The state of health care and adult social care in England 2019/20

State of Care

Care Quality Commission

The state of health care and adult social care in England
2019/20

Foreword

For the services we regulate – as for the rest of the world – the past year is divided into two parts. Pre-COVID, care was generally good, but with little overall improvement. In the NHS, improvement in some areas – for example, emergency care, maternity and mental health – was slower than others. The social care sector was fragile as a result of the lack of a long-term funding solution, and in need of investment and workforce planning. In primary medical services, the fact that the overall ratings picture remained broadly unchanged masked a more volatile picture of deterioration and improvement.

Since the arrival of COVID-19, we inhabit a different world, in which all these things remain true, but so much else has changed. As we take stock of the health and care system's initial response to the pandemic in order to learn lessons for the future, there are elements to build on – and elements to reassess.

The professionalism and dedication of the people who work and volunteer in health and care has always been the system's key strength – and from March onwards, this was more obvious than ever, as staff went to extraordinary lengths to protect those they cared for. This is cause for celebration – as well as for reflection on how to ensure that all staff are recognised for their work, regardless of the sector in which they deliver care.

The progress achieved in transforming the way care is delivered is also deeply impressive. In a matter of days, services developed new procedures and ways of working, often taking advantage of technology. Changes that were expected to take years – like the switch to more flexible GP consultations by phone and online – took place almost overnight. This report highlights many examples of how collaboration among services has made a real difference to people's care.

The challenge now will be to keep and develop the best aspects of these new ways of delivering services while making sure that no one is disadvantaged in the process. COVID-19 has magnified inequalities across the health and care system – a seismic upheaval that risks turning fault lines into chasms.

At the start of the pandemic, the focus on acute care was driven by the urgent imperative that the NHS should not be overwhelmed. Decisions were made in order to ensure capacity as quickly as possible – but as we move past the initial peak of the pandemic, priorities need to be reset in a more sophisticated way to ensure that the longer-term response includes everyone, regardless of what type of care they need or where they receive it.

This resetting of priorities starts with local leaders being empowered and having the capacity to respond together to the needs of their area. The fact that the impact of COVID-19 has been felt more severely by those who were already more likely to have poorer health outcomes, including people from Black and minority ethnic backgrounds, people with disabilities and people living in more deprived areas, makes the need for health and care services to be designed around people's needs all the more critical.

Over the summer, CQC reviewed the way health, social care and other local services worked together in 11 parts of the country. There were differences in the way they responded to the pandemic, but there is evidence that the places with established working relationships and an understanding of need in their local area were better able to care for their local population in a time of crisis.

The reviews have brought into focus the learning that needs to be used to help plan for a longer-term response to the virus. It is essential that the right support is available for all parts of a local health and social care system to drive improvements where they are needed, and to involve voluntary and community organisations in promoting health and wellbeing.

In social care, COVID not only exposed but exacerbated existing problems. The sector, already fragile, faced significant challenges around timely access to PPE, testing and staffing – and coordinated support was less readily available than it was for the NHS.

The pandemic highlighted the unstructured relationship between government and a sector comprised of a collection of over 25,000 businesses, some of which receive public funding and some of which do not. Over a few days, COVID required the redrawing of that relationship. It also reinforced the need for more clearly defined expectations on both sides, with more extensive oversight and understanding of financial performance of businesses in order to target support.

Social care's longstanding need for reform, investment and workforce planning has been thrown into stark relief by the pandemic. The legacy of COVID-19 must be the recognition that issues around funding, staffing and operational support need to be tackled now – not at some point in the future.

Alongside this, there needs to be a new deal for the care workforce, which develops clear career progression, secures the right skills for the sector, better recognises and values staff, invests in their training and supports appropriate professionalisation.

In the NHS, emergency departments now face the prospect of a winter that combines pre-existing pressures with the urgent demands of a pandemic. As other services restart, physical distancing will provide significant challenges, both logistically and in terms of managing capacity, alongside a backlog of people who could not access care during lockdown.

The impact of COVID-19 on the NHS in terms of elective and diagnostic work has been enormous. For people, this means life-changing operations that have still not been rescheduled, and people whose cancer remains undiagnosed or untreated. The NHS is working hard to develop innovative solutions, but it is difficult to predict the long-term consequences of these delays. These services must be protected in future so that more people do not suffer.

It will also be particularly important that those services where improvement was already not quick enough – for example mental health and maternity – do not fall further behind. While we paused routine inspections at the start of the pandemic, we have carried out risk-based inspections in response to concerns about these service areas and taken enforcement action as a result.

Alongside the recognition that COVID-19 has fundamentally changed so much, it is important to recognise what has not changed. Problems that existed before the pandemic have not gone away – and people are still more likely to receive poorer care from some types of service for reasons that pre-date COVID. We will maintain scrutiny on these services, supporting improvement and taking action to protect people where necessary – and we will continue to highlight factors, including commissioning and staffing, that impact on care but cannot be resolved at provider level alone and demand a national response.

We will also be conducting targeted programmes of work specifically focused on building resilience in the health and care system as it continues to respond to COVID, and looking for opportunities to actively support providers who are trying new ways to improve people's care.

What could the future look like? Pre-COVID, the health and care system was frequently characterised as resistant to change. COVID has demonstrated that this is not the case. The challenge now is to maintain the momentum of transformation and innovation, but to do so in a sustainable way that delivers for everyone. And the pace of change makes it more important than ever that there is a safety culture across health and social care where staff, patients and their families feel able to speak up openly about what has worked and what has not, and that learning is then shared and acted on.

There is an opportunity now for government, Parliament and health and care leaders to agree and lay out a vision for the future at both a national and local level. This should include plans for addressing the inequalities accentuated by COVID, the workforce challenges that have become even more acute, and the necessary investment in technology.

As we adjust to a COVID age, the focus must be on shaping a fairer health and care system – both for people who use services, and for those who work in them.

Ian Trenholm
Chief Executive

Peter Wyman
Chair

Summary

The care that people received in 2019/20 was mostly of good quality. But while the quality of care was largely maintained compared with the previous year, there was generally no improvement overall. And in the space of a few short months since then, the pandemic has placed the severest of challenges on the whole health and care system in England.

Quality of care before the pandemic

There was some improvement in NHS acute care, where 75% of core services were rated as good or outstanding compared with 72% the previous year. But there are still services where the quality of care needs to improve substantially – more than half of urgent and emergency care services in hospital were rated as requires improvement or inadequate as at 31 March 2020, as were almost a third of medical care and outpatient services. The quality of maternity services has barely changed, with at least one in four rated as requires improvement overall at 31 March 2020.

Among mental health services, we continued to find more poor care in inpatient wards for people with a learning disability and/or autistic people. The overall proportion of services rated as inadequate rose from 4% to 13%.

Before the arrival of the coronavirus pandemic, we remained concerned about a number of issues. While most care is rated as good across different settings, there were some areas that remained a great cause for concern. These were typically in those areas where care was harder to plan for – where providers cannot by themselves control the flow of people into their services and, as a result, they have to plan for an unpredictable level of care.

The social care sector continued to be fragile as a result of the lack of a long-term funding solution, and in need of investment and workforce planning, and there was a continued need for Parliament and government to make this a priority.

Some of the poorest services struggled to make any improvement. A very small proportion of GP services (1% of all practices) have never been rated better than requires improvement. In adult social care, 3% of care homes have never been rated better than this.

Across all sectors, some people were not able to access the care they needed when they needed it. Challenges included:

- pressures on emergency departments due to local demand, often linked to access issues elsewhere in the system

- NHS trusts struggling to meet referral-to-treatment times – the total number of people waiting for treatment carried on rising, reaching 4.4 million in February 2020

- significant gaps in access to good quality mental health care, with particular difficulties in accessing child and adolescent mental health services.

There were persistent inequalities in some aspects of care and there remained considerable variation between different areas and services in how well they consider the needs of people from different groups – particularly people from Black and minority ethnic groups, people from religious groups and disabled people.

The impact of the coronavirus pandemic

As the pandemic gathered pace, health and care staff across all roles and services showed resilience under unprecedented pressures and adapted quickly to work in different ways to keep people safe.

In hospitals and care homes, staff worked long hours in difficult circumstances to care for people who were very sick with COVID-19 and, despite their efforts to protect people, tragically they saw many of those they cared for die. Some staff also had to deal with the loss of colleagues to COVID.

Very quickly, care homes stopped visits from family and friends to try and control the virus. Measures put in place had a huge impact on people, with some residents confined to their rooms, social events cancelled, and shared areas in the home – such as dining rooms and lounges – closed due to physical distancing. The impact on people not being able to visit partners or spouses during lockdown has increased loneliness and stress.

The impact of COVID-19 on people in terms of delays to elective and diagnostic care, and urgent services such as cancer and cardiac services, is enormous. In real terms, this means people who have not yet had the life-changing operations they need, and people whose cancer remains undiagnosed or untreated. And overall, the pandemic has had a significant impact on many people's mental health and wellbeing.

Among the many challenges faced by providers in recent months, services have had to make sure they have enough employees with the right skills to cope with new and increased demands. A key challenge for providers has also been maintaining a safe environment – managing the need to socially distance or isolate people. Effective infection prevention and control will remain essential to protect people from acquiring COVID-19. Providers need to make sure they are taking action to minimise the risk of cross-infection. For all health and care services, this includes maintaining the highest standards of infection control in all areas, as well as mitigating the challenges caused by social distancing rules, such as reduced capacity in waiting rooms and reception areas.

The speed and scale of the pandemic required health and care providers to respond in new ways. The crisis has accelerated innovation that had previously proved difficult to mainstream, such as GP practices moving rapidly to remote consultations. The effectiveness of these changes are yet to be fully evaluated, but during the pandemic they have proved beneficial to, and popular with, many. However, many of these innovations exclude people who do not have good digital access, and some have been rushed into place during the pandemic.

Arrangements and planning for people who are vulnerable to digital exclusion must not be lost in the rush to prioritise innovative and resource-saving online

options. The challenge now will be to keep and develop the best aspects of these new ways of delivering services while making sure that no one is disadvantaged in the process.

It has become clear that COVID-19 has had a disproportionate effect on some people with protected characteristics: people from Black and minority ethnic backgrounds, older people, and people with some long-term health conditions and other disabilities have been hit harder by the pandemic and its knock-on effects. These unequal effects have affected health and social care workers as well as people in need of care.

While we are yet to understand all the reasons for these disparities, they do serve to shine a light on existing inequality in the health and social care system.

Collaboration between providers

Over the summer, CQC reviewed the way health, social care and other local services worked together in 11 parts of the country. The reviews have brought into focus the learning that needs to be used to help plan for resurgences of the virus.

We found that the success of collaboration among providers to keep people safe was varied, often affected by the maturity of pre-existing relationships within the system. Understanding the needs of the local population, including cultural differences, was especially important. At times the pace of change felt overwhelming for health and social care providers.

Where we found well planned governance, clear decision-making arrangements and escalation plans, those system-wide responses were most effective. In contrast, where we found multiple or unclear governance arrangements, those areas experienced higher levels of confusion and duplication of effort.

Sectors did not feel consistently engaged in the coordination of responses to the crisis. The views of sector partners varied as to the effectiveness of joint and supportive working arrangements, particularly between care homes and GP practices.

System areas benefitted from the pace of effort to secure a regional level grip across communication, support and joint working approaches in response to confusion from the pace of national guidance.

Strategies to manage staff and resources across sectors and partnerships were inconsistently navigated, causing varied success of collaboration within systems. The voluntary sector played a critical role in supporting health and social care to keep people safe. System-wide leaders were concerned about capacity to meet the demands of subsequent peaks without this support.

Accelerated and shared digital approaches supported providers to work together and keep connected well. However, advanced IT and technology did not always assist with efficient and timely access to care for people.

Looking forward, the challenges and opportunities ahead

The problems that existed before the pandemic have not gone away. People are still more likely to receive poorer care from some types of service, and from some providers, for the same reasons that they would have been more likely to receive poorer care pre-COVID.

The fact that the impact of COVID has been felt more severely by those who were already likely to have poorer health outcomes makes the need for services to be designed around people's needs all the more critical. It is important that new pathways and practices are developed in ways that reduce health inequalities and improve people's lives.

Social care's longstanding need for reform, investment and workforce planning has been thrown into stark relief by the pandemic. There needs to be a new deal for the adult social care workforce that reaches across health and care – one that develops clear career progression, secures the right skills for the sector, better recognises and values staff, invests in their training and supports appropriate professionalisation. The legacy of COVID-19 must be the recognition that issues around funding, staffing and operational support need to be tackled now – not at some point in the future.

The increased waiting lists and backlog of urgent and elective care need to be addressed – services need to assess and prioritise patients so that they are treated according to clinical need and that people waiting for long periods for treatment are kept safe. Going forward, hospitals and other healthcare services need to finely balance the capacity to provide COVID and non-COVID care, and make sure that people have the confidence to come forward for the care and treatment they need.

Primary care services similarly need to make sure that people are given the confidence to interact with them early, provide a range of ways for them to access the care they need, and make it easy for them to do so.

Mental health is a key area where we have previously raised concerns about the lack of community care and early diagnosis and support. It is likely that people who have been unable to access mental health services since the start of the pandemic will be looking for more help once services are re-established. Enhanced mental health support will be needed for people and communities.

Health and social care providers across the country need an equal and consistent offer of improvement. Providers and systems need access to shared learning, information, advice and support, so they can be empowered to help themselves. Information is needed so they can understand their performance against similar services, which in turn can help them access the specific support they need to implement changes.

As the health and care system continues to wrestle with the pandemic, providers, regulators and system partners need to maintain the appetite to work together and at pace. We must make sure that we learn from the response to the crisis, that we lock in positive changes, and that we drive a new way of working that is supported at a national, regional and local level by the whole health and care system.

The way we plan, commission and deliver health and care must be shaped by the experience of dealing with a national health emergency, which has shown so very clearly how interdependent health and care truly are.

Evidence used in this report

This report sets out the Care Quality Commission's (CQC's) assessment of the state of care in England in 2019/20. We use data from our inspections and ratings, along with other information, including that from people who use services, their families and carers, to inform our judgements of the quality of care. Most of the analysis in this report is generated by CQC, specifically:

- Quantitative analysis of our inspection ratings of more than 31,000 services and providers, drawing on other monitoring information including surveys to engage staff and the public including using CQC's online participation platform. In previous years, we have used ratings as at 31 July, to enable as contemporaneous a view as possible. Because we suspended our routine inspections and ratings in March 2020 as a result of the coronavirus pandemic, the ratings in this report are as at 31 March 2020 and all comparisons with the previous year are with ratings as at 31 July 2019.

- A programme of primary qualitative data collection and analysis to gather evidence to inform the messages of this report. Through this work, we have heard from 153 people through focus groups or interviews with CQC inspection colleagues and external stakeholders. All interviews and focus groups took place between February and April 2020. Due to the timing of the data collection, these evidence sources represent a pre-pandemic view. We adopted the following methods and objectives for this work:

  - Thematic analysis of 22 focus groups, four interviews and five written responses. These were conducted with CQC inspection colleagues and representatives from local Healthwatch and supplemented by a small number of interviews with other external stakeholders. Focus groups with inspection colleagues operating in each of the seven NHS England/ Improvement regions aimed to gather insight about cross-sector working and successes and challenges at a regional level. In addition, interviews and focus groups with external stakeholders in each of the regions aimed to explore what stakeholders understood to be the primary successes and challenges for their local health and social care systems. The discussion focused on pre-defined themes: access, local communities and innovation. Analysis identified high-level findings related to these three themes.

  - Thematic analysis of two focus groups with a total of 19 CQC inspection colleagues, including mental health and adult social care inspectors and Mental Health Act reviewers with a particular knowledge and interest in Deprivation of Liberty Safeguards (DoLS). Acute hospital inspectors were unable to take part due to operational pressures relating to COVID-19. The work aimed to provide insight into CQC's knowledge about the operation of the DoLS system this year.

    We also carried out secondary qualitative analysis of 100 care home and 40 hospital inspection reports to understand what good, poor and improvement in DoLS practice looked like.

- Mixed-method analysis of comments submitted to CQC in 2019 through our online feedback service (Give Feedback on Care or Share Your Experience) on our website as well as complaints made to our National Customer Service Centre. The online form can be used by people using a service, family members and/or carers, and the public as well as healthcare professionals. Our colleagues in data science produced a national topic model, covering all NHS England/Improvement regions, that grouped just under 60,000 comments into 15 distinct topics. The 20 highest weighted comments within each topic were qualitatively analysed.

- Infection prevention and control (IPC) – we analysed the outcomes of 138 Emergency Support Framework calls between our inspectors and all acute and specialist trusts. These calls discussed each trust's 'Board Assurance Framework' to identify how the trust was assuring itself of good IPC across 11 key areas. During August 2020, we carried out a special programme of IPC inspections in 301 care homes selected as potential examples of where IPC was being done well, and also reviewed IPC in 139 care home inspections that we carried out in high-risk services. During these inspections, we reviewed how well staff and people living in care homes were protected by IPC measures, looking at assurance overall and across eight key areas. There were 43 calls with GP practices to discuss their IPC measures in response to the pandemic, to understand what they had done, and hear about good practice they wanted to share and challenges they had faced.

- As the scope and focus of this year's report shifted with the emergence of the pandemic, additional work was carried out to understand the impact of COVID-19. In July and August 2020, we rapidly mobilised teams to carry out provider collaboration reviews, to find out how care providers have worked together in response to the pandemic to improve care for older people, who are most at risk of COVID-19. We analysed data from 224 interviews as part of the evidence collected for the first phase of this programme. The interviews were conducted with a range of external participants from 11 sustainability transformation partnerships or integrated care systems across England.

  The speed of this project meant we had to focus on a sample of interviews from each area. Inspectors presented their findings to the area at the end of each review. We reviewed all these presentations to see if any key findings were missed because of analysing a sample of interviews.

- We also carried out a survey focusing on the experiences of patients who were admitted to hospital during the peak of the pandemic. More than 10,000 people across the country told us about the care they had received while in hospital, whether they were diagnosed with COVID or admitted for other reasons. The survey used many questions from CQC's annual adult inpatient survey, with new questions specific to the patients' experiences at that time.

- We also analysed enquiries from staff, people who use services and their relatives and carers, and members of the public, including Give Feedback on Care web submissions, received between March and July 2020. Enquiries relating to COVID-19 were tagged to high-level topics.

Evidence in this report, alongside our Annual Report and Accounts, enables us to fulfil our legal duties to report on equality issues. In particular, this is in sections 1.9, 2.4 and 4.1 of this report. Similarly, we report annually on the operation of the DoLS through this report, in accordance with the DoLS code of practice. This is in sections 1.8, 2.5 and 4.6.

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

1. Quality of care before the pandemic

> ## Key points
>
> - The care that people received in 2019/20 was mostly of good quality.
>
> - However, while quality was largely maintained compared with the previous year, there was by and large no improvement overall.
>
> - Before the coronavirus pandemic, we remained concerned about a number of issues:
>
>   - the poorer quality of care that is harder to plan for
>
>   - the need for care to be delivered in a more joined-up way
>
>   - the continued fragility of adult social care provision
>
>   - the struggles of the poorest services to make any improvement
>
>   - significant gaps in access to good quality care, especially mental health care
>
>   - persistent inequalities in some aspects of care.

1.1 Introduction

In our State of Care report in October 2019, we said that more and better community services were needed to improve people's experiences of care. We pointed to the need for better integrated services to prevent people ending up in crisis situations.[1]

We showed that some places had better care than others and there were parts of the country where people might find it harder to access good care. We said that the challenge for government, Parliament, commissioners, national organisations and providers was to change the way services work together so that the right services are being commissioned to deliver what people need in their local area.

This emphasis on community and working together is not a new theme. In 2017 we reported that more local collaboration and joined-up care was needed, especially with the complexity of demand, such as diabetes, obesity, cancer and long-term conditions, increasing in a health and social care system at full stretch. We said that services had to think beyond their traditional boundaries and reflect the experience of the people they support.[2]

In 2018 we reported how ineffective coordination of services was leading to fragmented care. Funding, commissioning, regulation and performance management all conspired to encourage a focus on the performance of individual organisations, rather than ensuring people got joined-up care based on their individual needs.[3]

Communities matter. For several years, we have been stressing the huge importance of local health and care systems that work closely together, of collaboration among providers and local organisations to put people at the centre of their care.

The importance of this is much more apparent in the light of the coronavirus pandemic that reached this country in the last two months of 2019/20.

This report looks at the quality of care in our health and care system over the past year, including the period before COVID-19 burst into the national consciousness and began to affect everyone's lives so fundamentally.

1.2 Quality overall before the pandemic

The care that people receive in England is mostly of good quality. As at 31 March 2020 (figure 1):

- 80% of adult social care services were rated as good and 5% as outstanding (31 July 2019: 80%, 4%)

- 89% of GP practices were rated as good and 5% as outstanding (31 July 2019: 90%, 5%)

- 67% of NHS acute core services were rated as good and 8% as outstanding (31 July 2019: 65%, 7%)

- 71% of NHS mental health core services were rated as good and 11% as outstanding (31 July 2019: 71%, 10%).

While it is clear that care providers were able to maintain the quality of care they provided, it is also clear that there was by and large no improvement overall. However, this overall picture does mask the improvement and deterioration that happens at a service level. For example, in the year to 31 March 2020, 192 GP practices improved their rating to good on re-inspection and 173 declined from a rating of good.

Figure 1: **Overall ratings for the main sectors, 2019 and 2020**

Adult social care

Inadequate: 285 (1%) 2019, 275 (1%) 2020
Requires improvement: 3,373 (15%) 2019, 3,429 (15%) 2020
Good: 18,404 (80%) 2019, 18,779 (80%) 2020
Outstanding: 887 (4%) 2019, 1,073 (5%) 2020

GP practices

Inadequate: 82 (1%) 2019, 84 (1%) 2020
Requires improvement: 271 (4%) 2019, 299 (4%) 2020
Good: 6,040 (90%) 2019, 5,975 (89%) 2020
Outstanding: 313 (5%) 2019, 318 (5%) 2020

NHS acute core services

Inadequate: 43 (2%) 2019, 30 (2%) 2020
Requires improvement: 452 (25%) 2019, 406 (23%) 2020
Good: 1,151 (65%) 2019, 1,193 (67%) 2020
Outstanding: 127 (7%) 2019, 148 (8%) 2020

NHS mental health core services

Inadequate: 15 (3%) 2019, 15 (3%) 2020
Requires improvement: 91 (17%) 2019, 77 (15%) 2020
Good: 383 (71%) 2019, 365 (71%) 2020
Outstanding: 54 (10%) 2019, 57 (11%) 2020

Source: CQC ratings data, 31 July 2019 and 31 March 2020.

There was some improvement in NHS acute care, where 75% of core services were rated as good or outstanding compared with 72% the previous year. Looking at our individual key questions ratings, the proportion rated as good for safety rose from 61% to 63%, and for well-led from 68% to 70% (figure 2a).

But there are still services where the quality of care needs to improve substantially – more than half of urgent and emergency care services were rated as requires improvement or inadequate as at 31 March 2020, as were almost a third of medical care and outpatient services. A quarter of maternity services were rated as requires improvement (figure 2b).

## Figure 2a: **NHS acute core services, key question ratings, 2019 and 2020**

		Inadequate	Requires improvement	Good	Outstanding
Safe	2020	2	34	63	1
	2019	3	36	61	1
Effective	2020	1	16	79	4
	2019	1	19	77	4
Caring	2020	<0.5 2		86	13
	2019	<0.5 2		87	11
Responsive	2020	1	25	67	7
	2019	1	25	68	6
Well-led	2020	2	19	70	8
	2019	3	21	68	7

0%   20%   40%   60%   80%   100%
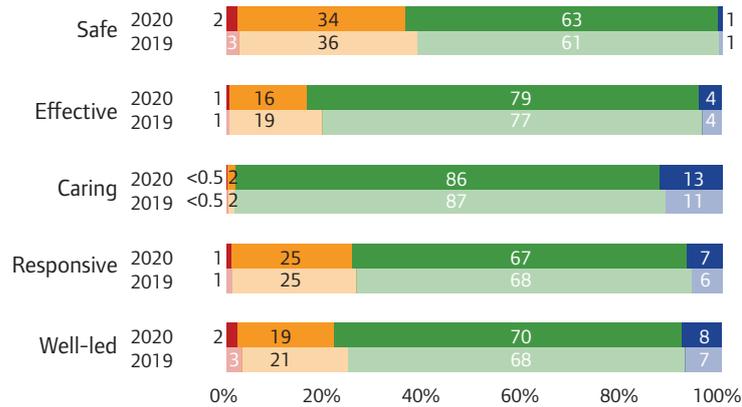
Figure 2b: **NHS acute core services, overall ratings, 2019 and 2020**

|		Inadequate	Requires improvement	Good	Outstanding
End of life care (209)	2020	1	11	70	17
	2019	1	18	69	13
Critical care (202)	2020		16	70	14
	2019	1	21	66	13
Services for children and young people (181)	2020	2	14	78	6
	2019	2	17	78	4
Surgery (254)	2020	1	23	69	7
	2019	2	25	67	6
Maternity (123)	2020		26	69	5
	2019	1	25	69	5
Medical care (including older people's care) (251)	2020	1	30	62	7
	2019	2	33	57	7
Outpatients (125)	2020	2	30	65	2
	2019	7	33	59	2
Urgent and emergency services (209)	2020	7	44	44	5
	2019	8	44	44	4
Outpatients and diagnostic imaging (154)	2020		12	79	8
	2019	1	19	74	7
Maternity and gynaecology (69)	2020		14	77	9
	2019	1	18	74	7

0%   20%   40%   60%   80%   100%

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated core services at 31 March 2020.

We were pleased to see an improvement in community health care ratings, with 75% of all core services rated as good and 12% rated as outstanding at 31 March 2020, compared with 74% and 10% in 2019 (figure 3).

Figure 3: **Community health core services in all settings, overall ratings, 2019 and 2020**

| 2019 2020 | 2019 2020 | 2019 2020 | 2019 2020 |
| Inadequate | Requires improvement | Good | Outstanding |
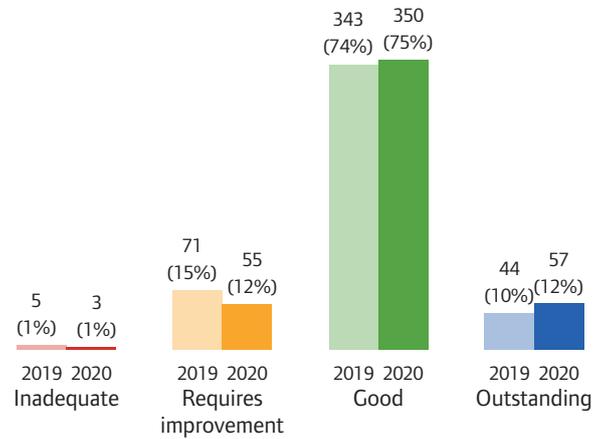
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

However, among mental health services, we continued to find more poor care in inpatient wards for people with a learning disability and/or autistic people. The overall proportion of services rated as inadequate rose from 4% to 13% (figure 4). Almost all of this happened in independent services, where the proportion of services rated as inadequate rose from 5% to 22%; in contrast, NHS services rated as inadequate remained at 3% of the total.

Figure 4: **NHS and independent mental health core services, overall ratings, 2019 and 2020**

Service	Year	Inadequate	Requires improvement	Good	Outstanding
Community mental health services for people with a learning disability or autism (54)	2020			91	9
	2019	2		89	9
Community-based mental health services for older people (55)	2020		4	80	16
	2019		5	78	16
Long stay or rehabilitation mental health wards for working age adults (159)	2020	1	13	74	12
	2019	1	17	70	11
Child and adolescent mental health wards (70)	2020	7	10	69	14
	2019	6	17	64	14
Wards for older people with mental health problems (76)	2020	1	17	74	8
	2019	4	16	74	7
Forensic inpatient or secure wards (96)	2020	1	18	72	9
	2019	3	20	67	10
Community-based mental health services for adults of working age (69)	2020	4	19	74	3
	2019	3	21	73	3
Mental health crisis services and health-based places of safety (56)	2020	4	21	70	5
	2019	2	18	75	5
Wards for people with learning disabilities or autism (80)	2020	13	18	56	14
	2019	4	18	63	16
Specialist community mental health services for children and young people (67)	2020	6	27	57	10
	2019	6	20	63	11
Acute wards for adults of working age and psychiatric intensive care units (103)	2020	6	36	54	4
	2019	6	38	52	4

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated core services at 31 March 2020.

