COVID INSIGHT

BETTER CARE THROUGH COLLABORATION

Collaboration is key

To understand the quality of care that people receive and try to make sure people are safe, we need to find out what is happening locally among different health and social care services. The speed and scale of the response required by the pandemic has highlighted the benefits of collaborating to achieve creative and innovative solutions. Responses to the pandemic have promoted partnership working to drive better experiences and outcomes for people using care services.

It is particularly important that providers in a local area collaborate in the delivery of care. From our previous work we know that a lack of collaboration between local services can be a significant barrier to people getting good care.

In advance of our work on our Provider Collaboration Reviews, in May/June we talked to representatives from a range of local stakeholder organisations and reviewed local support plans, to gather some perspectives on the extent to which collaboration was happening at a local level.

Provider Collaboration Reviews

➤ Throughout July and August we are carrying out a rapid piece of work, engaging with partners and using our data and intelligence, to review how providers are working collaboratively in response to the coronavirus pandemic.

➤ These Provider Collaboration Reviews will involve understanding the journey for people aged 65 and over, with and without COVID-19, across health and social care providers, including the independent sector and council and NHS providers.

➤ We will report back on our findings in our next COVID-19 Insight report in September and in our State of Care report in October.

1. What's the local vision?

Of the people we spoke to and the plans we reviewed, just over half said there was an agreed vision for responding to COVID-19 that was signed up to by all providers. By contrast, about a third said there was no agreed vision. A small minority said that there was an agreed vision, but that it was only signed up to by some providers.

Where local agreements were followed, services reported collaborative working towards a unified goal, while being flexible and sharing of resources. We were given examples of NHS trusts that had modified their existing visions or strategies to ensure they were relevant to the pandemic.

The pace of change has created challenges in reaching agreement. Where there was only partial agreement, issues included stakeholders having different priorities for managing the pandemic locally.

Lack of time and prioritisation of other objectives were among the reasons where places had no agreed vision among stakeholders. There was siloed working with each provider organising its own response.

The pandemic has brought to the fore some good examples of collaboration across sectors and shared learning among services in the way they use technology. As has been seen across the country, there has been a significant increase in the use of technology and streamlined software, such as online team and multi-team working.

Challenges in systems have been managed through cross-sector meetings and networking, and early learning shared. Some services say they will continue these relationships after the pandemic.

Webinars have been used for training and more adult social care providers now have access to, and are using, NHSmail. There are many more remote consultations (GPs and outpatient clinics), which help to provide a safe way to be seen. Doctors have been able to see more patients and spend more time with them. However, one challenge in adult social care settings is how to fully understand a person's condition – for example in treating pressure areas remotely, the need for the consulting clinician to see how the person is positioned in their bed.

2. The importance of shared governance in a system

There have been barriers to collaboration, including:

- multiple requests for information from different places

- using different sources of information to inform decision-making

- a sense of command and control at a regional or national level, which can limit timely local solutions

- potential for more dialogue between primary and secondary care.

However, some pre-pandemic barriers to collaboration are being overcome. The pace of change and a determination to meet the challenge of COVID-19 has put a focus on joint-working, with a willingness to collaborate to 'get the job done'.

The importance of streamlining and securing shared governance arrangements was highlighted to support timely decision-making. This was underpinned by a clear audit trail of why, when and by who decisions were made, which led to a much more rapid response to issues. Allied to this was a consideration of the need, in some cases, to streamline system performance management.

3. The staffing challenge

Among the many challenges faced by providers in recent months, services have had to consider their capacity for caring for people. They have tried to make sure there were enough employees with the right skills to cope with new and increased demands resulting from the pandemic.

Strategies have included the redeployment of existing staff, for example staff moving from one area of a hospital to another, commonly to critical care. Some people were redeployed to another sector, such as hospital and community staff with appropriate clinical skills moving to care homes. There have also been news stories about staff leaving their families and moving into residential care homes to protect the residents.

As well as recruiting new staff, some services have deployed staff who have returned from retirement, or used volunteers. Local authorities used recruitment campaigns to attract new staff; one of them reported a "bank of... unemployed (but experienced and qualified) staff... available at short notice".

There was significant interest from the public in volunteering and supporting their local communities, but there were also concerns about the coordination of volunteer strategies, such as how recruited volunteers might be implemented in the system.

Local responses to support staff capacity also described supporting employees' wellbeing. Examples included:

- rota systems within COVID-19 positive wards in hospitals, so that people were not always working in high pressure environments

- signposting to employee assistance programmes

- implementing enhanced risk assessment for staff from Black and minority ethnic backgrounds, resulting in more homeworking for colleagues at increased risk from coronavirus.

Providers want to build on the momentum of collaboration that has happened during the pandemic. For some, the circumstances have led to a better understanding among services and improved relationships. They have described smarter working and greater efficiency – a reduction in financial constraints has helped.

Among the benefits, some staff have been 'upskilled' and have taken on extra or new roles. Patients have benefitted from an increased focus on the needs of people in the local community – for example, those who are clinically vulnerable or shielding. Some services have seen improved data sharing, and changes to patient pathways with new digital solutions.

Continuing this collaboration, providers see an opportunity to resolve pre-existing problems and work together more across different pathways and services. Some services had concerns about a return to pre-COVID-19 behaviours, preferring to consider how they might streamline approaches in future to support a shared purpose. Our Provider Collaboration Reviews will look in more detail at the way providers have worked together.

Collaboration – examples from the front line

In June, we published on our website a [wide range of examples](#) from the front line, which health and care providers from all sectors had shared with us showing how they have innovated and adapted working practices to respond to the challenges of COVID-19. Here are three of those examples of working together that highlight the characteristics of good collaboration.

Working together using data to protect extremely vulnerable groups

Using a data dashboard tool developed by a local expert GP and taken up by the CCG, Nottinghamshire Healthcare Foundation Trust worked with their local integrated care system to identify populations vulnerable to high COVID-19 risk. This meant community and mental health services could not only identify individuals under their care, but the distribution of risk across deprivation and ethnic group categories was understood by all healthcare organisations involved. The data tool was particularly helpful in ensuring that those with severe mental illnesses were identified to receive support via Primary Care Network areas, as this group is often difficult to capture through primary care data alone.

This work has implications beyond the COVID-19 crisis as it enables a better understanding of and approach to population health as a whole, identifying high risk groups down to Lower layer Super Output Areas (LSOAs) – equating to a population size of around 1,500.

