Health and Adult Care Scrutiny
16th June 2020

PREPARATION AND RESPONSE FOR THE COVID-19 EMERGENCY

Report of the Associate Director of Commissioning (Care and Health) and the Director of Commissioning (Devon CCG)

1. Recommendation

1.1. **To note the summary of arrangements for planning for and responding to the COVID-19 emergency within the health and care system in Devon.**
1.2. **To note the restoration and transformation of services following the COVID-19 emergency.**
1.3. **To recognise the commitment and achievements of all health and care staff across the period.**

2. Background

2.1. The COVID-19 pandemic has been devastating for those personally affected but it has also brought out the best in our staff and the communities of Devon.

2.2. The bravery, hard work and dedication of NHS and Care staff on the front line is something that the whole of Devon should be proud of. They have and continue to do an amazing job caring for us and our loved ones in incredibly difficult and often harrowing circumstances.

2.3. Hundreds of staff across our system, have been redeployed and retrained to undertake duties at the front line and this support has ensured that all patients and vulnerable people are looked after in the same caring way we strive for throughout the pandemic.

2.4. We also owe a debt to the fantastic voluntary and business sector in Devon who have provided huge support in the response to the pandemic. They have they provided over 21,000 pieces of protective equipment (PPE), including the manufacture of gowns and visors, and offered accommodation, parking and transportation. This support has really had a positive impact.

2.5. Devon communities have played a critical role in the response to the pandemic. People have rallied to support those in need across the county by looking out for neighbours and joining local support groups to make sure that people get essential supplies, a helping hand and a friendly voice at the end of a telephone.

2.6. As we now enter a new phase of the crisis, with fewer COVID-19 cases in hospitals and an easing of the lockdown, we must not forget that a new and rising wave of need might be upon us.

2.7. As well as running services as normally as possible for those who need our support, our staff are also preparing to reset our system to deal with the challenges living with this virus will bring.

2.8. Both Devon County Council and NHS Devon CCG are classed as emergency response organisations by the Civil Contingencies Act 2004 (CCA). This Act places duties upon emergency response organisations to prepare for emergency incidents, co-operate and co-ordinate with other emergency response organisations, and to respond in an integrated manner with other emergency responder organisations.

2.9. NHS Devon CCG is required by the NHS Act 2006 and national NHS policy to ensure that it, and its commissioned service providers, meet the NHS England nationally mandated core standards in preparing for emergencies.

2.10. Once Public Health England had identified the risk to the UK from the virus, organisations across Devon put in place their incident response structures and engaged with each other and other emergency response partners responding to government direction and guidance.

3. Planning and Preparation

3.1. Planning for a possible pandemic began in January / February with Emergency Preparedness, Resilience and Response (EPRR) resources across the health and care system beginning work to ensure that Pandemic Planning and Business Continuity Plans were up to date.

3.2. Building on preparation for a 'No Deal' Brexit and Pandemic Influenza we prepared to respond to the different risk profile of a Pandemic Coronavirus. Incident Directors were identified, and Devon System-wide teleconferences established to co-ordinate the response across all NHS service providers and with LA partners. This approach is the standard NHS co-ordination process for emergency and other incidents; it has worked well through-out the response to date, giving all partners a voice, an escalation route and support when required.

3.3. Devon County Council and NHS Devon Clinical Commissioning Group both established Incident Management Teams (IMT) in early March.

3.4. The Adult Social Care (ASC) Service Incident Management Team formed one of 17 IMTs within Devon County Council (DCC), operating as part of the wider council response to the pandemic.

3.5. The CCG IMT initially included three supporting Cells – Clinical, Primary Care and Communications. This approach worked well, enabling focused support and direction to be provided to Providers in this early stage of response. It also offered the flexibility necessary to expand the number of Cells as the response matured.

3.6. NHS Devon Clinical Commissioning Group (CCG) continues to act system convenor for the whole health and care system response across the Devon

Sustainability and Transformation Partnership area across geographic Devon. This has included hosting daily system calls at the peak of the Pandemic involving the following organisations:

- NHS Devon Clinical Commissioning Group
- University Hospitals Plymouth NHS Trust
- Royal Devon and Exeter NHS Foundation Trust
- Northern Devon Healthcare NHS Trust
- Torbay and South Devon NHS Foundation Trust
- Devon Partnership NHS Trust
- Livewell Southwest CIC
- Southwestern Ambulance Service
- Devon Doctors Ltd
- Devon County Council
- Plymouth City Council
- Torbay Council

3.7. This joined up approach to governance has developed positive partnerships and galvanised collective focus on key challenges as they emerged.

3.8. Local Authorities and the CCG also participate in LRF multi-agency co-ordination structures. The CCG represents the health system, on the LRF Tactical Co-ordinating Group (TCG) and also supports NHS England at Strategic Co-ordinating Group (SCG) meetings.

Clinical and Service Level Preparation

3.9. The Devon health and social care system, in line with the rest of the UK, had planned extensively over the years for a pandemic.

3.10. All NHS providers, Public Health England, Devon County Council, Plymouth City and Torbay Councils, NHS England / Improvement came together quickly through established emergency arrangements to implement guidance for the managing the new coronavirus.

3.11. There were **six aims** to this initial system response, delivered by the actions undertaken by health and social care providers and commissioners.

Aim One: Free-up the maximum possible inpatient and critical care capacity.

- To enable the postponement of all non-urgent elective operations and immediate urgent discharge of all eligible patients, referrals already in the system were clinically reviewed as a matter of urgency. Where the service was closed due to the outbreak and where clinical risk was low, referrals were held until services re-open. Where there could be some clinical risk referrals were clinically triaged and where appropriate either sent on to the local secondary care provider or held until services reopen.

- To make ready bed space that could be used in the event of surge of infection the entire Health and Care estate was assessed as to its ability to host critical care beds. This included NHS Property Services making ready some bed spaces, which thankfully have not been required.

- Provider trusts also undertook extensive work on their estates to repurpose beds, operating theatres and recovery facilities to provide respiratory support for COVID-19 patients.

- Alternative venues were also sought for services which needed to continue throughout the pandemic. A good example is the partnership between Plymouth Argyle Football Club and University Hospitals Plymouth which enabled important, lower risk appointments to continue in space provided at the Home Park Stadium without creating added footfall at Derriford Hospital and GP practices.

- Throughout this crisis response Emergency admissions, cancer treatment and other clinically urgent care have continued.

Aim Two: Prepare for, and respond to, large numbers of inpatients requiring respiratory support

- As part of surge planning Devon provider Trusts developed enhanced bedside oxygen availability and provided training for all clinical and patient facing staff.

Aim Three: Supporting our staff, and maximise staff availability

- Initially testing was targeted at NHS symptomatic staff. Health and care organisations were urged through consistent communications to put staff forward for appointments at the Plymouth drive-through Covid-19 testing centre, and later sites provided across the Devon geography.
- Colleagues in providers trusts have assisted staff in finding alternative accommodation when they were affected by the 14-day household isolation policy. They also provided alternative working arrangements for staff members at increased risk.

Aim Four: Support the wider population measures announced by Government

- In addition to the work undertaken by the Local authority in caring for Shielded people, GP practices have identified additional vulnerable people who required shielding. All shielded people who required a face-to-face consultation should have been seen at home. Where this was not possible, appointments had been managed with the lowest possible risk in terms of time and location.
- Planning for Covid-19 primary care sites was undertaken by GPs with the CCG, to manage essential face-to-face primary care assessments some of these services are currently in operation.
- The CCG put in place a rapid mobilisation process to enable practices to access the advantages of online consultations, this meant many practices were able to begin using eConsult within just seven days. The CCG also provided additional IT hardware to support GP practices and Microsoft Teams was made available to each GP Practice for all NHS Staff, replacing the need for other video conferencing software.
- In addition to this the CCG authorised the lease of vehicles to provide a COVID-19 home visiting services.

Aim Five: Stress-testing operational readiness

- In anticipation of a prolonged pandemic the health and care system revised business continuity plans and standard operating procedures. The EPPR functions at the CCG stress tested the ability to cope with many infected staff

and ensured that adequate business continuity plans were in place. All providers and commissioners across Devon undertook similar exercises.
- The IMT set up a cell to ensure distribution of guidance and information across the health system.

Aim Six: Removal of routine burdens

- The Government removed several routine burdens to assist in surge planning, these included –

    - Immediate cancellation of all routine CQC inspections;
    - Suspension of some requirements on GP practices and community pharmacists;
    - deferred publication of the NHS People Plan, the Clinical Review of Standards and NHS Long Term Plan Implementation Framework;
    - moved to block contract payments 'on account' for all NHS Trusts and foundation Trusts for the initial period of 1 April to 31 July 2020.

3.12. **The information above provides a small selection of the work undertaken across health and social care services. As a result of the above actions, the system was in a good position to deal with any surge in covid-19 cases and maintained acute capacity at 50% at the peak of this wave.**

4. Ongoing Response

4.1. Following the initial emergency response, DCC and the CCG supported providers across the health and care system. As a novel virus, little was known about the characteristics of the SARS-CoV-2 virus and the resulting COVID-19 disease in the early stages of planning and response.

