Meeting: Overview and Scrutiny Board **Date: 22 July 2020**

Wards Affected: All

Report Title: PREPARATION AND RESPONSE FOR THE COVID-19 EMERGENCY

Is the decision a key decision? No

When does the decision need to be implemented? N/A

Cabinet Member Contact Details: N/A

Supporting Officer Contact Details: Simon Tapley, Accountable Officer NHS Devon Clinical Commissioning Group

1. Purpose and Introduction

This report provides a summary of arrangements for planning for and responding to the COVID-19 emergency and plans for restoration and transformation of services within the health and care system.

2. Proposed Decision

1. To note the summary of arrangements for planning for and responding to the COVID-19 emergency and plans for restoration and transformation of services within the health and care system.
2. To recognise the commitment and achievements of all health and care staff across the period.

3. Reason for Decision

The committee's consideration of this report supports the statutory role to scrutinise health services in the area of Torbay.

Supporting Information

N/A. The report provides an update to members on the actions taken by health service partners across Torbay and the wider Devon geography.

5. Possibilities and Options

N/A

6. Fair Decision Making

N/A

7. Public Services (Social Value) Act 2012

N/A

8. Risks

N/A

Appendices

- Appendix A Activity and Performance

Additional Information

Advice and guidance provided to the sector in reference to Covid-19 is available here https://www.england.nhs.uk/coronavirus/

Background

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

1.2. The bravery, hard work and dedication of NHS and Care staff on the front line is something that the whole of Plymouth, Devon and Torbay 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.

1.3. 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.

1.4. We also owe a debt to the fantastic voluntary and business sector 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.

1.5. Our 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.

1.6. 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.

1.7. 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.

1.8. 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.

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

2. Planning and Preparation

2.1. 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.

2.2. 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 system-wide teleconferences established to co-ordinate the response across all NHS service providers and with Local Authority 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.

2.3. NHS Devon Clinical Commissioning Group both established Incident Management Teams (IMT) in early March. 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.

2.4. 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
- Plymouth City Council
- Devon County Council
- Torbay Council
- Livewell Southwest CIC
- 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
- Southwestern Ambulance Service
- Devon Doctors Ltd

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

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

Clinical and Service Level Preparation

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

2.8. 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.

2.9. 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-opened. 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.

2.10. **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.**

3. Ongoing Response

3.1. Following the initial emergency response, 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

3.2. It became clear early in the response that PPE stocks nationally would be under significant pressure. In light of this PPE cells were established within the CCG which worked together with Public Health specialists to provide 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 the CCG took a decision to secure PPE from the open market to ensure supply, jointly procuring some items with Local Authorities.

3.3. 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.

3.4. 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.

3.5. The voluntary and business sectors 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

3.6. The CCG has 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.

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

3.8. 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.

Testing

3.9. 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.

3.10. 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.

3.11. 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.

3.12. 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.

3.13. 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

3.14. 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.

3.15. 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. Digital technology included the use of **143,703** e-Consults in GP practices, and **18,313** video consultations (Accurx) and Consultant Connect/Attend Anywhere (**31,380** consultations) in outpatient clinics. 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.

3.16. 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.

3.17. 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.

3.18. 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

3.19. The Nightingale Hospital will be used to ensure the South West is ready and well prepared for future healthcare requirements. Following the completion of the building the Nightingale Exeter will remain on standby, ready to provide care if required.

3.20. To clarify some recent reports, while it remains the case that the Nightingale Exeter isn't needed for COVID patients, we will be using our CT scanner to help local GPs and hospitals provide people with safer and faster access to tests for a range of conditions, not just cancer.

3.21. The hospital beds are specifically designed for people with COVID needs, and throughout this time the facility will remain ready to quickly revert to our primary purpose and receive patients with COVID, if the number of cases in the region rises significantly.

Staff

3.22. 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 were increased across the system.

3.23. 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.

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

4. Restoration and Transformation

Guiding principles for recovery

4.1. 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'.

4.2. 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.

4.3. 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.

4.4. 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 Covid-19 waves; and plan to retain beneficial ways of working and outcomes that have arisen through the crisis.

4.5. 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.

4.6. Whilst both the CCG and councils are developing recovery plans, it is recognised that any recovery requires a multiagency response. Recovery work is developing and ongoing, and we will look for opportunities for alignment, where appropriate.

NHS Restoration and Transformation

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

4.8. 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.

4.9. 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.

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

4.11. 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 NHS England expectations.

4.12. 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.

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

4.14. 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

4.15. 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.

