COVID-19 INSIGHT

Issue 7

January 2021

STATE OF CARE

COVID INSIGHT

HOSPITAL BED OCCUPANCY AND DESIGNATED SETTINGS

In the last edition of this Insight series, we looked at the regional data we have on designated settings. These settings are intended for people who are discharged from hospital with a COVID-positive test who will be moving or going back into a care home setting. We also included 'alternative settings', where some local authorities have agreed with local NHS partners to make use of NHS settings to fulfil the role of a designated setting.

We provide a weekly update on the number of assured designated locations on our website.

Last month, we reported a wide variation in the number of beds in designated settings or alternative arrangements when compared with the number of older people and the ongoing rates of infection in each region.

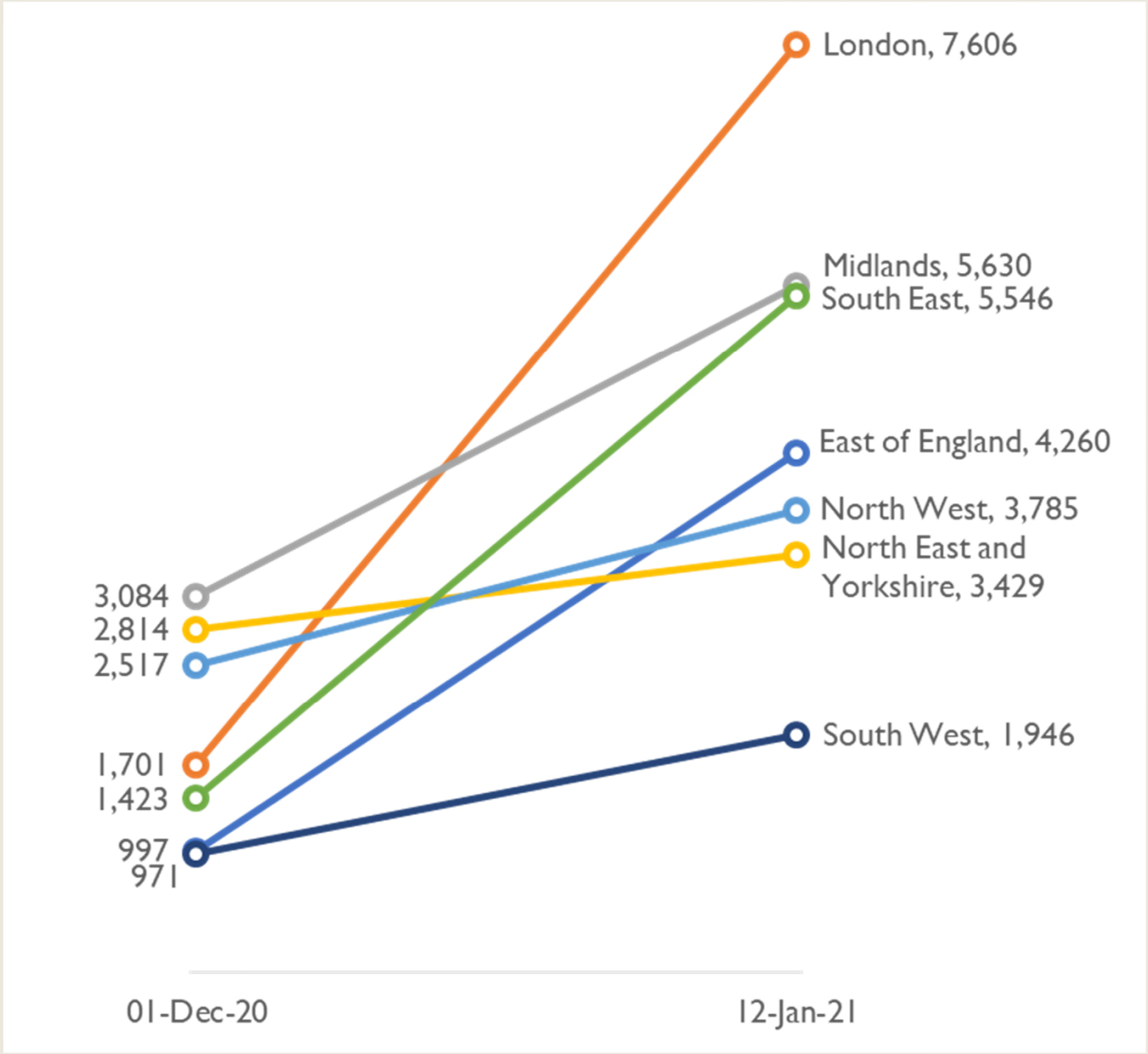
Since our last report the emergence of a new variant of COVID-19, which is known to be more contagious, has seen infection rates rise dramatically, starting in the South East of England and rapidly spreading into other parts of the country from there. This has had a knock-on effect on admissions to hospitals since December and increased the already high pressure on the NHS and adult social care.

In this edition, we look at how the increase in COVID-19 hospital admissions compares with the overall capacity of beds in designated settings and alternative arrangements in each region of England. As levels of infection continue to increase, it is more likely that, for those who have tested positive, hospitals will need to access the capacity created by the designated setting scheme. This is as part of a wider consideration of people's social care needs as they leave hospital, such as support for those who can go home with some care or reablement, and those who those who need a care home who can go directly to a bed.

Between 1 December 2020 and 12 January 2021, the number of acute hospital beds occupied by COVID-19 patients increased by around 138% nationally. The average COVID-19 occupancy rate was 27% in the seven days to 12 January, compared with 22% in the previous seven days. Two trusts currently have rates above 50%; more than half of their beds are occupied by patients with confirmed COVID-19.

