COVID-19 INSIGHT

Issue 12

July 2021

In this issue:

- Death notifications involving COVID-19 from individual care homes
- Infection prevention and control in NHS trusts
- Identifying and responding to closed cultures

STATE OF CARE

COVID INSIGHT

DATA ON DEATH NOTIFICATIONS INVOLVING COVID-19 RECEIVED FROM INDIVIDUAL CARE HOMES IN ENGLAND BETWEEN 10 APRIL 2020 AND 31 MARCH 2021

Every number represents a life lost

The COVID-19 pandemic has affected the lives of everyone in the UK, and for some its impact has been intense, or even devastating. This impact is likely to have been felt particularly by those using, and working in, health and social care services.

Tragically, COVID-19 has contributed to an increase in the number of deaths across the population, including people living in care homes, both in England and throughout the world.

In many cases, the loss of a loved one has been made even harder for the relatives and friends of people in care homes who were unable to be as near to them as they would have wished in their final days and weeks due to COVID-19 restrictions. Losses will also have been felt by the staff who have cared for and supported them, and who may have built up a relationship over years.

This article accompanies our publication of data about the number of death notifications involving COVID-19 we have received from 10 April 2020 to 31 March 2021, from each care home location in England registered with us.

The data covers deaths of residents involving COVID-19 under the care of the provider as notified to us, regardless of where the death occurred, including in the care home, in a hospital, in an ambulance or any other setting. For example, a resident may have been admitted to hospital with a fracture and contracted COVID-19 while in hospital, and then subsequently died. The provider must notify CQC of the death of their resident and that this was involving COVID-19, but this alone would not indicate that the care home had positive cases of COVID-19.

In considering the data, it is important to remember that every number represents a life lost, and families and friends who are having to face the sadness and consequences of their death. It is also an opportunity to reflect on the dedication of those who worked to save and comfort lives.

Death notifications alone are not a reliable indicator of quality or safety

Tragically, COVID-19 has contributed to an increase in the number of deaths across the population, and within residential care settings.

We are presenting the data on the number of death notifications involving COVID-19 of care home residents across regions of England alongside government data on all COVID-19 deaths, so that people can view care home deaths against deaths in the wider community (which include deaths of care home residents) to help understand the wider impact of COVID-19 in their areas.

The numbers of deaths notifications alone, however, are not a reliable indicator of quality or safety in individual care homes.

Our inspectors use all the data and information we receive about a service to monitor for indications that there is a risk to the quality of care, which may lead to an inspection. Notifications of deaths are only one of these indications, but they are not in themselves a good predictor of poor-quality care, particularly given the potential influence of variable factors, including rates of local community transmission and size of the care home. Other variable factors include the characteristics of people living in the care home, including their age, health and care needs, and whether they are from Black and minority ethnic groups, for whom the pandemic has had a disproportionate impact.

There are many factors that lead us to carry out an inspection. We carried out 5,577 inspections of residential adult social care providers between 10 April 2020 and 31 March 2021. Those inspections that were risk-based were likely to be triggered by information of concern, including safeguarding referrals, whistleblowing and complaints. These, and other indicators, such as previous regulatory history, absence of a registered manager, and other notifications are more likely than death notifications to indicate where there is a risk of poorer quality care.

As well as our constant monitoring of adult social care services, we have carried out infection prevention control inspections during the pandemic so that the public can be assured across a number of key criteria that services have an effective approach to infection prevention. We looked at assurance across eight questions, which including looking at whether:

- Adequate personal protective equipment (PPE) is available for staff and residents to control infection safely
- Staff are properly trained to deal with outbreaks and the proper procedures are in place
- Shielding and social distancing are being done correctly
- Layout of premises, use of space and hygiene practice promote safety.

In November 2020, we published a report on these inspections that showed high levels of assurance in all areas of infection prevention and control. Across the eight questions we looked at, assurance ranged from 82% (for whether the service had an up-to-date infection prevention policy) to 91% (for infection prevention for visitors). Nearly two-thirds of care homes (65%) demonstrated assurance in all eight areas we looked at. Most of the report highlights good practice, but where we saw poor practice through these inspections, we took action to ensure providers acted quickly to improve the quality of care they were delivering.

Our State of Care report later this year will show how this level of assurance has risen even further, despite these findings mainly being based on 'risk-based inspections', which have been carried out in response to concerns about safety and quality.

How we have published and used this data since April 2020

From 28 April 2020, COVID-19 deaths in care homes notified to us have been published on a weekly basis at local authority level by the Office for National Statistics (ONS). This was in addition to ONS' own weekly publications of COVID-19 deaths based on death registrations.

We also shared this information with the Department of Health and Social Care and other national partners to support the monitoring, planning and response to the pandemic.

In our first COVID-19 Insight report in May 2020, we highlighted the challenges, including about PPE, testing and staffing, faced by the adult social care sector from the pandemic and shared national and regional-level data on the number of deaths notified to us from care homes.

In June 2020 we wrote to all social care providers to remind them of the need to share appropriate information with families regarding outbreaks and deaths and have continued to highlight this.

We have used information from individual care homes about deaths involving COVID-19, alongside other information and any concerns received, to assess risks and make decisions about where to inspect, taking action to protect people where necessary.

We have carried out formal regulatory activity through our inspections and our monitoring approach at over 70% of care homes. This does not include any informal support that inspectors will have given to providers throughout the pandemic.

Most care providers that we have inspected have demonstrated good practice. However, where we have had concerns, we have taken swift action, including publishing the actions a provider must take, restricting a service's operation or, in cases of significant concern where there is no safe alternative, taking action which would lead to the closure of a service.

All of these measures are designed to ensure providers act quickly to improve the quality of care they are delivering. Throughout the pandemic, we have acted to protect people by responding to specific information of concern from both system partners and from people using services, their families and from staff.

Why we are publishing now

Registered providers are required to notify us of the death of a person using their service under Care Quality Commission (Registration) Regulation 16.

Since 10 April 2020, we have asked providers to tell us whether those deaths are confirmed or suspected of being a result of COVID-19.