Personal Protective Equipment

4.2. It became clear early in the response that PPE stocks in Devon would be under significant pressure. .

4.3. In light of this PPE cells were established across both DCC and the CCG which worked together with Public Health specialists to provide Providers and Partners with clinical advice and guidance on the use of Personal Protective Equipment and Infection Prevention and Control. With the well reported national supply issues and rapidly developing guidance both DCC and the CCG took a decision to secure PPE from the open market to ensure supply, jointly procuring some items.

4.4. Utilising donations and non-traditional supply routes, the PPE Cell put in place 72-hour PPE 'Rescue Packs' for providers, if they were unable to obtain the necessary supplies to maintain safe care. DCC provided PPE directly primarily to Children's Social Care, the Excess Deaths Team including Funeral Directors and to Adult Social Care and the wider Care Market, distributing over 1.5 million units of PPE through its distribution network.

4.5. A mutual aid process operated throughout together with a digital stock monitoring platform was implemented which included all acute providers. The system has ensured even distribution across the system and has helped

support smaller providers. The system has allowed the PPE stock to be used as efficiently as possible, reducing the “burn” rate of stock being used in fit testing and allowing more stock to be used in clinical settings.

4.6. DCC ensured that adult social care providers had access to Personal Protective Equipment sufficient to practice by linking them to arrangements for accessing national stockpiles. DCC also provided a local contingency by acquiring additional stocks on the open market as a supplier of last resort.

4.7. The voluntary and business sector in Devon have provided huge support in the response to the pandemic. Following a call for assistance communicated through media channels, they have they provided over 21,000 pieces of protective equipment (PPE), including the manufacture of gowns and visors.

Support for Care Homes

4.8. DCC and the CCG have worked closely with General Practice and community health service providers to support to all CQC registered care homes. Throughout the pandemic the CCG has worked with local authority colleagues to ensure adequate PPE supplies are available in the social care sector.

4.9. This work continues with CCG staff providing addition support and training in care homes. This includes hands on support with infection prevention and swabbing.

4.10. The CCG, alongside local authorities have led weekly webinars for social care staff across Devon. Topics for discussion have included, but not been limited to, PPE, infection control and testing.

4.11. DCC has developed frameworks of financial and other support to ensure the ongoing viability of adult social care providers in the residential/nursing, domiciliary and ‘unregulated’ sectors with the primary objective of maintaining continuity of service during the Pandemic period and the sustainability of market sufficiency into the future in line with our Care Act 2014 duties.

Testing

4.12. The initial response in Devon involved the establishment of processes to identify, isolate and test individuals suspected of having contracted the virus. The CCG’s IMT supported Providers when establishing new testing processes at short notice.

4.13. Led by the Peninsula Pathology Network, trusts in Devon and Cornwall agreed a shared approach using a combination of in-house and nationally run testing sites to provide quick results, reduce journey times and enable better data collection.

4.14. Staff across the health and social care sector were encouraged to contact their employers to arrange testing through local, rather than national routes, to enable a faster result. Local Testing routes were expanded to include Asymptomatic Testing for Social Care providers offered via local acute hospital testing, ahead of the National care home testing portal.

4.15. Devon County Council SIMT set up a Testing Workforce cell to support all Social Care staff to navigate the complex Testing arrangements as they were rolled out, this in the main, focussed on support to care home providers.

4.16. Additional drive through centres were established in Plymouth and Exeter and are run by the Department of Health and Social Care (DHSC). Linked to these sites are several Mobile testing units (MTUs), run by the military.

4.17. Partners are now working with Public Health colleagues on the local deployment of the national Test and Trace service and the Local Outbreak Management Plan..

Primary care

4.18. As a precaution to protect patients, staff and the public, most GP practices across Devon have been using online consultations as preferred first contact. Patients still have the option to speak to someone over the phone and if they do need to see somebody, they will be offered a face-to-face appointment where it is clinical necessary and safe to do so

4.19. Before the impact of COVID-19 Devon had led the way with introducing digital tools in primary care (e.g. eConsult) making the best use of practice resources and ensuring patients see the right person at the right time. During April and May, more than **13,000** video appointments were delivered. All Devon GP practices now offer video and online consultations and across April into May, **68,758 e-consults** were submitted to Devon GPs. Primary care along with secondary care, community, mental health and social care have all implemented new ways of working that involve increased use of technology at pace.

4.20. A huge collaborative effort by Primary Care was undertaken to establish Covid Primary Care Hubs across the localities of Devon. These sites have allowed a safe and dedicated pathway for patients with suspected covid-19.

4.21. As with Care Homes, weekly Primary Care webinars have provided an important forum for the exchange of knowledge and issue identification and resolution with colleagues on the frontline of Primary Care.

4.22. Additional financial support has been available for general practices for spend on such requirements as workforce, IT, telephony, PPE, equipment and individually commissioned services.

Nightingale Hospital

4.23. A new NHS Nightingale Hospital will be opened in Exeter to provide 120 extra beds for patients with coronavirus symptoms if needed.

4.24. The five hospitals in Devon and Cornwall will provide most of the care for critically ill patients with coronavirus.

4.25. NHS Nightingale Hospital Exeter will be hosted by the Royal Devon and Exeter NHS Foundation Trust. It will be run as a system level model to ensure resilience across the Devon, Cornwall and wider South West region, with a sub-structure of geographically aligned clinical networks.

Staff

4.26. Health and care services operate seven days a week and twenty-four hours a day. To support our providers in their round-the-clock delivery of services in the context of a Pandemic out-of-hours and on call capacity have been increased across the system.

4.27. This has included extending the hours of the ASC management service and monitoring incoming queries with the ability to respond flexibly and at short notice by deploying a range of specialist staff in extended, weekend and bank holiday shifts.

4.28. The council has also supported provider staffing through the recruitment of temporary and permanent staff via the Proud to Care campaign that now also includes their training, induction and deployment into the independent sector as well as assigning agency staff to settings experiencing an outbreak and consequent staffing shortage.

4.29. The CCG has redeployed over 100 staff to external organisations, including hospital providers, Livewell, Devon Doctors and NHS 111. The CCG also has over 160 staff whose role has been temporarily re-purposed due to the COVID-19 crisis.

4.30. Many CCG staff worked across recent bank holidays to provide essential support to frontline services, where bank holiday provision was also stepped up.

5. Restoration and Transformation

Guiding principles for recovery

5.1. The presence of coronavirus in our communities is likely to be with us for some time, we must sustain effective response arrangements whilst also considering how we broaden work programmes towards a ‘new normal’.

5.2. As we move to stepping down the intensity of some of our activity in response to Covid19, it is timely to consider how we build on and learn from the experience of our response as we move forward to living with Covid19.

5.3. In doing so, it is recognised that different parts of the Council, NHS and our partners will consider recovery at different times. Any response must recognise that some impacts are still happening in parts of the system.

5.4. Recovery does not imply a return to pre-Covid19 strategic priorities, infrastructure or operational delivery. It needs to align to population need and health and care urgency; be over a realistic period; be responsive in relation to any future Covid19 waves; and plan to retain beneficial ways of working and outcomes that have arisen through the crisis.

5.5. Some of the learning gathered during this pandemic is set out below, and will inform our recovery plans, alongside the impact on people, their families/carers and what matters to them going forward.

- Transformational increase in non-face to face appointments in primary care, IAPT and secondary care outpatients.

- Significant deployment and embedding of technology across all arenas (e.g. Consultant Connect, Attend Anywhere, e-Consult, AccuRx).
- Increased 7 day working.
- Stress-Tested System Emergency Preparedness, Resilience and Response.
- Increased homeworking of staff across health and social care.
- Primary care hot hubs.
- Professionals operating at top of licence (e.g. anaesthetists upskilled to support in intensive care as part of critical care team).
- Some more efficient ways of working have rapidly developed (e.g. managing incoming work, duty systems, virtual reviews in care homes).
- Hospital discharge flow – discharge to assess model.
- Good risk management processes in working with service users – using strengths/asset based approach.
- There has been a strong community response to the crisis. We have developed positive local links with the VCS that operational teams can pull on when needed (including out of hours).
- The identification and initial development of a more local/integrated way of working that responds to local demand with a more localised supply.

5.6. Whilst both the CCG and County Council are developing recovery plans, it is recognised that any recovery requires a multiagency response, including Local Resilience Forums. Recovery work is developing and ongoing, and we will look for opportunities for alignment, where appropriate.

NHS Restoration and Transformation

5.7. The NHS is focusing on recovery activity through the Devon Restoration and Transformation Programme.

5.8. On the 29th April 2020, NHS England sent out a letter to all NHS organisations which gave thanks to the NHS teams for the remarkable response to the greatest global emergency in our history. The letter noted that every patient needing hospital care, including ventilation, has been able to receive it.

5.9. The letter set out actions required as part of a second phase of the NHS response to COVID19, based on the assumption that there would continue to be cases of COVID19 and the need to ensure that the NHS fully stepped up non-COVID urgent services within the following 6 weeks. It also asked that each organisation considered what routine non-urgent elective services could be stood up whilst maintaining capacity to deal with COVID19 cases but recognised the need to factor in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies.

