CareQuality Commission

COVID-19 INSIGHT

Issue 4
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STATE OF CARE

COVID INSIGHT

INFECTION PREVENTION AND CONTROL

Acute hospitals

To review infection prevention and control (IPC) in acute hospitals, we analysed the outcomes of the Emergency Support Framework calls between our inspectors and all acute and specialist trusts. These calls discussed each trust's 'Board Assurance Framework' to identify how the trust was assuring itself of good IPC across 11 key areas.

Broadly they said they had high assurance across all the areas (figure 1).
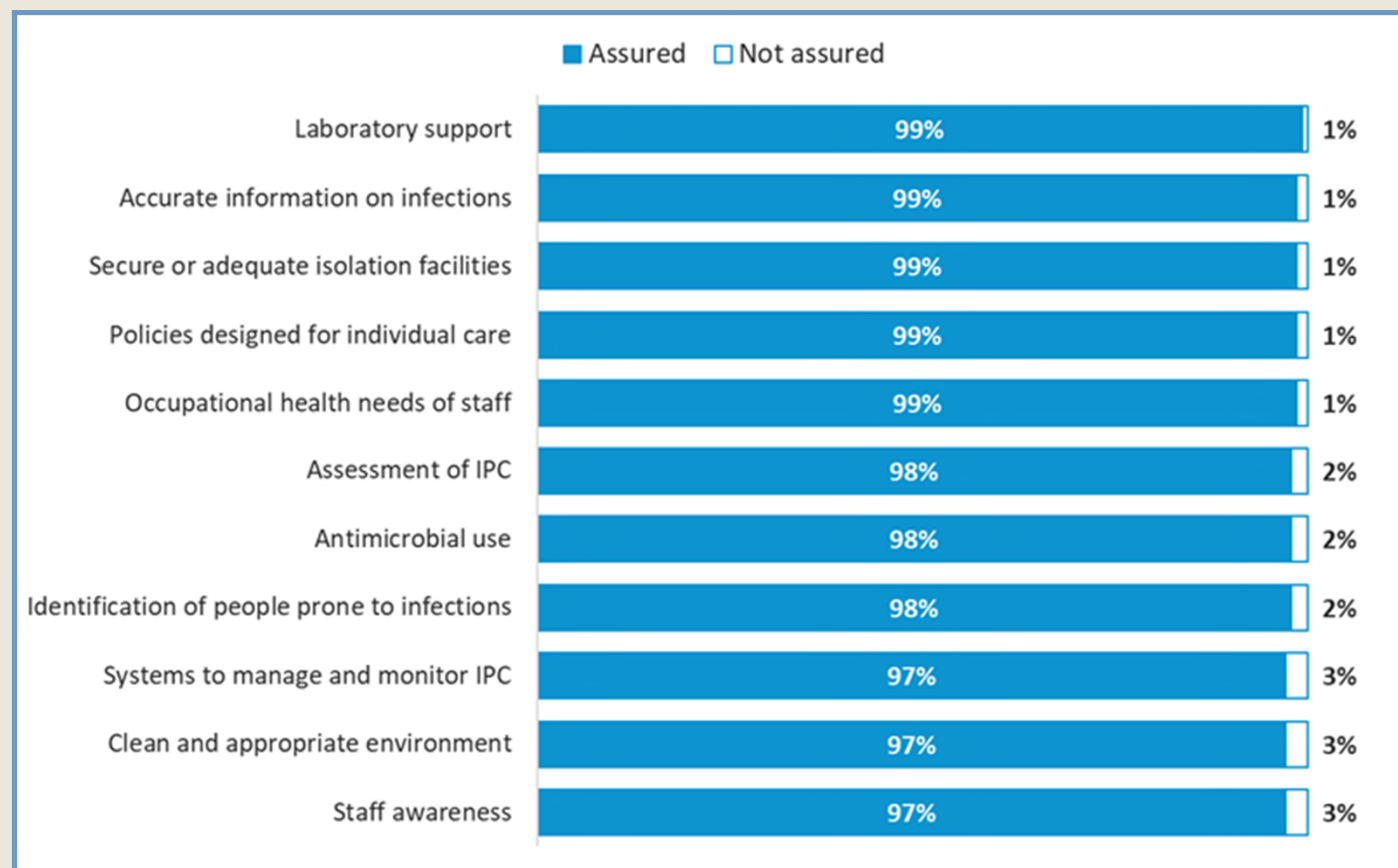

Figure 1: Percentage of NHS acute trusts assured, by infection prevention and control question

Source: Emergency Support Framework responses from 138 NHS acute trusts across all questions. Responses from the remaining four trusts were incomplete at the time of reporting (15 September).

Gaps in trust assurance

While most trusts assured themselves that they were managing IPC systems and mitigating risks, there were some examples of where the systems and procedures were ineffective.

There were a few trusts with ineffective systems to manage and monitor IPC. Robust audits were not always taking place during the peak of the pandemic, including audits of personal protective equipment (PPE), waste disposal and the screening of other healthcare-associated infections. Where audits were taking place, there were a few examples of trusts not being able to show any learning from them.

Oversight of IPC training varied between trusts, meaning some trusts could not always be assured that staff had been adequately trained in IPC procedures. Non-clinical and non-ward staff were not always provided with COVID-19-specific training or guidance. In one example, the trust was unaware of the IPC training or guidance that contractors had received or whether any had been provided at all.

Some trusts had challenges that limited their ability to isolate and cohort COVID-19-positive patients. Insufficient side room capacity was commonly reported, particularly for trusts with older estates, as was limited ventilation. Trusts that were able to provide assurance, despite an older estate, had carried out robust risk assessments and put mitigation plans in place, for example using pop-up isolation facilities, repurposing other areas of the hospital for COVID-19 patients and adding doors to the entrance of bays.

Good practice and innovation

Trusts reporting that good systems were in place to respond well to the pandemic said that they implemented gold, silver and bronze commands to provide good governance and oversight. While some trusts suspended audits during the pandemic, others maintained these throughout, especially around antimicrobial stewardship, cleaning and hand hygiene. This enabled board assurance.

Trusts had implemented front door triage and streaming systems to categorise patients, often into RAG-rated systems (red, amber, green) to ensure their safe movement throughout the hospital, alongside new swabbing protocols. Relevant polices had been reviewed, updated and were well communicated among staff, patients and communities. Most cleaning regimes had been reviewed, with increased targeting in high-risk areas.

Where trusts told us about their good practice and innovation during the pandemic, certain topics stood out.

IPC teams

Where trusts had established well-staffed IPC teams, these held a vital role intrinsic to delivering good IPC. IPC nurses and chief nurses were available at all times. Some trusts had put extra resource in place (creating seconded posts) and included experts such as microbiologists and virologists. One trust had recruited an additional 24 IPC safety officers, which included previous cabin crew because of their expertise in safety and customer care.

IPC teams led in a range of key areas:

- risk assessments

- identifying and communicating changes in guidance

- identifying issues on wards and putting mitigations in place

- carrying out audits

- acting as the link between ward and board

- helping to ensure compliance by being visible on wards and advising around PPE, fit testing and hand hygiene

- training cleaning staff, including cleaning contractors.

"If areas of learning are identified, the IPC team will immediately attend to the ward and organise education for the staff."

PPE

PPE was a challenging area throughout the height of the pandemic. Issues included the pace of change of PPE guidance and the challenge of there being multiple suppliers of PPE – for example, different types of mask needing separate fit testing. However, there were strong examples of partnership working in response. Trusts supported each other with supplies and some of them worked with the fire service to help with fit testing. 'PPE safety officers', 'COVID champions' and 'donning and doffing buddies and videos' were used to keep people up-to-date and ensure compliance.

Where we were told of good practice, trusts had got to grips with the pace of change in PPE guidance and ensured this was understood and well communicated throughout the trust.

Some trusts came up with creative solutions to PPE challenges, for example working with volunteers to produce more than 27,000 gowns, and manufacturing their own visors, hand gel and dialysis fluid when there had been a national shortage.

