneficial for some people as it made it easier for people, for example those with chaotic lifestyles, to keep scheduled appointments. However, the use of digital technology was not accessible or suitable for everyone, and excluded some, with the importance of face-to-face appointments still recognised.

A long wait for mental health care

After around nine months of experiencing anxiety and depression, while she was extremely apprehensive about seeking help and was unclear where to seek it from, Meira eventually made the decision to seek advice from her GP. Meira's GP suggested that she self-refer to IAPT (Improving Access to Psychological Therapies), as they believed this would be the quickest route. Following her self-referral, Meira waited around four months to be contacted.

At this point, Meira received a telephone triage call from an IAPT consultant who advised her that it would be more appropriate if she sought support from a psychologist and would need to go back to her GP to be referred. Meira was extremely frustrated at this point and disheartened to have waited so long, while still struggling with anxiety and depression.

Meira's GP referred her to a psychologist at her local mental health clinic. Her first appointment, which was face-to-face, went well until she was told she would need to wait several more months to receive the psychological support she needed. This wait ended up being over six months, during which there were no check-in calls, either by her GP or by the mental health clinic. This left her feeling hopeless and desperate.

Meira began 'talking therapy' in the autumn of 2020, which was virtual due to the pandemic. She found this extremely odd given the deeply personal, sensitive and private information she was divulging over a computer screen. Meira felt that, although the virtual appointments gave her the flexibility to access support without depending on public transport or others to drive her, being able to meet the therapist in person would have been more comfortable, and she would have liked the option to choose.

Meira found that communication deteriorated during the pandemic, as she was having to check that individual appointments had been made, report instances of not receiving booking confirmations, and highlight invalid or broken virtual links to therapy sessions.

Meira would like to have seen the GP and the psychologist communicating with each other to allow the latter to understand her journey with treatment and medication as she waited for therapy.

Interview with a member of the public

Children's and young people's mental health

During the pandemic, there has been a significant increase in concerns around children and young people's emotional wellbeing and mental health. As part of our programme of provider collaboration reviews, we have been looking at how systems have responded to the challenges of the pandemic to provide mental health care and support for children and young people. Many of our

initial findings align with the section that follows, and we will be publishing the full findings of our review in November 2021.

In February 2021, Young Minds published a survey of almost 2,500 young people aged 13 to 25 with a history of mental health needs, conducted during a period of national lockdown in early 2021. This demonstrated the devastating impact of the pandemic on many young people, with some respondents reporting that they had started self-harming again, were having panic attacks or suicidal thoughts, or were losing motivation to carry out basic tasks or to look after themselves. Of the young people who responded, 67% believed that the pandemic would have a long-term negative effect on their mental health.³⁴

This is supported by data from Childline. From 1 April 2020 to 31 March 2021, the service carried out 73,088 counselling sessions about mental or emotional health. More than 5,500 of these sessions were with children aged 11 or younger, an increase of nearly a third (29%) compared with the year before.³⁵

A review of emerging evidence conducted by the Centre for Mental Health in early 2021 highlighted the unequal effects of COVID-19 on young Black men. It found that across many key areas the disparities faced by young Black men are widening including mental health, educational outcomes and employment prospects.³⁶

As a result, it is unsurprising that there has been a significant increase in demand for children and young people's mental health services.³⁷ In a short pulse survey of 35 mental health trust leaders conducted by NHS Providers in May 2021, all respondents said that the demand their trust or local system was experiencing for children and young people's services was significantly or moderately increasing compared with six months previously.³⁸

The same survey showed that the majority of trust leaders were concerned about their trust or local system's ability to meet the level of anticipated demand for children and young people's mental health care in the next 12 to 18 months.

Our inspectors have had a particular concern about demand for children and young people's eating disorder services. This was supported by a May 2021 report from the All Party Parliamentary Group on eating disorders, which highlighted that, since 2015/16, eating disorder services had received far more referrals than had originally been expected and commissioned.³⁹ Similarly, in the May 2021 NHS Providers survey there is evidence that a significant proportion of mental trust leaders are concerned about meeting this demand.

The impact of the pandemic has exacerbated these concerns. In September 2020, Beat, the UK's eating disorder charity, reported that the pandemic has had an unprecedented impact on those affected by an eating disorder. It reported that demand for its helpline services had increased by 97% in the previous six months compared with the same period last year.⁴⁰ This is supported by the NHS Confederation August 2021 report 'Reaching the tipping point', which showed that the number of young people completing an urgent pathway for eating disorders had increased by 141% between quarter four in 2019/20 and quarter one in 2021/22.⁴¹

‘A little boy stuck in the middle’

Kate has three children, including Sam who is nine years old. He is severely dyslexic and his mental health is currently poor.

Kate tried to get a self-referral to child and adolescent mental health services (CAMHS) for Sam for his low mood, low self-esteem and self-harming by biting himself. CAMHS responded that Sam did not meet the threshold of need.

Kate paid privately for an educational psychologist to assess Sam, who recommended that she apply for Sam to attend a specialist school, as mainstream school had been linked to his trauma. The local authority turned this down at application and at a further tribunal. Sam has subsequently been home schooled for the last 21 months.

Kate re-approached her GP because Sam wasn't sleeping and was suffering with night terrors. Kate's GP helped her complete a self-referral form again to CAMHS. The response from CAMHS was that there were too many children with a greater need and the waiting lists are too long.

Kate is exhausted, and says the experience has affected her mental health. She feels that responsibilities just keep getting passed on to different people, which means that "there is a little boy stuck in the middle not getting the help he needs".

Interview with a member of the public

Generally, problems for children and young people were compounded by the closure of schools during the pandemic, which play an important role in the early identification and support of children and young people with mental health needs.

Between September 2020 and April 2021, Mind conducted research into the experiences of young people affected by mental health problems at secondary school.⁴² This found that young people couldn't get support when they needed it or received inadequate support that did not meet their needs. The report highlighted that secondary schools struggle, with minimal resources and over-stretched staff, to support young people with behaviour that is resulting from their mental health. Our forthcoming provider collaboration review report will point to some examples of good collaborative working with schools and mental health support teams by local health and care systems.

Problems with accessing child and adolescent mental health services (CAMHS) are not new, but have been made worse by the pandemic.⁴³ Our children's services team reported that a national shortage of specialist inpatient beds had led to a number of children and young people being inappropriately admitted to general paediatric wards or adult wards for prolonged periods of time. Not only does this have an impact on the ability of services to meet the needs of the children and young people who are inappropriately placed, but we have also heard how staff feel traumatised if they have to restrain very distressed young people when this is not their area of practice.

Because of the challenges with securing CAMHS beds, in our learning disability provider collaboration review we heard that learning disability and mental health teams supporting children and young people in one area had tried to address this by offering more intensive home support. This had highlighted the importance of earlier intervention at home, and the positive impact that avoiding inpatient care could have for the child or young person.⁴⁴

In terms of children's access to health care generally, our children's services team have highlighted how reductions in access to services during the pandemic meant that routine developmental checks may have been missed or delayed, therefore reducing opportunities to provide early intervention. Children's health staff were often redeployed to support COVID-19 functions, with a knock-on effect on access to treatment.

Our children's services team also noted that the reduction in face-to-face contacts and the increase in virtual working led to children and young people being less visible to health services. They have heard concerns about levels of safeguarding referrals regarding non-accidental injuries.

Increased strain on carers

Many people rely on family, friends and other unpaid carers for care and support, and for when they need help to access health and care services.

Carers UK estimated in June 2020 that an additional 4.5 million people had become unpaid carers since the pandemic began, bringing the total to 13.6 million. They said that 2.8 million people who had started caring since the outbreak were also juggling paid work and care.⁴⁵

Research published over the last year has highlighted several challenges faced by carers. These challenges are not new but have been intensified by the pandemic.

In a May 2020 survey conducted by Carers UK, the top three challenges most frequently highlighted by unpaid carers were: managing stress and responsibility (71%); negative impacts on their physical and mental health (70%); and not being able to take time away from caring (66%).⁴⁶ Surveys carried out by Healthwatch branches during the early months of the pandemic also highlighted negative impacts on carers' family life and relationships, employment, and finances.⁴⁷

But there are also new challenges. Research has highlighted that carers faced issues accessing basic food and medicines during the pandemic. They also experienced fear of infection – due to both the risk of catching COVID-19 and passing it on, and not being able to continue their caring duties. Some carers also faced difficulties in being able to explain lockdown measures, when the people that they cared for had a lack of understanding of the pandemic and its restrictions. Carers have also shared experiences of feeling isolated and lonely, and unsupported and undervalued through the pandemic.⁴⁸

For children and young people with complex care needs, some parents and carers had to provide extra care to their children without the professional support and expertise they were used to. We heard of the strain this placed on families and the children and young people themselves.

Healthwatch and Carers UK have called for recognition of the role and contribution of carers from government, asking for action on funding, services and policies, as well as help to ensure carers receive adequate breaks.⁴⁹ Another key recommendation from these organisations was better signposting and clear communication about available services and support. There is also a call from Carers UK for increased carer's allowance and help so carers can balance jobs and caring responsibilities, including paid carer's leave and support for longer periods of unpaid leave.⁵⁰

A carer's experience during lockdown

Leah cares for her mother who has dementia. She says the challenges for her include the number of daily tasks and lack of support, coping with the lack of comprehension that her mum has about the pandemic, and the impact on her own mental health.

"We're not getting any external support. We have tried but we have been told that as a family we are doing a great job – I feel like we are victims of our own success. We have thought about getting carers, but mum doesn't settle with new people in the house... caring, while being rewarding, takes its toll in lots of different ways. It's had a massive impact on all our lives."

Source: Healthwatch

Workforce stress and burnout

Since our last State of Care report in October 2020, health and social care services have been under greater strain than ever as the country has continued to experience the effects of the COVID-19 pandemic. People across all professions, and carers and volunteers, have worked tirelessly to help those who needed care.

The impact of working under this sustained pressure cannot be underestimated. A wide range of stakeholders and organisations have highlighted the negative effects on health and social care workers, including anxiety, stress, exhaustion and burnout.⁵¹

In June 2021, a report by the Samaritans identified healthcare workers as one of five groups whose suicide risk may be exacerbated as a result of the pandemic. The report described how healthcare workers have struggled with feelings of anxiety, trauma and mental fatigue from their work during the pandemic, alongside the impact of being surrounded by serious illness and death at unprecedented levels, while often struggling for support and resources.⁵²

The British Medical Association reported that 41% of doctors who responded to their COVID tracker survey in February 2021 said they were suffering from depression, anxiety or another mental health condition, which had worsened since the start of the pandemic; and that 59% said their current level of fatigue or exhaustion had been higher than normal during the crisis.⁵³

The June 2021 report from the House of Commons Health and Social Care Committee concluded that burnout is a widespread reality in today's NHS. It highlighted the negative consequences this has for the mental health of individual staff, impacting on their colleagues and the people they care for, and identified chronic excessive workload as a key driver. It also highlighted that many adult social care staff had the additional emotional strain of taking the place of the family and loved ones who could not visit care settings.⁵⁴

Staff sickness rates were up in adult social care last year – pre-pandemic sickness rates for adult social care staff were 2.6%, whereas these almost doubled to 5% between March 2020 and June 2021.⁵⁵

The NHS workforce has been displaced for significant periods over the past year. The NHS Staff Survey 2020 reported that 10% of staff had been shielding – either for themselves or members of their households – while 19% were redeployed, especially among acute and community NHS trusts. More than a third (34%) of NHS staff had worked on COVID-19 wards at some stage, and 36% had been required to work remotely/from home.⁵⁶

Many people took on additional roles voluntarily during the pandemic – for example, covering COVID-19 vaccination centres on their days off. While admirable, there are potential negative impacts on staff wellbeing to consider.

The crisis has also brought to light and exacerbated longstanding problems, including excessive work pressures and staffing challenges. For example, our inspectors have described how responding to the pandemic, and the increased focus on providing care to people at home, placed pressures on the community health workforce, which was already experiencing challenges with staff recruitment and retention.

Through our provider collaboration reviews we heard about initiatives to support the mental health and wellbeing of staff during the pandemic.

These included:

- dedicated wellbeing spaces that provide a calming environment for staff
- informal catch up calls and team meetings such as 'sharing cuppas' and one-to-ones with a wellbeing focus
- access to professional help such as employee assistance programmes and counselling
- mental health trusts facilitating access to counselling or other psychological therapies for NHS colleagues.

The House of Commons Health and Social Care Committee report welcomed the additional support given to health and social care staff during the pandemic, but highlighted the need to maintain this going forward. This included embedding a culture where staff are explicitly given permission and time away from work to seek help when it is needed. Feedback from our engagement with voluntary and community sector organisations similarly highlighted the importance of continuing to provide increased support to staff as services recover from the pandemic.



2. Flexibility to respond to the pandemic

Key points

- After the initial prioritisation of urgent care, there was a gradual push to bring systems back in line with pre-pandemic levels. Of the NHS acute areas we examined (cancer, cardiovascular, A&E and mental health services), cancer services have achieved the best response and recovery.
- The NHS was able to expand its critical care capacity to respond to the needs of the patient population at a time of crisis, although it put extra pressure on staff and other types of care and treatment.
- We have serious concerns about ambulance handover delays at hospitals, which puts the safety of patients at risk
- The 'discharge to assess' model for managing transfers of care has helped to support services in both health and social care. It has been a good step towards helping people after they leave hospital, although there needs to be greater consistency in how it is implemented.
- The vital role of adult social care was made clear during the pandemic, but urgent action is needed to tackle staffing issues and the increased pressures and stresses caused by staff shortages.
- GP practices had to rapidly move to a more remote model of care in the pandemic – this was welcomed by many people needing GP care, but it did not benefit everyone and some struggled to get the appointments they wanted.
- Access to NHS dental care was an issue since before COVID-19, and there are clear signs that this has been compounded by the pandemic.

Critical care expansion

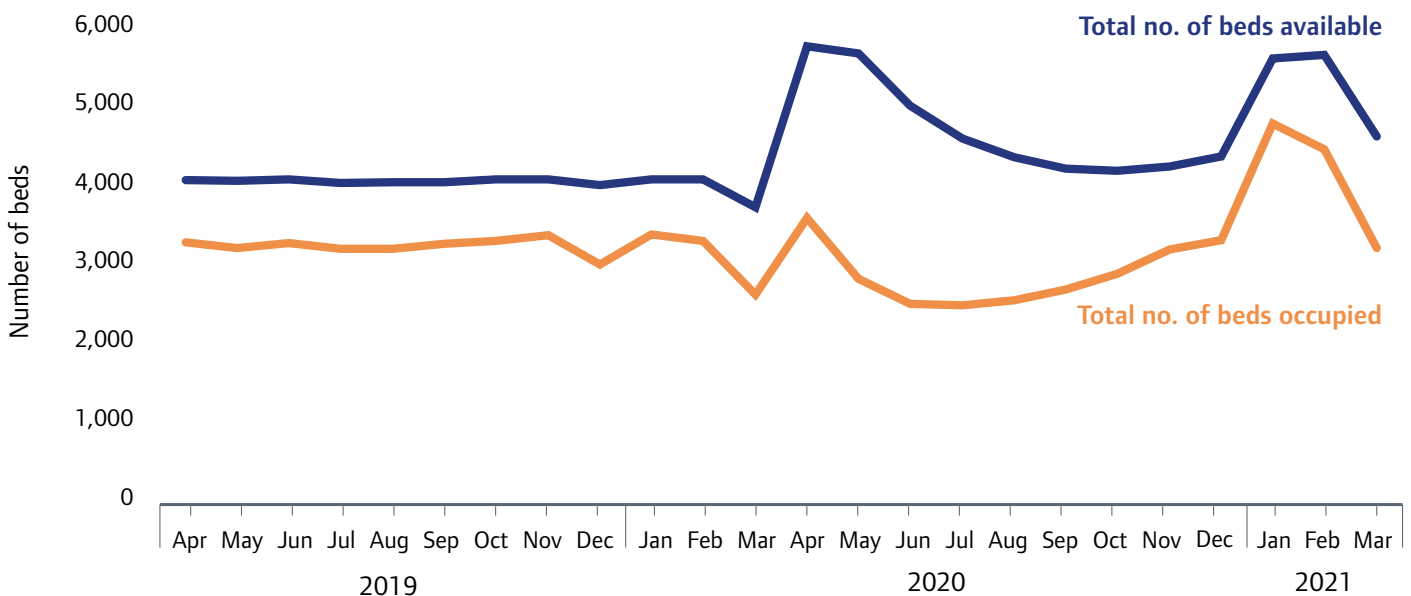
The COVID-19 pandemic has highlighted the need to be able to respond appropriately to the increase in demand for critical care services across NHS trusts.

Adult critical care was affected the most by the pandemic compared with, for example, bed occupancy in neonatal and paediatric intensive care, which remained relatively unchanged. NHS providers carried out a huge and rapid exercise to repurpose both clinical environments and staff to rapidly increase critical care capacity. This added pressure on staff and had an impact on elective treatment, as shown in the section below on NHS acute capacity.

Between April 2019 and February 2020, critical care bed capacity in NHS trusts remained steady at just over 4,000 beds available, with an average occupancy of around 3,300 beds (figure 1). By April 2020, capacity had rapidly increased. The total number of beds available peaked at 5,814 in April 2020, as the total number of beds occupied also rose.

In January 2021, when infection rates were high, occupancy reached its highest levels, with an average of 4,837 beds occupied. This exceeded the average number of beds available before April 2020, indicating the increased requirement for critical care support at this time. It also shows the NHS's ability to expand its critical care capacity to respond to needs of the patient population at a time of crisis.

Figure 1: Adult critical care bed availability and occupancy in NHS trusts, England, April 2019 to March 2021



Source: NHS England, Monthly sitreps 2019-2020, 2020-2021. Note: The collection of critical care bed data was suspended during March 2020 and resumed in April 2020.

NHS acute capacity

In last year's State of Care, we highlighted the reduction in healthcare activity at the beginning of the pandemic, citing a fall of 69% in the number of new referrals to treatment between February and April 2020.⁵⁷

As at July 2021, there were a total of 5.6 million people waiting for treatment (incomplete referral to treatment pathways).⁵⁸ Five per cent of these had been waiting for more than a year. The Institute for Fiscal Studies, in its most optimistic scenario has projected that the number of people on NHS waiting lists will jump to nine million in 2022, returning to pre-pandemic levels by 2025. In its worst case scenario, it would jump to 14 million in 2022.⁵⁹

The management of waiting lists and prioritisation will be key as we move into recovery. For those experiencing delayed care, there is a need to provide interim support.

Many acute services have addressed the challenge of care provision during the pandemic by increasing the use of digital technology and telephone appointments to meet demand. For example, between April and September 2020, the proportion of face-to-face child and adolescent mental health (CAMHS) appointments fell from 74% to 30% of all appointments when compared with 2019 (545,000 fewer appointments). Whereas the proportion of CAMHS telemedicine webcam appointments increased from less than 1% to 9% of all appointments (276,125 additional), and CAMHS telephone appointments increased from 22% to 54% of all appointments compared with 2019 (636,135 additional).⁶⁰

After the initial prioritisation of urgent care, there was a gradual push to bring systems back in line with pre-pandemic levels and in meeting the NHS Long Term Plan goals.⁶¹ Of the four NHS acute areas we analysed (cancer, cardiovascular, A&E and mental health) in the year following the start of the pandemic (February 2020 to March 2021), cancer services have achieved the best response and recovery, generally closing the gap in access on pre-pandemic levels more so than any others, though this still leaves a large backlog.

