Performance analysis

The performance analysis for 2021/22 is a detailed explanation of our performance during the year, with evidence to support the performance summary. It is arranged under the priorities, ambitions and outcomes of our Strategy.

Priority 1: People and communities

Our ambition is that the needs and experiences of people drive our regulation, and that we are focused on what is important to people and communities when they access, use and move between services.

51% increase in people sharing their experience with us through our Give Feedback on Care service in 2021/22

3,335 instances of workforce pressures recorded through our data capture following inspection or Direct Monitoring Activity

479 visits carried out to keep the operation of the Mental Health Act under review as part of our statutory duty

Outcome 1: Our activity is driven by people's experiences of care

Because we all care

Across the year we continued to develop ways to ensure people's experience of care is used to bring about improvements. In July 2020 we launched an award-winning 'Because we all care' campaign jointly with Healthwatch England. This year we continued to market this campaign in each quarter, with focuses on different audiences. For example, in March 2022 our campaign focused on unpaid carers. Through our campaign, we encourage people to share experiences of care – their own and those of a loved one, creating a strong feedback culture.

Receiving feedback from people receiving care is a key element of our strategy, whether the feedback is good or bad. We use all feedback to help keep track on the quality of care that services provide. It can help us decide what action we need to take, such as inspect a service or take enforcement action.

As part of our 'Because we all care' campaign, as well as through other channels, we have promoted our Give Feedback on Care service**.** We use what people tell us to understand the quality of care they get from services, including care homes, care agencies, hospitals and GP practices.

This financial year we saw a 51% increase in the volume of feedback we received. We received more than 64,000 individual pieces of feedback about health and social care services, an increase of more than 20,000 on 2020/21. The biggest increase was in the primary medical services sector, with a 127% increase from the previous financial year and notable peaks in February and March 2022.

Achieving an increase in feedback is progress towards our strategy. A key measure of success is the number of unique services from which we received feedback. In 2020/21 we received feedback about 15,771 services; in 2021/22 this increased to 19,029.

Information of concern (safeguarding, whistleblowing, concerns and complaints)

During the year we received a total of 1,047,101 enquiries. Enquiries are generated through emails, calls to our National Customer Service Centre, statutory notifications from providers, and feedback through our online Give Feedback on Care service. All areas of feedback have been a focus in our 'Because we all care' campaigns. Of the total, 134,178 were whistleblowing, safeguarding, concerns and complaints (which we refer to as information of concern enquiries).

We continue to use all feedback and information we receive to review and monitor services. As part of our business plan reporting, we monitor where information of concern is a risk trigger for when we need to use our regulatory powers. Where our inspection activity was triggered by the enquiries we received, 49% was triggered by information of concern, compared with 55% in 2020/21. Other inspection triggers include statutory notifications from providers (such as a notification of an unexpected death) and information and intelligence from other stakeholders.

When we receive safeguarding information, we quickly inform local authorities of the most urgent and serious information of concern (known as safeguarding alerts). For safeguarding alerts our target is to ensure local authorities receive an alert of the information within 24 hours. In 2021/22 our performance remained good at 95%, against our target of 95%. This compares with performance of 97% in 2020/21. Across the year we improved our performance on safeguarding concerns (where we are not the only stakeholder who is aware of the information of concern), with a year-end performance of 97% in taking action within 5 days, compared with 95% in 2020/21.

Some of the information we receive is shared with us by people who work, or have worked, for health and care organisations that are registered with us – or people who provide services to those organisations, such as agencies. It is important that people who work at health and care organisations feel they can speak to us about issues that cause them concern, and that our response is prompt and appropriate. We describe the concerns we receive from them as whistleblowing enquiries.

In 2021/22 we received 17,937 whistleblowing enquiries. This was a 13.3% increase from 2020/21 when we received 15,827. The majority of these enquiries (80%) were about adult social care services, 15% were about hospitals and the rest were about primary medical services.

When we receive an enquiry, we consider the information carefully and prioritise which action to take according to the level of risk. The most serious enquiries, for example where there is a risk of harm to an individual, will trigger a safeguarding process that may include a referral, such as to the local authority. Other actions include bringing forward inspections and conducting responsive inspections. There are some enquiries that remain completely anonymous – when this happens, we may not be able to take action due to lack of information.

Mental Health Act and Second opinion appointed doctors

We made 479 visits to keep the operation of the Mental Health Act (MHA) under review as part of our statutory duty. The previous year's visits were heavily impacted by the pandemic, and therefore this year has seen a substantial increase in activity.

The second opinion appointed doctor (SOAD) service is a statutory provision of the Mental Health Act 1983. Its purpose is to provide a mechanism for detained patients who do not, or cannot, consent to treatment for mental disorder. As an organisation we administer the service but are not responsible for the individual clinical opinion. This year we received 13,165 SOAD requests, compared with 20,200 in 2020/21.

'Monitoring the Mental Health Act' is our annual report on the use of the Mental Health Act. It looks at how providers are caring for patients, and whether patients' rights are being protected. In our findings we highlighted concerns that reduced access to community mental health services during the pandemic may have contributed to an increase in the number of people being detained under the MHA. In 2020/21 there was a 4.5% increase in use of the MHA to detain people with mental health problems in hospital for assessment and treatment. We have previously reported on the impact of COVID-19 on children and young people's mental health and services' ability to meet increased demand. Our report raised concerns about children and young people being placed in unsuitable environments while they wait for an inpatient child and adolescent mental health services bed.

Outcome 2: We clearly define quality and safety in line with people's changing needs and expectations. This definition is used consistently by all people, and at all levels of the health and social care system

Insight reports

During the height of the pandemic, our Insight reports informed everyone involved in health and social care, shared learning and helped services to reflect on what went well. They helped services and systems prepare better for the future. They continued to be a key part of our engagement and sharing with the public and the sector across the year. The Insight reports are intended to help everyone involved in health and social care to learn from what we know through our conversations and regulatory activity. This includes sharing and reflecting on what has gone well, understanding and learning what hasn't and helping health and care systems to work together better in the future.

This year's reports included the following key areas:

- The impact of the pandemic on access to dental services, and examples of the innovative ways that local services have collaborated to care for people with cancer or suspected cancer (May 2021).

- Publication of our provider collaboration review of how services across seven local areas in England worked together for people with a learning disability during the pandemic (June 2021).
- Notifications of deaths involving COVID-19 received from individual care homes, our inspections of acute NHS services monitoring infection prevention and control, and what we have learned about how risks can build into a closed culture (July 2021).
- How NHS trusts were planning for people's care while tackling the backlog caused by COVID-19 and their assessment of challenges (September 2021).
- Medication safety in NHS trusts, focusing on the role of medication safety officers (November 2021).
- Staff vacancies in care homes and the quality of ethnicity data recording for mental health services (March 2022).

National reports

In September 2021 we published our 'Home for Good' report. This highlighted how successful community support can be achieved for people with a learning disability, people with mental health needs and autistic people. The report included 8 stories of people who had previously been placed in hospital settings, often called assessment and treatment units. In all the case studies, the people were shown to be thriving in community services. There is no single model of care and support that explains this success and each story is different.

