



COVID-19 INSIGHT

Issue 8

February 2021

In this issue:

- Winter pressures for urgent and emergency care

 STATE OF CARE

COVID INSIGHT

WINTER PRESSURES FOR URGENT AND EMERGENCY CARE



In June 2020 [we expressed concern](#) that the combined effect of the COVID pandemic with seasonal winter pressures would cause severe challenges for urgent and emergency care. In this section, we look at the evidence so far about how services have been affected by the pandemic during this winter, and discuss what action CQC is taking to provide constructive support.

What does the data tell us about winter pressures this year?

Figure 1 shows how atypical monthly attendances at emergency departments have been since the start of the pandemic, when the numbers immediately plunged in April to levels not seen for many years. These numbers started to recover from May, but peaked in August before falling again throughout the autumn, resulting in the number of attendances in January 2021 being 27% lower than the five-year average for January.

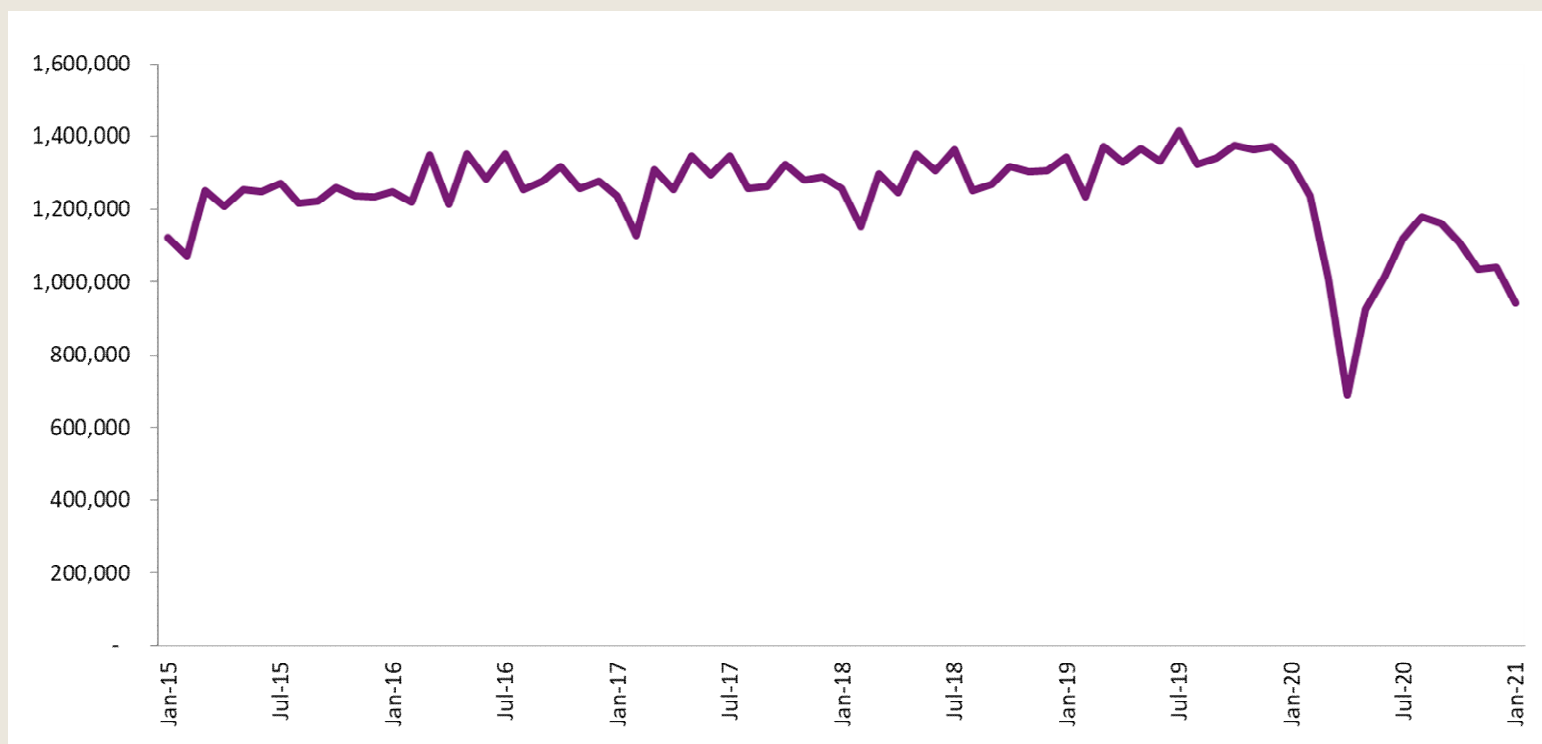


Figure 1: Total monthly attendances to major emergency departments (type 1), January 2015 to January 2021

Source: NHS England, A&E attendances and emergency admissions statistics

Despite this lower level of activity, performance against the four-hour target, which rose in April to monthly levels not seen since mid-2015, has fallen sharply since then (figure 2). In January, 70% of people attending type 1 emergency departments spent less than four hours from arrival to admission, discharge or transfer elsewhere. This is lower than any month in recent years, except December 2019. There are challenges particular to the pandemic that are compounding the problems faced by trusts this year, such as the need to manage the emergency department environment in line with physical distancing requirements.