There are 10 NHS ambulance trusts in England, of which one was rated as outstanding, eight as good and one as requires improvement as at 31 March 2020.

We continue to have some significant concerns about independent ambulance services, following our 2019 report on the sector.[4] Having been given the powers to rate independent ambulance services, we began a second round of inspections. As at 31 March 2020, 11% of 101 services were rated as inadequate and 33% as requires improvement. While there are clearly good services in the sector, these ratings highlight our ongoing serious concerns, particularly about safe recruitment and safeguarding practices. As a result, we have taken a significant amount of enforcement action.

1.3 Care that is harder to plan for was of poorer quality

While most care is rated as good across different settings, there were some areas that remained a great cause for concern. These were typically in those areas where care was harder to plan for – where providers cannot by themselves control the flow of patients to their services and, as a result, they have to plan for an unpredictable level of care.

For example, the quality of urgent and emergency care in NHS acute hospitals had barely changed compared with the previous year, and there was still too much that needed to improve. Seven per cent of these services were rated as inadequate at 31 March 2020, and 44% were rated as requires improvement.

The quality of maternity services has barely changed, with at least one in four 'maternity' core services rated as requires improvement overall at 31 March 2020. Looking across both 'maternity' and the older 'maternity and gynaecology' services, 41% were rated as requires improvement for safety and 1% were rated as inadequate for safety. We continued to see some services where staff did not have the right skills or knowledge, where poor working relationships between obstetricians, midwives and neonatologists posed a barrier to safe care, and where there was limited oversight of risk and a lack of investigation and learning when things go wrong.[5]

And while, in NHS and independent mental health services, there was some slight improvement in the quality of acute wards for people of working age, 6% were still rated as inadequate and 36% as requires improvement. In addition, specialist community services for children and young people got worse, with 6% rated as inadequate and 27% rated as requires improvement.

1.4 Care services needed to do more to join up

During 2019/20, we saw a greater willingness among services to work together, and a shift in providers' mindset from being competitive to being more collaborative – acknowledging the benefits and need to work with others to provide joined-up person-centred care and to ensure the specific needs of communities are met. This has been borne out in some of the provider collaboration reviews we did in the summer of 2020, to consider the impact of COVID-19 on services for people aged 65 and over (see chapter 3).

However, our inspectors and external stakeholders have highlighted the wide variation in collaborative working in all regions, and within local areas. This variation has been seen around the type, purpose, development and implementation of local system working. The differing levels of maturity of system working are due to a number of factors, including the role of commissioning bodies and the strength of working relationships, as well as local characteristics. This could mean the same initiatives – such as primary care networks – might work well in one area but not another.

> *"Each local area's very different and that's what we pick up when we meet as a West Yorkshire and Harrogate group and when we meet as the Yorkshire and Humber group… our local health and care services are very different because of our local contexts."*
>
> **Healthwatch**

The national drive for better local system working has been happening for several years and we have pointed to good and bad examples through local system reviews. Some places are better than others, but it is still sometimes difficult to see the impacts for people using services because many system-working initiatives are in their infancy.

The importance of involving people in health and social care planning and decision-making, including around innovation, was recognised.

> *"In Leeds we lead a group called <u>The People's Voices Group</u> made up of engagement professionals from across health and care organisations. Together we make sure that people from communities or people with lived experience are at the centre of health and care decision-making, so I think we've got a lot of the really positive building blocks in place in Leeds."*
>
> **Healthwatch**

We have heard examples of good community engagement, where the views and experiences of local people were gathered. However, these examples were not widespread. We have heard concerns from external stakeholders that if people who use services are not involved in local system planning and evaluation, they may not engage with these new ways of working.

We have seen examples of local developments, partnerships and collaborations in all regions, both within-sector and cross-sector. Within-sector examples include acute trusts working together to solve capacity issues, through sharing services based on clinical need or sharing learning.

> *The Prosper project introduced prosper champions for care homes, who are trained in nutrition and hydration, falls avoidance and mobility. It pioneered pimp my Zimmer and luminous lights that come on at night time to show people the way to the toilet, and glow-in-the-dark toilet seats – initiatives that are aimed at reducing hospital admissions.*

Where cross-sector working was taking place, the sectors were working together to address local issues – for example, improving specific patient pathways or relieving pressure points in the system to make life easier for people. We have seen examples of systems to share data and medical records across providers and between sectors, which has increased understanding of performance and demand. However, a lack of access to NHS digital systems can prevent adult social care providers from working with other partners.

In addition, inspectors and external stakeholders reported that adult social care organisations are not always involved as system partners, and that smaller organisations or those with workforce issues can struggle to engage with wider system working.

Although inspectors and external stakeholders have seen large variation in the implementation and impact of primary care networks, they were seen as enabling primary care providers to work together to share resources and offer people better access to services – for example by offering extended opening hours and a wider range of appointments to meet people's needs. They also provide a basis for working with other organisations, achieving better access to social prescribing, pharmacists, physiotherapy and paramedic support.

1.5 Adult social care remained very fragile

For many years, we have been calling for a better funding settlement for adult social care. Last year, we warned that the continuing lack of a long-term sustainable solution for adult social care was having a damaging impact on the quality and quantity of available care.

Even before the pandemic, we said that the failure to find a consensus for a future funding model continues to drive instability in this sector, and we pointed to an urgent need for Parliament and government to make this a priority.

Previously the Competition and Markets Authority's market study into residential and nursing care homes for older people found that the current model of service provision cannot be sustained without additional public funding. Their analysis suggested that about a quarter of care homes had more than 75% of their residents funded by the local authority, and that these are the ones most at risk of going out of business. Many care homes are relying on higher prices charged to self-funders to remain viable, even when providing the same services.[6]

In March 2020, our Market Oversight report highlighted that, in the absence of mitigating action, any further shocks to the labour market would be expected to increase the existing level of market fragility, place more pressure on local authority finances and possibly increase unmet care needs.[7]

1.6 Some of the poorest quality services were struggling to make any improvement

Among the majority of care providers that are mostly good, some had improved from being rated as inadequate and requires improvement, including some of those in special measures. But there remains a small minority of underperforming services that have continually failed to improve.

While 6% of GP practices were rated as inadequate or requires improvement at 31 March 2020, there are 46 practices (1% of all practices) that have never been rated better than that. These practices equate to just under 294,000 people on practice lists who have never had access to care rated as good. In addition, there were 3% of practices (196) that have had one rating of good or outstanding but at 31 March had fallen back to inadequate or requires improvement – and these practices account for a total patient list size of more than 1.8 million people.

In adult social care, 3% of care homes (512 homes, covering nursing and residential homes and accounting for just under 23,000 beds) have never been rated better than requires improvement, and a further 8% (1,216) have had one good or outstanding rating but are currently rated as inadequate or requires improvement (accounting for just over 42,000 beds). For community social care 3% (212, providing services to more than 9,000 people) have never been rated better than requires improvement, and a further 5% (393, providing services to more than 18,000 people) have had one good or outstanding rating, before falling back to inadequate or requires improvement by 31 March 2020.

The special measures regime for NHS trusts exists to give them extra help and support to improve after they have been rated as inadequate. There have been 37 NHS trusts in special measures since they were introduced in 2013 – roughly one in six of the total number of trusts across those seven years. The support offered as part of special measures has largely been successful – of the 37 trusts, 32 have improved enough to exit special measures.

However, four of them deteriorated again and were put back into special measures at a subsequent date (Northern Lincolnshire and Goole NHS Foundation Trust, United Lincolnshire Hospitals NHS Trust, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, and Norfolk and Suffolk NHS Foundation Trust). As at 31 March 2020, there were nine trusts in special measures overall.

The time it has taken to turn around trusts has been longer than expected – the average time between entering and exiting special measures has been 27 months, and the longest time so far for a trust to be in special measures has been 57 months. It is clear that some of the problems holding back trusts are deeply embedded and that the fundamental changes and external support that are needed take longer than originally envisaged to bring about improvement.

1.7 There were significant gaps in access to good quality care

Across all sectors, some people were not able to access the care they need when they need it. Inspectors and external stakeholders have highlighted challenges in all sectors, including:

- Pressures on emergency departments due to local demand, often linked to access issues elsewhere in the system. For some people, A&E can be the way to get the care they need, either because it is more convenient than attending their GP surgery, they are not registered with a GP, or they are unaware of other services available.

- NHS trusts struggling to meet referral-to-treatment times – the total number of people waiting for treatment carried on rising, reaching 4.4 million in February 2020.[8] We heard about long waiting times for ophthalmology and people experiencing difficulties accessing cancer treatment, orthopaedics, dermatology, gynaecology and physiotherapy.

- Difficulties accessing child and adolescent mental health services, with long waiting times for those with neurodevelopmental conditions, and long waiting lists for children who have been sexually abused to receive counselling support.

- Difficulties across the country for people who need residential care with nursing – this was linked to workforce challenges, with the recruitment of nurses a particular challenge for the sector. A related issue is a lack of suitable provision for people with high support needs, including people living with dementia.

- Lack of access to high-quality, person-centred home care, especially in rural locations; a reliance on a few large providers in some areas poses significant risks if these providers struggle to meet demand.

- Long waits for social care assessments and support, and in some localities people only had access to poor quality services.

- General problems for people in getting routine GP appointments – there was a long-term decline in people saying it was easy to get through to the practice on the phone, from 81% in 2012 to 65% in 2020 [9] – and difficulties for some people with substance misuse or mental health issues in registering with a GP.

- Difficulties accessing NHS dental care, and the cost of dental treatment being a barrier to access for some people; and difficulties accessing dental care for people living in residential care settings and those in custody.

- Despite prompt assessment of acute need, poor access to secure mental health beds meant that adult prisoners remained in inappropriate custodial settings for prolonged periods, awaiting transfer.

Staffing issues in all regions have been a key factor affecting access to services. Inspectors and external stakeholders have heard about services competing for staff, with smaller services and those in rural or deprived areas facing particular challenges filling vacancies. Local factors can affect staff recruitment and retention, such as:

- higher rates of pay in London attracting people from neighbouring regions to work in the capital

- alternative opportunities in popular tourist spots during the summer affecting the social care workforce

- areas that do not have universities or training colleges nearby limiting the graduate recruitment market.

Recruitment to health services in the criminal justice and immigration detention sectors is particularly challenging, leading to high use of agency staff in many services.

People who use services and care professionals who shared their experiences with us through our online form have raised their concerns about low staffing levels in care homes. People felt that the safety and quality of care that residents in care homes experienced was reduced, as was their continuity of care when staff were leaving. The most recent data from Skills for Care shows how turnover rates for care workers and senior care workers have risen steadily over many years (figure 5).

Figure 5: **Turnover rates for key roles in adult social care, 2014/15 to 2018/19**
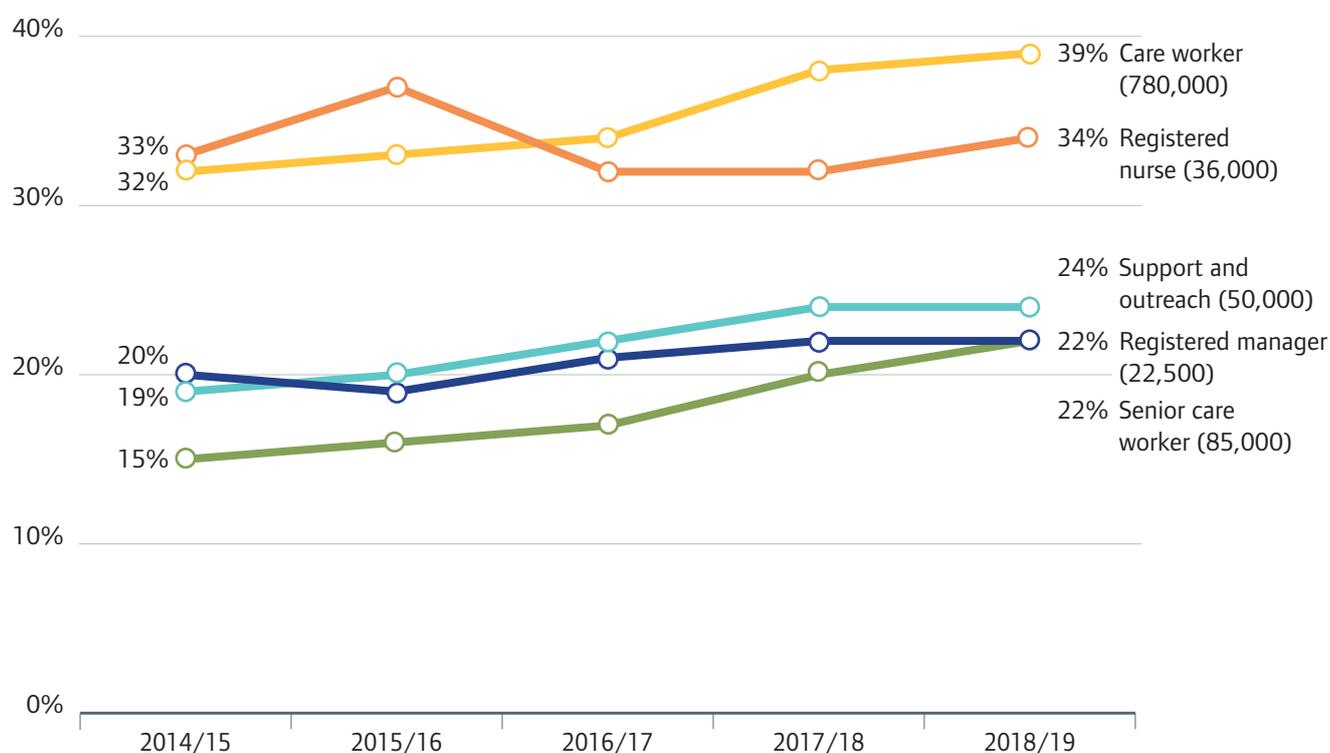
Source: Skills for Care - Recruitment and retention.
Numbers in brackets denote the total number of staff within that job role in 2018/19.

Issues around access to good quality care have also featured prominently in the experiences that people have shared with us through our online form. These included: problems for individuals struggling with poor mental health in accessing appropriate support, especially in the community, leading to a further decline in their wellbeing; issues with being able to book suitable primary care appointments, leading to a loss of confidence in services; and people being left frustrated and in pain when they struggled to access the right medical care and treatment. Also prominent in the experiences people have shared with us have been in adult social care services, with issues around poor personal care, hygiene and nutrition, and injuries such as fractures and pressure sores caused by poor care.

In the face of these challenges, we did hear about a range of positive initiatives to improve access to care. For example:

- In general practice: extended opening times, care navigators, advanced nurse practitioner-led services, increased use of telephone and video appointments, social prescribing schemes, and GP practices actively engaged in outreach work.

- In dental care: a mobile surgery visiting a children's home to help young people overcome their fear of seeing a dentist, and using oral needs analysis to secure more funding and improved access to dental care in prisons.

- In hospitals: work to reduce demand on emergency departments, including GP triage, and to improve access for people with protected equality characteristics and those in vulnerable situations, for example clinics for sex workers.

- In mental health care: GP practices commissioning in-house mental health services, and upskilling police officers to signpost people to appropriate local services.

- In adult social care: multidisciplinary collaboration including contracts between care homes and GPs to make GP access easier in residential care and nursing home settings.

- For children and young people: digital services that are proving beneficial for mental health and wellbeing by providing access to online counselling or therapeutic input, and face-to-face drop-in services for young people.

A fundamental change is needed for people with a learning disability and autistic people who need complex care

In our work looking at the use of restraint, seclusion and segregation in care settings for people with complex needs, it was clear that for people in segregation creating a package of care to meet their individual needs was often seen as too difficult to get right and they had fallen through the gaps.

Not getting the care and support in the community when people needed it started at a young age. This lack of support in the community often led to people becoming increasingly distressed. When people reached 'crisis point',

hospital was often the only option left – but hospital wards are not therapeutic environments for people with a learning disability and/or autistic people.

Complex commissioning arrangements and poor communication between providers and commissioners could lead to delays in identifying suitable community care or getting the care package ready. These delays and failed placements could lead to a deterioration in people's wellbeing and behaviour. As a result, people could find themselves being moved into more secure and restrictive environments, and could lead to them becoming 'stuck in the system'.

It is possible to, and we as a system can, do much better. We will be publishing the full findings from our review in October 2020 and we will be calling for immediate and tangible progress to be made.

Much better access was needed to mental health care and support

We have previously highlighted the difficulties that some people have had in accessing the right mental health care and support at the time they need it. Alongside this State of Care report, we are updating on three pieces of work that show there was limited progress in improving access for people.

- **Inpatient rehabilitation services**: From 2017 to 2019, there had been only a small increase in the number of people receiving inpatient rehabilitation care close to home, and too many people continued to be sent far from home for treatment. People being cared for by independent providers were still staying longer in hospital, and were further away from home, than those in NHS services.

  We remain concerned at the high number of wards that continued to identify as 'locked rehabilitation' – this is against the least restrictive principle that mental health services should apply and potentially represents a breach of human rights.

- **Children and young people's mental health care**: In following up the 2018 recommendations for local action that we made about access to mental health care for children and young people, we found that these were being implemented in varying degrees in the health and wellbeing areas who responded to our self-assessment questionnaire. For example, while our findings indicated there was stronger prevalence of joint commissioning, almost one in five local health and wellbeing boards reported back that there was no joint commissioning of support for teenagers and young people as they move to adult services.

- **Mental health care in acute trusts**: Between September 2017 and March 2019, we looked at how well NHS acute trusts were meeting the mental health needs of people – in emergency departments, acute medical wards, maternity wards, and children and young people's services. Staff we met were caring and working very hard in challenging circumstances, but often they felt unsupported and unprepared to care for the mental health needs of their patients. We found that mental health training for staff varied across the trusts.

A lack of availability of community crisis services meant people were frequently left with no other option than to attend the emergency department. Once in hospital, we found that there was poor coordination and joint working between acute and mental health services, with delays in assessments and securing beds.

Patients were not always provided with a safe, therapeutic environment. Every hospital emergency department should have a dedicated room that is equipped to provide a safe and private environment for psychiatric assessments. The safe rooms we saw did not always meet these standards. We also found that people in crisis were not given information about when they would be seen, or how long they would have to wait for an assessment or admission to hospital.

1.8 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) legislation is in place to protect people in care homes and hospitals who may need to be deprived of their liberty. The safeguards help to ensure that the correct process is used to protect people's human rights if they lack the mental capacity to consent to the arrangements for the care they need, are under continuous supervision and control, and are not free to leave.

As a part of the Mental Capacity Act 2005 (MCA), the safeguards help to ensure that some of the most vulnerable people using services are protected, while ensuring that a decision to deprive someone of their liberty can only be made through a legal process. Decisions made for a person lacking the relevant capacity by using the MCA should always use the best interests decision-making processes, consider the less restrictive option, and carefully balance respect for the person's wishes and feelings with the need to keep them safe.

In last year's State of Care report, we highlighted our concerns about the level of services' awareness and understanding of the DoLS legislation, and that this was a primary reason for poor practice.[10]

Research we carried out before the start of the pandemic showed that there had been some improvements since last year. Where improvements had been made, the following were key:

- Safeguarding action was taken where our inspectors raised concerns.

- Management showed accountability, took ownership of poor practice, and carried out a reassessment of care planning to determine how relevant and appropriate decision making had been.

- In response to previous training concerns, management scheduled in new training or refreshers specifically related to DoLS and the MCA.

- Management were able to show that they had implemented lasting improvements – examples included new systems to track applications, and introducing new or streamlined forms and protocols to ensure compliance.

However, despite years of the legislation being in place, there is still huge variation in understanding and practice, and in the quality of training. We found several possible explanations behind this variation, including the amount of support given to a service from the local authority, and specific geographic arrangements of care providers. We also found that working age services for people with a learning disability in adult social care and hospital settings often had a better understanding of DoLS compared with services for older adults, and staff in these services also had a better understanding of broader mental capacity issues.

For example, staff in hospital-based mental health services for older adults did not always know when DoLS can be applied – assuming it should only be used, for example, if a person was actively trying to leave the service. In fact the main criteria for determining if a deprivation of liberty is occurring is whether the person (assessed as lacking capacity to consent to the arrangements for their care) is under continuous supervision and control; and not free to leave, regardless of whether they are actually trying to do so – the 'acid test'. The question to be asked is: what would staff do if the person did try to leave?

In other instances, despite DoLS being in place for many years, many providers still did not understand what a good quality mental capacity assessment and best interest decision looks like.

Where we saw examples of good practice in care homes, staff showed a good understanding of the legislation in practice. This included always seeking people's consent before carrying out their caring duties; supporting people to make decisions to the best of their ability (for example through non-verbal communication); and when people lacked mental capacity for a certain decision, providing care in line with their best interests.

We found that the type of service sometimes reflected the amount of positive risk taking that staff were prepared to make. In working age learning disability services, it was noted that staff were often more willing to take more positive risks than those in services for older adults. In addition, those staff had access to wider communication methods, tools and systems to help enable and support people to make their own decisions.

We found that training remains an area of concern, with huge variety in its quality. Training did not always consistently provide staff or services with the understanding, level of awareness or practical knowledge to effectively embed learning into practice. There had also been very little innovation in training, with expectations that the training will be outdated with the introduction of the replacement system for DoLS, the Liberty Protection Safeguards.

Where there was good quality training, it was often characterised by a focus on 'real-life' and practice-based examples, rather than generic learning modules. Simplifying legal terms, and discussing DoLS in an accessible and relevant way, helped staff to better understand and apply what they had learned for the people they cared for. Collaboration with local authorities and other bodies (such as forums) had also facilitated good training and improved awareness of DoLS in services, but it was apparent that this is not widespread practice.

The relationship between providers and local authorities is critical in the DoLS process. Inspectors told us that providers' engagement with local authorities was mostly focused on DoLS application status. Set against a context of continued delays and backlogs, there were concerns that providers were not effectively escalating applications when needed. Some people using services were being treated like they had an authorised DoLS where there had only been an application.

1.9 Inequalities in care persisted

In last year's State of Care report, we spoke about how high-quality care was not always as easily accessible to people with some protected equality characteristics.[11] Many of the same quality and accessibility issues continued in 2019 and into 2020. In the 2019 adult inpatient survey, which asked more than 75,000 people about their experiences at acute NHS trusts, people with dementia, people with mental and behavioural conditions, and younger adults in the 16-35 age group all consistently reported poorer experiences of care than others.[12] Separately, data from NHS Digital showed that people in the most deprived areas of England were almost twice as likely to visit A&E as those in the least deprived areas in 2019/20.[13]

Navigating the complex health and social care system, and the services within them, is not always easy. This is partly because different services work individually, rather than in partnership. This affects people with some protected equality characteristics more negatively than others, and puts those whose preferred language is not English (including British Sign Language users) at a disadvantage from the beginning, as information about services and how to navigate care pathways is not always accessible to them and interpretation services are not always available.

We have heard from inspectors and external stakeholders of considerable variation between different areas and services in how well they consider the needs of people from different groups – particularly people from Black and minority ethnic (BME) groups, people from religious groups and disabled people. We also heard that the needs of people experiencing homelessness, prisoners, and people who experience distress that leads to behaviour that services find difficult, may not always be adequately planned for.

As well as for people using services, inequality affects staff working in the health and social care system. For people who work in the NHS, the Workforce Race Equality Standard (WRES) and the Workforce Disability Standard (WDES) give us information about how people from BME backgrounds and disabled people fare in their workplaces, compared with their white and non-disabled colleagues.

Nationally, there has been a variable amount of change in the key WRES indicators over the four years of annual WRES reports.[14] Figure 6 shows that there has been marked improvement in some areas, such as BME board membership and equal treatment in whether staff from BME groups and white groups enter disciplinary proceedings. For other indicators, such as those concerned with harassment and discrimination at work, there has been a slight decline for staff from BME groups.

Figure 6: **Percentage change in key Workforce Race Equality Standard (WRES) trends, 2016 to 2019**
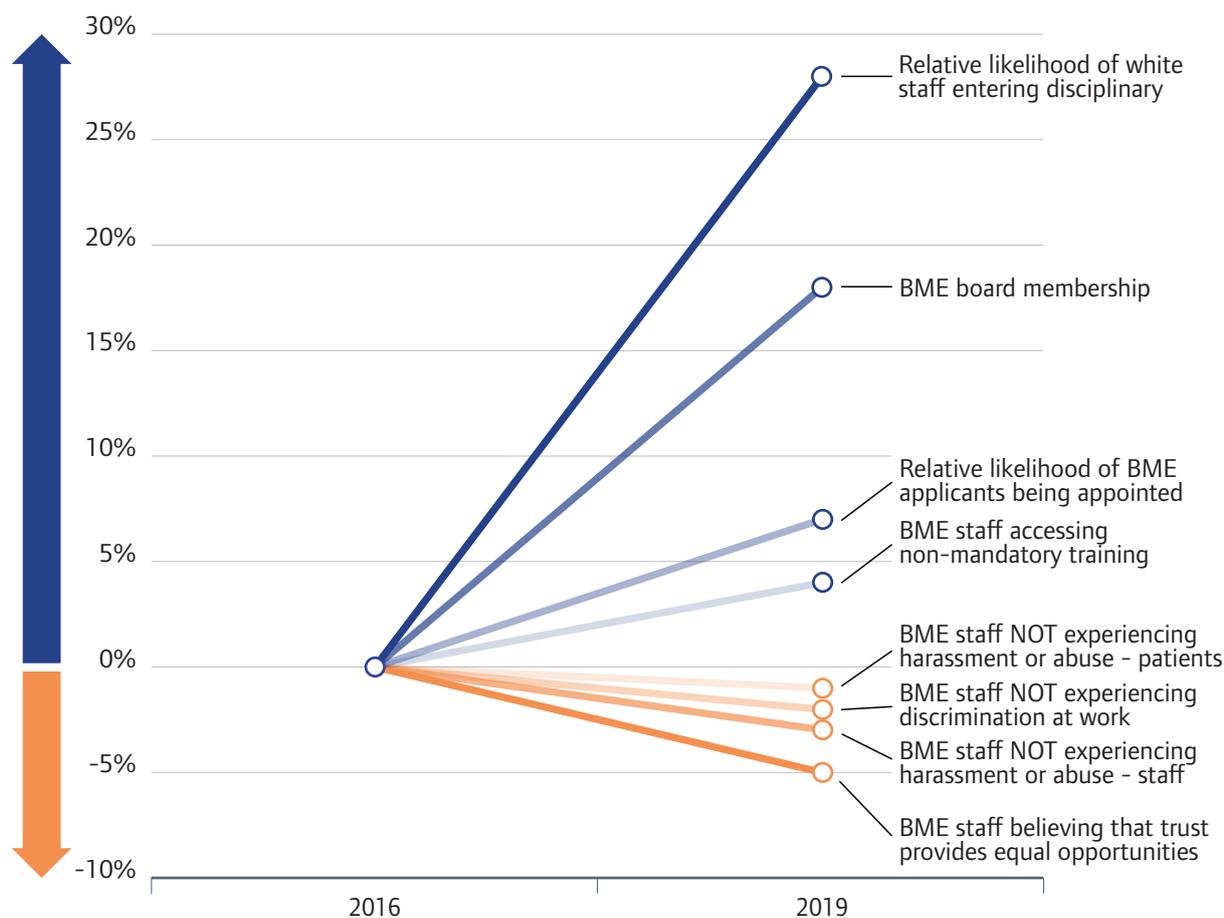
Source: NHS England, NHS Workforce Race Equality Standard - 2019 Data Analysis Report for NHS Trusts.

