



# COVID-19 INSIGHT

## Issue 6

December 2020

 STATE OF CARE

# COVID INSIGHT

DESIGNATED SETTINGS AND CARE HOME CAPACITY



# Designated settings

[In the last edition of this Insight series](#), we shared findings and good practice from our inspections of care homes in August and September 2020, which looked at how care homes managed infection prevention and control (IPC).

We have continued this focus by carrying out over 500 IPC inspections in October and November, measuring assurance against eight questions. The results of these inspections are published on our website.

Increasingly, these have included inspections of designated locations. These inspections are in support of a scheme led by the Department of Health and Social Care to allow people with a COVID-positive test result to be discharged safely from hospital.

The Department has asked local authorities to speak to local care providers and find suitable designated locations for people to be safely discharged to. Once these locations have been identified, we then assess the location with an IPC inspection and a specific focus on a service's ability to zone COVID-19 positive residents with a dedicated workforce and high levels of ventilation.

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

We provide a weekly update on the number of assured designated locations on our [website](#).

The Government's aim is for each local authority to have access to at least one designated setting as soon as possible.

Now that the designation scheme is up and running, we can look at numbers of approved settings across regions. The table below shows the number of designated beds and those covered by alternative arrangements per 100 care home beds, per 100,000 people over 65 in each region and measured against the average COVID infection rate per 100,000 people.

The table shows that there is wide variation. For example, the lowest figure of designated beds per 100 care home beds is in the South East (0.19) and the highest figure is in London (1.00). There is a similar level of variation by looking at the number of designated beds against the number of people over 65.

By comparing the provision of approved designated beds against the average regional rate of infection in the population, these differences are reduced, although by no means entirely. For example, the ratio of approved designated beds to infection rate in the South West and South East is around a half or less of the ratio for North East and Yorkshire, Midlands and London. This suggests a potential shortage of provision in the South West and South East.

**Figure 1: Beds in designated settings or alternative arrangements per 100 care home beds, per 100,000 people over 65, and per average infection rate per 100,000 people**

Region	No. of beds in approved designated settings & alternative arrangements	Ratio of beds in designated settings & alternative arrangements to 100 care home beds	Ratio of beds in designated settings & alternative arrangements to 100,000 people 65+	Ratio of beds in designated settings & alternative arrangements to average infection rate per 100,000 population tested under Pillar 1 and 2 (week 48)
East of England	211	0.38	14.39	1.74
London	356	1.00	32.92	2.36
Midlands	510	0.57	27.88	2.76
North East and Yorkshire	545	0.70	32.74	2.90
North West	272	0.45	20.80	1.81
South East	162	0.19	9.25	1.24
South West	114	0.21	9.09	1.22

We have also analysed regional provision of approved designated beds against recent rates of hospital admission for COVID-19 and found similar patterns.

It is important to note that these figures do not show the full picture. Although we have included figures for alternative arrangements where we have the relevant information, these may not be complete. Designated settings are continually being submitted, considered and inspected, and infection rates are constantly changing, so all these figures will change over time. However, these figures are helping to inform the conversations about designated settings that are taking place in each local area.

# Care home capacity

In our [July edition of this Insight report](#), we highlighted concerns about the financial viability of some care homes due to the ongoing impact of the pandemic. At that time, analysis from our Market Oversight function indicated that recovery in care home admissions was slower for self-funded places compared with admissions funded by local authorities. We said that this could put added financial pressure on homes that are more reliant on people who fund their own care.

For care homes that fall within the Market Oversight scheme (approximately 30% of the total care home sector), occupancy levels were on average 87% prior to the pandemic. These levels are estimated to have reduced by around 10% at the height of the first wave of the pandemic. While average occupancy levels increased over summer to approximately 80%, they remain considerably below normal and may fall again.

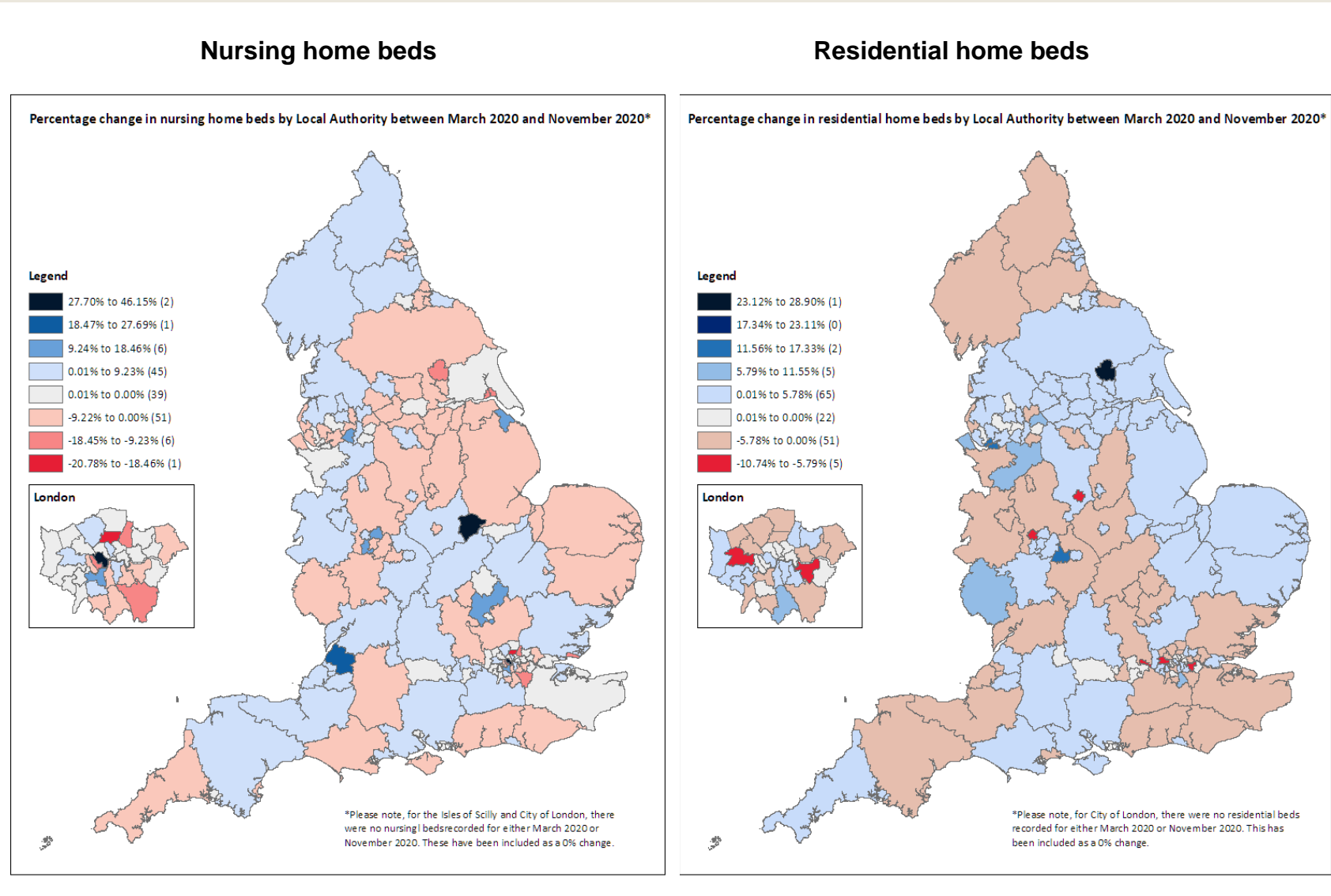
An Association of Directors of Adult Social Services (ADASS) [report](#) in June said that a quarter of directors were concerned about the financial sustainability of most of their residential and nursing providers following the outbreak.