Chris Packham, Associate Medical Director for Nottinghamshire NHS Foundation Trust, said they established an innovative longstanding data sharing process and encouraged local GPs to download data to a CCG-held database. The collected data helped identify quality improvement work at individual patient level for practices. Acute, mental health and community trust data was added to the database, enabling better identification of patients with higher risks of poor outcomes during the pandemic.

"The data brings population health management to life," says Chris Packham. The data is now used by an Integrated Care System to inform Population Health Management (PHM) approaches that can guide commissioning. For example, the mental health PHM work identified seven interventions/topics that could prevent escalation of mental ill-health, exacerbated by the pandemic. The aim is to collectively use resources, skills and expertise to support the local population through integrated data sharing and PHM.

Collaboration – examples from the front line

The power of trusted relationships

The benefits of a good relationship between a care home, a community pharmacy and local GP have contributed to the care and safety of the care home's residents during lockdown and will become a normal way of working post-COVID.

Zoe Fry, owner of Valerie Manor Nursing and Residential Care home, says that relationships developed before the COVID outbreak have been invaluable during lockdown. This has enabled the streamlining of processes around the urgent provision of care when required, allowing prescriptions to be requested, dispensed and collected/delivered within a matter of hours under normal circumstances. The pharmacy can provide a 24/7 service for urgent medication if necessary.

The three-way relationship, built on trust and shared values, has meant that if, for example, stock levels of a particular medication are low, the Steyning Medical Practice can send a prescription to the pharmacy, Upper Beeding Pharmacy, which the pharmacy will only dispense if it is needed. This also means the care home does not have to carry large stocks of emergency medication.

As well as providing guidance on medicines management, helping the home implement new guidance as it is issued, the pharmacy carries out monthly reviews of stock levels via Skype and works with the home and GP to carry out regular video medication reviews of the home's residents. The pharmacy is available via video calling technologies, if there is a need for less qualified staff to administer medications within the home, to help provide safety and quality assurance.

Coordination of new resident admissions to the home can be eased by pharmacy involvement with GP surgeries, with the pharmacy aiming to provide correct and up-to-date blister packed medication to coincide with patients being admitted.

Valerie Manor has also worked with the GP to ensure that all residents are reviewed by the GP at least every 28 days – a greater frequency than pre-lockdown and important in terms of death notification requirements.

Collaboration – examples from the front line

Building better relationships between primary and social care

The Five Lane Primary Care Network has aligned local care homes to the four practices in the PCN to improve continuity, reduce social contact and build a better relationship with the care homes. While this approach is embedded in the new GP contract, the partnership took this action independently on its own initiative in response to COVID-19.

Rachel Thompson, Practice Manager at the Rockwell and Wrose Practice, said that the plans to align the homes with the partnership were put in place before the crisis hit, as they recognised the growing pace of COVID-19.

This plan received very positive feedback from care home managers. Many residents at the care homes were registered under the care of doctors at another practice, so the partnership consulted with those practices, and residents and families. The partnership asked for the care homes' help in discussing the transition with patients and relatives to seek consent and created a letter for relatives to explain the reasons and ask for their approval.

The change also found approval with the local district nursing team, which is based in the same building as the partnership. The co-location of district nursing and GPs improves the coordination of care and helps the work of the multi-disciplinary team.

The practice supplied Sats oximeters and digital thermometers to the care homes and asked staff to undertake daily observations of the residents and report any outlying readings. Staff needed training to use this equipment which was supplied by the GPs, and they were invited to take observations if any patient became unwell and needed a GP.

Since lockdown, as well as being available for urgent calls, GPs at the partnership have dedicated time every Thursday morning to perform a ward round of the residents (either telephone, video or face-to-face as needed). This step has significantly improved patient care, professional to professional relationships, networking and medicines management.

COVID INSIGHT

RESPONDING TO FEEDBACK ABOUT CARE SERVICES

The importance of hearing about concerns about the care people receive

Throughout the COVID-19 crisis, our regulatory role has not changed. We continue to ensure that health and social care services provide people with safe, effective, compassionate, high-quality care. At the start of the pandemic we moved quickly to support providers to keep people safe.

While routine inspections have been paused, we have never stopped regulating. We have continued to inspect in response to immediate risks and concerns about safety, we have engaged with providers constantly, and we have continued to monitor services to identify where extra support is needed.

Staff have been going to extraordinary lengths to deliver good, safe care during this global crisis. Their voices are crucial to understanding the quality of care on the frontline and listening to them is key to keeping people safe and well cared for.

We have strengthened our processes to help ensure that we can listen and respond as effectively as possible. Our contact centre automatically allocates calls from care workers who have concerns about the safety or quality of care to an inspector or senior member of the team to investigate so these calls are fast-tracked, offering a quicker resolution to the issues raised.

We reported in mid-June about the increase in calls to CQC's national contact centre from staff raising concerns about care, many of which related to issues with PPE, infection control and the challenges posed by social distancing.

We have now carried out 50 inspections in adult social care services since 16 March; 24 of these were as result of concerns raised by staff or members of the public, and the remainder were in response to concerns we identified through our Emergency Support Framework, notifications from the provider or information from key stakeholders. Our decisions to inspect have been informed by very heightened risks to people using those services, based on both the previous history of some services and new concerns raised with us. Often these have reflected the key failures of care found before the pandemic.

(continues next slide)

The reasons included indications of closed cultures, where we were not able to get the information we needed to assure us of people being safe in a service. We found that in some of the services where we had concerns about safety, there had been a recent change of manager or no current registered manager. Reports of poor infection prevention and control also alerted us in a small number of cases, both in services where there had been an outbreak of COVID-19 and in those without active cases.

In some cases we were alerted to instances of extremely poor and unsafe care, with people's most basic needs not being met – specifically in relation to falls management, nutrition and hydration, and wound and pressure area care. This was underpinned by staff not assessing and supporting people safely and a lack of oversight by the registered provider – resulting in, for example, poor medicines management and reports of staff not responding appropriately to incidents.

Where appropriate we are taking urgent action to protect people using services (including stopping new admissions and on rare occasions closing services), and we will publish individual inspection reports on our website.

We have also now carried out 20 inspections in hospitals (including mental health and independent services) since 16 March, of which 10 were as result of concerns raised by staff or members of the public, and five inspections of primary medical services, of which three were as result of concerns raised by staff or members of the public.

Because We All Care is a new campaign led by CQC and Healthwatch England in response to COVID-19. As the country pulls together to recover from the impact of coronavirus, Because We All Care aims to encourage more people to share their experiences of care to help the NHS and social care services identify and address quality issues and provide the best care possible.

