

Wales COVID-19 Evidence Centre (WCEC) Rapid Evidence Summary

What evidence is there of the inverse care law in social care in Wales and has this been exacerbated by the COVID-19 pandemic? Report number RES_00019 (February 2022)

TOPLINE SUMMARY

What is a Rapid Evidence Summary?

Rapid Evidence Summaries are designed to provide an interim evidence briefing to inform further work and provide early access to key findings. They are based on a limited search of key resources and the assessment of abstracts. Priority is given to studies representing robust evidence synthesis. No quality appraisal or evidence synthesis is conducted, and the summary should be interpreted with caution.

Background / Aim of Rapid Review

This work was conducted following a rapid review about [innovations to attract, recruit and retain social care workers](#) for Social Care Wales. The 'Inverse care law', states that the availability of good medical care tends to vary inversely with the need of the population served (Tudor Hart, 1971). The aim of this rapid evidence summary (RES) was to explore if the Inverse Care Law could be applied to access and use of *social care* in Wales and whether unmet needs were exacerbated by the pandemic.

Key Findings

Extent of the evidence base

- **No UK studies** were identified that investigated the inverse care law in social care and whether this had been exacerbated by the COVID-19 pandemic
- **One Swedish study** was identified that investigated the inverse care law in social care
- Three papers were identified that addressed the **inverse care law in healthcare** during the COVID-19 pandemic (including digital health) and seven described **social determinants of health inequalities**

Recency of the evidence base

- Most studies were from **2019 – 2022** to include the impact of the COVID-19 pandemic
- A pre-pandemic report from 2018 by Social Care Wales on the economic value of the adult social care was included for reference

Summary of evidence gaps identified

- There is a **lack of evidence of the inverse care law applied to social care in Wales during the COVID-19 pandemic from the COVID-19 databases**

- **Protected characteristics were often not reported** therefore, it is unclear which groups experience the greatest health inequality and thus need for services
- Most of the studies identified related to individuals over 65 years; therefore, there are **gaps in knowledge about children, and other vulnerable populations** regarding social care
- There is a lack of evidence about **social care delivered in domiciliary settings**

Policy Implications

The evidence gaps identified in this work can be used to inform future primary research calls.

Strength of Evidence

There was insufficient evidence to proceed to a Rapid Review. Due to the nature of a rapid search, it is unclear whether there is more evidence of the inverse care law in social care in Wales. No quality appraisal was conducted.

This rapid evidence summary should be cited as:

RES00019. Wales COVID-19 Evidence Centre. A rapid evidence summary indicating the evidence of the inverse care law in social care in Wales and has this been exacerbated by the COVID-19 pandemic? February 2022

<http://www.primecentre.wales/resources/RES/RES00019-Wales COVID-19 Evidence Centre-Inverse Care Law in Social Care-February 2022.pdf>

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Contents

1. What is a Rapid Evidence Summary?	4
2. Production of this Rapid Evidence Summary	4
3. Requesting stakeholder group(s)	4
4. Context / Background	4
5. Research question(s)	5
6. Summary of the evidence base	6
6.1 Type and amount of evidence available	6
6.2 Key Findings	6
6.3 Areas of uncertainty	8
6.4 Options for further work	8
7. Next steps	8
8. Methods used in this Rapid Evidence Summary (RES)	8
9. Results	9
10. Acknowledgements	30
11. About the Wales COVID-19 Evidence Centre (WCEC)	30
12. APPENDIX – Resources searched during Rapid Evidence Summary	31

Wales COVID-19 Evidence Centre (WCEC) Rapid Evidence Summary

What evidence is there of the inverse care law in social care in Wales and has this been exacerbated by the COVID-19 pandemic? **Report number RES_00019 (February 2022)**

FULL REPORT

1. What is a Rapid Evidence Summary?

Rapid Evidence Summaries are designed to provide an interim evidence briefing to inform further work and provide early access to key findings. They are based on a limited search of key resources and the assessment of abstracts. Priority is given to studies representing robust evidence synthesis. No quality appraisal or evidence synthesis is conducted, and the summary should be interpreted with caution.

2. Production of this Rapid Evidence Summary

The following individuals were involved in the Rapid Evidence Summary process and production of this report:

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3. Requesting stakeholder group(s)

The research question followed on from an earlier rapid review about innovations to attract, recruit and retain social care workers, identified from the WCEC prioritisation process and submitted by Social Care Wales.

4. Context / Background

In 1971, Welsh general practitioner Julian Tudor Hart published the 'Inverse care law', which states that, "*The availability of good medical care tends to vary inversely with the need for it in the population served. This operates more completely where medical care is most exposed to market forces and less so where such exposure is reduced*" (Tudor Hart, 1971). It is expected that the COVID-19 pandemic had a negative impact on health inequalities by widening the gap between the social determinants of health such as quality of health care, housing, employment, education, and environment among communities with high levels of multiple deprivation (Griffith et al., 2020; Wolfson & Leung, 2020). High levels of deprivation typically denote poorer health and less access to health and social care (Iacobucci, 2020). Prior to the COVID-19 pandemic, many communities around the UK sharing common protected characteristics such as race, disability, geography, and gender, experienced high levels of multiple deprivation (Iacobucci, 2020). A quasi-experimental study measuring years of life lost (YLL) associated with the COVID-19 pandemic in England and Wales concluded that the most deprived regions in England and Wales with long standing health inequalities reported the highest numbers in potential YLL (Kontopantelis et al., 2022). The aim of this

rapid evidence summary (RES) was to see to what extent the Inverse Care Law describes access to and use of social care in Wales and if unmet needs were exacerbated by the COVID-19 pandemic.

A 2001 cross-sectional study conducted in England and Wales found that 7.6% of the population reported that their health was ‘not good’ and that they lived with a long-term illness or disability which impacts their daily work and activities (Shaw & Dorling, 2004). Shaw and Dorling stated that the 7.6% were in the greatest need of care. Furthermore, census data from 2001 found one million people provided at least 50 hours per week of unpaid care to family members, friends and neighbours. Shaw and Dorling highlight that in areas where health care is most needed, distribution is inverse to the need and therefore informal care is greatest in these areas. They suggest that the Inverse Care Law doesn’t apply to social care because of the likelihood that the supply of unpaid care might be more plentiful in deprived areas where the need is greater – and the ‘positive care law’ might apply. This provides a challenge to healthcare providers given that the burden of unmet need is carried by unpaid caregivers, making it difficult to truly quantify and understand the level of unmet care need.

Dr Julian Tudor Hart asserts that both the inverse care law and the positive care law are examples of market failure which are solved by benevolent acts of affected communities (Hart, 2004).