Maintaining cancer care through the pandemic

Rose's son Billy, aged 6, was diagnosed with Hodgkin Lymphoma in November 2020, having been referred by their GP after finding a lump on his neck.

As soon as they got the diagnosis, Billy was assigned a MacMillan nurse who was amazing throughout, and always got back to Rose by email, phone or WhatsApp. She was always there to support Rose and help her access the different support that she and her family needed.

Rose commented that the department where Billy received his care was so slick and well organised, especially when compared with other departments in the hospital she'd dealt with. She felt comfortable that the hospital was sterile, as it was being cleaned constantly. The only issue was that, initially, the hospital wouldn't let both parents in, but Rose wanted her partner at certain appointments so they could make joint decisions about Billy's treatment.

Rose never felt rushed during appointments with the oncologist. Billy was always involved in his care. He was there when the oncologist gave his parents the diagnosis, and always ensured they talk to Billy, even though he did not understand the severity of his illness. Generally, communication from the hospital was very good, and they kept the GP up-to-date on all treatment.

Billy was given access to toys, video games and snacks while he was using inpatient services – this was all he needed to be happy!

Rose's access to the hospital-based psychologist was excellent. She thought that the ward had their own team, which was why there was no delays in accessing them. She asked for about five appointments, which were carried out as video calls – this meant she could be at home rather than having to commute into town. Rose thinks this could be a good option for people even after the pandemic.

Due to restrictions, only Rose could be with Billy to stay over or be with him, which was tough. Apart from that she would not have known she was in the middle of a pandemic. She feels so lucky to have access to that hospital.

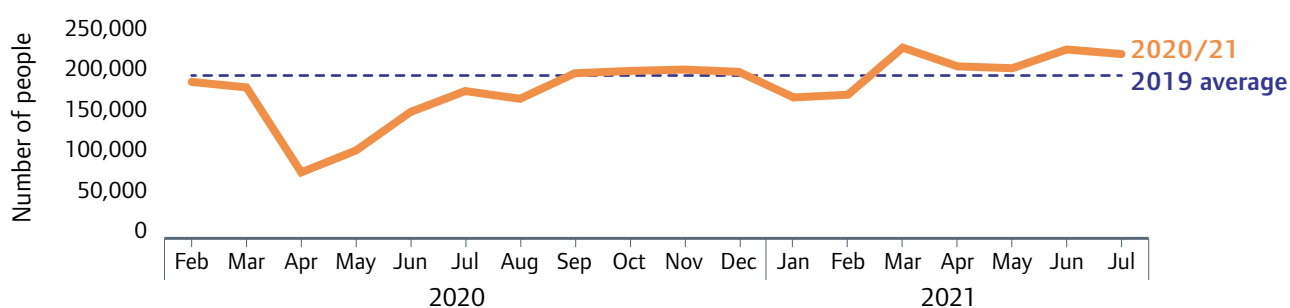
Interview with a member of the public

Even before the pandemic, cancer services were struggling to meet demand. At the beginning, additional stresses from lockdown measures and redeployment of resources towards COVID-19 care caused widespread disruption to the cancer care pathway. In the first month of the pandemic, between March and April 2020, the number of people seen by a specialist following an urgent referral dropped from 183,603 to 80,031 (57% reduction) (figure 2).

Between April and September 2020, this number recovered from 80,031 to 201,013. Despite this recovery, between March and September 2020 there was a total of 335,555 fewer people seen by a specialist following an urgent referral from a GP in 2020 compared with 2019.

In autumn and winter 2020, cancer service capacity was once again affected, although the impact appeared to be far less apparent than at the beginning of the pandemic, possibly indicating learning and better preparedness. There were still 19,553 fewer patients seen following an urgent referral between November 2020 and February 2021 than between November 2019 to February 2020. However, it is encouraging to see that the number of people seen since February 2021 is now above the 2019 average.

Figure 2: Total number of first consultant appointments following an urgent cancer referral, England, 2020/21 compared with 2019 average



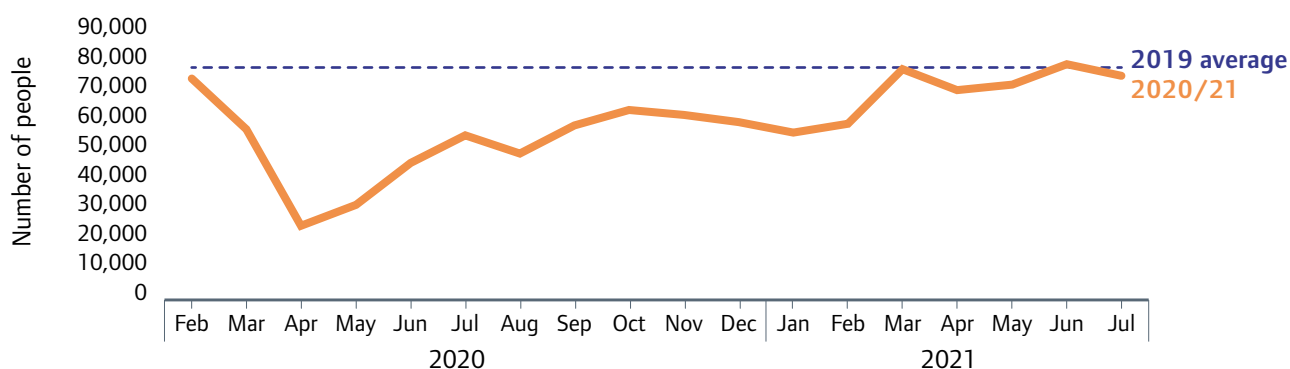
Source: NHS England, monthly cancer waiting times.

The impact on cancer referrals appearing to be smaller in the autumn and winter 2020 compared with the start of the pandemic is also reflected in cancer treatment. However, this is not seen so clearly in other acute services, such as cardiovascular services.

In the first month, between March and April 2020, the total number of new pathways, following referral-to-treatment, for cardiology fell from 56,471 to 24,597 (figure 3) and echocardiographic waiting lists increased by more than 11,000 (a 30% increase).

Although new pathways showed some signs of recovery from April 2020, capacity is yet to consistently match pre-pandemic levels. This contributed to a growing backlog of people waiting to, or not starting, treatment; in total there were 194,180 fewer new pathways initiated in cardiology between April and September 2020, compared with the same period in 2019 (a 41% reduction).

Figure 3: New cardiology pathways initiated, England, 2020/21 compared with 2019 average



Source: NHS England, consultant-led referral to treatment waiting times.

Ambulance handovers

Our inspectors have reported ongoing challenges around ambulance handover delays at emergency departments, which has raised concerns about patient safety.

Once it arrives at a hospital, an ambulance is not a suitable place for a patient to receive treatment or wait to be admitted. Furthermore, a parked ambulance is not available to attend other emergencies and ambulance crews are sometimes unable to end their shift because they can't leave the patient.

In a survey of UK emergency department clinical leads, conducted in August 2021 by the Royal College of Emergency Medicine, half of respondents said their emergency department had been forced to hold patients outside in ambulances every day. This compared with just over a quarter in October 2020 and less than a fifth in March 2020.⁶²

In our March 2021 COVID-19 insight report, we looked at the first five of 13 inspections of hospital emergency departments that took place between 30 November and 21 December 2020, and how they had responded to the challenges of COVID-19 during the winter period.⁶³

Most of the departments were not queuing or cohorting patients in corridors to avoid overcrowding and maintain social distancing during the pandemic. However, this had a knock-on effect on ambulances. Patients were being held in ambulances, either awaiting treatment or until a place on a ward could be found.

The implementation of rapid assessment and treatment (RAT) systems was helping to address problems in some departments. However, progress was slow in one case, with just under half of patients not meeting the hospital's 15-minute handover target in December 2020. At another hospital there were long ambulance handover delays where medical and nursing staff were not able to ensure patients waiting in the ambulances always received timely clinical intervention. The delays also had an impact on ambulance crews' wellbeing and their ability to respond to other patients in the community.

At all the hospitals inspected, inspectors found that the wider capacity of the hospital was a factor on delays in the emergency department. Hospitals wards were operating routinely at capacity, often having been reconfigured themselves to allow for the social distancing and streaming requirements of the pandemic, and this was affecting patient flow. We heard about delays in ambulance turnaround times, with patients were being held in ambulances due to capacity issues in the emergency department and the wider hospital.

Some hospitals had oversight of the risks and these were well managed. However, at other hospitals there was no clear governance structure in place and risks were not effectively managed.

“Managers were able to describe the three biggest risks to the department. However, the team did not include recurring delayed handovers of patients from ambulance crews as one of their biggest risks. Although they were aware of the issue, they did not appear to take ownership of the risk or have a system to mitigate it.”

Extract from inspection report

Some of the hospitals were demonstrating good partnership working with ambulance trusts. Emergency department staff worked with hospital ambulance liaison officers (HALOs) to support patient flow. Ambulance crews could pre-alert departments to the arrival of certain conditions and be greeted by HALOs to divert patients for speedy treatment. They attended hospital meetings to support good communication and could oversee patients in corridors during busy times so ambulances could be released.

Discharging patients

Discharge to assess

The ‘discharge to assess’ model for managing transfers of care, also known as ‘home first’ or ‘step down’, was introduced in NHS trusts in England in 2016. It aims to discharge patients from hospital as soon as they no longer need acute care but who may still need care services – providing them with short-term, funded support in their own home or another community setting during a period of recovery and reablement. Assessment for longer-term care and support needs is then carried out in the most appropriate setting and at the right time for the person.

Our 2018 report, *Beyond barriers*, noted that discharge to assess pathways were well established and understood by staff across health and social care, but that capacity and coordination issues could mean that people who were discharged home did not receive an assessment quickly enough, which caused distress and risk of harm.⁶⁴

At the start of the pandemic, in March 2020, the government's COVID-19 Hospital Discharge Service Requirement guidance required acute and community hospitals to discharge all patients as soon as it was clinically safe to do so, expecting to free up to at least 15,000 beds.⁶⁵

In October 2020, Healthwatch England, working with the British Red Cross, reported their findings from a survey of more than 500 patients and carers with experience of hospital discharge between March and August 2020, as well as interviews with staff members from the health and social care sector.⁶⁶

There were several positive findings from this work, including how discharge to assess encouraged better collaboration and information sharing between services. The national discharge fund provided by the government helped to cover some of the cost of post-discharge recovery and support services, rehabilitation and reablement care following discharge from hospital. We have also heard that discharge to assess has given the financially vulnerable adult social care sector some more security.

However, the report highlighted some concerning factors from the first six months of the pandemic; 82% of respondents did not have their recovery and longer-term support needs assessed in the community at a follow-up visit, and nearly one in five of these (18%) reported having unmet needs. Worryingly, 45% of people with a disability and 20% of people with a long-term condition said they had support needs that were not being met following their discharge.

Healthwatch have highlighted some positive examples that have benefited patients following discharge. For example, a project was commissioned to check in with recently discharged patients to check they had the support they needed and signpost and help them where necessary. This resulting Healthwatch report showed that the project not only made the experience better for patients but could also prevent emergency re-admissions because they were able to identify problems and act earlier.⁶⁷

A survey carried out by Carers UK in March 2021 found that over half (56%) of carers providing significant care said they were not involved in decisions about discharge from hospital and what care and treatment the person they cared for needed.⁶⁸

In the 2020 adult inpatient survey, patients were also not always clear about what would happen next in their care after leaving hospital. Almost a third of patients did not receive any written information about what they should or should not do after leaving hospital. Twenty-three per cent of respondents did not feel involved in the decisions around their hospital discharge, and 21% did not receive enough support to help them recover or manage their condition.⁶⁹

The Department of Health and Social Care has recently published updated guidance that emphasises how the discharge to assess model can support more people to be discharged to their own home and improve joint working across the health and social care sectors.⁷⁰

Designated settings

As set out in its adult social care winter plan in Autumn 2020, the government committed to deliver with CQC a scheme for designating settings for people who were discharged from hospital with a COVID-positive test and who would be moving or going back into a care home setting.⁷¹

The government asked local authorities to speak to local care providers and find suitable locations for people to be safely discharged to. Once these were identified, we assessed each location with an infection prevention and control inspection and a specific focus on a service's ability to zone COVID-19 positive residents, and care for them with a dedicated workforce and high levels of ventilation.

In addition to these locations, some local authorities agreed with local NHS partners to make use of 'alternative' NHS settings to fulfil the role of a designated setting.

In the early stages of the process, some local authorities were putting services forward that did not meet the agreed criteria, which included being able to physically separate people who were discharged from hospital with a COVID-positive test and having a dedicated workforce in place. In a number of cases, the service did not know that they had been put forward. Once these issues had been addressed, the process ran well.

In December 2020, in our COVID-19 Insight report, we looked at numbers of assured settings across regions set against potential demand. This showed some variation. For example, the lowest figure of designated beds per 100 care home beds was in the South East (0.19) and the highest figure was in London (1.00).⁷²

We followed this in the next month with an article looking at how the increase in hospital occupancy, resulting from the emergence of the alpha variant of COVID-19, which saw infection rates rise dramatically, compared with the potential capacity of beds in designated settings and alternative arrangements in each region of England.⁷³

Again, we saw variation. For example, the South West region had the lowest rate of designated beds per 100,000 people aged 65 and over than any other region, but also the lowest regional occupancy of hospital beds by COVID-19 positive patients. In contrast, the South East had the second lowest rate of designated beds, but their COVID-19 bed occupancy level was in the top three in the country.

Conversations our inspectors had during early April 2021 with providers of designated settings gave some insights into discharge arrangements, as well as the general running of the services.

Providers spoke of effective coordination and clear procedures between different agencies to ensure smooth transition to and from the designated setting, including the clinical commissioning group, local authority, hospital teams and social workers. However, where there were issues, these included people being discharged when they were still ill, requiring re-admission to hospital, or being discharged from hospital with the wrong or missing medicines.

Providers were generally positive about the establishment and running of the designated settings scheme. Although demand was initially high at the peak of winter, many designated settings experienced lower demand as the number of COVID-19 patients fell.

Some sites reported that they never ran at full capacity, with one provider saying that they had had no new referrals since February 2021. By the end of March 2021, designated settings were starting to switch off due to falling demand.

Infection prevention and control

Infection prevention and control (IPC) is an essential part of safety in care settings. It became even more important during the COVID-19 pandemic in protecting people using services and staff by preventing the spread of infection.

Our IPC inspections of care homes and hospitals were able to shed a light on some of the challenges faced by services, but also share good practice.

Care homes

In November 2020, we published a report on how care homes managed infection prevention (IPC) and control during the coronavirus pandemic, based on a programme of 440 care home inspections in August and September 2020 that looked at assurance across eight questions.⁷⁴

Across these inspections, most providers demonstrated that they had faced the challenges of the pandemic well, with assurance in all eight questions for nearly two-thirds of care homes (65%).

Since our report, we have continued to inspect, using information we gather about services, including feedback from staff or people using services and their families, to make sure that people receive appropriate and personalised care, while being protected from the spread of COVID-19.

Across our inspections of more than 5,000 care homes from summer 2020, we were assured in 69% of care homes against all eight IPC questions. This represents a four percentage point increase between September 2020 and August 2021.

Assurance has also risen against almost all the questions we looked at (figure 4). The biggest improvement has been for the question about whether people are admitted into the service safely, which saw a six percentage point increase.

Some services were carrying out pre-admission assessments remotely, accounting for people's individual needs and involving families where appropriate.

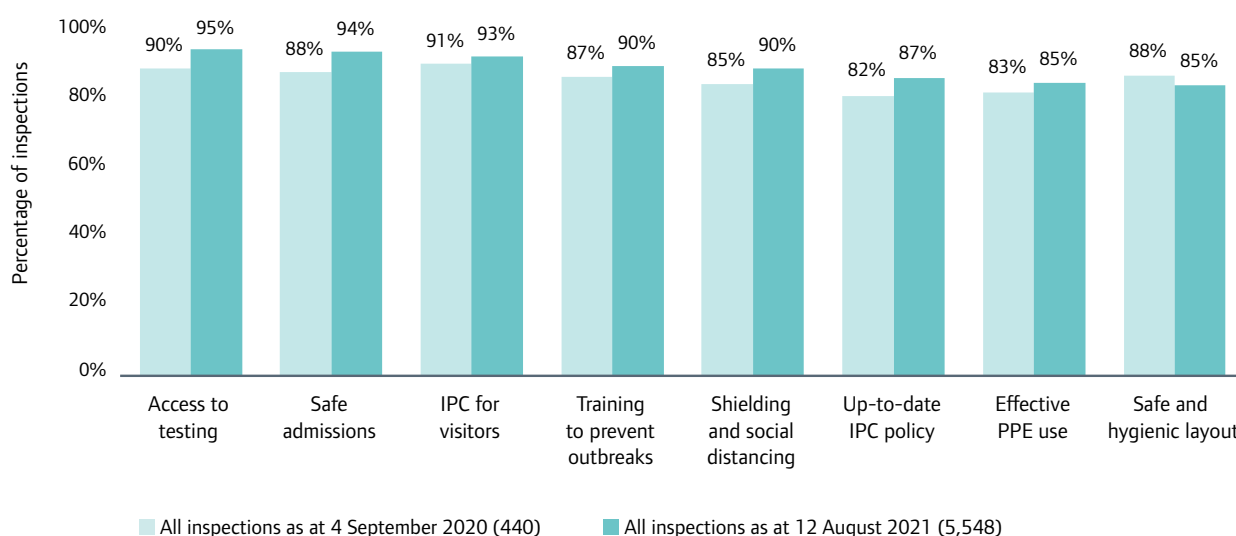
“[Person] had dementia and was very physically fit and active. Decision at pre-assessment that self-isolating on arrival would not be successful and impact on their mental health. Risk assessment completed, [person] had both vaccines, testing and self-isolating at their own home prior to admission.”

The other highest increases were seen in access to testing, shielding and social distancing, and up-to-date IPC policies (all five percentage point increases).

For our question about whether there is adequate access and take up of testing, care home managers told our inspectors that they would talk to staff and people using services to reassure and educate them about the importance of testing and vaccinations.

“Where staff have been hesitant about vaccination, they had 1:1 discussions with a manager to understand their concerns and to try to address them.”

Figure 4: Infection prevention and control assurance findings across all care home inspections, England, 4 September 2020 and 12 August 2021



Source: CQC inspections. Note: Most inspections were risk-based, with those services assessed to be at higher risk prioritised.

NHS hospitals

In our July 2021 COVID-19 Insight report, we reviewed our first nine focused well-led inspections in acute NHS services to monitor infection prevention and control.⁷⁵

The inspections highlighted that good IPC practices have been implemented in most trusts inspected. They have adapted existing guidance and processes to respond to the COVID-19 pandemic to ensure the safety of staff and patients. This is despite challenges to good infection prevention, which included the layout of some hospital buildings limiting patient flow, and vacancies in the IPC team reducing staff support.

“There was daily oversight of safe staffing levels. Part of this process was to ensure that staff were not moved between COVID-19 positive and negative areas to minimise the risk of spread of infection.”

The trusts had dedicated IPC directors and teams that provided expertise to staff and regular updates to the board. In most occasions, these teams were comprised of staff from across the trust who had been redeployed.

“The trust’s IPC nursing team had development posts for nurses to gain the skills and experience needed to proceed to a more senior role.”

Prior to our inspections, several trusts had seen an increase in the number of nosocomial infections (infections acquired in the hospital), particularly around December 2020 to January 2021, and had action plans and objectives to reduce them. They carried out reviews and shared learning from any outbreaks.

