Introduction

In the space of a few short months, the coronavirus pandemic has placed the severest of challenges on the whole health and care system in England. A crisis so widespread and fast in its impact was always going to test the resilience and responsiveness of the system like never before.

The response of the people involved in the delivery of health and social care has been impressive. We have seen health and care staff demonstrating resilience in the face of unprecedented pressures and adapting quickly to work in different ways to keep people safe. There has been a rapid transformation in clinical practice, new approaches to delivering care, and a greater understanding of the skill, value and flexibility of the whole health and care workforce.

There are examples of collaboration between hospitals, primary care, social care and community services – services working together in a more integrated way and at pace to manage the immediate pressures of COVID-19. In some cases, the closer system working we have been calling for over the past three years has been brought about within a matter of weeks – we all need to support and build on that achievement and help ensure it is more widespread.

As we move beyond the peak of the outbreak and a significant reduction in the number of deaths from COVID-19, CQC has an important role – working with others – to bring together the insight we have gathered on the pressures that services and local systems have faced and the efforts that have been made to tackle them. This is what we set out to do in these reports.

Now is the time for us all to work together to learn from the first stages of the pandemic – to share and reflect on what has gone well, to understand and learn from the experience of what hasn't, to understand the barriers there are to greater collaboration, and to take forward the vital lessons from the crisis that will help all of health and care to prepare better in future.

We want to highlight the importance of collaboration between services as integral to meeting people's needs, and stress how vital it is that positive transformational changes are not lost; that efforts to improve system working become widespread.

Ian Trenholm
Chief Executive

COVID INSIGHT

HOW PROVIDERS ARE WORKING TOGETHER ACROSS SYSTEMS IN RESPONSE TO COVID-19

The importance of local systems

In our 2018 report *Beyond Barriers: How older people move between health and social care in England*, we wrote that health and care services can achieve better outcomes for people when they work together. We found that joint working was not always easy, that the health and social care system was fragmented and organisations were not always encouraged or supported to collaborate.

An effective system that supports older people to move between health and care services depends on having the right culture, capability and capacity. In the work for that report, we looked for effective system-working and found examples of the ingredients that are needed. These include:

- a common vision and purpose, shared between leaders in a system, to work together to meet the needs of people who use services, their families and carers
- effective and robust leadership, underpinned by clear governance arrangements and clear accountability for how organisations contribute to the overall performance of the whole system
- strong relationships, at all levels, characterised by aligned vision and values, open communication, trust and common purpose
- joint funding and commissioning
- the right staff with the right skills
- the right communication and information sharing channels
- a learning culture.

What underpins good collaboration

In response to COVID-19, we have recently talked to representatives from a range of local stakeholder organisations and reviewed local support plans to gather perspectives on the extent to which these characteristics have been to the fore among providers working together to tackle the crisis.

In this issue, we are highlighting the early findings from the feedback we have received around approaches to secure collaboration, and examples of the positive impact of these efforts. In future issues, we aim to further explore what challenges there have been to effective collaboration, share collective learning on what might be done to overcome the barriers to it, and focus on the experience of people moving within the system.

What are the most important actions that health and social care providers can take collectively to manage the response to COVID-19?

A number of the characteristics highlighted above were seen as important in the conversations and feedback that we had from stakeholders. There was an acknowledgement of the importance of establishing a clear local picture, to identify priorities for support, and to ensure that all stakeholders within a health and social care system are on the same page, with an agreed strategy that all stakeholders are signed up to, and effective communication plans.

Collaboration was seen as vital, with strong relationships between providers and across sectors being the key to the success of managing in a crisis. Positive working relationships reduce the time taken to accomplish goals – for example in procuring personal protective equipment. The discharge and flow of patients between and within appropriate care settings was crucial, and this is influenced by the quality of relationships between providers (for example, between care homes and acute trusts). Similarly, collaborative working between local authorities, acute trusts and clinical commissioning groups was important to ensure timely access to clinical advice for care home staff.

In responding to COVID-19, how have leaders collaborated to plan and deliver services and support staff across providers to work together?

Most of the people we spoke to and the support plans we reviewed indicated that the collaboration by local leaders in their areas had been very effective in planning and delivering services and supporting staff across providers to work together. This included:

- Setting up meetings and working groups – these were regular (usually daily or weekly), with some areas making use of existing meetings and networks to make the most of existing relationships. Membership varied but could include a range of service types (local authorities and councils, clinical commissioning groups, ambulance services, primary care networks, acute, community and mental health trusts, social care and voluntary sector) and roles (including public health, performance monitoring and infection control leads).

- Providers working together to reduce the spread of COVID-19 – working especially to make sure supplies of personal protective equipment were available across services, supporting local testing, and working to make training in infection prevention and control available.

- Monitoring data and ensuring capacity across the system – for example using independent hospitals or volunteer networks to pick up some of the activity or demand that could not managed during the peak of the pandemic. In addition they used data and intelligence to identify services most in need of support – for example by monitoring the availability of PPE, the number of people with suspected or confirmed COVID-19, and workforce data.

A number of stakeholders said that working together on the response to COVID-19 has led to improvements to local system working: better collaboration across services, breaking down of longstanding boundaries, and better understanding of all services available in their area.

What barriers have there been to provider collaboration in responding to COVID-19?

Our conversations yielded a range of responses on the barriers that stakeholders had faced in collaborating to respond to the crisis.

- Good collaboration depends on good communication and dialogue between partners, and there was a feeling that there was room for more dialogue between primary and secondary care. Quickly establishing shared responsibility was a challenge when set against the statutory responsibilities that some organisations hold.

- A need to share resources fairly (across a wide range of areas: redeployment of staff, medicines, workload and PPE) and in a timely way was a big challenge – this was most successfully overcome by a sheer 'willingness to collaborate' to get the job done and through joint discussions and solutions.

- The need to work at pace has been a big challenge – the sheer speed with which changes to procedures and guidance were made has been difficult to manage, as has been maintaining governance oversight at speed. Acute trust stakeholders also highlighted that NHS structures do not aid quick decision making.

- Ensuring the delivery of the right information was a barrier when the need to answer daily requests for information was so prevalent. Duplication of information requests was sometimes a problem too.

Collaboration – examples from the front line

On 4 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: *adult social care provider, North East Essex ICS, primary care networks, community teams*

St Helena Hospice agreed with the Suffolk and North East Essex ICS to take on a leadership and coordination role for all end of life care delivered outside of hospital in North East Essex during the pandemic.

Mark Jarman-Howe, chief executive of St Helena said, "The COVID pandemic has brought huge challenges to community palliative and end of life care. In North East Essex, St Helena Hospice coordinated the community end of life response on behalf of the North East Essex Health and Wellbeing Alliance, creating a hub and spoke model. Non-urgent hospice visiting ceased and community specialist nurses, rehab and family support teams joined the single point of access team to create an enhanced community rapid response hub. Continuing health care funding resources were allocated through the hub, and local voluntary services coordinated relief services for those on the palliative care register. We created a 24-hour non-medical prescriber rapid response service in partnership with Anglian Community Enterprise to enhance overnight nursing capability and offered bereavement services across the community.

"We created integrated spoke teams with weekly virtual meetings between primary care, community nursing and the hospice, and developed a single caseload between the providers to enhance care coordination.

"We developed our electronic palliative care coordination system to capture advance care planning discussions about COVID and gained access to it for care home staff. We rewrote anticipatory prescribing guidance, verification of death procedures, created patient group directives, wrote policies to allow hospice medications to be taken into the community for urgent visits and supported carers to learn to administer subcutaneous medication. We expanded the hospice inpatient unit and also a virtual ward in collaboration with a local care provider and merged community hospital and hospice beds into an integrated community bed base. We taught colleagues across the community about symptom control and advance care planning. We ate a lot of cake and spent a lot of time on Microsoft Teams.

"Three months later, what do we know? We learned, like many others, that a crisis created more inter-organisational co-operation in two weeks than years of previous meetings. We learned how many more people can be cared for in the community at the end of life when organisational barriers are dismantled. A crisis made us do it differently and showed us what can be achieved when organisational barriers are broken down and service is driven by the needs of the patient."