WDES is a newer standard, and this is the first year we have reported on it here. The NHS England 2019 annual report on WDES showed that disabled people felt less valued, were less likely to be appointed during recruitment, had lower engagement scores, and felt they were less likely to be considered for promotion than non-disabled people.[15] Disabled people were found to be more likely to be subject to bullying, abuse and harassment, pressured to work when unwell, or subject to formal capability processes than their non-disabled colleagues. Disabled people are under-represented on boards.

We are committed as a regulator to consider workforce equality in our assessment of whether trusts are well-led, so we were pleased to see that NHS England and NHS Improvement have also emphasised their ambitions in this area. In July, they published an update to their people plan, which sets out their plans to improve inclusive employment practices and develop better support for the wide variety of people who work in the NHS.[16]

2. The impact of the coronavirus pandemic

Key points

- As the pandemic gathered pace, health and care staff across all roles and services showed resilience under unprecedented pressures and adapted quickly to work in different ways to keep people safe.

- In hospitals and care homes, staff worked long hours in difficult circumstances to care for people who were very sick with COVID-19 and, despite their efforts to protect people, tragically they saw many of those they cared for die. Some staff also had to deal with the loss of colleagues to COVID.

- A key challenge for providers has been maintaining a safe environment – managing the need to socially distance or isolate people due to COVID-19. Good infection prevention and control practice has been vital.

- The crisis has accelerated innovation that had previously proved difficult to mainstream, such as GP practices moving rapidly to remote consultations. The changes have proved beneficial to, and popular with, many. But many of these innovations exclude people who do not have good digital access, and some have been rushed into place during the pandemic.

- The pandemic has had a major impact on elective care and urgent services such as cancer and cardiac services, and there is huge pent-up demand for care and treatment that has been postponed.

- The pandemic is having a disproportionate effect on some groups of people, and is shining a light on existing inequality in the health and social care system. It is vital that we understand how we can use this knowledge to move towards fairer and more equitable care, where nobody's needs go unmet.

- It is important that the learning and innovation that has been seen during the pandemic is used to develop health and social care for the future. New approaches to care, developed in response to the pandemic and shown to have potential, must be fully evaluated before they become established practice.

2.1 The impact on people

During February and March 2020, COVID-19 emerged as one of the greatest public health crises that the UK has faced for 100 years. In the space of a few short months, the pandemic placed the severest of challenges on the whole health and care system in England. A crisis so widespread and fast in its impact was always going to test the resilience and responsiveness of the system like never before.

In this report, written as we started to leave the initial crisis phase of the pandemic and begin to think about how we learn to live with the virus for some time to come, our focus is on the impact it has had on health and adult social care services, their staff and the people using them. We do not consider the overall handling of the pandemic itself. However, at a time of rapid response, we take the opportunity to emphasise the learning and improvement that has taken place across the system.

The impact of the pandemic was starkly shown through the tragic increase in deaths in April, May and June. As well as the deaths from confirmed or suspected COVID-19, there appears to have been an increase in other deaths compared with the average of the last five years (figure 7). Deaths overall had returned to their average rates by the end of June.

Figure 7: **Number of deaths registered by week, England and Wales, 28 December 2019 to 28 August 2020**

● Non COVID-19 deaths 2020   ● COVID-19 deaths 2020   — All deaths five-year average
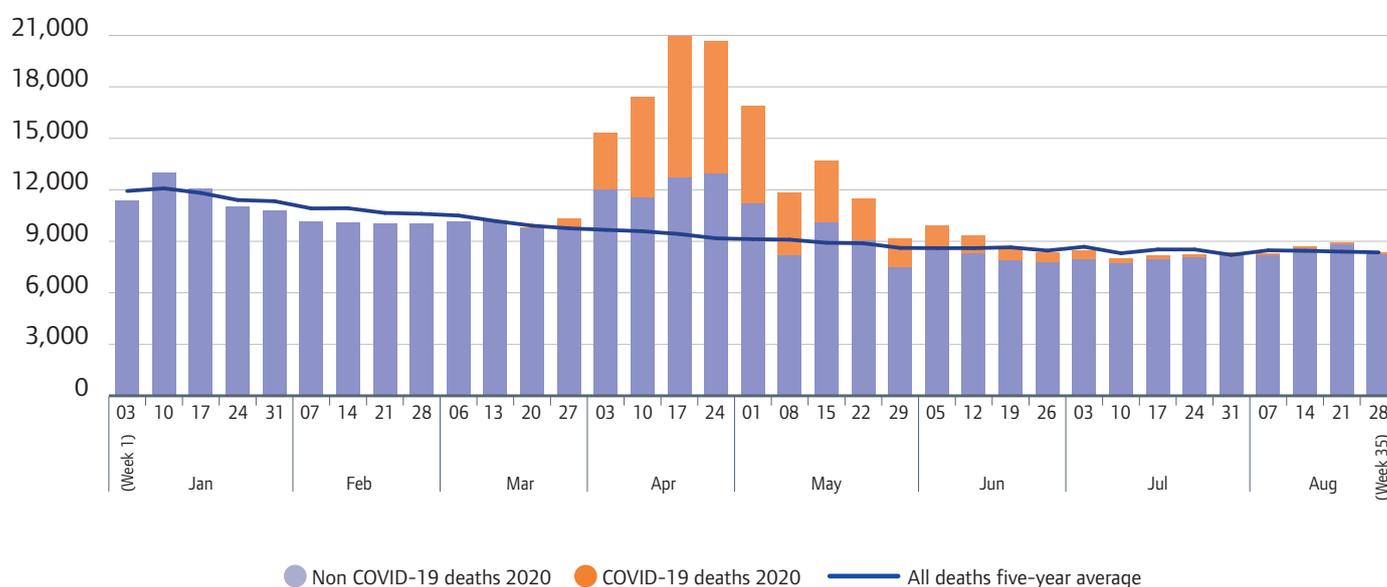
Source: Office for National Statistics, Deaths registered weekly in England and Wales, provisional, week ending 28 August 2020.

For people receiving care in adult social care services, the pandemic has been particularly severe. The Office for National Statistics published a report in July that highlighted the particular impact of COVID-19 on people in care homes. The number of deaths of care home residents occurring in England and Wales from 28 December 2019 to 12 June 2020 (registered up to 20 June 2020) was

93,475; this was 29,393 more than the same period last year, a 46% increase. Of these deaths, 19,394 mentioned "novel coronavirus (COVID-19)", which was 21% of all deaths of care home residents.[17]

At the beginning of the pandemic, more deaths involving COVID-19 among care home residents occurred in a hospital setting; but from the beginning of April, deaths of residents in the care homes increased more rapidly, becoming much more prevalent and highlighting the terrible burden that care homes faced (figure 8).

Figure 8: **Number of deaths of care home residents involving COVID-19 by place of death from 2 March to 12 June 2020, registered up to 20 June 2020, England and Wales**
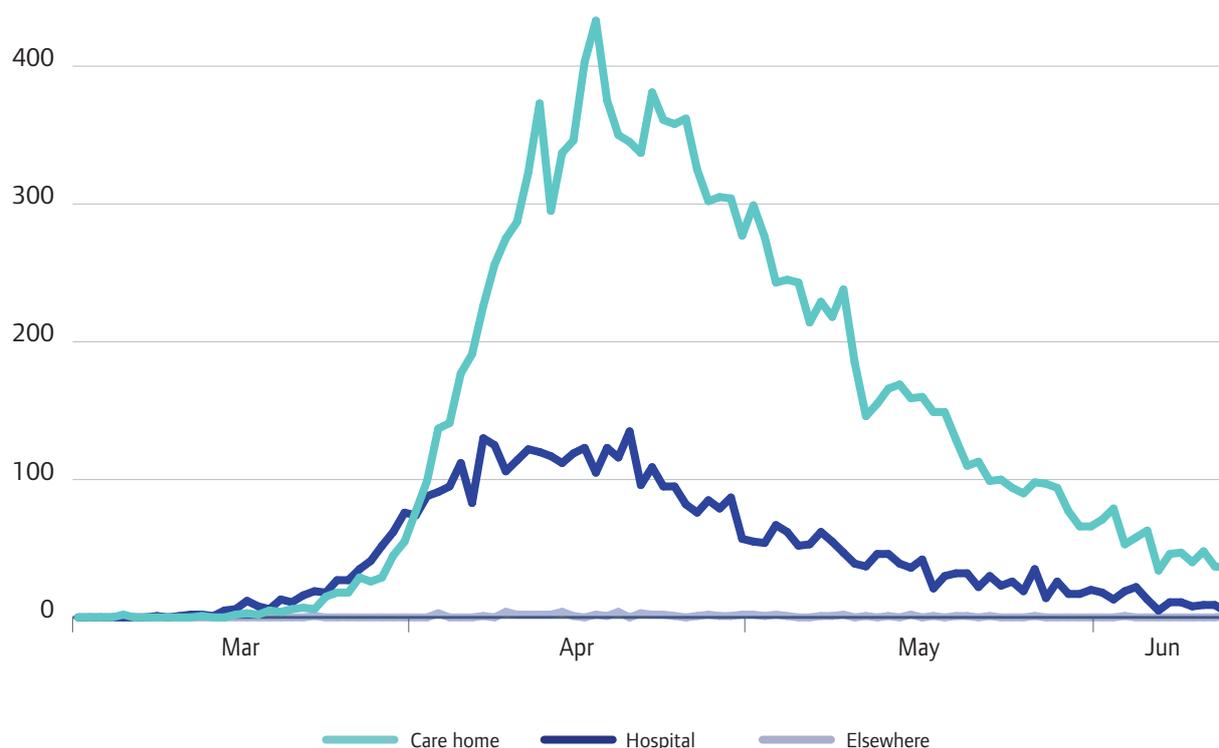
Source: Office for National Statistics, Deaths involving COVID-19 in the care sector, England and Wales.

The Office for National Statistics also reported that the decline in COVID-19 mortality from mid-June brought weekly deaths in hospitals and care homes down to average levels. However, deaths in private homes remained at 30% to 40% above what would normally be seen. Over the course of the pandemic as a whole, the proportion of deaths occurring in hospitals has been lower compared with the same period in previous years (40% versus 47%). The proportions of deaths occurring in care homes and private homes increased.[18]

The virus has had a disproportionate impact on care for older people. Very quickly, care homes stopped visits from family and friends to try and control the virus, which prevented a crucial source of emotional support for older people. Measures in place to try and prevent the spread of the virus within homes had a huge impact on people, with some residents confined to their rooms, social events cancelled, and shared areas in the home – such as dining rooms and lounges – closed due to physical distancing.

Relatives were worried about how their older relative receiving care would cope without the regular support of friends and family, and the impact on people not being able to visit partners or spouses during lockdown has increased loneliness and stress.

Adult social care providers and staff have had to balance the priority of reducing the risk of COVID-19 transmission in services with the importance of maintaining a focus on the needs and rights of individuals in their care. Many services have used creative solutions to maintain social contact while still observing physical distancing, as shown in the care home example below.

Maintaining safe social contact during lockdown

We spoke to Sarah, whose mother, Lesley, has Alzheimer's disease and lives in a specialist dementia unit at a care home. Lesley is cared for by specialist nurses and care assistants, as well as support from a dementia consultant several times a year and her GP when needed. Sarah and other family members used to visit Lesley frequently, and they feel that Lesley is happy in her home and receives good care from the friendly and helpful staff.

Earlier this year, the home where Lesley lives had some cases of COVID-19, and decided to go into lockdown before the official government advice came out. Sarah was supportive of this, although it meant she was no longer able to visit her mother, because she understood the actions were being taken to keep people safe.

Sarah and her family called the home every day to check how Lesley was doing, and the staff were always happy to provide an update and support Lesley to speak to her family directly over the phone. When it became clear that lockdown was going to last for a longer period, the care home arranged for video calling between the family and Lesley, and supported Lesley to use this. The staff noticed that Lesley would offer her family tea and cake over the video call, and suggested to Sarah that they arrange to call at teatime, so they could all have tea and cake together. They arranged a special tea at Easter, and decorated an Easter bonnet for Lesley to wear.

When lockdown measures started to ease, the care home arranged for garden visits so that Sarah and other family members could see Lesley in person. Staff made sure that safety measures were in place, such as providing gloves and masks, allowing one visitor at a time, and keeping to physical distancing advice.

During lockdown, Lesley's consultant from the hospital was able to carry out her quarterly assessment by video-link, and later commented that he was impressed with how well the staff knew Lesley's condition and the level of detail they were able to provide.

Sarah told us that she "could not fault the care that [Lesley] had been given by the staff pre and during COVID". She is fully confident and it helps to know that her mother is being so well cared for in these difficult times.

Some homecare services faced a significant challenge in maintaining continuity of care for the people they looked after. Our first COVID-19 Insight report highlighted that, in early May, agencies that submitted data to our tracking survey had on average 9% of their staff absent because of the impact of the coronavirus.[19]

Homecare staff responded to the COVID restrictions by introducing new ways to keep people safe during the pandemic, while maintaining contact with their loved ones – for example by sending videos, photos and regular, reassuring emails to family members through the registered manager. Staff at another homecare agency delivered letters from pupils at a local primary school. One recipient said, "I started the day feeling really fed up, but when my letter arrived, it really brightened my day and I now look forward to writing back."

A forthcoming report by the Think Local Act Personal Insight Group, which has key partners from across the social care and support sector (including CQC), highlights the importance of good communication and willingness to engage with people and families, together with a commitment to maintain personalised approaches to care and support.

Mental health care

The pandemic has had a significant impact on many people's mental health and wellbeing. Healthwatch England highlighted what they had heard from people about the negative impact – loneliness and social isolation, bereavement, employment and financial stress, and anxiety about their health all played a part. Some autistic people were feeling more anxious due to not being able to follow their usual routines. Healthwatch England described the effect that the reduction in services had on people, and that people wanted more regular, consistent support by phone or face-to-face contact – particularly if they were close to crisis point.[20]

For people with severe mental health conditions, we have seen examples where COVID-19 has resulted in delayed discharges into community placements, and also of community placements no longer being available, for example care homes and residential schools being closed to admissions.

There was an increase in calls to CQC's helpline about, or from, people detained under the Mental Health Act – often expressing distress or confusion about why people were more likely to be confined to their rooms rather than being able to move around freely. Of the eight mental health services we inspected by mid-June since pausing routine inspections, five were as a direct result of concerns raised with us by staff or members of the public.

From our monitoring carried out since the start of the pandemic, we have found some examples of mental health providers giving good support to their patients. These include:

- Helping people to access family and friends and informal support networks, by providing them with digital devices for video calling and contact. Patients have been very appreciative of this where it has been done well.

- Providers proactively arranging for advocacy services to be brought into wards in a remote way, for example by 'walking' an advocate round a ward on a tablet screen to engage patients 'on the spot'. Some face-to-face advocacy meetings are now taking place.

- Providers arranging remote contact with other support services, for example interpreters.

- Providers arranging for family members to be involved in care planning meetings.

In hospitals, we saw examples of patients' leave being cancelled or restrictions placed on their movements, as well as limits on visits from friends and family, in line with government COVID-19 advice. Cancelled leave and restrictions on movements, including visits from loved ones, can increase the risk of closed cultures developing.

We have seen examples of services managing this challenge well, with increased mobile phone access and the use of video calling. However, some patients have expressed concern that restrictions on communicating with families will increase once the crisis is over. We will continue to work with services to challenge any increase in restrictions.

Reduction in healthcare activity

At the beginning of the pandemic, there was a substantial drop in the number of new referrals to treatment (figure 9), falling from 1.6 million in February 2020 to less than 500,000 in April, a fall of 69%. Since then, the number of new referrals has risen each month, reaching almost 1.2 million in July.

In addition, the length of time that patients were waiting for a diagnostic test rose sharply. At the end of May, more than 571,000 patients (58% of the waiting list) were waiting at least six weeks for a diagnostic test. This was a substantial increase since the end of March, when 10% were waiting at least six weeks.[21]

Figure 9: **Referral to treatment times: monthly number of new referrals ('clock starts'), November 2015 to July 2020**
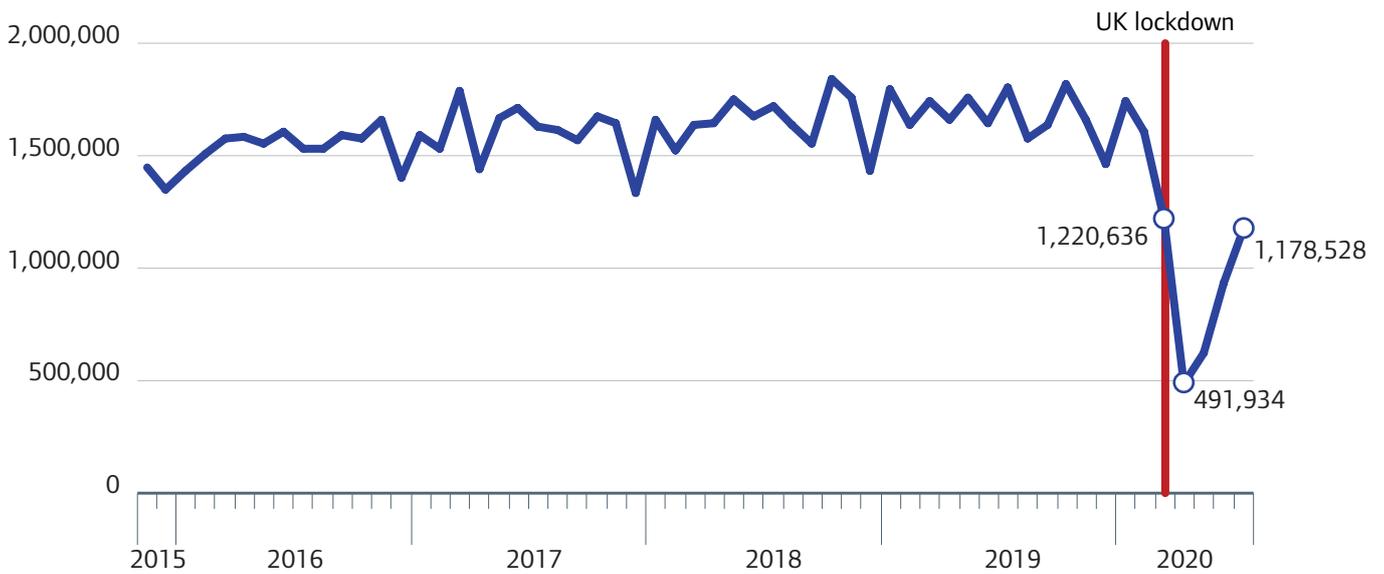
Source: NHS England, Consultant-led referral to treatment waiting times.

At the same time, treatment for patients also fell substantially: the number of admitted patients starting treatment fell to just over 41,000 in April 2020, while for patients on non-admitted pathways the number starting treatment fell to a low point of just over 505,000 in May. In both instances these were the lowest they had been since at least April 2015, although activity has subsequently recovered somewhat (figure 10).

Figure 10: **Referral to treatment times: monthly number of treatments started ('clock stops'), November 2015 to July 2020**


Non-admitted pathways — Admitted pathways
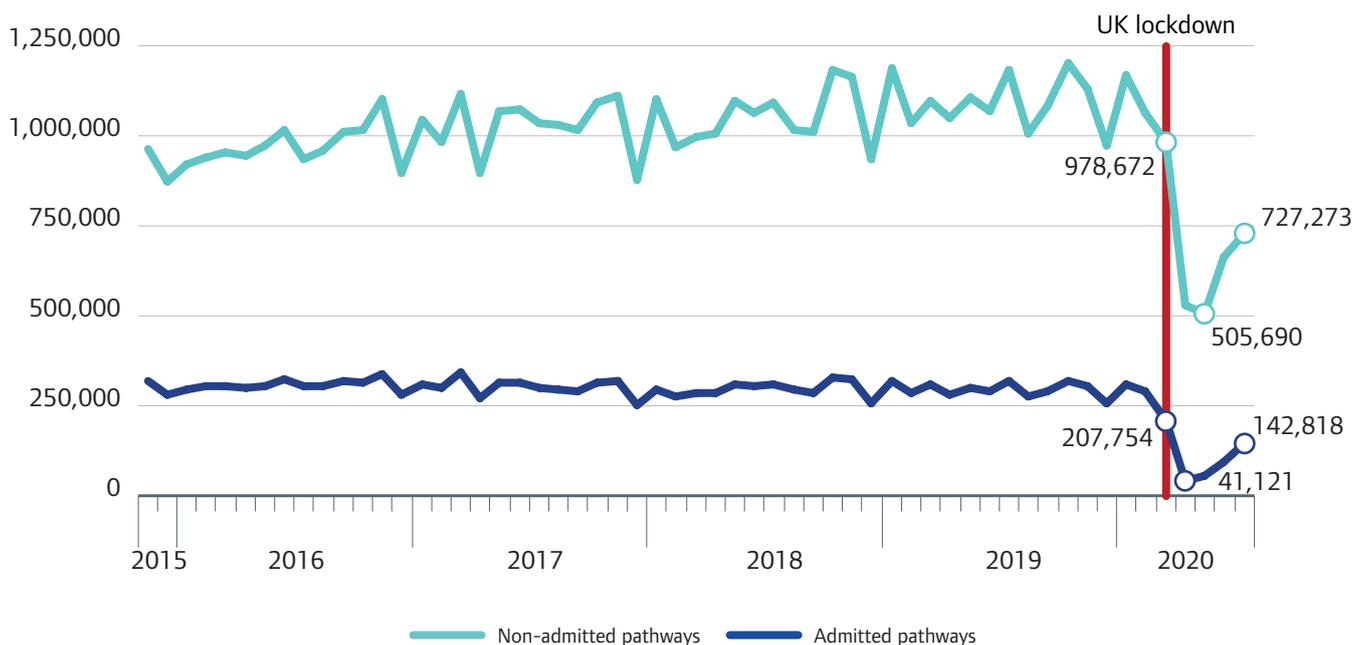
Source: NHS England, Consultant-led referral to treatment waiting times.

As a result, the length of time that patients were waiting for treatment increased substantially. The proportion of patients who had been on the waiting list for more than 18 weeks increased by 36 percentage points between February and July 2020.[22]

Cancer services were significantly affected. There was a 58% fall in the number of cancer referrals to acute trusts in April 2020 compared with April 2019. And despite the fall in referrals, the proportion of people seen within two weeks of referral also fell sharply, with no region meeting the 93% standard in April 2020 (figure 11), although there has been some recovery since then.

Figure 11: **Percentage of patients waiting less than two weeks from GP urgent referral to first consultant appointment, all cancers, April 2019 to July 2020, England and regions**
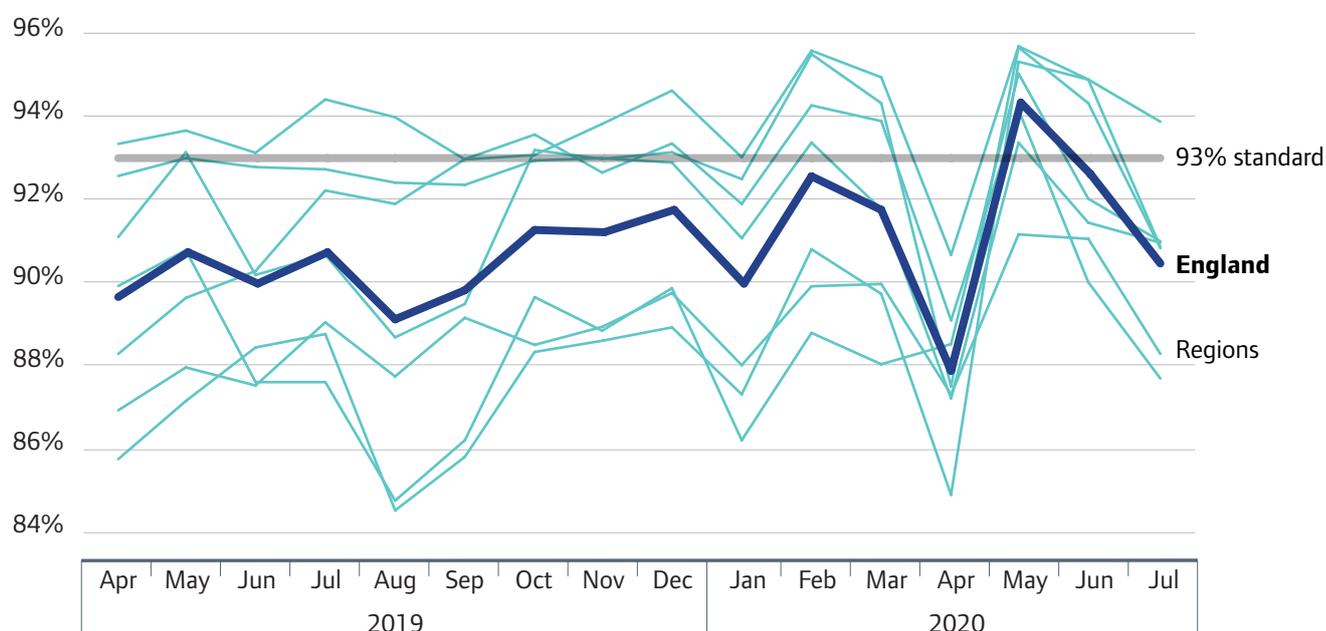
Source: NHS England, monthly cancer waiting times.

However, for those already with a cancer diagnosis, the rate at which patients started treatment within the target 31-day period was largely maintained.

In June 2020 Cancer Research UK highlighted the impact of pausing cancer screening, noting the increasing backlog. At 10 weeks after the introduction of lockdown, they estimated there were 2.1 million people waiting for breast, bowel or cervical screening.[23] Delays in screening reduces opportunities to detect cancers at an early stage, and increases risk for people.

We saw a similar decline in people accessing urgent and emergency care, with 57% fewer people attending urgent and emergency care in April 2020 than in April 2019. Since then, attendances have started to rise again, by August reaching more than 1.7 million (up from just over 0.9 million in April), but this was still 19% lower than 12 months previously (figure 12).

Figure 12: **Total monthly attendances at all A&E departments, August 2015 to August 2020**
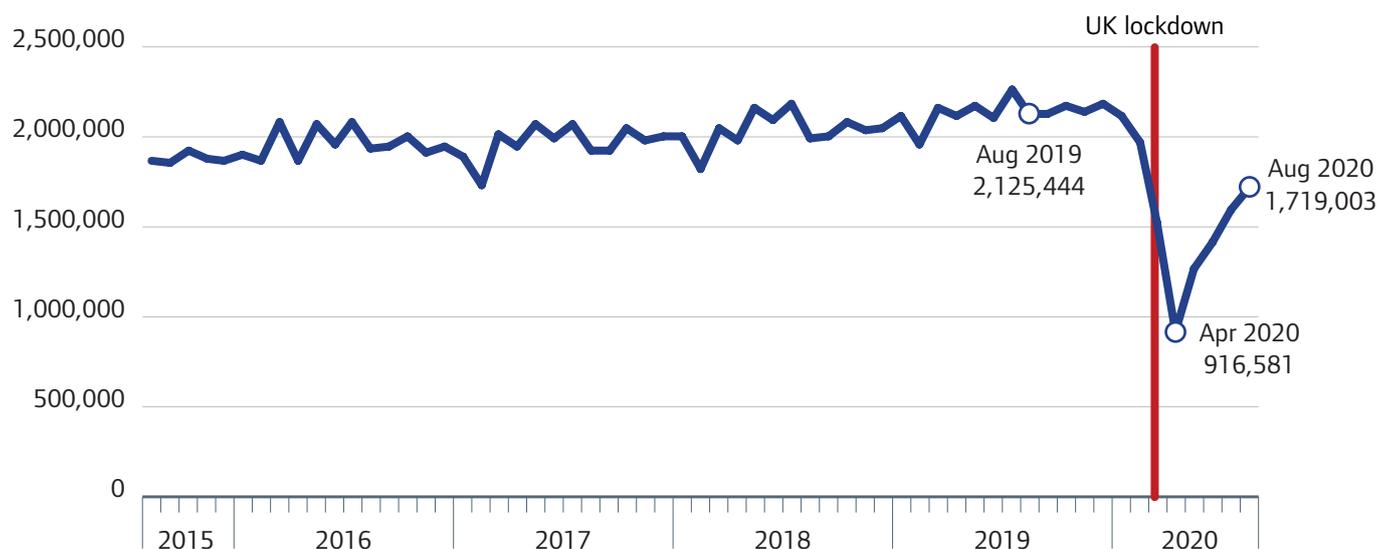
Source: NHS England, A&E attendances and emergency admissions statistics.