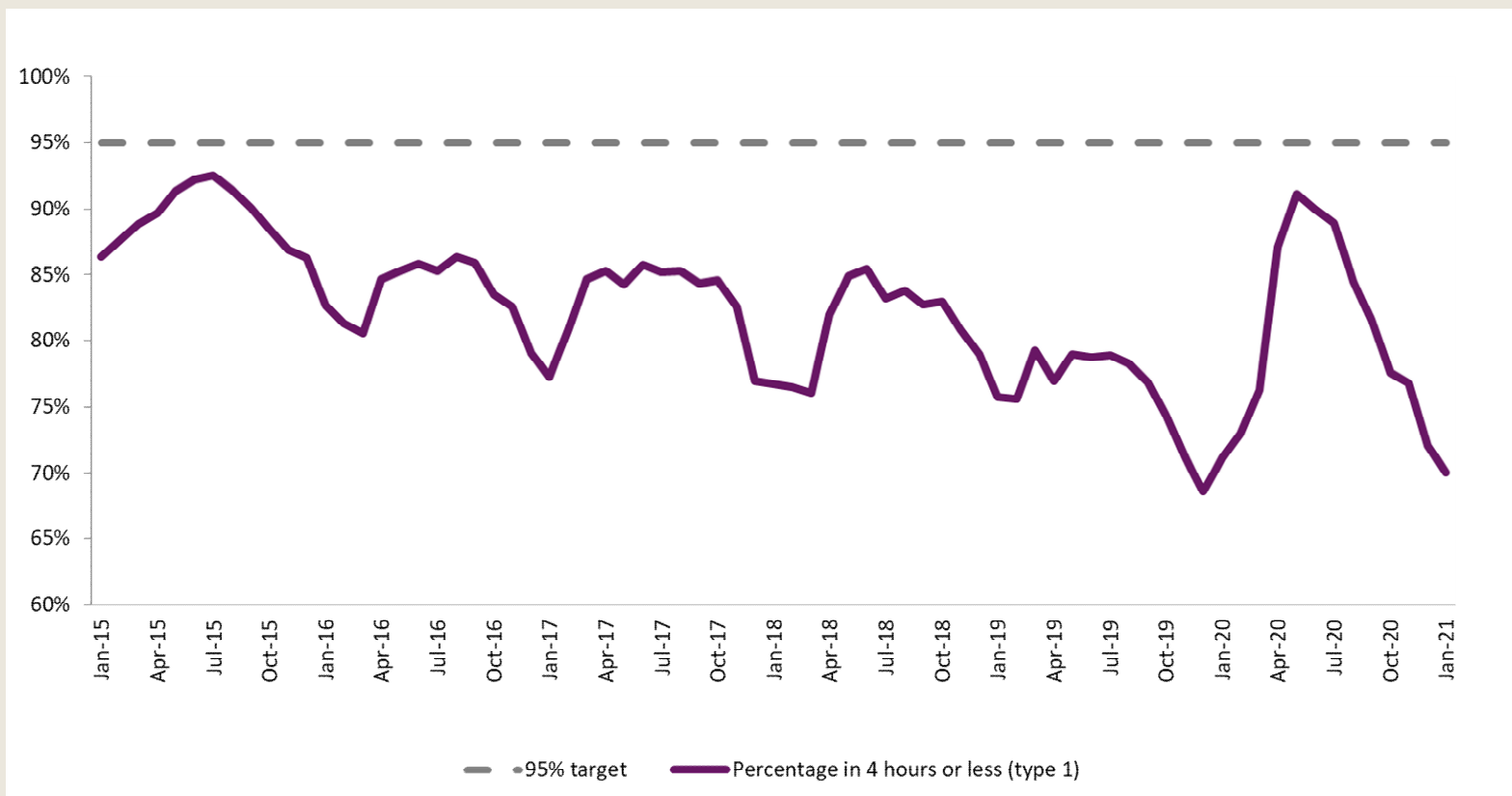


Figure 2: monthly performance against the four-hour target in major emergency departments (type 1), January 2015 to January 2021

Source: NHS England, A&E attendances and emergency admissions statistics

Of those who attended type 1 emergency departments, the proportion who were admitted to hospital peaked at 37% in April 2020 (affected by the sharp fall in the overall number of people attending). Since then, the proportion fell during the summer in line with the pattern seen in previous years, before then rising again throughout the autumn (figure 3). This suggests that, while attendances remain depressed, the acuity of those attending is rising.

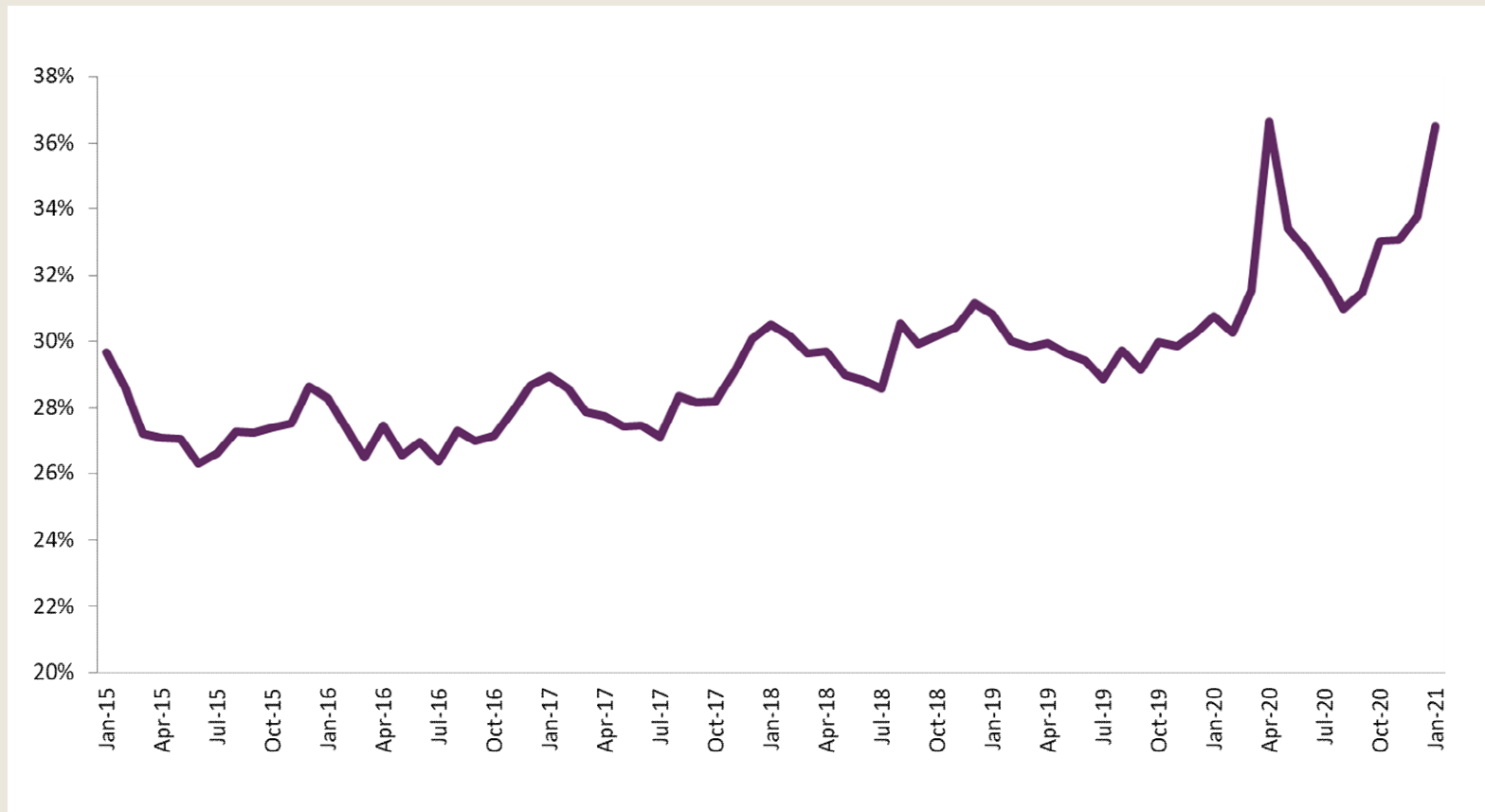


Figure 3: Percentage of monthly attendances to type 1 emergency departments admitted via major acute emergency departments, January 2015 to January 2021

Source: NHS England, A&E attendances and emergency admissions statistics

Still focusing on people who attended emergency departments and were then admitted, there has been a very sharp rise in the number of people who had to wait more than 12 hours to be admitted (figure 4).