Collaboration – examples from the front line

Working together: *adult social care, hospital trust, clinical commissioning groups*

Carebridge have run a bridging service for the last two years from September to March to facilitate safe and effective hospital discharges. This service was extended during the pandemic and they tripled their hours to provide a 72-hour implementation period.

Carebridge supplied Hertfordshire East and North CCG and were approached to set up the service. This consisted of well-trained carers and nurses who had been carefully selected to safely respond to the patient's needs with the relevant clinical skills. Early steps were taken before being instructed to supplying full barrier nursing PPE including facemasks and eye guards.

Along with discharge teams in Herts social services and continuing health care, Carebridge agreed a full process and management plan and tracked daily to measure effectiveness, response times and client needs. They implemented a referral form to collate the necessary information before assessment, and then on discharge deployed a response car with an appropriately trained individual to complete the assessment at home.

The number of hours and needs fluctuated daily. They flexed care hours in response to needs, rather than requesting a block contract, offered counselling and engaged with voluntary support services for all clients and members of the team. There were regular supervision sessions with the in-house clinical team for those dealing with difficult circumstances. The senior management team shared an on-call rota and provided clinical support when required. All staff received additional training on COVID, including how to safely apply and discard PPE, and resilience training was included for more complex cases. The above process was discussed at bi-weekly conference calls among the clinical governance team to ensure quick changes of practice to ensure best delivery outcomes and optimum care.

Carebridge also supported additional tasks such as shopping, collecting medicines and dropping off PPE. They also implemented a nutrition and hydration project at the same time, dispensing slow cookers and menus to families that were isolating and relying on staff to receive home cooked, fresh meals.

Collaboration – examples from the front line

Working together: primary care, district nursing services, ICO area

The De Parys Group in Bedford has been working to provide services tailored to the needs of its predominately older patient group.

A multi-disciplinary group meets fortnightly to review older patients referred to the group by any health or social care professional. Membership includes GPs, community nurses, social care professionals, mental health professionals, social prescribers, and practice nurses who lead on care home support. This group has been well supported by its members and the senior teams in the respective organisation. It has been very successful in reviewing and case managing vulnerable older people and developing care plans, and provides a clear focus for all health professionals when they are concerned about a patient, especially where a multi-agency response in needed.

The De Parys Group has been working closely with care homes aligned to it. This includes providing a named point of contact in the surgery; phone 'check-in' on a weekly basis; clinical leadership through a named practice nurse with special interest; and medicines reviews conducted by its clinical pharmacists in conjunction with the CCG 'Medicines Optimisation in Care Homes' team.

It has also been supporting the care homes by supplying PPE and helping them to set up video consultation capability. During the early COVID period, it worked extensively with the care homes to ensure all patients had an up-to-date advanced care plan and that their wishes regarding DNAR were clearly documented. It is continuously developing its joint working with care homes and has developed a Project Charter to guide this work.

The service offer for older patients has included home visits – taking on considerable amounts of wound care and phlebotomy for housebound and vulnerable patients, therefore supporting the district nursing services during the crisis.

The Group also developed the first red site in the region, and then worked collaboratively with partners to upscale it to deliver for the whole borough. It is seen as the model of a collaborative working across Bedfordshire, Luton and Milton Keynes, our ICO area.

Next steps

In the next edition of this report, we will report further on the themes arising from the conversations we are having with local leaders about collaboration among organisations to respond to the pandemic.

In addition, 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 COVID-19 pandemic.

The speed and scale of the response required by the COVID-19 pandemic has highlighted how any fragmentation in our current health and care systems may significantly impair the ability to respond effectively. These Provider Collaboration Reviews will involve understanding the journey for people with and without COVID-19 across health and social care providers, including the independent sector and council and NHS providers.

We are focusing on the over-65 population because of the risks that have emerged between health and social care, supporting the providers and people living in care homes and/or receiving home care. While there are risks to all population groups in a fragmented health and care system, we have decided to focus initially on those aged 65 and over given the size of that population group.

This work will support providers by sharing learning and best practice from local areas working together, across the country. The reviews will include experiences of people who use services.

COVID INSIGHT

HOW THE CARE FOR PEOPLE FROM DIFFERENT GROUPS IS BEING MANAGED
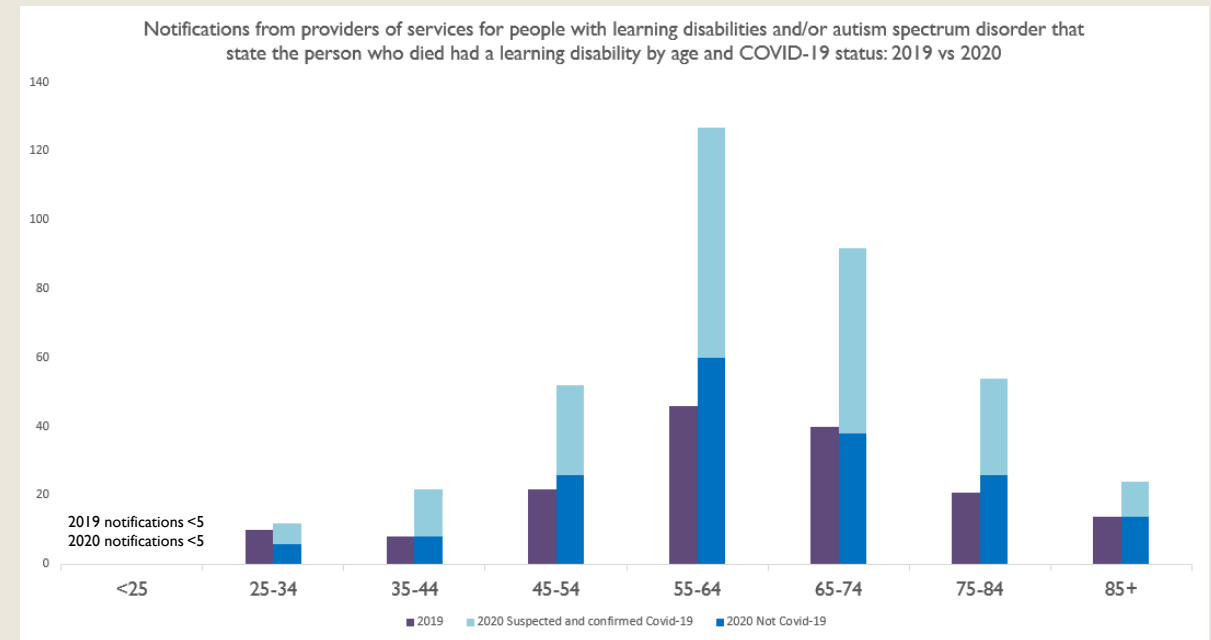
Deaths of people with a learning disability

On 2 June, 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. This showed that between 10 April and 15 May this year, there were 386 deaths of people with a learning disability (some of whom may also be autistic). This compares with 165 people who died in the corresponding period last year. This was a 134% increase in the number of death notifications this year.

Of the 386 people who have died this year, 206 were as a result of suspected and/or confirmed COVID-19 as notified by the provider and 180 were not related to COVID-19.

We know that people with a learning disability are at an increased risk of respiratory illnesses. In March 2020, NHS England highlighted how people with a learning disability have higher rates of morbidity and mortality than the general population, and die prematurely. In 2018/19, at least 41% of people with a learning disability who died, died as a result of a respiratory condition. They have a higher prevalence of asthma and diabetes, and of being obese or underweight; all these factors make them more vulnerable to coronavirus.

Our figures show that the impact on this group of people is being felt at a younger age range than in the wider population. Since the initial release of this data, DHSC has announced that testing will be rolled out across residential adult social care settings, including to adults of working age with a learning disability.

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

* The data in this chart is also shown in table form in the data appendix (slide 30).

Deaths of people with a learning disability (cont'd)

The 386 deaths of people with a learning disability occurred in 313 individual care settings. It is possible that any of the services also reported more COVID-19 related deaths but they were not of people with a learning disability.

Of the 386 people who died, 184 were receiving care from community-based adult social care services and 195 were receiving care in residential social care settings.