"The trust deployed a roving team to deliver in-situ training on PPE. When national shortages of PPE impacted supply, it implemented a roving fit testing team."

Wellbeing of staff

Wellbeing initiatives for staff have included providing quiet spaces, called 'wobble rooms', for staff to take time out.

There were examples of having tissue viability nurses and dermatology support on hand for staff suffering skin damage due to the use of PPE. One trust had a psychologist based in critical care that staff members could access, as well as a psychologist doing daily ward rounds. Trusts told us that they provided hotel accommodation for staff so they could continue to work while allowing people to shield in their households.

Efforts have been made to keep in touch with shielding staff and those on maternity leave so they still felt part of teams and were kept up-to-date. Most trusts had put in place daily communication bulletins for staff or had improved existing communication methods.

"The trust was running 'keeping in touch days' in local parks for staff on maternity leave, which included their families, to keep up-to-date in a safe environment."

Supporting patients and visitors

Visiting has been hugely restricted throughout the pandemic, so trusts have set up a range of systems for people to keep in touch with their loved ones, while preventing infection. This included using tablet computers on every ward, and providing drop-off services so families could leave patients the things they may need. One trust increased the number of volunteers they had to help patients with online communication, while another identified patients who did not have any relatives and nominated a member of staff to write them letters. Another employed staff to sit with dying patients to make sure no one died alone.

As restrictions have been lifted and some visiting resumed, this has taken place in outside spaces or by appointment. Visitors are given information on websites and through clear signage, and meet and greet services ensure masks are worn and social distancing is maintained. For example, one trust employs 'pandemic receptionists' to ask screening questions and provide PPE.

Meeting demand

Trusts reported high levels of activity to redeploy staff and repurpose spaces to meet the changing demands on the service. Staff were moved to work in high demand areas, such as critical care, or worked to support testing and tracing and PPE supply.

Wards were changed to provide additional intensive therapy unit beds or to support cohorting and social distancing measures. In one example the trust converted their sexual health clinics into testing facilities. Another worked in partnership to use the local football stadium to house antenatal clinics, pregnancy scanning and a maternal day unit, so that these services could be provided outside of the hospital environment.

System collaboration

The pandemic represented a shared goal and saw trusts unite with local systems to ensure a coordinated response, which they committed to maintain beyond the emergency. There were positive examples of routine collaboration between neighbouring trusts, local authorities, clinical commissioning groups, primary care and care homes to ensure joint working and consistent messaging. For example, trusts in the North West worked together to develop a consistent visiting policy.

> "The trust's command and control structure worked particularly well both for the trust and in the local system, with representation from the ambulance service, care homes and community teams."

There were examples of good support to care homes, including support with PPE, testing and training. For example, to avoid hospital attendance, one trust provided therapy teams to care homes, supported by fortnightly calls and IPC training and supplies.

One trust supported their local prison with remote outpatient appointments and provision of some PPE, and helped them to develop their response in the event of a COVID-19 outbreak.

Care homes

During August, we carried out a special programme of inspections of infection prevention and control (IPC) in 300 care homes selected as potential examples of where IPC was being done well. We have been encouraged by the findings so far:

- Very few of these services turned out not to be managing well and requiring a fuller inspection.

- Across the 300 inspections, we've had more than 90% assurance across all the elements we were looking at.

- Feedback from the initial inspections has identified good practice examples, such as these:

"Staff had organised an Eid dinner via [video conference] for a person who had always shared this with their family. Staff decorated the room and played the video link through a large television. The manager told us this made the person feel they were sitting at the table with their family."

"Staff bought face coverings to suit people's personality and interests to encourage their use. For example, one person who is very keen on public transport has a mask with buses on it. Another person who loves anything military has been given a camouflage mask."

"Staff introduced new indoor activities, such as themed nights. Providers invested in new equipment for the garden to keep people engaged, for example a large outdoor above-ground swimming pool. Resident surveys are completed regularly to monitor people's wellbeing and assess their needs during the pandemic."

We will report fully on the findings of this programme in November.

The following section focuses on the evidence we collected during 59 high-risk inspections of care homes during the first half of August 2020. These were inspections carried out specifically in response to concerns about safety and quality, or to feedback from staff or people using services and their families.

During these inspections we reviewed how well staff and people living in care homes are protected by IPC, looking at assurance overall and across eight key areas.

Despite these being services where we may have had concerns about quality, we were assured or somewhat assured in all areas of good IPC in the majority of services (figure 2). The findings allow us to review the two areas where we had greatest assurance, in safe admission and IPC for visitors, as well as the two areas where we had least assurance, IPC policy and effective use of PPE. This highlights areas of relative strength, as well as the gaps and barriers most commonly missed by services, which providers can use to reflect on and improve their practice.

Where CQC has been assured that people are protected, we will not need to take any further action. However, in cases where we have concerns, we can take a range of regulatory action, including issuing lower-level requirement notices, through to warning notices and, in cases of significant concern, placing conditions on a provider's registration.

Figure 2: Percentage of care homes assured, by infection prevention and control question
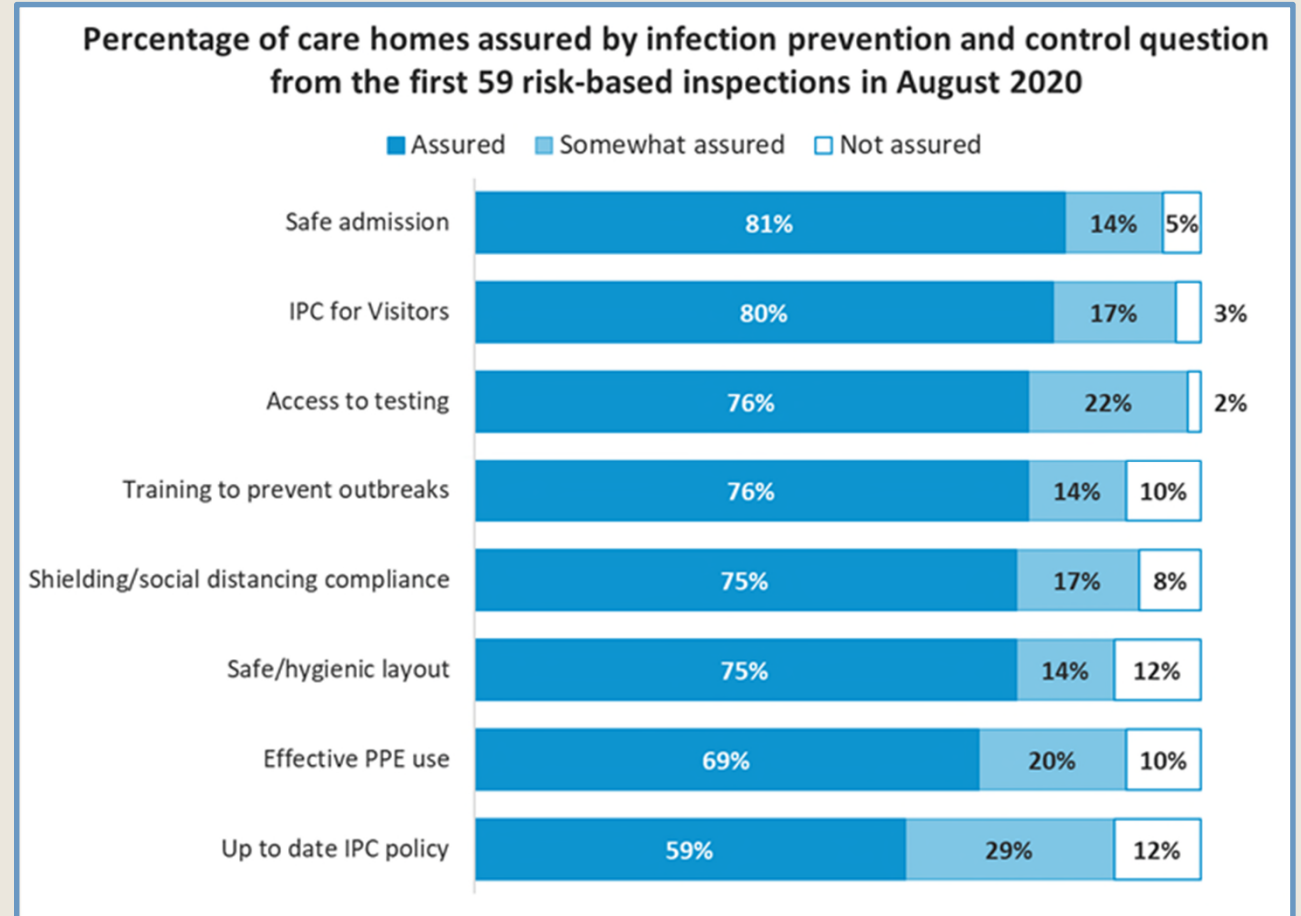
Source: Responses from 59 risk-based care home inspections across all questions.

