CQC INSIGHT

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STATE OF CARE

CQC INSIGHT

STAFF VACANCIES IN CARE HOMES

Introduction

One of the key messages from our State of Care report for 2020/21 was that staffing pressures were being felt by people using and working in all health and care settings. We highlighted, however, that the impact was being seen most acutely in all areas of adult social care, including care homes and home-care services. In this sector, providers were competing for staff with the retail and hospitality industries, which can offer higher salaries.

We also highlighted that staff from adult social care may take up vacant posts in hospitals – especially registered nurses. We warned that these influences, combined with the effects of the requirement for all care home workers to be fully vaccinated against COVID-19, which came into effect on 11 November 2021, may lead to more care staff leaving.

These workforce pressures were reflected in information submitted to CQC by providers of residential care (care homes), which showed an increase in vacancy rates between April to September 2021.

This article provides an update to that data, showing that care home staff vacancies have continued to increase across England. We also give a breakdown of vacancies by region.

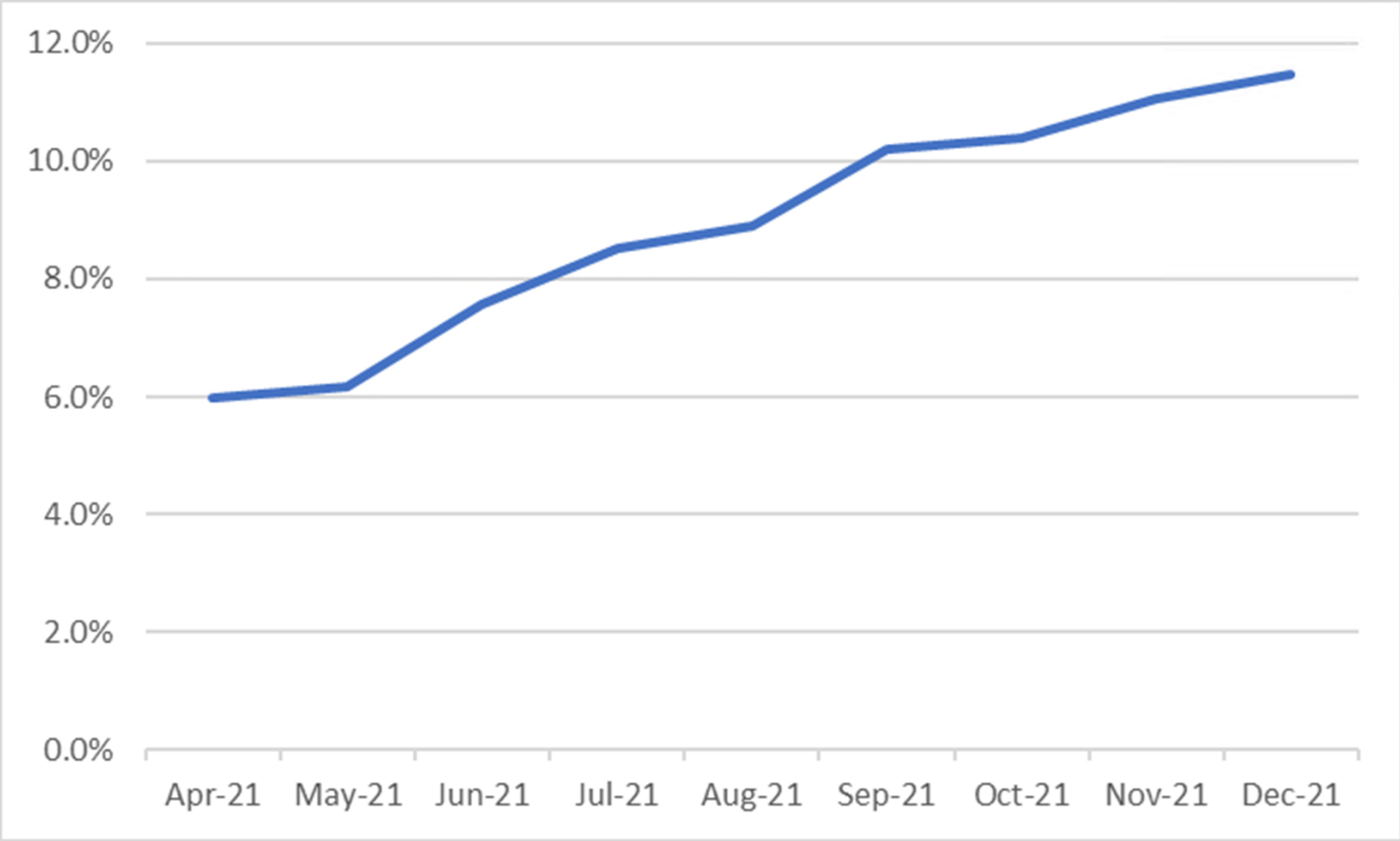
The data is taken from our provider information return (PIR) of residential adult social care. The data for this update consists of PIRs returned between 1 April to 31 December 2021, relating to 8,260 services, which is about 54% of all residential adult social care services. We plan to update these figures as the dataset builds and widen our analysis of workforce issues in other areas of adult social care.