Separately, the Healthcare Safety Investigation Branch have investigated the factors that underpin the management of nosocomial infections. They identified some of the challenges hospitals faced in reducing the risk of nosocomial infection and they have made a number of recommendations.⁷⁶

In the 2020 Urgent and Emergency Care survey, just under seven in 10 (69%) people who attended a major consultant-led A&E (type 1 services) said the department was ‘very clean’. This was 78% for urgent treatment centres or minor injury units (type 3 services). For both types of service, this is an 11 percentage point increase on 2018 results. These findings are among the largest year-to-year differences ever observed by NHS Patient Survey Programme surveys and are likely to reflect enhanced infection control and prevention measures in urgent and emergency care services in response to the COVID-19 pandemic.⁷⁷

In the 2020 adult inpatient survey, almost all people (98%) in the survey experienced good levels of cleanliness in their hospital room or ward.⁷⁸

The central role of adult social care

The pandemic has reinforced how vital adult social care is for the many people who rely on it. Services have faced massive challenges in keeping people safe during the pandemic, while supporting them to live fulfilling lives through person-centred care.

The impact of the pandemic on people who draw on and work in adult social care services has been devastating and, despite the best efforts of staff, COVID-19 has contributed to a significant increase in the number of deaths in nursing and residential care homes in particular. Our data on the notified deaths of people living in care homes in England conveyed the tragic loss of life of people using adult social care services to COVID-19.⁷⁹

Based on our programme of infection prevention and control inspections of care homes, we reported that most care providers that we have inspected have demonstrated that they have faced their challenges well. They have been supported by staff who have showed resilience under unprecedented pressures. They have gone the extra mile to keep the people in their care healthy, active, and as independent as possible, while keeping family members and carers informed and engaged.⁸⁰

Trusted home-care throughout the pandemic

Claire has a pacemaker, fibromyalgia (a long-term condition that causes pain all over the body) and chronic obstructive pulmonary disease. She has received home-care support for seven years, which is arranged by the council.

Claire's carer, Michelle visits every day, and helps with personal care, as well as housework and shopping. She stays as long as needed. If Claire does not need anything, she will phone the agency to cancel, but if this is unexpected Michelle will pop in to double check everything is alright.

Michelle continued to visit during the pandemic. Claire felt very confident and trusted that Michelle was doing everything to keep her safe, such as wearing all the personal protective equipment and washing her hands regularly.

Very occasionally, Michelle was unable to visit because she was extra busy with clients due to COVID-19. Claire would be offered an alternative carer, but she refused because she has built up such a trusting relationship with Michelle that she only wants support from her – particularly with personal care, such as showering. In these cases, she would put off tasks until the next day or ask her family to help.

Claire became quite anxious about the pandemic, resulting in her not wanting to leave the house. Michelle understood this and, as well as carrying out her usual tasks, took time to try and relieve some of Claire's anxiety. She encouraged Claire to sit with her in the porch with the front door open while they chatted. This helped Claire a great deal and she now leaves the house.

Michelle continues to be a trusted carer and great support to Claire.

Interview with a member of the public

Holistic, person-centred care has always been important, but during the pandemic it has become even more critical as adult social care staff have taken an even bigger role in the lives of people in their care during periods of lockdown.

Where people using services have had less contact with people during the pandemic that understand and affirm their culture, such as family and friends, it has been important that care staff have been alert and responsive to people's beliefs or conventions. In May 2021, we supported care providers, managers and staff with an online resource that details some key aspects for supporting culturally appropriate care, and provides examples of good practice, including many that we have seen when we've carried out inspections of adult social care services.⁸¹

It is work like this that highlights the importance of a career in adult social care in enhancing the day-to-day health, wellbeing and experiences of people using services, as well as providing support and comfort at the end of their life.

‘The best possible care’ during mother’s final months

“The recent lockdown has really made me appreciate the outstanding care and compassion that the team at her care home provided for my late mother, during her final months after her short battle with mouth cancer.

The care team became her closest friends and they helped her to overcome her anxieties, as she started to interact more with others. Consequently, she actually became more social than before she came!

The dedicated team of nurses, carers and staff were extremely friendly and approachable. We were always kept informed and involved in developing her care plan.

I was also humbled by the way all the major Hindu festivals were celebrated at the home in an inclusive, safe and enjoyable manner. Unfortunately, my mother was not well during Diwali, which is one of the biggest festivals in the Hindu calendar. However, the team made special efforts to celebrate it in her room, which the family were invited to. It turned out to be one of the most special and memorable Diwali’s we had as a family. It highlights how the team always went the extra mile to make residents happy.

The wide range of activities played a huge part in my mother’s physical and mental wellbeing. It is always hard to see a loved one deteriorate, but the team motivated not only my mother, but also us, to participate in key activities, such as karaoke, yoga, cooking, bingo, board games and much more.

The home manager was exceptional. She was very approachable and available to speak with us anytime – even out of hours if we had any concerns.

While the past year has been a very distressing and anxious time for many families, on reflection following my mother’s passing, I have been comforted to know that she was fortunate to receive the best possible care during her last few months.”

Account of a family member, received through our Give Feedback on Care service

Adult social care fragility

Adult social care is a sector that was under pressure even before the pandemic. COVID-19 has increased this even further, threatening the financial viability of some providers and services.

Care home providers and their representatives have told us about the operational challenges they continue to face as a result of decreased occupancy, reduced admissions, increased costs and difficulty recruiting and retaining staff.

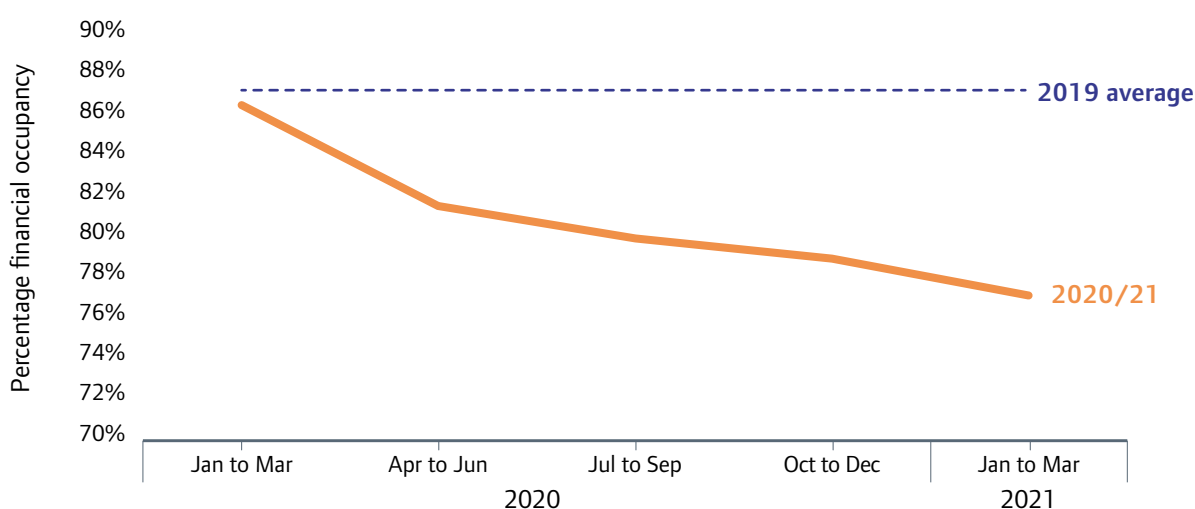
There is evidence that the pandemic may have impacted patterns of accessing adult social care. Representative bodies of adult social care providers told us

that feelings of uncertainty, anxiety and fear over safety as well as restrictions on visiting, may have led to families choosing not to send relatives into care homes or take up home-care services.

We know that in the pandemic people have relied more on family and friends for informal support. For example, Carers UK reported that, by October 2020, 81% of unpaid carers reported that they were providing more care since the start of the pandemic.⁸² In discussions, both our staff and stakeholders have stressed that if these changes to patterns of care continue, it may have long-term implications for the sector and its recovery.

Analysis of providers in our Market Oversight scheme (covering 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) indicates that the impact of the pandemic has been most pronounced for non-specialist care homes (principally those that care for older people). This significant group of providers saw a fall in occupancy throughout 2020/21, as seen through average financial occupancy figures for each quarter (figure 5).

Figure 5: Non-specialist care home financial occupancy, England, January 2020 to March 2021 compared with 2019 average



Source: CQC Market Oversight data. Note: figures for 2020/2021 are average occupancy rates per quarter. Y axis has been truncated and does not start at 0.

This shows a continuing reduction in occupancy compared with the 2019 average. This, coupled with the increased costs of PPE requirements and additional staffing and fluctuations in the level of government support available, has had an impact on profitability (as calculated using 'EBITDARM', which is a high-level measure of profit that excludes key expenses such as rent, depreciation and interest charges; this is a relative measure only and should not be equated with overall profitability). Profit margins declined through October 2020 to March 2021 to the lowest level since the Market Oversight scheme began in 2015, including earlier in the pandemic.

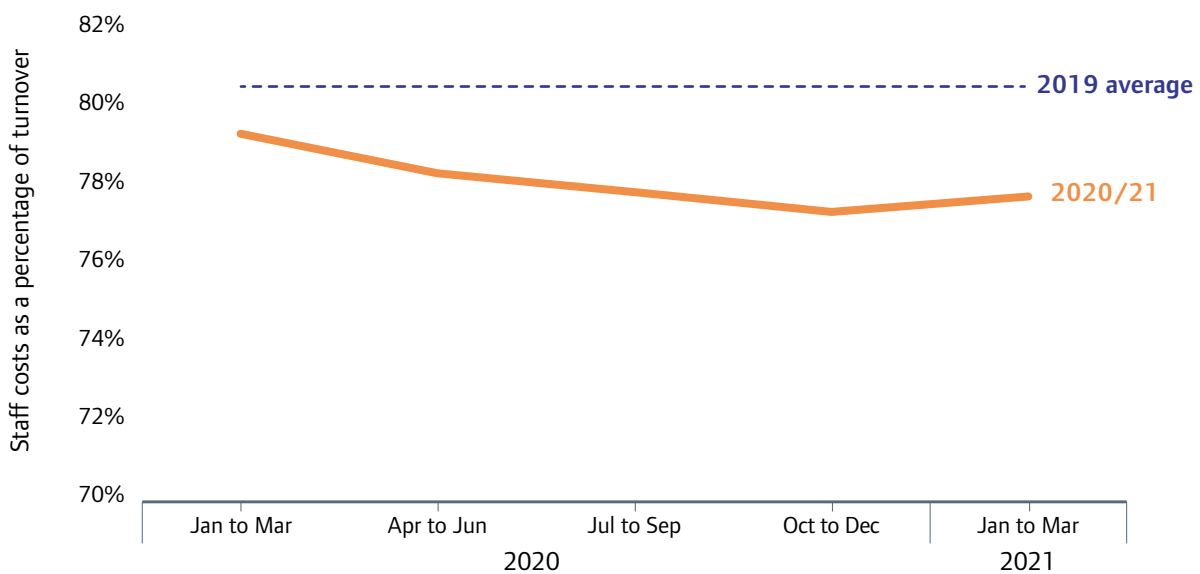
Similarly, profitability per registered bed also declined to a three-year low in March 2021 for providers in the scheme. Reduced profit means that providers have less cash to pay debts, build and refurbish homes and invest in quality improvement.

Market Oversight data also signals a change in the funding mix as a result of the pandemic, with non-specialist care homes seeing a decrease in the proportion of privately funded beds relative to those funded by local authorities or the NHS (from 46% in the quarter ending March 2020 to 41% in the quarter ending March 2021). This is the reverse of the trend seen before COVID-19 and could have a long-term impact on the sustainability of those providers dependent on the higher level of private fees. Care home providers with a low proportion of self-funders saw occupancy fall nine percentage points from the quarter ending March 2020 to the quarter ending March 2021, whereas providers with a high proportion of self-funders saw occupancy fall 11 percentage points over the same period.

These reductions in occupancy should be seen against a backdrop of a relatively unchanged position in the number of registered care homes beds. Our registration data shows that, between April 2020 and March 2021, there was an increase of just one nursing bed per 1,000 people aged 65 and over in England, while for residential beds this figure remained unchanged.

There are signs from Market Oversight analysis that home-care providers had greater flexibility to respond to fluctuations in demand throughout the pandemic. This is seen through staff costs (as a proportion of turnover) reducing and generally being lower than previous years (figure 6). Home-care providers in the Market Oversight scheme have seen stable or improved profit margins over the course of 2020/21.

Figure 6: Non-specialist home-care staff costs as a percentage of turnover, England, January 2020 to March 2021 compared with 2019 average



Source: CQC Market Oversight data. Note: figures for 2020/2021 are average staff costs as a percentage of turnover per quarter. Y axis has been truncated and does not start at 0.

Until very recently, the indications were that adult social care services had managed to avoid both widespread home closures and home-care contract handbacks. It is likely that the market has been protected by short to medium term funding, including the ring-fenced funding for infection prevention and control of almost £1.5 billion, discharge to assess funding, and support for testing of almost £400 million in care settings.

But, while extra funding from the new health and social care levy announced by the government in September 2021 will be welcome, substantial questions remain about the sustainability of adult social care providers. In the 2021 Spring survey by the Association Directors of Adult Social Service, 82% of directors reported that they were concerned about the sustainability of some of their home care providers, and 77% about some of their care home providers. One of the report's key messages was that "COVID-19 short-term funding has helped to prevent failure but there is profound uncertainty about the future".⁸³

Urgent action is needed to tackle staffing pressures and the stresses caused by staff shortages, and the long-term impact of emotional exhaustion of staff. Monthly data from information submitted to CQC by providers of residential care shows their staff vacancy rate rising steadily from 6.0% in April 2021 to 10.2% in September 2021.

Workforce data from Skills for Care also shows that vacancy rates are increasing. As at August 2021, the vacancy rate in adult social care, for employers updating ASC-WDS data since March 2021, was 8.2%. This is a 2.1 percentage point increase since March 2021 and 0.2 percentage point increase on pre-pandemic levels (as at March 2020). Vacancy rates were highest for home-care services at 11.3% (a 0.9 percentage point increase since March 2020) and for registered nurses at 13.4% (a 5.0 percentage point increase since March 2020).⁸⁴

There are regional differences. London has the highest vacancy rate at 11.0% (an increase of 2.2 percentage points since March 2020). The North West has the lowest vacancy rate at 6.5% (an increase of 1.9 percentage points since March 2020).

Skills for Care has also estimated that turnover rates across adult social care remained high in 2020/21, at 28.5% overall. For registered nurses, the rate was higher at 38.2%; this compared with 8.8% for equivalent roles in the NHS.⁸⁵

Furthermore, the Skills for Care monthly data also shows that, pre-pandemic, sickness rates for adult social care staff were 2.6%. They almost doubled to 5% between March 2020 and June 2021. Care homes with nursing saw the biggest change with a 2.7 percentage point increase in sickness compared with pre-pandemic levels, followed by care homes without nursing at a 2.5 percentage point increase and home-care agencies at a 2.4 percentage point increase.

We have heard examples of care homes having to cancel their registration to provide nursing care because their attempts at recruitment have failed, leaving residents needing to be found new homes in local areas that given staffing challenges are already at, or close to, capacity.

Residents forced to find new home because of nursing shortages

An established nursing home, which had been facing care and nursing staff issues, recently contacted us to discuss their staffing contingencies. Over the following weekend there were unforeseen staff absences and the local authority and CCG worked together to provide emergency nursing cover. Meetings between CQC, the provider, the CCG and the local authority sought assurances about the level of safe staffing in the service and the provider described having taken every step they could to find nursing cover and to recruit.

The provider subsequently informed key partners that, as a result of nursing shortages, they would be de-registering from the regulated activity of treatment of disease, disorder or injury, and the 15 people who required nursing support would need to be found new homes. They said that there was such a shortage of nurses (and the fees were in the thousands every week for agency nurse cover) that it was untenable to continue providing nursing care. Partner agencies are supporting the service to find people new homes, but this will place further pressure on other nursing services in the area that are also struggling for staff and working in a system with little staffing capacity left.

We are concerned that vacancies may increase further as hospitality and travel industries speed up recruitment and offer incentives to new staff. These industries can offer higher salaries than the care sector. Staff from adult social care may also take up vacant posts in hospitals – especially registered nurses. These influences, combined with the effects of the requirement for all care home workers to be vaccinated against COVID-19, may lead to more care staff leaving, unless a new deal for the care workforce is developed. This should consider recruitment and retention, training, pay and rewards, the professionalisation of the workforce, and workforce resilience.

Access to GP care

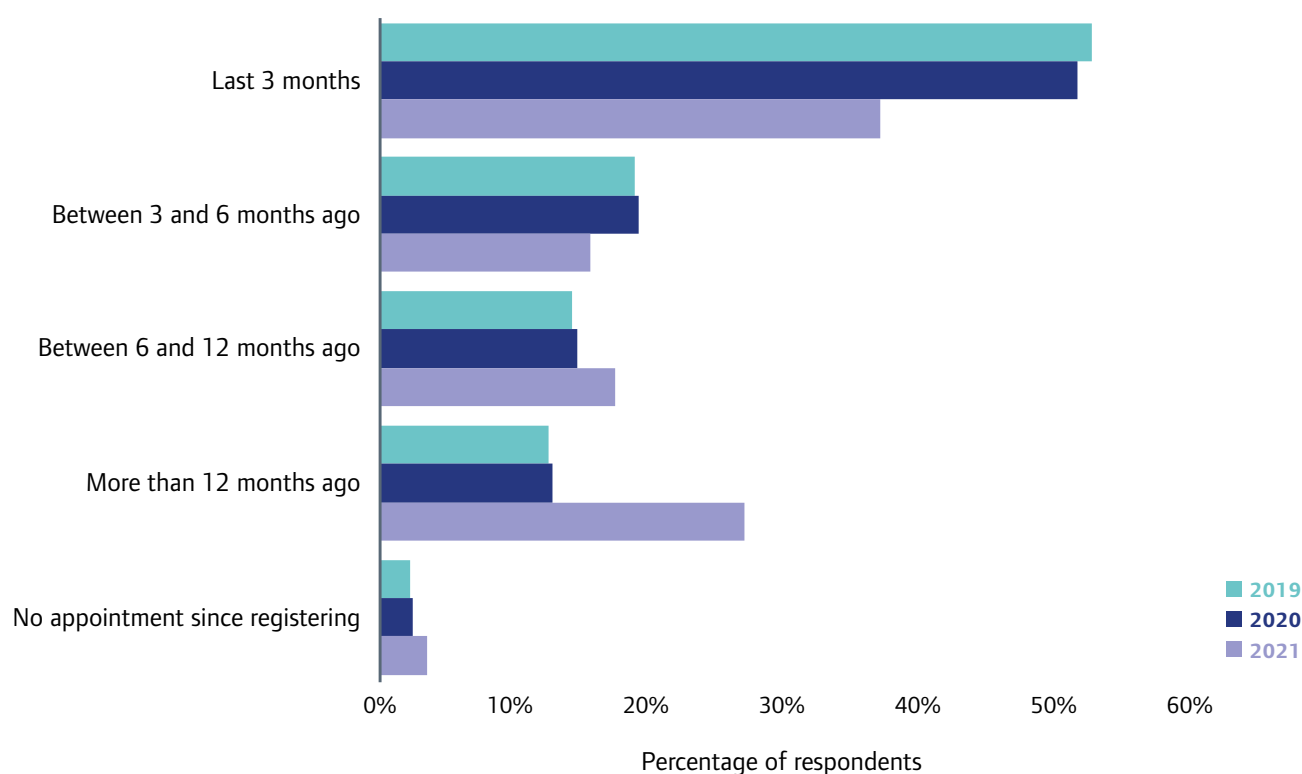
Like all health and care services, GPs and their teams have had a crucial role to play in supporting the health needs of their communities throughout the pandemic, as well as keeping people safe. GP practices, following national directives and drivers from government, have had to accelerate innovation, such as moving rapidly to remote consultations, to respond to the pandemic.