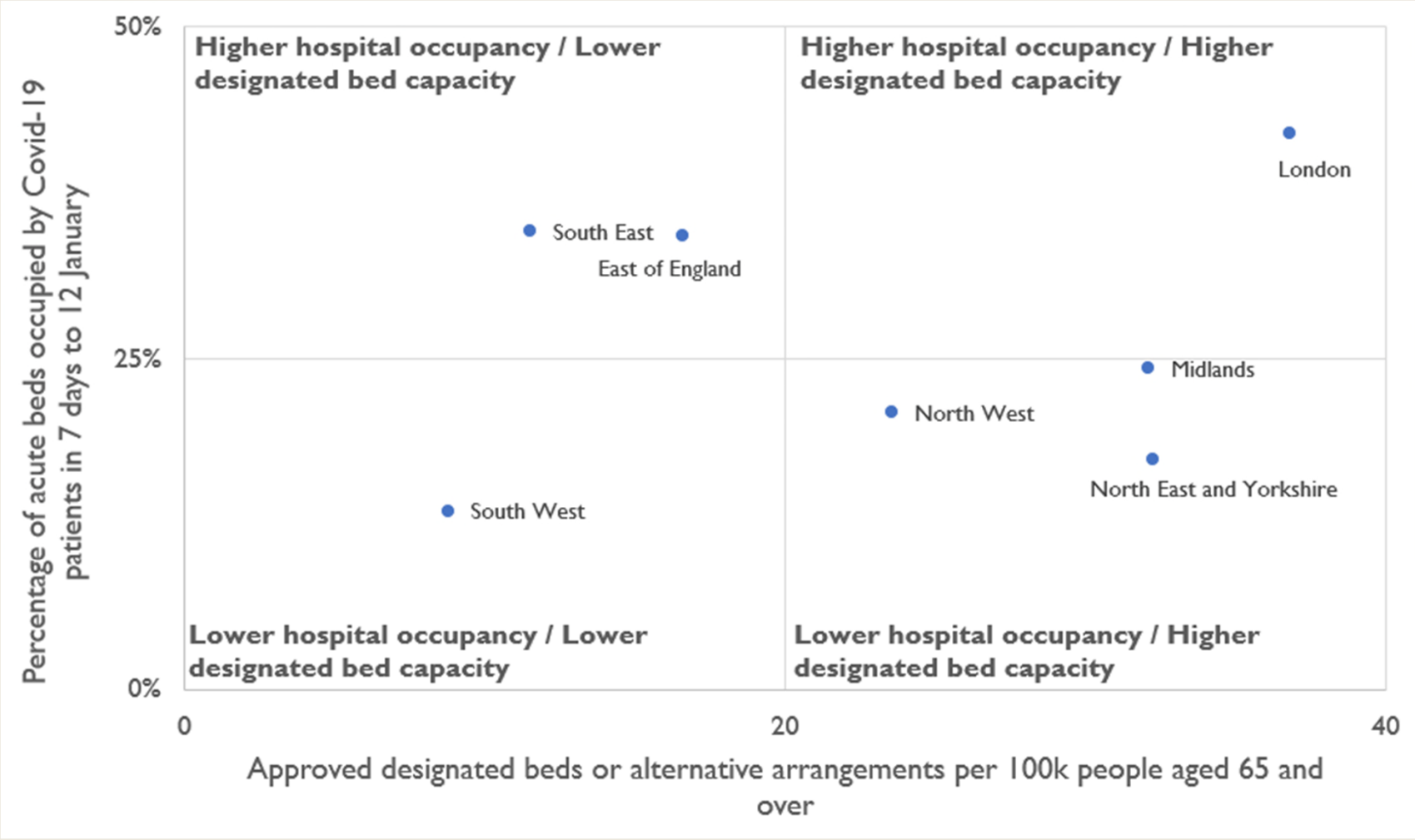
The changes have varied considerably across regions (figure 1). Whereas, for example, the North East and Yorkshire saw a relatively small increase from 1 December 2020 to 12 January 2021, the South East, East of England and London have all seen very large increases. The number of acute beds occupied by COVID-19 patients in London more than quadrupled in the space of six weeks.

Figure 1: Number of acute hospital beds occupied by COVID-19 patients on 1 December 2020 and 12 January 2021, NHS region



The marked increase in COVID-19 bed occupancy has not yet seen the same sort of increase in designated beds within these regions. As a result, there are local systems of note within the South East and East of England with higher COVID occupancy and lower rates of designated beds than other areas. In these areas there is a risk that people who have been identified as COVID positive and will be returning or moving into a care home may not be able to leave hospital in a timely way.