Type of adult social care service notifying us of the death*	Number of notifications where the person did not have COVID-19	Number of notifications where the person had confirmed or suspected COVID-19	Total
Community-based adult social care services	86	98	184
Residential social care	90	105	195

*We only show this breakdown of service types for adult social care. Other services who notified us of deaths of people with a learning disability number less than 10; to avoid identifying individuals we have not included them here.

We are working to improve the data set that underpins this information and will include more analyses in future editions.

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 5 June 2020, we have been notified of 75 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 152 notifications from mental health providers in the 2020 period (covering all causes of death), 113 were from NHS organisations, of which 49 deaths were indicated as being COVID-19-related, and 39 were from independent providers, of which 26 deaths were COVID-19-related.

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. The split of deaths by age and gender are shown in the data appendix, at slide 29.

Statutory notifications (regulation 17)	Year (1 March to 5 June 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	86	69	81	68	152	75
Non mental health providers	5	3	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.

Our focus remains on responding to concerns about people's care

During the COVID-19 pandemic, we have inspected, and we will inspect, mental health, learning disability and autism services where we have, or are alerted to, serious concerns about people's care and where there are breaches of human rights. We have committed to having a full programme of responsive inspections underway again for these types of settings, but this will not delay us from inspecting services where we are concerned about risks right now.

In addition, our Mental Health Act Reviewers are still monitoring the use of the Mental Health Act and will complete site visits if they identify concerns. Their monitoring includes collecting information from a range of sources by phone, email or video calls with staff, people who use services and families. If there are risks of harm, ill-treatment or human rights breaches, we will carry out additional activity, which may include a site visit.

Deaths of people from BME groups in adult social care settings

We know that people from black and minority ethnic (BME) groups appear to be at greater risk of dying of COVID-19, and this is an area where more research is urgently needed. While the data we hold has a number of limitations, the lack of data on ethnicity across adult social care as a whole makes it more important that any information in this area is shared - both to aid understanding and highlight the need for more robust data.

Providers are required by law to notify us of the death of a person accessing their service. We ask for a range of demographic information about the person who died, using a structured reporting form ('SN16'). The form asks for the ethnicity of the person who died, but it is not mandatory for the service provider to provide it. (This information is also not available from a death certificate.) The ethnicity reported on the SN16 form reflects the ethnicity that the provider selects – we cannot be sure that this would be the same as that which the person who died would self-report.

The data that follows includes death notifications in adult social care settings from 10 April to 15 May 2020 (and the equivalent period in 2019). The percentage of forms where ethnicity was unknown, not stated, missing or could not be analysed (due to factors including illegibility of hand written forms) was 13.8% in 2020 and 13.4% in 2019. It is possible that the death notifications where ethnicity is not recorded include a higher proportion of people from BME groups, but we are not able to determine this.

Preliminary analysis of the forms that could be analysed indicates that the vast majority of reported deaths in adult social care settings are of people in the White group. However, the percentage of deaths notified to us of suspected or confirmed COVID-19 compared with non-COVID deaths is higher in people from BME groups (44.2%) than White people (41.4%). Further indications are that the impact for Black groups is likely to be higher than for BME groups overall (see slide 31), and we are currently verifying these numbers.

We cannot contextualise these figures due to the lack of data on ethnicity across the adult social care sector population as a whole; this data is not consistently collected on admission by care homes or by other adult social care providers. We are carrying out a targeted piece of work to review death notifications and how we work with providers to ensure the data provided to us is both accurate and accessible. We will be looking at how we collect data on ethnicity as part of this.

There is a much wider question of how ethnicity is recorded across adult social care, as there is limited research or information on this.

COVID INSIGHT

FOCUS ON PRIMARY CARE

The changing face of general practice and online primary care

Primary care is the first port of call for most people needing health care and it has brought about huge changes in the way it works in the face of the challenges of COVID-19.

GP practices and other primary care services have made an impressive transformation in response to the pandemic to continue to support the needs of people in the community.

Our inspection teams have noted:

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

- changes to prescribing, with more medicines being prescribed for longer periods of time

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

- practices rapidly adapting to the use of technology – accelerating the intention behind NHS England's Digital First Programme.

In initial feedback from conversations we have had with GP practices in the course of our regulation, they said that practice teams have been working well together and more closely in response to the challenges they have faced, which has enhanced people's working relationships.

They have said that the switch to remote consultations by phone and video has been working well, and there has been positive feedback from clinicians and patients.

Practices have also indicated that they had received good support and engagement from others to help them manage the pandemic, including clinical commissioning groups and primary care networks.

In terms of the challenges they have faced, a common theme in early feedback was one of information overload, particularly practices struggling with guidance from different sources that was changing or conflicting. Practices have said that going forward, guidance needs to be much better coordinated and streamlined.
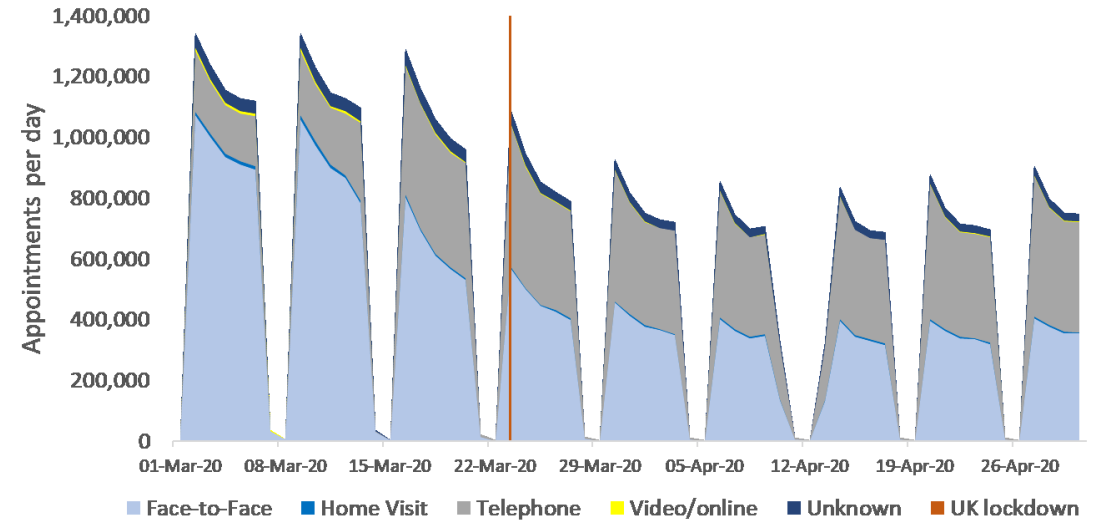
During March, general practice increasingly moved to new ways of working, including implementation of 'total triage' and online/remote consultation.

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

However, GP practices' own systems haven't fully reflected this rapid shift in ways of working and the increasing use of online or video conference to deliver appointments. The recording of GP activity is still at the experimental data stage. The data generally only count appointments delivered via traditional modes of delivery, which recorded a sharp fall around the time of the lockdown, with an increasing proportion delivered as telephone consultations: 1.34m appointments on Monday 2 March, of which 15% were recorded as being by phone; and 0.93m appointments on Monday 30 March, a week after the lockdown, of which 46% were recorded as being by phone. During April, however, the number of appointments delivered via traditional modes, including the proportion of face-to-face appointments, had started to rise.
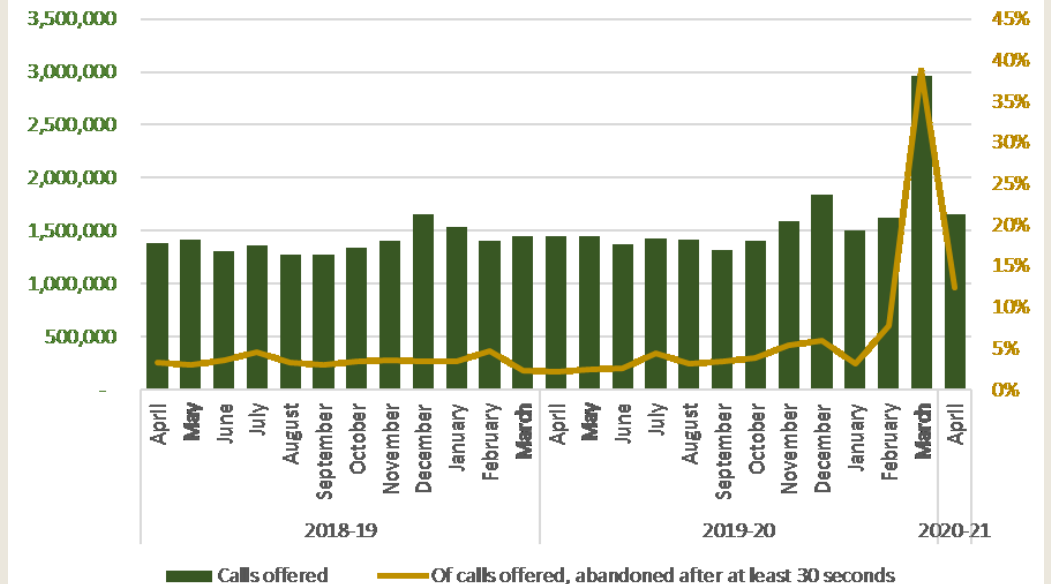
At the same time, there were more than a million extra calls to NHS 111 in England, in response to the public campaign to highlight the need to contact 111 first with any concerns. Calls almost doubled in March compared with preceding months, before falling back to more normal levels in April.