Safe admission

We were assured in more than four-fifths of care homes in our risk-based inspections that the homes were following the guidance in relation to safe admissions. This included carrying out tests to make sure they knew people's COVID-19 status. Some care homes would only accept people from hospital with a negative test. Others had procedures in place to safely accommodate people while they awaited test results. This required the person to be cared for in isolation until a negative test was obtained, by allocated staff who always wore appropriate PPE.

"Current measures in place are person is escorted to their bedroom – set up a PPE station outside their room – clothes are labelled so they are left for 72 hours. Staff will be in full PPE."

Examples were provided to demonstrate how all new admissions had isolated for 14 days, including those returning from a hospital visit. Care homes carried out routine monitoring throughout the isolation period. Other homes routinely monitored all the people who lived there and had procedures in place should they identify concerns. A few services had a 'no new admissions' policy in place.

There was some evidence to suggest services had considered the Mental Capacity Act, Deprivation of Liberty Safeguards and best interest decisions around COVID-19 and isolation for those who lacked capacity.

IPC for visitors

We were assured in four-fifths of care homes in our risk-based inspections that all types of visitors were prevented from catching and spreading infection.

Care homes' approaches to visiting should be appropriate for the service and consider and meet the needs of people living in them. Care homes we inspected had different visiting policies, ranging from a few that still had a 'no visitors' policy, those that were facilitating window or garden visits, through to a few that were now allowing essential visitors into the home. Inspectors were assured, however, that the different approaches taken by these homes were appropriate for the service and the people living in it, and managed well.

> "For one person with a learning disability there are special arrangements for a relative to visit, which greatly relieves his anxiety. A special room is set aside for them and PPE is worn at all times."

Where no visitors were allowed into the home, there was usually an exception for people receiving end of life care.

When visitors entered a care home there were often screening procedures in place, such as a questionnaire or declaration and temperature checks. PPE was required and, in most cases, provided if the visitor did not have their own. Handwashing facilities and hand sanitiser were available, and their use prompted by staff. Inspectors saw good signage at the entrance to care homes and reminders throughout the home.

It was most common for visits to be supported in the garden, which could be accessed without entering the care home. If the weather was poor some services had identified indoor spaces, which again could be accessed without entering the main body of the home. Visitors were required to wear face masks and maintain a safe social distance. Contact with staff members was limited.

Some care homes allowed visits only at open windows, by appointment to avoid crowding. Another service allowed relatives to come in their car and see their relative or friend through the open car window. Care homes had written to families to explain their visiting policy and the majority had alternatives to face-to-face visiting. Inspectors described how people living in the care home were supported to contact their relatives and friends by video.

Visits tended to be by appointment only, restricted to one visitor at a time and staggered to allow cleaning between visits. Inspectors were assured by seeing the policy in action.

> "Provider had offered [app] to people using services' families free of charge during COVID-19... to keep them up to speed with their relative's care, daily activities and wellbeing. Staff take photos and videos of the person and send them to families, who can respond back. The home also bought two portals to facilitate visual, real-time interaction between people using services and their families."

IPC policy

We found the lowest level of assurance (59%) against the question, "Is your IPC policy up-to-date and implemented effectively to prevent and control infection?". Inspectors reviewed each care home's policy and interviewed staff to understand whether it had been implemented effectively. We found examples of IPC policies that were out-of-date. Some had been updated early on in the COVID-19 outbreak but had not been amended since and so contained out-of-date information. This posed a risk to the staff and people who live in the care home. Others had not been updated since 2019.

Another barrier to effective infection prevention control was limited, or a lack of, contingency planning. One care home had completed a plan, but it only covered the hot weather and did not include preparations for autumn and winter.

We also found examples of care homes that lacked risk assessments for people from Black and minority ethnic groups and others who were at higher risk due to the pandemic, as well as for staff members. Our inspectors also found that risk assessments for these groups had not been actioned.

Effective use of PPE

The second lowest area of assurance in these risk-based inspections (69%) was whether services used personal protective equipment (PPE) effectively to safeguard staff and people using services. In care homes where PPE was not worn at all or not worn correctly, IPC was compromised. This was seen in different areas of the homes, such as during break times, while handling or serving food, and when in close proximity with the people they provided care for. There were instances where it was only one member of staff who was not using PPE correctly, through to no consistency with its use among different staff members.

In one service we found staff were not changing masks due to limited supplies. They said that PPE supplies were restricted and they had to request supplies throughout the shift because they were locked away, with only the manager and lead domestic having access.

PPE should be stored safely in a clean, dry area to prevent contamination.[1] We observed care homes that lacked a specific area for donning and doffing PPE, which could lead to contamination of other surfaces, and PPE that was stored uncovered.

[1] https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/standard-infection-prevention-control-precautions-sicpsall-pathways

"There are no specific donning and doffing stations. Staff use the staff toilet to do this, or don and doff in corridors where the aprons and gloves are kept, and not always covered to prevent cross infection. Observed aprons hanging over towel rails – not covered. Saw much of the PPE not covered."

Another barrier to effective infection prevention control was PPE that was not disposed of correctly as healthcare waste. We also found that appropriate bags for the disposal of used PPE were not always available. Inspectors saw PPE in regular waste bins that had not been sealed and bagged separately.

GP surgeries

This section highlights some of the infection prevention and control (IPC) measures taken by GP surgeries in response to the COVID-19 pandemic. The findings are drawn from conversations with 43 GP surgeries to understand what they have done, as well as good practice they want to share and challenges they have faced.

PPE and cleaning procedures

Respondents were generally positive about the use of personal protective equipment (PPE), telling us that staff and patients or visitors were wearing appropriate PPE and were practising regular handwashing. Practices reported that people complied with wearing face coverings and clinical staff donned gloves, visors and full scrubs where appropriate. These were appropriately changed between patients.

They told us that staff training and access to PPE for clinicians had improved. For example, disposable aprons and gloves were stored around the service, and 'grab-bags' of PPE were readily available for home visits.

While PPE supplies were being regularly audited and availability had generally improved, some services had experienced difficulties in obtaining adequate stock in a timely manner, especially during the early stages of the pandemic.

GPs also told us that hygiene and cleanliness had improved as a result of the pandemic. Cleaning schedules were widely enhanced, and staff were proactive, allowing themselves enough time between patients to disinfect workstations and rooms.

Social distancing and minimising patient contact

GP practices were able to reduce the number of face-to-face consultations, including home-visits, through the use of remote triaging. Video and phone consultations, and ordering prescriptions direct to pharmacies, played an important role in reducing footfall in services, meaning that only patients with the greatest need were attending appointments in person.

A number of services told us that they were taking patients' temperatures on arrival and screening for COVID-19 symptoms. They also introduced 'hot zones', or designated areas of the service to see patients with suspected symptoms. They said this has helped to contain potential infection, identify where and when full PPE should be worn, and target deep cleaning.

Services commonly adopted a 'locked door policy' to minimise the number of people in a service at any one time. The use of intercom, chaperoning and one-way systems further facilitated social distancing and limited the time spent in the building. Perspex screens were often fitted in reception areas, and waiting rooms were reconfigured to allow for space between people. One practice converted their car park into a temporary waiting area and another operated a system where visitors could be collected from their cars.