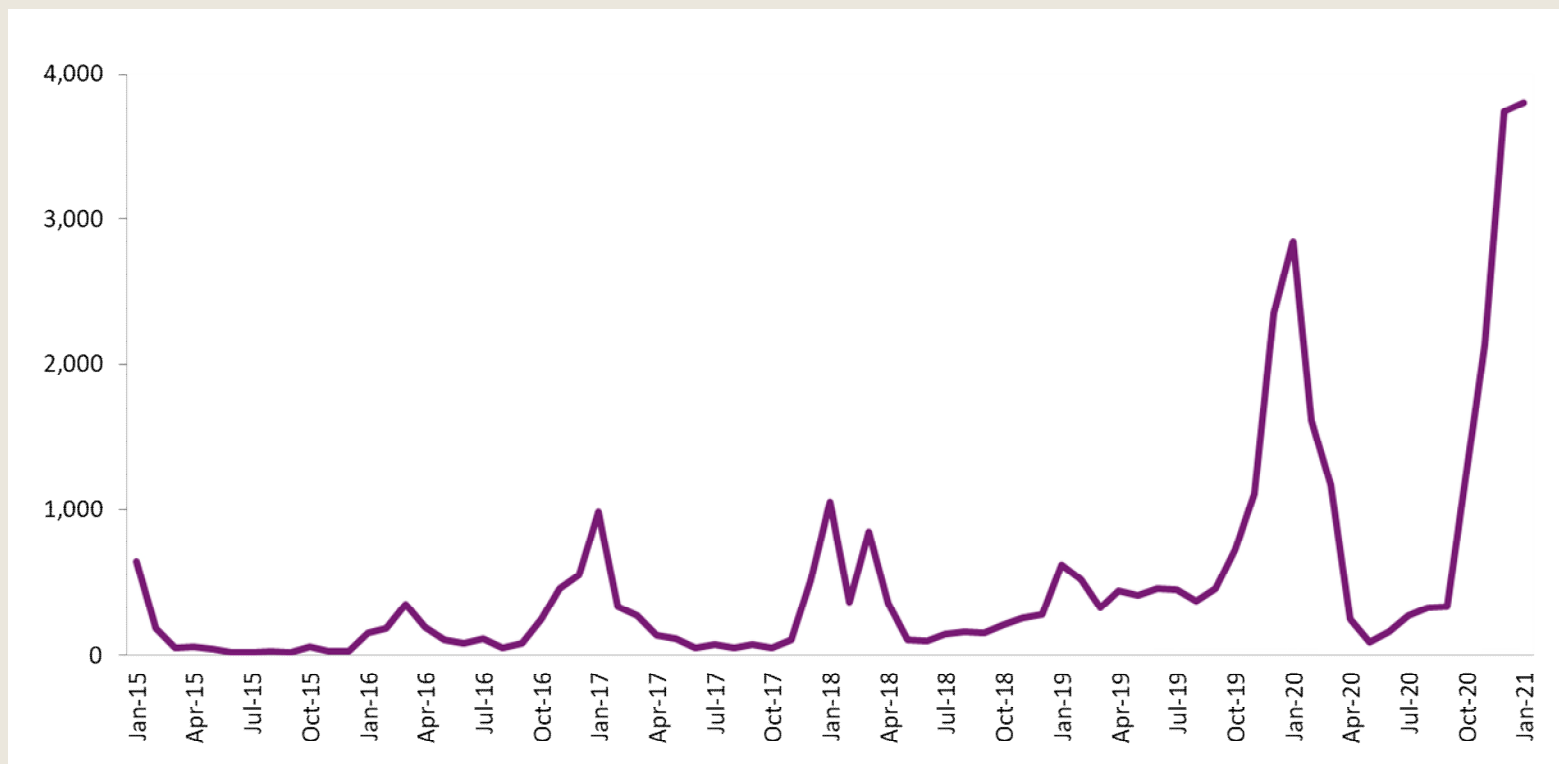


Figure 4: Number of patients spending more than 12 hours from decision to admit to admission each month (all types of emergency department), January 2015 to January 2021

Source: NHS England, A&E attendances and emergency admissions statistics

The numbers of people experiencing such long waits has consistently peaked each winter, but 2019/20 and the current winter have seen numbers far higher than previously, reaching 3,745 in December 2020. This equated to just under 1% of all those who were admitted in December.

The data above shows that, although overall numbers of people attending emergency departments have remained lower than in recent years, services have faced challenges in managing the flow of people, including admitting patients in a timely manner where admission

is required. Very high numbers of beds occupied by patients with COVID-19 over December and January will have been a major factor in this, as well as the challenge of managing services safely (including physical distancing and other stringent infection control measures) within confined environments.

One impact of this is that people are being held in ambulances outside emergency departments, known as ‘handover delays’. Figure 5 compares the number of delays over 60 minutes each day nationally this winter (2020/21) with last winter (2019/20).