Our research shows that more than two-thirds of people are more likely to act to improve health and social care services since the outbreak of COVID-19, with close to two thirds saying they would be more willing since COVID-19 to support NHS and social care services by actively providing feedback on their care.

Through the campaign, we are encouraging people to feedback on care, both good or bad, as this information supports our ongoing monitoring of services. Everyone can play a part in improving care by directly giving feedback to services, and by sharing information and experiences with us so that we can take action when we find poor care and highlight good care.

#BecauseWeAllCare about NHS and social care – share your feedback with **@CareQualityComm**

COVID INSIGHT

FINANCIAL VIABILITY AND STABILITY IN THE ADULT SOCIAL CARE SECTOR

Impact on financial viability during the pandemic

Previous issues of this report have highlighted the financial vulnerability of the adult social care system before the pandemic, and the further impact that COVID-19 has had on a sector that cares for primarily older people, often with underlying conditions. The government has 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 an additional £600 million through a new adult social care infection control fund.

In our first issue, in May, we said that some providers may face a reduction in people using their services due to the tragic increase in deaths, coupled with fewer admissions. We also said that some providers were struggling with the costs of ensuring they had enough personal protective equipment. These have continued to be themes in some of the discussions our inspectors have been having with providers through our emergency support framework.

These concerns have been echoed by the Association of Directors of Adult Social Services in their Coronavirus Survey, published last month. This said that a quarter of directors now have concerns about the financial sustainability of most of their residential and nursing providers since the outbreak. Also, 15% of directors now had concerns about the financial sustainability of most of their homecare and community care providers, whereas this figure was only 3% before the onset of COVID-19.

Market Oversight

We have previously signalled, through our Market Oversight scheme, that COVID-19 is having a significant impact on the financial viability of adult social care services. We think this impact continues and will continue to monitor the market carefully.

Recent analysis of providers in our Market Oversight scheme shows an overall reduction in admissions to care homes during the pandemic, but the rates vary significantly. Although admissions funded by local authorities have now risen to an average of 72% of the number received in the same period in 2019, admissions for the week ending 7 June 2020 ranged from 43% to 113% of the 2019 amount. Self-funded admissions, by comparison, ranged from 25% to 51% of 2019 levels, with an average of 35%. This could put added financial pressure on homes that are more reliant on people who fund their own care.

Again looking at Market Oversight figures, homecare services also appear to be experiencing lower levels of activity, but to a smaller degree. Homecare hours are at 94% of pre-pandemic levels, but have stabilised, and are now forecast to increase going forward. Homecare providers that are commissioned by local authorities have typically continued to be paid on planned hours, which should have insulated these providers from the reduction in hours.

Care home and community services capacity

Financial difficulties in adult social care do not yet appear to be translating into significant amounts of reduced capacity or service closures, according to our registration data. Comparing the change in overall numbers of care homes in March to June in 2019 and 2020 shows that the number of services has remained relatively stable; indeed, the change in residential homes is less in 2020 than it was in 2019.

Looking at changes in the numbers of care home beds gives a similar picture so far. Considering the size of the care home market (approximately 450,000 beds), these numbers seem relatively small. However, these figures could be showing a delayed impact of COVID-19, as it is likely that providers have not yet borne the full cost of the pandemic.

Nursing homes: change in overall number of services

Residential homes: change in overall number of services

Residential homes: change in number of beds

Source: All charts, CQC registration data
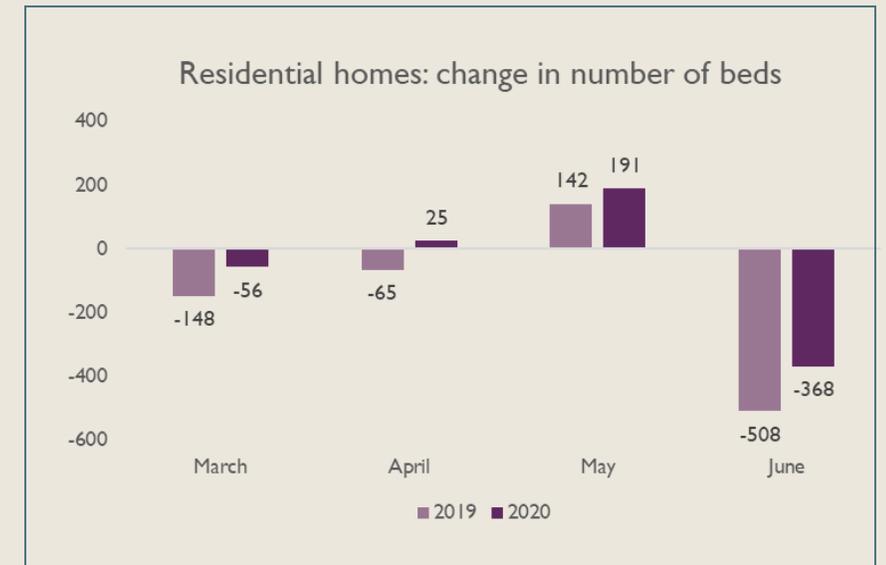
Fewer new adult social care community services (including homecare agencies) registered this year, compared with the same period in 2019. As with care homes, the changes in the overall numbers of community services between March and June this year are relatively low, given that there are around 9,000 homecare agencies in England.