The GP practices we spoke to said they have implemented some innovative ways to reduce the risk of infection for people who use services. For example, we heard that some services have staggered clinic times, seeing people who are most vulnerable early in the morning, and holding 'one-stop' clinics for people with more complex/co-morbid conditions such as diabetes.

We heard of other cases where services have worked in new ways to best respond to people's needs during the pandemic. For example, some services have introduced welfare calls with certain patients to offer ongoing remote support. Other GP practices have worked with other agencies to best respond to local needs.

"The homeless community were particularly vulnerable to infection and without anywhere to quarantine. Initially we closed the car park and bought tents in for symptomatic patients until we were able to find some accommodation. But then when national funding arrived, we worked with the council to set up 'care and protect' hotels; one of these is always a symptomatic patient site, where patients can be triaged, tested and quarantined. We're still supporting all these sites with daily GP and nurse rounds."

These changes in the way GP practices are working have not come without cost. For example, we were told that some staff and patients have felt increased levels of stress and frustration with remote care.

There were also some concerns that some non-urgent patients who require procedures like routine screening and immunisation are not being seen in a timely manner because they are worried about contracting COVID-19 during a visit to the surgery, or because they think their GP could lack capacity to see them. This may be having implications on patients' health.

Guidance/communication around COVID-19

There have been mixed messages around the clarity and effectiveness of communication around national IPC guidance. Respondents raised concerns that messages, particularly in the early stages of the pandemic, were inconsistent and confusing.

However, they also told us that communication around IPC practice within services and with local stakeholders, such as clinical commissioning groups and local authorities, has been good, with many examples of daily meetings.

"Working closely with the other GP practice and services located within the health centre ensures a consistent message regarding infection prevention and is sent to all patients entering the centre."

Communication with patients was viewed as positive, with people being kept informed via text messages, social media alerts and websites. Many practices said they had made a great effort to regularly contact patients that were hard to reach and those with chronic and mental health conditions, to ensure they were fully informed of the implications of the COVID-19 pandemic on their ongoing care.

IPC audits

The majority of respondents told us that they had carried out IPC audits before or as a result of the pandemic, making changes and improvements to mitigate the risks identified. This often meant that cleaning schedules were enhanced, non-wipeable furniture was replaced in practices, and IPC record keeping improved. Some services told us that they are now carrying out more regular IPC audits to monitor and identify issues, such as stock of PPE, to ensure they are continuing to maintain as safe an environment as possible.

COVID INSIGHT

PROVIDER COLLABORATION REVIEWS

As we reported in previous issues of our COVID-19 Insight report, in July and August we rapidly mobilised teams to carry out reviews in 11 different English localities, to find out how care providers have worked together in response to the pandemic. We wanted to find out how providers have collaborated to improve care for older people, who are most at risk of COVID-19.

These Provider Collaboration Reviews (PCRs) have been a very useful experience for everyone involved, collating the best of innovation across systems under pressure and sharing learning. We aim to drive system, regional and national learning and improvement, and there has been significant support for the reviews from the providers we have engaged with.

The 11 reviews focused on the interface between health and social care for people aged 65 and over. In each system we carried out a deep dive review of a local authority area and then fed this information back to the Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) leads. To get a comprehensive picture, we engaged with a wide variety of organisations locally, including primary care networks, local medical committees, adult social care providers, directors of social services, NHS trusts and independent hospitals, urgent care providers, NHS 111, community care providers, integrated care teams, urgent dental services, local Healthwatch and other organisations that represent those who use services, their families and carers.

Tackling the issues related to COVID-19 has required effective strategic planning, good relationships and practical, deliverable solutions. Some localities appear to have fared better than others, depending on the strength of previously established working relationships. Learning lessons now is especially important, so that providers can be prepared for any second peak of the virus and times of pressure on the system, such as winter.

We will publish our complete PCR findings in October, but we can already see some clear messages emerging. The reviews have brought into focus some themes and learning that can be used to inform planning for this winter and any possible resurgence of COVID-19. So far, we can see:

- Understanding local population needs, including cultural differences, was especially important.

- The quality of existing relationships between local providers played a major role in the coordination and delivery of joined-up health and social care services that meet the needs of the local population.

- There was an increased focus on shared planning and system wide governance, but pre-existing plans may not have been fit for purpose to cope with COVID-19.

- Staff across health and social care worked above and beyond their roles – we spoke to dedicated, passionate staff, committed to supporting everyone including people aged 65 and over.

- There was a range of initiatives to ensure the safety and wellbeing of staff working both on the front line and in support services.

- The move to digital working accelerated and impacted on access to services, and more generally digital solutions supported data-sharing and communication between health and social care partners and within health and social care organisations.

The individual reviews have helped to identify where provider collaboration has worked well to the benefit of local people. Sharing that learning will help drive further improvements across systems. Findings of the reviews were fed back to each ICS/STP via a high-level presentation that they could share with the providers across their system.

We will report our full findings from these first 11 PCRs in our State of Care 2019/20 report to Parliament in October 2020, considering in more detail the positive outcomes from good collaborations we have seen, and examining barriers to better collaboration. By the end of 2020/21 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, ensuring we consider how providers are collaborating to provide high-quality, safe care across a variety of pathways and population groups. We will also look at how providers are re-establishing services and pathways in local areas.

Good practice examples

Our reviews have been focused on four lines of enquiry. In advance of our full report, we want to share here some of the examples of collaborative working that we found.

People at the centre

As part of the PCR process, we wanted to see how providers had collaborated to ensure that people aged 65 and over were seen at the right place at the right time. We wanted to see how providers had worked together to understand the local population and to ensure care pathways were developed to keep people safe and how they had worked to ensure people received effective, responsive care.

During the reviews we have found examples where providers had worked collaboratively to ensure people were well supported during COVID-19.

In our Devon STP PCR, we were told about support for bereaved people through a local hospice in Plymouth. This approach meant that other providers could be assured people were getting the support they needed while dealing with other aspects of the pandemic.

Support for bereaved people – Devon STP

... In 2018, Plymouth was awarded compassionate city status by Public Health Palliative Care International – the first city in England to be named as such. This was following a conference organised in the city by St Luke's Hospice with delegates from across many directorates and organisations. The compassionate city work evolved from that conference and has led by St Luke's Hospice to the create of a network of over 90 individuals and organisations signed up to the charter formally adopted by Plymouth City Council. Part of being a compassionate city is recognising that care for one another at times of crisis and loss is everyone's responsibility. The hospice has trained and established 72 end of life champions in local care homes in Plymouth.

During the COVID-19 pandemic, St Luke's Hospice realised its compassionate friends' cafes, which had been set up to support those who were bereaved or on that road, would not be able to continue. It therefore set up a compassionate friends' telephone service and staffed this with trained people able to offer support for those who had been or were close to being bereaved. There was also a single point of contact telephone line for those who needed it.

People were signposted to services and networks that could support them or offered time to talk and be listened to. There were then regular calls to those who needed them to ensure the bereaved did not feel isolated. Links were made back through the support of the local public health team if other support was needed, such as access to food banks, income support and medication deliveries.

During the pandemic, the whole approach to death and the dying, and those who were left behind, has been underpinned by the multi-agency work to be a compassionate city. The local authority, adult social care, NHS trusts, the clinical commissioning group and public health all commented on the work of the St Luke's Hospice during the pandemic and its holistic care during difficult circumstances for many families and friends.

Hospital discharge wellbeing – Sussex Health and Care Partnership ICS

Healthwatch Brighton and Hove provides the Hospital Discharge Wellbeing Project in partnership with Brighton and Hove City Council, Brighton and Sussex University Hospitals NHS Trust and the Sussex Health and Care Partnership (the integrated care system).

The project started on 7 April 2020 as part of the response to COVID-19. The service is offered to people discharged from hospital including those aged 65 and over, not just those with COVID-19 or related conditions.