4.16. 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.

4.17. 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.

4.18. 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. 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.

4.19. 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.

Next steps

4.20. Work continues to develop proposals for recovery, restoration and transformation.

4.21. The CCG and council partners will look for opportunities to align our response, where appropriate, to improve the experience for people and avoid duplication.

Recommendations

The committee is requested –

1. **To note the summary of arrangements for planning for and responding to the COVID-19 emergency and plans for restoration and transformation of services within the health and care system.**
2. **To recognise the commitment and achievements of all health and care staff across the period**

Appendix A

Appendix A Activity and Performance

Cases

In Plymouth the number of lab-confirmed positive tests for COVID-19 has been comparatively low. 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.

There were 272 lab-confirmed cases in the Torbay Council area up until 07/07/2020 with the peak day being 19/04/2020.

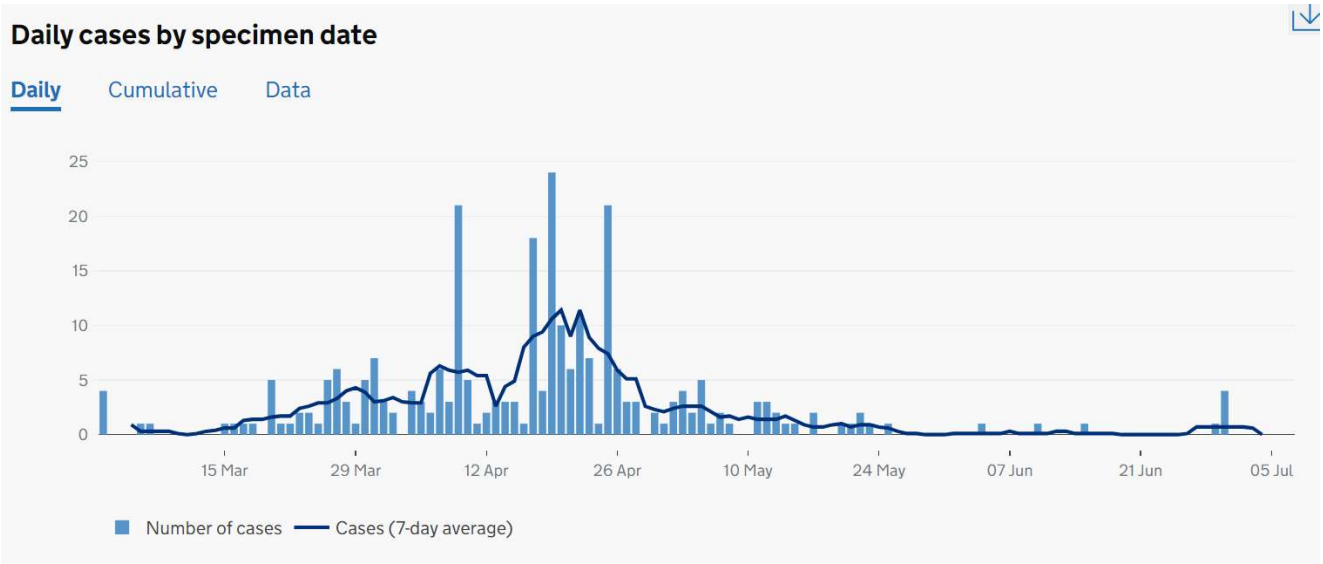

Figure: Daily lab-confirmed infections in Torbay 05/07/2020[1]

Fatalities

All local authority areas in the STP geography are in the bottom decile for COVID-19 in England, which is noteworthy given that these rates are not age-standardised. For instance, Devon STP account for 2.67% of all deaths in England in 2018, but accounts for only 0.76% of COVID-19 deaths in England.

Area	COVID-19 Deaths	Population	Deaths per 100,000
Torbay	**58**	**136,300**	**42.6**
Plymouth	86	262,100	32.8
East Devon	47	146,300	32.1
Exeter	39	131,400	29.7
Torridge	20	68,300	29.3
West Devon	15	55,800	26.9
North Devon	26	97,100	26.8
Teignbridge	33	134,200	24.6
Mid Devon	17	82,300	20.7
South Hams	12	87,000	13.8

[1] Data source: Department of Health and Social Care Definition: An infection is recorded if an antigen swab test is lab-confirmed as positive / The case is recorded by the date of specimen taken

Hospital Activity

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.