5.10. The letter also asked for organisations to consider the learning from the response to the crisis and how the innovations could continue.

5.11. The letter laid out 43 objectives to be completed by the 12th June 2020 which came under the following areas:

- Urgent & Routine care
- Cancer
- Cardiovascular Disease, Heart Attacks & Stroke

- Women & Children's
- Primary Care
- Community Services
- Mental health and Learning Disability & Autism Services
- Screening & Immunisations
- Reduce the risk of cross-infection and support the sage switch-on of services by scaling up the use of technology-enabled care

5.12. The CCG had already set up at team to co-ordinate the COVID19 Restoration and Transformation planning for the CCG. The Restoration and Transformation team worked with groups which were already established, to deliver usual business work programmes to review the actions required and to ensure that everything was in place to deliver all the NHSE expectations by the 12th June 2020.

5.13. An example of this is for cancer actions, where the Restoration & Transformation Team are working with the Cancer Alliance team to take ensure that all the actions required are delivered.

5.14. Many of the actions had already been considered by the group and were either in place or plans were in place for their delivery.

5.15. There are plans in place to deliver all the NHSE requirements laid out in the letter of 29th April 2020 and confidence that these will be delivered.

5.16. Some of the actions which are taking place to meet the expectations of NHSE as part of phase 2 are:

- Strengthening the capacity in out of hours services including 111
- Communication campaigns to encourage people who should be seeking emergency or urgent care
- Review of patients waiting for treatment to ensure those patients requiring time-critical treatment are prioritised
- Enhanced discharge planning to ensure timely, safe and appropriate discharge
- Prioritisation of acute cardiac surgery and other time-critical cardiology services
- Further support to care homes including identifying a clinical lead for each care home and setting up weekly virtual "care home round" of residents needing clinical support
- Prioritisation of home visits where there is a safeguarding concern
- Preparing for possible longer-term increase in demand for mental health services
- Enhance psychological support for all NHS staff who need it

Moving forward some services will need to be delivered differently to account for the impact of PPE, social distancing etc and to ensure that services are delivered safely for patients.

5.17. Some non - urgent services have already started to offer routine services. The delivery of these services will be prioritised for patients with the highest clinical need. These include some services within the following areas:

- Physiotherapy & podiatry services across Devon

- Audiology
- Community Health Visiting
- Some vasectomy clinics
- Hospice at Home
- Speech and Language therapy
- Outpatient clinics
- Fertility clinics

5.18. There have been many transformation positive changes in the way that healthcare has been delivered across Devon and we plan to ensure we learn from this and embrace these changes moving forward.

5.19. A good example of this is an increase in non-face to face appointments in primary care, mental health services and secondary care outpatients. This has been supported by embracing the use of digital technology including the use of e-Consult in GP practices and Consultant Connect and Attend Anywhere in outpatient clinics.

5.20. This has meant that patients have been able to continue to access health services safely during the crisis without having to travel to healthcare sites.

5.21. Some more examples of positive changes which have been embraced and are being taken forward are:

- The launch of a free for all parenting programme, this is a digital package to support parents from birth to 19 which includes free courses which are available for all parents in Devon
- e-Consult is a service now offered by all practices in Devon, where GPs and other primary care staff offer online consultations to their patients
- The autism service for young people has moved to online assessment where possible and have noticed an increase in the number of families engaging in the service. Online videos and resources and a family education/support programme has been made available to those waiting for diagnosis as well as those with a diagnosis

5.22. The crisis will have had an impact on staff health and wellbeing and the local teams are working to ensure that support is available to staff who need it.

5.23. There is a focus to ensure that mental health services can deal with any increased demand due to the impact of COVID19 on the health population in Devon.

5.24. The communications team have launched a publicity campaign “NHS is here for you” to ensure that patients still access care in current times and know that the NHS is still available.

Devon County Council Recovery

5.25. DCC agreed in April to set out the scope and framework for Devon’s multi-agency Recovery Coordination Group. Draft Terms of Reference for the Group set out high level objectives, principles and phases of recovery, to be built on with partners. It is proposed that:

“The Recovery Co-ordination Group will work with communities to bring together representatives across Devon to help rebuild, restore and rehabilitate Devon and its

economy, and to reflect on what we have learnt together in order to reimagine and redesign public services."

5.26. Alongside this, adult care and health has been considering recovery planning, with activity grouped as follows:

- The way that we will work (our practices) and how we build on and learn from how we have worked during our Covid19 response.
- What we take from the changed landscape and the impact of our response actions to change how we commission and deliver support for people going forward.
- The physical environment that we will work in (according to latest national guidelines).

5.27. We have made some changes in the last few weeks that would take longer in other circumstances. We need to capture, understand and build on the progressive elements of our response so we don't necessarily 'revert back to the old system' and move forward to a more sustainable health and care system for people. Work is underway to outline the steps to take towards recovery, including prioritisation of services and links to other teams.

5.28. The strategic principles that will inform our work include:

- We will support local people to drive the delivery of care, health and wellbeing in communities across Devon so that people feel safe, healthy, connected and able to help themselves and each other.
- We will not presume a return to what was provided before.
- Our recovery will be informed by the views of people, their families and carers, of their experience during the Covid-19 response.
- We will harness/build on support by the voluntary and community sector as a first port of call.
- Our leadership will set the strategic direction and devolve decision making where appropriate.

5.29. Some of the emerging key issues for building on the changed landscape for Adult Care and Health are set out below.

- Impact on the market, including resilience and financial implications. Impact on our market strategy, the workforce (including pay rates) and demand profiles.
- People who used Day Centres (which closed during the immediate crisis) have been supported in different innovative ways. What do people and their families/carers think of this and what might it mean for our future offer?
- There has been a strong community response to the crisis. We have developed positive local links with the VCS that operational teams can pull on when needed (including out of hours). How might we ensure that the VCS have greater participation in the offer for people's care and support?
- The identification and initial development of a more local/integrated way of working that responds to local demand with a more localised supply.
- How we might build on the health and care support that has wrapped around care homes moving forward.

Next steps

5.30. Work will continue to develop proposals for recovery, restoration and transformation.

5.31. The CCG and County Council will look for opportunities to align our response, where appropriate, to improve the experience for people and avoid duplication.

6. Consultations/Representations/Technical Data

6.1. To inform our Equalities Impact Assessment DCC commissioned Living Options to seek feedback from service users and carers through our Engagement Framework Contract which allows them to draw on the networks of a range of representative organisations. The report produced covered the impacts of lockdown arrangements as well as of COVID-19 itself.

6.2. People's views will continue to inform our work. We will continue to listen to residents and actively involve them in planning, shaping and reviewing support. We will work with a range of partners, including the District Councils, the voluntary and community sector, people and their families/carers.

6.3. We maintain active relationships with the providers we commission care and support from in Devon and beyond including via:

- Our Devon Provider Engagement Network website;
- Associated communication channels including email and social media;
- Our COVID-19 mailbox, responding to provider queries;
- The PEN Reference Group and additional COVID-19 for a for each sector of the market;
- Our care homes webinar held jointly with NHS Devon Clinical Commissioning Group attended by upwards of 150 providers each week;
- Written communications where appropriate.

6.4. We have established several daily reports and online tools to support monitoring of the situation and our response to it. Key data is presented in the report 'Activity and performance during the covid-19 emergency period to date.'

7. Financial Considerations

7.1. In Devon County Council, the Adult Social Care Incident Management Team has agreed and where appropriate escalated the decision-making regarding a range of financial commitments to support service continuity and recognise additional costs borne by providers during the pandemic period. This includes commitments regarding:

- The domiciliary care market, with fees uplifted to cover £10 per hour for care workers;
- The residential and nursing care market, with a general uplift of 5% and a targeted uplift of 4% for those providers accommodating residents who are COVID-19 positive;

- The ‘unregulated’ or ‘other’ care market including support to people in supported living settings;
- The temporary suspension of charging for non-residential care;
- Funding of a range of temporary residential capacity in care homes and ‘care hotels’;
- Additional capacity to staff and support care homes experiencing pressures and where appropriate their travel and accommodation e.g. as the result of an outbreak;
- Recruitment, training and induction of additional workforce and their deployment into independent sector providers;
- Equipment and technology to support hospital discharge;
- Additional weekend and out-of-hours capacity.

8. Sustainability Considerations

8.1. To date Adult Social Care has committed approximately £22.5m on additional expenditure relating to the COVID-19 emergency, manly relating to our support of providers of adult social care services. Of this, just under £3m is considered to be recurring, relating to the increase in rates paid for personal care to establish a minimum hourly pay rate for domiciliary care workers of £10ph.

8.2. These commitments have been underwritten by the £36.7m of additional funding so far granted to Devon County Council in support of its response to the COVID-19 emergency. This does not include the additional £10.5m funding recently announced as an infection control fund, the significant majority of which is being passported onto providers, especially providers of nursing and residential care, proportionate to their size.

8.3. We are in the process of reviewing these financial support arrangements, seeking to establish frameworks that are sustainable and flexible to changes in the situation with the overarching objective being to maintain continuity of service the citizens of Devon we support.