By the end of May 2020, a total of 350 people had been referred and the Brighton and Hove Healthwatch team now have 60 to 80 referrals a week. People are phoned by Healthwatch trained volunteers within a few days of discharge from hospital, usually in the first week to signpost and assist people to find the help they need.

Forty-three per cent of people needed some additional support and 35% had issues or questions related to their hospital discharge. Most discharges were handled well, and in the 350 referrals, there were three discharges where significant, but avoidable, errors emerged. These were all resolved promptly and in a spirit of putting the person first.

This Healthwatch Brighton and Hove project has demonstrated that where there is a willingness, hospitals, social care and volunteers can act together quickly to help local people. This project was funded for six months as part of the COVID-19 response. The team are now extending the service to help check on people using home care services, particularly those whose home care packages have reduced over the COVID-19 period.

Understanding the local population – Frimley Health and Care ICS

Frimley Health and Care ICS covers the area of Slough. At the very beginning of the crisis, through a primary care initiative working with the local council, the mosques across Slough were closed a week earlier than rest of country.

A local GP had recognised that Friday prayers could potentially spread the risk of contracting the virus. A significant proportion of the Muslim population in the area are aged 65 or over, with the impact of this initiative meaning that potentially a significant proportion of older people in the area were not exposed to the virus.

The Frimley system also instigated female only COVID-19 testing sites as they recognised that local Muslim women would be disenfranchised about attending if male staff worked at the sites. This initiative ensured that this group of the population could access testing in a culturally sensitive way.

Local providers worked closely with the voluntary sector for food packages to be delivered to vulnerable people that were culturally sensitive.

System working

As part of the process we looked to see how leaders and managers within providers had collaborated to ensure well planned service delivery across their system. We also looked at what providers had learnt through the pandemic and how they had shared this learning.

During the PCRs we were told about a range of new governance or command and control structures that were created in response to the pandemic. Collaboration between system leaders was facilitated by the creation of cells or groups – linked to the local resilience forum or similar governance structures – to plan and deliver services across the system for specific pathways of care or population groups, including those aged 65 and over.

Local resilience forums – Lincolnshire STP

The STP lead felt it was proven to be the right way to work, bringing health and social care together. Cells included one main provider of each type. They had cells for palliative care (set up by the council), primary care, pharmacy and prescribing, recovery, patient and discharge, volunteering and community response (to ensure there is a route for feedback and that pathways are safe). They felt these cells enabled clear escalation routes and sharing of information and ideas. Through this effective way of system working, leaders made an early decision to not discharge patients to care homes unless their COVID status was known.

Effectiveness of established relationships – Frimley Health and Care ICS

We were told that Frimley ICS was a well-established system with existing governance structures in place. System leaders met regularly at a variety of meetings before the pandemic, and these meetings were used during the emergency period, so there was no need to create new systems and processes or ways of sharing information.

We spoke with people from across the system, including the chief executives of the local authority in Slough and the acute trust, who told us that these strong pre-existing systems and relationships assisted with the response to COVID-19.

The chief executive of the local authority told us that, once they had received feedback from individual adult social care providers about difficulties on discharge of people from hospital, they spoke directly with the chief executive of the trust.

The conversation was described as helpful and productive due to the constructive feedback. It was recognised that system partners were able to be honest, open and work and pace as they all respected and trusted one another before the pandemic.

Workforce capacity and capability

We looked at how staffing across health and social care has been impacted during the pandemic – how providers had worked together across systems to ensure staffing capacity. We considered how 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. We have also looked at how providers worked together to keep staff safe.

Staff deployment and wellbeing – Bedfordshire, Luton and Milton Keynes ICS

Across the Bedfordshire, Luton and Milton Keynes (BLMK) ICS review, we were told that there was a shared strategy to ensure there was a sufficient number of staff with the right skills across health and care services.

East of England Workforce and Human Resource Cell supported workforce modelling and planning for surge during the COVID-19. They identified skills and workforce requirements and shortages at ICS level and shared these with Bedford, Luton and Milton Keynes Human Resource Directors network.

System surge plans reflected deployment requirements across the system and were discussed at Bedfordshire Local Health and Social Care Cell and tactical meetings for the system. There were also weekly calls with human resource directors from across the system to discuss all things workforce related. A BLMK ICS workforce strategy was established and there were agreed workstreams around workforce modelling and supply.

We were also told how the ICS had worked with providers across the system to keep staff safe.

A mutual aid agreement had been put in place that extended across NHS and to social care, particularly to support care homes. Individual risk assessments and adjustments were made to the working environment, with those at very high risk/shielded being moved to working at home with immediate effect and/or supplied with appropriate PPE.

We were told that senior leadership communicated with staff on a regular basis though virtual meetings, individual check-in calls, communication cascades and health and wellbeing support offers – including national and local initiatives such as talking therapies, virtual sessions for mindfulness, and pilates. There were regular updates to all on infection protection and control (IPAC) measures across the health and care system and provision of IPAC training to all care homes.

Shared learning – North West London STP

To support patients in the community with the management of long-term conditions, the STP developed a COVID-19 learning forum that supported a wide range of clinicians to understand the impact on how to deliver safe and effective care remotely.

Led by primary care networks and specialists across secondary care, weekly webinars were developed on the rapidly changing disease, particularly focused on the tailored needs of primary care and the issues affecting patients in the community. There were 17 weekly sessions delivered with live questions and answers; 5,000 hours of training had been achieved, with more hours planned.

Attendees said that a range of high impact points were taken away from each session. There was effective access to specialists including those in diabetes, respiratory and musculoskeletal, which was critical and helped to change working practices for the benefit of patients who couldn't be seen in hospital during the early part of the pandemic.

Care Home frailty pharmacist – Lancashire and South Cumbria ICS

The trust (Morecambe Bay) appointed a care home frailty pharmacist to identify patients coming into hospital from care homes and those being discharged from hospital to care homes. They implemented a post-discharge service to care homes – the frailty pharmacist followed up patients after discharge to deal with medicines queries and promote safer transfer of care. Improved communication meant that they also picked up issues, other than medicines, that helped to signpost people in the right direction to resolve them.

Digital solutions and technology

We have looked specifically at initiatives related to digital and technology in responding to COVID-19 and the impact that they have had in terms of organisations working together.

Community hub – Sussex Health and Care ICS

In Brighton and Hove, the community hub brought together the local authority, health care providers and voluntary sector organisations to ensure that people at risk, such as older people and people who were shielding, got the support they needed. The community hub engaged with its partners to share data and matched all this up to build an app that gave a view of everyone on the list and what their needs were.

The local authority built a web-based system that updated daily with a list of people who were shielding – this could be filtered by specific needs through integrated datasets. They could filter the list to find out if the person was already known to a support organisation or statutory agency, such as housing, a voluntary sector organisation or the council foodbank, and overlay with maps of the city.

They then arranged which organisation was the best to maintain contact with the shielding or vulnerable person. They said that the "pandemic hurtled us towards developing the 'single point of contact' which was already in train, but this accelerated it". They quickly developed an app because at the start of the pandemic they realised they were all contacting the same person; the app allocated a leader for each shielding contact.

The IT system generated consistent templates for letters and emails so that all correspondence from local authority and voluntary sector organisations was consistent and accounted for communication needs, British Sign Language or different languages.

Having an app and the system being web-based meant that staff across the hub could access the information they needed remotely, within agreed governance arrangements. When out and about, having map overlays to the data meant staff could access information when they were out in the community supporting people and could focus on giving people the tailored support they needed when they needed it.