A remarkable achievement since December 2020 has been the rollout of the COVID-19 vaccination programme, with GP practices and primary care networks at the forefront of this critical task. Many different local services have worked together at speed on a programme that has shown the NHS at its most versatile and patient-centred. Across the UK, more than 92 million vaccinations had been given by mid-September 2021 – in a nine-month period, almost 90% of people aged 16 and over had received their first dose and over 80% had received both doses.⁸⁶

Data from NHS Digital up to the end of May 2021 shows that, after dropping considerably in April 2020, the total number of GP appointments started to pick up from June 2020 with the end of the first national lockdown, and by September 2020 was broadly in line with figures for the previous year.⁸⁷ This data does not show the totality of GP workload such as COVID-19 vaccination activity, and there are known issues with data quality that are likely to have been exacerbated by the pandemic.

The pandemic had an impact on patient behaviour. Findings from the 2021 GP patient survey (based on responses from January to March 2021) showed that the proportion of respondents spending more than a year without attending a GP appointment more than doubled to 27% in 2021 compared with the previous years (figure 7).⁸⁸

Figure 7: Time since last GP practice appointment, England, 2019 to 2021



Source: NHS England, GP patient survey 2021

When asked whether, at any time in the last 12 months, they had avoided making a GP appointment for any reason, 42% of respondents confirmed that they had. The top two reasons were because people were worried about the burden on the NHS (20%), and because people were worried about the risk of catching COVID-19 (17%).

This was reflected in a Healthwatch report from March 2021, which found that people were worried about “overloading” services and not speaking to their GP practice unless they felt their health issue was of extreme importance. This was especially prevalent in feedback from older people.⁸⁹

People need to feel confident in seeking advice and treatment from their GP if they have health concerns, as these can deteriorate and have an impact on their long-term health, and place greater demands on the health and care system in future.

The GP workforce will need to be able to cope with the potential backlog of patients, once people feel more confident to return to practices. However, workforce data from NHS Digital shows some areas of concern. Although the total number of full-time equivalent GPs from September 2020 onwards is higher than it has been previously, the number of qualified permanent GPs, which excludes GPs in training grade and locums, has been falling, with figures in June 2021 nearly 3% lower than they were in June 2017 (the earliest point at which data for June is available).⁹⁰

Furthermore, the total number of full-time equivalent (FTE) GPs per 100,000 patients reduced from 58 per 100,000 in June 2017 to 55 per 100,000 in June 2020. While figures for June 2021 show an increase, there are still fewer FTE GPs in total per 100,000 patients than there were in 2017. Over the pandemic, the number of qualified permanent FTE GPs per 100,000 patients has been at its lowest level in recent years.

To help mitigate workforce issues in general practice, the Additional Roles Reimbursement Scheme (ARRS) provides funding for primary care networks to recruit 26,000 additional roles to create bespoke multidisciplinary teams to support people where it is most needed.⁹¹ It is important that local systems, including GP practices, have the capacity to make sure that these new roles are supervised and supported to meet the ambitions of the scheme.

Getting a GP appointment

We carried out 58 risk-based inspections from mid-May to end of June 2021, as well as holding conversations with several GP ‘at scale’ providers (providers who are working collaboratively to offer services from more than one practice), to better understand how GP practices have been working to ensure access to services during the pandemic. We found that, in line with guidance, practices had moved to a triage model for everyone seeking an appointment, to help to keep people safe from infection and to avoid vulnerable people coming into contact with people who were COVID-positive.

Most commonly the triage process took place by telephone, either involving a member of reception staff or a clinician (usually a nurse, advanced nurse practitioner or GP). Some practices had more than one layer of triage, with an initial screen by reception staff being followed up by a clinician.

Sometimes, the triage process took place through an online service. Our inspectors raised concerns about this in a few practices, such as describing staff who were “unsupported by their technological systems to provide a fully effective service”, or noting that “patient satisfaction with this [triage] approach was mixed”. Some practices, which were unable to provide online triage, had removed online appointment booking facilities in order to triage patients by telephone.

In the 2021 GP patient survey, in answer to the question, “Generally, how easy is it to get through to someone at your GP practice on the phone?”, 68% said ‘easy’ in 2021, compared with 65% last year. Nearly 71% of respondents described their experience of making a GP appointment as ‘good’ in the 2021 survey, compared with 65% in 2020.⁹²

However, these survey results do not reflect everyone’s experience. In our analysis of feedback received via our Give Feedback on Care service, phone calls and social media between April and December 2020, we found that many people who contacted CQC about access to GP services told us about their inability to make an appointment. People described finding it difficult to figure out the best or ‘correct’ way to contact practices. When calling by phone, people told us they were often on hold or in a queue for a long time. Some people found that, when they did make a telephone appointment, the doctor did not call them during the allotted time or at all, and they had to go through the booking process again.

In March 2021, Healthwatch reported that, despite a reduction in complaints about contacting a GP practice by telephone in the initial part of the lockdown, by September 2020 complaints had increased to pre-pandemic levels. These included complaints about long queues, lines consistently being engaged, people having to try to make contact several days in a row, and some who were unable to remain on hold for long due to the cost of the calls.⁹³

Trying to get a GP appointment

Terry has diagnosed Bipolar. The pandemic made him feel anxious, which for him was a warning sign, so he wanted to speak to a GP for reassurance.

He made a considerable number of calls to his surgery trying to get through to make an appointment, which added to his stress – “If you’re not the first person on the line at 8am you will not get an appointment”. There were also no online consultation slots available. He understands there is a country-wide problem and he is sympathetic, but at the same time felt it wasn’t acceptable.

When he eventually got through to the surgery, Terry was given an approximate time when the doctor would call him back. The GP was very good and put him at ease by talking him through the vaccine options that were soon to be rolled out. It was exactly what he needed.

Now that the pandemic has calmed down it still takes quite a number of calls to get through, which Terry feels is still not acceptable and will put off some people from calling.

Online prescriptions have worked well for him. He feels that the pharmacy staff keep him safe when he goes to collect his prescription.

Interview with a member of the public

Findings from our inspections have noted issues with telephone systems, resulting in long hold times, people being cut off while waiting, and repeated engaged tones causing frustration for people trying to get through.

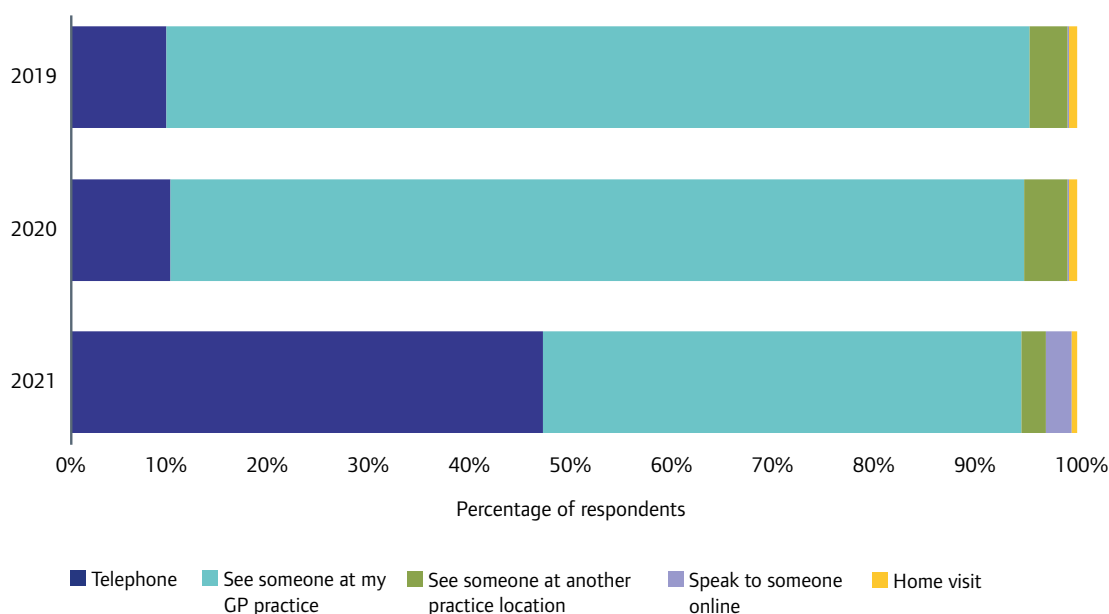
Other practices have tried to address this by increasing their phone line capacity or upgrading their telephone systems to meet need. Some have used newer telephone systems to actively monitor their telephone waiting times. A practice in London, for example, had live telephone performance information displayed on a screen in the waiting area. The manager of this practice was also able to review the performance from a dashboard.

How appointments were delivered

Results from the 2021 GP patient survey show that remote appointments as a whole increased substantially since the onset of the pandemic. The majority of those were telephone appointments. The last time people booked an appointment 47% were carried out over the phone, compared with only 10% in the previous year’s survey (figure 8). Although online consultations, such as video calls, are still relatively low at 3%, their increase is considerable compared with the negligible levels in previous years.

As noted in the Royal College of General Practitioners’ August 2021 statement, face-to-face appointments have continued to be offered wherever safe and appropriate throughout the pandemic, and this is supported by the 2021 GP survey data, which shows that 48% of respondents said their last appointment was to see someone at their GP practice (compared with 85% the previous year).⁹⁴

Figure 8: Type of appointment people received the last time they booked, England, 2019 to 2021



Source: NHS England, GP patient survey 2021

Improved GP practice prioritises the needs of its patients

When we inspected Rishton and Great Harwood Surgery in October 2020 – about six months into the pandemic – to follow up on previous concerns, we rated the GP practice as good, a huge improvement from its previous rating of inadequate. With a new practice manager in place, the practice developed and implemented a comprehensive improvement plan. They were supported in this by the Royal College of General Practitioners.

In responding to the pandemic, the practice kept up-to-date with the advice and guidance from NHS England to make sure it was COVID secure. It carried out regular reviews and spot checks to ensure staff were distancing safely, washing hands and wearing appropriate personal protective equipment. The practice was granted funding to change the reception and waiting areas at the Rishton surgery so that risks from cross infection could be reduced further.

The practice adapted how it offered appointments in line with guidance to maintain the safety and welfare of patients and staff. Telephone appointments were offered in the first instance, all triaged by the GP. All patients who needed it were offered a telephone appointment on the day and, if required, a face-to-face appointment. Pre-bookable appointments in the evening until 8pm and at weekends were also available at local hub sites. If a face-to-face appointment was needed, patients were offered a choice of three surgery sites.

All patients assessed as vulnerable or advised to shield received a welfare check from the practice. These calls ensured they had the right support for both their healthcare and social care needs. In addition, the practice called all patients with a positive COVID-19 result to make sure they knew what to do if their symptoms got worse, and how to get additional support if they needed it.

The practice used a clinical tool to identify older patients who were living with moderate or severe frailty – these people received a full assessment of their physical, mental and social needs. The practice also followed up on older patients discharged from hospital.

Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. Nurses explained they were mostly able to carry out reviews over the phone for stable patients, and updated care plans were sent out in the post. Those patients with acute symptoms were offered a face-to-face appointment with a clinician.

The practice shared their staff availability every day with their clinical commissioning group (CCG). This enabled the CCG to maintain an overview of GP services in the local community and direct additional support to practices that were short of staff.

In May 2021, the Royal College of General Practitioners (RCGP) published a report that noted that remote or digital consultations (which are not in-person but carried out by telephone, video or online) offered a variety of benefits to patients, but only when supported by effective technologies, and where individual patients' needs are met.⁹⁵

In our provider collaboration review of services for people with a learning disability, we heard that remote consultations were more accessible for some people with a learning disability and their families and carers, as they removed the barriers imposed by travelling to appointments, particularly cost and time.⁹⁶ In our provider collaboration review looking at cancer care, we heard that, since many people with cancer are immunosuppressed due to their treatments, remote interaction helped ensure their safety and alleviate anxiety.⁹⁷

However, all the local systems we spoke to recognised that there are significant challenges using remote consultations, including digital poverty, poor access to the internet, English not being a first language, and variation in digital literacy. Other issues raised included concerns about confidentiality, and difficulties in building a relationship with a person using the service or identifying signs of deterioration in health and wellbeing when not being able to examine them.

The pandemic has created a steep learning curve for some GP practices in terms of remote access. We support the RCGP's call for an evaluation of what 'good' looks like for digital triage systems, co-designed with patients and clinicians, to ensure that they do not exacerbate health inequalities.⁹⁸

One of the principles in Healthwatch's report on digitally excluded people's experiences of remote GP appointments calls for traditional models of care to be maintained alongside remote methods and support.⁹⁹

The sector needs to think about the future impact of remote or digital appointments, to make sure everyone gets the appropriate access to meet their needs safely.

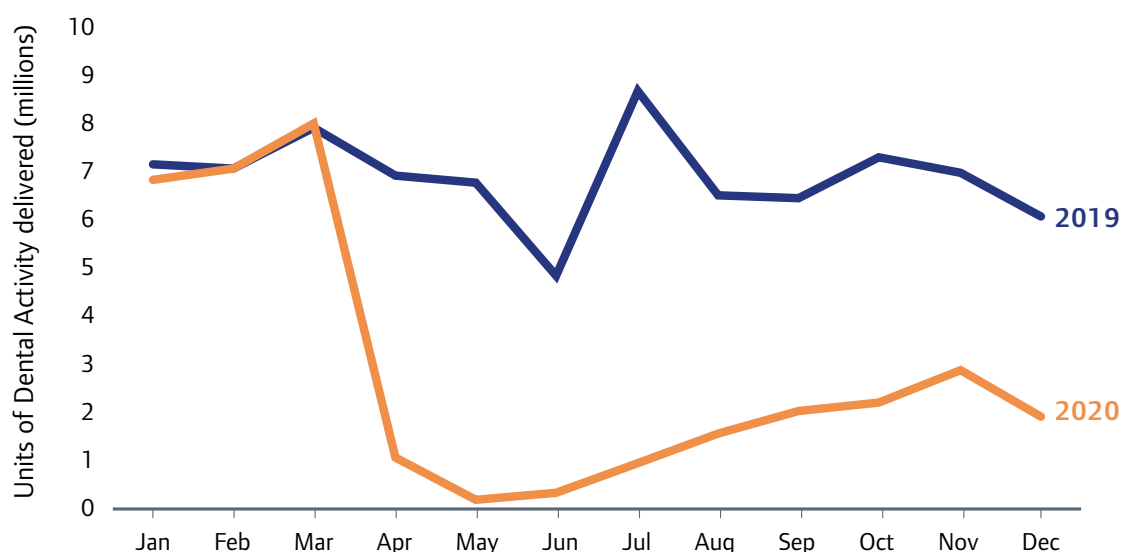
Access to dental care

Like all health and care services, COVID-19 has challenged how primary dental care is delivered.

Access to NHS dental care for all has been highlighted as an issue before the spread of COVID-19, and there are clear signs that this has been compounded by the pandemic.¹⁰⁰ At the start, routine NHS dental services were paused in the interest of patient and dental staff safety. From June 2020, practices steadily restored services, while introducing enhanced infection prevention and control measures, such as using additional personal protective equipment, leaving fallow time between procedures, and carrying out more frequent deep cleaning.

The impact of COVID-19 on the service available is clearly seen in data from the NHS Business Services Authority on the total units of NHS dental activity (UDA) recorded – in 2020, this was 58% lower than it was in 2019. Activity levels fell to their lowest in May 2020, a reduction of 98% on the same month in 2019 (figure 9).

Figure 9: **Total units of NHS dental activity, England, 2019 and 2020**



Source: NHS Business Services Authority

Access to NHS dentistry is one of the recurring issues that Healthwatch have regularly reported on. Even so, the total volume of feedback from the public that Healthwatch received increased dramatically during the pandemic, with feedback about dentistry increasing at a much higher rate than any other area of health and social care. From July to December 2020, more than seven in 10 people who contacted Healthwatch to share their experiences of NHS dentistry said they found it difficult to access help and support when they needed it. Issues around booking routine care, restarting treatment that began before the pandemic, and getting emergency treatment were common themes.¹⁰¹

This was reflected in feedback we received through our Give Feedback on Care service, phone calls and social media between April and December 2020. The personal impact described by people who did not have good access to services (across both dental and GP services) was sometimes significant, with people feeling abandoned, disrespected, frustrated, and sometimes in pain.

“We called for an emergency dental appointment. They point blank refused to see us, and told us to call the emergency dentist. When we advised they were not seeing anyone, they told us they couldn’t help.”

Feedback to CQC’s Give Feedback on Care service

Our inspectors heard about the particular problems that children and young people had in accessing routine dental care during the pandemic. We know that poor oral health can be linked to neglect, and this may therefore have affected the most vulnerable children.

According to the 2021 GP patient survey, which includes a section on NHS dentistry, the percentage of respondents who described their experience of NHS dentistry as 'good' fell from 84% in 2020 to 77% in 2021.¹⁰²

In May 2021, we reported on activity we carried out to improve our understanding of how dental practices have managed and supported people to access appropriate treatment during the pandemic.¹⁰³

The dental providers we spoke to expressed pride in their staff, including their adaptability to new ways of working. Employees tended to feel supported by their employers to feel safe and have the skills they needed, with one practice organising "regular updates and team learning and WhatsApp groups for the staff team, which has helped with improving each other's mental health".

We have seen examples of dental providers adapting their practices well to respond to the pandemic. These included:

- supporting staff to triage patients – for example, in services where the receptionists were responsible for triaging, the provider indicated that they were trained by nurses or clinicians. In some cases, senior staff monitored incoming calls and, in many cases, dentists were available for support if necessary
- offering additional hours in order to manage the number of people waiting for a service, including opening on Saturdays and extending hours during the week to as late as 8pm
- referring people between sister practices, and using buddy arrangements between different providers, to take on each other's patients in the event of a sudden closure
- enabling staff to have remote access to the practice network in case they needed to work from home or unexpectedly close.

There were some examples of dental services working well with other health and care providers in a community, such as community pharmacies, NHS 111, secondary care services and urgent dental centres. However, our provider collaboration reviews found that dental services were not always invited to be an integral part of the system for shared planning and system-wide governance.

As a result of our findings, in our May 2021 report we presented four important questions that the dental sector needs to address:

- How will confidence be restored that access to NHS dental services is available for everyone?
- What measures need to be taken to prioritise and improve access to urgent dental care through NHS 111?
- Is there enough NHS dental capacity commissioned, and how will NHS policy leaders and commissioners deal with the demand to ensure those who are vulnerable and without a dentist have equality of access to NHS care?
- With a move to system working and joined-up working in a place, how will oral health be seen as an integral part, providing access to the right service, in the right place, first time?



3. Ongoing quality concerns

Key points

- Through our reviews of high-risk mental health services, we are concerned that people continue to be put at risk in a small number of services where there are warning signs of closed cultures.
- Improvements in maternity care are far too slow, with continuing issues around staff not having the right skills or knowledge, poor working relationships, and not learning from when things go wrong. Other concerns include a lack of engagement with local women by maternity services and limited action taken by these services to improve equitable access.
- While services have largely maintained levels of Deprivation of Liberty Safeguards during 2020/21, they need to have a continued focus on people subject to a deprivation of liberty. We continue to have concerns about delays in authorisations, which mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

Risk of closed cultures

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.¹⁰⁴ This risk has been further exacerbated during the pandemic by more services becoming closed environments due to a lack of visitors, and from the potential impacts of staffing and management pressures.