8.4. We are also beginning to assess the longer-term impacts of the pandemic on demand for our services, the supply of those services, and their cost – all key to recovery planning.

8.5. We want people to lead meaningful lives within their communities. There are clear social and economic benefits in supporting all adults to live as independently as possible.

9. Carbon Impact Considerations

9.1. The impact of COVID-19 and attendant lockdown measures on adult social care will broadly have been carbon neutral, with no significant long-term shifts in activity levels anticipated in Devon given the comparatively low level of impact on the demand for and supply of services.

10. Equality Considerations

10.1. Devon County Council has published a corporate Equalities Impact Assessment relating to COVID-19 Pandemic Incident Management which will be updated iteratively.

10.2. Adult Care and Health have made significant contributions to this assessment, highlighting the most significant impacts on service users and carers relating to their protected characteristics resulting either from COVID-19 itself, the lockdown measures introduced as part of the national response, and local measures implemented during our management of the incident.

10.3. This assessment was informed by the consultation of service users and carers convened by Living Options and its partners summarised in paragraph above.

10.4. Any impact assessment is provisional and iterative: we will continue to collect quantitative and qualitative information on how the situation is impacting on the lives of the people we serve, reassess its impacts and their mitigations, and ensure our assessment is used in each update of the published corporate assessment.

11. Legal Considerations

11.1. We have assessed the approaching 1,000 items of new government guidance relating to COVID-19 for its impact on adult social care on a daily basis, developing detailed policy, practice and communication responses where appropriate.

11.2. Each week we have conducted a review of the implications of this guidance to ensure our response is consistent with it and sensitive to all of its impacts, communicating with our care management staff, provider organisations and the wider organisation and its partners accordingly.

11.3. Where professional legal, HR, procurement or financial advice has been required we have sought it from colleagues, with cells embedded in our Incident Management Team arrangements.

12. Risk Management Considerations

12.1. In preparation for the Incident, DCC highlighted the key risks in a series of entries onto our corporate and service-level risk registers.

12.2. As DCC assess this first phase of response and consider the risks associated with second or subsequent waves of infection, we will update our risk register accordingly.

12.3. DCC have maintained a register of lessons learned throughout and are now initiating a formal debrief so that we learn and apply that learning to preparing for and responding to any second or subsequent wave of infection, or a future pandemic.

13. Public Health Impact

13.1. The Devon County Council response to the COVID-19 has been led by the Director of Public Health through chairing of the Pandemic Incident Management Team, attendance at the Local Resilience Forum and on the Devon health and care system gold call coordinating action across the partners in the Devon Sustainability and Transformation Partnership ‘Together for Devon’.

13.2. Throughout our health and care system response we have sought specialist Public Health advice on infection prevention and control measures including the use of Personal Protective Equipment and Testing.

13.3. Similarly, health and care organisations are key in working with the Director of Public Health on the development of a Local Outbreak Management Plan by the end of June to ensure that we identify and act on any outbreaks in settings in our area including hospitals and care homes which will be key to keeping infections at a level that does not lead to a significant second or subsequent wave of COVID-19 in our communities.

Sonja Manton
Director of Commissioning (Devon CCG)
Tim Golby
Associate Director of Commissioning (Care and Health)

Electoral Divisions: All
Cabinet Member for Adult Social Care and Health Services: Councillor Andrew Leadbetter
Chief Officer for Adult Care and Health: Jennie Stephens

LOCAL GOVERNMENT ACT 1972: LIST OF BACKGROUND PAPERS

Background Paper	*Date*	*File Reference*
Nil		

Appendix A

ACTIVITY AND PERFORMANCE DURING THE COVID-19 EMERGENCY PERIOD TO DATE

1.1 To note the summary of data presented indicating that Devon was comparatively less impacted by COVID-19 in terms of cases of infection, resulting fatalities, and outbreaks in care home settings than was typical in the south-west region which in turn has been the least impacted region in England.

1.2 To note that the capacity of the health and care system in Devon has been sufficient so far to provide care and support to those infected with COVID-19 including hospital bed and critical care bed capacity.

2. Background

2.1 We have established a number of daily reports and online tools to support monitoring of the COVID-19 emergency situation and our response to it.

2.2 Local breakdowns of national data are available from a number of sources, with differences in definition, time period covered and time lag. Footnotes provide information regarding the data used.

2.3 Devon County Council commissioned Living Options to seek feedback from service users and carers through the Engagement Framework Contract which allows them to draw on the networks of a range of representative organisations. The report produced covered the impacts of 'lockdown' arrangements as well as of COVID-19 itself and is summarised below.

3. Activity and Performance

3.1 Infections

3.1.1 In Devon the number of lab-confirmed positive tests for COVID-19 has been comparatively low against the national picture. As with national and other local authority area data the number of confirmed cases is dependent upon the capacity for testing and the number of people tested as well as the prevalence of infection in the community. Testing capacity available in local laboratories is 3,500 per day.

3.1.2 There were 810 lab-confirmed cases in the Devon County Council area up until 25/05/2020 with the peak day being 04/04/2020.

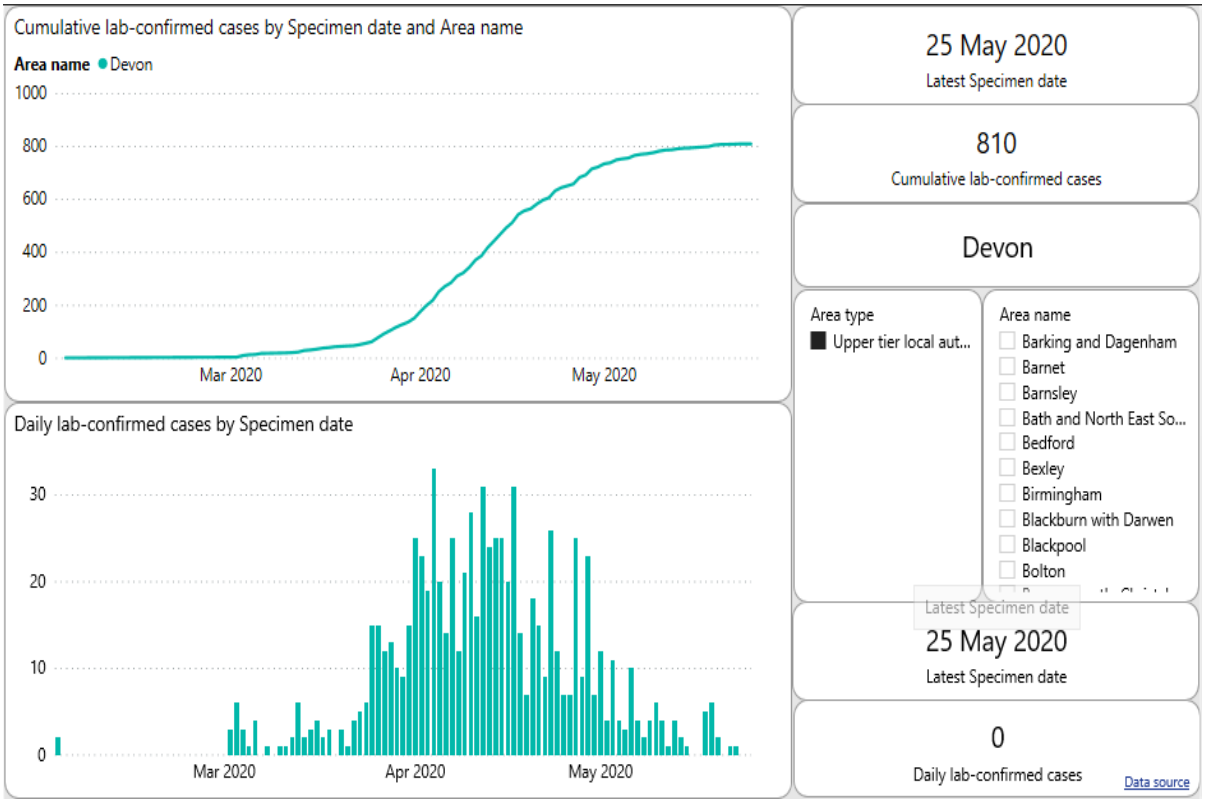


Fig 1: lab-confirmed infections in Devon by day and cumulatively to 25/05/2020[1]

3.2 **Fatalities**

3.2.1 In the Devon County Council area 191 deaths where COVID-19 was recorded were registered at 23/05/2020.

3.2.2 The peak of fatalities in Devon in this first wave of infection occurred in the week ending 17/04/2020. This was the peak in both hospital and care home settings.