From 28 April 2020, COVID-19 deaths in care homes notified to CQC have been published on a weekly basis at local authority level by the Office for National Statistics (ONS). This data includes notifications of deaths of care home residents involving COVID-19, regardless of where the death occurred.

We are now publishing data showing the number of death notifications involving COVID-19 we have received from 10 April 2020 to 31 March 2021 for each care home location in England registered with us.

The information presented is deaths of care home residents involving COVID-19, regardless of where the death occurred, so the data will include deaths of care home residents that occurred in the care home, in a hospital, in an ambulance or any other setting.

We are presenting this data as interactive dashboards enabling the viewer to see the data at national, regional and individual care home level.

We have a duty to be transparent and to act in the public interest. We made a commitment to publish data at this level, but only once we were able to do so accurately and safely.

Given the evolving national uncertainty around COVID-19 and its spread across people and communities, we felt releasing the data at the height of the pandemic could have a serious impact on continuity of care, with concerns people could use it to make decisions that inadvertently put people at wider risk if they were considering the data as a single indicator of safety. Our decision was accepted by the Information Commissioner's Office.

We have spent time completing quality assurance processes required for publication, and have given care providers advanced sight of the data we will publish on their service, based on their notifications to us.

We believe that changing factors in the pandemic have reduced the risks around publication. The number of death notifications involving COVID-19 from care homes have decreased substantially, and there has been a successful take-up of the COVID-19 vaccine across the country.

In publishing this data we aim to provide a more comprehensive picture of the impact of COVID-19 on care homes, the people living in them and their families.

Notes about the data

It is important to note the following about the death notification data being published alongside this report held by us:

- Providers have a legal duty to notify us of deaths of people under their care. This data is based on the notifications that care home providers have sent to us.
- The notification form asks care homes to tell us whether the death was a result of suspected or confirmed COVID-19. Since it is not clear if the cause of death is COVID-19, throughout this publication release we discuss these figures as 'deaths involving COVID-19'.

- ONS publishes their own weekly data on deaths in care homes in England. These figures may not completely tally with the deaths published by ONS. This is because ONS data is based on death registrations and the date of death, whereas CQC data is based on the date that providers notify us of a death potentially involving COVID-19.

  These figures will also be different from the data published by the government, which reports deaths that occurred within 28 days of a positive COVID-19 test both by date of death and date reported to Public Health England.

These notes should be read alongside our transparency statement, which is published with this report.

Support for people who have been affected

We are grateful for the time that families who lost their loved ones during the pandemic have spent meeting with us and the personal experiences they have shared. These discussions have helped us shape our thinking around the complex and sensitive issue of publishing information on the numbers of deaths of people involving COVID-19 notified by individual care homes.

When considering this data, we would ask for consideration and sensitivity to be shown to people living in care homes, families who have been affected, and staff working in very difficult circumstances.

It is understandable that people living in care homes, their families and staff will continue to be anxious about the risks presented by COVID-19. This is likely to be felt even more acutely where people have died after contracting the virus.

If people have concerns about the quality of care they or their loved one receives, they should be encouraged to discuss this with their care provider.

- They can also tell us about it in the following ways:
- Using our online form Give feedback on care
- By email: enquiries@cqc.org.uk
- By telephoning: 03000 616161

For those who have been bereaved, there is support available at charities such as Cruse Bereavement Care.

COVID INSIGHT

INFECTION PREVENTION AND CONTROL IN NHS TRUSTS

Introduction

Infection prevention and control (IPC) is an essential part of safety in hospitals. In response to the COVID-19 pandemic, we carried out a review of IPC board assurance in NHS trusts during the summer of 2020.

Following this, we carried out 13 unannounced focused well-led inspections within acute NHS services to monitor IPC. These took place between January and March 2021.

This article reviews the first nine of the inspection reports published in response to these inspections. The full reports can be found on our website:

- East Kent Hospitals University NHS Foundation Trust
- Frimley Health NHS Foundation Trust
- Gloucestershire Hospitals NHS Foundation Trust
- Mid and South Essex NHS Foundation Trust
- Royal Devon and Exeter NHS Foundation Trust
- South Tyneside and Sunderland NHS Foundation Trust
- Surrey and Sussex Healthcare NHS Trust
- Wirral University Teaching Hospitals NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust

Summary

The inspections highlighted that good IPC practices have been implemented in most trusts inspected. They have adapted existing guidance and processes to respond to the COVID-19 pandemic to ensure the safety of staff and patients. This is despite challenges to good infection prevention, which included the layout of some hospital buildings limiting patient flow, and vacancies in the IPC team reducing staff support.

The trusts had dedicated IPC directors and teams that provided expertise to staff and regular updates to the board. In most occasions, these teams were comprised of staff from across the trust who had been redeployed.

Prior to inspection, several trusts had seen an increase in the number of nosocomial infections (infections acquired in the hospital), particularly around December 2020 to January 2021. This article details some of the measures trusts have taken to reduce infection and prevent outbreaks.

The key factors identified as affecting services' ability to provide IPC in trusts were:

- Leadership
- Culture and communication
- Strategy plans and guidance
- Risk management and prioritisation
- Monitoring and record keeping
- Engagement, collaboration and information sharing
- Learning and improvement.

Leadership

A dedicated leadership team who supported staff, had oversight of IPC processes, managed priorities and mitigated risk was essential for good infection prevention within the trusts.

The leadership teams had oversight over hospital wards to ensure risks were well managed. Some executive teams used ward rounds to monitor compliance with IPC protocols. Visibility, approachability and engagement of the senior leadership team was key to staff buy-in.

> "Members of the leadership team undertook ward rounds called 'Safety Walks,' to ensure cooperation with IPC practices and compliance. Alongside this, IPC team visited wards daily to review IPC practices. The antimicrobial team supported the IPC team with daily ward visits to ensure antibiotics were being administered correctly and documented in line with trust and national guidelines."

Good oversight by the leadership team enabled issues to be identified and interventions to be implemented quickly during the evolving pandemic.

> "Leaders identified staff compliance with wearing the correct personal protective equipment, especially in non-ward areas, as an area for improvement. They had improved signage throughout the hospital and ensured mandatory IPC donning and doffing training was completed by staff."