Figure 2: Acute COVID-19 bed occupancy and provision of approved designated beds or alternative arrangements, by NHS region, week ending 12 January



In the period 5 to 12 January 2021:

- The **South West** region had the lowest rate of designated beds per 100,000 people aged 65 and over than any other region. This situation was mitigated by having the lowest regional occupancy of hospital beds by COVID positive patients. Weekly rates of bed occupancy remained stable compared to the previous week.
- The **South East** had the second lowest rate of designated beds per 100,000 people aged 65 and over. The regional rate of COVID bed occupancy levels increased to 35% and remained in the top three in the country. This region may see local areas in which acute hospitals have fewer options to discharge COVID positive patients.
- The **East of England** saw a large proportional increase in COVID bed occupancy to 34% and had the third lowest rate of designated beds per 100,000 population aged 65 and over.
- **London** saw a notable increase in COVID bed occupancies to 42%. The region had the highest rate of COVID occupancy and the highest rate of designated beds per 100,000 people aged 65 and over, with a rate of 37. Individual acute hospitals have seen even greater increases in COVID occupancy.
- The **Midlands** had the fourth highest COVID hospital bed occupancy of the seven regions (24%) but the largest volume of designated beds. The 270 alternative arrangement beds in the Birmingham local authority made up a significant proportion of these. When looking at the average rate of designated beds per 100,000 of the population aged 65 and over, the Midlands had the third highest rate after London and North East and Yorkshire.
- **North East and Yorkshire** has seen a comparatively stable rate of COVID bed occupancy and had the second lowest regional level (17%). The average rate of designated beds per 100,000 people aged 65 and over was relatively high and the second highest across the English regions.
- The **North West** had a regional rate of COVID bed occupancy at 21%, but a lower rate of designated beds per 100,000 people aged 65 and over (24) compared to Midlands and North East and Yorkshire.

This is a very fast-moving situation. This analysis of the capacity of regional health and adult social care systems to support increasing numbers of people who are COVID-positive aims to highlight some of the challenges that local systems face. It should support conversations happening locally between local system stakeholders, trusts and local authorities as to plans for expanding a range of solutions (including designated beds), making sure these can be fully deployed, and developing any alternative arrangements for COVID-positive people coming out of hospital who need social care support.

COVID INSIGHT

FURTHER EXPLORATION OF DEATHS IN ADULT SOCIAL CARE

In previous briefings, we have published data drawn from the notifications of deaths in adult social care, submitted to CQC from April 2020 onwards. We have specifically looked at the numbers of deaths of people with a learning disability or autistic people, compared with the numbers in the previous year, and analysed all deaths in adult social care by ethnicity and COVID-19 status.

We found that in care homes in particular, a higher proportion of Black and Asian people who had died had confirmed or suspected COVID-19 flagged on their notification form than was the case for White people. In our previous update, covering deaths notified from 10 April to 16 November 2020, we found that 31% of the deaths of Black people were flagged as 'confirmed or suspected COVID-19' compared with 23% of White people.

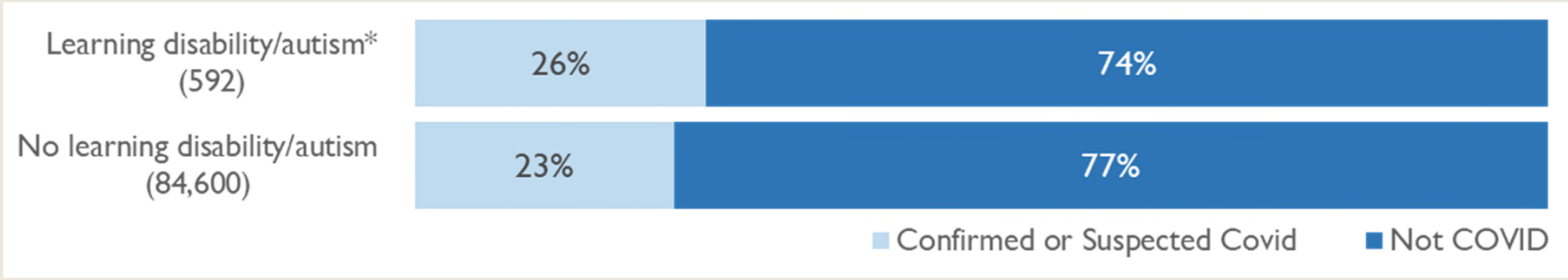
We have now carried out further analysis on this dataset in an effort to improve our understanding of these issues.

We first examined whether there were any differences in the propensity for deaths to be flagged for COVID-19 between people with a learning disability or autism and those without.

1. People with a learning disability were slightly more likely to have died with confirmed or suspected Covid-19 than others in care homes whose death was notified to us

While the vast majority of deaths in care homes were of people with no learning disability (84,600), we have identified almost 600 deaths of people with a learning disability or autism and 26% (152) of these were flagged for COVID-19 compared with 23% of those without a learning disability.

Figure 3: Covid and non-Covid deaths for residential care service locations split by learning disability/autism* and no learning disability/autism



* A person who had a learning disability and was reported by a provider who provides services for people with learning disability and autism. Please note, deaths with missing disability data have been excluded from this analysis

We then looked at the disaggregation of the data by learning disability status, ethnicity and COVID-19 status.

2. Our data showed no discernible differences based on sufficiently large numbers between the deaths of people from Black and minority ethnic groups, with and without a learning disability or autism, and White people with or without a learning disability or autism.

This could be due to the very low numbers of deaths in some of the categories once the data was disaggregated: out of almost 79,000 deaths for which we held data on ethnicity and disability status, 28 were of BME people with a learning disability or autism, which represented 0.04% of deaths.

Finally, we examined the deaths in our dataset by ethnicity, COVID-19 status and age group.