In November 2021 we published our report on the Ionising Radiation (Medication Exposure) Regulations 2017, known as IR(ME)R. These provide a regulatory framework to protect people against the dangers from being exposed to ionising radiation in a healthcare setting. We enforce the regulations in England by carrying out inspections, acting on information from other areas of our work, and reviewing statutory notifications from healthcare services about significant accidental or unintended exposure to patients.

Our report provides a breakdown of the number and type of notifications we receive about IR(ME)R and findings from our inspections. This year we carried out 45 IR(ME)R inspections, compared with 13 in 2020/21.

As part of our business plan reporting, we track the online views of our national reports in the first 3 months following their publication. This help us to understand the impact they have on the sector and, in particular, how many unique views they receive. State of Care received the highest volume across the 3 months with 23,735 unique views, followed by the Home for Good report which received 5,351 views.

During the year, Healthwatch England published new research to help understand the experiences of people who use services. Topics included:

- vaccine confidence among people from African, Bangladeshi, Caribbean and Pakistani backgrounds
- digital exclusion, looking at groups who may have struggled to access care remotely, people who have language barriers, and individuals who lack interest in using technology
- the experiences of people on NHS waiting lists
- access to dental care for children.

Vaccination as a condition of deployment

In 2021, the government introduced vaccination against COVID-19 as a condition of deployment in care homes, as part of changes to the Health and Social Care Act 2008. This came into effect on 11 November 2021. From this date we reviewed vaccination status as part of our inspection methodology, as well as during registration processes.

In response to increasing concerns about available staff in the adult social care sector in December 2021, we launched a data collection tool. This was to capture information about workforce pressures whenever we inspected a service or carried out a direct monitoring activity (DMA). At the end of 2021/22, we had carried out 3,335 workforce pressure reviews. Thirty-eight per cent of services indicated there had been a negative impact due to workforce pressures, and 27% indicated a delay in people accessing health care.

In March 2022, following consultation by the government, vaccination as a condition of deployment was revoked for all health and social care staff, including staff working in or deployed to care homes. During the period from 11 November to the condition being revoked, we issued 28 breaches of regulation in relation to vaccination as a condition of deployment. Each location that was found in breach of regulation 12(3) has since had their inspection report reviewed. Where the location's rating was impacted by this breach of regulation, we have taken the necessary action, treating each location individually and assessing the circumstances.

Outcome 3: Our ways of working meet people's needs because they are developed in partnership with them

Experts by Experience and specialist professional advisors

In transforming our regulation, we have continued the use of Experts by Experience and recognised the importance of user voice in our work. Experts by Experience have provided more than 5,000 days of support during the year, both on-site as part of inspection teams and remotely speaking to family members and staff as part of our regulatory activity.

Specialist professional advisors (SPAs) are a key part of our methodology and across the year have provided over 4,000 days of support in regulatory activity – an increase of 31% from the previous year.

Key areas of performance from Priority one in 2021/22:

- Emergence of the Omicron variant of COVID-19 added to staffing pressures in the adult social care sector, with large numbers of care workers required to self-isolate. In response, we launched a digital data collection on workforce pressures.
- We published 6 COVID-19 Insight reports during the year.
- We carried out 479 Mental Health Act visits. On average, inspection reports were published in under 15 days.
- We received 17,941 whistleblowing enquiries, compared with 15,827 in 2020/21, with an additional 2,114 enquiries received from staff members. In 88.2% of whistleblowing we recorded our mitigating action within 5 days of the information being received.
- There were 26,424 safeguarding enquiries during the year (safeguarding concerns and safeguarding alerts). This is a slight decrease from 26,568 received in 2020/21. The split across the sectors was adult social care (20,833), hospitals (5,135) and primary medical services (388). Adult social care and primary medical services both saw an increase from the previous year, whereas the hospitals sector saw a 9% reduction.
- We have a 95% KPI of responding to safeguarding alerts in 1 day and safeguarding concerns in 5 days. Ninety-five per cent of alerts had action recorded within 1 day and 97% of concerns had action captured within 5 days.
- Across the year 1,440 inspections had an element of on-site activity that was out-of-hours (before 8am, after 6pm or on a weekend or bank holiday).
- 91% of services and 67% of our strategic partners and other stakeholder survey respondents said they use our definition to inform their work and improve quality and safety (increasing to 85% when just looking at local stakeholders).
- During 2021/22 we held 114 co-production activities involving 26,840 people, including organisations that represent them, to inform our ways of working. Of these, which 78 (involving 11,329 people) included those more likely to have poor care.

Priority 2: Smarter regulation

Our ambition is to be a smarter, more dynamic and flexible regulator that provides up-to-date and high-quality information and ratings. We want to make it easier for others to work with us and we aim to deliver a more proportionate response when we inspect.

46% increase in inspections carried out compared with the previous year, carrying out 10,306 in total

53,165 registration applications received, an increase of 3,709 from the previous year

4,392 Direct Monitoring Activities completed across 4,003 different services in 2021/22

Outcome 4: We are an effective, proportionate, targeted, and dynamic regulator

Our regulatory approach

Throughout the pandemic we have continually reviewed our regulatory approach, in recognition of the changing pressures health and social care services have found themselves working under and the difficult challenges that everyone, both providers and people needing care, have faced. Our priority has always been to support services to ensure people receive safe care. We strive to ensure that our approach is appropriate and proportionate.

In December 2021, as the acceleration of the vaccine booster programme was announced, we made the decision to postpone on-site activity in acute hospitals, ambulance services and general practice for 3 weeks, except in cases where we had evidence of risk to life, or the immediate risk of serious harm to people. We took this decision in response to the extremely fast-moving situation, with the aim of being as supportive as possible in response to the increased pressure on the NHS. Our priority, as ever, remained to keep people safe.

Throughout the year we expanded our approach to our regulatory activity. This included the following (see below for further information):

- direct monitoring calls
- provider statements for services that we assess as low risk
- quality assurance sampling
- workforce pressures data collection
- infection prevention and control inspections
- designated settings
- improvement inspections and a focus on services that had not been inspected, or those inspected but not rated
- visiting concerns
- GP access.

In March 2020 we suspended our routine inspection programme in response to COVID-19 and developed our ability to remotely monitor and regulate services. During 2021/22 we further developed our monitoring approach to ensure the public have assurance about the safety and quality of the care they receive, while still focusing on risk. We piloted our new approach in June 2021 and rolled it out more widely in July 2021.

Our monitoring approach, including direct monitoring calls

The direct monitoring approach (DMA) was built on our learning from the previous year. Where the information we have does not find evidence that tells us we need to re-assess the rating or quality at a service, we now publish a short statement on the profile page on our website for these services. This helps to inform the public and people who use services that this review has taken place and that we had no concerns based on the information we held at the time. The review of our intelligence and information is carried out each month. This has helped us target our resources where they are most needed. In cases where the information review indicates that we may need to reassess a rating or the quality of care, our inspectors may need to gather more information. They may do this via an on-site inspection or using the DMA. Across the year we published a public statement for 21,169 services following our evidence review.

Quality assurance

To ensure we're making consistent and robust decisions, we have also been carrying out sample inspections of services to ensure our monitoring activity is consistent with our inspectors' findings. Since the DMA launch in July 2021 we have carried out 263 sampling inspections. In 46 cases, the inspection identified a breach of regulation, and in all cases we have carried out a comprehensive review of the findings and our intelligence approach. For sampling in primary medical services, we also did clinical searches using SPAs alongside direct monitoring calls with the providers.