We have looked at the latest data from our register of care homes, and this shows that the total number of registered care home beds is still relatively unchanged. The total number of care home beds across the country at 1 November 2020 was 457,636 compared with 456,892 at 1 March 2020. This shows a very small increase in beds (less than 0.2%).

Financial challenges do not yet appear to have given rise to home closures, but it is unlikely that this can be maintained if occupancy levels decline over the long term. In their June report, ADASS said reported that, as a result of COVID-19, around three-quarters of councils had seen a drop in occupancy of residential and nursing homes used mainly by state-funded residents, and over half had seen a decline in occupancy in homes mainly for self-funders.

This stability in registered provision at national level to some extent masks some more marked changes at local level, particularly when nursing homes are distinguished from residential homes (see figure 2).

Figure 2: Percentage change in nursing and residential home bed capacity from 1 March to 1 November 2020 by local authority



Source: CQC register

Areas of the maps shaded tan to red indicate a reduction in the number of beds within the local authority area, and shades of blue indicate an increase. Comparing the nursing and residential homes maps side by side it can be seen that some areas have seen an increase in nursing home capacity at the same time as a reduction in residential home capacity (for example Cumbria, Northumberland, Devon and Somerset), while others have seen the reverse trend (parts of Yorkshire, Norfolk, Suffolk and Cornwall).

There is some indication that such trends may be driven by services in some areas changing their registration from nursing homes to residential homes or vice versa. There are 19 local authorities that have seen at least one home change registration from nursing to residential, accounting for more than 1,000 beds. In comparison, there are four local authorities that have seen at least one home change from residential to nursing, accounting for around 240 beds.

Although the long-term trend has been that numbers of residential homes have been reducing at a faster rate than nursing homes, these recent figures show that almost all the overall increase in the number of beds was in residential homes (703 beds) rather than nursing homes (41 beds). This could be linked to workforce challenges that we flagged in State of Care, with the recruitment of nurses a particular challenge. A potential reduction in nursing home provision is concerning, as it is vital for the care and support of people with high support needs, including people living with dementia.

Other parts of the country have seen either a reduction in both nursing and residential capacity (including East and West Sussex, Bromley, and Nottinghamshire), or an increase (such as Hampshire, Oxfordshire, Cambridgeshire and Lancashire).

# COVID INSIGHT

PROVIDER COLLABORATION REVIEWS:  
URGENT AND EMERGENCY CARE





As we reported in the September COVID-19 Insight, and our State of Care report in October, we are embarked on a programme of provider collaboration reviews. These reviews aim to show the best of innovation across systems under pressure, and to drive system, regional and national learning and improvement. There has been significant support for the reviews from the providers we have engaged with.

Our latest review has looked at urgent and emergency care in eight areas in October and November. Urgent and emergency care (UEC) covers a wide range of services that people turn to when they need immediate help, including NHS 111, GP out-of-hours services, urgent treatment centres, accident and emergency, ambulance services and pharmacies.

Even before COVID-19, the UEC system in England faced many challenges. These are not simply issues within hospital emergency departments or a result of seasonal variation – issues are present year-round and across the entire care system.

During our review, we looked at new models of collaborative provision across systems, including access to care and the flow of people through the system and ensuring people using urgent and emergency services receive high-quality, safe care. We interviewed other providers about their interaction with urgent and emergency care services, including care homes and home care agencies, as well as engaging with local Healthwatch.

We also set out to capture what was understood about inequalities, particularly any disparity in access to care. In addition, we looked at what collaboration took place to help care for children and young people.

The reviews have brought into focus some themes and learning that can be used to inform planning for this winter and any further impact from the pandemic. Tackling COVID-19 has required effective strategic planning, good relationships and practical, deliverable solutions. Some urgent and emergency care systems appear to have fared better than others, sometimes benefitting from the strength of previously established working relationships.

We will publish the full findings from our review in January 2021, but some key points are emerging from our evidence. So far, we can see:

- The pandemic was a catalyst for innovation and change, requiring providers to respond at pace, work together and deliver care in new ways – it was an enabler for system working at UEC level.

- The quality of existing relationships between local providers played a major role in the coordination and delivery of joined-up UEC services to meet the needs of the local population.
- Providers expressed their concern for the mental health and resilience of their staff as they approached winter. Some NHS trusts said the pandemic's impact on staff resilience was the biggest risk. There were examples of good collaboration to ensure staffing levels, but we saw little evidence of widespread shared strategies – at a whole-system level – for managing the anticipated increase in demand for UEC services.
- Some people told us they were very positive about the care they received – a theme was associating good care outcomes with organisational efficiency. But some complained about disjointed care where they experienced a lack of communication between services on their care pathway. Providers told us that communicating well with the public about what service to access and when was challenging.
- For different reasons, some people or groups may have missed out on the care they needed. There was a lack of capacity in some places and closures in mental health, dental and primary care affected some UEC services that remained open, especially NHS 111.
- Inequality was found in some places – for people who needed care as well as for staff at different care providers. There was varied understanding of inequalities in people's access to UEC locally, while individual services tried to protect more vulnerable employees, including people from Black and minority ethnic groups.
- Digital technology was used more widely and more often to enable people's access to services. Some systems have worked to address negative impacts, trying to ensure patient choice and tackle any digital exclusion.