Source: NHS Digital, Appointments in General Practice, March and April 2020
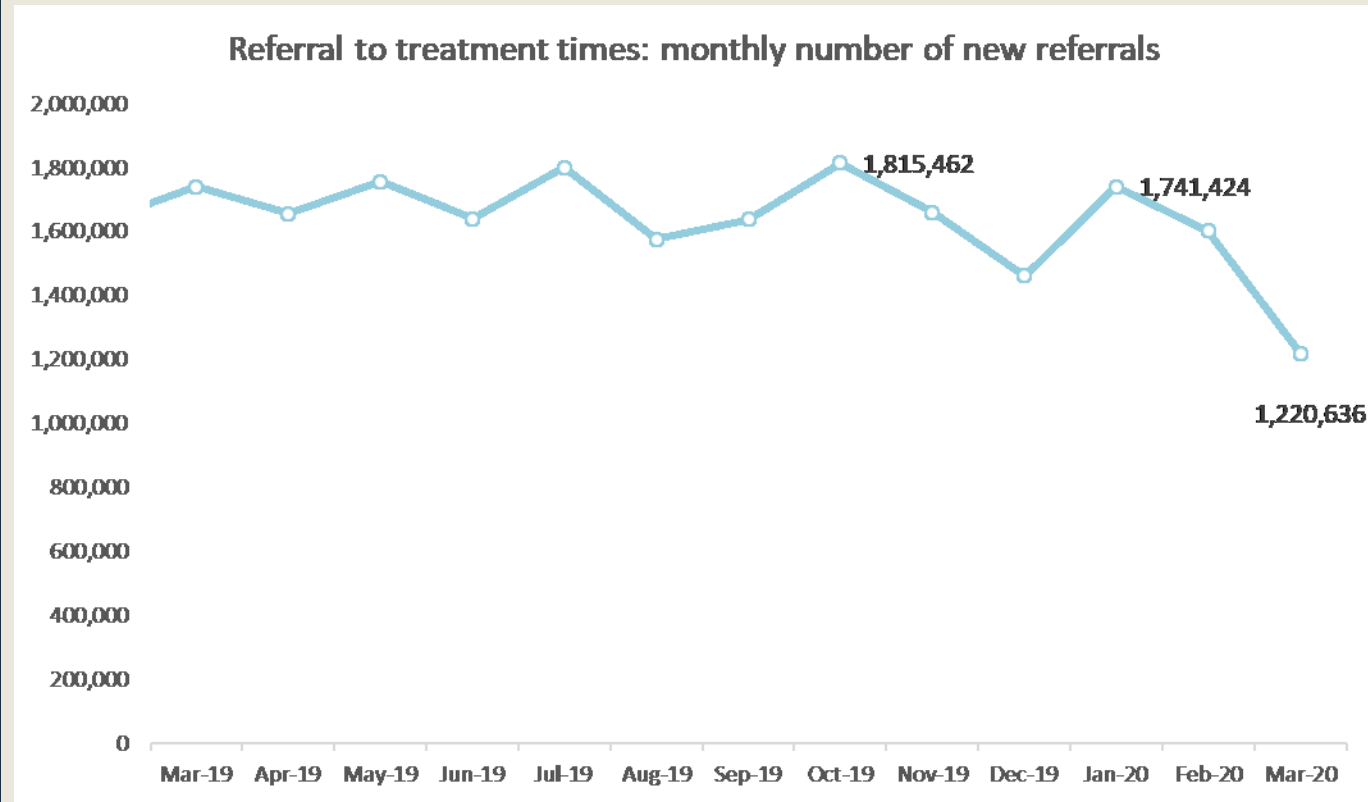

Source: NHS England, NHS 111 Minimum Dataset

Primary care services have responded by increasing remote consultations and have remained open. There have been fewer booked appointments taking place overall. There have been falls in referrals onto the 18-week pathway, in patients seen in hospital on the two-week cancer pathway, in CAMHS referrals, and in A&E attendances. It remains unknown what this might mean in terms of any increased short and long-term risks to people's health in the general population.

The impact may include:

- missing early identification of serious illnesses, including cancer
- difficulties in managing long-term conditions effectively
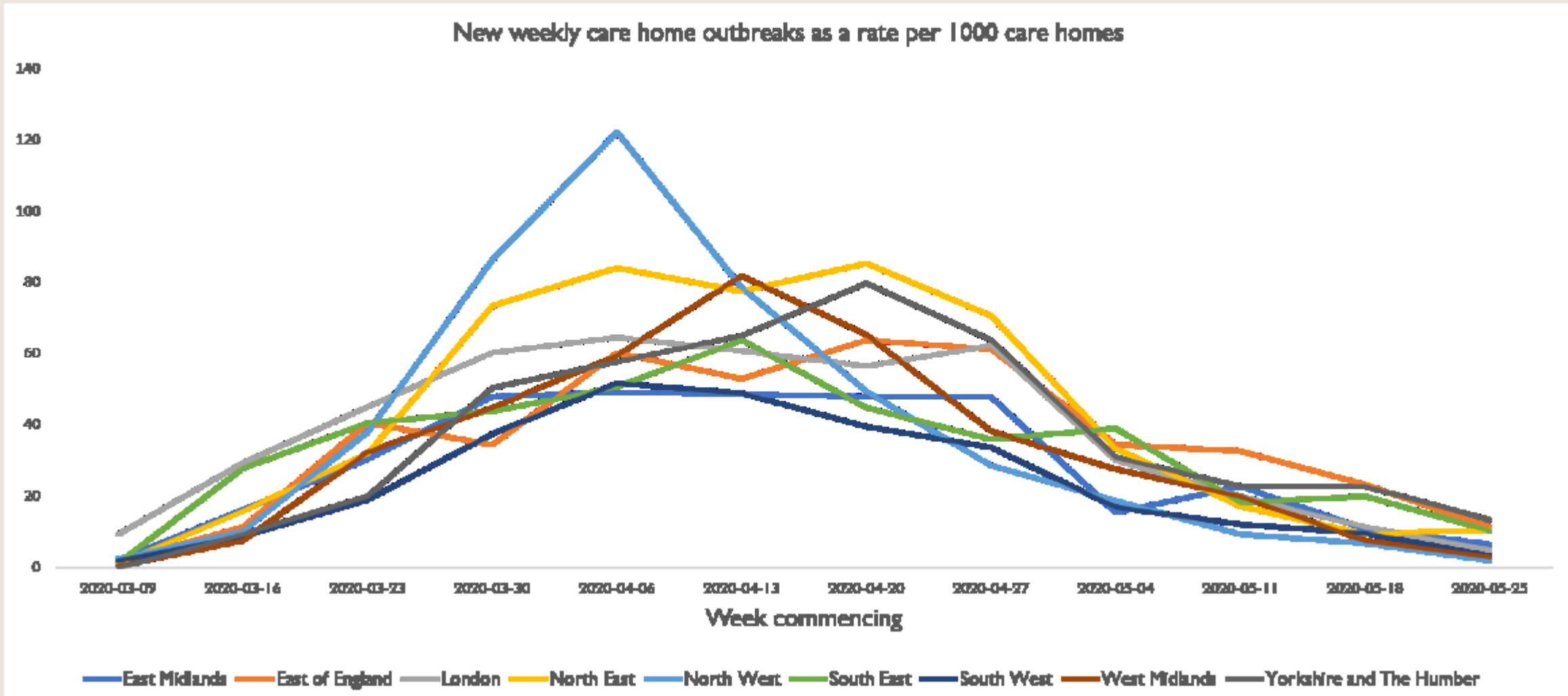- the potentially lower uptake of childhood immunisation.
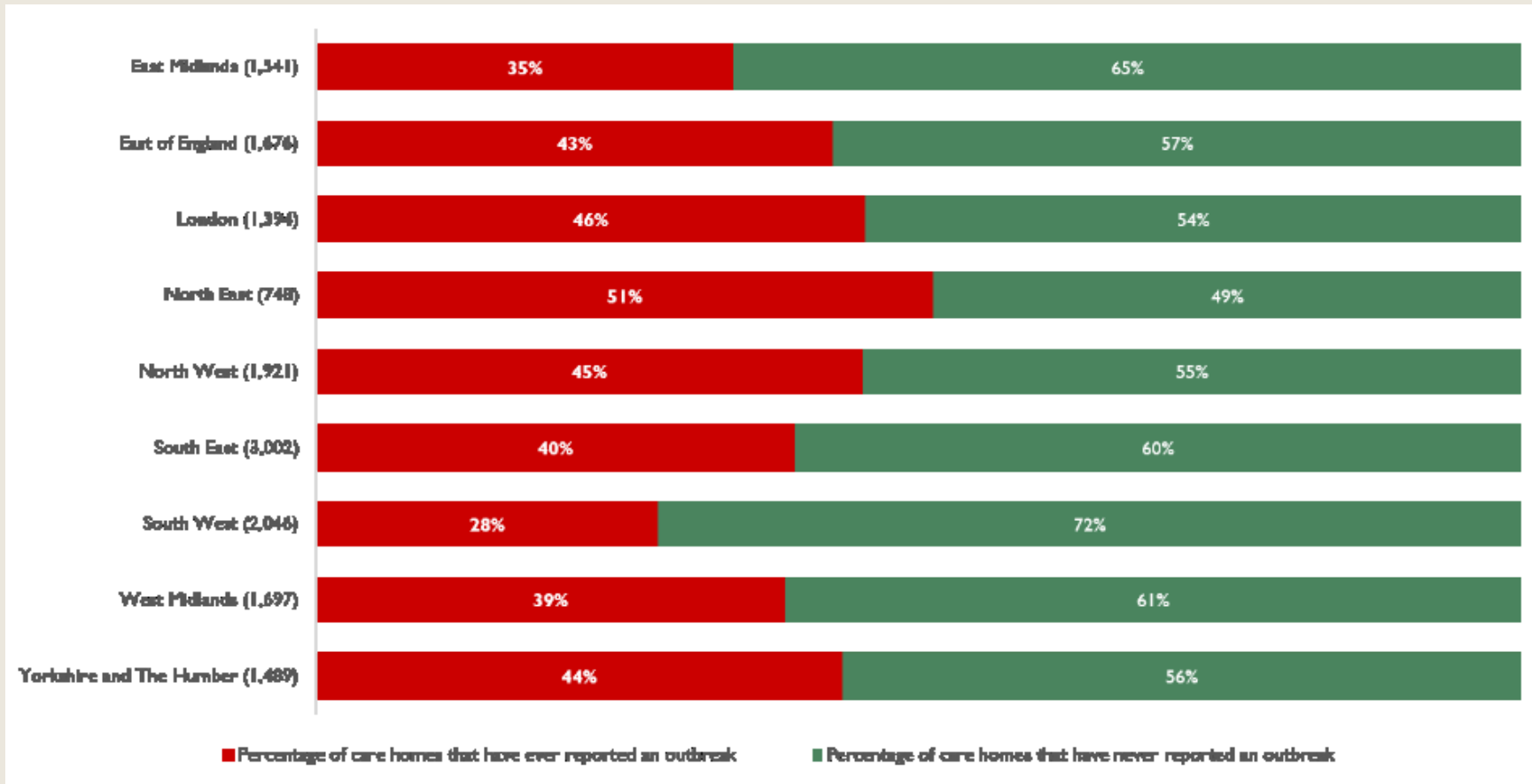

Source: NHS England

COVID INSIGHT

New weekly outbreaks in care homes

New weekly care home outbreaks as a rate per 1000 care homes

Legend: 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 09/03/20 – 31/05/2020, published 04/06/20
https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

23

Cumulative total of care homes with outbreaks in each region

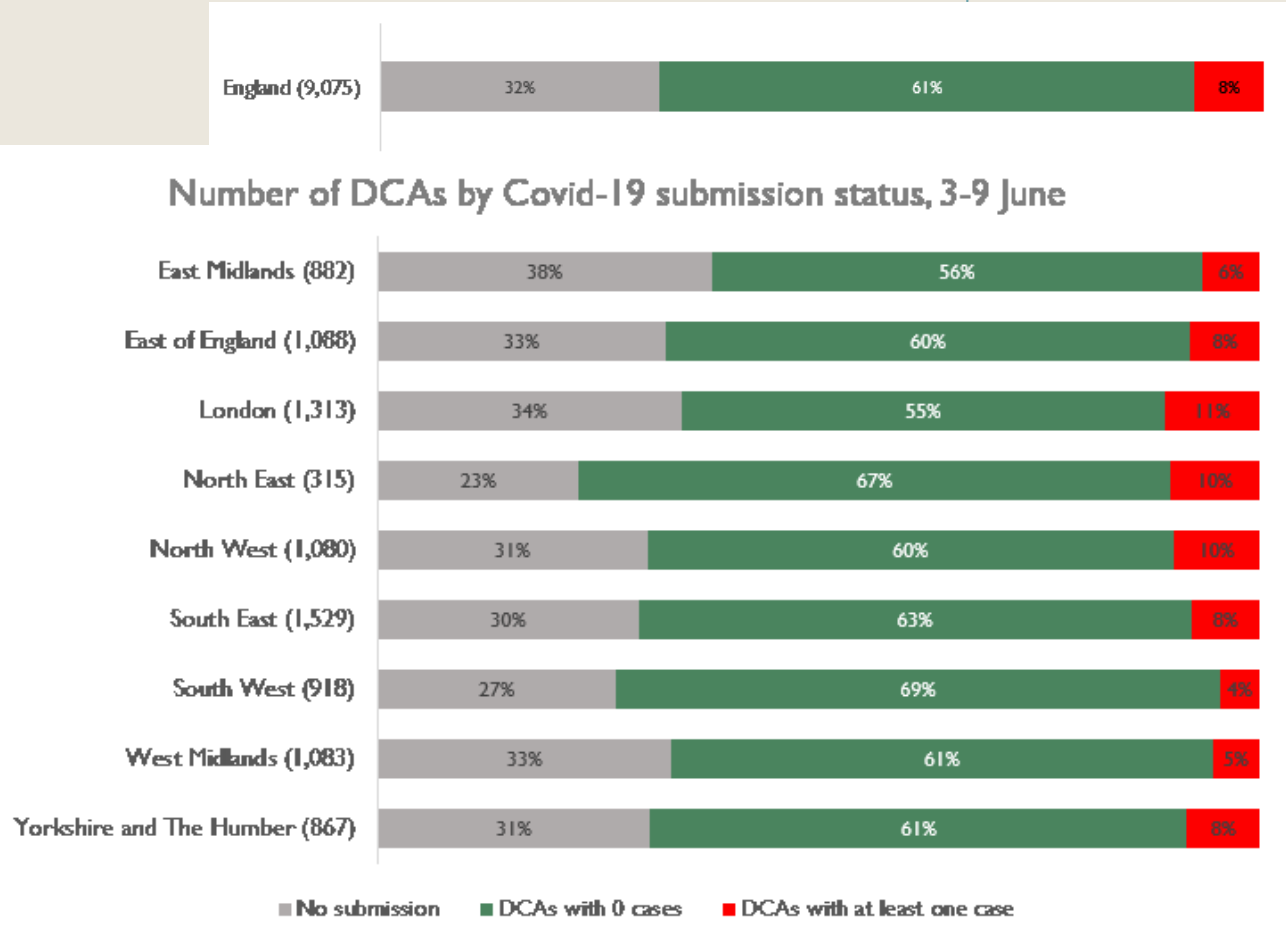The figures in brackets show the number of care homes that PHE assign to each government region.