Workforce pressure data collection

We have used technology to revolutionise the way we collect and use data and insight. This is helping us to become a flexible and insight-driven regulator.

In December 2021, we started a data collection on workforce pressure in adult social care. Inspectors captured insights from inspections and direct monitoring calls. We recorded whether services had workforce challenges, the causes of these, any workforce retention challenges or staff absences, and how staffing shortages affected their ability to provide their previous level of service. Some 68% of our data collection came from inspection – if we found that workforce pressures were impacting on the safety or quality of care, we took action during the inspection process.

Registration

We have continued to ensure our registration service has been responsive to the needs of the sector. We fast-tracked applications where a provider intended to deliver services that provided additional health and social care capacity or contributed to the control of the pandemic, or the treatment of people who contracted COVID-19. During winter we also ensured that any applications that supported winter pressure planning for NHS trusts, clinical commissioning groups or a local authority were fast tracked.

Prioritising applications to the support sector was critical to ensure performance in our registration service, because the volume of applications increased from previous years. This year we received more than 53,000 applications, an increase of 3,709 compared with the previous year.

We categorise applications in 3 ways: simple, normal and complex. In 2021/22 we set a target of reducing the time taken to complete applications of each type by 15% compared with the previous year's average. We achieved a 4.7% reduction in the time taken to complete simple applications; for normal applications we achieved an 8.1% reduction.

The average time taken to complete complex applications increased by 16.1%. Complex applications include 'Notice of Proposals' to refuse registration or register with conditions.

At the start of the financial year there were 8,720 registration applications in the system; at 31 March 2022 there were 7,747, representing an 11% reduction across the year.

Throughout the year we monitored the types of registration applications we receive to find out what knowledge or intelligence they offered about the sector. To help understand how the market is changing, when providers in adult social care contacted us proposing to cancel their application in March 2022, we asked them about their decisions so we might understand why they wanted to withdraw from the market. Eighteen providers took part in this pilot, but no key trends or reasons for leaving the market were identified for further action or information sharing.

Outcome 5: We provide an up-to-date and accurate picture of quality

State of Care report

State of Care is our annual assessment of health care and social care in England. Our report looks at the quality of care over the previous year, considering trends and sharing examples of good and outstanding care. We highlight where care needs to improve and where national and local system stakeholders need to focus their efforts.

This year we focused on people's experiences of care, flexibility to respond to the pandemic, ongoing quality concerns, and the challenges for local health and care systems. We recognised that COVID-19 continued to affect all aspects of life, especially the health and care system. We said that increased stability in social care and real collaboration is key across health and care and vital to reduce the risk of a deep and widespread unmet need.

The report was well-received among our stakeholders, with a substantial number of influential organisations reacting publicly to what we said. It also received widespread news coverage across regional and national print and broadcast media, as well as in social media.

Visiting in social care settings

Over the course of the year, government guidance has been changed in relation to visiting in social care residential settings. We have continued to support the engagement and learning across the sector via chief inspector updates and supportive statements.

Where we identify visiting concerns, we introduced a rigorous process to review evidence so that swift and appropriate regulatory and enforcement action could be taken to ensure people were supported to have visitors. From 1 December 2021 to 31 March 2022 we received and reviewed 272 visiting concerns, with 114 containing allegations about blanket bans. We reviewed every concern raised with us and took action where needed, including following up with providers, inspecting, raising safeguarding alerts where applicable, and following up with local authorities.

Infection prevention and control

In 2020/21 we launched a shortened inspection methodology, primarily in adult social care, to review infection prevention and control (IPC) in services. We continued IPC stand-alone inspections throughout 2021/22, as well as reviewing IPC practices in services that we inspect. This year we reviewed IPC practices in 4,066 adult social care settings during 4,412 inspections; 1,099 of these were stand-alone IPC inspections.

We continued to work with the DHSC, local authorities and individual care providers to provide assurance about the safety and quality of designated settings, which are part of a scheme to allow people with a COVID-19-positive test to be discharged safely from hospitals. Although designated settings were mostly set up in 2020/21, this year we inspected some additional locations to check whether they were appropriate to be a designated setting.

When we were assured of the IPC practice in a designated setting, we carried out supportive phone calls at regular intervals, using our DMA process. We completed 153 of these calls over the year.

Ratings and progress on methodology changes

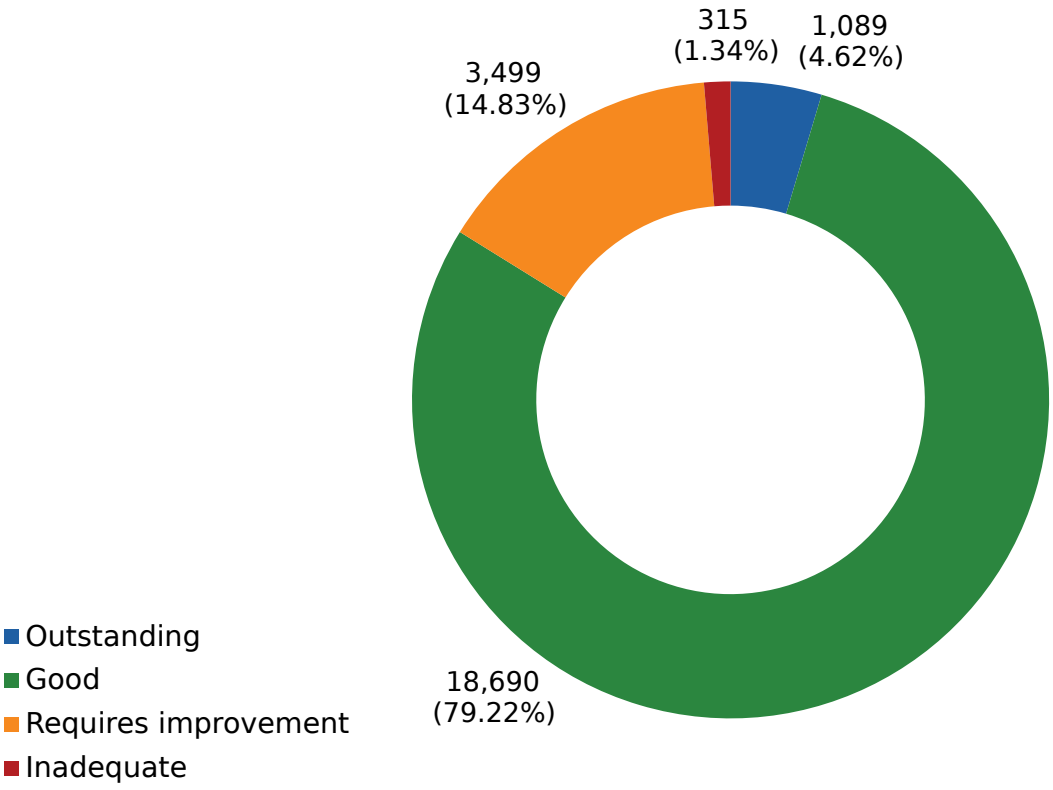
Following our main strategy consultation, we launched a second formal consultation in January 2021. This was to hear views on our proposals for specific changes – building on our learning from our regulation during the pandemic and moving us towards our ambition to be a more dynamic, proportionate and flexible regulator. As a result, in October 2021 we stopped providing separate ratings in GP practices for the 6 population groups. In 2022/23 we are going to work with providers, our partners and key stakeholders to develop our assessment approach for NHS trusts, and review and develop our framework and approach to rating and reporting in line with wider changes to our regulatory approach.