They provided ongoing support to staff and were responsive to requests for advice and assistance. At one trust, staff told us that "the IPC team was available seven-days a week, including evenings and nights on-call."

Staff valued when managers supported their development, particularly in relation to improving their IPC skills. This included the provision of additional training and the opportunities for extra responsibilities.

> "The trust's IPC nursing team had development posts for nurses to gain the skills and experience needed to proceed to a more senior role."

Culture and communication

Services with an open culture, where staff mental and physical health were considered, performed well in relation to IPC. Clear communication channels, where leaders spoke candidly when updating staff, also encouraged good IPC practice within a trust.

A no-blame culture was vital to ensuring IPC concerns were raised and handled appropriately. Staff who could challenge colleagues on IPC processes in a constructive manner, without fear of retribution said they "felt heard" by the leadership team.

> "The trust had devised a number of ways in which staff could raise safety concerns relating to IPC. These included hotlines, through incident reporting, by speaking to a freedom to speak up ambassador, staff support groups or networks, a Facebook question and answer facility and a live Facebook session with the chief executive where staff could ask them questions or raise concerns directly."

Trusts had implemented initiatives to ensure staff felt valued and that their wellbeing was still considered, despite issues such as social distancing in break areas.

> "Measures taken and long-term plan for health and wellbeing team included provision of support by the chaplaincy team, and by a newly formed health and wellbeing team… who could provide psychological support to individuals or small groups. There were helplines and other support services advertised around the trust for staff to access with regard to practical and emotional support, counselling, and financial help etc."

A whole team approach to IPC promoted a positive culture. This involved working cooperatively and constructively with staff across the trust, including non-clinical staff, to ensure patient safety was the main priority.

> "The IPC team worked closely with the hospital bed management team and acted together as one team to ensure patients were moved in accordance with safe IPC practices."

Efficient and timely information cascading ensured staff felt informed on IPC protocols and changes. The trusts had a variety of methods to communicate with staff including daily safety huddles or IPC meetings, cascading via team structures, bulletins, posters, staff intranet pages and social media.

> "The chief executive officer sent out a daily email to all managers providing updates and information. Managers told us this was appreciated and meant they felt informed of concerns, challenges and actions to overcome these. All staff we spoke with, reported they felt well informed and information was cascaded effectively."

Strategy plans and guidance

All trusts had action plans and guidance in place at the time of inspection; these were used to monitor progress. While these were individual to the trust, they aimed to align them with the wider systems goals and to enable continuous improvement in services.

> "The trust strategy included team objectives, annual priorities, strategic objectives, values and vision with the patient being the main focus."

Action plans and guidance documents reviewed at inspection contained a wide variety of IPC themes which support safe, high-quality, sustainable care. Some of the topics included were staff training and compliance targets, COVID-19 and Influenza vaccination programmes, measures implemented for visitation and environmental changes in response to social distancing. For example, staff movement was minimised within trusts to prevent infection spread.

> "There was daily oversight of safe staffing levels. Part of this process was to ensure that staff were not moved between COVID-19 positive and negative areas to minimise the risk of spread of infection."

All trusts implemented enhanced cleaning processes, particularly in 'high-touch' areas. For example, some trusts used ultraviolet light to check the effectiveness of cleaning on frequently touched services.

Trusts monitored increases in nosocomial infections and had action plans and objectives to reduce them. They carried out reviews and shared learning from any outbreaks.

> "The IPC action plan included achieving or improving performance targets against healthcare associated infections with alert organisms and bacteraemia; sepsis; reduction in surgical site infections; surveillance; development of the IPC team; uptake of flu vaccination; training and improvement of estates."

One of the trusts had introduced rapid on-site testing to reduce the risk of infection outbreaks. Patients were then allocated to 'red' and 'green' wards depending on their test result. Another trust identified that poor ventilation contributed to their nosocomial transmission rates and therefore are investing in air purifying equipment for additional areas of the hospital.

Risk management and prioritisation

Leaders and the board had oversight of risks across the trusts' departments through regular meetings. Trusts reported no financial constraints to implementing effective IPC and said personal protective equipment supplies throughout the pandemic have been adequate.

> "Risks and actions were updated and the trust board reviewed risks monthly. The board had a summary report that highlighted to them the most significant risk level changes from the previous month with a short explanation for the change."

Staff completed COVID-19 risk assessments for all patients and recorded these in their notes. Patients were triaged on admission to identify those at higher risk, such as people from Black and minority ethnic groups. Risk assessments were also completed when patients were moved between different wards. Staffing, pathways and personal risk assessments were also carried out.

> "Elective pathways had been fully risk assessed and this included assessment of environment and staffing. Staff worked in bubbles and if they needed to go from the elective area to work in another area, they were not able to return until they had been tested and cleared."

> "Some examples of actions taken to reduce risks included: washable bags for staff to take uniform home, streaming of patients, one-way systems, Perspex sheets around reception areas and nurses' stations, use of appropriate signage to identify cleaned rooms and equipment and to identify restrictions to access."

Monitoring and record keeping

Staff completed detailed, up-to-date records of patients' care and treatment to help keep them safe. In most of the trusts inspected, these records were consistently updated. However, in a small number of trusts, staff did not always keep clear patient records (for example, there were inconsistencies in reporting COVID-19 test results). This meant information sharing was less efficient and there was an increased risk of staff being unaware of a patient's care and treatment needs.

> "Four antibiotic medication records had a diagnosis, name, dose, route, frequency, and pharmacy review recorded. However, three had no reason for continuing [to give medication] beyond five days, and none had an intended duration recorded."

The trusts that used effective IT systems to record and present patient data enabled staff to easily monitor risk. Accessible electronic systems also allowed staff to communicate and collaborate effectively. Information on outbreaks could then be shared with external partners.

> "The computer system used by the acute and community services in the trust provided the IPC nurses with a trust-wide dashboard of relevant and up-to-date information. The information provided a clear oversight of patient infection status and enabled reports to be run. This meant decisions could be made more easily to improve patient management and safety."

> "IT systems enabled the gathering of outbreak data to allow earlier and focused responses. Outcomes, actions and recommendations were shared with all trust staff and external agencies such as Public Health England and NHS England and NHS Improvement."