The IT system supported the local authority and voluntary organisations to make referrals to each other through online forms (for help with food, medicines, financial hardship and social care). The community hub was part of the local authority cell structure that included food, vulnerable people, communication and rough sleepers and fed into silver command through the deputy director of adult social services. The work on the single point of contact, and local authority and voluntary organisations working well together before the pandemic, meant the hub could be set up quickly and information governance issues were not a barrier or delay.
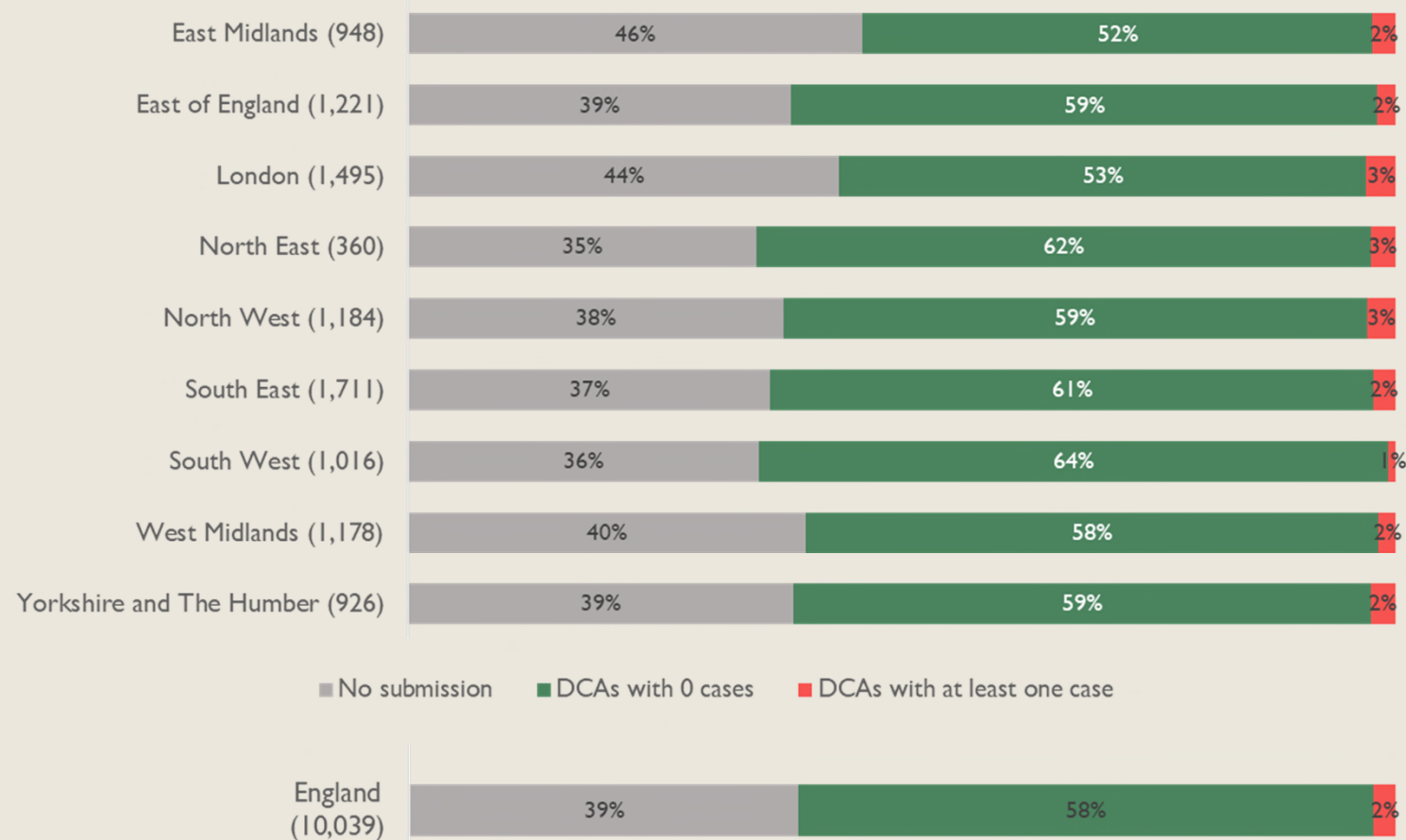
COVID INSIGHT

Homecare providers – prevalence of COVID-19

Percentage of DCAs by Covid-19 submission status, 30 August - 5 September

Region	No submission	DCAs with 0 cases	DCAs with at least one case
East Midlands (948)	46%	52%	2%
East of England (1,221)	39%	59%	2%
London (1,495)	44%	53%	3%
North East (360)	35%	62%	3%
North West (1,184)	38%	59%	3%
South East (1,711)	37%	61%	2%
South West (1,016)	36%	64%	1%
West Midlands (1,178)	40%	58%	2%
Yorkshire and The Humber (926)	39%	59%	2%
England (10,039)	39%	58%	2%

■ 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
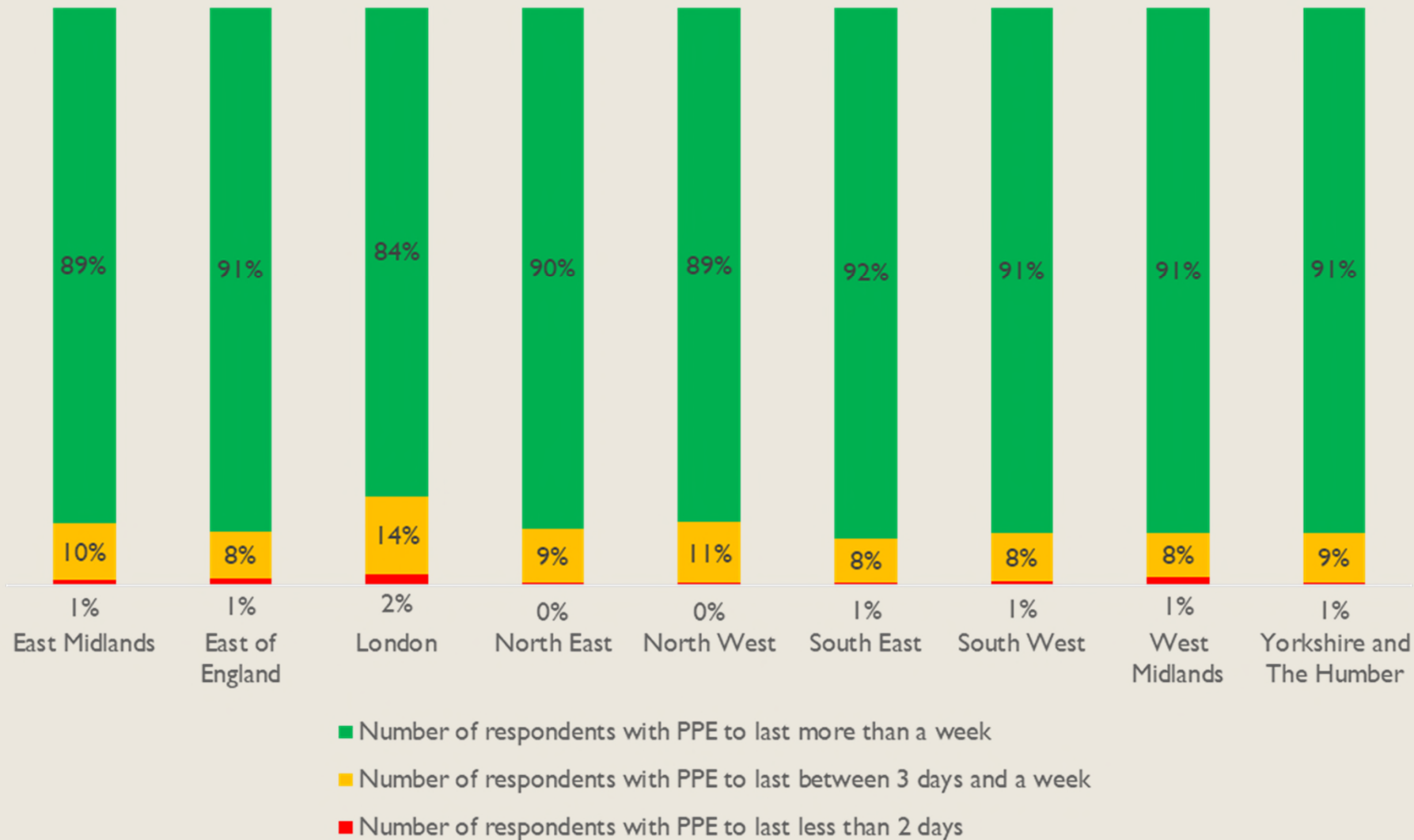
Region	PPE to last more than a week	PPE to last between 3 days and a week	PPE to last less than 2 days
East Midlands	89%	10%	1%
East of England	91%	8%	1%
London	84%	14%	2%
North East	90%	9%	0%
North West	89%	11%	0%
South East	92%	8%	1%
South West	91%	8%	1%
West Midlands	91%	8%	1%
Yorkshire and The Humber	91%	9%	1%

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

Source: CQC Domiciliary Care Agency Survey – latest response in period 30 August – 5 September inclusive

Homecare providers – staff absence

DCA staff who deliver care to people absent because of coronavirus

Region	Percentage
East Midlands	2%
East of England	2%
London	4%
North East	2%
North West	3%
South East	3%
South West	2%
West Midlands	3%
Yorkshire and The Humber	6%

Source: CQC Domiciliary Care Agency survey – latest response in period 30 August – 5 September inclusive. Includes staff who are self-isolating or have care commitments. England average: 3%.

