Care Quality Commission

The state of health care and adult social care in England
2022/23

State of Care

HC 1871

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HC 1871

Dedicated to our colleague Ian Dodds (1965-2023), who shaped and led the State of Care report since CQC's establishment in 2009.

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Foreword

This year has been a turbulent one for health and social care. In addition to the ongoing problem of 'gridlocked' care highlighted in last year's State of Care, the cost of living crisis is biting harder for the public, staff and providers – and workforce pressures have escalated. This combination increases the risk of unfair care, where those who can afford to pay for treatment do so, and those who can't face longer waits and reduced access.

Adult social care providers are facing increased running costs, including food and electricity, with some struggling to pay their staff a wage in line with inflation, which affects recruitment and retention. This is likely to have an impact on people, both in the quality of care they receive and in providers' ability to re-invest in care homes – data from our Market Oversight scheme shows that care home profitability remains at historically low levels.

Local authority budgets have failed to keep pace with rising costs and the increase in the number of people needing care. As adult social care places funded by a local authority are often less profitable, there is the risk that people who live in more deprived areas, and are more likely to receive local authority-funded care, may not be able to get the care they need.

Some people who pay for their own care at home have had to cut back on visits to support their basic needs. One homecare provider told us that, due to the cost of living crisis and increased fuel prices, it had to increase the rates charged. Because of this, some people had to reduce their care visits to a minimum, which had an impact on their quality of life.

Workforce pressures, already a huge challenge, have further intensified, with ongoing industrial action by NHS staff unhappy with pay and conditions. The number of people on waiting lists for treatment has grown to record figures and in the face of longer waits, those who can afford it are increasingly turning to private healthcare. Research from YouGov shows that 8 in 10 of those who used private health care last year would previously have used the NHS, with separate research showing that 56% of people had tried to use the NHS before using private healthcare.

The danger is that the combination of the cost of living crisis and workforce challenges exacerbate existing heath inequalities, increasing the risk of a two-tier system of health care. People who cannot afford to pay could end up waiting longer for care while their health deteriorates. Our adult inpatient survey, based on feedback from over 63,000 people, found that 41% felt their health deteriorated while they were on a waiting list to be admitted to hospital.

People may also be forced to make difficult financial choices. We heard from someone who receives benefits who resorted to extracting their own tooth because they were unable to find an NHS dentist. They then had to pay £1,200 on a credit card for private treatment, doing without household essentials until the debt was paid.

While the publication of the NHS Long Term Workforce plan has been a positive step in addressing workforce pressures, implementation will be challenging – particularly without a social care workforce strategy to sit alongside it. We continue to call for a national workforce strategy that raises the status of the adult social care workforce and ensures that career progression, pay and rewards attract and retain the right professional staff in the right numbers. It is encouraging that Skills for Care has made this a focus.

In our inspection activity, we have continued to take a risk-based approach this year, focusing our inspection activity on those core services that, nationally, are operating with an increased level of risk, and on individual providers where our monitoring identifies safety concerns. Ratings data shows a mixed picture of quality, with a notable decline in mental health and ambulance services.

We have continued our focused programme of maternity inspections, with the overarching picture emerging of a service and staff under huge pressure. Ten per cent of maternity services are rated as inadequate overall, while 39% are rated as requires improvement. Safety and leadership remain particular areas of concern, with 15% of services rated as inadequate for their safety and 12% rated as inadequate for being well-led.

While it has been encouraging that all maternity units inspected so far have adjusted the level of consultant cover to meet recommendations made in the Ockenden report, the cover model is often fragile, with rotas relying on every consultant being available. We have seen examples of services taking action to manage staff shortages safely – but we have also seen issues with governance and lack of oversight from trust boards, delays to care and lack of one-to-one care during labour, as well as poor communication with women and difficult working relationships between staff groups.

Alongside our programme of maternity inspections, we have commissioned a series of interviews with midwives from ethnic minority groups to explore their experiences of working in maternity services and their insights into safety issues. A common theme from these interviews was that care for people using maternity services is affected by racial stereotypes and a lack of cultural awareness among staff. One midwife told us; *"The NHS is amazing, but it was built by white people for white people. We need to adapt, because now we have a diverse population and workforce."*

Access to and quality of mental health care also remain key areas of concern, with gaps in community care continuing to put pressure on mental health inpatient services and many inpatient services struggling to provide beds. This, in turn, is leading to people being cared for in inappropriate environments – often in emergency departments. One acute trust told us that there had been 42 mental health patients waiting for over 36 hours in the emergency department in one month alone. When people do get a bed in a mental health hospital, the quality of care is often not good enough. Safety continues to be an area of concern, with 40% of providers rated as requires improvement or inadequate for safety.

Recruitment and retention of staff remains one of the biggest challenges for the mental health sector, with the use of bank and agency staff remaining high and almost 1 in 5 mental health nursing posts vacant. We've raised concerns that staffing issues in mental health services are leading to the over-use of restrictive practices, and we've worked with our expert advisory group for autistic people and people with a learning disability to develop a clearer and stronger position on these practices, including restraint, seclusion, and segregation. We expect all providers of health and social care to recognise restrictive practice and to actively work to reduce its use.

Many of the challenges described in this year's State of Care are to some degree caused by a lack of joined-up planning, investment, and delivery of care. Integrated care systems present the opportunity of bringing together local health and care leaders with the populations they support to understand, plan, and deliver care at a local level. This would, in time, move some of the focus of care away from big institutions and towards local and self-care provision, with autonomy to act on the needs of a local population and an increased focus on preventing poor health – not just treating it.

However, in our first look across local care systems, we found that while all systems have some equality and health inequalities objectives, not all these plans have timeframes and measures. All systems need clear and realistic goals, and support to achieve these, that reflect how they will address unwarranted variations in population health and disparities in access, outcomes, and experience of health and social care.

This opportunity must be grasped to ensure fairer care for everyone – so people get the care they need, not just the care they can afford.

Ian Trenholm
Chief Executive

Ian Dilks OBE
Chair

Summary

Access to care

Problems with people's access to care in England is an enduring issue that we have raised in successive State of Care reports.

Getting access to services remains a fundamental problem, particularly for people with protected equality characteristics. Along the health and care journey, people are struggling to get the care they need when they need it.

Record numbers of people are waiting for planned care and treatment, with over 7 million people on elective care waiting lists in June 2023. But the true number of people could be much higher, as some people who need treatment are struggling to get a referral from their GP.

In the community, people are facing ongoing struggles with getting GP and dental appointments. As a result, some people are using urgent and emergency care services as the first point of contact, or not seeking help until their condition has worsened.

Once at hospital, people are facing longer delays in getting the care they need. In 2022, over half (51%) of respondents to our urgent and emergency care survey said they waited more than an hour before being examined by a nurse or doctor, up from 28% in 2020.

Insufficient capacity in adult social care is continuing to contribute to delays in discharging people from hospital. Ongoing staffing and financial pressures in residential and community services are having an impact on the quality of people's care, with some at greater risk of not receiving the care they need.

Quality of care

The quality of care that people experience is affected by many different factors.

Increasing demand and pressures on staff are taking a toll on their mental health and wellbeing. Staff have told us how, without the appropriate support, this is affecting the quality of care they deliver.

Many people are still not receiving the safe, good quality maternity care that they deserve, with issues around leadership, staffing and communication. Ingrained inequality and the impact on people from ethnic minority groups remains a key concern.

The quality of mental health services is an ongoing area of concern, with recruitment and retention of staff still one of the biggest challenges for this sector.

Innovation and improvement varies, but the use of artificial intelligence (AI) in health care has the potential to bring huge improvements for people. Given the speed of growth of AI, it is important to ensure that new innovations do not entrench existing inequalities.

Inequalities

In our State of Care report in October 2022, we reported that inequalities pervade and persist – this year we highlight some people who are more likely to face inequalities in access and experience when using health and care services.

Midwives from ethnic minority groups say that care for people using maternity services is affected by racial stereotypes and a lack of cultural awareness among staff. They described a 'normalised' culture where staff tolerate discrimination from colleagues, and say they are less likely to be represented in leadership and managerial roles.

People from ethnic minority groups who have a long-term condition felt they were talked down to about their treatment and were not treated as individuals. They also said a lack of cultural competency was a barrier to receiving good quality care.

These people were also more than 2.5 times more likely to say that staff in the emergency department talked as if they were not there, compared with people in White ethnic groups who did not have a long-term condition.

Failures in the system and a lack of funding can mean that budgets are prioritised above truly person-centred approaches to support in supported living services.

The health and care workforce

Staff regularly fed back to us of being overworked, exhausted and stressed – sometimes to the point of becoming ill, injured or leaving their job altogether. They say this can affect their ability to provide safe and effective care to people.

Just over a quarter (26%) of NHS staff were satisfied with their level of pay. This is 12 percentage points lower than before the pandemic. Dissatisfaction with pay is linked to industrial action by healthcare staff during 2023.

In adult social care, some providers are struggling to pay their staff a wage in line with inflation.

Over half of the respondents to our survey of adult social care providers in England said they were having challenges recruiting new staff, and 31% said they were having challenges in retaining them.

Despite this, there has been a steady decrease in staff vacancy rates for care homes, from 11% in January to March 2022 to 7% in April to June 2023.

In 2022/23, approximately 70,000 people arriving to work in the UK from overseas started direct care roles in the independent adult social care sector, compared with around 20,000 in 2021/22. Providers of adult social care services have told us that recruiting staff from overseas has enhanced the diversity and skills of their team and helped resolve staffing issues.

But there is a growing trend of unethical international recruitment practices. In 2022/23, we made 37 referrals for concerns regarding modern slavery, labour exploitation and international visas – more than 4 times the number made in 2021/22.

Deprivation of Liberty Safeguards

There are ongoing problems with the current Deprivation of Liberty Safeguards system that have left many people who are in vulnerable circumstances without legal protection for extended periods.

In 2022/23, the number of applications to deprive a person of their liberty increased to over 300,000, with only 19% of standard applications completed within the statutory 21-day timeframe.

Delays in implementing the Liberty Protection Safeguards mean these challenges are likely to continue.

Systems

The way health and social care works in England has changed significantly over the past year, with new integrated care systems now formalised.

Local systems should now implement plans to address unwarranted variations in population health and disparities in people's access, outcomes, and experience of health and social care.

Local authorities are tackling workforce problems in adult social care and trying to address gaps in care as they plan for the future. But they will need to demonstrate an understanding and preparedness for the changing and complex needs of local populations.

Assessing carers' needs is vital. Carers, including many unpaid carers, are a critical part of all local care systems and they are not always getting the support they need – there is variation across the country and many carers are facing financial problems.

The effectiveness of urgent and emergency care services can indicate how effectively health and care services are co-ordinated across a local system. But we've seen that people's experience in urgent and emergency care continues to be poor and the problems are pointing to issues that require a local system level response.

Evidence used in this report

This report sets out the Care Quality Commission's (CQC's) assessment of the state of health care and adult social care in England in 2022/23.

In this report, we use data from our inspections and ratings, along with other information and personal experiences, including that from people who use services, their families and carers, to inform our judgements about the quality of care.

We have collected bespoke qualitative evidence to supplement our findings. Through this work, we have gathered views from our Operations teams and subject matter experts on quality issues, in particular for specific sectors of health and social care or aspects of our monitoring and regulatory approach.

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

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

Here, we provide further detail relating to the evidence used in this report.

People's experiences and what they have told us

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

- To understand the concerns and issues faced by the health and social care workforce, we analysed a random sample of 700 comments received from staff through Give feedback on care between 1 April 2022 and 31 March 2023. The sample was selected to represent all sectors in proportion to the number of staff from each sector who had left feedback throughout the year. This meant that the larger part of the feedback we analysed was from staff working for adult social care providers, with relatively fewer comments from people working in hospitals, GP practices and other care settings.
- We looked at 4,368 comments from Give feedback on care that we received from the first 42 locations that were part of the National Maternity Inspection Programme between August 2022 and March 2023. We also reviewed the first 30 published reports from the National Maternity Inspection programme to understand the emerging themes.

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

Towards the end of 2022, we recruited a group of young people aged between 13 and 25 from across England as 'Young Champions'. This is a group of volunteers who support and challenge us on the way we reach and engage with young people and represent their experiences across our work. We invited the Young Champions to help us inform this year's State of Care by co-designing and testing a survey about their experiences of health and care services and circulating it within their networks. We received feedback and experiences from 159 young people from the end of May to the beginning of July 2023.

In June 2023, we used our CitizenLab digital platform to reach out to providers to ask for feedback on their experience of using PEOPLE FIRST as part of the evaluation of this resource. This was to better understand how providers use this and other mechanisms to support them to improve. We received 384 responses to the questionnaire, including 97 from people in NHS services or integrated care systems, before the survey closed on 7 July 2023.

In June 2023, in partnership with Care England, we conducted a survey of adult social care providers. The survey sought to understand the challenges facing providers and asked questions around capacity, recruitment and retention, sustainability, innovation, and engagement with the local system. We received 1,928 responses spread across all regions and types of service. The survey closed on 12 July 2023.

Our National Clinical Advisors, Dr Emily Audet, Dr Victoria O'Brien and Dr Natalie Vanderpant co-led a piece of work to deepen our understanding of what good workforce wellbeing looks like. We created a survey sent to staff, providers and a wider group of stakeholders across all sectors to assess their views on workforce wellbeing. This had 2,420 respondents representing all health and social care sectors. We also engaged with health and care professionals, providers, and our own inspectors, through a series of focus groups to further explore what good workforce wellbeing looks like, and how CQC can help improve this. Responses from the survey and focus groups were analysed using both quantitative and qualitative methods.

To better understand factors affecting the experience of patients with long-term conditions, we conducted quantitative analysis of our inpatient, and urgent and emergency care surveys, as well as the GP Patient Survey from NHS England. We focused on how experiences differed for patients from different ethnic backgrounds.

For maternity care, we commissioned qualitative research to explore the experiences of staff from ethnic minority groups working in NHS maternity services. The research comprised 10 interviews with midwives from ethnic minority groups during June and July 2023.

To ensure we have a better understanding of the voices of people from ethnic minority communities who have a long-term health condition, we commissioned the NHS Race and Health Observatory and the Race Equality

Foundation to review relevant literature and conduct interviews with people with lived experience. This project involved 30 participants from a range of ethnic backgrounds and demographics. It included 2 group interviews with 23 people and 7 one-to-one interviews during July 2023.

Specific areas of risk

For this year's report, we also used information from our Medicines Optimisation team about specific areas of risk with medicines. The team gathered information by:

- speaking with NHS trusts to understand how well prepared they were to ensure that people who experience a sickle cell crisis can access timely and effective pain relief
- speaking with a range of providers and other stakeholders to understand how they were managing medicines in virtual wards and how CQC can work with them to help drive improvement in this area
- highlighting areas of risk and good practice in relation to the safer management of controlled drugs, through our regulatory oversight activity and inspection findings in 2022.

Local health and care systems

To form an initial view of the performance of local authorities regarding their adult social care duties, we carried out a desk-top assessment of 2 quality statements: 'care provision, integration and continuity' and 'assessing needs'. The quality statements in our new assessment framework are the commitments that providers, commissioners and system leaders should live up to and show what is needed to deliver high-quality, person-centred care. The findings of this review are based on our review of publicly available information for all 153 local authorities in England. It includes, where available, carers strategies, joint workforce development plans and market position statements. We only considered documentation from March 2020 and did not measure how they were implemented or their impact as part of this methodology.

For a view on local systems, we undertook a desk-top assessment of the 'equity in access' quality statement for all 42 integrated care systems in England. Our findings are based on reviewing publicly available information that related to the system's vision and strategies for: integrated care, equity in access or equalities, engagement or people and communities, as well as Healthwatch reports and minutes of board meetings. We considered publicly available health data reflecting healthcare inequalities to understand differences in care provision across areas. Again, we did not measure how the documents were implemented or their impact on equity of access, as it was too early to do so.

Providers of health and care services

For providers of health and adult social care services, we have used the data and insight gained through our routine monitoring of and engagement with providers, for example information collected through our surveys and our notifications data.

To help us understand how adult social care providers are responding to challenges and improving services, we qualitatively analysed information submitted through provider information returns. We ask adult social care providers to complete a provider information return (PIR) form every year. As well as helping to monitor the quality of care, the PIR gathers qualitative data through a set of 12 open-ended questions, asking the provider about any changes that have been made in the past 12 months and how they are ensuring their service is safe, effective, caring, responsive and well-led. We used PIRs submitted between 1 April 2022 and 31 March 2023 in this analysis. We analysed a random sample of 97 PIR documents, using a mix of adult social care providers, including both residential and homecare services.

Provider information returns were also used to report on vacancy, turnover and occupancy rates in adult social care providers between 1 April 2021 and 31 July 2023.

We analysed notes from group discussions of the Supported Living Improvement Coalition (collected August to December 2022), inspection additional question notes (collected May and June 2022), and transcripts from interviews and focus groups with Coalition partners. Our thematic analysis explored what respondents told us and made inferences about what their feedback might mean.

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

We have conducted quantitative analysis of our inspection ratings of more than 33,000 services and providers. Aggregated ratings for the main sectors and services we regulate are provided in the data appendix of this report. In March 2020, we paused routine inspections and focused our activity where there was a risk to people's safety. Since then, we have continued to carry out inspection activity where there were risks to people's safety or where it supported the health and care system's response to the pandemic. We have also started to carry out inspections in low-risk services to quality-assure our risk identification process.

We continue to review and improve our ratings data on an ongoing basis. This means our figures for 2022 ratings may vary to what we published in last year's State of Care.

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

The ratings data for primary medical services, adult social care and NHS ambulance trusts were extracted on 1 August 2023, while ratings for NHS acute hospital services and independent health services were extracted on 7 September 2023.

Statutory responsibilities

We report on our own notifications data for Deprivation of Liberty Safeguards (DoLS) received between 1 April 2022 and 31 March 2023, excluding Court of Protection orders and notifications from primary medical services, as well as the annual data publication from NHS England published on 24 August 2023.

We also analysed qualitative data gathered from a survey distributed in June 2023 to members of an Expert Advisory Group to examine the DoLS system. It included 6 open-ended questions seeking insights around the management of the safeguards, instances of unlawful deprivation of liberty and the impact caused by delays in the implementation of Liberty Protection Safeguards. Nine professionals engaged in the field of DoLS participated.

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 DoLS.

Access to care

Key points

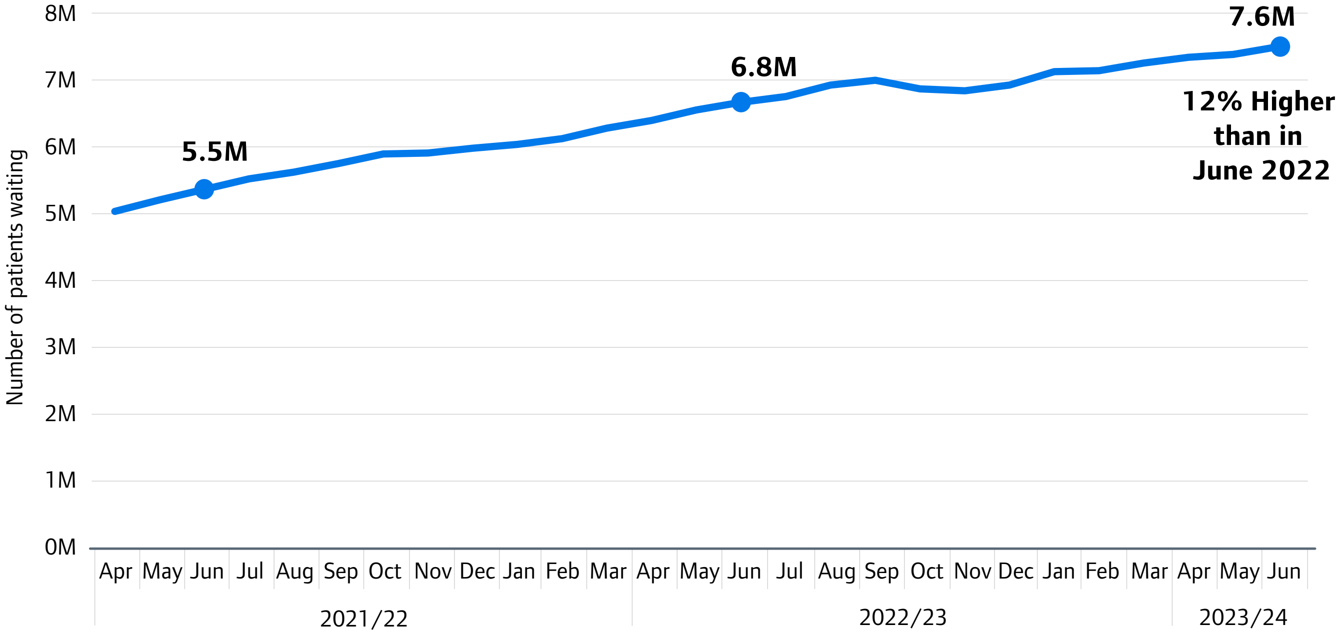
- Getting access to services remains a fundamental problem, particularly for people with protected equality characteristics. Along the health and care journey, people are struggling to get the care they need when they need it.
- Record numbers of people are waiting for planned care and treatment, with over 7 million people on elective care waiting lists at June 2023. But the true number of people could be much higher, as some people who need treatment are struggling to get a referral from their GP.
- In the community, people are facing ongoing struggles with getting GP and dental appointments. As a result, some people are using urgent and emergency care services as the first point of contact, or not seeking help until their condition has worsened.
- Once at hospital, people are facing longer delays in getting the care they need. In 2022, over half (51%) of respondents to our urgent and emergency care survey said they waited more than an hour before being examined by a nurse or doctor, up from 28% in 2020.
- Insufficient capacity in adult social care is continuing to contribute to delays in discharging people from hospital. Ongoing staffing and financial pressures in residential and community services are having an impact on the quality of people’s care, with some at greater risk of not receiving the care they need.

Long waits for care

Access to services remains a fundamental problem. At every point along the health and care journey, people are struggling to get the care they need when they need it.

This is reflected in the number of patients waiting for treatment. Over the last year, this has continued to increase. In June 2023, the number of people waiting for treatment was 12% higher than in June 2022. This reached record levels with almost 7.6 million people on the waiting list for planned hospital treatment (figure 1).[1]

Figure 1: **Number of people waiting for treatment, April 2021 to June 2023**



Source: NHS England Consultant-led referral to treatment times

Our recently published adult inpatient survey is based on feedback from over 63,000 people who were in hospital in November 2022.[2] This found that 39% of patients who were on a waiting list would like to have been admitted sooner, and 41% felt their health got worse while they were on a waiting list to be admitted to hospital.

This picture is unlikely to be improved by a year of industrial action.

NHS England published information collected from NHS hospitals which indicates that, as at the end of September 2023, 119,153 operations and 895,914 outpatient appointments were rescheduled over the 48 days of strikes since December last year. However, analysis from the Nuffield Trust suggests that strikes alone are not to blame for continued long waits, given that the number of planned operations hadn't yet recovered even to pre-pandemic levels before the strikes began.[3]

To address the problem of long waiting lists, in February 2022 NHS England published its elective recovery plan. This set out its commitment that by

April 2023, no one would have to wait more than 78 weeks for treatment. Although there has been substantial progress towards this goal, figures show that as at June 2023, there were still more than 7,000 patients waiting more than 78 weeks (down from more than 69,000 when the plan was published in February 2022).

The NHS Constitution sets out that patients should wait no longer than 18 weeks from a GP referral to starting treatment.[4] However, the percentage of patients starting treatment within 18 weeks has continued to get worse (declining from 72% in April 2022 to 67% in June 2023). The proportion of people waiting for more than 52 weeks as at June 2023 varied between the regions in England: from 3% in both the London region and the North East and Yorkshire region, to 7% in the North West region.

Tackling long waiting lists

One Devon is an integrated care board (ICB) with an innovative approach to tackling long waiting lists in its local area in Devon. It worked with local NHS trusts, including the Royal Devon University Health Foundation Trust (RDUH), Torbay and South Devon Foundation Trust, and University Hospitals Plymouth Trust to improve access by creating new ‘elective accelerator’ sites. To do this, the ICB supported RDUH in its bid to secure some of the £160 million funding from NHS England to convert the Exeter Nightingale hospital, set up as part of the emergency response to COVID-19, into an elective centre delivering additional orthopaedic, ophthalmology and diagnostic activity.

Two clinical leaders – one from RDUH and one from the Torbay and South Devon Foundation Trust – then developed a new model of care for patients. Examples included people who needed hip and knee replacements being treated as day cases or, at most, having one overnight stay. The unit started taking patients in March 2022, initially operating 3 days a week but later extending this to 6-day working.

The new unit means patients are seen more quickly, with shorter inpatient stays and improved outcomes. Of 854 patients treated, over 99% have gone home within a day, with 57% of them leaving the same day. The centre has also improved how services work as a system and has shared learning across the trusts.

For more information see the NHS Confederation website

Often, people are struggling to get a referral in the first place. Results of a survey by Healthwatch, published in April this year, looked at the experience of 1,500 people trying to get a referral for a hospital appointment from their GP. It highlighted the ‘hidden waiting list’ of people needing a referral for hospital treatment and found that nearly 1 in 5 people (18%) had to visit their GP 4 or more times before getting a referral. Furthermore, the survey found 11% of people had to wait over 4 months from their first GP appointment to being referred. GPs are being encouraged to use Advice and Guidance services and other community pathways before referring people to hospital, which may have contributed to this.[5]

Waiting for treatment is not only a risk to people's physical health, but also their mental wellbeing. In its December 2022 Winter Survey, the Office for National Statistics (ONS) reported that of the 2,524 respondents, around a third (34%) of adults currently waiting to start NHS treatment said the wait had a strong negative impact on their life, while 42% reported it had a slight negative impact on their life. The most commonly reported negative impacts were:

- 'my wellbeing is being affected' (59%)
- 'it has made my condition worse' (36%)
- 'my ability to exercise is being affected' (34%)
- 'my mobility is being affected' (33%).[6]

In the face of longer waits, some people are turning to private health care.

A recent survey of 2,000 people commissioned by the Independent Healthcare Provider Network showed that 46% of those who'd used private health care said being unable to get an NHS appointment was a factor in their decision. It also showed that 56% of people had tried to use the NHS before using private healthcare.

Furthermore, a YouGov survey of over 8,000 adults earlier this year showed that 1 in 8 respondents had used private health care in the last 12 months. Of these people, 33% said it was the first time they had used private health care instead of the NHS. A further 48% said while it was not their first time using private health care, they would usually use an NHS service.[7] This means that around 8 in 10 of those who used private health care last year were people who previously would have always or typically used the NHS.[8] Over half (53%) of people who had used private healthcare said it was so they could be seen more quickly.[9]

This is likely to exacerbate existing health inequalities and increase the risk of a two-tier system of health care, with people who can't afford to pay having to wait longer for care and risking deteriorating health.[10,11,12]

Referrals for cancer treatment

In last year's State of Care, we highlighted our concerns around the length of time people were waiting for elective care and cancer treatment from NHS services, with people living in the worst performing areas more than twice as likely to wait more than 18 weeks for treatment as people living in the best performing areas.[13]

In a bid to address lengthy wait times, NHS England introduced a new target called the Faster Diagnosis Standard (FDS) in April 2021. The target is that, by March 2024, at least 75% of people should either receive a cancer diagnosis or have it ruled out within 4 weeks (28 days) of an urgent GP referral.

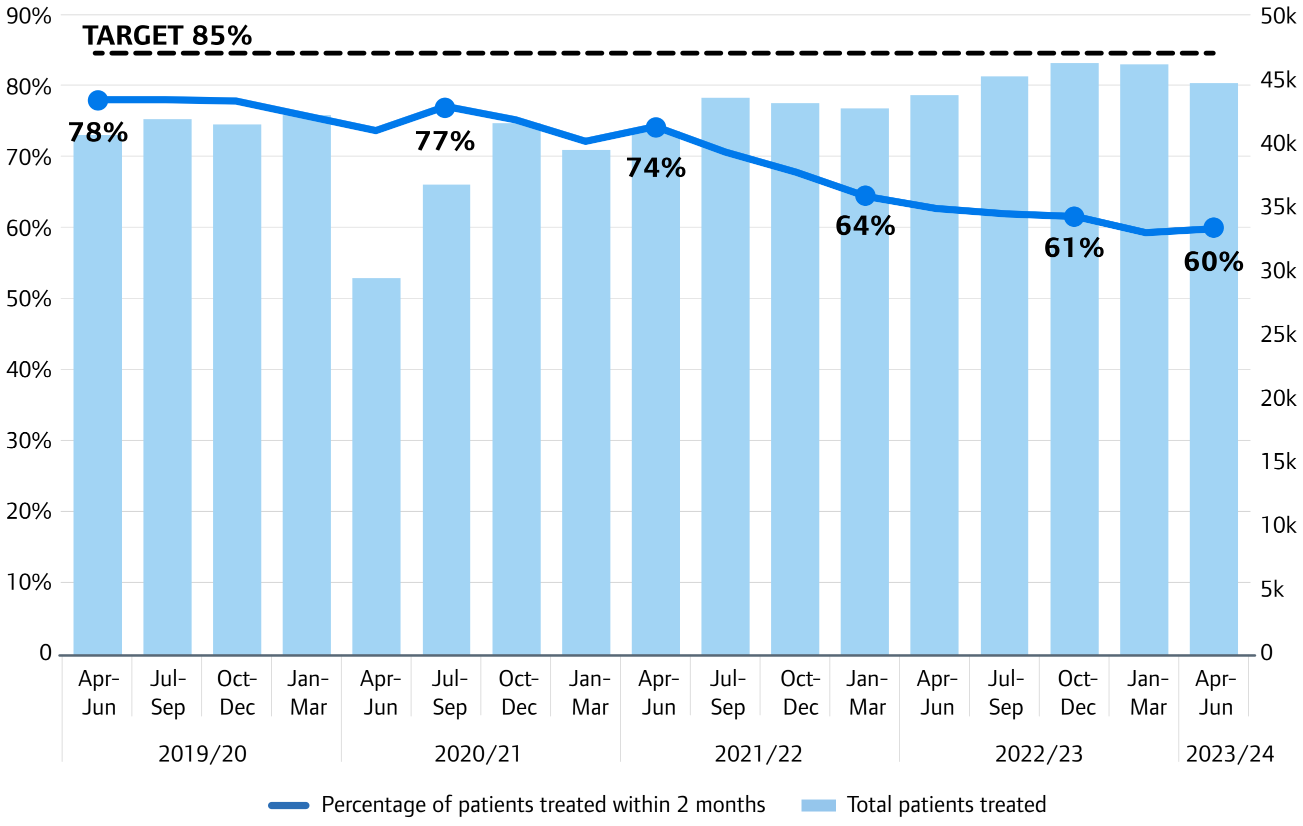
In August 2023, NHS England confirmed plans to consolidate the 10 performance standards for cancer, including the FDS, into 3 key standards. This includes the '28-day Faster Diagnosis Standard', which outlines that patients with suspected cancer who are referred for checks by a GP, screening programme, or other route should be diagnosed or have cancer ruled out within 28 days.[14]

It is important to acknowledge that national data does not always fully reflect people's experiences. Research from Healthwatch published in July 2023 highlighted an additional 'hidden wait' specifically for cancer care. In this survey of 385 adults who were referred or expected to be referred for cancer treatment, almost half (45%) said they were not referred for suspected cancer at their first appointment, and over 1 in 4 (28%) had to wait up to a month after their first appointment to be told they were being referred.[15]

As with the delays in GP referrals for other conditions, in some cases, people said this was because the GP team wanted to try other treatment or medication first before referring them. But in other cases, people described feeling that their condition was not being taken seriously, or that they felt they struggled to make themselves heard or understood.[16]

Once they received a referral, people said they often faced ongoing delays. This is supported by data from NHS England, which shows that overall waiting times for people waiting to start cancer treatment are continuing to get worse. In the period April to June 2023, of those receiving their first treatment, 18,193 people (40%) had waited more than 2 months to start treatment following an urgent GP referral (figure 2).

Figure 2: **Two-month wait from GP urgent referral to a first treatment for cancer by quarter, April 2019 to June 2023**



Source: NHS England Cancer Waiting Times

Note: Total number of patients to receive a first treatment for cancer following a decision to treat, both within and outside the target, per quarter.

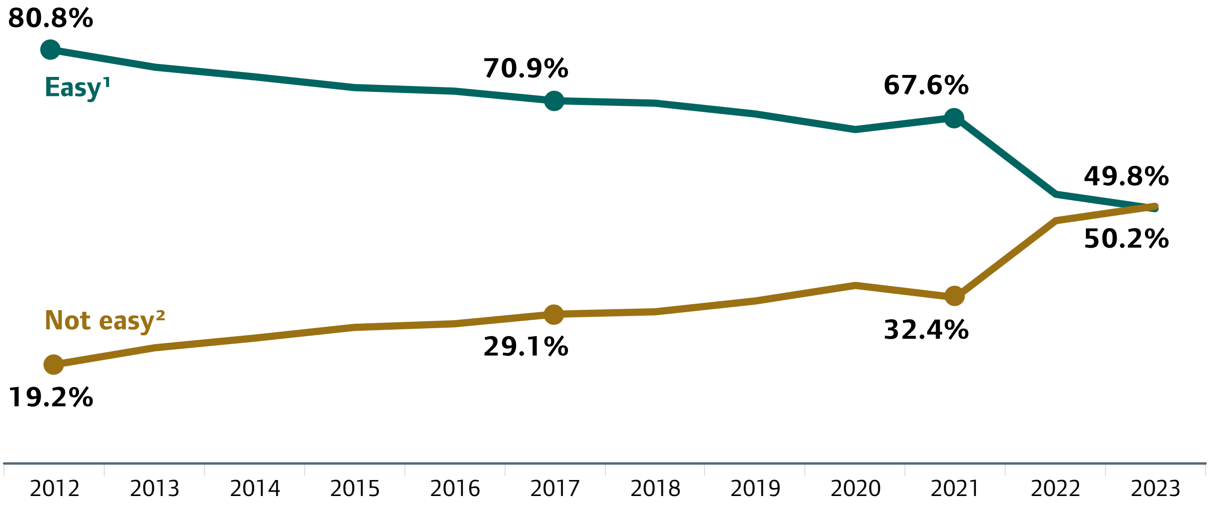
In its July report, Healthwatch England also found that nearly a quarter (23%) of people who experienced a delay in their cancer referral said their condition deteriorated. Respondents also highlighted the negative impact on their mental health and wellbeing.[17]

This is supported by the findings of an April 2023 survey of 1,000 UK adults who have had or currently have cancer. Carried out by cancer charity Maggie's, it found that 3 in 5 (58%) respondents said they felt that the mental challenge of cancer is harder to cope with than the physical treatment and side effects. In addition, 52% of people with cancer who responded said they felt there was support for the physical impact of cancer, but not for the emotional effects.[18]

Access to GP practice appointments

For many people, getting an appointment at an NHS GP practice is the first challenge. The 2023 NHS GP Patient Survey shows that people are finding it more and more difficult to contact their practice. This year, only half (50%) of the respondents said it was easy to get through to someone at their GP practice on the phone (figure 3). This is lower than all previous years since the question was introduced in 2012.

Figure 3: **2023 GP Patient Survey – how easy is it to get through to someone at your GP practice on the phone?**



Source: NHS England GP Patient Survey

Note: Easy[1] = 'very easy' + 'fairly easy', Not easy[2] = 'not very easy' + 'not at all easy'

At the same time, data from NHS England shows that over the last 2 years, more people are waiting for over 2 weeks for an appointment with a healthcare professional from their GP practice, as 16% of appointments are taking place more than 2 weeks after they were booked.

While some of these appointments will be deliberately booked for 2 weeks or more ahead, findings from the GP Patient survey show that satisfaction with appointment times has decreased to the lowest level across the last 6 years. Out of over 750,000 respondents to the survey, 16% said they were not initially able to get an appointment when they last tried to make one (either they did not take the appointment offered or they were not offered an appointment). Of these:

- 43% said they were not offered an appointment (an increase from the 2022 and 2021 surveys)
- 32% said there were no appointments available for the time or day they wanted
- over 11% said the appointment wasn't soon enough.

Some people are at greater risk of not being able to see their GP. For example, for people living in areas of higher deprivation the ratio of GPs to patients is much lower than in more affluent areas. Data from the ONS shows that, at October 2022, GP practices in the most deprived areas in England had 2,400 patients for each fully-qualified doctor, compared with 2,100 patients for each fully-qualified doctor in the least deprived areas.[19] Although the number of patients per fully-qualified doctor has increased since 2018, regardless of the level of deprivation, the numbers of patients per qualified doctor have increased more slowly in areas with the lowest levels of income deprivation.[20]

On average, people living in more deprived areas have shorter lives and spend more time living with diagnosed long-term illness and, as a result, will need to see their GP more often.[21] Having more patients for each GP means that people in these areas are at higher risk of not being able to see their GP and get the care they need, in turn compounding existing health inequalities. The findings of the 2023 GP Patient Survey also show that people living in the most deprived areas reported a less positive overall experience.

We have seen some positive examples of providers taking steps to address issues of inequality when trying to access care. In the following example, a project took proactive steps to improve the heart health of people in a local population by spotting the early signs of heart disease and preventing the need for an urgent GP appointment.

Liverpool Healthy Families Heart project

Cardiovascular disease is the largest cause of premature deaths in deprived areas. It's also been identified as the single biggest area where the NHS can save lives over the next 10 years.

Liverpool Heart and Chest Hospital NHS Foundation Trust recognised the risk this disease posed to people living in its local area, where nearly half of the city's primary schools are in highly deprived areas. To tackle this problem, the trust worked with the Heart Research UK charity, Liverpool Football Club Foundation and Aintree Primary Care Network to pilot a health check day at a local primary school.

As part of the day, a Heart Health Bus was parked outside the school to enable nurses to check blood pressure and pulse for teachers, carers and parents. This would help to identify any early signs of heart disease, so that people could be referred for further checks. Healthcare professionals were also on hand to give out healthy lifestyle advice and signpost people to other support services such as stopping smoking.

Evaluation of the day suggests it had a big impact in the community – both in terms of raising awareness of cardiovascular disease and identifying people potentially at risk of developing it. Of the 101 people who attended the bus during the day, nurses found that 16% of the attendees had raised blood pressure. While a single reading is not a diagnosis, for some this will be the first important step on the way to confirm high blood pressure and to manage their risk of developing heart disease.

The same issue also affects people receiving adult social care. Some adult social care service providers have told us about the difficulties in getting an appointment at their GP practice for the people they care for. Anecdotally, we have heard this is particularly hard for people in supported living services, with some reports of managers having to wait on hold on the phone for hours to get a GP appointment.

When people cannot have regular health check-ups, treatments and specialist services, their existing medical conditions are more difficult to manage and this can lead to their health getting worse.

Access to primary and preventative health care is a particular risk for autistic people and people with a learning disability. Data from the 2021 LeDeR report (Learning from Lives and Deaths – people with a learning disability and autistic people) showed that 49% of deaths of people with a learning disability were avoidable, compared with 22% for the general population.[22]

The section in this report on autistic people and people with a learning disability provides more detail about the experiences of health and social care for this group.