Engagement, collaboration and information sharing

All the trusts inspected engaged actively and openly with staff members, patients, families, the wider public and partner organisations, with the aim of improving services and IPC methods.

Collaboration with wider organisations, such as partners in the trusts' Integrated Care Systems, supported good IPC practices, for example by facilitating patient pathways, with easier discharge to suitable accommodation.

> "Staff described helpful links and effective working with external agencies including the local County Council, the Mental Health and Community trust, Public Health England, NHS England and NHS Improvement. IPC professionals from the trust were involved in sharing their experiences at national groups, such as the Hospital Onset COVID-19 Committee for Infection. They shared challenges and solutions the trust had experienced and took learning from other participants."

One of the trusts also worked with external partners to deliver training to support their local care providers.

> "The trust had delivered training and support to local care homes at the start of the pandemic. Elderly care clinicians and the IPC team met with care home staff to talk through guidelines, discharge and held virtual follow-up calls. This was received positively by staff and patients. It also helped to facilitate smoother discharge and aided flow through the hospital."

The pandemic caused trusts many challenges in communicating IPC measures, including to relatives visiting patients. Trusts listened to concerns from families and patients and reassured them using their engagement channels. New methods of virtual visiting and communication had been embedded within many trusts, based on people's feedback.

> "Staff told us that, during the first wave, patients understood why they couldn't accompany their relative. However, as restrictions had begun to ease, some patients became frustrated at the restrictions. Staff overcame this by taking the time to explain why this was still important and told us that this had been received well by that patient group."

> "The website had an option of 'virtual visiting' where a video call could be arranged. There was also a 'message to a loved one' service, where relatives and friends could send letters, photographs, etc to a designated email address, and staff would print these out and deliver them to the intended patient."

> "We saw there was a variety of leaflets for patients being discharged home after having a hospital admission for COVID-19. These were available in different languages for patients whose first language was not English."

Changes had been implemented based on engagement. The trusts presented these back through posters and on their websites.

> "Noticeboards with 'you said, we did' were displayed in wards and departments. For example, we saw on the ward that patients were not getting enough information about their discharge so now all patients received a copy of their discharge summary."

Learning and improvement

The trusts demonstrated systems and processes for learning, continuous improvement and innovation of IPC practices. This included documenting and learning from incidents, disseminating findings from audits and working with external partners to share learning.

Outbreaks in nosocomial infections were investigated by the trusts and learning shared among staff. One trust shared evidence where improved external engagement may have prevented a potential outbreak.

> "Leaders gave an example where information regarding the patient's COVID-19 status was not shared with the trust in a timely manner and this contributed to a nosocomial outbreak. They stated the trust had learnt from this to improve communication with nursing and care homes."

The trusts worked with system partners and external organisations to share updates on outbreaks. This improved the sustainability of the services and ensured capacity throughout the system could be managed during peak times. Established links between organisations also allowed resources to be shared where necessary.

> "The critical care unit offered mutual support to other hospitals when demand for intensive care beds extended their capacity. Information was shared effectively in the South West Critical Care Network and extended to sharing of equipment when this was required."

The trusts sought to learn from external partner reviews, such as from Public Health England, NHS England and NHS Improvement and CQC. Where possible, trusts used learning from other partners to introduce new processes internally.

> "The trust had received feedback from CQC and NHS England and NHS Improvement on IPC. The trust had used this feedback to produce an improvement plan with 117 actions and set up an IPC improvement group to ensure a focus on this action plan."

Conclusion

Despite the pressures of the pandemic, during these inspections we mainly observed both good practice and many examples of close attention by all staff from executive level to those in ward areas to keeping patients safe. Trusts have achieved this by adapting their existing infection prevention and control guidance and processes.

Our inspection findings of what was happening in these providers paint a positive picture of how they responded to the unprecedented impact of the pandemic to try and protect their patients and staff.

COVID INSIGHT

IDENTIFYING AND RESPONDING TO CLOSED CULTURES

The abuse at Whorlton Hall, Winterbourne View, Mid Staffordshire Hospital and other services highlighted breaches of human rights that resulted from closed cultures, and the impact that these had on people using services.

We define a closed culture as ‘a poor culture that can lead to harm, including human rights breaches, such as abuse’.

While there is no single factor that can lead to a closed culture developing, we know that there are certain risk factors. These include:

- people being placed in services far from their family, friends and communities
- people staying in inappropriate environments for months or years at a time
- weak leadership within a service
- staff not having the right skills, training or experience to support people
- poor culture, with a lack of positive and open engagement and communication between staff, and with people who use services and their families.

The development of closed cultures can be deliberate or unintentional – but either way it can cause unacceptable harm to a person and their loved ones.

In this article, we highlight what we have learnt so far about how risks can accumulate and build into a closed culture. We want to raise awareness of the warning signs so that care service providers and managers can take action.

Our work so far

Identifying and taking action on closed cultures is a central part of our regulatory work. In December 2020, we published the second part of Professor Glynis Murphy's Independent Review into our regulation of Whorlton Hall.

We are currently implementing and incorporating these recommendations into CQC's operating model for high-risk services. We are doing this in collaboration with a wide range of stakeholders, including people who use services, families, voluntary sector organisations, providers and other groups, as well as our own staff.

We know that closed cultures, and the possibility of breaches of human rights, may occur across a wide range of health and social care settings. We also know that some services, such as places where people with a learning disability or autistic people live, are more at risk than others.

This risk has been further exacerbated during the COVID-19 pandemic, with more services at risk of becoming closed environments due to a lack of visitors, and the potential impacts of staffing and management pressures.

To improve our understanding of, and how we identify, the risks associated with closed cultures, we are proactively reviewing information we hold on services we think could be at risk of developing a closed culture. This includes reviewing whistleblowing concerns, feedback about the quality of care from people using services and their carers and staff, and notifications that services must send us.

Where we have identified services as having a closed culture, we have taken appropriate action. This has ranged from initiating focused inspections, issuing urgent notices to restrict admissions, placing services into special measures and, where necessary, ensuring people are relocated to other care services. In these cases we have worked with the local authority to find suitable alternative accommodation.

In cases where we have had concerns about a service, but we did not find evidence of a closed culture on inspection, we continue to monitor them as part of our ongoing regulation.