By spring 2021, we will have looked at provider collaboration in all ICS and STP areas in England. Our full programme of reviews will focus on different topics, considering how providers are collaborating to provide high-quality, safe care across a variety of patient care pathways and population groups.

# Good practice examples

Our reviews have demonstrated some examples of strong collaborative working among services.

## People at the centre of their care

We wanted to see how UEC providers collaborated to ensure that people were seen in the right place and at the right time – and how providers worked together to ensure care pathways were developed to keep people safe, and how they had worked to ensure people received effective, responsive urgent and emergency care.

In **Cornwall**, community assessment and treatment centres (CATUs) were created to bring multi-disciplinary teams together, closer to people's homes. With a focus on frailty, geriatricians were moved from acute sites into the CATUs to help keep older and frail people out of hospital. This approach was welcomed by system partners and the model was explored by neighbouring STP/ICS systems.

In **Newham**, East London, a multidisciplinary discharge hub was created early in the pandemic. It included hospital and social care staff, a clinical commissioning group (CCG) infection and prevention control nurse, Age UK, and an equipment service provided by the local authority. The hub was considered successful in making hospital discharges safer. This has encouraged providers to assess ways of continuing the service in future.

UEC services had to rapidly formulate their communication strategies during a time of confusion and uncertainty about capacity and demand. They had to strike a balance between encouraging people to seek help if needed and staying away from emergency departments.

A good example of proactive messaging happened on the **Isle of Wight**, where NHS communications worked with the CCG and local authority communications to get messages to the local population. A regular slot on local radio was used to share important messages with the public.

## Inequalities

In **Cheshire and Merseyside**, we saw that a focus on health inequalities was a priority. Recognising the need to better understand and to measure the needs of the people in the system who are most at risk, a population health laboratory was developed. They used a set of pooled data from all providers to design and deliver the most appropriate service for certain communities. Daily updates were provided to the system – the infection rates and patient groups affected showed where gaps in provision could be.

There was limited information on ways in which providers identified and responded to the needs of people from a Black and minority ethnic background when they accessed UEC services. But some services tried to identify risk, including a system in **Herefordshire & Worcestershire** where patients' vulnerabilities were flagged on the electronic patient record with **West Midlands Ambulance Service**, and made known to emergency departments in advance.

The public health team at the local authority in **Northamptonshire** had established an equality impact framework, looking at groups that may have been disadvantaged. It was published on the council website so that different providers and commissioners could make use of it in decision making.

Different ways communicating advice and guidance were used, in particular social media and local radio. In some systems, people in local communities helped to deliver key messages to help improve the spread of important information. In **East London** they used community leaders and influential people on TV and on Bengali radio channels.

## Workforce capacity and capability

We looked at how staffing across UEC was affected during the pandemic – how providers worked together across systems to ensure staffing capacity. We also considered how UEC providers had tried to make sure there were enough employees with the right skills to cope with new and increased demands resulting from the pandemic. And we considered how providers worked together to keep their employees safe. Examples included:

In **West Yorkshire and Harrogate**, children's safeguarding training at level 3 was turned into an online version and included topics that were emerging during lockdown, such as the risks in online medical consultations.

In **Hampshire and the Isle of Wight**, the widely known ‘Think Family’ model was strengthened through staff training. Ambulance crews were taught to ‘think family’ to strengthen their assessment of potential safeguarding issues for children. This was important because there were very few professionals who were seeing children in their home environments during the pandemic.

A shared strategy for workforce planning in **Northamptonshire** looked ahead to the winter months, considering national and local staffing as well as staff skills, to see where it could be beneficial to move staff around – and where upskilling would be useful.

The evidence we gathered around protecting Black and minority ethnic employees was found almost exclusively within individual providers. However in **Northamptonshire** we heard how the local authority had set up a ‘scientific advisory cell’ for the system, which included information about the increased risk from COVID-19 to people from Black and minority ethnic groups.

**Liverpool City Council** commissioned a workforce capacity dashboard across health and social care in Cheshire/Merseyside. They also held a workshop with providers to review winter pressures. Joint commissioning of winter plans had started early and was an example of open dialogue.

In the **Suffolk and North East Essex** ICS a gap in dental nurse provision was identified by the 111 service that supported people calling with non-urgent dental enquiries. The local system subsequently recruited dental nurses, who are generally self-employed, via a social media campaign.

## Digital solutions and technology

We looked for digital and technological initiatives used in response to COVID-19 and at the impact that they had for UEC providers working together across health and social care.

The purchase of electronic tablets for care homes by one of the NHS providers in **Cornwall and the Isles of Scilly** was widely celebrated. This technology enabled virtual ward rounds and primary care assessments, ensuring residents had continued support in their homes.

**Healthwatch Essex** carried out an evaluation of digital literacy for their ICS. During our review, the second phase of this project was ongoing, also involving **Healthwatch Suffolk**. The ICS was keen to maintain patient choice and reduce the digital exclusion gap.