Staff vacancy rates across England

The care home staff vacancy rate has continued to steadily increase throughout 2021 in England. The rate nearly doubled from 6% at the end of April, to 11.5% at the end of December 2021 (figure 1).

This month-by-month increase in staff vacancy rates is reflected in information for all types of social care published by Skills for Care. Although our figures are generally higher than Skills for Care's, when similar methodologies are applied, the results are comparable.

Figure 1: Staff vacancy rates in residential adult social care services, April to December 2021, England



2021	Vacancy rate
Apr	6.0%
May	6.2%
Jun	7.6%
Jul	8.5%
Aug	8.9%
Sep	10.2%
Oct	10.4%
Nov	11.0%
Dec	11.5%

Source: CQC residential adult social care PIRs, returned 1 April to 31 December 2021. Some PIRs were excluded from the analysis due to failing data validation. Data validation is under continuous review which may result in changes to historical figures when applied retrospectively.

Staff vacancy rates by region

We also looked at care home staff vacancy rates at a regional level. Figure 2 shows regional vacancy rates in quarters 1, 2 and 3 (April to June, July to September and October to December 2021).

The quarter 3 figures show that the south generally has higher care home staff vacancy rates than the north. The regions with vacancy rates higher than the England average are the South East, the South West, the East of England and London, whereas the regions with lower than average rates are the Midlands, the North East and Yorkshire and the North West.

The North East and Yorkshire had the lowest staff vacancy rate in quarter 3 (9.6%), and London had the highest (12.5%).

Comparing the change between quarter 1 and quarter 3 vacancy rates shows that the East of England had the largest increase – 6.8 percentage points, whereas London had the smallest increase at 2.8 percentage points. The East of England had the lowest vacancy rate in quarter 1 (5.3%) and London the highest (9.6%).

Figure 2: Staff vacancy rates in residential adult social care services by region, quarter 1 (April to June), quarter 2 (July to September) and quarter 3 (October to December) 2021, England

Region	Apr to Jun 2021 (quarter 1)	Jul to Sep 2021 (quarter 2)	Oct to Dec 2021 (quarter 3)	Difference (percentage points)
London	9.6%	9.4%	12.5%	2.8
South West	6.2%	8.8%	12.1%	5.9
East of England	5.3%	9.9%	12.1%	6.8
South East	7.5%	10.5%	11.8%	4.3
England	**6.6%**	**9.2%**	**10.9%**	**4.4**
North West	5.4%	8.0%	9.9%	4.5
Midlands	6.4%	8.8%	9.7%	3.3
North East and Yorkshire	6.1%	9.1%	9.6%	3.6

Source: CQC residential adult social care PIRs, returned 1 April to 31 December 2021. Some PIRs were excluded from the analysis due to failing data validation. Data validation is under continuous review which may result in changes to historical figures when applied retrospectively. Figures are rounded to one decimal place; difference was calculated before rounding.

Further exploration of workforce issues

We will continue to monitor and publish these vacancy figures. We will also provide more information on workforce issues in adult social care more widely, including:

- more context from the adult social care PIRs on the reason for vacancies
- the findings from our adult social care workforce survey carried out by our inspectors during their conversations with residential and home-care services. This survey explores the impact of workforce challenges and staffing shortages on people using the service and on the staff delivering the service
- information we may collect about the impact of workforce issues on the adult social care market more generally.

We know that adult social care services are under exceptional pressure during this winter. This is compounded by the Omicron variant of COVID-19, which is causing huge increases in infections. We will increase the number of infection, prevention and control inspections we carry out over the winter months, while expanding them to gather information on visiting practices.