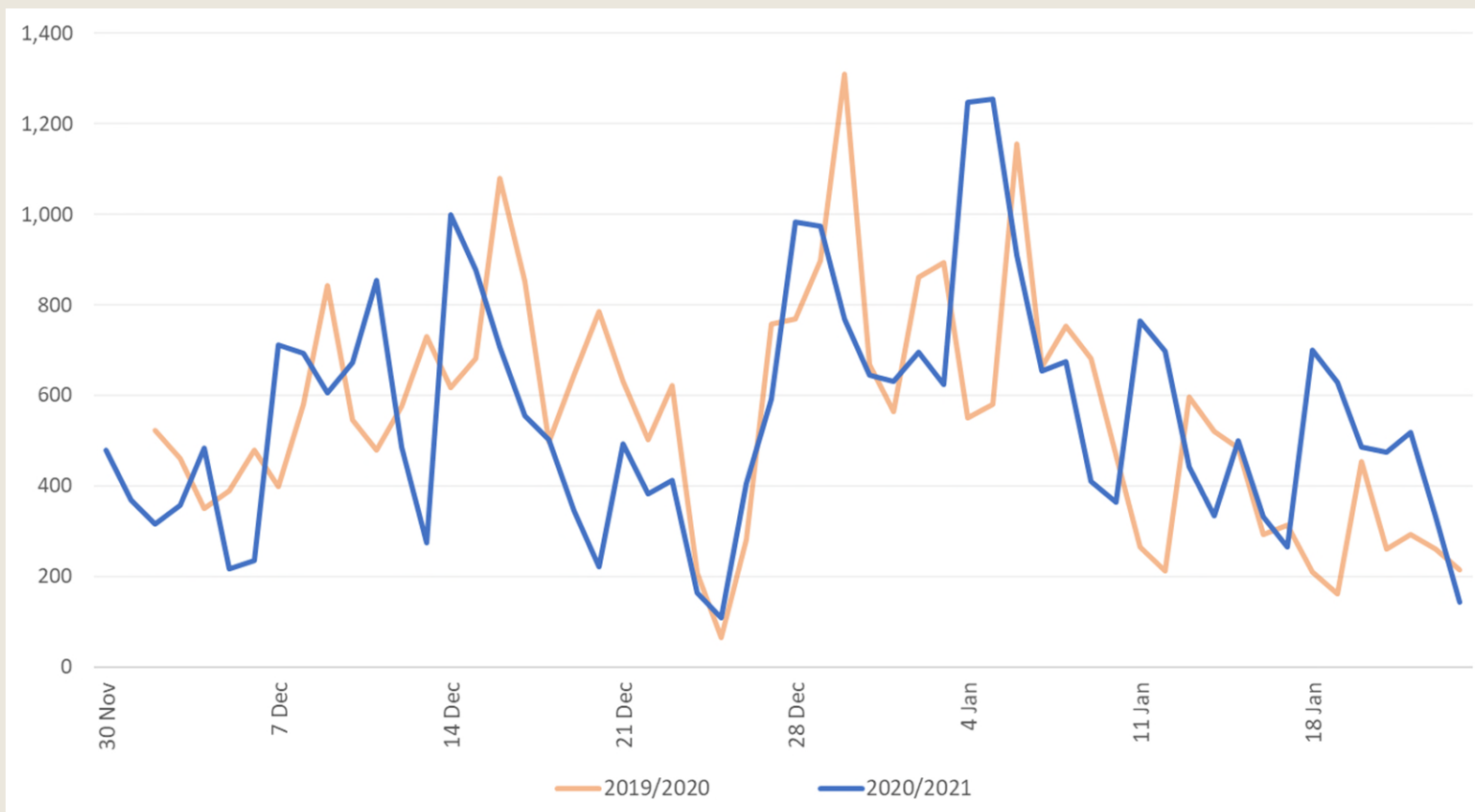


Figure 5: Number of daily ambulance handover delays over 60 minutes

Source: NHS England and NHS Improvement – Daily Hospital Situation Reports (number of patients arriving by ambulance and ambulance handover delays)

The overall numbers are broadly similar, but it is important to recognise that the data only measures how many delays that breached 60 minutes, and not the total length of each delay. We are hearing about frequent instances of patients waiting as long as eight hours in ambulances outside emergency departments. This is a poor experience for patients, as well as having a major impact on the availability of ambulances and their crews to respond to the next case.

The total number of ambulance arrivals from the start of December to 24 January this year is approximately 10% lower than the same period last year. Figure 6 shows the number of delays over 60 minutes as a percentage of ambulance arrivals – the average for the latest period is 4.4% compared with 3.9% last year, so a slight rise.

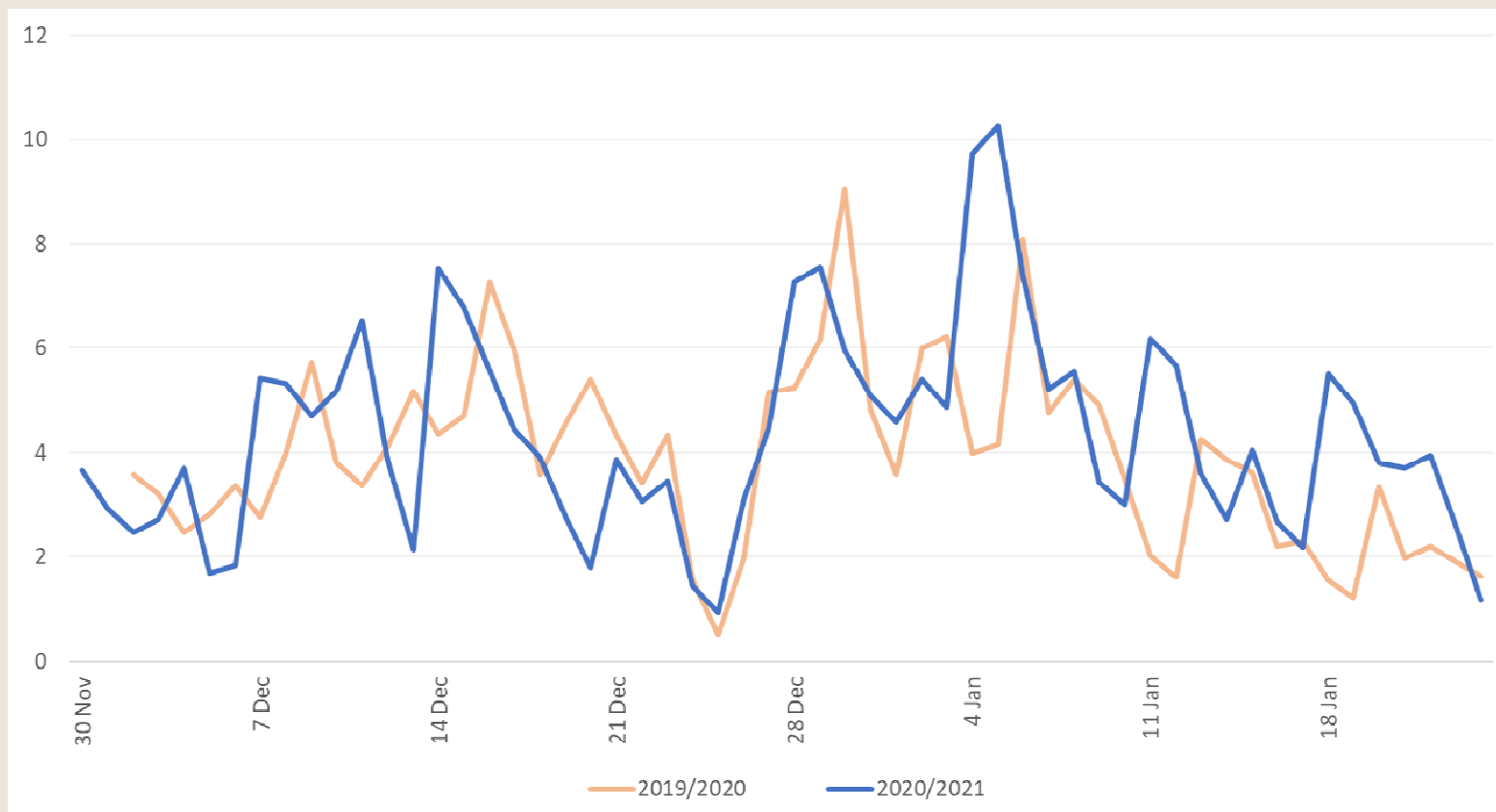


Figure 6: Percentage of ambulance arrivals with handover delays over 60 minutes

Source: NHS England and NHS Improvement – Daily Hospital Situation Reports (number of patients arriving by ambulance and ambulance handover delays)

Where we do see more variation, however, is between the regions. Figure 7 shows that:

- the East of England, London and Midlands regions all follow a similar pattern to England, in showing a broadly similar trend this year compared with last year
- in the North East and Yorkshire and North West regions, there has been a markedly lower percentage of ambulance arrivals resulting in handover delays of at least 60 minutes
- in the South East and South West regions there has been an increase this year.