Urgent primary medical care services

The pandemic has raised significant challenges for urgent primary medical care services, such as NHS 111, urgent treatment centres and out-of-hours services. Similar to other services, they had to adopt strict infection prevention and control measures to protect staff and people who use services, including the need to socially distance. Many staff switched to working remotely, where possible, to ensure that people can continue to receive safe and effective services. To support this, leaders have provided them with the appropriate technology and training.

There was a large spike in demand at the start of the pandemic – more than a million extra calls to NHS 111 in England – in response to the public campaign to highlight the need to contact 111 first with any concerns. Calls almost doubled in March compared with preceding months, before falling back to more normal levels in April.[24] To keep up with demand, providers of NHS 111 had to speedily recruit and train new staff, including call handlers, which often meant bringing staff offline to support training. This then led to a build-up of calls. Additional staff were mostly staff redeployed from other parts of services, which meant that once the crisis was over, and demand returned to pre-COVID levels, many services lost this additional resource.

We know that during the early stages of the pandemic, there was a lot of confusion surrounding many health and care services and how and when people should access them. We have also heard of examples of people needing an urgent primary care service being passed around different services or unclear of who to contact to get the care they needed – many of whom were people who did not show COVID-19 symptoms but needed care for other urgent illnesses.

Inpatient survey

We commissioned a survey of hospital inpatients to find out about their experiences during April and May of 2020, when the first wave of the pandemic was at its height. Overall, most patients reported positive experiences of care, as has been found in previous adult inpatient surveys.

Most patients overall (83%) said they felt safe from the risk of catching COVID-19 in hospital, though those who were diagnosed while in hospital were the group who felt least safe (68%), when compared with those who did not receive a COVID diagnosis (84%).

Perhaps unsurprisingly, people with COVID while in hospital reported consistently poorer experiences than those who didn't have COVID. The most pronounced differences were during discharge and when thinking about care after leaving hospital. When leaving hospital, 33% of people with COVID did not know what would happen next with care, compared with 18% for people without COVID. Of those discharged to a care home, 37% said they did not know what would happen next with their care after leaving hospital, up from 25% in 2019. Higher rates were also seen for those with a learning disability or a mental health condition.

Oldest patients (75+) were much less likely than other age groups to say they kept in touch with family and friends while in hospital. Patients with pre-existing long-term conditions, those with Alzheimer's, or who were blind or partially sighted said they were also less likely to have kept in touch with others.

Dental care

At the end of March, dental practices were advised to suspend all routine treatment, as part of plans to prevent the spread of coronavirus. NHS regions were instructed to set up local urgent dental care centres to help people with emergency dental problems. This caused a lot of access problems nationally. Some areas were quick to respond due to already well-established system relationships; others took more time. Some dental practices provided care in the absence of urgent dental centres.

Healthwatch England has highlighted how, while routine appointments were on hold, people did not know how to access emergency dental care – causing them stress while experiencing acute dental pain or other serious symptoms. In June, as dental practices started to reopen for routine appointments, they heard that the information being provided from some services was inconsistent or confusing, leaving people unsure about whether they were running again, and what treatment would be available.[25]

Dental practices have needed to modify their methods of delivering care to account for the need of social distancing and enhanced PPE for staff. Following some clinical procedures, the treatment room has to be left 'fallow' before cleaning to reduce the risk of transmission of COVID-19. This has resulted in a large reduction in treatment capacity for practices and it is likely to be some time before full capacity is reached.

Community health services

At the start of the pandemic, many community health services quickly adapted their delivery model to offer access to services by telephone, video or internet to ensure that access could be maintained. For example, sexual health services moved to a booked online service and this received positive feedback from people using services and health professionals.

District and community nursing teams have also explored options for working remotely but there is a need to be mindful that this may not work for everyone. This is particularly apparent in services for children and young people where reduced contact with families has led to a concerning decrease in referrals for support.[26] Redeployment of staff in these services to support the pandemic response also increased the case load for health visitors and this has impacted on the ability of community health services for children to provide safe and effective care.

Community health services are likely to be a key player in supporting the COVID recovery. While there is a strong emphasis on rehabilitation in the community, community hubs and cross-sector multi-disciplinary team working, the challenge for the workforce will be to manage the complexity of COVID rehabilitation while at the same time restarting discontinued services, dealing with a backlog of non-COVID cases, and not suffering poor health as a result of increased workload.

Services for children and young people

The pandemic caused disruption and changes to healthcare provision and access to services for children, young people and families. Services responded rapidly, aiming to balance requirements for continued provision with the call to support the broader health and care system. The full and long-term impact of responses and arrangements for children and young people are yet to be fully understood.

Children and young people presented less frequently to the urgent and emergency healthcare system compared with pre-pandemic times. This meant that those children and young people who did attend for emergency care were more acutely unwell at the time of presentation than might have previously been expected. Some acute services diverted children and young people from emergency departments to be assessed in the children's ward.

There was a substantial reduction in referrals for mental health services at the start of the pandemic (the number in April 2020 was 41% lower than in April 2019). The low referral rate is a likely consequence of children not attending GPs, school or accessing school nurses, who are the primary referrers (indeed, the number of referrals from primary healthcare fell by 63%).[27] The reduction in activity is likely to lead to longer waiting times for assessments and specialist interventions, including access to inpatient beds, as services work to catch up. Until the long-term impact of reduced or delayed referrals is understood, there remains a risk that children may be suffering without support and experience further deterioration in their mental health.

School-based immunisations were suspended due to school closures for most children. While the programme has restarted, the full recovery timeline for the

immunisation programme remains a challenge. Access to other areas of routine care proved a challenge for families, for example healthy child programme screening and access to dental care.

The absence of school for the majority of children and young people meant many were not able to access support services provided only through school. This was a concern for families of children and young people with complex health care needs, special educational needs and disability. Service provision was already varied across local areas. Reduced support resulted in increased pressure on families to meet those complex health and care requirements without their usual levels of support. Families and educational settings also struggled to access the necessary supplies for the provision of complex care, where responses to the pandemic had seen shortages for the system. We also heard that access to ongoing therapy interventions and support was difficult for families, as a result of the deployment of therapy professionals to other areas of the system response.

Accelerated digital approaches across the health system meant that children, young people and families were able to access virtual appointments and assessments. However, the drive for digital approaches, coupled with less contact with system-wide professionals and a reduction in the number of referrals for support seen at the peak of lockdown, means that there is a risk that not all children and young people were protected from harm through the crisis.

2.2 The impact on health and social care staff

As the pandemic gathered pace, health and care staff across all roles and services showed huge resilience in the face of unprecedented pressures and adapted quickly to work in different ways to keep people safe. They had to learn at pace about the new disease and how to care for people with COVID-19.

In hospitals and care homes, staff worked long hours in difficult circumstances to care for people who were very sick with COVID-19 and, despite their efforts to protect people, tragically they saw many of those they cared for die. Some staff also had to deal with the loss of colleagues to COVID. It took a substantial emotional toll on care staff, concerned as they were not only for the wellbeing of their patients and residents but also for their own families and loved ones, as they worked to understand the nature of the disease and protect people to the best of their ability.

For the first time ever, the NHS stopped the majority of its non-emergency services. The need to adapt quickly to manage demand and keep people safe became imperative. This was seen, for example, by the NHS responding to feared capacity issues with the rapid opening of five emergency, or Nightingale, hospitals. Two core services, critical care and end of life care, were at the forefront of managing the most seriously ill patients.

Emergency departments were reconfigured into streams to separate COVID and non-COVID patients; clinical expertise at the 'front door' increased, with improved access to face-to-face specialists; and there was closer working between departments, such as emergency department and radiology.

Through the height of the crisis, our inspectors contacted more than 80% of adult social care providers – more than 20,000 care homes – to better understand the impact of COVID-19, and to offer support, advice and guidance. We heard that care staff had to suddenly cope with a whole range of new tasks and take on aspects of care that they had never had to do before. The lowest paid staff had an enormous burden put on them. They had to care for large numbers of people faced with a new and complicated illness, understand complex guidance, and often be the only one to be with the person as they died, sometimes relaying families' messages of comfort to the dying person.

Adult social care staff themselves were additionally vulnerable: data from Skills for Care showed that a quarter of staff (340,000 people) were aged 55 or over, and 1.4% (18,500) of staff were aged 70 or over.[28] Data collected by Skills for Care showed that 7.5% of working days were lost to sickness (including self-isolation and shielding) up to August 2020 during the COVID-19 period, compared with 2.7% pre-COVID-19.[29]

GP practices and other primary care services have made a rapid transformation in response to the pandemic to continue to support the needs of people in the community. We saw:

- a fall in the number of face-to-face GP appointments and a rise in those conducted remotely, especially by phone and email

- digital systems becoming more available, including ways for patients to send information to practices as well as arrangements for video consultation

- urgent dental care centres established across the country to provide care for people with urgent and emergency dental problems.

Among the many challenges faced by providers in recent months, services have had to make sure they had enough employees with the right skills to cope with new and increased demands. Strategies included the redeployment of existing staff, for example staff moving from one area of a hospital to another, commonly to critical care, while minimising the risk of transmission. Some people were redeployed to another sector, such as hospital and community staff with appropriate clinical skills moving to care homes.

There was significant interest from the public in volunteering and supporting their local communities, although there were also concerns about the coordination of volunteer strategies and how recruited volunteers might be best used.

2.3 Infection prevention and control

Our new data collection and digital monitoring tools – the Emergency Support Framework (ESF) – enabled our inspectors to have structured and consistent discussions with providers about the impact of coronavirus on staff and people using services, and helped us identify where we might need to inspect or escalate concerns to partners. A key part of the framework focuses on infection prevention and control.

We saw an increase in calls to our national contact centre from health and social care staff raising concerns about care. The biggest increase came from staff in the adult social care sector: we received 2,612 calls from adult social care staff raising concerns in the period 2 March 2020 to 31 May 2020, compared with 1,685 for the same period in 2019 – a rise of 55%.

We also saw an increase in information sharing from people using services, their relatives, and staff, including through our online Give Feedback on Care service. At 12 July, we had received more than 4,600 COVID-19 enquiries, relating to more than 3,300 services. These peaked in the two weeks beginning 13 April, when more than 2,000 enquiries were raised.

Infection prevention and control (IPC) was the most common theme from this feedback, appearing in 44% of enquiries. Related issues included:

- how hygiene and infection control is practised in the service

- cleaning facilities and the wearing of personal protective equipment (PPE)

- movement of staff between wards, services or people's homes

- self-isolation of people with symptoms

- movement of people using the service.

NHS acute and specialist trusts told our inspectors in ESF calls that they had high board assurance around their IPC procedures, and we heard of a number of good practice examples. While most trusts assured themselves that they were managing IPC well and mitigating risks, there were some examples of where the systems and procedures were ineffective. Robust audits did not always take place during the peak of the pandemic, including audits of PPE, waste disposal and the screening of other health care-associated infections. Oversight of IPC training varied between trusts, meaning some could not always be assured that staff had been adequately trained in IPC procedures. And some trusts had challenges on space that limited their ability to isolate and cohort COVID-19 positive patients.

Results of our survey of hospital inpatients during April and May 2020 showed that the observation of IPC-related practices (such as handwashing with hand sanitiser or soap, staff wearing PPE, staff disposing of gloves and plastic aprons, cleaning of surfaces and waste bins being provided) were all relatively high (90% or above in all cases). However, respondents reported seeing social distancing measures (such as markers on the floor or signage at the entrance) to a lesser extent (65%).

During August, we carried out a special programme of IPC inspections in 301 care homes selected as potential examples of where IPC was being done well. We have been encouraged by the findings so far, with more than 90% assurance across all the elements we were looking at, and plenty of good practice examples. In an analysis of IPC in 139 inspections in high-risk services from 1 August to 4 September, we were mostly assured by the approaches those care homes had taken. The main areas that needed to improve were around having out-of-date IPC policies and not using PPE in the most effective way.

In the first months of the pandemic, we have not seen any clear relationship between care home ratings and the number of deaths due to COVID-19 in those homes. As at 7 July 2020, for every 1,000 beds there were 40 deaths in care homes rated overall as inadequate, 47 in those rated as requires improvement, 44 in those rated as good and 41 in those rated as outstanding. There was a similar pattern when comparing against the specific ratings for the safe and well-led questions.

Our calls to a sample of GP practices showed that they generally had good PPE and cleaning procedures, procedures for social distancing and audits of IPC. Those we talked to said that one challenge had been around the clarity and effectiveness of communication around national IPC guidance – saying that messages, particularly in the early stages of the pandemic, were inconsistent and confusing.

2.4 The unequal impact of COVID-19

It has become clear that COVID-19 has had a disproportionate effect on some people with protected characteristics: people from Black and minority ethnic (BME) backgrounds, older people, and people with some long-term health conditions and other disabilities have been hit harder by the pandemic and its knock-on effects. These unequal effects have affected health and social care workers as well as people in need of care.

While we are yet to understand all the reasons for these disparities, they do serve to highlight the inequality in health outcomes that existed before the pandemic. For example, we analysed data on colorectal cancer pathways, which suggests that patients from BME backgrounds and from the most economically deprived backgrounds are at disproportionate risk from late diagnosis and are less likely than average to access the national screening programme.

This raises questions about whether people from BME groups and those who are from economically deprived backgrounds are less likely to have easy access to other types of screening or early interventions, including those that might put them at greater risk from COVID-19. People from all BME groups represent 36% of those admitted to critical care services with COVID-19, and are up to twice as likely to die from the disease in England, compared with people identified as White British.[30]

Analysing our data about death notifications in adult social care from 10 April to 15 May, we found that the proportion of deaths in all adult social care services due to confirmed or suspected COVID-19 was higher for Black (49%) and Asian (42%) people compared with White people (41%) and people from mixed or multiple ethnic groups (41%). This difference increased when looking at care home settings only, where 54% of deaths among Black people and 49% of deaths among Asian people were related to COVID-19 compared with 44% of deaths of White people and 41% for mixed or multiple ethnic groups.[31] We also received a 134% increase in notifications of deaths of people with a learning disability, compared with the same period the previous year. These notifications were from providers registered with CQC to provide care to people with a learning disability. Of these deaths, 53% were from suspected or confirmed COVID-19.[32]

Along with others, we have raised concerns about a lack of testing for adults with a learning disability and autistic people living in residential care settings, and the staff who work in them. While access to testing for this group was introduced from early June, a gap remained for people who live independently and receive care in their own homes.

A survey by the Alzheimer's Society found that 76% of care homes reported that GPs have been reluctant to visit them,[33] and another survey by the Queens Nursing Institute found that 32% of care home leaders found it difficult to access GP services on behalf of the people they care for.[34] These indicate that older people, those with dementia, those with a learning disability and autistic people living in residential adult social care settings may be at greater risk from general health problems being left untreated, as well as COVID-19.

In a joint statement on 7 April, we expressed concerns that advance care plans, sometimes including Do Not Attempt Cardiopulmonary Resuscitation orders, were being placed on groups of older people and disabled people without individual discussions taking place to make sure this was appropriate.[35] These plans should only ever be made on a person-by-person basis.

We made another statement in August when it became clear that some older and disabled people living in care homes were not getting access to urgent hospital treatment, and this may have been based on assumptions that some groups are less entitled to care and treatment than others rather than on clinical need.[36] Where the right processes are not followed, this may indicate an attitude that older and disabled people's lives are worth less than others'. This would be unacceptable and discriminatory, and may breach people's human rights.

Organisations and individuals must reflect on these issues, put in place protocols to eliminate them, take steps to eradicate the underlying causes, and move towards normalising discussions of advance care plans with individuals. In our third COVID-19 Insight briefing, published in July 2020, we talked about how collaboration has been essential to creating an effective response to the pandemic.[37] This may be all the more important for people with some protected equality characteristics, who we know can be more severely affected when organisations within the health and social care system do not work well together.

Pregnancy and maternity are protected characteristics under the Equality Act 2010. Disparities in maternal and neonatal mortality rates for women from BME groups are persistent and well-documented. Women from minority ethnic backgrounds have poorer experiences of care and face additional maternity risks, with maternal mortality rates significantly higher than for white women. These disparities have only been exacerbated by the pandemic: research shows that Black women are eight times more likely to be admitted to hospital with COVID-19 during pregnancy, while Asian women are four times more likely. We support the work of the Maternity Transformation Programme Board, who are developing a national equity strategy for action to tackle this important challenge.

We carried out engagement via surveys and interviewed groups of people with different equality characteristics, to find out about their experiences of care since the beginning of lockdown measures. We heard there was a feeling that communication from the health and care sector had not always been done well, with some people left feeling uncertain about what services were available to them during this time.

We heard about overcrowding on wards for people with mental health conditions, raising concerns around infection control. More positively, of the people we surveyed, 73% of those who had tried to access gender identity clinics had found it very or somewhat easy to do so, and of that group, most people felt their needs had been met.

In our letter to the chair of the Women and Equalities Committee earlier this year, we stressed that blanket measures, such as a total ban on hospital visitors, had a disproportionate effect on some faith groups and people who do not speak fluent English and their families. This may also have had an impact on the confidence of people from these groups in the NHS as a whole; where people do not feel their needs are being taken into account, they may be less likely to seek help for health problems, whether related to COVID-19 or not.

In our survey of the experiences of hospital inpatients during April and May 2020, we found worrying indications that some groups of people have found their hospital stays more difficult than others:

- Across several of the questions we asked, people with dementia (including Alzheimer's disease) had worse experiences:

  - They were least likely to say they were involved in decisions about their care or received answers to questions that they could 'always' understand.

  - They were least likely to 'always' understand staff who were wearing PPE.

  - Among groups with long-term health conditions, they had by far the lowest rate of feeling able to keep in touch with their families during their stay in hospital (23% said they 'never' spoke with friends or family while in hospital).

- Deaf people, those with a learning disability, people aged over 85, and autistic people also found it particularly difficult to understand staff when they were wearing PPE.

- Younger adults were the least likely age group to report feeling they were 'always' treated with dignity and respect while in hospital (78% compared with an average of 86%). Patients who had a pre-existing mental health condition, that was the reason for their admission, were most likely to say they were 'never' treated with dignity and respect during their stay (13%)

We will publish the full results of this survey in November 2020.

2.5 The impact of COVID-19 on Deprivation of Liberty Safeguards

During the pandemic, we continued to monitor notifications to us of the outcome of a Deprivation of Liberty Safeguard (DoLS) application. It is important to note that this may not necessarily reflect a drop in applications made, as providers need only notify CQC once they know the outcome, not when they make the application. From March to May, we saw a sharp fall in the number of notifications compared with the same period in 2019 (figure 13). Notifications from adult social care services dropped by almost a third (31%), and in hospitals by almost two-thirds (65%), compared with the same period in 2019. By July, the numbers received from adult social care services had risen again, although they fell back in August.

There was variation between regions. In adult social care, London saw the largest percentage change with a 37% drop in March to May 2020 compared with 2019, while the South West fell by 25%. For hospitals, the South East saw the largest percentage reduction in March to May of 82%, while the South West and East of England regions each fell by 52%.

Figure 13: **Notifications to CQC of DoLS application outcomes by month and sector, 2019 and 2020**
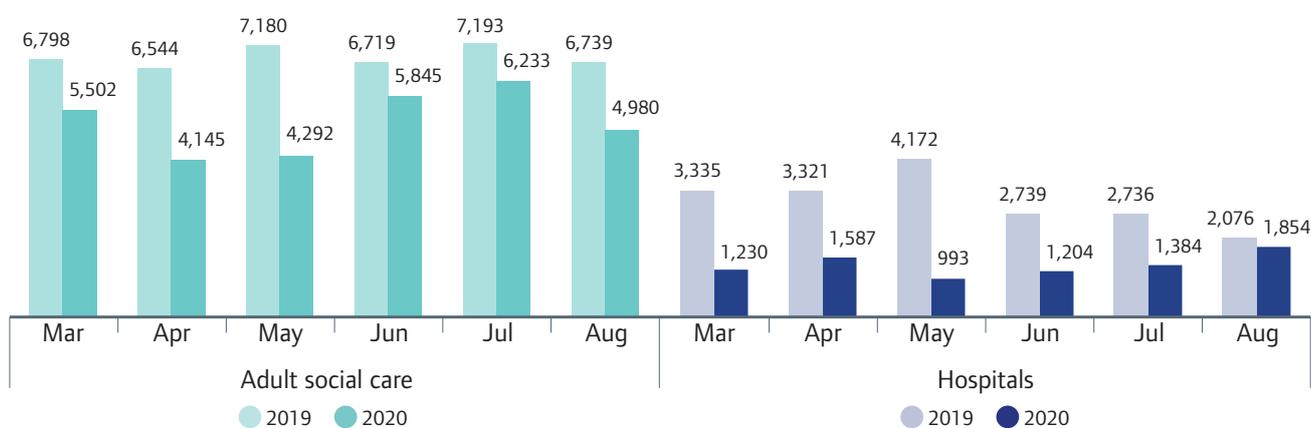
Source: CQC notifications. Excludes very small numbers of notifications from primary medical services.

In line with government guidelines for COVID-19, adult social care providers and hospitals introduced new restrictions to enable people to be isolated and/ or socially distanced. This included restricting access in and out of buildings and implementing enhanced infection control.

Providers had to introduce certain restrictions into an already complex and confusing picture, with the lack of understanding about DoLS potentially having an impact on providers' confidence about whether such restrictions amount to a deprivation of liberty or not. To help providers, in April 2020 the Department of Health and Social Care introduced specific guidance on looking after people who lack mental capacity. This explained that, during the pandemic, no legislative changes to the Mental Capacity Act were being made. Providers would still need to apply for a DoLS if the conditions were met. The guidance

also set out pertinent case law and considered the relevancy of specific public health powers in some limited cases.[38]

The pandemic also introduced an additional challenge for providers, in balancing restrictions to keep people safe from COVID-19 with ensuring that they are applying the less restrictive principle in line with the Mental Capacity Act. Some providers continue to actively mitigate the impact of COVID-19 restrictions, aware that some people with complex conditions, such as dementia, are particularly at risk of isolation.

This includes, for example:

- buying screens and encouraging people who use services to video call their families

- introducing 'relay walks', where services stagger access to communal areas of a care home (while maintaining appropriate infection control) – this encourages mobility and allows people to spend more time outside of their room.

We will continue to monitor how services are managing this balance and following the relevant guidance as it evolves.

2.6 Innovation and the speed of change

The speed and scale of the pandemic required health and care providers to respond in new ways. The enormity of the challenges they faced meant that, at very short notice, services developed new procedures and ways of working.

In June we published more than 300 examples from the front line of changes that providers had made, so that they could quickly learn from each other and consider whether innovations brought about by the crisis could help shape services in the future.[39]

The examples, from small home care agencies to large acute hospitals, are a celebration of the dedication and resourcefulness of health and care providers and staff. They illustrate their tremendous resilience and imagination, and their determination to think differently to meet the needs of people who use services and keep people safe in a time of crisis.

They included:

- A GP who carried out a virtual ward round to two care homes by video call. She saw every patient in the homes registered on the practice list. She then telephoned the next of kin for each patient to reassure them that their loved ones were being supported.

- Another GP surgery pledged that each member of staff would ring one potentially isolated patient for a chat every day during the pandemic. This good practice was followed by all GP practices in the primary care network.

- A homecare provider has been using tablet computers to record baseline observations of people using its service. Monitoring temperatures and vital signs has helped to identify early signs of infection, enabling them to apply

additional social distancing measures and to use consistent care teams to help limit any potential spread of the virus.

- A service for people with a learning disability contacted their favourite local pub to help them create their own pub, while observing social distancing guidelines. The local pub kindly donated items to help make it as authentic as possible.

- An NHS trust introduced a new role of family liaison officer to support patients, their families and loved ones, as well as staff teams. The trust also set up a drop-off and collection station so that people could send items to their loved ones on the wards through the officer.

- A mental health NHS trust set up a 24/7 mental health emergency department with a dedicated phone line for patients in crisis, so that they could avoid acute hospital emergency departments.

Creative thinking to help people understand the dangers of COVID-19

At a care home supporting people living with a learning disability or dementia, one problem staff faced when the pandemic started was how to help residents understand COVID-19 and the changes it was going to make to their everyday lives. The home knew a one-size-fits-all approach would never work, and that true person-centred care would be essential to keep people happy and safe.

The home supported people to do hand washing exercises by adding glitter to the water to represent germs. They found that without soap the glitter sticks to your hands. With soap it all comes off, meaning the germs had gone! People loved doing this, with residents even asking to do it daily for fun.

People were supported to make and decorate hand shapes for the corridors. Every two metres one hand has a piece of coloured cotton wool put on it to represent the germ. This use of visual aids has helped people keep to social distancing guidelines in a safe and engaging way.

One resident had enjoyed the activities at a day service that was no longer running. Rather than let that fall away the manager talked to them and asked, 'what can we do to help you?'. The solution not only helped that person but the other residents too. They made a weekly timetable to accommodate all the activities of the day centre that staff supported. Some of the quieter residents even got involved and it has made a massive difference to emotional and mental wellbeing.

Some residents still wanted to go out, so staff worked with them to come to an agreement and understanding. Staff accompanied them and showed how to stay safe by using hand gel, staying two metres apart and avoiding busy places.

The provision of health and care services was already changing, but the pandemic has sped up that change. This has happened when groups of people have come together to solve an urgent problem, such as the development of the Nightingale hospitals.

The crisis has also accelerated innovation that had previously proved difficult to mainstream, such as GP practices moving rapidly to remote consultations following the requirement to move to a remote triage-first model of care. In the week beginning Sunday 1 March, 14% of appointments reported to NHS Digital were recorded as being by phone. By the week beginning Sunday 29 March, a week after the lockdown, this had jumped to 46%. It has remained around this figure every week since then (figure 14).

Figure 14: **Average daily GP appointments by week, by type of appointment, as reported to NHS Digital**
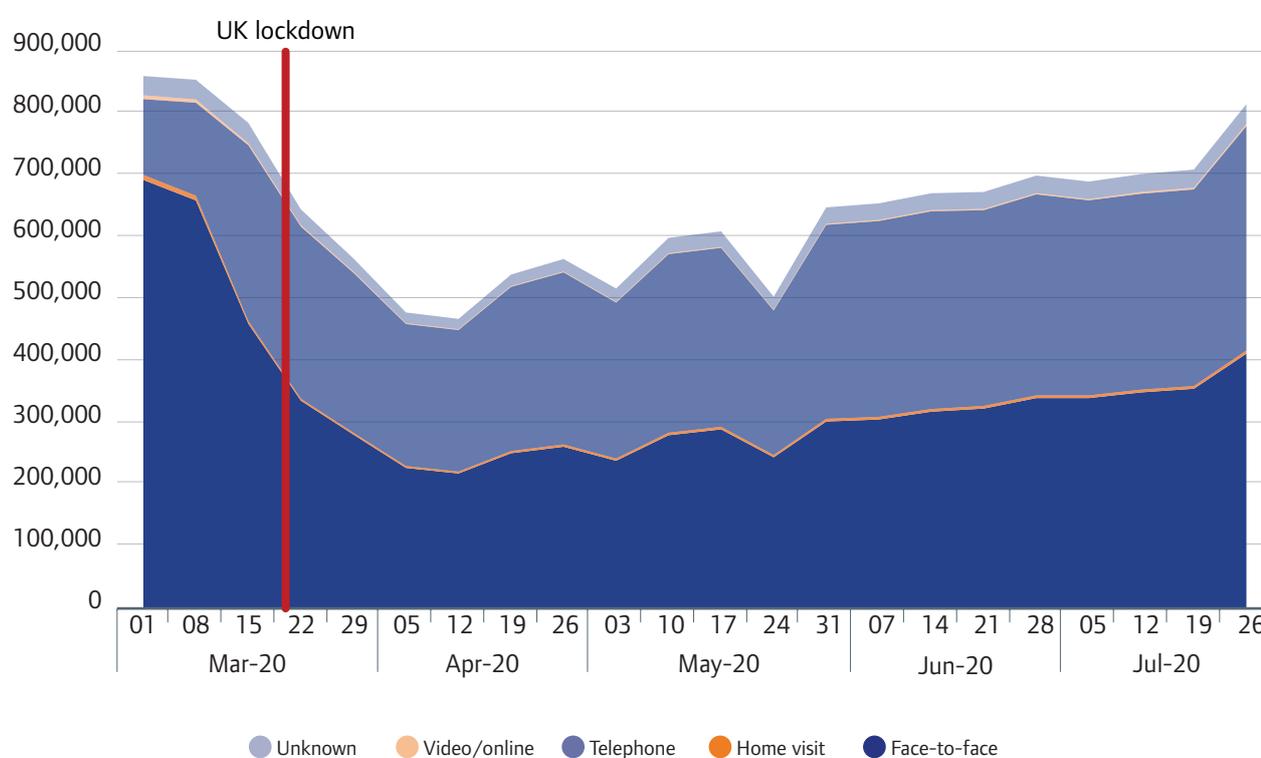
Source: NHS Digital, appointments in general practice.