5. Research question(s)

Review question	
<i>What evidence is there of the inverse care law in social care in Wales and has this been exacerbated by the Covid-19 pandemic?</i>	
Participants	Users of social care services (children and adults)
Intervention / exposure	March 2020 onwards
Comparison	2009 onwards
Outcomes	Need (demand) e.g. waiting times Availability (supply) e.g. staffing levels Good (quality) e.g. evidence of standards being met/not Inequality within social care
Other Study Considerations	
Primary, secondary, grey literature, preprints	

6. Summary of the evidence base

6.1 Type and amount of evidence available

Of the 18 included papers, 17 were peer reviewed publications and one was a technical report. The domains found include social care (n=6), healthcare (n=5), and combined health and social care (n=7). The publications included were mixed-method reviews (n=2), quantitative study designs (n=4), qualitative study designs (n=4), viewpoint papers (n=2), systematic review (n=1), editorial (n=1), a technical report (n=1), review article (n=1) and commentaries (n=2).

6.2 Key Findings

Evidence is limited on whether the inverse care law plays a role in social care in Wales and subsequently whether the COVID-19 pandemic has exacerbated its effects.

Inverse care law in social care

This section includes four publications that were found on the inverse care law in social care (Glasby & Needham, 2020; MacInnes, Walsh, & Österberg, 2021; Senior et al., 2015; Wheatley, Poole, & Robinson, 2022).

- Only one Swedish paper was found on inverse care law in social care (MacInnes et al., 2021). This found that the likelihood of using long term care services increased with the number of medicines withdrawn and with increased age. There is also evidence of the inverse care law among service users with greater financial means than others
- 44% of prisons in England and Wales do not have an older prisoner policy (Senior et al., 2015). The most prevalent unmet need on prison entry is the sharing of information about inmate care needs
- Reduced service provision for Dementia patients in England and Wales during the COVID-19 pandemic is a concern for Dementia care professionals (Wheatley et al., 2022). Dementia patients were more advanced in their symptoms once services were reopened

Inverse care law in healthcare (including digital health)

This section includes six publications that addressed the inverse care law in healthcare, including digital health (Best & Myers, 2019; Calthorpe & Smyth, 2021; Davies, Honeyman, & Gann, 2021; Davillas & Jones, 2021; Hunt & Adams, 2021; Johns et al., 2021; Verhagen et al., 2020)

- Best and Myers (2019) outline an innovation to meet the care needs of individuals living in rural and low-income areas in Wales. The innovation includes raising awareness for good practice and building capacity for self-help (Best & Myers, 2019)
- Hunt and Adams (2021) conducted a cross-sectional study in the USA and found that individuals dealing with more impairments and individuals from marginalised groups reported more unmet needs than their counterparts (Hunt & Adams, 2021)

- Three publications indicated that there is evidence of the inverse care law in digital health. Accessing digital health interventions during the COVID-19 pandemic was difficult for patients over the age of 50 and those who suffer from dementia (Calthorpe & Smyth, 2021; Davies et al., 2021; Johns et al., 2021)
- Geographic location has a large impact on the quality of care that is available to specific communities with mitigating socioeconomic factors (Barboza, Marttila, Burström, & Kulane, 2021; Gaynor & Wilson, 2020; MacInnes et al., 2021; Verhagen et al., 2020)

Social determinants of health inequalities

Seven publications that were found on the social determinants of health inequalities (Alang, 2019; Barboza et al., 2021; Carey, Crammond, & Malbon, 2019; Gaynor & Wilson, 2020; Hunt & Adams, 2021; Kerpershoek et al., 2020; Rens, Dom, Remmen, Michielsen, & Van Den Broeck, 2020).

The social determinants of health affect whether patients' healthcare needs are met (Alang, 2019; Carey et al., 2019; Hunt & Adams, 2021; Kerpershoek et al., 2020; Rens et al., 2020).

- Healthcare professionals should pay attention to the social determinants of health that patients face to address their unmet dementia care needs (Kerpershoek et al., 2020)
- Carey et al (2019) found that improvement in the wider social determinants of health may lead to better outcomes in social care (Carey et al., 2019)
- Protected characteristics are often a precursor to unmet need (Hunt & Adams, 2021; Kerpershoek et al., 2020)
- Race and culture play a role in whether certain groups access care and this is largely due to stigma and lack of trust in care providers. Anti-racism education for healthcare professionals is needed to reduce unmet need within the black community (Alang, 2019)
- Black people in America were at a disproportionately higher risk of death from COVID-19 than other racial groups (Gaynor & Wilson, 2020)
- Evidence indicates that the COVID-19 pandemic may have widened the gap to access to dementia care for families with already limited support in Sweden (Barboza et al., 2021)

Other findings

The economic value of social care in Wales has previously been highlighted in a technical report published in 2016.

- The Economic Value of Social Care sector report highlights that an estimated 2,070 residential care sites provided adult social care in Wales in 2016. Most of these sites provided nursing care. A further 1,700 individuals receive direct payments and employ Personal Assistants (PAs) (James & White, 2018).

6.3 Areas of uncertainty

Remaining uncertainties include:

- Due to the nature of a rapid search, it is unclear whether there is other evidence of the inverse care law in Wales with regard to social care
- The levels of health inequality prior to the COVID-19 pandemic were only noted in four of the 18 papers found for the RES
- It is unclear which groups experience the most health inequality because their protected characteristics are not reported
- There was a minimal amount of grey literature on inverse care, and social care inequality in Wales, all grey literature found on this topic was pre-2020, and therefore pre-COVID-19 pandemic
- Most of the studies were related to individuals over 65 years; therefore, there are gaps in knowledge about children, and other vulnerable populations regarding social care. Children's social care is mentioned in The Economic Value of the Adult Social Care sector report, but it is not possible to disaggregate children's social care from adult social care
- There is a lack of evidence about social care delivered in domiciliary settings. Only one of the papers included in the RES focused on social care within a domestic setting

6.4 Options for further work

According to the findings of the RES, there was a lack of evidence for the inverse care law in social care in Wales. Furthermore, the RES searches did not offer adequate evidence of unmet social care needs or information about the supply or quality of social care in Wales. However, some evidence was found regarding the 'digital inverse care law', the social determinants of health and health inequalities.

7. Next steps

Based on the minimal evidence, it was decided at the final stakeholder meeting **not to proceed to a rapid review**. However due to the lack of evidence, **future primary research should be directed** to this area.

8. Methods used in this Rapid Evidence Summary (RES)

COVID-19 specific and general repositories of evidence reviews noted in our resource list were searched in February 2022. An audit trail of the search process is provided within the resource list (Appendix). Searches were limited to English-language publications and did not include searches for primary studies if secondary research relevant to the question was found. Search hits were screened for relevance by a single reviewer.