The variation is the same if viewed as absolute numbers of delays, so is not related to a variation in numbers of ambulance arrivals between regions. Figure 7 is presented as percentages of arrivals to account for different sizes and levels of activity between regions.

We can also see a distinct variation in the proportion of arrivals tending to result in delays of over 60 minutes, with the highest proportions in East of England and the Midlands, and much lower proportions in North East and Yorkshire and the North West.

As mentioned above, what this data is unable to tell us is the length of each delay beyond 60 minutes. We are aware that there have been some very long delays occurring this winter, but it is not possible to identify from the data whether the numbers of extremely long delays (such as those greater than five hours) has increased since last winter.

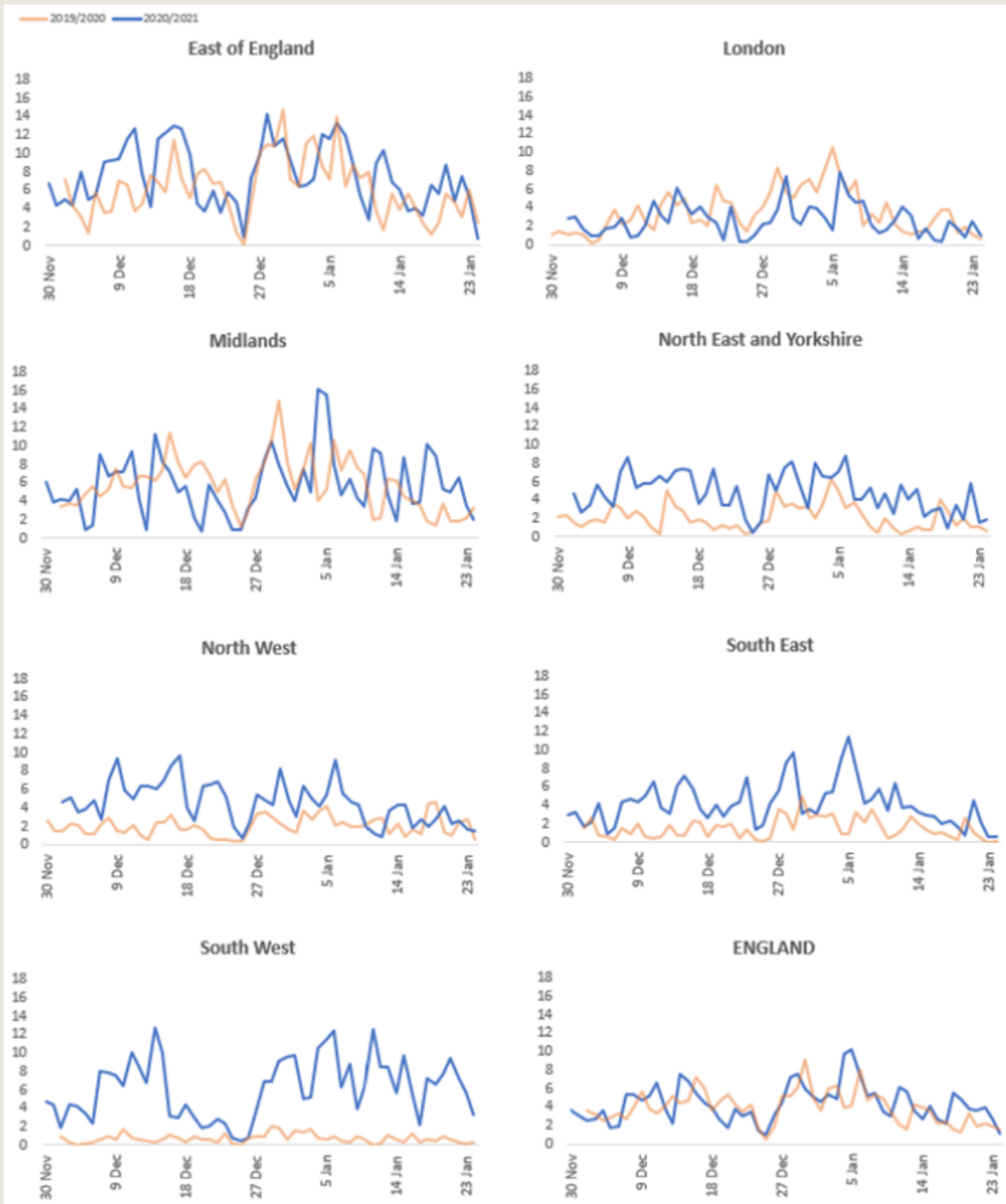


Figure 7: Percentage of ambulance arrivals with handover delays over 60 minutes, NHS regions and England

Source: NHS England and NHS Improvement – Daily Hospital Situation Reports (number of patients arriving by ambulance and ambulance handover delays)

Working in partnership with clinicians to maintain safe care

Since April 2020, we have been working with frontline clinicians from emergency departments throughout the country to understand the pressures they have faced and what action services could take to mitigate risk and maintain safe care when under such exceptional pressure.

This led to the publication of the [Patient FIRST framework](#) in October 2020. The framework was developed in partnership with the clinicians as a tool to help support those working in NHS trusts and the wider health and care system to understand what lessons can be learnt from the impact of the pandemic, and what good practice can be harnessed to support improvement.

It contains a number of practical examples of actions that can be taken at a departmental, trust and wider system level to maximise capacity, maintain effective patient flow, and keep staff and patients safe. FIRST stands for:

Flow

Infection control (including social distancing)

Reduced patients in emergency departments

Staffing

Treatment in the emergency department.

During autumn 2020, our programme of Provider Collaboration Reviews examined how providers were working together in urgent and emergency care. As part of this work, we published the briefing '[Collaboration in urgent and emergency care](#)', which includes good practice examples from different parts of the urgent and emergency care system, showcasing how some services have taken steps to put them in a better position to withstand the current challenges, including the double impact of 'normal' winter pressures and the pandemic.

During October and early November we applied our 'transitional regulatory approach', through which our inspectors have held discussions with executive directors of trusts with major emergency departments, including those with stand-alone paediatric emergency departments. These calls provided the opportunity for trusts to demonstrate how they have prepared for the winter months, including how they have provided executive level support to the emergency department and patient flow through the hospital.