[1] Definition: An infection is recorded if an antigen swab test is lab-confirmed as positive and the case is recorded by the date of specimen taken

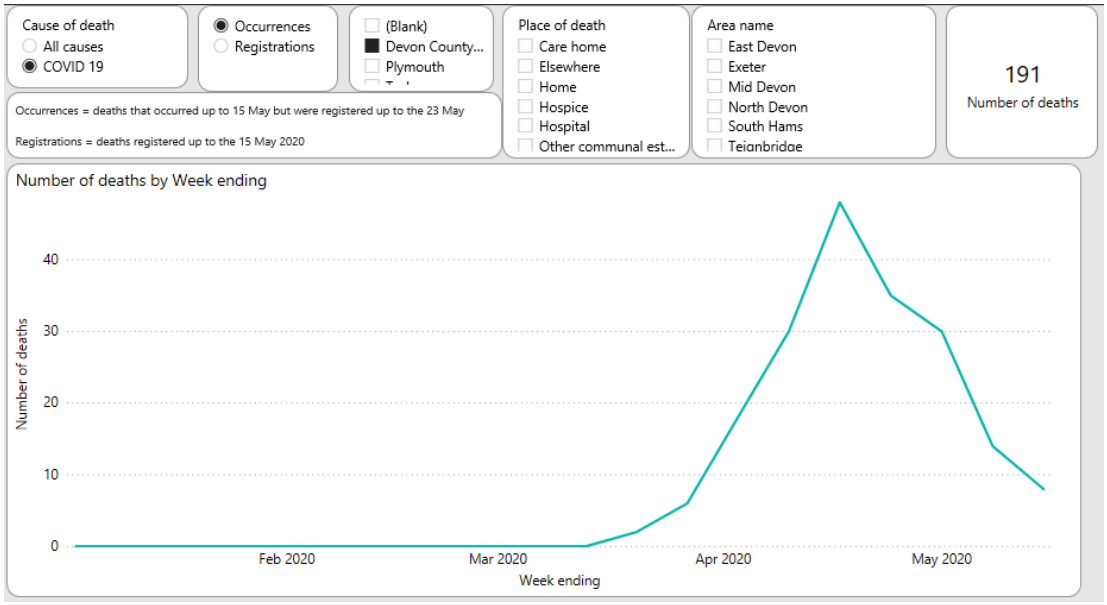


Fig 2: deaths registered with COVID-19 mentioned on the death certificate. [2]

3.2.4 The number of deaths has varied by District and City Council area:

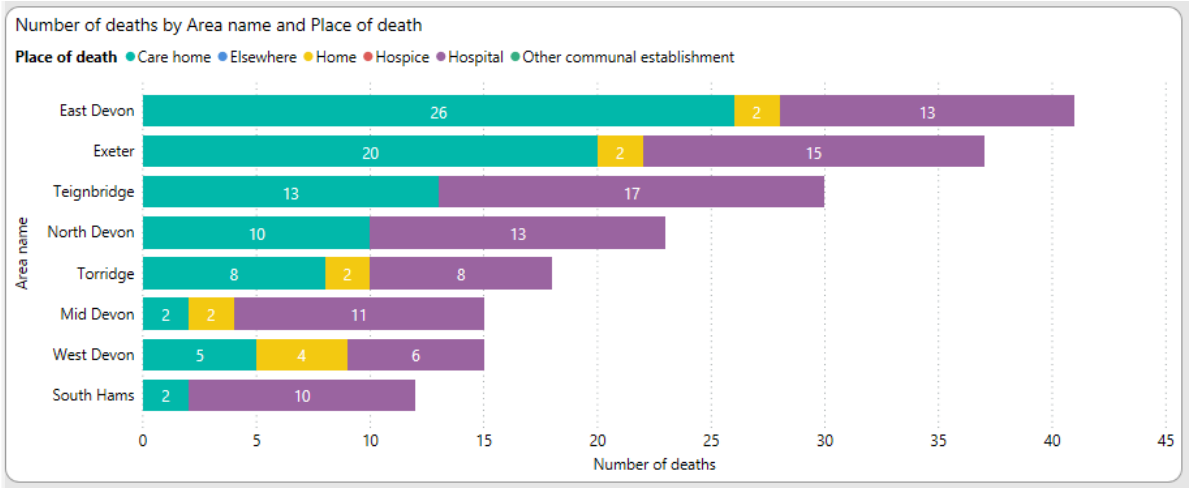


Fig 3: number of deaths due to COVID-19 by place of death and District Council area

3.3 Hospital Activity

3.3.1 At the instruction of NHS England all Hospital Trusts were instructed to make available a minimum of 50% of their bed capacity in order to ensure sufficient provision for any surge of demand relating to COVID-19 by creating new capacity and also postponing non-urgent activity.

[2] Data source: Office for National Statistics.
Definition: There is a time lag in the registration process of up to 10 days.
Mention of COVID-19 as a cause of death on the death certificate does not indicate that it was the only cause of death.
Lack of mention of COVID-19 as a cause of death on the death certificate does not mean that the person was not infected with COVID-19; not all instances of infection at death have been certified, especially earlier in the epidemic.

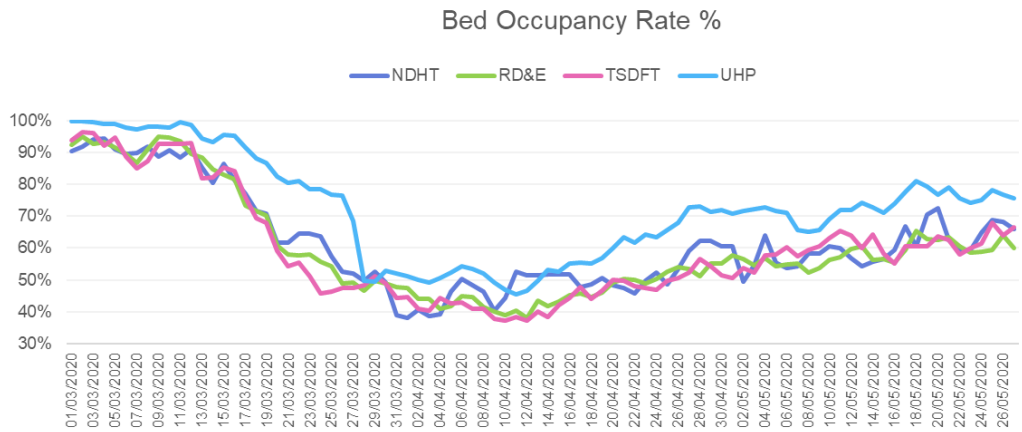


Fig 4: Percentage of occupied hospital beds by Trust.

3.3.3 The number of critical care beds was increased across the system in anticipation of a surge of demand from COVID-19 patients requiring ventilation/oxygenation. The system has managed within capacity throughout the pandemic.

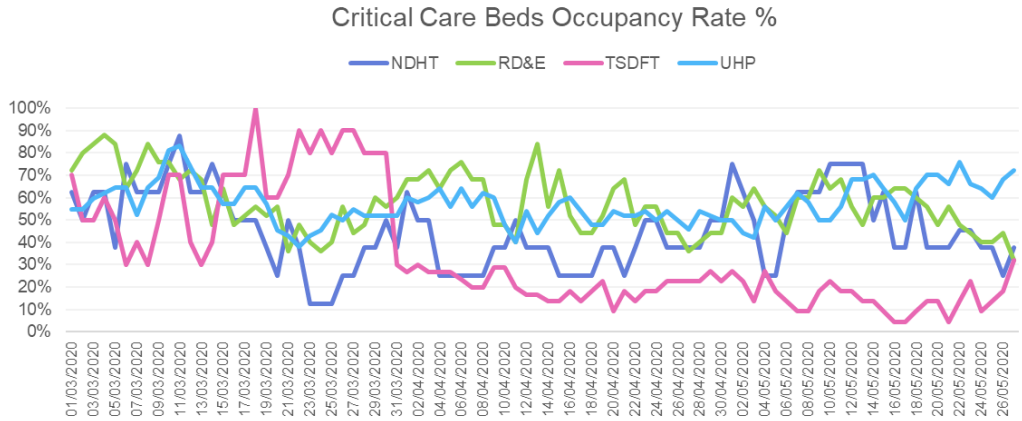


Fig 5: Percentage of critical care hospital beds by Trust occupied. Source: Urgent and Emergency Care Daily Collection[3]

3.3.5 The number of acute hospital beds occupied by Covid-19 patients across Devon peaked at 210 in mid-April, with a maximum of 39 people in Critical Care (HDU/ITU) beds. Covid-19 admissions rose sharply from late March to mid-April and have reduced more slowly as the infection rate fell.

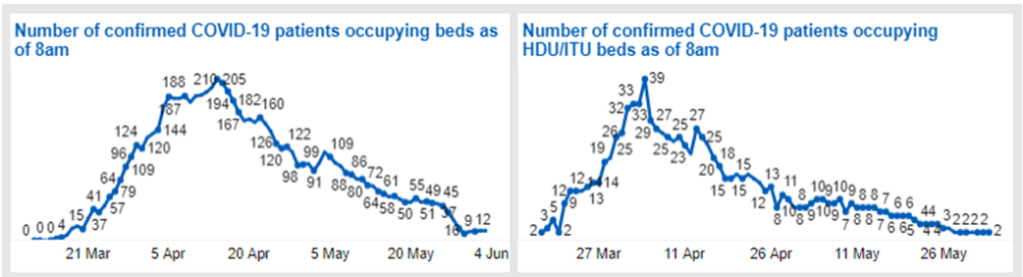


Fig 6 a/b: Bed Occupancy Data source: National Sitrep reporting[4] *Data source: Devon Covid Sitrep*

[3] Definition: occupied critical care acute beds as a percentage of overall acute beds by Trust / A critical care bed is ICU capable
[4] Definition: Fig 6.A total occupied acute beds / Fig 6.B occupied critical care acute beds

3.3.7 The number of ventilators, key to dealing with the more serious symptoms of Covid-19, rose from 185 in early April to a current level of 233.