‘I may have been unwell, but I knew what was happening was wrong’

“When I was a patient in a closed culture on a psychiatric ward, I felt completely vulnerable. The staff had all the power and I felt that whatever I did or said I was completely powerless. Some of the senior staff were so arrogant that they controlled everything. I could tell that some of the more junior staff disagreed with what was happening, but even they didn’t feel able to speak up for the patients’ rights (and presumably for their own working environment too). Even when I did try to say that things weren’t safe, I was ignored. It felt like all my experiences, past education, training and work counted for nothing because I was the one who was mentally ill and they were the ‘professionals’. I may have been unwell, but I still knew that what was happening was wrong and was rejected when I tried to articulate this to the ‘powers’ in the organisation.”

We are committed to improving our regulation of services where there is a closed culture or a high risk of a closed culture developing. As part of this, we will continue to review whistleblowing concerns, feedback about the quality of care from people using services and their carers and staff, and notifications that services must send us – to proactively identify services we think could be at risk of developing a closed culture. We also continue to review these risks through our work and our visits to services to monitor the operation of the Mental Health Act.

In our July 2021 Insight report, we shared our learning from a sample of 29 inspections where we have found evidence of closed cultures.¹⁰⁵ In this, we identified six common features of closed cultures:

- incidents of abuse and restrictive practice
- issues with staff competence and training
- cover-up culture
- lack of leadership and management oversight
- poor-quality care generally
- poor-quality reporting.

While closed cultures can develop in any type of health and care setting, we are particularly aware of the increased risk in services that care for people with a mental health condition, people with a learning disability and autistic people.

Through our reviews of high-risk mental health services, as well as through engaging with others to hear from people who have had experience of closed cultures, we are concerned that people continue to be put at risk.

Our concerns include:

- **The use of restrictive practices**

“No clothes, just a hospital thing, I didn’t have a telephone, because they had taken my telephone, you’re not allowed telephones on the ward for security reasons, no money, no medication, nothing.”

People should be given options and control over as much as possible when in hospital. With many of their freedoms already restricted, not giving people the ability to choose activities and what time to go to sleep can make them feel trapped.

We heard that individual incidents for a specific person had been used to justify the introduction of blanket bans, without individual risk assessments. For example, one service had introduced a blanket ban on access to mobile phones because of one individual allegedly using her phone to film staff and patients.

We also heard of staff using punitive approaches where patients had to earn ‘privileges’, such as access to fresh air. These privileges could also be removed in punishment. In one example, an informal patient was threatened with being detained under the Mental Health Act if they tried to leave the ward.

- **Issues with staffing and management**

Poor leadership styles and approaches to providing care can lead to closed cultures. These approaches often get transported around different care settings as staff teams shift locations and job roles.

We were particularly concerned about services having a lack of staff, which may suggest a lack of planning from managers. It also suggests that they may be trying to run the services with the minimum number of staff and not fully considering the needs of individuals, such as ‘off-ward’ activities. In addition, we heard how the use of bank or agency staff meant people were not always cared for by staff who were familiar with the setting or with their personal needs and preferences.

Not having enough staff, or employing staff without the right skills, knowledge and attitude can affect the safety of people using the service. It could also have an impact on people’s quality of life. For example, it can restrict people from being able to go out into the community as people often need staff support to do this.

- **Lack of external oversight**

The outbreak of the COVID-19 pandemic increased the risk of closed cultures developing, as restrictions introduced in response to the pandemic prevented external bodies, such as reviewers, and friends and family from visiting.

In services with closed cultures where adequate care is not being provided, families can feel forced to take on care responsibilities. Not only can this cause unnecessary stress, when family members have caring responsibilities, they may feel in denial about their own health concerns, meaning their conditions can go ignored and untreated.

Through our reviews, we were concerned that services were not proactive enough in communicating changes due to COVID-19, such as restrictions on visiting, to patients, relatives and staff. As a result, the impetus fell on relatives to chase for updates on the care of their loved ones, and when those updates were received, they weren't always detailed enough.

Where we find concerns about a service, we continue to monitor them as part of our ongoing regulation.

Where we have identified services as having a closed culture, we have taken appropriate action. This has ranged from initiating focused inspections, issuing urgent notices to restrict admissions, placing services into special measures and, where necessary, ensuring people are relocated to other care services. In these cases we have worked with the local authority to find suitable alternative accommodation.

As an organisation, we are continuing to improve our regulation of services at risk of developing a closed culture. We are testing a new methodology that is designed to get under the culture of a service and better understand what it is like for people who live there. This includes using feedback more effectively and addressing concerns quickly when the risks of a closed culture are found. Human rights are at the heart of our new approach, and we will always look at services from the perspective of people using them.

Maternity improvements are too slow

In most cases pregnancy and birth are a positive and safe experience for women and their families. But when things go wrong the results can be devastating; in some cases leading to the death of babies or mothers, and/or causing serious, long-term disability.

Our ratings data shows that the improvement in the safety of maternity services is too slow. In our report 'The state of care in NHS acute hospitals 2014 to 2016', published in April 2018, we raised our concerns that half of all maternity services were rated as requires improvement or inadequate for the key question 'are maternity services safe?'.¹⁰⁶ Our Getting Safer Faster briefing in March 2020 showed that this had improved slightly to 39%.¹⁰⁷ Our latest report, Safety, equity and engagement in maternity services, highlighted that as of July 2021, 41% of services are rated as requires improvement or inadequate.¹⁰⁸

In July 2021, the Health and Social Care Committee published its report on 'Safety of maternity services in England'. In this, it highlighted "the worrying variation in the quality of maternity care which means that the safe delivery of a healthy baby is not experienced by all mothers".¹⁰⁹

To explore issues around safety in more depth, we visited nine maternity services where we had concerns between March 2021 and June 2021. As part of these inspections, we looked at the safety, teamwork and culture of services, as well as how they worked with their local Maternity Voices Partnerships (MVPs) to engage women in their local area. We also looked at what they were doing to address inequalities for women and babies from Black and minority ethnic groups and deprived communities.

While our review was focused on services with potential risks to safety and was not therefore a national picture, we are concerned that many of the issues we found may be occurring in other maternity services.

The culture of services varied across the nine trusts we visited, with evidence of poor working relationships between obstetric and midwifery teams, and between hospital and community-based midwifery teams in some services. Poor teamwork was also characterised by staff feeling unsupported, not feeling confident to seek support from senior colleagues or being afraid to challenge decision-making.

While we saw some evidence of multidisciplinary team training taking place, there were concerns that not all staff were engaged with training. The quality of training and support for staff to maintain and develop their individual capabilities and core competencies also varied between the trusts we looked at. Leaders of maternity services must tailor the training requirements for individuals to ensure that they are 'fit for purpose'.

From our visits, we found limited evidence of how services were ensuring that women from Black and minority ethnic groups had equal access to care in order to promote equitable outcomes. The majority of services we visited had carried out some work to implement the four actions from the Chief Midwifery Officer¹¹⁰ to support maternity equity for women from Black and minority ethnic groups. However, we were concerned that in many cases the actions had been interpreted narrowly, rather than considering what further actions were needed to make services truly equitable and safer for all women, and ensuring that all women felt informed and supported.

One of these four actions was to ensure that the importance of vitamins, supplements, and nutrition in pregnancy is discussed with all women. It is well known that, due to low sunshine levels, people living in the northern hemisphere may not get enough vitamin D. Women from Black and minority ethnic groups who have melanin pigmented (darker) skin or who cover their skin when outside may be particularly at risk. We found that recording of discussions about vitamin D was often inconsistent or absent in the services we visited. This creates the risk that vitamin D is not being discussed and/or offered to women who need it.

Another area we looked at was around continuity of carer teams. Studies have shown that continuity of care has been linked to improved outcomes for women and their babies, particularly women from Black and minority ethnic groups.^{111,112} The NHS Long Term plan set out a target that by March 2021, most women would receive continuity of the person caring for them during pregnancy, during birth and postnatally. It also set out the target that for women from Black and minority ethnic groups, and women from deprived groups, 75% should receive continuity of care by 2024.¹¹³

At the time of our inspections, just over half of the services we visited had active continuity of carer teams providing support to small numbers of women identified as higher risk. Where services did not have these teams in place, we heard that they had been put on hold or disbanded, primarily due to staffing issues in the pandemic.

We found that engagement by maternity services was often generic, rather than being targeted towards women from Black and minority ethnic groups. This was echoed by MVP chairs who told us that they were concerned MVPs were not fully representative of their local area, and that engaging with women from Black and minority ethnic groups to understand their views and experiences was an area for improvement. MVP chairs described a lack of funding as a major challenge to meaningful engagement with women from Black and minority ethnic groups, and that greater remuneration for their time would also encourage more women from deprived areas to be involved.

The pandemic had also had an effect on the ability of MVPs to engage with women. MVP chairs told us that not being able to meet face-to-face during the pandemic had been a major barrier to engagement. Before this, events such as 'walking the patch' to talk to mothers on the ward and visiting children's centres and baby groups presented opportunities to connect with women who may not have otherwise contacted their MVP.

The use of digital technology had created some new opportunities for better engagement. One MVP chair noted that attendance of their meetings had increased, possibly because women who are less mobile when they have a newborn baby or lack transport may find it easier to attend online MVP meetings. Online meetings also enabled professionals from the maternity service to attend, as well as increased representation from community groups and other professional stakeholders.

While this is positive, we also heard that reliance on digital technology during the pandemic made it harder for women without the access to, or skills to use, digital technology to keep informed and have their voices heard.

Tackling health inequalities is a core ambition of our new strategy. In line with this, we will continue to monitor maternity services' work on equity and engagement, including how they are using people's experiences and equality data to review and act on outcomes and respond to the needs of their local population. We will also continue to learn from women who use services and face inequity, and apply what we have learned to other core services and areas of our work.

Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are an important part of the Mental Capacity Act 2005 (MCA) and work within the core MCA principles. They aim to safeguard many of the most vulnerable people using health and social care services, and ensure that a decision to deprive a person of their liberty is subject to a proper legal process, including a right of appeal. DoLS are due to be replaced by the Liberty Protection Safeguards in 2022.

Any decision made for a person lacking the relevant mental capacity should be made in accordance with the key principles of the MCA – in line with the best interests process and less restrictive principle – and strike the right balance between a person’s wishes and feelings, and their safety.

We have previously highlighted some continuing concerns around DoLS including:

- variation in knowledge and understanding of DoLS legislation, and in the quality of training
- poor quality mental capacity assessments and best interest decision-making
- delays and backlogs at a local authority level and providers not effectively escalating applications when needed.¹¹⁴

Over the past year, we have continued to monitor how services have managed DoLS as the pandemic has evolved. Many of the issues we have reported on previously have continued and/or have been exacerbated in the context of the pandemic and associated pressures on the system.

We continued to monitor notifications relating to the outcome of a DoLS application. Providers are required to notify CQC without delay when the outcome of an application for a DoLS authorisation is known, including when authorisation has not been granted.

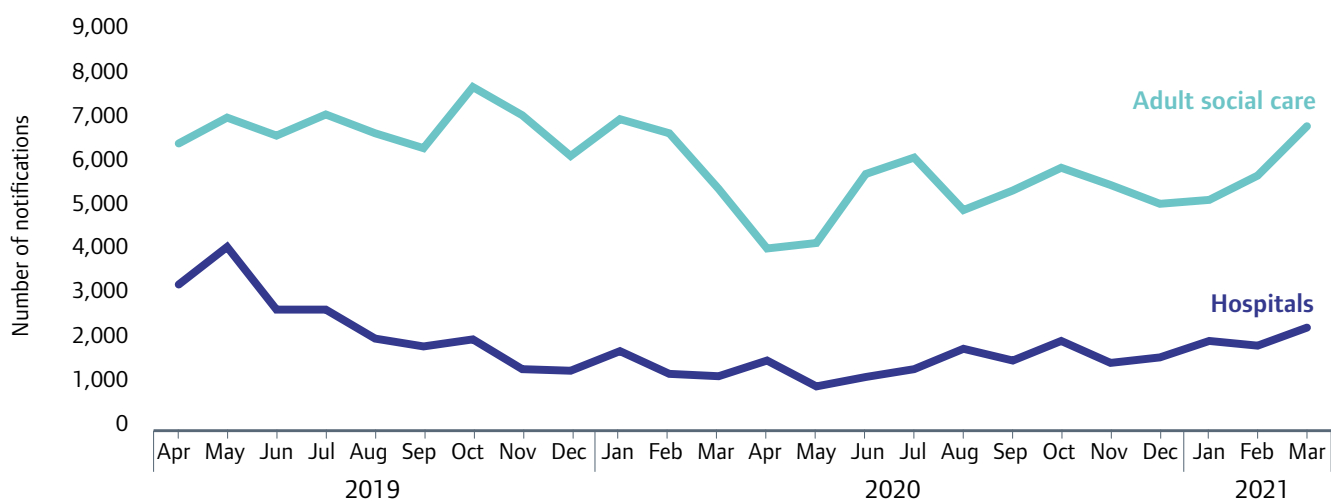
Numbers of notifications from adult social care services and hospitals reached their lowest point during the early months of the pandemic (figure 10). In adult social care, we saw a sharp fall in the numbers of notifications received between March and April 2020. In hospitals, numbers were lowest in May 2020.

It is understandable that during the pandemic, particularly at the beginning, attention shifted onto managing COVID-19. Providers faced a significant challenge in balancing adhering to government guidelines on infection prevention and control and managing the risk presented by COVID-19, with ensuring that they met any existing individual’s DoLS conditions or new DoLS needed.

However, the number of DoLS notifications from hospitals had been dropping steadily since before COVID-19.

Notifications from both sectors have risen since the lowest figures. By March 2021, numbers for adult social care services had increased by 6% compared with April 2019. The trend in hospitals has been a gradual rise (since May 2020), although the figure in March 2021 was still 30% less than in April 2019.

Figure 10: Deprivation of Liberty Safeguards notifications, England, 1 April 2019 to 31 March 2021



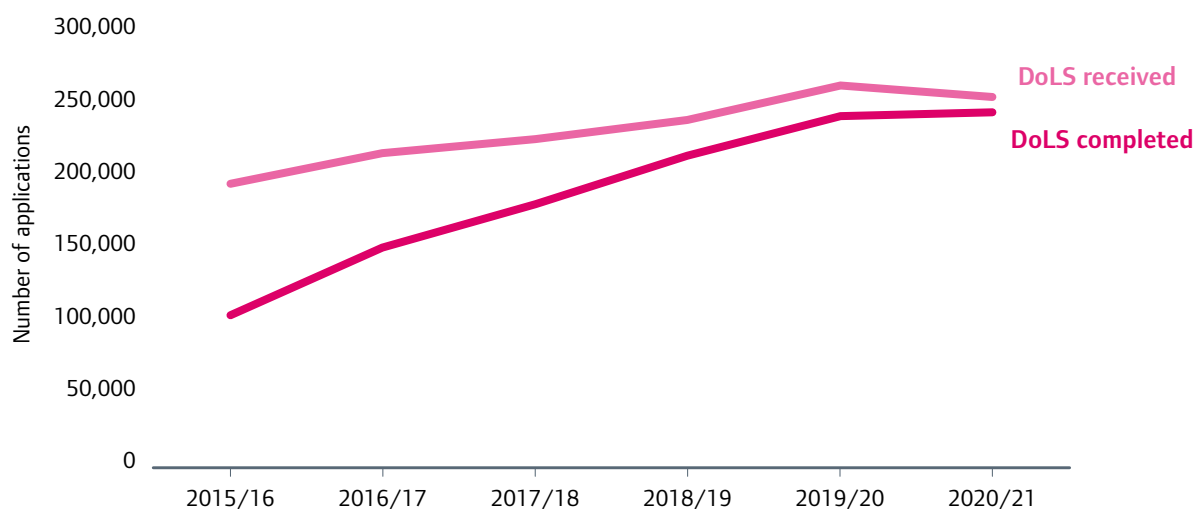
Source: CQC notifications. Note: This excludes notifications made through the Court of Protection and notifications from Primary Medical Services (PMS). There were a total of 60 notifications from PMS over the two year time period.

NHS Digital official statistics on DoLS in 2020/21 also reflect some fluctuation in activity through the year, with applications received by local authorities reaching their lowest point in April 2020 (17,480). By comparison, lowest levels for applications completed by local authorities were reached in August 2020 (17,775).¹¹⁵

However, England-level annual totals suggest that providers and local authorities were largely able to maintain overall levels of DoLS activity compared with 2019/20. There was a small drop of 3% in the numbers of applications received by local authorities in 2020/21 compared with 2019/20. The numbers of applications completed by local authorities rose by just over 1%. NHS Digital also reports that the number of cases not completed (in other words, the backlog) also fell for the second consecutive year since reporting began in 2015/16 to an estimated 119,740.

There was some regional variation; West Midlands and East of England saw significant increases in applications completed compared with the previous year (16% and 15% respectively).

Figure 11: Deprivation of Liberty Safeguards applications received and completed by year, England, 2015/16 to 2020/21



Source: NHS Digital. Please note: The England-level statistics for 2020/21 have been estimated as one local authority was not able to submit data.

However, the small increase (1%) in total number of applications completed during 2020/21 remains significantly below the 24% average increase seen each year over the previous four years (2015/16 to 2019/20) (figure 11). The 3% fall in the number of applications received by local authorities in 2020/21 also counters the average growth rate of 8% each year seen between 2015/16 and 2019/20. Delays in authorisations may mean that individuals are deprived of their liberty longer than necessary, or without the appropriate legal authority and safeguards in place.

Ensuring that the less restrictive principle is being applied in line with the MCA while balancing COVID-19 restrictions continued to be a challenge for providers. In some services, we saw good examples of providers thinking creatively to support social distancing and isolation in the least restrictive way possible – for example, allowing multiple individuals who had tested positive to socialise in one area of the care home. Our Expert Advisory Group also shared examples of homes using mirrors and windows to keep people in visual contact, to counter loneliness, while being kept physically separate.

However, in some cases, we were concerned that providers' focus shifted away from DoLS towards managing COVID-19 restrictions. When conditions on DoLS that are there to support the person, such as being able to go out, are not followed, this has a significant impact on the person. For example, we have had concerns around people being isolated and withdrawn, as well as increases in distressed behaviour, poor mental wellbeing, and breakdowns in relationships with family members and loved ones. The impact can be especially profound for people who have limited capacity to understand why these restrictions were in place. Restrictions on visitors for people receiving end of life care were also devastating both for the individual and their loved ones.

Our inspectors have had concerns that social distancing and other restrictions have made it more difficult to meaningfully implement the DoLS process in a way that supported people's human rights. In particular, they have had concerns around a lack of visits from Relevant Person's Representatives (RPRs), families and other professionals, and the move to online assessments.

While virtual best interests assessments worked for some people, others were unable or struggled to use technology to participate. Also, if families, professionals and other representatives had not been able to visit a person for some time, it meant that staff at a service may be the only people able to give a truly up-to-date picture of a person's life.

For example, one service had completed a mental capacity assessment and believed the person lacked capacity for a particular decision relevant to DoLS. The person was Italian and had reverted back to their first language, and no interpreter was available. While the virtual assessment was being completed the person just answered yes to all questions and the assessor was unable to pick up on the non-verbal cues that showed the person did not understand. This meant a DoLS authorisation was refused in the first instance and the service had to reapply.