New ASC community services

	March	April	May	June
2019	135	147	121	117
2020	135	108	88	92

Community ASC: change in overall number of services

	March	April	May	June
2019	62	-14	36	26
2020	42	36	37	-32
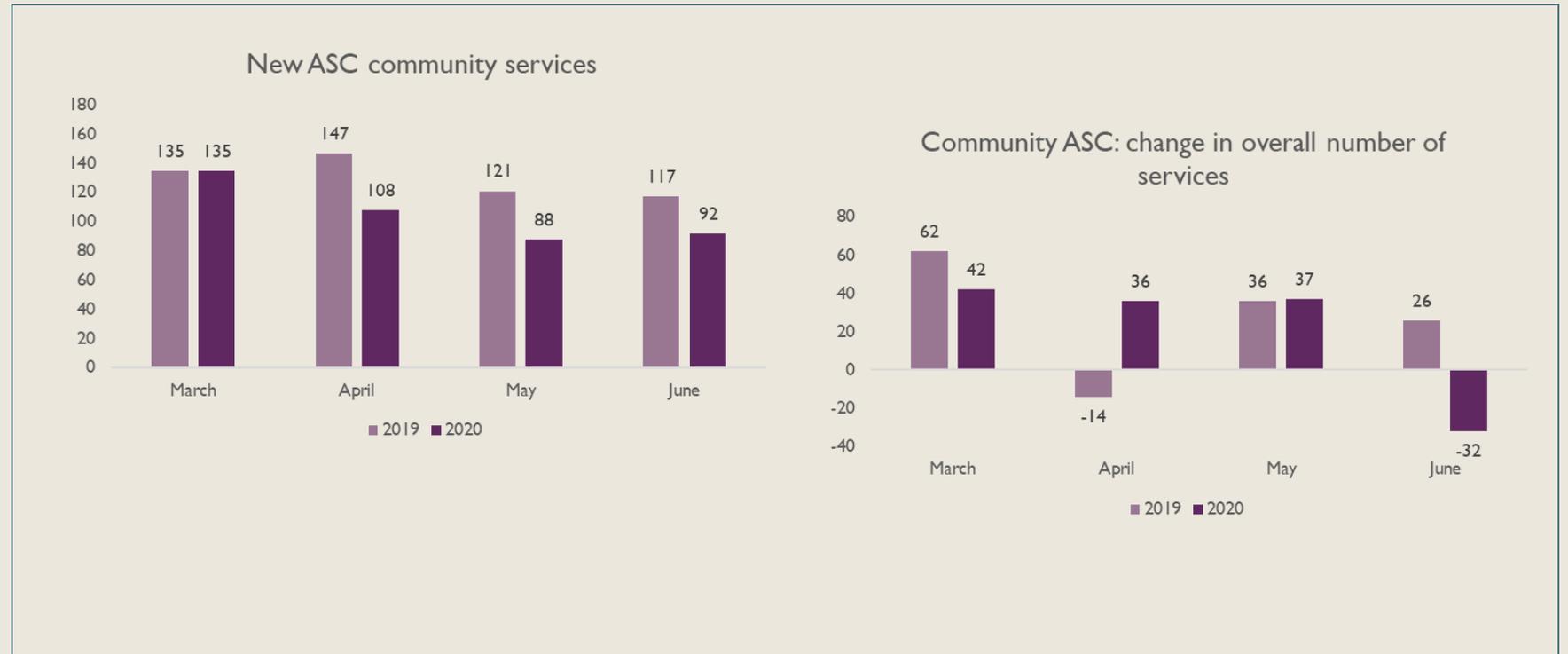
Source: All charts, CQC registration data

COVID INSIGHT

THE IMPACT OF COVID-19 ON THE USE OF DEPRIVATION OF LIBERTY SAFEGUARDS

Introduction to 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 their human rights and provide the care they need.

In our State of Care report last year, we said that people were waiting too long to have their DoLS applications processed, which risked infringing their human rights. We also highlighted that, while our inspections showed evidence of increasing awareness around DoLS, providers' lack of understanding and confusion around the legislation remained a primary reason for poor practice.

The Liberty Protection Safeguards, which are intended to provide a simpler process that will better support the safeguards that people need, were set to replace DoLS from October 2020. However, because of the current pressures the pandemic is putting on the health and social care sector, this is now delayed.

Where we saw better DoLS practice previously, we found examples of clear leadership and training for staff in providers, better involvement of friends and family in the DoLS process, and good partnership working between providers and local authorities.

What's the current picture?

All providers must notify CQC about the outcome of an application to deprive a person of their liberty. We have continued to monitor notifications during the COVID-19 pandemic and seen a sharp fall in the number of notifications between March and May compared with the same period in 2019.

Since the start of lockdown, we have seen notifications from adult social care services drop by almost a third (31%), and in hospitals by almost two-thirds (65%).

The decrease has varied across the regions. In adult social care, London saw the largest percentage change with a 37% drop, followed by a 35% reduction in the East of England. For hospitals, the South East saw the largest percentage reduction of 82%, followed by 71% in London.

	March-May 2019	March-May 2020	% change
Adult social care	20,301	13,914	-31%
Hospitals	10,756	3,807	-65%

The challenges faced by providers

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

Providers have had to introduce certain restrictions into an already complex and confusing picture, with a potential lack of understanding about DoLS that might affect 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 during the pandemic. This explained that during the pandemic, in most cases, changes to a person's care or treatment would not constitute a new deprivation of liberty, and a DoLS authorisation would not be required.

However, our inspectors have seen that, with providers increasingly looking towards the introduction of the Liberty Protection Safeguards (LPS), providers' focus on DoLS has waned and training in some areas has stagnated. Poor understanding of DoLS has remained a fundamental issue. 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.

There is an additional challenge for providers in balancing introducing restrictions to keep people safe from COVID-19, with ensuring that they are applying the least restrictive principle in line with the Mental Capacity Act. Some providers are actively mitigating 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 the home – the aim being to encourage mobility and allow people to spend more time outside of their room

COVID INSIGHT

PROTECTING PEOPLE'S RIGHTS UNDER THE MENTAL HEALTH ACT

The challenges faced by providers in protecting people's rights under the MHA

We have a duty under the Mental Health Act 1983 (MHA) to monitor how services exercise their powers and discharge their duties when people are detained in hospital or are subject to community treatment orders or guardianship. To do this under the current COVID-19 restrictions, since 8 April we have been using a new remote method of monitoring individual mental health wards. This has included collecting data from a range of people via phone, email or video calls. We have also spoken with patients and their families and carers by phone or online to identify, support or seek response to the new challenges impacting patients, such as visits by families and carers, blanket restrictions and decision making.

We have seen how the pandemic and related restrictions have created challenges for providers of mental health care, requiring them to balance the need to keep people safe from the virus with their duty to meet the requirements of the MHA, ensuring that they are upholding people's human rights.

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. This is a particular concern for people with a learning disability and/or autistic people, who may end up staying in hospital due to the unavailability of community placements.

What's the current picture?

From the new remote monitoring carried out so far, we have found some examples of providers giving good support to their patients. This includes:

- 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 facilitated 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 in order 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.

However, a key challenge for providers has been maintaining a safe environment – managing the need to socially distance or isolate people due to COVID-19 – while also maintaining a therapeutic environment. As wards are often unsuitable environments in which to socially distance, this has increased the risk of segregation and seclusion. Some hospitals have created cohort wards for suspected COVID-19 patients. With access to testing for all now available, new admissions can be safely integrated onto wards as soon as test results are obtained, although services still have to manage keeping patients apart while awaiting test results, or if they test positive. We have encouraged services to ensure that patients in isolation have adequate staff contact and support, as well as access to activities and to fresh air.

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. While we do not think this will happen, we will continue to work with services to challenge any increase in restrictions.