3.4 Community Response

3.4.1 The first service to see a significant impact of Covid-19 was 111. The 111 service received an average of 1,171 calls per day in January and February 2020. In March this increased by **53%** to an average of 1,786 calls per day. April saw numbers reduce but daily calls remained higher than previously experienced at 1,289 from the period 1st April to 14th April. However, this then fell to under 1,000 calls per day on average for the second half of April and has remained at anticipated levels since then.

3.4.2 Routine referrals for elective hospital appointments reduced from around 600 per day across Devon in early March to around 230 by the end of March and have remained low through April and May. 2 week wait cancer referrals also fell from an average of 300 per day to just over 90 per day, although as a result of communications campaigns this has now increased to around 215 per day.

3.4.3 Although GP appointments fell during April and May, there has been a significant increase in the use of e-Consult. This increased by 50% across Devon as a whole, but significant increases have been seen in areas with previously low take up, such as Eastern Devon (up by **300%**) and Northern Devon (up by **200%**).

3.5 Future hospital capacity

3.5.1 During the first wave of COVID-19 infections in Devon the acute system has operated within the capacity identified to treat COVID-19 positive patients.

3.5.2 The projections going forward are based on three values of the R-number. For COVID-19, without social distancing and other mitigations, the R-number is assessed as being 3. The government's target is to maintain the R-number nationally and locally at 1. Given the low prevalence of COVID-19 infection in Devon, if the R-number is kept below that level we can expect infections in the community to fade. However, an increase to only 1.15 could lead to a second wave later in the summer and put the health and care system under pressure again if not addressed by further national or local measures.

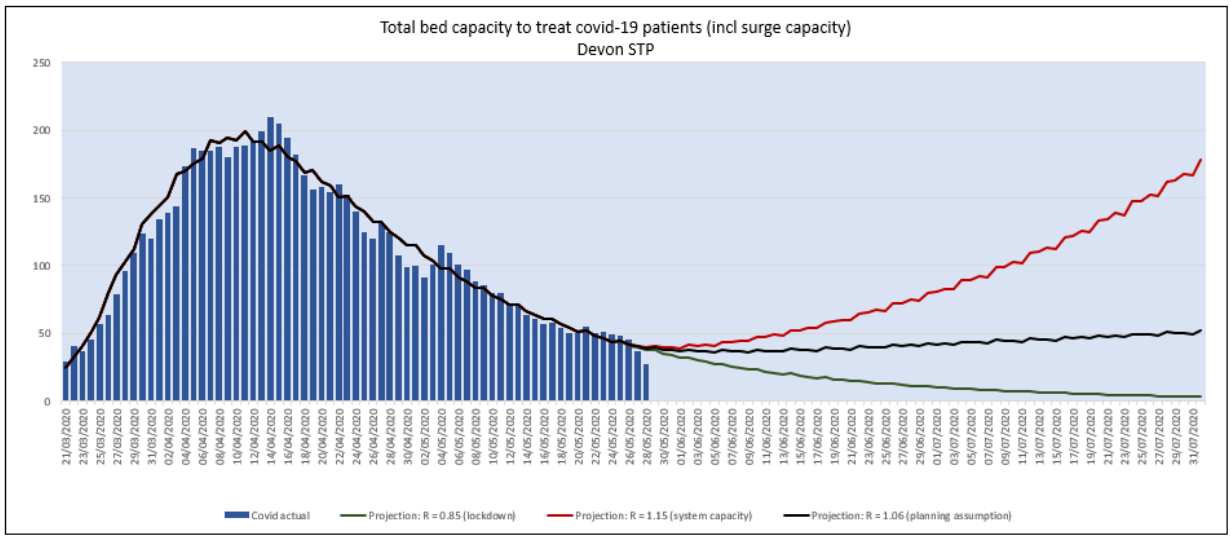


Fig 7: actual and projected use of bed capacity to treat COVID-19 patients including surge capacity Source: Urgent and Emergency Care Daily Collection[5]

3.6 Care Home Outbreaks

3.6.1 In Devon the number of confirmed and unconfirmed outbreaks peaked on 23/04/2020 and the number of confirmed outbreaks peaked on 06/05/2020. Given the criteria for closure of an outbreak, there is a lag between a situation being under control and it being closed.

3.6.2 At the notification of a suspected outbreak system partners work to support the home with:

- Information and advice including in infection control;
- Access to Personal Protective Equipment;
- Additional staffing, especially where staff are self-isolating;
- Moral support including regarding bereavement.

[5] Definition: the total bed capacity to treat COVID-19 patients is that designated as such by the four acute Trusts in Devon.
R-number: the average number of people each infected person goes onto infect. Scenarios:

- 0.85 = estimated R-number under current social distancing measures
- 1.06 = planning assumption if measures are relaxed and compliance reduces
- 1.15 = the limit of the R-number if the capacity of the local health and care system is not to be stretched in the summer period

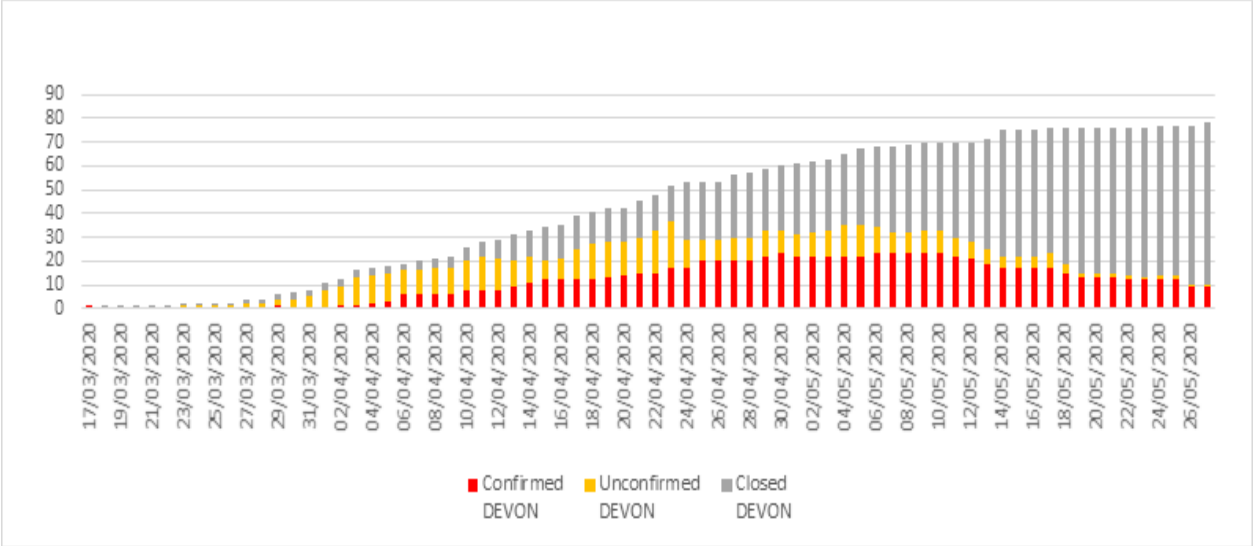


Fig 8: Care home outbreaks in Devon as at 27/05/2020 Data source: Devon County Council / Public Health England[6]