Priority was given to robust evidence synthesis using minimum standards (systematic search, study selection, quality assessment, and appropriate synthesis). The secondary research identified was not retrieved as full text or formally quality assessed. The included research may vary considerably in quality, and the degree of such variation could be investigated during rapid review work which may follow on. Citation, recency, evidence type, document status and key findings were tabulated for all relevant secondary research identified in this process.

Date of Search	February 2022
Search Concepts Used	The effects of the inverse care law on social care: Inverse 'care law', social, social care, COVID-19, unmet need, services, social workers, social support, equity, care standards, Wales, 'quality of care'.
Search Completed by	Abraham Makanjuola, Jacob Davies, and Kalpa Pisavadia; Bangor Institute for Health and Medical Research (BIHMR), Bangor University.

9. Results

Table 1. Summary of review evidence identified

Evidence type	Total identified	Comments
Systematic reviews (SRs)	1	
Rapid reviews (RRs)	0	
Clinical Guidelines (CGs)	0	
Protocols for reviews that are underway	0	
Economic evaluations (EE)	0	
Primary Studies	10	Including Quantitative study design (Cross-sectional, and cohort studies), Qualitative study designs (telephone and semi-structured interviews) and Mixed-Method Review study designs
<i>[Other..]</i>	7	Including Technical reports, reviews, editorials, viewpoint papers and commentary papers

A more detailed summary of included evidence can be found in Table 2.

Table 2: Summary of included evidence

Primary and Secondary / Tertiary research						
Resource	Citation	Recency (Search dates)	Evidence Type*	Status**	Key findings from abstracts	Reviewer comments
Inverse care law in social care						
VA-ESP	Glasby & Needham, 2020 The neglect of adult social care during covid-19 doi: https://doi.org/10.1136/bmj.m3103	2020	Editorial	Published	<ul style="list-style-type: none"> • WHO has found that many countries failed to support their long-term care sectors. • Domiciliary care, which supports more people than care homes, is often left out of the story altogether (and not mentioned directly in the Public Accounts Committee (PAC) report), partly because the data are so poor. • Most of the debate to date has been about older people, without considering the experiences of people of working age (representing around half of social care's annual expenditure). • One of the reasons why central, top-down approaches tend not to work in adult social care (if they work anywhere) is that the sector is much more complex and fragmented than many people realise. Around 1.5 million people are working in adult social care in England, with roles spread across the public, private, and voluntary sectors. 	<p>UK based Editorial</p> <p>The authors of this editorial note that top-down, centralised policies fail to work in a sector as fragmented and complex as the social care sector</p> <p>The King's Fund argues that talk of potential takeovers arguably misses the point as social care isn't about medical interventions but about a type of care, support, and philosophy that isn't a strength of the NHS.</p> <p>This paper referenced the Health Foundation report on the impact of COVID-19 on social care users and staff in England from July 2020</p>

					<ul style="list-style-type: none"> • Some 145 000 roles are directly employed by individuals who design and commission their own care through mechanisms such as direct payments. • Over 30 500 excess deaths have been reported in care homes in England since March. • PAC focuses on the discharge of 25 000 untested patients into care homes between mid-March and mid-April, denouncing the government's handling of this. 	
<p>PubMed</p> <p>Secondary research resources for (non-COVID-19) reviews</p>	<p>Mac Innes et al, (2021), The inverse care law and the significance of income for utilization of long-term care services in a Nordic welfare state Social Science and Medicine https://doi.org/10.1016/j.socscimed.2021.114125</p>	2021	Quantitative study	Published	<ul style="list-style-type: none"> • Receiving less than nine drugs per year means a lower likelihood of using long-term care services (LTCS), when compared with receiving more than 65 medicines per year. • There is a steady increase in the likelihood of LTCS with increasing age. • The level of education seems to be less critical. • Living in one of the three biggest cities in Sweden represents a higher likelihood of receiving LTCS, than living in a medium sized city. • Investigates the likelihood of LTCS among Swedish-born older persons who do and do not have a partner. The likelihood of using LTCS increases with the number of medicines withdrawn and with increased age. <p>Level of education seems to be less critical for those who have a partner compared with those who do not have a partner.</p>	<p>Sweden based study</p> <p>Long-term care services (LTCS) in Sweden includes:</p> <ol style="list-style-type: none"> 1. Home support in the form of help with domestic chores (such as household tasks) and personal care (such as getting dressed and personal hygiene). 2. A series of ancillary services that assist in keeping older people living in their communities (e.g. respite care for carers, meals on wheels, safety alarms, day-care centres, and mobility assistance). 3. Residential care, where support can be provided full-time by care professionals in residential facilities. <p>Case managers within each municipality, usually social workers, assess the care needs of older persons under the Social Services Act, which stipulates that municipalities in Sweden are</p>

						obliged to meet the care needs of the ageing population.
<p>Google Scholar</p> <p>Secondary research resources for (non-COVID-19) reviews</p>	<p>Senior et al, (2015), Health and social care services for older male adults in prison: the identification of current service provision and piloting of an assessment and care planning model NIHR Journals Library</p>	2009-2012	Mixed method study	Published	<ul style="list-style-type: none"> Nearly half (44%) of establishments do not have an older prisoner policy. There is a lack of integration between health and social care services because of ambiguity regarding responsibility for older prisoners' social care. The responsible social service may be located a considerable distance from where the prisoner is held; in such instances, local social services do not co-ordinate their care. The most frequent unmet need on prison entry was the provision of information about care and treatment. <p>Release planning for older prisoners was frequently non-existent.</p>	<p>Study based in England and Wales</p> <p>This mixed-methods study explores the needs of older men entering and leaving prison and describes current provision of services, including integration between health and social care services.</p> <p>There is a lack of integration between health and social care services because of ambiguity regarding responsibility for older prisoners' social care. The most frequent unmet need on prison entry was the provision of information about care and treatment. Release planning for older prisoners was frequently non-existent.</p>
<p>L'OVE Primary Studies</p>	<p>Wheatley A, Poole M, Robinson L on behalf of the PriDem study team Changes to post diagnostic dementia support in England and Wales during the COVID-19 pandemic: a qualitative study BMJ Open 2022;12:e059437. doi: 10.1136/bmjopen-2021-059437</p>	February and May 2021	Qualitative study	Published	<ul style="list-style-type: none"> Some dementia services closed, while others adapted and continued to provide support thus potentially widening existing inequalities. The first response was frequently to implement additional telephone support, as people living with dementia were thought more likely to have access to telephones compared with computers, tablets or smartphones. Dementia symptoms, such as difficulties with memory and concentration, compounded by loss of contextual information, 	<p>Study based in England and Wales</p> <p>This qualitative study formed part of the larger PriDem study of post diagnostic support in England and Wales,</p> <p>Delivering post diagnostic dementia support during COVID-19 required essential adaptations. While some changes were detrimental to service users, others were identified as potentially beneficial and highly likely to become the new 'norm', for</p>