Deaths notified by care homes

Care Home Covid-19 Deaths:
7 day moving average

— Number of death notifications involving Covid-19 occurring in care homes   ⋯⋯ 7 day moving average
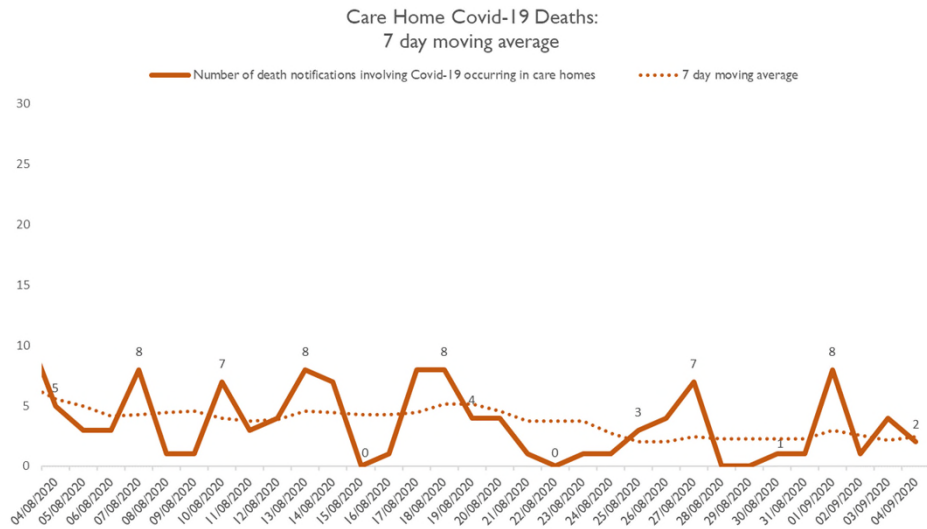
Source: CQC Death Notifications submitted 04/08/20 - 04/09/20

Number of notifications by care homes of deaths*
where COVID-19 is reported as suspected or
confirmed per 1,000 care home beds – 10 April
to 4 September 2020

Lowest 20%
nationally

Highest 20%
nationally
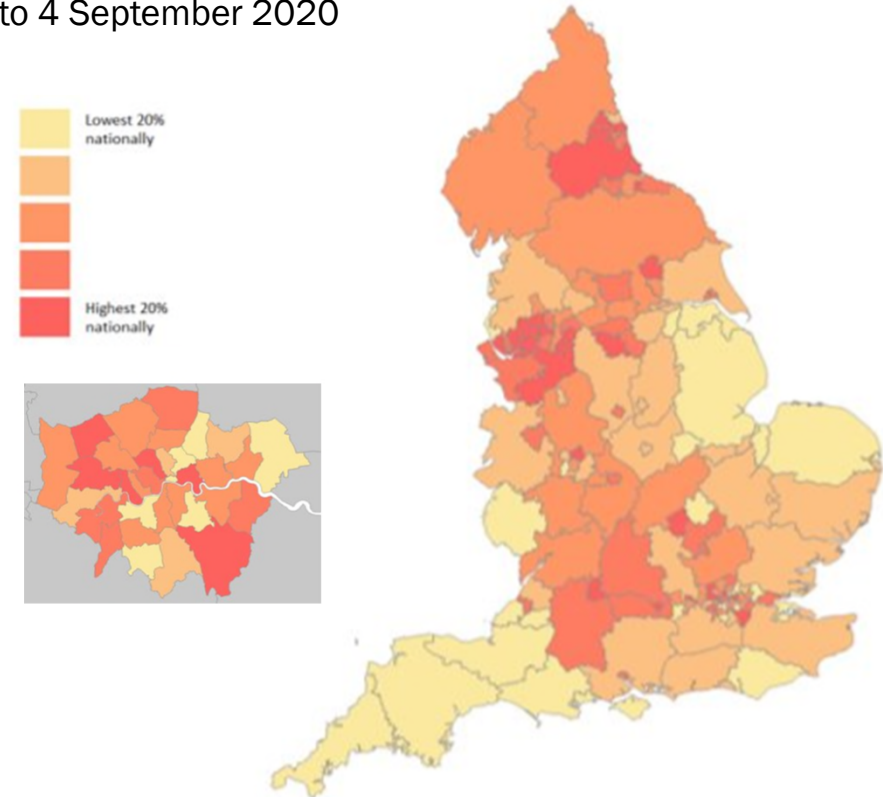
Source: CQC death of service user notifications from 10 April to 4 September 2020
For this map, notifications are of deaths no matter where the resident died, so it
includes deaths in hospitals and hospices

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 4 September 2020, we have been notified of 94 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.**

The chart shows the number of deaths by week of death. To date there have been no notifications of any COVID-19 related deaths that have occurred after 4 July; however, this could change due to time lags in providers submitting notifications and/or identifying that a particular death was COVID-19 related.