NHSX reported that, by 1 June 2020, 87% of general practices were live with technology to enable online consultations, a figure that has increased markedly during the COVID-19 period. NHSX has also reported that more than two-thirds of practices saw appointments booked online using GP Connect.[40]

GPs have told us they have received positive feedback from patients, and this is generally supported in the surveys we have carried out with people who use services during the pandemic. Most of those who responded to us wanted the access routes available during the pandemic, such as online appointments and telephone and video consultations, to remain available in the future.

However, these remote forms of access were less popular with certain groups, such as people in low-income households, and face-to-face appointments remain important. Healthwatch England heard concerns from people about the accessibility of remote care for people with additional communication needs, as well as people who do not use the internet. They highlighted how digital or telephone appointments and assessments are not always suitable for people living with dementia, autistic people, and those with a learning disability.[41] A recent report from Healthwatch England, National Voices and Traverse, The Doctor Will Zoom You Now, said that, "Key to a successful shift to remote consultations will be understanding which approach is the right one based on individual need and circumstance. A blended offer, including text, phone, video, email and in person would provide the best solution."[42]

Experiences of using remote consultations during the pandemic

Jennifer had a car crash just before lockdown. She went to the hospital and found she had strained muscles in her neck. The pain got worse so she contacted her GP. She received a phone consultation from a GP the same day she contacted them and was subsequently referred for physiotherapy.

During the pandemic, Jennifer has received GP appointments by telephone and physiotherapy by video consultation. She has mixed feelings about these remote sessions.

She didn't find the telephone consultations very accessible, and would prefer to see her GP face-to-face, even if this involves a video call. She is only given a five-minute slot for telephone appointments, and would like them to be longer. When Jennifer rings the GP for an appointment she is told she will get a call back that day, but often no time slot is given so it is difficult to plan the rest of her day.

However, Jennifer found the video physiotherapy sessions "absolutely brilliant", as she did not have to travel to an appointment, which is often difficult when she is in pain. She could see the physio and they could see her to explain exercises. She was given all the information and support she felt she needed. It was also conducted through a very popular app that she is used to using for conversations with her family, so it was instantly familiar. Jennifer thinks she "received better care during COVID-19", as she "didn't feel as though as I had been left out by not attending face-to-face appointments".

Kerri suffers with anxiety and often has panic attacks. She has experience of accessing the GP and a counselling service but since the coronavirus pandemic, everything has moved online. Although she is used to face-to-face appointments with her GP, she now uses the online chat function on her surgery's website. Kerri knows that if she uses this they will get back to her within 24 to 48 hours. She likes to use the chat function as she can tell her story more by writing everything down and she doesn't forget anything. She thinks they are listening and reading her messages before contacting her, which feels more like a one-to-one service. If she needs medicine, her prescriptions get sent straight to the pharmacy for her to collect.

However, before the pandemic, Kerri explains she could call the GP and get a same day appointment, but using this chat function it takes longer to speak to someone. Kerri has worries about accessing services on a weekend; if she needs to speak to a GP at the weekend, she knows she will have to wait until Monday. "When it gets to the weekend, I feel a bit isolated."

Kerri's counsellor now uses standard video apps for consultations. Kerri is quite happy using technology to access services. She likes being able to access services in the comfort of her own home without needing to sit in waiting rooms, especially when she is not feeling well.

Before the pandemic, Kerri would speak to lots of different GPs and counsellors, but since the pandemic started this has changed and now Kerri only speaks to one GP and one counsellor, which she prefers. She likes not having to repeat her story each time. Since appointments have moved online, she has found they have been on time. She had experienced delays when everything was face-to-face.

In initial feedback from conversations we had with GP practices during the pandemic, they said that practice teams have been working well together and more closely in response to the challenges they have faced, which has enhanced people's working relationships. Practices also indicated that they had received good support and engagement from others to help them manage the pandemic, including clinical commissioning groups and primary care networks.

In terms of the challenges they have faced, a common theme in early feedback was one of information overload, particularly practices struggling with guidance from different sources that was changing or conflicting. Practices have said that going forward, guidance needs to be much better coordinated and streamlined.

Some of the rapid innovations we have seen since the emergence of COVID-19 have been positive for people with protected characteristics. The Think Local Act Personal group has published a number of encouraging case studies of positive responses to the pandemic, available on their website.[43] They include examples from different parts of the health and social care

system, aimed at different groups including yoga for disabled people, inclusive digital innovations for people with a learning disability, and new support systems for Black and minority ethnic staff at an NHS trust.

Some innovations, though, have brought to light the need for equality impact assessments to become an integral part of developments in health and social care, even in emergency situations. For example, we were unable to register two proposed Nightingale-style step-down centres for people recovering from COVID-19 because they were unsuitable for many physically disabled people and older people.

It was clear even before the pandemic that digital solutions such as online consultations and triage apps work well for many. However, many of these innovations exclude people who do not have access to a smartphone or computer, and some have been rushed into place during the pandemic. Arrangements and planning for people who are vulnerable to digital exclusion must not be lost in the rush to prioritise innovative and resource-saving online options.

We have worked with other health and care organisations to identify a set of principles that can help enable innovation in health and social care providers. This work was funded by a grant from the £10 million Regulators' Pioneer Fund launched by the Department for Business, Energy and Industrial Strategy (BEIS) and administered by Innovate UK. These principles will be published in a report in the autumn.

State of Care

3. Collaboration between providers

Key points

- The success of collaboration between providers to keep people safe was varied, often affected by the maturity of pre-existing relationships within the system.

- Understanding the needs of local populations including cultural differences, was especially important.

- Sectors did not feel consistently engaged in the coordination of responses to the crisis.

- Health and social care staff worked above and beyond, with a shared drive to look after people well and keep them safe.

- System areas benefitted from the pace of effort to secure a regional level grip across communication, support and joint working approaches, in response to confusion from the pace of national guidance.

- The voluntary sector played a critical role in supporting health and social care to keep people safe. System-wide leaders were concerned about capacity to meet the demands of subsequent peaks without this support.

- Where we found well planned governance, clear decision-making arrangements and escalation plans, those system-wide responses were most effective.

- Areas with sector and pathway oversight cells secured increased communication, timely information sharing and collective partnership decisions.

- Where we found multiple or unclear governance arrangements, those areas experienced higher levels of confusion and duplication of effort.

- The engagement of all sectors to system level responses varied. Where there was less engagement, there was a disconnect between communication and information within and across providers.

- Views of sector partners varied as to the effectiveness of joint and supportive working arrangements, particularly between care homes and GP practices.

- Strategies to manage staff and resources across sectors and partnerships were inconsistently navigated, causing varied success of collaboration within systems.

- Initiatives to manage professional skills capacity across providers was managed well in some areas, with demonstrable impact.

- A wide range of measures were introduced to keep staff safe, although implementing them caused challenges.

- Accelerated and shared digital approaches supported providers to work together and keep connected well.

- Advanced IT and technology did not always assist with efficient and timely access to care for people.

- At times the pace of change felt overwhelming for health and social care providers.

The speed and scale of the response required by the COVID-19 pandemic early in 2020 has highlighted the benefits to services, and the people who use them, of creativity and innovation through collaborative working.

In July and August 2020, we rapidly mobilised teams to carry out provider collaboration reviews in 11 different English localities, to find out how providers had worked together in the face of the pandemic. The reviews have brought into focus themes and learning that can be used to inform planning for this autumn and winter with the resurgence of COVID-19.

The reviews focused on care for people aged over 65 – the age group most impacted by COVID-19. The 11 integrated care system (ICS) or sustainability and transformation partnership (STP) areas were:

- Bedfordshire, Luton and Milton Keynes ICS
- Devon STP
- Frimley Health and Care ICS
- Lancashire and South Cumbria ICS
- Lincolnshire STP
- Norfolk and Waveney STP
- North East and North Cumbria ICS
- North West London STP
- One Gloucestershire ICS
- Sussex Health and Care Partnership ICS
- The Black Country and West Birmingham STP.

We had four areas of focus for our reviews and some key questions about the response to COVID-19:

- **People at the centre:** How did providers collaborate to ensure that people moving through health and care services were seen safely in the right place, at the right time, by the right person?

- **System leadership:** Was there a shared plan, values and system-wide governance and leadership during the first months of the pandemic in England?

- **Workforce capacity and capability:** Was there a strategy for ensuring sufficient health and care skills across the health and care interface?

- **Digital solutions and technology:** What impact have digital solutions and technology had on providers and services?

To get a comprehensive picture, we spoke to a wide variety of organisations locally, including primary care networks, local medical committees, adult social care providers, social services teams, NHS trusts and independent hospitals, urgent care providers, NHS 111, community care providers, integrated care teams, urgent dental services and local Healthwatch.

The individual reviews helped to identify where provider collaboration worked well to the benefit of local people. The reviews have drawn out examples of creativity, innovation and rapid new ways of working, as well as identifying the challenges for provider partnerships and those accessing care. Sharing that learning will help drive system, regional and national learning and improvement.

Taken together, the reviews have brought into focus the themes and learning that can be used to inform planning for the coming winter and any subsequent spikes of COVID-19. But more than that, they are intended to help providers and leaders of local health and care systems plan and work more effectively together as a matter of course.

The reviews bolster recommendations we made in our 2018 report <u>Beyond Barriers</u>, when we called for a reform of planning and commissioning of services, particularly to support older people in their own homes. We said that a new approach was needed for system performance management and joint workforce planning, as well as better oversight of local system performance.[44]

Our ambition is to look at provider collaboration in all ICS and STP areas in England by the end of 2020/21. Our reviews will consider the impact of collaboration across different pathways and population groups. This will include looking at how providers are re-establishing services and pathways in local areas, alongside continued responses to the impact of COVID-19. The next review will focus on how providers are working together to deliver urgent and emergency care services.[45]

3.1 How did care providers collaborate to keep people safe?

How have providers collaborated to ensure people over 65 are seen at the right place at the right time and by staff with the right skills? We wanted to see how providers have worked together to understand the local population and to ensure care pathways were developed to keep people safe – and how they have worked to ensure people received effective, responsive care.

Before the pandemic, we knew that different parts of the country were at different stages in progress towards better collaborative working between health and social care services, as well as work with other support services.

Across the 11 local areas, we found varying success as providers worked to keep people safe by working together. Each local area was different and had localised arrangements for health and social care provision – and while there were some similarities in each area's reaction to the pandemic, each area had its own strengths and challenges.

Some areas coped better where there were well-established working relationships among local providers – there was better collaboration and decision-making. But the sheer pace of change during the early stages of the pandemic stretched even the most solid working relationships and made it challenging for parts of local systems to consult each other and work together.

System areas benefitted from the pace of effort to secure a regional level grip across communication, support and joint working approaches, in response to confusion from the pace of national guidance

With so much unknown about COVID-19, decisions had to be made at speed, at the same time as receiving a high volume and frequency of changes to guidance from central authorities. Providers said this caused confusion and at times they felt overwhelmed.

We heard that some places found the national messages were conflicting, such as the messages around not overburdening the NHS but people should seek help if they needed it. Providers told us communication and guidance at a national level was not nuanced enough to meet the needs of the local population. They also told us it was often not tailored for non-English speakers.

During the well-publicised issues around the supply of personal protective equipment (PPE) early in the pandemic, there were localised problems. Despite these problems, in each area we visited there were systems in place to try to manage the supply of PPE.

We also heard about varying experiences with approaches to coronavirus testing – some providers and staff had good arrangements in place, whereas others struggled. Providers in some systems reported that COVID-19 testing was a major challenge at the beginning of the pandemic but, at the time we conducted the review, they said it had improved.

System areas benefited from the pace of effort to get a regional grip across communication, support and joint working approaches. This included providing training and support to care homes, and we heard about collaboration between local authorities, NHS trusts, clinical commissioning groups and the voluntary sector to manage the pandemic.

Pathways and services were redesigned to manage people with confirmed coronavirus and non-coronavirus illness, and aimed to reduce pressure on urgent and emergency services. Community hubs and NHS 111 services were crucial in reducing hospital admissions. Urgent dental care centres were set up, although sometimes difficult to access, and some areas told us they adapted dental services to support vulnerable people.

Keeping people safe

Our reviews highlighted that system areas consistently had an understanding of those who were most vulnerable within their populations. Support included services keeping in regular contact with people who needed care, informing them of changes to services and offering welfare checks and practical support, such as prescriptions and food parcels.

There was support for families and carers and recognition that they were taking on more caring responsibilities. There was also awareness among services that some people may need more emotional support due to the impact of COVID-19, rather than just practical support.

Providers identified people who may be hard to reach or lonely, and supported wellbeing through a range of communication channels, such as webinars on how to manage anxiety and sleep. There was also support from voluntary sector organisations and the wider community, including contacting vulnerable people, delivering supplies, supporting discharge and carrying out tasks to take the pressure off front line health and social care staff.

For people in care homes, staff worked hard to maintain contact with relatives, either virtually or by organising socially distant visits, and to provide residents with stimulating activities.

We heard about many examples of care to keep people safe, including a helpline set up in Lincolnshire for mental health patients, which allowed them to self-refer, rather than needing to be referred by the GP. It worked well to reach vulnerable people. Individual examples included dental support for people who were not on the dentist's patient list in Bedfordshire, Luton and Milton Keynes ICS.

Identifying those most in need of support

In Norfolk and Waveney, the 'COVID Protect' project helped identify and support the people most clinically vulnerable to COVID-19. A letter was sent to 42,000 people explaining how they could regularly go online to get extra support (clinical and social) through a portal unique to them. Those people who did not or could not go online were proactively contacted by a team of about 100 non-clinical call handlers, consisting of redeployed CCG and trust staff, to support and encourage them to use the system.

People identified in more deprived areas did not log on as often, so they were sent an additional letter and were specifically targeted by the non-clinical call handlers – this more than doubled the engagement and support available for that population. There was a multi-organisational response: county council, health, voluntary sector and other representatives across Norfolk and Waveney.

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

In previous years, we have reported in State of Care and other local systems reports about how services need work to make sure people are kept safe and seen in the right place, at the right time and by the right person. To do this well, local providers and systems need to understand their populations.

In our reviews, we heard how during the pandemic providers used a range of data, such as daily situation reporting and information gathered by clinical commissioning groups (CCGs), and their work with public health teams to access the latest data on the virus and understand what it meant for local people. This data could be shared across providers to make sure everyone had the most up-to-date information and could ask questions.

We were told about a variety of scenarios in responding to the pandemic where things went well locally, because there was an understanding of the local population. This also included quicker responses where there was an existing understanding of the local community, including population risk factors:

- local leaders and community groups working together to create networks and find solutions

- regular communication to identify needs and respond actively, typically based on existing relationships between partners, but formalising these processes to allow for more robust and faster communication.

Enhanced council support

In Blackpool there was a focus on helping homeless people and people with substance misuse problems. This involved the council in supporting the community with their medical needs and setting up local accommodation. We were told that this helped break down some barriers and that this group in the population now has more trust in the authorities.

Understanding the needs of local people

In Slough, mosques were closed a week earlier than the rest of country. A GP recognised that Friday prayers could potentially increase the risk of contracting the virus – and a significant proportion of the Muslim population in the area are over 65 years of age. Female-only COVID-19 testing sites were set up so that Muslim women could feel more confident about attending. The local authority worked closely with the voluntary sector so that culturally appropriate food packages could be delivered to vulnerable people.

Good engagement with families

In North West London, a dental practice was able to offer support because they knew their patients well. The practice identified a small number of patients from the over-65 age group and was able to include families in the delivery of advice and treatment. Approaches were developed to engage with people whose first language was not English.

Providers told us that local system leaders, such as CCG and council leads, worked with community groups to create networks and find solutions for those most at risk. This included voluntary organisations and members of the local community. Community groups played an important role in getting messages out to the local population as well as feeding back to the system so action could be taken.

We heard how rapidly evolved delivery models presented barriers for those needing to access care. Examples included people not having internet access for online support approaches, and ways of working were not accessible for those with increased communication needs. Some providers worked with voluntary organisations and local groups to make sure communication was accessible to all – such as translating messages and using local radio. Some national directives and communication were described as confusing and difficult to apply at a local level.

Despite the positive examples described above, sometimes there was concern about the ability to identify vulnerable people, linked to the need for clear

guidance and access to data. When the pandemic began, local areas worked rapidly to identify people who needed to be shielded and decisions were made to help protect vulnerable groups – this involved PPE provision, shielding and risk assessments, as well as engaging local communities.

Some areas told us there was confusion at first around identifying who needed to be shielded. We heard about a list that was developed nationally and described as 'chaotic'. We were told in some places there were multiple lists of people who were shielding, held by multiple organisations, which caused difficulties. Services had to work quickly to update these lists. We were told that some services, such as ambulances and adult social care, were unable to access the information and so took precautions, such as extra PPE and treating all residents as if they needed to be shielded.

Information sharing in Sussex

This system created their own list of vulnerable people, that additionally could be sorted by their particular needs. The community hub engaged with its partners to share data, and matched all this up to build an app that gave a view of all who was on a list and why/what their needs were. They could then filter the list to find out if the person was already known to a support organisation, such as housing services or the voluntary sector. They then decided which organisation was the best to maintain contact with the shielding or vulnerable person, to minimise the risk of duplication.

Service changes

Across the 11 areas, we found services were reviewed and redesigned, with risks proactively monitored to keep people safe. Services adapted to reduce people's interactions with physical healthcare sites. We were told how non-urgent appointments were cancelled and there was a shift to assessing, treating and supporting people in their own home. We heard how this involved:

- Virtual assessment, treatment and support, such as virtual GP appointments; 'virtual ward rounds' in care homes; and wellbeing telephone chats delivered by voluntary organisations.

- Enhanced support in the community and care homes. For some people, this included home visits by GPs and district nurses; enhanced use or establishment of community care hubs and mental health hubs; more resources and support for carers and families to assist people at home; and the delivery of medicines, wellbeing packs and other resources.

We were told how healthcare sites were reorganised into hot and cold zones or buildings to reduce the risk of spreading infection. This applied within services and between services. There were separate hospital wards for COVID and non-COVID patients, and GP providers worked together to assign surgeries as hot or cold for transport vehicles.

Providers told us there was more support in the community to reduce the chance of hospital readmission – they said that the Discharge to Assess process helped people to be manged in the most suitable setting, and that integrated care and multidisciplinary teams played a key role.

There was a mixture of experience in care homes. Some services decided to lockdown early, but we were told about concerns about the impact of social isolation for some residents. Some care homes felt very supported by others in the system, through virtual GP rounds and training of in-house staff. But others felt they were unsupported and let down. Tensions arose between providers within some systems, as the pace of the situation could result in confusing communications and changes to people's responsibilities and workloads.

We heard how services worked together and offered support, such as dedicated GPs for nursing homes, quality teams supporting testing, and coordination around patients' discharge. Community services also supported other services with PPE.

Where changes implemented because of COVID-19 had a positive impact, providers told us they would like to keep them long-term. This includes keeping the service redesigns, such as virtual consultations and new pathways between GPs and consultants, as well as collaborative ways of working, such as joint agreements for integrated clinical pathways.

The voluntary sector played a critical role in supporting health and social care to keep people safe. System-wide leaders were concerned about capacity to meet the demands of subsequent peaks without this support

Across our reviews, we heard about how important a role the voluntary sector played in supporting health and social care services to help keep people safe. They contacted vulnerable people, delivered supplies, supported discharge from hospitals and did tasks to take the pressure off front line health and social care staff.

Working together

The 'One Slough' voluntary sector and community response was described to us by a Frimley Health and Care professional as the most amazing mobilisation. It brought together faith groups, the council, voluntary groups and local businesses to support both vulnerable and shielding people.

However, the voluntary sector struggled to be able to do what they felt was necessary because of a lack of resources. There was a concern that voluntary services might disappear in a second wave, but also that people may not go above and beyond next time because of the impact that the COVID-19 response had had on their own personal health and wellbeing. Voluntary sector staff were reportedly exhausted.

3.2 System-wide governance and leadership

How have leaders collaborated across local systems to ensure well-planned service delivery for older people during the pandemic? We looked at governance structures and how effective these were in supporting safe delivery of care – and what providers have learned, and how they have shared learning.

We wanted to find out how local leadership and governance across a system and a shared plan had helped services to care for people. Our work in local systems in recent years has showed that people who use services can benefit where there is a common vision and purpose that is shared between leaders in a system.

Across the 11 local areas we reviewed, we found different kinds of plans were in place to manage health and social care services in the event of an emergency. We were told that pre-existing emergency plans were intended to deal with the likes of a flu pandemic or a single incident – not a crisis on the scale of COVID-19 – and they therefore needed to be adapted. We heard how some areas were not prepared for many types of service being shut down at the same time.

Where we found well planned governance, clear decision-making arrangements and escalation plans, those system-wide responses were most effective

Local leaders in some areas told us that COVID-19 has brought about an increased focus on shared planning and system-wide governance that includes all parts of the local system. A number of things went well in some places, including:

- Governance structures with clear process for decision-making and escalation of issues across the system that enabled an effective system-wide response.

- Increased communication and collaboration, particularly through the use of cells focusing on specific pathways of care. This enabled information sharing, good practice, collective decisions and escalation of issues.

- New or improved lines of communication and collaboration between sectors to share information and provide more joined-up care.

Some organisations found that responding to COVID-19 brought them towards what was described as a shared purpose, and enabled them to strengthen relationships with system partners. The ICS in Sussex was newly formed in April 2020 and, while leaders from Sussex CCG and Sussex Partnership Trust acknowledged that the relationship had been formed before the pandemic, they felt it had galvanised change overnight towards real collaboration.

Across the localities we reviewed, there was often an acknowledgement that COVID-19 had accelerated collaborative working across health and social care,

but there needed to be a focus on communication and engagement for the local systems. It was widely recognised across the areas we visited that local communication was the key to local success.

Where we found multiple or unclear governance arrangements, those areas experienced higher levels of confusion and duplication of effort. The views of sector partners varied as to the effectiveness of joint and supportive working arrangements, particularly between care homes and GP practices

In some places, there were barriers to good shared planning and governance. Multiple governance structures could lead to confusion and duplication of effort. There was a perception in some cases that communication across the system was disjointed, and reportedly a lack of clarity in terms of who was in charge. Sometimes there was a disconnect between the views of ICS leads and providers on the ground.

Some services were left out of system-level discussions and acute care dominated. There was sometimes a lack of communication between sectors – mainly hospitals and social care when discharging patients.

Some care homes said that it was difficult to get GP access and others said that virtual ward rounds were helpful. Some care homes didn't know what the offer was to them. In some cases, GPs were reportedly not visiting care homes – some adult social care services said they felt like a second-class service. In one system, this was described as a rift between some adult social care services and GP practices. This was because of access issues within care homes to primary care services and the additional responsibilities being placed on some adult social care staff to provide verification of deaths.

In some care home interviews, it became apparent that some services felt completely isolated and stranded. An example was given of a care home manager that had been called at 10:30pm one night to inform them that 24 of their residents had tested positive for COVID-19. They were then left overnight to deal with the situation unsupported.

In such a fast-moving environment, leaders found it was challenging to make decisions to give the clarity that providers wanted. Local systems told us that national guidance was not always published with the speed needed to support them, causing confusion for staff when local decisions had to be changed to meet national requirements. We also heard how centralised guidance was not flexible enough to be readily applied to different local areas with very different local circumstances and populations. Providers felt overwhelmed by the amount of information changes and guidance.

We heard how clearly defined roles and hierarchical structures were important for escalating and responding quickly to emerging issues. Where there were multiple governance structures running alongside each other or recent changes in leadership, there was sometimes confusion around roles and responsibilities. For example, in one ICS the cells ran separately to the local resilience forum. Although each structure communicated with the other, there was a challenge to blend the two together that was said to have led to

duplication of effort. The pace of change also meant that a lot of people felt unclear about what they should be doing.

Not all of the local systems we reviewed experienced good governance across the system. In some there was little discussion of system-wide governance and collaboration. There was sometimes a disconnect between the views of system leaders and providers at ground level, with providers, particularly from social care, unaware of any collaboration at ICS level.

Shared decision-making

Across the Black Country and West Birmingham STP, a risk matrix was adopted. This allowed shared decision-making – we heard this idea came from a collaboration between clinicians. An STP dashboard was used to identify staffing challenges, and a domiciliary care tracker was used to monitor staffing levels and PPE. Information was shared between providers and the local authority.

Areas with sector and pathway oversight cells secured increased communication, timely information sharing and collective partnership decisions

New governance or command and control structures were created in response to the pandemic. The importance of these has been highlighted to us by ICS and STP leads, commissioners and some trusts.

Collaboration between care provider leaders happened through the creation of cells or groups, linked to the local resilience forum (LRF) or similar governance structures, to plan and deliver services across the system for specific pathways of care or population groups. These cells or groups brought together different care providers and sectors and enabled them to share information and good practice, escalate issues and make collective decisions quickly in response to emerging issues or events. Information and decisions could then be cascaded to the relevant organisations.

Clear escalation routes

In Lincolnshire there were strong views that LRF cells were key to collaboration. Cells were created for palliative care (set up by the local authority) and more, including: primary care, pharmacy and prescribing, recovery, patient and discharge, volunteering and community response (to ensure there was a route for feedback and that pathways were safe). These cells included providers across service type and sector. They enabled clear escalation routes and sharing of information and ideas – for example, in the primary care cell, questions were answered and shared across primary care networks to avoid duplication.

Sectors did not feel consistently engaged in the coordination of responses to the crisis

We found significant variation between localities when it came to social care inclusion in the collaboration for planning and delivery of services. We heard about an improved relationship between health and social care in some local systems, but in others there was little mention of interaction between them. People we spoke to felt that health partners, or specifically acute trusts, dominated the decision-making. Sometimes there were mixed views – where, for example, social care was not fully included in the system.

There was a recognition in many systems that adult social care needed to be more effectively integrated into the system. We heard in some areas that adult social care providers didn't always understand the shared strategic approach and didn't always feel that services met the needs of the whole populations. We also heard from many adult social care providers that described feeling overwhelmed and isolated.

Some dentists also told us that they felt excluded from system-level collaboration and reported a lack of communication.

Ambulance services spoke about the challenges of covering a large geography that means they cover multiple systems without necessarily having the resource to effectively engage with them all. They also tend to be led by national rather than local directives, and during the pandemic were under the strategic command of the National Ambulance Coordinating Centre.

Pre-existing structures and relationships enabled more effective collaboration

Providers consistently highlighted that the structures they already had in place, and the strength of existing relationships between system partners, provided the building blocks for collaboration in responding to COVID-19.

Some providers talked about the value of existing relationships with other providers and stakeholders, including formal networks. For example, participants linked the strength of system working in Frimley to the fact that it was already a mature ICS system – strong and trusting personal relationships between system partners already existed.

There were also examples of informal action. Early in the pandemic, the registered manager of an 'extra care' housing provider in Gloucestershire used a network of contacts from a training session she had attended to get advice from public health professionals when she had COVID-19 positive tests among residents and staff.