All regions have increased by 2-7% 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 09/03/20 – 31/05/2020, published 04/06/20
https://www.gov.uk/government/statistical-data-sets/covid-19-number-of-outbreaks-in-care-homes-management-information

Homecare providers – prevalence of COVID-19

6,203 responses

England (9,075): No submission 32%, DCAs with 0 cases 61%, DCAs with at least one case 8%

Number of DCAs by Covid-19 submission status, 3-9 June

Region	No submission	DCAs with 0 cases	DCAs with at least one case
East Midlands (882)	38%	56%	6%
East of England (1,088)	33%	60%	8%
London (1,313)	34%	55%	11%
North East (315)	23%	67%	10%
North West (1,080)	31%	60%	10%
South East (1,529)	30%	63%	8%
South West (918)	27%	69%	4%
West Midlands (1,083)	33%	61%	5%
Yorkshire and The Humber (867)	31%	61%	8%

■ 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
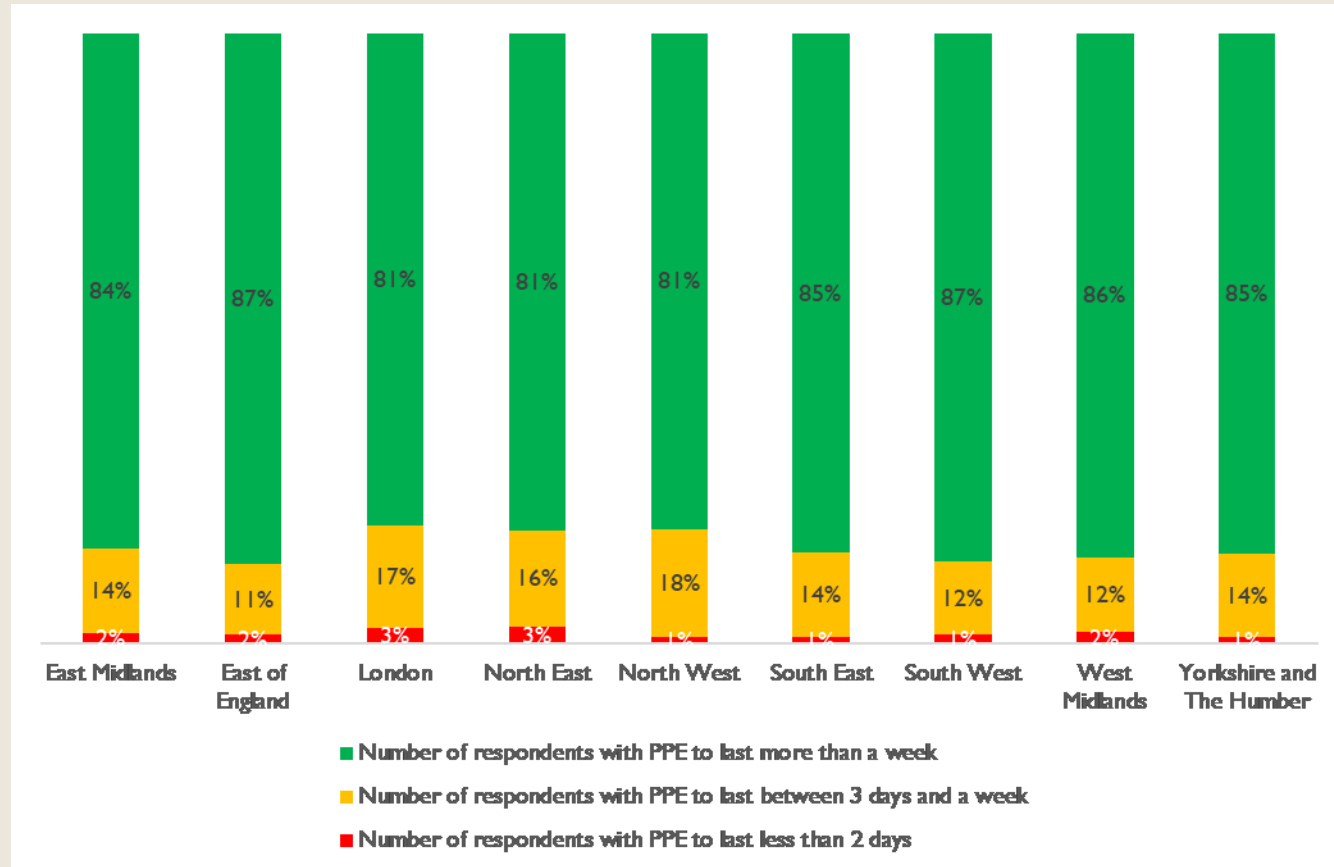
Source: CQC Domiciliary Care Agency Survey – latest response in period 3-9 June inclusive

Homecare providers – staff absence

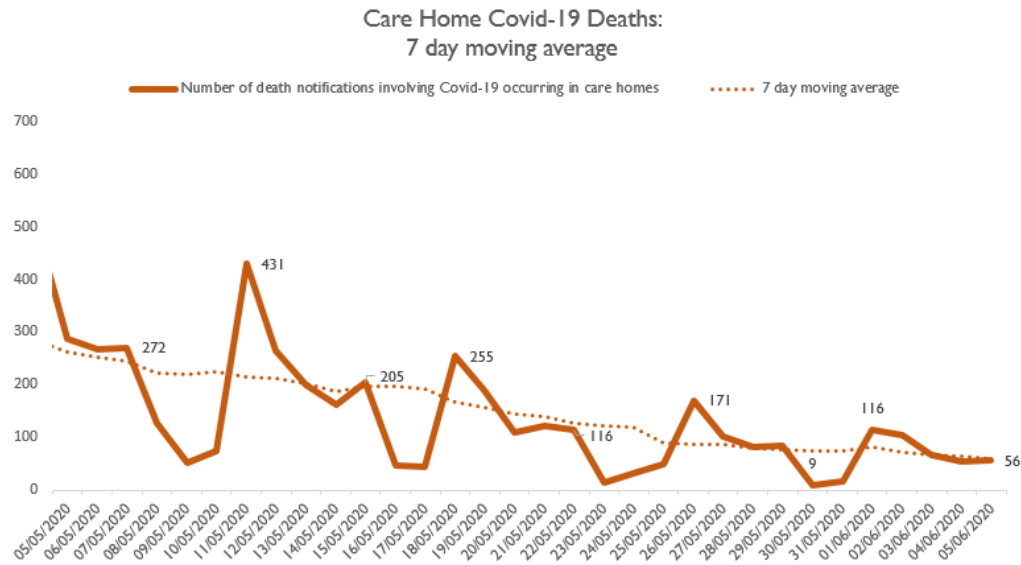DCA staff who deliver care to people absent because of coronavirus
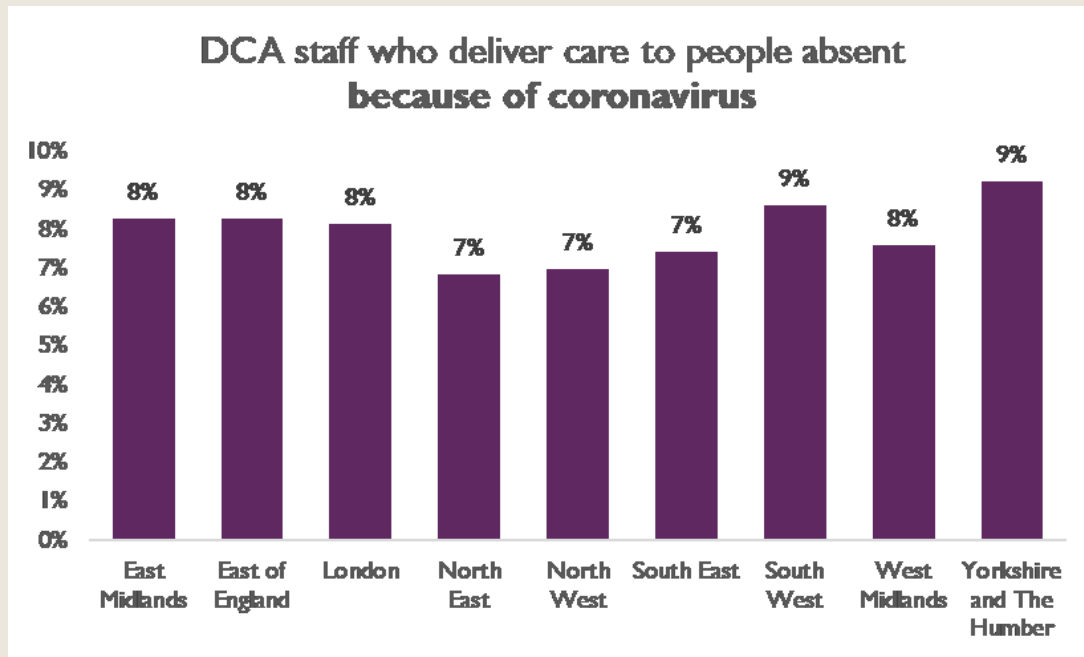
England average: **8%**