Where we have found immediate concerns, we have been working to ensure any rules put in place are proportionate and in line with the MHA Code of Practice and any emerging national guidance to support people during COVID-19. We have also been sharing information from our MHA work with NHS England/NHS Improvement and the Department for Health and Social Care to help inform the development of guidance, making sure the minimum restrictions necessary are required and human rights are protected for people subject to the Act.

COVID INSIGHT

DATA APPENDIX

New weekly outbreaks in care homes

New weekly care home outbreaks as a rate per 1,000 care homes
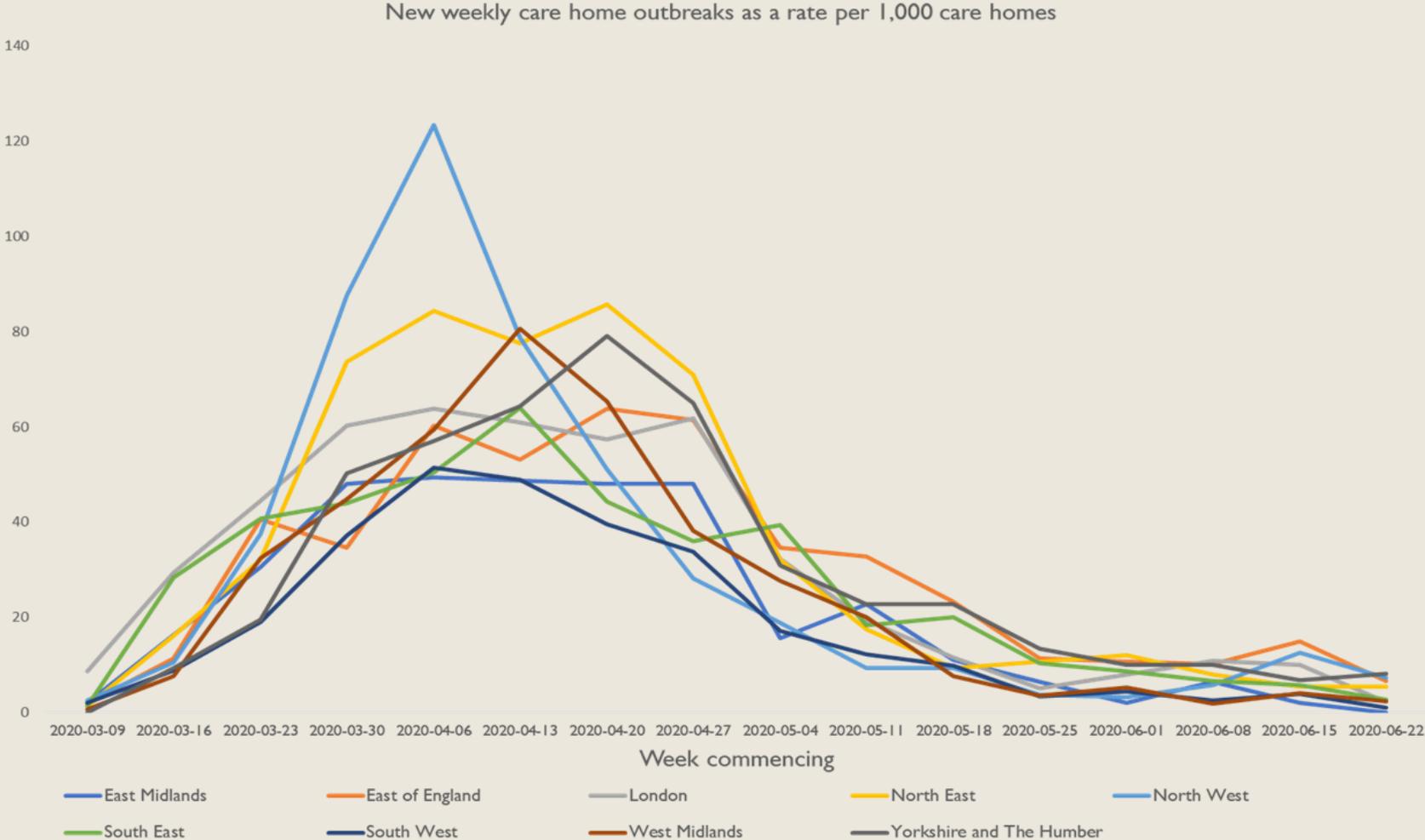
This shows the weekly progression of outbreaks in each region (per 1,000 care homes). Care homes are only counted once, when they first experience an outbreak.

Week commencing

- East Midlands
- East of England
- London
- North East
- North West
- South East
- South West
- West Midlands
- Yorkshire and The Humber

Source: PHE COVID-19 Outbreaks in care homes, cumulative figures from week commencing 09/03/20 to week commencing 22/06/2020, published 02/07/20
https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

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Cumulative total of care homes with outbreaks in each region

Region	Percentage of care homes that have ever reported an outbreak	Percentage of care homes that have never reported an outbreak
East Midlands (1,538)	36%	64%
East of England (1,676)	47%	53%
London (1,393)	49%	51%
North East (747)	54%	46%
North West (1,919)	49%	51%
South East (2,998)	42%	58%
South West (2,045)	29%	71%
West Midlands (1,699)	40%	60%
Yorkshire and The Humber (1,492)	47%	53%

■ Percentage of care homes that have ever reported an outbreak   ■ Percentage of care homes that have never reported an outbreak

The figures in brackets show the number of care homes that PHE assign to each government region.

All regions have increased by 1-4% since the last update.

There are some very small differences with our own classification; this is likely to be as a result of new registration activity and/or service type descriptions.

Source: PHE COVID-19 Outbreaks in care homes, cumulative figures from week commencing 09/03/20 to week commencing 22/06/20, published 02/07/20
https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

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Homecare providers – prevalence of COVID-19

6,591 responses

| England (9,895) | 33% | 62% | 5% |

Percentage of DCAs by Covid-19 submission status, 29 June - 5 July

East Midlands (943)	41%	55%	4%
East of England (1,193)	32%	63%	5%
London (1,474)	36%	58%	7%
North East (357)	30%	66%	4%
North West (1,172)	32%	62%	6%
South East (1,684)	32%	64%	4%
South West (991)	30%	67%	3%
West Midlands (1,168)	34%	62%	4%
Yorkshire and The Humber (913)	31%	65%	4%