Forums and other groups were valued for sharing information, good practice and ideas – and sometimes resources such as PPE or beds. For example, Brent Care Homes Forum held weekly meetings that enabled open conversation and good peer and professional support. Bedfordshire, Luton and Milton Keynes ICS dentists quickly established a collaborative approach, setting up urgent dental care cluster meetings and enabling them to share PPE, good practice and risk assessments.

Providers have also discussed the value in increased support and communication from commissioners and other bodies. For example, in Devon STP, social care providers highlighted the helpfulness of regular contact from local authority teams, such as a quality assurance and improvement team, and a new care home liaison team.

We also heard about positive outcomes from good leadership in local medicines optimisation leadership cells. They brought leaders together, and regional medicines optimisation webinars helped local leaders to understand both national and regional challenges with medicines, and to share learning.

Making sure medicines were available

Throughout the collaboration reviews, we wanted to know about local plans to make sure medicines were available for people in a timely way.

We looked at the way medicines were managed for people who needed end of life care, as well as for those who live in very rural areas. We saw it involved significant cross-sector working between community pharmacies, CCGs, GP surgeries and local palliative care specialists.

We found significant planning went into medicines supply generally, including medicines used in acute settings for people with COVID-19. In some places, there were plans in place that would allow sharing of these medicines, not just within an ICS or STP but across a wider geographical area if needed.

Providers told us that community pharmacies were under a great deal of pressure during the pandemic. In some areas, providers were mindful when they made changes to processes or guidance that could impact on pharmacies.

Many providers continued to provide medicines support and advice for care homes – sometimes this was done remotely.

People told us that local medicines optimisation leadership 'cells' worked well to bring leaders together to help facilitate planning and response to COVID-19. National and regional medicines optimisation webinars (from NHS England/Improvement) helped local leaders to understand challenges and share learning.

Some community pharmacies had difficulty accessing PPE, particularly at the beginning of the pandemic. We were told that, in one area, local community businesses helped by providing donations of PPE.

We heard that the Electronic Prescription Service (EPS) has worked well. EPS enables GPs or out-of-hours services to send prescriptions electronically to a pharmacy. Stakeholders told us that there was increased use of EPS, but where it wasn't in place, many providers and local leaders tried to find a pragmatic solution to reduce the need for patients to travel to clinics to pick up paper prescriptions.

3.3 Ensuring sufficient health and care skills where they were needed

We looked at how workforce and staffing across health and social care have been affected during the pandemic: how have providers worked together across systems to ensure staffing capacity, and how have providers tried to make sure there are enough employees with the right skills to cope with new and increased demands? Also, how have providers worked together to keep staff safe?

Strategies to manage staff and resources across sectors and partnerships were inconsistently navigated, causing varied success of collaboration within systems. Initiatives to manage professional skills capacity across providers was managed well in some areas, with demonstrable impact

There were numerous strategies for making sure the right professionals and skills were available where they were needed to care for people. Across our reviews, we heard about collaborative working between providers, commissioners and other system partners, including local organisations and national bodies such as NHS England and NHS Improvement and Public Health England. There was a focus on workforce planning and monitoring, recruiting and redeploying staff, training, COVID-19 testing, and wellbeing initiatives.

However, understanding of shared strategies for staffing was mixed across the systems we reviewed. Although we spoke to people in all systems who were aware of shared strategies, we also heard from those who said they were not.

We heard many examples of workforce planning and sharing staff at organisation, provider and sector level. However, we were told how staffing plans and initiatives did not always extend to all sectors, for example adult social care. We heard about the challenges of transferring staff between health and social care settings, and how barriers were created by issues such as organisational boundaries, a lack of existing relationships and indemnity.

We were also told about the complications and time commitments of setting up the necessary arrangements to facilitate cross-sector working, meaning support was not always available when it was most needed in the early stages of the pandemic. Some providers had reservations about system-level working because it was not well established and contained a number of uncertainties, and felt it was important to develop and implement their own organisational strategies. We also heard about the difficulties of bringing in new staff to some services at short notice, because specialist skills and training were needed.

Coordinating staff support could be a challenge – some areas were not able to attract large numbers of people back to work, and some small providers struggled when senior staff were ill or isolating.

We heard how learning was in place across systems, particularly in London and Sussex, including virtual learning networks and learning from areas that experienced peaks of the virus earlier than others.

There were some specific challenges and successes in different places. In Lincolnshire we heard that the transfer between health settings was easier than transfer from health to social care settings due to indemnity issues. A memorandum of understanding was agreed to mitigate this issue and allow flexible transfer of staff between settings.

Also in Lincolnshire, there was the implementation of a 'workforce cell'. We heard there were many conversations about redeployment of clinical staff and sharing clinical staff between providers. HR directors worked together to make unanimous decisions for consistency of information reaching staff. We heard this did not involve social care, but that rapid support would have been offered if needed. The rapid redeployment and upskilling of staff by acute trusts was described as a big success.

> ### Workforce bureau
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> In Frimley, a 'workforce bureau' went live on 30 March in response to a request from the ICS board and from the CCG collaborative, to establish a central conduit for all workforce allocations. They did this so they could provide a strengthened workforce model across all systems for the pandemic period. We heard this was mandated one week and went live the following week. There was a virtual team from staff redeployed across the system and the team was pulled together in 48 hours.

Health and social care staff worked above and beyond, with a shared drive to look after people well and keep them safe

Across our reviews, we found that a range of approaches were initiated by providers and systems to ensure sufficient capacity and skills to meet demand. This included upskilling existing staff to take on additional responsibilities, former employees returning to work, using bank and agency staff, medical students joining the team, and recruiting new staff and volunteers.

Across the systems, we heard praise for the contributions of staff and their willingness to support and adapt to changing circumstances. Positive examples included care home staff volunteering to reside at the service when needed, and teams moving from a five-day to a seven-day working pattern. It was clear that the goodwill of staff had been a key factor in enabling organisations to cope during difficult times.

Levels of staff sickness were different in different places, as were the numbers of staff and volunteers in high-risk groups or needing to shield at home. Some providers said they were reliant on using agency staff, but this resource could be difficult to access and was costly. There were also concerns about the risks of virus transmission if staff moved between services. We heard about staff, including part-time and sessional staff, working extra hours and restrictions being placed on annual and study leave at certain times in some services.

> ### Retraining and returning employees
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> In Bedfordshire, Luton and Milton Keynes, we found there was a strategy in place to increase staffing capacity in the intensive care unit (ICU). They very quickly established a process for retraining staff. The department had around 80 retired staff return to practice. We were told that not all carried out clinical work, depending on their risk factors, and that the CCG also sent some clinical staff to support them. The outpatient department and recovery workforce were on standby for ICU. We were told this was a huge undertaking, – all staff were assessed for competency and this was signed-off.

In the Black Country and West Birmingham, we heard how the trust realised very early on they would need a new cohort of volunteers. They recruited new volunteers and made use of them in all areas – they said this was something they wanted to invest in for the future.

From Devon, we heard how a home care provider developed a fast-track recruitment system for other home care providers in the system. They said this was successful and crucial for supporting gaps in the workforce – and that they were trying to keep this innovation.

In Frimley, we were told how some staff were supported to train for skills they did not have before. Receptionists were trained in phlebotomy to ensure there was enough staff to carry out these roles.

A wide range of measures were introduced to keep staff safe, although implementing them caused challenges

Keeping staff as safe as possible throughout the pandemic was quickly acknowledged to be critical to ensuring people accessing health and care received the best care possible. We heard from many providers and systems about the impact the pandemic was having on their staff – the levels of staff anxiety were described as unprecedented. There were worries about the supply of PPE, particularly early in the pandemic.

Employees were afraid that they might pass on the coronavirus to their families and others. There was high anxiety about accessing COVID-19 testing, and examples of poor communication about local testing sites and challenges accessing them for staff who do not drive.

Our reviews found a range of measures to ensure staff were kept safe during the pandemic. This was primarily at organisation level, rather than system level. There were examples of frequent communication from leaders and managers, information and training for staff to ensure they could keep others and themselves safe, changes to the physical layout of health and social care settings, infection prevention and control protocols, and mental health and wellbeing support.

Organisations carried out individual risk assessments for staff in high-risk groups, including people from Black and minority ethnic groups, and

supported those who needed to shield. Opportunities were created so staff who were shielding took on alternative jobs so they could work from home.

> ### Clinical triage and assessment from home
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> In Norfolk and Waveney, there was a high percentage of shielding staff working at home as that have an older workforce. They implemented a range of initiatives to support staff, such as sending tokens of appreciation and implementing a training and support package. We heard that they had one doctor running the clinical triage and assessment from home, so his skills could be used effectively.

> ### Concerns from staff
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> In Bedfordshire, Luton and Milton Keynes, the executive team listened when staff said they were not feeling safe with the recommended guidance. Black, Asian and minority ethnic staff were given higher levels of support once the additional risks to them became clear. Close working with staff psychologists also helped to pick up on concerns from staff. Video conferences held by executive team members helped to address staff questions and concerns.

We were told how staff were provided with appropriate PPE and guidance to use it – with some providers acting quickly (prior to government advice) and, where staff had concerns, providing higher levels of protection than those recommended. Some organisations introduced COVID-19 testing for staff early in the pandemic.

There was a range of approaches implemented to support employees' mental health and wellbeing. These included ensuring regular breaks during shifts, taking annual leave when possible, having dedicated spaces for staff to take time out and 'de-stress', sharing positive stories and feedback, and the use of mindfulness activities and apps. We were also told about 'debrief and reflective practice sessions', access to mental health first aiders, employee assistance programmes, confidential helplines, talking therapies and bereavement support.

In Gloucestershire, the workforce hub established in 2019 had its hours increased to 24 hours a day, seven days a week, to offer support to staff. We were told this was a single point of access for staff who could be signposted and offered support and advice on a range of issues – childcare, counselling, goodie bags from the community. 'Wobble rooms' were established, providing a safe place for staff to use.

From Lancashire and South Cumbria, we heard that in care homes where there were outbreaks and deaths, staff were traumatised. Realising this was a significant risk, a counselling service was commissioned and there was group work via Skype.

However, while some systems had providers with leaders and managers viewed as approachable and caring in their support for staff, we heard this was not the case everywhere – some providers told us that leaders were not visible. In addition, in several local areas, there was concern that the ongoing pressures and stress faced by staff might impact on future workforce capacity and resilience.

3.4 The impact of digital solutions and technology

We looked at digital and technology initiatives in responding to COVID-19 and the impact they have had in terms of organisations working together.

Before the pandemic, we know that the safe use of technology in health and care services was making a positive impact on many people's lives. In some places, the pandemic has accelerated the use of technology, and it was rolled out at pace, quickly advancing digital solutions to support people's care in areas where there was previously reluctance.

Digital systems opened up access to virtual consultations and clinics, as well as allowing relatives and friends to have contact with people who use services and those shielding in adult social care settings.

They allowed oversight, advice, online prescribing, and data-driven decision-making around service delivery, and aided information sharing – including individual patient records and shared treatment plans.

Video conferencing within the system enabled improved communication – this helped share learning and information quickly, including records. More joined-up work was possible between teams and this improved how patients were managed.

However, IT systems were sometimes a barrier – not all services had a digital presence, and not all people had online access. There were some concerns about the pace at which systems were implemented. Some staff still didn't feel confident using the new digital systems while some patients struggled to adapt to using the new digital systems, which led to missed appointments.

Some providers (especially larger ones) were already well set-up with the right hardware. This made it easier to move to remote consultations, with good communication and better information sharing. Others had to procure equipment – sometimes it was the CCG or ICS that provided laptops, tablets, and webcams, and sometimes it was the provider.

We heard that a lack of equipment (computers, tablets and webcams, and/or a lack of funding for equipment – particularly in care homes and for smaller dentist and GP practices) made it more difficult for them to jump straight into remote consultations and communication. Also, poor wi-fi or no wi-fi was a problem in some places.

We heard positive comments about common access to the central NHS email system, which is now also available to care homes. More NHS email accounts have been created to enable safe exchange of information – one comment

described how the NHS email account meant it had been easy to share records, such as discharge assessments, discharge letters and medicine charts between the acute setting and the care homes. We also heard from some dentists who said they used NHS email for sending prescriptions to pharmacies and to receive pictures from patients. However, access and use of NHS email wasn't consistent in every system we reviewed, with one system noting that full implementation across the ICS would improve digital interoperability.

Among the main reflections across all of our reviews, there is a call for further development of a common integrated care record across care areas, with national support, across the system. People say this would enable much better information sharing and collaboration. However, while further development of an integrated care record is a priority area, there were uncertainties about who could access it. A statement by the Information Commissioner's Office has helped, in which they said they would take into account the compelling public interest in sharing information during the pandemic in decisions on the interpretation and enforcement of the General Data Protection Regulation.[46]

While the majority of people we spoke to indicated they were assured about the safety of digital and technological innovations shared across health and social care providers, information governance issues were raised in light of the pace at which systems were implemented. Security concerns were raised around the use of video-calling apps such as Zoom, and some staff resorted to personal IT equipment, such as laptops, for work with patients, which also may pose a data security risk.

Advanced IT and technology did not always assist with efficient and timely access to care for people

Across the areas we reviewed, technology has enabled remote healthcare as a replacement for familiar face-to-face care. This has included remote triage, appointments/consultations, ward rounds and prescribing. It also included some remote services for people living in care homes, using a variety of apps, platforms and systems.

Generally, this has been seen as a positive development, helping people to access care during the pandemic. Services told us they got positive patient feedback, and that some form of remote consultation would be likely to continue in the long-term.

In some cases, moving to remote care has been beneficial compared with face-to-face consultations. For example, some people with social anxiety have found a video call with their therapist more productive than a face-to-face meeting, and some people who had struggled to get to GP or other appointments have benefitted from faster access to health care. Many older people were able to use online services, either on their own or with help – it was not necessarily the case that older people found it harder to access health and social care digitally because of their age.

However, it was acknowledged that remote care would not be appropriate for certain clinical scenarios and there was some concern that this could prevent other medical or social conditions or safeguarding issues being spotted. We heard that for some people, remote care will never be appropriate or work

safely. For example, some older people (especially people living with dementia or visual and/or hearing impairments), accessing and learning about new information technology can be stressful or impossible. The impact on patients and their treatment from remote care is yet to be fully understood, and it needs to be monitored and reviewed.

We heard how people's first experience of digital care was important, how it can be hard to get people back on board if their first experience was not a good one. In addition, some people are less digitally literate and need to be supported by friends, family or care staff to access healthcare digitally. Websites in English-only could be a barrier for people who do not read English well.

We also heard that caution is needed when directing people to 'digital-first' services – some older people saw signposting to online support like a door being closed on them, and it was important to retain alternatives to digital or online appointments. Feedback from Healthwatch suggests that some people may have "fallen through the cracks" – patients who wanted to access a service but may not have met the relevant criteria in the options within the primary care digital triage tool.

Enabling virtual appointments in areas of deprivation

In some areas, providers helped one another to access necessary IT equipment. In Devon, we heard how larger providers helped smaller providers with equipment. In Lincolnshire, we heard how access to digital technology was limited in some places – or there were specific areas of deprivation – so offices were provided where people could access IT equipment, where they could have virtual appointments. And in Sussex, we heard about a coordinated approach to ensuring that providers had access to the digital equipment and training they needed.

Accelerated and shared digital approaches supported providers to work together and keep connected well

Care providers needed to adapt quickly so they could effectively communicate with one another in local systems, and with people who needed their services. Within individual workplaces and between system partners, the move to online communication, hastened by the pandemic, has been very well-received by the people we interviewed. A positive example for some was the time saved by not having to travel.

The use of video and messaging software in the workplace to hold meetings, communicate and deliver training was thought to be time-saving and effective by many. For some organisations the change was described as revolutionary. Online meetings between different providers or system partners enabled collaboration and information sharing in, for example, primary care network meetings or multidisciplinary teams.

However, we heard how online meetings led to a loss of staff cohesion in some cases, as well as increased tiredness and back-to-back meetings that meant less time to digest information.

Some providers with residents or inpatients provided people with equipment such as tablets or phones, or they supported people to communicate with loved ones. For some people this also improved their digital skills and confidence. However, some residents needed significant support to use digital platforms – and some people with dementia were unable to share the benefits.

We have heard from many across our reviews about the way local systems have gathered and shared information in response to COVID-19. Providers used digital means to share care records and individual patient information both internally and with system partners. There were a number of dedicated platforms for them to do this, including some well-established electronic systems. Those providers or ICSs with existing systems appear to have fared better than those who have had to establish them more recently.

Some systems also collated and shared information to build an understanding about the wider population, such as data to identify coronavirus hotspots or information on people who were shielding during the pandemic. We also heard how shared information about vulnerable people provided a safety net, including an example of a database that enabled food to be sent to people identified as being vulnerable.

However, some places had a less joined-up experience, especially where there was no shared or electronic system. Some local areas struggled because their own technologies would not work with partner organisations. We heard of examples where referral systems did not successfully link together. There was recognition that more work was needed to develop system-wide integrated care records.

Oral health care

Our collaboration reviews included work to find out how dental services were provided during the early stages of the pandemic.

Access to dental care became a problem when lockdown occurred, as dental practices were advised to provide advice, analgesia and antibiotics where necessary to treat infection. Where possible, this was to be provided over the phone. Where active treatment was necessary, practices were to refer patients to urgent dental care centres. Some places responded quickly to set up urgent hubs as they had well-established system relationships. Others took more time. We were told how managing people's expectations of what was classed as 'urgent' was initially difficult and that affected some people's mental health.

We found that despite the challenges, community dental services with their specialist teams continued to provide services for the most vulnerable, making them the ideal place to set up the urgent hubs.

In most places, community dentists provided training to care home staff in line with government and Public Health England guidance, and they provided easy access for urgent questions and advice.

We also found that high street dental practices adapted their working patterns to accommodate and make vulnerable people feel safer, for example seeing them at the start or end of the day when there were no other patients in the practice.

We heard across the reviews how there was a more specific focus on care provision and support for vulnerable groups – for example, in rural communities, for homeless people and people from Black and minority ethnic groups.

We heard PPE described initially as a huge challenge and access to 'fit testing' to make sure staff have the right type of well-fitting PPE remains a concern. Generally, there was prompt implementation of a coordinated approach and infrastructure to ensure that PPE was available for the urgent dental centres. We heard that where local systems took the lead for PPE, this was managed effectively between local dental committees (LDC), local dental networks (LDN) and Public Health England.

We heard general concern that guidance national messaging could have been more effective and timely. Sector expert groups worked to pull together local guidance. National guidance was described as "difficult to follow" and as coming from several, sometimes conflicting, sources. LDCs and LDNs told us they translated this guidance to ensure it made sense for everyone.

Looking at shared planning and system-wide governance, oral health in most areas was not seen to be an integral part of the system – this included joined-up technology access and development of system-wide governance, such as development of online consultations.

LDCs and LDNs were central to communications – updates were emailed directly to all registered providers. Protocols are now in place and learning has been shared so systems are now better prepared. We also heard about good joint working between local leaders to simplify medicines-related governance.

Dental providers were proud of their staff and said how well people had adapted to a new way of working. In ensuring safety of staff, and looking at health and care skills, we found:

- Employees felt supported through training, shared experiences, technology and online groups.

- Regular communications ensured staffing levels and skills shortages were monitored.

- Support from employers was offered in different ways, such as risk assessments, counselling, bereavement services and team meetings. In one area, there was a team baking event on Zoom, so that people furloughed still felt included.

- Some dental professionals supported acute services, testing sites and NHS 111 triage. We were told in areas where oral health staff worked in hospital settings, people's oral health was monitored, and training was given to staff for continuity.

Technology assisted oral health care responses. We heard how many people over 65 were able to use technology to access information and services. They recognised the benefits and value in virtual consultations – they were satisfied with remote appointments and we heard they would be happy to use these appointments the future. In one area, a reported barrier was clinicians not wanting to use a digital option due to privacy and difficulty in diagnosing.

There were some issues for dental practices, such as not having access to the electronic prescribing system. We heard this caused problems at first, when practices were trying to reduce travel and face-to-face contacts. We heard that improvements could be made to integrate oral health in future. Other findings included:

- Use of NHS email across health and social care services was inconsistent – full implementation across all dental practices would improve consistent communications.

- Dental providers have a lack of access to summary care records and this has been a continued barrier to ensuring people can move through a system effectively with one record. In Cumbria and Lancashire, they told us they had developed an urgent referral tool that linked to the summary care record to ensure the best continuous care for people.

State of Care

4. Looking forward, the challenges and opportunities ahead

> ## Key points
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> - The problems that existed before COVID-19 have not gone away.
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> - The fact that the impact of COVID has been felt more severely by those who were already likely to have poorer health outcomes makes the need for services to be designed around people's needs all the more critical.
>
> - There needs to be a new deal for the adult social care workforce that reaches across health and care – one that develops clear career progression, secures the right skills for the sector, better recognises and values staff, invests in their training and supports appropriate professionalisation.
>
> - Primary care services need to make sure that people and patients are given the confidence to interact with them early, provide a range of ways for people to access the care they need, and to make it easy for them to do so.
>
> - The increased waiting lists and backlog of urgent and elective care need to be addressed – services need to assess and prioritise patients so that they are treated according to clinical need and that people waiting for long periods for treatment are kept safe.
>
> - We must use the learning from the pandemic to lock in positive changes, and drive a new way of working that is supported at a national, regional and local level by the whole health and care system.

All areas of the health and care system have met the challenges of the pandemic head on, with staff going to great lengths to respond to this unprecedented health emergency. To manage the demand and keep people safe, we have seen services rapidly adapting the way they work.

But alongside the recognition that COVID-19 has fundamentally changed so much, it is important to recognise what has not changed. The problems that existed before COVID have not gone away. People are still more likely to receive poorer care from some types of service, and from some providers, for

the same reasons that they would have been more likely to receive poorer care before. We will maintain scrutiny on these services and providers, supporting improvement and taking action to protect people where necessary.

Throughout the pandemic it has been important to have a learning culture and proactively respond to emerging best practice. Looking forward, we need to harness that learning and focus on what needs to be done to keep people safe, and at the same time continue to make sure people have access to high-quality care that meets their individual needs.

Coming together to make sure people continue to get the care they need

Val and Peter are a married couple in their eighties. Peter has motor neurone disease, and Val has been his main carer for the nine years since his diagnosis. In the past three years, as Peter's condition has worsened, he has been unable to leave their home. Peter is now paralysed from the neck down, and needs a ventilator to help him to breathe.

Val and Peter are supported by carers who visit three times a day, a specialist hospital in London, a local motor neurone disease specialist nurse, their GP and pharmacy, district nurses, and the Motor Neurone Disease Association charity. Val told us that, when pandemic lockdown measures were introduced, she expected that some of this support might change or fall away.

Instead, support has continued for both Val and Peter. The care agency has managed to make sure that the same carers attend to help Peter with personal care, which is important to him as some of this – such as bathing – is very intimate. The only change has been in the PPE that they must now wear. The specialist nurse, who used to visit them monthly, now contacts Val and Peter on the phone to check in and make sure they have everything they need. Their GP has also provided remote appointments, and the pharmacy is continuing to deliver medicine to their home.

Support groups provided by the Motor Neurone Disease Association have moved to Zoom, which Peter can access on a specialised computer and which he operates with an eye-tracking device instead of a mouse and keyboard. This has been an improvement for Peter as, despite technical issues, he has been able to attend for the first time since he stopped leaving the house.

Val works hard to provide Peter with care, and while lockdown has not changed this, the couple are hoping to arrange some respite care for Peter during the week. This would mean Val could leave the house for longer periods to socialise, without worrying about Peter or having to frequently check her phone.

Having the consistent support of health and social care services has lessened the impact of the pandemic on Val and Peter, and the couple are very appreciative of the help they receive.

The commitment and resourcefulness shown by health and care staff during the pandemic has been recognised by the public in a groundswell of appreciation. Our research has shown that people are more likely to engage with their local services: since the start of the pandemic, more than two-thirds of people said they would be more likely to act to improve health and social care services, and 57% said that they would be more willing to support services by actively providing feedback on their care.

We have joined forces with Healthwatch England to launch a joint new campaign Because We All Care to help shape health and social care. The campaign aims to support and encourage more people in England to give feedback on health or social care services they or a loved one have experienced.

It is important that the learning and innovation that has been seen during the pandemic, both in individual services and in local systems, are used to develop health and social care for the future. This applies to both the short term, in planning for the coming winter, as well as longer-term strategic planning.

4.1 Tackling inequalities

Services and systems have an opportunity to learn from new ways of working that have been put in place during the first wave of the pandemic. It is important that new pathways and practices are developed in ways that reduce health inequalities and improve people's lives. The fact that the impact of COVID has been felt more severely by those who were already likely to have poorer health outcomes, including people from Black and minority ethnic backgrounds, disabled people and people living in more deprived areas, makes the need for health and care services to be designed around people's needs all the more critical.

People must have access to person-centred care that is based on individuals' needs. Local systems need to work together to identify where there are differences in outcomes for different groups, what the causes are for these differences and how they relate to individual needs. Local systems and providers must then take action to make sure people have their needs met and gaps in outcomes reduced.

In writing to NHS trusts, GP practices and commissioners in July about the continuing response to COVID-19, the NHS chief executive and chief operating officer put a great emphasis on action to reduce inequalities.[47] We agree that this needs to be a key feature of the months ahead.

We have seen some examples of promotion of equality already happening, mostly by anticipating where inequality might arise. For example, one NHS trust realised that people from South Asian communities might need targeted information, advice and support to encourage people to continue using healthcare services with a 'no visitor' policy. The trust organised a proactive campaign using community radio and TV and through voluntary organisations. They strengthened their bilingual support services to relatives and raised the profile of their chaplaincy provision, to provide a strong conduit between patients and their loved ones, particularly when patients were at the end of their life.

Occasionally improvements to equality have been as result of unintended positive consequences, from changes brought in during the pandemic. These improvements will only have a lasting impact if services take time to assess these changes on equality and human rights for people.

For example, in one care home for people with multiple health conditions and disabilities, changes to the way professionals visit the service as a result of coronavirus have resulted in more free time for people living at the home, giving them more choice and control over their lives. The residents decided they would like to have at least one day a week where no visiting professionals come to the home, even once pandemic conditions have eased. The manager is planning to put this in place and they expect this to have benefits beyond improving people's choices around their leisure time. This includes being able to move staffing resources from dealing with visitors to providing direct care, and refocusing meetings with professionals to concentrate more on individual people's needs.

4.2 Adult social care

The impact of COVID-19 on adult social care has been severe. Care homes in particular have borne the brunt of a disease that disproportionately affects older people and those with multiple conditions and care needs. Adult social care staff have worked hard to keep people safe, but the sector, already fragile, has faced significant challenges.

During the peak of the pandemic, we heard how staff being off sick or self-isolating led to some providers not being able to accept people. We heard of some positive examples of local authorities stepping in during the pandemic to support providers where there were significantly reduced staff numbers. However, challenges around staffing and not being able to accept new admissions meant that some providers were facing a shortfall in people using their services, putting the financial viability of some care homes at risk. Recent analysis of providers in our Market Oversight scheme indicates that recovery in care home admissions is slower for self-funded places compared with admissions funded by local authorities. This could put added financial pressure on homes that are more reliant on people who fund their own care.

In June the Association of Directors of Adult Social Services said that a quarter of directors were concerned about the financial sustainability of most of their residential and nursing providers following the outbreak. Also, 15% were concerned about the financial sustainability of most of their homecare and community care providers; before the onset of COVID-19, this figure was 3%.[48]

To support the sector, the government provided £3.7 billion of extra funding to local authorities to help them address the pressures they are facing across the range of public services including social care, and also £600 million through a new Infection Control Fund.

In June, the Social Care Sector COVID-19 Support Taskforce (which included representation from CQC) was commissioned to ensure that concerted and determined action is taken to reduce the risk of transmission of COVID-19, both for those who rely on care and support and for the social care workforce. This was followed in September by the government's winter plan for adult

social care.[49] This coincided with an extension of the Infection Control Fund, with a further £546 million to help the sector restrict the movement of staff between care homes to stop the spread of the virus.