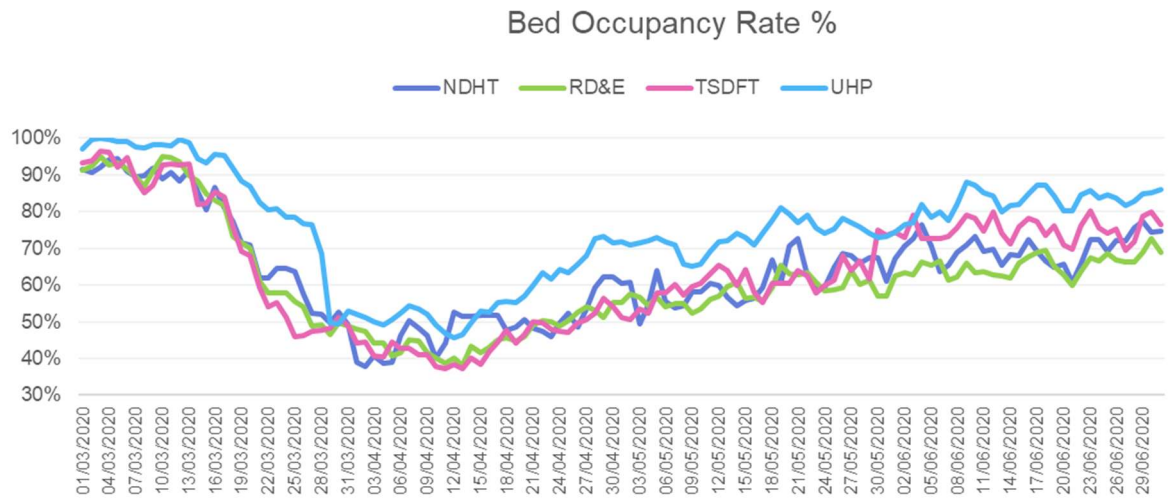

Figure: Percentage of hospital beds by Trust occupied. [2]

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 epidemic period.

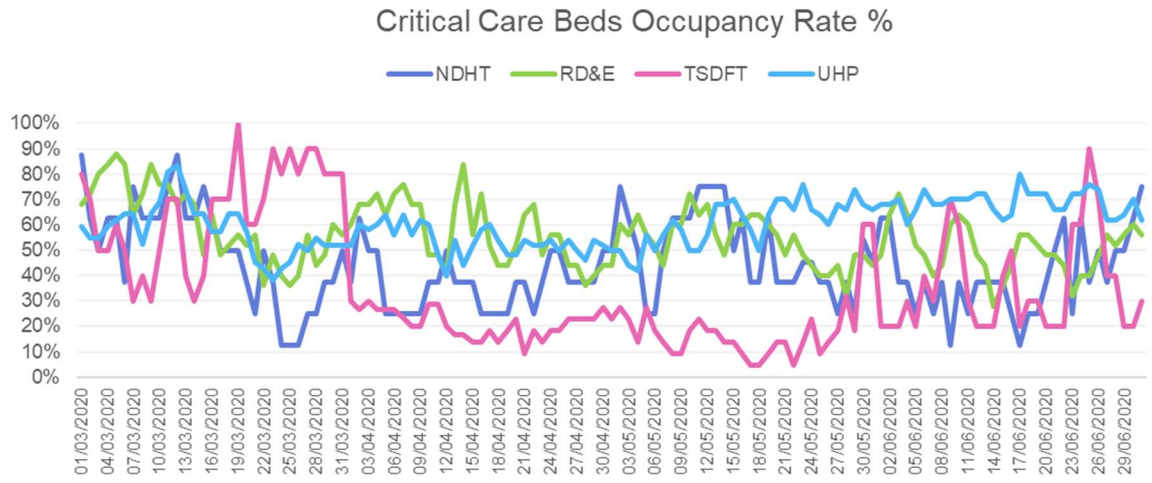

Figure: Percentage of critical care hospital beds by Trust occupied.[3]

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.