The learning shared in this article is based on a sample of 29 inspections where we have found evidence of closed cultures. These include services in both the independent mental health and adult social care sectors.

Common features of closed cultures

In this section we describe some of the common features of services where we have found evidence of closed cultures.

- **Incidents of abuse and restrictive practice.** People were not safe in some services – there were cases of violence between people using the service and evidence of people being abused by staff. Inspectors had concerns about unlawful restraint being used, meaning people were at risk of being harmed. Blanket restrictions were in place in some services, meaning care was not person-centred and people were not supported to have maximum choice and control over their lives.

  We received information that referred to people being treated in undignified and inappropriate ways, including mocking, threatening and dehumanising behaviour, as well as physical, verbal and emotional abuse. There were also indications of bullying between staff and between management and staff.

  We also heard about management refusing to provide personal protective equipment (PPE) at the start of the COVID-19 pandemic, before patients and staff showed symptoms of the virus.

- **Issues with staff competence and training.** Concerns about staff competence mostly related to people not being supported when experiencing distress. The recurrence of similar incidents highlighted poor record keeping, poor communication between staff, and a lack of person-centred care. It also suggested that the process to identify and meet training needs was poor.

- **Cover-up culture.** Some services were not transparent about incidents or concerns raised by staff or people using the service. This included claims of under-reporting of violence between people using the service, people being unable to access the police or social workers following cases of abuse, and managers being unwilling to investigate concerns. Staff were not encouraged to speak up and in some services staff were told not to report incidents or raise concerns. In some services, managers had a defensive attitude and tried to blame others when we raised concerns about the standard of care.

- **Lack of leadership and management oversight.** Services did not appear to learn from incidents or act to prevent future incidents. We heard about management prioritising staff retention over people's care needs, by failing to address poor staff performance.

  Managers were not accessible to those using the service, choosing not to attend care meetings or go on a ward. Notifications were sometimes submitted in a defensive tone, aiming to shift guilt from the service onto the people in their care.

  We found risks repeated across services at a regional and corporate provider level. This suggested that providers did not have reasonable oversight of their services or appropriate mechanisms for improvement.

- **Poor-quality care.** A lack of person-centred care was frequently reported, with care plans lacking detail about people's needs. People's individual needs, in particular in relation to their specific communication and sensory needs, were not clearly reflected in their care plans. This resulted in people being given inappropriate care and subject to increased levels of restrictive practice.

- **Poor-quality reporting.** Issues ranged from a lack of reporting to delayed notifications. While quality of reporting alone is not necessarily an indicator of a closed culture, and most cases of poor-quality reporting were not seemingly intentional, there were some concerns that notifications were delayed on purpose. Deliberate attempts to conceal issues, either from CQC or from higher-level management, are an indication of a culture within a service or provider that fails to promote safety and honesty and to implement improvements.

Next steps

We know that the COVID-19 pandemic has led to increased pressure on services, as well as fewer people visiting services, which makes the development of closed cultures at all services possible.

We want our regulation to be driven by what people expect and need from services. As a result, we are testing a new methodology that is designed to get under the culture of a service and really understand what it is like for people who live there. This includes using feedback more effectively and addressing concerns quickly when the risks of a closed culture are found.

While closed cultures can develop in any type of health and care setting, we are particularly aware of the increased risk in services for people with a learning disability and autistic people.

As an organisation, we know that our regulation of services that care for people with a learning disability and autistic people needs to improve. In response to this, we are carrying out a year-long programme of work to transform the way we regulate services for people with a learning disability and autistic people.

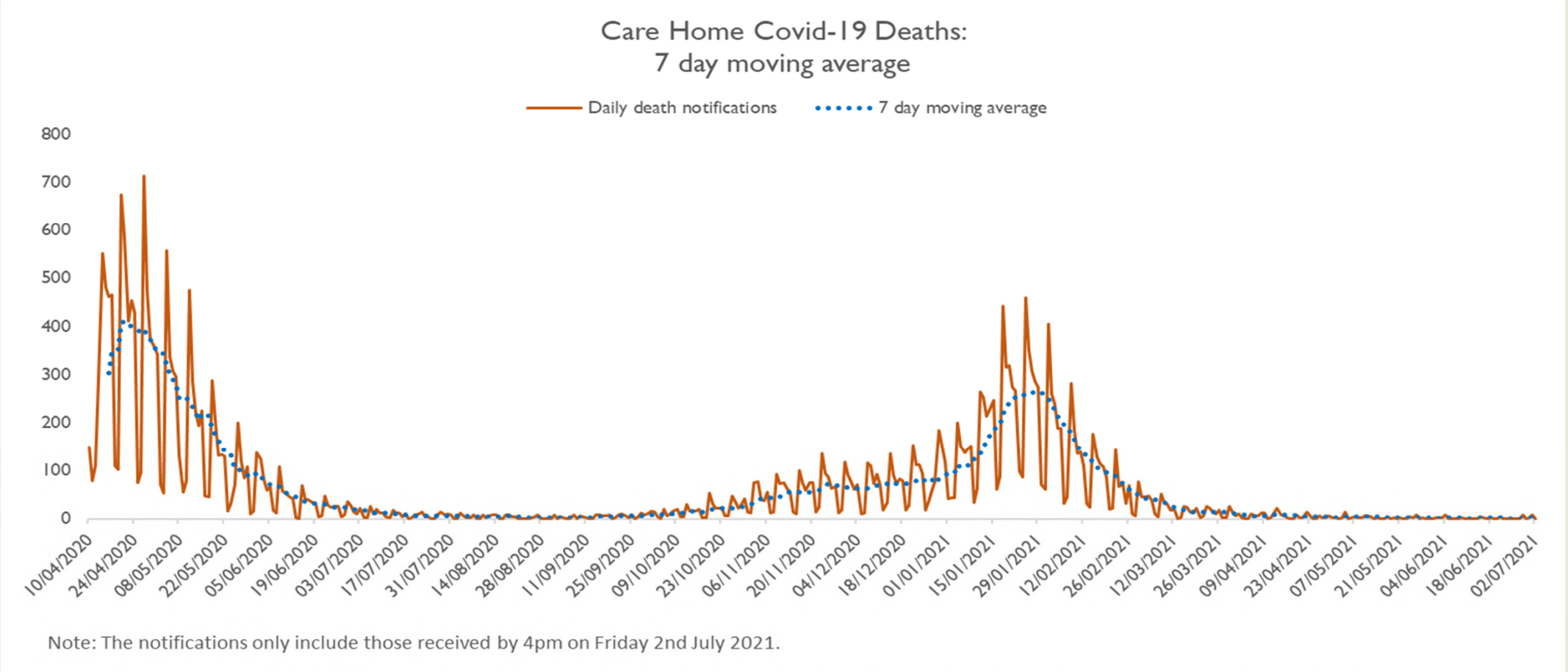
Above all else, we want to make sure that services for people with learning a disability and autistic people are good. To do this, we are focusing on three key areas:

- **Registering the right services** – I use services that support me in the way I want to live and where I want to live.
- **Supporting providers to improve** – I will not be asked to move to a service that isn't safe, I won't be expected to continue to live in a service that doesn't meet my needs.
- **Influencing the improvement of care pathways** and ensuring that people are receiving the right care at the right time – I can access local services that meet my needs and get the right healthcare when I need it.

COVID INSIGHT

DATA APPENDIX

Deaths notified by care homes



Source: CQC death notifications submitted 10/04/2020 to 02/07/2021

The chart shows the number of death notifications of people in care homes flagged with COVID-19 submitted each day up to 2 July 2021, with a seven-day moving average line showing the smoothed trend. The numbers of notifications of deaths appear to have peaked for the second time by late January 2021 and have been steadily falling since then.

Deaths of people detained under the Mental Health Act (MHA)

All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained, under the MHA.* Based on date of notification, from 1 March 2020 to 2 July 2021, we have been notified of 168 deaths that mental health providers indicated were suspected or confirmed to be involving COVID-19 (an increase of two since we reported in June). A further eight deaths of detained patients involving COVID-19 were reported by other (non-mental health) providers (no further recorded deaths since we last reported).**

* 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. These changes may relate to data cleaning or delays in notifying CQC of a death of a detained patient.

Of the 581 notifications from mental health providers in the 2020/21 period (covering all causes of death from 1 March 2020 to 2 July 2021), 466 were from NHS organisations, of which 127 deaths were indicated as involving COVID-19, and 115 were from independent providers, of which 41 deaths were involving COVID-19.

We have identified 34 detained patients whose deaths have been notified to us from 1 March 2020 to 2 July 2021 who had a learning disability and/or were autistic: the majority (23) were not identified as involving 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.

Deaths of people detained under the Mental Health Act (cont.)

The table below shows all notifications of deaths of detained patients (across all provider types) between 1 March 2020 to 2 July 2021, by age band, and COVID-19 status.

Age band	16-17	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19	0	1	4	9	11	29	39	49	22	12	176
Not COVID-19	4	20	42	37	54	71	70	70	23	51	442
Total	4	21	46	46	65	100	109	119	45	63	618

The table below shows all notifications of deaths of detained patients (across all provider types) from 1 March 2020 to 2 July 2021, by gender and COVID-19 status.

Gender	Female	Male	Transgender	Unknown or unspecified	Total
Suspected or confirmed COVID-19	57	105	0	14	176
Not COVID-19	139	248	1	54	442
Total	196	353	1	68	618

Deaths of people detained under the Mental Health Act (cont.)

The table below shows all notifications of deaths of detained patients (across all provider types) from 1 March 2020 to 2 July 2021, by ethnicity and COVID-19 status.

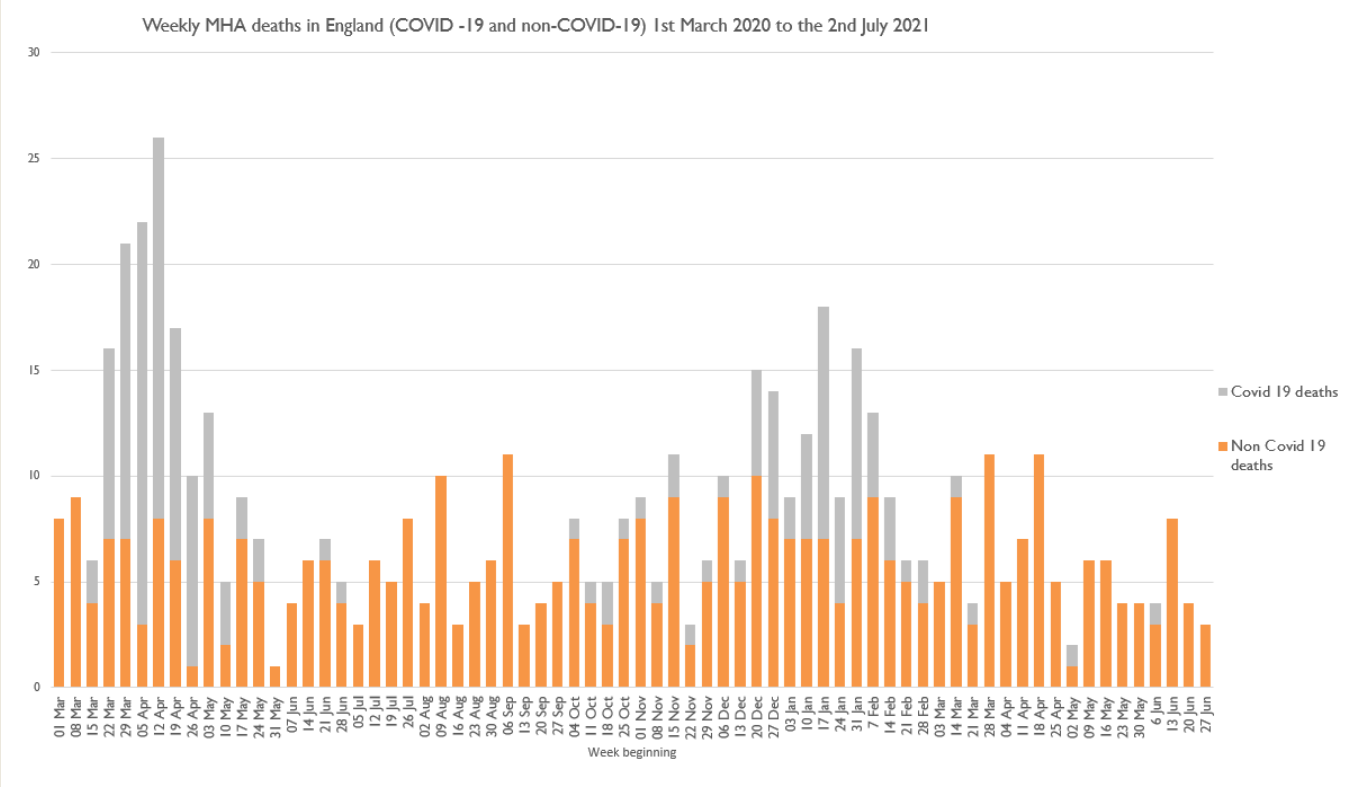
Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	7	9
Black	21	31
Mixed	7	10
Other ethnic groups	1	3
White	99	248
Unknown	22	40
Not stated	19	101
Total	176	442