					<p>eye contact and body language, could make remote consultations and meetings confusing and tiring. Some professionals were therefore concerned that people living with dementia's voices were marginalised when interacting remotely.</p> <p>With the reduction in service provision, professionals expressed concern about unmet dementia support needs. Those attending services once they reopened were found to be more advanced in their dementia due to a combination of delays in diagnosis, lack of proactive support and the effects of isolation</p>	<p>example, use of blended approaches, combining virtual and face-to-face work, thus allowing more flexible, integrated care.</p>
Inverse care law in healthcare (including digital health)						
<p>Google Scholar</p> <p>Secondary research resources for (non-COVID-19) reviews</p>	<p>Best and Myers, (2019), Prudence or speed: Health and social care innovation in rural Wales Journal of Rural Studies, doi.org/10.1016/j.jrurstud.2017.12.004</p>	2019	Review	Published	<ul style="list-style-type: none"> Provides case examples of rural innovation involving voluntary sector and social enterprise and identifies professional and network practices and more holistic approaches to health and well-being e.g. <ul style="list-style-type: none"> Investors in Carers (IiC), a framework to raise awareness and provide credit for good practice and support services provided to carers by GP practices. The scheme helped to identify over 100 carers who were not receiving carer allowances. The main benefits for carers included: improved choice and access to services; signposting to respite care; and recognition of carer contribution. 	<p>Wales based study</p> <p>This review considers the role of social enterprise in identifying and fostering innovation in low income, rural areas in ways that provide close-to-patient/service user services and address local issues and health determinants to provide more sustainable and resilient community-based health and social care provision.</p>

					<p>The capable coping project aimed to build capacity for self-help and community action. This was achieved through the establishment of Volunteer Village Wardens (VWVs) whose role was to assist in social care activities, and a Dawn Patrol Scheme. The latter encouraged school children to check daily on the welfare of older residents. VWVs was well received by local communities and received around six new referrals a month with an average of seven visits per person. The most sought after services included: accessing local amenities; companionship; transport; and help with completing forms</p>	
<p>WHO Global Coronavirus Database</p>	<p>Calthorpe RJ, Smyth AR. Telehealth after the pandemic: Will the inverse care law apply? (Commentary). J Cyst Fibros 2021;20:47–8. doi:10.1016/J.JCF.2021.08.023</p>	2021	Commentary	Published	<ul style="list-style-type: none"> IT infrastructure issues may be a challenge for tele-health. it requires internet access, suitable digital device and a space to undertake a private consultation Reported advantages of telehealth, include: saving time having to travel to clinic and not having to take time out from work or school. In a 2020 UK survey, CF teams reported that virtual clinics appeared fragmented and provided patients with more limited access to the full multidisciplinary team, compared to face to face reviews (Connett G, personal communication) The 2020 UK survey (Connett G, personal communication) suggests that the speed of 	<p>UK centric commentary</p> <p>This commentary is based within the Cystic Fibrosis care domain but has some transferability by the way of online care provision. · Although Solomon et al. study referenced in text, there is no citation to the study.</p> <p>Connett G, personal, relates to work undertaken by Dr G. Connett, University Hospital Southampton NHS Foundation Trust, for access and use of the UK Cystic Fibrosis Medical Association 2020 survey data</p>

					<p>implementation has raised challenges for the longer-term delivery of virtual CF care</p> <ul style="list-style-type: none"> • Many CF centres reported a lack of IT infrastructure or funding available to fully support the delivery of services online. Clinical teams therefore report a mixed experience of telehealth. • 35% of respondents to the survey found telehealth quality was worse than F2F care. 	
<p>PubMed</p> <p>Secondary research resources for (non-COVID-19) reviews</p>	<p>Davies et al, (2021), Addressing the Digital Inverse Care Law in the Time of COVID-19: Potential for Digital Technology to Exacerbate or Mitigate Health Inequalities J Med Internet Res doi: 10.2196/21726</p>	2021	Viewpoint paper	Published	<p>Underlying factors contributing to digital inequalities:</p> <ul style="list-style-type: none"> • Access to digital connectivity and infrastructure: <ul style="list-style-type: none"> - In 2019, 7% of households in the UK did not use the internet, 10% of adults did not use the internet regularly. The same proportion has been reported in the United States, increasing with age to 27% among people aged ≥65 years. A population-wide survey across 17 European countries revealed that 51% of people aged ≥50 years do not use the internet. - (n=534) [21], 454 (85%) nursing professionals reported that poor connectivity in patients' homes is the greatest challenge to effective mobile working in the community. - data poverty - Over 25,000,000 mobile phone users in the UK are pay-as-you-go customers, with the majority of users having 	<p>UK based viewpoint</p> <p>This viewpoint paper addresses digital inequalities as a result of COVID-19 pandemic and the sustained shift to the adoption of digital approaches to working and engaging with populations, which will continue beyond the COVID-19 pandemic.</p> <p>Included in the viewpoint paper is the description of factors which contributing to digital exclusion, such as health and social inequalities, and the potential factors that need to be addressed to prevent it.</p> <p>Inverse information law" (also called "digital inverse care law") and digital inequalities, as people who are most in need of support (in particular, older people and those experiencing social deprivation) are often least likely to engage with digital platforms.</p>

					<p>a low income. Community organisations have reported examples of vulnerable groups spending up to half the family budget on incurring mobile phone costs</p> <ul style="list-style-type: none"> • Digital skills and literacy: <ul style="list-style-type: none"> - 10,500,000 people (16% of the adult population of the United Kingdom) cannot perform basic activities with digital devices, such as turning on a device, connecting to the Wi-Fi, or opening an app by themselves. In total, 7% of the population of the United Kingdom (3,600,000 people) is almost completely offline • Engagement with digital platforms: <p>25% of people aged over 65 years and 40%-45% of people from households earning less than £25,000 would not opt for a web-based video consultation with their general practitioner.</p> 	<p>This viewpoint paper discussed measures that can be taken to mitigate the risk of digital inequalities exacerbating health inequalities. In Wales, there has been a rapid roll out of the Attend Anywhere video consultation service, accompanied by the supply of 1000 tablet devices to hospitals, care homes, and hospice settings, to enable vulnerable people to access the service on the internet.</p>
<p>WHO Global Coronavirus Database</p>	<p>Davillas & Jones, 2021. Unmet health care need and income-Related horizontal equity in use of health care during the COVID-19 pandemic doi/10.1002/hec.4282</p>	<p>2021</p>	<p>Health Economics letter (commentary)</p>	<p>Published</p>	<ul style="list-style-type: none"> • Unmet need was most evident for hospital care, and less pronounced for primary health services (non-emergency medical helplines, GP consultations, community pharmacist advice, over the counter medications and prescriptions) • No evidence that horizontal equity, with respect to income, was violated for NHS hospital outpatient and inpatient care 	<p>UK centric commentary</p> <p>This health economics commentary discusses the notion of unmet care in primary and secondary healthcare services and discusses where evidence was found for inequities in relation to income. Pro-rich inequity with respect to ability to pay could be considered in care domain as 1/3 of social care in Wales is paid for by individuals.</p>