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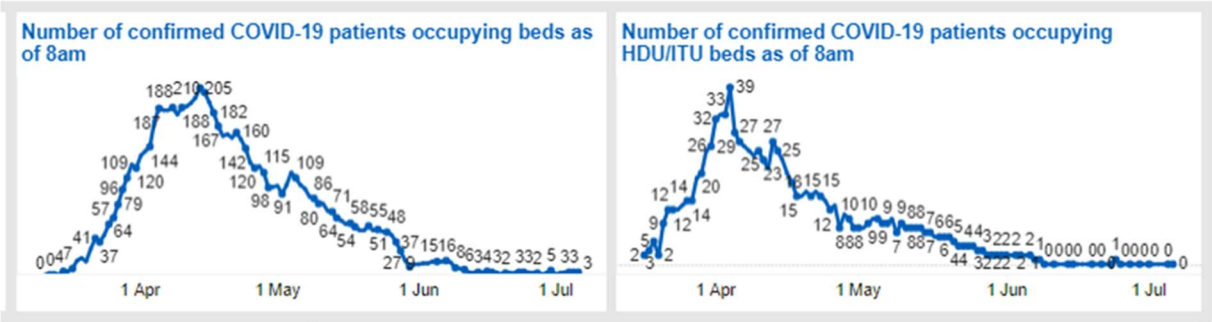
[2] Definition: occupied acute beds as a percentage of overall acute beds by Trust. Source: Urgent and Emergency Care Daily SitRep Collection

[3] Definition: occupied critical care acute beds as a percentage of overall acute beds by Trust. (A critical care bed is one that has Intensive Care Unit capabilities including forms of ventilation/oxgenation)
Source: Urgent and Emergency Care Daily SitRep Collection (NDHT / RD&E / TSDFT / UHP)



Data source: National Sitrep reporting[4]

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.

Community Response

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 relatively normal levels since then.

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 this has now increased to around 215 per day.

Although GP appointment fell during April and May, there has been a significant increase in the use of e-Consult (non face-to-face appointments). These increased by 50% across Devon as a whole but by far more in areas with relatively low pre-Covid-19 levels, such as Eastern Devon (up by 300%) and Northern Devon (up by 200%).

Future hospital capacity

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.

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.

[44] Definition: total occupied acute beds / occupied critical care acute beds (a critical care bed is one that has Intensive Care Unit capabilities including forms of ventilation/oxygenation).

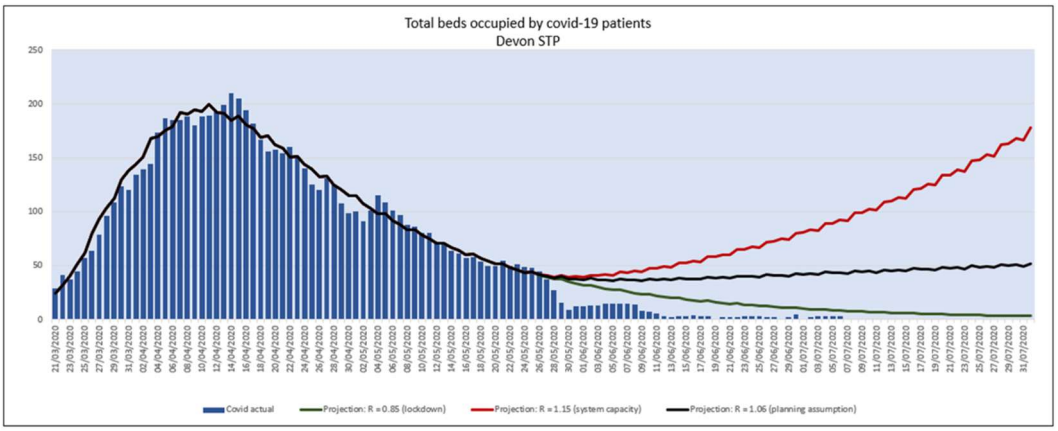


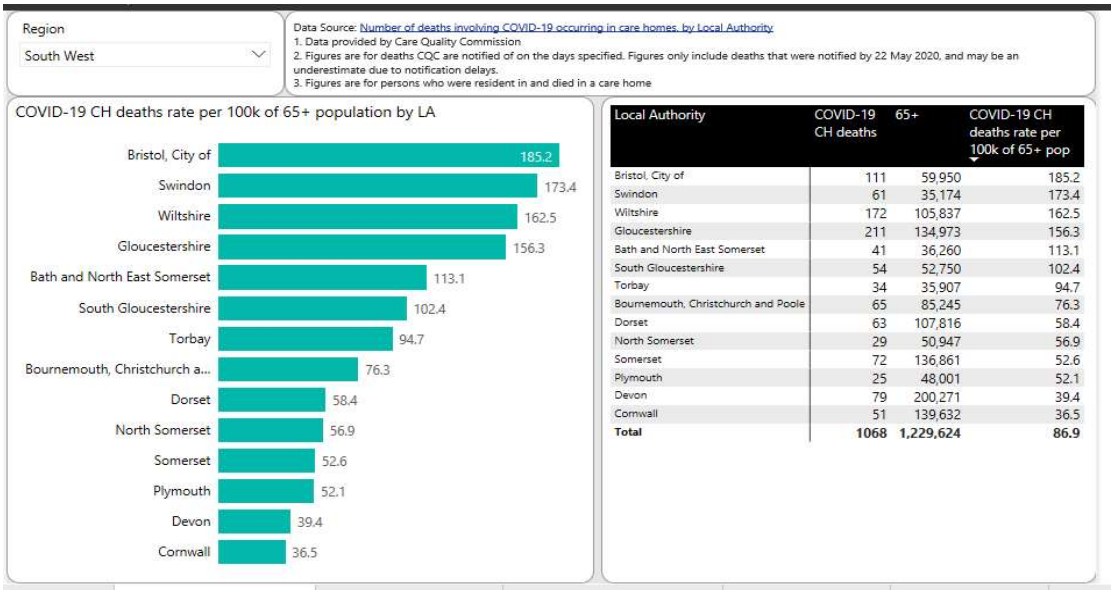
Figure: actual and projected use of bed capacity to treat COVID-19 patients including surge capacity[5]