Access to dental care

In last year's State of Care, we highlighted the huge impact of COVID-19 on dental services. Although there had been some improvement, the amount of dental treatment being delivered (measured in units of dental activity) was 30% lower than before the pandemic.[23] This year, recovery has continued to be slow with data from NHS England for 2022/23 showing that the average quarterly units of NHS dental activity were 14% lower than the average activity in the 2 years before the pandemic. However, this had improved by the end of 2022/23, with units of dental activity reaching pre-pandemic levels in January to March 2023.

But getting access to NHS dentists is still a key concern for people. Issues with access to NHS dental care are widespread, affecting almost every part of the country.[24] In last year's State of Care, we highlighted research from the British Dental Association (BDA) showing that across England, 9 out of 10 (91%)

NHS dental practices were not accepting new adult patients.[25] Data from a March 2023 YouGov survey of 2,104 people found that 1 in 5 respondents (22%) were not 'registered' with a dentist. Of those, 37% said this was because they couldn't find an NHS dentist.[26]

Looking across England, data from NHS England shows that up to the end of June 2023, only 38% of adults in the South East had seen an NHS dentist in the previous 2 years, compared with 48% in both the North West and North East and Yorkshire. In London, 50% of children had seen an NHS dentist in the previous 12 months compared with almost two-thirds (61%) in the North West of England.

"Finding a dentist in our area is a massive problem"

"In March 2020, I went to my dentist for a root canal treatment and was given a temporary filling. I am 49 and, until the pandemic, had been with the same dentist since I was 19. My family never struggled to get an appointment and the dentist's care went above and beyond.

When it was time to go back for a permanent filling, we went into the first COVID lockdown. Two weeks into lockdown, the temporary filling fell out and I was in excruciating pain. I phoned the dentist but was told they were retiring and the practice was due to close completely. I wasn't given any advice on finding alternative NHS treatment.

I managed to find a temporary filling kit but this made the pain worse. In April 2022, I joined the waiting list for a local NHS dental practice. I was able to get emergency NHS treatment with them, before being accepted on their books, and had a filling, which temporarily relieved my pain.

When the tooth eventually cracked in half, I went back to the practice but was told they were not treating emergencies, only people already on their books. I felt forced to literally take matters into my own hands by wobbling the tooth for a few hours until I finally managed to remove it. But some roots remained in my gum and caused awful pain. I also felt very self-conscious about the gap left by my DIY extraction.

My struggle to access emergency NHS treatment continued. My mum even asked if her own NHS dentist could treat me, but they said they did not have capacity. However, they did have a private dentist who could offer treatment, at a cost of £1,200. This put me in a difficult position as my family receive tax credits and our dental treatment had been free previously. My mum offered to pay and the dentist was absolutely lovely; he was very apologetic about not being able to take me on his NHS books but explained his NHS quota was full.

The following year, I developed extremely painful toothache on the other side of my mouth. The dental practice where I was on the waiting list could only offer private treatment. They suggested I visit A&E but I absolutely didn't want to do that. I might have been able to have the tooth extracted in A&E, but without a replacement, I know having a gap in my teeth would have affected my self-esteem and I wouldn't have wanted to smile again. I also felt I should have been able to access NHS dental care in the first place, and was very reluctant to add to the already-stretched workload at my local A&E.

> I eventually spent another £1,200 on private dental treatment, which I'm still paying for on a credit card. This means making difficult decisions about which household essentials we can go without until the debt is paid. Finding an NHS dentist in our area is a massive problem. Three and a half years later, I'm still on the waiting list and it seems the only way forward is to go private. I'm worried about something else happening and still not getting in at an NHS dentist."
>
> **What a person told us about their personal experience**

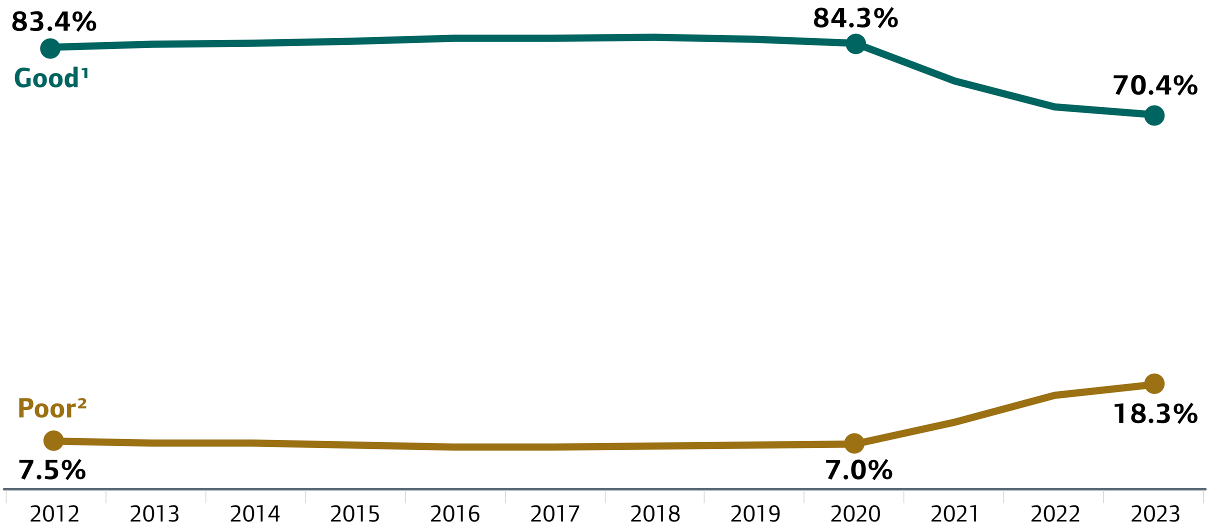
In the 2023 NHS GP Patient Survey, 53% of those who responded said they had tried to get an NHS dental appointment in the last 2 years (compared with 52% in 2022 and 56% in 2021). Of those who hadn't tried, over 1 in 5 (22%) said it was because they didn't think they could get an NHS dentist. This is an increase from 18% in the 2022 survey. Of the people who had tried to get an appointment, 10% said they were unable to as the dentist was not taking on new patients, and 10% said there weren't any appointments available.

We reflected a similar picture in our progress report on oral health care in residential care homes. This found that people living in care homes are still missing out on vital care from dental practitioners – both at the right time and in the right place. Between our original review in 2019 and the progress report this year, the proportion of care home providers saying that people who use their services could 'never' access NHS dental care rose by more than 4 times – from just 6% in 2019 to 25% in 2022.[27]

Not getting the care they need, when they need it, is leading to some people feeling they need to take matters into their own hands. The YouGov survey reported that 1 in 10 respondents (10%) admitted attempting their own dental work. Of those who said they've performed DIY dentistry, most (56%) did so within the last 2 years, including 36% within the last year.[28]

Even when people were able to get dental care, more people reported having a poor experience. In the 2023 NHS GP Patient Survey, 18% of respondents said they had a poor experience, up from 16% in the 2022 survey (figure 4).

Figure 4: **2023 GP Patient Survey – how would you describe your experience of NHS dental services?**



Source: NHS England GP Patient Survey

Note: Good[1] = 'very good' + 'fairly good', Poor[2] = 'very poor' + 'fairly poor'

The Department of Health and Social Care has set out some of the steps it is taking to help people to get access to NHS dental treatment. As well as investing £3 billion a year to deliver NHS dentistry, the government has introduced changes to the dentistry contract to encourage more dentists to offer NHS work to increase the number of available appointments, and is making efforts to grow the dental workforce.[29]

However, in July 2023, the Health and Social Care Committee's report on NHS dentistry was clear that current efforts were not enough and that NHS dentistry needs "urgent and fundamental reform" to ensure people get the care they need.[30]

Access to urgent and emergency care

The difficulty in getting care from a GP practice has a knock-on effect for other services. We can see this through the 2022 NHS urgent and emergency care patient survey, which showed that 24% of people approached urgent and emergency care services as the first point of contact because they did not think the GP practice would be able to help with their condition. Of the respondents, 12% said they could not get a GP appointment.

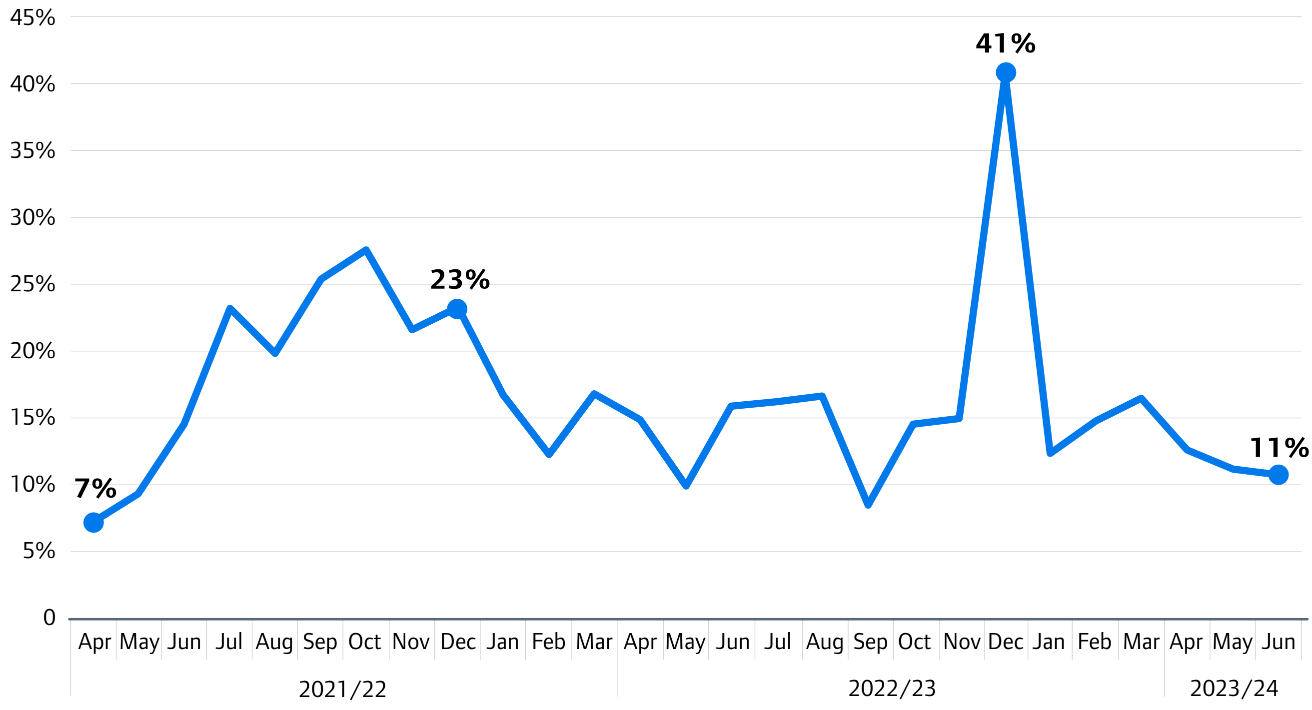
The survey also showed that of those who had contacted another service before attending an emergency department (A&E), such as NHS 111 or a GP, fewer people had been referred (down from 69% in 2020 to 64% in 2022). Additionally, more people were attending A&E because they couldn't get a GP appointment quickly enough or whose condition had got worse.

NHS England's Hospital Accident & Emergency Activity highlights geographical inequalities in care. Rates of A&E attendances per head of population for people living in the most deprived areas are nearly double those of the least deprived areas.[31] When looked at alongside data on the numbers of GPs for people in the local population, one implication is that people in deprived areas may be more likely to end up in hospital because they can't get the help they need, early enough, in the community.

It is well known that the challenges in accessing care, and the resulting pressure on services, are made worse every year with the onset of cold weather and increases in respiratory conditions. While this pressure has been building over the last few years, December 2022 saw a spike in the number of people needing care and treatment for flu, putting even more burden on services and the people working within them.[32]

Figures from NHS England show that in December 2022, NHS 111 received nearly 3 million calls. Excluding 2 weeks in the first month of the COVID-19 pandemic (March 2020), this period included the highest number of 111 calls ever recorded.[33] During this period, a high volume of callers to NHS 111 ended the call without speaking to someone, with an abandonment rate of 41% – over double for the average for the rest of the year (figure 5).

Figure 5: **NHS 111 call abandonment rate, April 2019 to June 2023**



Source: Integrated Urgent Care Aggregate Data Collection (IUC ADC)

In 2022, we reported on a 'gridlock' in the health and care system that led to some very poor experiences for people when they needed care the most. The situation remains the same for many, with people facing longer waits to be seen in urgent and emergency care.

The 2022 urgent and emergency care survey showed a large increase in the percentage of people saying they waited more than an hour before being examined by a nurse or doctor, from 28% in 2020 to 51% in 2022.

People are still facing lengthy waits in A&E. Data from NHS England shows that in July 2023, from their arrival at A&E, over half a million patients waited more than 4 hours to be either admitted, transferred or discharged. In the 2022 urgent and emergency care survey, people who spent longer than 4 hours in A&E reported poorer than average experiences. In addition, while there has been some improvement, in July 2023 there were almost 24,000 people waiting over 12 hours from the decision to admit to actually being admitted to hospital.

Each year, we talk about the increasing pressures on the health and care system – including on the staff – during winter. Last winter was no exception and again was considerably more challenging than previous years. Reasons for this included ongoing problems with patient flow through hospitals, combined with additional disruptions from more cases of seasonal flu and workforce issues, including industrial action.

In response, in January 2023 the Department of Health and Social Care and NHS England set out plans to boost capacity and speed up discharge of patients through the Delivery plan for recovering urgent and emergency care services. This includes scaling up intermediate care to relieve pressure on hospitals and move people into settings that are better suited for their needs. The plan has been supported by £1 billion of dedicated funding to support capacity in urgent and emergency services, alongside £250 million worth of capital investment to deliver additional capacity, and £200 million for ambulance services to increase the number of ambulance hours on the road.[34]

NHS England has also announced its plans to deliver operational resilience across the NHS this winter. This includes introducing care ‘traffic control’ centres to speed up discharge, delivering additional ambulance hours on the road, and providing extra beds. It has also published its 2023/24 winter plan earlier than usual this year.

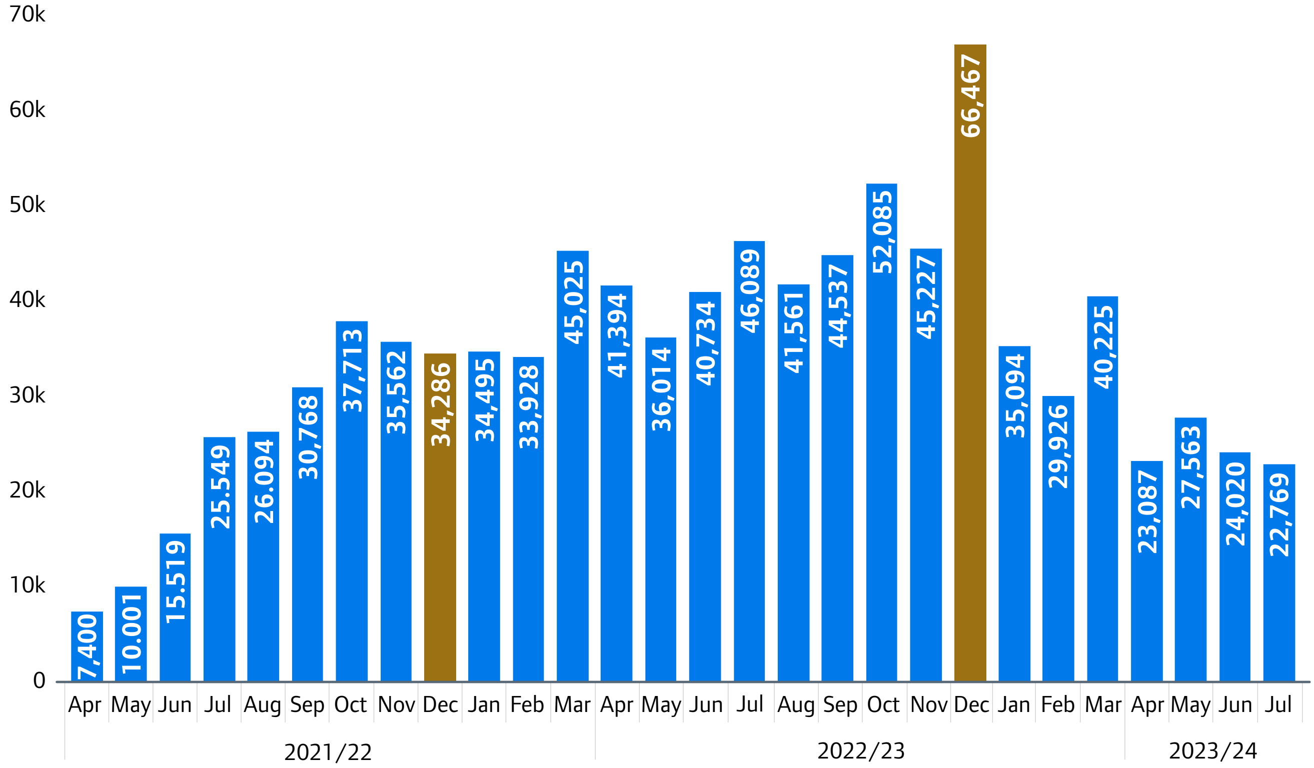
As highlighted in last year’s State of Care, and repeated in our September 2023 blog Planning for the coming winter, the focus of winter pressures is often on emergency departments. But what we see there is symptomatic of a much wider capacity problem across the whole health and care system. This means it is essential to co-ordinate any changes and improvements across the whole system to keep people safe and provide the best quality care possible.

Access to emergency ambulance services

One of the greatest challenges for ambulance services is when there are problems with moving people through care pathways within a hospital. In last year’s State of Care, we reported that a significant impact of delays in emergency departments is people being held in ambulances outside departments, known as ‘handover delays’, which in turn affects the care they’re able to provide.

Data from the Association of Ambulance Chief Executives (AACE) shows ongoing delays in ambulance handovers. In December 2022, nearly a quarter of handovers took more than an hour, compared with 10% in December 2021. Data shows that delayed handovers have generally improved so far this year. However, 22,769 handovers took more than an hour in July 2023 (figure 6).

Figure 6: **Number of ambulance handovers taking over 60 minutes, April 2021 to July 2023**



Source: Association of Ambulance Chief Executives (AACE).

> On 22 November 2022, there were 56 patients in the emergency department. The longest wait was for a patient waiting for a trauma and orthopaedic bed, who had been waiting for 24 hours and 28 minutes. The data showed that waits above 20 hours were happening daily. At 8am, there was an 8-hour wait to see a clinician and 6 patients waiting in ambulances with an ambulance offload wait of approximately 4 hours.
>
> **From a CQC inspection report**

Delays in handovers at hospital can have a direct impact on the ability of services to respond to calls. We can see this in NHS England's data on ambulance response times. During December 2022, when demand was at its highest, response times for category 2 calls were 1 hour 33 minutes on average against the target of 18 minutes. Calls classed as a category 2 involve people who are in a potentially serious condition that may require rapid assessment, urgent on-scene intervention or urgent transport. For example, a person may have had a heart attack or stroke or be suffering from sepsis or major burns.[35]

This year, we've heard about the impact of shortages of ambulance staff on waiting times – both for calls to be answered and for ambulances to arrive. Evidence from our provider information return for adult social care providers suggests that existing challenges facing ambulance services have been exacerbated by industrial action across the NHS, as the following quote shows:

> *"Barriers within the NHS that are challenging are the current strike actions, which affect the residents when they need emergency treatment or following a fall. Ambulances can take hours, sometimes more than 21 hours, before any assistance arrives. This is not good for the resident and can be quite an anxious time for the care staff who are trying to look after the resident with no medical knowledge."*

As well as delays in emergency care leading to poorer outcomes for people, anecdotally, and through our provider information return, we've heard about the impact on care homes, both for the resident and care home staff:

> *"Current waiting times for ambulances have also caused an obstacle. [Waits for] residents that require emergency medical attention are far longer than normal. This tends to affect residents [who express their feelings through their behaviour] the most, as they have cognitive impairments and are [not] able to understand the situation that's posed before them. This then means when emergency services do arrive and support them, it often takes longer than normal as we need to de-escalate challenging situations."*
>
> **Feedback from CQC provider information return**

Through engaging with homecare services, we have heard about the knock-on effects of ambulance delays when supporting people who have fallen. For example, one homecare provider told us of a local authority directive that a member of homecare staff had to remain with someone who was waiting for an ambulance. As well as the impact on the people waiting for an ambulance, the provider said this created significant challenges in scheduling care visits, with ambulance wait times over 10 hours for category 3 calls in the local area. Not only did this mean people were left on the ground for extensive periods, which evidence suggests leads to worse health outcomes, but it also led to unexpected increased care needs.

In response to these challenges and long ambulance waits, through our Regulators' Pioneer Fund work, we heard from a homecare provider looking for innovative ways to reduce demand for an ambulance, get people off the ground faster and free up staff to deliver care who would otherwise need to wait with someone until an ambulance arrived.

The provider told us how they developed an 8-week trial of technology that safely lifts a person off the ground after having a fall. The new technology was coupled with a post falls assessment tool to determine when a person could be lifted safely. The trial resulted in a 76% reduction in ambulance callouts and prevented an estimated 2,912 hours of annual additional care.

We have also seen examples of ambulance services innovating to improve care.

Making the best use of ambulance journeys

The ambulance service had developed a process to enable its paramedics to 'call before they convey' to get advice before bringing a patient to hospital when they may well be better cared for in the community.

Telephone conference calls allowed an emergency medical consultant to join a call, together with other specialists in the receiving hospital, to provide clinical advice and guidance on the patient's condition. Staff used this process to get additional clinical advice, both when on scene and when transferring a patient to hospital.

From a CQC inspection report

Access to adult social care

Problems and delays in one type of service or sector have a knock-on effect on others. For example, a factor affecting patient flow through hospitals is their inability to move patients back into the community once they have been assessed as no longer needing to be an inpatient. As at August 2023, the number of patients waiting in hospital who no longer met the criteria to reside was nearly 12,000. This is down from a peak of 14,000 in January 2023.

Delays in discharging people from hospital settings can result from a lack of capacity in adult social care. Data from our provider information return shows that of the beds in CQC-registered care homes, 84% were occupied in July 2023, an increase from 82% in July 2022. This is approaching pre-pandemic occupancy rates of 85% as published by the Office for National Statistics (ONS) based on our provider information returns between August 2019 and February 2020.

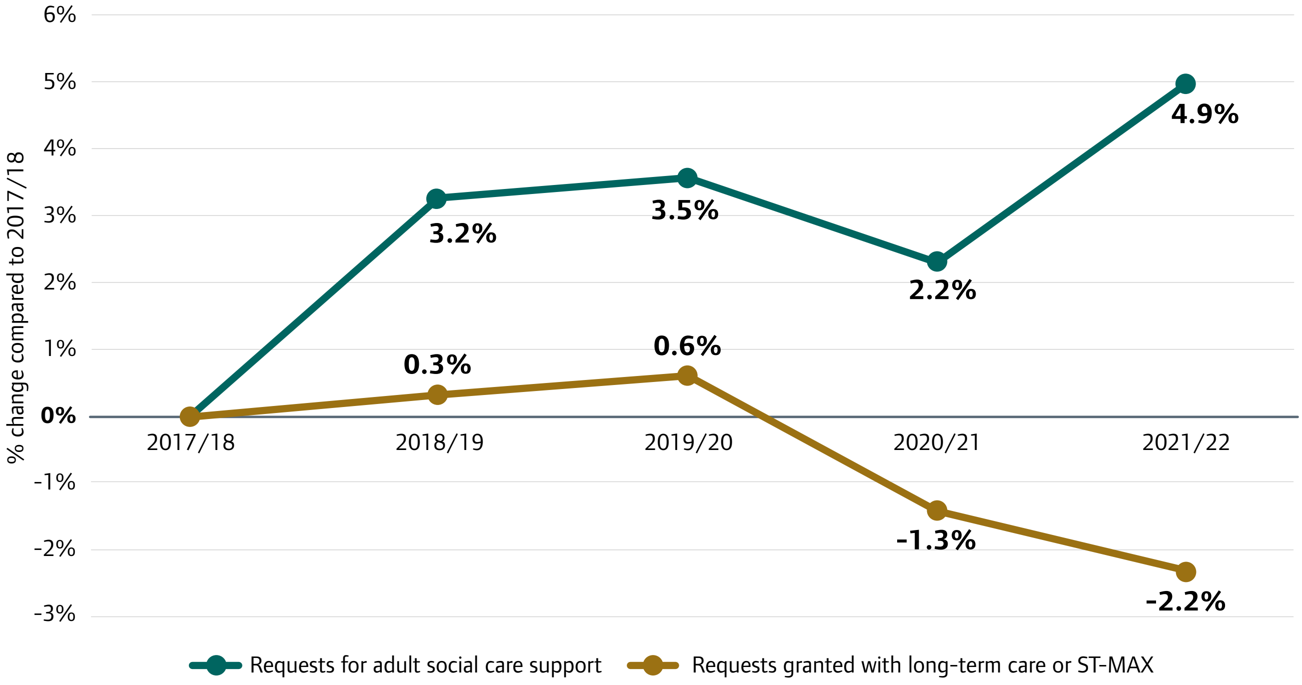
While occupancy rates have increased, our register of adult social care services shows that the number of registered beds decreased by 0.6% (2,905) between July 2023 and July 2022. Alongside this, our data on registrations show fewer care home locations compared with last year.

As we report in our section on systems, the new integrated care boards (ICBs) are responsible for developing plans for meeting the health and care needs of their local populations, which includes enabling sufficient access to care homes and community-based services. A recent survey by the Association of Directors of Adult Social Services (ADASS) received responses from directors of adult social services in 94% of the 153 councils in England. This found that 99% of respondents agree increased pressures on the NHS will result in additional pressures for adult social care in the next year.[36]

Adult social care services can be either fully or partly funded by a local authority, also called state-funded care. Services funded by local authorities are increasingly struggling to keep up with demand. NHS England data shows that the total number of new requests to councils for adult social care support increased by 3% between 2020/21 and 2021/22 to reach nearly 2 million requests. However, of the requests made for services, more than half a million (568,685) did not result in additional support, an increase of over 4%. A further 522,850 received only universal services or were advised to contact non-council services (such as the voluntary sector), an increase of 2% on the previous year.

Since 2017/18, the rate of new requests for adult social care support has increased by 5% from 4,214 to 4,419 per 100,000 population aged 18 and over. Over the same period, the rate of new requests granted with either short-term care to maximise independence or long-term care has decreased by over 2%, from 915 to 895 per 100,000 population aged 18 and over (figure 7).

Figure 7: **Percentage change in requests for support and number granted with either long or short-term care, per 100,000 population, compared with 2017/18**



Source: CQC analysis of NHS England Adult Social Care Activity and Finance Reports.

Note: ST-Max is a time limited period of short-term support intended to maximise the independence of clients and reduce, or prevent, longer-term reliance on social care.

In particular, requests for support from adults of working age have increased over the last 5 years. Although they make up the minority of new requests for adult social care support (31% in 2021/22), the rate of requests from working age adults per 100,000 population increased by 15% over the last 5 years, equating to over 87,000 more requests. In 2021/22, over 205,000 adults aged 18 to 64 were not provided with adult social care support when they requested it.

At the same time, the number of new requests to councils for support for older people increased by around 47,000 over the same 5-year period. As a rate per 100,000 population, it has remained relatively unchanged.

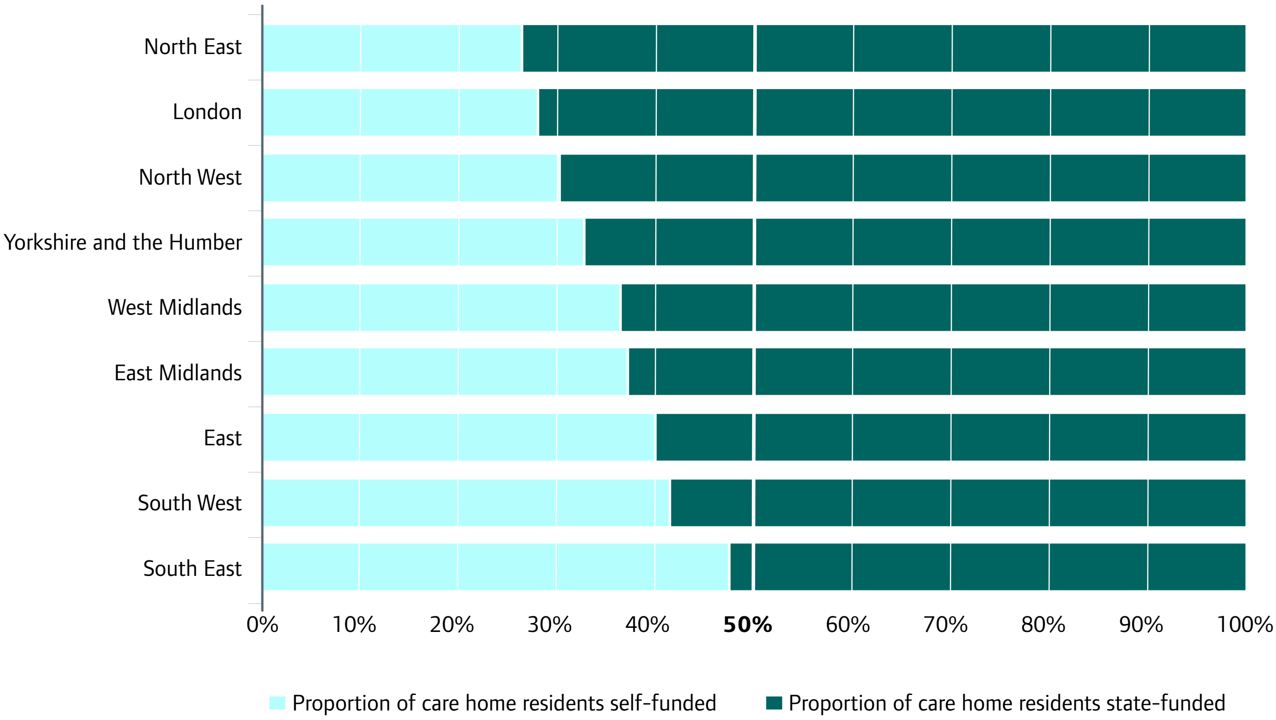
The ADASS survey results show the number of people waiting for an assessment, care and support to begin, or for a review of their care plan, has reduced from 491,663 in August 2022 to 434,243 in March this year. However, the number of people waiting more than 6 months for an assessment of their care needs remains high, increasing from 81,000 to 82,000 over the same time period.

As well as an assessment of needs, people also need a financial assessment or 'means test' to check if they are eligible to receive local authority funded care. People with more than £23,250 in savings will not be able to receive care funded by their local authority. This threshold has not increased in line with inflation since 2010/11, if it had increased more people would qualify for support. As part of wider reforms of adult social care, the government announced in 2022 that from October 2025 the upper threshold will be increased to £100,000.

The ONS has estimated the size of the 'self-funding' (privately funded) population in care homes in England (see also figure 8). Published in July 2023, key findings show:

- From 1 March 2022 to 28 February 2023, there was a significant 3% increase in the number of people living in a care home. Of these, 37% funded their own care, which is an increase from last year.
- Most care homes (60%) had a mix of self-funded and state-funded residents.
- The South East remained the region with the highest proportion of self-funded care in care homes (48%), which is significantly higher than the North East, which had the lowest proportion of self-funded care (26%).
- Care homes providing care for older people remained those with the highest proportion of self-funded care (49%), which was significantly higher than all other care home types. Care homes for younger adults remained the lowest (2%).
- Smaller care homes, with 1 to 19 beds, remained those with the lowest proportion of self-funded care (12%), which is significantly lower than all other sizes of care homes.
- Of care homes with a CQC rating, those rated as outstanding remained the care homes with the highest proportion of self-funded care (51%), which was significantly higher than care homes rated as inadequate, which remained the lowest (24%).[37]

Figure 8: **Proportion of self and state-funded care home residents by region, 2022 to 2023**



Source: ONS Care homes and estimating the self-funding population, England: 2022 to 2023. Analysis based on CQC Provider Information Return data.

Our Market Oversight scheme helps us to monitor adult social care providers that have a large national, local or regional presence which, if they were to fail, could disrupt continuity of care in a local authority area. From this, we have seen that a greater proportion of care home fees have been privately funded over the last year. Data from the ONS also supports these findings.

When there is less access to state-funded care, there's a greater risk of inequality. Data shows that the proportion of care home residents who receive state-funded care increases as the levels of deprivation increase. In areas with the lowest levels of deprivation, just over 2 in 5 care home residents are state-funded (43%) whereas in areas with highest deprivation 4 in 5 residents (80%) receive state-funded care.

People who cannot access state-funded adult social care may not be able to fund their own care because of the cost of living crisis and could become more reliant on friends, family and voluntary organisations for support.
In some cases people may not have access to family or community support.

Earlier this year, a survey by Age UK found that 1 in 3 older carers "have felt overwhelmed because of the care and support they provide".[38] This is supported by a survey of adult social services directors, in which 91% agreed that unpaid carers came forward with an increased level of need in their area over the last 12 months. The survey also showed that directors ranked burnout as the number one reason that has contributed to an increase in carer breakdown over the past year.

In the section on systems we point out that most local authorities have not published a recent carers' strategy.

Challenges facing adult social care services

During 2022/23, a few providers told us they received more referrals to their services, but they weren't able to accept the new clients as they don't have enough care staff to meet their needs:

> *"Because recruitment is an issue, increasing the number of clients is always a balancing act, we always need to be under capacity to cover sickness and holidays without putting too much strain on the team. This means hospital discharges for new [packages of care] are more limited than we would like. When carers have sickness, we may need to cut short certain visits such as [social visits] to prioritise the more critical visits."*
>
> **Feedback from CQC provider information return**

The Autumn 2022 survey from the ADASS received responses from directors of adult social services in 76% of the 152 councils in place last year. This echoed these views, as it found more than 9 in 10 adult social services directors in England did not believe there was the 'funding' or 'workforce' to meet care needs of older and disabled people in their area ahead of winter 2022/23.[39]

Staff in both residential homes and care homes with nursing have also described feeling they are unable to provide adequate care and support due to a shortage of staff, lack of funds and absent or poor management.

Concerns about ongoing financial pressures on adult social care providers are not new. Last year, we highlighted the impact of financial pressure – both on capacity within the market and on the wider NHS. Over the last year, the cost of living crisis has continued to increase this pressure, with adult social care providers struggling with escalating staff and running costs.

Providers tell us that the adult social care system is under-resourced, and that local authority budgets have failed to keep pace with rising costs and the increase in the number of people needing care:

> *"Another barrier that is very relevant is the funding from local authority. The fees paid from the local authority… have not kept up with inflation. While this currently does not impact the standard of care we deliver, it does limit the improvements that we can make in areas such as the care home environment, technology, and innovations."*
>
> **Feedback from CQC provider information return**

To build capacity and improve market sustainability, in June 2023 the Department for Health and Social Care announced that it would be providing almost £2 billion funding over 2023/24 and 2024/25 through its Market Sustainability and Improvement funds.[40]

In July 2023, we carried out a survey of adult social care services to find out more about the challenges they face. We received 1,928 responses and, while the survey does not represent the adult social care sector as a whole, it has provided valuable insights into concerns around unused capacity, workforce and funding.

The survey found that nearly a third of respondents (29%) said they were worried about the financial stability of their service. Over a quarter (26%) of services said they had considered leaving the adult social care sector in the past 12-months. As local authority-funded adult social care places are often less profitable, there is the risk that people who live in more deprived areas, and receive local authority-funded care, may not be able to get the care they need.

Similarly, in community adult social care we've heard how less urgent visits are not being prioritised. This includes, for example:

- calls that should have 2 care workers being delivered by only one person, with too little time allocated to each visit
- overloaded rotas
- overlapping call times
- not allowing for travel time between clients.

Again, this was echoed in the comments we received through our Give feedback on care service:

> *"We are constantly short staffed… We are not given enough travel time, which means we are unable to spend the correct amount of time with people. We are always late to visits. It makes us look really bad. In the evenings sometimes from 3pm to 10pm, I have up to 10 people to prepare dinner for and personal care and get into bed... It's an accident waiting to happen."*

For some people paying for their own care, the rising cost of living means they have not been able to prioritise their health needs and, in some cases, they have had to cut back on the amount of care they were receiving:

> *"There are some financial barriers. Due to the cost of living crisis, increased fuel prices etc, we have had to increase the rates for service users. To retain staff, wages have been increased. The outcome was that some of our services users, mainly self-funders have reduced their care visits to a minimum of what is required. This has had an impact on their quality of life."*
>
> **Feedback from CQC provider information return**

Less time spent with people reduces the amount of care they are receiving, which can lead to a deterioration in their quality of life.

Information from our Market Oversight scheme shows continued financial pressures on providers. While only a snapshot of a section of the market, it shows that care home profitability has remained at historically low levels during 2022/23. While much of this pressure has been a result of staff costs, between October 2022 and March 2023, we have seen the impact on profitability because of increases in non-staff costs, specifically gas and electricity price rises, as well as inflation in food and other costs.

Increasing financial constraints are likely to have an impact on people, both in the quality and consistency of care they receive and in providers' ability to re-invest in care homes.

Analysis of our provider information return suggests that smaller providers are experiencing additional sustainability issues during the cost of living crisis. For example, one smaller provider explained losing out on care packages to larger companies that can deliver care at a lower price. Staff from community adult social care providers have told us about packages of care being cut, delayed or not delivered at all.

The number of care hours delivered in the 3 months to March 2023 by providers covered by our Market Oversight scheme was nearly 15% lower than in the equivalent period to March 2021, with providers changing or limiting the hours delivered and the packages of care they offer.

Despite ongoing problems with capacity in the adult social care sector, over the last year we have seen increasing pressure to discharge people from hospital. In the face of this pressure, we have heard examples of people being discharged too early without appropriate risk assessment or having a care package or intermediate care in place. Unsafe discharges are putting people at risk, potentially leading to poorer outcomes in their health and care, and being re-admitted to hospital.′ During the 12 months to June 2023, on average around 9% of people had to go back to the emergency department within 7 days of their previous attendance.

Recognising that NHS performance relies on the adult social care system, in its Autumn 2022 statement, the government announced up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 to help support adult social care and discharge from hospital.

Quality of care

Key points

- Increasing demand and pressures on staff are taking a toll on their mental health and wellbeing. Staff have told us how, without the appropriate support, this is affecting the quality of care they deliver.
- Many people are still not receiving the safe, good quality maternity care that they deserve, with issues around leadership, staffing and communication. Ingrained inequality and the impact on people from ethnic minority groups remains a key concern.
- The quality of mental health services is an ongoing area of concern, with recruitment and retention of staff still one of the biggest challenges for this sector.
- Innovation and improvement varies, but the use of artificial intelligence (AI) in health care has the potential to bring huge improvements for people. Given the speed of growth of AI, it is important to ensure that new innovations do not entrench existing inequalities.

Current picture of quality

During 2022/23, we continued to take a risk-based approach to inspections, focusing our activity on those core services we know that, nationally, are operating with an increased level of risk, and on individual providers where our monitoring identifies safety concerns.