While the Department for Health and Social Care has produced guidance around this area, we continue to be concerned that lack of understanding about DoLS is having an impact on providers' confidence about whether restrictions introduced in response to the pandemic amounted to a deprivation of liberty or not.

Better training is needed to improve staff knowledge and understanding of DoLS and the MCA, and their importance in protecting people's human rights. As we highlighted in *Protect, respect, connect*, our review of 'do not attempt cardiopulmonary resuscitation' decisions during the pandemic, a lack of understanding of the MCA can lead to issues such as people being assessed as having capacity for a relevant decision when they no longer do. It can also prevent health and care workers, particularly those in care homes, from being able to identify and raise concerns. This means that people may not be protected from unsafe care or treatment, and may be at risk of having their human rights breached.¹¹⁶

Medicines safety in NHS trusts

In March 2021 we published our look at the safe and effective use of medicines at NHS trusts, considering NHS hospital pharmacy services during the pandemic.¹¹⁷ This report came from our routine engagement with hospitals' chief pharmacists.

We also wanted to know about medicines safety learning, and 95% of NHS trusts took part in a separate review where we focused on the role of the medication safety officer (MSO), which all trusts are required to have.

All the trusts we spoke with had a named MSO. We heard that the main challenge for MSOs is that their responsibilities are often added to their current role.

MSOs told us they help to make the use of medicines safer – they respond to medicines safety alerts and improve reporting of medicines incidents so that lessons can be learned, and they ensure actions from learning can be shared with frontline staff. They also told us that the change from paper-based to electronic systems will lead to a greater ability to oversee medicines use and safety.

Medicines governance

We heard that most MSOs were listened to and were able to escalate medicines concerns effectively through trust governance systems. Where support for the role from trust leaders was given, this helped to develop a strong culture around medicines safety.

We also heard that, in some providers, the engagement of other professions in medicines governance committees remained a challenge, and that unclear governance structures meant that information about medicines safety did not flow effectively between committees. This meant there was limited executive oversight of certain medicines risks.

Incident reporting and learning

All MSOs described how they monitored the reporting systems for medicines incidents and near misses. We found that a multidisciplinary team approach helped with engagement of frontline staff across professions and promoted sustained, positive change. MSOs said that where they felt there was a good trust-wide medicines safety culture, this supported people to report and learn from incidents.

Guidance and support

We found that guidance and support for MSOs was available, including national and local professional support networks. We also heard many good examples of collaborative work and sharing of learning and experiences. But we heard that a lack of dedicated capacity and funding in different areas led to variation in delivery across the country. Some MSOs described a reactive service that responded to medicines incidents and alerts at the time, rather than a proactive medicines safety agenda.



4. Challenges for systems

Key points

- Collaborative working was varied among the local systems we reviewed. Cross-sector working was helped by good communication, information sharing and shared values.
- There was a lack of integration of adult social care providers into system-level planning and decision-making.
- Most systems had some understanding that inequalities in care existed in their areas before the pandemic, as well as how they had worsened or changed due to the pandemic. But tackling these inequalities was often not a main priority for them.
- Workforce planning is a major priority and challenge for local systems and providers. Recruitment and staff retention continue to be severe problems.
- In adult social care, the situation is serious and deteriorating. There must be a sharp focus on developing a clearly defined career pathway and training, supported by consistent investment that will enable employers to attract and retain the right people.

Collaborating for better care

The pandemic has magnified issues already faced by local health and care systems. They have tried to maintain or adapt services where possible to support their local populations in different ways. The response to COVID-19 has acted as a catalyst for good care in some places, through an advancement in collaboration.

During a series of provider collaboration reviews (PCRs) in the past year, we have looked at how the different services in local systems worked together to understand and meet the needs of their local populations in the face of the pandemic.¹¹⁸

Navigating disruption to services

Closure or disruption to services during the pandemic has meant that some people have not received care they needed. Access has varied by sector and locality. We heard how access to urgent mental health care, primary care or dental care became more difficult, sometimes increasing demand in other parts of the urgent care pathway, such as hospital emergency departments.

Systems tried to ensure access in different ways. For example:

- A general practice worked with the voluntary sector and their local authority to support homeless people. They were provided with hotel accommodation and received better access to care because providers knew where they were. Some were provided with the technology required for remote consultations.
- North West Ambulance Service employed pharmacists in their NHS 111 call centres to support prescription requests – this helped people avoid going to A&E. Similarly, specific medication was made available to ambulance crews to administer at people’s homes to support patients at the end of their life.
- Leicester, Leicestershire and Rutland Clinical Commissioning Group expanded the provision of chemotherapy at home, ensuring patients continued their treatment plans and in a safer environment.
- When we reviewed cancer services in several regions, they all used mutual aid and/or staff redeployment based on capacity needs to ensure sufficient levels of staff with the right skills – this included movement of staff between providers, as well as movement of staff within a single provider.
- Efforts were made by some systems to respond to reductions in cancer referral rates at the beginning of the pandemic, by identifying areas where screening uptake was poor and promoting access to cancer screening services for early referral and diagnosis. Cancer screening messages were also targeted to people living in deprived areas or in areas where certain cancers are more prevalent.
- One collaborative multi-agency approach we heard about involved health, education, social care services and parents – this met the needs of a young person with a learning disability during a period of crisis, by securing rapid access to specialist intervention, an appropriate education setting and a bespoke curriculum.

Communicating the status of services to people who needed to access care was often challenging. Some local systems and providers used social media, local radio and television to reach out to communities. Some used their multilingual workforces to create videos in different languages.

We reported in last year’s State of Care about the high volume of guidance from central authorities for providers and how it frequently changed. In trying to keep people up to speed, we heard how providers sometimes struggled with the pace of change – they described ‘information overload’ and sometimes conflicting guidance during the peaks of the pandemic.¹¹⁹

Many appointments changed to a remote or digital method of delivery, including for example counselling sessions for people with cancer and some day care activities for people with a learning disability.

These helped to improve access for many people, but remote or digital consultations were not right for everyone or for some population groups. The flexibility of digital care was identified across local systems as something to maintain for some patients, while it was acknowledged that they were not ideal in all circumstances.

Redesigning pathways

The pandemic has led to significant changes in how NHS services are delivered and used. The NHS is keen to build on some of these changes, as seen through its priorities for 2021/22, which include transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments and reduce length of stay.¹²⁰

Through our PCRs, we have seen how the flow of people through the health and care system has been supported by the redesign of health and care pathways or models of delivery in many places, in direct response to the need to keep people safe and reduce the pressure on services treating patients with COVID-19.

In the PCR looking at urgent and emergency care during autumn 2020, we heard about changes to pathways to reduce the pressure and demand on emergency department attendance and hospital admission. For example, some health and care systems established 24-hour mental health crisis lines to support people with urgent mental health needs away from a hospital setting if this was clinically appropriate. Also, some primary and community care services made the decision to provide urgent care in people's own homes rather than asking them to attend an urgent care service, as they considered this a safer option.¹²¹

The NHS 2021/22 priorities document set out the request to every local system to set out their plans to accelerate the rollout of the two-hour crisis community health response at home (8am-8pm, seven days a week) by April 2022. Systems have also been asked to progress work already underway to promote the use of NHS 111 as a primary route into all urgent care services.

Keeping older and frail people safe

We saw during our provider collaboration review of urgent and emergency care how the community assessment and treatment centres (CATUs) in Cornwall brought together multi-disciplinary teams that were closer to people's homes. With a focus on frailty, geriatricians were moved from acute sites into the CATUs to support keeping older and frail people out of hospital during the pandemic. This approach was developed before the pandemic, but then accelerated, as a long-term way of caring for older and frail people. It was welcomed by system partners and the model is being explored by neighbouring systems.

Collaboration makes a difference

Health and social care providers have been operating in different conditions during the pandemic. At the start, NHS England took on extensive powers normally held by clinical commissioning groups (CCGs) – this enabled the purchase of services from the private sector and powers to exercise CCG functions to support the provision of services across the NHS.¹²²

Representative organisations, think tanks and other bodies – for example The King’s Fund and NHS England – have pointed to the way collaborative approaches have allowed commissioners to share ownership of challenges and responsibility for service improvement, with a focus on cooperation and collective leadership, as well as joint ownership of risk and accountability among commissioners and providers.^{123,124}

Integrated care systems, bringing together commissioners and providers of health and social care services with local authorities and other partners, intend to offer a more strategic outcomes-based approach to care. The pandemic has sped up some of this collaboration, strengthened relationships between system partners, and provided the opportunity for peer support and the sharing of resources.

We saw in some systems that where collaborative relationships already existed, they remained strong in the pandemic. Some systems had established efficient system-working before the pandemic – this then helped them in their timely response as they were able to build on existing structures and relationships. Similarly, the Local Government Association reported that a shared purpose has resulted in stronger relationships both within and across organisations in local places during the pandemic.¹²⁵

Cross-sector working was helped by good communication, information sharing and shared values – it was acknowledged that this enabled better outcomes for people.

Among the systems we reviewed in our report on cancer services, a priority was maintaining personalised care for people. There were multidisciplinary team meetings and system-wide calls to plan and deliver cancer services collaboratively.

System partners worked together, including hospices, adult social care providers, mental health providers, the voluntary sector, local authorities and NHS trusts. For example, we heard about a hospice that worked in collaboration with the local authority to enable cancer care in the community. They also worked with GPs and district nurses to develop training and provided medicines administration training to families and carers.

In one local system, expectant mothers with a learning disability were supported through a planned multi-agency approach. They were given an enhanced package of care including hospital passports – and they had pre-birth tracking meetings attended by public health, midwifery and a learning disability team.

However, collaborative working was varied among the systems we reviewed. Where we found less collaboration among services, we heard concerns about the effect this had on providers' ability to plan for care that might be needed in local populations.

There was a lack of integration of adult social care providers into system-level planning and decision-making. Smaller providers and home care services in particular did not feel represented at system-level. Similarly, when we reviewed services for people with a learning disability, there was a lack of involvement in wider system planning. A key finding from our cancer review was that the lack of adult social care integration would be a barrier to wider system recovery plans.

When we looked at urgent and emergency care, some adult social care providers said they did not feel supported or included by GP practices and NHS trusts – this was particularly around the coordination of discharge of people from hospitals to care homes or into people's own homes. We also found limited evidence about the involvement of voluntary and community services in planning.

Among cancer services, we found in our collaboration review that most systems reported gaps in recording people's demographic data. This may affect how well providers can monitor people moving through cancer pathways, their understanding of health inequalities and the effects on people's experiences.

Do not resuscitate decisions – the challenges different sectors face in working together

In October 2020, the Department for Health and Social Care commissioned CQC to conduct a special review into 'do not attempt cardiopulmonary resuscitation' (DNACPR) decisions. The review was commissioned following concerns raised early in the pandemic that DNACPR decisions, also known as DNRs and DNARs, were being made without involving people, their families and/or carers if so wished, and were being applied to groups of people.¹²⁶

Applying a DNACPR decision to groups of people of any description (known as 'blanket' DNACPR decisions) is potentially discriminatory and unlawful under the Equality Act 2010. People's rights may also be at risk where individuals are not properly informed or involved in conversations about putting a DNACPR decision in place, or where decisions are not reviewed in a timely way.

Through our review, we found that people and those close to them had mixed experiences of how well they were involved, and supported to be involved, in conversations about their care. When people were involved in conversations, the huge number of acronyms and use of inaccessible language could be confusing and prevent people from being fully engaged.

We heard that conversations around whether people would want to receive cardiopulmonary resuscitation (CPR) often came out of the blue and that, due to increased pressure on staff time during the pandemic, happened at a faster pace in busier settings. People told us that they felt that they were not given the time or information to fully understand what was happening or even what a DNACPR was. In some cases, people were not always aware that a DNACPR decision was in place. This could be hugely distressing for people and their families and/or carers.

We also heard that there was a general lack of awareness and confidence among people, families and care workers about what a DNACPR decision meant, and how to challenge this.

Every area we looked at had taken steps to make sure that services were aware of the importance of taking a person-centred approach to DNACPR decisions and advance care planning. However, we found that providers had to cope with a huge amount of guidance about all aspects of the pandemic that lacked clarity and changed rapidly, leading to confusion.

While there was a wide range of training available for staff, we were concerned that not all clinicians, professionals and workers had access to this due to a lack of funding and difficulties freeing up time to attend training sessions. Where staff had training, there were concerns about whether it gave them the necessary knowledge and skills to engage with people in a meaningful way, and ensure that their needs were met and their rights protected.

At a system level, we found that advance care planning, end of life care and DNACPR decisions were often not sufficiently high on the agenda, and leaders lacked oversight of DNACPR decisions. For example, we found evidence of poor record keeping, a lack of learning being shared across systems, and underdeveloped strategies for advance care planning and end of life care.

While collaboration generally increased during the pandemic, it also tested how well commissioners, health and social care providers and patient representative bodies were able to work in partnership to make decisions and provide guidance around advance care planning and DNACPR decisions. Areas that already had infrastructure and governance processes in place were better able to work together to manage the overall challenges created by the pandemic.

Tackling health inequalities

We have found that most systems had some understanding that inequalities in health and social care existed in their areas before the pandemic, and how they had worsened or changed due to the pandemic.

But tackling inequalities was often not a main priority for systems, or strategies to identify and tackle health inequalities across some systems were not yet well established.

In the urgent and emergency care review, some providers and systems had little to say about how they were tackling health inequalities, for example stating that COVID-19 took priority or that tackling barriers for Black and minority ethnic communities was not a priority because they had a small Black and minority ethnic population. In the cancer review, the absence of a system-wide strategy meant that some providers were without a clear vision of how inequalities among cancer patients were being addressed in their system.

We found that better data on demographics (for example on age, gender and ethnicity) is needed to make it easier to identify health inequalities and gaps in care for people who need cancer services or urgent and emergency care.

The needs of people with a learning disability had variable consideration within system-level strategies. We heard that sometimes people with a learning disability were not a prioritised group or they were included in the category of vulnerable people, rather than being recognised as people with specific and complex needs. We stressed the importance of having learning disability specialists or champions as part of governance structures.

There were service gaps for people with a learning disability across systems, including: the transition between child and adult services; completion of annual health checks; out-of-hours support; hospital discharge and outreach; and forensic and crisis support.

Overall, across all our provider collaboration reviews, we highlight the strong need for leaders in local systems to work hard to understand the inequalities that exist in their areas, and to develop strategies to specifically address them.

Workforce challenges

Workforce planning is a major priority and challenge for local systems and individual providers. Recruitment and staff retention continue to be severe problems, particularly in adult social care and primary care.

We set out in chapter 2 our concerns about the sustainability of the adult social care workforce and how COVID-19 has magnified these significantly. Urgent action is needed to tackle the staffing issues in adult social care, and the increased pressures and stresses caused by staff shortages.

Similarly we highlighted how in mid-2021 there were fewer FTE GPs in total per 100,000 patients than there were in 2017. A BMA survey in February 2021 found that around 50% of doctors were more likely to reduce their working hours in the following 12 months. One in four were more likely to take early retirement and another fifth were more likely leave the profession.¹²⁷

While there has been an increase in the number of mental health staff working in the NHS recently, there has been little growth over a nine-year period. The Nuffield Trust has reported how average staff numbers have increased by about 1% a year, but the number of mental health nurses have decreased by 3% in total over that period.¹²⁸

As we highlighted in chapter 1, health and care staff have continued to work under immense pressure. As at May 2021, NHS Digital data on NHS sickness absence rates showed that anxiety, stress and depression was the most reported reason for staff absence, accounting for more than 493,000 full-time equivalent days lost and 29% of all sickness absence – not infectious disease or coughs and colds/respiratory (which might suggest COVID-19).¹²⁹ Sickness rates were highest among support to ambulance staff. In the NHS Staff Survey 2020, 44% (up from 40% in 2019) of staff reported feeling unwell as a result of work-related stress in the last 12 months.¹³⁰

The House of Commons Health and Social Care Select Committee report on workforce burnout and resilience in the NHS and social care, published in May 2021, set out the extent of the workforce challenge for health and social care. In their evidence to the committee, the Health Foundation stated that that the NHS workforce gap in 2020/21 was 115,000 full-time equivalent (FTE) staff. In adult social care, the Health Foundation and the Institute for Fiscal Studies projected that 458,000 additional FTE staff would be needed in England by 2033/34.¹³¹

We highlighted the absence of a people plan for social care in last year's State of Care report.¹³² This lack of equivalence was also noted in the Health and Social Care Select Committee report.

In concluding their report, the House of Commons Health and Social Care Select Committee called for "a total overhaul of the way the NHS does workforce planning". It recommended that the government instigate a requirement for publishing annual, independent workforce projections to cover both NHS and adult social care. It also advocated for the development of an approach to workforce planning that takes into consideration capacity and demand and makes clear "the opportunity cost of not training, employing and retaining sufficient numbers of staff".

Recovery of services

We have talked to a broad range of organisations that represent health and social care service providers, as well as many that work on behalf people who use services, about the challenges for the recovery of services after the effects of the pandemic.

- **Meeting people's needs and maintaining their wellbeing**

There was widespread recognition from public and provider stakeholders that the key to successful recovery is ensuring services meet people's needs and providing appropriate access. Provider stakeholders highlighted the challenges they face in meeting public expectations about the care and support they want.

There was a strong view from provider stakeholders in secondary care that a national focus is needed to support people while they are on a waiting list, and to support people to manage aspects of their own health care. Public stakeholders said that the management of waiting lists will be key and, for those experiencing delayed care, interim support needs to be provided. One comment from provider stakeholders was that there

needs to be a cultural change away from thinking about NHS services as individual transactional interactions, toward whole pathways that are person-centred.

Overall, provider and public stakeholders were united in the view that people's wellbeing should be a focus of recovery. People who use care services have often become isolated during the pandemic. Health and social care staff across all sectors are feeling exhausted, demoralised, stressed and dealing with trauma from the pandemic.

- **System working and innovation**

Overall there was a view that the pandemic prompted improved system working, and that this shouldn't be lost during recovery; instead it should be strengthened and embedded. We heard how general practice has worked closely with adult social care providers, and the independent sector with the NHS, to deliver care. The successful delivery of the vaccination programme is a good example of the kind of effective system working providers would like to see more of.

Allied to this was a strong view from provider stakeholders that the pandemic had enabled and accelerated significant innovation in use of technology and service models, and that a 'good' recovery should maintain this innovation where it has been successful. They stressed that to enable this, there needs to be good evaluation on where innovation has worked well, including the impact on people using services and the impact on the wider system.

However, public stakeholders highlighted that delivery of remote or digital health and social care needs to take on a more sophisticated and personalised model. They warned that the system needs to be careful about making assumptions about who might be happy with digital care delivery and who won't be.

The importance of monitoring the impact of remote appointments post-COVID was highlighted. Public stakeholders raised concerns they have around the use of online appointments for people with severe mental illness, people with sensory/cognitive impairments, and those who need interpreters.

More broadly, there were concerns about new models of care, that have emerged during the pandemic, that are inaccessible or exclude some population groups. This link between access and inequality is highlighted, for example, where digital primary care excludes people who do not have access to digital infrastructure. Provider stakeholders had a clear view that recovery should focus on addressing health inequalities, in particular those that were amplified by the pandemic.

- **Importance of data**

There was a strong view from adult social care representatives that the pandemic has accelerated the need for better and consolidated data

collection. We heard how data collection during the pandemic was disjointed and created barriers to effective service delivery – so a strong central plan to remove duplication and improve how adult social care data is collected from the sector would be key to understanding how to effectively support recovery.

There was general agreement that a key part of successful recovery will be a better use of data to design and deliver care. This includes recognising and fixing where current data is poor, either in particular parts of the system or for specific population groups. This should also include ensuring that the system improves its ability to provide relevant and accurate information that the public can use.