■ No submission   ■ DCAs with 0 cases   ■ DCAs with at least one case
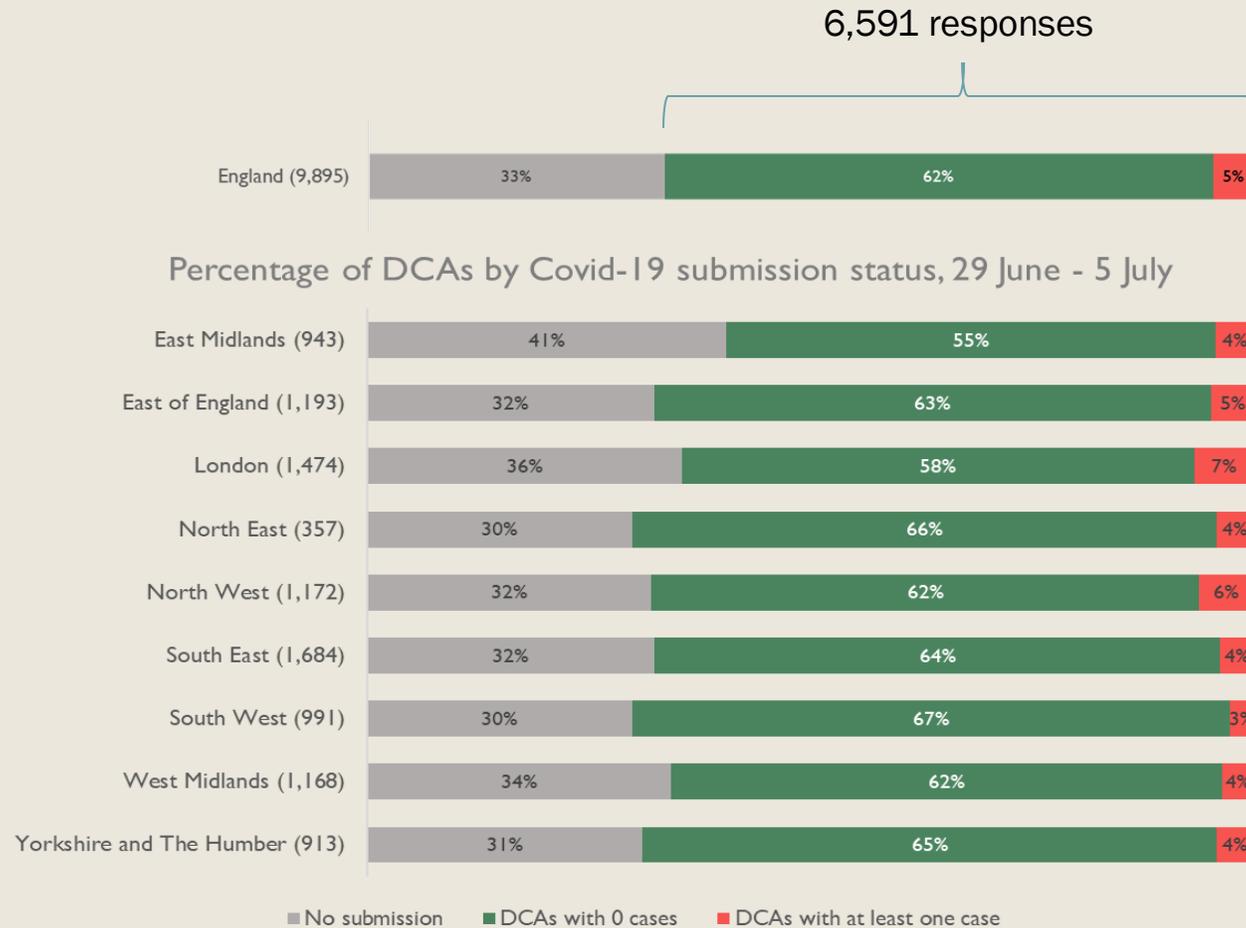
Source: CQC Domiciliary Care Agency Survey. Homecare providers with at least one case include suspected AND confirmed cases. Numbers in brackets show number of services that are primarily homecare providers in the region. Included in these figures are homecare services currently lying dormant, so completion rates are slightly higher for fully active services than this might suggest. Percentages may not add to 100% due to rounding.

Homecare providers – availability of all PPE
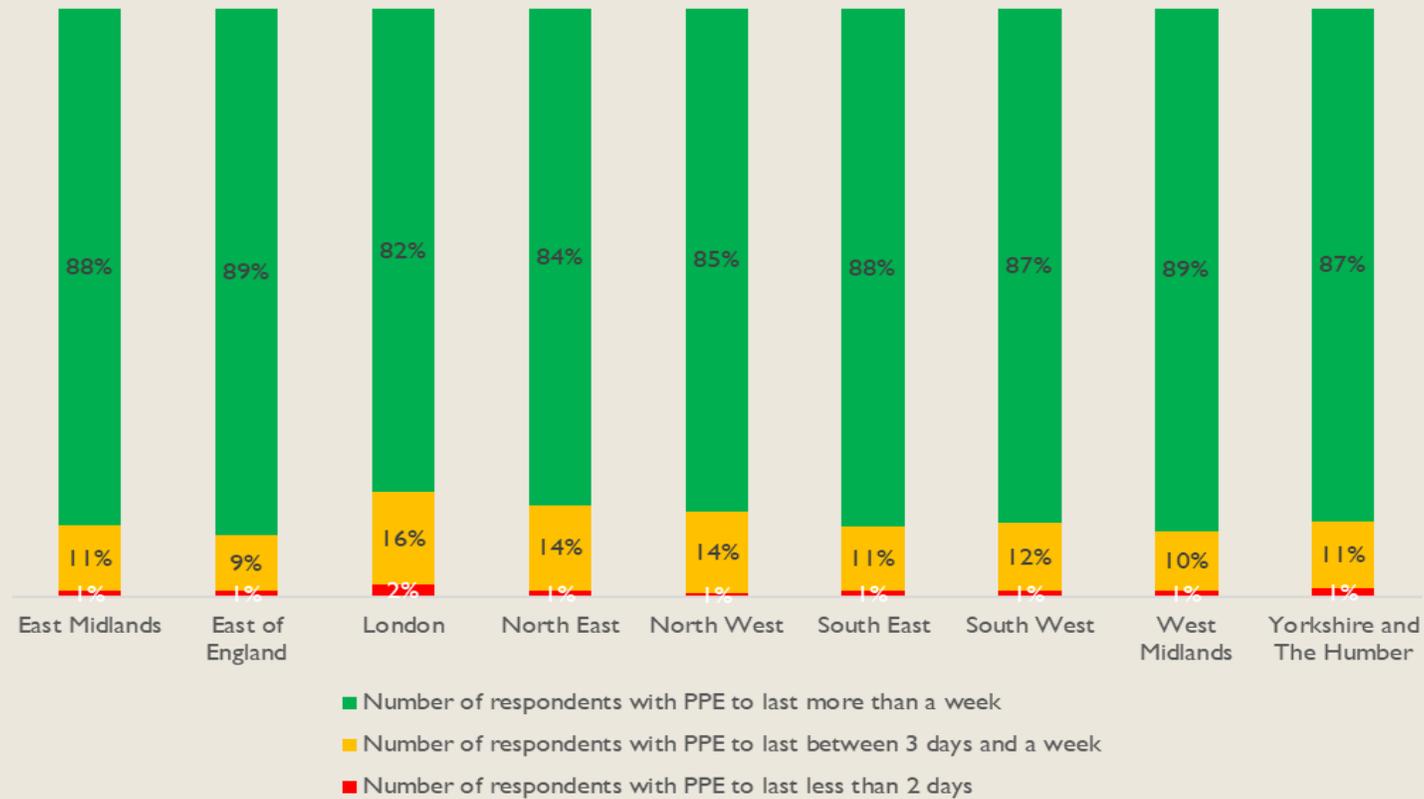
	East Midlands	East of England	London	North East	North West	South East	South West	West Midlands	Yorkshire and The Humber
Green (more than a week)	88%	89%	82%	84%	85%	88%	87%	89%	87%
Yellow (3 days to a week)	11%	9%	16%	14%	14%	11%	12%	10%	11%
Red (less than 2 days)	1%	1%	2%	1%	1%	1%	1%	1%	1%