We continually reviewed our approach and we considered both the risk to people using the service and the burden on the provider during the pandemic. For this reason, we utilised our thematic and targeted inspection methodology in a large volume of inspections which does not include a re-rating of the service. Of those inspections that we re-rated, 69% of services that were previously rated as inadequate improved and 52% of services that were previously rated as requires improvement improved.

At the end of the year there are 50,982 registered locations and 32,552 registered providers. Of the registered locations, 4.97% were rated as outstanding, 81.45% as good, 12.3% as requires improvement and 1.28% as inadequate, showing very minimal change in percentage terms compared with the end of 2020/21.

Adult social care directorate

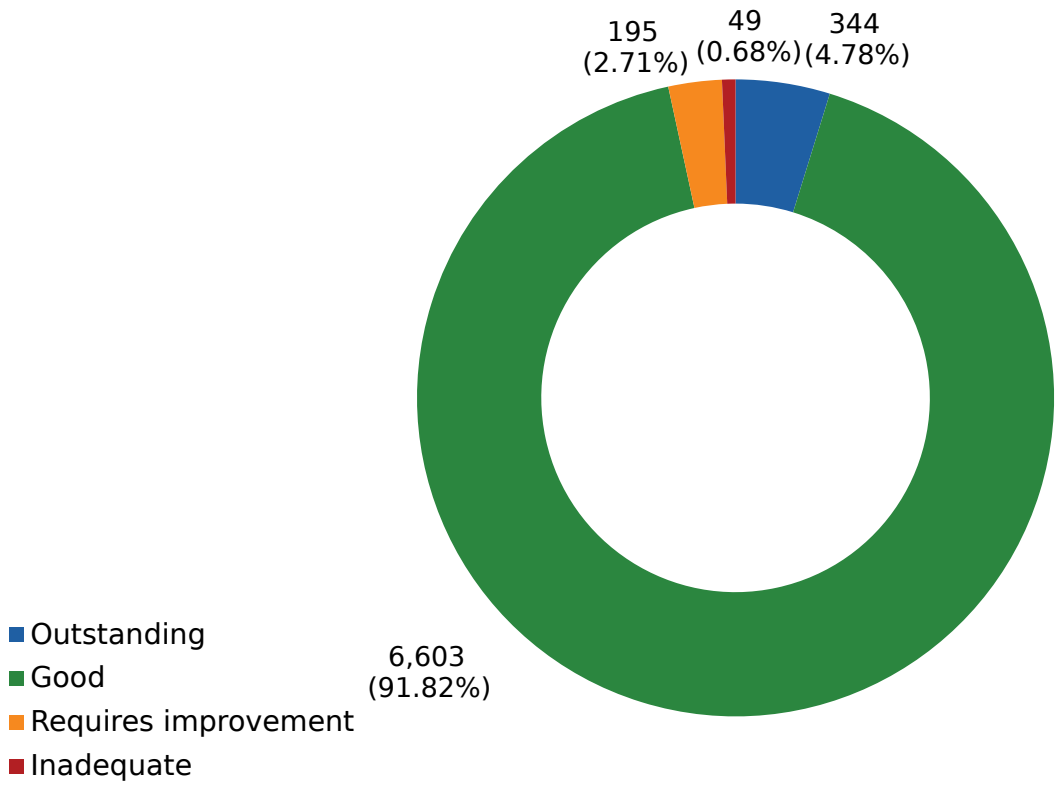
Chart | Data table



Outstanding	1,089
Good	18,690
Requires improvement	3,499
Inadequate	315

Primary medical services directorate

Chart | Data table



Outstanding	344
Good	6,603
Requires improvement	195
Inadequate	49

Hospitals directorate

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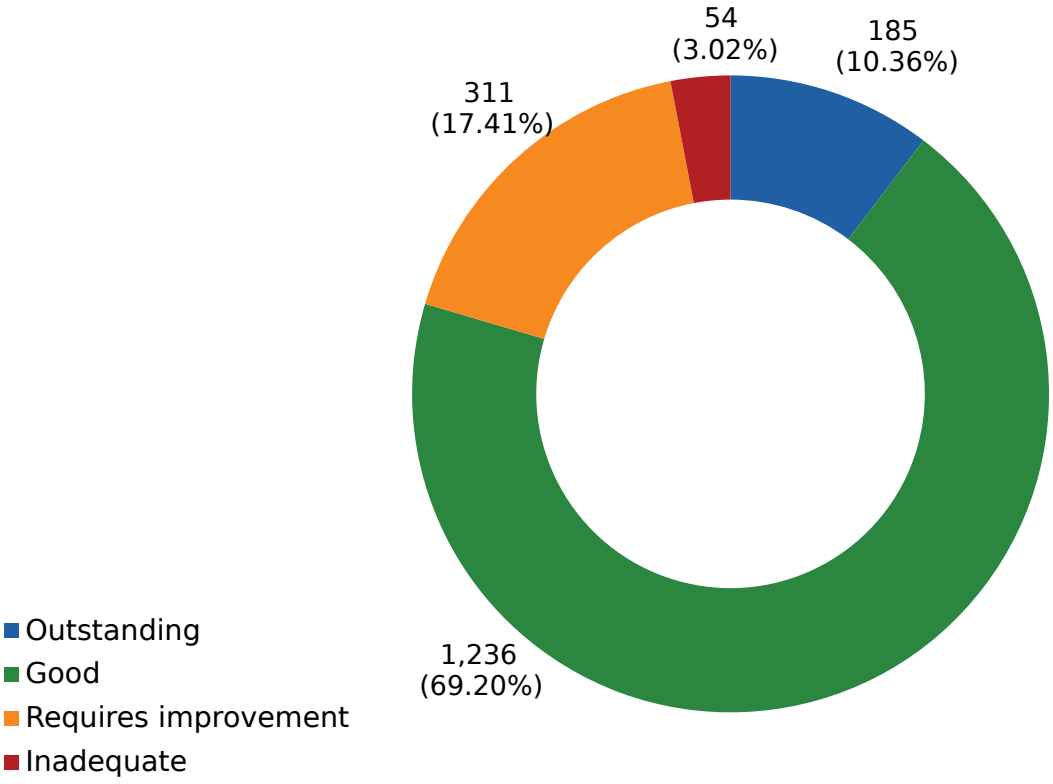

Outstanding	185
Good	1,236
Requires improvement	311
Inadequate	54

Urgent and emergency care

From November 2021 we started a programme of inspections at a number of urgent and emergency care (UEC) services across an integrated care system (ICS). An ICS consists of all healthcare partners in a specific geographical area. These inspections are conducted to understand how services respond to the challenges they face as individual providers, but that require a system-wide response. They are also intended to support ICSs to better understand the journey that people experience when seeking urgent care and identify where they can make improvements.

The inspections are part of a pilot that test a coordinated, multidisciplinary approach to assessing services across an ICS. Our UEC system-wide inspections continue into 2022/23.