3. People from Black and minority ethnic groups who died were slightly younger in age than White people who died, reflecting demographic trends in the wider population

Figure 4, overleaf, shows that there is a slightly younger age profile for the deaths of all people from BME groups (regardless of COVID-19 status) than for White people, for whom a higher percentage of deaths were among those aged 85 and over. Among White people who died, the deaths flagged as confirmed or suspected COVID-19 appear to be slightly skewed towards those aged 75-84, compared with those aged 85 and over. This pattern is not surprising as it reflects population data which shows the proportion of the population identified as BME is much lower in the older age groups than across the population as a whole. Estimates based on the 2011 census suggest 98% of people over 85 in the UK are White, falling to 95% of those aged 65 to 85 and 84% of those under 65.[1]

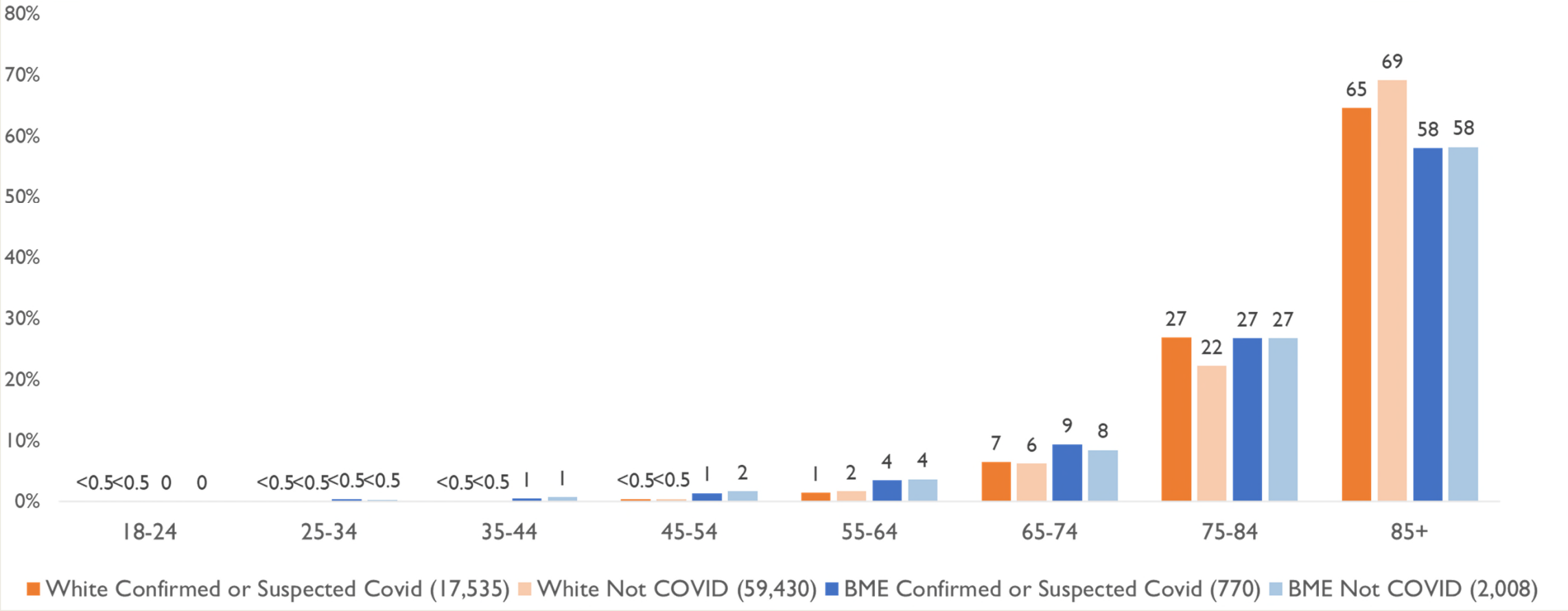
What does the analysis tell us about COVID-19 deaths in adult social care?

This further disaggregation of the data does not explain why people from BME groups or those with a learning disability or autism might be more likely to have died with COVID-19 flagged on their notification form than others, but the broad patterns do align with the findings of other organisations, for example Public Health England[2] and the Learning Disabilities Mortality Review (LeDeR) Programme.[3]

1. https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/age-groups/latest#age-profile-by-ethnicity
2. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf
3. http://www.bristol.ac.uk/media-library/sites/sps/leder/Deaths%20of%20people%20with%20learning%20disabilities%20from%20COVID-19.pdf

Figure 4: The percentage of residential social care service locations deaths at different age bands split by ethnicity and Covid/non-Covid status