- Number of respondents with PPE to last more than a week
- Number of respondents with PPE to last between 3 days and a week
- Number of respondents with PPE to last less than 2 days

Source: CQC Domiciliary Care Agency Survey – latest response in period 29 June – 5 July inclusive

Homecare providers – staff absence

DCA staff who deliver care to people absent
**because of coronavirus**

Region	Percentage
East Midlands	7%
East of England	7%
London	7%
North East	11%
North West	6%
South East	7%
South West	6%
West Midlands	7%
Yorkshire and The Humber	7%

England average: **7%**

Source: CQC Domiciliary Care Agency survey – latest response in period 29 June – 5 July inclusive
includes staff who are self-isolating or have care commitments

Deaths notified by care homes

The latest data, from 3 June – 3 July, continues to show that deaths in care homes due to COVID-19 are decreasing.
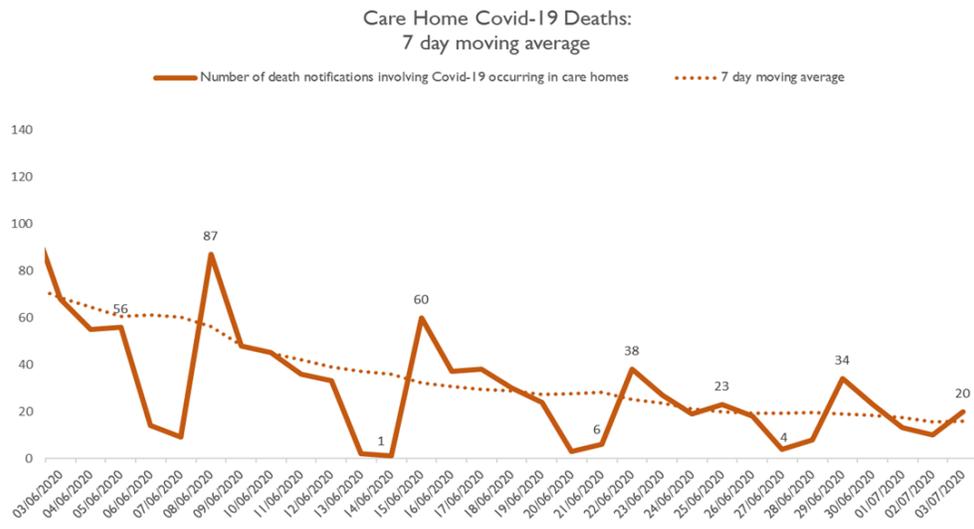
Number of notifications by care homes of deaths* where COVID-19 is reported as suspected or confirmed per 1000 care home beds
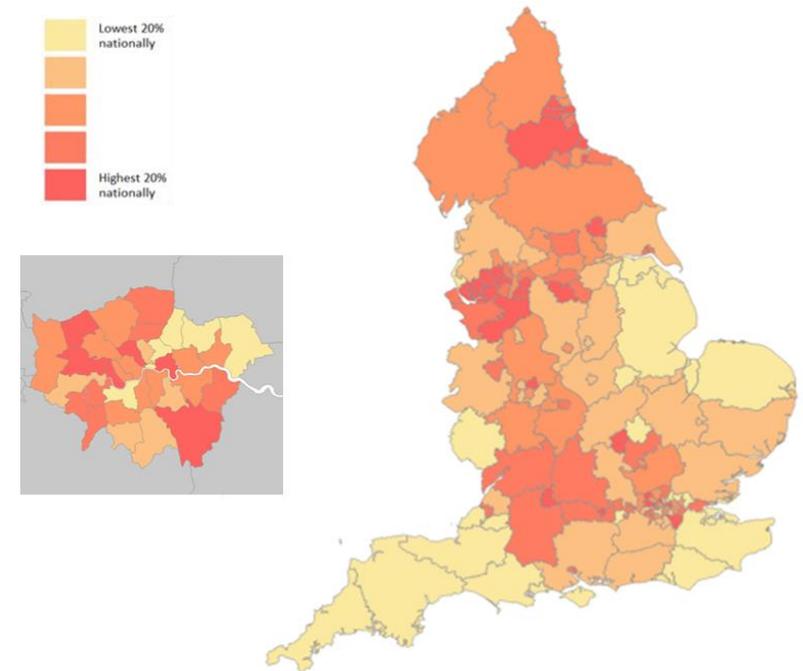
Care Home Covid-19 Deaths:
7 day moving average

—— Number of death notifications involving Covid-19 occurring in care homes   ⋯⋯ 7 day moving average

Lowest 20% nationally

Highest 20% nationally

Deaths of people detained under the Mental Health Act

All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained, under the MHA. From 1 March to 3 July 2020, we have been notified of 76 deaths that mental health providers indicated were suspected or confirmed to be related to COVID-19. A further three COVID-19 related deaths of detained patients were reported by other (non-mental health) providers.*

Of the 176 notifications from mental health providers in the 2020 period (covering all causes of death), 132 were from NHS organisations, of which 50 deaths were indicated as being COVID-19-related, and 44 were from independent providers, of which 26 deaths were COVID-19-related.