Source: CQC Domiciliary Care Agency survey – latest response in period 3-9 June inclusive
* includes staff who are self-isolating or have care commitments

Deaths notified by care homes

The latest data, from 10 April – 5 June, continues to show that deaths in care homes due to COVID-19 are decreasing.

Care Home Covid-19 Deaths:
7 day moving average

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

Number of notifications by care homes of deaths* where COVID-19 is reported as suspected or confirmed per 1000 care home beds – 10/04/2020 to 03/06/2020
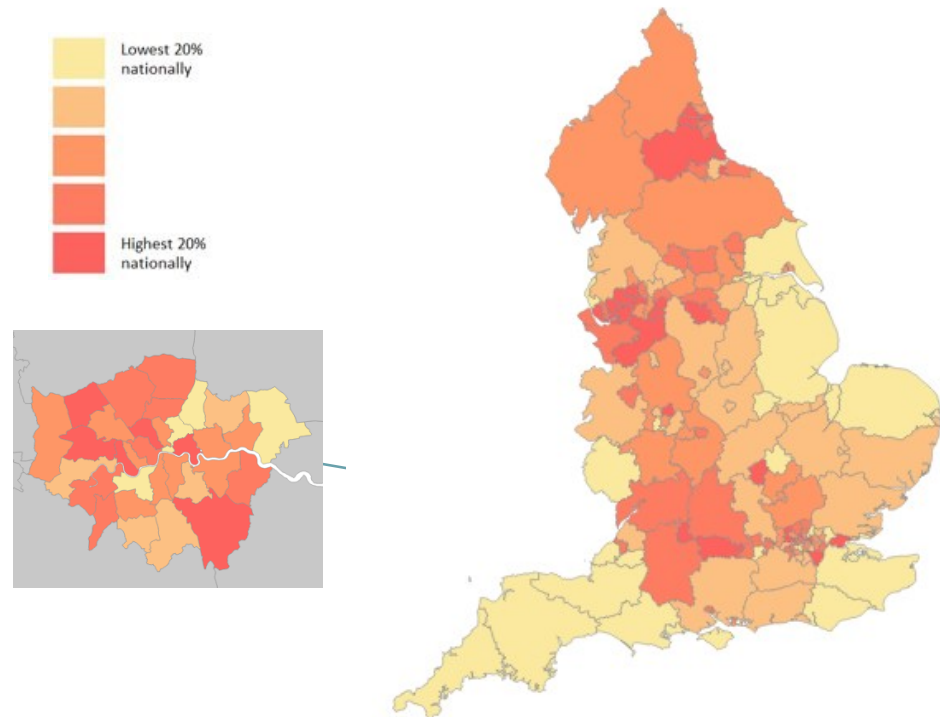
Lowest 20% nationally

Highest 20% nationally

Deaths of people detained under the Mental Health Act – by age and gender

The table below shows all deaths of detained patients notified to CQC from 1 March to 5 June 2020, broken down by age and gender, where known, 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	5	11	12	19	14	6	82
Not COVID-19	3	6	4	13	17	16	12	5	11	85
Total	4	7	8	18	28	28	31	19	17	160

	Female	Male	Unknown	Total
Suspected or confirmed COVID-19	22	52	8	82
Not COVID-19	26	39	13	78
Total	48	91	21	160

Deaths of people with a learning disability notified by providers who told us they provide care for people with a learning disability and/or autism
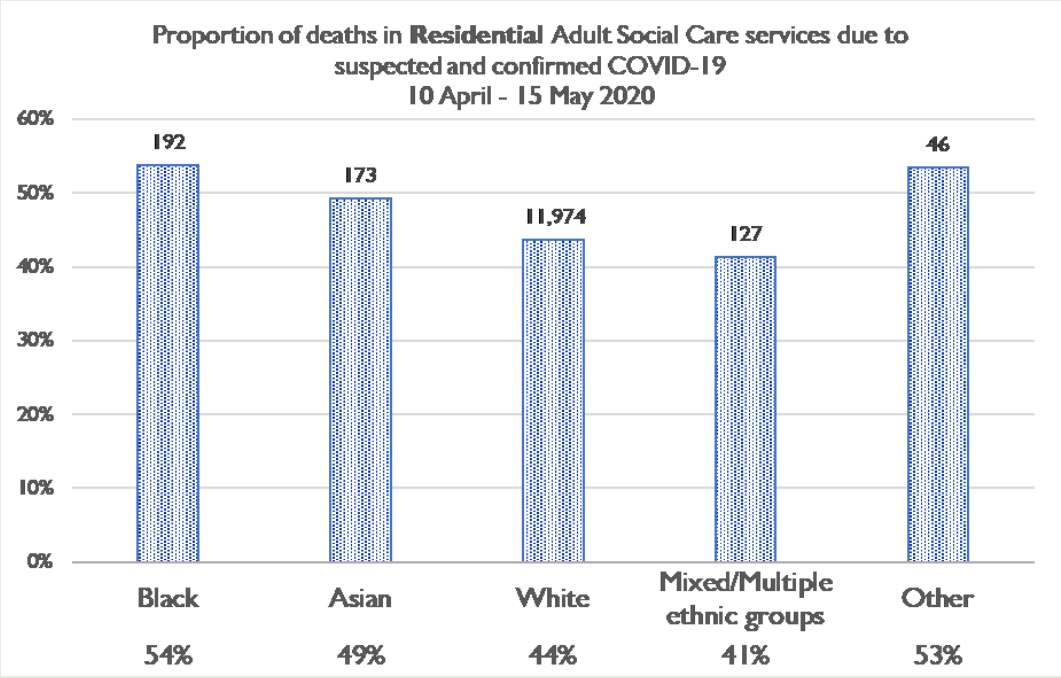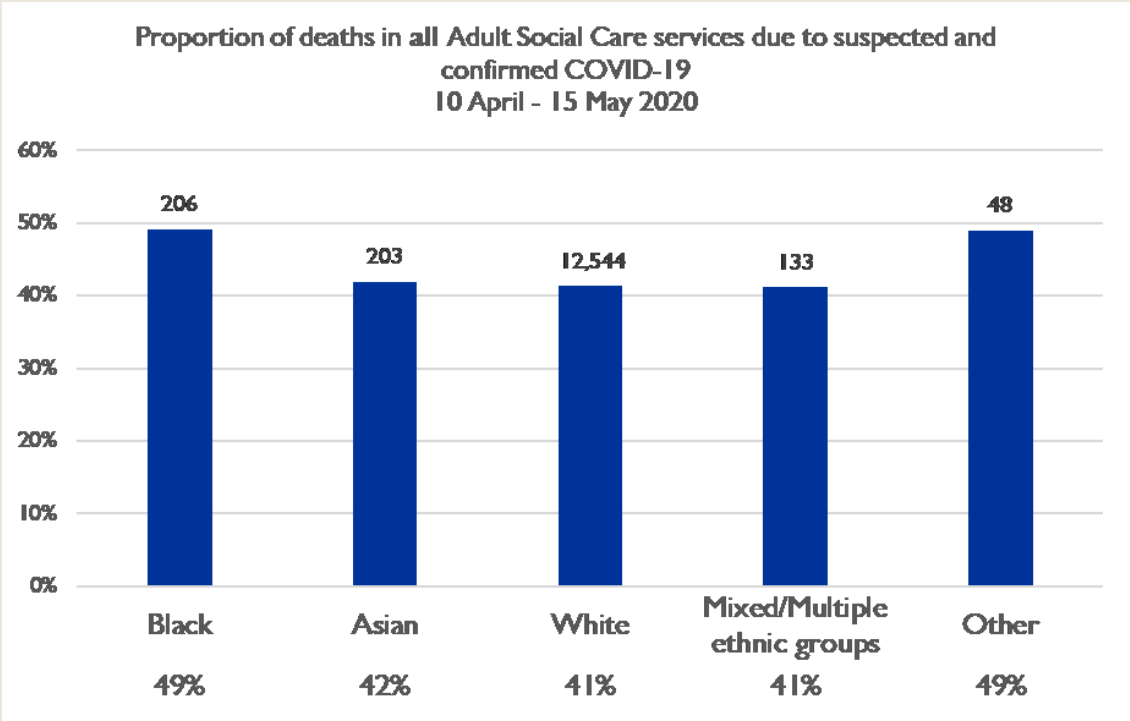
The table below shows the breakdown by age and COVID-19 status of people who died in services that provide care for people with a learning disability, where the provider notified us that they had a learning disability.
Please note that in this instance we have supressed figures under 10 for data confidentiality purposes. The chart showing this information was published on 2 June and the table added to our website shortly afterwards.
We have suppressed figures where the deaths notified to us number less than five, in line with the method used by our partners at NHS England as part of the Learning from Deaths Review (LeDeR) data collection.