Weekly MHA deaths in England (COVID and non-COVID)
1 March to 4 September 2020

Week beginnning

COVID-19 deaths

Non COVID-19 deaths
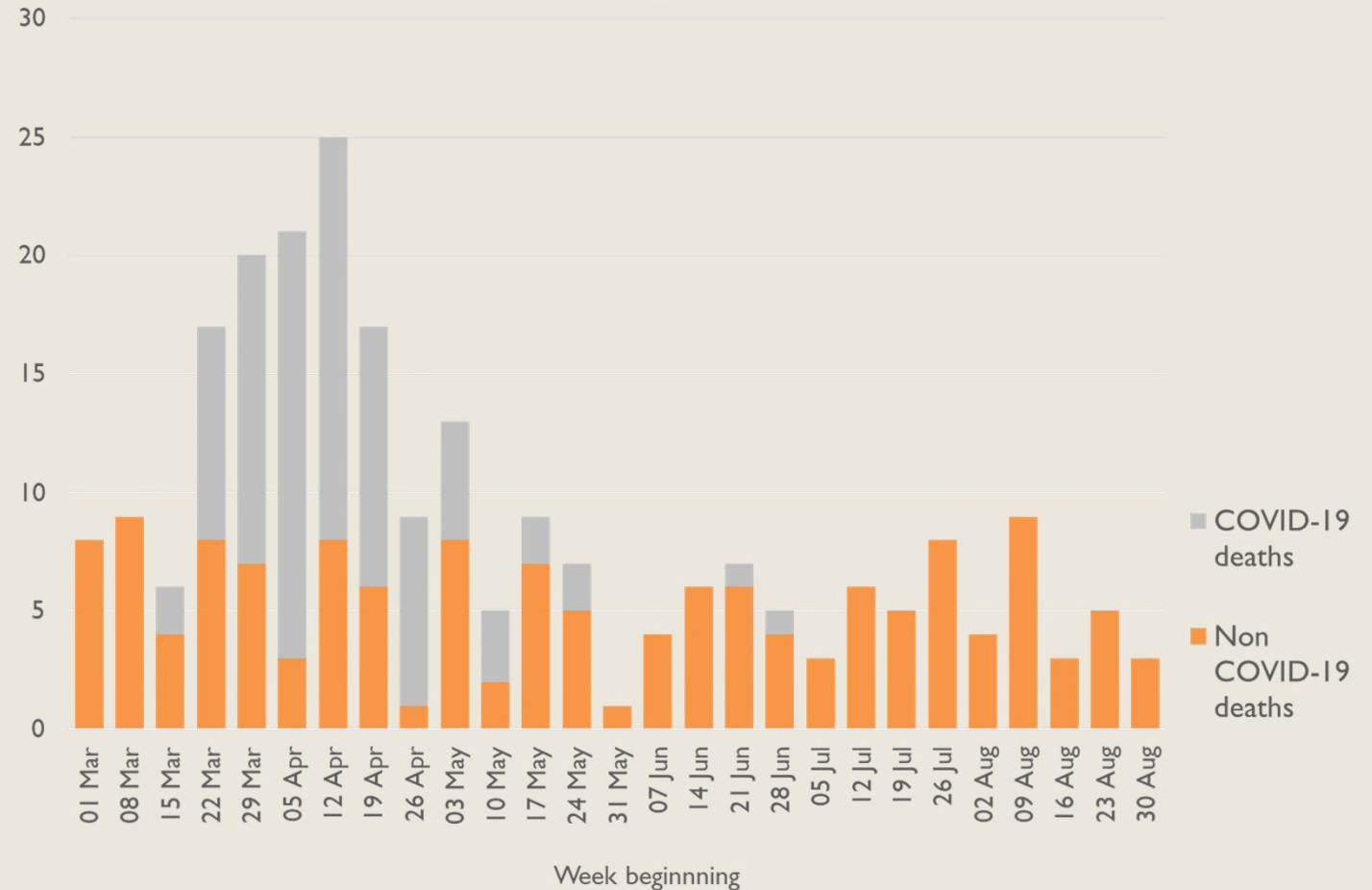
* Includes detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. 'Detained patients' also includes patients subject to holding powers such as s. 4, 5, 135 or 136, and patients recalled to hospital from CTO.
** Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers unrelated to new cases.

Deaths of people detained under the Mental Health Act

Of the 239 notifications from mental health providers in the 2020 period (covering all causes of death), 188 were from NHS organisations, of which 68 deaths were indicated as being COVID-19-related, and 51 were from independent providers, of which 26 deaths were COVID-19-related.

We have identified 13 detained patients whose deaths have been notified to us from 1 March to 4 September 2020 who had a learning disability and/or were autistic: the majority were not identified as related to confirmed or suspected COVID-19. Of these people, most also had a mental health diagnosis. Please note that these patients were identified both from a specific box being ticked on the notification form and a review of diagnoses in the free text of the form.

Deaths of people detained under the Mental Health Act

The table below shows all deaths of detained patients from 1 March to 4 September 2020, by age band and COVID-19 status.

Age band	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19	1	1	4	6	13	18	30	18	6	**97**
Not COVID-19	6	13	8	23	29	29	20	11	13	**152**
Total	**7**	**14**	**12**	**29**	**42**	**47**	**50**	**29**	**19**	**249**

Deaths of people detained under the Mental Health Act

The table below shows all deaths of detained patients from 1 March to 4 September 2020, by gender and COVID-19 status.

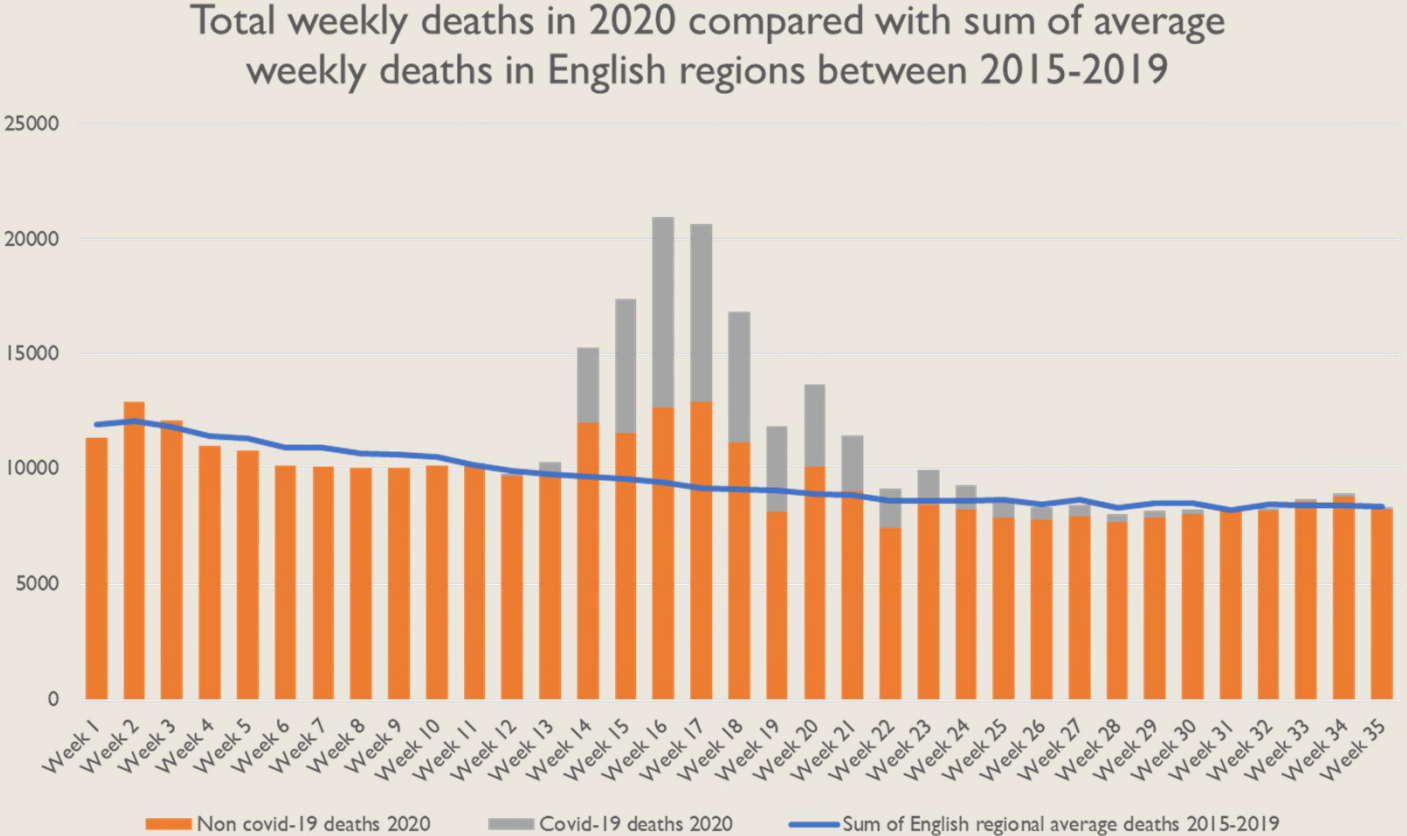|	Female	Male	Unknown or not specified	Total
Suspected or confirmed COVID-19	34	55	8	97
Not COVID-19	49	88	15	152
Total	**83**	**143**	**23**	**249**

Deaths of people detained under the Mental Health Act

The tables below show all deaths of detained patients from 1 March to 4 September 2020, by ethnicity and COVID-19 status and by place of death and COVID-19 status

Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	3	1
Black	11	11
Mixed	1	4
Other ethnic groups	0	1
White	60	85
Unknown	12	20
Not stated	10	30
Total	**97**	**152**

Place of Death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	57	48
Psychiatric ward	32	48
Hospital grounds	1	4
Patient's home	0	15
Public place	0	2
Other	1	22
Not stated	6	13
Total	**97**	**152**

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

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 35: week ending 28 August 2020

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

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.