- **System response and commissioning**

There was a strong view from provider stakeholders that they need government and system partners to support ‘good’ recovery by focusing much more on outcomes for people using services – and by a change in culture that provides funding, and supports commissioning and oversight that is focused on this rather than other measures.

Allied to this was a need for clear roadmap and plan for system recovery, accompanied by high-quality and easy to understand guidance from the Department of Health and Social Care and government. Public stakeholders agreed that greater direction is needed on how the system will get back up and running.

All provider stakeholders agreed that to support effective recovery and long-term service delivery, commissioning needs to improve – in terms of commissioning being more flexible and focused on people’s needs but also that commissioning needs to be more integrated across health and social care.

- **Workforce**

There was a shared view that current workforce challenges are a key barrier to successful recovery, in particular the ability to recruit and retain staff in key areas. We heard a number of suggestions on how this should be addressed, including updated national workforce strategies that cover all sectors, raising the status of the adult social care workforce to achieve parity with health care, and ensuring that career progression, pay and rewards are suitable to recruit and retain people across all sectors. We also 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 performed by health professionals. The ability of staff to continue to do this well will need investment in workforce development and formal changes in service specifications.

One impact of COVID-19 was the restriction or cancellation of different services. In many places, resources were redirected. Furthermore, the pandemic caused some people to not come forward for care and treatment they needed. These factors have caused a backlog and increased current

demand for all kinds of care that people need, ranging from non-urgent surgery in hospital to vital cancer or cardiology care.

Equal access to care is critical as local systems and providers try to grapple with longer waiting lists. To tackle inequality, systems must first do more to understand the needs of local populations – better use of data could help design and deliver care. In our provider collaboration reviews this year, we found that not all systems were aware of local population needs, particularly some minority groups that were known to be more vulnerable to COVID.

While every local area is different, we have seen strategic planning in some local systems that is focused on the longer term and making sure care is happening in the best place – plans need to involve all the organisations in a local area, include adult social care providers more prominently in decision-making, and value the contribution of carers and the voluntary sector in maintaining people’s wellbeing.

To help drive recovery nationally, providers highlighted to us the need to examine how health and social care services have changed, and to evaluate the impact of these changes. This includes building on the digital transformation and using it innovatively to create new approaches to care, but also taking the time to understand how it can be used fairly and accessibly for all those who need care and support.

We have heard how shared electronic records during the pandemic has enabled care to be tailored specifically to meet individual needs when accessing services.

Better use of information will be important as services recover. Among the learning we have seen during the pandemic, local systems were innovative when under extra pressure to protect vulnerable people. In our review of collaboration among providers during a peak of COVID-19, we reported on the way some urgent and emergency services adapted.

It was important that care professionals knew about people’s vulnerabilities so that care could be adapted. The electronic patient record (EPR) helped, as well as access to any ‘flags’ – notes on GPs’ patient records highlighting important medical information about a patient.

In one system the EPR was used to record known patient vulnerabilities and it was available to emergency departments (EDs) before a patient arrived at hospital. Shielding letters that had been sent to patients were also shared with EDs and added to patient records so this would flag if the patient attended an ED. At a care home, people’s vulnerabilities were included on residents’ care plans – these were shared with ambulance crews, as well as with visiting clinicians and hospital staff.

Hospitals’ plans for recovery

In May and June 2021, we asked 73 NHS trusts about their approaches to longer waiting lists and how they are considering people’s care in a fair and equal way.¹³³

Trusts have told us their focus in tackling the backlog is people with the greatest need according to clinicians’ priority codes, and those who have waited longest.

The scale of the task varies from place to place – some trusts say they are back to pre-COVID lengths of lists, others say their lists are “hugely challenging”.

We have heard about trusts’ focus on communicating with patients about their delayed treatment and efforts to make sure people are ‘waiting well’, as well as patient monitoring to assess risks.

Trusts are tackling waiting lists in a variety of ways, including use of the private sector, patient-initiated follow-up (PIFU), ‘accelerator sites’ and virtual outpatients. We have also heard how collaboration is already key in service recovery. Primary care services are taking advice and guidance from NHS trusts about diverting patients to more appropriate routes for their care – this was helping to slow the growth of waiting lists. However, we are also aware that this places extra pressures on primary care.

Technology and digital solutions are a significant part of trusts’ plans for helping people who need care while tackling their waiting lists. For example, we heard about an interactive digital outpatient platform in orthopaedics, enabling patients to track their post-operative recovery, check in on any changes in condition, and request follow-up or advice and guidance rather than following traditional face-to-face review methods. However, the trusts said that much of the innovation was in its early stages and had yet to be evaluated for its impact and outcomes for people who use services.

Increasing capacity will be important in tackling backlogs. In many hospitals, this starts with the de-escalation of intensive care unit capacity and reclaiming operating theatres, to create elective bed capacity, and bringing staff back to their substantive roles.

There are challenges for trusts: some hospitals are still experiencing high levels of COVID-19 patients, with intensive care unit beds and operating theatres used for these people; social distancing and infection prevention and control arrangements reduce the capacity of hospitals, especially for those with older estates or reduced space; and trusts report vacancies in key areas that they are struggling to fill.

We have heard how tackling inequalities is a focus in many recovery plans. However, much of this was in the planning – there were few examples of established initiatives or outcomes. We heard that people from areas of higher deprivation were more likely to experience longer waits or get admitted to hospital via ambulance, or not attend outpatient appointments.

Better NHS trust patient records and linkage with primary care datasets will be important for addressing inequality as local systems recover. Some trusts have acknowledged they need to improve the completeness of their records – this could help to identify barriers to care and help ensure that people’s characteristics are recorded on initial registration, or fill gaps during subsequent patient interactions.

Looking ahead

The pandemic has presented health and care services with major new challenges, but many of the problems it has revealed were present before it began. We know that many of the models of care designed before the

pandemic will not meet the needs of a post-pandemic world that has an increasingly aging population living with more complex co-morbidities.

There has been learning from the pandemic that is worth building on. The appetite to operate at pace, and encourage and fund new ways of working, could now help to develop better, more coordinated care for people delivered by local services working more effectively together.

The £5.4 billion investment in health and social care announced in September 2021 is welcome – this includes £500 million across three years to support the adult social care workforce. But we are increasingly seeing social care providers struggle to attract and retain staff, and the situation is serious and deteriorating.

There must be a sharp focus on developing a clearly defined career pathway for social care staff – linked to training and supported by consistent investment that will enable employers to attract and retain the right people.

Increased stability in social care is needed because it is also the key to 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 complex co-morbidities.

The discharge to assess fund during the pandemic has improved the flow of people out of hospital and made a crucial difference to the viability of some social care providers. Continuing this funding would enable social care providers to make longer term investments to provide much-needed step-down care, and build more meaningful relationships with primary, secondary and community care services, as well with third sector organisations and with carers. In addition to a commitment to longer-term funding, there is a need for accelerated funding to be made available now to targeted areas that are particularly struggling with demand, in order to urgently increase capacity over winter.

Ensuring services work for people locally has always been the challenge for everyone involved in health and care. For those leading services now, it means increasingly thinking of themselves as leader for their area as well as their organisation.

The goal for these leaders must be to use what we have learned from the pandemic around collaboration, and with that build both a better understanding of the health and care needs of their local area – accompanied by a single, fully resourced and outcome focused plan that includes all health and care professionals and everyone else involved in health and care.

These plans are being developed and implemented in some areas – the challenge is to create an environment that ensures they happen everywhere. The role for national leaders, including CQC, is to support this work and to maintain the focus on improved outcomes for people who use services.

Appendix: Ratings charts

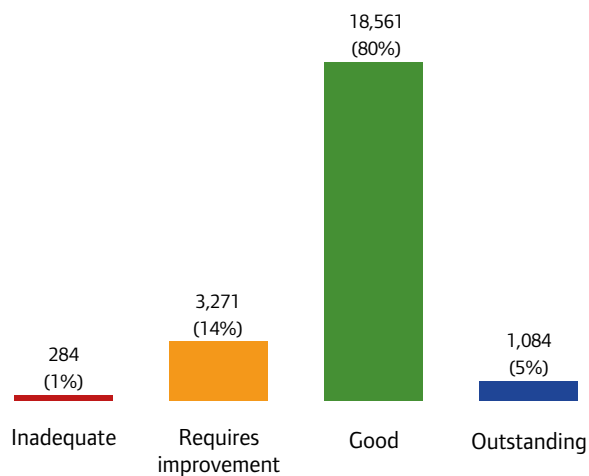
The care that people receive in England is mostly of good quality.
As at 31 July 2021:

- 80% of adult social care services were rated as good and 5% as outstanding
- 90% of GP practices were rated as good and 5% as outstanding
- 67% of NHS acute core services were rated as good and 8% as outstanding
- 68% of all mental health core services (NHS and independent) were rated as good and 10% as outstanding.

Adult social care

Figure A1

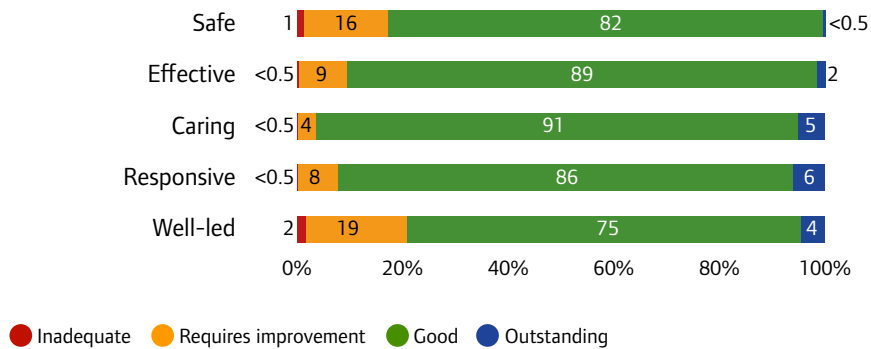
Adult social care, overall ratings, July 2021



Source: CQC ratings data, 31 July 2021 Note: The 2021 ratings also included 10 'insufficient evidence to rate' overall ratings, which represented 0.04% of the total ratings (including 'insufficient evidence to rate').

Figure A2

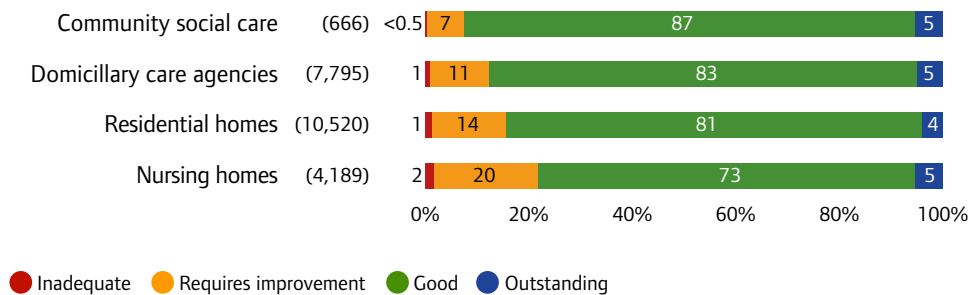
Adult social care, key question ratings, July 2021



Source: CQC ratings data, 31 July 2021. Note: percentages may not add to 100 due to rounding. At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.02% for caring, safe, effective and well-led and 0.03% for responsive.

Figure A3

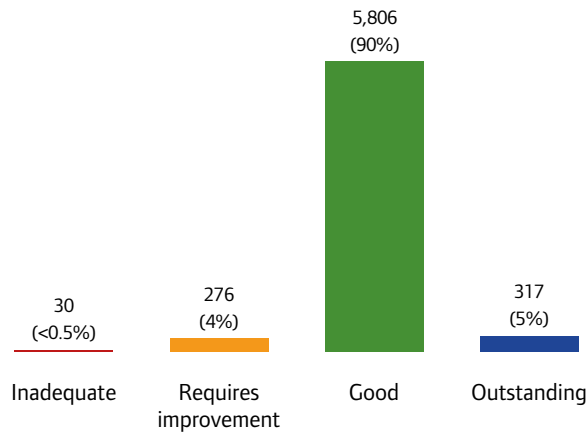
Adult social care, overall ratings by service type, July 2021



Source: CQC ratings data, 31 July 2021. Note: percentages may not add to 100 due to rounding. The 2021 ratings also included 2 'insufficient evidence to rate' overall ratings for nursing home, which represented 0.05% of the total ratings (including 'insufficient evidence to rate'). Numbers in brackets denotes the number of rated locations as at July 2021.

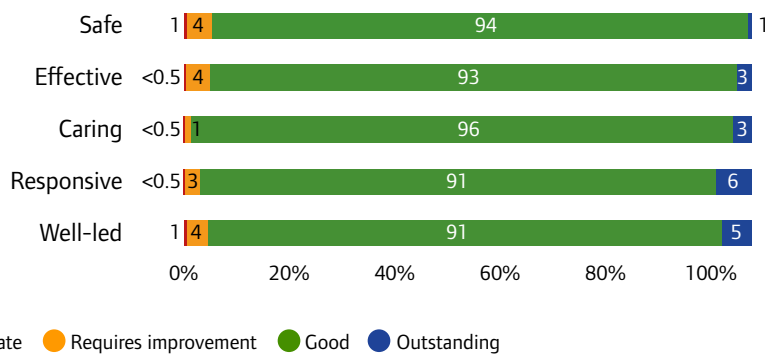
Primary care

Figure A4
GP practices, overall ratings, July 2021



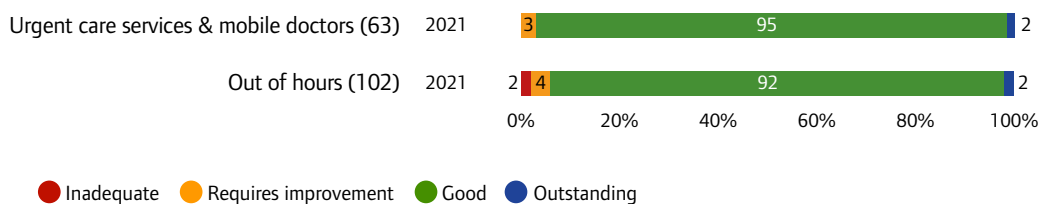
Source: CQC ratings data, 31 July 2021. Note: The 2021 ratings also included 11 'insufficient evidence to rate' overall ratings, which represented 0.02% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding.

Figure A5
GP practices, key question ratings, July 2021



Source: CQC ratings data, 31 July 2021. Note: 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, 0.06% for effective and 0.05% for responsive. Percentages may not add to 100 due to rounding.

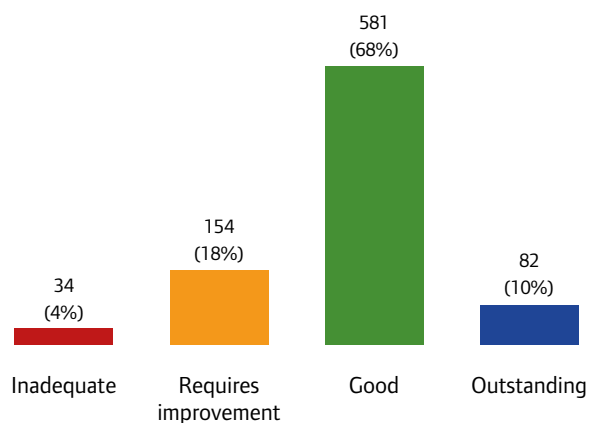
Figure A6
Other primary medical services, overall ratings, July 2021



Source: CQC ratings data, 31 July 2021. Note: number in brackets denotes the number of rated locations as at 31 July 2021.

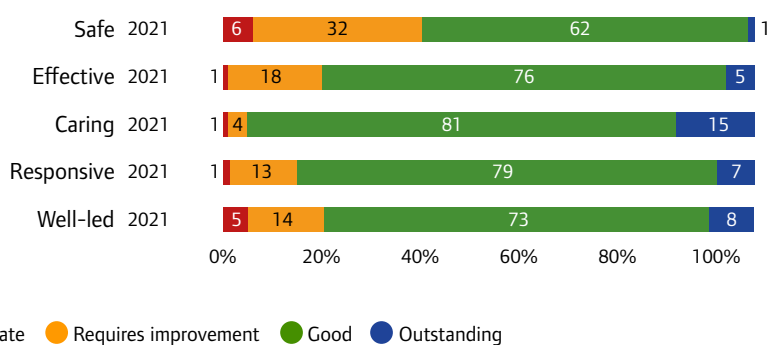
Mental health care

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



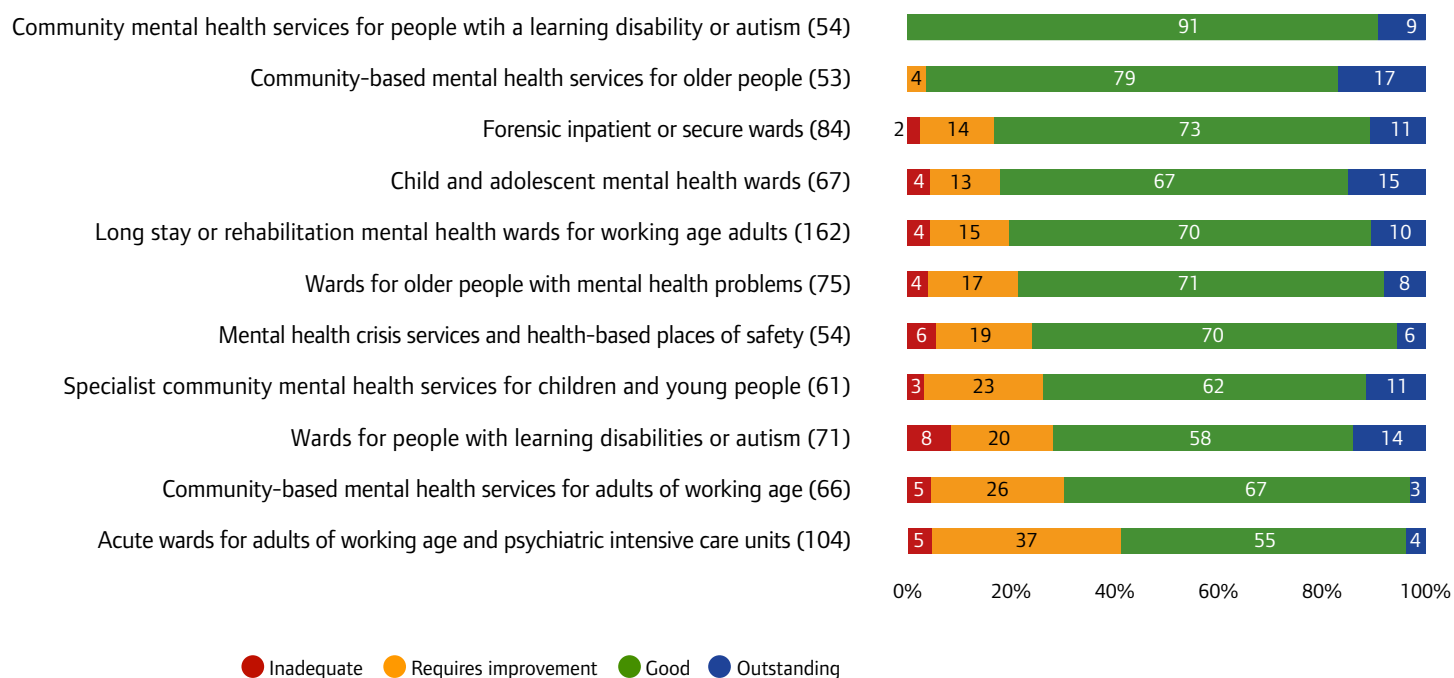
Source: CQC ratings data, 31 July 2021. Note: The 2021 ratings also included 3 'insufficient evidence to rate' overall ratings, which represented 0.4% of the total ratings (including 'insufficient evidence to rate').