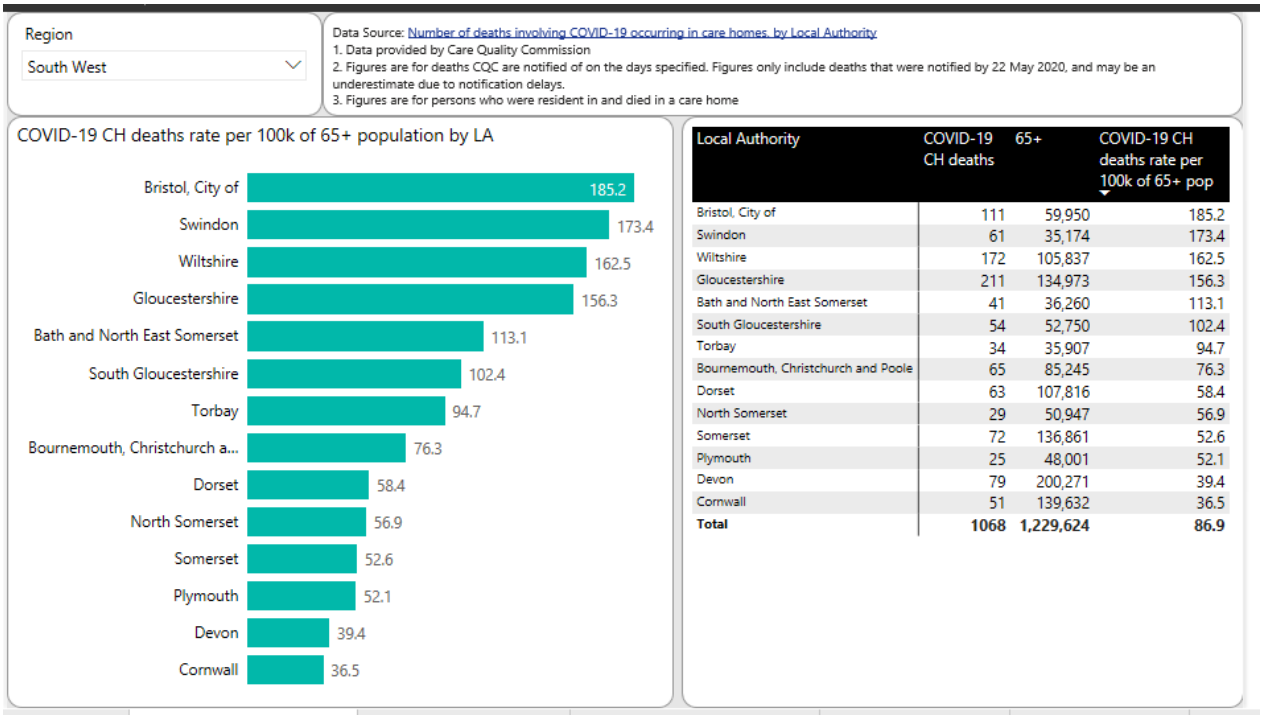
3.7 Fatalities in Care Homes relative to population

3.7.1 The South-West is the region of England with the lowest proportion of its population infected with COVID-19, the lowest proportion of its population dying as a result and the lowest proportion of its population dying in care homes.

3.7.2 Devon and Cornwall are the local authority areas in the region with the lowest death rate in care homes due to COVID-19 relative to its 65+ population size. Data analysis suggests the following protective factors:

- A low level of community-based infection;
- A high proportion of Good and Outstanding care homes;
- A high proportion of smaller care homes;
- A low proportion of Nursing Care homes;
- Fewer instances of staff working across multiple settings;
- Local health and care system capacity and capability to support in infection prevention and control.

[6] Definition:
A care home outbreak is recorded as unconfirmed when it is reported by a care home to Public Health England.
A care home outbreak is recorded as confirmed following two positive test results.
An unconfirmed care home outbreak is closed test results are negative.
A confirmed care home outbreak is closed when there has been no one in the setting showing symptoms of COVID-19 for 14 days



Local Authority	COVID-19 CH deaths	65+	COVID-19 CH deaths rate per 100k of 65+ pop
Bristol, City of	111	59,950	185.2
Swindon	61	35,174	173.4
Wiltshire	172	105,837	162.5
Gloucestershire	211	134,973	156.3
Bath and North East Somerset	41	36,260	113.1
South Gloucestershire	54	52,750	102.4
Torbay	34	35,907	94.7
Bournemouth, Christchurch and Poole	65	85,245	76.3
Dorset	63	107,816	58.4
North Somerset	29	50,947	56.9
Somerset	72	136,861	52.6
Plymouth	25	48,001	52.1
Devon	79	200,271	39.4
Cornwall	51	139,632	36.5
Total	**1068**	**1,229,624**	**86.9**

Fig 9: COVID-19 Care home death rate per 100,000 65+ population[7] Data source: Office for National Statistics 26/05/2020.

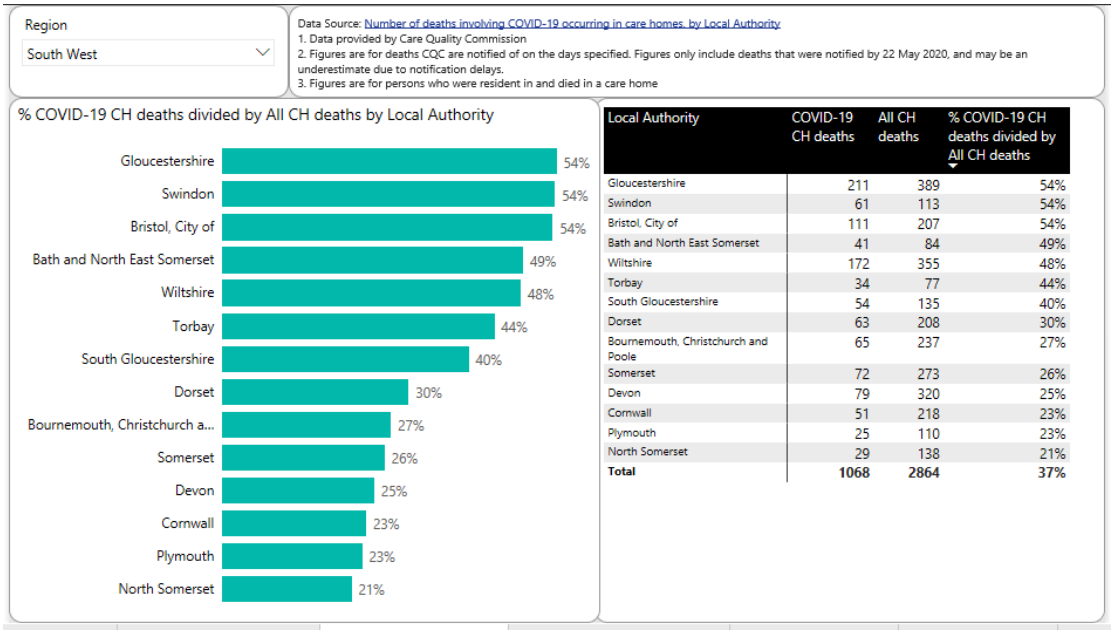
3.8 Proportion of deaths in the local area occurring in care homes

3.8.1 Given lower levels of infection and deaths due to COVID-19 are generally correlated with lower numbers of deaths in care homes, it is useful to also look at the proportion of deaths in the area due to COVID-19 that occur in care home settings.

3.8.2 Devon is among those local authority areas in the region with below a quarter of deaths due to COVID-19 occurring in care homes, although again there is a clear correlation between the areas experiencing most infections and those experiencing the largest proportion of deaths in care homes indicating it is easier to prevent outbreaks than to control them and the best way of limiting outbreaks in care homes is to limit infections in the community.

[7] Definition:

- The fatalities recorded are those notified to the Care Quality Commission by the care home as being due to COVID-19;
- Only those who were both resident and died in the setting are included;
- Up to 20% of deaths in hospital nationally are also estimated to be care home residents.



Local Authority	COVID-19 CH deaths	All CH deaths	% COVID-19 CH deaths divided by All CH deaths
Gloucestershire	211	389	54%
Swindon	61	113	54%
Bristol, City of	111	207	54%
Bath and North East Somerset	41	84	49%
Wiltshire	172	355	48%
Torbay	34	77	44%
South Gloucestershire	54	135	40%
Dorset	63	208	30%
Bournemouth, Christchurch and Poole	65	237	27%
Somerset	72	273	26%
Devon	79	320	25%
Cornwall	51	218	23%
Plymouth	25	110	23%
North Somerset	29	138	21%
Total	**1068**	**2864**	**37%**

Fig 10: Deaths in care homes as a proportion of overall deaths in the area due to COVID-19 Data source: Office for National Statistics 26/05/2020. [8]

3.9 PPE in Care Homes

3.9.1 Earlier in the epidemic supplies of Personal Protective Equipment nationally and locally were under pressure given supply chain issues with the national stockpile and means of access. All providers that have followed advice have been able to secure required supplies.

	Acceptable level of PPE or confident of ongoing supply	Supplies available but will run out within 7 days	No supplies at the location or will run out within 48 hours
Aprons	261	43	1
Eyes	259	39	7
Gloves	273	30	2
Masks	228	68	9
Sanitiser	267	34	4

Fig 11: Number of care homes with levels of supply by item of Personal Protective Equipment as at 27/05/2020 Source: National Capacity Tracker updated by care homes locally[9]

[8] Definition:
- The care home fatalities recorded are those notified to the Care Quality Commission by the care home as being due to COVID-19.
- Only those who were both resident and died in the setting are included.
- Up to 20% of deaths in hospital nationally are also estimated to be care home residents.
- The overall number of deaths are those recorded by the Office for National Statistics on the basis of registration of death including mention of COVID-19.

[9] Definition: Aprons, Eye Protection, Gloves, Masks and Hand Sanitiser are the key items of PPE recommended for use by different roles for different activities in care homes

3.9.3 Commissioners have sought to secure contingency stocks across the range of items required for use in settings including adult social care, both residential and domiciliary. We currently have good stock levels for all items but reusable eye protection and are working on maintaining adequate contingency stocks of all items.

	Stock	DCC usage per day	Days left	Adjusted RAG days left based on future orders
Aprons	518,120	22,802	23	
Gowns (long sleeve)	CCG now dealing with distribution			
Glasses (reusable)	3,540	2,168	2	
Gloves (all sizes)	1,140,050	41,249	28	
Masks (Type IIR)	276,103	8,753	32	
Masks (Surgical)	133,048	3,452	39	
Masks (FFP3)	CCG now dealing with distribution			
Sanitiser (Hand)	50,389	3,001	17	

Fig 12: Number of items in stock by category and days of supply left at current usage levels as at 26/05/2020. [10]

[10] Definition: Estimated supply left: Red = under 5 days, Amber = 5 to 20 days, Green = >20 days.