Social care's longstanding need for reform, investment and workforce planning has been thrown into stark relief by the pandemic. The legacy of COVID-19 must be the recognition that issues around funding, staffing and operational support need to be tackled now – not at some point in the future.

In its April COVID-19 action plan for adult social care, the government made a commitment to "ensure that social care gets the recognition and parity of esteem that it deserves. An important legacy of this crisis must be the value that we place on social care as an essential service, core to delivering the frontline response to this crisis, and to ensure everyone understands that people who work in social care are key workers, in every sense."[50]

We support this call for parity. The pandemic has powerfully underlined the essential value of social care in helping people to live the lives they want to lead. To ensure the very best care and support for people in the future, there needs to be a new deal for the care workforce – one that develops clear career progression, secures the right skills for the sector, better recognises and values staff, invests in their training and supports appropriate professionalisation.

4.3 Primary care

Access to care, and in particular inequality in access to care, remains a key concern. Before the pandemic, we heard from inspectors and external stakeholders how some people continued to face difficulties registering with a GP. This included people experiencing homelessness, as well as people with substance misuse or mental health issues. We also know that people who are registered with a GP can sometimes experience difficulties in accessing routine appointments. This included challenges in getting through by phone to make appointments and having to wait several weeks to be seen.

We have since seen a huge transformation in the way primary care services are delivered. GP practices were quick to rise to the challenge and rapidly adopt remote consultations by phone and video to continue to support the needs of their communities. NHS 111 online has seen a huge surge in use during the pandemic, as more people have used digital channels to access medical help or health advice – more than 30 million users visited the online service from the end of February to mid-August.[51] Dental care providers have had very difficult challenges to overcome in reorienting their services to maintain levels of care.

While the work to bring about these changes must be applauded, there are important considerations about how to make best use of them to benefit all patients. For example, relying on telephone and online appointments raises concerns over GPs potentially missing diagnoses or not referring patients in a timely way. We are also concerned that people may not have been seeking help when they needed it because they did not have access to online or telephone care, were worried about catching COVID-19, or did not want to bother their GP at the time of a pandemic. Feedback from the public to Healthwatch England

shows that without alternative options for those who need them, the shift to digital and telephone care risks leaving many people behind.

The substantial drop in the number of new referrals to treatment and the rise in the length of time patients were waiting for a diagnostic test show that there is huge pent-up demand for care that needs to be addressed. Not being able to access a GP and delays in referrals or diagnostic tests could potentially lead to a deterioration in people's conditions. This is particularly important for people with time-sensitive conditions, such as cancer.

Primary care services need to make sure that people and patients are given the confidence to interact with them early, provide a range of different ways for people to access the care they need, and make it easy for them to do so.

As NHS 111 providers prepare for winter, and a resurgence of COVID-19, they have told us they are learning from the last six months and have already started putting in measures to ensure they continue to meet demand and deliver safe and effective care. For example, they are continuing to recruit new staff and support them with the appropriate training. Also, providers are starting to build flexibility into their business models to account for uncertainty, including new working arrangements for staff. This is needed more now as the government looks to introduce the new NHS 111 First model, where people calling into NHS 111 can be offered a booked time slot into an emergency department.

4.4 Acute hospitals

The impact of COVID-19 on people in terms of delays to elective and diagnostic care is enormous. In real terms, this means people who have not yet had the life-changing operations they need, and people whose cancer remains undiagnosed or untreated.

The increased waiting lists and backlog of urgent and elective care need to be addressed. Services need to assess and prioritise patients so that they are treated according to clinical need and that people waiting for long periods for treatment are kept safe. There must be learning to make sure these services are protected in any further resurgence of COVID-19.

The decline in the numbers of people attending emergency departments at the start of the pandemic made it more possible for hospitals to manage patient flow in a safe and effective way. It is worth noting that, while performance against the 95% four-hour target has not been met since July 2015 (falling to its worst level in December 2019), the reduction in attendances enabled emergency departments to get back close to achieving the 95% target in May, although performance has since fallen as attendances have begun to rise (figure 15).

Figure 15: **Monthly performance against the four-hour A&E target, August 2015 to August 2020**
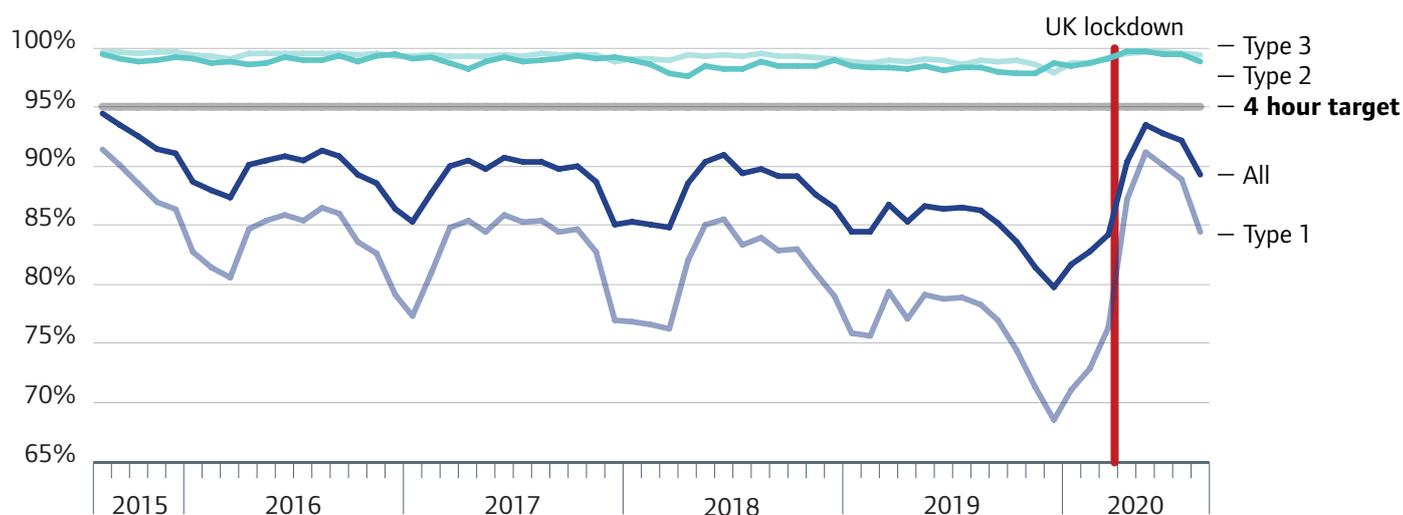
Source: NHS England, A&E attendances and emergency admissions statistics.

Since May the numbers of people attending urgent and emergency care have been increasing. There are concerns that this heightened demand and continued workforce pressures could lead to a return to the overcrowding in emergency departments and corridor care that was seen last winter. Balancing this increasing demand alongside continued COVID-19 care brings significant challenges – particularly as we head into winter, with the additional risk that subsequent spikes of the virus may coincide with seasonal flu.

We have worked with a group of frontline clinicians from good and outstanding emergency departments across the country to better understand what lessons can be learned from the initial impact of COVID-19 and what good practice can be usefully shared to support long-term service improvements. This includes examples of closer working between departments and greater collaboration between hospitals, primary care and community services that can help increase capacity, ensure robust infection control, allow effective social distancing, and support patients to access the service most appropriate to their needs.[52]

Effective infection control will remain essential to protect people from acquiring COVID-19. Providers need to make sure they are taking action to minimise the risk of cross infection. This includes – like for all health and care services – maintaining the highest standards of infection control in all areas, as well as mitigating the challenges caused by social distancing rules, such as reduced capacity in waiting rooms and reception areas.

This applies equally to controlling the spread of COVID-19 between different services. It is essential that information about patients' COVID status is shared appropriately and in a timely way, so that all health and care professionals are able to take steps to protect themselves and everyone else in their care.

Going forward, hospitals and other healthcare services need to finely balance the capacity to provide COVID and non-COVID care, and make sure that

people have the confidence to come forward for the care and treatment they need.

Working closely with other local care providers will be crucial. Those working in acute healthcare services need to take this step and move beyond their natural boundaries. Forming closer partnerships and working as one integrated system has never been more important than now.

4.5 Mental health care

Mental health is a key area where we have previously raised concerns about the lack of community care and early diagnosis and support. Primary care is the first port of call for people with mental health needs, and accessing this help has been disrupted in the pandemic. It is likely that people who have not accessed primary care services since the onset of COVID-19 will be looking for more help going forward. Enhanced mental health support will be needed for people and communities.

Not being able to access the right care at the right time can lead to people reaching crisis point and ending up in hospital. In our October 2020 report on the care for people with mental health needs in acute hospitals, we have highlighted our concerns that, once in hospital, people are not receiving the care that they need, with poor co-ordination and joint working between acute and mental health services and delays in assessments and securing beds. These delays can then be made worse if there is a lack of availability of mental health beds, with people in distress having to stay in inappropriate and sometimes unsafe environments.

Workforce issues and an ongoing decline in the number of inpatient mental health nurses continue to add to difficulties with people accessing acute services, for example leading to longer waiting lists. During the early stages of the pandemic, in April 2020, there was a sharp fall in mental health activity – for example there were only 7,646 admissions to mental health hospitals, compared with 9,933 in April 2019, and almost 100,000 fewer mental health referrals in April 2020 compared with April 2019 (a fall of 31%).[53] Although activity has started to pick up again, this will have affected people's ability to access services during this time, and add pressure to waiting lists.

Ensuring accessible and appropriate mental health provision will be critical if the right care is to be available to those that need it.

A lack of access to local community services can lead to people being placed in hospital far from home. Although the total number of inappropriate out of area placements fell sharply in April 2020, this was in line with overall reductions in referrals and admissions, and the numbers started to rise again in May and June.[54]

As highlighted in our report on the care for people with mental health needs in acute hospitals, the noise and environment of hospital wards can often be distressing for people, particularly those with a learning disability and autistic people, and can lead to them being segregated or secluded. This risk has increased during the pandemic as wards are often unsuitable environments in which to socially distance.

Being placed far from home and families also increases the risk of closed cultures developing. A closed culture is a poor culture in a health or care service that increases the risk of harm. This includes abuse and human rights breaches.[55] We are concerned that this risk has increased during the pandemic, with restrictions on people's movements and services having to restrict or stop families from visiting their loved ones. As part of our work on closed cultures, over the next year we will be working with people who use services, families, providers, frontline staff and other stakeholders to improve the way that we regulate services where there is a closed culture, or a high risk of a closed culture developing.

4.6 An uncertain future for Liberty Protection Safeguards

The Liberty Protection Safeguards (LPS), which are intended to provide a simpler process that will better implement the safeguards that people need, were set to replace the Deprivation of Liberty Safeguards (DoLS) from October 2020. However, because of the current pressures the pandemic is putting on the health and social care sector, this has been delayed until April 2022 (although some provisions about training and new roles are anticipated to come into force before that date).[56]

With providers increasingly looking towards the introduction of the LPS, we found that progress on DoLS varied significantly. In some services, great efforts had been made to improving understanding of LPS prior to its implementation, and to build their confidence in understanding the Mental Capacity Act. However, in other services inspectors noted a reduction in the provision of training for the current DoLS legislation, and lack of drive to improve awareness. Poor understanding of DoLS has remained a fundamental issue throughout its years in legislation. This, together with the delays and uncertainty over the progress of LPS, may mean there is an increasing risk of people being deprived of their liberty without the proper authorisation.

Given that DoLS authorisations can last up to a year, it may not be until March 2023 that DoLS is fully behind us. This underlines the importance of continuing to improve the way providers, local authorities and others work together to support the proper use of the DoLS – and to give careful consideration of how the two systems will work alongside each other in the first year of implementing the LPS. The time ahead also provides an opportunity to consider what can be done now within the current DoLS system to ease the transition.

It remains vitally important, both in the DoLS now and the LPS in future, to make sure people using services, together with their families, supporters and advocates, are kept at the heart of the process. The human rights and quality of life of many thousands of people made vulnerable by their circumstances depend on it.

4.7 Support for improvement

The support that is available to help services improve the quality of their care varies between and within health and care sectors, and across England. Some services have limited access to the support they need.

Health and social care providers across the country need an equal and consistent offer of improvement. Providers and systems need access to shared learning, information, advice and support, so they can be empowered to help themselves. Information is needed so they can understand their performance against similar services, which in turn can help them access the specific support they need to implement changes.

Technology changes present an opportunity for rapid improvement in health and care, but services don't always understand or implement them well. A culture of learning is paramount if individual services and systems of care are to drive the improvements needed.

There is often a need for localised improvement across health and care services in an area. It is important to get this right for people who use different services within a system, as improvement results in ways that people recognise: easier access to the most appropriate services at the right time, fewer avoidable mistakes, and better experiences and outcomes, all delivered by a diverse workforce that is thriving.

4.8 Collaboration and system working

In our State of Care report for 2018/19, we said, "The challenge for government, Parliament, commissioners, national organisations and providers is to change the way services work together, so that the right services are being commissioned to deliver what people need in their local area."[57]

We have found that the amount of progress being made in system working varied, with some good examples of local system working but some examples of ineffective coordination. Evidence from our focus groups with inspection staff and external stakeholders for this year's report suggested that things were moving in the right direction. We heard that providers were more willing to work with others in the system and could see the benefits of working collaboratively.

We have seen evidence of this during the pandemic, with some excellent examples of good joined-up care between health and social care professionals working together to keep people safe. In some cases, plans for more integrated working that providers have long wanted to implement were put into action in a matter of days. Examples included care homes being aligned to GP practices to support better care planning, and clinical commissioning groups working with local authorities to provide all local care homes with an iPad and video conferencing so that GPs could do virtual ward rounds in addition to physical visits.

In the prison system, partnership working between commissioners, prisons and healthcare providers has enabled the spread of the virus to be well controlled. This joint working has strengthened partnerships, which will promote closer working in the future.

But the challenge we set out is still present. While we have seen some examples of good collaboration in response to the crisis, it has not been evident everywhere and barriers to effective system working have been clear. Governance structures, leadership, working relationships, communication and finance remain key factors in the development and implementation of system working.

As the health and care system continues to wrestle with the pandemic, providers, regulators and system partners need to maintain the appetite to work together and at pace. We must make sure that we learn from the response to the crisis, that we lock in positive changes, and that we drive a new way of working that is supported at a national, regional and local level by the whole health and care system. The way we plan, commission and deliver health and care must be shaped by the experience of dealing with a national health emergency, which has shown so very clearly how interdependent health and care truly are.

Appendix: Ratings charts

Adult social care

Figure A1: **Adult social care, overall ratings, 2019 and 2020**

18,404 (80%) 18,779 (80%)

3,373 (15%) 3,429 (15%)

285 (1%) 275 (1%)

887 (4%) 1,073 (5%)

2019 2020
Inadequate

2019 2020
Requires improvement

2019 2020
Good

2019 2020
Outstanding
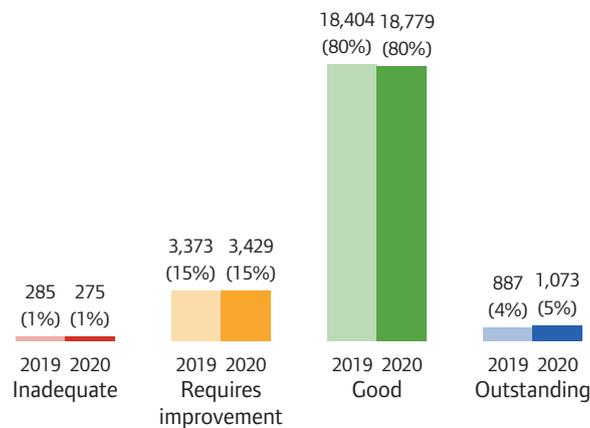
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A2: **Adult social care, key question ratings, 2019 and 2020**

		Inadequate	Requires improvement	Good	Outstanding
Safe	2020	1	17	82	<0.5
	2019	1	17	81	<0.5
Effective	2020	<0.5	10	88	2
	2019	<0.5	11	87	1
Caring	2020	<0.5	4	91	5
	2019	<0.5	4	91	4
Responsive	2020	<0.5	9	85	6
	2019	<0.5	9	85	5
Well-led	2020	2	20	74	4
	2019	2	19	75	4

0%   20%   40%   60%   80%   100%

● Inadequate ● Requires improvement ● Good ● Outstanding
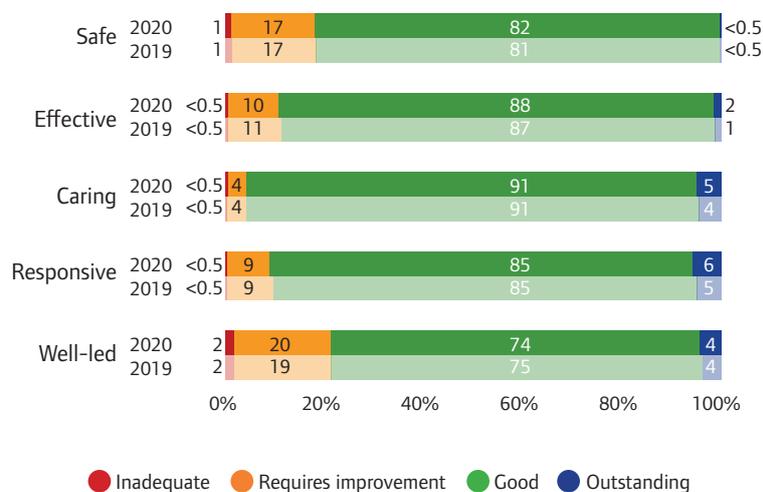
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A3: **Adult social care, overall ratings by type of service, 2019 and 2020**
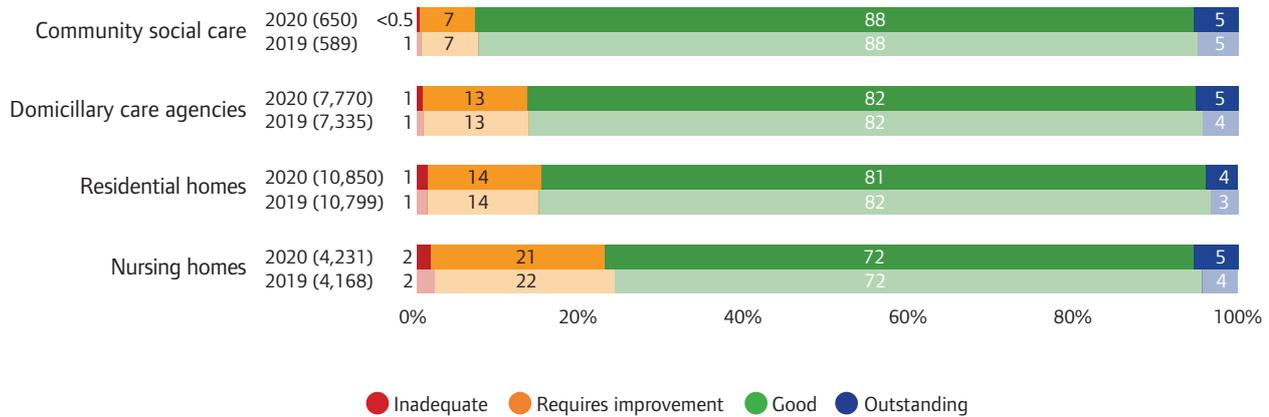
Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated locations at 31 March 2020.

Figure A4: **Adult social care, overall ratings by region, 2019 and 2020**
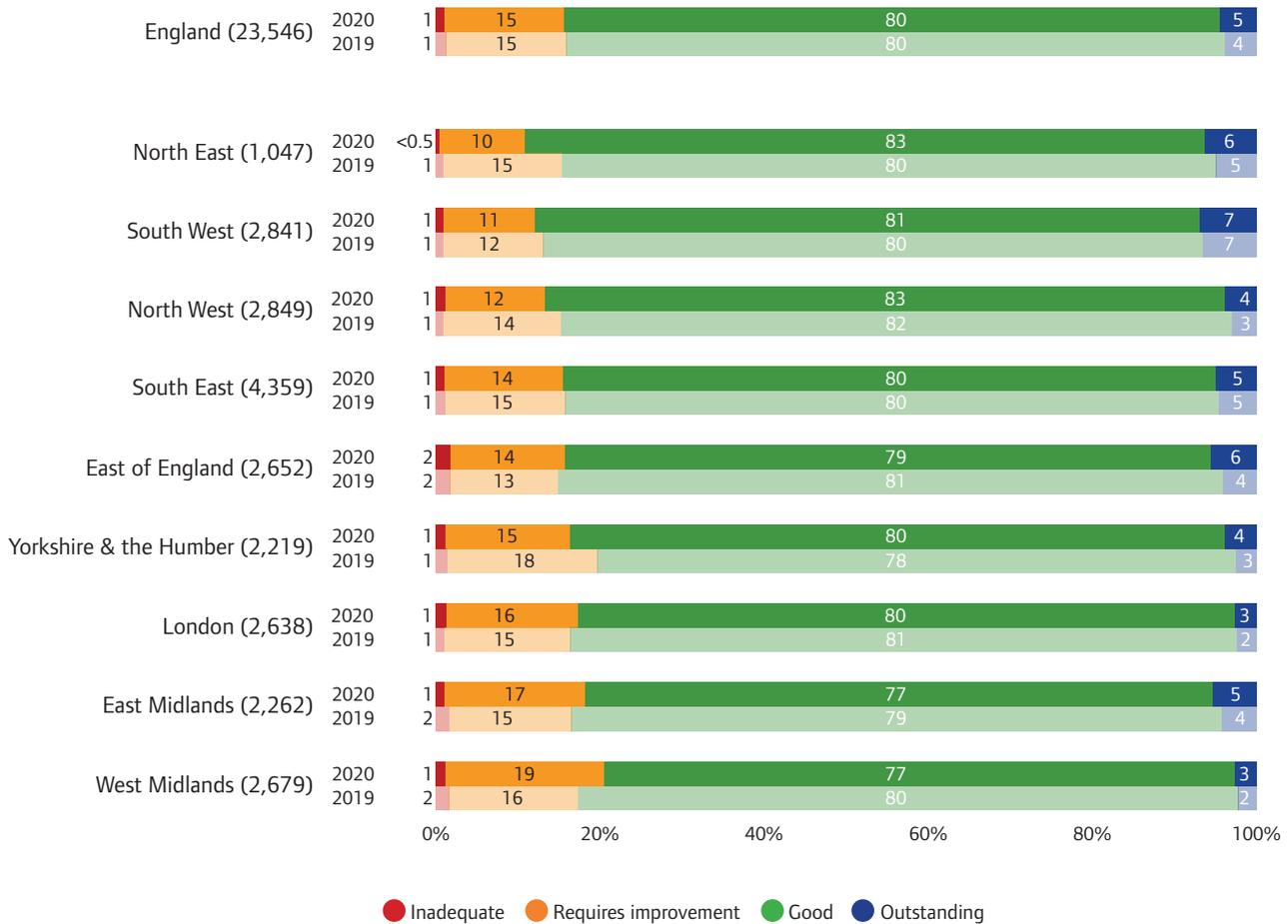
Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated locations at 31 March 2020.

Primary care

Figure A5: **GP practices, overall ratings, 2019 and 2020**

82 (1%)	271 (4%)	(90%)	313 (5%)
84 (1%)	299 (4%)	(89%)	318 (5%)
2019 2020 Inadequate	2019 2020 Requires improvement	2019 2020 Good	2019 2020 Outstanding
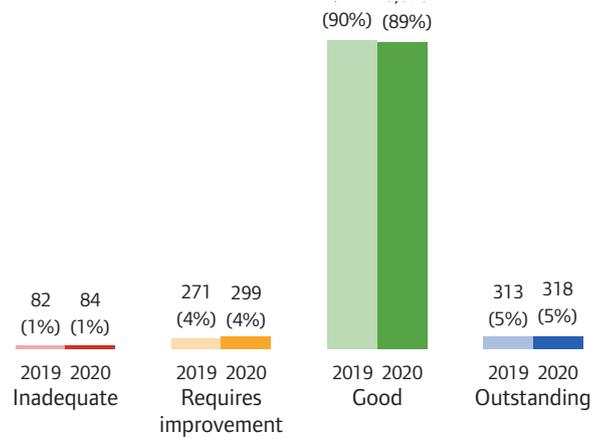
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A6: **GP practices, key question ratings, 2019 and 2020**

		Inadequate	Requires improvement	Good	Outstanding
Safe	2020	1	5	93	1
	2019	1	6	92	1
Effective	2020	1	4	92	3
	2019	1	4	93	3
Caring	2020	<0.5	1	95	3
	2019	<0.5	1	95	3
Responsive	2020	1	3	90	6
	2019	<0.5	3	91	6
Well-led	2020	1	4	89	5
	2019	1	4	90	5

● Inadequate ● Requires improvement ● Good ● Outstanding
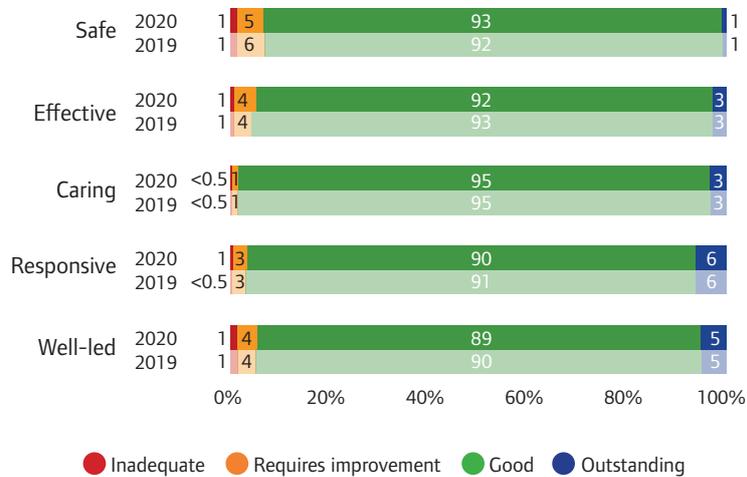
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A7: GP practices, overall ratings by region, 2019 and 2020
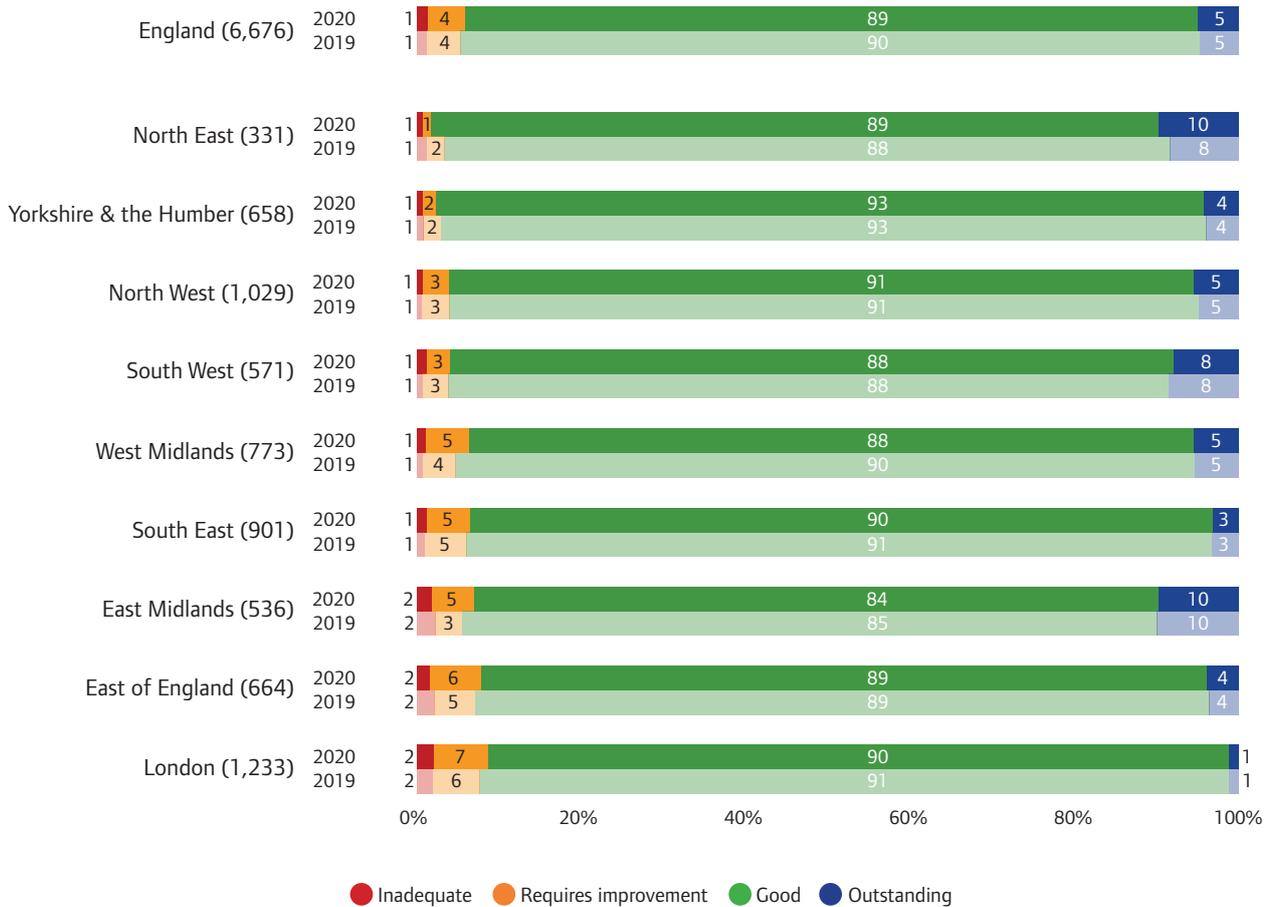
England (6,676)
2020: 1, 4, 89, 5
2019: 1, 4, 90, 5

North East (331)
2020: 1, 1, 89, 10
2019: 1, 2, 88, 8

Yorkshire & the Humber (658)
2020: 1, 2, 93, 4
2019: 1, 2, 93, 4

North West (1,029)
2020: 1, 3, 91, 5
2019: 1, 3, 91, 5

South West (571)
2020: 1, 3, 88, 8
2019: 1, 3, 88, 8

West Midlands (773)
2020: 1, 5, 88, 5
2019: 1, 4, 90, 5

South East (901)
2020: 1, 5, 90, 3
2019: 1, 5, 91, 3

East Midlands (536)
2020: 2, 5, 84, 10
2019: 2, 3, 85, 10

East of England (664)
2020: 2, 6, 89, 4
2019: 2, 5, 89, 4

London (1,233)
2020: 2, 7, 90, 1
2019: 2, 6, 91, 1

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated locations at 31 March 2020.