As stated in our Update from our Chief Inspectors on our regulatory approach, we will also:

- inspect where there is a clear risk to safety. Using appropriate focused and targeted inspection methodologies
- begin a programme of activity to inspect providers currently rated as requires improvement to identify where improvement has taken place and possibly re-rate, with a view to supporting the creation of additional capacity in the system
- carry out activity to support the system over winter, including supporting the establishment of new designated settings to help ensure people can be safely discharged from hospital when they are medically fit to leave.

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ETHNICITY DATA RECORDING IN MENTAL HEALTH

In this article, we look at the quality of ethnicity data recording for mental health services within local health and care systems.

Background

Our 2020/21 annual State of Care report highlighted the impact of the pandemic on people's mental health. This included the increased demand for services. We also shone a light on the fact that the pandemic has not affected everyone equally. For example, some people from deprived areas and people from Black and minority ethnic groups have been affected more.

As highlighted in State of Care, according to Public Health England, at the end of May 2021 the cumulative age-standardised mortality rate in the most deprived areas in England was 2.4 times the rate in the least deprived areas. The mortality rates in people from the Black and Asian groups were more than double the rate in people from the White group.

Inequality in care was also highlighted by the findings of our provider collaboration review on children and young people's mental health. Again, this showed that the COVID-19 pandemic has demonstrated the inequalities faced by some people with mental health needs. In some cases, the pandemic made these inequalities worse.

Concerns around inequalities in mental health care were also highlighted by NHS Digital's annual figures on the Mental Health Act, published in October 2021.

Not being able to access the right care and support at the right time increases the risk of an individual's mental health deteriorating.

Health inequalities are a significant and long-standing concern for the NHS, with preventing inequality a key feature of the NHS Long Term Plan.

Some systems in our provider collaboration review told us how they were trying to address these inequalities. For example, some areas told us they were now working together better to identify children and young people who need mental health care and support. This included people from Black and minority ethnic groups, Travellers, and asylum seekers.

But we found that tackling inequalities was often not a main priority for systems. While some areas were using equalities monitoring data to identify children and young people in need of mental health support, the data was not always captured well. As a result, we were concerned that this could lead to missed opportunities to adapt care to meet the needs of individuals and local populations.

Quality of ethnicity recording in mental health data sets

Reliable, quality evidence is a fundamental tool in identifying, tackling and improving service equality.

In June 2021, the Nuffield Trust and NHS Race and Health Observatory published their report on Ethnicity coding in English health service datasets. This identified substantial data quality issues with many health datasets for hospitals and community health care. In particular, the report highlighted concerns that a large proportion of data was not linked to a known patient ethnicity. It also reported a notable and growing reliance on 'not known' and 'not stated' ethnicity codes. Without this information, health providers will not be able to use the data effectively to monitor equality and detect inequalities in access to services and outcomes.

The report recommended that assessing the quality of ethnicity coding should be made part of our inspections and ratings. Publishing this report is a first step in our work to consider how we can use quality of ethnicity data recording in our regulation.