Outcome 6: It is easy for health and care services, the people who use them and stakeholders to exchange relevant information with us, and the information we provide is accessible, relevant, and useful

Talking mats

This year we launched the use of 'Talking mats', a communication tool that helps people express themselves. Talking mats can be used to support communication with anyone who may have difficulties communicating their experiences of care. This includes people who have dementia, people who have had a brain injury, people who have a mild to moderate learning disability, deaf people, people who do not have English as their first language and people with mental health conditions. We completed an initial Talking mats pilot, training 19 colleagues including inspectors, Mental Health Act reviewers and assistant inspectors. A further 40 colleagues will be trained following the success of the pilot.

Primary medical services – clinical searches

Our national clinical advisers for primary medical care and medicine optimisation specialists have developed a suite of clinical searches that are routinely used to gather evidence in our GP practice inspections. Over the course of the year we carried out a 12-month pilot partnership with a healthcare informatics provider, to create, review and deliver the searches we currently use on primary care inspections, as well as developing new searches to support our inspection programme. The pilot was a great success and the searches have been important in providing objective evidence about clinical outcomes, particularly in relation to the safety and effectiveness of clinical care. Following the pilot, we have continued our partnership and now have 100% coverage of practices for the clinical searches to be used on inspection and for practices to access beforehand.

National inspection programmes

We work with HM Inspectorate of Prisons and other inspectorates to protect and promote the interests and rights of people who use health and social care services in secure settings. This includes health and social care in prisons and young offender institutions, health care in immigration removal centres (holding centres for detainees awaiting decisions on their residency status or deportation following an unsuccessful application) and police custody facilities.

This year, alongside partners, we carried out:

- 37 inspections with HM Inspectorate of Prisons
- 16 inspections of secure children's homes
- 3 inspections of secure training centres
- 9 inspections of police custody facilities
- 3 inspections of youth offending teams.

In 2018 we started an inspection programme looking at sexual assault referral centres. We looked at the quality of care provided to adults and children who have been sexually assaulted, or who are victims of alleged sexual abuse. Across this year we carried out 8 inspections. Following an inspection, we make a judgement on whether the service is meeting the regulations and necessary legal requirements. We do not have legal powers to award a rating for the quality of care provided.

Through the Modern Slavery Victim Care Contract, we independently inspect safehouses and outreach support. These services support people who are potentially or confirmed victims of human trafficking and modern slavery. This year we carried out 18 safehouse inspections.

We received 12 referrals from the Government Agency Intelligence Network (GAIN) over the past year and have sent a further 16 to GAIN for sharing of information on topics such as illegal workers, modern slavery and financial exploitation. There has been a significant rise in modern slavery referrals.

Survey technology

This year we have continued to invest in our processes and technology. We redesigned our Annual Provider Survey and Stakeholder Survey and collected the survey responses using Microsoft Customer Voice. The new tool allows responsive data collection, in a mobile friendly way, and a way to capture performance data (including how long it takes a provider to complete the survey).

Maternity survey

One of the cornerstones of our NHS Survey Programme is the maternity survey. This year we asked women who gave birth between 1 and 28 February 2021 to take part – this was during the third national lockdown for the COVID-19 pandemic. This means that respondents will have gone through their antenatal, labour and birth, and postnatal stages under pandemic conditions. In previous surveys, the picture of maternity care in England had been one of year-on-year improvement. This year, we saw a change in direction and results declined in many areas. This likely reflected the impact that COVID-19 had on services and staff.

The 2021 survey was the first mixed-mode maternity survey in the NHS Survey Programme, where women were encouraged to respond online (but were also given the option of postal completion). The response rate increased substantially, from 36% in 2019 to 52% in 2021, with 89% of women taking part online. Analysis of responses also suggested that the new methodology was encouraging women from different demographic groups to take part, helping to make the results more representative.

Key areas of performance from priority 2 in 2021/22:

- We carried out more than 10,306 inspections across all sectors, a 46% increase on the previous year.
- We completed 4,392 direct monitoring calls, across 4,003 services.
- We had regulatory contact through inspection and direct monitoring calls with 28.5% of registered services during the year.
- 21,169 services have a public statement published on our website following our intelligence review. (From July 2021 we introduced a monthly review of information we have on most of the services we regulate. The monthly review helps us to prioritise our activity and guide how we respond. Where our review indicates that a service may be lower risk, we now publish a statement on our website.)
- We received 53,165 registration applications, an increase of 3,709 compared with 2020/21.

- Where we had to take urgent enforcement, in 94% of cases the enforcement was served within 3 days.
- There were more than 23,000 responses to the 2021 maternity survey. The response rate increased substantially from 36% in 2019 to 52% in 2021, with 89% of women taking part online.
- The average days to publish our inspection reports was 28 days, compared with 26 in 2020/21.
- We carried out 45 Ionising Radiation (Medical Exposure) inspections, compared with 13 in 2020/21.
- In our Annual Stakeholder survey, 92% of respondents said that we create an environment where their organisation can openly share information with us.
- 46% of the public are aware that they can feedback their experience of using health and social care services to us.
- 90% of survey respondents who provided feedback via Give Feedback on Care said they were able to tell CQC everything they wanted to and 96% said it was easy to fill in the form.
- Of those who have accessed assessments and ratings on our website: 77% said they were easy to find (including 66% of the public and 85% of other stakeholders), 78% said they were accessible (including 66% of the public and 85% of other stakeholders) and 85% said they were useful (including 75% of the public and 92% of other stakeholders).

Priority 3: Safety through learning

Our ambition is to regulate for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives.

1,099 infection prevention and control (IPC) inspections carried out, plus a further 3,245 reviews of IPC as part of a wider inspection

96.8% of social care services were facilitating visits in line with guidelines during our IPC visits

Outcome seven: There is improvement in safety cultures across health and care services and local systems that benefit people because of our contribution

Closed cultures

In 2021/22 we launched a closed cultures dashboard to help us review the inherent risk factors in residential care, services for people with a learning disability, and care services that restrict people's liberty. The closed cultures dashboard is one of the products to come out of our new Data and Insight Unit, which launched in March 2022.

Our 'Out of sight – who cares?' report, published in October 2020, looked at the use of restraint, seclusion and segregation in care services for people with a mental health condition, people with a learning disability or autistic people. We made recommendations for people to receive the support they need, when they need it, to lead fulfilled lives without the need for restrictive practice.

Throughout this year we reviewed our approach to inspections of services for people with a learning disability and autistic people – part of our work on transforming the way we regulate these services. It includes implementing the recommendations from Glynis Murphy's reports into the regulation of Whorlton Hall, and recommendations in our restrictive practice review. We carried out 95 new methodology inspections and used a new Quality of Life tool. The tool sets out the areas we need to explore, and it was developed to address recommendations from Glynis Murphy's first report.

In December 2021 and March 2022, we published progress updates. We found that the rates of restraint, segregation and seclusion were not reducing, although we did find some evidence of positive changes. We concluded that not enough progress has been made to address the recommendations and much still needs to be done to improve the health and care experiences of people with a learning disability and autistic people.

There are still too many people with a learning disability and autistic people in hospital. Once in hospital they often stay too long, do not always experience therapeutic care and are still subject to restrictive interventions.