Our ratings data shows a mixed picture of quality, with a notable decline in maternity, mental health and ambulance services. During 2022/23, the quality of the 10 NHS ambulance trusts in England has declined, with 4 out of the 10 trusts now rated as requires improvement or inadequate. Full details on our ratings for 2022/23 are available in the appendix.

Increasing demand, workforce challenges and the cost of living crisis are all having an impact on the quality of care people receive. The 2022 NHS staff survey shows a substantial decline in the proportion of staff agreeing that if a friend or relative needed treatment, they would be happy with the standard of care provided by their organisation, which at 63% is down nearly 5 percentage points since 2021. This is 11 percentage points lower than in 2020 (74%). While all types of NHS trust have deteriorated on this measure year-on-year since 2020, the decline is most marked in ambulance trusts, which have declined more than 18 percentage points since 2020, from 75% to just under 57%.

The impact of workforce wellbeing on care

Higher demand and more pressure in the health and care system is continuing to affect the health and wellbeing of staff. As we discuss in our section on workforce, 2022/23 has seen continued high levels of sickness rates for staff, with a high proportion of staff saying they felt sick as a result of work-related stress.

We have seen this in our analysis of comments from staff received through our Give feedback on care service, where they have described being under-staffed and overworked, and the negative impact this has on their wellbeing:

> *"I witnessed multiple occasions where staff raised concerns about their mental wellbeing, and were forced to continue working, or were considered to be time-wasting…I myself was signed off sick from work by my GP for poor mental health, and received no support or welfare checks from my line manager or the department."*

Staff have told us how, without the appropriate support in place, stress and burnout is affecting the care being delivered. This includes, for example, staff making errors with medicines, people's choices not being respected and people receiving worse care, or less care than they need.

The NHS staff survey shows that a third of staff said they saw errors, near misses or incidents in the last month that could have hurt staff or people using services. Ambulance staff were more likely than those in other types of trusts to have witnessed errors, with over 40% saying they had witnessed errors, near misses or incidents in the last month.

While most NHS staff (86%) said their organisation encourages them to report errors, near misses or incidents, there has been a decline in the number of staff saying they would feel safe to raise concerns. The greatest deterioration was seen in the percentage of staff who would feel secure raising concerns about unsafe clinical practice, which declined from 75% in 2021 to 72% this year. Staff who do raise concerns are also less confident that their organisation will address them.

During this inspection, we invited clinical and non-clinical staff from all services to complete a survey [which] received 481 responses… The results showed over 50% of staff did not feel safe to report concerns without fear of what would happen as a result and did not believe that the organisation would take appropriate action. Although 43% of staff felt the trust did encourage staff to be open and honest with service users and staff when things went wrong, 35% disagreed.

From a CQC inspection report of an NHS ambulance service

Staff across all health and care sectors have used our Give feedback on care service to tell us about stress, burnout and issues with poor leadership and negative workplace cultures. Some staff have told us they feel their concerns or complaints are being ignored or even actively suppressed by leaders, as the following quotes show:

“Not enough staff on the ward especially when we have a 1:1 and some patients have 2:1, which means there isn’t enough staff to do the observation or take patients out on leave. This has been spoken about and expressed by multiple [members] of staff but all the managers do is shout and say ‘deal with it’…Managers aren’t doing anything and they’re just neglecting us.”

“The acute medical unit (AMU) … has had multiple near misses and serious incidents happen over the last 6 months. Senior staff raise concerns and are requested to stop email trails. [In] April a patient died in the corridor … AMU was plus 24 in the corridor across the footprint, resulting in multiple unsafe incidents. Concerns are consistently escalated.”

Issues with staffing and the resulting impact on the safety and quality of care is a theme emerging from all areas we inspect. In hospitals, despite providers' attempts to address the issues, we have continued to raise concerns about the shortage of staff – in particular nursing and support staff – on the safety of services.

> Workforce was a challenge and risk across the organisation, but in particular within the urgent and emergency care, medical and end of life services. Within the medicine core service, due to national shortages of nursing and support staff and high levels of staff absence, the service did not always have enough [of these] staff to keep patients safe. Managers of the service told us they had increased the nurse staffing establishment to allow for absences and vacancies so they could provide safe care. However, staff in the clinical areas we inspected told us they were often short of qualified nursing staff.
>
> **From a CQC inspection report**

Workforce challenges are a particular concern in mental health services. Consistent staffing is fundamental to therapeutic relationships, so a high turnover of staff can have negative impact on patient recovery and lead to longer stays in hospital. We've also heard how a lack of staff affects services' ability to provide therapeutic care.

A high staff turnover is also leading to skills gaps, particularly in services for autistic people and people with a learning disability. For example, in our work to understand learnings from the Supported Living Improvement Coalition, we found staff turnover resulted in the need for more training around people's individual needs, which meant people sometimes received care from staff who did not know them well enough to support them in a person-centred way.

Through our inspections, we have also found that staff do not always have the training to carry out important assessments or reviews. As a result, we have seen delays in people receiving (or not receiving at all) higher level assessments, such as fully formulated sensory assessments, communication assessments, dysphagia assessments, functional assessment and ongoing functional analysis of behaviour. This leads to people receiving poorer quality and unsafe care. Staff also need to be able to communicate well with people to ensure the service protects their human rights.

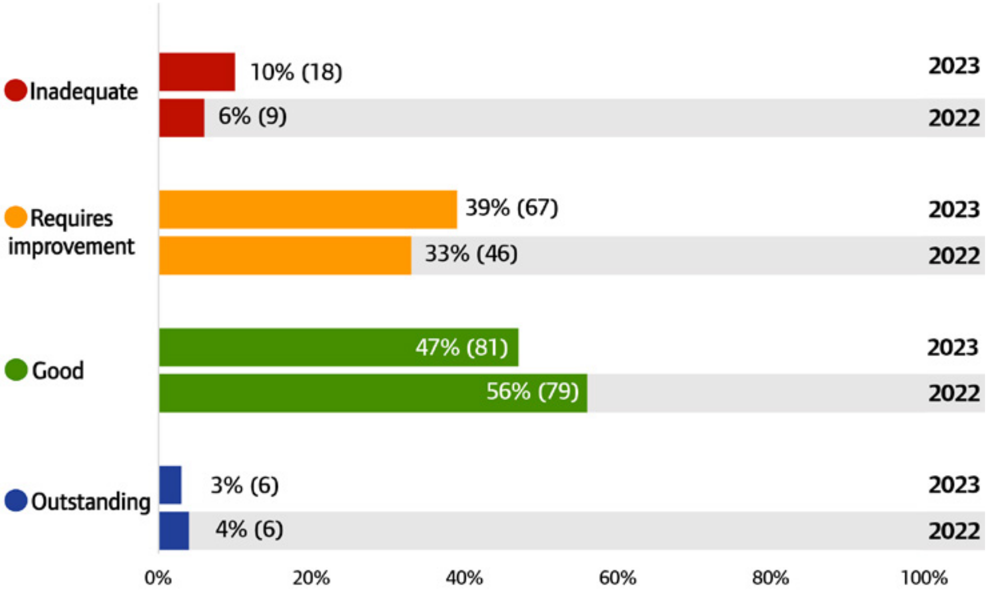
As the demand on health and care services continues to grow, so will the stress on staff, and in turn, their ability to provide safe, effective, and person-centred care that also protects people's human rights and rights to equality As we discuss in the section on Investing in staff wellbeing, staff have told us they need better support, which includes meeting their basic needs.

Focus on maternity services

In last year's State of Care report we reiterated our ongoing concerns about the safety of maternity services, and the impact of poor training, poor culture and poor risk assessments on people's care. We again stressed the inequity in maternity services and the fact that women from ethnic minority groups continue to be at higher risk.

This year, we continue to have concerns around the quality of maternity services. Ten per cent of maternity services are rated as inadequate overall, while 39% are rated as requires improvement. Safety and leadership remain particular areas of concern, with 15% of services rated as inadequate for their safety and 12% rated as inadequate for being well-led.

Figure 9: **Overall NHS maternity core service ratings, 2022 and 2023**



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Over the last year, we have continued our programme of focused inspections of maternity services in NHS acute hospitals. We committed to inspecting all services that we hadn't inspected and rated since April 2021. As at September 2023, we had inspected 73% of services. The overarching picture is one of a service and staff under huge pressure. Through our Give feedback on care service, people have described staff going above and beyond for women and other people using maternity services and their families in the face of this pressure. However, many are still not receiving the safe, high-quality care that they deserve.

In the following sections, we explore some of the themes emerging from our national maternity inspection programme, including leadership, staffing and communication.

Leadership

In our report on Safety, equity and engagement in maternity services, we highlighted the importance of having a strong maternity leadership team, where the service level manager, midwifery, and obstetric leaders are all working well together to provide care that meets the needs of people using the service.

Findings from our maternity inspection programme indicate that leadership remains an area of concern, with the quality of leadership varying between trusts.

However, we have seen some good practice during our inspections, including at board level, as the following examples show.

At Hexham General Hospital, there was a clearly-defined management and leadership structure. Maternity services were led by a triumvirate, comprising the Head of Midwifery, General Manager, and Clinical Director. The Head of Midwifery was supported by 4 matrons with different responsibilities, a public health midwife and professional midwifery advocates. This team worked together, along with the rest of the trust and external agencies and bodies, to enhance the care it provides.

At University Hospital Coventry, the trust had 3 board level champions who met with the Director of Midwifery for weekly updates regarding maternity services. They completed regular walk-arounds, and scrutinised data and reports. They were knowledgeable about the service, and proactive about holding the leadership team to account. Staff found them approachable and keen to hear their views and experiences to drive improvement.

We've also seen examples of trusts actively taking part in national audits, surveys, and initiatives to benchmark performance and identify areas for improvement. Where local leaders have clear board-level oversight, scrutiny and support, services are empowered to improve.[41]

However, we have still found issues with governance and lack of oversight from boards, including challenges in identifying issues and packages of support at service delivery level. We also have concerns about problematic working relationships between service level managers, neonatal, midwifery and obstetric leaders.

To address these leadership concerns and develop a positive safety culture, NHS England's Three year delivery plan for maternity and neonatal services includes a commitment that all neonatal, obstetric, midwifery and operational leads will have been offered the perinatal culture and leadership programme by April 2024. This includes a diagnosis of local culture and practical support to nurture culture and leadership.[42]

Staffing issues

As well as difficult working relationships, staffing remains a key challenge for many leadership teams. Through our inspections we have seen examples of significant staffing issues in many of the trusts we have visited. Issues include high vacancy rates and staffing levels that fell below the recommended workforce numbers for full time equivalent midwives, as well as gaps in leadership teams themselves. In some cases, staffing shortfalls have led to the closure of birthing suites, or women and other people using maternity services being sent to other hospitals to give birth.

In our July blog about our programme of focused inspections, we highlighted our specific concerns around obstetric consultant cover for maternity units. While we were encouraged that the majority of units were meeting the recommendations of the Ockenden report, we highlighted that the cover model is often fragile, with the rotas relying on every consultant being available. On top of this, consultants face additional pressure from, for example, having to cover registrar rotas and extra on-call shifts to meet the needs of their service.

Issues with staffing and the impact on patient care was a theme emerging from our analysis of comments received through our Give feedback on care service, with many people describing staff as overstretched and overworked. This is supported by findings from the NHS staff survey, which showed that only 20% of midwives would say that they are able to meet all the conflicting demands on their time at work.

Not having enough staff can lead to delays in care and, in some cases, people not receiving one-to-one care during labour.[43] In one extreme example, the lack of staffing resulted in inadequate home birthing support options and led to one woman giving birth unaided in a birthing pool at home.

The impact of staff shortages on care after giving birth was also evident in comments received through our Give feedback on care service. While people appreciated that maternity staff were often doing their best despite being very busy, many described feeling that they were not a priority and did not get the help they needed, as the following feedback shows:

> *"I couldn't move and asked someone to help me feed my baby and was told 'you can do it yourself' … [The midwife] also told me that she was very busy and had other patients that took priority – when I still couldn't move."*

> *"I did understand that the midwives were busy and the induction patients were a more urgent priority, but I did very much feel like I was of no importance and they didn't see me as 'their' patient. At this point I'd had surgery to have my daughter at 29 weeks and was very tired, stressed and overwhelmed and only 2 midwives in the 10 or 15 I had were empathetic and properly took time to care for me and help me."*

Despite these challenges, we are seeing examples where services are taking action to manage staff levels safely. For example, one service consistently used policies on escalation and closure to keep senior managers and clinicians informed and involved during busy periods. This included having arrangements embedded to call on trained general nursing staff to support with care that was not midwifery-specific, such as providing post-surgical care.

Communication

Effective communication is essential to ensuring that women and other people using maternity services are engaged in their care. It also supports shared decision-making. NICE guidance on antenatal care sets out several principles for effective communication. This includes providing clear, understandable and timely information that considers people's individual needs and preferences.

From the initial findings of our inspection programme, we are concerned that poor communication is affecting the quality of care for women and other people using maternity services.[44] This is supported by the findings of the 2022 maternity survey, which showed that just 59% of women and other people using maternity services said they were always given the information and explanations they needed during their care in hospital.[45]

Looking at more detailed responses to the maternity survey, we found many accounts of women and other people using maternity services feeling they were not being listened to, and their choice being taken away due to poor communication and information. In some cases, we found that people were not receiving key information relating to the care of themselves or their baby, as these quotes from the survey show:

> *"There was a lot of miscommunication and lack of recording and documentation of my personal circumstance, which resulted in less overall effective care."*

> *"I do not feel I was given enough information about jaundice and the impact that it was having on my baby's feeding, whilst on the postnatal ward. Communication about how much and how often my baby needed to feed was conflicting, which made me worry that I was somehow making the jaundice worse."*

This echoes findings from recent research from Healthwatch, where new mothers were interviewed about their experiences. A key concern for the mothers was around miscommunication about their care. They told Healthwatch that this meant they didn't have the opportunity to make their needs heard, and that sometimes they didn't fully understand the care options they were consenting to.[46]

In services where we have seen good practice, information has been available in different formats to cater for a range of needs and empower people to make informed choices about their care. For example, one trust used personalised care guidelines to keep staff focused on providing individualised care. Women and other people using maternity services were offered genuine choice, informed by unbiased information.[47]

But it is not just about ensuring people have the information they need. The way in which staff communicate can also have a huge impact on their experience. Many comments received through Give feedback on care referred to midwives as being friendly, reassuring, comforting and helpful. Many people also felt that midwives treated them with genuine care, offering a listening ear at times of difficulty and taking the time to make them feel supported and confident.

However, we also found several instances of people describing negative staff interactions, noting staff in general as often being rude and unhelpful, discouraging, inconsiderate of individuals' feelings, patronising and unsupportive. As the following quotes show, a few people who commented through Give feedback on care noted the lack of empathy and bedside manner of midwives and consultants, identifying these interactions as unnecessarily upsetting:

> *"The midwives on the ward were horrendous. They were rude, condescending and made me cry on a daily basis."*

> *"Midwives and staff need to be refreshed on empathy, compassion, support. I appreciate hundreds of women give birth every day, but each one of those women is an individual going through their own journey and should be treated as such."*

Impact of inequalities on maternity care

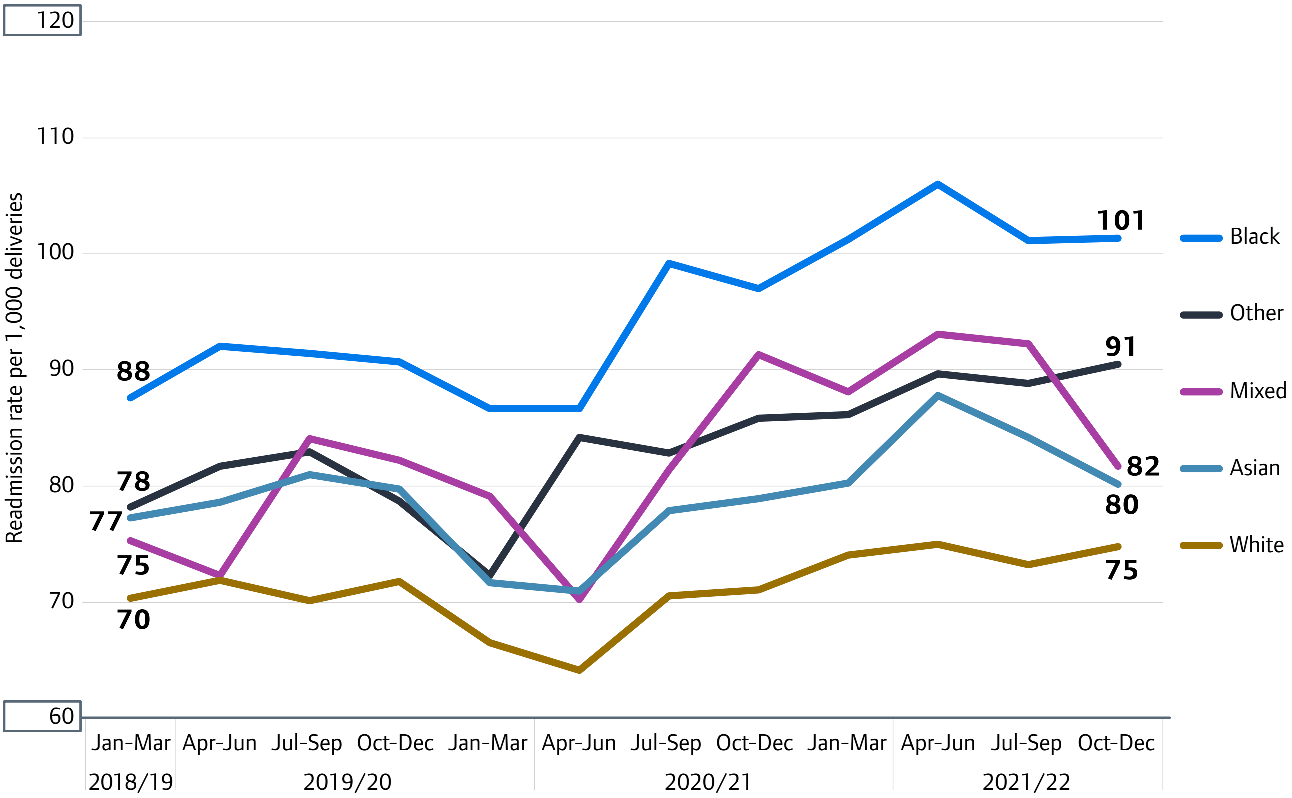
Despite multiple reviews, reports and recommendations on maternity care, a lot of the issues we are finding through our national maternity inspection programme are not new.

Some women and other people using maternity services face inherent inequalities. As we highlighted in last year's State of Care, women from ethnic minority groups continue to experience additional risks compared with women in White ethnic groups that – without the right interventions – can lead to poor outcomes.[48]

In its August 2023 QualityWatch report on Stillbirths and neonatal and infant mortality, the Nuffield Trust highlighted that in 2021, the infant mortality rate among Black ethnic groups was substantially higher than any other groups, with 6.6 deaths per 1,000 live births. Asian ethnic groups had the second highest infant mortality rate at 4.8 deaths per 1,000 live births. By comparison, White ethnic groups consistently had the lowest infant mortality rates with 3 deaths per 1,000 live births in 2021.[49]

During 2022, re-admission rates of Black women during the 6-week postpartum period have continued to rise, and are still significantly higher than re-admission rates for women of other ethnicities (figure 10).

Figure 10: **Rate of re-admissions per 1,000 deliveries during the postpartum period by quarter, January 2019 to December 2022**



Source: Hospital Episode Statistics

We wanted to understand more about inequalities in maternity care for people from ethnic minority groups. To do this, in July this year we commissioned a small, bespoke piece of research interviewing midwives from ethnic minority groups about:

- their own personal experiences of working in maternity services
- their insights into the experiences of people from ethnic minority groups who were using maternity services, and related safety issues.

Full findings from the research are detailed in the section on Inequalities.

Quality of mental health care

Access to mental health care and the quality of the care remain a key area of concern. As we reported in last year's Monitoring the Mental Health Act report, unavailability of community care continues to put pressure on mental health inpatient services, with many services struggling to provide a bed. In turn, this is leading to people being cared for in inappropriate environments.[50]

A recent report from the National Audit Office highlighted that an estimated 8 million people with mental health needs are not in contact with NHS mental health services. Some people in need of help are facing lengthy waits for treatment. As at June 2022, an estimated 1.2 million people were on the waiting list for community-based NHS mental health services. This is despite more funding and increasing staffing levels for mental health services, and more patients being treated.[51]

In 2022, NHS England set out its proposals for new mental health waiting time standards. These included proposals that people who need non-urgent mental health care from community-based mental health services should wait no more than 4 weeks after being referred.[52]

Not getting the help they need, when they need it can lead to people reaching crisis point and seeking help from, for example, urgent and emergency care. This is a particular concern for children and young people.

In May 2023, the Community Network published the results of its survey of 67 community provider leaders. Respondents were from trusts (accounting for nearly two-thirds of the sector) and community interest companies. Results show that despite the best efforts of community providers, there are still concerning waits for services for children and young people, which has a significant impact on children and families, and on staff morale. Respondents particularly highlighted the impact on those children presenting with more complex or specialist needs. They said that deterioration in conditions over time could lead to increased needs when the child is seen, as well as more children presenting at emergency departments or in crisis.[53]

This is supported by a 2022 survey of nearly 14,000 young people aged 25 and under by YoungMinds. While not nationally representative, the results showed that 58% of young people who tried to get mental health support said their mental health got worse during their wait, with over a quarter (26%) saying they had tried to take their own life.[54]

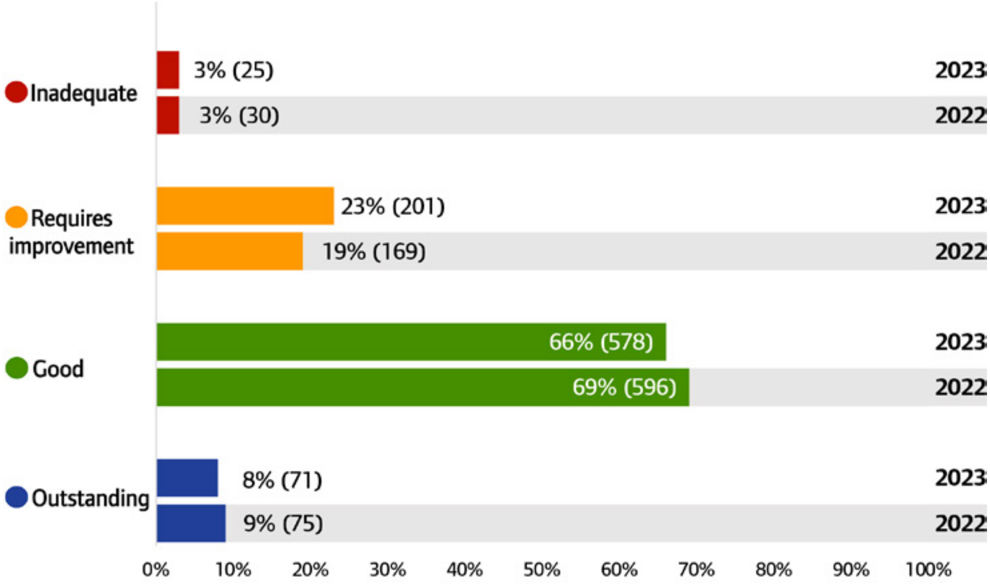
The lack of mental health beds means that people are then facing lengthy waits in an emergency department while they wait for a mental health bed to become available.

> In one trust, we saw evidence of a significant number of mental health patients waiting for long periods in cubicles until appropriate mental health inpatient beds became available. We found this was a significant issue of concern, as 42 people were waiting more than 36 hours in the emergency department in October alone. The trust subsequently provided data to show that during October and November 2022, it had the equivalent of 10 [emergency department] cubicles full of mental health patients.
>
> **From a CQC inspection report**

As well as long waits, people are often facing the prospect of being sent far from home for care and treatment. Despite a government commitment to ending out of area placements, as at May 2023, there were 775 out-of-area placements across England. As we have highlighted in our other reports, placing people in hospitals far from home and away from friends, family and support networks can affect their recovery and increase the risk of a closed culture developing.[55]

When people do get a bed in a mental health hospital, the quality of care is still not good enough, with areas of concern including the use of dormitories and mixed sex wards. Using our risk-based approach to inspection, our ratings data shows a slight decrease in the proportion of providers rated as good. At a key question level, the safety of services continues to be an area of concern, with 40% rated as requires improvement or inadequate (figures 11 and 12).

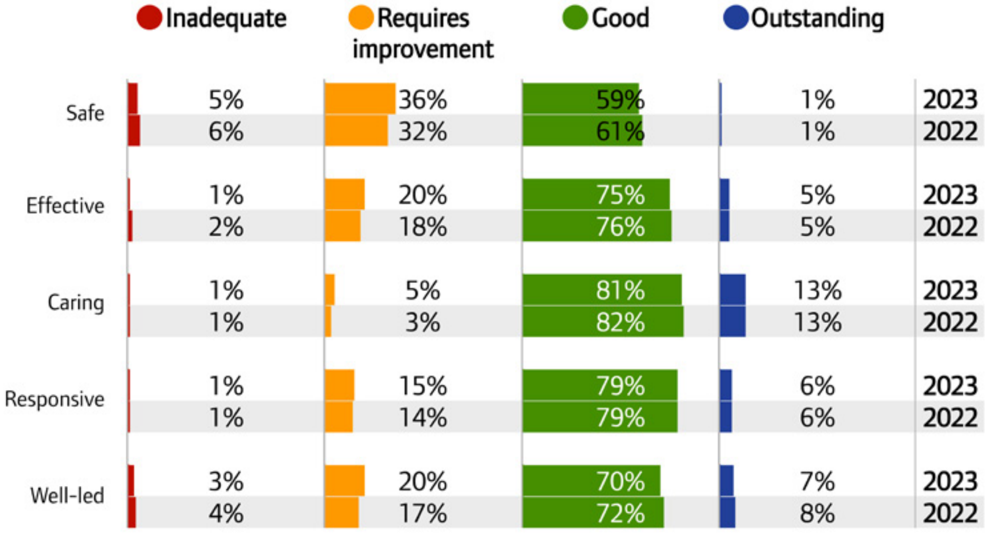
Figure 11: **NHS and independent mental health services overall ratings, 2022 and 2023**



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure 12: **NHS and independent mental health services key question ratings, 2022 and 2023**



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Staffing challenges

Recruitment and retention of staff remains one of the biggest challenges for mental health services, with the use of bank and agency staff higher than ever. This is supported by data from NHS England, which shows that, in the first 3 months of 2022/23, almost 1 in 5 mental health nursing posts were vacant.[56]

The use of agency staff puts pressure on permanent staff and increases risk to people using services, as staff do not always know them. For example, we visited one hospital where there were 7 permanent staff and 6 agency staff on one shift caring for 12 patients. The role for all the agency staff was to escort patients to home or to health appointments, but they did not necessarily even know the patient and their needs.

Where the quality of care does not meet the fundamental standards or where there's a need for significant improvement, we can issue a Warning Notice. In the last year, we issued Warning Notices to NHS and independent mental health care providers because of staffing issues including:

- not having enough registered nurses
- poor mandatory training figures
- poor records management.

For example, we served one trust with 4 Warning Notices to make sure it addressed significant concerns, including staffing. This trust had high levels of vacancies, which meant people were often treated by temporary staff who were unfamiliar with their needs. We also found that staff did not always follow the trust's policies and procedures on reporting and recording incidents.

When following up a Warning Notice at a different service, again we were concerned to find it did not have enough appropriately skilled staff to meet people's needs and keep them safe. There was only one full-time nurse and the service was overly reliant on bank and agency staff, especially at evenings and weekends, who didn't understand people's individual needs.

We are particularly concerned about longstanding issues with staffing at all 3 of England's high secure hospitals. These specialist psychiatric hospitals provide care for people with mental illness and personality disorders who represent a high degree of harm to themselves or others.

At the time of each inspection, all 3 high secure hospitals continued to have a significant shortage of staff, particularly registered nurses. Challenges with staffing significantly restrict patients' access to therapies and activities. This is often because staff delivering therapy or activities are used to cover for general nursing staff or other staff shortages, or in some cases, because there are not enough staff to escort patients to the relevant activity areas.

We have written to the leaders of all 3 high secure hospitals with our expectations that they consider people's individual circumstances when making decisions about night-time confinement. We have often seen blanket restrictions applying to everyone on the ward, which rarely consider the clinical and psychosocial grounds for reviewing confinement. Limitations on activities and blanket restrictions will inevitably have a negative impact on people's recovery.

Reducing restrictive practices

Time and again we have heard about the devastating impact of the use of restrictive practices on people receiving care and the trauma they experience as a result. Earlier this year, we developed a new policy position on reducing restrictive practice.

While we recognise that using restrictive practices may be appropriate in limited, legally justified and ethically sound circumstances, our policy is clear that its use should be rare and could be seen as a failure of care. It sets out our expectations for everyone working in health and social care and includes the expectation that providers understand the events that led up to restrictive practice being used. They must also report on the use of restrictive practices, learn from them, and actively work to reduce them in future.[57]

Focus on risks with medicines

As the regulator, we are responsible for making sure that providers, and other regulators in England, maintain a safe environment for the management and use of controlled drugs. These commonly used medicines are subject to additional legal controls as they carry a higher risk of being misused or causing harm.

Our work spans NHS and independent services in both health and adult social care, and we work closely with NHS England in this area.

During our inspections in 2022, we have found good and poor practice in how controlled drugs are managed and used.

An area of concern in relation to medicines is where care is shared between NHS providers and independent or private services. Examples include concerns such as evidence of clinicians prescribing controlled drugs to patients without the relevant medical and medication history. We have seen examples where private prescribing services have not requested these details from the person's NHS GP or secondary care provider before issuing prescriptions, as well as examples of GP services that don't supply these details in an appropriate way when asked.

Shared care can be ineffective when medicines licensed for attention deficit hyperactivity disorder (ADHD) are prescribed privately, as monitoring patients is a key concern, especially when they need tests at certain intervals. Private prescribing of Schedule 2 controlled drugs overall increased by 80% between 2021 and 2022, which was largely driven by the increase in prescribing for medicines licensed for ADHD.

Another current issue is prescribing controlled drugs in instalments, which is currently only available on paper prescriptions. There is a real need to move this to electronic format through the Electronic Prescription Service. This would help to prevent avoidable harm and provide more seamless care for patients by avoiding delays or missed doses of medicines if prescriptions have been lost, delayed in transit, or as a result of miscommunication between different care providers.

We have previously raised concerns about over-prescribing medicines that cause dependence and withdrawal. These include opioid medicines for pain, the gabapentinoids, benzodiazepines and Z-drugs (medicines that act in a similar way to benzodiazepines), and antidepressants.

Better awareness and initiatives to address this type of prescribing will improve patient outcomes in NHS GP services. In March 2023, NHS England released a Framework for action for integrated care boards (ICBs) and primary care to help support this ongoing priority. Actions at integrated care system (ICS) level have the potential to provide leadership and improve local collaboration to benefit patients.

Over the last year, we have heard about examples of this good work, including:

- A range of opioid reduction projects in the North East that include a campaign aimed at helping GP practices to review opioid prescribing in primary care. This includes videos of patients' lived experiences.
- The 'Living well with pain' programme in Gloucestershire, which uses a system-wide approach to help bring services together for effective patient care. This is an evidence-based programme, focused on exercise and improved access to mental health services, to help people with chronic pain live as well as possible.

It's not just healthcare services that handle controlled drugs. Each year, we ask registered adult social care providers to provide information about whether they administer controlled drugs, and if so, how many controlled drug-related medicines errors occurred in the service in the previous 12 months.

Of the providers that responded:

- 67% (13,501) of services (20,184) said they administered controlled drugs
- of the services that administer controlled drugs, 17% (2,248) reported controlled drugs incidents in the previous 12 months
- 39% (7,846) of services (20,122) reported no medicines errors at all.

Staff need to feel supported to be open about reporting errors and to learn from them. This is crucial to reduce the risk of a similar event happening again.

During some of our inspections of adult social care services in 2022, we found examples of good awareness of the principles and application of STOMP guidance (stopping over-medication of people with a learning disability, autism or both). Some medicines that STOMP guidance refers to are controlled drugs, such as benzodiazepines or Z-drugs.

One of the key aspects of this guidance is ensuring that prescribing and administration of these medicines is appropriate and, where possible, that non-drug options are available so these medicines are not used to control people's behaviour.

The pandemic brought into sharp focus the challenges associated with managing pain and relieving symptoms for people at the end of their lives. We hear from care home providers about the cost and lengthy process associated with obtaining a Home Office licence to hold a very small quantity of controlled drugs as anticipatory medicines. In practice, this means that many care homes don't hold any stock, so they need to use other routes to prescribe and supply controlled drugs to ensure that patients can access these medicines.

We know there is a great deal of excellent work in relation to anticipatory prescribing to ensure that people get the medicines they need at the right time. However, it is sometimes difficult to predict when a patient might be nearing the end of their life, which can mean the right medicines are unavailable both within the care home setting and when people choose to die at home.

In some cases, delays to treatment and additional work can be caused by issues such as:

- incorrectly written prescriptions or authorisations to administer
- unavailability of stock
- access to medicines out of normal hours.

This is especially relevant given the ongoing pressures on health and care staff after the pandemic.

Medicines optimisation in virtual wards

Virtual wards (also known as 'hospital at home') allow people to get hospital-level care at home in familiar surroundings, including care homes. According to The British Geriatric Society, the benefits of virtual wards, particularly for older people, include preventing delirium, falls and hospital acquired infections.

They are a key priority for NHS England to help increase capacity across the system. By December 2023, integrated care systems are expected to have developed virtual wards towards a national ambition of 40 to 50 virtual beds per 100,000 population.

NHS England published a series of case studies on virtual wards, which demonstrate their advantages in supporting people to get better in their own homes. For example, in one case study, a care home reported that fewer people attended the emergency department and it was able to treat people holistically, improving their clinical and wellbeing outcomes.

Most people admitted to virtual wards are taking medicines. To understand the best ways to use medicines in these settings, our Medicines Optimisation team held discussions with acute and community health providers and other key stakeholders between December 2022 and March 2023. Providers told us about concerns as well as good practice, and how CQC can work with them to drive improvement in this area. We identified some key themes.

Workforce and governance: Often, pharmacy teams were not involved in setting up a virtual ward from the outset, so they had no influence in decisions on the use and supply of medicines. Sometimes there was no allocated budget for pharmacy staffing, which meant leadership often fell to a trust's chief pharmacist without any additional resource, resulting in policy, practice, and governance of medicines being overlooked.

One provider addressed this by using existing pharmacy staff in primary care networks and community pharmacists to support the virtual ward, which also improved continuity of care.

Stakeholders voiced their concerns over which medicines guidance and formularies virtual wards should use. Medicines such as antimicrobials and those for end of life care must be prescribed correctly for optimal patient outcomes. Leadership accountability needed to be clearly defined, particularly where multiple providers are involved.

Use of technology and digital systems: A lack of integration and compatibility between digital systems in acute, community trusts and primary care made transferring information challenging. Prescribing and recording medicines administration, including when people were self-administering their medicines, presented additional digital challenges.

One trust used a smart phone messaging facility to enable patients to contact staff if there were problems with their medicines and their supply was low.

Storage and supply of medicines: Challenges include storing medicines securely and assessing and mitigating these risks, as well as being clear around the accountability of medicines stored in people's own homes. Transporting medicines to people's homes could also be difficult and different providers used various ways to supply medicines to people. One trust had identified community pharmacies that opened late so they could direct late prescription requests to them when needed. But the problem remained when people needed medicines that could only be supplied by the hospital.

Virtual wards and health inequalities: NHS England's supporting information for ICS leads outlines the positive impact of virtual wards on health inequalities by broadening equity of access and optimal care in people's own homes, although it is important to avoid digital exclusion.

Providers felt it would be useful to review admission criteria to identify and mitigate any geographical inequalities in access. It's also important to consider individual needs when interacting with people on virtual wards, for example where English is not a first language or for people with no access to technology.

Collaborative working, improvement and shared learning: To improve medicines optimisation in virtual wards, providers identified the need for leaders to collaborate and share learning across systems, and to involve pharmacy teams from the start. We are continuing to collaborate with stakeholders and providers to drive improvements in this type of setting.

Innovation and improving care

Innovative practice and technological change are important tools to drive improvement and deliver better outcomes and experiences for people. This might be through digital technologies, but it can also mean new ways of working or new care models that improve their outcomes.

One of our strategic ambitions is to accelerate improvement in health and care. We want to use our unique position to support health and care services, and local systems, improve how they deliver good care for people, and to identify and address their own challenges. A key part of this is encouraging innovative practice and technological changes where they benefit people.

Over the last year, we have carried out work funded by the Regulators' Pioneer Fund. Through this, we have heard anecdotally how staffing pressures and strains on resources are hindering innovation. As we highlight in the challenges facing adult social care services, a lack of support and investment from integrated care systems can have a negative impact on the ability of providers to re-invest in their services and improve care for people.

With these pressures, there is the risk that innovations may be focused on improving efficiencies for the health and social care system, rather than driving better quality care for people. Innovation must focus on the individual people receiving care, and must be at the heart of designing and measuring the outcomes of an innovation.

It has been encouraging to see evidence of providers using innovation – both technology and non-technology driven – to improve the quality of care in the face of these challenges.

Example of using AI to improve care

Staff at one care home were noticing that large quantities of antipsychotic medicines were being prescribed for people with dementia. When people were distressed and were communicating this through behaviour, there appeared to be little consideration of the reasons why, and so they were given antipsychotics in response. But staff were convinced that these distress responses were a reaction to pain – not because the person had a diagnosis of dementia.

The care home therefore worked with developers to pilot a new app that used artificial intelligence (AI) technology to help care staff identify when people were in pain. The app helps the caregiver to recognise and record facial muscle movements and identify other behaviours that indicate pain. It then calculates an overall pain score and stores the result.

After it was introduced in 2021, the care home has not only been able to offer more pain relief to people, but there have been fewer conflict-related safeguarding referrals and more time available for staff. Importantly, there has also been a 10% decrease in antipsychotic medicine use across all 23 homes. This has improved the quality of life for people with dementia.

The use of AI in health care has the potential to bring huge improvements for people using services. However, given the speed of growth, it's important to ensure that new innovations do not embed existing inequalities. These can occur at different stages of AI development, for example bias at the design and development stage. Everyone involved in bringing new technology to care must take responsibility for making sure that innovations reduce inequalities. This includes a role for developers working on these products, but also for providers that adopt them to monitor outcomes and implement robust governance and evaluation of the changes.

To ensure that people benefit from AI, health and care providers also need to ensure that staff are properly trained to use it. The recent Health Education England and NHS AI Lab report found that if people receiving care are to benefit from AI, healthcare workers will need specialised support to use AI safely and effectively as part of clinical reasoning and decision-making.

As the regulator, we're also considering the role we play as AI becomes more widespread in health and care. Along with the National Institute for Health and Care Excellence, the Medicines and Healthcare products Regulatory Agency, and the Health Research Authority, we form part of the AI and digital regulations service. This is a cross-regulatory advisory service that supports developers and adopters of AI and digital technologies. The service provides guidance across the regulatory, evaluation and data governance pathways.