# COVID INSIGHT

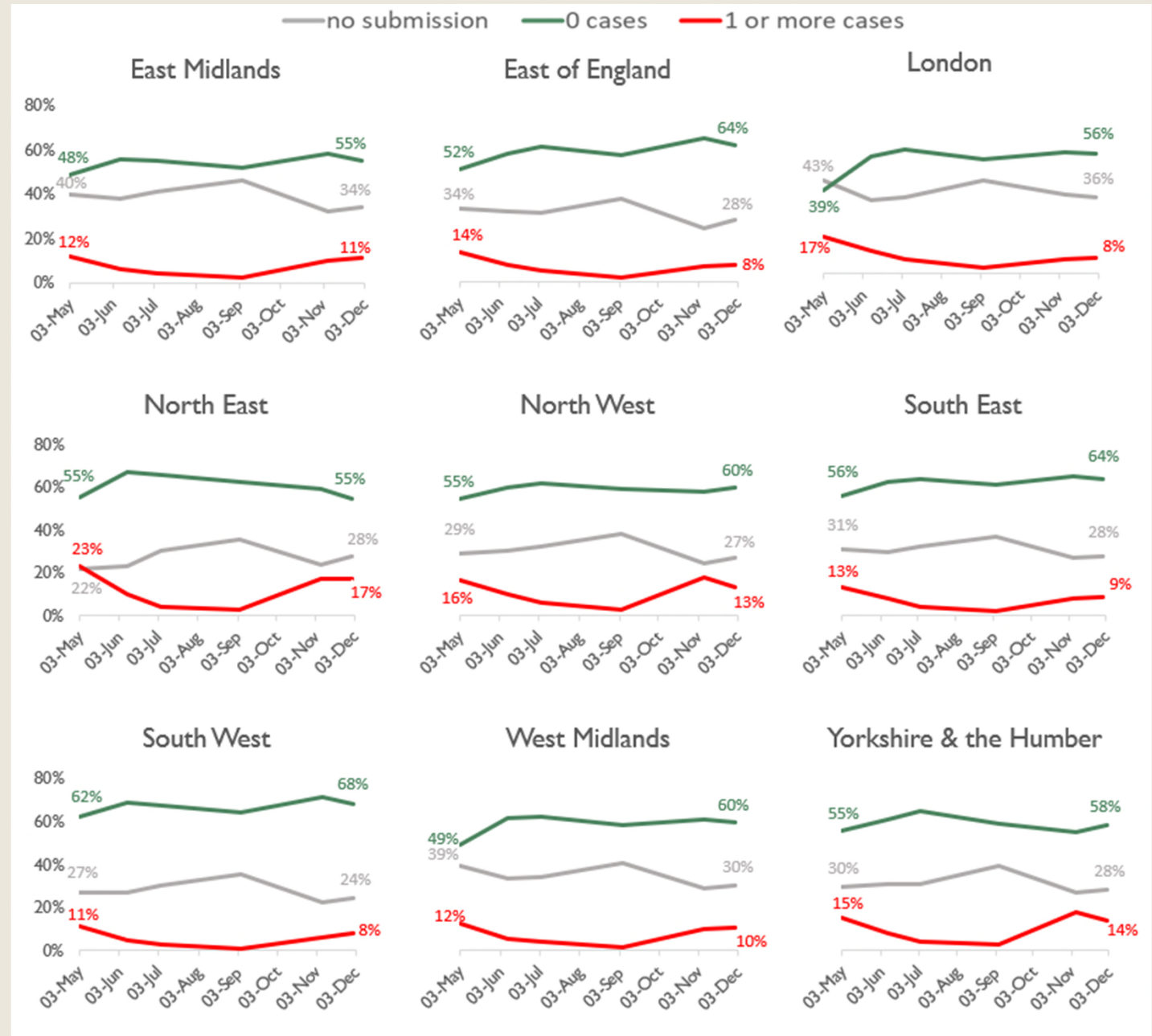
DATA APPENDIX



# Homecare providers – prevalence of COVID-19

Source: CQC Domiciliary Care Agency Survey, data extracts from 3 May to 2 December 2020

Homecare providers with at least one case include suspected AND confirmed cases. 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



Source: CQC Domiciliary Care Agency survey – data extracts from 3 May to 2 December 2020



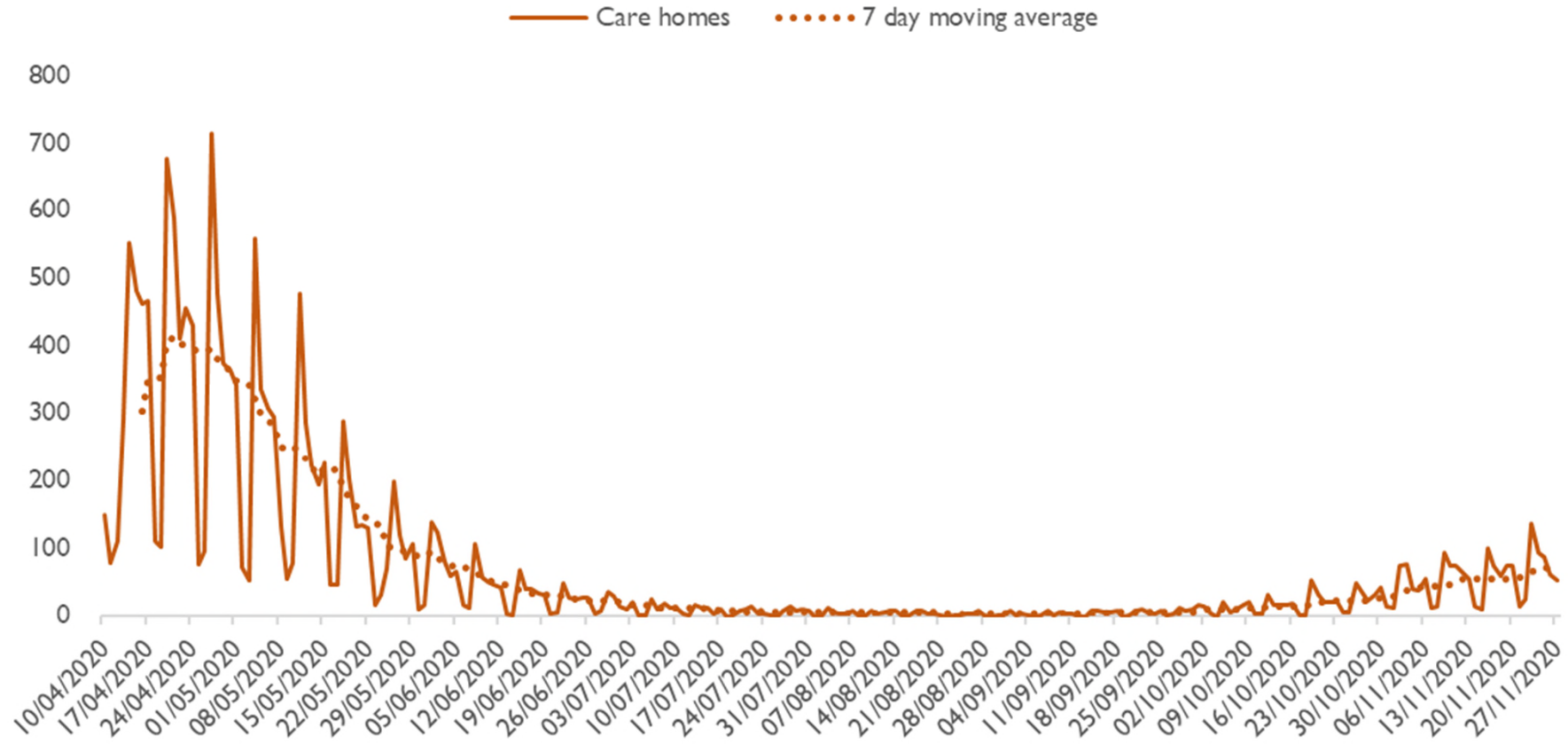
# Homecare providers – staff absence



Source: CQC Domiciliary Care Agency survey, data extracts from 3 May to 2 December 2020  
Includes staff who are self-isolating or have care commitments.