The discussions are structured around our key questions of safe, responsive and well-led, and cover the following key lines of enquiry:

Safe

1. How do systems, processes and practices keep people safe and safeguarded from abuse?
2. How are risks to people assessed, and their safety monitored and managed, so they are supported to stay safe?

Responsive

3. Do services take account of the particular needs and choices of different people?
4. Can people access care and treatment in a timely way?

Well-led

5. Is there leadership capacity and capability to deliver high-quality, sustainable care?
6. Is there a culture of high-quality, sustainable care?
7. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
8. Are there clear and effective processes for managing risks, issues and performance?
9. Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?
10. Are there robust systems and processes for learning, continuous improvement and innovation?

Among the areas outlined above, those which flagged the greatest risk were questions 2 and 4 in the list above, and those which flagged the lowest risk were questions 6 and 10.

As in previous winters, we have been monitoring key performance metrics at NHS trust level which has helped to flag where services may be facing the greatest challenges, making use of the winter situation reports data published by NHS England.

Informed by the transitional regulatory approach process, the monitoring of situation reports data outlined above, and intelligence from local inspections teams, a number of emergency departments have been identified for inspection, with visits taking place throughout the winter.

Reports on these inspections will be published over the next few weeks, but so far we have found that the issues and challenges facing services are similar to those experienced in previous years, albeit exacerbated by the pandemic. The key factors affecting services' ability to provide a good standard of care include:

- the capacity to manage the flow of people through the system, from ambulance handover delays to hospital admissions
- staffing shortages exacerbated by high numbers of people off sick or isolating due to COVID-19.

Effective local leadership and active support for the emergency department from the hospital and wider system remain essential for managing the pressures well.

COVID INSIGHT

DATA APPENDIX



Designated settings scheme

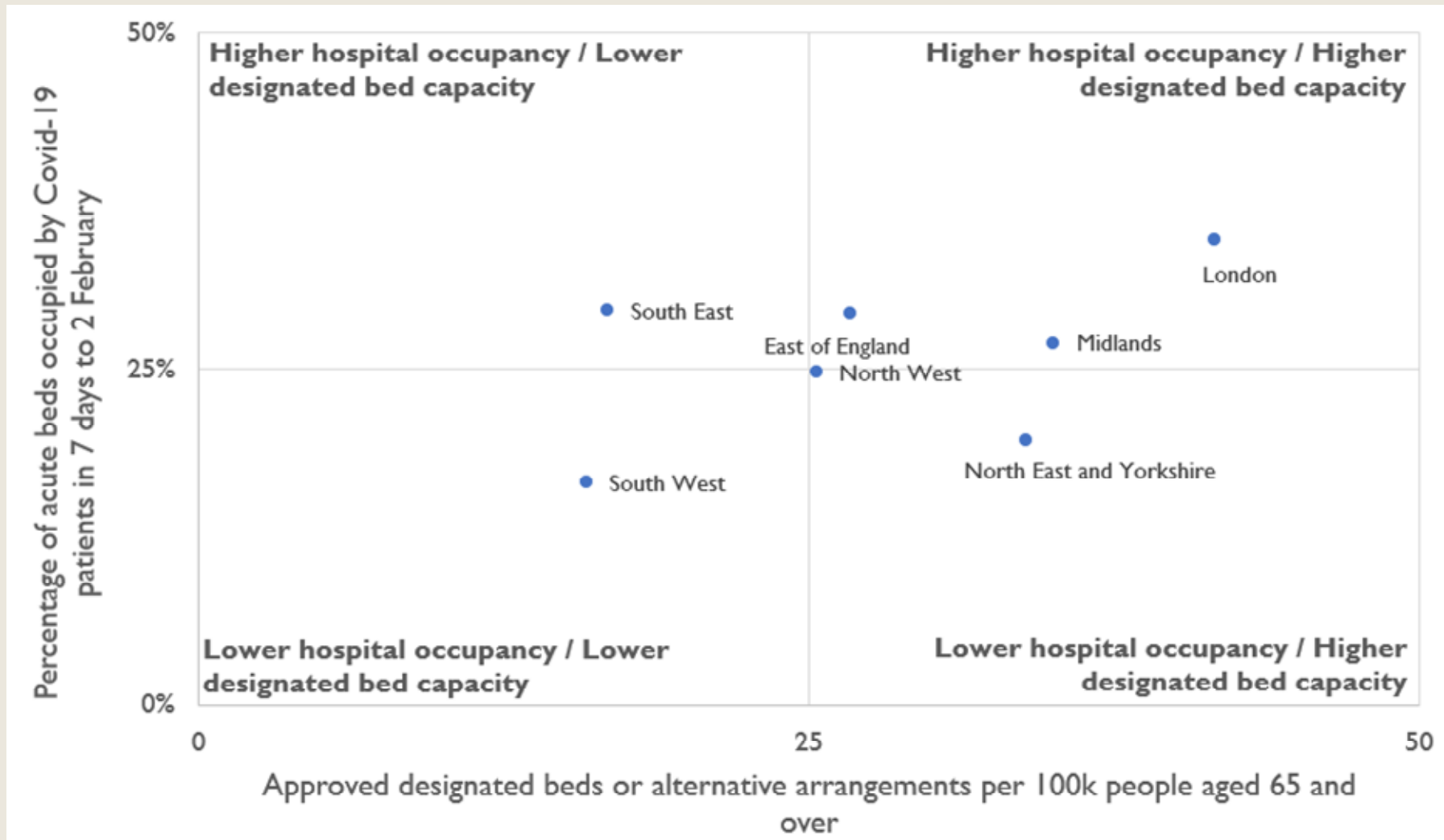
We continue to work with the Department of Health and Social Care, local authorities and individual care providers to provide assurance of safe and high-quality care in designated settings, which are part of a scheme to allow people with a COVID-positive test result to be discharged safely from hospitals who will be moving or going back into a care home setting. Our website has a [weekly update on the number of assured designated locations](#).

As of 4 February, there were 156 assured designated settings within 109 local authorities. Some local authorities have chosen not to participate in the scheme, and in some areas they have agreed with local NHS partners to make use of NHS settings to fulfil the role of a designated setting. There are currently 40 settings of this alternative type.

In [previous issues](#), we have looked at the regional data we have on designated settings. The chart overleaf shows the latest regional picture up to 2 February 2021, set against rates of acute bed occupancy by people with COVID-19.