While innovation such as the use of AI is important, it's just one tool to support improvement. We recognise that it is not only providers rated as outstanding or good that innovate. Innovation does not always look the same and can include, for example, advances in digital technology, new models of care and new ways to treat, monitor and care for people. Innovation is not a one-off activity and requires a culture that supports both innovation and improvement to thrive.

Inequalities

Key points

- Midwives from ethnic minority groups say that care for people using maternity services is affected by racial stereotypes and a lack of cultural awareness among staff.
- Midwives from ethnic minority groups described a ‘normalised’ culture where staff tolerate discrimination from colleagues, and say they are less likely to be represented in leadership and managerial roles.
- Patients from ethnic minority groups who have a long-term condition were more than 2.5 times more likely to say that staff in the emergency department talked as if they were not there, compared with patients in White ethnic groups who did not have a long-term condition.
- People from ethnic minority groups who have a long-term condition felt they were talked down to about their treatment and were not treated as individuals. They also said a lack of cultural competency was a barrier to receiving good quality care.
- Failures in the system and a lack of funding can mean that budgets are prioritised above truly person-centred approaches to support in supported living services.

Inequalities in health and care experienced by people from ethnic minority groups

Last year, we reported on how the COVID-19 pandemic had a disproportionate impact on people from some ethnic minority groups in terms of higher mortality rates. We also highlighted ongoing ethnic inequalities across a number of areas, including maternal and neonatal health care and mental health care. For example, rates of detention for people from the Black or Black British group were over 4 times those of people from the White group.[58]

This section highlights findings from work we have carried out or commissioned to explore the experiences of people from ethnic minority groups using health and care services.

Insight of staff into the experiences of people from ethnic minority groups using maternity services

We wanted to look more closely at inequalities in maternity care for people from ethnic minority groups. To do this, in July this year we commissioned a small, bespoke piece of research interviewing midwives from ethnic minority groups about:

- their own personal experiences of working in maternity services
- their insights into the experiences of people from ethnic minority groups who were using maternity services, and related safety issues.

Our interviews with midwives from ethnic minority groups for this report gave us valuable insight on equality, diversity and inclusion in maternity services in England.

The negative experiences they told us about for those using services ranged from not having the information they need about their own or their baby's health, disengaging from services, and physical and mental ill-health.

Language and communication
There was a strong consensus across the midwives interviewed that having poor or no English is associated with worse experiences of care. This ranged from staff 'not bothering' to try and communicate effectively with people who don't speak English, to actively targeting people for worse treatment. Even where women and other people using maternity services from ethnic minority groups can speak English, midwives told us they are less likely to be listened to than people in White ethnic groups:

> *"We are still not listening to the women who are most under-served. They are being made to feel inadequate. Especially those not speaking English – it is like, speaking English gives you status and the right to better care. Staff see [people who don't speak English] as lowly, they dismiss them. This affects care because they are not listening..."*

It was felt that there was not enough importance on ensuring that people are able to understand information:

> *"Staff need to be very mindful that you will get people nodding their head but not understanding. And instead of just choosing to accept that, staff need to make sure that they have understood."*

We heard about the impact on women and other people using maternity services when they were not being enabled to understand information or communicate their feelings, needs or questions. This ranged from not having the information they need about their own or their baby's health, to very serious physical and emotional trauma with long-lasting effects.

Midwives told us of a lack of willingness among some colleagues to use interpreting and translation services. Despite these services being generally available, they are not being used consistently, as it is seen as taking too long, or not worth bothering with – especially in less critical situations, such as a routine appointment: *"We have access to the interpreters, but no-one is picking up the phone to use them. It takes longer to use the interpreter, so people are not wanting to do it."*

It was noted that a standard 20-minute appointment is not long enough to allow for the extra time needed for translation, so even if an interpreter is used, a person who doesn't speak English may still not get care of the same standard:

> *"You try and use that 20 minutes to see a woman that doesn't speak English – it is not enough time. We talk about individualised care, but it doesn't feel as if you can make that happen. The result is they don't understand their care, don't know if they need more appointments. Midwives are rushing because they have their next appointment. Things are missed."*

Stereotypes and cultural awareness

Midwives told us how care was affected by racial stereotypes and a lack of cultural awareness among staff, which led to negative experiences and potential safety issues.

One such racial stereotype of Black women as being 'aggressive' was seen to be directed towards women using services, as well as towards midwives themselves. The midwives interviewed said this stereotype was common and not always recognised or acknowledged as being problematic by those using it – even when challenged.

The other racially stereotyping term that came up in interviews was 'princess' (of Asian women). Midwives thought that colleagues viewed this as an acceptable term, rather than acknowledged as offensive. One interviewee, from an Asian background, even found herself using it of people using the service, as it was so common to hear her colleagues doing so, *"You wonder, has the system turned me? To fit in, you find yourself following the culture."*

The following are some examples of stereotypes, misconceptions or lack of knowledge about physical characteristics and symptoms that affect how maternity staff address clinical scenarios for people using maternity services from ethnic minority groups.

- Misconceptions around bodies – interviewees reported hearing the following said by colleagues, including senior colleagues:
  - 'You have an African pelvis.'
  - 'Black women have thicker skin, so they are less likely to have a tear after delivery.'
  - 'You are African, you are tough – you don't need pain relief, you get on with it.'
- Lack of knowledge or interest in conditions more common to some ethnic minority groups:
  - *"If I bring up fibroids or sickle cell, those are conditions that affect more ethnic minority women, and I find that [staff] don't know as much about them – and those study days are not as well attended as the ones on conditions like diabetes and pre-eclampsia. Is that because they don't affect white women?"*
- Failure to recognise symptoms that look different on the skin of people from ethnic minority groups, for example:
  - jaundice not being recognised because staff have been trained to recognise how it looks on white skin
  - deep vein thrombosis symptom taught as the calf going red, again only applicable to white skin
  - "The white body is the norm in the textbooks, which means diagnosis is not effective in Black women."

Further impact of poor experiences

Interviewees highlighted that negative experiences of maternity care can lead to the risk that people disengage from services, and do not attend appointments or seek care when they need it:

> *"Even when it is partly the workload that has contributed to their poor experience, they will see it as they got poor care because they weren't listened to or weren't valued. They will feel that their ethnicity meant they did not get as good care as the person next door. Some of them then tend to shy away from being in hospital – they just want to leave as soon as they have the baby."*

Midwives also spoke about the cumulative psychological impact for women and other people using maternity services of feeling they have not received equitable care and respect:

> *"All these [negative] exposures to the health service involve a negative impact – we are very much focused on physical harm, but the psychological impact of this is also a form of harm – long term, it accumulates. Being repeatedly made to feel dismissed – that has a long-term impact."*

Addressing issues and what needs to be done
Some midwives saw improvements over recent years in how their trusts were addressing issues for staff and people using services from ethnic minority groups. These included:

- maternity networks to share people's views in the running and development of services, especially when they are representative of the populations being served
- specific roles, such as cultural safety champions, as long as they are backed up with wider support and resources.

Nevertheless, there was a clear view that there is a huge amount to be done in terms of tackling inequitable care and workforce experience, and this must be based on more open acknowledgement of the root cause. One of the most common phrases used by interviewees was that issues of inequality are 'swept under the carpet'.

Some actions were suggested to support change for people using maternity services – all requiring funding and support of leaders and managers:

- channels for staff and people using services to feel safe in reporting inequitable care, such as networks and groups, and approachable senior people with accountability
- more availability and use of translation services and interpreters to help people who do not speak English to navigate their care
- increasing the knowledge of staff about cultural practices and traditions, to address misconceptions and misunderstandings and to tackle unconscious bias
- outreach and engagement with ethnic minority communities, to better understand the needs and concerns of people using maternity services and how services can be better oriented to these.

Experiences of people from ethnic minority groups who have a long-term condition

In last year's State of Care report, we said that there was less satisfaction among people with a long-term health condition with being able to access services when they need them and in a way that suits them. We also found links between long-term health conditions and people living in more deprived areas.

We also reported on the inequality experienced by people from ethnic minority groups, for example in terms of delays or cancellations of hospital treatment.

This year, we look at the link between these 2 groups of people, from the viewpoint of people from an ethnic minority group who have a long-term condition. This is to see how their experience of health and care differs from others in the population. To do this, we used 2 areas of work:

- We looked at patient experience surveys, where we found people with long-term conditions, particularly those with multiple long-term conditions, reported worse experiences. These experiences are influenced by a range of other factors, including age, gender and ethnicity. For this report, we focus on the interaction between long-term conditions and ethnicity.
- We commissioned qualitative research to get first-hand insights from people from ethnic minority groups who have lived experience in accessing health and social care for their long-term health condition.

Recent access to GP services
People from ethnic minority groups with a long-term condition told us that in the past 12 months, they have found it increasingly difficult to meet with their healthcare provider. For example, follow-ups are less regular than previously and there is an emphasis on them self-monitoring their condition. They have also noted a difference in how services manage appointments and reported repeated delays and cancellations, as well as miscommunication about missed appointments:

> *"Trying to make a phone call to try and get an appointment with the doctor or the specialist, you just can't get through. So then you just give up and look for other things that are going to help me, because the process is just too long."*
>
> **Interview with a Black British woman with a long-term condition**

The survey of patients who have used NHS GP services was open from January to March 2023.[59] This shows the differences between patients who have a long-term condition and those who don't in how easy they found it to get through to someone at their GP practice on the phone. This depended on the patient's background, with an improved experience for white patients and a worse experience for patients from ethnic minority groups. There were differences between the different ethnicities with long-term conditions, with patients from an Asian background being the most likely to report a negative experience (57%), as opposed to white patients (51%) and other ethnic minority groups (48%).

People with long-term conditions are also likely to be affected by cost of living pressures. A Prescription Charges Coalition survey of people with long-term conditions found that nearly 1 in 10 people have skipped medication in the past year due to the cost of prescriptions.[60] Of this group, almost a third (30%) now have other physical health problems in addition to their original health condition.

People from ethnic minority groups who have a long-term condition told us they have noticed an increasing use of telehealth to provide medical care. However, many have expressed a preference for in-person appointments. They feel that care feels more human and person-centred instead of being remote and medicalised. Furthermore, some have demonstrated issues with using technology and how inequalities in access to care might be exacerbated. For example, a patient with an autoimmune condition said their doctor was unable to see a rash on their skin through the video call so put that down to their skin colour:

> *"I had a rash on my hands and I had to take a picture of it and then send it. They kept saying 'I can't see it, I can't see'. And I'm thinking is that because I'm Black? I don't think they made me an appointment. It wasn't deemed as important enough because they couldn't see what I was talking about."*
>
> Interview with a Black British woman with a long-term condition

Respect and involvement

People with long-term conditions from ethnic minority groups told us they felt 'talked down to' about their treatment, but also that they were not being treated as individuals. Instead, they felt over-medicalised and that they had to push hard to get the medication and treatment that worked best for them.

They also said that decisions were made about their care without consulting them and that asking for things which were best for them was difficult:

> *"That feeling of 'I don't know what I'm talking about'. They know best. Like, they're the medical professionals. So I found that off-putting."*
>
> Interview with a Black British woman with a long-term condition

The feeling of being talked down to reflects a lack of respect also seen in our survey of patients who stayed at least one night in hospital as an inpatient during November 2022. Although the figures are low, in this survey more patients from ethnic minority groups with a long-term condition reported that they were never treated with respect and dignity while in hospital (3.4%) compared with white patients with a long-term condition (2.3%). This compares with 1.7% for white patients who did not have a long-term condition.

This lack of respect is also reflected in our survey of patients using emergency departments between 1-30 September 2022.[61] It found that patients with a long-term condition were more likely to say staff talked about them as if they weren't there (21%), compared with patients with no long-term condition (14%). We also saw that patients from ethnic minority groups were more likely to report the same issue (25% compared with white patients 16%).

Within these groups, the biggest difference was between patients with a long-term condition from ethnic minority groups (30%) and white patients with no long-term condition (12%). This means that patients with long-term conditions from ethnic minority groups were more than 2.5 times more likely to say that emergency department staff talked about them as if they were not there, compared with white patients with no long-term condition.

Care and support
Our survey of patients using emergency departments showed that fewer patients from ethnic minority groups with a long-term condition reported that expected care and support was available when they needed it after leaving A&E (53%). This compares with patients from ethnic minority groups with no long-term condition (68%), white patients with a long-term condition (61%) and white patients with no long-term condition (72%).

The people we spoke with for this report who are from an ethnic minority group and who have a long-term condition also spoke of a lack of follow-up from their healthcare professionals. They felt that in instances of lifelong conditions, there should be greater emphasis on health care delivered in the longer term.

For example, one person noted that they were only provided with 3 sessions of physiotherapy, essential to managing their condition, but could not understand how that would be considered appropriate for a life-long condition:

> *"The day I was discharged from the hospital, I felt that I should not just be allowed to leave like that. The following day, I took my daughter to school. And then I lost consciousness. So just imagine what if I died or something tragic just happened? So yes, I just feel that there's supposed to be a follow-up, don't just leave people. And I just felt is it because I am from a Black community. Honestly, those things just come to my mind; I just don't expect to be left alone like that."*
>
> **Interview with a Black Nigerian woman with a long-term condition**

Linked to this lack of follow-up, some people we spoke with said that, although they understood medical professionals had expertise, they lacked the lived experience. This meant they sometimes felt unheard, but that support groups with lived experience acted to alleviate this tension.

People felt these support groups gave them a source of empowerment, as they also offered advice when dealing with healthcare professionals and allowed them to understand what to ask for if they experienced symptoms or side effects:

> *"I went online for a few support groups, exchanging messages with people that have the same condition. Just hearing their stories. It makes you feel more empowered. I take injections every two weeks. It is painful and scary. Even the doctors, they're great, but they don't do that on themselves. They understand the disease, but they don't go through it."*
>
> **Interview with a Latin American (South American) woman with a long-term condition**

Looking for other sources of support could partly be explained by the results of the survey of people who have used GP services. This shows that people with a long-term condition were more likely not to have confidence and trust in their GP practice based on their last appointment (7%) compared with those with no long-term condition (6%). We also saw that patients from an ethnic minority background were more likely to report the same issue (9% compared with 6% white patients). Within these groups, people from ethnic minority groups with long-term conditions were twice as likely to say they did not have confidence and trust in their GP practice (10%), compared with white people with no long-term condition (5%).

As well as a lack of lived experience, a lack of cultural competency was also seen as being a barrier to receiving good-quality care. A South Asian man with long-term conditions emphasised the need for better cultural awareness so that care plans are complete and appropriate: *"The lack of cultural competency in service design and provision is clearly an issue. How can you prescribe a care plan for people that you don't understand."* This mirrors comments about cultural awareness expressed by midwives.

Our findings on the experiences of people with long-term conditions from ethnic minority groups are reflected in other research:

- A review carried out by the Race Equality Foundation concluded that the "intersection of disability and ethnicity results in compounded discrimination".[62] The review stated, "Such discrimination exacerbates inequalities in access and experiences of healthcare for people with a learning disability from ethnic minority backgrounds". By comparing life expectancy, the review found that the average age of death for people with a learning disability who are from an ethnic minority group is 34 years – this is just over half the life expectancy of white counterparts, at 62 years of age.
- A report by the National Institute for Health and Care Research on how mental health services meet the needs of people from different ethnic groups found that mental health services often did not consider wider factors such as how racism, migration stress, and complex trauma can affect people's mental health.[63] People who participated in the research wanted more personalised care that was less medical. But mental health professionals said a lack of time prevented them from providing more person-centred care.

Focus on care for people with sickle cell disease

Sickle cell disease is a long-term condition. People with the disease produce unusually shaped red blood cells that can cause health problems. This includes very painful episodes known as sickle cell crises. Sickle cell disease is particularly common in people with African or Caribbean heritage, therefore any poor care in sickle cell services will have a disproportionate impact on this group.

We know that people with sickle cell disease do not always receive high-quality care. In No One's Listening, The Sickle Cell Society reported on the findings of the All-Party Parliamentary Group inquiry into avoidable deaths and failures of care for sickle cell patients. The inquiry found:

- evidence of sub-standard care for sickle cell patients in general wards or emergency departments (A&E)
- low awareness of sickle cell among healthcare professionals
- frequent reports of negative attitudes towards sickle cell patients and a weight of the evidence suggests that such attitudes are often underpinned by racism
- concerns leading to a fear and avoidance of hospitals for many people living with sickle cell.

To focus more on this area, our Medicines Optimisation team spoke with Chief Pharmacists and their clinical colleagues at nearly all NHS trusts in England to gain a better understanding of how prepared they were to ensure that people who experience a sickle cell crisis can access timely and effective pain relief, in line with national guidance.

People experiencing a crisis are often treated in acute hospital or ambulance settings. NHS trusts told us that people sometimes choose to go to specialist trusts because they knew they would be able to access the specialist teams there. Some specialist centres recognised the need to engage better with smaller trusts to enable them to benefit from their expertise. Specialist trusts also said they couldn't always get quick access to detailed information from secondary and primary care providers about the people they were treating.

Some community and mental health trusts viewed sickle cell treatment as the responsibility of the acute trust, so they didn't see a need to develop their own guidelines or provide awareness training for staff. But, as people with sickle cell can be using any healthcare setting, it is crucial that providers consider how to support someone experiencing a crisis. This includes providers that care for people who are detained, such as in mental health and prison settings where access to acute services may be delayed.

We also found that:

- not all trusts had policies or procedures to support staff to offer safe and effective treatment, including the right pain relief
- some trusts had policies for either children or adults, but not both
- there was a gap in the knowledge of agency staff.

Our conversations with trusts highlighted these gaps, and prompted many to review their practice (such as policies and training). We are following up with trusts to make sure they have made improvements in these areas.

More positively, other trusts were responding to the Sickle Cell Society's report by reviewing guidelines, carrying out audits, working through action plans and determining how to ensure people with sickle cell disease are clearly flagged on electronic health records. Specific responses to improve treatment included:

- an app developed by an ambulance trust to give clear and up-to-date clinical guidance
- an acute trust that had developed a specific route for admission for people with sickle cell disease, enabling them to avoid waits at the emergency department and be linked directly to the on-call haematology team to be treated rapidly
- a mental health trust that had proactively ensured that people with sickle cell disease were linked in with the appropriate specialist teams for regular review.

Autistic people and people with a learning disability

For too long, autistic people and people with a learning disability have faced inequalities when accessing and receiving health and social care.

Our inspections of services for these groups of people have a deeper focus on the cultures in these services. This is so we can understand people's experiences – both positive and where they may be at risk of harm and not treated as equal citizens.

Barriers to equality

Successive reports have shown how autistic people and people with a learning disability face barriers to equality when using services that are vital for promoting their independence and quality of life.

Our progress report on 'Out of sight – who cares?' in March 2022 found there were still too many autistic people and people with a learning disability in hospital in mental health inpatient services.[64] They often stay for too long, do not always experience therapeutic care, and are still subject to restrictive interventions. While people are in these limited and sometimes overly restrictive environments, they will not be able to be equal citizens and are at high risk of human rights infringements.

Our report found that challenges in the system, such as a lack of community services, prevented people from accessing early intervention and crisis support in the community, which can be particularly difficult for autistic people. They then end up in hospital as an inpatient.

The numbers of autistic people and people with a learning disability in hospitals are still high – at the end of June 2023, there were 2,035 inpatients. Over half have been there for over 2 years (1,125).[65]

Our recent Mental Health Act Reviews also show that autistic people and people with a learning disability continue to be in hospital inappropriately when they should be receiving care in the community. Inappropriate hospital placements can cause considerable harm, especially if a person is in long-term segregation. Mainstream psychiatric inpatient care environments are usually bright and noisy and unsuitable for neurodiverse people.

In November 2022, we published 'Who I am matters', a report that looked at what autistic people and people with a learning disability experience when they need physical health care and treatment in hospital.[66] We looked at a range of treatment and support, from minor injuries in emergency departments to surgery – all of which can cause anxiety for anyone. The report found not only issues around critical patient safety, but also key equality issues.

Needs arising from other protected equality characteristics, such as age, race and sexual orientation, risked being overshadowed by a person's learning disability or autism because staff lacked knowledge and understanding about inequalities. All too often, good care came from specialist staff or individual members of staff going the extra mile for people they were caring for.

People also told us they found it difficult to access care as reasonable adjustments, such as communication aids or sensory tools, weren't always used.

Unequal access to healthcare services

We see through our inspection activity that care providers do not always address the physical health needs of autistic people and people with a learning disability.

A residential care home providing personal care and accommodation for autistic people and people with a learning disability was rated as inadequate. This was because of failures that included not assessing or managing people's safety well and not working well with other agencies to protect people from the risk of abuse.

Staff used practice that put people at increased risk of harm, including:

- delaying seeking appropriate medical attention for 2 people in response to injuries
- failing to take another person to the correct hospital as part of their emergency plan, which delayed treatment.

We reported these concerns to commissioners and required urgent assurances from the provider to give details of the actions they were taking to mitigate risks to people. Commissioners placed their own health and social care professionals at the service 24 hours a day to monitor people's safety and completed reviews of people's care with the provider.

We also worked very closely with the safeguarding team, commissioners, intensive support teams from a local NHS trust and other healthcare professionals to improve the service and find alternative placements where the service did not have the skills to support people.

From a CQC inspection report

In line with our strategic ambition to tackle inequalities in care, we presented some perspectives from autistic people on challenges they experienced when using primary care services. 'How you see me matters' included aspects like the importance of consistency and seeing the same healthcare professional to reduce anxiety.[67] Using these personal experiences will help to improve how we assess healthcare providers that deliver care for autistic people. They also highlighted areas where providers and systems can improve experiences for autistic people by:

- providing training for staff to meet regulatory requirements, noting the Oliver McGowan draft code of practice on statutory learning disability and autism training that was out for consultation until autumn 2023
- making reasonable adjustments to premises, processes, and communication
- ensuring timely access to diagnostic assessments for autism and support after diagnosis – autism may present differently in different age groups, genders and ethnicities
- working together with other services to co-ordinate people's care.

In 'How you see me matters', people also described how short appointments with a GP or dentist make it difficult for them to fully discuss all the concerns that led to the appointment, and to make shared decisions about their ongoing care and treatment.

This is supported by a recent NHS Race and Health Observatory report on access to healthcare services for people from ethnic minority groups who have a learning disability.[68] This found that inadequate reasonable adjustments, including unsuitable methods of communication and inflexibility with appointment times, inadvertently resulted in sub-standard care and treatment. For example, one carer described a lack of easy-to-read information about the health check, no flexibility around appointment times, and not enough time for the GP appointment itself:

> *"There's supposed to be adjustments and the guidelines suggest that GPs should have extra time for all of these appointments as well. There was absolutely none of this and it took literally 10 minutes to do his blood pressure, height, weight, and the general nodding of heads saying 'consultants are dealing with this so we don't need to talk about it'."*

As part of our ongoing activity in this area, we're working to identify what CQC can do that will have the most impact on the health of autistic people and people with a learning disability. A key area of work will be around identifying the barriers and issues for these groups of people in being able to see their GP. For example, we want to focus on the quality of annual health checks and action plans to ensure referrals and onward assessment, diagnosis and treatment are made at the right time to reduce mortality.

Findings from our inspections

To help respond to the issues described above, we are continuing to develop our approach to inspections and assessments of services for autistic people and people with a learning disability. We are doing this to really understand people's actual experiences – 'What is it really like to live in or use this service?'. We will also support providers to do the same.

To help us identify closed cultures in services, we focus on listening and observations as well as using Experts by Experience with recent personal experience of health and care. We will continue to strengthen and embed this approach, through our new assessment framework and out-of-hours visits, to listen to and spend time with people. We will continue to look at how we can spot signs of a closed culture early.

Examples of outstanding and inadequate care homes for autistic people and people with a learning disability

We assessed and rated these 2 services using the principles in our 'Right support, right care, right culture' guidelines.[69]

The outstanding care home
Our inspector describes the first service as, "Amazing. The owner is so dedicated. The staff all follow the visions and values of the organisation." The inspection report comments on how the "leaders and the service culture they created drove and improved high-quality, person-centred care."

The influence of staff on the quality of care

- Although staff were trained to use physical interventions if needed, they told us they did not use these.
- They understood how providing structure, activities, opportunities to contribute to the household, and personalised communication reduced people's anxieties and distress.
- If they needed help and advice from colleagues, they asked for it. For example, when people were worried about an appointment, staff asked external nurses for support. If people could not express their needs using words, staff referred to pictures they produced with the nurses that described how people expressed pain, and what they could do to reduce this.
- Staff took their time to get to know people and understand why they reacted and communicated in specific ways. For example, one person did not allow staff to brush their hair. The staff used observation, reflective practice and discussion to understand why. They supported the person to buy hair accessories and to feel safe with their hairbrush. As a result, the person became more comfortable and actively asked staff for support with haircare, seeing this as a fun and positive activity.

The inadequate care home
The inspector describes the second care home as, "a closed culture, where staff did not treat people well or respectfully. There had been a lack of consistent management and leadership and this had an impact on the way the

staff behaved. They had lost sight of why they were there and how to care for people. People were not treated as individuals and no effort was made to support them to live full and interesting lives." This service is now in special measures. We have also issued Warning Notices and shared our findings with the local authority.

The influence of staff on the quality of care

- They talked about people in front of them and others, sometimes in a demeaning way, for example describing one person as "like a 5-year-old".
- Notice boards still displayed the activity plan for a person who had died the previous year. Staff had crossed out the name of person who had also died on a room allocation sign and simply replaced it with the new occupant's name.
- They didn't give people a choice about food. On the morning of our inspection, one person told staff which specific meal they would like for lunch and that they would like to help prepare this. This meal was not provided, and the person was not invited to help prepare any food. The 5 people who ate lunch were all given the same meal, which staff had put on plates before they arrived in the dining area so they did not know what they would be given in advance and were not able to make choices.

One finding from our recent inspections of services for autistic people and people with a learning disability is a lowering of expectations – that less than good care is good enough, because we are still recovering from the pandemic.

In one care home, people with a learning disability were not supported to go out and participate in activities that were meaningful to them. We reviewed records for 3 people and found limited evidence that they were able to pursue their individual hobbies and interests – both within the home and in their local community. For example, one person enjoyed swimming and their care plan stated they should be supported to go swimming once a week. However, there were no records to show evidence that this person had been swimming since before the COVID-19 pandemic and staff confirmed this.

When we discussed the shortfalls identified during our inspection, the registered manager told us they were disappointed and explained the impact of the pandemic on the service. However, they recognised it was now time to improve.

Supported living

To understand why autistic people and people with a learning disability experience inequality, we're listening to experiences and working with other partners to improve care and how services are regulated.

In last year's State of Care, we reported how we had set up the Supported Living Improvement Coalition as part of improving our regulation and achieving equality for autistic people and people with a learning disability. The Coalition's aim is to drive the improvements needed to change outcomes for people who access supported living, which can enable adults to live in their own home with the help they need to be independent. Partners in the Coalition include people who use supported living services, advocacy groups, care providers, local authorities and housing association representatives.

The discussions and issues raised so far in the Coalition have provided much learning, with some main concerns:

- there are failures in the system in which supported living services are operating, which hampers their ability to respond when people need support
- there are inconsistent outcomes for people using supported living services, as not everybody receives the same level of personalised care; for example, relationships between people and staff could range from being like a "friendship to a hotel staff worker"
- a lack of funding can mean that budgets are prioritised above truly person-centred approaches to supporting people.

Concerns around funding for supported living services are supported by our Market Oversight financial data. This shows a large fall in profitability in 'specialist services', which include supported living services and other residential and homecare services for autistic people and people with a learning disability.

Profitability is calculated using 'EBITDARM', which is a high-level measure of profit that excludes key expenses such as rent, depreciation and interest charges. It shows that profitability in these specialist services has declined consistently between September 2021 and March 2023 (by 5.1 percentage points to a profit margin of 14.6%).

Higher staff costs have been the key factor in this profit reduction for specialist services (increasing by 3.4 percentage points). This is further exacerbated in residential settings, which have a higher use of agency staff and are more affected by recent inflationary increases in non-staff costs, such as heating and food.

Some providers have told us they may have to hand back unsustainable packages of care:

> *"One of the issues we've had over the last 12 months is having to use agency and that has absolutely [scuppered] us in terms of any surplus we might have had."*
>
> **Quote from a provider during research interviews with Supported Living Improvement Coalition partners**

We are concerned that, although specialist providers such as supported living services tell us they have achieved some efficiencies using rostering systems and overtime, these efficiencies alone are not enough to guarantee financial sustainability in the long term. Services such as these are more likely to be funded by local authorities, so they are less likely to be able to subsidise packages of care by increasing private fees (compared with care homes for older people, for example). Increased funding for these specialist types of service is vital to be able to support autistic people and people with a learning disability in the future.

Alongside funding, Coalition partners said that the broader economic context was having a significant impact on the lives of people in supported living, with people being at particular risk of not being able to fund their own care.

The attitude of staff was discussed as a barrier to good supported living. Although some Coalition partners talked about support staff being "really good, caring people", others talked about the impact of negative attitudes shown by staff. One person with lived experience talked about feeling discriminated against by support staff.

Choice in Supported Living services

Example of poor communication
A supported living provider arranged to have an electrician install covered electrical wiring through the bedroom of an autistic woman with Down's syndrome for an outside light. Although the provider asked the member of staff for permission, they didn't tell the woman herself, and staff didn't ask her if it was OK.

When she got home, she was really upset as she was told, "Oh, we're just going to have to reconfigure your bedroom." That was a massive deal for her as they moved her bed. Once the family found out, they got the wiring removed and the bedroom back to how it was. They explained that they weren't happy, and that if they'd explained beforehand the reasons for the work with her, rather than just doing it to her, they could have avoided a lot of stress.

Example of good communication
"[My relative] used to volunteer in the kitchen at a charity café and she had started to get quite upset. So, we asked her if she still enjoyed going, and she answered, 'Yes, yes'. But then she became even more upset. A staff member began to notice and flagged it to us, saying 'We're not quite sure what's going on here; it is affecting her moods in other activities and we can only pin it to working here'. Eventually, we said OK, let's get together and ask her: 'Do you want to do this? This is what your schedule would look like without it.' She answered, 'Yes, I don't want to do it anymore.' So that was a big choice for her that she's made recently. She's much happier. She's joined a gym instead and goes to Zumba and swimming."

Accounts from a Supported Living Coalition partner who is a family member of a person using a service

Restrictive practice

We are able to hear the views of people with lived experience, their family members and partners in the wider system through our Expert Advisory Group. The group helps us to set the direction and focus of our activity in driving improvements in care for autistic people and people with a learning disability. Members told us that the use of restrictive practice can cause trauma and harm to those experiencing it, and fed back to us that:

- Autistic people and people with a learning disability need more support to communicate their needs and be listened to, and have those needs acted on. Blanket policies and a lack of person-centred care and care planning cause issues and frustration.
- Staff need to get to know the people they support. Too often, they use the threat of restraint to respond when they find it difficult to interpret or manage the way a person is communicating. This is often due to a lack of training, a poor relationship between staff and people, or just not having enough time.
- There is insufficient funding for research into alternatives to restrictive practice, and not enough independent advocates.

The Expert Advisory Group asked us to act to help reduce the use of restrictive practice, and we have made it one of our priority areas. We have now shared our policy position on restrictive practice, which clarifies that we expect leaders of services, systems, and all those working in health and social care to take immediate steps to identify and reduce restrictive practices in their services, where possible.[70]

It is not acceptable that there is still a big inconsistency in outcomes for autistic people and people with a learning disability.

As well as reducing the use of restrictive practices, strong leadership is critical in bringing together people, those speaking up on their behalf, staff, providers, and system partners, to:

- ensure better availability of community-based options to reduce hospital admissions and provide actual choice for people to receive safe, preventative and high-quality care where they live
- improve the equality of access to health services, including reasonable adjustments, to keep people well, reduce health crises and prevent early mortality.

Children and young people

Last year, we highlighted how services, especially for mental health, were struggling to meet the needs of children. We have engaged closely with children and young people to hear first-hand about their health and wellbeing, as well as their experiences of services.

Mental health

Through our inspection and monitoring activity over the last year, we can see the continuing impact of the pandemic on the mental health of children. Too many children have long waits for mental health support, fuelled by increasing demand and staff shortages. The mental health charity, YoungMinds, recently reported that the number of urgent referrals of children to crisis teams has reached a record high.[71] The data also found that the number of children and young people undergoing treatment or waiting to start care using children and young people's mental health services reached 466,250 referrals in May 2023, the highest number on record.

Providers tell us that children typically present with worse mental health issues than before the pandemic.

Research by the NHS Confederation also supports these findings. This estimates that in the next 3 to 5 years, 1.5 million children and young people will need new or additional support for their mental health, including seeking treatment for eating disorders. In the last 2 years, the number of children and young people being referred for urgent support for eating disorders has increased by nearly three-quarters – at a time when mental health services have seen increased demand and waiting times.[72]

Young Champions group

Towards the end of 2022, we recruited a group of young people aged between 13 and 25 from across England as 'Young Champions'. The group's purpose is to:

- steer and challenge CQC on how we engage with and listen to young people and embed their voice and views across our work
- support our colleagues to speak to young people about their care
- encourage other young people to give feedback to CQC
- support young people to develop their skills and confidence.

Issues such as mental health were central to the Young Champions' life experiences, and the reason why they joined. One applicant said, "I believe that the voices of young people needed to be heard about mental health."

We invited the Young Champions to help us inform this year's State of Care by co-designing and testing a survey about their experiences of health and care services and circulating it within their networks. We received feedback and experiences from 159 young people. The following results reflect the experiences of this group of young people rather than necessarily representing the experiences of all 13 to 25-year-olds.

Nearly 2 in 5 young people (38%) reported having a problem with their mental health (diagnosed or undiagnosed) in the last 18 months. When asked to describe these problems, many referred to anxiety or depression, with a small number saying they had attempted suicide or thought about it:

> *"I have seen child and adolescent mental health services face-to-face twice – once in October last year for an initial appointment and once a few weeks ago. I begged to see the crisis team in person because I was very suicidal. This is after a 2-year wait and being in the most urgent category since February. I have felt like this before and it has been very dangerous not getting the support I need. I feel failed."*
>
> **Respondent to young people's survey of health and care**

When asked about the factors they believed contributed to young people's mental health problems over the past 18 months:

- three-quarters (76%) of young people thought social media had contributed
- 7 in 10 (71%) thought academic pressure had played a role
- 7 in 10 (70%) thought the pandemic had affected young people's mental health.

Asked about the other effects of their poor mental health:

- 68% said their diet and physical health had deteriorated
- 57% had decreased academic performance
- 53% had strained relationships.

Of those who responded, 7 in 10 felt that the services they accessed, such as counselling or crisis helplines, did not help them or they were unsure if they had helped (35% felt that the services they accessed didn't help them, 35% felt unsure):

> *"I am a young [late teenage] female. I have struggled with my mental health for years and only last October one person mentioned to me at a CAMHS initial appointment that I might be autistic. I have been dismissed and not listened to for years, despite displaying clearly autistic traits, but I believe because I am a young female it has been missed and I now suffer with anxiety and depression from not getting the support. I also live in a rural area and there is a definite lack of mental health services and funding."*
>
> **Respondent to young people's survey of health and care**

When asked about general health and care services, only around 3 in 10 respondents were able to access all the services they needed in the last 18 months. The most reported barrier to access was waiting times for appointments or diagnoses. For example, one person complained of an *"Extremely long waiting list and not enough long-term help"*; another said, *"Bad experience with dentists – no NHS options in the area, so issue has gotten worse"*. Availability of face-to-face appointments was also a concern.

These findings reflect what we are seeing through our inspections and monitoring – for example, a significant increase in waiting times for community children's services, such as speech and language therapists. A recent report by NHS Providers and NHS Confederation warns that long waits can often affect outcomes for children more severely than adults because delays in assessment and treatment have a knock-on effect on communication skills, social development and educational outcomes as well as their mental wellbeing.[73]

The British Dental Association (BDA) has warned that inequality in oral health care among young people is set to widen, as research published in May 2023 estimates that over 15 million appointments for children have been lost since the pandemic lockdown. NHS England data up to the end of June 2023 shows that 5 million children have not been seen by an NHS dentist for at least a year.[74]

The BDA warns the lack of access will disproportionately affect lower income, higher needs families – widening the UK's oral health gap.

Government data also shows that the tooth extraction rate in NHS hospitals (which indicates a lack of primary care dentistry) for children and young people living in the most deprived communities was nearly 3 and a half times that of those living in the most affluent communities.[75] Also, tooth decay was the most common reason for hospital admission in children aged between 6 and 10 years.

Our survey of young people found that around 3 in 10 (29%) had a very positive or positive experience when trying to access the health and care services they needed, but 13% had a negative or very negative experience (31% did not respond to this question).

When asked if young people felt like they had been treated fairly when using health or care services, only just over half of respondents (55%) felt they had. Some young people (18%) felt unsure if they had been treated fairly and 13% reported that they didn't feel like they had.

Of those who were unsure or felt they hadn't been treated fairly, the most common reason was because of their age. Some other young people felt like they weren't treated fairly because of where they live (16%), their disability (14%) or their gender (12%). A few young people said they thought they were treated unfairly because of their ethnicity, with one saying, *"The way I'm viewed and listened to is often different because of misconceptions and it makes opening up hard"*.

Equality for the health and social care workforce

In this section, we look at the inequalities experienced by staff working in health and social care services.

Equality for disabled staff

The Workforce Disability Equality Standard (WDES) is a set of 10 specific measures for NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.[76]

Overall, results indicate poorer experiences for staff with a disability. For example:

- the proportion of staff with a disability who experienced harassment, bullying or abuse at work from managers (16%) was higher than staff who did not have a disability (9%)
- a higher proportion of staff with a disability (28%) felt pressured to work when feeling unwell compared with staff who did not have a disability (20%).

Workforce equality for ethnic minority staff in the NHS

Data on the NHS Workforce Race Equality Standard shows the vital contribution to the NHS made by staff from ethnic minority groups.[77]

Since 2018, the number of staff from an ethnic minority group has increased by over 100,000 (with representation of the total workforce increasing from 19% to 24%). An increase in internationally educated nurses and international medical graduates is likely to be a significant contributor to this.

A large increase in 2021/22 saw the number of staff from ethnic minority groups increase by over 27,500.

London had the highest proportion of staff from ethnic minority groups at 50%, while the South West had the lowest proportion at 13%.

Staff from ethnic minority groups are still under-represented at the top of the NHS. Although they represent nearly a quarter of the workforce, they make up just 1 in 10 of very senior positions.

There are some signs that staff from ethnic minority groups are beginning to be represented more in NHS leadership positions. The total number of staff from ethnic minority groups at very senior manager level has increased by 70% from 201 in 2018 to 341 in 2022. However, these numbers are relatively small: in comparison, there were 2,754 staff in very senior manager levels in White ethnic groups.

Although the NHS is working to improve the inclusivity of recruitment and promotion, in 2022, White applicants were 54% more likely to be appointed from shortlisting compared with applicants from an ethnic minority group. This is lower than 2021 (61%), but higher than in 2018 (45%).