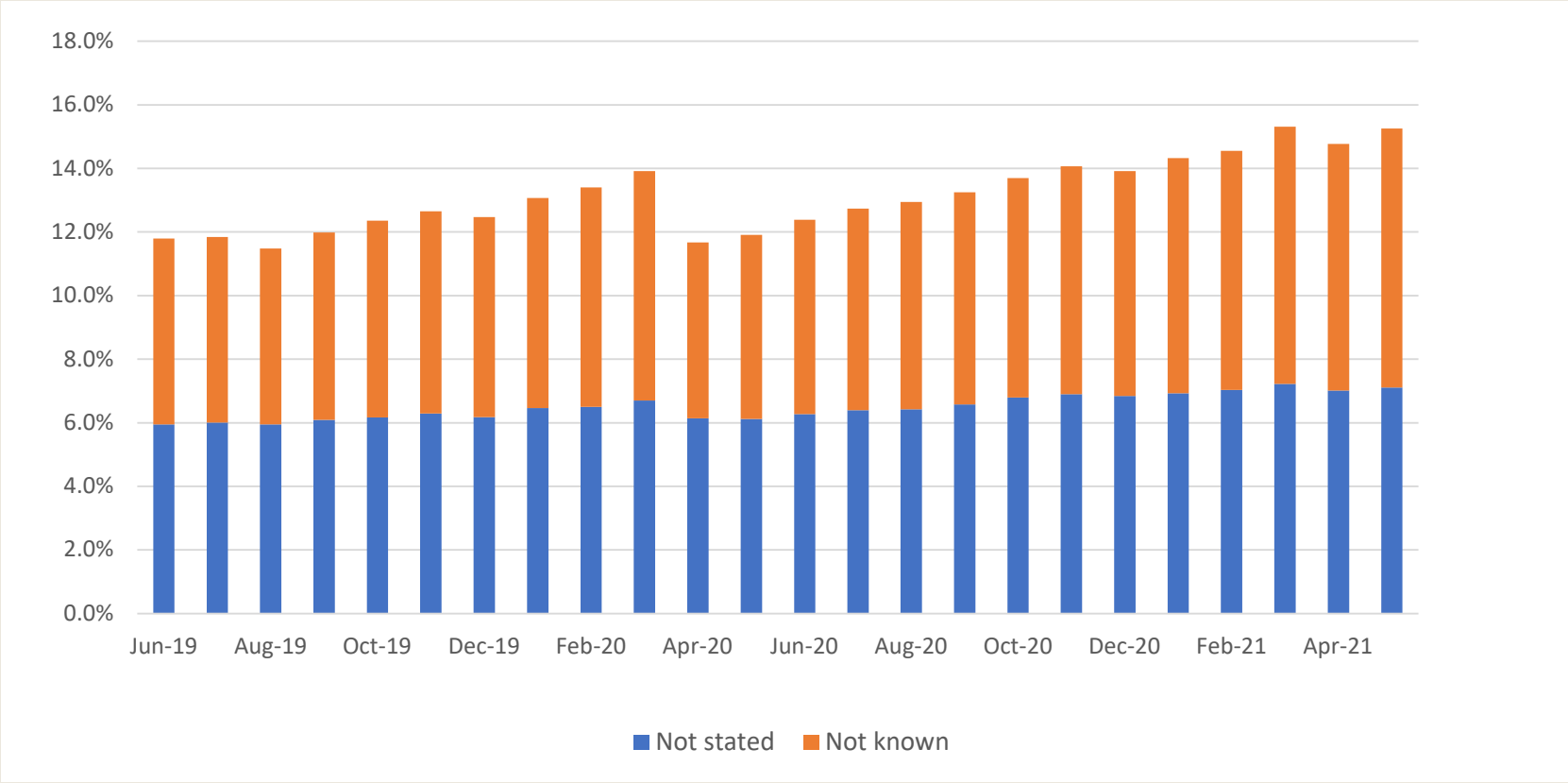
Building on the findings from this report, and following the concerns raised in our provider collaboration review on mental health around data on ethnicity, we have looked at the quality of ethnicity coding for mental health services who report to the Mental Health Services Data Set (MHSDS). To do this, we analysed a sample of the MHSDS ethnicity data from June 2019 to May 2021.

In line with the national mandatory standard, the MHSDS data set groups ethnicity into 16+1 ethnic data categories. These have been grouped into the following categories for the purposes of this analysis:

- Asian and Asian British
- Black and Black British
- Mixed
- White
- Other
- Not known – ethnicity is missing or otherwise not known
- Not stated – an individual chooses not to give their ethnicity.

Similarly to the report of the NHS Race and Health Observatory, we found that there was a substantial and growing proportion of patients whose ethnicity was recorded as 'not known' and 'not stated'. In the most recent month analysed (May 2021), we found that the ethnicity of nearly one in six patients (15.2%) was recorded under these categories (figure 1).