For the first time we have identified the total number of detained patients whose deaths have been notified to us from 1 March to 3 July 2020 who had a learning disability and/or were autistic: in this period current records show less than 10 such deaths, of which the majority were identified as related to confirmed or suspected COVID-19.** Of these people, most also had a mental health diagnosis. Please note that these patients were identified both from a specific box being ticked on the notification form and a review of diagnoses in the free text of the form. We are also now able to publish data on ethnicity and place of death, where known, and these are shown at the end of this section.

The table below compares the number of deaths notified to CQC in the above period with equivalent periods in preceding years. When interpreting trends, please note that such low numbers are subject to fluctuation.

Statutory notifications (regulation 17)	Year (1 March to 3 July in each year)					
Type of provider	2016	2017	2018	2019	2020 (without duplicates)	2020 reported deaths due or suspected to be due to COVID-19
Mental health providers	107	92	97	89	176	76
Non mental health providers	8	4	6	9	8	3

* Includes detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. 'Detained patients' also includes patients subject to holding powers such as s. 4, 5, 135 or 136, and patients recalled to hospital from CTO. Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers unrelated to new cases.

** In line with our approach to the publication of data on deaths of people with a learning disability and/or autistic people in other settings, we are not publishing exact numbers at this level to avoid identifying individuals.

Deaths of people detained under the Mental Health Act

Deaths of detained patients from 1 March to 3 July 2020, by age band and COVID-19 status

Age band	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19	1	1	4	6	13	15	20	12	7	79
Not COVID-19	4	9	4	17	23	20	13	6	9	105
Total	5	10	8	23	36	35	33	18	16	184

Deaths of detained patients from 1 March to 3 July 2020, by ethnicity and COVID-19 status

Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	1	1
Black	11	9
Mixed	1	4
Other ethnic groups	0	1
White	50	60
Unknown	8	10
Not stated	8	20
Total	79	105

Deaths of detained patients from 1 March to 3 July 2020, by gender and COVID-19 status.

	Female	Male	Unknown	Total
Suspected or confirmed COVID-19	27	43	9	79
Not COVID-19	31	64	10	105
Total	58	107	19	184

Deaths of detained patients from 1 March to 3 July 2020, by place of death and COVID-19 status

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	46	30
Psychiatric ward	24	32
Hospital grounds	1	3
Patient's home	0	10
Other	1	21
Not stated	7	9
Total	79	105

ONS data on all weekly deaths in England (COVID and non-COVID) compared with the average for 2015-2019
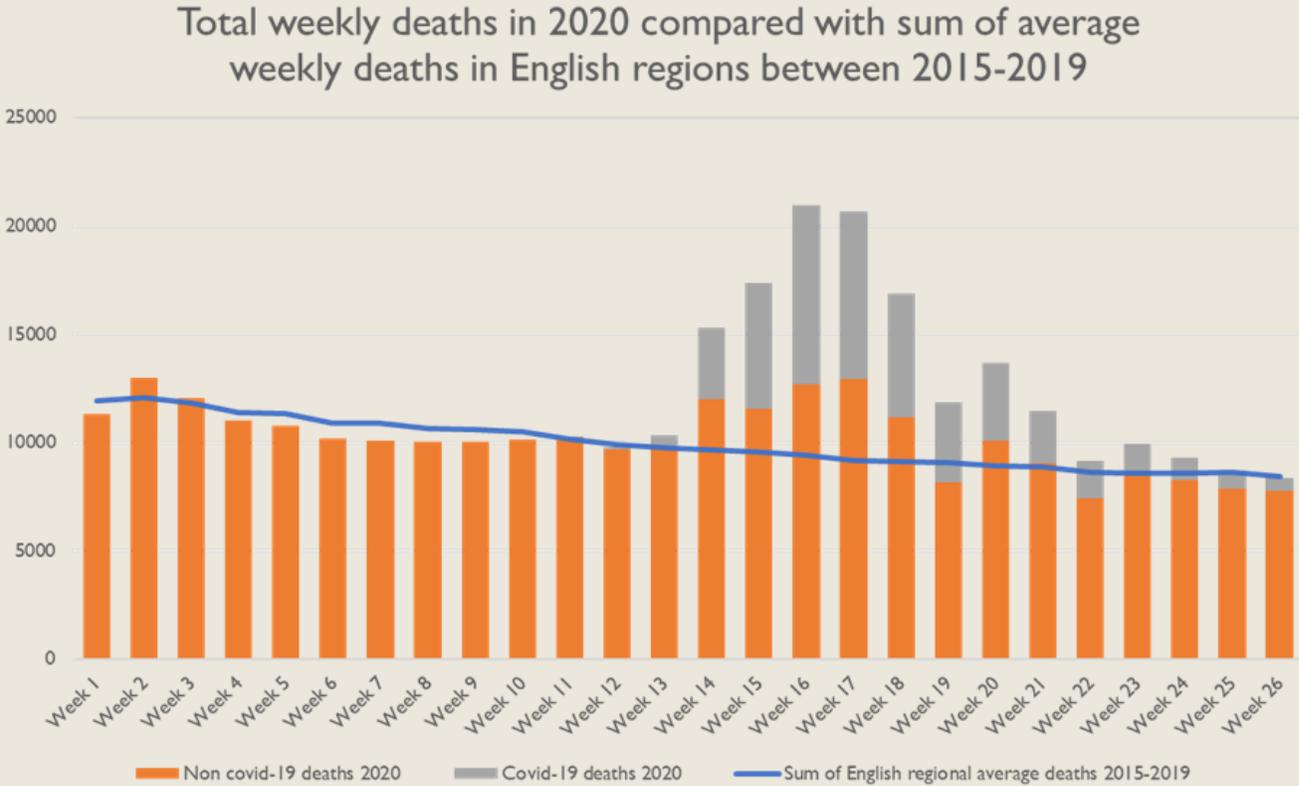
Total weekly deaths in 2020 compared with sum of average weekly deaths in English regions between 2015-2019

Legend: Non covid-19 deaths 2020 · Covid-19 deaths 2020 · Sum of English regional average deaths 2015-2019

Sources
Deaths data: Office for National Statistics and CQC supplied to ONS.
Homecare provider PPE, COVID status and staffing data: CQC Domiciliary Care Agency survey
Outbreaks data: Public Health England

The data date ranges are shown on the relevant slides
Data is contemporaneous where possible; most figures refer to the same week, or are counted to the end of that week.