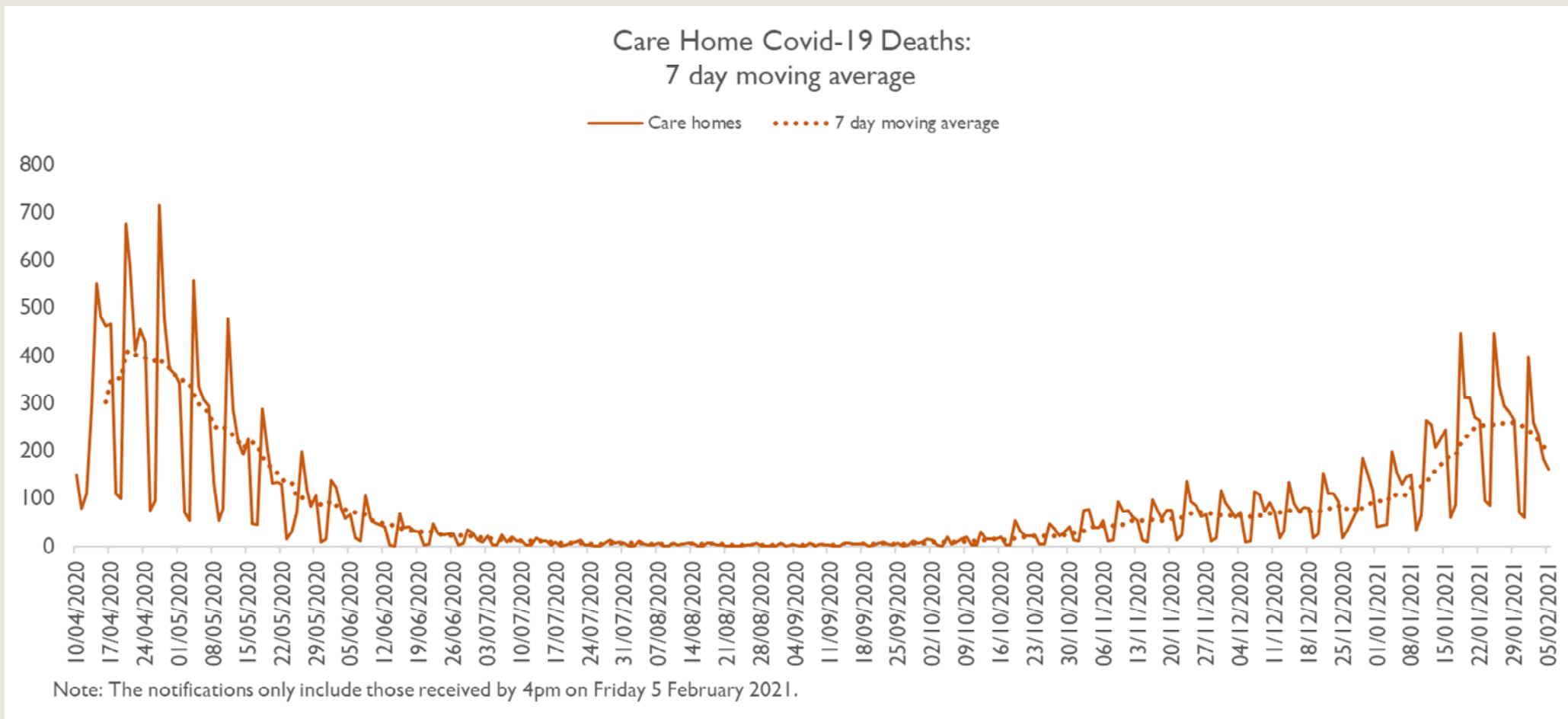
- The South East remained under pressure, with high rates of COVID bed occupancy and lower numbers of designated beds to discharge COVID positive people to.
- The South West had seen increases in designated beds since the previous week. The total designated beds grew from 135 to 199.
- London, the North West and the South West had higher occupancies in approved designated settings locations. However, London and the South West also had a higher proportion of alternative arrangement beds, which may reduce the reliance on designated settings alone.

Rate of designated beds per 100,000 population aged 65 or over vs hospital beds occupied by COVID patients, by region



Source: NHS England and CQC

Deaths notified by care homes



The chart shows the number of death notifications of people in care homes flagged with COVID-19 submitted each day up to 4 February 2021, with a seven day moving average line showing the smoothed trend. The numbers of deaths appears to have peaked in mid January and to have begun falling since then, although it remains higher than at any time between late May and late December 2020.

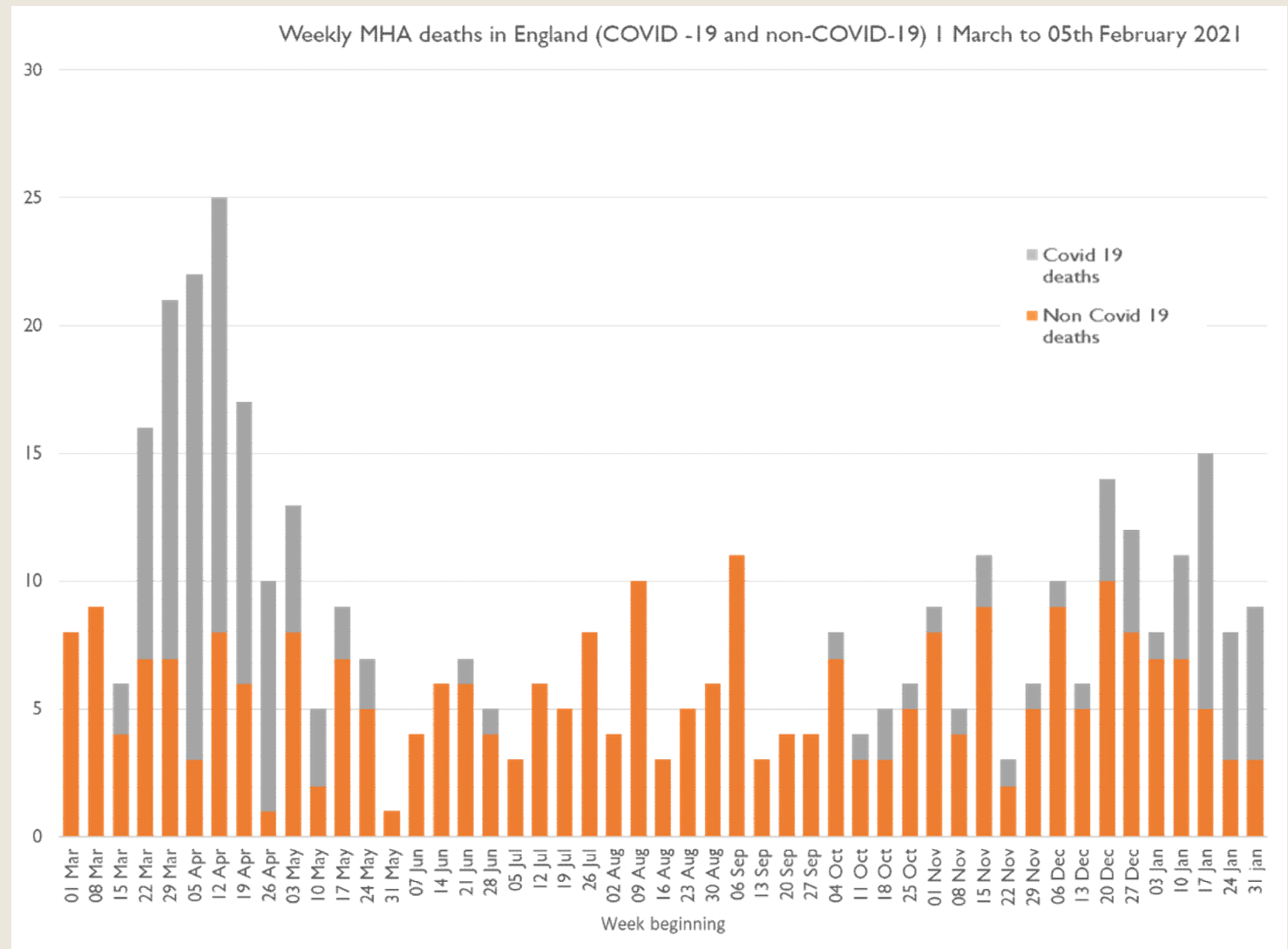
Deaths of people detained under the Mental Health Act