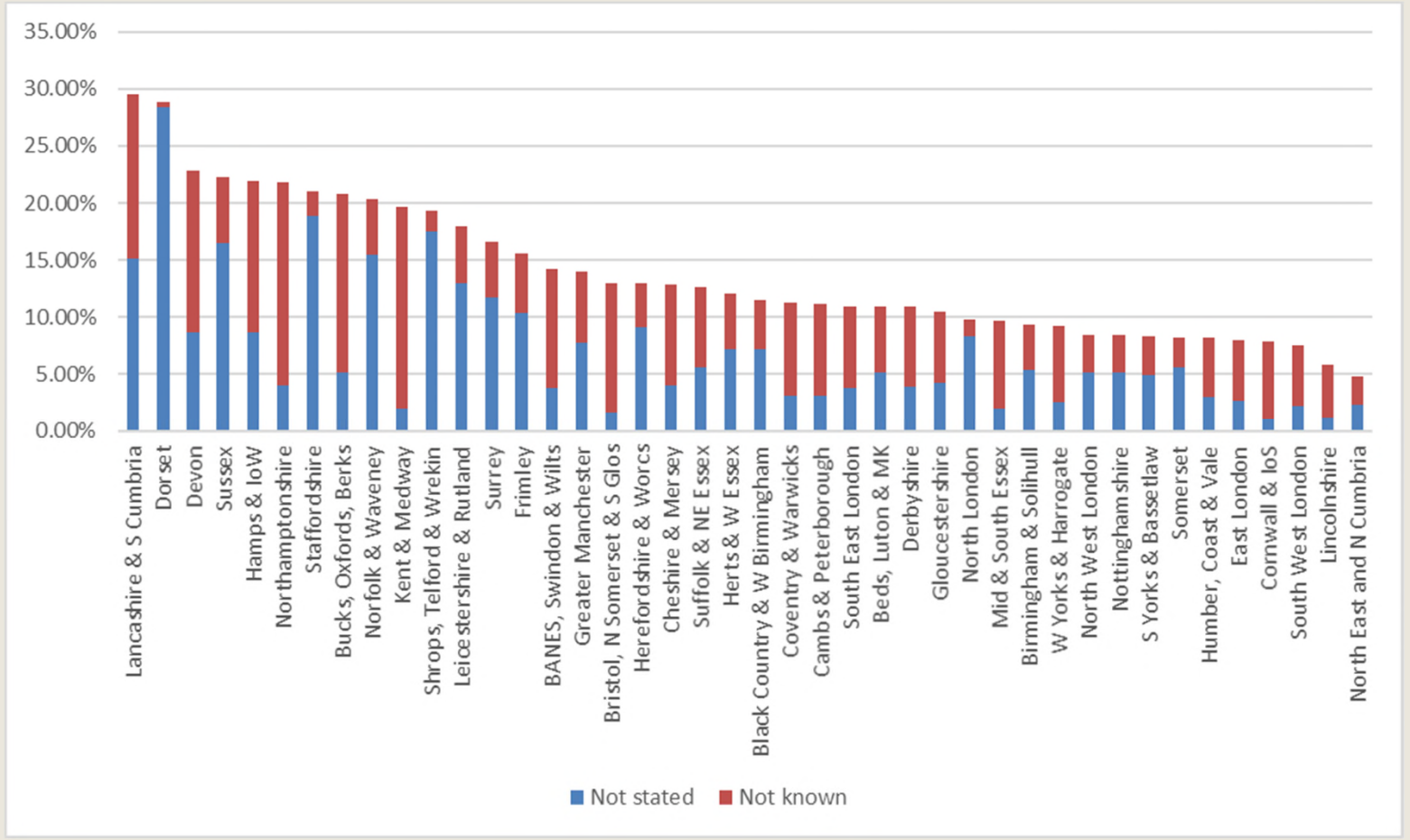
Figure 1: Monthly proportion of mental health patient records with an ethnicity code of 'not known' or 'not stated', June 2019 to May 2021, England



It is not clear why these categories have increasingly been reported. It is possible that the unprecedented demands of COVID-19 on health services may have reduced staff ability to make sure they are being recorded appropriately.