Experiences of staff from ethnic minority groups

Staff from ethnic minority groups also continue to have poorer experiences compared with staff in White ethnic groups.

The NHS Staff Survey National results briefing 2022 describes how staff from ethnic minority groups were 4 times more likely to experience discrimination from patients, people using services, their relatives or other members of the public in the past 12 months than staff in White groups (20% compared with 5%).[78]

And in 2022, a higher percentage of staff from ethnic minority groups (29%) than White groups (27%) were harassed, bullied, or abused by patients, family, or the public. This figure is particularly high for female staff from a White Gypsy or Irish Traveller background (43%).[79]

We look in more detail in the section on workforce about increases in international recruitment, as well as concerns about modern slavery and human trafficking.

Addressing staffing inequalities
A London hospital introduced maternity cultural safety champions to address inequalities and improve equity for staff and people using services. The champions delivered yearly mandatory cultural safety training to encourage staff to reflect on unconscious biases, understand existing inequalities in maternal and neonatal outcomes and consider how staff can improve their practice to reduce inequalities.

Staff were consistently positive about working at the hospital and told us they felt well supported and able to raise concerns when needed, and were part of an inclusive culture.

From a CQC inspection report

Through our inspections and Give feedback on care service, we hear how staff working in hospitals, care homes and in other health and social care services are subject to racism. We have published a Statement on tackling racism within health and social care alongside an open statement to healthcare providers signed with the NHS Race and Health Observatory, Nursing and Midwifery Council, and the General Medical Council.[80] This makes clear that leaders should ensure that health and care staff across the country are protected from racism, or any other form of discrimination, as they go about their vital work.

Experiences of midwives from ethnic minority groups

Our interviews for this report with midwives from ethnic minority groups gave us valuable insight on equality, diversity and inclusion in maternity services in England.

Career progression

We identified that career progression was one of the key challenges affecting midwives from ethnic minority groups. They reported a range of issues in this area, all broadly feeding into reduced opportunity to develop and progress, compared with counterparts from White groups.

Midwives said they were less likely to be represented in leadership and managerial roles, and noted a pattern of White colleagues being better prepared for, and more likely to secure, promotion.

There was a view that promotion was based on ‘who you know’, rather than who would be good for the job:

"The talk on the shop floor is 'so and so will get the job because they are very pally with so and so on the panel'. Who goes out with who for drinks, who is in the same circle. Not about merit and considering who would be good for the job. It's based on people having the same cultural background."

Midwives from ethnic minority groups may also be disadvantaged in the job interview process. People on panels may not include those from ethnic minority groups, which does not set an encouraging and supportive tone. Even when it does happen, a midwife from an ethnic minority group told us she did not feel she had an equal voice to white people on panels.

Cultural norms may also affect interview performance. For example, cultural perceptions around eye contact affected one midwife during an interview, where her lack of eye contact was construed as a sign of poor communication or even rudeness: *"Getting this feedback throws me, because culturally where I come from, making eye contact would be very disrespectful. I was disadvantaged by their lack of understanding of that."*

Culture

In our 2021 report, Safety, equity and engagement in maternity services, we highlighted the importance of open and inclusive cultures.[81] We described how this was not only necessary for good clinical care, but that it also helps to drive a culture of safety and improvement.

However, in our interviews, midwives described a culture in which it is normalised for people from ethnic minority groups to tolerate discrimination from colleagues, and work harder to progress than their white counterparts.

They experienced and witnessed colleagues' language and behaviours that reflect racial stereotypes and a lack of cultural awareness.

Midwives found themselves having to act as educators about race, explaining aspects of culture or religious practices, such as wearing the hijab. Or explaining why certain words constitute a microaggression and are therefore not acceptable to use:

"They will say about a [white] staff member, 'that person is so passionate', and when it's a Black person, it is called 'aggressive'. Even though those two people are saying the same thing."

Some midwives told us they were frustrated by being expected to act as interpreters for people using maternity services. While they want to help, this is not part of their job, and made them feel 'used' by colleagues:

> *“You feel used for translation. I would be pulled here, there and everywhere to translate, and it is not part of my job. But I am doing it because that is the worst thing for someone – to be in an emergency situation and not know what staff are telling you.”*

As well as colleagues explicitly drawing attention to their difference, midwives talked about more subtle behaviours that contributed to them feeling a sense of exclusion, a lack of belonging and not feeling part of the team:

> *“I feel like I can't be my true self in work. I might be somewhere and there are 2 midwives talking and the conversation stops when I come in. You want to reflect and offload with other midwives about patient care. So it's very hard when you don't feel you have anyone you can do that with.”*

A very common theme in the interviews was around speaking up about concerns – whether about patient care, or about mistreatment of midwives themselves. There was a clear view that speaking up was likely to be a negative experience, and that the risks and consequences of doing so had to be weighed up – 'how will this affect how I am treated against my desire to call out unfair treatment'.

Participants overwhelmingly felt that issues were 'swept under the carpet', or addressed only superficially, showing a lack of genuine accountability either by individuals or the organisation.

Interviewees also highlighted that historical and cultural factors play a role:

> *“It goes back to culture and growing up – our parents and grandparents came here and worked and they struggled and there is this narrative of being grateful – you don't say anything, racism is normal, you stay quiet and move on – that has been so ingrained in you.”*

The impact of the challenges and issues experienced by midwives from ethnic minority groups were felt in terms of reduced wellbeing, mental health, confidence, motivation and career options.

Addressing issues and what needs to be done
There was variation in the extent to which the midwives interviewed were aware of any work underway in their trusts to address challenges and issues for staff from ethnic minority groups, and the extent to which they thought this work was making a positive difference. Interviewees who were more aware were those in roles with a specific remit around equalities, and they, along with the other interviewees, generally agreed that awareness of any improvement work or initiatives 'on the shop floor' was low.

All interviewees agreed that it is hugely important to staff and people using maternity services to have ethnic diversity within the workforce that reflects the population it serves – particularly at senior level. This is because it helps to ensure there is awareness of the reality of racism and discrimination, as well as helping staff to:

- feel equal and represented
- have role models and advocates for progression
- feel able to speak up and raise concerns.

> *"Why is it that in the hospital we don't have staff that look like the women who are using maternity services? Women want that – they tell me, 'I feel I will be more open and therefore get better care'."*

The midwives interviewed felt there was a need for more education and mandatory training about race and culture, and more opportunities for staff to talk about race in informal ways, such as:

- events celebrating colleagues from the Windrush generation
- more support and encouragement at senior level for grassroots action
- building trust by acknowledging and addressing issues.

Tackling inequalities in health and care

It is clear that the pandemic and the cost of living crisis have widened and exacerbated inequalities – both for people using health and social care services and those who work in these services.[82]

The 2023 Edelman Trust Barometer Special Report on Trust and Health found that the cost of living crisis is regarded as the number one societal factor worsening health.[83] Seventy-one per cent of respondents to the survey in the UK said that inflation is negatively affecting their health. The report also highlighted that the cost of living crisis risks making socio-economic health inequalities worse. Over half (58%) of respondents on lower incomes said there is a gap between how well they're taking care of their health and how well they should be, compared with 39% of high income earners.

Data from the Office for National Statistics shows that in 2018 to 2020, female healthy life expectancy at birth in the most deprived areas was 19.3 years fewer than in the least deprived areas; for males it was 18.6 years fewer.[84]

In this report, we have highlighted people who are more likely to face inequalities in access and experience when using health and care services, including:

- people from an ethnic minority group
- people who have a long-term condition
- autistic people or people who have a learning disability
- children and young people.

There are still some basics that health and care providers need to improve, such as:

- more consistent compliance with the Accessible Information Standard to help fulfil their legal responsibilities under the Equality Act 2010
- providing more consistent access to interpreters
- having a better understanding of how structural racism can disadvantage people.

While there is still room for improvement once people step through the door of health and social care services, even bigger gains will be made through addressing equity in access to services and tackling some of the underlying causes of health inequalities. Because inequalities vary by area, each area must have its own tailored response to meet the needs of its local population.

Reducing health inequalities is the most effective way to improve both the health of people in England and to invest in people's futures. Health spending should be seen as an investment, rather than a burden. And systems need to see reducing health inequalities as their core purpose.

Impact of low income and the rising cost of living on a person with long-term health conditions

Stacey has chronic pain due to a deformity of her spine, depression, anxiety, and severe asthma. She also has a neurological condition that causes pressure around the brain.

She was previously employed in retail, but because of constant migraines and other symptoms she is now "permanently off sick" until she can "get fixed."

Stacey said, "I have never struggled so hard in my life before [on Universal Credit]." The issues of her health are intertwined with problems around her low-income. For instance, when Stacey is particularly ill and cannot leave the house, she struggles to shop for groceries as she cannot afford to get a food delivery.

Stacey firmly believes that the cost of living crisis is exacerbating her treatment times and experiences with more people needing help adding pressure to the healthcare system.

Stacey gets no extra money from the system for health care travel-related costs. The bus ride to the local hospital to see her neurologist is £2 each way, but is still expensive for her. However, the specialist hospital is an hour and a half away, so her mother must absorb the costs of taking Stacey to hospital as she cannot afford a taxi.

Stacey needs the dentist, with a broken tooth giving her constant toothache. However, she cannot afford the £50 appointment fee of visiting a dentist. In Stacey's words "I've got an empty fridge right now, paying for a dentist is a luxury."

Stacey's plan is to wait until the tooth "gets so bad [that she] cannot take it anymore" and at that point she is confident it would classify as emergency surgery, and she can then attend an emergency dentist who will just extract the tooth there. She knows this will mean living in pain for some time. Stacey also knows that if she could afford it, a private dentist could treat her very quickly, which adds to her frustrations.

What a person told us about their personal experience

Working to reduce health inequalities

As part of our work funded by the Regulators' Pioneer Fund, we published some guidance in March 2023, which explains what innovation is, along with examples of innovative practice in NHS GP providers that aim to reduce health inequalities.[85] This followed work, which we are continuing, around fairer regulation for GP providers, led by doctors from ethnic minority groups.

The guidance shows that innovative practice to address health inequalities:

- needs to be tailored to an individual GP practice and the needs of its population
- doesn't have to be about treating disease or illness – it may focus on improving life chances and the overall physical, mental and social wellbeing of patients
- isn't just about developments in technology – indeed, sometimes these advances may exclude certain groups, such as people with particular disabilities and people facing poverty
- is often more successful when delivered collaboratively across a system.

Examples of innovative practice included a GP practice that secured funding through its primary care network to carry out staff training and get involved in the Pride in Practice programme to support the LGBT+ community to have better access to GP services.[86] The practice revised its policies and language to be more inclusive of LGBT+ people and supported staff to challenge any homophobic or transphobic language or actions.

Another GP practice supported a community centre to set up a 'health befriender scheme' for asylum seekers and refugees. This helped these patients navigate the NHS and access help and support for their health needs by matching up new arrivals with asylum seekers and refugees who had settled in the local community to support them with booking appointments and getting to consultations.

Measures to tackle health inequalities – NHS ambulance trust
We inspected an ambulance trust serving some of the most deprived areas in England. The trust had a strategy to plan, manage and improve services. This involved leaders and staff actively engaging with patients, staff, equality groups, the public and local organisations.

One outcome from this was the recruitment of over 90 community ambassador volunteers working in ethnic minority communities. This had resulted in more than 1,300 community members being involved in helping to improve awareness and how to access services, and more than 1,000 community members trained in lifesaving skills, including CPR and use of defibrillators.

From a CQC inspection report

Systems and inequalities

One of our core strategic ambitions is tackling inequalities in people's access, experiences and outcomes when using health and social care services. To help fulfil this ambition, we are starting to look more at the different factors that affect health and care in our new assessments of providers and local systems. We need to be able to feed this back to integrated care systems to help reduce health inequalities and improve quality of care.

Local authorities and integrated care systems have a responsibility to ensure they apply effective approaches to reduce health inequalities between geographic areas. This could be through:

- funding the expansion of an effective model across the system
- convening services in an area to share best practice
- providing peer support services to share learning among services.

Effective areas seem to have a clear health inequality reduction strategy, strong delivery structures and clearly defined, multiple levels of local autonomy to reduce health inequalities.

Engagement with communities is vital in defining strategic local-level and neighbourhood priorities for tackling health inequalities and in delivering trusted interventions at local level. We discuss more information about how local systems are responding to the challenge of inequalities and how we are assessing them in the section of this report on Systems.

Deprivation of Liberty Safeguards

Key points

- Ongoing problems with the current system have left many people who are in vulnerable circumstances without legal protection for extended periods.
- In 2022/23, the number of applications to deprive a person of their liberty increased to over 300,000, with only 19% of standard applications completed within the statutory 21-day timeframe.
- Delays in implementing the Liberty Protection Safeguards mean these challenges are likely to continue.

The Deprivation of Liberty Safeguards (DoLS) are an important part of the Mental Capacity Act 2005. Care homes and hospitals should apply them where a person aged 18 or over does not have the mental capacity to consent to their care arrangements, and they need to be deprived of their liberty. In practical terms, this involves continuous supervision and control and means the person is not allowed to leave the place where they are being cared for. DoLS are important human rights safeguards; they aim to ensure that such deprivation of liberty only happens when it is necessary, proportionate and in the person's best interests.

In our previous State of Care reports, we have highlighted ongoing concerns about how the system operates. The number of applications to deprive a person of their liberty has grown significantly over the last decade. This is mostly the result of a landmark judgement handed down by the Supreme Court in 2014, which clarified and broadened the definition of what constitutes a deprivation of liberty. In the year following the judgement, there were 10 times as many applications. Data from NHS England shows that the number of applications received by local authorities has generally continued to increase since this time.[87]

While the safeguards offered are essential to protect people's human rights, we remain concerned that the current system is unable to cope with the demand for assessments. Ongoing problems with the process, including delays in processing applications and the varied knowledge of staff about the safeguards, have left many people who are in vulnerable circumstances without legal protection for extended periods. These concerns were echoed by our Expert Advisory Group, with one member describing DoLS as a "broken system".

Liberty Protection Safeguards

In response to these issues, the Liberty Protection Safeguards (LPS) were developed as part of the Mental Capacity (Amendment) Act 2019. These will replace the Deprivation of Liberty Safeguards by establishing a simpler and more efficient system, aiming to place the person subject to the safeguards at the heart of the decision-making process. The new safeguards will also address various limitations of the previous system:

- The new scheme extends to cover 16 and 17-year-olds.
- They apply to all settings, including those outside of the scope of DoLS, such as supported accommodation and in people's homes.
- Whereas DoLS apply to a specific location and cannot be transferred, a Liberty Protection Safeguard authorisation could include multiple settings.
- Local authorities will no longer be the only organisations other than a court authorising deprivation of liberty arrangements. NHS trusts and integrated care boards will also be responsible for authorisations, depending on where the person is being treated or cared for.

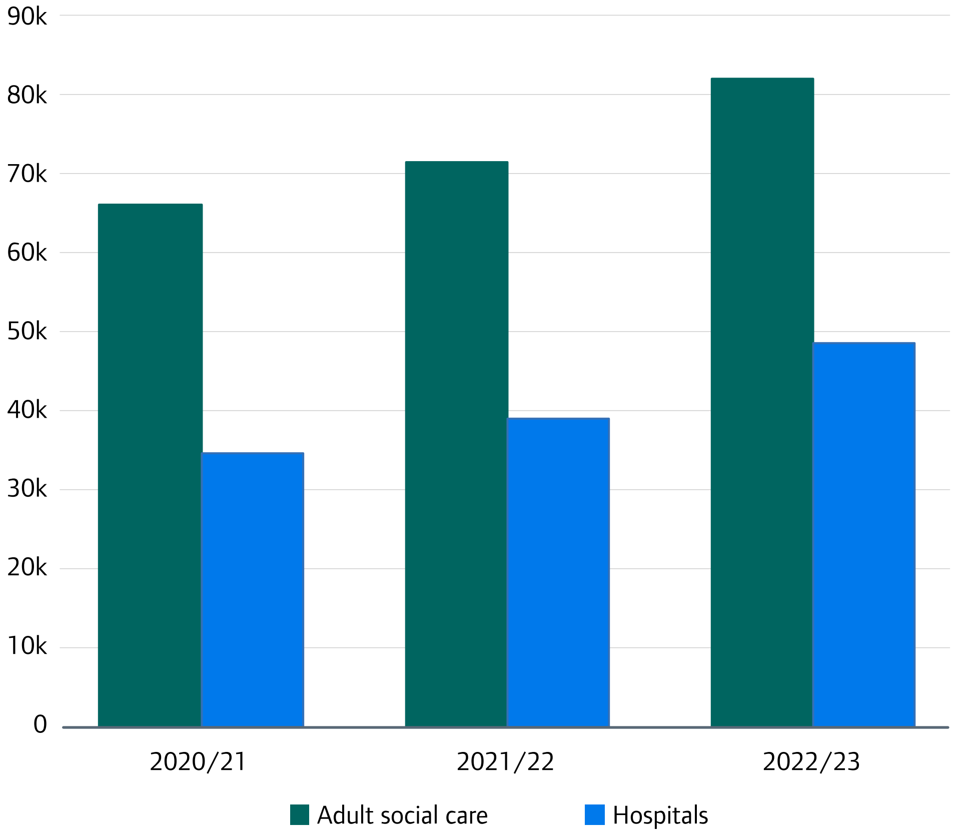
Liberty Protection Safeguards were originally due to be implemented in October 2020, but were postponed because of the COVID-19 pandemic. In April 2023, the government announced that the implementation would be delayed 'beyond the life of this Parliament'.

We are concerned about what this means for people being potentially deprived of their liberty unlawfully, for their family and friends, and for providers and local authorities. Disabled people and older people are more likely to require the safeguards offered by DoLS and will therefore be disproportionately affected by the decision to delay LPS.

DoLS applications and waiting times

Providers must formally notify CQC without delay when they know the outcome of an application for a deprivation of liberty, whether it was made to the Court of Protection or under DoLS. This includes both when an authorisation has not been granted or the application has been withdrawn. In 2022/23, we received over 131,000 DoLS notifications (figure 13). This was an 18% increase on the previous year and the number has increased year-on-year since April 2020 in both adult social care and hospital settings.

Figure 13: **Deprivation of Liberty Safeguards notifications, April 2020 to March 2023**



Source: CQC notifications

Note: this excludes notifications for DoLS applications made to the Court of Protection and notifications from primary medical services.

NHS England collects data from local authorities on the number of DoLS applications they received and completed in the last year, which shows over 300,000 applications were made in 2022/23.[88] This is an 11% increase on the previous year. Although the number of completed applications also increased, the number of incomplete applications rose by 2%, with over 126,000 cases incomplete as at 31 March 2023.

There are 2 types of DoLS authorisations: urgent and standard. Urgent DoLS authorisations can last up to 7 days and are initially granted by the hospital or care home where the person is being cared for, known as the 'managing authority'. If needed, urgent authorisations can be extended for a further 7 days. This type of authorisation can be used if a person urgently needs to be deprived of their liberty before they have had a full assessment.

In all other circumstances, the managing authority should request a standard authorisation. The relevant local authority then has 21 days to carry out assessments to ensure that the deprivation of liberty is appropriate. Standard authorisations should be reviewed regularly and can last up to 12 months.

Data from NHS England shows that the proportion of requests for urgent DoLS authorisations remained at 56% in 2022/23. Only 19% of standard applications were completed within the 21-day timeframe, which is a slight decrease from last year (20%). Concerningly, the average application took 156 days – over 7 times the statutory timeframe. Over 39,000 people had been waiting for longer than a year for their DoLS application to be completed as at 31 March 2023.

Faced with increasing volumes of applications, local authorities are having to triage assessments. A member of our Expert Advisory Group from a local authority explained having to make "decisions you should never have to when it comes to prioritising one person above another". A recent survey by the Association of Directors of Adult Social Services (ADASS) found 50% of directors of adult social care services in local authorities lack confidence in meeting their statutory duties relating to DoLS.[89] When asked about all statutory duties, DoLS was identified as the third highest concern.

The Local Government and Social Care Ombudsman acknowledged that many councils are struggling with the number of applications they receive. But they noted some challenges that arise from using prioritisation tools. In March, the Ombudsman upheld a complaint against a local authority for failing to assess DoLS requests in accordance with the statutory timescales set out in the Mental Capacity Act:

"Based on the statistics that I have seen, the council is failing to issue DoLS authorisations within the statutory timescales and in many cases the delay is so significant that the person has moved to another care or nursing home or has died without the council's DoLS authorisation.

"We cannot remedy the injustice that may have occurred to those who have died without a DoLS authorisation being assessed, who have had unlawful restrictions to their liberty.

"However, there may be many people who, because of the council's delays in assessing DoLS requests, have had restrictions placed on them that were not the least restrictive options, had they been properly and promptly assessed."

To tackle these resourcing issues, some local authorities are carrying out remote assessments in cases where there are no concerns. Frequently used during the pandemic, we found that a remote assessment may not always provide enough detail to assess the care environment. A member of our Expert Advisory Group questioned the suitability of this type of assessment, especially for people who have conditions such as advanced dementia, which may affect communication.

Meanwhile, people who are waiting to be assessed may be restricted without the appropriate authorisation in place. This could mean that people are being deprived of their liberty for longer than they should have been, or where less restrictive options could have been identified if they had been assessed. When assessments are delayed, staff face the challenge of keeping people safe while protecting their rights. This is particularly difficult if an urgent DoLS authorisation expires before the person has been assessed for a standard authorisation. Providers are not always clear on how to navigate the difficult legal situation of caring for people who are waiting for an assessment. This situation also affects people's ability to challenge the deprivation of liberty, as public funding for legal support depends on an authorisation being in place.

The legal framework around deprivation of liberty is particularly complex in certain hospital settings, such as urgent and emergency care. Delays in the wider health and care system mean people are spending longer in an emergency department. A member of our Expert Advisory Group told us they are particularly concerned about the number of people in emergency departments who are waiting for a bed on a ward. These people may lack the mental capacity to consent to their care arrangements but be prevented from leaving because of potential risks to their physical health. If people spend significant periods in an emergency department, staff treating them may be unsure about whether the person is being deprived of their liberty and whether the safeguards apply. This puts people at risk of being unlawfully deprived of their liberty.

Understanding and applying DoLS

Through our monitoring activities, we continue to see that some providers have a limited understanding of the DoLS framework. As a result, we have seen that staff do not always implement the conditions attached to a DoLS authorisation. For example, these conditions could be facilitating access to a place of worship or arranging visits to a relative's home. Providers have an obligation to comply with any conditions attached to a DoLS authorisation. If this does not happen, the deprivation of liberty may no longer be in the person's best interests and could be infringing their human rights.

We also continue to see poor recording of mental capacity assessments.

On inspections, poor knowledge and application of the Mental Capacity Act has affected ratings for providers, and in some cases, has led to enforcement action. For example, last September we issued 2 fixed penalty notices to an NHS trust for failures around consent. Our investigation found failures with the trust's documentation around capacity assessments when treating a man with complex health needs who is also deaf. We found that the trust had decided he lacked capacity without carrying out a sufficient assessment of his mental capacity. Organisations should not assume people lack capacity simply because their communication needs are different. Instead, they should fully explore all options to ensure equality.

In mental health settings, we continue to see a variable understanding of the interface between the Mental Capacity Act, which DoLS are part of, and the Mental Health Act. Where both frameworks could be used, it is not always clear how staff decided that using the DoLS framework would be most appropriate for a particular patient.

These issues are compounded by the lack of certainty around the future of DoLS, leaving providers feeling confused and frustrated. We have observed some providers not delivering adequate training on DoLS, resulting in a lack of understanding among staff.

Members of our Expert Advisory Group told us that some local authorities have held off implementing support to process DoLS applications, instead waiting for the new Liberty Protection Safeguard framework. One local authority reported an increase in applications following the announcement that the new safeguards would be delayed. This was attributed to staff deferring referrals in anticipation:

> *"I think a lot of referrals may not have been made in light of the impending LPS implementation, with providers feeling that 'LPS will deal with it'; however, now this is not the case, we seem to be having more and more referrals daily."*

Impact on people and their carers

We are concerned that poor understanding of the Mental Capacity Act and issues with the management of DoLS are contributing to the overuse of restrictive practices. We have seen restrictions put in place without considering whether less restrictive options are available in line with the Act. This includes installing sensor mats or bed sides and not always viewing these measures as restrictions. We heard from our Expert Advisory Group that some providers in the adult social care sector continue to use stricter measures introduced during the pandemic without recognising them as potential human rights infringements. Although COVID-19 restrictions have been lifted, we found that services do not always proactively encourage care home residents to re-join activities in their local community.

DoLS authorisations and mental capacity assessments should be reviewed regularly to make sure that measures remain necessary and proportionate. However, this does not always happen in a timely way, meaning providers miss opportunities to reduce restrictions and adapt to people's changing needs. It also means that people's human rights are put at risk. One Expert Advisory Group member told us that managing authorities often do not have a plan to reduce restrictions. Another reported "an assumption that people subject to DoLS lack capacity in all areas" and therefore are not capable of making smaller decisions for themselves.

When visiting mental health inpatient services for older people, we have seen a considerable number of patients subject to DoLS authorisations that had expired. People subject to DoLS authorisations are not always clear about the detail of their situation. This lack of communication also affects families and carers. Families often do not understand the DoLS system and are not given information about their roles and rights.

Feedback from our Expert Advisory Group indicated how this prevents families from being able to "meaningfully participate in the process", leaving them "unable to properly represent their relatives". Further to this, where families are not given advance notice that Best Interests Assessors (BIAs) would be coming to their house or calling them, the lack of information and warning has a significant negative impact.

Becky's experience highlights the benefits of having a DoLS authorisation in place and the importance of clear communication with carers and relatives:

Becky's story

Throughout her life, my Nan was an independent woman. When she was 72, she started accepting help, mainly with cooking and cleaning. As the year progressed, her condition deteriorated and she didn't seem like herself anymore. My sister and I became her carers. We arranged for her to be checked by her GP but we were told she was fine.

Things continued to get worse. She would call in the middle of the night, thinking it was daytime. We had to go round to ensure she ate. One night, the police found her walking in the streets at 3am and she was very disorientated. It was so sad to see her like that.

We spoke to her GP again and a week later, social services visited. That week felt like a long time and the lack of communication made us doubt if anyone would come. She was then assessed by the mental health team. They said my Nan was unfit to stay at home and she was admitted to hospital.

She was given a diagnosis of dementia. My sister and I felt like we had let our Nan down as we could no longer look after her in her own home. However, staff at the hospital advised us on potential care homes and involved us every step of the way. The hospital told us about DoLS. They explained it was about looking after Nan in a way that protects her best interests and we were given a leaflet explaining what the safeguards mean. In my Nan's case, the DoLS were in place to prevent her from going out unaccompanied and if needed, to restrain her for personal care. A member of staff mentioned that we could challenge DoLS and the leaflet provided details on how to do this. They also tried to explain the reasons for applying for a DoLS authorisation to my Nan. The hospital ran focus groups for families in similar situations, which were very helpful. It was nice to know that we were not alone, and that support was available.

Although I felt less involved with my Nan's care, I was happy for her to be on a DoLS and felt it made her safer. I was concerned about what might happen when the safeguards expired or when she was waiting for the care home DoLS authorisation, but we did not have to wait long.

Our experience of DoLS has been generally positive but that may have been different without my Nan's hospital admission. Speaking to some families at the care home whose relatives are also on a DoLS, they have much less information and support about the system. I would advise people in similar situations to get as much information as possible, to do their own research and to keep in regular contact with hospitals are care homes.

My Nan has been in the care home since November 2022, and we realise this was the right decision for her. We no longer worry about her leaving the house in the middle of the night, we can go and see her as much as we like, and we live our lives knowing that she is safe. I am grateful that she has a DoLS authorisation in place and feel like she is protected by the safeguards and the staff at her care home.

What a person told us about their personal experience

Although people have the right to challenge their DoLS authorisation, only a minority have independent support from advocates. In some circumstances, family members or friends may represent people. However, we have seen a particular lack of advocacy in older people's services, where people do not have anyone to represent their views. We have also heard that this lack of investment means there are not enough advocates for everyone who needs one, despite the 'legal and moral gravity' of the role.

Working with DoLS

Delays to the implementation of Liberty Protection Safeguards mean that the existing challenges with the DoLS system will likely continue unless short-to-medium term changes are introduced. We are concerned about the impact of these delays for people being deprived of their liberty, for their family and friends, for providers, local authorities and other stakeholders.

As highlighted in the government's LPS draft equalities impact assessment, disabled people and older people are more likely than others to require the safeguards offered by the current DoLS system.[90] Delays to LPS implementation are therefore likely to have a disproportionate impact on some groups of people with protected characteristics under the Equality Act 2010, and steps should be taken to mitigate this.

The number of DoLS applications made by health and social care providers continues to increase and local authorities are unable to meet the current demand for assessments. We have also heard about the limited availability of trained Best Interests Assessors, which can contribute to the delays in completing DoLS assessments.

The postponement of the LPS reforms means that deprivation of liberty outside of a care home or hospital will continue to require a court authorisation, as those settings are not included within the scope of DoLS. A member of the Expert Advisory Group has told us that they are concerned about the processing times required by the Court of Protection to authorise deprivation of liberty in community settings.

Considering the inconsistent application of DoLS, and most importantly, the negative impact on the experiences of people at the heart of the system, we welcome the announcement of an updated Mental Capacity Act Code of Practice. Improved understanding of the Act is an important step that will also help to implement the Liberty Protection Safeguards in the future.

Looking ahead, as we continue working with the DoLS framework, we are considering how we can improve our new monitoring role as we roll out our new assessment framework.[91] In the future, our new local authority assessment functions may support us in gaining a new perspective on the impact of DoLS application backlogs on local authorities and individuals.

The health and care workforce

Key points

- Staff regularly fed back to us of being overworked, exhausted and stressed, sometimes to the point of becoming ill, injured or leaving their job altogether. They say low staffing levels can affect their ability to provide safe and effective care to people.
- Just over a quarter (26%) of NHS staff were satisfied with their level of pay. This is 12 percentage points lower than before the pandemic. Dissatisfaction with pay is linked to industrial action by healthcare staff during 2023.
- Some adult social care providers are struggling to pay their staff a wage in line with inflation.
- Over half of respondents to our survey of adult social care providers in England said they were having challenges recruiting new staff and 31% said they were having challenges in retaining them.
- There has been a steady decrease in staff vacancy rates for care homes, from 11% in January to March 2022 to 7% in April to June 2023.
- In 2022/23, approximately 70,000 people arriving to work in the UK from overseas started direct care roles in the independent adult social care sector, compared with around 20,000 in 2021/22.
- Providers of adult social care services have told us that recruiting staff from overseas has enhanced the diversity and skills of their team and helped resolve staffing issues.
- In 2022/23, we made 37 referrals for concerns regarding modern slavery, labour exploitation and international visas – more than 4 times the number made in 2021/22.

Staff wellbeing and satisfaction

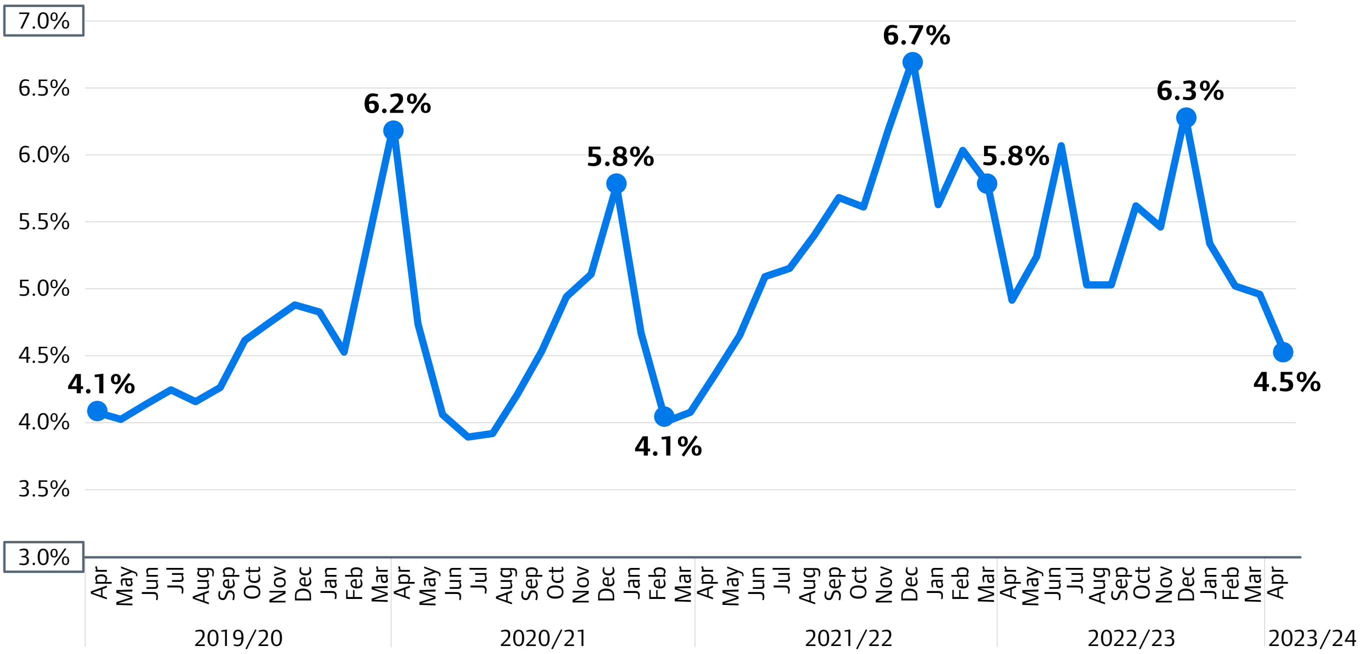
In this section, we consider what affects the wellbeing and satisfaction of staff working in some health and adult social care services. We look at rates of sickness and job satisfaction and some of the reasons behind those findings.

Staff sickness absence

Since July 2021, rates of sickness absence in the NHS have largely remained at around 5% to 6%, although in April 2023 these did drop to 4.5%.[92] Spikes in January 2021 (5.8%) and January 2022 (6.7%) coincided with spikes in COVID-19 infection rates. However, despite the falling number of COVID-19 cases, sickness rates for NHS staff remained high in 2022, and have increased since 2020 overall, with another large spike in December 2022 (6.3%) (figure 14). These recent figures are generally higher than before the pandemic (2017-19), where sickness rates fluctuated between 3.5% to 5%.

As at April 2023, staff in support roles and ambulance staff had the highest sickness rates followed by midwives.

Figure 14: **NHS workforce sickness absence rates, April 2019 to April 2023**



Source: NHS Sickness Absence Interactive Dashboard

Sickness absence for 'cold, cough, flu – influenza' tends to increase seasonally around December, with a large spike seen in December 2022, when 22% of the working days lost to sickness were from these illnesses.

NHS sickness rates are not available for primary care services, but in adult social care, data from Skills for Care shows that the number of days lost to sickness has steadily reduced from 8 days per person in April 2022 to 6.4 days in July 2023.[93] However, these figures are still higher than before the pandemic – for example, the average number of days lost to sickness was 4.6 in 2019/20.

Working conditions – stress and anxiety

Looking at the reasons for staff sickness, over the last 2 years NHS staff have generally been more than twice as likely to record ‘anxiety/stress/depression’ as the cause of their sickness absence than any other reason. This accounts for 20% to 28% of sickness absence. However, the proportion of staff absent for this reason in 2022/23 has decreased slightly from 2021.

In relation to why levels of stress and anxiety are so high, the 2022 NHS staff survey showed the percentage of staff who agreed that there are enough staff has declined to a 5-year low, at 26% (compared with 38% in 2020).[94] This is despite the total full-time equivalent staff rate in the NHS appearing relatively positive (see ‘Staff numbers’).

The NHS staff survey for 2022 also reveals that 15% of staff experienced at least one incident of physical violence in the last 12 months from patients or other people using services, their relatives or other members of the public. This follows similar percentages in recent years.

Figures are even higher for non-violent abuse, as 28% of staff experienced harassment, bullying and abuse from patients or other people using services, their relatives or other members of the public.

These findings are reflected in the views expressed by staff across all areas of health and adult social care who share their experiences through our Give feedback on care service. They regularly fed back to us about being overworked, exhausted and stressed, sometimes to the point of becoming ill, injured or leaving their job altogether. Feedback also included concerns around the management of the workforce and the support offered to overworked staff. Comments included:

> *“The trust is seriously understaffed. Nurses are harassed to hurry up and give medications fast. Staff are constantly told off, with some staff reduced to tears. A lot of staff have quietly resigned and left”*, and *“The workload is so excessive. No travel time or breaks are permitted on a regular, consistent basis. Clients go without care and are not always informed.”*

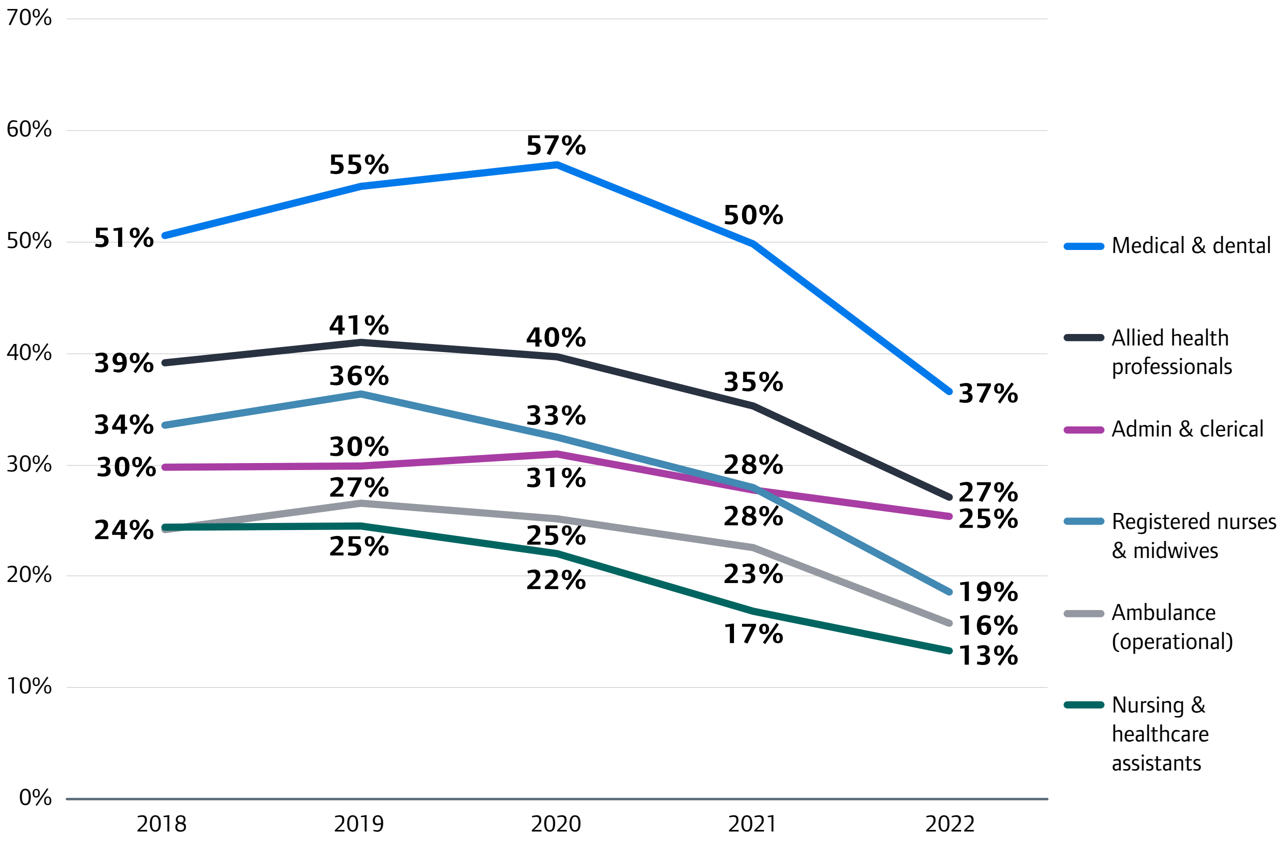
Job satisfaction for staff

Linked with the current cost of living pressures, satisfaction with pay has been a key factor in job satisfaction in public services.