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 5 February 2021, we have been notified of 144 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 seven COVID-19 related deaths of detained patients were reported by other (non-mental health) providers (an increase of two 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 426 notifications from mental health providers in the 2020/21 period (covering all causes of death from 1 March 2020 to 5 February 2021), 335 were from NHS organisations, of which 109 deaths were indicated as being COVID-19-related, and 91 were from independent providers, of which 35 deaths were COVID-19-related.

We have identified 20 detained patients whose deaths have been notified to us from 1 March to 5 February 2021 who had a learning disability and/or were autistic: the majority (13) 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.

The table below shows all deaths of detained patients from 1 March to 5 February 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	7	9	23	31	39	22	18	151
Not COVID-19	1	13	27	25	37	52	47	47	16	38	303
Total	1	14	28	32	46	75	78	86	38	56	454

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

The table below shows all deaths of detained patients from 1 March 2020 to 5 February 2021, by gender and COVID-19 status.

Gender	Female	Male	Unknown or unspecified	Total
Suspected or confirmed COVID-19	51	87	13	151
Not COVID-19	87	173	43	303
Total	138	260	56	454

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

The table below shows all deaths of detained patients from 1 March 2020 to 5 February 2021, by ethnicity and COVID-19 status.

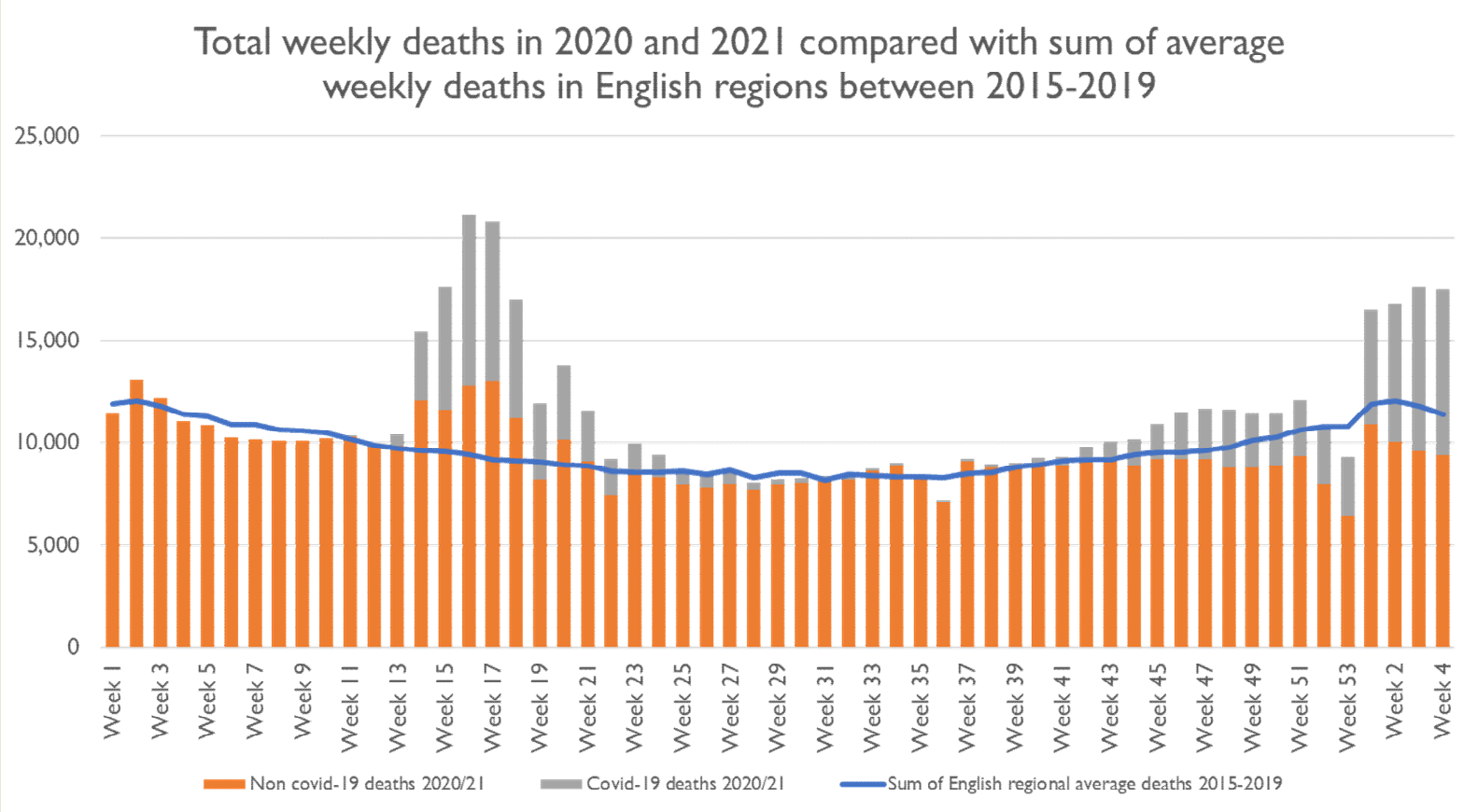
Ethnicity	Suspected or confirmed COVID-19	Not COVID-19
Asian	5	7
Black	16	25
Mixed	4	5
Other ethnic groups	1	3
White	87	182
Unknown	32	70
Not stated	6	11
Total	151	303

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

The table below shows all deaths of detained patients from 1 March 2020 to 5 February 2021 by place of death and COVID-19 status.

Place of death	Suspected or confirmed COVID-19	Not COVID-19
Medical ward	99	94
Psychiatric ward	38	96
Hospital grounds	1	6
Patient's home	0	26
Public place	0	6
Other	3	38
Not stated	10	37
Total	151	303

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 4, 2021: week ending 29 January 2021