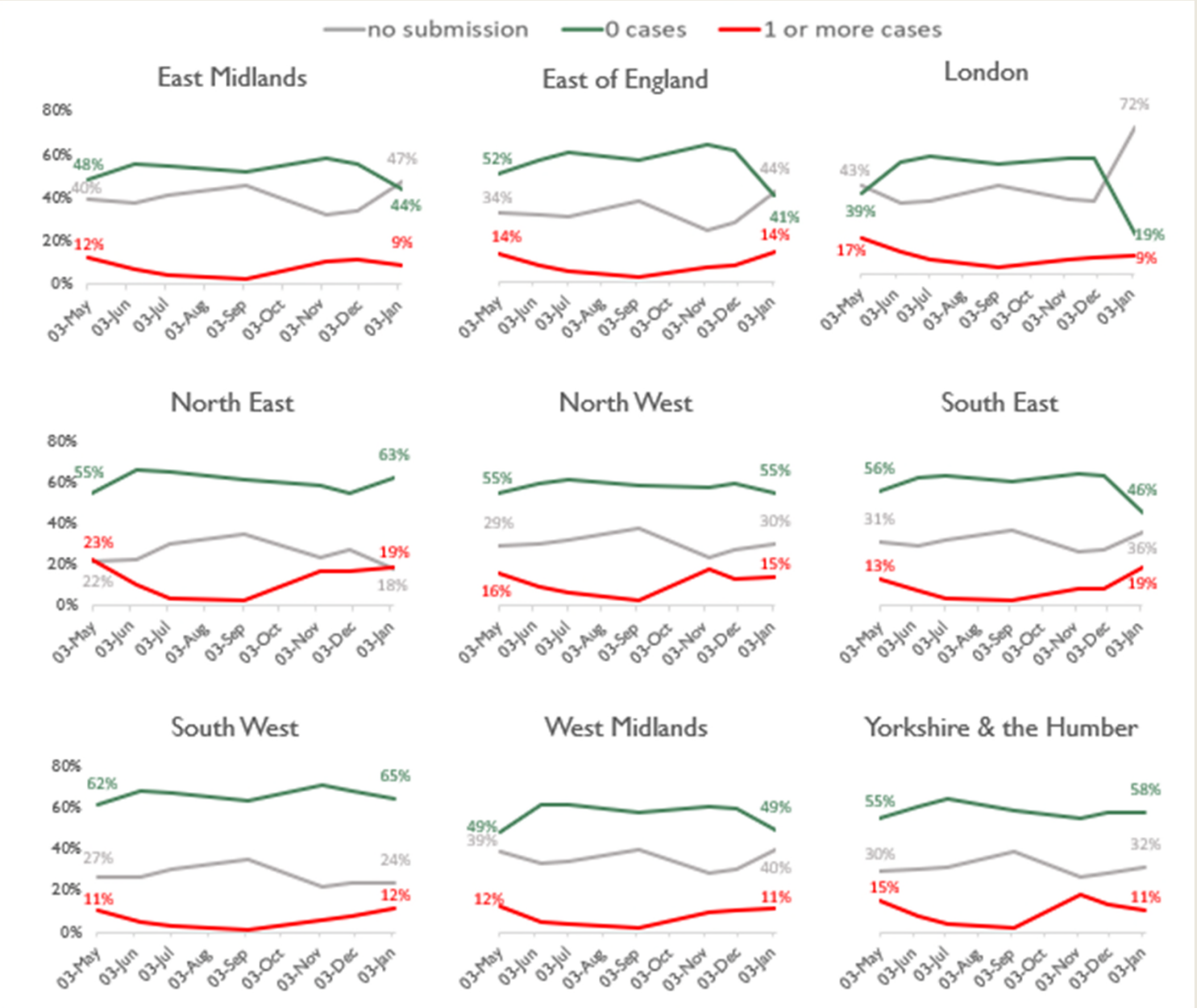
* Please note deaths with missing ethnicity or age data have been excluded from this analysis



COVID INSIGHT

DATA APPENDIX

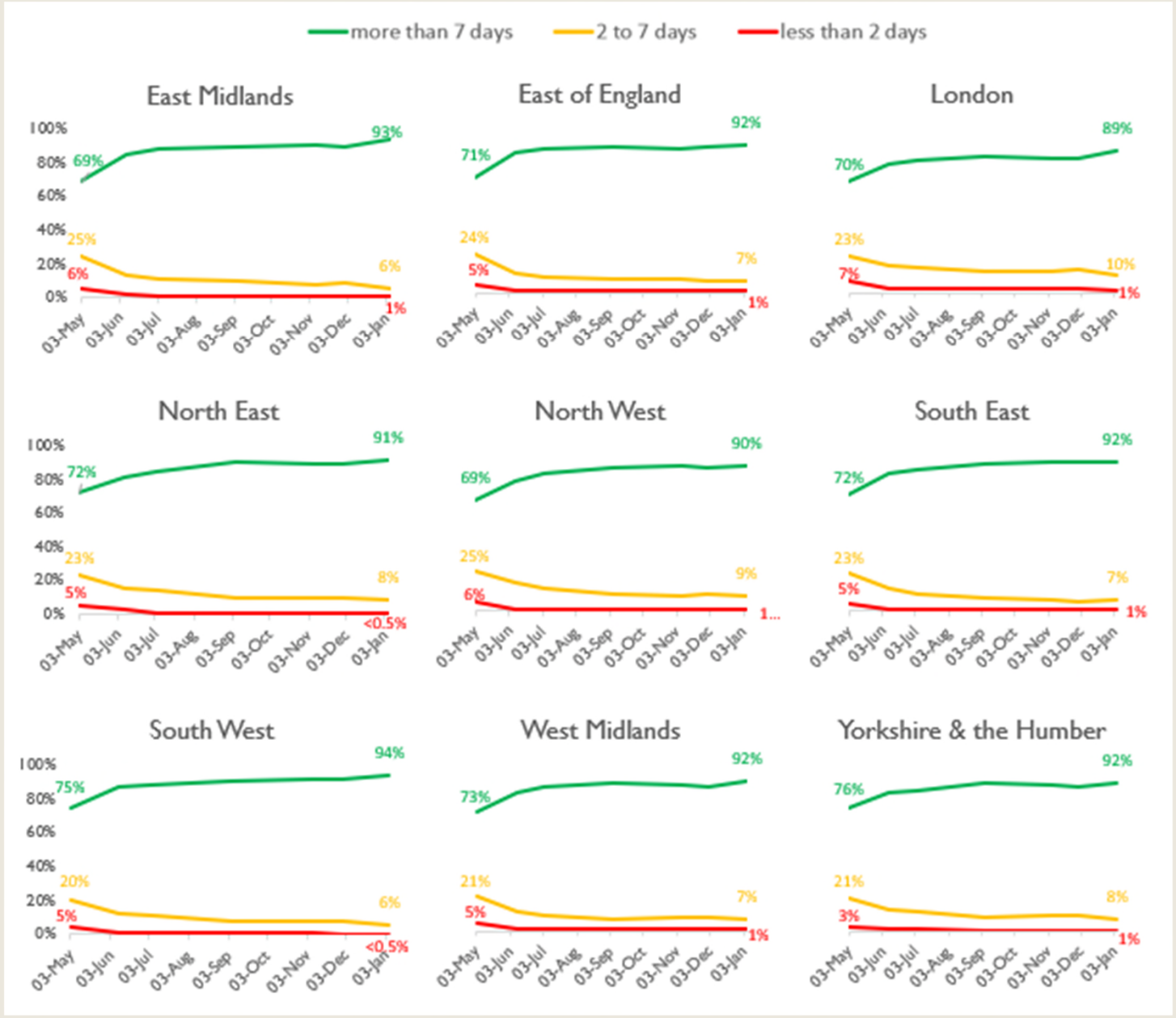
Homecare providers – prevalence of COVID-19