The percentage of NHS staff who feel their work is valued has remained static. However, satisfaction with pay has reduced considerably. According to the briefing for the 2022 NHS staff survey national results, just over a quarter (26%) of NHS staff were satisfied with their level of pay. This is 7 percentage points lower than 2021 and 12 points lower than before the pandemic (2019).

Satisfaction with pay is lowest among nursing and healthcare assistants (13%) and ambulance staff (16%), but there has been a downward trend in all occupation groups since 2019 or 2020 (figure 15).

Figure 15: **2022 NHS Staff Survey - Percentage of staff who were 'very satisfied', or 'satisfied' with their level of pay – by occupation group**



Source: 2022 NHS Staff Survey National Results

The same NHS survey also shows that, related to morale, more staff are thinking of leaving. In 2022, 32% of staff said they often think about leaving their organisation. This compares with 27% in 2020. Staff in ambulance trusts were most likely to say they were thinking of leaving (43%) and staff in community trusts the least likely to indicate this (27%).

The cost of living crisis has caused household expenses to increase dramatically. Since 2021, the UK population has experienced a huge rise in the costs of goods, services, bills, and housing. Care workers have encountered a fall in disposable income, with some facing financial hardship.[95]

We have heard from some adult social care providers through our provider information return that they are struggling to pay their staff a wage in line with inflation:

> *"As with many health and social care providers, the cost of living increases have affected staff members and their own household costs, which are not reflected in their wages and not reflected in packages of the funding authority. Reviews of all packages are being requested, though the commissioners do not have an endless allocation of funds, so the uplift received this year fails to cover rises in costs."*
>
> **Feedback from CQC provider information return**

The current situation has pushed some care staff into vulnerable financial positions. Through our adult social care provider information return, providers describe that some care staff are struggling to afford basics, so employers are supporting them with the basics, such as food, fuel and toiletries:

> *"We are trying to support our staff through the cost of living crisis by things like offering to wash uniforms on site, staff meals, and putting a basket in the staff washroom with personal toiletries and sanitary items for their use."*
>
> **Feedback from CQC provider information return**

Dissatisfaction with pay has been linked to industrial action taken by healthcare staff during 2023 – particularly considering cost of living difficulties.[96] But our discussions with providers have shown that other factors, such as working conditions, strongly influence staff satisfaction.

As we have seen, NHS ambulance staff have among the highest sickness absence levels and are most likely to say they are thinking of leaving the NHS. A significant factor affecting the workforce across all ambulance services has been the delays in handing over patients at emergency departments across the country. The delays, which take the frontline ambulance workforce off the road for significant periods, result in longer response times and poorer outcomes for patients. This is a major component of dissatisfaction in ambulance staff surveys.

The frustration and dissatisfaction from prolonged delays at emergency departments have also resulted in higher levels of sickness associated with stress – both for frontline staff and the staff working in control centres. The delays have prompted increasing concerns over work experience and training, as staff may only see 1 or 2 cases in each shift. This is particularly important for students and newly qualified paramedics.

Services need to address low levels of staff satisfaction and high levels of stress and work overload, much of which relate to staff burnout from the pandemic – see our section on Investing in staff wellbeing.

Workforce capacity pressures on providers and staff

This section looks at staffing numbers in health and social care, and the impact of high levels of staff vacancy and turnover.

Staff numbers

NHS workforce data shows that, overall, there has been an increase in the number of full-time equivalent (FTE) staff working in NHS hospital and community health service trusts and other organisations in England (excluding primary care staff).[97] The number of all FTE staff increased by 5% between May 2022 and May 2023. Professionally qualified clinical staff (which include hospital and community doctors, qualified nurses and ambulance staff) make up over half of these, increased by 4.4% over the same period.

Looking at General Practice Workforce Statistics, there has been a small overall increase (of 2.6%) between July 2022 and July 2023 in the number of FTE staff across all staff groups.[98] However, numbers of fully qualified GPs decreased over the same period (by 1.2%). Without intervention, the shortfall in fully qualified GPs reported in the NHS Long Term Workforce Plan is projected to be around 15,000 by 2036/37.[99]

In adult social care, latest data from Skills for Care shows that, despite an increase of 1% in filled posts (roles with a person working in them) in England between 2021/22 to 2022/23, there are 45,000 fewer filled posts in 2022/23 than in 2020/21.[100] However, the number of FTE staff in post has recovered to 2020/21 levels.

Recruitment challenges

In our recent survey of adult social care providers in England, of over 1,900 respondents, more than half (54%) said they were having challenges recruiting new staff and 31% said they were having challenges in retaining them. Supported living services and extra care housing services reported having the most difficulties recruiting new staff.

Respondents to our survey also highlighted how workforce pressures resulted in reduced capacity in the system. Over a quarter of respondents (26%) said that staff shortages due to recruitment and retention issues were resulting in unused capacity.

Many adult social care services described through their provider information return difficulties attracting new staff to roles to fill the vacancies. They cited low pay, high pressure, and staff burnout as key causes of the many care workers who are leaving the sector for better paid jobs in less pressurised environments.

Pay differences are shown in Skills for Care data, which found that, as at December 2022, median social care worker pay (at £10.03 per hour) was 9p lower than the median hourly pay for sales and retail assistants and £1.08 lower than healthcare assistants.[101] Adult social care providers are telling us that this is having an impact on their ability to retain staff, which also affects capacity:

> *“We do get very minimal response from our [job] adverts. There is a national shortage throughout the industry at present. There seems to be a lot of reluctance for people wanting to go into care work as a lot of other sectors, for example retail, can be paying more wages than the care industry, and within the care industry there is a lot more responsibility.”*
>
> **Feedback from CQC provider information return**

> *“Due to lack of funding we have lost 50% of our staff in the past 14 months, which means we have also lost 50% of our hours of service delivery. Many of the staff we lost have moved to local authority or NHS homecare teams. As a private provider we can’t compete with government department wage rates.”*
>
> **Feedback from our survey of adult social care providers**

Recruitment challenges can also be influenced by regional factors. The rising cost of housing in certain areas of England has meant that, even if providers have managed to recruit staff to their vacant posts, new recruits have not taken up the offer of employment as they have been unable to find affordable housing. For example, an NHS trust in the South West had between only 40% to 60% of the adult community-based mental health staff that it should have. The lack of clinical psychologists and occupational therapists led to long waiting lists for patients and long waits for a range of therapies. The trust attempted to mitigate this by building temporary housing to accommodate new recruits.

Recruitment is often worse on the boundaries between local areas offering different wages, such as inner and outer London weighting, where staff choose to work where they can earn more.

One director of a provider of residential and supported living services for autistic people and people with a learning disability told our inspectors they were having a particular problem recruiting quality staff in London, despite offering them a welcome payment. Often, staff move on to another provider with similar welcome incentives as soon as they’re able. This prevents the people who are using the service from forming and developing meaningful relationships with staff.

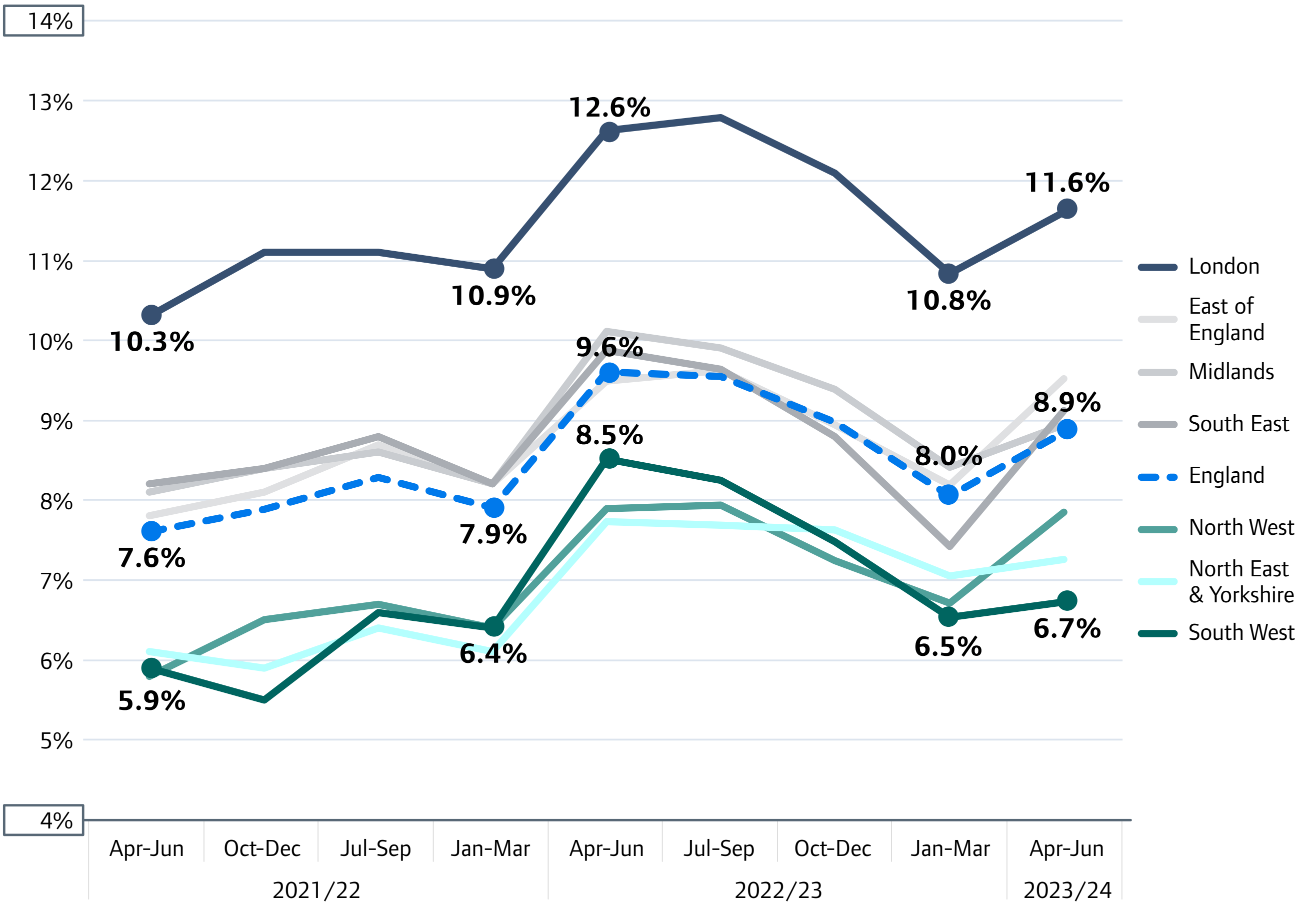
Vacancy rates

According to NHS vacancy statistics, there was a slight decrease in vacancy rates in England from 10% for the period April to June 2022 to 9% for the period April to June 2023.[102]

Despite the same general trend across all areas, there was some regional variation in vacancy rates for NHS services. For example, for the period April to June 2023, London continued to have the highest vacancy rate across

England at 12% compared with 7% in both the North East and Yorkshire region and the South West region, and a national average of 9% (figure 16).

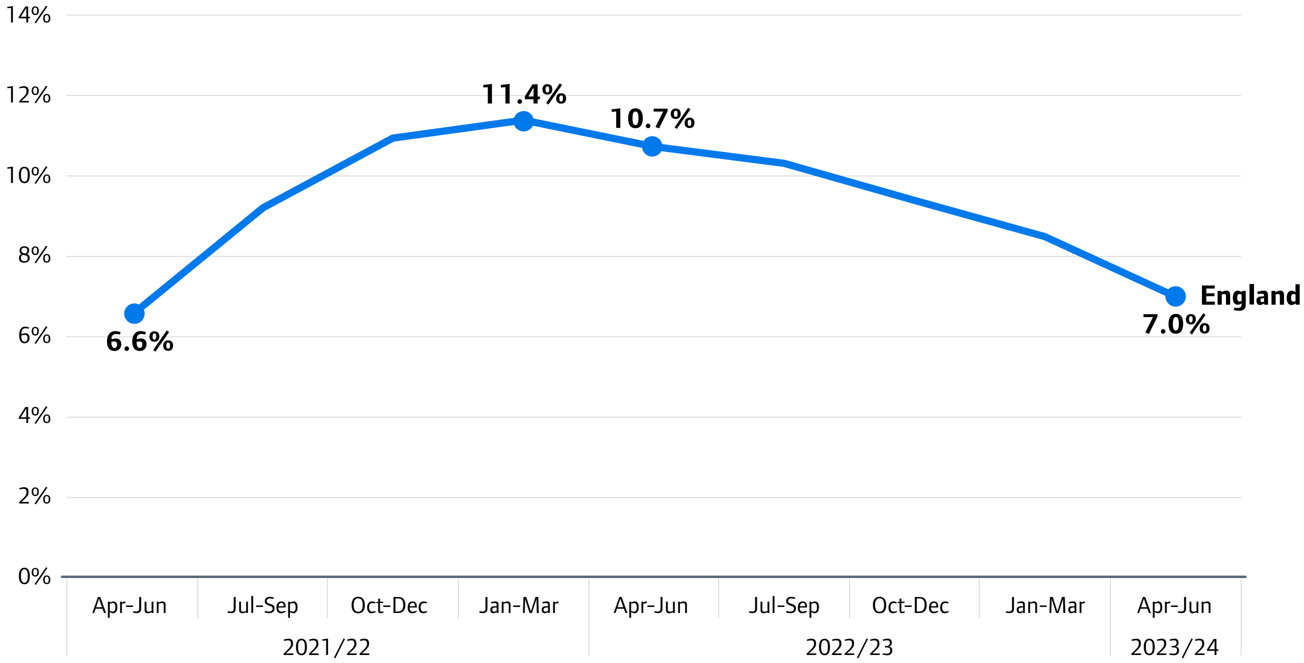
Figure 16: **NHS workforce vacancy rate by quarter, April 2021 to June 2023**



Source: NHS vacancy statistics

In adult social care, data from our provider information return shows a steady decrease in staff vacancy rates for care homes, from 11% (January to March 2022) to 7% (April to June 2023) (figure 17).

Figure 17: **Care home staff vacancy rate by quarter, April 2021 to February 2023**



Source: CQC provider information returns

Data from Skills for Care shows a small reduction in the overall adult social care vacancy rate from 10.6% in 2021/22 to 9.9% in 2022/23.[103] However, the figures for homecare have remained consistently high, with the vacancy rate in 2022/23 at 13%. This compares with an average for homecare of 9% in 2019/20.

Staff turnover

In NHS services, rates of staff turnover (number of leavers divided by the average number of staff in the last 12 months) have reduced from 13% in June 2022 to 11% in June 2023. This followed a steady increase throughout most of 2021 (from 9% in March 2021).

High turnover rates in an NHS ambulance trust

Turnover rates for call handlers had increased from 17.5% during 2020/21 to 28.3% during 2021 and 2022.

Frontline staff we spoke with described a hard-working culture, with lots of demands and work-related stress associated with their roles.

Staff told us that sickness and vacancy rates had made their roles and workloads much more difficult, and they felt this had increased risks to callers who had to wait longer for responses as they did not have the capacity within the teams.

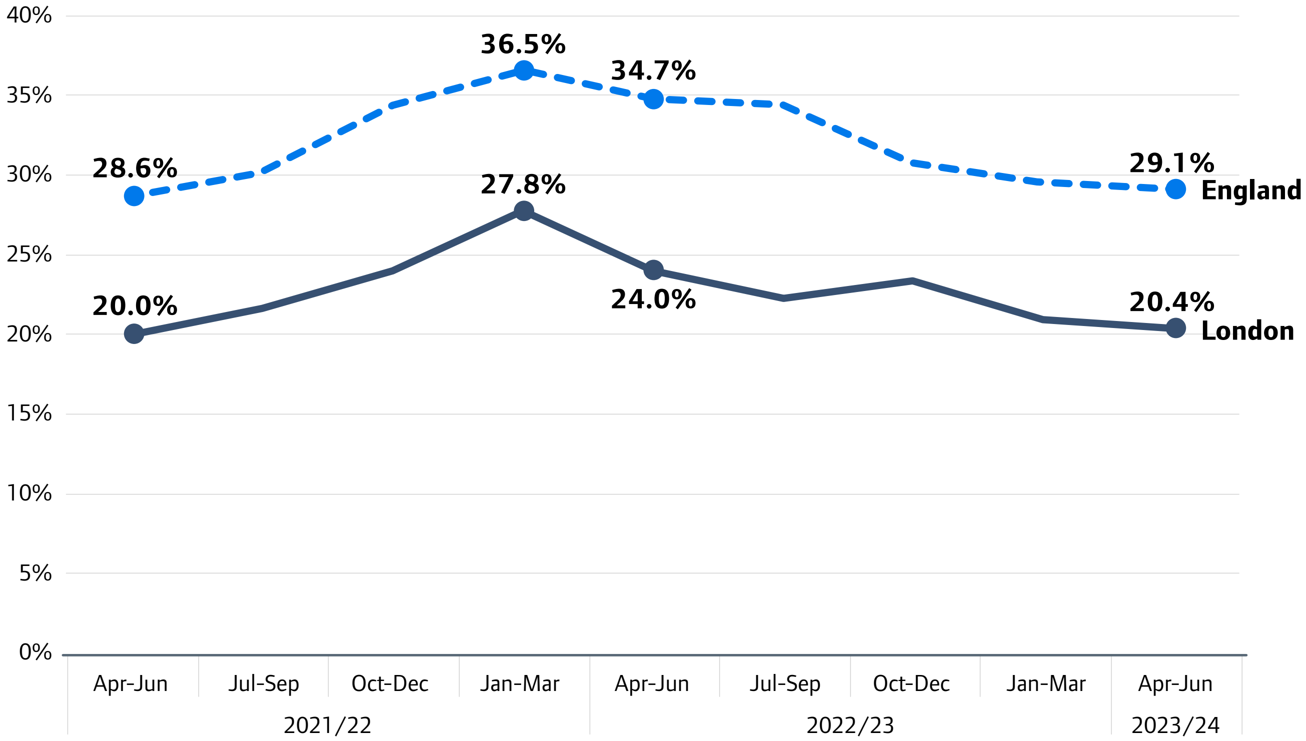
From a CQC inspection report

For GPs, turnover rates for qualified permanent GPs increased by 2.3 percentage points over the past 2 years, from 6.5% in June 2021 to 8.8% in June 2023.

In adult social care, according to data collected from our provider information return, the turnover rate in care homes decreased from 37% for the period January to March 2022 to 29% for the period April to June 2023 (figure 18).

At a regional level, London has persistently had a lower turnover rate compared with other regions. During the period April to June 2023, the rate in London was 20%, compared with an England average of 29%.

Figure 18: **Care home staff turnover rate by quarter, April 2021 to February 2023**



Source: CQC provider information returns

How workforce pressures are affecting adult social care

Our provider information return indicates that staff shortages have led some adult social care providers to reduce their capacity to provide services to people, which in turn was a barrier to providing good quality care over the past year (also see our section on access). Providers said they are concerned about staffing levels, and that this will be an ongoing issue, as the following feedback shows:

> *"A lack of staff is our biggest barrier to providing good care. It also makes continuity in the carers that those who use our service come in to contact with very difficult."*

> *"I feel care work has become undesirable and not sustainable for people to work in this area. This ultimately has a negative effect on the people living in care settings."*
>
> **Feedback from CQC provider information return**

In adult social care, different types of providers respond to workforce in different ways. For example, homecare services are better able to 'flex' how they provide care to fit workforce resource. Our data shows that workforce challenges have limited the number of care hours that homecare providers in our Market Oversight scheme can deliver, with hours down nearly 15% in the last 2 years.

Feedback from the provider information return shows how different homecare providers are reacting to the challenges. Some providers are focusing on more profitable work, mitigating the effect of staffing challenges on profitability. Others are de-prioritising less urgent visits or cutting them short (see the section on 'Access to care' in this report).

The lack of capacity in adult social care services places further pressure on the wider healthcare sector. For example, staff shortages have made it increasingly difficult for some services to accept referrals, such as people being discharged from hospital.

During 2022/23, some homecare providers told us they had seen an increase in hospital referrals, which they were unable to accept as they did not have the care staff to meet the needs of these people. This can increase the likelihood of people having to stay in hospital for longer than necessary, increase the demand for hospital beds, and affect people's independence and quality of life:

> *"We have also found that due to high demand from local councils and the NHS and the strategic plan to allow care at home, it has meant a higher need for staff in the community along with a higher push for staff to work more hours."*
>
> **Feedback from CQC provider information return**

Less homecare capacity also works against the government's aim, set out in People at the Heart of Care: adult social care reform white paper. This states, "Wherever possible, care and support should be in a person's own home."[104]

Workforce pressures in adult social care are not new. Two years ago, we highlighted the need for updated national workforce strategies that raise the status of the adult social care workforce to achieve parity with health care, and ensure that career progression, pay and rewards are suitable to recruit and retain the right professional staff in the right numbers.[105]

We continue to call for a cross-sector social care workforce strategy to sit alongside the NHS Long Term Workforce Plan.[106]

Impact of workforce pressures on people using services

Importance of sufficient specialist staff

Having the right amount of staffing resource with the right skills and experience is closely linked to achieving the best outcomes and experiences for people who use health and care services. Some types of service rely on more specialist staff.

We launched the Supported Living Improvement Coalition in February 2022 with people with experience of supported living services, their relatives and representatives, care providers, charities, and local authorities among others.[107] This group has given us learning and insights into the difficulties of staffing pressures in supported living services.

The Coalition stressed that to work effectively and build an understanding with the diverse group of people who rely on supported living services, providers and care staff need a vast amount of active effort and specialist knowledge.

One person using supported living services explained the importance of building that understanding with staff: *"They understand me very well, they know what I want in life."*

A coalition partner reflected that *"people are very different and have different needs. There seems to be this lack of understanding sometimes in terms of the heterogenous [mixed] nature of people with learning disabilities who might be in supported living."*

The impact on people using supported living services

We heard that issues around staff recruitment and retention have affected the capacity of services to function. This reduced the ability of staff to provide real choice and build meaningful relationships with people.

Coalition partners described the impact of staff turnover, or "churn", on training needs for new staff and the impact on the care given to people:

> *"It's that constant having to train and learn, which is a fantastic part of being part of the care sector; but when you have staff that are only there for 6 weeks… you have a workforce that don't always have the necessary training that we would like them to have to deliver that high quality, person-centred care."*

Family members said that a lack of supported living spaces nationally meant that changing care provider would be "very difficult" or "impossible" – even though choice was seen as a key aspect of what makes a good supported living service.

The impact on people using other health and care services

Across the full range of services we regulate, staffing numbers and vacancies was a recurring issue, as significant shortages have an impact on the people who use services. Staff who responded to our online Give feedback on care service have remarked on how low staffing levels were affecting their ability to provide safe and effective care to people.

From our inspections and monitoring, we have seen the effects of severe workforce issues, with examples where staff shortages have meant people haven't been able to receive care:

- a shortage of staff on a community inpatient ward meant that beds were 'closed', which meant people had to wait longer for a bed
- some hospital wards for people with a learning disability have either fully closed, do not accept new admissions, or have reduced or stopped NHS-led respite care
- a shortage of staff has also led to some skill gaps within multidisciplinary teams, which can lead to delays in people receiving the assessments we would expect in hospitals and communities.

Impact of staff shortages in an NHS acute hospital trust
Our inspectors found that the service did not always have enough staff to care for patients and keep them safe. Ward staff said that the actual number of staff working on the ward did not always meet the planned number of staff for a shift. Staff described the effect this had on patient care.
This included:

- patients only having hand and face washes rather than full washes
- patients sometimes having to wait for assistance
- a higher number of patient falls.

From a CQC inspection report

We have also seen the deep impact of staff shortages during our inspections of mental health services. We see recruitment difficulties in all areas, such as for psychologists, occupational therapists, nurses, and permanent consultant psychiatrists. Patients are not getting one-to-one time with their named nurses as they don't have time, risks and concerns are missed, and treatment reviews are not happening often enough.

The use of bank and agency staff to cover vacancies is high. This can put pressure on permanent staff and can increase risks to patients, as staff don't always know them. Consistent staffing is fundamental to therapeutic relationships. Constantly changing staff is likely to extend length of stay.

There are similar difficulties with healthcare staffing in health and social care services in secure settings. We work with HM Inspectorate of Prisons to protect and promote the interests and rights of people in prisons and other secure establishments. But we have seen that services have to compete to offer higher wages or greater flexibility, and there is competition from other prisons for staff – particularly in the South East of England. Establishments in more remote parts of the country also struggle.

Staffing pressures at an immigration removal centre

A joint inspection of an immigration removal centre in the South East of England in Summer 2022 resulted in issuing a Requirement Notice as the service did not always have enough nursing and support staff. There was a 51% vacancy rate, coupled with difficulties in securing agency staff. The service tried to maintain staffing levels with 2 healthcare practitioners, 2 healthcare assistants and 2 mental health nurses during the day – even though each type of role needed 3 people.

Often, there was only 1 member of the mental health team on duty. This person had to triage new applications, attend assessment reviews and see patients on the team's caseload. At the time of the inspection, there was no psychology provision as the provider was unable to recruit into these positions.

When we carried out a follow-up inspection in early 2023, we found the provider had made improvements, including making some key appointments to strengthen the service, such as a mental health team lead and a paramedic, and was meeting the regulations and requirements.

From a joint inspection report

A personal experience of working in the NHS

Michelle has been an NHS nursing associate at a women's prison for the past 7 years. She lives with her partner and their baby.

Michelle enjoys supporting the prisoners in her care, getting to know their stories and helping them to look after their mental and physical health.

Since the pandemic, Michelle has noticed that a lot of people don't want to work in the prison system because it struggles to recruit and retain staff. This puts pressure on the existing workforce.

Michelle is very worried about the cost of living. Her mortgage has gone up by £500 a month because of rising interest rates, as well as "horrendous" electricity and gas bills. She feels like the price of the weekly shop has doubled and that all the household bills feel huge.

Michelle is considering leaving the NHS. She would like to stay, but the cost of living is making it difficult. "I haven't really got an option," she said. If she wants to work towards promotion, she has to work full-time, but working full-time means that she has to pay for costly childcare, which doesn't leave much to pay the ever-rising household bills.

Her two main reasons for wanting to leave the NHS are staffing problems and the rate of pay. She suggests the situation could be improved by focusing on recruitment and retention of staff. She said: "It's hard to run a service when there aren't people to run the service."

What a person told us about their experience

How providers and staff are responding

Providers are responding to workforce challenges in various ways, by being flexible with roles and capacity where possible, and making considerable use of international recruitment.

Adapting and moving roles

Where GP providers are having difficulty recruiting, many practices are increasing their use of roles such as paramedics, clinical pharmacists, advanced nurse practitioners and physician associates, as promoted in the Delivery plan for recovering access to primary care.[108] These additional roles add value to general practice teams in terms of speciality, and improved access to the right professional without the need to refer and wait for further treatment or advice. We recognise that new staff joining the practice will require supervision and support to carry out their roles.

Staff working in adult social care services have also been moving to different roles within the sector. But an issue in the last year has been the number of homecare staff leaving the role to work in a residential care setting. Providers attributed this to the significant increase in travel costs caused by the hike in petrol and diesel prices, which peaked in July 2022 as the following quotes from our provider information show:

> *"The main barrier at this time is the cost in fuel. Since the price has gone up we have lost 2 good carers to local care homes and we feel there will be more to follow due to this issue."*

> *"The cost of travel has also increased, therefore our staffing team consists of only local carers who do not have to pay for their travel to work. All of this makes staff retention very challenging."*
>
> **Feedback from CQC provider information return**

To improve continuity of care and avoid the movement of staff out of the homecare sector, some providers implemented new strategies, which included:

- increasing mileage allowances
- paying for travel time
- purchasing fuel cards
- carefully planning travel routes to reduce the journey time for staff between people's homes.

"We have purchased fuel cards for carers to allow for the high rise in fuel. This has led to carers feeling supported and them also seeing we recognise the difficulties with the cost of living. We have a forward-thinking team where rounds have been re-planned for less travel."

"To support the workforce with the ever-rising cost of living, the organisation has introduced a monthly travel allowance. This has been successful in retaining the staff, which in turn offers continuity of support and care that is delivered to all the people using our services."

Feedback from CQC provider information return

Opportunities from international recruitment

Internationally recruited staff form a vital part of the health and social care workforce, and recruitment from overseas is an important part of the solution to workforce challenges across all sectors.

The NHS equality, diversity and inclusion improvement plan acknowledges how the NHS has benefitted from the expertise, compassion and commitment of internationally recruited healthcare professionals.[109] As one of the 6 high impact actions for improving workforce equality, diversity and inclusion, the plan includes an action for NHS organisations to implement a comprehensive induction and development programme for these staff.

In oral health care, recent reforms to international registration should start to tackle the backlog of overseas dentists looking to join the dental register, but this will take time to filter through to improving access for people.[110]

The independent acute hospital health sector, which appears to be maintaining good staffing levels, is also recruiting from overseas. For example, one large provider recruited 60 nurses from the Philippines, who were supported to successfully complete their registration and become valuable members of the nursing workforce.

Providers of adult social care services have told us through the provider information return that recruiting staff from overseas has enhanced the diversity and skill set of their team and helped to resolve staff shortage issues.

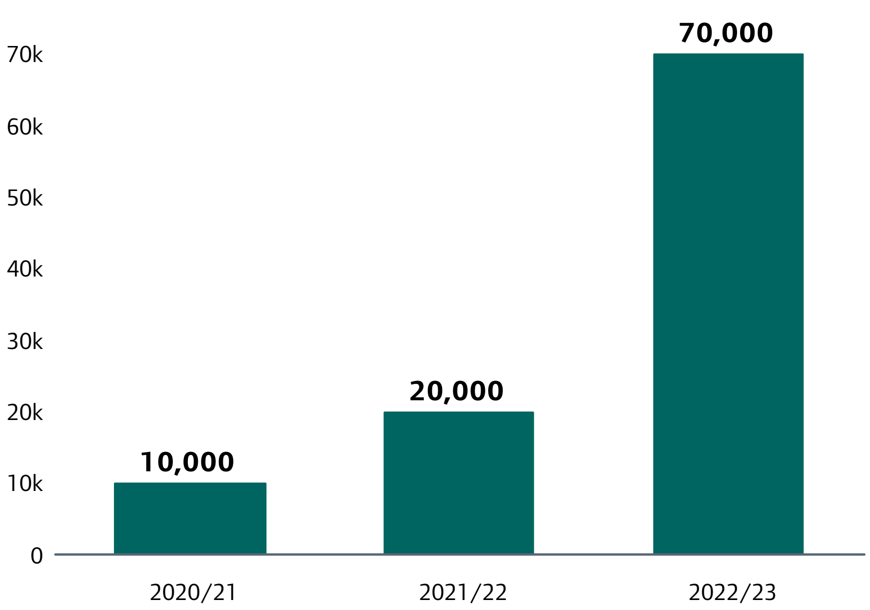
In February 2022, care home and homecare managers and workers were added to the government's Shortage Occupation List and the Health and Care worker visa route.[111] This meant that workers who met the salary threshold and had a licensed sponsor could come to the UK to take up care worker roles.

In addition, the government has made available £15 million for the 2023/24 financial year to help local areas establish support arrangements for international recruitment and bolster the workforce in adult social care.

In 2022/23, an estimated 70,000 people have started direct care roles in the independent adult social care sector, having arrived in the UK during that period (figure 19).

This is a substantial increase in international recruitment on previous years (20,000 in 2021/22) and has helped to fill more posts and reduce vacancies over the period.

Figure 19: **Estimated number of people arriving in the UK that start direct care roles in the adult social care independent sector, April 2020 to March 2023**



Source: Skills for Care estimates

Note: Skills For Care defines the 'independent sector' as any service that is not run by the local authority, so includes private, not for profit and charities etc.

The most common countries of birth for these workers were India, Nigeria, and Zimbabwe.

Challenges and risks from international recruitment

Recruiting from overseas provides a valuable workforce across health and care. It also requires providers and the wider system to provide appropriate support and education for international recruits to ensure safe delivery of services and good staff wellbeing.

> *"The increasing number of overseas staff means we have had to work with our existing team to talk about the needs of incoming staff. Overseas staff do not have the same background or experience and often aren't familiar with the types of food people eat, or the way it's served or eaten. There are also challenges with language sometimes, where staff have good written or spoken English, but may struggle with more colloquial styles of talking. We have appointed a training manager to provide additional support to new staff."*
>
> **Feedback from CQC provider information return**

Practical issues with recruiting staff from overseas included acquiring staff accommodation, obtaining company vehicles and insuring the staff to use them. Although, it's clearly vital to train internationally recruited staff and make sure they are fully integrated into the service and community, providers tell us these additional tasks are time-consuming and could take senior leadership teams away from other managerial duties.

Over 40% of all GP trainees are international medical graduates (IMG). However, many are finding that difficulties with obtaining a visa are causing them stress and anxiety. A 2022 survey by the Royal College of General Practitioners found that around 30% of all IMG trainees considered not working as an NHS GP because of difficulties with the visa process.[112]

Our interviews with midwives from ethnic minority groups for this report also highlighted the risks of staff not being fully embedded within organisations. Several interviewees felt that the experience and knowledge of internationally trained midwives was not respected and there were perceptions of hierarchies and a Western-centric attitude in terms of delivery and training:

> *"People from another country are learning to navigate the system. I think we need more recognition that they respond to situations differently, based on their experiences, and that doesn't mean it is wrong just because it is different. The NHS is amazing but it was built by white people for white people. We need to adapt, because now we have a diverse population and workforce."*
>
> **Interview with a midwife from an ethnic minority group**

Over 2,700 providers and locations registered with CQC across all types of health and care services hold a UK Visa and Immigration sponsor licence, most of which are adult social care providers. Changes to immigration and visas have been a positive step to help ease the workforce shortages in health and care, and the Code of practice for the international recruitment of health and social care personnel in England aims to promote high standards of practice in the ethical international recruitment and employment.[113] However, over the past year we have started to learn of some abuse of both the immigration process and the migrant workers themselves.

There is a growing trend of unethical international recruitment practices, which sees the international worker being controlled and coerced through their immigration visa or through debt bondage. The Independent Chief Inspector of Borders and Immigration has issued a call for evidence to assess the extent to which the Home Office's immigration functions support the social care sector.[114]

A particular concern is when services, either knowingly or unknowingly, become involved in modern slavery and human trafficking. Data from the Home Office's National Referral Mechanism showed that in 2022, nearly 17,000 referrals about potential victims of modern slavery were made by authorised first responder organisations, including local authorities, police forces and specified government agencies.[115] This is a third higher than the previous year, and the highest annual number since the Referral Mechanism began. Of all these referrals this year, 41% were for potential victims who claimed exploitation as children.

We fully support the government's objective to eradicate modern slavery and human trafficking. As a public sector body, CQC must align its work with the Human Rights Act (1998). This includes the right for people to be free from slavery and forced labour. We also have a duty to report criminal activity. In 2022/23, we made 37 referrals through our national enforcement team to relevant agencies for concerns regarding modern slavery, labour exploitation and international visas – this was more than 4 times the number made in 2021/22 (8 referrals).

We heard of a number of concerns about potential victims working in health and social care settings from our inspectors, as well as complaints against providers, and workers who have left comments through our Give feedback on care service. From this feedback, it would appear that a small number of providers are exploiting victims of modern slavery, and the wider system, through:

- financial abuse, including: low pay, accommodation, transport or food that is tied to the job; excessive sponsorship fees, having to pay for their own registration or training, long working hours, lack of breaks and holidays, and tax avoidance
- physical, sexual, and psychological abuse
- racial and religious discrimination
- threats and blackmail, often using the person's sponsorship or visa status as leverage to exploit and degrade them.

Investing in staff wellbeing

Earlier in this report, we discuss how leadership plays a key role in shaping the culture of organisations. Our engagement with health and care services shows that the importance of providers building this culture by really investing in their staff and considering their wellbeing.

For example, in general practice, new workforce and wellbeing indicators under the Quality and Outcomes Framework take steps to create a compassionate and inclusive culture, improve wellbeing and resilience, and reduce the risk of staff burnout.[116]

In adult social care, we see how services that successfully develop career progression and training for staff have higher retention rates. The same goes for providers that develop wellbeing initiatives to retain staff and avoid using agency staff. Examples include offering flexibility such as part-time working, engaging with the community, and supporting staff with childcare or supporting them through the menopause.

These measures should be further supported through the government's workforce reforms, set out in the Next steps to put People at the Heart of Care.[117] The reforms include £250 million of investment to better recognise social care as a career, partly through a plan to introduce a new Care Workforce Pathway and Care Certificate qualification.

Some adult social care providers are going the extra mile to support their staff to combat the current cost of living crisis. Initiatives from both residential and homecare providers that have helped retain staff, included:

- paying a good hourly rate above the living wage for the area
- providing a free breakfast bar for staff before or after their shift, and free meals during shifts
- inviting all staff to talk to the manager if they are experiencing financial hardship, resulting in weekly boxes of free food and support with things like children's clothing
- giving bicycles to staff
- reward/recognition schemes to make their employees feel valued and appreciated for their work.

To explore what good workforce wellbeing looks like, we carried out a survey with a range of providers and professionals working in health and social care, the organisations that represent them, and wider stakeholders.

We received 2,420 responses – over half of which were from the adult social care sector:

- 91% agreed that assessing workforce wellbeing is an important part of CQC's new assessment approach, which suggests that providers saw staff wellbeing as a real priority
- 74% said the organisation they work for monitors data and collects feedback on the wellbeing of its workforce – this was highest in adult social care (82%)

- for the question ‘Does your organisation involve staff in co-designing workforce wellbeing initiatives?’, 61% answered ‘yes’, 23% said ‘no’ and 16% ‘don’t know’.

Our survey asked professionals for examples of workforce wellbeing initiatives in their organisations. The main types of initiative were:

- professional wellbeing, including learning, development and training, supervision and performance management, wellbeing champions and teams, flexible and hybrid work schedules, and staff networks and groups
- psychological and emotional wellbeing, such as counselling, reflective staff groups, mindfulness, and occupational health and therapy
- financial wellbeing, through pay increases, bonuses and awards, extra paid holidays, free food and drink, support with housing and transport costs, and financial support and advice including pay advances
- social wellbeing, including team awaydays and gatherings, and celebrating religious and other holidays.