# Deaths notified by care homes

Care Home Covid-19 Deaths:  
7 day moving average



Source: CQC death notifications submitted 10/04/2020 to 27/11/2020

# Deaths of people detained under the Mental Health Act

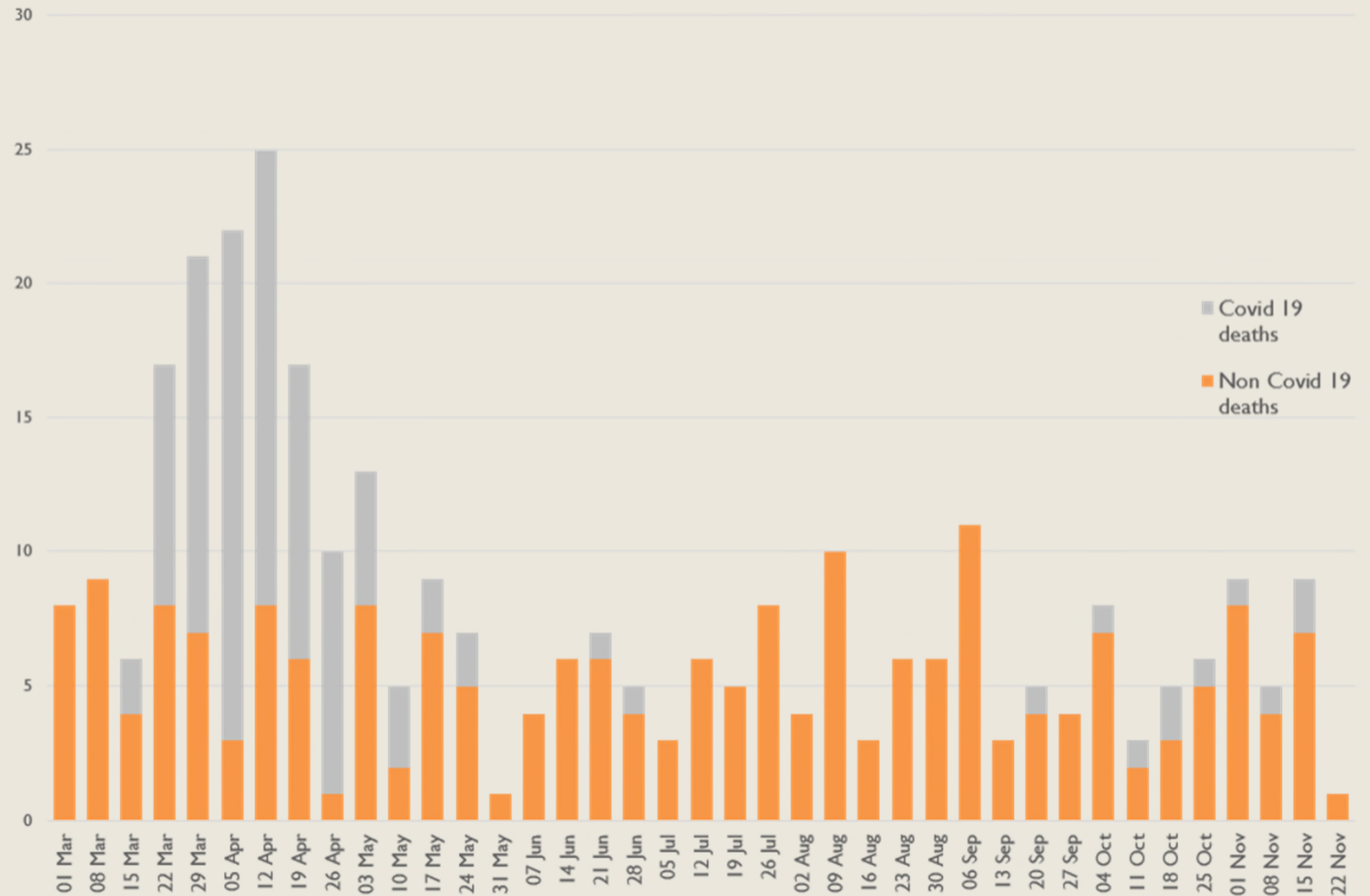
All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained, under the MHA.\* From 1 March to 27 November 2020, we have been notified of 106 deaths that mental health providers indicated were suspected or confirmed to be related to COVID-19 (an increase of four since we reported in November). A further five COVID-19 related deaths of detained patients were reported by other (non-mental health) providers (no increase since we last reported).\*\*

The chart shows the number of deaths by week of death.

\* 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. These counts may also include notifications about the deaths of people subject to the MHA who are in the community and not in hospital.

\*\* Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers unrelated to new cases.

Weekly MHA deaths in England (COVID and non-COVID)  
1 March to 27 November 2020



# Deaths of people detained under the Mental Health Act (contd)

Of the 321 notifications from mental health providers in the 2020 period (covering all causes of death), 250 were from NHS organisations, of which 77 deaths were indicated as being COVID-19-related, and 71 were from independent providers, of which 29 deaths were COVID-19-related.

We have identified 16 detained patients whose deaths have been notified to us from 1 March to 27 November 2020 who had a learning disability and/or were autistic: the majority were not identified as related to confirmed or suspected COVID-19 (no change on our report in November). 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.

The table below shows all deaths of detained patients from 1 March to 27 November 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	16	21	34	20	8	111
Not COVID-19	9	16	16	33	42	40	33	13	33	235
<b>Total</b>	<b>10</b>	<b>17</b>	<b>20</b>	<b>39</b>	<b>58</b>	<b>61</b>	<b>67</b>	<b>33</b>	<b>41</b>	<b>346</b>

# Deaths of people detained under the Mental Health Act (contd)

The table below shows all deaths of detained patients from 1 March to 27 November 2020, by gender and COVID-19 status.