Fatalities in Care Homes relative to population

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.

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.



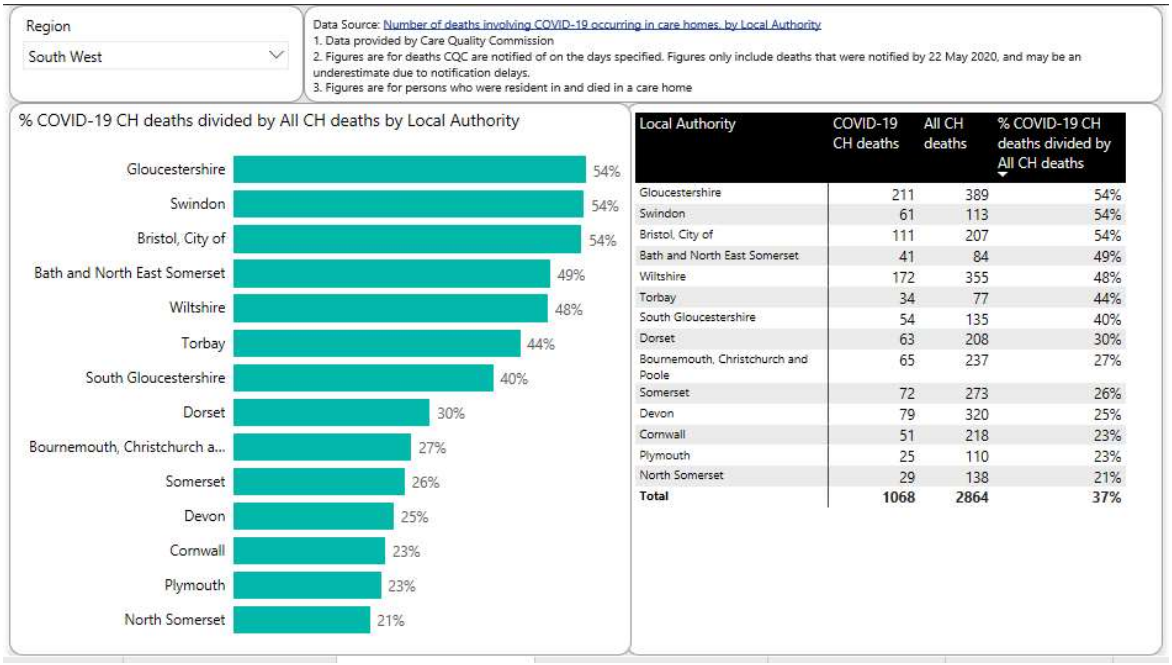
Local Authority	COVID-19 CH deaths	65+	COVID-19 CH deaths rate per 100k of 65+ pop
Bristol, City of	111	59,950	185.2
Swindon	61	35,174	173.4
Wiltshire	172	105,837	162.5
Gloucestershire	211	134,973	156.3
Bath and North East Somerset	41	36,260	113.1
South Gloucestershire	54	52,750	102.4
Torbay	34	35,907	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**

Figure: COVID-19 Care home death rate per 100,000 65+ population Data source: Office for National Statistics 26/05/2020. [6]

[5] Definition: the total bed capacity to treat COVID-19 patients is that designated as such by the four acute Trusts in Devon. Source: Urgent and Emergency Care Daily SitRep

[6] 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.

Proportion of deaths in the local area occurring in care homes



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%**

Figure: 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. [7]

[7] 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.