					<p>during the first wave of the pandemic.</p> <ul style="list-style-type: none"> • There is evidence of pro-rich inequities in use of GP consultations, prescriptions and medical helplines at the peak of the first wave, but these were eliminated as the pandemic progressed. • There are persistent pro-rich inequities for services that may relate to individuals' ability to pay (over the counter medications and advice from community pharmacists) • For primary care, systematic pro-rich inequity in GP consultations in April. These inequities diminished as the response to the pandemic progressed. similar results are also observed for prescription medicines and for the use of medical helpline services. • On the other hand, pro-rich inequity in over- the-counter medications persists over time, although with variations in levels across waves. • Pro-rich inequity is also observed for accessing advice from a community pharmacist, with the results statistically significant at the 10% level in the first two waves of data (p-values: 0.080, 0.054). • Levels of unmet need were most pronounced for inpatient and outpatient hospital care but 	
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					<p>less evident for the other health care services examined.</p> <ul style="list-style-type: none"> • Unmet need peaked at the peak of the pandemic in April and then declined as the impact of the pandemic became less severe and lockdown measures were eased. • Overall, our results suggest that, despite the rationing of care and high levels of unmet need, the principle of horizontal equity with respect to income was not violated for NHS secondary care during the first wave of the COVID-19 pandemic in the UK. 	
VA-ESP	<p>Johns et al, 2021 Connecting and connectivity: providing video consulting in care homes in Wales</p>	2021	Qualitative study (telephone interviews)	Published	<ul style="list-style-type: none"> • From 101 interviews, findings suggest that while care homes are responsive to video consulting (VC), there is a need for further awareness, better training and support for care home staff. • In total, 101 care homes were interviewed, of which 92% reported to be using VC • Interestingly, issues around connectivity, lack of equipment and technical literacy were highlighted as minimal barriers. VC should be encouraged as a long-term service to support the health and wellbeing of care home staff and residents. • Issues affecting access to VC, such as poor or no internet connectivity, a lack of available 	<p>Wales based study</p> <p>Technology Enabled Care (TEC) Cymru and the Welsh Government are making recommendations for the sustainable use of VC in care homes. Further work is looking at linking up care homes and a wider range of services, such as healthcare, social care and third sector agencies, to get the best out of VC in the future.</p>

					<p>resources/device or limited technological literacy of staff, all impact on the uptake of VC.</p> <p>Study Results:</p> <ul style="list-style-type: none"> • Overall, 71% of 84 respondents reported some initial difficulties with using VC with their residents. • A total of 45% of 86 respondents reported specific issues with devices and technology. The most common was relating to Wi-Fi and internet connectivity • 74% stated that they would use VC once COVID-19 had passed, although some stated that it would be used in specific circumstances or only when necessary • 48% of VC was conducted 	
VA-ESP	<p>Verhagen et al, 2020 Forecasting spatial, socioeconomic and demographic variation in COVID-19 health care demand in England and Wales https://doi.org/10.1186/s12916-020-01646-2</p>	2020	Quantitative study	Published	<ul style="list-style-type: none"> • Areas face disproportionate risks for COVID-19 hospitalization pressures due to their socioeconomic differences and the demographic composition of their populations. • The early outbreak of COVID-19 in the UK was concentrated in densely populated urban areas with larger groups of ethnic minorities such as London. As of early May, there were higher levels of hospitalization due to COVID-19 in the north-west of England, particularly in Manchester and Liverpool. 	<p>Study based in England and Wales</p> <p>This quantitative study investigated the demand on health care in England and Wales. Although the emphasis was on healthcare, the focus on demographics and access to healthcare in England and Wales, is also relevant to social care access and use.</p>

					<p>These areas have the highest levels of risk, including older populations, and higher rates of social deprivation and related comorbidities such as obesity and population density.</p> <ul style="list-style-type: none"> • Within Greater Manchester are some of the most deprived wards in Greater Manchester, having the highest levels of unemployment and lowest life expectancy. • The aggregated national average of 2.5 hospital beds in England and 3.3 hospital beds in Wales per 1000 is unequally distributed at both the Administrative Region and CCG level. • Specific pressure points where COVID-19 demand is likely to outstrip the baseline local supply were identified and included rural areas in Wales. • Hospital capacity is the highest in Cardiff and along the coast, which is logical since they also have the highest levels of population density. Yet it reveals a demographically vulnerable middle rural region of Wales, consisting of an ageing population that are simultaneously far away from hospitals and, in particular, from critical care provisions. • Identification potential health care pressure points in Wales where expected hospitalization rates are disproportionately high 	
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					and the per capita availability of hospital beds is relatively low (Rural Areas of Wales. Powys also named as being particularly troublesome).	
Social determinants of health inequalities						
PubMed Secondary research resources for (non-COVID-19) reviews	Alang, (2019), Mental health care among blacks in America: Confronting racism and constructing solutions . Health Serv Res. 2019;54(2):346-355. doi:10.1111/1475-6773.13115	2011 to 2015	Mixed method study	Published	<ul style="list-style-type: none"> Data from the 2011-2015 National Survey on Drug Use and Health were pooled to create an analytic sample of black adults with unmet mental health need (N = 1237). Qualitative data came from focus groups (N = 30) recruited through purposive sampling. Using sequential mixed methods, reasons for unmet need were regressed on sociodemographic, economic, and health characteristics of respondents. Higher education was associated with greater odds of reporting stigma and minimisation of symptoms as reasons for unmet need. The fear of discrimination based on race and on mental illness was exacerbated among college-educated black people. Racism causes mistrust in mental health service systems. <p>Participants expressed the importance of anti-racism education and community-driven practice in reducing unmet need.</p>	<p>USA based Study</p> <p>Describes reasons for unmet need for mental health care among black people, identifies factors associated with causes of unmet need, examines racism as a context of unmet need, and constructs ways to improve service use.</p> <p>The author concludes that mental health systems should confront racism and engage the historical and contemporary racial contexts within which black people experience mental health problems. Critical self-reflection at the individual level and racial equity analysis at the organisational level are critical.</p>
Lit Covid/ Cochrane	Barboza, M., Marttila, A., Burström, B. et al. Covid-	2021	Qualitative study	Published	<ul style="list-style-type: none"> Semi-structured interviews were carried out with 23 child health 	Swedish based study