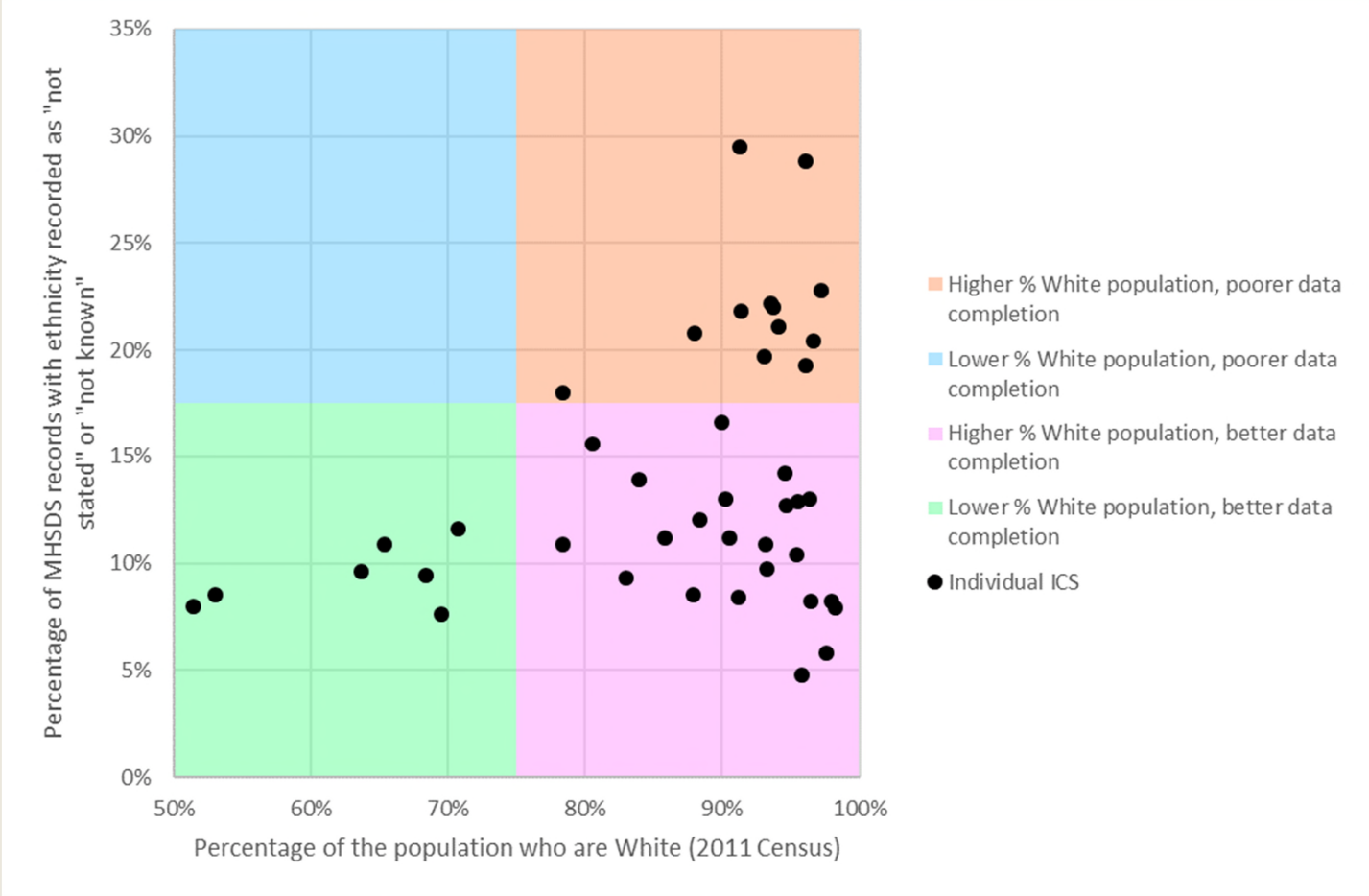
Systems with higher rates of not known and not stated will not be able to effectively understand, and in turn address, inequalities in the care being provided. How much the 'not known' and 'not stated' categories for recording ethnicity are used varies across integrated care systems. Together, use of these categories ranges from 4.8% to 29.5% (figure 2). Which code is used also varies across systems. For example, some integrated care systems tend to report greater levels of 'not known', while others report greater levels of 'not stated'.

Figure 2: Proportion of mental health patient records with an ethnicity code of 'not known' or 'not stated', June 2019 to May 2021, England



Why recording varies across systems is unclear. But local demographics, policy and leadership may all play a role. To try and explore this further, we looked at the use of ‘not known’ and ‘not stated’ categories against the ethnic diversity of each system’s local population (figure 3). While areas with the lowest proportion of the population identifying as White (7 out of 42) tended to have lower rates of MHSDS records with ethnicity recorded as “not known” or “not stated”, the analysis found no clear correlation between ethnic diversity and rates of data completion. We will continue to carry out work to better understand how the quality of ethnicity recording relates to other information we hold about quality at provider and ICS level.

Figure 3: Rate of ‘not known’ and ‘not stated’ categories versus proportion of White population by integrated care system, June 2019 to May 2021, England



We are concerned that poor recording of ethnicity, and an overreliance on the categories of ‘not known’ and ‘not stated’, is masking equality issues. Poor-quality recording makes it more difficult for organisations to interrogate and use data to address potential inequalities and that services are meeting the needs of individuals. For mental health services, this will reduce their ability to understand variation in referrals, treatments and deaths by ethnicity.

As highlighted in our provider collaboration review of children and young people’s mental health services, looking forward, it is important for systems to continue to increase their focus on addressing health inequalities. We encourage services to support system-wide efforts in tackling existing, and preventing future, health inequalities by improving how data to monitor equalities is captured and used, and improving training for staff on coding.