Deaths of people detained under the Mental Health Act (cont.)

The table below shows all notifications of deaths of detained patients (across all provider types) from 1 March 2020 to 2 July 2021 by place of death and COVID-19 status.

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	121	142
Psychiatric ward	40	140
Hospital grounds	1	8
Patient's home	0	39
Public place	0	9
Other household	0	3
Other	3	53
Not stated	11	48
Total	176	442

Deaths of people detained under the Mental Health Act (cont.)



The chart above shows the number of deaths notified to CQC based on the date of death. These figures will be lower than the counts of notifications presented in the previous section due to time lags in reporting and data cleaning. Data may be updated over time and therefore successive extracts may lead to changes in overall numbers.

We will also be reporting on the deaths of detained patients and deaths of patients subject to community treatment orders from 1 April 2020 to 31 March 2021 in our MHA annual report later in the year. This report will include further information about the causes of deaths, including COVID-19. The cause of deaths in detention is usually determined through the coroners' courts, which leads to a delay for accurate statistical reporting.

Death notifications of people in services caring for people with a learning disability or autistic people

In June 2020, we first published data on the number of notifications of deaths of people who were receiving care from services that provide support for people with a learning disability or autistic people between 10 April and 15 May 2020. We have subsequently published a number of updates, extending the time period each time. This issue now covers deaths between 10 April 2020 and 31 March 2021.

This data is derived from death notifications submitted to CQC. A proportion of notifications are submitted as scans or are handwritten and cannot be included in this analysis. This means the numbers reported in this appendix and previous updates may be below the true numbers of deaths. In the 2020/21 period the proportion of unextractable notifications was 5.5%, and in the 2019/20 period it was 6.7%.

We are taking action to improve the way we capture and process information from providers through our notifications.

While unextractable notifications are not represented in published figures, throughout the pandemic we have used this information, alongside other information and any concerns received, to assess risks and make decisions about where to inspect, taking action to protect people where necessary.

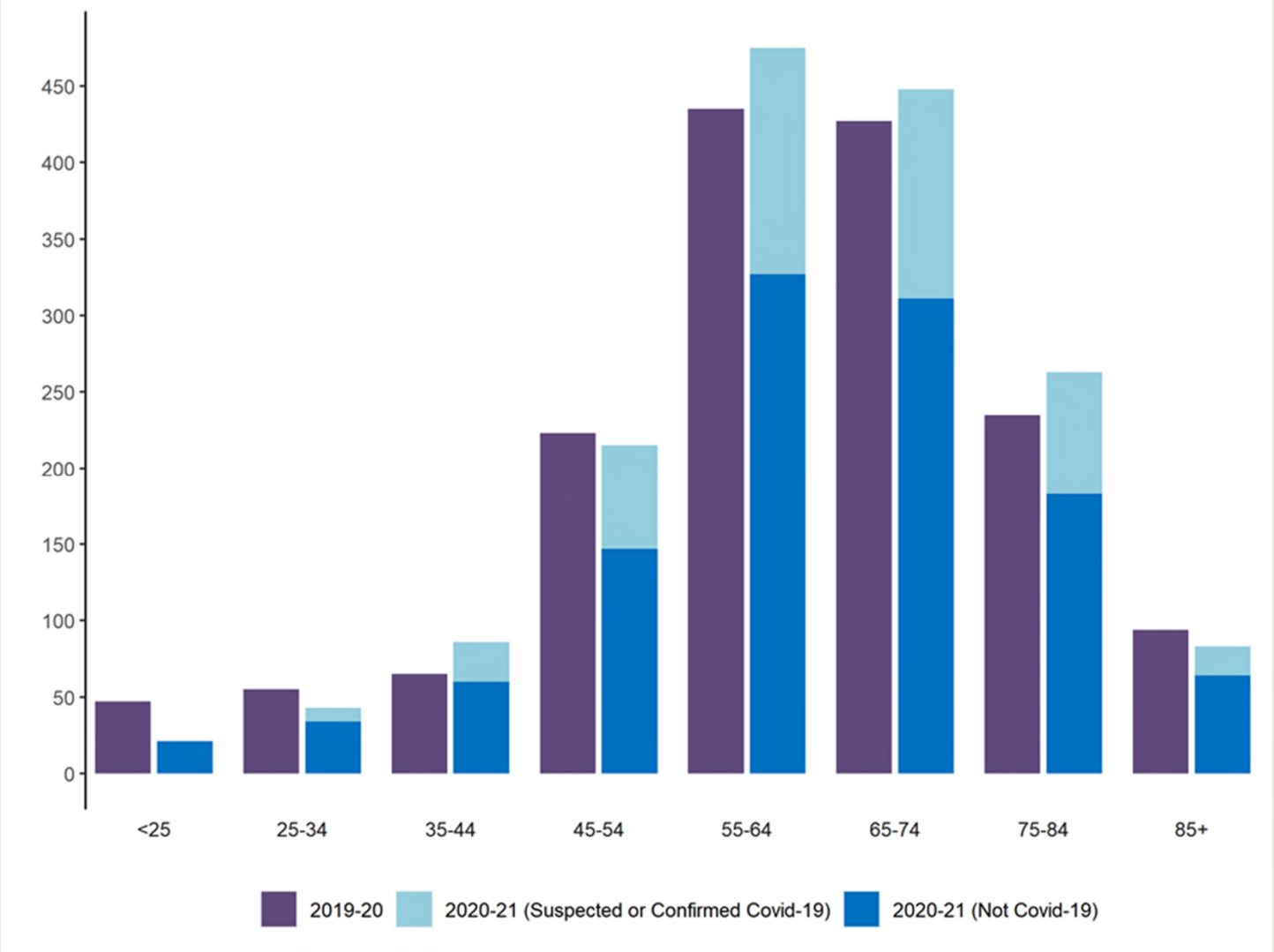
The inclusion of a death notification in published figures is based on providers recording that a person had a learning disability or autism on the notification submitted to CQC.