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



Source: CQC ratings data, 31 July 2021. Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.4% for safe and well-led, 0.2% for caring and effective and 0.7% for responsive. Percentages may not add to 100 due to rounding.

Figure A9 NHS and independent mental health core services, overall ratings, July 2021

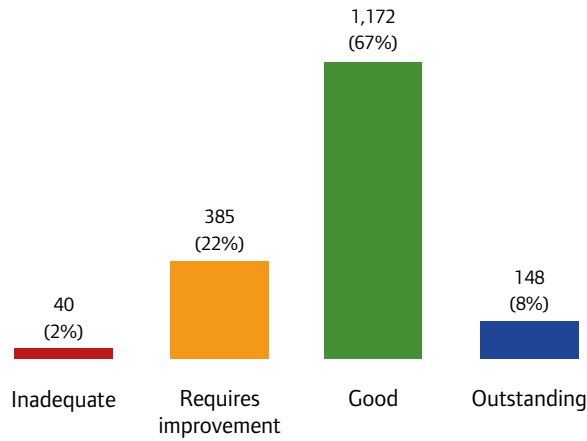


Source: CQC ratings data, 31 July 2021. Note: Numbers in brackets denotes the number of rated core services as at 31 July 2021. The 2021 ratings also included 3 'insufficient evidence to rate' overall ratings, which (including 'insufficient evidence to rate') represented the following proportions of the total core service ratings: 1% for 'acute wards for adults of working age and psychiatric intensive care units', and 'wards for older people with mental health problems' and 2% for 'community mental health services for people with a learning disability or autism'. Percentages may not add to 100 due to rounding.

Acute hospitals, ambulance services, community health care

Figure A10

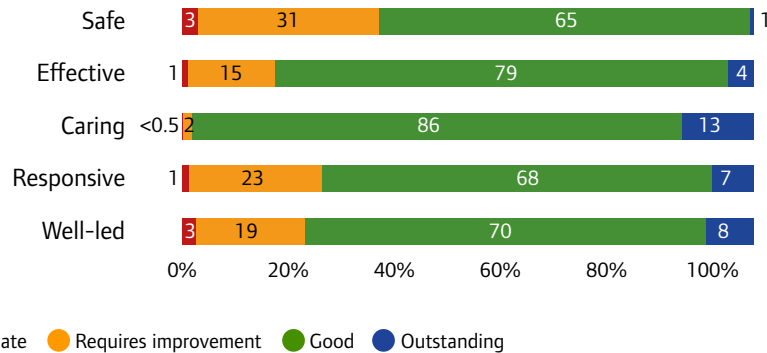
NHS acute core services, overall ratings, July 2021



Source: CQC ratings data, 31 July 2021. Note: The 2021 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

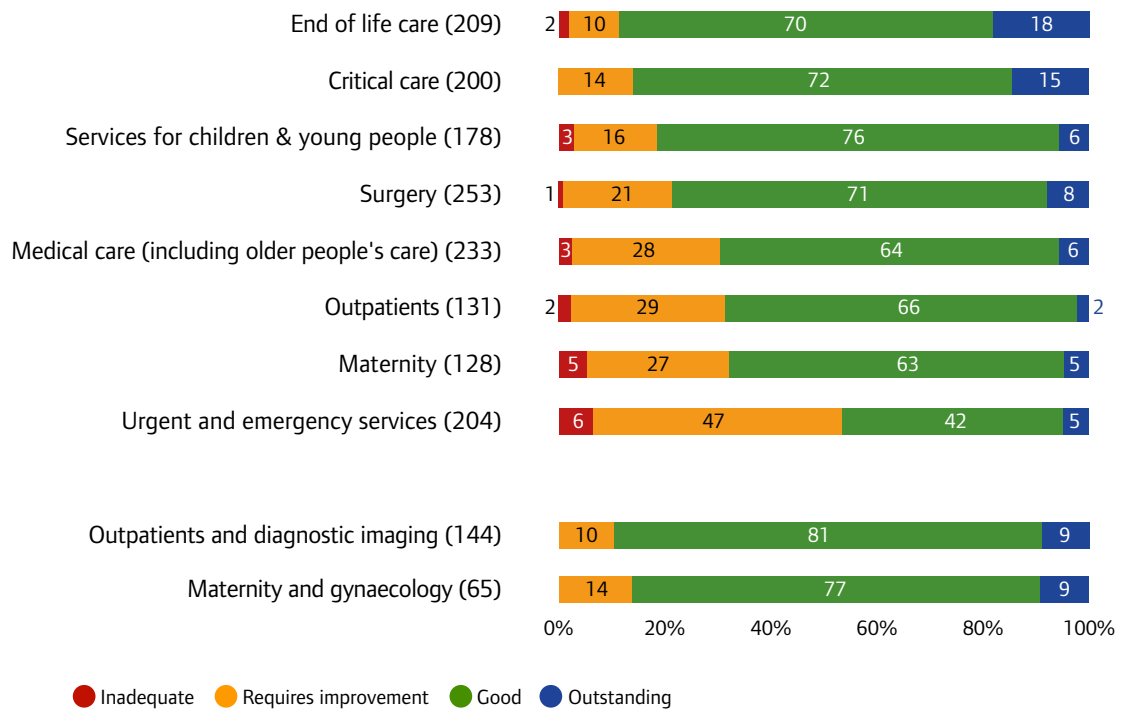
NHS acute core services, key question ratings, July 2021



Source: CQC ratings data, 31 July 2021. 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, 0.3% for caring and 10.3% for effective. Percentages may not add to 100 due to rounding.

Figure A12

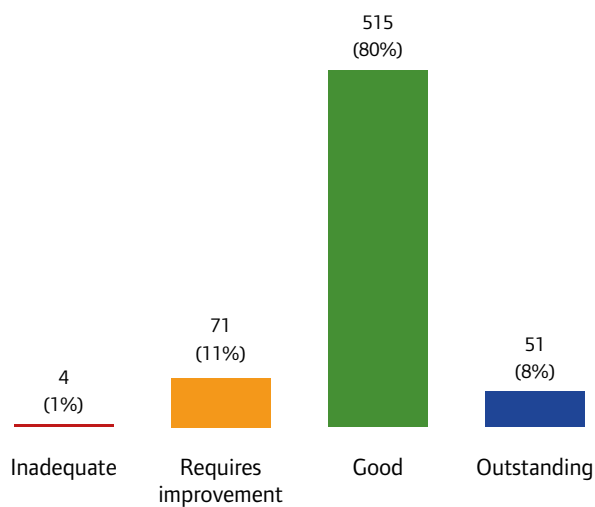
NHS acute core services, overall ratings, July 2021



Source: CQC ratings data, 31 July 2021. Note numbers in brackets denotes the number of rated core services as at 31 July 2021. The 2021 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', 0.7% for 'outpatients and diagnostic imaging' and 1.5% for 'maternity and gynaecology'. Percentages may not add to 100 due to rounding.

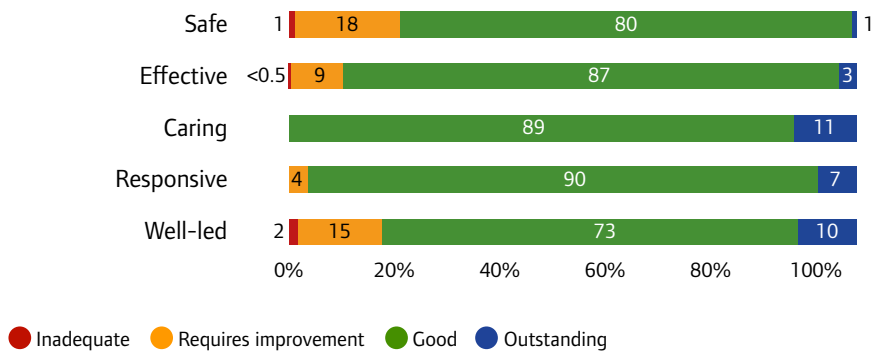
Figure A13

Independent health acute (non-specialist) core services, overall ratings, July 2021



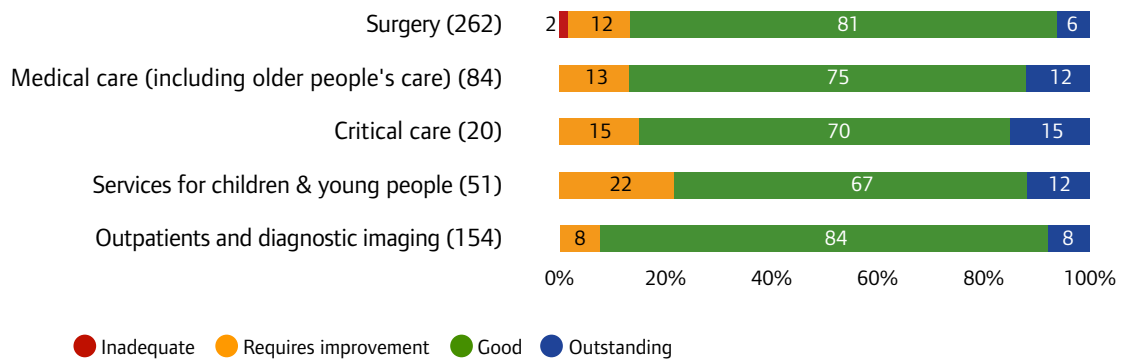
Source: CQC ratings data, 31 July 2021. Note: The 2021 ratings also included 14 'insufficient evidence to rate' overall ratings, which represented 2.1% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding.

Figure A14
Independent health acute (non-specialist) core services, key question ratings, July 2021



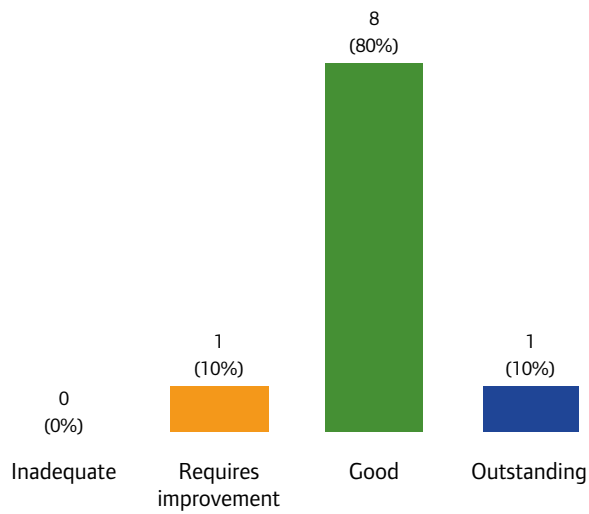
Source: CQC ratings data, 31 July 2021. Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 1.8% for safe, 2.1% for responsive, 2.0% for well-led, 4.8% for caring and 24.0% for effective. Percentages may not add to 100 due to rounding.

Figure A15
Independent health acute (non-specialist) core services, overall ratings, July 2021



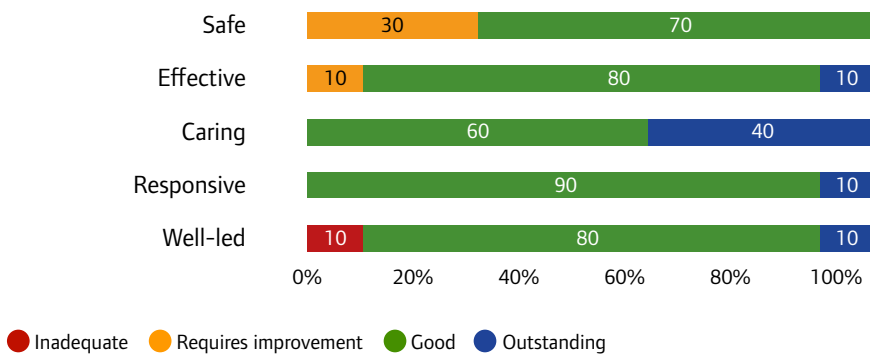
Source: CQC ratings data, 31 July 2021. Note: numbers in brackets denotes the number of rated core services as at 31 July 2021. The 2021 ratings also included 14 'insufficient evidence to rate' overall ratings, which (including 'insufficient evidence to rate') represented the following proportions of the total core service ratings: 9.1% for 'critical care', 5.6% for 'medical care (including older people's care)', 8.9% for 'services for children and young people' and 0.8% for 'surgery'. Percentages may not add to 100 due to rounding.

Figure A16
NHS ambulance trust, overall ratings, July 2021



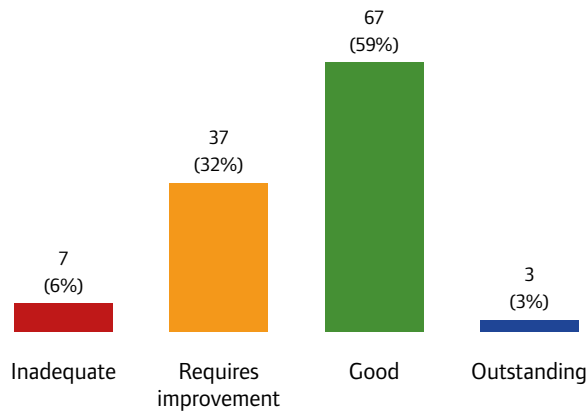
Source: CQC ratings data, 31 July 2021

Figure A17
NHS ambulance trust, key question ratings, July 2021



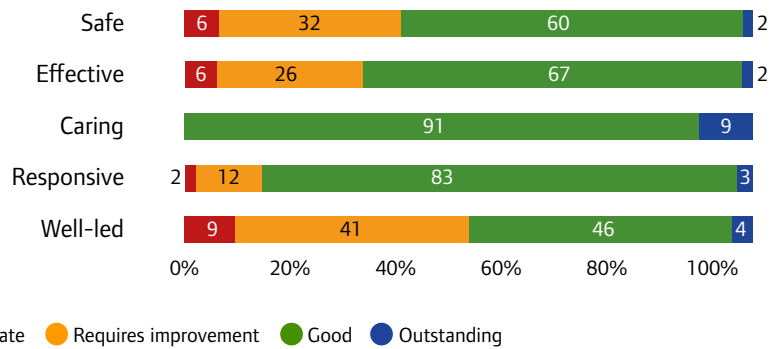
Source: CQC ratings data, 31 July 2021

Figure A18
Independent ambulance locations, overall ratings, July 2021



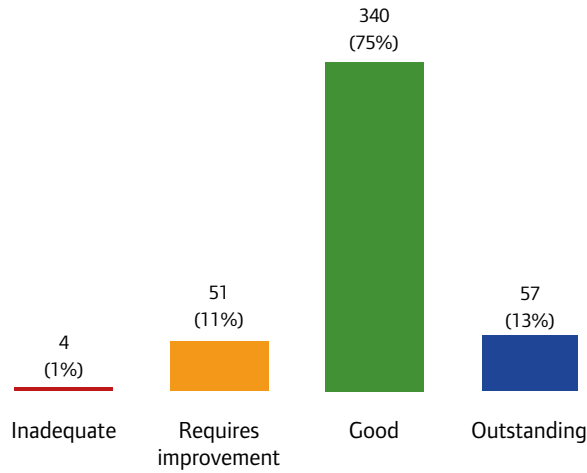
Source: CQC ratings data, 31 July 2021. Note: The 2021 ratings also included 48 'insufficient evidence to rate' overall ratings, which represented 0.9% of the total ratings (including 'insufficient evidence to rate').

Figure A19
Independent ambulance locations, key question ratings, July 2021



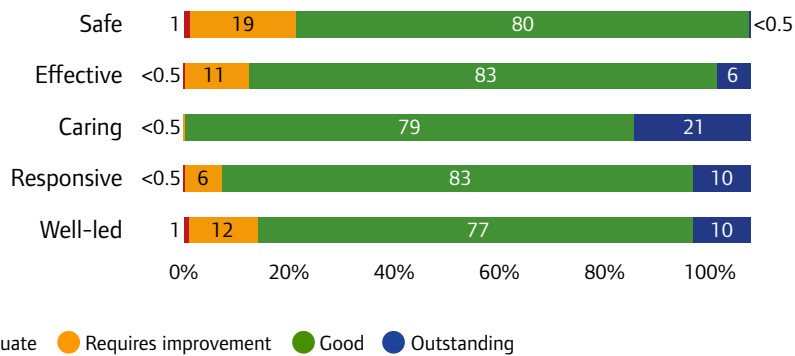
Source: CQC ratings data, 31 July 2021. Note: At key question level, 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.9% for safe, 2.7% for responsive, 1.8% for well-led, 36.0% for caring and 4.5% for effective. Percentages may not add to 100 due to rounding.

Figure A20
Community health core services in all settings, overall ratings, July 2021



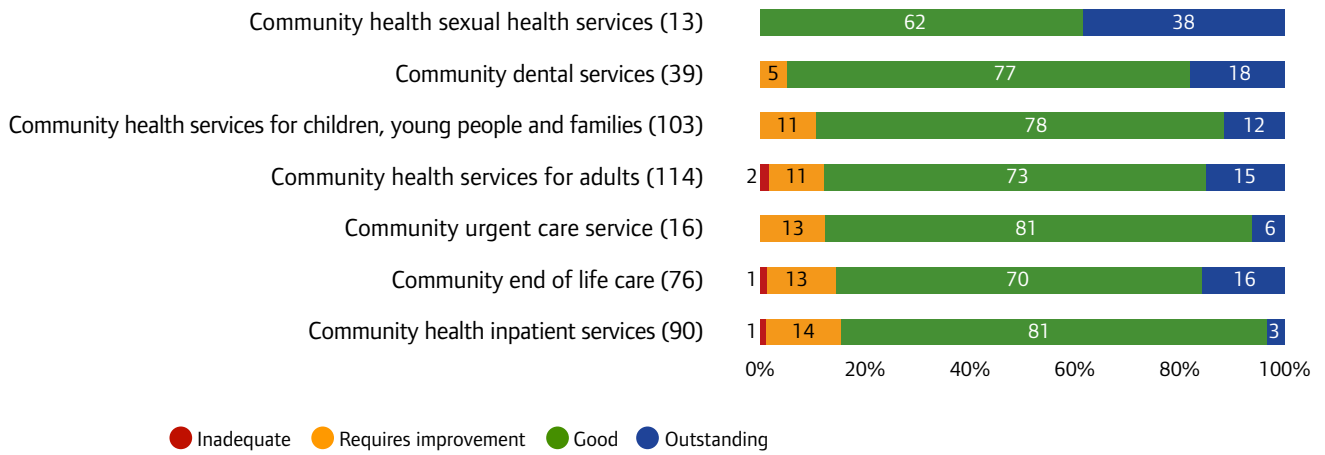
Source: CQC ratings data, 31 July 2021. Note: The 2021 ratings also included 6 'insufficient evidence to rate' overall ratings, which represented 0.2% of the total ratings (including 'insufficient evidence to rate').

Figure A21
Community health core services in all settings, key question ratings, July 2021



Source: CQC ratings data, 31 July 2021. 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 and well-led, 0.4% for effective and responsive and 0.7% for caring. Percentages may not add to 100 due to rounding.

Figure A22
**Community health core services in all settings,
 key question ratings, July 2021**



Source: CQC ratings data, 31 July 2021. Note: numbers in brackets denotes the number of rated core services as at 31 July 2021. The 2021 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: 2.6% for 'community health inpatient services'. Percentages may not add to 100 due to rounding.

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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

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