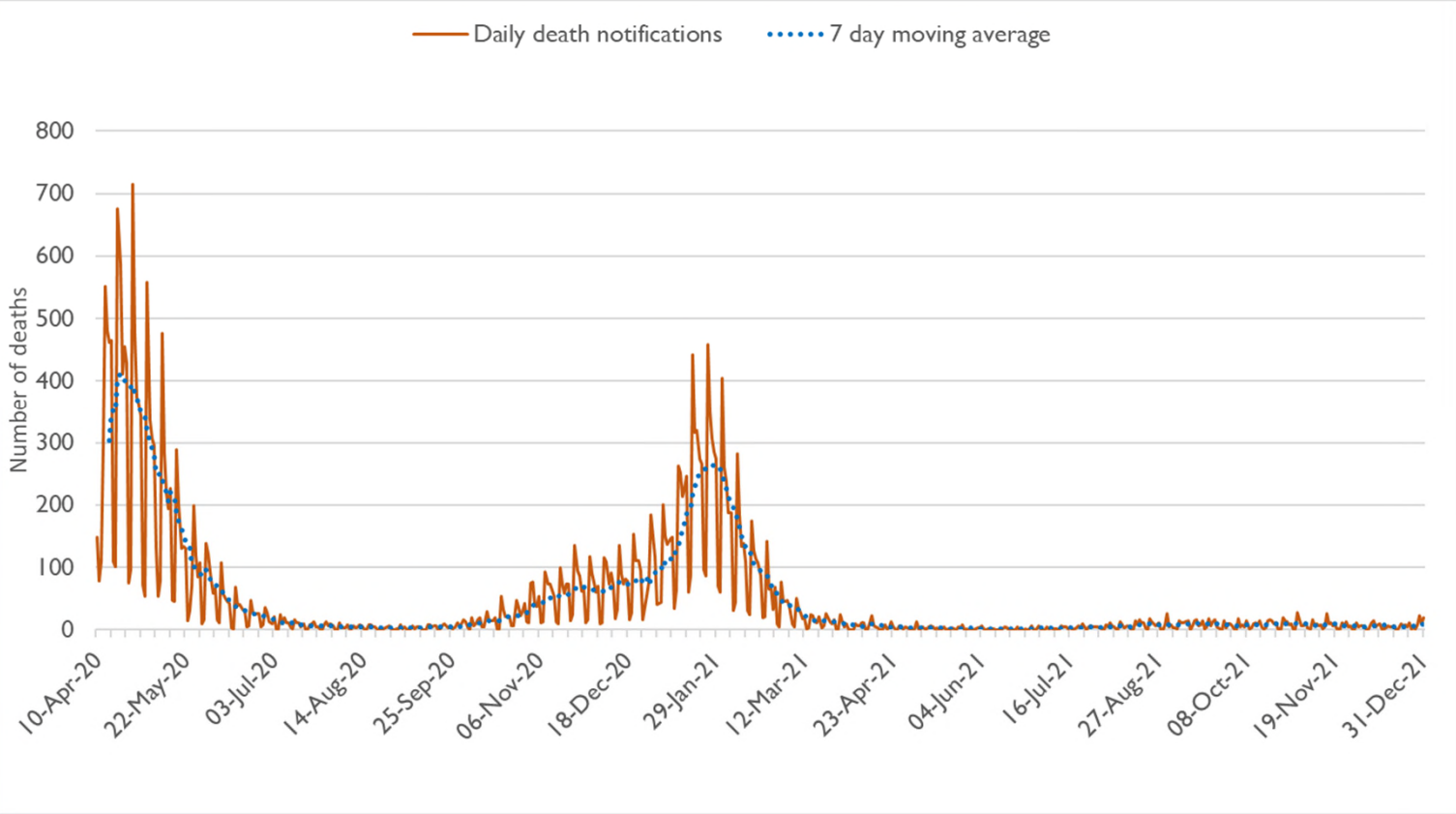
However, this needs to be part of a system-wide approach. As highlighted in the report by the Nuffield Trust and NHS Race and Health Observatory and a King’s Fund report on Ethnicity coding in health records, a key element will be updating guidance on recording of ethnicity as current guidelines were published in 2001.