Gender	Female	Male	Unknown or unspecified	Total
Suspected or confirmed COVID-19	38	63	10	111
Not COVID-19	73	125	37	235
<b>Total</b>	<b>111</b>	<b>188</b>	<b>47</b>	<b>346</b>

# Deaths of people detained under the Mental Health Act (contd)

The table below shows all deaths of detained patients from 1 March to 27 November 2020, by ethnicity and COVID-19 status.

Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	4	6
Black	12	22
Mixed	1	3
Other ethnic groups	1	2
White	68	138
Unknown	22	54
Not stated	3	10
<b>Total</b>	<b>111</b>	<b>235</b>

# Deaths of people detained under the Mental Health Act (contd)

The table below shows all deaths of detained patients from 1 March to 27 November 2020 by place of death and COVID-19 status

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	66	70
Psychiatric ward	35	70
Hospital grounds	1	6
Patient's home	0	22
Public place	0	5
Other	1	29
Not stated	8	33
<b>Total</b>	<b>111</b>	<b>235</b>

# Deaths of people with a learning disability

In June 2020, we published new data on the number of deaths of people who were receiving care from services that provide support for people with a learning disability and/or autism between 10 April and 15 May 2020. In our [fifth Covid Insight Briefing](#) we updated this analysis for the period 10 April to 30 September, and have now extended this to 16 November 2020.

We received notifications of the deaths of 1,205 people with a learning disability or autism from services identified as caring for people with learning disabilities or autism between 10 April and 16 November. This is 35% higher than the 892 deaths notified in the comparable period in 2019.

Of the 1,205 people who have died during the period this year, 302 were as a result of suspected or confirmed COVID-19 as notified by the provider, and 903 were not identified as related to COVID-19.

We provided further contextual discussion in relation to this in our [last briefing](#).

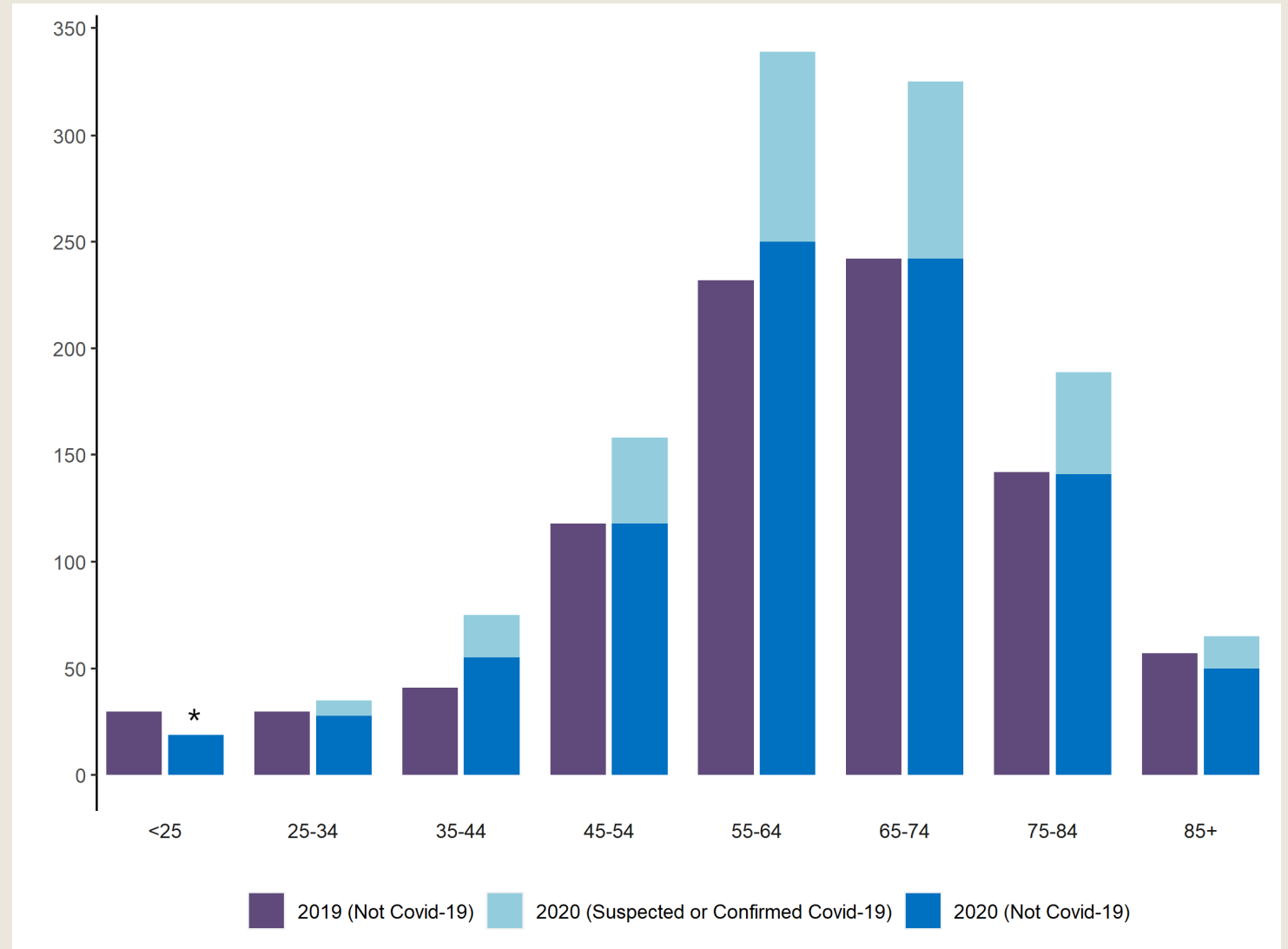


# Deaths of people with a learning disability (contd)

Notifications from providers of services for people with learning disabilities and/or autism spectrum disorder that state the person who died had a learning disability by age and COVID-19 status: 2019 vs 2020

\* Denote bars where data has been suppressed due to low numbers

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April to 16 November 2020, and comparable period in 2019



# Deaths of people with a learning disability (contd)

Of the 1,205 people who died, 1,180 were received from adult social care settings. The table shows the distribution by COVID-19 status and service type.

Type of adult social care setting	Confirmed or Suspected Covid	Not Covid	Total
Community based adult social care services	147	440	587
Residential social care	152	441	593

We only show this breakdown of service types for adult social care. The remaining 25 deaths were of people notified to us by types of service in numbers less than 10; to avoid identifying individuals we have not included them here.