Age	<25	25-34	35-44	45-54	55-64	65-74	75-84	85+
2019, not COVID-19	*	10	8	22	46	40	21	14
2020, suspected and confirmed COVID-19	*	6	14	26	67	54	28	10
2020, not COVID-19	*	6	8	26	60	38	26	14

Proportion of deaths in adult social care services, by ethnic group

Proportion of deaths in **all** Adult Social Care services due to suspected and confirmed COVID-19
10 April – 15 May 2020

	Black	Asian	White	Mixed/Multiple ethnic groups	Other
Count	206	203	12,544	133	48
Proportion	49%	42%	41%	41%	49%

Proportion of deaths in **Residential** Adult Social Care services due to suspected and confirmed COVID-19
10 April – 15 May 2020

	Black	Asian	White	Mixed/Multiple ethnic groups	Other
Count	192	173	11,974	127	46
Proportion	54%	49%	44%	41%	53%

Note: the numbers at the top of the bars are the total counts of deaths due to suspected or confirmed COVID-19 in that ethnic group in the relevant settings, where stated for that group and where analysable – see slide 17 for more information on the limitations of the data. The percentages at the bottom of the bars are the proportion of deaths that were due to suspected or confirmed COVID-19 in that ethnic group in the relevant settings.

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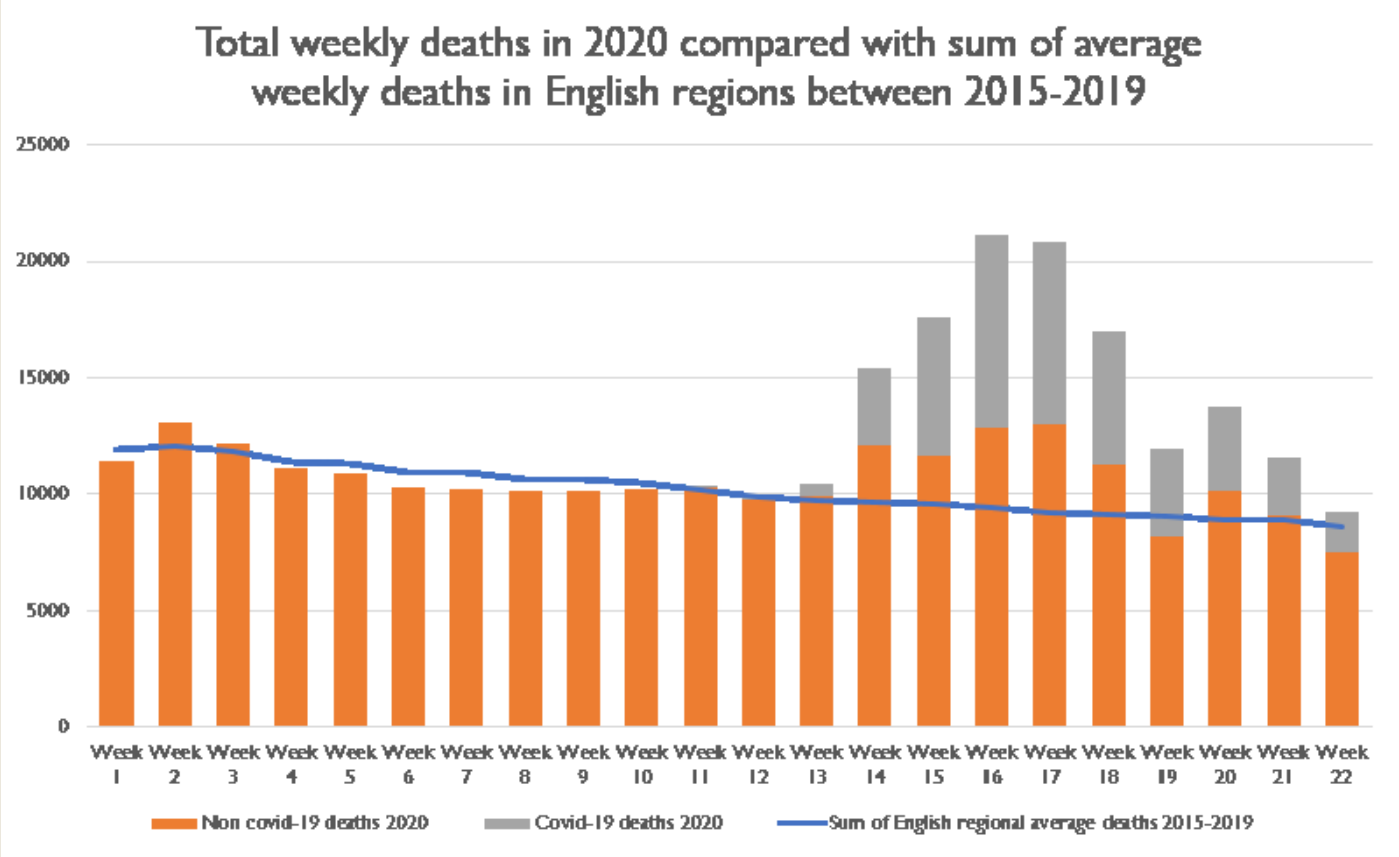
Total weekly deaths in 2020 compared with sum of average weekly deaths in English regions between 2015-2019

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

Data notes

Slides 5-7 – For this report we carried out an initial review of feedback and local support plans from 18 out of 33 representatives, covering local stakeholder organisations from hospitals, primary care and adult social care.

Slide 13 – This data is the most accurate data we are able to produce at this point but it has a number of limitations:

- It is not mandatory for providers to tell us if someone has a learning disability when submitting a death notification.

- We could not extract detailed data, including whether or not the person who died had a learning disability, from a small number (around 4%) of the forms we included in this analysis due to the way the information was provided to us – i.e. illegible handwritten forms.

- Despite removing a large number of duplicates from this data, we cannot guarantee that every duplicate has been removed.

- It does not account for those detained under the Mental Health Act – see slides 15 and 29.

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.