We engaged further with health and care professionals through focus groups. The frontline staff we spoke with, many of whom worked in the NHS, called for improvements in meeting the basic needs of staff, such as regular breaks, places to rest, safe working environments, and flexible work schedules to enable caring and other responsibilities, alongside their psychological needs.

They told us they want employers and leaders to:

- be visible in championing workforce wellbeing
- demonstrate a proactive as well as a reactive response to workforce wellbeing. For example, implementing a wellbeing strategy that understands the needs of their workforce with supportive measures to allow them to thrive – rather than focusing all resource and initiatives on reacting to burnout
- provide a culture where the workforce feels listened to and has regular opportunities to give feedback
- understand their workforce and to be able to meet the needs of different staff groups, especially those who might need tailored support, such as internationally recruited staff or those with certain protected equality characteristics
- nurture the professional development of staff through training and regular appraisal.

Systems

Key points

- Local systems must implement plans to address unwarranted variations in population health and disparities in people's access, outcomes, and experience of health and social care.
- Local authorities are tackling workforce problems in adult social care and trying to address gaps in care as they plan for the future, but they will need to demonstrate an understanding and preparedness for the changing and complex needs of local populations.
- Assessing carers' needs is vital. Carers, including many unpaid carers, are a critical part of all local care systems and they are not always getting the support they need – there is variation across the country and many carers are facing financial problems.
- People's experience in urgent and emergency care continues to be poor and the problems are pointing to issues that require a local system level response.

A changed system

The architecture for the way our health and care services are delivered in England was changed in 2022. New integrated care systems (ICSs) were formalised along with their respective integrated care boards (ICBs). Challenges for systems include: improving outcomes in population health and health care, and reducing inequalities in people's access to care, their experiences and outcomes from care.

In line with these changes, we are changing the way we do things at CQC. Assessing local systems is one of our core strategic ambitions to enable us to provide independent assurance to the public of the quality of care in their area.

We have a new responsibility to provide a meaningful and independent assessment of care in a local area. We want to know if different parts of a system are working together and meeting the needs of their local populations. Our new work involves a review of local authorities in some aspects of their duties, as well as a review of the provision of health care and adult social care within an ICB's area – and to assess how well the ICS functions.

As a result, we will be able to present a more in-depth and holistic view of health and adult social care services by assessing how well local systems perform against the important things that matter to the people in that community.

Moving forward, we will be looking at how services are working together within an integrated care system, as well as how systems are performing overall against the 4 key aims of: improving outcomes, tackling inequalities, enhancing productivity and value for money, and helping the NHS to support broader social and economic development. CQC also has a new role in looking at how local authorities meet their duties under the Care Act (2014).

This will be informed by data and insight and include more about the experiences of people who use services. Our new way of working is not fully operational, but for this report, we have begun to examine some aspects of care at a system level.

Our approach will use a subset of quality statements from our new assessment framework. In 2023/24, we began pilot assessments of how systems are working together to meet their aims following government approval of interim guidance and the quality statements for ICSs. This process began with a focus on themes in the equity in access quality statement.[118]

We are currently running 2 pilot assessments, testing how we will assess leadership, integration, and quality and safety across ICSs. The full programme of ICS assessments will begin in 2024.

In last year's State of Care report, we reported on the challenges and opportunities for ICSs.[119] Systems that understand their local populations and their needs have an opportunity to plan across all services for greater equity in people's access to the care they need.

In this section, we present some snapshots of aspects of the new local systems in their early stages, considering how they are shaped to act on opportunities and tackle the challenges ahead.

Local authority assessments

As we prepare for our new formal assessments of care across local systems, we begin to understand the starting point from which services are operating.

Since April, we have been reviewing data and publicly available evidence from across all 153 local authorities, focusing on themes in 2 of our new quality statements: care provision, integration and continuity; and assessing needs.[120]

At a national level, we have seen evidence that local authorities are aware of increasing demand for care and support and complexity of need across all population groups. Workforce capacity and capability pressures, and concern about financial pressures, are forcing some care providers out of the market or increasing the reliance on people who pay for their own care (self-funded care).

Nationally, local authorities have reported:

- under-provision in some types of specialist care, such as services for autistic people, specialist dementia care, and in the availability of beds in care homes with nursing
- traditional forms of support remain dominant, but some examples of new and innovative models of support are emerging, including highly personalised and bespoke support
- more flexible use of beds in residential care homes to respond to local needs
- prevention and reablement models and home first policies, including using technology to help people to remain independent[121]
- a strategic focus on unpaid carers, including identifying carers more proactively using co-production to understand their needs, working with employers to support carers to stay in employment, and a focus on young carers[122]
- an intention to promote direct payments as a way of providing more flexible and personalised care. We have not seen evidence of how local authorities will achieve this.

Regional and national variation

There are similar areas of focus for future service provision across regions, with a clear shift from long-term care to community-based services that promote independent living, prevention and enablement.

Local authorities are planning for increased demand for services for people whose needs are more complex to meet. This includes specialist dementia care, managing multiple long-term conditions or services for people with a learning disability. There is a focus on moving away from traditional provision of residential care for these groups of people, in favour of services to meet people's needs in the community.

However, significant market investment will be needed to provide extra care housing, supported living and suitable community housing, as well as homecare services.

There is a need for respite, reablement and step-down/discharge-to-assess services to help support the speedy discharge of people from hospital to the most appropriate place for their needs – preferably into the community.

We found that few local authorities had published workforce plans – and even fewer had joint workforce plans with the wider system. Across local authorities, the adult social care workforce is identified as a clear risk to sustainability and reform, with all highlighting the challenges of staff recruitment and retention. There is also recognition of a skills gap for more experienced or specialist staff that will be needed to care for people whose needs are more complex to meet.

Unpaid carers

Support for unpaid carers is a crucial area of local authority responsibility. We reviewed this against our quality statement on assessing needs. Carers are not being identified enough, which affects their ability to access care and support. The unpaid carer ‘workforce’ is a key lynchpin in adult social care provision, worth about £162 billion a year.[123] In April 2023, The Health Foundation pointed to the small percentage of unpaid carers who approach their local authority for help.[124]

In October 2022, the government announced new laws entitling unpaid carers to one week of unpaid leave a year to ‘support those most in need’ – the Carer’s Leave Act 2023 came into being in May 2023.

Analysis shows clear variations across authorities – and across all metrics – on the number of carers accessing timely support and levels of satisfaction with the support received. Also, not all local authorities had a published carers strategy, but where plans were available, most acknowledged there was work to do to identify and support unpaid carers.

In detail, we wanted to find out what local authorities know and share publicly about:

- the needs of unpaid carers
- demographics and people’s needs
- gaps in care
- forecasting the care needs of the population
- partnership working
- workforce risks and challenges
- system-wide workforce planning.

We found that most local authorities have not published a recent carers strategy and there is little up-to-date data on local carers that they have shared publicly. They are also often using 2011 census data. Some census data from 2021 was only recently available and there is more to come.

There were some common themes across local authorities:

- although the number of carers is increasing, sometimes they do not identify themselves as carers and so they are not identified by local authorities
- carers are caring for longer in both the number of hours each week, and the length of time (months or years) they provide care

- carers are caring for people with increasingly complex conditions; this is affecting their physical and mental health, as well as financial and employment opportunities
- for young carers, there is a negative impact on their education
- some councils report that carers from ethnic minority groups are less likely to seek help than their counterparts from White groups.

Some local authorities share more strategic information and there is evidence of joint working with targets and evaluation criteria. However, evidence of their actions to meet the needs of carers is not easily available.

Most publish advice and guidance for carers on their websites, with information about assessments, access to support, including financial support, support for young carers, health and wellbeing support, training, and [how to access] respite care. They don't all have good information on how to get emergency support in a crisis.

Where there was evidence of a strategic approach, some common themes included:

- raising awareness to enable people identified as a carer to find information about assessment and support
- identifying the need for a more 'culturally sensitive' approach, to encourage more people in ethnic minority groups to identify and seek support
- including unpaid carers in some market position statements as part of an approach to shaping the care market, including in relation to hospital discharge and enabling people to go home.

A recent survey from the Carers Trust suggests there is some way to go before carers feel they are adequately supported in their role.[125] Many of those surveyed said their local authority, health services or other organisations didn't advise them where to get support and instead had to find out about available help themselves. The experience was worse for people from ethnic minority communities, where 16% said their local authority had told them where to get support, compared with 31% of White carers, and only 6% had received support.

In the 2023/24 financial year, the Department of Health and Social Care earmarked £327 million from the Better Care Fund to provide short breaks and respite services for carers. This also funds additional advice and support to carers and a small number of additional local authority duties.

Demographics

Most local authorities publish information about their local population. Some also had up-to-date market position statements, which describe the changing needs and services they want to develop in future to meet people's needs. Almost all are predicting growth in their older populations and an increase in demand related to complex health needs, dementia care and long-term conditions. Some of this need is predicted to be early onset of chronic conditions.

Many local authorities also tend to provide information about working age populations in relation to learning disabilities, autism, physical disabilities and mental health needs. They also record information about workforce pressures, and market sustainability in relation to quality and cost of living/inflationary pressures. Some also share information about health inequalities, and some note a strong correlation with deprived areas and places where people lived in poor health for longer.

Gaps in care

Local authorities have identified gaps in care. These are often around care for people with needs that are more complex to meet and for specialist dementia care, as well as services for people with a learning disability or mental health needs and autistic people.

There appears to be a trend towards a more flexible approach to care, with an outcomes-based focus, as well as preventative and reablement services, and a community or care at home first approach. Local authorities anticipate the need for more high-quality community care provision.

There is an increased demand for care in people's homes – this is often identified where there are workforce challenges, and sometimes where transport links are an issue.

Although there is plenty of residential care, there are not enough nursing beds for people whose needs are more complex to meet. Most councils recognised this nationally.

They also recognise that services can be unevenly distributed and not always where there is demand – they reference the impact of people who pay for their own care in the market, a lack of provision in areas of deprivation, and fewer options for people in rural areas.

There is evidence of some local authorities focusing on preventing unnecessary hospital admissions and promoting reablement with local system pressures in mind. For example, converting beds in residential adult social care into beds for more complex care or nursing, or short-term reablement to help people get discharged from hospital. Some authorities are planning to support better system working by helping people get care in the right place, relieving pressure on hospitals and improving patient flow. There is also evidence of prevention-based approaches to reduce hospital admissions – for example, safety at home and falls prevention interventions.

Other gaps identified include culturally appropriate care provision, which some local authorities are looking to address. Workforce development is a recognised factor to help shape the markets.

Forecasting care needs of the local population

Not all local authorities have shared information about longer-term plans to support people's changing needs in the years ahead. Where we have seen plans, they tend to be short-term – they are focused on important areas including early intervention, caring for people at home where possible, prevention and reablement. Independent living and community-based solutions are also evident.

There are investment plans as councils look to 'Extra care' and supported living (for older people and people with specialist needs), community housing, reducing isolation and supporting people with dementia or more complex needs, while preventing the need for residential care or hospital admissions.[126] Plans also cover support for people with a learning disability, autistic people and people with physical disabilities to enable them to stay in communities and get support to lead more independent lives and find employment.

Partnership working

So far, there is a lack of detail from most local authorities about potential joint commissioning strategies. For example, some London boroughs refer to their 'whole system' approach, but with little detail. Others have reported on work with neighbouring boroughs to shape provision in the market – especially where people are placed out of their local authority area.

In Greater Manchester, there is evidence of health and social care teams working closely at neighbourhood level and in developing the workforce.[127] The area has been working to a people and culture strategy since 2022 and was described in Parliament in 2023 as the 'most mature' of the ICSs. Other authorities in the North West are planning to partner with neighbouring authorities or ICSs.[128,129]

Workforce risks

Local authorities are concerned about risks to their care workforces, but they recognise that workforce development is important for their strategies – especially recruitment and retention of staff. Aspects affecting the wider system include a lack of nursing staff and the importance and growth of the homecare workforce to enable appropriate hospital discharges and the move to more care in the community where it can meet people's needs.

There are challenges with the adult social care workforce that require effective collaboration. However, in our survey of adult social care services, when asked whether their local authority consulted or engaged with them, only 18% of responding providers said 'completely', with a further 44% responding as 'somewhat' consulted.

The most common reason care providers gave for unused capacity was a lack of commissioning opportunities. Providers told us that poor access to, or a lack of transparency in the bidding process, affected their ability to increase capacity and to recruit accordingly.

Despite the recognised challenges for staffing, very few authorities have published workforce strategies. They report working with service providers in different aspects of workforce development and recruitment, such as setting up academies to train and develop staff, training to upskill people to care for people with more complex medical needs, and working with primary care on nursing associate roles where there is less need for registered nurses.[130]

System-wide workforce planning

There are some examples of a system-wide workforce approach. One local authority described 'blended roles' in a homecare service, where staff worked alongside a district nurse and were trained to provide low-risk services.[131] The aim is to improve joined-up care, workforce retention and to offer staff progression through development.

In the North East, we saw that some councils and health partners worked together to explore practical solutions for a nursing care problem. Where there was a shortage of nurses in residential care, this involved a pilot homecare service to help with people's emerging needs overnight after being discharged from hospital.[132]

Support for carers

Across England and Wales, there are an estimated 5 million unpaid carers, according to Carers UK.[133]

At this early stage in our new role with local authorities in England, we are interested in the experiences of carers and their contribution to people's needs locally. NHS England publishes a biennial survey – the Personal Social Services Survey of Adult Carers in England (SACE). This reports on the opinions of unpaid carers aged 18 or over, who are caring for a person aged 18 or over, on topics considered to be indicative of a balanced life alongside their caring role.[134]

Results for the 2021/22 period show variation in experience across England.

About a fifth of carers (22%) say that they feel in control of their daily lives, with carers living in the South West less likely to report this. Even fewer carers are able to spend their time doing things that they value or enjoy (16%), again carers in the South West are less likely to report this.

On average, less than a third (32%) of carers are accessing support groups or have someone to talk to, with only 22% of carers in the North East able to access support.

When excluding carers who had not received support or services, 36% reported being 'very' or 'extremely satisfied' with their support from social services. There were differences geographically, as 6 of the 10 local authorities with the lowest satisfaction score were in London. There was also variation in terms of receiving support, with 35% of carers in Yorkshire and the Humber not receiving any support or services.

Across England, there is significant variation in the numbers of carers who access support that allows them to take a break from caring. For carers accessing support for a rest from caring (for between 1 and 24 hours) it ranges from 7% to 61% across the local authorities. On average, only 20% of carers access this kind of support.

There was also significant variation in carers accessing support for a break from caring for more than 24 hours. Nationally, 13% of carers accessed this support but there is huge variation for carers in different local authorities, with this ranging from 4.7% to 40%.

Sometimes, carers need to access support services so they can take a break from caring at short notice or in an emergency. Accessing this type of support varied between different local authorities, ranging from 2.7% to 27%, with the national average of 11%.

Carers are also experiencing financial difficulties because of their caring responsibilities – 43% of carers reported this. The highest proportion of carers reporting this was in the London region, where 52% had experienced financial difficulties because of their caring responsibilities.

The impact of reducing a care package

Joy told us about her experience of caring for her 3 children, aged 8, 4 and 3, which has become increasingly difficult since her son's care package was reduced. Her 4-year-old has complex care needs; he has cerebral palsy, epilepsy and hydrocephalus. He is non-verbal and uses a wheelchair.

Joy and her husband are both disabled, and their eldest child is autistic and has attention deficit hyperactivity disorder (ADHD). The reduction of the care package has affected the whole family, leaving them in a "very dire situation".

Joy's 4-year-old son has had a care package from when he was 6 months old. The family were allocated a paid carer for 6.5 hours every day. Joy described how the paid carer helped with essential aspects of care such as washing and lifting her son, as well as taking him out on activities. This had a profound positive effect, providing the extra support the family needed and allowing Joy and her husband to spend more time with their other 2 children.

In February this year, Joy was given a month's notice that the care package was going to change. The paid carer would now only visit twice a week, providing care at weekends only. A social worker from their local council told Joy this was because of lack of funding and the fact that her son would be starting primary school later in the year.

Joy initially felt confused about not being consulted about this life-changing decision. She told us that she then felt angry about the lack of support, particularly in the evenings and school holidays, and the impact this would have on the family. She worried about times when they would be slower to react to her son's needs and times when they may not be able to lift him because of their own disabilities.

The other 2 children are already noticing the additional stress on their parents. The eldest child has said things like, "I don't want to be a bother" and "I know you guys are busy, it's fine", which is upsetting for Joy. She explained that it doesn't feel fair to rely on the generosity of grandparents and that she feels they are being a burden.

The reduced care package also has financial repercussions. After initially cutting back her hours at work, Joy eventually had to leave her job in retail.

For Joy, the reduction in care has taken a huge toll. She told us: "We can no longer function as well as a family… we are in a very difficult situation."

What a person told us about their personal experience

The Joseph Rowntree Foundation published research that found carers lose on average £8,000 a year after 6 years of caring.[135] It found carers are forced to reduce their working hours, don't follow career opportunities or give up work altogether to provide unpaid care, pushing some people into poverty. The Survey of Adult Carers in England (SACE) shows the percentage of carers accessing support to keep them in employment was low across the country (2.8%) but higher in London (4%) than in other regions.[136] Also, over a fifth (21%) of carers reported not being in paid employment because of caring responsibilities – this was higher in London, where 28% of carers reported this.

This highlights why local authorities must be proactive in identifying unpaid carers in their area and ensure they are aware of the information, advice and support available to them. We found some examples of authorities that have considered the importance of carers and have published plans, including South Gloucestershire[137] and Bournemouth, Christchurch and Poole.[138]

Urgent and emergency care

In 2022, our State of Care report described a "health and care system in gridlock" that was having a negative impact on people's experience of care. We reported how many people had to wait too long for the health and social care support and treatment they needed – and the effect on people needing urgent and emergency care.[139]

The effectiveness of urgent and emergency care services can indicate how effectively health and care services are co-ordinated across a local system.

Variation across emergency departments
Local health systems can work better when patients flow through services in an effective way – making sure people are seen in the right place and at the right time. But with many factors affecting patient flow, sometimes people get stranded where they don't need to be – for example, people remaining in hospital if there is no onward social care provision. Hospital emergency departments are a critical part of this system, and often the centre of attention because of the urgent nature of their work.

Across England, the performance of NHS emergency departments varies. For example, at a regional level, there are different outcomes in terms of converting people's attendances into hospital admissions. And there are differences in the numbers of patients waiting more than 12 hours for a hospital bed after a decision to admit.

Attendance and admission
At a regional (NHS England) level at June 2023, the percentage of emergency department attendances that were admitted (known as a conversion rate) ranged from 13% (53,243 people) in the London region to 19% in both the North East and Yorkshire (66,488 people) and the South West regions (34,970 people). The England average was 17%.

Regionally, there was a large variation in the percentage of ambulance handovers that took longer than 60 minutes – from 1% in the South East to 17% in the South West. The England average was 7%.

Waiting 12 hours or more after decision to admit
Once a decision is made to admit someone to hospital, there is sometimes a wait to be admitted. Across all NHS England regions as at June 2023, 7% of patients waited more than 12 hours from a decision to admit to being

admitted. At a regional level, this varied from 3% in the North East and Yorkshire to 11% in the North West. There is variation in waiting times within regions too, with people in some ICB areas likely to have much longer waits than others (figure 20).

Figure 20: **Emergency admissions through A&E waiting more than 12 hours from decision to admit to admission, by region (June 2023)**

Region	Total waiting more than 12 hours from decision to admit to admission	Total emergency admissions through A&E	% waiting over 12 hours
East of England	2,054	41,376	5%
London	5,196	53,243	10%
Midlands	6,217	72,809	9%
North East and Yorkshire	1,831	66,488	3%
North West	6,323	56,114	11%
South East	2,517	62,972	4%
South West	2,393	34,970	7%
England	26,531	387,972	7%

Source: A&E attendances and emergency admissions (NHSE)

Responding to the crisis in urgent and emergency care and the recognised systemic problems, we published the PEOPLE FIRST resource in 2022.[140] It is the product of work by a group of senior clinical leaders in CQC's National Emergency Medicine Specialist Advisor Forum.

This resource recognised the need for solutions 'across the artificial divides between primary, secondary, community and social care'. It aims to support the design of person-centred urgent and emergency care services and encourage innovation across integrated care systems.

In 2023, we surveyed providers to find out if PEOPLE FIRST was influencing their work. Although we learned about the level of understanding of the resource, the majority of those who responded took the opportunity to tell us about the significant pressures and problems they were facing. They told us about fatigue and stress, while some mentioned the immediate problems faced by providers over the last year, such as industrial action.

From the 384 responses, 96 were from NHS emergency care providers or representatives from integrated care boards. Respondents told us about barriers to change including time, costs and staffing – these were the overwhelming factors among responses to the survey.

Some providers told us they were aware of plans to mitigate against the winter pressures ahead. These varied in focus from system leadership programmes and crisis contingency plans to specific practical measures such as embedding paramedics in community response hubs.

Asked about innovative ongoing work, one respondent told us about using ambulance clinical audit data. For example, using data on falls and for the ambulance sector to see if work to avoid admissions has been safe and effective.

Other responses to emerge from the survey included leadership, culture and change fatigue. One person told us there was "complete apathy" and "a lack of understanding from management". They said that "clinical decisions [were] being shaped by non-clinicians" and there was "disagreement about permissible level of risk".

People's experience in urgent and emergency care

We specifically highlighted last year how urgent and emergency care services were in crisis – people could not get the care they needed, and when they needed it most urgently. Looking ahead to winter 2023/24, we wanted to consider the factors that are some hallmarks of better urgent and emergency care systems, and people's experiences that might point to systemic issues.

More effective urgent and emergency care services can be a sign of better co-ordinated health and care services across a local system.

In our own 2022 survey of people who used urgent and emergency care services, we analysed type 1 (major accident and emergency department) services to understand how people experienced this care.[141] It covered 122 NHS trusts and gives insight into some aspects of care – how long people waited for care, how their pain was managed and how they felt their dignity was affected. These findings are based on responses from 29,357 people who used an emergency department (A&E) in September 2022 and an analysis of what people freely chose to tell us in the survey.

We know that waiting times increased significantly as 32% of respondents waited more than an hour to first speak to a doctor or a nurse, compared with 15% in 2020, 19% in 2018 and 18% in 2016. And 17% said they waited more than 4 hours to be examined – the equivalent was 4% in 2020.

People told us these waits were made more challenging by the environment, which could be overcrowded, uncomfortable and lack the basic facilities needed when waiting for extended periods – often 8 hours or more. Not knowing how long they would have to wait made the situation difficult. We heard that: "No-one spoke to us about what was happening", it was described as feeling like they had been "forgotten". Three-quarters (76%) of people were not told how long they would be waiting, and the majority (82%) did not get updates on this.

People's pain was not managed as well as in previous years. They said dealing with pain in public and in an uncomfortable environment could be traumatic. Fewer people in the 2022 survey (51%) said staff 'definitely' did everything they could to control their pain, compared with 60% in 2020.

Busy, crowded environments meant people's privacy and dignity was not supported well. We were told about how waits on trolleys, and treatment in corridors and waiting rooms, and a lack of personal care had compromised people's dignity. One person described the experience as "embarrassing and humiliating".

Analysis showed fewer people (78%) felt they had enough privacy while being examined and treated, compared with 84% in 2020, 83% in 2018, and 82% in 2016. The percentage of respondents feeling they were treated with respect and dignity had also dropped to 72% in 2022 compared with 81% in 2020.

Similarly, when asked about privacy and communication, people were less likely to feel they had enough privacy at reception. In 2022, fewer patients (45%) felt they 'definitely' had enough privacy when discussing their condition with the receptionist, compared with 55% in 2020.

Despite the waiting times and the associated impacts, there remained some strong praise for the staff. People reported being satisfied with their care and treatment. Even when describing a negative experience, respondents usually attributed this to the 'system'. People described staff in positive terms, using words such as:

> *Caring, kind, helpful, fantastic, professional, reassuring, brilliant, excellent, polite, efficient, fabulous, friendly, understanding, exceptional, attentive, amazing, wonderful*

The survey provided evidence to suggest that poor system-working had an impact on urgent and emergency care. For example, some people said they attended the emergency department because of difficulty accessing their GP, or they attributed poor experiences to a lack of good joined-up care and follow-up care.

There were concerns about a failure to share existing information about a patient's past medical history or medication. One patient said the hospital she attended had informed her it could not correspond with a previous hospital she attended because they *"did not communicate with hospitals outside their area"*. Another patient said: *"Every time I go into hospital my medication is recorded incorrectly… time, dose and type"*.

These experiences suggest that at least part of the problem is due to a lack (or perceived lack) of communication between different service providers, either by area or type of service, or the inability to share electronic records effectively.

Similar issues were raised around discharge from hospital. Patients' notes or results were not always shared with a GP and promised referrals for further care did not happen soon enough. People were dissatisfied where they felt they were offered either no advice or 'very inconsistent advice'.

People also said they felt 'rushed or dismissed'. Only 40% of respondents who were prescribed medicines were 'completely' told about side-effects. Less than half (46%) were 'completely' told about what symptoms to watch for when they were at home or their place of residence (compared with 53% in 2020 and 51% in 2018). And 51% of respondents were 'definitely' given enough information to care for their condition at home, compared with 60% in 2020 and 59% in 2018.

For some people, the issue was about being discharged without sufficient onward care organised, rather than poor medical treatment.

One patient told us: *"…I felt I had no other option but to sign myself out… I felt like no one had the time to care. I left the hospital alone and stood alone in the dark outside waiting for a taxi."*

A failure to provide suitable follow-up care, or a failure to show effective joined-up care, can lead to a poor overall view of the emergency care experience. Sometimes the failures might not be due to failings in the emergency departments but instead represent a miscommunication or a failing in other systems, which may not connect effectively. For emergency departments and the wider system, an impact could be people returning to their GP or being re-admitted to hospital. A few people told us how they went on to seek a second opinion or get private healthcare.

Equity in access across systems

We have started to look at the way ICSs are approaching their role of ensuring everyone has equal access to care.

Our formal assessments of integrated care systems will begin in 2024.[142] Our initial work has a focus on publicly available information that systems have published in relation to our Equity in access quality statement.[143]

This quality statement is part of the 'quality and safety' theme of our assessment framework for integrated care systems, which uses a subset of the quality statements from the new overall assessment framework. This is the commitment for providers to make sure that everyone can access the care, support and treatment they need when they need it.

Based on NHS England guidance and recognising that most integrated care systems are relatively new, we considered these focus areas:

- Creating an enabling system context
- Building a clear and shared understanding
- Maintaining a sense of urgency and commitment to act
- Focus on implementation, impact and evaluation.[144]

Reviewing publicly available information related to this quality statement for all integrated care systems in England, we can see there are continuing challenges for many people who want to access health and social care. This is regardless of people's socio-economic background, geographical location, protected equality characteristic status or their inclusion in other groups more vulnerable to health inequalities.

These challenges are sometimes exacerbated for people living in the most deprived areas, for people with protected equality characteristics, or people who are otherwise vulnerable to inequalities in accessing, experiencing or outcomes from health care.

There are themes of unequal access for people across ICSs in mental health services, particularly for children and young people. We can also see these themes in access to oral health care, when people are contacting GPs (by telephone and online), in digital exclusion, and in delayed access to adult mental health services.

We also saw themes around inclusivity and a lack of cultural understanding acting as a barrier to accessing care.

Creating an enabling system context

Across England, most integrated care systems demonstrated a commitment to engaging with people living in their area. We found that most systems publicly recognised the importance of equality, diversity, and inclusion, and addressing health inequalities and equity in access to care services.

Protected equality characteristics had been considered in various strategies that we saw, but we did not find evidence that they had all considered under-served and marginalised groups that may be affected by inequalities.

We could not find clear plans for all integrated care systems to reflect how they would address unwarranted variations in population health, disparities in access, outcomes, and experience of health and social care.

NHS England points out the importance of ‘creating an enabling system context’. It says system leaders in ICBs, integrated care partnerships, provider collaboratives and within individual NHS bodies need to consider whether they are creating the necessary conditions for improvement.

Building clear and shared understanding

While integrated care systems show an understanding of the value of engaging with residents, their approach to engagement and co-production varied across the country. Some systems did recognise the need to reach people whose voices are seldom heard, and under-represented groups.

Most integrated care systems ran engagement events leading to bespoke engagement strategies – some strategies had more focus on equity in access than others. We saw that where NHS England best practice guidance had been used to produce engagement strategies, these were innovative and focused on engagement principles, use of community assets, anchor organisations, community influencers, faith leaders and the community they served.[145] An example where this worked well was when Healthwatch supported women from the Bangladeshi community, autistic people and people with a learning disability to be involved in work linked to the menopause, to ensure they had the appropriate information to access services. Teaming up with national public health teams, breast screening recall letters were also available in an easy to read format for people who needed them.

It is evident that where ICSs have made efforts to engage directly with residents and through the voluntary, community and social enterprise sector, Healthwatch and other bodies, there was a stronger focus on reaching and engaging people who are less likely to engage. Engagement strategies aimed to enhance collaborative working, improve people's experiences and health outcomes, and reduce health inequalities.

We also saw that all ICSs were engaged with Healthwatch to some extent. Evidence of wider engagement with the adult social care sector was less evident. In July 2023, we carried out a survey of adult social care services to find out more about the challenges they face. Only 8% felt that their ICS 'completely' consulted with them and 45% reported having never been consulted or engaged with.

Urgency and commitment to act

We have identified a strong intention and commitment to address inequalities and act on issues, including equity in access. However, few integrated care systems have demonstrated an urgency to act on this area.

Engaged leadership can support effective, well-performing health and care systems, but we found a mixed level of urgency to act on equity in access. In systems where there was apparent urgency, this was reflected across their work with clear plans in strategies, policies and other documentation. These considered the impact on equity in access when making decisions and taking action on relevant issues.

Focus on implementation and assessment

The ICSs in England are in various stages of maturity. We know that systems have been working together at different levels and in different forms before the new ICBs assumed legal status in July 2022, so there is variation in implementation and assessment.

We have seen that all ICSs have some equality and health inequalities objectives, but they did not all include timeframes and measures. A lack of clear and realistic goals and key performance indicators could be detrimental to meeting shared objectives. Research shows that to support effective and well-performing health and care systems, it is important to have:

- a shared strategy and vision that includes realistic and attainable goals
- a structured plan
- the use of key performance indicators and continuous improvement supports.[146]

The Equality and Human Rights Commission required integrated care boards to publish their staff equality information and equality, diversity, and inclusion objectives by 30 March 2023. However, we have not found this documented for all boards. Equity in access has been discussed at some board meetings in relation to other matters, but we have not seen evidence of equity in access on board agendas – either as a set agenda item or a strategic key performance indicator.

Looking ahead

Going into 2024, the development of our focus on health and social care across systems takes another step forward – we have begun our new pilot assessments of integrated care systems in Birmingham and Solihull and in Dorset.

We are collecting the evidence that we need to review and, as part of our assessment, we are speaking directly with people using health and care services and with staff working in these systems about their experiences.

We will also carry out on-site interviews for each ICS in the pilot. Specialist advisors and executive reviewers, who are experts in different health and care sectors, will be part of the team carrying out the assessments. During the pilots, we will be testing our assessment methods, including how we:

- work with partners and stakeholders, including NHS England
- use feedback from providers and people using services
- involve Experts by Experience effectively in our assessments
- use our tools and methods, including the information return
- enable efficient ways of working.

For each of the pilots, we want to look at:

- how leadership works
- whether systems are integrated
- progress towards reducing inequalities
- how quality and safety is managed across local services.

We will also be acting on our responsibilities to assess how well local authorities are meeting their duties under Part 1 of the Care Act (2014) for people accessing care and support.

These assessments will use a subset of quality statements from our new assessment framework. They will be structured specifically around the context, aims and roles of a local authority and focus on 4 themes:

- Working with people
- Providing support
- Ensuring safety within the system
- Leadership

The intention of CQC's assessment of local authorities is to increase transparency and local accountability and make good practice, positive outcomes and outstanding quality easier to spot locally and share nationally. The government hopes this will identify where improvement and additional support is needed.

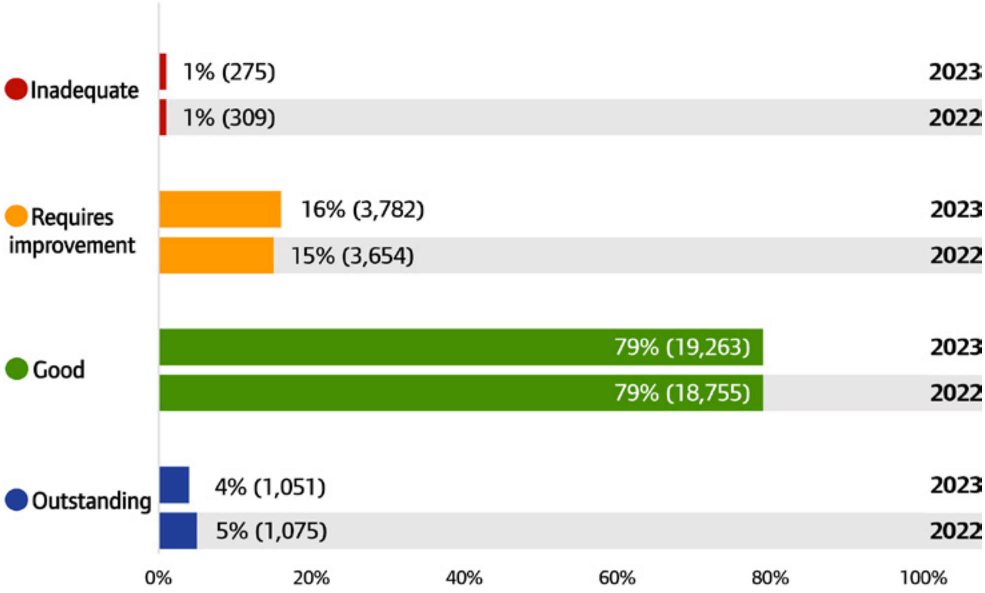
The pilot phase for our assessments is underway at 5 local authority sites: Nottinghamshire, Lincolnshire, Birmingham, North Lincolnshire and Suffolk.

The Secretary of State for Health and Social Care will approve the final approach to assessments, as required by the Health and Care Act 2022.