Feedback from service users and carers on their lived experience during the COVID-19 emergency period

Using our engagement framework contract, Living Options were asked by Devon County Council to contact a wide range of partners to gather their perspectives on how their often vulnerable and hard to reach service users were coping with COVID-19 under lockdown. They provided 55 pages of feedback to five set questions, summarised below:

	How are people coping with social isolation?	**Are people able to get in touch with Care Direct or any local social care offices OK?**	**How is technology being used to combat social isolation?**	**What sources of community support are being used?**	**How is shielding working for vulnerable people; are GPs in regular contact as per government advice?**
Age UK Devon (Older People)	Most older people are coping quite well. Some are finding it difficult to adapt to changes in routine. Those struggling most are the socially isolated with mental health needs.	There were some problems reported in the first weeks of lockdown, but none recently. People are confused about financial assessment and what is and isn't being charged for when.	Older people are increasingly using social media and video calls to stay in touch with family and friends but there are many who can't or won't. Older people tend to be reliant on others who can no longer visit for technology support. Befriending services have been inundated.	Widespread use of community groups setup by town and parish councils e.g. shopping, prescriptions The vulnerable but not shielded have reported problems accessing online delivery slots from supermarkets but generally people have working arrangements.	No one has mentioned receiving checking calls from GP surgeries. Some confusion over who is vulnerable, who is very vulnerable and shielded; who can do what; who is entitled to what support. Some instances of poor and rushed hospital discharge arrangements.
Devon Carers (Carers of all client groups)	Many carers are socially isolated anyway. Some are concerned about they and their cared for person missing social	Carers are happy to engage by phone, wanting to minimise home visits. There have been reports of respite providers not accepting	About half of carers are using technology to stay in touch with family and friends with varying levels of confidence; the other	Carers are blending informal and formal support depending on their circumstances and networks.	Where GP surgeries have made checking calls they have been appreciated. Those involved in social prescribing have

	opportunities they enjoyed. Some are enjoying a slower way of life; others are struggling e.g. those who suspended external support arrangements. Many are benefiting from formal and informal support. Carers are increasingly challenged by the unknown duration. Many are anxious about how they'd cope if they or the person they care for catching the virus. But often anxieties have diminished as people have got used to the situation and a new rhythm of life.	clients receiving home visits. Getting through to CareDirect has been fine but follow-up work timescales have been variable from quick to slow. Some don't want to bother health and care services as they assume they are very busy.	half remain excluded or disinterested. For many telephone and video calls give their days and weeks structure. Some are looking for information and advice online from various sources and finding it useful. For those online, remote consultations seem to be working and save travel time and cost.	Most are in touch with their GP. Some voluntary sector organisations have been praised for their support e.g. Alzheimer's Society. Many report that informal support from their community has made them feel more connected. The main form of support accessed is shopping and prescriptions. There seems to be no shortage of volunteers! While it was difficult to get online shopping delivery slots, that has improved and many local shops and takeaways are now also delivering.	been active in offering and arranging support. Some were late in receiving shielding letters; others had to chase to get registered.
Devon Disability Network **(People with Physical Disabilities)**	Many friendship groups are innovating with virtual meetups and activities. Some carers have been pulled over and questioned by police.	No reported problems.	Widespread use of social media and video calls. When travelling by car, disabled drivers have noticed people without disabilities using disabled parking bays	Using trusted organisations to signpost to the best local support has helped. Lack of access to maintenance and repair	Some heard they were shielded very late. Some GPs are keeping in touch by text; often knowing they are there and care is enough. Remote consultations seem to be working

	Some people with physical disabilities are missing exercise opportunities e.g. swimming.		and parking bays made inaccessible.	services has been an issue for some. For many, informal support from family, friends and neighbours is enough.	well for those using them. 111 has been responsive.
Devon Link Up **(People with Learning Disabilities and/or Autism)**	Buildings based services have had to rethink how they support people: staff contacted people by phone to make sure they had access to what they needed. The most concerning are those hardest to reach who may be suffering in silence. People are sociable by nature and they miss seeing others, having a routine and getting outside for activity. People are anxious about what the 'new normal' might be. Some of those with mental health needs have escalated with unclear contingency arrangements.	Social care doesn't always recognise that needs are changing and escalating in lockdown. Government Easy Read information was slow in coming; local agencies filled the gaps. Changing government messages have been confusing. People are as anxious about not understanding the rules as their impact. Service changes haven't always been well communicated. People are worried about the long-term impact on budgets and services. They fear a 'reset' rather than 'return to normal' means less for them.	Support agencies are using the internet and social media to promote activities and connect people. The use of art and creativity has been invaluable and communicates non-verbally. Again, it is those who don't, won't or can't engage online that cause the most concern. Professionals are worried about online exploitation but also abuse in the home including domestic violence.	Most seem unaware of community support groups and haven't been accessing them. Some people with learning disabilities and autism are volunteering to help others themselves. Some find people wearing masks intimidating. While volunteers are plenty, many CVS organisations are concerned about funding, including the means to engage and support in new ways.	Many people with autism and learning disabilities also have health issues making them vulnerable or extremely vulnerable. Shielding letters have not been in accessible formats. Contact from GPs has been rare with most receiving none. 111 has been variable.

Devon People First **(People with Learning Disabilities)**	Most people contacted say they are coping okay. People in supported living seem to be doing better than those living alone.	Most people contacted haven't tried contacting social services but some have been contacted by community social care and health teams.	People are making increasing use of online facilities, especially YouTube for entertainment and instruction.	Most spoken to are managing with pre-existing arrangements; few are benefiting from community support.	There is confusion about the meanings of vulnerable, extremely vulnerable; and socially distanced, socially isolated and shielded.
Dimensions for Autism **(People with Autism)**	At worst, one person said they were starving, being too scared to go out. Not all realised they were an exception who could exercise more than once a day. Anxiety has shifted from adjusting to the lockdown to readjusting post-lockdown.	Most haven't needed to contact CareDirect.	Those with the facilities use them well. Some were dependent on library computers and so feel cut-off. DfA have established online support groups. Those unable to participate have been offered 1:1 support.	Most haven't sought community support, preferring to rely on those they know and trust.	Most aren't in the shielded group; some have others in their household who are.
Hikmat **(BAME)**	55 people from 17 nationalities were consulted by phone. There was a spectrum of responses from 'badly' to 'very well' but the majority are coping okay.	Of those that needed social services support, the significant majority reported no issues in accessing it; some used mediated support through Hikmat.	Many are staying connected with family, friends, special interest and faith groups online.	A large minority were accessing community support, including through Hikmat itself. Experiencing Ramadan in lockdown has been challenging for many Muslim families.	Most don't think of themselves as vulnerable and don't understand the term 'shielded'.
Intercom Trust **(LGBT)**	The results of a more in-depth survey will be shared by the end of the month.	No reported issues connecting with social services. Some are concerned with disruption to	While there have been many positives to online communication, more emboldened hate speech is apparent.	LGBT+ people are concerned that community support sometimes rejects	Only one person who is shielded responded: they have weekly contact with GP, food

	Most are okay most of the time but those already isolated have become more so. Often older members of the LGBT+ community who live alone without access to technology are the most isolated. For younger members of the LGBT+ community, the challenge is more likely to be living with unsupportive family members.	Gender Identity Services.	Nevertheless, many LGBT+ people are using technology positively in many aspects of their lives: work, school, social, mutual support.	those perceived to be outsiders.	parcels, community support.
Plymouth and Devon Racial Equality Council **(BAME)**	Variable and dependent on support network and how well English is spoken. Some of the GRT community report practical difficulties e.g. accessing drinking water.	No difficulties reported.	BAME tend to work in less well paid and insecure jobs meaning they tend to have less access to technology. Where people do participate in online support groups, they value them.	Observing Ramadan in lockdown has been difficult for many Muslim families. There have been concerns about race hate crime. People from BAME groups mainly rely on mutual support.	None mentioned being shielded.
Time to Talk **(Hearing Impairment)**	Social isolation compounds sensory impairment, especially for the shielded. People are reporting increased mental health needs	Service users are reporting suspended or reduced levels of service. In particular, day services and some aspects of personal	Older service users tend not to use technology; others are excluded financially. Many don't have the opportunity to communicate in sign	Local helplines and support are being accessed. Some see lockdown as giving others the opportunity to experience their usual	People are confused about who falls into which cohort. For some, communications were received very late.

	compounded by uncertainty, confusion, lack of meaningful contact and activity. Lip reading is impossible when people use masks.	care such as hair washing. Concern that those with less acute needs are being deprioritised. Many just want specialist information and advice.	language because of social restrictions. Those that use social media and online calls value them highly.	levels of isolation and exclusion. Volunteers are using local shops which are more expensive.	Some are being contacted by multiple organisations, others none at all. Worry was significant but is abating now.