Provider Collaboration Reviews

Our Provider Collaboration Reviews (PCRs) aimed to find out how providers worked collaboratively to meet the challenges posed by the COVID-19 pandemic. Each review focused on providers of an integrated care system (ICS) or sustainability and transformation partnership (STP) area. Our aim was to look at provider collaboration in all ICS and STP areas. As well as looking across systems, each review focused on one or more local authority areas within the system. This year we published 2 new PCR reports.

Outcome 8: People receive safer care when using and moving between health and social care services because of our contribution

Health and Care Act 2022

The new Health and Care Act 2022 has implications for our future operations. This includes new responsibilities in assessing how local authorities are meeting their duties under the Care Act, as well as our role in reviewing and assessing integrated care systems. We are committed to co-producing our approach to system and local authority assessment to ensure it is built on what matters to people using services, avoids duplication with other existing oversight activities, and encourages a shift towards more integrated services and improved outcomes for people using services.

Our work with DHSC, care providers and local authorities was to ensure people could be discharged safely from hospitals, while also preventing the spread of COVID-19 in care homes. Designated settings admit people who are discharged from hospital with a COVID-positive test who will be moving or going back into a care home setting. Designated settings inspections use our infection prevention and control (IPC) framework created the previous year.

When we carry out the assessments, we publish judgements in 8 areas: visitors, shielding, admission, use of personal protective equipment (PPE), testing, premises, staffing and policies. For each area we state if we are assured, somewhat assured or not assured by the provider of the service. Our judgements in relation to IPC can be found on the profile page for care homes that have been assessed. This helps to ensure our findings are also visible to the public, family and friends of people receiving care.

When we changed our operational priorities in December 2021, specifically around the primary medical sector and NHS trusts, the colleagues from these sectors supported adult social care inspectors in carrying out further IPC inspections.

Urgent and emergency care

Urgent and emergency care (UEC) services across England have been, and continue to be, under sustained pressure. In response we have conducted a series of coordinated inspections, monitoring of calls and analysing data within local teams. This helps us identify how local services work together to ensure people receive safe, effective and timely care. The UEC work helps to further pilot ways to assess services across integrated care systems. Each provider receives their own report with our findings, which includes a system summary. We have engaged with system partners as well as providers to share our findings and discuss opportunities to improve patient safety and system-wide working.

Key areas of performance from priority 3 in 2021/22:

- IPC inspections: indicated that 96.8% services were facilitating visits in line with current guidelines.
- We carried out 1,039 IPC inspections of social care services. In a further 3,245 inspections, we completed a review of IPC as part of a wider inspection.
- 95% of services said we have encouraged them to have a strong safety culture including: involving people in decisions (89%); an open and honest reporting culture (94%); and learning and improving from concerns and incidents (94%).
- 79% of services said our safety guidance, tools and frameworks, and 63% said our signposting to external organisations and their resources, has supported this.
- 83% of local stakeholder survey respondents said we have encouraged them to improve safety cultures of services.
- 90% of services said we encouraged them to improve safety including: safe staffing levels (64%); safe discharge (57%); infection, prevention and control (80%); people feeling safe in care received (78%); and people feeling safe in the care environment (78%).
- 86% of services and 70% of local stakeholder survey respondents said we effectively ensure people have their human rights upheld.

- In our annual provider survey, 94% of providers agreed that we have encouraged their service to learn and improve from concerns and incidents.

Priority 4: Accelerating improvement

Our ambition is to enable health and care services and local systems to access support that will help improve the quality of care where it is needed most.

We examined concerns raised by some GPs that ethnic minority-led GP practices were more likely to have a poorer experience or outcomes from regulation than non-ethnic minority-led practices

We carried out a review of sexual safety in ambulance services, built on learning from our regulatory activity within the independent ambulance sector

14,146 patient treatment plans reviewed by the Second Opinion Appointed Doctor (SOAD) service

Outcome 9: We have accelerated improvements in the quality of care

In February 2021, we began work to examine concerns raised by some GPs about ethnic minority-led GP practices. The question was whether they were more likely to have a poorer experience or outcomes from regulation than non-ethnic minority-led practices. The research showed that ethnic minority-led practices are more likely to care for populations with higher levels of socio-economic deprivation and poorer health. This can affect their ability to achieve some national targets used in assessments of quality and it increases their challenges around recruitment and funding.

While the limited data within the health and care system meant that it was not possible to establish any relationship between the ethnicity of practice leadership and ratings, this work has identified contextual factors that can disproportionately affect ethnic minority-led practices and their ability to demonstrate how they provide good care – for example, the finding that they are more likely to care for populations with higher levels of socio-economic deprivation. GPs from ethnic minority backgrounds who contributed to this report also cited a lack of leadership support from external bodies.

In response to this work, we are reviewing and strengthening how we consider the context in which a GP practice works when we make assessments about quality and ratings. We have also taken the learning and insight shared by minority ethnic GPs and inspection colleagues into our developing approach to assessing integrated care systems.

This year we carried out a review of sexual safety in ambulance services, following learning from regulatory activity in the independent ambulance sector. We wanted to better understand the scale of incidents and identify what we could do to improve how the sector responded to the risk of sexual safety to both patients and staff.

In understanding the scale and impact of concerns raised, we have worked with the sector and stakeholders to improve provider awareness and responses, and limit access for sexual predators seeking to abuse a position of trust.

Engagement and actions from the project have been discussed with key stakeholders, such as the Disclosure and Barring Service, the Independent Ambulance Association, the Association of Ambulance Chief Executives and NHS England Safeguarding.

Outcome 10: We have encouraged and enabled safe innovation that benefits people or results in more effective and efficient services

In response to our annual provider survey, 90% of respondents agreed that we encourage their services to improve the safety of care provided to people, with 89% also agreeing that we have a sufficient focus on improving safety of care. Sixty-three per cent of providers agreed that we had encouraged or supported their service to improve safety culture by signposting them to external organisations and their resources, support and advice about safety culture.

Key areas of performance from priority 4 in 2021/22:

- Our Mental Health Act (MHA) report 2020/21 highlighted how services apply the MHA to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people. In 2020/21, we carried out 682 MHA monitoring remote reviews of wards, and interviews with 1,895 patients and 1,111 carers. We handled 2,280 complaints and contacts from patients and others raising issues about the MHA.
- Our NCSC ensured that where intelligence was received on sexual safety incidents, it was logged consistently and labelled so that the intelligence could be reviewed.
- 68% of services said we have encouraged or supported them to make changes to improve the quality of care (24% of services neither agreed nor disagreed).
- 72% of services said our regulation provides an environment where services can innovate and try new ways to deliver safe care (20% neither agreed nor disagreed).

Strategic objective: Assessing local systems

In April 2022, the Health and Care Bill completed all parliamentary stages in the House of Commons and House of Lords and received royal assent to become the Health and Care Act 2022. The legislation gives us a new duty to review each integrated care system (ICS) in England, as well as a new duty to assess local authorities on the delivery of their social care duties under Part 1 of the Care Act 2014.

Our colleagues have been working closely this year with the DHSC, NHS England and other stakeholders to start to progress this important role. For the requirement to assess each local authority, we have started to design our approach collaboratively with key stakeholders such as the Local Government Association, the Association of Directors of Adult Social Services and DHSC. We expect to begin our assessments of local authorities and reviews of ICSs in 2023 and we will continue to work with stakeholders on the timetable.