Source: CQC Domiciliary Care Agency Survey, data extracts from 3 May 2020 to 3 January 2021

Homecare providers with at least one case include suspected AND confirmed cases. Included in these figures are homecare services currently lying dormant, so completion rates are slightly higher for fully active services than this might suggest. Percentages may not add to 100% due to rounding.

Homecare providers – availability of all PPE



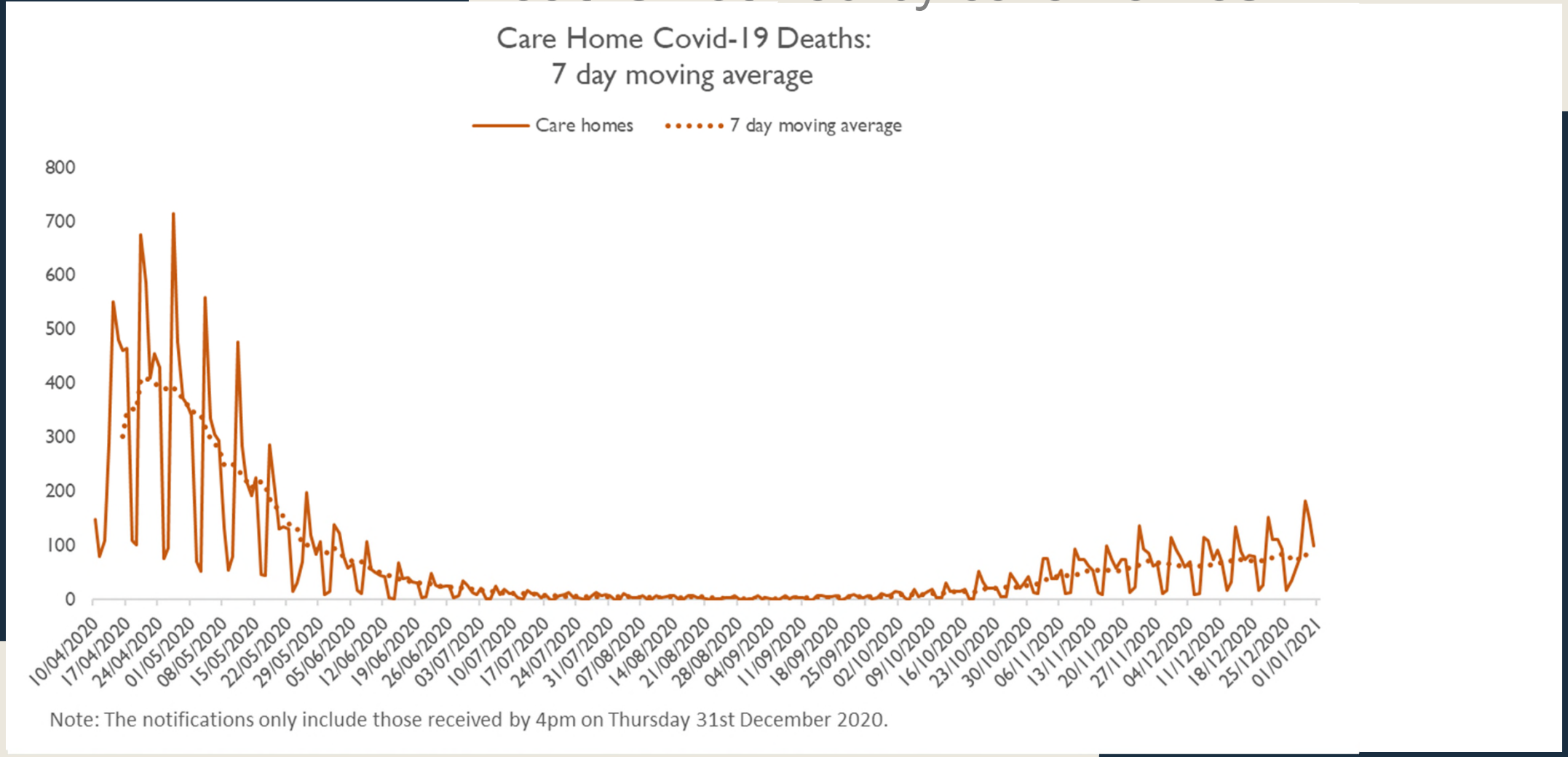
Source: CQC Domiciliary Care Agency survey – data extracts from 3 May 2020 to 3 January 2021

Homecare providers – staff absence

Percentage of homecare staff unable to work due to Covid-19

Source: CQC Domiciliary Care Agency survey, data extracts from 3 May 2020 to 3 January 2021
Includes staff who are self-isolating or have care commitments.