# Deaths of people from Black and minority ethnic groups in adult social care settings

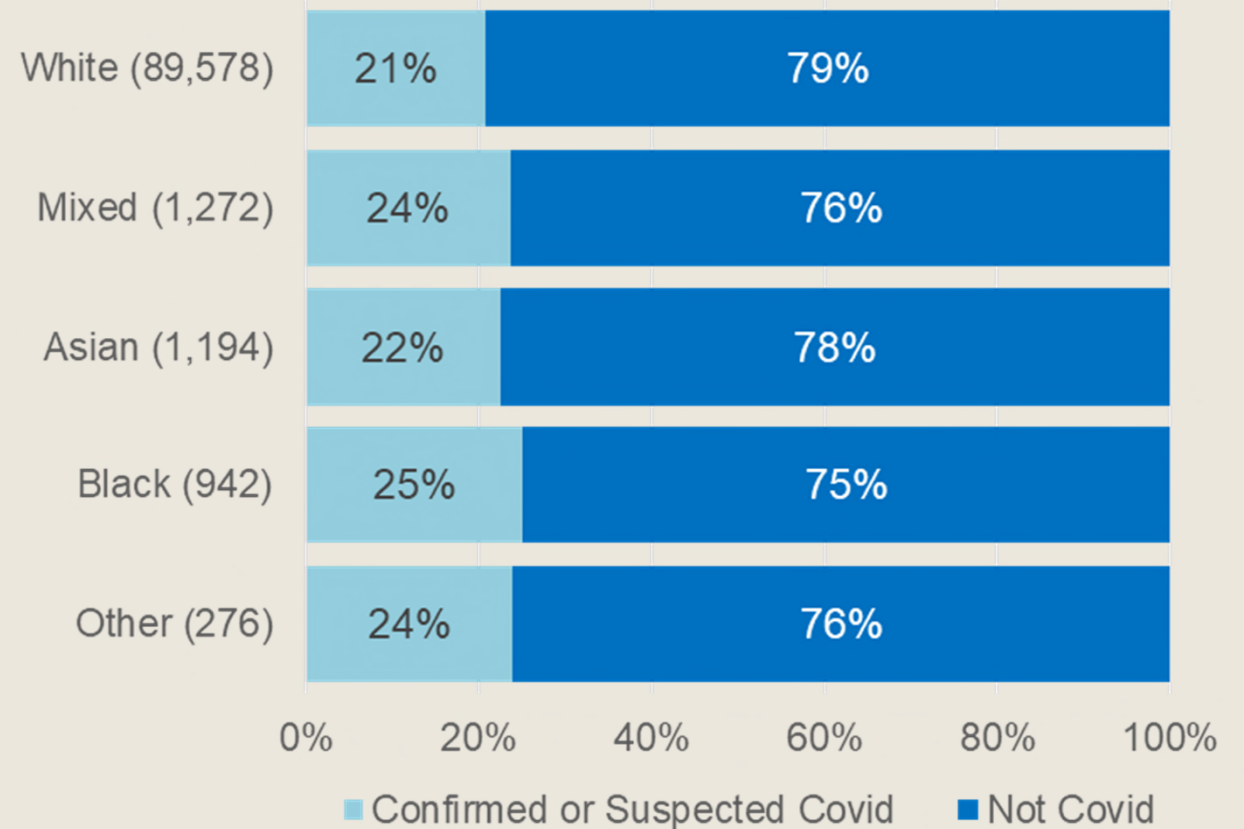
In our second COVID-19 insight briefing we published exploratory data on the ethnicity (where known) of people whose death in adult social care settings was notified to us between 10 April and 15 May 2020. We then updated this in our [fifth briefing](#) to 30 September 2020.

We have now updated this analysis to 16 November 2020. As we noted previously, the ethnic category fields in the notification forms are not mandatory, and for the period in question this information was missing in 12.8% of forms, the same level as in our previous update.

Of deaths with a known ethnicity, 96% of those notified during this period were White, with Mixed, Asian and Black all just over 1% each, and 'Other' less than 0.5%. Therefore while the vast majority of deaths in these settings were of White people, once again we found that Black people in particular who died were more likely than White people to die with confirmed or suspected COVID-19 flagged on their notification form. The chart shows that 21% of White people who died were flagged as confirmed or suspected COVID-19, compared with 25% of Black people.

Notifications of deaths in all adult social care settings 10 April to 16 November 2020 by ethnic group and COVID-19 status

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April to 16 November 2020



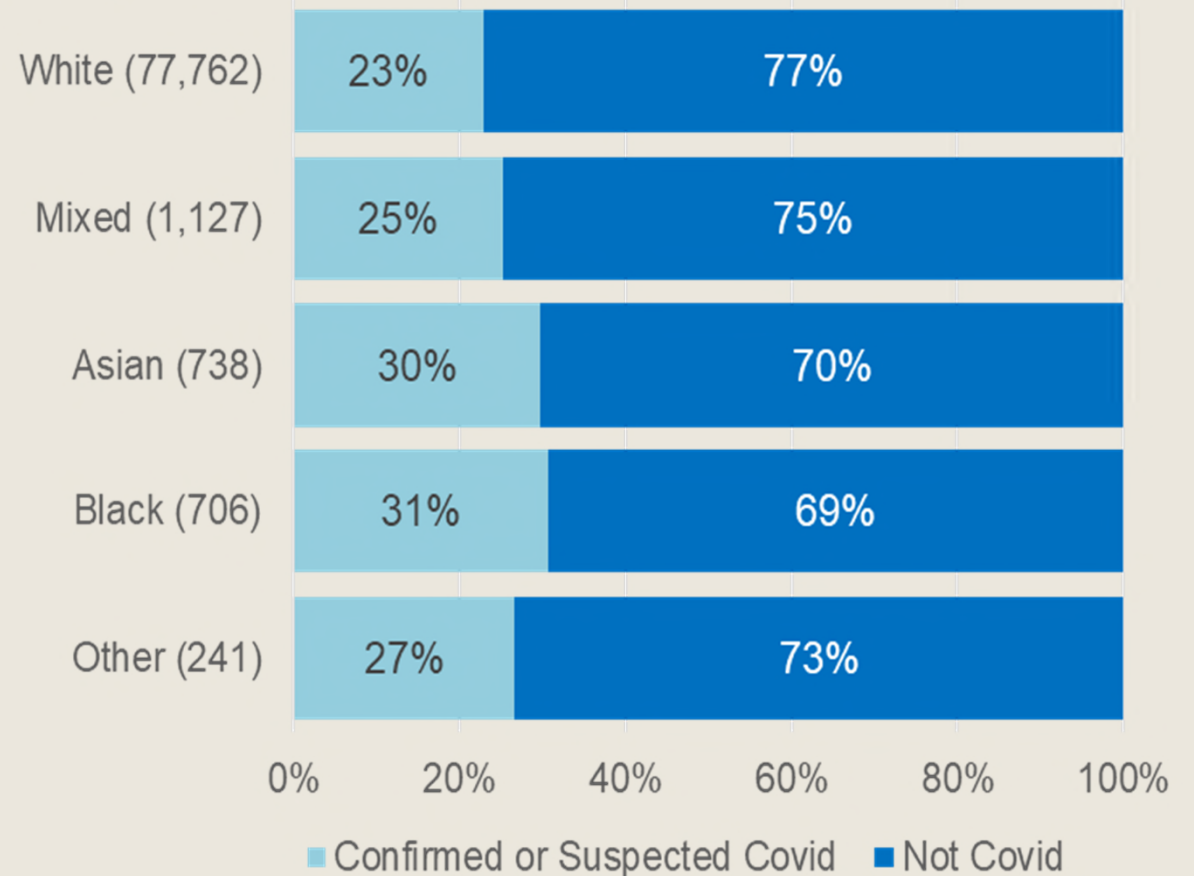
# Deaths of people from Black and minority ethnic groups in adult social care settings (contd)