Highlights of performance in 2021/22:

- 78% of services and 60% of local stakeholder survey respondents said our work has encouraged them to work with others to ensure effective care pathways for people (17% of services and 19% of stakeholders neither agreed nor disagreed).

Strategic objective: Tackling inequalities in health and care

Our regulatory equality objectives were agreed by our Board in July 2021 and then published. The objectives give us an organisational focus and impetus to ensure our regulation adequately considers the quality of care for everyone. The objectives play a key role in delivering our strategic ambition to encourage organisations to tackle inequalities.

Our equality objectives are:

- amplifying voices of people more likely to have poor care
- using data to understand and respond to equality risks
- working with others to improve equality of access, experience and outcomes
- using our independent voice to reduce inequalities.

The equality objectives run from 2021 to 2025 and we have already made progress on them. Highlights include the launch of a British Sign Language service in our NCSC, and our thematic work on acute care for people with a learning disability and autistic people.

Our equality objectives are embedded into our transformation work and are a key part of our plans for 2022/23, for example as part of operating model transformation and ensuring we capture equality risks in our regulatory model.

Our national reports published this year have also highlighted issues relating to inequalities. This included a focus on inequalities in our annual State of Care report. Also, our report on maternity services covered maternity equity for women from ethnic minority groups, and one of our Insight reports focused on restoring NHS services post-pandemic to address health inequalities.

In February 2022, in partnership with disability charities, Healthwatch England launched a new campaign, 'Your Care, Your Way', to ensure health and care services take account of people's additional communication needs when providing care.

In February 2022, we published our Monitoring the Mental Health Act (MHA) report 2020/21. The report highlighted concerns that reduced access to community mental health services during the pandemic may in part have contributed to an increase in the number of people being detailed under the MHA. In 2020/21, there was a 4.5% increase in the use of the MHA to detain people with mental health problems in hospital for assessment and treatment.

Highlights of performance in 2021/22:

- 88% of services said our work has encouraged them to reduce inequalities in access, experience and outcomes for people who use, or need to use, their services (9% of services neither agreed nor disagreed).

Improving organisational efficiency and effectiveness

Our approach

Much of our focus in 2021/22 has been on building and implementing an overarching transformation programme that will take us towards our ambition of being a leading 21st century regulator.

We are changing the way we work to make our strategy a reality. Our vision is to be a smarter regulator, accelerating improvements in how people experience health and care services, for a safer future. The transformation programme has been organised into 3 key areas that intersect and gradually build towards the future shape of our organisation.

- Regulatory Framework – We're developing our regulatory model to guide how we develop our new regulatory services and shape what skills we need in the future.
- Organisational Design and Development – We're making sure we have the skills and culture we need to deliver our new strategy.
- Regulatory Services – We're developing and delivering new services, processes, data and technology driven by our regulatory model.

A key milestone in our transformation was the launch of the Technology, Data and Insight directorate in March 2022. This directorate plays a key role in building new, digitally enabled data and regulatory platforms that will revolutionise how we collect and use data and insight, helping us to become a more flexible and insight-driven regulator. The directorate also provides an array of data and technology systems and services that underpin our organisation's daily working life and gives colleagues the right tools to do their job well.

Our people

We conducted our main people survey in November and December 2021. It included questions on all aspects of working for CQC, the majority of which were last asked in November 2019. The results showed improvement since then, with several large increases, notably about the visibility of leaders (up 21%) and the direction given by leaders (up 17%). There were higher scores for the behaviours and values of executive leaders (up 13%) and a significant increase in people's response to having the right equipment and technology to do their jobs (up 15%). Continued areas of strength include line management, teamwork, and commitment to our purpose and values – these all saw incremental increases and remain as high positive responses.

Scores remained low for change, workload, and confidence that action will result from the survey. Our overall employee engagement index (EEI) score was 64%. This represents a decrease of 3 percentage points since 2019 and follows the reduction of 5 percentage points seen in the 2019 survey. At the corporate level, improvement activity is linked to our People Plan. This is being reviewed, and updated where necessary, to ensure planned activity addresses feedback from the survey. Communications will identify and raise awareness of key themes at corporate and local level and updates shared as to action being taken. Future pulse surveys will be used to measure progress against key themes arising from this survey.

We conducted a wellbeing focused pulse survey in July 2021 to understand our progress against the priorities of our mental health and wellbeing strategy. The results continue to inform our future priorities in this area as well as our work with Mind and our wellbeing network.

CQC has a network of Speak Up Ambassadors whose purpose is to be approachable, listen well and signpost colleagues to the various options available to them based on their individual situation. This is an additional voluntary role.

We have a number of staff-led equality networks:

- the Carers Equality Network
- the Disability Equality Network
- the Gender Equality Network
- the LGBT+ Network.
- the Race Equality Network

All our equality networks have an executive sponsor who make sure they receive full support. The role of the sponsor is to provide senior leadership commitment to the networks they are representing, act as a role model, and support with any barriers they may be facing. We have developed clear roles and responsibilities for executive sponsors to support them with this role. A representative from our equality networks attends each monthly Board meeting.

Everyone is encouraged to notice and celebrate the good work of colleagues and use the tools in place to say thank you and to celebrate success throughout the organisation. We want to nurture a culture of recognition that engages, motivates and inspires us to excellence. In 2021/22, 787 colleagues (26% of the organisation) received a voucher in recognition of their demonstration of Success Profile behaviours.

Our estate

The use of CQC's estate continued to be limited during 2021/22 due to COVID-19. Our proportion of homeworkers has now increased to 90% of the organisation. We have continued to reduce the size of our estate to match our changing requirements; in 2021/22 this reduced by a further 11% on the previous year. A further floor was given up in our Newcastle office this year, we reduced our Bristol office footprint, and notice was given to enable us to vacate our Leeds office in late 2022. We reached agreement to share almost half of our Birmingham office with the UK Health Security Agency. We have also given notice on our Penrith satellite office.

In March we asked our office-based colleagues to start returning to our workplaces and we resumed face-to-face meetings where appropriate, providing guidance to colleagues on how best to use technology and our offices. We are gradually re-shaping our offices to offer more meeting and collaboration spaces, rather than just desks.

Our sustainability

Our aim is to reduce the impact of our business on the environment and to actively promote the wider sustainability agenda.

CQC is working to meet all Greening Government Commitment targets relevant to us as an organisation. We are confident of achieving Net Zero by 2040. Year on year our estate footprint is reducing, though we will start assessing the carbon impact of our home working population. Our level of business travel continues to reduce. As we inspect and regulate health and social care providers, we will always need to visit provider locations across England so encouraging CQC colleagues to move to greener modes of transport is part of our plan. We are working on the development of a Net Zero plan and using the new baseline year of 2017/18 we are developing our own targets for all measures. Key actions in 2021/22 included:

- providing new guidance to all colleagues on how we will work post-pandemic, focusing on reducing travel, harnessing technology more and moving to greener modes of travel where possible
- engaging a 'zero to landfill' partner for recycling/reusing redundant ICT equipment
- taking action to further reduce our estate by over 900 square metres
- scoping a new sustainability role to further drive our approach on sustainability
- reducing our online stationary ordering list from 165 items to 61
- agreeing our Green Plan to reduce our environmental impact as an organisation.