Deaths notified by care homes



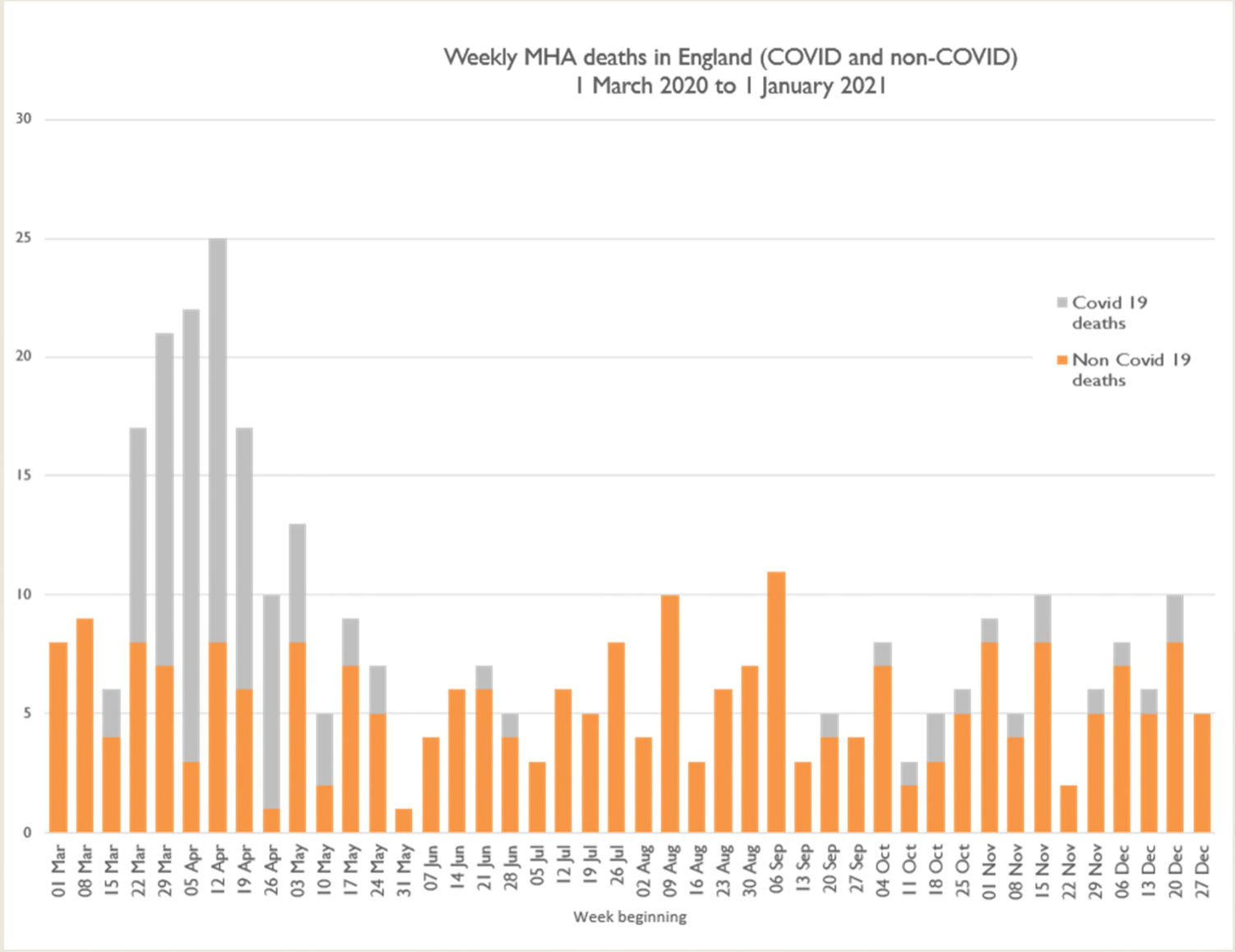
Source: CQC death notifications submitted 10/04/2020 to 31/12/2020

Deaths of people detained under the Mental Health Act

All providers registered with CQC must notify us about deaths of people who are detained, or liable to be detained, under the MHA.* From 1 March 2020 to 1 January 2021, we have been notified of 113 deaths that mental health providers indicated were suspected or confirmed to be related to COVID-19 (an increase of seven since we reported in December). A further five COVID-19 related deaths of detained patients were reported by other (non-mental health) providers (no increase since we last reported).**

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

* Includes detained patients on leave of absence, or absent without leave, from hospital, and conditionally discharged patients. 'Detained patients' also includes patients subject to holding powers such as s. 4, 5, 135 or 136, and patients recalled to hospital from CTO. These counts may also include notifications about the deaths of people subject to the MHA who are in the community and not in hospital.
** Data on notifications may be updated over time and therefore successive extracts may lead to changes in overall numbers unrelated to new cases.



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

Of the 359 notifications from mental health providers in the 2020 period (covering all causes of death), 279 were from NHS organisations, of which 84 deaths were indicated as being COVID-19-related, and 80 were from independent providers, of which 29 deaths were COVID-19-related.