CQC INSIGHT

LATEST DATA

Deaths notified by care homes in England

Deaths involving COVID-19 notified by care homes with 7-day moving average, April 2020 to December 2021, England

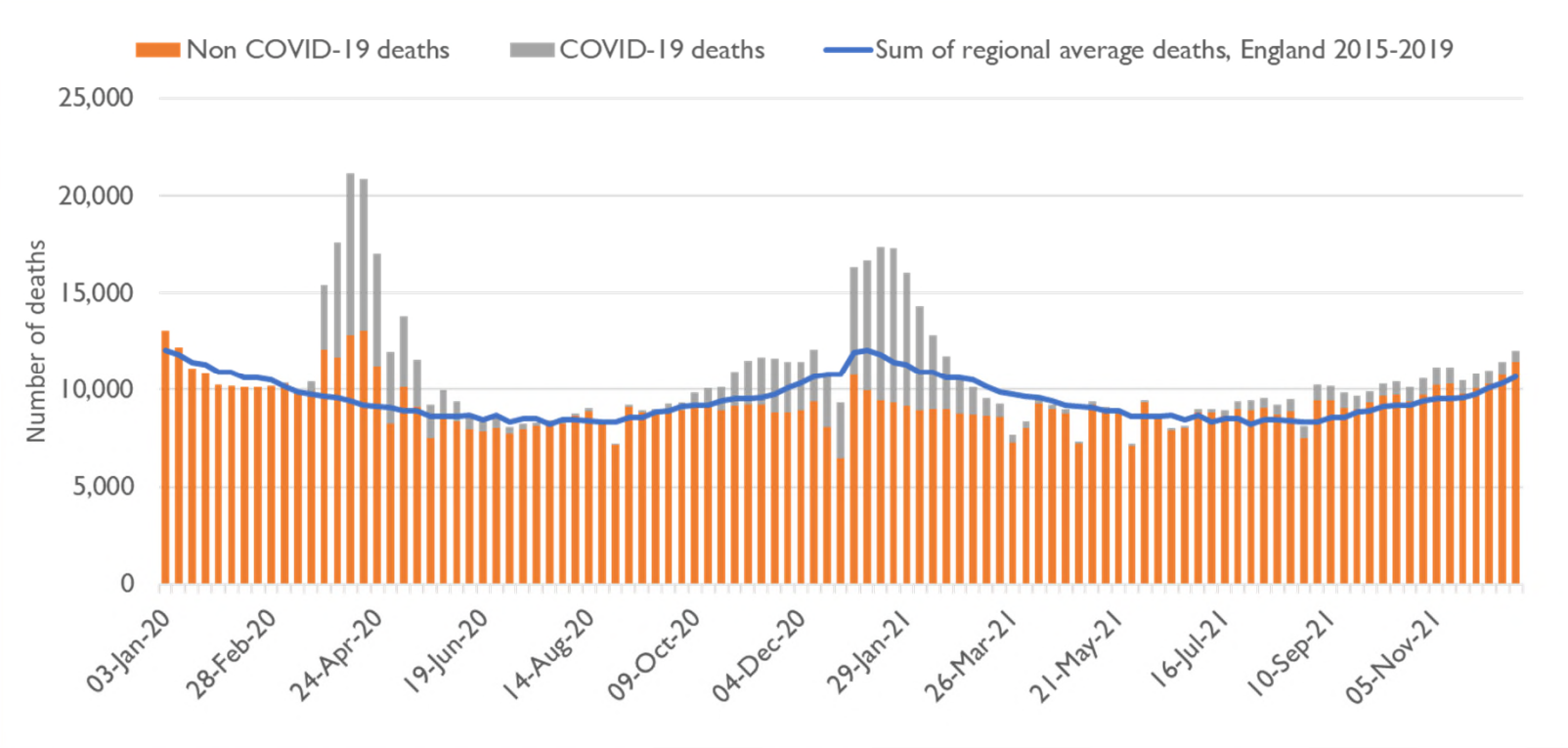


Source: CQC death notifications submitted 10/04/2020 to 31/12/2021. Note: The notifications only include those received by 4pm on Friday, 31 December 2021.

The chart shows the number of death notifications of people in care homes flagged as involving COVID-19 submitted each day up to 31 December 2021, with a seven-day moving average line showing the smoothed trend. The numbers of notifications of deaths peaked for the second time by late January 2021 and fell steadily until late April 2021. Numbers have remained relatively low since then, although we have seen small fluctuations in numbers since August.

Office for National Statistics weekly death registrations and occurrences

Total weekly deaths registered in 2020 and 2021 (involving COVID-19 and not involving COVID-19) compared with the average for 2015-2019, England



Source: ONS COVID/non-COVID 2020 and 2021 death data:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/deathregistrationsandoccurrencesbylocalauthorityandhealthboard
and 2015-2019 death data from:
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/11674fiveyearaverageweeklydeathsforenglishregionsandwalesdeathsthatoccurredbetween2015and2019
Week 51, 2021: week ending 24 December 2021