<p>COVID-19 Study Register/L'O VE Primary Studies</p>	<p>19 and pathways to health inequities for families in a socioeconomically disadvantaged area of Sweden – qualitative analysis of home visitors' observations. Int J Equity Health 20, 215 (2021). https://doi.org/10.1186/s12939-021-01556-6</p>				<p>care nurses and parental advisors working in a home visiting programme.</p> <ul style="list-style-type: none"> • This study took place in an area of Stockholm, Sweden with high indications of socioeconomic disadvantage, a large part of the population with foreign background, as well as higher levels of poor health than the county average. • Living in a segregated society, covered the collective experience of lack of control on community level. The Covid-19 pandemic was observed to negatively affect all pathways and thus potentially aggravate health inequities for this population. • The pandemic has also limited the delivery of home visits to the families which creates further barriers in families' access to resources and increases isolation for parents with already limited social support. 	<p>The additional negative consequences of Covid-19 indicate the need for sustainable preventive early childhood interventions for families in such areas.</p> <p>Health inequities are already well understood, and that further research may contribute to increased labelling and stigmatisation of communities</p>
<p>PubMed Secondary research resources for (non-COVID-19) reviews</p>	<p>Carey et al (2019) Personalisation schemes in social care and inequality: review of the evidence and early theorising Int J Equity Health 18, 170 https://doi.org/10.1186/s12939-019-1075-2</p>	<p>1990-2017</p>	<p>Systematic review</p>	<p>Published</p>	<ul style="list-style-type: none"> • Examination of how different social groups benefit from personalisation schemes in social care and how this widens and entrenches social inequities, and – in turn – what can be done to mitigate this. • A range of factors were identified that were associated with better outcomes. These were: education, being employed, having capable networks and support, knowledge and skills in navigating complex systems, household income, 	<p>Studies found came from Europe, UK and Australia</p> <p>Personalisation schemes in social care: Individuals purchase services from a 'service market' using individual budgets or vouchers given to them by governments.</p> <p>Carey et al (2019) argue that personalisation schemes are likely</p>

					knowledge of where to access information and the capacity to self-manage individual budgets.	to be entrenching, and potentially expanding, social inequalities. Therefore, more attention needs to be given to this aspect of personal budgets by policymakers and researchers.
VA-ESP	<p>Gaynor & Wilson 2020, Social Vulnerability and Equity: The Disproportionate Impact of COVID-19 https://onlinelibrary.wiley.com/doi/10.1111/puar.13264</p>	2020	Viewpoint paper	Published	<ul style="list-style-type: none"> • A community's ability to respond to and recover from a disastrous event rests on social and economic resources. Being able to carry out the recommended practices to “flatten the curve” and slow the spread of COVID-19 requires individuals and communities’ access to the privileges that afford such a response. • Article discussed the disproportionately higher risk the black community in the USA faced during the COVID-19 pandemic. <p>Investigating Social Vulnerability and Black Deaths</p> <ul style="list-style-type: none"> • Indicators to social vulnerability in 2 counties (Cuyahoga, OH and Wayne County, MI) are highlighted below [these indicators highlight populations that are more susceptible to being most impacted by any disaster including a pandemic]. • Population over 65, Single Parent, Household with children under 18, Household structures with more than 10 units, Household with more people than rooms, Household with no 	<p>USA based viewpoint</p> <p>This viewpoint paper mentions the importance of communities in responding to the COVID-19 pandemic. The large proportion of informal and domiciliary care within the social care sector is highlighted</p> <p>The identification of social vulnerability indicators may allow for identification of most at risk populations in Wales and the disproportionately more difficult pandemic period they may have faced.</p>

					vehicle, Population below poverty line, Minorities.	
PubMed Secondary research resources for (non-COVID-19) reviews	Hunt et al, (2021), Perception of Unmet Need after Seeking Treatment for a Past Year Major Depressive Episode: Results from the 2018 National Survey of Drug Use and Health Psychiatr Q. doi: 10.1007/s11126-021-09913-y	2018	Cross-sectional study	Published	<ul style="list-style-type: none"> • Cross-sectionally compared two groups of individuals who both met criteria for a past year Major Depressive Episode (MDE) and sought mental health treatment. • One group reported an unmet treatment need and the other did not. • Results indicate a variety of personal identity and social factors associated with perceiving an unmet treatment need, including age, race/ethnicity, sexual attraction, marital status, poverty level, health insurance, substance misuse, global health, and role impairment. • This study found that, in general, individuals with a past year MDE from minoritized and socially marginalised groups, with co-occurring substance use disorders, or more impairment reported unmet treatment needs at higher rates than their counterparts. 	USA based study This cross-sectional study provides evidence of disparities in depression treatment at the consumer, provider, and systemic levels that have downstream effects for health equity policy and public health promotion.
PubMed Secondary research resources for (non-COVID-19) reviews	Kerpershoek et al, (2020), Is there equity in initial access to formal dementia care in Europe? The Andersen Model applied to the Actifcare cohort Int J Geriatr Psychiatry 35(1):45-52. doi:10.1002/gps.5213.	Not stated	Cohort study	Published	<ul style="list-style-type: none"> • A total of 451 People with middle-stage dementia and their informal carers from eight European countries were included. • No formal care at baseline. Expectation for people to start using formal care within the next year. • Logistic regressions were carried out with one of four clusters of service use as dependent variables (home social care, home personal care, day care, admission). 	Europe based study Predisposing, enabling, and need variables were investigated in his cohort study to find out whether there is equitable access to dementia-specific formal care services. Authors suggest that health care professionals should pay attention to predisposing factors such as region of residence, gender, and

					<ul style="list-style-type: none"> The most significant predictors for the different care clusters are disease severity, a higher sum of (un)met needs, hours spent on informal care, living alone, age, region of residence, and gender. The Andersen model provided for this cohort the insight that (besides need factors) the predisposing variables region of residence, gender, and age do play a role in finding access to care. <p>The number of hours spent on informal care, living alone, needs, and disease severity are also important predictors within the model's framework.</p>	age to ensure that they do not become barriers for those in need of care.
<p>PubMed</p> <p>Secondary research resources for (non-COVID-19) reviews</p>	<p>Rens et al, (2020), Unmet mental health needs in the general population: perspectives of Belgian health and social care professionals Int J Equity Health. doi: 10.1186/s12939-020-01287-0.</p>	<p>October 2019 to January 2020</p>	<p>Qualitative study</p>	<p>Published</p>	<ul style="list-style-type: none"> Four focus group discussions and two interviews with 34 participants were conducted Participants' professional backgrounds encompassed social work, mental health care and primary care in one rural and one urban primary care zone in Antwerp, Belgium. A topic guide was used to prompt discussions about which groups have high unmet mental health needs and why. <p>Themes that emerged:</p> <p>Socio-demographic determinants and disorder characteristics associated with unmet mental health needs; non-reimbursed psychotherapy is too expensive, while waiting times in reimbursed services are long. Professionals state that poverty hinders help-</p>	<p>Belgium based study</p> <p>This qualitative conducted in Belgium aimed to explore unmet mental health needs in the general population from the perspective of professionals working with vulnerable groups.</p> <p>Professionals believe that currently far too little is done about prevention, partly because the need for curative care is high and budgets and time are limited.</p>