We have identified 17 detained patients whose deaths have been notified to us from 1 March to 1 January 2021 who had a learning disability and/or were autistic: the majority (10) were not identified as related to confirmed or suspected COVID-19 (an increase of 1 from our report in December). Of these people, most also had a mental health diagnosis. Please note that these patients were identified both from a specific box being ticked on the notification form and a review of diagnoses in the free text of the form.

The table below shows all deaths of detained patients from 1 March to 1 January 2021, by age band and COVID-19 status.

Age band	16-17	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	Unknown	Total
Suspected or confirmed COVID-19		1	1	4	8	17	24	34	20	9	118
Not COVID-19	1	12	19	22	34	47	43	36	15	38	267
Total	1	13	20	26	42	64	67	70	35	47	385

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

The table below shows all deaths of detained patients from 1 March to 1 January 2021, by gender and COVID-19 status.

Gender	Female	Male	Unknown or unspecified	Total
Suspected or confirmed COVID-19	40	67	11	118
Not COVID-19	76	150	41	267
Total	**116**	**217**	**52**	**385**

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

The table below shows all deaths of detained patients from 1 March to 1 January 2021, by ethnicity and COVID-19 status.

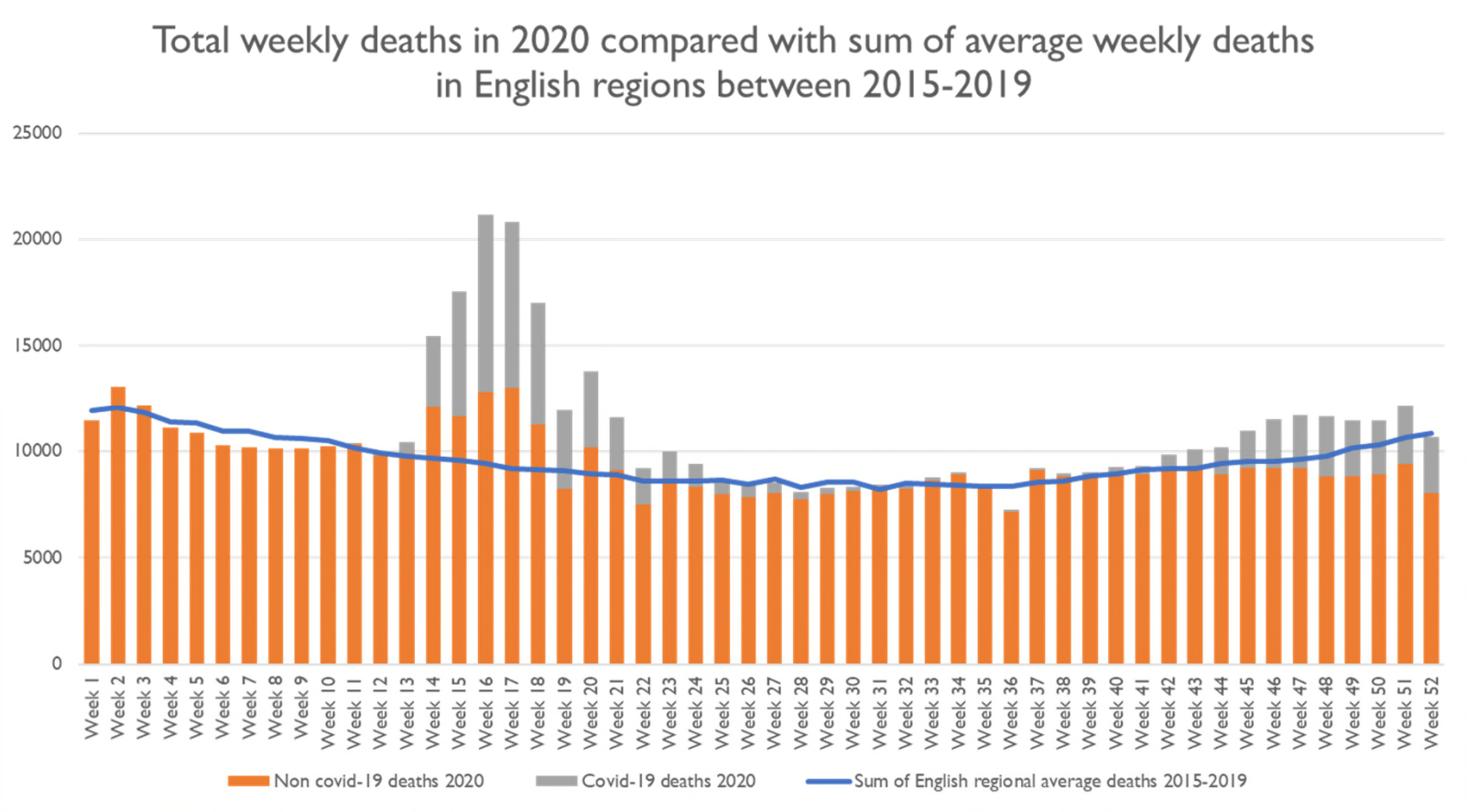
Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	4	6
Black	12	23
Mixed	3	5
Other ethnic groups	1	2
White	69	156
Unknown	24	63
Not stated	5	12
Total	118	267

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

The table below shows all deaths of detained patients from 1 March to 1 January 2021 by place of death and COVID-19 status.

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	71	81
Psychiatric ward	36	85
Hospital grounds	1	6
Patient's home	0	24
Public place	0	6
Other	1	29
Not stated	9	36
Total	**118**	**267**

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



Source: ONS COVID/non-COVID 2020 death data:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard
and 2015-2019 death data from:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019
Week 52: week ending 25 December 2020