Figure A8: Other primary medical services, overall ratings, 2019 and 2020
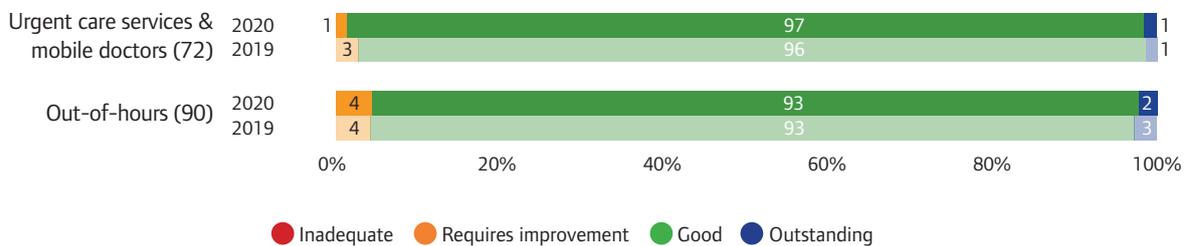
Urgent care services & mobile doctors (72)
2020: 1, 97, 1
2019: 3, 96, 1

Out-of-hours (90)
2020: 4, 93, 2
2019: 4, 93, 3

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated locations at 31 March 2020.

Mental health care

Figure A9: **NHS mental health core services, overall ratings, 2019 and 2020**

	2019	2020
Inadequate	15 (3%)	15 (3%)
Requires improvement	91 (17%)	77 (15%)
Good	383 (71%)	365 (71%)
Outstanding	54 (10%)	57 (11%)
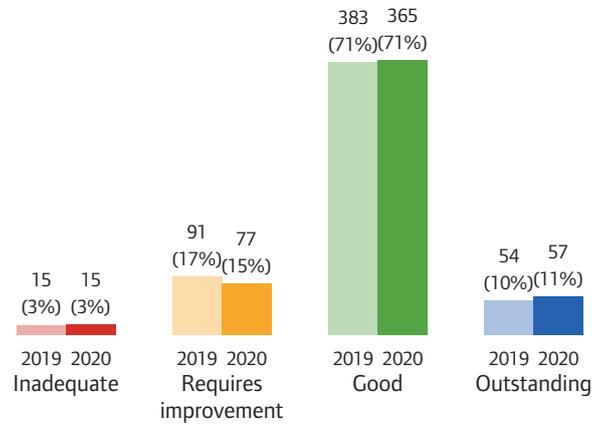
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A10: **NHS mental health core services, key question ratings, 2019 and 2020**

		Inadequate	Requires improvement	Good	Outstanding
Safe	2020	4	29	67	1
	2019	4	30	66	1
Effective	2020	1	13	80	6
	2019	1	17	77	6
Caring	2020	<0.5	3	81	16
	2019		3	83	14
Responsive	2020	2	12	78	8
	2019	2	11	80	7
Well-led	2020	3	12	75	10
	2019	3	13	75	8

● Inadequate ● Requires improvement ● Good ● Outstanding
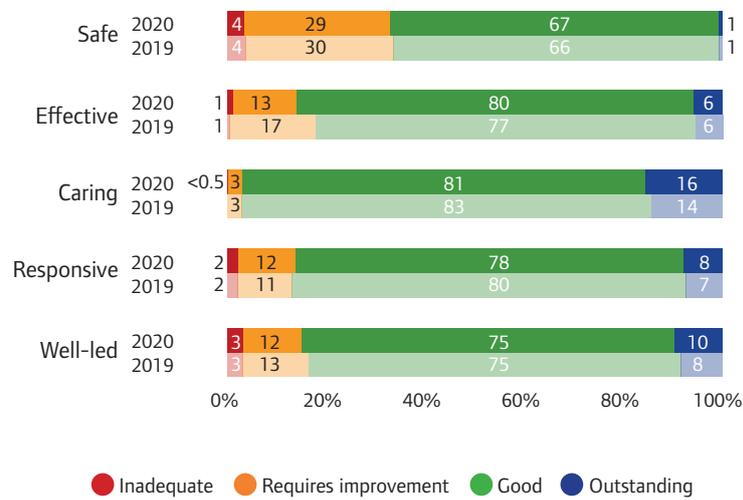
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A11: **Independent mental health core services, overall ratings, 2019 and 2020**
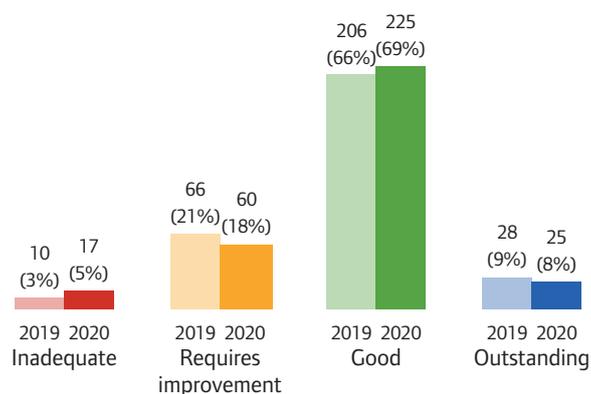
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A12: **Independent mental health core services, key question ratings, 2019 and 2020**
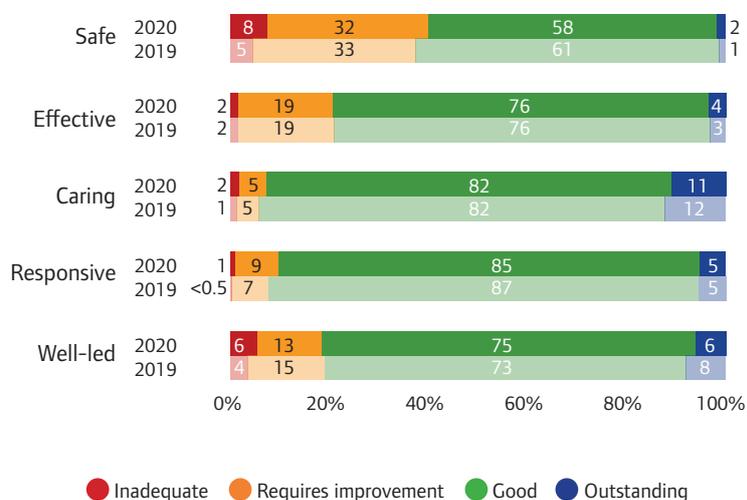
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A13: **NHS and independent mental health core services, overall ratings, 2019 and 2020**

Service	Year	Inadequate	Requires improvement	Good	Outstanding
Community mental health services for people with a learning disability or autism (54)	2020			91	9
	2019		2	89	9
Community-based mental health services for older people (55)	2020		4	80	16
	2019		5	78	16
Long stay or rehabilitation mental health wards for working age adults (159)	2020	1	13	74	12
	2019	1	17	70	11
Child and adolescent mental health wards (70)	2020	7	10	69	14
	2019	6	17	64	14
Wards for older people with mental health problems (76)	2020	1	17	74	8
	2019	4	16	74	7
Forensic inpatient or secure wards (96)	2020	1	18	72	9
	2019	3	20	67	10
Community-based mental health services for adults of working age (69)	2020	4	19	74	3
	2019	3	21	73	3
Mental health crisis services and health-based places of safety (56)	2020	4	21	70	5
	2019	2	18	75	5
Wards for people with learning disabilities or autism (80)	2020	13	18	56	14
	2019	4	18	63	16
Specialist community mental health services for children and young people (67)	2020	6	27	57	10
	2019	6	20	63	11
Acute wards for adults of working age and psychiatric intensive care units (103)	2020	6	36	54	4
	2019	6	38	52	4

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote number of rated core services at 31 March 2020.

## Acute hospitals, ambulance services, community health care

Figure A14: **NHS acute core services, overall ratings, 2019 and 2020**

1,151
(65%)

1,193
(67%)

452
(25%)

406
(23%)

43
(2%)

30
(2%)

127
(7%)

148
(8%)

2019	2020	2019	2020	2019	2020	2019	2020
Inadequate		Requires improvement		Good		Outstanding	
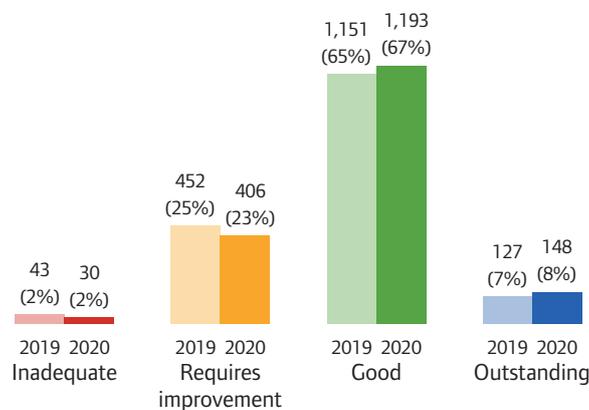
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A15: **NHS acute core services, key question ratings, 2019 and 2020**

		Inadequate	Requires improvement	Good	Outstanding
Safe	2020	2	34	63	1
	2019	3	36	61	1
Effective	2020	1	16	79	4
	2019	1	19	77	4
Caring	2020	<0.5	2	86	13
	2019	<0.5	2	87	11
Responsive	2020	1	25	67	7
	2019	1	25	68	6
Well-led	2020	2	19	70	8
	2019	3	21	68	7

0%   20%   40%   60%   80%   100%

● Inadequate   ● Requires improvement   ● Good   ● Outstanding
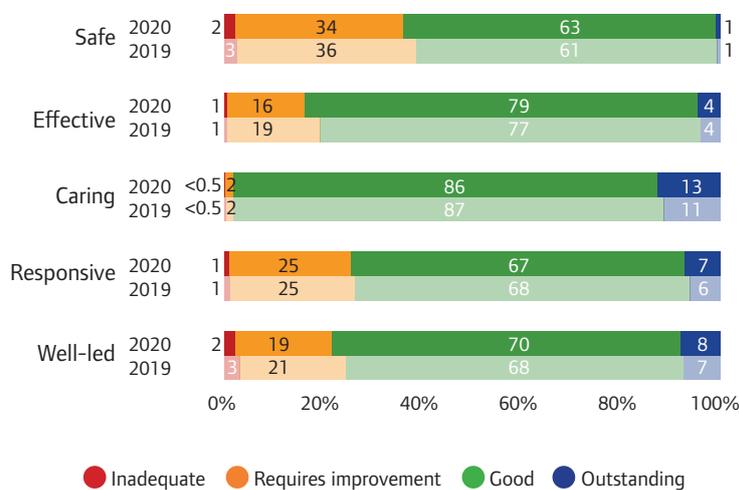
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A16: **NHS acute core services, overall ratings, 2019 and 2020**

	Inadequate	Requires improvement	Good	Outstanding
End of life care (209) 2020	1	11	70	17
End of life care (209) 2019	1	18	69	13
Critical care (202) 2020		16	70	14
Critical care (202) 2019	1	21	66	13
Services for children and young people (181) 2020	2	14	78	6
Services for children and young people (181) 2019	2	17	78	4
Surgery (254) 2020	1	23	69	7
Surgery (254) 2019	2	25	67	6
Maternity (123) 2020		26	69	5
Maternity (123) 2019	1	25	69	5
Medical care (including older people's care) (251) 2020	1	30	62	7
Medical care (including older people's care) (251) 2019	2	33	57	7
Outpatients (125) 2020	2	30	65	2
Outpatients (125) 2019	7	33	59	2
Urgent and emergency services (209) 2020	7	44	44	5
Urgent and emergency services (209) 2019	8	44	44	4
Outpatients and diagnostic imaging (154) 2020		12	79	8
Outpatients and diagnostic imaging (154) 2019	1	19	74	7
Maternity and gynaecology (69) 2020		14	77	9
Maternity and gynaecology (69) 2019	1	18	74	7

● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated core services at 31 March 2020.

Figure A17: **Independent health acute (non-specialist) core services, overall ratings, 2019 and 2020**

	2019	2020
Inadequate	3 (1%)	2 (<0.5%)
Requires improvement	95 (17%)	78 (13%)
Good	425 (74%)	483 (78%)
Outstanding	51 (9%)	57 (9%)
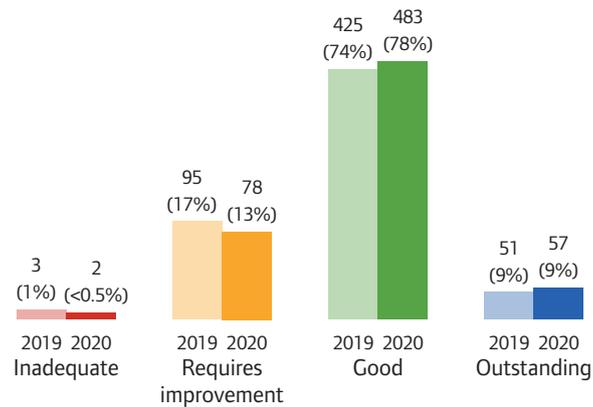
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A18: **Independent health acute (non-specialist) core services, key question ratings, 2019 and 2020**

Safe 2020: 1, 20, 78, 1
Safe 2019: 1, 27, 71, 1
Effective 2020: <0.5, 10, 86, 3
Effective 2019: <0.5, 14, 83, 2
Caring 2020: 88, 12
Caring 2019: 89, 11
Responsive 2020: 3, 89, 7
Responsive 2019: 4, 89, 7
Well-led 2020: 2, 16, 71, 11
Well-led 2019: 2, 20, 67, 11

● Inadequate ● Requires improvement ● Good ● Outstanding
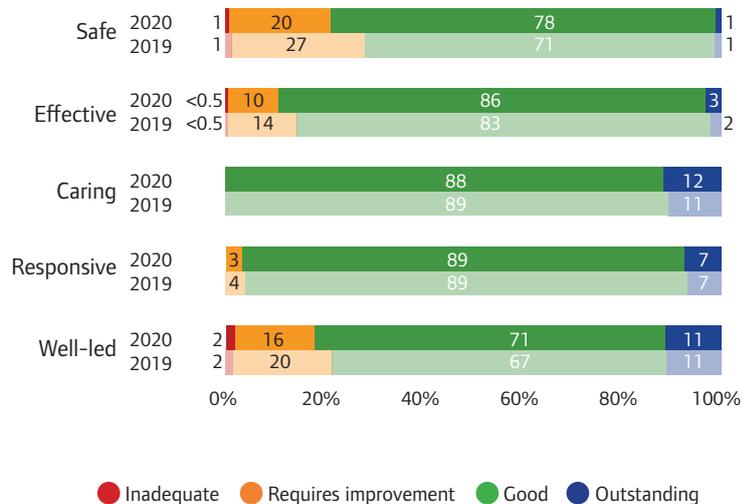
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A19: **Independent health acute (non-specialist), core service ratings, 2019 and 2020**
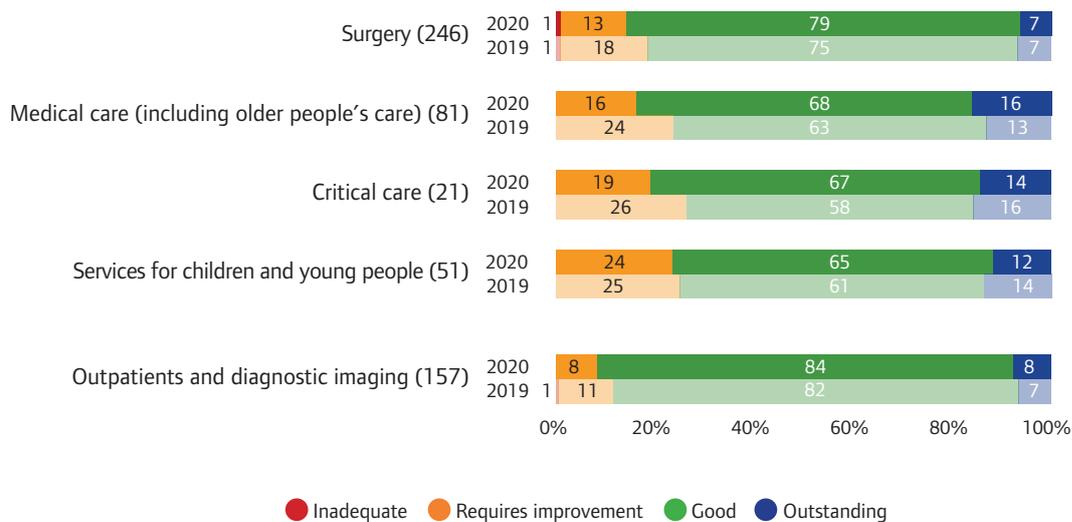
		Inadequate	Requires improvement	Good	Outstanding
Surgery (246)	2020	1	13	79	7
	2019	1	18	75	7
Medical care (including older people's care) (81)	2020		16	68	16
	2019		24	63	13
Critical care (21)	2020		19	67	14
	2019		26	58	16
Services for children and young people (51)	2020		24	65	12
	2019		25	61	14
Outpatients and diagnostic imaging (157)	2020		8	84	8
	2019	1	11	82	7

● Inadequate   ● Requires improvement   ● Good   ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote the number of rated core services at 31 March 2020.

Figure A20: **NHS ambulance trusts, overall ratings, 2019 and 2020**

0
(0%)
0
(0%)
2019 2020
Inadequate

2
(20%)
1
(10%)
2019 2020
Requires improvement

7
(70%)
8
(80%)
2019 2020
Good

1
(10%)
1
(10%)
2019 2020
Outstanding
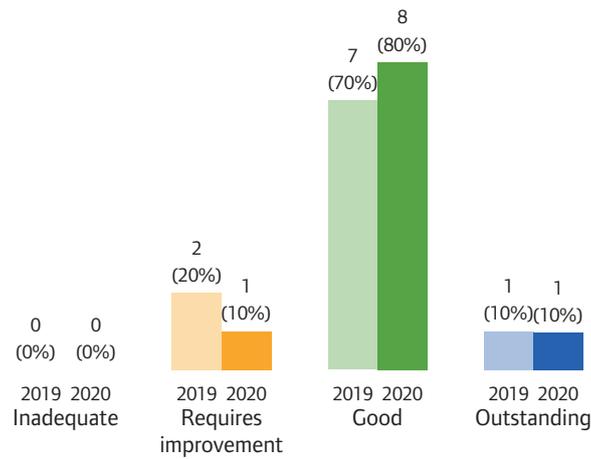
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A21: **NHS ambulance trusts, key question ratings, 2019 and 2020**

|			
Safe	2020	30	70
	2019	30	70
Effective	2020	10	80 / 10
	2019	20	70 / 10
Caring	2020	60	40
	2019	50	50
Responsive	2020	90	10
	2019	10	90
Well-led	2020	10	80 / 10
	2019	10 / 10	80

0%   20%   40%   60%   80%   100%

● Inadequate ● Requires improvement ● Good ● Outstanding
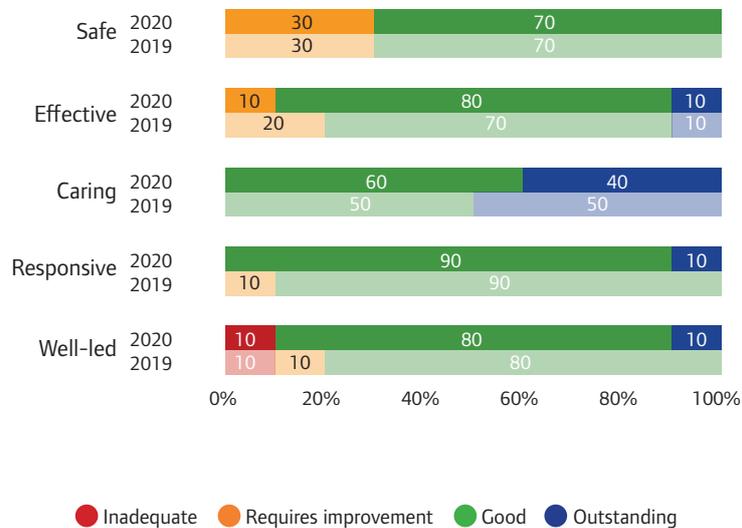
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A22: **Independent ambulance locations, overall ratings, 2020**
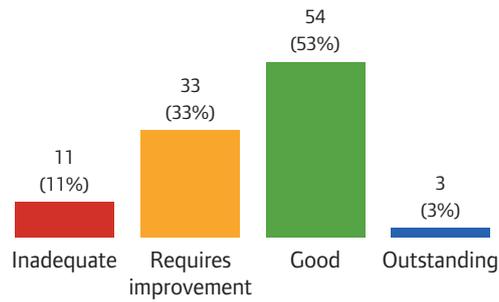
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A23: **Independent ambulance locations, key question ratings, 2020**
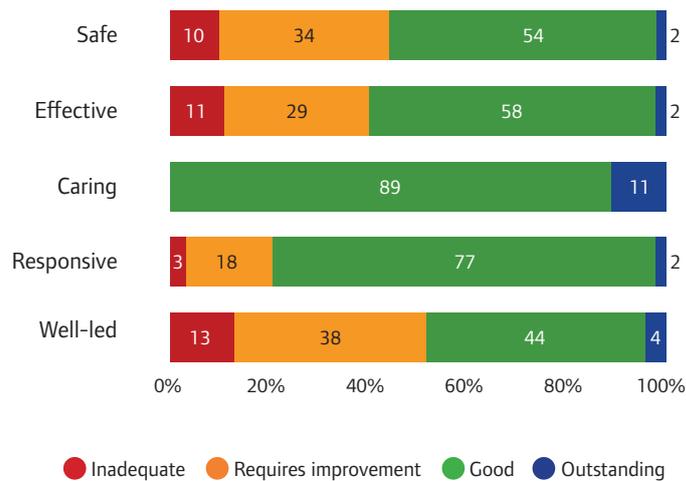
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A24: **Community health core services in all settings, overall ratings, 2019 and 2020**
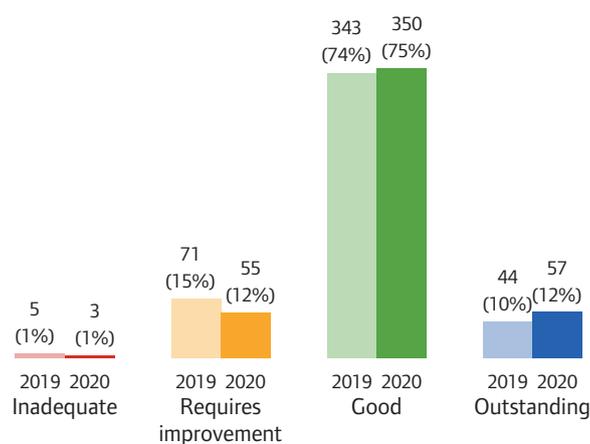
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

Figure A25: **Community health core services in all settings, key question ratings, 2019 and 2020**
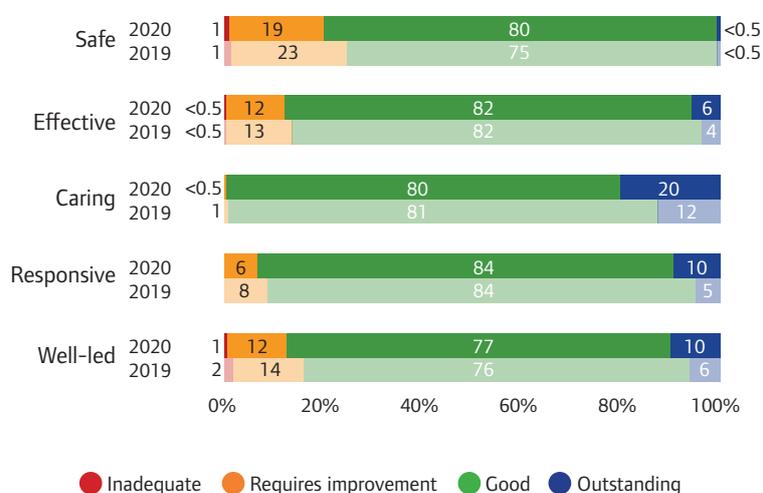
Source: CQC ratings data, 31 July 2019 and 31 March 2020.

## Figure A26: **Community health core services, overall ratings, 2019 and 2020**

Community health sexual health services (20)
- 2020: Requires improvement 5, Good 70, Outstanding 25
- 2019: Requires improvement 18, Good 71, Outstanding 12

Community dental services (38)
- 2020: Requires improvement 5, Good 76, Outstanding 18
- 2019: Requires improvement 8, Good 73, Outstanding 19

Community health services for adults (110)
- 2020: Requires improvement 10, Good 75, Outstanding 15
- 2019: Inadequate 1, Requires improvement 13, Good 75, Outstanding 11

Community health services for children, young people and families (103)
- 2020: Inadequate 1, Requires improvement 11, Good 78, Outstanding 11
- 2019: Inadequate 2, Requires improvement 12, Good 78, Outstanding 9

Community end of life care (76)
- 2020: Inadequate 1, Requires improvement 12, Good 70, Outstanding 17
- 2019: Inadequate 1, Requires improvement 14, Good 73, Outstanding 12

Community health inpatient services (88)
- 2020: Inadequate 1, Requires improvement 17, Good 78, Outstanding 3
- 2019: Inadequate 1, Requires improvement 21, Good 74, Outstanding 3

Community urgent care service (30)
- 2020: Requires improvement 20, Good 73, Outstanding 7
- 2019: Requires improvement 31, Good 62, Outstanding 7

Legend: ● Inadequate ● Requires improvement ● Good ● Outstanding

Source: CQC ratings data, 31 July 2019 and 31 March 2020.
Numbers in brackets denote number of rated core services at 31 March 2020.

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