In relation to Greening Government requirements we are on track to meet the 2025 target, though accurate and consistent data from landlords is particularly difficult to obtain. As a relatively small, largely home-based organisation with a small built estate and no fleet, CQC produces no Scope 1 emissions. Scope 2 and Scope 3 emissions, waste, water, paper use and car travel are reported below:

	CQC performance 2017/18	CQC performance 2021/22	Greening Government 2025 target (2017/18 baseline)

Energy consumption *			
Electricity (kWh)	3,130,011	217,959	Reduce greenhouse gas (ghg) emissions
Gas (kwh)	914,872	195,695	Reduce greenhouse gas (ghg) emissions
Business travel			
Rail (km)	16,009,891	539,341	Reduce ghg emissions
Flights (km)	324,556	24,850	30% reduction in emissions and air travel miles
Car fleet			
Staff lease car use (km)	8,750,800	481,282	Reduce ghg emissions
Staff hire car use (km)	487,003	50,224	
Waste minimisation and management			

Recycling (tonnes)	23	8	70% of overall waste
Landfill (tonnes)	8	0	Landfill less than 5% of overall waste
Paper use			
A3 (reams)	506	11	50% reduction in use
A4 (reams)	11,525	1,510	
A5 (reams)	0	0	
Water consumption			
Water (m^2)	633	717	8% reduction in consumption

* Please note figures from 2017/18 covered 7 office locations and 2021/22 figures cover 2 shared office locations (Leeds & Birmingham), this is due to changes in leases and reporting obligations as DHSC and Government Property Agency (GPA) now report for our other locations.

Waste minimisation and management - we have stopped buying any single use plastics and our stationery supplier is now single use plastic free.

Sustainable procurement - we embed sustainability into our procurement practices wherever possible. We procure the majority of goods and services via Crown Commercial Services framework agreements. Sustainability is covered in the framework clauses in the contract.

Nature recovery and biodiversity action planning - we do not have a biodiversity action plan as we only have a small rented office estate and no natural capital assets.

Climate change adaptation - we are reviewing the need for a Climate Adaption Plan. Through our assessment framework we encourage providers to think about sustainability and climate change. Our internal business continuity planning recognises the risks presented by climate change to our operation as an organisation.

Reducing environmental impacts from ICT and Digital - we are committed to reducing our environmental impact from technology. We are now reporting progress to the DEFRA STAR team and are represented though DHSC. We have a contract in place to reuse, recycle or recover all devices and equipment no longer used. Through this, in 2021/22 we had 630 items reused and 333 items recycled, with nothing going to waste or landfill. We have introduced sustainability criteria into our procurement approach and procure 99% through Government framework agreements. We have moved to cloud computing and now monitor resulting energy consumption to inform planning.

Sustainable construction - No construction or refurbishment projects were undertaken during this reporting period.

Our financial performance

Despite external pressures such as rising costs due to inflation and COVID-19, and the additional duties CQC has facilitated, we managed a level of operating expenditure in 2021/22 (£215.4 million) that was lower than those 5 years ago in 2017/18 (£222.1 million) – the point at which we moved to full cost recovery of our fees – a £6.5 million (3%) reduction. This demonstrates a sustained reduction to our cost base by working more efficiently and using the technology we have invested in, while ensuring we are in a good place to realise our future strategy. Highlights include:

- Pay costs were £6.0 million or 4% less in 2021/22 than in 2017/18, as we absorbed pay awards and made the necessary organisational change to realise our strategy.
- Following effective estate planning, our estates expenditure was £8.5 million or 68% less than in 2017/18.
- Travel and subsistence was £8.4 million or 78% less than in 2017/18, as we used our technology improvements to allow for more effective virtual working.
- While we have made many technological advances, which have provided many benefits, our information technology (IT) cost base remains at the same level as that in 2017/18.
- Within an overall lower operating expenditure base than 2017/18, we have also been able to invest an additional £18.6 million revenue in our Transformational Change programme as we take the opportunity to accelerate improvement.

During this period, we have provided stability and certainty for our providers by keeping our fees scheme the same since April 2019 (3 consecutive financial years) to assist their financial planning, in appreciation of the turbulence and uncertainty providers continue to endure. Furthermore, compared with pre-full cost recovery levels, we are less reliant on DHSC funding. In 2016/17 fees represented 68% of our funding, compared with 88% in 2021/22; and of our £14.3 million in-year capital investment, £10.8 million (76%) was funded through our retained earnings reserve, with the remaining £3.5 million funded through grant-in-aid (GIA) (in 2017/18 our £7.7 million capital spend was fully funded by GIA). We have again realised Spending Review efficiencies against our GIA allocation for core activities.

Sustained reductions in expenditure have allowed us to drive forward our transformation programme over the last 3 years, enabling us to realise our strategy and deliver effective regulation for the years ahead. In addition to our £18.6 million added revenue investment, we spent a further £6.6 million capital in 2021/22 compared with 2017/18. This represents a combined additional investment of £10.9 million compared with pre-pandemic levels in 2019/20.

The benefits of this will be smarter regulation, reducing the burden on providers and driving a more economical and effective use of our operating budget – this provides greater value for money for providers we regulate and taxpayers. This is an area which will continue to see greater investment in 2022/23 as we work to deliver our strategy and new operating model.

In addition to making further sustained reductions to our expenditure, we have worked hard to improve our aged debt and the efficiency within which we pay our suppliers. With more effective fee income collection, we have realised a 51% reduction to our 60+ day aged levels from the end of March 2021. By paying our suppliers in a timelier manner, we have seen a 11% increase in volume and 17% increase in value of invoices paid within HM Treasury 5-day payment target since the end of March 2021.

Key areas to note from our organisational data in 2021/22:

- We remain committed to reporting to the Workforce Disability Equality Standard for CQC, addressing any inequality of opportunity and improving the experience of people.
- Our Action for Race Equality Group (AREG) has launched a Quality Improvement project to improve access to, and take-up of, learning and development opportunities for colleagues from ethnic minority groups in the organisation. Five workshops for colleagues ran across January and February 2022.

- We received 289 complaints overall for the year 2021/22. Of these, 146 did not proceed due to: being withdrawn by the customer; other CQC processes being active; signposting to other organisations/processes; or they were resolved in other ways.
- We investigated 143 complaints against CQC: 12 were upheld, 29 were partially upheld, 61 were not upheld, and 3 were unable to be determined.
- Of the 143 complaints, 31 complaints are still in progress which means that the timeframe for response has not yet concluded on that investigation.
- Throughout the pandemic, we have supported our staff in several ways, including our national wellbeing strategy and Schwartz Rounds.
- We have renewed our contract with Headspace, meaning that colleagues access hundreds of guides on meditations, sleepcasts, courses and more for free.
- Throughout the year, there have been a number of connection events to bring together colleagues at times of increased isolation and remote working. These include wake-up desk yoga and lunch time mindfulness/meditation sessions and stretch and energise.
- Strengthened technology – anyone in the organisation with a CQC phone has now received a replacement. The new phones have been very well received by colleagues; they are easier and better to use, with more enhanced remote working functionality.

Ian Trenholm
Chief Executive
Care Quality Commission

4 July 2023