					<p>seeking because mental health needs are subordinate to basic needs such as housing and food. Second, people with an ethnic minority background were seen as a hard-to-reach group for mental health care. Cultural differences in taboo and stigma and a lack of trust in professional care were identified as hindering factors for help-seeking in this group.</p> <p>(1) Demand-side barriers: professionals argued that many people with mental health issues do not perceive a need for mental health care. Taboo and stigma hinder people from disclosing mental health problems and seeking help.</p> <p>Supply-side barriers: underfinancing of mental health care resulting in the lack of structural resources was regularly mentioned as an important underlying factor for unmet mental health needs (UMHNs). Due to creativity of health care providers, local initiatives were installed, often financed by local organisations and authorities. This was particularly the case in the rural zone.</p>	
Other findings						
Grey Literature Google Search	The Economic Value of the Adult Social Care sector -Wales, Integrated Care Fund	2018	Report on the estimated economic value of the adult social	Published	<p>Sector characteristics</p> <ul style="list-style-type: none"> An estimated 2,070 sites were involved in providing adult social care in Wales in 2016. Most of these sites were provided nursing care. A further 1,700 individuals 	<ul style="list-style-type: none"> This economic report provides a useful overview of the baseline figures of Social Care sector in Wales pre-pandemic.

			care sector in Wales.		<p>receive direct payments and employ Personal Assistants (PAs)</p> <ul style="list-style-type: none"> • There were an estimated 79,800 jobs in the adult social care sector in Wales in 2016. Most of these jobs were involved in providing residential care. There were a further 3,600 jobs due to individuals employing PAs, meaning there were a total of 83,400 jobs in the adult social care sector in 2016 • There were an estimated 60,000 Full-Time Equivalent (FTEs) in the adult social care sector in Wales, and a further 1,600 FTEs employed as Pas • Most of the adult social care workforce providing regulated services were employed at sites run by private sector providers (44,500) • The level of employment in the adult social care sector represents 6% of total employment in Wales • The average earnings in the adult social care sector in Wales was estimated to be £16,900. <p>Economic value of the sector (using the income approach)</p> <ul style="list-style-type: none"> • It was estimated that in 2016, adult social care sector Gross Value Added (GVA) was £1.2 billion. Most of this was estimated to be in residential care (£328 million, 28%) • This represents 1.9% of total GVA in Wales • It was estimated that the average level of productivity (GVA generated per FTE) in the 	<ul style="list-style-type: none"> • This report contains information on all sectors of social care: residential, nursing and domiciliary. • Children’s social care is mentioned in the report, but it is not possible to disaggregate children’s social care from adult social care.
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					<p>adult social care sector was £18,700</p> <ul style="list-style-type: none"> The estimated GVA in the adult social care sector in Wales is estimated to be higher than the Agriculture, forestry and fishing, Arts, entertainment and recreation and Water supply; sewerage and waste management sectors <p>Indirect and induced value of the sector (using the income approach)</p> <ul style="list-style-type: none"> The indirect effect of the adult social care sector (resulting from the purchase of intermediate goods and services by the adult social care sector in delivering its services) was estimated to contribute a further 31,200 jobs (23,000 FTEs) and £554 million of GVA to the Welsh economy The induced effect of the adult social care sector (resulting from purchases made by those directly and indirectly employed in the adult social care sector) was estimated to contribute a further 12,200 jobs (9,000 FTEs) and £543 million of GVA to the Welsh economy The total direct, indirect and induced value of the adult social care sector in Wales was estimated to be 126,800 jobs - (93,600 FTEs) and £2.2 billion in 2016. 	
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Abbreviations: **CCG** - Clinical Commissioning Groups, **CF** - Cystic Fibrosis, **F2F** - Face to Face, **FTE** – Full Time Equivalent, **GVA** - Gross Value Added, **IiC** – Investors in carers, **IT** - Information Technology, **LTCS** – Long-term care services, **MDE** - Major Depressive Episode, **NSDUH** - National Survey of Drug Use and Health, **PA** – Personal Assistant, **TEC Cymru** - Training and Educational Consultancy, **UKHLS** UK Household Longitudinal Study, **UMHNS** – unmet mental health needs, **VC** Video Consulting, **VVWS** – Volunteer Village Wardens.

10. Acknowledgements

The WCEC would like to thank Jon Day and Lisa Trigg of Social Care Wales for their guidance and expertise during the formulation of the research question, and contributions during stakeholder meetings.

11. About the Wales COVID-19 Evidence Centre (WCEC)

The WCEC integrates with worldwide efforts to synthesise and mobilise knowledge from research.

We operate with a core team as part of [Health and Care Research Wales](#), are hosted in the [Wales Centre for Primary and Emergency Care Research \(PRIME\)](#), and are led by [Professor Adrian Edwards of Cardiff University](#).

The core team of the centre works closely with collaborating partners in [Health Technology Wales](#), [Wales Centre for Evidence-Based Care](#), [Specialist Unit for Review Evidence centre](#), [SAIL Databank](#), [Bangor Institute for Health & Medical Research/ Health and Care Economics Cymru](#), and the [Public Health Wales Observatory](#).

Together we aim to provide around 50 reviews per year, answering the priority questions for policy and practice in Wales as we meet the demands of the pandemic and its impacts.

Director:

Professor Adrian Edwards

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Website: <https://healthandcareresearchwales.org/about-research-community/wales-covid-19-evidence-centre>

All reports can be downloaded from our library:

<https://healthandcareresearchwales.org/wales-covid-19-evidence-centre-report-library>

12. APPENDIX – Resources searched during Rapid Evidence Summary

A single list of resources has been developed for guiding and documenting the sources searched as part of Rapid Evidence Summary. Where relevant, all 'priority resources' will be searched, but not all resources will be searched. Some sources will be searched as part of the subsequent Rapid Review (or Rapid Evidence Map).