We identified notifications of the deaths of at least 1,633 people with a learning disability or autistic people from services identified as caring for people with learning disabilities or autistic people between 10 April 2020 and 31 March 2021. This is 3% higher than the 1,581 deaths notified in the comparable period in 2019/20.

Of the 1,633 people with a learning disability or autistic people that we have identified as having died during the period in question, 486 were identified by the provider as deaths involving COVID-19 (either suspected or confirmed), and 1,147 were not identified as involving COVID-19.

Compared with the last time we updated this analysis (which covered the period 10 April to 16 November 2020), there now appear to be fewer deaths not involving COVID-19 in most age categories in 2020/21 than there were in the comparator period (2019/20 – comparing the purple columns with the dark blue segments).

Death notifications of people in services caring for people with a learning disability or autistic people (contd)



Identified death notifications from providers of all types of services for people with learning disabilities and/or autism spectrum disorder that state the person who died had a learning disability or was autistic, by age and COVID-19 status: 2019/20 vs 2020/21

Source: notifications of deaths under Statutory Notification 16 to CQC, 10 April 2020 to 31 March 2021, and comparable period in 2019/20.

Note: no bar is shown for 2020/21 (suspected or confirmed COVID-19) in the under-25 age category, as low numbers have been suppressed. The data covers all relevant service types but the vast majority come from community or residential social care.

Death notifications of people in services caring for people with a learning disability or autistic people (contd)

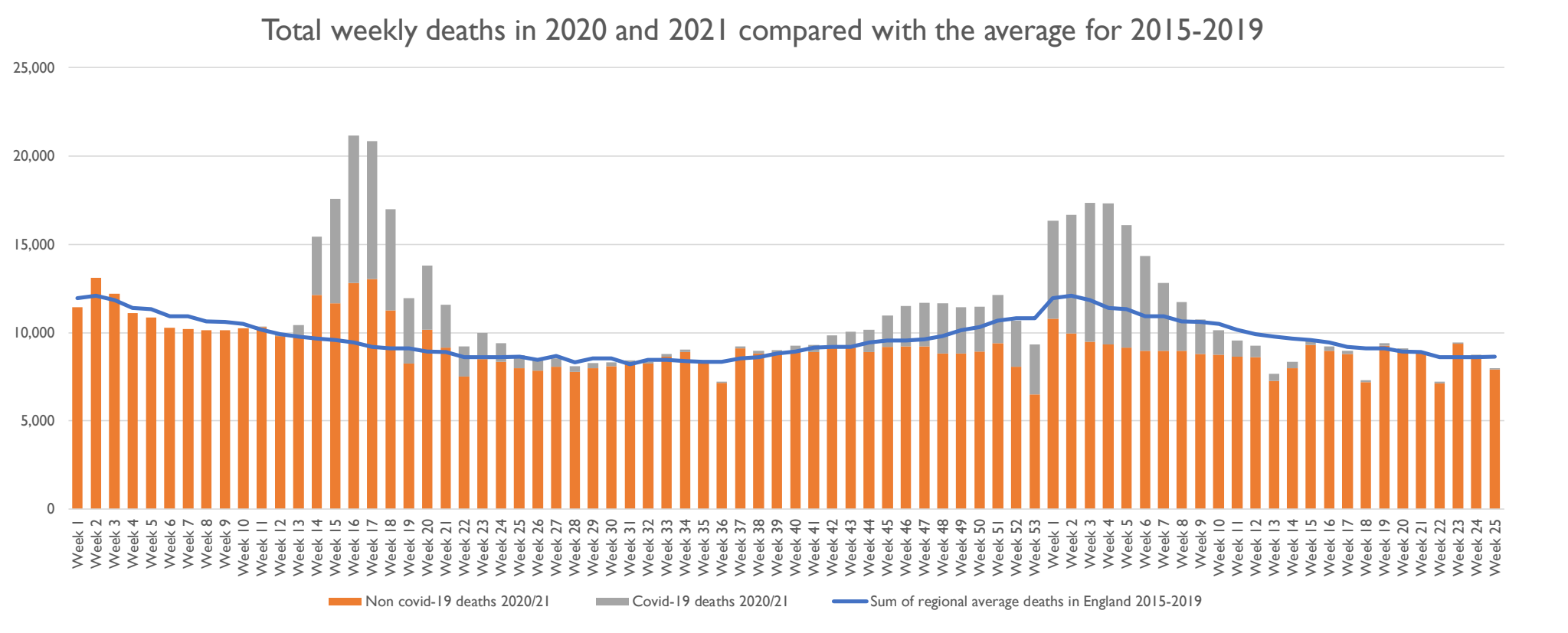
Of the 1,633 people with a learning disability or autistic people that we have identified as having died, 1,592 were receiving care from adult social care settings.

The table shows the distribution by COVID-19 status and service type of notifications of deaths of people with a learning disability or autistic people.

Primary inspection category	Confirmed or Suspected COVID-19	Not COVID	Total
Community-based adult social care services	210	551	761
Residential social care	268	563	831

We only show the breakdown of service types for adult social care. The remaining 41 deaths were of people notified to us by types of service in much lower numbers. To avoid identifying individuals we have not included them here.

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 and 2021 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 25, 2021: week ending 25 June 2021