Appendix: CQC ratings charts

Figure A1

Adult social care, overall ratings, 2022 and 2023

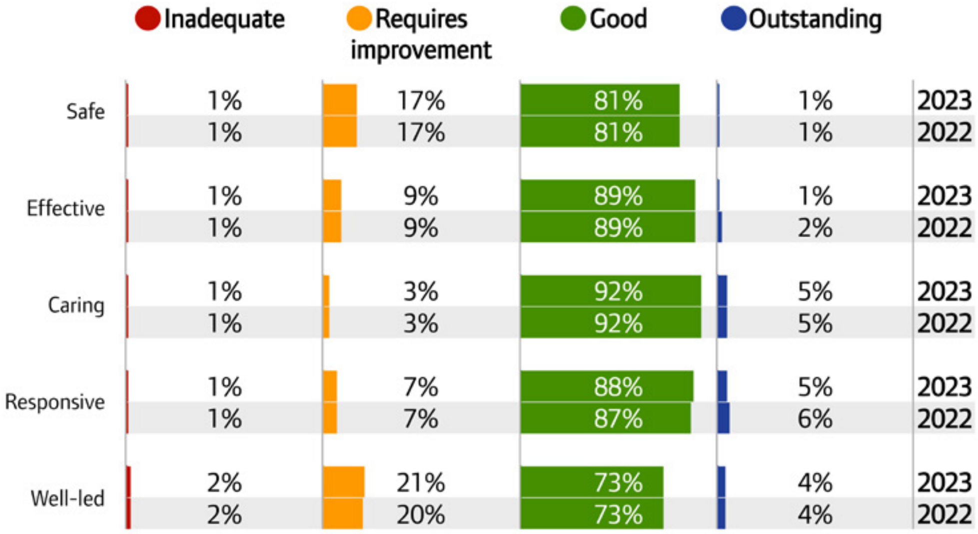


Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: The 2023 ratings included 18 'insufficient evidence to rate' which represented 0.2% of the total ratings (including 'insufficient evidence to rate'). Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A2

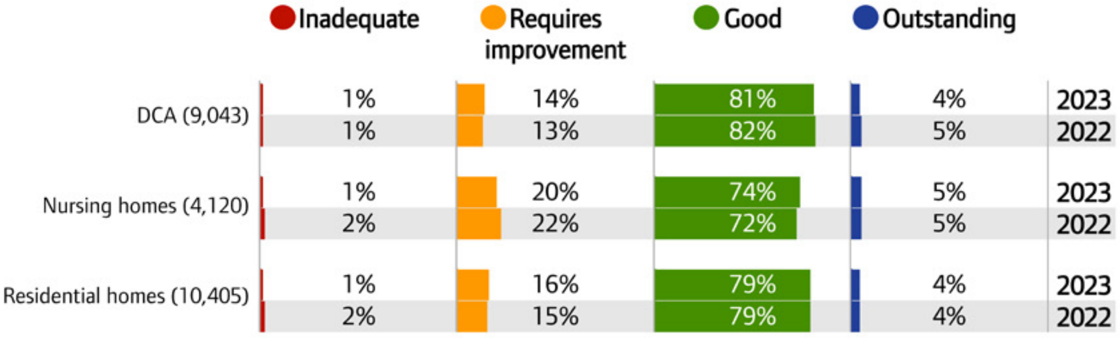
Adult social care, key question ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: In 2023, at key question level, 'insufficient evidence to rate' ratings represented the following proportions of home care (domiciliary care agencies – DCA): 0.12% for caring, 0.15% safe and well-led and 0.13% for responsive and 0.14% for effective. Of residential homes: 0.01% for well-led and safe, 0.02% for responsive, caring and effective. Of nursing homes: 0.05% for responsive and caring. Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

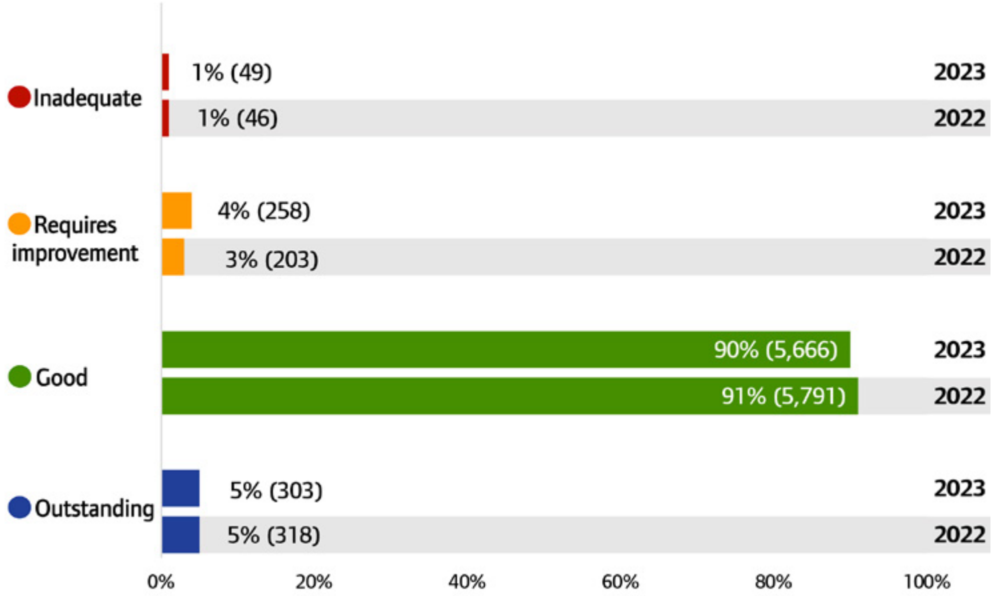
Figure A3
Adult social care, overall ratings by service type, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: The 2023 ratings included 17 homecare (domiciliary care agencies – DCA) ‘insufficient evidence to rate’ and 1 residential homes ‘insufficient evidence to rate’ rating. This represented 0.19% and 0.01% of the total ratings respectively (including ‘insufficient evidence to rate’). Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

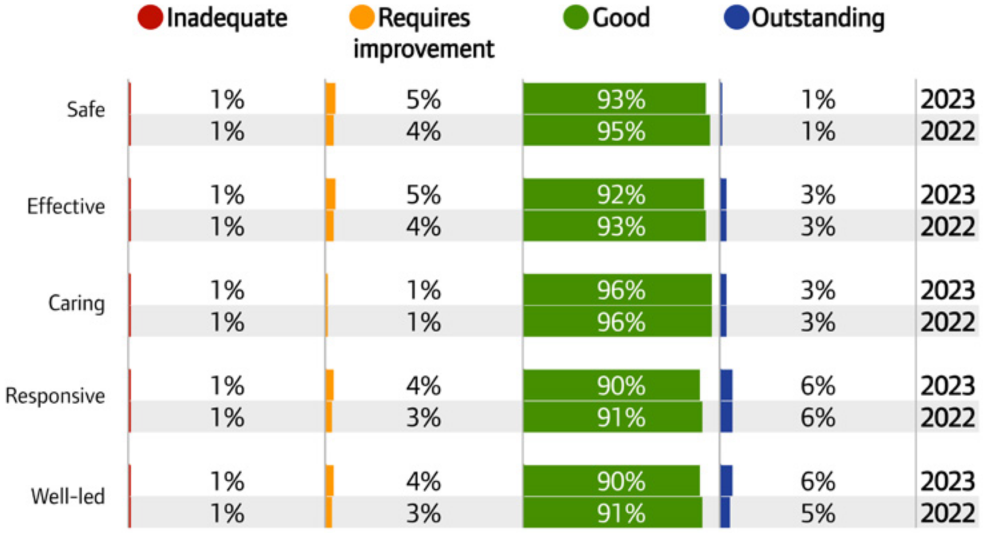
Figure A4
GP practices, overall ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

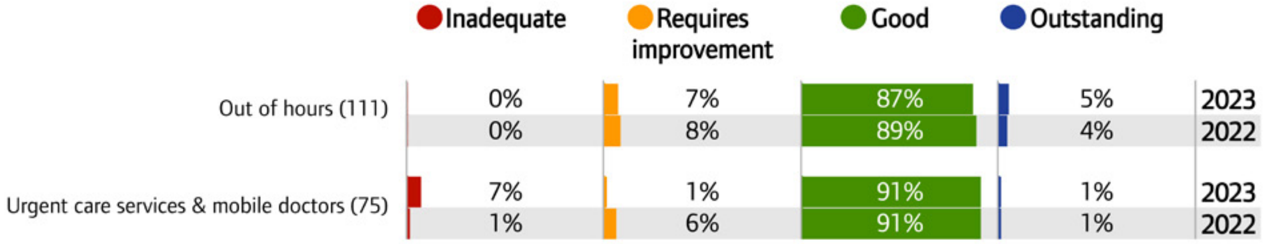
Figure A5
GP practices, key question ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: At key question level for the 2023 ratings 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.016% for safe, and 0.03% for effective, caring and responsive. Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A6
Other primary medical services, overall ratings, 2022 and 2023

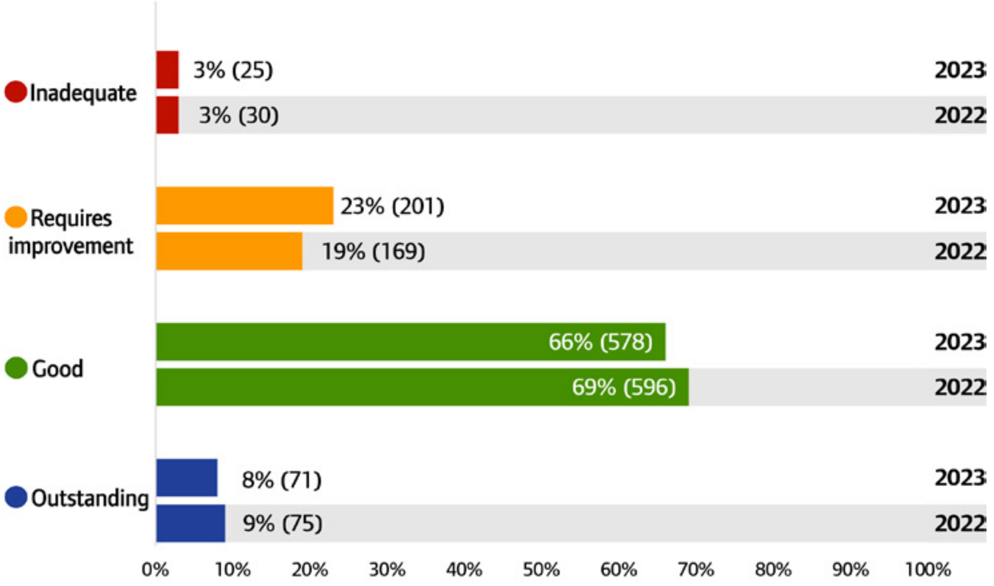


Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A7

NHS and independent mental health core services, overall ratings, 2022 and 2023

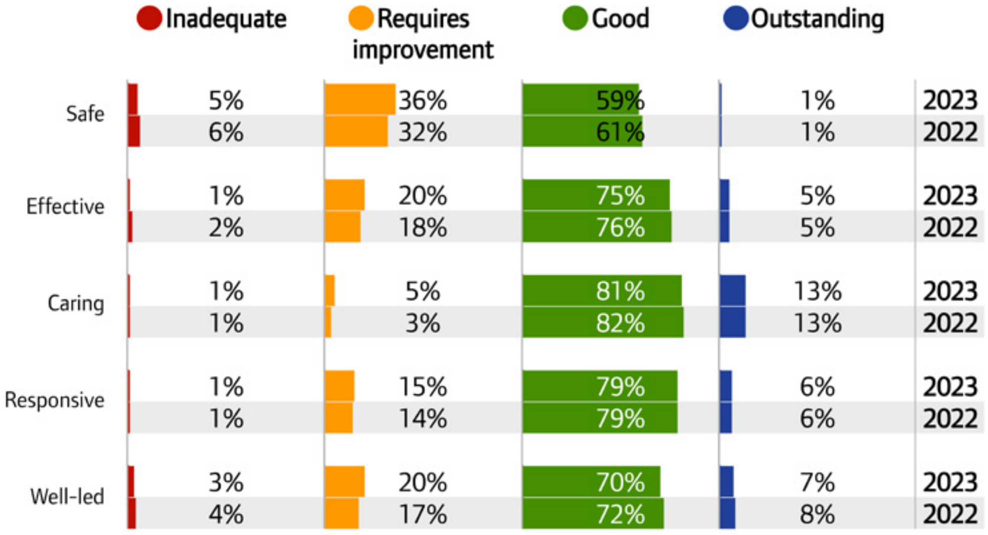


Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding.

Figure A8

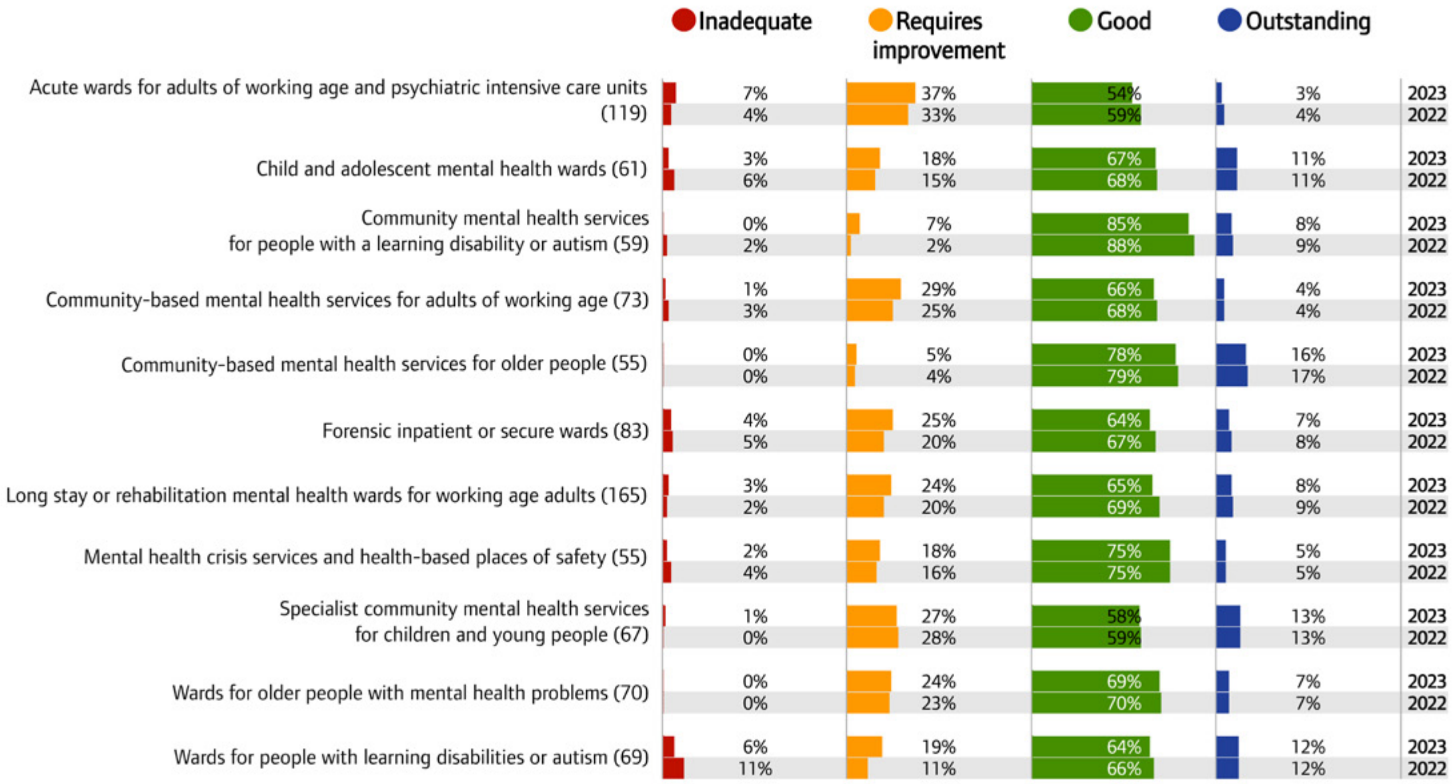
NHS and independent mental health services key question ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

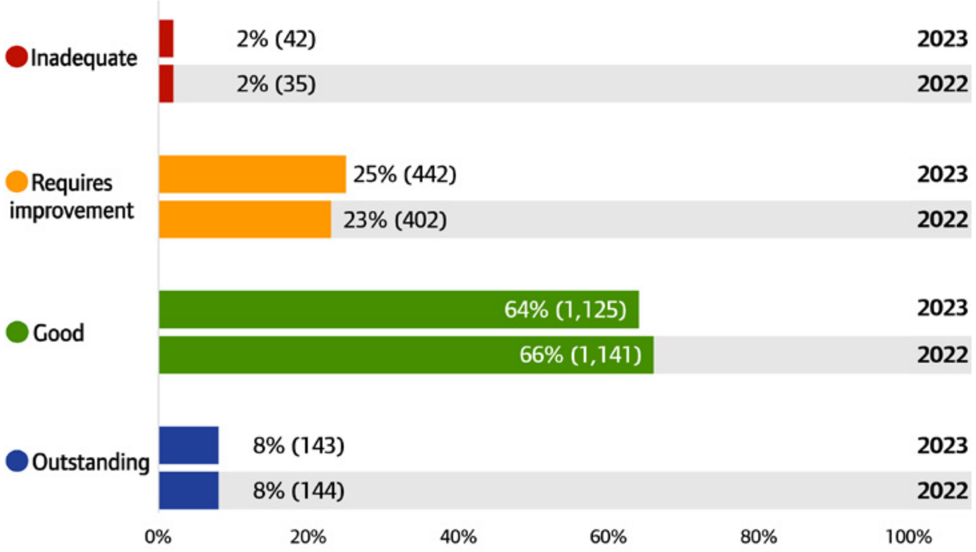
Figure A9
NHS and independent mental health core service, overall ratings, 2022 and 2023



Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A10
NHS acute core service, overall ratings, 2022 and 2023

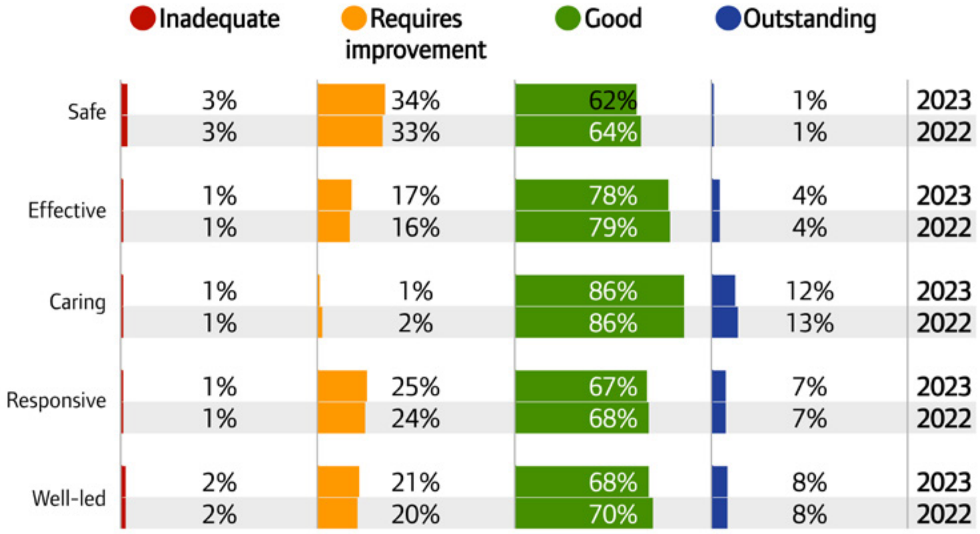


Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A11

NHS acute core service, key question ratings, 2022 and 2023

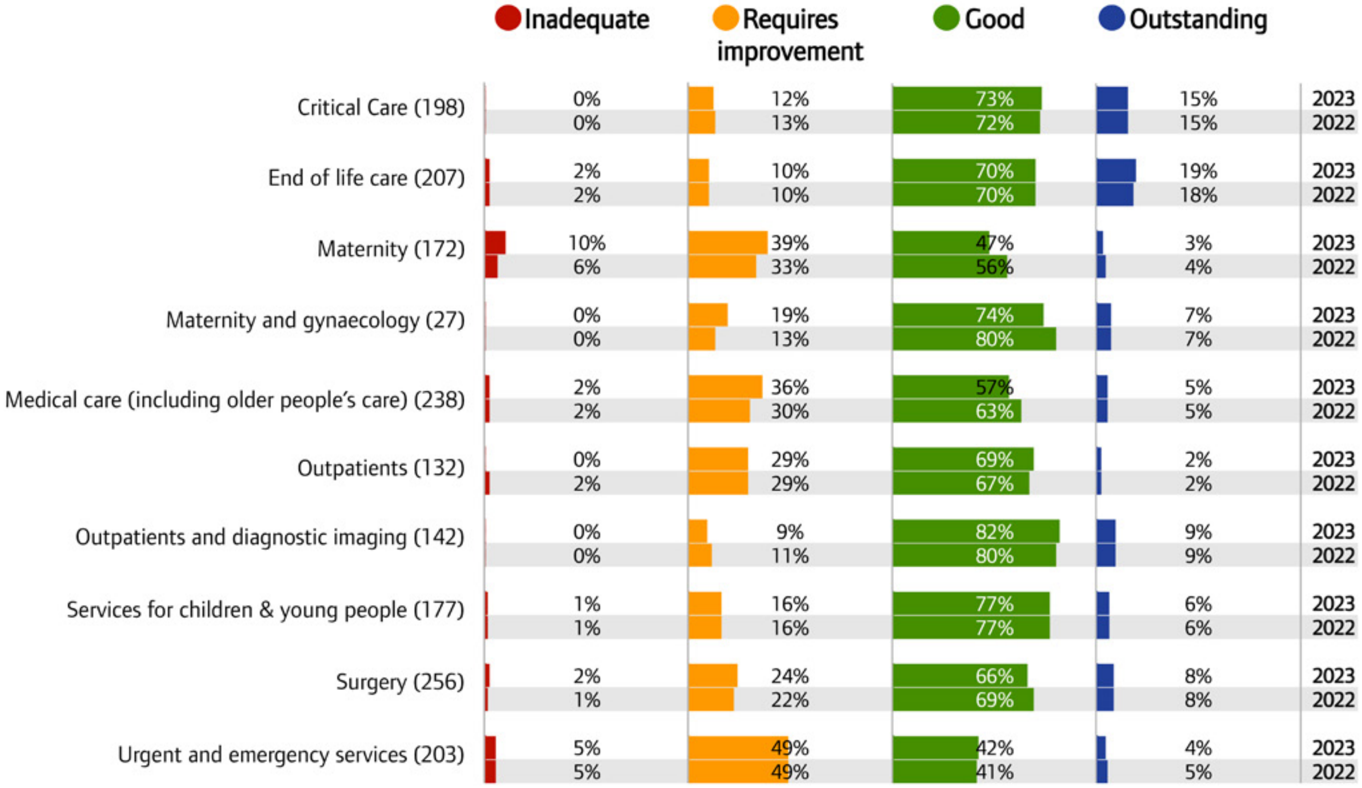


Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A12

NHS acute core service, overall ratings, 2022 and 2023

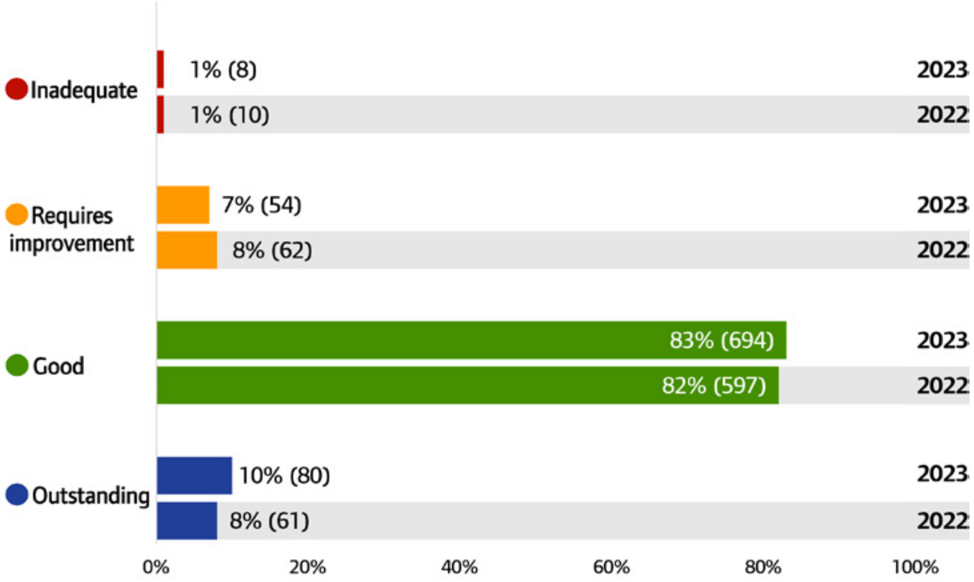


Source: CQC ratings data, 31 July 2022 and 7 September 2023

Note: At key question level for the 2023 ratings 'insufficient evidence to rate' ratings represented the following proportions of the total (including 'insufficient evidence to rate'): 0.5% for End of life care and Urgent and emergency services, and 0.1% of all core services. Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A13

Independent health acute core services, overall ratings, 2022 and 2023

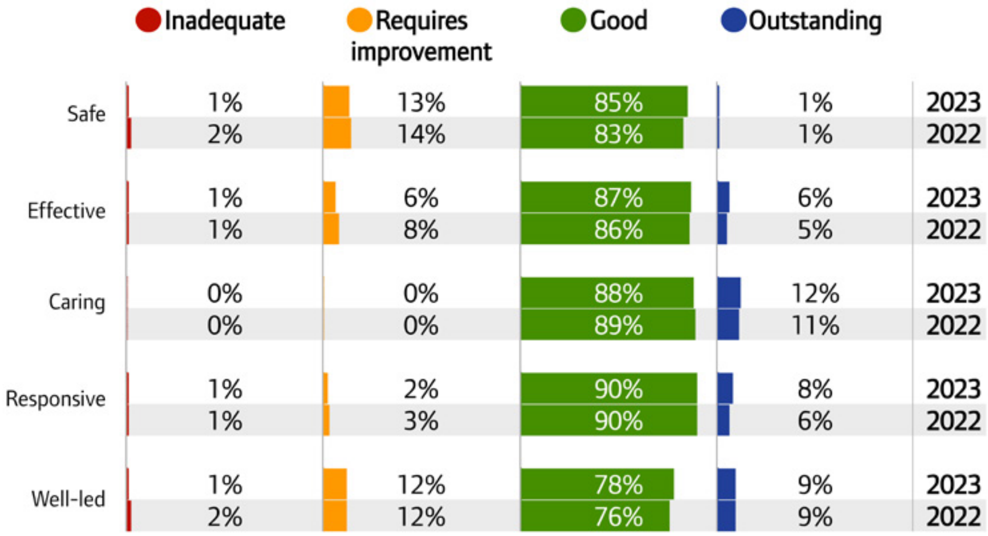


Source: CQC ratings data, 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A14

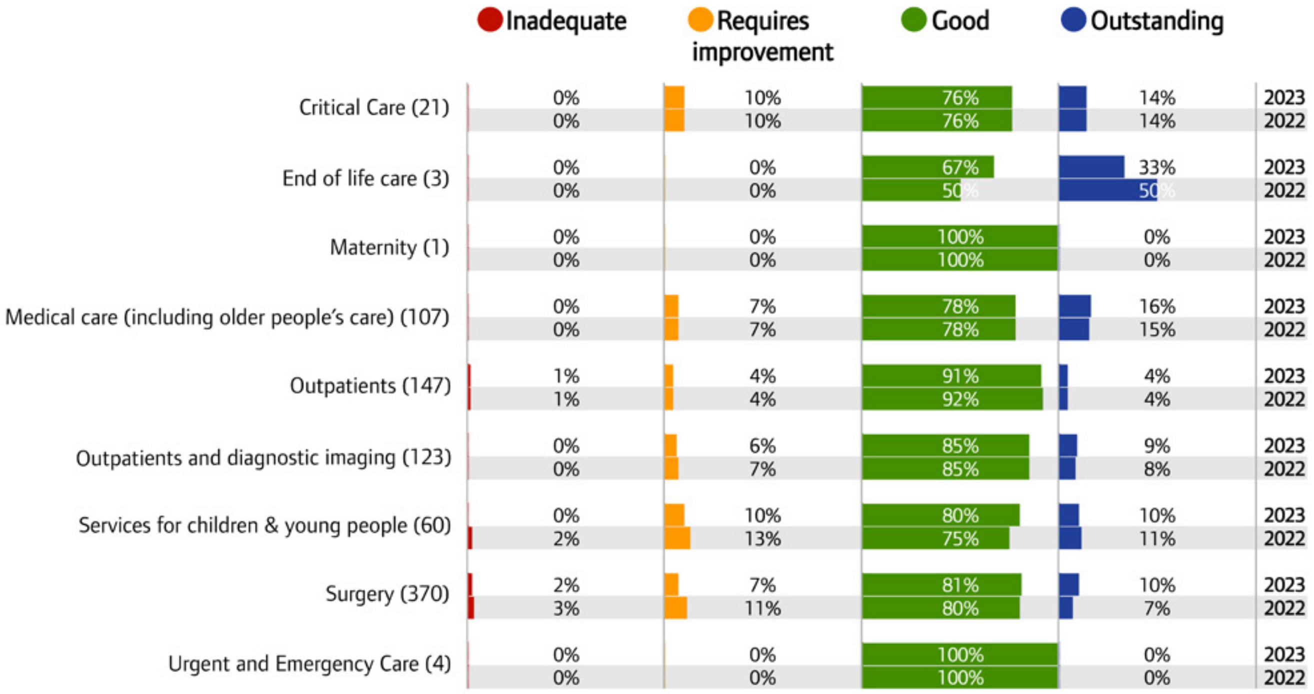
Independent health acute core services, key question rations, 2022 and 2023



Source: CQC ratings data, 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

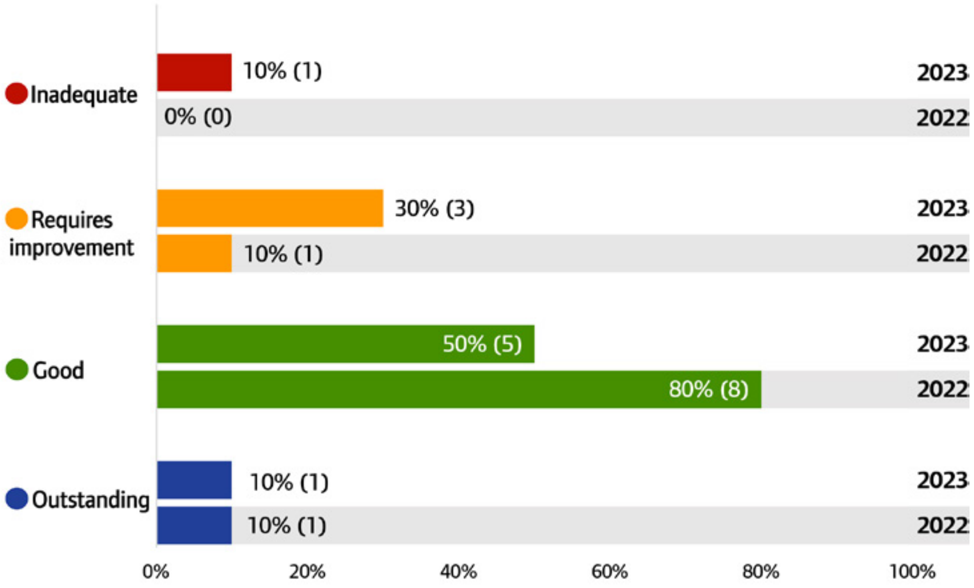
Figure A15
Independent health acute core services, overall ratings, 2022 and 2023



Source: CQC ratings data, 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A16
NHS ambulance trust, overall ratings, 2022 and 2023

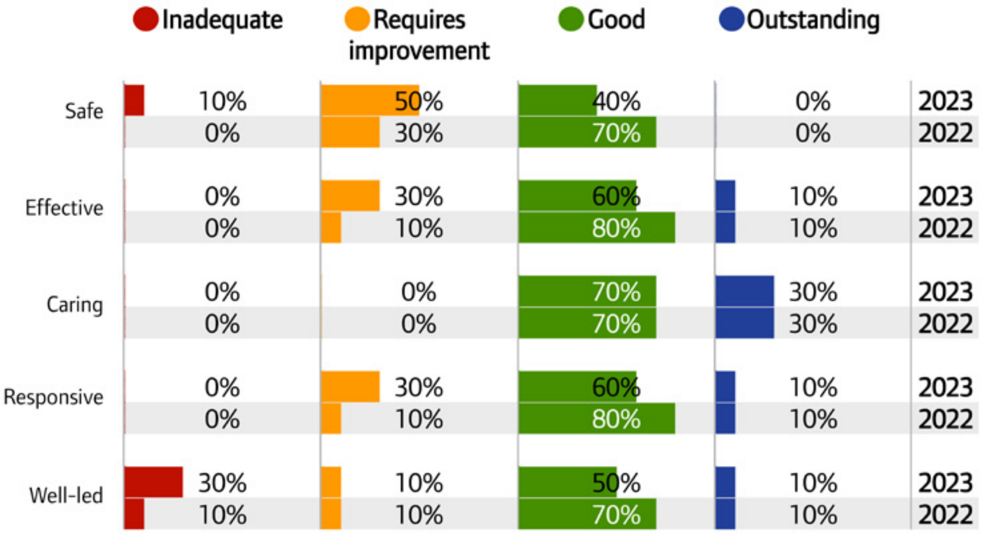


Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A17

NHS ambulance trust, key question ratings, 2022 and 2023

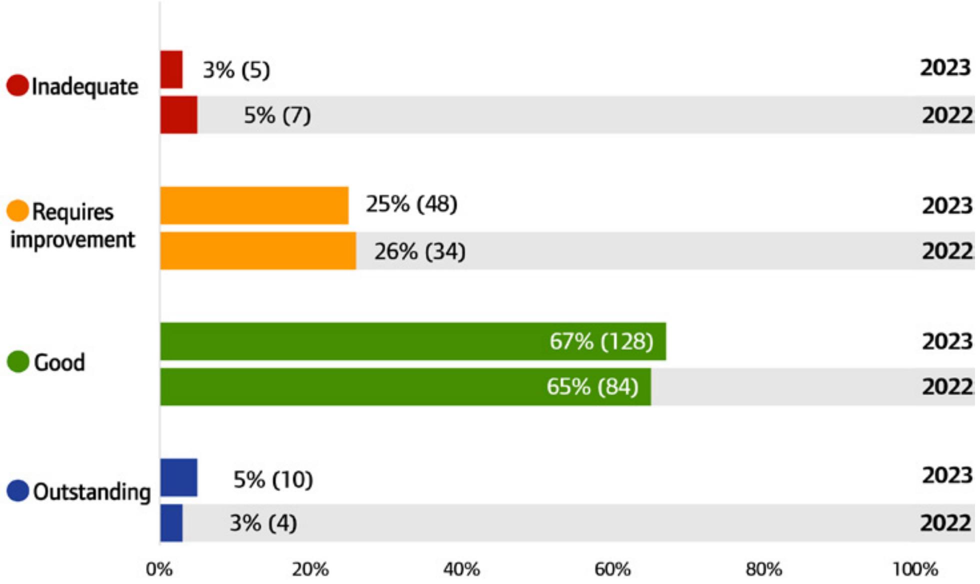


Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A18

Independent ambulance locations, overall ratings, 2022 and 2023

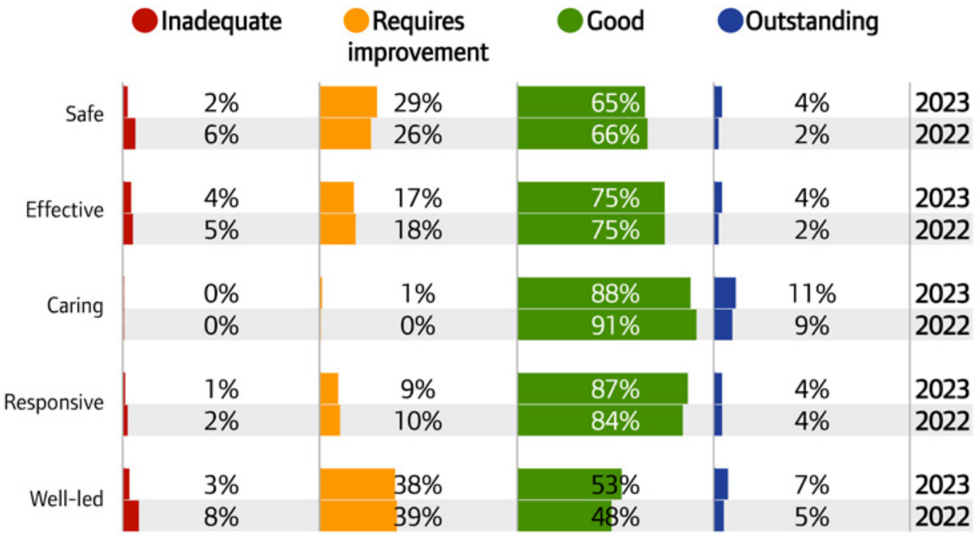


Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A19

Independent ambulance locations, key question ratings, 2022 and 2023

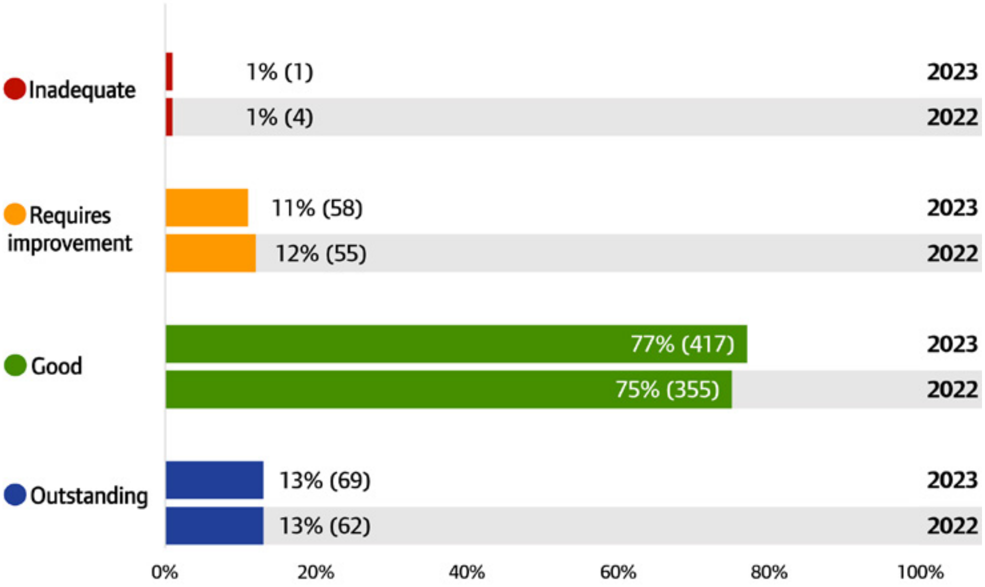


Source: CQC ratings data, 31 July 2022 and 1 August 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A20

Community health core services in all settings, overall ratings, 2022 and 2023

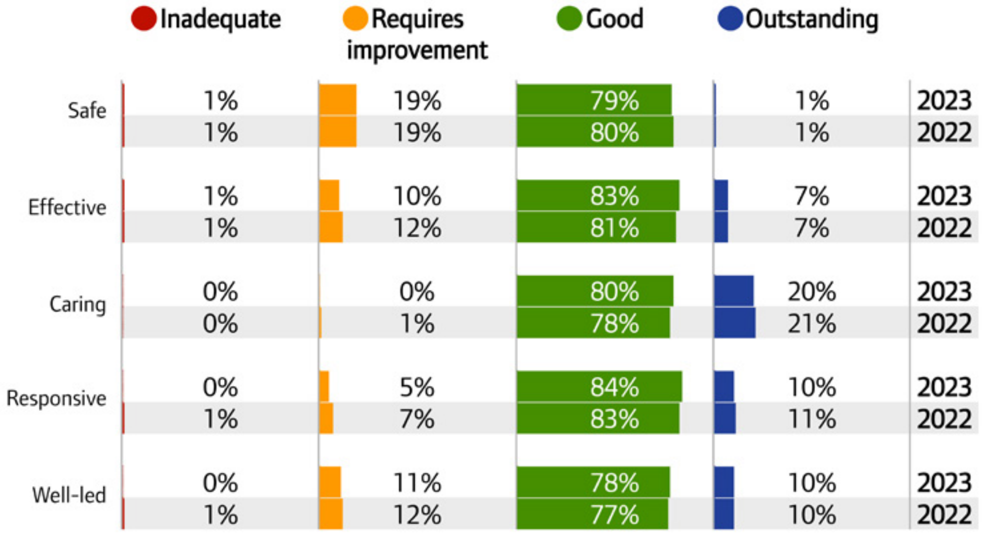


Source: CQC ratings data, 1 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A21

Community health core services in all settings, key question ratings, 2022 and 2023

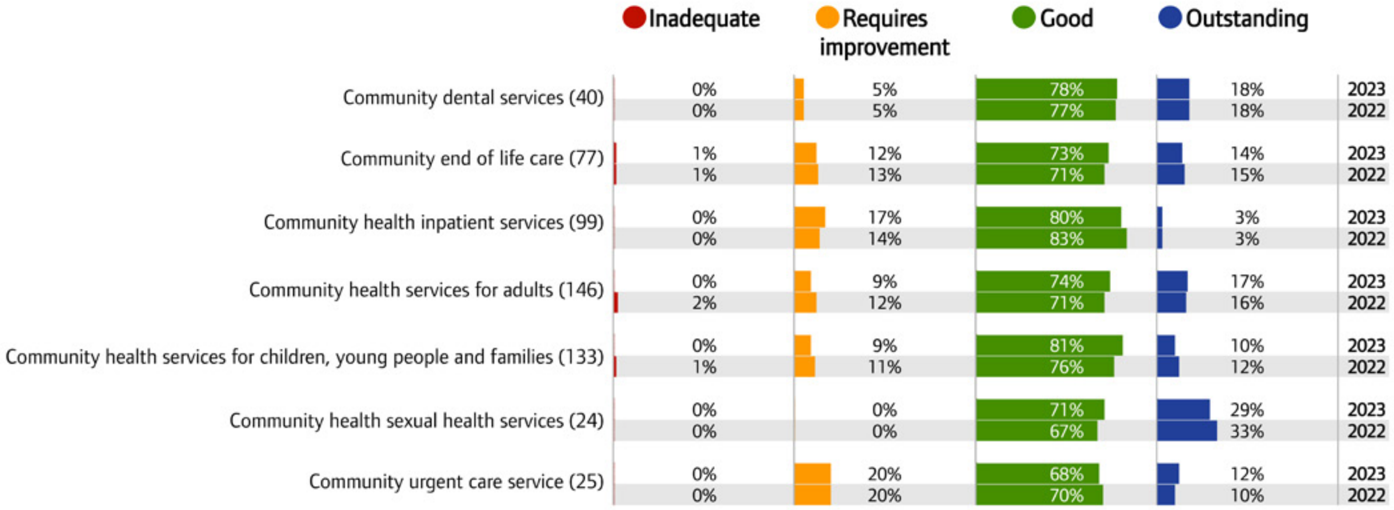


Source: CQC ratings data, 1 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

Figure A22

Community health core services in all settings, overall ratings, 2022 and 2023



Source: CQC ratings data, 1 July 2022 and 7 September 2023

Note: Percentages may not add to 100 due to rounding. Percentages between 0.01% and 1% have been rounded up to 1%.

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