If we look only at care homes, this pattern is slightly more distinct. The chart shows that while 23% of White people who died were flagged as confirmed or suspected COVID-19, for Black people who died the figure was 31%.

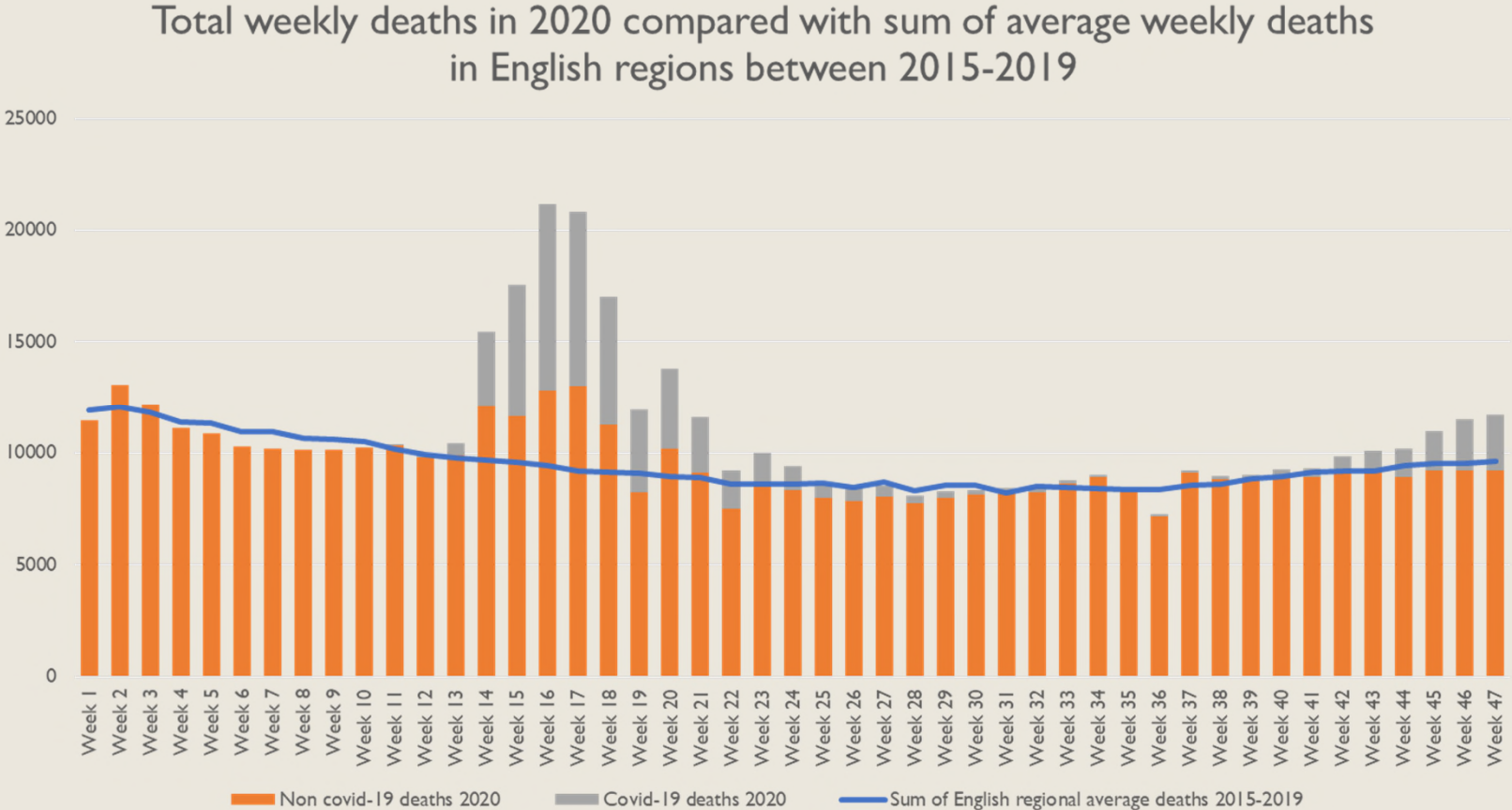
It should be noted that all these figures have fallen slightly since we first reported for the period 10 April to 15 May – this is to be expected because the new time period covers a much longer period after the first wave of COVID-19 subsided.

## Notifications of deaths in care homes 10 April to 16 November 2020 by ethnic group and COVID-19 status

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April to 16 November 2020



# ONS data on all weekly deaths in England (COVID and non-COVID) compared with the average for 2015-2019



Source: ONS COVID/non-COVID 2020 death data: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard> and 2015-2019 death data from: <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019>

Week 47: week ending 20 November 2020