Each resource will be recorded as being:

- *searched; nothing found*
- *searched; results found*
- *not searched; not relevant*
- *not searched, maybe relevant*

Resource	Success or relevancy the retrieval
Priority COVID resources for reviews	
Cochrane COVID Review Bank https://covidreviews.cochrane.org/search/site	Searched, results found
WHO Global Coronavirus Database https://search.bvsalud.org/global-literature-on-novel-coronavirus-2019-ncov/	Searched, results found
L*OVE – COVID-19 https://app.iloveevidence.com/loves/5e6fdb9669c00e4ac072701d?population=5e7fce7e3d05156b5f5e032a&classification=systematic-review	Searched, results found
VA-ESP https://www.covid19reviews.org/index.cfm	Searched, results found
Additional COVID resources for reviews <i>(Tailor the list according to the topic and potential evidence base. In some cases, it may be preferable to scan the main (generic) source rather than COVID-19 specific product; listed under secondary research)</i>	
LitCovid https://www.ncbi.nlm.nih.gov/research/coronavirus/	Searched, results found
Rolling collaborative review of Covid-19 treatments - Eunethta (Not a searchable database but a list of living reviews) https://eunethta.eu/covid-19-treatment/	Not searched, maybe relevant
EPPI-Centre - Living map of the evidence of studies on COVID-19 identified in MEDLINE and EMBASE, that groups the evidence into broad themes https://eppi.ioe.ac.uk/eppi-vis/Review/Index	Searched, results found
For technology / treatment questions	
International HTA database (ITS-HTA) (for technology questions only) https://database.inahta.org/	Not searched, not relevant
EUnetHTA – COVID 19 response (not a searchable database but a list of evidence covering diagnostics and treatments) https://eunethta.eu/services/covid-19/	Not searched, not relevant
For topic specific / focused review questions	

<p>COVID-END– Evidence summaries (McMaster Health Forum) (Incorporates multiple COVID-19 resources, including many listed here. May be useful for topic specific/focused questions; may not be useful for border questions) https://www.mcmasterforum.org/networks/covid-end</p>	Not searched, not relevant
<p>COVID-19 Evidence Alerts from McMaster PLUS™ Usefulness dependent on topic; may not be user friendly for broad/complicated questions https://plus.mcmaster.ca/COVID-19/</p>	Searched, nothing found
<p>Additional COVID resources for primary studies</p>	
<p>L*OVE primary studies https://app.iloveevidence.com/loves/5e6fdb9669c00e4ac072701d?population=5e7fce7e3d05156b5f5e032a&classification=primary-study</p>	Searched, results found
<p>Cochrane COVID-19 Study Register https://covid-19.cochrane.org/</p>	Searched, results found
<p>LitCovid https://www.ncbi.nlm.nih.gov/research/coronavirus/</p>	Searched, results found
<p>Secondary resources for reviews relevant to local/UK context</p>	
<p>United Kingdom Health Security Agency's (UKHSA's) COVID-19 Rapid Reviews https://ukhsalibrary.koha-ptfs.co.uk/covid19rapidreviews/</p>	Searched, nothing found
<p>NICE resources for COVID reviews Any queries regarding ongoing or planned reviews contact Chris Connell: Chris.Connell@nice.org.uk</p>	Searched, nothing found
<p>Healthcare Improvement Scotland – COVID-19: Evidence for Scotland (not a searchable database but a lists Once for Scotland guidance, rapid evidence reviews, NICE rapid guidelines evidence covering diagnostics and treatments) http://www.healthcareimprovementscotland.org/our_work/coronavirus_covid-19/evidence_for_scotland.aspx</p>	Searched, nothing found
<p>Ireland, HSE Library, Covid-19 Summaries of Evidence not a searchable database but a list of all summaries of evidence that HIQA have been asked to address) https://hselibrary.ie/covid19-evidence-summaries/</p>	Searched, nothing found
<p>HIQA Health Information and Quality Authority (Ireland) – Rapid reviews https://www.hiqa.ie/reports-and-publications/health-technology-assessment/rapid-review-public-health-guidance</p>	Searched, nothing found
<p>SAGE https://www.gov.uk/government/organisations/scientific-advisory-group-for-emergencies</p>	Searched, nothing found
<p>Secondary resources for reviews produced by key international organisations</p>	
<p>NCCMT COVID-19 rapid reviews (Canada): https://www.nccmt.ca/covid-19/covid-19-rapid-evidence-service</p>	Not searched, not relevant
<p>ECDC European Centre for Disease Prevention and Control (COVID-19 outputs) https://www.ecdc.europa.eu/en/publications-data</p>	Not searched, not relevant

CDC centre for Disease Control and Prevention - Guidance for COVID-19 (US) https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance.html	Not searched, not relevant
AHRQ Agency for Healthcare Research and Quality (US) https://www.ahrq.gov/coronavirus/health-systems-research.html	Not searched, not relevant
NASEM The National Academy of Sciences Engineering Medicine - Coronavirus Resources Collection (US) https://www.nap.edu/collection/94/coronavirus-resources	Not searched, not relevant
Australian National COVID-19 Clinical Evidence Task Force - Living Guidelines; mainly treatment https://covid19evidence.net.au/ (also incorporated in Trip)	Not searched, not relevant
Secondary research resources for (non-COVID-19) reviews (Tailor the list according to the topic and potential evidence base, talk to stakeholder before proceeding with this type of search)	
Trip (Trip Pro can be accessed by an institutional based subscription based via institution, otherwise use Trip) https://labs2020.tripdatabase.com/ Link to search for COVID-19 related research: https://www.tripdatabase.com/search?criteria=%22covid+19%22+OR+%22novel+coronavirus%22 (As a covid resource for guidelines - add an additional COVID search term and filter by UK guidelines, covers NICE, and SIGN. Can also filter for non-UK guidance)	Not searched, not relevant
Cochrane Database of Systematic Reviews (CDSR) https://www.cochranelibrary.com/cdsr/reviews	Not searched, not relevant
Campbell Collaboration https://www.campbellcollaboration.org/better-evidence.html	Not searched, not relevant
JBI (via OVID) (Subscription based service – WCEBC has a subscription)	Searched, results found
Epistemonikos https://www.epistemonikos.org/en/advanced_search	Not searched, not relevant
PROSPERO https://www.crd.york.ac.uk/prospero/	Not searched, not relevant
Pubmed Clinical Queries https://pubmed.ncbi.nlm.nih.gov/clinical/	Not searched, not relevant
PubMed Filter by systematic reviews, reviews or meta-analysis once search undertaken https://pubmed.ncbi.nlm.nih.gov/	Searched, results found
Additional resources searched	
Google Advanced Search https://www.google.co.uk/advanced_search	Searched, results found